

Gender, Equity and Access to Covid-19 Vaccines and Beyond

A Virtual Consultation

18th December 2020



Organized By

SAMA Resource Group for Women and Health

Report by Sandhya Srinivasan and Neelanjana Das

Table of Contents

Introduction ... 3

Rationale for Consultation ... 3

Presentation on inequity and access to Covid-19 technologies ... 5

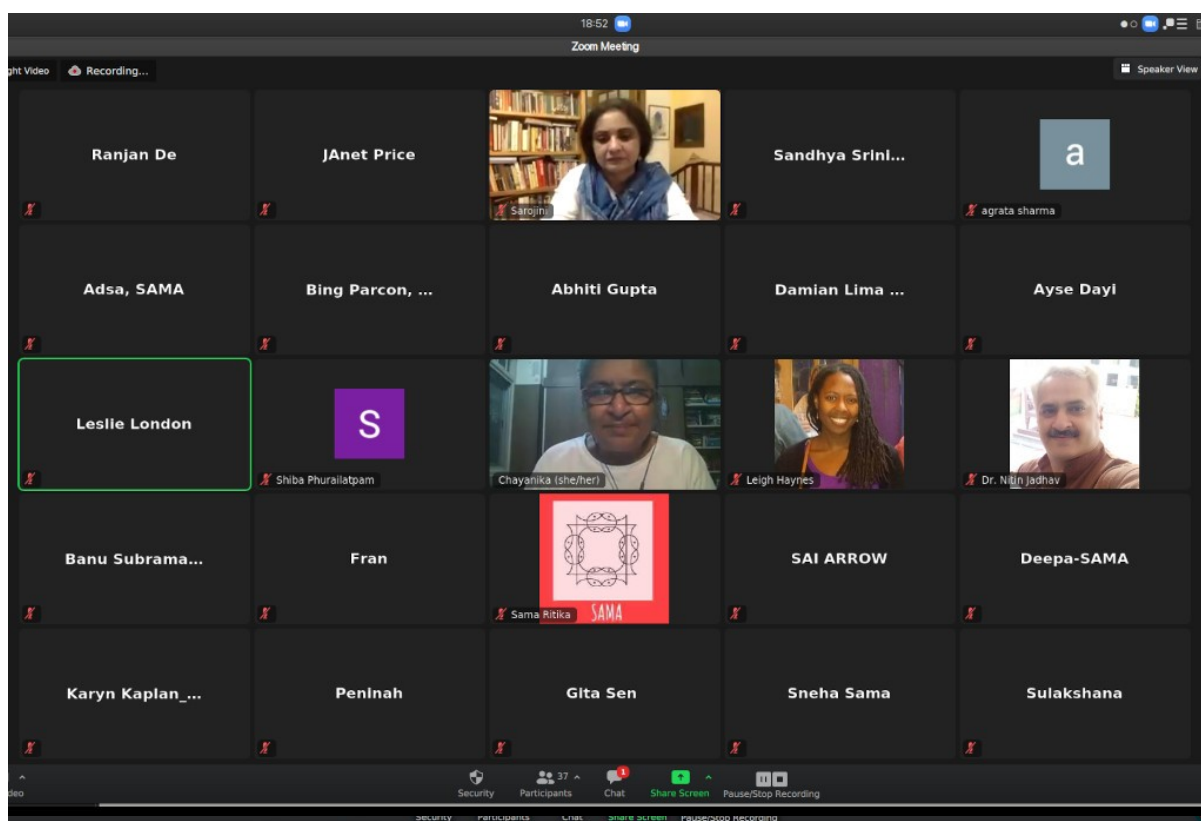
Equity and marginalization and Concerns
at the global level/country level experiences ... 10

Themes emerging from presentations and group discussions ... 18

Conclusion ... 23

Annexure (List of Participants) ... 24

Sama would like to acknowledge Asia Catalyst for its support.



Introduction

The Covid-19 pandemic has exposed the fault lines of society at every level, showing once more how intersectional inequities increase vulnerability to illness as well as deny access to health care; how these inequities affect access to a safe and effective vaccine and other technologies related to Covid-19.

The consultation called by Sama Resource Group for Women and Health was an opportunity to “collectively think about the concerns and also the strategies to address these issues”. The online meeting brought together some 50 participants from across the world (attached as Annexure 1), representing diverse groups of activists in public health, movements, academics, and national, regional and international groups. As one of the participants noted, the meeting was confirmation of the need to share experiences and ideas, as well as of the commonalities of concerns across borders, and the similarity in struggles.

Rationale for the consultation

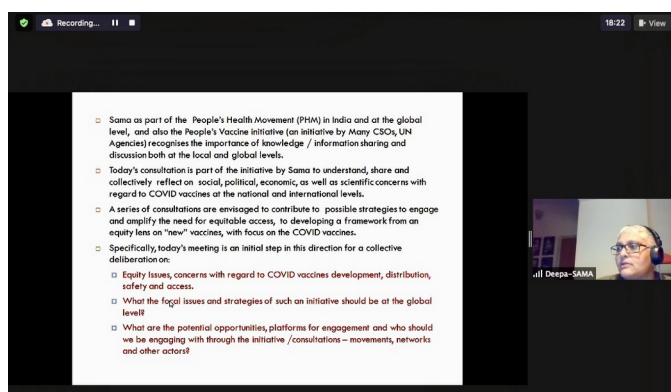
Deepa from Sama introduced the rationale, objectives of the series of Consultations planned by Sama. Whether in low- and middle-income countries (LMIC) or in high income countries, the impact of the Covid-19 pandemic, as well as the after-effects of

arbitrary responses, such as sudden lockdowns — on marginalised communities/groups from various socio-economic locations, has been disproportionate and severe. Inevitably, structural and intersectional inequities have been aggravated by the pandemic, which are bound to determine access to, and priority with regard to, any vaccine, drug or other technology being developed for the pandemic.

Movements, organisations, activists and advocates have long been discussing the politics of health and health care at the global and local levels. As a feminist group, Sama has been involved in research and advocacy on public health policy and regulation regarding assisted reproductive technologies, clinical trials, access to medicines, biotechnology, and other issues, using an intersectional lens. It has raised critical questions for public health ethics and equity, not only in the Indian context but also at the international level.

