Vaccine Access & Global Health Working Group Statement

To the 2nd G20 Health Working Group Meeting
6 & 7 June 2022, Lombok, 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 groups²,³, marginalised communities⁴ and key populations⁵ 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 2nd G20 Health Working Group (HWG) Meeting in Lombok, 6 – 7 June 2022.

We emphasise that any decision for global mechanisms and initiatives developed as part of the Global Health Architecture should be done so within a globally established and recognised system such as the United Nations – with a strong role of the World Health Organization (WHO) and involve other health multilateral organisations of proven effectiveness on dealing with diseases, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In addition, this needs to ensure the voices and involvement of those that are most affected, such as low-and-middle income countries (LMICs) and communities and civil society are not left behind.

We note that the ongoing discussions on the Global Health Architecture is addressing the strengthening of the coordination of the global health development landscape, but that ongoing and fragmented discussions across different mechanisms and platforms involving different groups and/or not all stakeholders are threatening the holistic discourse.

We call for the strengthening of existing institutions (such as the WHO), rather than undermining them with new and/or parallel systems. For example, the Global Fund has demonstrated its capacity to deliver with results, and it has been investing in activities that contribute towards pandemic preparedness and response (PPR), as well as health systems strengthening since its inception. Existing institutions that are part of the Global Health Architecture not only need to be strengthened, but reform is necessary as many are only accountable to “member states” and exclude the voices and representation of the people we are ultimately accountable to.

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.

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.
In many cases, public investment from Governments contributes towards the development and research of health technologies and commodities and should be a public good. Therefore, G20 countries should recognise all lifesaving medical technologies and tools as global public goods during emergencies and enforce existing mechanisms (or legislate mechanisms) to ensure that these are provided in an equitable manner and waive or suspend all intellectual property rights (IPRs) during global health emergencies.

1. Structure for Essential Health Resources Mobilisation Mechanisms
We note and commend the efforts of the establishment of ACT-A through governmental funding to speed up COVID-19 responses by supporting the development and equitable distribution of diagnostics, treatments and vaccines the world needs to reduce mortality and severe disease; as well as restoring full societal and economic activity globally in the near term and facilitating high-level control of COVID-19 disease in the medium term.

While ACT-A has accelerated new health tools with urgency, it has not truly delivered on its promised aims of ensuring equity in the deployment of diagnostics, therapeutics, and vaccines.

We note the flaws as follows:

1. Governance & Decision Making:
   a. The lack of engagement and meaningful input from LMICs and communities and civil society in its creation, and their under-representation in the governmental structure of ACT-A which presents a huge disconnect against its objectives as it did not include the groups it intended to serve. This reinforces the donor-recipient mentality and top-down approach and dilutes country ownership. In addition, communities and Civil Society took several months of advocacy to persuade COVAX to accept communities and civil society as a critical and important partner.
   b. Any potential new structure within the new Global Health Architecture has to enshrine meaningful engagement of communities and civil society from the very beginning with full mandate to participate. This participation should not just be as observers or providers of ideas during consultations, but as part of the planning, decision making, implementation and monitoring.
   c. Two years after its creation, it is still unclear how decisions are made within ACT-A and COVAX. 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.
   d. The structure relied too heavily on an outdated international aid model driven by governments and global health actors in high-income countries (HICs) rather than an approach of equal partnership. In addition, the model focused primarily on the vaccines pillar.

2. Global Supply Chains – Approximating Manufacturing, Supply, Demand and Allocation:
   a. A limited number of manufacturers/producers – resulting in insufficient COVID-19 tools, especially vaccines resulting in most intended recipient countries being unable to secure sufficient. Ensuring support for regional and local capacities reduces the risk and it means that responses can be quickly adapted to the context of getting ahead of the pandemic;
   b. The stockpiling of COVID-19 tools by rich countries (sometimes more than three or four times the number required for their population) despite the WHO fair allocation framework. Vaccines were only donated after a substantial proportion of their own population were vaccinated; and
   c. The lack of transparency of pricing and monopolies resulted in high pricing as with limited supplies of vaccines, most LMICs vaccinated their population only in the first half 2021 through bilateral deals with Chinese companies outside of COVAX.

The potential role of the World Health Organization (WHO) COVID-19 Technology Access (C-TAP) which was set up to share technology, know-how and IP to enable quality manufacturers in LMICs to produce COVID-19 tools was overshadowed by patent and intellectual property (IP) rules and regulations. In addition, COVAX overly relied on the good will of pharmaceutical companies to the extent that almost all vaccine doses came from AstraZeneca, which in turn unrealistically relied on one Indian
company to produce for LMICs and the number of doses needed. This dependence on highly concentrated and controlled manufacturing did not consider normal glitches in productions, nor the India ban on exportation during the height of its pandemic crisis that impacted uncertainties for the second dose of vaccines face by Africans. A diversified production and manufacturing strategy is necessary to mitigate the impact of production and exportation glitches.

