

From Charity to Solidarity: Building a Networked Platform for Equitable Countermeasures for the Pandemic Age

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Executive Summary

Several studies published early in the pandemic showed that an equitable rollout of COVID-19 countermeasures would have allowed us to get over COVID-19 more quickly, saving numerous lives and limiting socio-economic harm. Yet the response to the pandemic was far from equitable. Rather, the response showed that the current system for the development, production, allocation, and distribution of pandemic countermeasures is trapped in a market-driven charity frame. This system is based on a business model for health technologies that prioritizes financial and self-interests over health. It is characterized by a fundamental inequity in technological capacity to create and own innovations. Equitable access is only considered at the procurement phase of product development and distribution, which results in products that are not suitable, tested for, or equitable for all settings, and an unsustainable race for unpredictable funding to purchase countermeasures. During COVID-19, this left bodies like ACT-A competing with high-income countries (HICs) to procure countermeasures. ACT-A, which relied heavily on donor funding and lacked political negotiating power, never stood a chance of winning that race. As a result, low- and middle-income countries (LMICs) were at the back of the queue for purchasing countermeasures and had to wait for donations from rich countries to be able to tackle the pandemic. Regional bodies, including in Africa, sprung up to fight this entrenched system, offering some hope for the future. As we think about the design of a future PCM network, therefore, it is clear that the current system presents a model illustrating how not to approach equity.

A new pandemic countermeasures (PCM) platform offers a real opportunity to break from past models and to reimagine how equity could be delivered. Structures were set up during COVID-19 with the stated aim of achieving equity – but the design of the Access to COVID-19 Tools Accelerator, for example, did not have equity embedded from the outset. What equity is and how it can be achieved need to be explored, agreed and to become the very foundations of a future countermeasures platform.

Because of the dominance of the business model approach during COVID-19, much of the debate has been focused on shoring up surge and at-risk financing for a future PCM platform. Such an approach keeps the focus on competition between countries, or regions, and risks deepening the world's reliance on market-driven and charity R&D and access models, rather than thinking differently about how to achieve equity.

To make global and equitable access central to the next PCM platform, equity must be embedded in the R&D process, initial governance structures through representation, in terms of access to contracts and in terms of access to technology and know-how.

A fundamental shift in mindset is needed.

ACT-A was described as an end-to-end platform, but its biggest focus by far was on pooled procurement by a global institution on behalf of LMICs and at the mercy of unfettered market forces. The future needs a model for health based on solidarity, designed to maximize health outcomes equitably, factoring the differing needs and contexts, not self-interest and profit. A future PCM platform therefore needs LMIC populations and decision makers as equal partners – convening partners –at every stage of the process so ‘end-to-end’ equity is actually delivered.

The current dominance of a few countries to design, manufacture, and buy up the majority of countermeasures must be consigned to the past. The future must design a system that puts an end to the ‘survival of the richest’ and beggar-thy-neighbor policies that characterized COVID-19, and instead put global public health at the center of policies, processes, and investments. Working together across continents and sectors, we can learn the lessons from COVID-19 as well as previous outbreaks (H1N1, Ebola, Zika etc.), and deliver a system that will benefit us all—but only with dedicated effort.

Recommendations

A new PCM Platform must include:

Putting people back at the heart of health policy

- Put human rights at the heart of the design of a future platform
- As a guiding principle, ensure a future platform maximizes health outcomes for all, including the most vulnerable across society and those in low resource settings
- Design structures, policies and operating systems that put business at the service of health outcomes in the event of a public health emergency or potential pandemic, not vice versa

Equitable governance

- Be convened and designed by LMIC regions and governments from the outset
- Ensure ongoing meaningful representation of LMICs with clear, equitable criteria (population/demographic defined) of inclusion at all decision-making levels and at the earliest stages
- Be underpinned by a common principle of shared global risks of pandemic threats and the imperative of shared responsibility to manage them
- Advance sustainable funding plans, such as leveraging the Global Public Investment model, to end the over-reliance on funding from HICs or private capital

