Vaccine Access & Global Health Working Group Statement

To the G20 1st Health Ministerial Meeting
20th June 2022, Yogyakarta, Indonesia

As the C20 Vaccine Access and Global Health Working Group (VAHWG)
1, we have the overarching goal of the Right to Health for all encompassing people-centred Universal Health Coverage (UHC). The health and well-being of people through rights-based, intergenerationally-inclusive and gender-transformative approaches are essential for evidence-based, economically beneficial and sustainable solutions inclusive of sexual reproductive health and rights and gender medicine through mechanisms/processes that are transparent and accountable for equitable health policies and solutions.

We put vulnerable groups
2, marginalised communities
3 and key populations
4 at the centre of global health strategies and responses, including ensuring the meaningful and inclusive participation of community-based and -led, and civil society organisations in all levels of political, decision-making, implementation and monitoring processes in achieving UHC for all.

The C20 VAHWG have the following key asks submits the following points ahead of the G20 1st Health Ministerial Meeting in Yogyakarta, 20 June 2022.

1. Strengthening Global Health Architecture, through Building Global Health Resilience and Mutual Recognition for International Mobility, and Manufacturing Hub & Research

We acknowledge the important role the G20 plays as the 20 largest economies of the world, making up approximately two-thirds of the world’s total population, more than 80% of global GDP and over 75% of global trade. However, we emphasise that any legitimate decisions that influence and impact the global community should be made inclusively to not deepen existing fault lines and widen gaps in expected recovery pathways. Therefore, recommendations and decisions that impact the global community (including strengthening the global health architecture) needs to be done inclusively with all member states and territories; as well as meaningfully engage communities and civil society.

A. Building Global Health Resilience

The C20 VAHWG submits the following recommendations/asks:

i. Principles: We call on G20 countries to align with the central, transformative promise of the 2030 Agenda for Sustainable Development Goals (SDGs) to leave no one behind. To achieve this, the FIF must:
   a. Focus on addressing existing inequalities to prevent future pandemics by prioritising rights based, transformative and people-centred approaches – focusing on equity and equitable access, technology co-creation and knowledge transfer, as well as creating larger ecosystems for developing, producing and delivering supplies.
   b. Ensure clear timelines for operationalisation, with in-depth engagement and regular consultations with donors, implementing governments, communities and civil society (as equal decision-makers) for the selection of implementers, modalities for access to funding, and implementation and monitoring and evaluation.

ii. Governance:

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1 The C20 VAHWG is one of the thematic working groups of the C20, a formal engagement group of the G20.
2 Vulnerable groups as specified in the 2030 Agenda include children, youth, persons with disabilities, people living with HIV (PLHIV), older persons, indigenous peoples, refugees, internally displaced persons, and migrants.
3 Including peoples impacted by war, conflict, terrorist insurgency, and political unrest.
4 This includes communities who are excluded from mainstream social, economic, educational, and/or cultural life.
5 Key populations are defined according to WHO as people who inject drugs, men who have sex with men, transgender people, sex workers and people in prisons and other closed settings.
a. **Representation for decision-making must be set up, co-created and grounded in equity and inclusion and ensure greater parity with strong representation from countries from LICs and LMICs, as well as communities and civil society.** All representatives should have equal decision-making power in decision-making processes and governance structures of the FIF to ensure that projects are truly country driven and meet the unmet needs of the population rather than the priorities of donor countries.

b. **Formal accountability and transparency mechanisms must be built into its governance structure, particularly on its engagement with pharmaceutical companies.** Transparency, in terms of spending, producer contracts as well as decision-making, is fundamental for accountability and effectiveness. This encompasses aspects of the real cost of research and development (R&D), public contribution, pricing and patents.

iii. **Learning from the Past and Building on Existing Mechanisms:** Key lessons must be drawn from challenges related to the implementation of the Pandemic Emergency Financing Facility (PEF) of the World Bank so that costly mistakes are never repeated. In addition, the G20 has to build on existing responses, infrastructures and lessons learned from HIV, tuberculosis (TB), malaria and COVID-19 – including institutions/mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the ACT-A.

iv. **Scope:**

a. **In supporting health resilience, it is important not to silo PPR for a single unknown disease that we are unable to foresee its occurrence, but to take the opportunity to ensure that we broaden the scope to ensure that responses can support not only unforeseeable pandemics but respond to existing ones.** The FIF should avoid the narrowly defined focus concerned with ‘security threats’ in ‘pandemics’ and include existing epidemics such as HIV, TB, malaria; antimicrobial resistance (AMR); noncommunicable diseases; and climate sensitive diseases – such as neglected tropical diseases (NTDs) and emerging infectious disease threats. The infrastructure needed for pandemics must be robustly supported and strengthened during intra-crisis times to both deliver necessary services, as well as to prevent, prepare for and respond to pandemics. An appropriately broad scope will help ensure a disruption in the cycle of panic and neglect for pandemics in which there is a surge of attention and investment during a crisis followed by years (or even decades) of inaction when a threat is perceived to have subsided in certain regions or globally – leading to innovation and manufacturing capacity left idle.

