Report of the 2nd International Consultation

on

Gender, equity and access to Covid19 vaccines and beyond

23 and 24 July, 2021

(online meeting)

Organised by

Sama Resource Group for Women and Health

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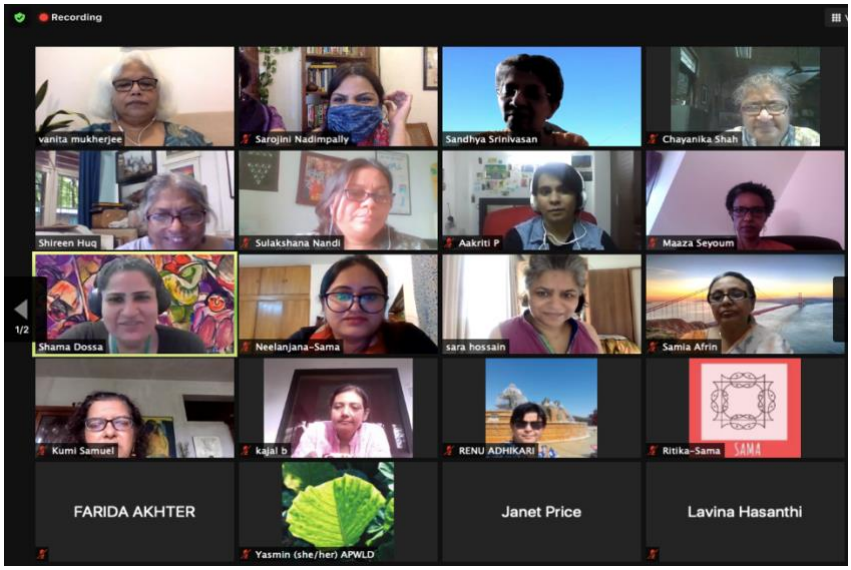


Introduction

The past two years had seen all of us reel under the pandemic – an intensely challenging time as countries and communities grapple with COVID surges and the devastation that has accompanied it. It has altered many of our lived realities and we continue to experience injustices, grief, loss of health and lives. Not only did we painstakingly witness deaths and illnesses all around us, but also saw worsening inequalities in our world - determining who could access our healthcare systems and at what cost. While countries in the Global South generally experience various challenges in obtaining ideal health outcomes due to various factors, now they are also struggling with additional challenges like the repercussions of lockdowns on their economies, weak social protection schemes, poor health structures, and political conflict – which has further worsened their response to COVID-19. Increase in gender-based violence, structural marginalization of sexual and reproductive health and rights, precarious environments within health systems for women and other frontline workers point towards the gendered fault lines in our societies and systems globally has been much more visible in this pandemic. The possibilities for diagnostics, treatment, and prevention of both - COVID-19 and non-COVID health problems are limited in a myriad way in several countries, and more so for the marginalized communities. But, amidst all this, the Big Pharma and authoritarian States unabashedly continued to drive their profiteering agenda and denial of human rights.

Unfortunately, there has been almost no discussion among global health institutions and governments towards a gender and equity analysis of the COVID-19 outbreak. Nor have there been adequate efforts to involve women, youth, LGBTI and other marginalized communities, in the policy process, COVID preparedness and response process in affected countries. In this context, SAMA made an attempt towards,

a. understanding not only the impact of the pandemic on the larger society but also analyzing the gaps in the response towards pandemic and;
b. strategizing how to move forward bearing an intersectional, feminist approach through various strategies.

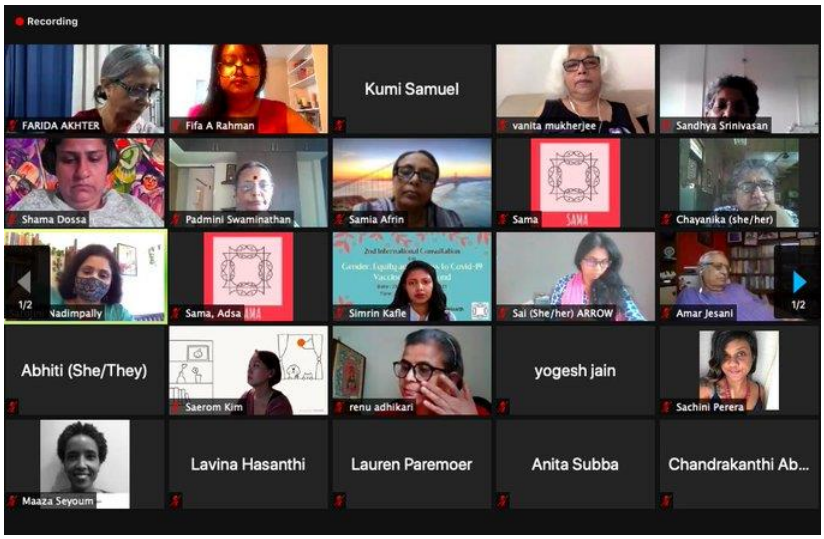
Further, SAMA recognised that the need of the hour was to develop a gender and intersectional analysis framework to assess equitable, universal access to COVID-19 vaccines which would serve to

inform global policy for just and equitable future access to health care technologies particularly vaccines. All this while, SAMA has been involved in hosting webinars on Ethical and Legal Challenges in Vaccine Research and Access; Training workshop on vaccine hesitancy; Gender, Equity, and Access to COVID-19 Vaccines and Beyond; Pandemics and Public Health: Learnings from the Past and Present and more. SAMA has also held regional level consultations with frontline workers (FLWs) and has been involved in relief work with community-based organizations in several states of India.

Consultations/Deliberations at International Level

The **first** international **Consultation** was organised in **December 2020** and the **second** international consultation was held on **July 23rd and 24th** with a wide range of groups and alliances – (feminist groups, young people's groups and LGBTQI alliances, sex workers networks, disability rights networks, feminist bio-ethics networks, public health networks, people's health movements, patient rights groups, etc.).

This diverse group of activists in public health, feminist, legal activists and representatives from various people's movements identified the cross-border commonalities and specificities in the aftermath of COVID-19 and embraced the consultation as a space for hope and solidarity in these trying times. The main objective of this two-day meeting was to create a feminist framework through discussions, sharing of experiences and to strategize how to move forward bearing an intersectional, feminist approach and to explore future collaborations.



Holding on tenaciously to our core basic feminist principles, over 80 participants hailing from countries across the South Asia, South East Asia, Africa, South America, Europe and UK. This report covers the

second International Consultation **held in July 2021**. A background note was developed along with the objectives and shared with the participants.

Day 1, 23 July 2021

Session 1

Rationale for the need for a Feminist approach to address the Pandemic

The meeting began with a song by Neelanjana Das from SAMA. Post the song, she introduced the participants, provided logistics information and the objectives of the Consultation. Adsa from SAMA shared the work done by SAMA on the issue and presented the two-day programme.