Networked and distributed capacity

- Establish regional and sub-regional R&D hubs working collectively with new technologies without intellectual property (IP) restraints, and engage stakeholders that will use these tools early in the R&D process
- Expand distributed manufacturing capacity of countermeasures across regions, especially in LMICs, with the rights to adapt technologies and use them for other purposes

Knowledge and knowhow sharing

- Back and develop policies to increase knowledge sharing, remove trade-related barriers including IP, and create tech transfer hubs that are also equipped for R&D
- Call for publicly financed research to guarantee global equitable and affordable access to the countermeasures it funded, as well as underlying technologies

Accountability and delivery

- Ensure the production, pricing, supply, financing, and delivery of pandemic countermeasures can be tracked from production to patients during a pandemic

Foreword, Pandemic Action Network's Africa Director, Aggrey Aluso

The rapid development of COVID-19 vaccines in just under a year demonstrated that much can be accomplished, when human ingenuity and well-resourced medical research come together in an enabling ecosystem. Yet, this same experience also reaffirmed the long-known fact that unless innovations and the means to innovate are governed by shared principles for the common good, equity remains an illusion and many people are excluded from its benefits. This limits the positive impact of health interventions, and creates unacceptable inequities that potentially exacerbate the health needs that such innovations, like vaccines, are supposed to address.

Beyond COVID-19, double standards continued to be witnessed in the handling of outbreaks in 2022, such as the Ebola outbreak in Uganda. The Ebola Sudan variant that ravaged Uganda has been recurring in predictable cycles since 1976 and Ebola has been [ranked topmost](#) in Africa in the epidemic prone disease ranking. The lacklustre response saw a vaccine candidate for clinical trials become available just when the recent Ebola outbreak was about to be declared over. Meanwhile, mpox, endemic in a host of West and Central Africa countries without eliciting much-needed global attention, only rose in profile when it spread to a few Global North countries. This brought to the fore the critical issues of power dynamics, skewed decision-making structures, and the impact of these inequities determining [when, how, and why critical pandemic countermeasure tools are developed and deployed](#).

The COVID-19 pandemic potently illustrated that equity in access to pandemic countermeasures “must never be a question of the end justifying the means” but an end-to-end concern that is infused in any response from start to finish. The current status quo and the acceptance that critical countermeasures such as diagnostics, vaccines, and therapeutics can be funded, researched, designed, and manufactured in a small section of the world and merely distributed to the rest of the world — mostly LMICs — through charitable and market-driven models failed during COVID-19. In the early stages of the pandemic, vaccine production was insufficient to meet global demand and many wealthy countries turned inwards, procuring vaccine doses through exclusive bilateral deals for their domestic populations (vaccine nationalism), and manufacturing countries, such as India, [imposed temporary export bans](#).

We must therefore completely rethink our approach, including how we conceptualize equity, in the context of pandemic countermeasures — and health equity in general. Equity should not be confined to efforts to respond to pandemics but must include equitable effort irrespective of the scale of outbreak, location, and demography to stop epidemic outbreaks when and where they occur. Equity must also address the questions of distributed capacity to finance, make decisions on, and own innovation and manufacturing, and

not only the distribution of final countermeasures. Attention must be deployed to remedying the power asymmetry that exists due to low investment in R&D by Africa and other LMICs through increased domestic financing, IP waivers and other flexibilities, and technology transfer and technical cooperation to address the underlying structural drivers of vaccine inequity.

More importantly, the connectedness of the global community and the shared risks of pandemic threats should inform the approaches as to how health responses, and rules around innovations, are governed. Since pandemics are global health threats whose risks transcend borders and impact various aspects of human life beyond health, innovations for countermeasures should be underpinned by the principles of Global Public Goods. Future pandemic countermeasures must be governed by principles that recognize the shared risks and inherent responsibilities as the basis for levels of efforts for preventive and responsive actions against pandemic threats; it also means that inclusion in the decision-making in governing organs for PCM platforms must include proportionate representation of communities.