b. **The FIF should support the mutualization of resources, where appropriate, so that they can be optimised and used for existing public health priorities.** This should include financing for strengthening health infrastructure, human resources for health, and service delivery to address new pandemics, existing epidemics, and pandemic-prone diseases at all levels of the health system, including at the primary care level.

c. **Community responses and systems should be recognised and financed as core components of an effective response to preventing, detecting, monitoring and responding to pandemics in strategic partnership with formal health systems at all levels.**

v. **Investment in R&D:** We must avoid the equity failures that are we still facing two years into COVID-19 and ensure that we have sustained and proactive investments in research, development, and delivery of medical countermeasures that are critical to responding effectively to the medical needs of the most vulnerable. This investment must also be sustainable and predictable, with clear priority given to open approaches and areas most likely to be neglected by the market.

vi. **Funding:** We refer to the recommendation made in “A Global Deal for our Pandemic Age” a June 2021 report of the G20 High Level Independent Panel on Financing the Global Commons for PPR with a clear recommendation that states clearly that the investments for international financing for PPR “must add to, and not substitute for, existing support to advance global public health and development goals”. As such, contributions towards the FIF should be
benchmarked, for example meeting 0.7% targets for ODA. We encourage that replenishment cycles of global health and financing institutions be set in the broader health development landscape and part of the Global Health Architecture discussions to ensure that priorities are aligned and to reduce competition between institutions.

While a global repository for health threat pathogens is needed, the C20 VAHWG cautions about the risks of creating a single point of failure. We call for an infrastructure that recognises equity, is ethical and can be publicly accountable and transparent for quality data and further request for clarity on the principles for data sharing that will guide the work of GISAID+ to be developed jointly with meaningful engagement of communities and civil society, as well as more information on data governance, oversight and transparency of decision making on this platform.

PPR is an essential component of a resilient and sustainable system for health (RSSH) and in this context, external financing cannot be silo-ed in its approach/mechanisms and fragmented across different funding mechanisms with additional application/reporting mechanisms. To ensure availability and timely accessibility of lifesaving medical tools during pandemics, R&D for new health tools should be diversified and its inclusion should be within the scope of any financing mechanism.

A key building block for any pandemic response to prepare for future pandemics is recognising, investing in, and utilising community systems and responses for health, as we have witnessed in HIV responses – including informal avenues of community monitoring and data collection. COVID-19 has exacerbated and veered country responses off-track for specific SDG targets – including SDG 3.3 to end the epidemics of HIV, TB and malaria. To be able to understand the impacts of a strengthened PPR mechanism, we must ensure that we monitor policies and data availability – including sex and gender-disaggregated data through ethical, regulatory and licensing pathways that pay attention to gender implications on the safety, efficacy and effectiveness, availability, accessibility and quality of all health commodities provided for during an emergency.

B. Harmonising Global Health Protocol Standards

In Implementing Global Health Protocol Standards for COVID-19 and for future pandemics, we stress the importance of ensuring that communities and civil society are meaningfully included in different processes of the possible development, implementation and evaluation processes in the usage of the Universal Verifier and further related standards that are planned to be gradually implemented in other countries given the potential impacts of travel restrictions which were experienced by a vast majority of People Living with HIV (PLHIV), and are still being experienced by TB affected communities.

We note the unequal distribution of vaccine access that have disadvantaged peoples in LICs and LMICs, this is especially evident with donor countries only acknowledging certain vaccines produced by specific countries even though many LICs and LMICs had to distribute and use non-MRNA vaccines to their populations due to the lack of access and that a PCR test is still a requirement to enter some countries if the traveller happened to have been vaccinated with the ‘wrong’ vaccines due to the lack of access.

In terms of the details of harmonising global health protocol standards, we stress the need for all countries to have the systems programmes and policies that need to be in place around the collection, storage, sharing and processing of data. To improve the operability between health information systems for international travel, inter-country agreements are needed on key issues including (1) data formats; (2) data fields; (3) data storage; (4) law enforcement access to policy data; and (5) technical standards that support data format and data fields.

We highlight the lack of intercountry policies and standards for data collection and use that must be agreed on to ensure the protection of individual privacy and data confidentiality whilst maximising the public health benefits of data.

With COVID-19, we have seen the digitalisation chasm that divides the global north and south, and even within countries in accessing digital devices, services and connectivity, especially for the poor,

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6 Building on pre-existing HIV infrastructure for monitoring and response, such as surveillance sites created by the HIV response that was used during COVID-19 – https://gh.bmj.com/content/6/12/e007980
marginalised and elderly and in under-developed, least developed and developing countries. This means that the usage of the Universal Verifier must not discriminate and accommodate conditions experienced by countries with specialised needs and solutions that support (human, financial and technical) must be accorded by developed G20 countries and beyond to ensure its interoperability.

