In 2022, the Indonesia G20 Presidency priorities—Global Health Architecture, Digital Transformation, and Sustainable Energy Transition aim for the world to Recover Together Recover Stronger from the impacts of COVID-19.

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

We put vulnerable groups\(^2\), marginalised communities, and key populations\(^3\) 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.

Ahead of the 1\(^{st}\) G20 Health Working Group, the C20 VAHWG submits the following points to be incorporated in your discussions:

1. **Building Global Health Systems Resilience**

   We stand behind recommendations from the **Italy C20 2021 Global Health and Finance Working Groups Communique** that the leading actor for any initiative developed within any global health architecture has to be the United Nations system, and that the role of the G20 must be played in support of the World Health Organization (WHO).

   We strongly recommend avoiding the establishment of new parallel institutions for the pooling of global financial resources, so as not to duplicate efforts and resources in its management and implementation. 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.

   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 to Fight AIDS, Tuberculosis and Malaria (Global Fund) has demonstrated its capacity to deliver with results, and it has been investing in activities that contribute towards pandemic preparedness and response, as well as health systems strengthening since its inception.

   The mechanism must enable a freer flow of knowledge and technology from the global north to south and to globally pool medical resources and expertise, it is essential to ensure a full waiver of all intellectual property (including patents\(^4\), copyrights, trademarks, trade secrets and industrial design) on medical technologies (including treatments, tests and other medical technologies – and not only vaccines) for the duration of the pandemic and without any geographic and income level barriers. The current leaked text of the IP waiver falls short in this regard.

   Pooled resources should also advance preparedness for outbreak-prone diseases\(^5\) 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.

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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.

\(^3\) **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.

\(^4\) This can also include computers to governance software, to patents relating to genomic techniques.

\(^5\) These can include but are not limited to Cholera, Ebola, Yellow Fever, Meningitis, Lassa Fever, Zika, Chikungunya, etc.
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 Quadrupartite Alliance on One Health to ensure that animal health infrastructure is included, including animal health professionals.

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 collection6. COVID-19 has exacerbated and veered country responses off track for specific SDG targets — including 3.3 to end the epidemics of HIV, TB and malaria. Pandemic preparedness and responses (PPR) cannot be strengthened in a vacuum and resources must be allocated and programmed responsibly for overall health systems to achieve UHC, including community systems.

As such, domestic financing of health systems must be addressed immediately, including the addressing of issues such as debt restructuring and introducing/implementing progressive taxation7 to increase the fiscal space needed sustainably. We urge G20 leaders that have not achieved the minimum target of 5% of GDP for public spending on health8, to increase public spending to reduce out-of-pocket health spending, and at the same time for donors to step up and meet their 0.7% target9 for ODA.

G20 leaders must find a pathway through these obstacles and barriers to facilitate sharing in a rights-based, inclusive and equitable manner.

2. Harmonising Global Health Protocol Standards

In developing any policy, it is of utmost importance to meaningfully include communities and civil society in consultations — especially as protocols may have unintended consequences, such as travel restrictions that were implemented faced by PLHIV and TB affected communities.

While much of the world still faces inequitable access to COVID-19 vaccines and therapeutics, there are also many that continue to be excluded from health systems and may not be registered or recognised in public health systems to have access to COVID-19 vaccinations. In addition, as the world shifts to living with COVID-19, there remain vaccine brands that are unrecognised for travel waivers, which unfairly penalise people who are not able to access vaccines that are recognised and hoarded by the global north. Therefore, it is important as we are developing policies to facilitate cross-border interconnectivity that these issues are resolved to minimise confusion and/or enable exclusion of people.

For improvements to interoperability between health information systems for international travel, there is a need for the agreement between countries to key issues including (1) data format; (2) data fields; (3) data storage; (4) law enforcement access to data policy; and (5) technical standards that drive data format and data fields. Policies and data collection must also protect the privacy and confidentiality of travellers.

Global health protocol standards should accommodate conditions faced by LMICs, as they often have inadequate capabilities and/or resources to attain the same standards of implementation of protocols as developed countries. Developed G20 countries must support LMICs in terms of resources (human, financial, technical) to implement the developed protocol standards.

As each country has a different system and requirements, and are updated at different intervals/periods, barriers to travel are created that can be difficult to navigate. Therefore, the need to streamline and standardised these requirements, whilst ensuring that people who do not have access to digital tools are not excluded.

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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-1 – https://gh.bmj.com/content/6/12/e007980
7 Committed at the High-level Meeting on Universal Health Coverage in 2019, paragraph 35.
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).
3. Expanding Global Manufacturing and Knowledge Hubs for Pandemic Prevention, Preparedness, and Responses

The C20 VAHWG fully supports the need to expand global manufacturing as the expansion and diversification of local production for vaccine, therapeutics, and diagnostic tools is particularly needed in LMICs where there is currently limited local manufacturing knowhow and capacity. The need for local research, innovation, and manufacturing to meet the specific local health needs for areas that are chronically underinvested in outside of high-income countries (HICs) has long been recognised, but not acted upon.

Policy makers must (1) create an enabling funding, regulatory, innovation and procurement environment to promote local production; (2) promote a research agenda that encompasses open innovation, sharing of IP and know-how, technology transfer and access-oriented conditions attached to R&D for local manufacturers; (3) ensure that local production is sustainable and meets local health needs; (4) strengthen regulatory mechanisms and public trust on locally manufactured products; and (5) countries with WHO-listed mRNA developers based on jurisdictions use all political, legal, and financial means possible for developers to share their technologies with capable manufacturers in LMICs.

The COVID-19 pandemic has demonstrated the problems of limited manufacturing capacities in LMICs, but at the same time revealed that innovation, R&D, and manufacturing capacity does exist in diverse regions — including local manufacturers manufacturing their own diagnostic tests without any external technology transfer. For vaccines, there are over 100 pharmaceutical manufacturers across Asia, Africa and Latin America with the existing technical requirements and quality standards to manufacture mRNA vaccines should the technology and knowhow be available. The creation of demand through pooled procurement that support local initiatives, a competitive pricing environment and avoiding monopolies can be created at regional levels like PAHO’s Strategic Fund for Medicines or Revolving Fund for vaccines.

A strong commitment to the full text of the TRIPS Waiver proposal is needed to maximise sharing of technologies and must overcome IP barriers that hamper the production of the required COVID-19 commodities. The world continues to rely only on a few manufacturers primarily in HICs to meet global needs with few manufacturers in LMICs receiving some level of technology transfer and ramping up manufacturing at different levels in the field of diagnostics, ranging from local assembly of semi-finished to full production, including raw materials. Therefore, strengthening the supply of raw materials, including reducing related trade barriers are necessary, as would allowing for advance purchase agreements with existing manufacturers, as well as applying similar timeframes (as with HICs) for the provision of raw materials to manufacturers in LMICs at an affordable and no-profit cost.

Finally, there is a need to recognise the importance of and investments for community responses to health and community systems in diseases surveillance. Community health workers in the network of “brains” need to be included beyond formalised medical or tech staff, and also community led- and -based and civil society organisations that have an informal role in the network of “brains”. In addition, there is a need to ensure that telehealth, telemedicine, digital health are incorporated through facilitation of early publication (pre-peer review) of research and learning; (2) supporting this research in each jurisdiction with funding for R&D; and (3) supporting educational institutions that will train future researchers and physicians, and healthcare workers.

We wish you fruitful deliberations and look forward to the points raised above incorporated in your discussions and working with you closely to leave no one behind.