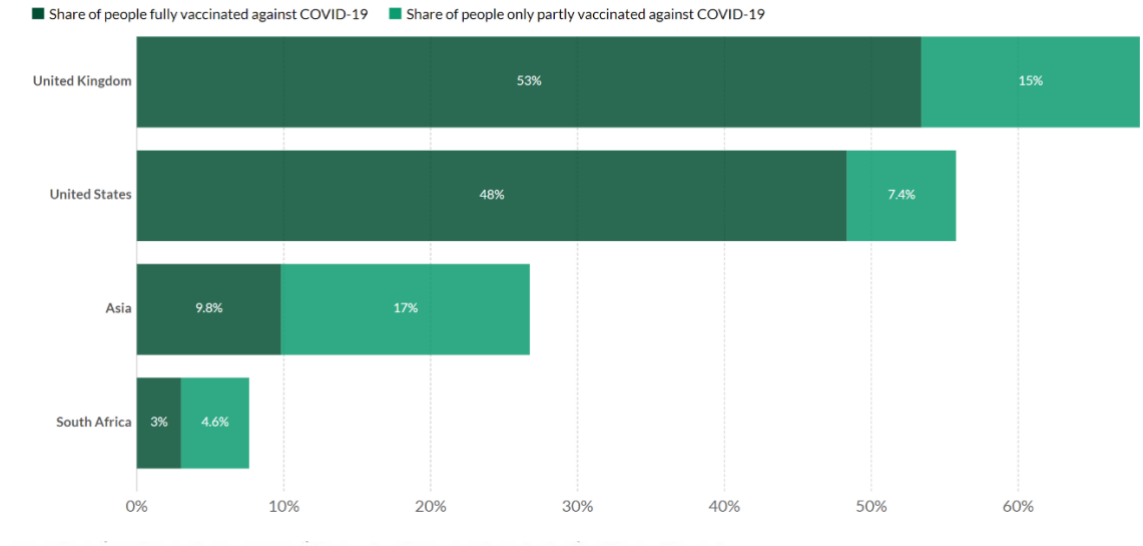
Sarojini Nadimpally from SAMA and Chayanika Shah reflected upon the need for initiating these conversations and pointed out how in the aftermath of the pandemic, the intersectional fault lines have become increasingly visible and there needs to be a greater urgency among various people's movements to strengthen solidarity. They also shared the acknowledgment that some facilitators and colleagues had to drop out because of COVID-19 emergencies particularly from Nepal and Indonesia where the oxygen crisis was at its peak.

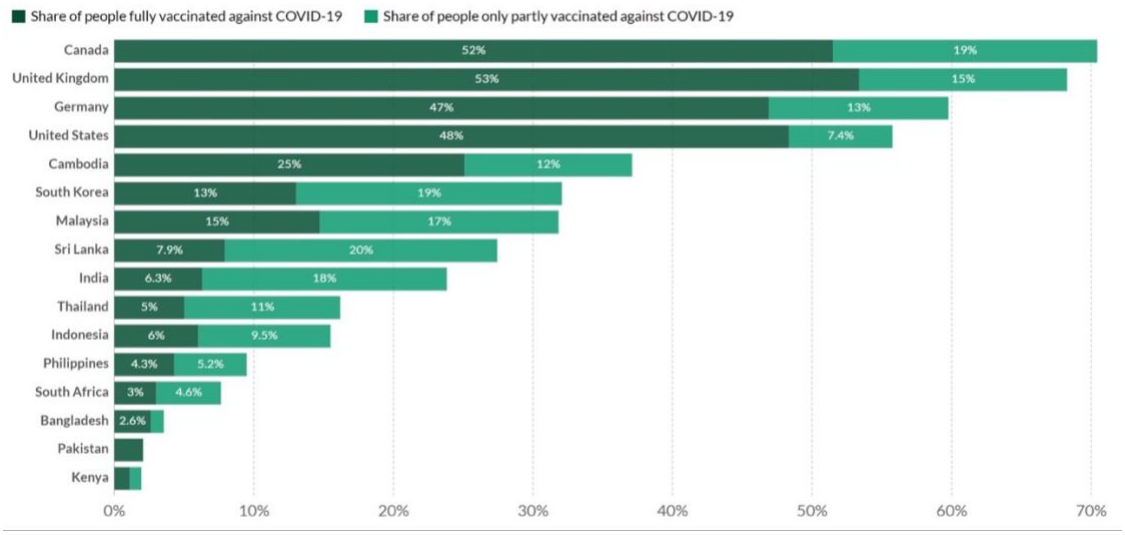
The opening presentation by Sarojini shared how inequalities and injustices have exacerbated on almost all fronts – social, cultural, economic, and public health, and more - over the last 18 months. The fault lines of our worlds drawn by gender, caste, race, ethnicity, and so on have become more oppressive under the neoliberal structures and authoritarian states. Social protections have dwindled, and democratic rights have been disavowed. The ignoring intersectional identities at various levels has been a fatal error, now more than ever.

The inequities in vaccine distribution

Sarojini also shared how the Global South has faced disproportionate effects. She presented this data from a compilation of global collaborative reports where the share of people vaccinated against COVID-19 shows the glaring disparities where the people in rich countries are vaccinated while millions in poorer countries are still in waiting. For example, only 1.2 percent of Africa's population of 1.3 billion is fully vaccinated.

Global North vs Global South

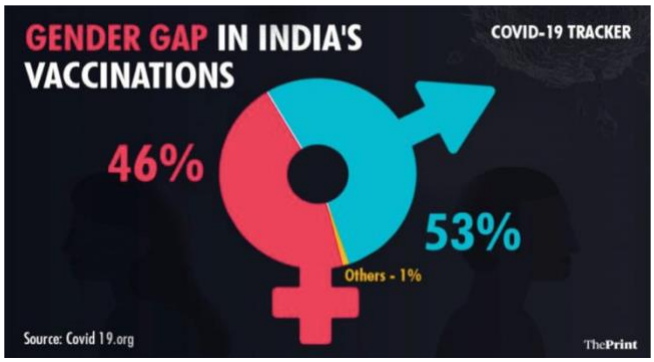




Chayanika reminded participants that while the previous consultation in this series last year was held at a moment when vaccinations were not available to the general public, times have changed drastically. The workings of vaccine nationalism and inequities, coercion and surveillance, and the profiteering of the Big Pharma is now out in the open. She said that we still have a lot to understand about this moment and this consultation is an attempt to do so together.

Gender Gap in vaccination

Sarojini noted that while some COVID-19-related vulnerabilities are shared by most people, it is important to acknowledge how the pandemic has widened the pre-existing inequalities. The disproportionate effect it has had on persons with different gender identities by widening pre-existing inequalities.



Further , there was a clear gender gap in vaccination in many South Asian countries, particularly in India, with more men getting vaccinated over women. An even harsher gap in the vaccination of trans persons, was reported in India. She noted that the governments also need to be gender-responsive and study the current vaccination trends to identify persons who are missing out on vaccinations and the reasons for the same.

Sarojini highlighted the issue of access to vaccination for persons with disability. She emphasised that the government must take adequate steps to ensure that there is a follow-up mechanism to support with side effects. This is needed specially since many persons with disability may be immunocompromised and have co-morbidities. This push also needs to come from the governments

given that the vaccines are not easily available for free, thereby the people's right to vaccines is often negated, and hardly addressed even within families.

Sarojini also spoke about the issue of vaccine hesitancy. On one hand information about the testing, approvals, rollouts, and after-effects of the vaccines was not made available to the public in a transparent timely manner, on the other hand, vaccines were administered with coercion in several cases, with a system of incentives and disincentives suggested to improve vaccination rates. There are also fears and hesitancy about COVID-19 vaccines. Also, certain myths about vaccination such as women should not get vaccinated while menstruating because their immunity is at its lowest, that the vaccine will lead to infertility, to name a few. In addition, the absence of credible, valid, accessible information worsened vaccine uptake.

She stressed that understanding the regional and cultural values of the community, health-seeking behaviours, their experiences, addressing their mobility challenges to access vaccination sites as well as providing trusted health information is very crucial in addressing vaccine hesitancy. Speaking about the need for better and immediate investments in healthcare, Sarojini cautioned that this is necessary not just for vaccinations. This includes ensuring affordable and accessible healthcare facilities - primary and tertiary intensive care, both. She mentioned that the oxygen crisis laid bare the need to facilitate global cooperation to avoid repetition of such devastations.

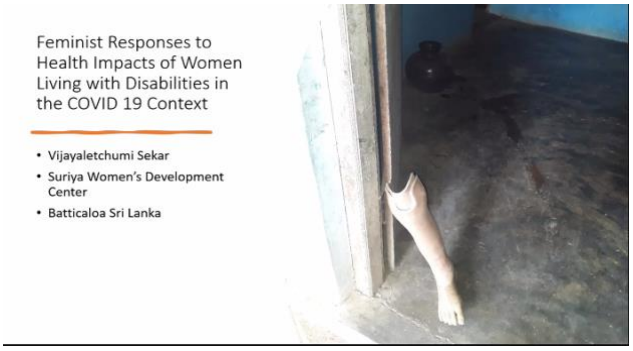
Lack of beds, oxygen, New Delhi continues to reel under Covid-19 stress

Chayanika spoke about the need to be cognizant of how the present moment is shrouded with grief and despair, and at the same time our worlds are also changing. The very nature of authoritarianism has changed, marginalized voices are relooking at understandings of multiple patriarchies and gender itself. The lack of intersectional gender responsive policies whether it is for vaccines and other health care technologies or for social determinants, access to health services, we believe it is critical to deepen an intersectional feminist analysis and learning from these situations.