C. Expanding Global Manufacturing and Research Hubs for Pandemic Prevention, Preparedness and Response

The C20 VAHWG expresses its immense disappointment at the outcomes of the recently concluded WTO MC-12 which resulted in a watered-down waiver of the TRIPS agreement related to the exports of vaccines which does little to keep up with the momentum from the Rome Declaration Principles endorsed by G20 leaders and committed to:

- The importance of open, resilient, diversified, secure, efficient and reliable global supply chains across the whole value chain related to health emergencies, including the raw materials to produce vaccines, and for the manufacturing of and access to medicines, diagnostic, tools, medical equipment, non-pharmaceutical goods, and raw materials to address public health emergencies.
- Support low- and middle-income countries to build expertise, and develop local and regional manufacturing capacities for tools, including by building on COVAX efforts, with a view to developing improved global, regional and local manufacturing, handling and distribution capacities.

This comes after two years into a pandemic that has killed 15 million people and twenty months after South Africa and India proposed a broad waiver of the TRIPS agreement covering COVID-19 vaccines, tests and treatments and the “compromise” while largely reiterates developing countries’ existing rights to override patents in certain circumstances, also tries to restrict even the limited right to countries which do not already have capacity to produce COVID-19 vaccines and presents new barriers that were not in the original TRIPS agree agreement text.

We note the increasing privatisation of state responsibility to ensure access as well as the reliance on market dynamics to deliver access (particularly in times of pandemics) threatens the realisation of universal and equitable access to medical tools for all as a fundamental right. This dilutes the obligations of states to ensure the rights through international cooperation and fails to recognise the need for concrete and enforceable mechanisms to ensure all lifesaving medical technologies are developed, produced and provided as global public goods in emergencies.

The C20 VAHWG calls on the G20 to fulfil its obligations towards its commitments to achieve the 2030 Agenda by putting lives before profits and take every step necessary to save lives and end the pandemic:

- In global health emergencies, health tools and countermeasures are global public goods, and must be free of intellectual property rights restrictions. Legal rights to control knowledge can act as a barrier, both to research and to large-scale production of affordable health technologies.
- The manufacturing capacity in LMICs need to be bolstered through open sharing of research data, knowledge, and technology on a non-exclusive basis, enabling adequate production scale-up to ensure sufficient supply, equitable allocation, and affordability.


The C20 VAHWG supports the G20 presidency in strengthening the multilateral support in fulfilling 2030 targets for TB and calls for the long-term domestic financing of health systems to be addressed immediately, including the addressing of issues such as debt restructuring and introducing/implementing progressive taxation 7 to increase the fiscal space needed for sustainability. We note that while blended financing may be introduced, we note the restricted space

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7 Committed at the High-level Meeting on Universal Health Coverage in 2019, paragraph 35.
accounted to communities and civil society in many of these innovative financial tools. In addition, PPR is within the remit and overall goal towards the attainment of resilient global, regional and national public health ecosystems. As such, we stress the importance for countries to be supported to achieve the minimum target of 5% of GDP for public spending on health\(^8\) to reduce out-of-pocket health spending, and at the same time for donors to step up and meet their 0.7% target\(^9\) for ODA. This is essential for complementary efforts by domestic sources.

We note the importance of integrating mental health care services into all TB programmes to maximise the impact against TB. Individuals with mental disorders have a 4 times greater risk for any negative TB outcome; and for people with TB, those suffering from depression are three times more likely to die. Research shows that alcohol use disorders are linked to 10% of all TB infections. People living with TB have higher rates of common mental health conditions including depression, which adversely affects treatment adherence. Without addressing mental health and substance use problems, an effective response to TB will remain elusive. As the largest financier for TB, the Global Fund provides 77% of all international financing for TB and the G20 must support its upcoming Seventh Replenishment to achieve its minimum goal of at least US$18 billion. If the world is serious about its commitments towards HIV, TB, malaria and achieving its 2030 goals.

The G20 should mobilise resources sufficient to ensure all nations have robust, always-active zoonosis and pandemic preparedness systems, as well as rapid response, containment, and tracing capabilities. All of this should be supported by an underlying system of distributed, up-to-date medical services facilities including health and nutrition centres aimed at reducing the incidence of diet-related non-communicable diseases. The sustainable development, quality of life, and productivity benefits of such systems warrant the investments as everyday resilience-building measures, creating more solid foundations for sustainable peace and health security. The G20 nations should mobilize sufficient resources to facilitate the development of these systems, while accounting for the role played by nature-positive investments in restoring ecosystems, cleaning watersheds, and reducing the risk of novel pathogen spill over. One Health—including climate-related trends and (economy-shaping) macro critical forces—should be used as an integrated approach to reducing risk and creating conditions for climate resilient development, fiscal resilience, and PPR. Countries must be able to share data with each other, with implementation of common standards around the type of surveillance data that is collected. As such, interoperable and open-source systems that are non-proprietary and inclusive of digital and non-digital systems are essential to ensure that developing countries have access to training and technologies to build and strengthen infrastructure needed. In addition, the global pooling of resources must be done in collaboration with the Quadripartite Alliance on One Health to ensure that animal health infrastructure is included, including animal health professionals.

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\(^8\) Committed at the High-level Meeting on Universal Health Coverage in 2019, paragraph 34.
\(^9\) The OECD-DAC 0.7% ODA/GNI Target (accessed 25th March 2020).