In the context of the Covid-19 pandemic, a few public health and bioethics practitioners - Sarojini. Amar Jesani, Yogesh Jain, Veena Johari and S Srinivasan organised a [series of webinars](#) in October, looking into research on and access to a Covid-19 vaccine in India, covering issues in science, public health and ethics, building upon a 2016 seminar co-organised by Sama titled “[New Vaccines for All: Why, Which, When?](#)” that had discussed the new technologies in terms of science, equity and ethics.

There is not much information, however, on the ground realities regarding the Covid-19 vaccines, the experiences of communities, their access to information, diagnostics and treatment, or other questions and concerns at the community level. Information dissemination regarding the policy planning process in the Covid-19 response has been largely inequitable and opaque.



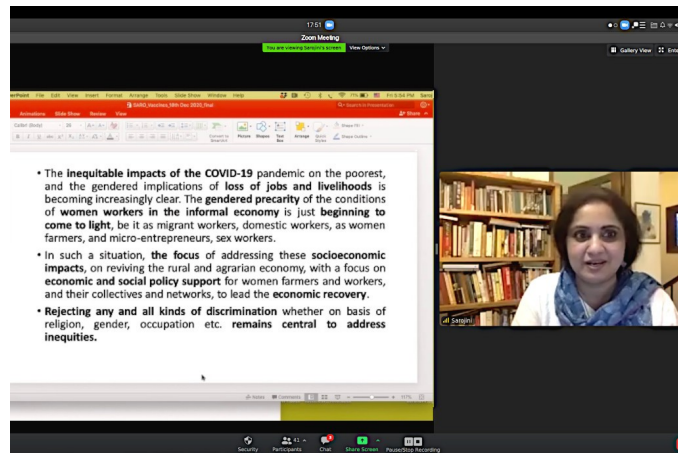
Deepa highlighting the objectives of the consultation and the need for collective deliberation for equitable access to COVID-19 vaccines.

Sama as a part of the Jan Swasthya Abhiyan and People's Health Movement and Asia Catalyst with its involvement in the vaccine initiative, recognises the importance of knowledge sharing at the global and local levels. This consultation, which was preceded by a national consultation on December 15, is part of this process. While the focus of this consultation was on Covid-19 and the vaccines, these discussions have implications for health care and health systems beyond the Covid-19

context. This Consultation was a part of the initiative by Sama with Asia Catalyst to share and reflect on socio-political, economic and scientific issues and concerns regarding Covid-19 vaccines at the national and international levels; to contribute to strategy, and to develop a framework for equitable access to new vaccines.

The objectives of the Consultation were to explore:

- The equity issues regarding the vaccine's development, distribution, safety and access;
- The focal issues and strategies at the global level;
- The plausible potential opportunities and platforms for engaging and whom should be engaging with.



Sarojini talking about the inequitable impact of COVID-19 on marginalized and vulnerable sections of the society.

The presentations and discussions that followed touched upon each of these questions to be explored further.

I. An introductory presentation on inequity, Covid-19 and on the current status of access to Covid-19 related technologies: Sarojini

Sarojini spoke on inequity, Covid-19 and health care with a focus on India. Her presentation included the following points:

Covid-19 is a public health crisis as well as a socioeconomic catastrophe. The state's response, with an authoritarian lockdown, will have a devastating, long-term impact, particularly on marginalised and vulnerable communities. The heightened inequalities are sustained by inequities of gender, work, location, sexuality, ethnicity, religion, geographical location. One instance of this is in the increased stigma and discrimination experienced by Muslims in the pandemic; by transgender communities; by people from the northeast, because they "looked Chinese", and so on.

The impact of structural, intersecting inequalities on people's access to determinants of health, such as food and other essential goods and services, has been stark. Hundreds of thousands of daily wage workers were deprived of their livelihoods during the lockdown, with no support from the state. Women reported increased gender-based violence in the home, health care centres, and beyond. The pandemic had a greater impact on the poorest, with gendered implications in the loss of jobs and livelihood, on women in the informal economy, farmers, and so on. The impact of these intersectional inequities — of caste, class, gender, religion, etc — is apparent at many levels. These discriminations are apparent even in conversations about technologies for Covid-19, including vaccines.

1.a. The health system and workforce

We have a weak and poorly resourced health system at every level (1).

- There is a severe shortage of intensive care beds, of supplies like personal protective equipment, etc. The patient-health care worker ratio is skewed, the working conditions of frontline health workers are abysmal, and their jobs are not secure. Sanitation workers and other cleaning and support staff of hospitals or mortuaries, who are most vulnerable to infection, almost always belong to Dalit communities.
- ASHAs or accredited social health activists are poorly paid, and have no social security. There are many reports of violations of the rights of the health workforce.
- **Inequities in Covid-19 care:** The corporate or private sector has profited from the pandemic. There is inequity in access to preventive, diagnostic and treatment technologies, and even information on Covid. Health services are also gendered, casteist, ablist. Sarojini mentioned that at the national consultation, a disability activist pointed out that in the context of the disabled, smart phones are not accessible to everyone. Similarly, in a patriarchal society, young girls may not have access to information available only on smart phones, as they are not allowed to use smart phones.
- **The impact on non Covid-19 care:** The health system's exclusive focus on Covid-19 is affecting access to, and side-lining, non-Covid-19 care. Sexual and reproductive health services have been unavailable or scarce; likewise, screening for diabetes, tuberculosis, cancers, etc. Dialysis services became particularly scarce during the lockdown.

1.b. Surveillance and the growth of centralised databases

Covid-19 provided as an "opportunity" to introduce more surveillance measures. There is an increase in the collection of health data; people must often share health data in order to get access to services. It is becoming mandatory to download apps developed with private collaborators; to provide one's Aadhaar card, biometrics, for tests, treatment, and now vaccines. This suggests that, for example, migrants without an Aadhaar card will not get Covid-19 related services. We need to look at the larger global context of this surveillance.