We do not support that the ACT-A model be transformed into a more permanent structure by G20 members, rather, a model that is agreed upon globally, including the involvement of LMICs is imperative. We stress that all countries must commit to:

1. **Meaningful engagement, inclusion and equal partnership of all stakeholders** in decision-making, including LMICs, communities and civil society, researchers and public health experts, as well as formal accountability and transparency mechanisms built into its governance structure and particularly in its engagement with the pharmaceutical industry;

2. **Funding towards all aspects of PPR**, including diagnostics and therapeutics besides vaccines;

3. **Collaborative research and development (R&D) of products** between research institutions north and south and sharing technology and knowhow especially with qualified manufacturers in LMICs. This includes ensuring technology transfer to LMICs via clear and transparent terms and conditions that ensure open sharing of research data, knowledge, and technology on a non-exclusive basis to enable adequate production scale-up (including local and regional manufacturing) to ensure sufficient supply, equitable allocation, and affordable as well as investing in local manufacturing capacity;

4. **Waiving IPRs on technologies that deal with the pandemic**. IP barriers are a key transversal workstream across all pillars and explicitly support the TRIPs waiver, non-exclusive licensing via C-TAP and/or MPP non-enforcement declarations, compulsory licensing, etc. This could include financing being conditioned upon ensuring that health products are developed as global public goods according to a clear and transparent public health-driven priority research agenda;

5. **Better supporting national emergency response mechanisms through strengthening national and regional regulatory mechanisms and functions**, as well as building healthcare infrastructure during times of non-emergency and through strengthening of global health institutions, such as WHO to coordinate and support global/regional/national efforts to support PPR;

6. **Provide more timely and accurate information on allocation decisions** which are based on allocation frameworks agreed upon upfront and timelines to all stakeholders involved for decision-making;

7. **Learn lessons from ACT-A and COVAX through an independent and robust evaluation** inclusive of all stakeholders of its governance, modalities and operations; and

8. **Establish principles that guide its governance, modalities and operations** for a roadmap with regular updates on progress against goals/indicators with the agility and flexibility to respond to emergencies.

### 2. Permanent Structure for Health Resources Mobilisation

While we fully support the need for a permanent structure for health resources mobilisation, we do not support the establishment of new parallel mechanisms for the pooling of global financial resources for health, such as the Financial Intermediary Fund (FIF) proposed in the White Paper for PPR by the World Bank (WB) **that will duplicate efforts and resources in its management and implementation** which would better serve the populations that it aims to fulfil its functions of. This is to avoid undermining effective work results to date.

The global pooling of financial and medical resources and expertise should be managed within existing systems through cooperation, and on principles of transparency, accountability and integrity, and developed and rolled out with the meaningful involvement of community and civil society. For example, the Global Fund has demonstrated its effectiveness and capacity to deliver with results, and it has been lauded as one of the most transparent financial mechanisms. Furthermore, the investments in activities of the Global Fund have contributed towards PPR, as well as health and
community systems strengthening since its inception. This was acknowledged at the Second Global COVID-19 Summit.

Pooled resources should also advance preparedness for outbreak-prone diseases that are not of a global nature but can have significant impacts on health systems in LMICs. G20 discussions should therefore have discussions beyond COVID-19 and beyond “emergencies” such as the current pandemic, and include existing threats such as HIV, TB, malaria, antimicrobial resistance (AMR) and neglected tropical diseases (NTDs) to be able to fulfil existing commitments in achieving SDG target 3.3. 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.

Creating a new structure would create competition between different institutions with diminishing financial resources available from donors for health. In addition, another structure set up for countries to access health financing will create additional burden for countries with different application modalities, timeframes and timelines, and reporting mechanisms. More importantly, we refer to the proposed White Paper by the World Bank on the FIF for PPR that any investment in the FIF should be additional to current development assistance to health and should not dislocate global/domestic investments in health and bilateral programmes. 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.

The focus should be with the long term aim of strengthening country level responses as highlighted in the paper authored by the WB and WHO which notes that “COVID-19 has highlighted an urgent need for global collective action to substantially scale up investments and support to strengthen the capacity of developing countries to prevent, prepare for, and respond to the next pandemic… It is the collective responsibility of the international community to ensure that the necessary investments in PPR are made, on an urgent and sustained basis, so that low-income and lower-income countries and regions are better prepared to face the next pandemic”.

