

## Consultation – Solidarity, Equity and the Global COVID-19 Experience

8 September 2021, 15:00-17:00 CEST

### Summary of Roundtable

The response to COVID-19—and in particular the distribution of countermeasures, such as vaccines—has been starkly unequal. Although solidarity has become a mantra, the global community has largely failed to take meaningful action, with nationalism, weak leadership and governance, the limitations of the multilateral system and systemic inequities to this failure.

To better understand the systemic causes of these inequities, and chart a concrete, actionable path forward to improve equity and solidarity in the global health emergency ecosystem, the GPMB hosted a roundtable on Equity, Solidarity and the COVID-19 Experience, the findings of which will form the basis for the GPMB 2021 Report.

As background to these discussions, the GPMB secretariat commissioned a short background document summarising aspects of inequity in the COVID-19 response and invited several civil society organizations (CSOs) to provide written contributions. CSOs that submitted responses were: ACT-Accelerator Civil Society Representatives; CIVICUS; Drugs for Neglected Diseases initiative (DNDi); Médecins Sans Frontières (MSF) Access Campaign; People's Health Movement; and Third World Network. A summary of their contributions was also provided as background.

The roundtable was chaired by Elhadj As Sy and included guest participants, Ayoade Olatunbosun-Alakija, Jim Yong Kim, Mbulawa Mugabe, Reema Nanavati, Livingstone Sewanyana, and Michel Sidibé, and Board members (see Annex for list of participants).

### Session format

Guest speakers were asked to provide short opening comments on the following guiding questions, followed by discussion and questions from Board members. At the end of the session, guests providing concluding priorities and remarking.

#### **Guiding questions**

##### **Inequities in the global COVID-19 response**

*Where has the global response to COVID-19 succeeded and/or failed in delivering equity?*

##### **Getting to the roots of inequity**

*What are the root causes for these successes/failures?*

##### **Moving from inequity to equity**

*What concrete steps are needed to improve the global health emergency preparedness ecosystem so that the response to the next pandemic is more equitable?*

## Summary of Discussion

### 1: Inequities in the global COVID-19 response

*Where has the global response to COVID-19 succeeded and/or failed in delivering equity?*

#### **Failings**

- The global response to COVID-19 has overwhelmingly been inequitable. A person's nationality and position in society, not equity, has determined access to vaccines and treatment for COVID-19. Several roundtable participants had had been seriously ill themselves or had witnessed colleagues and loved ones endure and sometimes succumb to COVID-19; the impact of this inequity was felt personally and profoundly.
- The response of individual countries has been varied and often chaotic. In many countries, leaders have exploited the pandemic to place restrictions on citizens.
- The rollout of vaccines during COVID-19 has been neither equitable nor adequately planned. Less than 3% of world's vaccines have been administered in Africa. Many people in Africa won't be vaccinated until 2024, increasing the risks of spread of variants to the detriment of all. African countries are paying the highest prices in the world for vaccines.
- Vaccine access has been the paradigmatic failing of the global COVID-19 response. However, there has also been unequal access to treatment, including oxygen, and high-quality care. Access to quality information has been inequitable, contributing to vaccine hesitancy..
- Where poorer countries have gained better access to medical countermeasures, this has often been through regional supply (for instance Australian/New Zealand supplies to Fiji) rather than through the global system
- Countries participating in COVID-19 clinical trials should benefit early from treatments developed from them, yet this has not been the case in South Africa. COVID-19 is not just as a health equity crisis, but a much wider care, economic, a human security crisis which that has exacerbated multiple forms of inequity. Rich countries in the global north have bounced back from it, while poorer countries cannot. Rural areas have been especially vulnerable, with healthcare workers concentrated in urban areas.
- COVID-19 has impacted upon the most vulnerable, including women, children, elders and migrants. Women in the informal economy have lost employment, access to food and have needed to care for children and the sick. Mental health problems are greatest among vulnerable people. Reduced access to food/clean water are other forms of inequity experienced during the pandemic.
- There is a crisis for young people arising from COVID-19 that could affect countries' political stability in the longer term. 1.9 billion children have been out of school.