The vaccine is being viewed as the sole "cure" for the pandemic, though it will not put an end to nonpharmaceutical interventions. There is tremendous emphasis given to vaccines with every step in their development and testing being publicised. As during the lockdown, there is danger that essential health services may get drawn into the Covid-19 vaccine programme. Quoting Banu Subramanian, Sarojini said that the biotech

enterprise in India, which includes vaccines, should be viewed in the context of structural inequities and poverty, with a population suffering an enormous burden of preventable disease, and lacking basic health care needs. It is thus very important to locate biotechnology within a political, economic, cultural and national context. There is also a need to discuss the ethics of vaccine research, manufacture, and the access of marginalised groups to technologies such as vaccines.

The image shows two presentation slides titled "Indian Landscape of Covid-19 Vaccines". The left slide is labeled "(1/2)" and the right slide is labeled "(2/2)". Both slides feature a table with the following columns: Product, Indian Manufacturer, Collaborator, and Current Stage.

Product	Indian Manufacturer	Collaborator	Current Stage
Covishield (Chimpanzee Adenovirus)	Serum Institute of India, Pune	Astra Zeneca	Phase II/III Applied for EUA*
Covaxin (Inactivated Virus)	Bharat Biotech International Ltd, Hyderabad	Indian Council of Medical Research, India	Phase III Applied for EUA*
ZyCoV-D (DNA vaccine)	Cadila Healthcare Ltd, Ahmedabad (Zydus Cadila)	Department of Biotechnology, India	Phase II
Sputnik V (Human Adenovirus vaccine)	Dr Reddy's lab., Hyderabad	Gamaleya National Center, Russia	Phase-II over, Phase-III to start next week

*Emergency Use Authorization

Product	Indian Manufacturer	Collaborator	Current Stage
NVX-CoV2373 (Protein Sub-unit)	Serum Institute of India, Pune	Novavax	Phase III under consideration in India
Recombinant (Protein Antigen based vaccine)	Biological E Ltd, Hyderabad	MIT, USA	Pre-clinical animal studies concluded Phase I plus II human clinical trials started
HGCO 19 (mRNA based vaccine)	Genova, Pune	HDT, USA	Pre-clinical animal studies over Clinical trials (Phase I and II) to start
Inactivated rabies vector platform	Bharat Biotech International Ltd, Hyderabad	Thomas Jefferson University, USA	Pre-clinical (Advanced)

■ Another vaccine, which is in the initial stage, is being developed by Aurobindo Pharma

I.c. The landscape of Covid-19 vaccine development in India

India is the largest vaccine manufacturer in the world, supplying more than 60% of all vaccines in the world, particularly those for low-income countries. Despite getting government support, vaccine research and manufacture are driven by commercial interests.

This is true of the Covid-19 vaccine as well, not just in India. Though the vaccine should be a public good, it is being developed as a multinational, for-profit enterprise, even when funded by governments. There are at present nine Covid-19 vaccine candidates under development and testing in India, in collaboration between industry, governments, international funding agencies and global alliances. No public sector unit is manufacturing the vaccine.

By mid-December, two companies had applied for “emergency use authorisation” without completing the clinical trials. One of these is the Serum Institute of India (SII), which has received money from the Bill and Melinda Gates Foundation’s strategic investment fund

through the Global Alliance for Vaccines and Immunisation (Gavi), to manufacture 1 billion doses of a vaccine developed by the Oxford University and licensed to Astra Zeneca (AZ). These doses are for LMIC to be distributed through the Gavi/ COVAX (Covid-19 Vaccines Global Access) Initiative. *[India is expected to receive a certain number of doses through COVAX and buy the remaining doses that it needs directly from manufacturers.]*

The Indian government is preparing for the vaccine rollout, and specific groups — those with work-related risk or biological vulnerability — have been identified for priority access to the vaccine, and state governments are drawing up lists of health workers, frontline workers, and those above 50 years of age and those with comorbidities even if they are below 50 years of age. It has announced that it will administer the vaccine to 30 crore people in these categories in the first phase.

Some concerns about the vaccine development and rollout in India and internationally were flagged:

- **How will the vaccine be provided across the country without compromising on other health services?** India spends less than 1.5% of its GDP on health (1) The Oxford/AZ/SII vaccine is the cheapest at Rs 225 per dose. India needs 600 million doses (to cover 30 crore healthcare workers, frontline workers, and people with comorbidities). *[Covering 20% of the population will cost approximately Rs 13,500 crore on the vaccine alone.]* There is a danger that the major financial, infrastructural and human resources required to administer the vaccine across the country will overwhelm all other health services, which has already been seen during the lockdown period.
- **How will concerns regarding rights and equity be addressed in the vaccine rollout?** How can we prioritize such that vulnerabilities faced by Dalits, sex workers, Adivasis, transgender people and similar vulnerable groups is accounted for? What are the concerns about the use of biometrics for access to the vaccine? Will this be mandatory? Will informed consent be sought before administering the vaccine? Will compensation be given for adverse events following immunisation? Would health care workers be targeted in cases of ‘vaccine failure’? Have health care workers been consulted before making them a priority group?
- **Will vaccines be safe and well monitored?** Pharmaceutical companies have applied for “restricted use” for an emergency on the basis of limited safety and efficacy data. There are concerns about the safety of a product that will be used on millions of healthy people. Are they being approved on the basis of sufficient data? Are post-marketing monitoring mechanisms for adverse events after immunisation adequate? What level of transparency should we expect on

trial protocols? Several controversies related to regulatory approval, serious adverse events, and the conduct of trials have already emerged in India.

- **We need a fundamental critique of warp speed development** which permits simultaneous conduct of phase 1/2 or 2/3 trials, approval based on smaller samples, shorter follow-up, and even approval on the basis of preliminary data of phase 3 trials. Do these compromise the vaccines' safety and efficacy? How does approval with incomplete data affect the standard of care for future vaccine trials? Is vaccine development driven by scientific need, market demand or government pressure, or all of these?
- **We need to evaluate WHO's equitable action framework for prioritised access** to diagnostics, therapeutics and prophylactics.
- **We need to examine international alliances** (COVAX, GAVI, Coalition for Epidemic Preparedness Innovations) for research and development of vaccine candidates and their provision to LMIC. Do they ensure fair and equitable access worldwide?
- **We need to look at the global scenario of vaccines and investments** — public and private investment, intellectual property rights, and the ramifications for equitable access. There are inequalities across countries in vaccine access, and rich countries have cornered the bulk of vaccines scheduled to be manufactured. Some countries are "assured" 5 doses for each person, while a country like Bangladesh is "assured" access to vaccinate only one in nine of its population.
- **We need to look at the political economy and ecology of vaccine regulation:** how a vaccine's safety and efficacy are defined, the role and functioning of subject expert committees, the interaction between regulators and industry, operationalising the ideal of vaccines as a public good.

