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T7 Task Force Global health

POLICY BRIEF

ENDING VACCINE INEQUITY AND INJUSTICE

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Abstract

Vaccine inequity has devastated millions of lives globally. It has not only impacted citizens of poorer countries who are unable to access vaccines but also people in more industrialised nations as access became stratified across race, income level and geographic location. Ultimately, the uneven rollout has affected the entire international community as variants continue to proliferate and raise the possibility of reduced vaccine efficacy against COVID-19. This inequity is a symptom of the larger malaise of uneven and skewed health systems, affecting economic development and, social stability. Thus, this moment is critical for both financial and moral reasons, providing the G7 with the opportunity to rethink and to act on equitable vaccine access and health priorities. This issue paper is set in the context that the worst effects of the COVID-19 pandemic may be waning (Murray, 2022) but there are stark warnings of increased occurrence and severity of pandemics in the future due to rapid and chaotic urbanisation, climate change and deforestation (Thoradeniya & Jayasinghe, 2021). It is therefore crucial that the next pandemic does not catch us unprepared as this one did, and we avert the tremendous toll on lives, livelihoods and societies. A vaccine delayed is a vaccine denied. The present injustice and vague promises should be replaced by genuine action to save lives—all lives. The current course of action will not contain transmission of the virus and we need continued joint collaborations and initiatives if we are to progress towards an equitable world.

Challenges

By December 2021, Africans only accounted for 2.8% of the world’s vaccinated people, despite making up 17% of the global population and approximately 5% of people in low-income countries are vaccinated, compared to 70% in high income countries (World Health Organization, 2021). These figures are deeply alarming as COVID-19 continues to wreak havoc around the world and the death toll rises to 5.8 million people since the pandemic began.

Despite surplus global supplies of vaccines, they have not reached the people who need them most, in low and lower middle-income countries as well as lower income citizens in wealthier nations. In mid-2021, G7 members pledged to donate 870 million of their 3 billion surplus doses by the middle of 2022 (UN News , 2021). However, this is a drop in the ocean when considering the 11 billion doses that are urgently needed to reach protective immunity for all populations around the world. The promises for improved global distribution of vaccines promised “support for collaborative efforts” on global vaccine distribution without providing specific details about the nature of this support.

The promises for technology and skills transfer to allow the global production of vaccines of vaccines have been vague. The G7 summit in Cornwall in June 2021 failed to make any resolutions related to the demand by lower income countries for a temporary waiver of Trade-Related Aspects of Intellectual Property Rights (TRIPS). Instead, G7 members agreed only to support manufacturing in low-income countries and promised to “engage constructively with discussions at the World Trade Organization on the role of intellectual property”.

The outbreak and spread of the Omicron variant, killing half a million people since December 2021, according to the World Health Organization has shown the failure of multilateralism and the world’s wealthiest nations to end the pandemic, despite the threat it continues to pose to the world.

There are several cross-cutting areas that have contributed to vaccine inequity including:

- I. **Concentration of production:** Production facilities have largely been concentrated in industrialised nations and this has posed multiple challenges to equitable global distribution. Poorer nations have been at the back of the queue, unable to produce their own vaccines (World Health Organization , 2021). Consistent and timely supplies have also been affected by global logistics upheaval and rising costs as well as the pandemic affecting production (Usman & Ovadia, 2021).
- II. **Funding of pharmaceutical production industry:** Wealthier nations have the resources to fund R&D and private pharmaceutical companies, ensuring they are first in the queue for vaccines. Due to limited fiscal abilities, for historical reasons, most poorer nations are unable to fund the research required neither do they have the capacity to develop and produce vaccines themselves (OECD, 2021).