More importantly, funds directed to countries should be allocated and used through transparent, accountable and inclusive decision-making processes for both governments, communities and civil society so that these groups lead the coordination at the national level, including decisions on where and how funds are spent. Learning from the International Health Regulations (IHR) and the response to previous pandemics, epidemics and outbreaks, it is clear that changes and actions happen at global, regional, sub-regional, national as well as at local levels. Therefore, global mechanisms must support national actions and funding needs to be directly provided at the national and local levels.

Currently, the FIF appears to propose financing to global institutions to then channel the funds to countries increasing both human and financial resources that could otherwise be directed to targeted countries, especially if the identified mechanisms do not have a good track record in delivering results and demonstrating value for money. This will further fragment responses and will not empower countries to own the process and allocate their own domestic resources to PPR which requires long term investments in health systems and animal health. For example, some of the fundamental functions of PPR are based on training and recruitment of a variety of health workers including allied and community health workers, and this funding must be primarily from government budgets to ensure sustainable financing. Without

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6 These can include but are not limited to Cholera, Ebola, Yellow Fever, Meningitis, Lassa Fever, Zika, Chikungunya, etc.
7 Financing Modalities for Pandemic Prevention, Preparedness and Response (PPR)
long term and continuous public investments in health workers, the functions of PPR cannot be implemented even with the financial support from global institutions.

Importantly, we call for the establishment of principles that will guide the work of the proposed FIF before establishing and finalising its governance, strategy, modalities and operations. World leaders must find a pathway to facilitate decision making processes (including for funding) in a rights-based, inclusive, equitable and people-centred manner. The ongoing COVID-19 pandemic has proved that no country is safe until all are safe.

3. Investments for Building PPR Capacity and Progressing towards the SDGs

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.

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.

PPR cannot be strengthened in a vacuum and resources must be allocated and programmed responsively for overall health systems to achieve UHC, including community systems. Investments at global and regional levels should be strategic and focused to support country outcomes and to promote co-investments.

The long-term domestic financing of health systems must be addressed immediately, including the addressing of issues such as debt restructuring and introducing/implementing progressive taxation to increase the fiscal space needed for sustainability. We note that while blended financing may be introduced, we note the restricted space accorded 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.

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8 Building on pre-existing HIV infrastructure for monitoring and response, such as surveillance sites created by the HIV response that was used during COVID-1 – https://gh.bmj.com/content/6/12/e007980

9 Committed at the High-level Meeting on Universal Health Coverage in 2019, paragraph 35.

10 Committed at the High-level Meeting on Universal Health Coverage in 2019, paragraph 34.
to reduce out-of-pocket health spending, and at the same time for donors to step up and meet their 0.7% target\textsuperscript{11} for ODA. This is essential for complementary efforts by domestic sources.

Finally, to ensure availability and timely accessibility of lifesaving medical tools during pandemics, R&D for new health tools should be diversified beyond a handful of countries in the global north. Resource mobilization mechanisms should include rapid scale-up and diversification of manufacturing and supply capacities, particularly in developing countries; removal of intellectual property and other legal barriers (including indemnification calls in exceptional circumstances if they are not strictly time-bound or safety data-bound); transparency and affordable prices for governments and treatment providers; and access to diagnostics, care, and treatment and preventive measures free of charge. During the non-pandemic/interpandemic period, manufacturing capacity and underlying system (infrastructure, trained workforce, and national registration and accreditation systems) should be strengthened especially in developing countries.

4. Technical Assistance for a Feasibility Study

Given that the 2\textsuperscript{nd} Health Ministerial Meeting is held in October this year, there is limited time (approximately four months) for a robust feasibility study to be conducted. While the G20 Health Working Group can refer to the independent strategic review of ACT-A, we note that this focused only on identifying challenges and opportunities for enhancing the role of ACT-A in the short term, which did not consider what would be required in the longer term and is not desirable.

More importantly we stress the importance that any feasibility study if undertaken, needs to be conducted with all stakeholders involved – including LMICs, technical agencies, existing health institutions as well as communities and civil society to ensure that all stakeholders are meaningfully involved at all stages of the feasibility study and ensure broad consultations through varied and transparent processes.

We wish you fruitful deliberations and look forward to the points raised above being incorporated in your discussions. The ongoing discussions at the G20 on building a more resilient and sustainable global health architecture and strengthening systems must be conducted in a way so that we truly leave no one behind.

\textsuperscript{11} The OECD-DAC 0.7\% ODA/GNI Target (accessed 25\textsuperscript{th} March 2020).