A future pandemic countermeasures platform must be guided and informed by the needs and priorities of all, particularly those who have faced equity challenges in the past (LMIC); the new mechanism should be guided by the principle of co-creation and co-ownership with clear rules of engagement that do not privilege rich regions and countries with the prerogative of being the convenors and designer of such processes and co-opting the LMIC countries at the tail end of the process for validation. It is unfortunate that despite the experiences from COVID and structures like ACT-A, conversations on possible countermeasures platforms are being driven by through the same model that exclude LMIC countries in the guise of urgency; this must be called out and necessary action to reengineer the processes towards a PCM that is inclusive and owned by all.

It is imperative therefore that all necessary efforts are deployed to enable the realization of the vision of Africa's New Health Order, with African countries collectively playing an equal role in global efforts. That means equitable and meaningful African and LMIC representation on global platforms; it also means a wholesale rethink of how future countermeasures platforms should operate — and we hope our learnings will contribute to kicking off that debate.

Aggrey Aluso, Pandemic Action Network Africa Director

Part 1 – What should we leave behind?

Despite the epidemiological case for equity, the charity model prevailed during the pandemic. Early in the pandemic, studies from [Northeastern University's Mobs Lab](#) and the [Eurasia Group](#) both showed that an equitable rollout of COVID-19 vaccines would have been more strategic than leaving countries to their own strategies and competing to buy pandemic tools. Focusing on a globally equitable strategy for the deployment of pandemic countermeasures would have both significantly increased the chances of getting over COVID-19 more swiftly and would have generated economic benefits for all countries. In September 2020, the Mobs Lab found that vaccine hoarding would lead to nearly twice as many deaths than if vaccines were shared equally across the globe. A few months later, in December 2020, the Eurasia Group report found that the economic benefits of a global equitable vaccine solution for ten major economies alone would be at least US\$153 billion in 2020-2021, rising to US\$466 billion by 2025. This was more than 12 times the US\$38 billion estimated total cost of the Access to COVID-19 Tools (ACT) Accelerator at the time. While WHO amplified these headlines and worked on equitable distribution models, this argument was never made in a consistent and compelling enough way to leaders and the general public.

Vaccine donations were the byproduct of rich country hoarding — the charity model cannot achieve structural equity and is not fit for purpose.

Some stakeholders proclaimed throughout the COVID-19 pandemic that there were enough vaccines in the world, and we just needed better distribution. On one level, this was true, but the question was: who had access to the procurement of those vaccines, who decided where they would be deployed, and when? The answer was a very small group of countries — a reality in stark opposition to equitable access.

This pattern of events wasn't anything new — history was repeating itself. [The 2009 H1N1 pandemic, for example, saw LMICs left behind in the scramble for vaccines](#). Africa found itself awaiting charitable donations through WHO's Pandemic Influenza A (H1N1) Vaccine Deployment Initiative rather than being able to buy vaccines themselves. Despite receiving more than 40% of the 78 million vaccine doses delivered through the scheme, these vaccines arrived after the peak and the H1N1 pandemic had run its course.

The inequitable response to COVID-19

The first cases of COVID-19 were detected in China in late 2019. Then WHO declared a Public Health Emergency of International Concern on Jan. 30 2020, and characterized the outbreak as a pandemic on March 11, 2020. The development of vaccines against COVID-19 started as soon as the virus' genetic sequence was published in January 2020. An unprecedented level of international cooperation then led to the first vaccines being available in under a year.

With the virus spreading quickly across the world, HICs rapidly procured vaccines through bilateral deals with pharmaceutical companies. [By September 2020, rich countries representing just 13% of the world's population had already bought 51% of the leading vaccine candidates.](#) HICs were hedging their bets and buying up to 10 times the amount they needed for their populations across many different candidates. This meant that after a short amount of time there were simply no more contracts left for the rest of the world.