Chayanika also highlighted that homogenized piecemeal approaches to the management of the pandemic have proven to be grossly ineffective. These have tended to be patriarchal and ableist and have ended up causing further exclusions. During the second wave of the pandemic, when social determinants of health were not paid heed to, the failures were starkly evident. She also mentioned that such a uniform way of handling the pandemic is not enough. Citing the example of the global campaigns for birth control in the Global North and the differing sexual and reproductive health needs in the Global South, she alerted the participants on the need for recognising contexts in any public health response. The true need of the hour, then, is to recognize and build connections from the individual to the global level. Both Chayanika and Sarojini spoke of how this is the moment to build meaningful solidarities to plan the road ahead towards a feminist post-pandemic world.

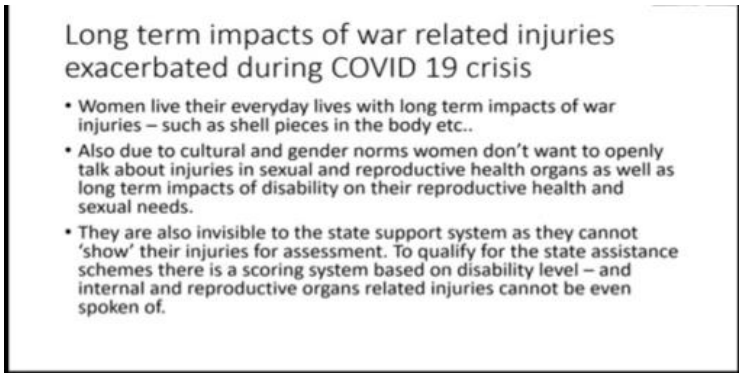
Session 2: Pandemic Injustices and Inequalities

The second session was jointly facilitated by Deepa Venkatachalam from SAMA and Priyam Lizmary Cherian from People's Health Movement (PHM). Priyam introduced the speaker for the session, Vijayaluxmy Sekar.



She was supported by her colleague and feminist activist, Ponni Arasu for translating her presentation in English from Tamil language. Vijayaluxmy Sekar is a feminist activist and community worker in Batticaloa, Eastern Sri Lanka. She is a Coordinator at the Suriya Women's Development Centre. She has been working with women living with disabilities in the post war context for the past 20 years.

Vijayaluxmy provided valuable insights on the struggles of women living with disabilities in the post-war context in Eastern Sri Lanka. She highlighted various prejudices and the blatant insensitivity with which women are subjected to in their daily lives not only by the State but also by the society. For instance, several women who have infections that have spread to their 'private parts' is left untended due to the stigma and struggle with their mental health issues. Moreover, women with disabilities have to face several barriers to access health services not only owing to their gender but due to their role in war that was brutally crushed by the Sri Lankan government. The repercussions of the war have scarred the lives of women. Even the few social schemes that exist remain inaccessible for the majority of them. The state welfare structures are predominantly male dominated which widens the gaps in accessing the services or claiming their rights.



Even their personal spaces are riddled with conflict. They face violence from their intimate partners. They often marry men who are previously married, or much older than them or alcoholic or fellow ex-combatant with disability(ies). Male ex-combatants are extremely controlling and continue to treat their wives within the same hierarchal structures present during armed struggles.

Their struggle for their rights is also an uphill climb since most disability rights groups being male-centered and dominated by male leadership. Additionally, associations aimed at providing support to women with disabilities, but their work remains restricted to the occasional symbolic events mandated by the state. Their work is purely tokenistic and does not result in achieving equal rights or dignity within the state structure or beyond.

During COVID-19, access to essential services became a struggle for these women. Access to public hospitals was hindered along with delay in access to essential drugs or prosthetics which hampered their well-being severely. The pandemic just highlighted the issues that were wrapped under social and political prejudices

for long. The struggle for their rights has always been arduous but the structures to ensure that these rights are protected and guaranteed are non-existent. There needs to provision of door-to-door vaccinations for persons with disability and adequate steps must be taken to ensure that there is follow up to support with side effects, especially since many persons with disability may be immunocompromised and have co-morbidities.

Discussion

Maaza Seyoum, the African Coordinator of the People's Vaccine Alliance and Partnerships Lead of the African Alliance, spoke about the frustrating story of vaccine apartheid in Africa. With barely 1.5 percent of the population vaccinated so far, she notes that this is worrying. She highlighted how 'vaccine hesitancy' is a mixed bag. People have questions about the speed of development of COVID-19 vaccines when we still do not have vaccines for diseases like HIV after all these years. The intense collaboration with ethicality and guidelines across the scientific community has made the vaccines possible, and this must be communicated to the people to quell their apprehensions. People do wish to get vaccinated and to say that people of colour shy away from vaccinations is flawed and problematic.

The Global North continues to enhance that narrative about people of colour showing vaccine hesitancy. Whereas the number of people denying vaccines is actually a minority. The crux of the problem, she noted, is the lack of access to vaccinations.

Apartheid – rich countries are vaccinated while in some countries that have no access to vaccines, companies like Pfizer are asking the government for indemnity, i.e. asking the government to cover the cost of civil cases that may stem from any issue with Pfizer's vaccines. So, in addition to lack of clarity as to who should be responsible for the adverse effects, there is push from corporates to shift the blame and responsibility to the government. The governments seem helpless since public health systems are frail. In Argentina and Brazil, Pfizer asked for sovereign assets to be put up as collateral for any future legal costs.

Naureen Lalani from Aahung, Pakistan shared her experiences from Pakistan. She noted that people are still struggling with Polio, a disease already eradicated from most places in the world. She wondered if there are

ways to navigate through spiritual and religious reasons for vaccine hesitancy. Maaza responded with the example of a Chief Justice in South Africa. He was a preacher too, and he had made statements about vaccines being the mark of the devil. The African society refused to accept this misinformation and took him to Court for accountability. Muslim leaders in UK and South Africa promised to issue public statements in support of COVID-19 vaccinations. There are barbers recruited in the US to counter anti-vaccine narratives within their customer base. While Government efforts to promote vaccinations is useful, the role of statements by community influencers must not be downplayed in these times.

Amar Jesani, a public health and bioethics practitioner, emphasized that to counter the vaccine hesitancy, we should not get carried away stating that all currently available vaccines are safe and effective. It would be far from the truth. Many vaccines have been given emergency use approvals and the AEFIs have not been duly investigated. Instead of lying to people about there being no risks at all in vaccination, we must speak about benefits outweighing the risks. It is the right of people to know whether and how the State plans to take care of them, if and when things go wrong. More complexities around vaccinations also arise from whether one must offer all the information about side effects and whether it will be recognized that all medicines and health treatments have side effects, not just vaccines. It was discussed how all possible information for informed consent should be given to people before getting vaccinated. This will also help in people developing trust in the government.

The increase in vaccine producers in India can also be confusing, he said. The public is not given transparent instructions on which vaccine to prefer and what could be the effects for each. The varying prices for each of the vaccines in the market, restrict people from making informed decisions in their best interests. Politicization of the pandemic have also been affecting effective pandemic management.

Peninah from People's Health Movement Kenya noted that after the devastating oxygen crisis in the country, they were holding on to one glimmer of hope: vaccines would be more accessible for all as it was to be free of cost. Yet, the ground reality was discouraging. The elite still chose to pay for the vaccines so as to access them sooner.