In conclusion, Sarojini summarised the government's responsibility in its response to the Covid-19 pandemic: *"to regulate with transparency, retain the public's trust in the research and approval process, and ensure equitable distribution of safe and effective vaccines, that have been ethically researched, without cost, for the marginalised, without coercion, keeping the social determinants of health in sight while addressing the needs of the pandemic."*

II. Equity and marginalisation and concerns at the global level /country level experiences

The overview presentation was followed by a few invited speakers to flag specific issues related to the global level. Referring to the many types of inequities identified by Sarojini,

II.a. The first invited speaker Prof Gita Sen proposed three questions to frame the discussion on “gender, equity and access”.

First, how robust is the evidence between economic inequality and health status/outcomes? All reviews have agreed that there is a clear and strong relationship between economic inequalities and a whole range of social outcomes, particularly health status and outcomes. This is important to recognise, because the pandemic is unfolding in the context of huge increases in inequalities, both global and within many countries. Any meaningful response to the pandemic that goes beyond the short-term “fixes” must address this problem of rising inequality.

The second question is: **which inequalities matter in this pandemic?** She suggested we should think about inequalities in terms of three ‘buckets’.

The first ‘bucket’ is what one might call **identity** inequalities — by birth, ingrained, or more malleable, changeable, etc. These include economic class, gender, disability, status, race, ethnicity, migrant status, religion, sexual orientation, gender identity and expression, etc. People face these inequalities on a daily basis directly. While this bucket of inequalities may vary in different countries and contexts, there is no doubt that the pandemic has had an enormous impact on those at the bottom of this bucket of inequalities, who are also at great risk of not having adequate access going forward.

The second ‘bucket’ is **structural**. The inequalities in this bucket are connected to the way in which health systems are structured, which determines access to various services; or the way in which labour markets are structured, and the labour hierarchies that exist. This is not only among health workers, where we know there are huge hierarchies which interplay with identity inequalities, but also among migrant workers, informal sector workers, and so on. There are also intergenerational, demographic structures that determine how the health system works and for whom – what happens with younger people, older people, and so on. Urban-rural inequality is another one of these. These buckets are “porous”; obviously identity and structural inequalities interact in many ways.

The third bucket is of structural inequalities that **operate at the international level**. This is very important in the context of the pandemic. For example, the IMF head says the poor must not suffer, while the IMF is pushing austerity packages for the poor in LMIC, which are likely to make it very difficult for LMIC to address the needs of their

health systems and the pandemic. Similarly, the COVID-19 Technology Access Pool (C-TAP) multi-country initiative to suspend IP clauses for Covid-19 related technologies has been blocked by governments. Covax has got more buy-in from different parties because it does not seriously challenge IP regimes. Currently there is the TRIPS waiver challenge proposed by India, South Africa and four other countries to waive IP clauses at this time.



Prof. Gita Sen emphasizing on addressing the structural inequities existing in the health system.

Gita Sen concluded by noting that the pandemic laid bare, made the world acutely aware of three things “endemic” in our systems: the huge increase in corporate power, not just the pharmaceutical industry but other things, like digital corporate power, which is closely connected to the way the pandemic and the vaccines are likely to play out; the huge challenge of authoritarian democracies; what that implies for health systems, the fact that *so many* of our health systems are broken, and finally the importance of ethics, human rights and accountability. She asked: is the crisis going to remain a crisis or an opportunity to push for change?

II.b. The second speaker was Leslie London, People’s Health Movement, South Africa.

South Africa has been severely hit by the pandemic. The first case was reported on March 5, 2020 and as of December 18, about 900,000 cases and 24,000 deaths were reported out of a population of 65 million. There is a very high unaccounted-for mortality

that is probably related to Covid. There has also been a severe impact on economic activity, burden on the poor, and people have lost livelihoods, though there have been some social relief measures such as Covid-19 grants for employers to pay workers. The second wave has now started. There has been a strong, spontaneous civil society response to the pandemic.

The screenshot shows a Zoom meeting interface. The main content is a presentation slide titled "South Africa's epidemic". The slide includes a line graph titled "RSA (Natural) Excess Deaths and Reported Covid-19 Deaths" showing a sharp peak in excess deaths in late May/early June. Text on the slide includes: "1st SA case March 5th - traveller to Italy", "To date, in a population of 65 million: 892813 confirmed cases, Officially 24011 deaths due to COVID-19 (unaccounted for deaths 20% to 80%)", "1st wave began W Cape, spread to other provinces, ended August", "Severe economic impact", "Some social relief of...", "Second wave...", "High variability between provinces", and "Strong Civil Society response: C19 Coalition, CANs". A video feed of Leslie London is visible on the right side of the screen.

Leslie London providing the situational analysis of COVID 19

Exacerbated existing inequalities: The pandemic has exacerbated existing inequalities: for example, gender-based violence increased during the lockdown, and there are gendered consequences of nonpharmaceutical interventions. Third, other health care services such as abortion services and services for disabled people have fallen by the wayside because of Covid-19.

The private sector exacerbates existing inequalities: South Africa has a two tiered system. Only 20% of the South African population uses the private sector, where they get much greater access to health care, but only upon payment. It is not clear how the private sector will have access to the vaccines, but we anticipate that just as it is [5.5 times] easier to get a Covid-19 test in the private sector, those who can afford to pay for the vaccine will jump the queue, reinforcing existing inequalities.