- III. **Hedging of procurement:** Wealthier nations bet on several vaccine options during the development race, ensuring they would receive stock, regardless of the outcome. Lower income countries did not have the financial resources to do this, and many joined the COVAX facility, to avoid the scramble for vaccines (Twohey, Collins, & Thomas, 2020).
- IV. **Hoarding surplus vaccines:** Despite wealthier countries having a surplus of doses due to their procurement strategy they did not share them with others, determined to hold onto them for booster shots (Bahar, 2002). This had the impact of prolonging the pandemic as variants emerged in unvaccinated parts of the world.
- V. **Delays in distribution to COVAX:** The global vaccine hub was deigned to distribute vaccines equally and fairly with the cross subsidisation by high- and middle-income nations of lower income countries. However, when wealthier countries concluded unilateral deals with vaccine producers, COVAX did not have the funding to secure doses. The vaccine hub therefore was heavily reliant on the Serum Institute of India for AstraZeneca doses which were delayed in March and April 2021 as the Government of India battled the Delta wave. The facility has also received donations late and close to expiration (Ducharme, 2021)

Proposals

Considering the urgent need to increase access to vaccines in poorer countries as well as prepare for future pandemics, we make the following recommendations. They should be foregrounded on the premise that people and communities are central to each recommendation and should be the focus of our efforts as to prevent future pandemics because pandemics start, spread and end within communities.

- I. **Establish international commission to undertake vaccine production and distribution in transparent and comprehensive manner:** Recognising that vaccine inequity does not just stem from skewed distribution but also asymmetrical production capacity, G7 leaders should increase engagement with representatives from low- and middle-income countries through a forum that is fair and balanced. The current mechanisms to address medicines' inequities —between developed and developing nations— have fallen short. The Access to COVID-19 Tools Accelerator (ACT-A) which prides itself on being an “unprecedented global partnership” has limited funding and it is often not clear to countries what the partnership offers them. (Ravelo, 2021). The Medicines Patent Pool (MPP) by the United Nations relies on pharmaceutical companies to voluntarily sign licencing deals for patents with lower income countries and this often excludes middle income countries with manufacturing capacity. (MSF, 2022). These mechanisms should be strengthened or amended for greater efficacy, through greater engagement with LMICs about what their requirements are.

Multi-stakeholder decisions should determine regional hubs for financial support for the production of vaccines and timely distribution. The 0.7% ODA/GNI target in 1970 where developed countries agreed to give at least 0.7% of their gross national income to aid has not been met. Recognising that

the entire ODA quota is unlikely to be directed towards vaccine equity, the international commission should establish funding targets and work through public-private partnerships to raise the required funding.

- II. **Strengthen health systems' capacity:** Vaccine inequity is due to the broader uneven access to healthcare. Thus, it is crucial to build capacity within LMICs' health systems and this can be led by prioritising the skilling and enlargement of the health workforce. G7 leaders should commit to respecting the integrity and needs of LMICs' health systems and not trying to lure valuable human resources through 'poaching'. Instead, they should commit knowledge and skills transfer including training for epidemiological surveillance systems and make LMICs more desirable employment centres for health workers. Recognising that many health systems in developed countries are also short staffed, strengthening global systems and surveillance provides global protection against future pandemics.
- III. **Enable private sector integration into health system:** While most international regulation is directed at governments in terms of the management of health systems and the provision of healthcare provision, all stakeholders in the health system should have clearly defined roles and responsibility to society. Large private healthcare providers receive substantial public funding in the form of grants and subsidies for R&D and other programmes. G7 nations having the largest spend on R&D should link public subsidies to pharmaceutical companies, to the implementation of a code of conduct, governing companies' relationship to products and services that have been clearly identified as being in the public good. This could include entering into purchase agreements with an institution like GAVI.

Implementation

At the 2022 summit, G7 nations should commit to:

- I. **Short-term:** Establishing an international commission to engage LMICs' representatives on vaccine production and distribution requirements and as a forum to set funding priorities, leverage and increase funding partnerships
- II. **Medium-term:** Developing a skills and knowledge transfer programme with LMICs health workers and undertake not to fill shortages in their own health systems from LMICs
- III. **Long-term:** Linking R&D grants and other sources of public funding flowing to pharmaceutical companies, to the implementation of a code of conduct, governing private companies' actions during health crises.