Others also highlighted that the shortage of vaccine supplies and mandatory identification proofs has been a barrier. Lauren Paremor from South Africa spoke about the plight of non-documented people. The acting

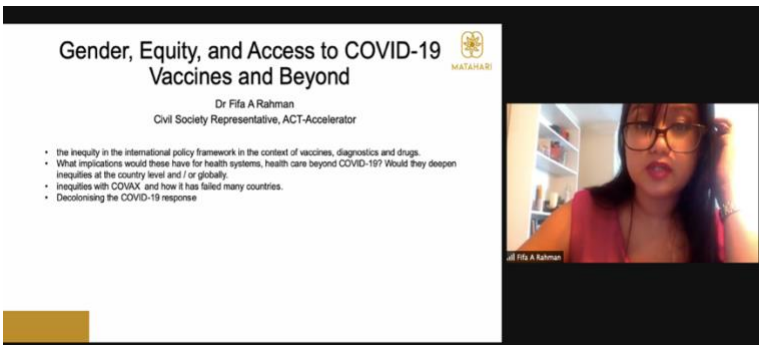
Health Minister had categorically mentioned that undocumented residents are illegal in the country and therefore are not deserving of the vaccines. In South Africa, too, many do not have identification proof and end up falling through the crack.

Session 3: The inequity in the international policy framework in the context of vaccines, diagnostics and drugs

This session was facilitated by Lauren from University of Western Cape and PHM South Africa. She shed light upon the inequitable situation around the structures of Access to COVID-19 tools- Accelerator (ACT-A)[1] and how the facilitation council is biased, and inequities are perpetuated across the globe. She shared about how the inequities impact the health systems and what are the ways we can attempt to decolonize the ACT-A.

For any systemic change, we can't be occupied with vested interests. Global solidarities are of indispensable importance now. The need to decolonize the ACT-A; calling out the LMICs who are under testing (to show lesser cases), and calling out rich countries that are hoarding vaccines, was discussed.

It is an issue by itself how a privately funded accelerator such as this one has been responsible for making global decisions about health for the last decade when even within its own structure there is lack of diversity, representation, and minority groups in positions of power.



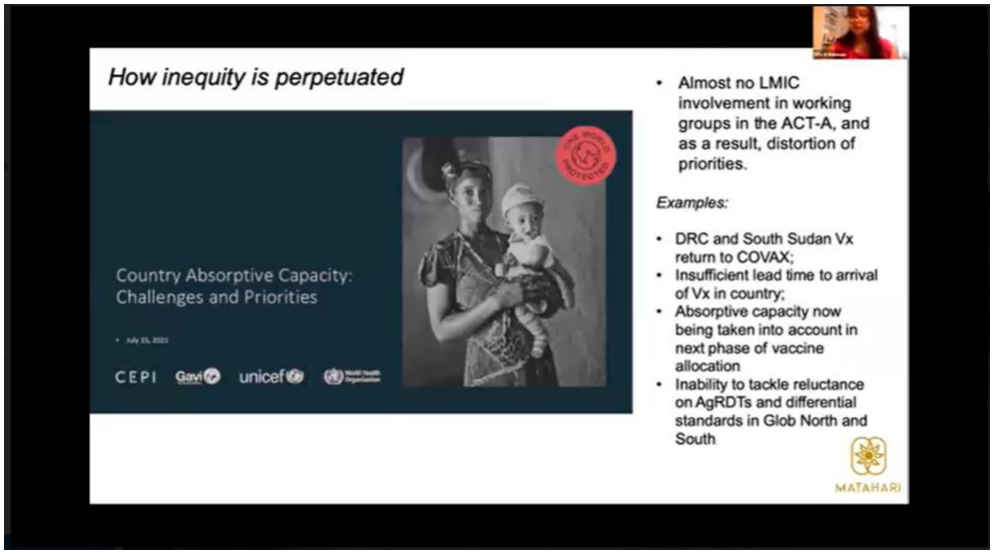
Dr. Fifa A Rahman, Civil Society Representative, ACT-A, shared an enlightening presentation about how the design of the ACT-A is inadequate and ineffective. The centre for global response to the pandemic is the ACT-A, which inherently is inequal in its structure (and includes the

[1] The Access to COVID-19 Tools (ACT) Accelerator, is a global collaboration launched by WHO to accelerate development, production, and equitable access to COVID-19 tests, treatments, and vaccines by bringing together governments, scientists, businesses, civil society, and philanthropists and global health organizations.

COVAX[2]) that lays the ground for access to treatment, drugs and diagnosis has been facing bottlenecks that it is unable to overcome. Fifa argued that understanding this is crucial to examining inequities in the international COVID-19 policy framework.

Referring to the above image from a principal meeting concerning the ACT-A, Fifa demonstrated that it represented the perpetuation of inequities. She added that the choice of the picture of an African woman and child is patronizing and offensive, to say the least.

She spoke about "country absorptive capacity" and how often countries with limited resources were not given enough time for preparation to deploy vaccines at the ground level. When Sudan was given vaccines, it could not do a rollout within the allocated time for roll out. The country was given a lead time of barely 5-10 days before vaccine rollout which was not enough for mobilizing their community health workers at the ground level. Since such a short time is not enough to complete training of frontline workers and put together the necessary infrastructure, Sudan returned the vaccines to COVAX.



GAVI's approach is to take the 'country absorptive capacity' to decide the volume of vaccines that the country will receive. While WHO, Gates Foundation and others were concerned about the approach being adopted, this is a cause of concern for the next batch of deployment. Fifa emphasized that there are questions need to be asked for the greater importance being given to "absorptive capacity" without ensuring that enough

[2] COVAX is the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator. OVAX is co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi and the World Health Organization (WHO), alongside key delivery partner UNICEF. Its aim is to accelerate the development and manufacture of COVID-19 vaccines, and to guarantee fair and equitable access for every country in the world.

community health workers are mobilized at the ground or leadership qualities to ensure the deployment is efficient and productive. They did not take into account that absorptive capacity is not a great metric for distribution of vaccines to low and middle-income countries that are already short strapped for resources.

Fifa highlighted that the problems associated with countries like Democratic Republic of Congo (DRC) and Sudan returning vaccines, is also to do with the fact that there is no representation from low- and middle-income countries (LMICs) in the working groups in ACT-A. This, in turn, reflects how the supremacy of the developed countries in the Global North causes distortion of priorities and bottlenecks that are not resolved. She flagged how this is an underlying reason for issues concerning access to essential drugs and diagnostics and not just vaccines, such as, easy availability of antigen rapid tests in countries like UK which are also free in NHS.

She took a leaf from Somalia's situation and shared how overwhelmingly larger number of males are vaccinated than women. Specifically, 75% men were vaccinated compared to only 25% women who were vaccinated. Few reasons behind this gap were, limited mobility to reach vaccination sites, restricted decision-making power in their health seeking behaviour and control over resources required for making informed health decisions. She also added how there has been no discussion about addressing gender gap in vaccine in the working international groups so far.