Denial of care due to IPR: For example, even at the peak of the epidemic, not enough tests were conducted. The TB test platform could have been used for PCR testing Covid-

19 but while South Africa had plenty of test kits, all available cartridges needed for the tests were bought up by the US. The national health laboratory services were prevented from manufacturing the test cartridge due to patent protection. People had to wait days, even weeks to be tested. Prevention was hit as testing of contacts was delayed. Many people died as a consequence.

Covax is Big Pharma: The COVAX mechanism is essentially health technology governance put in the hands of Big Pharma and Bill Gates. It supports patent control of the market and providing vaccines through a donor mechanism; it does not allow a fundamental systemic change. Surprisingly, countries such as Norway with progressive views have opposed patent waivers and supported COVAX.

Issues in equity in vaccine production, availability and distribution: South Africa has both public and private capacity for vaccine production. There are at least 3 vaccine trials ongoing. Johnson & Johnson recently concluded a deal with a local company. They have also applied to the regulator. However, it is not clear whether any vaccine from that agreement will be available locally or which vaccine will South Africa ultimately get under COVAX.

The country's president announced that the initial stock will cover 20% of the population in early 2021, but it is not known if that will be followed through. In any case, there is no clarity on priority populations. Some 30%-40% of the population is in vulnerable categories - age, obesity, diabetes, hypertension, etc.

In South Africa, there is no legal compulsion to be vaccinated, though the health services encourage it. Informed consent is nominally required but not always taken. Information about compensation for injuries following vaccination is not available; it is presumed that people who suffer injury following immunisation will have to sue privately for any compensation.

There has been no discussion in South Africa about gendered or intersectionality risks, or populations that are vulnerable because of their social situation — homeless, migrants, disabled, discriminated against because of sexual orientation, etc.

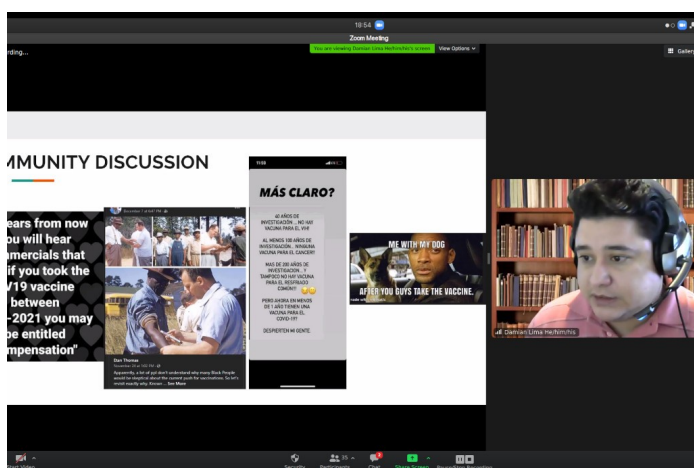
Vaccine disinformation — circulation of incorrect or misleading information on the vaccine's risks, including conspiracy theories on the vaccine's — has been a major problem in South Africa. (A survey conducted by the market research company Ipsos for the World Economic Forum in December 2020 found that only [53% of South Africans](#) would be willing to take the Covid-19 vaccine, down from 64% in August 2020.)

Importance of a civil society response: South Africa can use its experience of its strong civil society response to the HIV pandemic, when medicine prices were brought down through community mobilisation, advocacy, and legal challenges to IPR. A similar response to the Covid-19 pandemic is needed to make the health system act responsibly.

The People's Health Charter of the PHM reinforces the UN covenant on economic and social rights, and the right to the highest level of physical and mental health. This puts an obligation on the state to control the epidemic and other diseases, and to ensure access to services. The constitution in South Africa talks about the right to health care and the state's responsibility to take steps to the realisation of each of these rights. Access to the vaccines should be framed as a human right. In that context, civil society organisations could undertake a campaign for equitable access to vaccines, which means addressing the most vulnerable, giving voice to the people who have the greatest need.

II.c. Leigh Haynes and Damian Lima, PHM, USA

In the US, there is a huge politicisation of the virus, the response and the vaccine. Over 17.5 million infections and over 300,000 deaths were reported as of mid-December, when the first vaccines were rolled out.



Damian Lima drawing comparison between the Tuskegee study and Covid-19 vaccine rollout to highlight the reason of distrust among oppressed communities.

A history of distrust: The general sentiment is that of distrust, coming from a history of trauma, government actions on oppressed communities including testing on people of colour. Many people refer to the Tuskegee study as an instance of such experiments by the government. They do not trust the actions of the current administration, and there are suspicions about who created the vaccine, under what circumstances, and whether this is a US government plot. Given the inequities of racism and capitalism,

people's distrust of the health care system seems justified. Studies have found that 20% of trans people are refused medical care and face physical violence in the health care services.

Despite this mistrust, there is no public communication strategy from the federal or state governments to make sure people have a basic understanding of the vaccine and its safety.

Inequity and risk: Health care and essential workers are mostly women, people of colour, who can't take refuge from the virus as others have, so there is further inequity there.

There is also a human rights crisis among the incarcerated; worldwide, the US has the largest number of people in prison. Forty out of the 50 largest cluster outbreaks have been in jails and prisons. There is little or no access to care in prisons. People are dying, but no one is talking about it. The NAACP is filing lawsuits on this.

Inequities and health care

access: Gender inequities affect access. The medical system is privately managed. People without jobs, without transport, without literacy to apply for assistance, won't be able to get the vaccine. [One's access to a vaccine is also likely to be affected by insurance coverage, at least for any booster doses.]



Leigh Haynes talking about how inequities affect the marginalized sections inadequately.

Policy responses are largely

absent: There is no universal system of health care, and people have received huge hospital bills for Covid-19 care. The federal structure determines the public health response. Orders for lockdown, masks, closing schools, etc are imposed on communities differently. Policies on who gets the vaccine first and when, vary from state to state. Lee Hanes is in a rural community in southeast Texas where health care workers are getting the vaccine first, but only in cities and counties with large populations; the others have to wait. The state of Rhode Island covers the cost of testing, but Texas does not. The president elect [now president], Biden, says the vaccines will be free for the entire population but we will have to wait and see.