#### **Strengths**

- Scientific advancements had been the strength of the pandemic, notably the preparatory work on vaccines which enabled rapid and effective COVID-19 development, and the development of mRNA vaccines. This work has paid off in speed of development, but not in equitable access.

### 2. Getting to the roots of inequity

*What are the root causes for these successes/failures?*

#### **The human element**

- Selfishness, greed in exploiting COVID-19 for financial gain, and an unwillingness of sovereign states to collaborate and share resources are all reasons for the failure to deliver an equitable

response. Overall, the private sector appears to have pursued a profit-first model. These factors indicate a need for binding rules of engagement.

- Leadership – or more often the lack of leadership – have been a root cause of failures and inequity during COVID-19. This phenomenon has been seen before in preparedness, notably at the start of the HIV/AIDS crisis, when gaining the engagement of political leaders, notably in Africa, was a key determinant of effective response.
- Community engagement had been overlooked in vaccine rollout and the medicalized approach to COVID-19. For stability, communities need to own their response.

#### **Governance and the global health architecture**

- Lack of effective governance has been a key underlying cause of failure in the COVID-19 response. Health security and health diplomacy were highly disconnected; and different actors were not working effectively together. Governance can be strengthened with adoption of treaty.
- The response has raised questions about the sufficiency of the global health architecture. It was not clear when and how countries would collaborate with WHO, and the initial distancing of the US from WHO was particularly damaging. We need to revisit and renew multilateralism.

#### **Poor funding of health security**

- The dramatic underfunding of WHO, and of local and regional public health facilities, (including in rich countries) has contributed to the failed COVID-19 response.
- In Africa, some countries have lacked mechanisms to distribute vaccines, even where they were available, and have heavily underinvested in health systems.

#### **Living situations of poor people and how these relate to preparedness and response**

- Physical distancing and hygiene are often at odds with the realities of the lives of the poor, who often live in cramped accommodation, and have limited access to clean water.
- Urban economies often include poor, informal-sector workers in slum and low-income settlements. These workers have been left out of protection, preparedness, access to healthcare and vaccination. Their fragmented, insecure labour and economy leaves them without access the minimum basic income that is essential to ensure for pandemic response.
- Many vaccines that have been developed are not sufficiently stable to deliver in rural settings.

#### **Resource inequalities underpinning inequity**

- Science infrastructure – or the lack of it – has been a key determinant of inequity, with countries with a preexisting infrastructure much better equipped than those without.
- Inequalities in digital access have fuelled inequity during COVID-19, determining whether you can sustain a job and an income in isolation, and whether children have access to education during lockdowns. The way that vaccines are rolled out are often dependent on a digital system, which may not be available to people in rural areas.

#### **Impediments to equity in R&D, manufacturing and public health systems**

- All too frequently, the public health community has lacked ambition, abandoning intensive public health measures for surveillance, test and trace well before time, including in high-income settings.
- The geographic concentration of R&D and manufacturing has left the world vulnerable to export bans introduced by countries during COVID-19

### **3. Moving from inequity to equity**

*What concrete steps are needed to improve the global health emergency preparedness ecosystem so that the response to the next pandemic is more equitable?*

## **Governance and leadership**

- Governance is a fundamental weakness that needs to be resolved. Future governance needs to better anticipate and pre-empt the challenges experienced in the current pandemic, including the election of nationalists to powerful stakeholder governments. How can we make a global governance system more robust in the face of such an eventuality?
- Strong leadership is essential for pandemic response – both political leadership and technical leadership

## **Financing**

- The world needs a global emergency fund for pandemics and WHO needs to be appropriately funded to fulfil its mandate. There were different suggestions regarding how funding might be achieved: including WHO assessed voluntary contributions, and funding from parts of the private sector which have experienced enormous losses in pandemics, and are therefore amenable to supporting global health security.