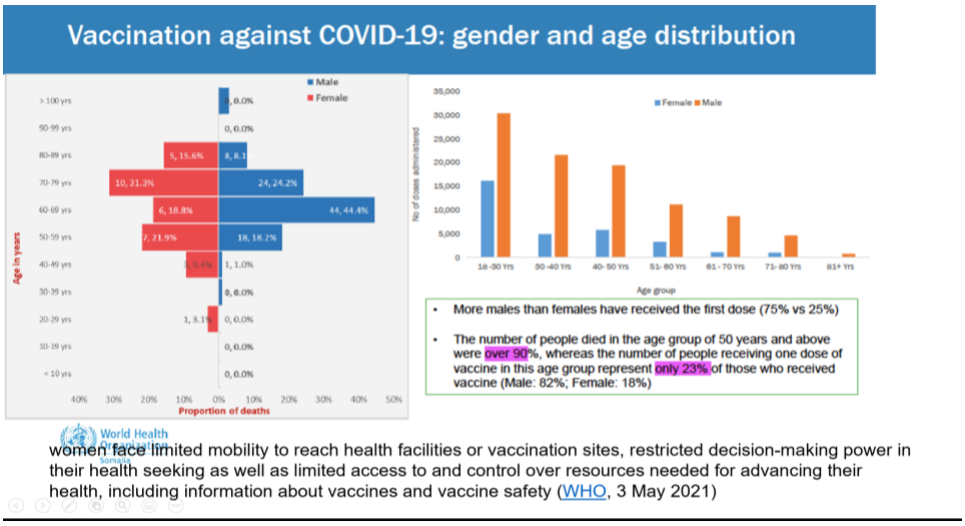
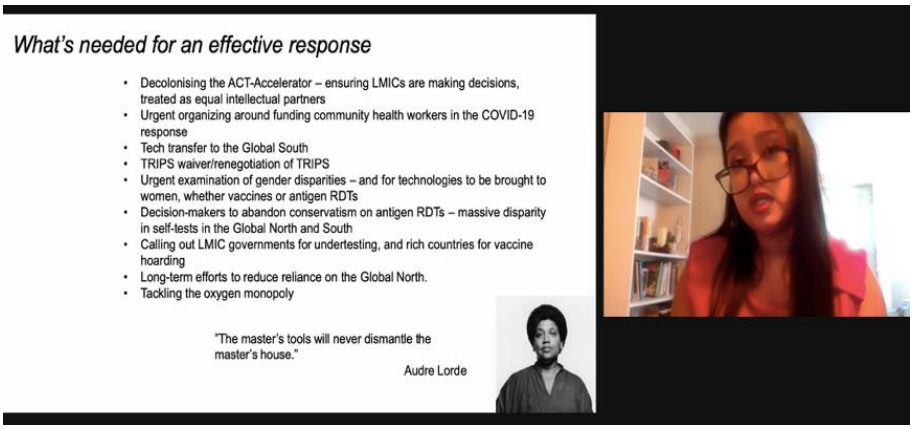


Figure: A screenshot of presentation showing the gender gap in vaccine distribution in Somalia

Fifa concluded by emphasizing on advocating for LMICs to be represented adequately in the international working groups, treating them with dignity and be considered equal intellectual partners, providing funding

and organizing community health care workers, ensuring transparency for funds being allocated, tech transfer to Global South, urgent examination of gender disparities, long term efforts to reduce reliance on the Global North among others.



Fifa pointed out that there are fundamental problems with the structure of the global health architecture with poor to no representation or inclusion of the global south, and there is a lack of interest or initiatives to look at it from a gender lens.

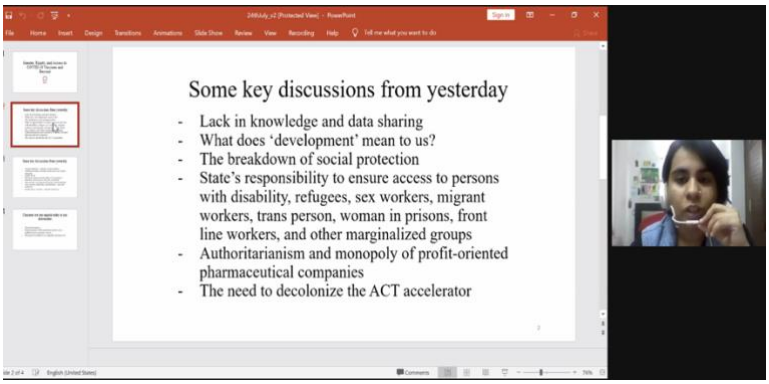
Discussion

Maaza added that many of the global actors are predominantly white and cis-male, and their language of technology sharing is also racist and exclusionary. She also talked about how there is 'mining of suffering' of people of colour in order to create narratives to highlight inequities existing in the Global South. Vanita Mukherjee from DAWN raised questions if COVAX is able to bridge the vaccine gap and truly, understand the nuances in vaccine deployment in LMICs.

Kajal Bharadwaj added that the COVAX to be a "baffling structure", set up in an undemocratic way that deals with global health decision related to COVID-19 and questioned the transparency and accountability of institutions like CEPI, GAVI, Gates foundation. These institutions have been critiqued for several of their global health decisions in the past decade. COVAX and COVID-19 Technology Access Pool (C-TAP) was designed to fail because it had vaccine nationalism built into it. The consultation held last year also emphasized that COVAX supports patent control of the market by providing vaccines through a donor mechanism. Further, COVAX it does not allow a fundamental systemic change. All our demands and efforts to decolonize the global pandemic response must then also include taking control back from Big Pharma, she added.

Day 2, 23rd July 2021

On the second day, the session began with Aakriti Pasricha from SAMA flagging some pertinent issues and key points that had emerged from first day's session. She recalled how participants engaged in the meaning of what development means to feminists. She talked about the breakdown of social protection in various countries in Global South, state's inaction in providing protection to vulnerable and marginalized during the lockdown, the growing privatization and monopoly of pharma companies as well as the need to decolonize and remove bias from working international groups. Vaccine apartheid, digital divide, gender gap in vaccines and the state of frail public health systems were few other key threads that cropped during the first day of discussion.



Session 4: Transparency & accountability: COVID-19 vaccines and other healthcare technologies

Amar Jesani, an independent consultant and the founder and editor of Indian Journal of Medical Ethics (IJME), facilitated a session on data and ethics related to development of vaccines. He raised pertinent questions on the Covishield vaccine (Astra-Zeneca vaccine) for which the data of the bridge trials were done in India. However, this data was not available in India, while it was submitted to a Canadian regulator.

Kajal Bharadwaj, a lawyer working on HIV, trade and Intellectual Property Rights (IPR)[3] related problems with drugs, presented facts and figures on the unfettered powers of Big Pharma's power during the pandemic. She cautioned that this is not a new phenomenon but has continued for over three decades. The fight against massive profiteering of Big Pharma at the cost of public health had a significant victory in 2001 with World Trade Organization (WTO) recognizing the need to make HIV treatment drugs affordable and accessible in countries that needed it the most.

[3] Intellectual property rights are the rights given to persons over the creations conceptualized from their minds. They usually give the creators an exclusive right over the use of their creations for a certain period of time. Intellectual property rights are customarily divided into two main areas: (i) Copyright and rights related to copyright (ii) Industrial property

She gave the background on how the recognition of the impact on IP came to be recognised at the international level when South Africa was struggling to receive ARVs. This was followed by the Doha Declaration in 2001 that affirmed that the provisions in TRIPS allowing compulsory license, government use etc. should be interpreted in a way that allow countries to protect public health. Over past two decades, treatment activists have been extensively relying on this Declaration.

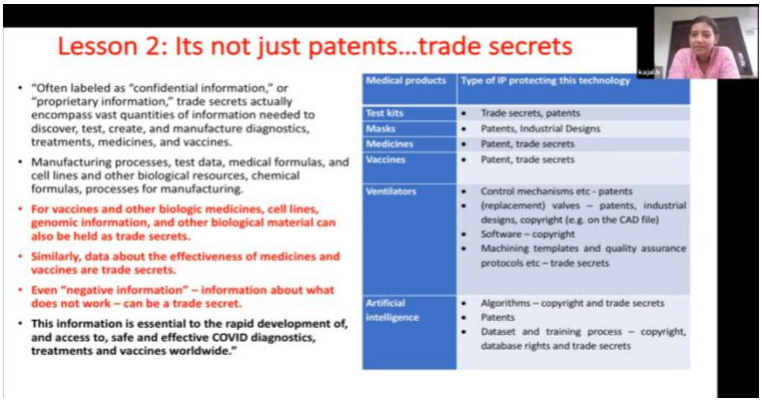
Kajal had an eclectic presentation and enlisted a few crucial lessons in the area of IPR and the impact of multinational pharma conglomerate across the globe, particularly over the past year and a half (she called it the "10+1 lessons"):-

***Lesson 1**: Patents is not just about medicines.*

Patent is not merely about medicines but extends to other essential medical products like masks, ventilators and diagnostics, and has created access to these essential items highly inequitable. This became evident during COVID-19 which showed that focus on addressing patents on medicines was not enough but had to extend on vaccines, masks, ventilators in order to ensure that trade knowledge could be shared.