Long-term implications for the health system: The pandemic will affect people's access to health care in the US long after it dies down. For example, if we need an annual booster of the vaccine, can people afford it? Will disability due to Covid-19 infection be a pre-existing condition that insurance won't cover?

Vaccine hesitancy and lack of outreach: Historically, oppressed communities are more likely to have doubts about taking the vaccine, fearing that they would be used as experimental subjects in the vaccine programme. The national equal employment opportunity commission issued a guidance permitting employers to make the vaccine mandatory for their employees. However, there are no efforts to make sure that people are confident that the vaccine is safe and is for their benefit. In this situation, some people may be forced to take the vaccine despite their hesitations, because they need to keep their jobs.

Global implications of US involvement: There is a lot of vaccine hoarding and no commitment to global access. The US's commitment to 'Covax' and TRIPS conditions may change with Biden, but this is doubtful.

II.d. Prof Janet Price, UK

The pandemic exposed the UK's "post imperial delusions, hubris, arrogance, failure to achieve many of the things we set out to do".

The destruction of the public health care system over the last decade is responsible for the failure to contain the pandemic in the UK. The public health system has been decimated, because of austerity cuts on health and social care systems in the UK especially in the last decade. The government contracted out the test and trace system to a private company as has been the case for many things. Health care and public health have struggled during this time.

The first cases of Covid-19 in the UK emerged during the Brexit negotiations and were ignored until cases spread up to the South. As the second wave hit the North, the rules have been different, with the lockdown more localised. The financial support that was available when Covid-19 hit the South has not been available to cities and towns in the North.

Britain is very centralised in politics. This produced the first real push in a long time for independent, city-led rule. The inability to get to grips of the pandemic, the dismay at government action, and the damage done to people's sense of what Britain is, all have sped up the breakup of Britain. Now Northern Ireland and Wales want to break off.

On the other hand, while Brexit split the country down the middle, with families falling apart, Covid-19 has seen a community coming together, shopping for neighbours, preparing meals, restaurants delivering meals to shielded groups of the population. There was a campaign to fund free school meals for schoolchildren who had been denied these meals during the holidays. The footballer Mark Rushford, who had been on free school meals himself, raised a fuss, and the government crumbled and agreed to pay for the meals.

There is a real tension around the country around the health system and its survival. Post Brexit there has been a push to force people out of the country – the Europeans who no longer belong here, and the Caribbean who are central to the health system are being deported on the basis that they are not legal immigrants. They are also the people who are dying in the largest numbers from Covid-19, not only as health care workers and technicians but also because they are vulnerable in other ways.



Prof. Janet Price explaining how weakening of public health systems impacted the management of COVID-19 outbreak in UK.

The UK was the first country in the world to vaccinate. As it scrambled to buy vaccines, it also cut aid for vaccines and health services in other countries. While providing a free public health system in the UK, it is also pushing to privatise health services broadly. Though all the contracts in Covid-19 have been private, little of the money has gone to public health.

There is a perception of an underlying eugenics in the government's actions. Though the older and disabled are on the priority list for the vaccine, there is a lot of suspicion and cynicism that the vaccine is being tested on the old, and vaccine failure or vaccine-related deaths among this group are seen as acceptable. There is a sense in the population that there is an underlying eugenic policy in the way that so many older people have been allowed to die.

Vaccine hesitancy: The vaccine is meant to go to the most vulnerable to reduce transmission and the number of cases, and to protect health and social care workers. The rollout will be very difficult — as many as 24% of the British public do not believe in the vaccine. There is an enormous public health education needed through TV networks and the social media.

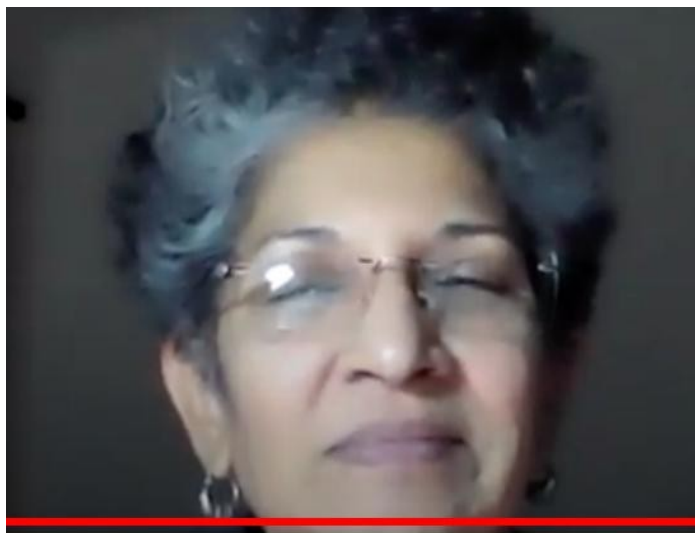
II. Themes emerging from the presentations and group discussions

The discussions touched on issues and strategies at the country, regional and the global level.

A. Multiple marginalization

The speakers' presentations highlighted various types of inequity experienced in their regions — such as of class, caste, ethnicity, gender and sexuality and disability. The pandemic has deepened existing inequities and risks. For example, there is evidence from many countries that gender-based violence increased during the lockdown. The status of migrants became threatened in the UK. Religion-based discrimination worsened in India: gatherings of Muslims were described as “super-spreader” events while there was no such labelling of gatherings of Hindus.

In the US, [research](#) has established what is commonly known: obesity, diabetes and hypertension are associated with racial discrimination, poverty and the high cost of a healthy diet; this contributes to the [disproportionate](#) burden of infection, hospitalisation and death from Covid-19 among people of colour.