Disclaimer:

All authors are responsible for the content and recommendations contained within this policy brief. The policy brief has been written as part of a consultation process for the T7 Taskforce for Global Health, led by Taskforce’s Co-Chairs Ilona Kickbusch, Anna-Katharina Hornidge and Githinji Gitahi, but it does not represent the official position of the Taskforce or the authors’ employers.

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A passionate advocate for pro-poor Universal Health Coverage, Githinji Gitahi joined Amref Health Africa as the Global Chief Executive Officer in June 2015. Amref Health Africa, founded in 1957, is the largest Africa-led international organization, reaching more than 11 million people each year through 150 health-focused projects across 35 countries. Until his appointment to Amref Health Africa, Dr Gitahi was the Vice President and Regional Director for Africa, Smile Train International. Prior to that, Dr Gitahi was Managing Director for Monitor Publications in Uganda as well as General Manager for Marketing and Circulation in East Africa for the Nation Media Group. He progressively held senior positions at GlaxoSmithKline and worked at the Avenue Group. Dr Gitahi is the former Co-Chair of the UHC2030 Steering Committee, a global World Bank and World Health Organization (WHO) initiative for Universal Health Coverage (UHC); and has recently been appointed as the Co-Chair Strategic Advocacy Committee PMNCH and a member of the Unilever Sustainability Advisory Council. He serves on a number of Boards, notably – Board of Directors of The Standard Group in Kenya, Board of Trustees of Safaricom Foundation and Governing Board of the Africa Centres for Disease Control and prevention (Africa CDC). He is also a member of the Commission/Taskforce on Africa’s COVID-19 Response. Dr Gitahi holds a bachelor’s degree in Medicine from the University of Nairobi, a master’s degree in Business Administration from the United States International University, as well as a Certificate for Strategic Perspectives for Nonprofit Management from Harvard University. In December 2018, Dr. Gitahi was bestowed the 2018 ‘Moran of the Order of the Burning Spear’ (MBS) by the President of Kenya, in recognition of his outstanding contribution and commitment to the health sector.

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Dr. María del Rocío Sáenz Madrigal is a Costa Rican doctor from La Salle University, Mexico, D.F. and a public health specialist. Former Executive President of the Costa Rican Social Security Fund 2014-2017 (CCSS). Former Minister of Health of Costa Rica and Coordinator of the Social Council (2002-2006). Member of the PAHO / WHO Health Emergencies Response Team with emphasis on Central America, with main functions related to support and assistance in the restoration of basic health services including water, sanitation and primary health care, and its corresponding evaluation.

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Professor K. Srinath Reddy is the President, Public Health Foundation of India (PHFI) and formerly headed the Department of Cardiology at All India Institute of Medical Sciences (AIIMS). Under his leadership, PHFI has established five Indian Institutes of Public Health (IIPHS) in different regions of India, to advance multi-disciplinary public health education, research, health technologies and implementation support for strengthening health systems. He was appointed as the First Bernard Lown Visiting Professor of Cardiovascular Health at the Harvard School of Public Health in (2009-13) and presently serves as an Adjunct Professor of Epidemiology at Harvard (2014-2023). He holds advisory positions in several national and international bodies and recently published a book *Make Health in India: Reaching A Billion Plus*. He is also an Adjunct Professor of the Rollins School of Public Health, Emory University and Honorary Professor of Medicine at the University of Sydney. He is the first Indian to be elected to the National Academy of Medicine, USA and was awarded several prestigious international and national doctorates and fellowships. He was President of the World Heart Federation (2013-15). He is a Padma Bhushan awardee. He is also an Advisor to the Governments of Odisha, Punjab, Haryana and Andhra Pradesh on Public Health. He served as physician to two Prime Ministers of India.



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