In case of vaccines, the pre-existing patents on other forms of coronavirus were obstructing the other companies from manufacturing other forms of vaccine. BioNTech was already suing other companies over patent related to vaccines.

***Lesson 2**: It is not just patents but also 'trade secrets'*



Kajal mentioned how Coco-Cola has not shared it 'secret recipe'. Similarly in the world of health care technologies, such as, test kits, masks, medicines, vaccines, ventilators, artificial intelligence trade secrets are confidential information that companies do not disclose to anyone-including as part of patent disclosures. Even in clinical trials, information is not revealed, and drug controllers refrain from revealing information stating they might be sued later for disclosing trade secret of the company.

Lesson 3: *AIDS medicines voluntary licensing model does not work.*

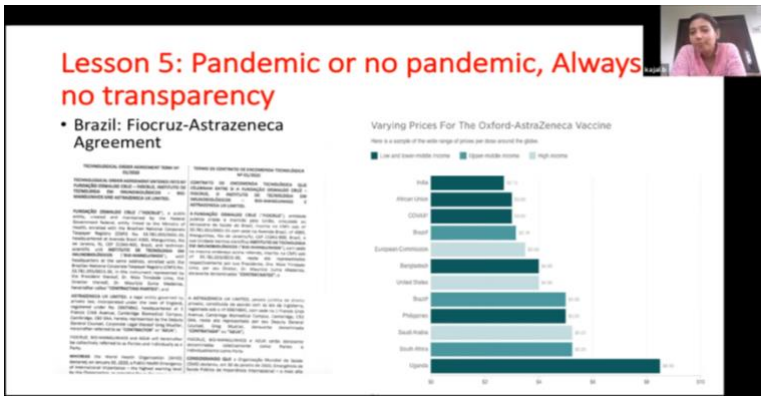
The model of voluntary licenses which saw a rise in the past decade, is one which allows companies to put their patents in a 'patent pool' for licensing. Generic companies can seek these licenses and develop these patented medicines and supply to those in need. This model was also used for AIDS medicines. In context of COVID-19 therapeutics she gave the example of 'Remdesivir' drug, which although an ineffective drug in case of COVID-19, was licensed to handful generic drug companies by the patentee-Gilead. These were limited licenses, as they allowed the licensees to cover only 127 countries. During the peak of COVID, the Indian companies barely managed to produce sufficient numbers for the Indian market, given that there were only a limited number of licensees for the drug. India was unable to produce sufficient quantities of the drug and had to import it. She explained that even if a drug does work, this model will still not be able to resolve the issue of access to essential drugs and diagnostics in developing countries during a pandemic. She pointed out that research suggested, how with sufficient number of companies manufacturing the drug could bring down the price of the treatment with remdesivir to less than USD 10 for ten days of treatment. This price stood in stark challenge to the price of USD 2340 being charged by the patentee for 5 days treatment course.

Lesson 4: *Public funding, Public Promises is not equal to Access*

The Oxford vaccine, Astrazenecea or Serum vaccine, was originally made by Oxford University. It was initially said that the technology would be shared with anyone who could produce it, and anyone could use it. However, Gates Foundation suggested the University to enter into an exclusive licensing agreement with AstraZeneca. Asztrazeneca entered into sub-licenses, which are kept secret. They entered into one license with a Brazilian public company, Fiocruz who had made the licensing agreement public. This license suggests that the pandemic would be over by July 2021, and the company can move towards "for-profit" pricing, instead of "no-profit" pricing.

Lesson 5: *Pandemic or not, no transparency on prices.*

There is no transparency in the bilateral agreements related to healthcare technology that is aiming for profit only including on what the prices are. Ironically, what is being seen is that developing countries are paying more than the developed countries for COVID-19 vaccines, for instance, Uganda is paying $8 per dose than compared to US, UK which is paying $3-4.



Moreover, even in India, when people thought that India was donating vaccines, most of the vaccines from Serum went out as commercial shipments through bilateral commercial deals and not through COVAX. COVAX was relying on Serum for donation but there was no transparency on how much Serum was producing, what shipments were going out and what deals were being made.

Lesson 6: *100% Profit and 0% responsibility*

Companies had some form of public funding support with companies like Moderna having 100% support from US and while they make billions of profits, these companies have demanded indemnity from legal action in all the countries. They do not want to take any responsibility in case of adverse events, even for the serious issues emerging from the vaccines. In fact, some of the companies have bullied the countries demanding that military assets be put as collaterals for providing vaccines to countries.

Lesson 7: Research and development (R&D), technology transfer and local production in developing countries is feasible, even for the short term. In the past 30 years, Bangladesh has been a testament to how a developing country can be equipped to do so. For instance, they developed the generic version of remdesivir even before the Indian companies could get a license to manufacture and sell them.

She pointed out that analysis of contracts related to COVID-19 has shown that it is possible to manufacture COVID-19 vaccines within 6 months of technology transfer. Despite this possibility, she pointed that the technology transfer and sharing, when it is needed the most, is not being done. She also mentioned about Vaxmap developed by the Third World Network which shows a map of the world where COVID-19 vaccines are being manufactured and filled and finished. She noted that the China, Russia, Vietnam, India, Thailand and Cuba have different vaccine candidates, which go on to show that there is considerable R&D capacity in the developing world, which is not being supported and used. She said that failure to support this capacity is failure of the WHO.

She also spoke about the narratives created around not sharing IP, stating that suspending IP will result in allowing other countries have access to important technology leading to security concerns. This was

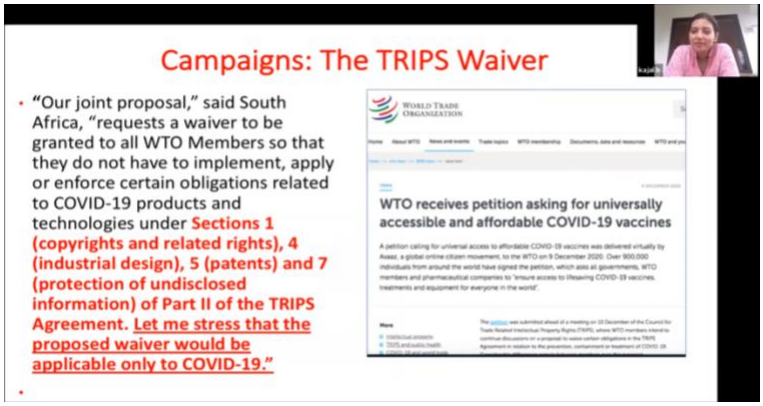
contradicted by the actions of the patent holders themselves like Moderna which projected plans to collaborate with manufacturing sites in China.

Lesson 8: *Governments do have the power to challenge big pharma's monopolies.*

She gave examples of laws that have been modified such as Brazil's parliament approving a bill that will allow automatic compulsory licensing in case of pandemics, Bolivia's request to Canada for compulsory licensing for exporting COVID vaccines, some countries already issuing compulsory licenses. She noted that there are countries that are not exercising this power. The most important example of this is India, which is sponsoring the waiver proposal before the WIPO but is refusing to issue compulsory licenses on COVID-19 technology in India despite several demands by civil society and before courts. India in fact, put out a "myth and facts" document saying why compulsory licenses was not a good idea for vaccines.

Lesson 9: *The challenge to Big Pharma is unlikely to come from the Governments. It must be a people's campaign.*

There are campaigns that are raising pertinent demands such as patent challenges to COVID-19 tools, various campaigns such as The People's Vaccine, TRIPS Waiver campaign. She mentioned one of the successes of people's campaign by highlighting the press release about the petition calling for universal access to affordable COVID-19 tools carrying 9000 signatures was put up on WTO website because of the huge pressure from the advocacy campaign.