Sandhya Srinivasan

All over the world, most of the health care workers who cannot take refuge from the virus are essential workers, caregivers, marginalised communities, whether Dalits (in India), people of colour, migrants, women. In the UK, the Europeans and Caribbeans who are being deported are central to the health system; they are also dying from Covid-19. In the US, 40/50 major outbreaks in the US were in prisons. [Older people face a different kind of discrimination. A

recent NYT article noted that [40% of all Covid-reported deaths in the US were in care homes.](#)]

Such inequities are also expressed in health care access at different levels. For example, some marginalised communities, such as trans people, face abuse, denial of care, by the health services. Hospital care for the rural poor is even more difficult to obtain than for the poor in cities and towns. At the level of technologies, rich countries have made

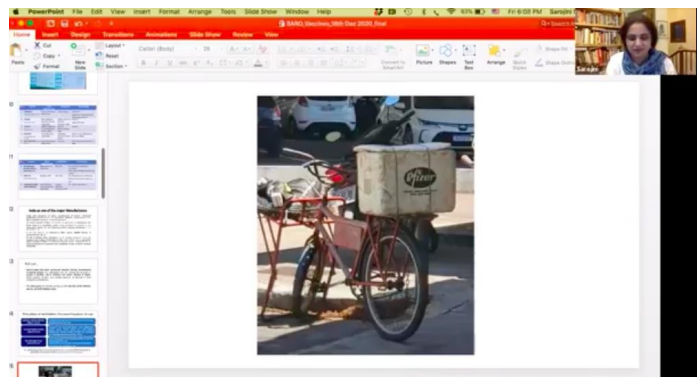
advance purchase agreements of vaccines in excess of their own needs, depriving poor countries.

Gita Sen referred to relationships between inequalities based on identity, and structural inequalities at the local and international levels. She also called saw the crisis as an opportunity, as the public is more keenly aware of how their lives are directly affected by corporate power, by broken health systems, and ethics and human rights violations. These issues were reflected to some extent in the discussions.

B. Privatisation and public health

The dominance of the private health sector exacerbates such inequities. All the country reports indicated that a major barrier to any equitable and effective response is the weak public health systems, and the dominance of private health systems which have always been unfriendly to those without money. Health care expenses are a major cause of impoverishment in highly privatised health systems of countries like India and the US.

Public health services suffering decades of neglect and financial deprivation have been brought to their knees by the pandemic. In India, government hospitals struggled to treat the large numbers of poor patients with Covid-19, sometimes abandoning even emergency care of all other kinds. In South Africa, delays in Covid-19 testing in the public system resulted in thousands of deaths. In the UK, where austerity cuts over the years starved the public health system. even during the pandemic, government funding went largely to privately contracted services. Other public health care services such as immunisation, abortion services and services for disabled people have fallen by the wayside because of Covid-19. All over the world, public health services will be overburdened by the vaccine rollout.



In many countries, the private sector has viewed the pandemic as an opportunity, and this is especially true for the vaccine industry. In India, the Serum Institute of India has announced plans to sell the vaccine to the private sector at five times the price set for government sales. The vaccine is likely to be made available in the private sector in many parts of the world, giving priority access to those who can pay for it.

In the US, too, where the medical system is managed privately, and there is no universal system of health care, people have borne the brunt of Covid-19 care expenses. Even if the vaccine is free for the entire population, access may be more difficult for those

without jobs, transport, or the ability to apply for support. In the longer run, access to Covid-19 care will be determined by the health insurance industry.

C. How government action engenders vaccine hesitancy

The pandemic is also an opportunity for increasing use of [digital databases](#) with biometrics. These are often developed in collaboration with [private software companies](#) and have been used for contact tracing and to control access to care. These surveillance mechanisms — often developed with private sector involvement — are justified as essential public health tools though they raise serious [privacy concerns](#).



Chayanika Shah

There is opacity in the actions of governments and corporations, and a nexus between government and private sector. For example, the politics behind approval of drugs and vaccines affects the most vulnerable. In India, regulatory authorities approved a vaccine without efficacy data, apparently in order to include an indigenously developed vaccine in the vaccine rollout. Another vaccine has been approved on the basis of incomplete data. Healthcare workers are the

first recipients of these vaccines. Such actions encourage distrust in the government as well as the health care industry.

Vaccine scepticism and hesitancy draw from this opacity. Vaccine hesitancy varies across countries, with a World Economic Forum [survey](#) finding vaccine acceptance ranging from 80% in China to as low as 40% in France. This hesitancy draws upon a history of racism in health care, and a history of health rights violations including testing on marginalised communities. This has fuelled conspiracy theories. There is an urgent need to develop a people-centred communication response, providing accurate information on the vaccine and its safety. (This is important for people to make an informed decision on whether or not to take the vaccine.)

D. Equitable vaccine access is blocked by the IPR regime

Finally, technology is central to the response to the pandemic. Vaccines, especially in a pandemic, should be viewed as a global good, and countries should be able to manufacture vaccines and diagnostic, therapeutic and prophylactic technologies according to the need. However, patent restrictions in Covid-19 technologies alone have cost hundreds of thousands of lives. Industry-supported mechanisms such as COVAX promise a fraction of the vaccines needed, and do not ensure equitable access and

sufficient coverage. The campaign against the IPR regime is essential to any campaign for vaccine equity.

What we can do

One step suggested in the discussions was to **conduct systematic comparative assessments** across countries. In addition to looking at issues such as health systems, patents, vaccine scepticism, discussed so far, there is a need to look at the vaccine rollout in different countries - the level of vaccine development, available stocks and other funds, level of preparedness, government strategies in delivering the vaccine, and what proportion of the vulnerable populations are getting the vaccines. This overview would be used as evidence for advocacy at the global level.

Alongside, there is a need to **critique the vaccine development process**. Vaccines for Covid-19 have been developed at “warp speed”, within a few months of the virus being identified, and less than nine months from the time a pandemic was declared, three vaccines have been approved for emergency use. This has entailed shortcuts such as running phase ½ trials, or Phase 2 /3 trials, at the same time. Vaccines have been approved and are being used on the basis of limited safety and efficacy data; it is felt that the urgent need for a vaccine outweighs the potential risks and the modest benefits. However, such decisions are taken by committees whose decisions are apparently not accountable to the public.

It is also necessary to **examine whether Covid-19 vaccines are in fact being treated as a public good**. This requires an evaluation of WHO’s equitable action framework for prioritised access to diagnostics, therapeutics and prophylactics, and an examination of international collaborations for equitable research, development and provision of vaccines.