## **Country responses**

- The global health community and other actors need to urgently make the case that health is an investment rather than an expenditure to country leaders. Some LMICS (including in Africa) heavily underinvest in health relative to other expenditure. These countries need to commit to investment in robust health systems and regulation as part of a move towards increased self-sufficiency of healthcare systems.
- A stronger community focus needs to be built within the architecture of pandemic preparedness with an outreach approach, health-workers going into communities, a central focus on primary healthcare.

## **IP transfer and localisation of production**

- There is an urgent need to focus on building manufacturing capacity in LMICS, especially Africa. Without localised production, barriers to access will remain. Localised R&D and manufacturing are essential not only for response to novel threats, but to combat longstanding diseases concentrated within LMICS, notably malaria.
- Removing IP barriers to localised production (while supporting protections around R&D that enabled the development of new drugs) is an essential part of this. Compulsory licensing, sign-up to the TRIPS waiver, generic licensing of drugs developed largely by public funds are ways to achieve it. Experience during HIV/AIDS, including WHO pre-qualification, pre-testing of facilities, could support this.
- Current efforts to organise health resources and create regional hubs of excellence (such as through the African CDC) will greatly support these efforts, combatting fake medicines and simplifying the system.

## **Multisectoral engagement**

- The global health system, including WHO, needs to work better with the private sector – despite private sector shortcomings, power “is where it is”. Effective multisectoral communications, making the case for preparedness to these sectors, is essential.
- We share a common goal of preventing and responding effectively to pandemics with those parts of the private sector that have been decimated by its consequences (e.g. airlines and airports). These can be key players in advocacy and funding: a \$50 billion, expert-managed emergency fund was one suggestion.

## Harness technology

- We need to better leverage scientific and technological advancements to deliver equity. For instance, future technology can help to support vaccine production in Africa. Technological and platforms that work against us – for instead, the spread of misinformation on social channels – could be leveraged to work for us, in getting good quality information on preparedness to citizens and communities.

## 4: Closing thoughts on building a more equitable future

- Focus on order, inclusion and the participation of all stakeholders. Strengthened governance is essential, notably a treaty on preparedness
- The inequities we have seen are not fundamentally an issue of resource constraints but of resource allocation, and a sense of care and morality.
- Invest in the foundations of health for all. We must strengthen health systems, including in the global south. Engage African leaders in health, and communicate to all leaders that health is an investment, not an expenditure.
- We need a Summit of Heads of State at the UN General Assembly
- COVID-19 is leading to uprisings, as young people have been driven into insecurity by the pandemic. Africa is a young continent: build consideration of these political consequences of pandemics into the preparedness agenda
- Focus on building women's/feminist leadership, to build a sustainable economy based on nurturing, community and family.
- Connect the dots – build relationships between the underfunded global health infrastructure and the rich private sector that stands to benefit from global health security. Leverage the private sector to put pressure on pharma for equitable licensing that will ultimately get business back on track. Consider innovative funding models (notably forms of holding capital in reserve) that could meet global health security needs
- Build a \$50 billion fund, but do not privatise global health. Build funding mechanisms that can reach and replenish the nano and micro sector.

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## Annex: Roundtable Participants

### Chair

- Elhadj As Sy (GPMB Co-chair)

### Guests

- Ayoade Olatunbosun-Alakija, Co-Chair of the Africa Union Africa Vaccine Delivery Alliance for COVID-19 (AVDA)
- Jim Yong Kim, 12th President of the World Bank Group (2012-2019).
- Mbulawa Mugabe, UNAIDS Special Advisor for Pandemic Preparedness.
- Reema Nanavati, Director of the Self Employed Women's Association's (SEWA) of India
- Livingstone Sewanyana, Independent Expert on the promotion of a democratic and equitable international order, Office of the High Commissioner on Human Rights.
- Michel Sidibé, African Union's special envoy for the African Medicines Agency.

### GPMB Members

- Dr Chris Elias
- Dr Daniel Ngamije