She also noted that there is another campaign going on, calling the Agreement on the Trade Related Aspects on Intellectual Property Rights (TRIPS) being the worst international agreement, and calling for abolishing the same. She said that COVAX and ACT-A despite being projected as mechanisms to ensure greater access, have continued to allow control to the big pharmaceutical countries.

Lesson 10*: It is important to remember that these discussions do not focus on COVID but also the impending non-Covid health crises.* She shared an interview with Mark Heywood that focuses on what we need to introspect while advocating about equitable access to medicines and diagnostics. The link to the interview is: https://www.youtube.com/watch?v=wVCJyI3uMVM

Referring to the interview with Mark Heywood, she noted that when Doha declaration was passed, the health movement had taken the power from the pharma conglomerates. However, over past some year, with market-based solutions, this power has been given back to them. The voluntary license model, or agencies like GAVI, has resulted in government off the hook. She added that the access movement needs to introspect how the companies could be allowed to reconsolidate such power whose effect has been seen in the past one year.

Discussion

Amar Jesani reiterated the need to question the control of data by Big Pharma. Medical journals also include articles by authors who do not go through the primary data themselves, often they write only based on what the companies provide to them. Most of the regulators also do not have control over the raw data. In India, especially, clinical data and research follows like this, and this ought to be challenged tooth and nail.

Maaza also reflected on the lack of transparency and mentioned that they had noticed a similar pattern in the case of the HIV prevention research done in South Africa where the results were not shared with participants and community health workers. The people had protested against this in those times, and yet the same has been happening with COVID now. While pandemic has given opportunities to reap benefits from this tragedy which has resulted in several new billionaires to be created, the common people are left in the lurch.

Few participants shed light on the situation around vaccines and vaccine diplomacy. In Pakistan, for instance, one of the primary reasons for the vaccine hesitancy is people's apprehension against the 'Chinese vaccines'. Pertinent questions like what determines acceptance of one vaccine over the other and what is the scope for accountability in a global system of withering multilateralism were raised.

Session 5: Developing strategies from feminist approach in response to the pandemic

This session was conducted in breakout sessions in small groups. Adsa from SAMA briefed the participants about the breakout sessions. She explained that participants will be divided into three groups with facilitators and discuss in-depth around a few questions and key themes that emerged from the discussions:

These questions were:

1. When seen from a feminist lens, centered around equity and intersectionality, what have been the gaps in our responses to the current crisis?

2. How do we deepen and consolidate our intersectional feminist analysis, articulation of the pandemic and responses to it with regard to:

   - social/economic/ political determinants
   - global, national health systems and institutions
   - drugs, diagnostics and vaccines

3. What mechanisms do we envisage and evolve for
   - Knowledge exchange about the management of the pandemic?
   - State/non-state actors' accountability-unpacking 'bias' and 'hesitancy' and vested interests; enabling equitable access in the context of vaccines

4. What must be our approach/strategy as feminist in and beyond pandemic times?

   - How much of the strategy could be realized?
   - What can be done by whom and how can it be done?
   - Who all should we engage with to build and share this feminist framework?
   - Who all can we engage with from other movements and spaces using this framework?
   - How can we extend global solidarity towards movement building and facilitating adopting this in our local/national contexts?

Feminist articulation of the pandemic and its response:

One of the key threads that emerged was how to articulate a feminist response to the pandemic. Efforts have to be made to take our conversations from margin to center and remain cautious of our feminist articulation and approaches. An important aspect would be to consciously not translate gender into women since a feminist framework must recognize that gender is an umbrella of identities and ensure that voices of people who are usually left on the side lines are also included.

- Feminist usually look at the broader picture so, they should make attempts to bridge the gaps in existing knowledge. One of the key challenges that countries from Global South continue to face is lack of 'Economic Justice Analysis' and how neoliberal policies continue to influence decisions regarding health, such as access to vaccines, and there is little

resistance against such macro policies which should also be an important component of the feminist analysis.

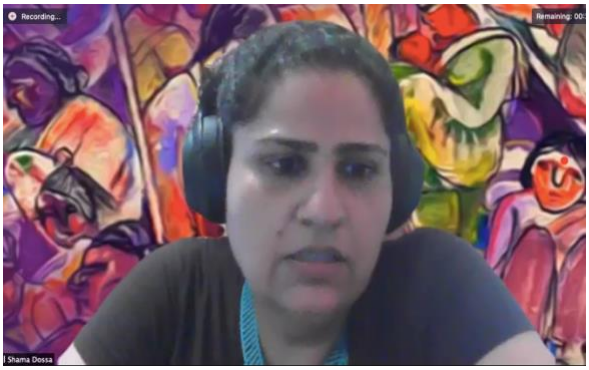
- One of the reasons behind this slip up is that many feminists have not been able to engage on healthcare, science, research, intellectual property till now and these are missed opportunities in the last few decades. However, this also reflects the state's failure, and the onus is not just on individuals.
- Reflecting on the need as to why feminists need to delve on access to medicines, a few reasons were highlighted, including a large number of healthcare workers being overwhelmingly women but also in the lower rungs of the healthcare system, rendering them vulnerable with low social support system; women undergoing increased violence after the breakout of pandemic, women having care responsibility at home with reduced incomes, education and SRHR services not being available and transgender community being affected and so forth.
- As feminists, we need to articulate the meaning of 'care' especially in the pandemic context. Does this comprise people not having food to eat or place to live or work opportunities? How do we define 'care spectrum'? Will it also extend to questions about food and livelihood? Under the rubric of care, is it possible to address these issues?
- Feminists have long emphasized about the institution of patriarchy and institutions of capitalism going hand in hand, i.e., and one cannot be addressed without addressing the other. However, issues like gender-based violence, access to restorative justice, access to mental healthcare, social protection and welfare rights must also be taken into account in the framework which can be articulated through an intersectional lens. This must be a part of our post-pandemic reimagining.
- Strategies were discussed on how to strengthen the feminist movements from local to global level.

Re-imagining a fairer and better health system

- Principles of care, kindness, and grief must find a place in our understanding of the post-pandemic future. While imagining a better and quality health care system, our personal should guide our political.
- Health care systems would have a gender responsive approach when data is present for the same. Thus, we need to focus on the gaps in our current ways of looking at epidemiology of Covid-19. We need to have gender-responsive data on vaccine rollouts, trials, deaths, infection rates, and more.

- Conversations on the current public healthcare crisis must also include issues of healthcare workers such as, frontline workers, sanitary workers, and workers in crematoriums and morgues who are often not considered an essential part of the health system. There is little effort to ensure their welfare and growth in the health system.
- Threats to freedom of expression of health workers must also be acknowledged as a pressing public health issue.
- The idea of public health being a public service is being undermined constantly. Several countries are grappling with severely low-funded public health systems and the dominant narrative is that private health system is the only solution has been deeply ingrained in the minds of people. Keeping in mind robust public health systems like Vietnam or states like Kerala of India is a beacon of hope.
- Health systems should be nationalized during pandemics as it should not be considered any less than emergency and the lives of countless people should not be left on whims of profit-driven markets.
- One must be cognizant of how far one has come in the realization of the Right to Health for all, and accordingly map one's way forward. That reflection is crucial to understanding social determinants of health and holding the States accountable.

Role of State in pandemic's response:



- A state has to be held accountable by the people for failure to handle the pandemic response. Often states tend to have misguided priorities and avoid accountability. Movements needs to look at different methods to ensure accountability from the State and not just through the legal systems.
- There has been a rise in severe backlash on people showing dissent and civil society spaces are shrinking. Harsh measures are being adopted to stifle voices. We need to re-invent ourselves as to how can we negotiate with authoritarian governments?