Ayse Dayi

There are **lessons from other struggles and opportunities for collaborations**. South Africa can use its experience of a strong civil society response to the HIV pandemic; medicine prices were brought down through community mobilisation, advocacy, legal challenges to IPR, resulting in a steep fall in the prices of antiretroviral drugs. Such campaigns have also been held against unethical research, and population control. A similar response to the Covid-19 pandemic is needed to make the health system act responsibly.

It was pointed out that the **campaign must expand its reach**. It is important to talk to the international disability community. There is also a need to expand the collective discussions to people from Latin America who can speak English and Spanish, and to people where English is not the first language.

There is a need to **connect vaccines with the Universal Health Care (UHC) process**. Reforms in UHC financing mechanisms have both national and global relevance, and TRIPS has an impact on this. Access to Covid-19 technologies should be seen as part of the full spectrum of technologies.

Organisations that can support a campaign for equitable access to Covid-19 vaccines

These inequities are long-standing and entrenched and will require the involvement of larger movements and networks. Even then, any major gains will take time. However, it is possible to do focused campaigns on specific barriers to care.



Maria Zuniga

The People's Health Charter of the **People's Health Movement** reinforces the UN covenant on economic, social and cultural rights, and the right to the highest level of physical and mental health. This puts an obligation on the State to control epidemics and other diseases, and ensure access to services. Access to vaccines should be framed as a human right. In that context, the PHM could undertake a campaign for equitable access to vaccines. Another organisation which can

support the campaign for access to covid19 vaccines is **Health GAP** (Global Access Project) is among those leading the agenda for WTO waivers, against Special 301 Watchlist, and other challenges to the patent regime. The [EACT PHM website](#) could serve as a clearing house for information. India, Korea, South Africa and PHM Global are working together and the methodologies might be useful as well.

Conclusion

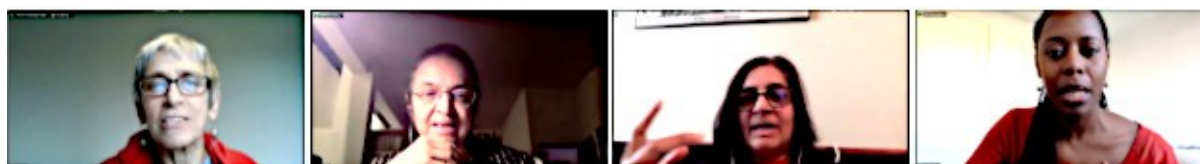
The Covid-19 pandemic has caused devastation across the world but unequally affecting groups marginalised across gender, class, caste and other equalities, and access to treatment and vaccines is restricted along the same and related inequalities.

The presentations and small group discussions gave a wide range of the nature of inequalities, inequities, differences in experiences, in health systems and across nations.

The situation, worldwide, is one of uncertainty of science, corporate greed and opacity of governments in an inequitable world.

Vaccines require collaboration but neither industry nor government is accountable to the public, and the concerns and voices from the ground are left out of many discussions. It is our responsibility to keep amplifying these voices, influencing bringing our concerns to the table, influencing these organisations as much as we can.

The issues raised in the discussions resonated across nations, and the conversations will be carried forward. Ideas are welcome on how to engage, and other platforms and alliances that can be involved.



Note

1. Public health spending is less than 1.5% of the Gross Domestic Product, compared to the 2.5% promised in the National Health Policy of 2017. In the [central government's budget, presented on February 2, 2021](#), allocations for health have increased marginally from Rs 65,011.8 crore in 2020-21 to Rs 71,268.11 crore in 2021-21 (with one-time additional allocation Rs 35,000 crore for Covid-19 vaccines “when needed”). However, these do not permit any structural reforms in the health system.

Annexure

List of Participants

S. No	Name	Country	Email id
1	Abhishek Royal	India	abhisekroyal2010@gmail.com
2	Aise Dayi, Germany	Germany	dayiayse0@gmail.com
3	Banu Subramaniam	US	banu@wost.umass.edu
4	Bing, WGNRR	Philippines	marevic@wgnrr.org, corine@wgnrr.org
5	Chayanika Shah	India	chayanikashah@gmail.com
6	Damian Bright	US	damian@maebright.com
7	Farida Akhter	Bangladesh	kachuripana@gmail.com
8	Fran Baum, PHM	Australia	fran.baum@flinders.edu.au, fbaum@phmovement.org
9	Gita Sen	India	gita@iimb.ernet.in
10	Janet Price	UK	janeteprice41@yahoo.co.uk
11	Kajal Bhardwaj	India	k0b0@yahoo.com
12	Karyn Kaplan	Thailand	kkaplan@asiacatalyst.org
13	Lauren Paremoer	South Africa	lparemoer@gmail.com
14	Leigh Haynes	US	leigh.kamore@gmail.com
15	Leslie London	South Africa	leslie.london@uct.ac.za
16	Loretta Ross	US	lorossta@gmail.com
17	Maria Zuniga	Nicaragua	mhamlin@phmovement.org
18	Marion Stevens	South Africa	muizmarion@gmail.com
19	Peninah Khisa	Kenya	peninahkhisa@gmail.com
20	Renu Rajbhandari	Nepal	suchana.renu@gmail.com
21	Ranjan De	India	ednajnar@gmail.com

S. No	Name	Country	Email id
22	Sai Jyotirmai Racherla	Malaysia	sai@arrow.org.my
23	Sandhya Srinivasan	India	sandhya199@gmail.com
24	Shiba Phurailatpam,	Thailand	shiba.p@gmail.com
25	Shireen Huq	Bangladesh	shireenhuq@gmail.com
26	Sulakshana Nandi	India	sulakshana.nandi@gmail.com
27	Veena Johari	India	veenajohari@gmail.com
28	Sarojini N	India	sarojinipr@gmail.com
29	Deepa V	India	sama.womenshealth@gmail.com
30	Nitin Jadhav	India	sama.publichealth@gmail.com
31	Adsa Fatima	India	sama.womenshealth@gmail.com
32	Ritika Kar	India	sama.genderhealth@gmail.com
33	Susheela Singh	India	sama.genderhealth@gmail.com
34	Sneha Makkad	India	sama.genderhealth@gmail.com
35	Abhiti Gupta	India	sama.genderhealth@gmail.com
36	Agrata Sharma	India	sharmagrata@gmail.com