Once vaccines had been procured by HICs, one of the only routes for many countries —and COVAX — to take was to call on HICs to share their doses in order to close the urgent vaccine gap in LMICs. In mid-2021, while HIC governments were stating that they didn't have enough doses to make truly impactful donations, [Duke University's Launch and Scale Speedometer](#) found that the G7 was likely to have in excess of 3 billion spare doses that year. As a result of civil society mobilization, HICs started making promises to share doses but were slow to deliver on them. In October 2021, a report by the [People's Vaccine Alliance](#) found that of the 1.8 billion COVID-19 vaccine donations promised by then, only 261 million doses (14%) had been delivered, while western pharmaceutical companies had delivered only 12% of the doses they had allocated to COVAX. In addition to causing a large number of infections, and [deaths that could have been averted](#), this also led to significant vaccine wastage in HICs, with up to [15 million doses reportedly thrown away in the United States alone between March and September 2021.](#)

As a result of this 'me-first' approach adopted by rich countries, the international response to COVID-19 largely failed to equitably allocate COVID-19 vaccines and other countermeasures. As we enter the fourth year of the pandemic, a large part of the world remains unvaccinated or partially vaccinated. In HICs 73% have been vaccinated with at least one dose as of Jan 18, 2023, [by comparison only 30% had received at least one dose in LICs.](#)

On the positive side, a collective approach was undertaken within the European Union (EU) between its 27 Member States and some of the EU's close partners. The EU should be encouraged to look at how to involve LMICs in this cooperative model.

Part 2 – Building a future pandemic countermeasures platform

Equity must start at the design phase

To ensure products are safe, effective, and globally accessible for diverse populations, it is important that LMIC populations are fully included from the early stages of the R&D process and through to the point of distribution. Too often, strategic and operational considerations for global uptake of new countermeasures are deprioritized throughout the product's R&D lifecycle, risking the development of products that are not suited for use in intended settings and/or will not achieve intended uptake. In the end, many of the COVID-19 tools have presented significant challenges for access and deployment in LMICs. For example, until the recent introduction of antiviral pills and injectable antibody therapies, treatment options were limited to monoclonal antibody therapies which had to be administered intravenously in a health care setting. These treatments remain hard to access quickly enough to be effective, even in wealthy countries. Leading vaccines require extensive cold chains, which are also not readily available or operational in all settings, especially those with the most vulnerable populations.

Central to empowering LMICs to design, develop and manufacture countermeasures according to their needs is the creation and investments in networked regional and sub-regional R&D hubs that can design and develop products in response to local needs and contexts as well as investments in distributed regional manufacturing capacity.

Equity and knowledge/technology transfer debates

The effectiveness of a future PCM platform will depend on the rules surrounding IP, technology sharing and knowledge transfers. Waiving IP rights during a pandemic is integral to boosting countermeasures supply and making them more affordable to LMICs. While decision-making on IP was housed 'elsewhere' at the WTO, there was a surprising disconnect between IP discussions and the development of the ACT-Accelerator. Even the shift in the U.S. position to back a TRIPS waiver — a 'Trade-Related Aspects of Intellectual Property' waiver to temporarily waive patents and certain other intellectual property protections associated with COVID-19 countermeasure — did not have a big enough effect on discussions. It is vital that a real debate — and action — on waiving IP rights during a crisis is prioritized as part of the lessons learned from the COVID-19 pandemic. [Regional and sub-regional R&D and manufacturing hubs must work as a network underpinned by the principles of collective intelligence and knowledge and technology sharing.](#) They must be able to work with new technologies with unrestricted sharing of knowledge, knowhow and IP, and be able to adapt technologies to emerging local health threats.

Public financing invested in research that leads to countermeasures (which means that the upfront highest risk is borne by the taxpayer) should also be tied to conditions related to global equitable and affordable access (pricing, IP, transparency) for the resulting pandemic tools as well as underlying technologies. In addition to decades of publicly funded research that laid the groundwork for the innovations created during the pandemic, most COVID vaccine candidates, as well as other countermeasures, [benefited from considerable government funding](#).