- States like India uses tools like the Epidemics Act which gives tremendous power to state and there was coercion on play and with time, such an act needs to be revisited that was drafted in the colonial period.
- States must ensure that the policies that are being implemented are well-thought and do not exacerbate inequity in the society. Digital divide is a huge barrier in accessing health services and the manifestations might be different across countries but lack of access to information is a huge hindrance, especially to oppressed genders.
- Complexities of the religious right-wing and the new ways of curtailing democratic rights
- must be taken into account while envisioning a post-pandemic future. It is crucial to remember that 'Vaccine Nationalism', too, is a twisted expression of this authoritarianism. People have also been disavowed from their right to timely healthcare explicitly because of their religious and/or caste identities in India. The state cannot abdicate its responsibility towards treating all its citizens fairly

Rise of Big Pharma & Philanthro-capitalists

- The role of philanthro-capitalism must be carefully studied in present times. For instance, Bill and Melinda Gates Foundation, has monopoly in determining what health research is conducted in developing countries and thus, has a crucial say in its health policies. Since funding is controlled by few philanthro-capitalists, it is crucial to find alternative ways to fund people's movements and organizations which have become more restrained over the years. Public funding and collaborative independent smaller organizations are the way to go.
- To address inequities in public health issues such as vaccinations, one must begin with the demand for transparent data from Big Pharma.
- The global campaign for contraception should serve as a reminder of how Big Pharma companies can tend to co-opt feminist language for their own vested interests and thus, efforts need to be made to challenge such trickery.
- The conversations of universal healthcare also have been co-opted in nefarious ways in the past. Instead of building reliable public healthcare systems and stronger social protections, it has translated into international players promoting privatization.

Global solidarity and the role of movements

- A return from imperial thinking is necessary. Pooling of resources to the Global North is a common factor that leads to a further deepening of the imbalance in Covid responses. That needs building deeper and persistent global connections.
- In the large overarching issues of trust and accountability, we must remember to build political consciousness and intergenerational conversations across various networks and people's movements in the Global South.
- A common thread in most countries from Global South has been the level of inequity in accessing COVID-19 vaccines, such as the country's dependence on international mechanism to deliver vaccines to private market prices of vaccines. All of this has links to colonialism and existing neoliberal policies. There is also the larger question of sidelining other important issues like unemployment, internal migrants, domestic workers, sex workers, people with disabilities in remote areas.
- If people's movements are strong then, governments have to also bow under its pressure. We need to strengthen people's movements across boundaries. Movements have to the power to make great changes as seen in the past.

Conclusion

Chayanika and Sarojini concluded by summarizing the discussions that spanned over the two-day consultation. Chayanika reflected upon the present crisis in our society and underlined the need to hold onto hope and how a better world is possible in face of adversity. The problems that are emerging in our society today is not newfound, but these changes have been gradually unfolding over the years. Taking a leaf from the movements that criticized the draconian and coercive population control measures, Chayanika emphasized how coalitions happened in the past successfully from different

movements and people were hopeful things would change for better unlike present times. With the rising inequalities and despair emerging in the society, the hope amidst common people is dwindling but there is a much greater expanse as to who can be part of this debate. Thus, the idea is to not restrain one's perspectives to singular issue by demarcating women and gender from the larger picture but rather, introspect what does one mean when one says that a feminist approach is required to understand pandemics which takes into account all the existing structures that come into play and connects all the issues to the larger picture.

Chayanika elaborated that it has become evident from our past discussions that all our issues are connected and when we talk about a disease, for instance, about COVID-19, this disease cannot be seen in the absence of a failed public health system, or in the absence of a failed state and lack social security of various kinds. One cannot look at the issues from a narrow lens, such as, the monumental impact of COVID-19 on migrant workers during the first lockdown is linked with the nature of unemployment that exists in our society and labour laws. So, when there are multifarious issues linked together, the question lingers how should one focus and what approach needs to be adopted?

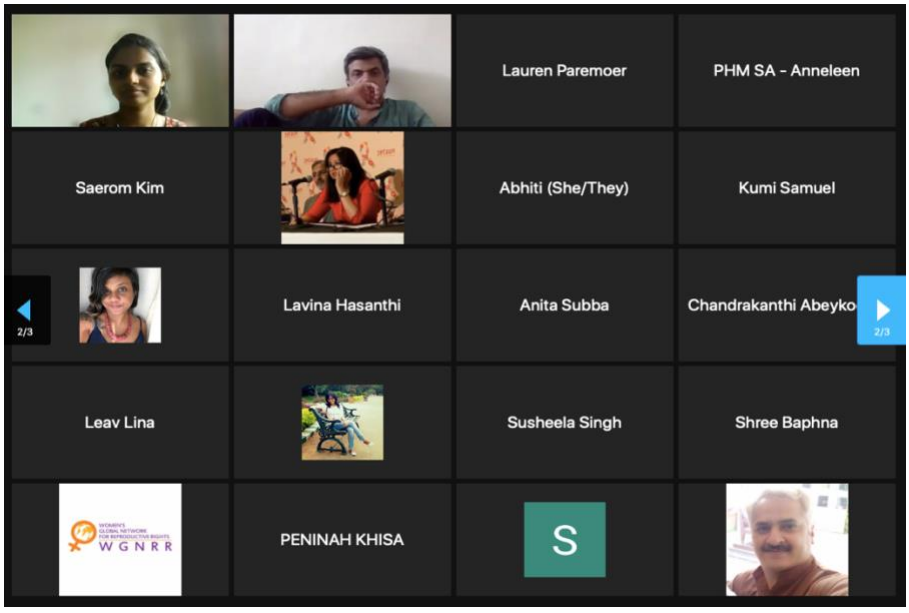
Thus, our efforts must be directed to at least to start a conversation about the right to not live with so much pain, with so much illness or ailments. While at first glance, it might seem like a negative thing as we are focusing on about "right not to do" but a counter to this perhaps, will be the right to build a world where all of us can sustain and grow with prosperity without endangering our environment. Thus, the framework aspires to draw from our imaginations of a better world, whether it will be realized or not in this lifetime is not pertinent, but it is an imagination that we should never lose sight of, it should guide us in our little battles for a better world.

Lastly, but more importantly, connection of various people's movements is very critical. While feminists tend to see the larger picture, it is also important to figure out ways as to how do we take discussions into those spaces where more concrete information sharing is happening in order to strengthen our campaigns. It is also important to take note from other countries that have repressive regimes and how they have managed to guard human rights in the absence of democratic state and structures? One should continually strive to seek answers that envision a fair and just world.

Sarojini talked about how the framework is a collaborative process and elaborated on how it was conceptualized, what was the rationale behind it and what would be the approach in drafting it in the future. The framework is an evolving process which will draw from parallel processes such as the discussions with community health workers, members of community-based organizations and community members hailing from marginalized and vulnerable communities. She mentioned how SAMA has made efforts in bringing forth varied perspectives of health workers working at different levels as well as voices from the ground.

Interviews have taken place with frontline workers, health activists and members of civil society from 5-6 countries of the Global South. There was a recommendation given during the consultation that these experiences need to be documented and how it will contribute to the existing process of enriching our knowledge and also, complement the framework.

Sarojini explained further how everyone can contribute to this process. The background note has been circulated and she requested everyone to dwell on the existing note and provide suggestions for any issues that might have been overlooked. Presently, the background note is broader as the intention was not to miss any issues that might have surfaced. The framework aims to encapsulate the intricacies that need to be embedded in an intersectional framework that deals with pandemic response and any suggestions on how to develop strategies is welcomed.



It is often considered that knowledge about patents, intellectual property is not required for all, for instance the concept of ACT-A is unknown to people not involved in public health policy but how do we ensure that it is relevant to a community-based worker? The truth is that knowledge about these concepts is

important because it talks about transparency, pricing, accessibility and many other issues for which people are striving at ground level. So, these issues cannot be looked separately.

Sarojini reiterated how this framework will be recognized as a collaborative effort and not a work of SAMA alone. While SAMA has played a predominant role in providing a podium for different voices to emerge, but the ownership will be to various movements, particularly from the Global South.

The session concluded with a song from Abhiti Gupta towards solidarities and freedoms and a vote of thanks to Asia Catalyst for their support and Ragini De who volunteered in supporting SAMA team for organizing the consultation.

Annexure 1

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