Access to contracts, transparency and accountability

Real equity also means LMICs getting equitable access to pharmaceutical contracts at affordable low-cost (preferably at-cost) prices. During COVID-19 efforts were made to right the wrongs of the total vaccine buy-out by HICs by asking countries to engage in ‘slot swaps.’ These swaps were intended to give LMICs or COVAX a better place in the queue for vaccines coming out of the production line — but this largely did not work. Working with the World Trade Organization and other relevant entities, a future countermeasures platform should enable equitable access to contracts, and low-priced products. For this to happen, increased transparency is needed to track tools from production to patients, including on how many doses are being produced; what are their cost; who owns them; and when will they come off the production line? Contracts and pricing should be made public.

Equitable governance

During COVID-19, key decisions on financing, development, procurement, and distribution of PCMs were taken in Geneva and other Western capitals, largely with little to no LMIC representation at any stage. Even when LMICs were engaged in the discussions, the level of engagement remained top level, government conversations, with little or no engagement of LMIC communities at all. A future PCM platform must operate on the principles of inclusivity and be underpinned by a common principle of shared global risks of pandemic threats and shared responsibility to manage them. Rules of engagement need to be agreed proactively before emergencies strike with clear, equitable criteria (population/demographic defined) of inclusion at all decision-making levels and at the earliest stages, so they can be put in place and countries held accountable to such rules during future pandemics. As recommended in [The Lancet](#) on March 13, 2023, for this to happen, it is vital that key discussions coming up over the next several months such as the WHO consultation on a ‘new platform for equitable access to medical countermeasures in pandemics’, the Intergovernmental Negotiating Body (INB) process to adopt a pandemic accord, the G7 and G20 processes as well as the UN high-level meeting on pandemic prevention, preparedness and response meaningfully involve “LMIC representatives, civil society and community organizations, the scientific research and public health communities, and humanitarian groups.”

Equitable governance also means sustainable funding plans ending the over-reliance on HIC governments’ funding for LMIC pandemic countermeasure procurement and empowering LMICs to be able to equitably

engage alongside other countries. The world must commit to solving this and establish at-the-ready funding that leverages the Global Public Investment model and global public goods principles to support a future PCM platform. The current multilateral development bank debates hold some promise in terms of potentially increasing countries' fiscal space, through reform of the capital adequacy framework and the reallocation of special drawing rights.

Conclusion

A new PCM platform offers the opportunity to **define what equity is and how it is achieved— and importantly, what it is not**. Discussions so far have all too often ignored the structural barriers (and their root causes) to equity. This has resulted in a focus on making sure countermeasures are *distributed* equitably — focusing on downstream challenges and only looking at equity at the point of distribution and suggestions for remedial action glossing over more fundamental, upstream issues. Real equity means ensuring LMICs can create, manufacture, and buy countermeasures when needed, and the tools and finances to enable this to happen. As mentioned in [The Lancet](#) on March 13, "health technologies for pandemic preparedness and response should be considered common goods, not private commodities." Without a complete reboot, LMICs and rich countries alike risk being stuck in a system that is not only a barrier to equity and access for all, but is also more likely to extend the timeframe of a global pandemic, harming us all.

A new pandemic countermeasures platform offers the **opportunity to define what equity is and how it is achieved — and importantly, what it is not.**

Scientists have warned that the risk of new pandemics is higher now than ever before. COVID-19 will not be the last and we must be ready for the next. The establishment of a new equitable, effective, and efficient PCM platform will be central to our ability to respond. The success of any new PCM platform will depend on its ability to truly reform the current approach to R&D, manufacturing, governance and access and offer a new pathway, leaving behind the current self-interest and charity models where profit and the interests of few are prioritized over health outcomes in favor of a global solidarity model for innovation that makes no distinction between rich and poor when it comes to health.

References

Pandemic Action Network's contributions for reference:

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