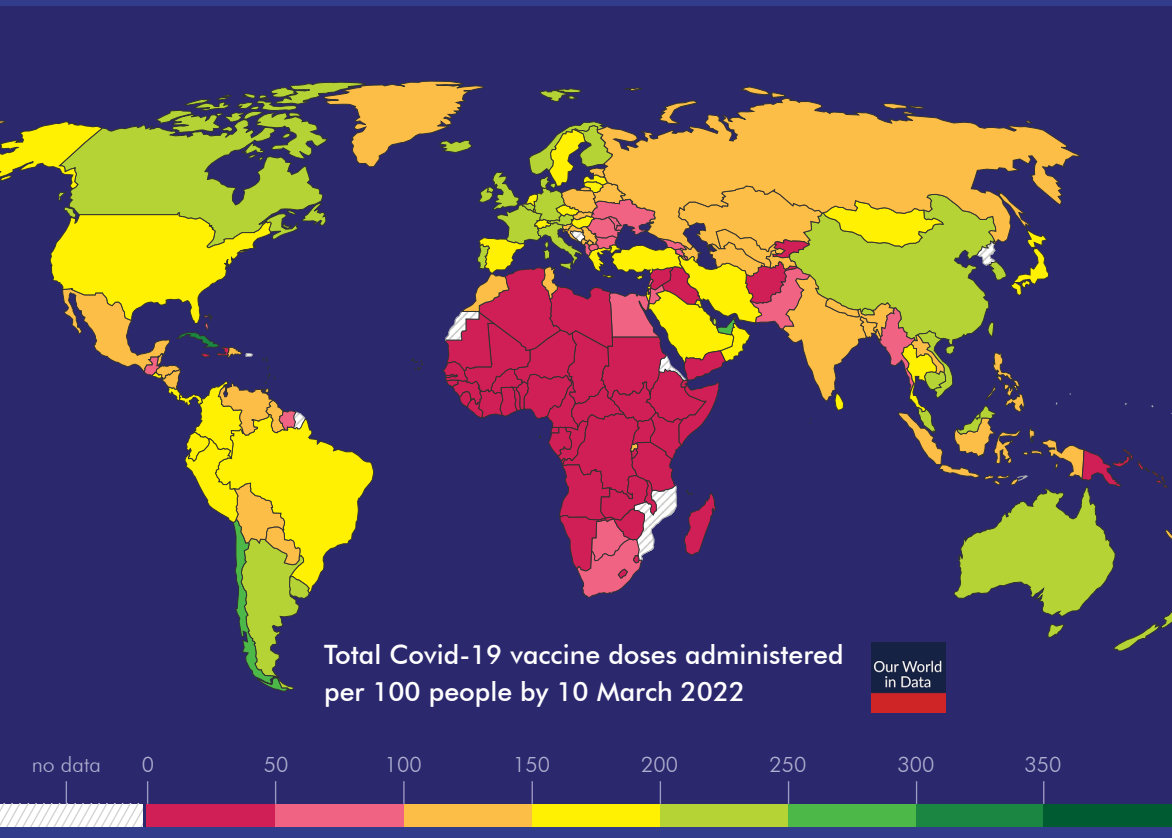
Pandemics and the illumination of "hidden things"

Lessons from South Africa on the global response to Covid-19

Fifa A Rahman

Lessons from the ACT-Accelerator: Into Future Pandemic Countermeasures Platforms



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Lessons from the ACT-Accelerator: Into Future Pandemic Countermeasures Platforms

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The ACT-Accelerator and its components have been described at different times as:

"the global solution we are looking for"
(United Nations, 2020)

"anti-democratic, because it's extraordinarily non-transparent, and opaque"
(Banco, et al., 2022)

"a blueprint of how to deliver vaccines at scale in an emergency"
(Berkley, 2022)

"naively ambitious"
(Furneaux, 2021)

The complete truth is somewhere in the middle. Not the global solution; certainly not a blueprint. Not as opaque as some claim. Definitely naïve in its failure to predict the limits of high-income country solidarity. A platform that delivered 80% of tests deployed in Africa in the first year of the pandemic (WHO, 2022a) and mobilised US$1 billion worth of oxygen supplies to more than 90 low and middle-income countries (Unitaid & Every Breath Counts, 2022). A platform with ultimately smart and good people from multiple agencies fighting for self-tests for low and middle-income countries at the same time as high-income countries but held back by ideological errors and failures by certain agencies. A platform with unprecedented collaboration between senior leadership of global health agencies and civil society meeting weekly on Thursdays to unpack the toughest weekly issues arising in the global Covid-19 response. A platform that birthed the Covid Vaccine Delivery Partnership (CoVDP) that delivered important work to integrate gender-inclusive vaccination approaches and increase uptake, in collaboration with countries. At the same time, a platform that did not know what to do on health systems. And a platform with poor intellectual ownership and expertise by and for low and middle-income countries.

In this chapter, I unpack the ACT-Accelerator from an insider-outsider perspective, drawing upon my insights and experience as a civil society representative within working groups and in high-level ACT-Accelerator meetings and working directly with colleagues within global health agencies on guidelines and responses, and as an outsider responsible for gathering and representing civil society feedback on the response through to global health agencies. I have grounded my analysis in data, in my own notes from meetings in crucial ACT-Accelerator working group and decision-making meetings, and secondary analysis from observers and stakeholders — and hopefully presenting to you, the reader, an illustration and analysis of power dynamics and neo-colonialism, structure and governance, efforts towards equity, and what key reforms are needed for future pandemic countermeasures mechanisms.

Introduction: The beginnings of the ACT-Accelerator

The Access to Covid-19 Tools Accelerator (ACT-Accelerator) was a global pandemic countermeasures platform — a group of loosely organised global health agencies, experts, and civil society that worked together to deploy and co-ordinate the global response to SARS-CoV-2. By and large, these were representatives of WHO, FIND, the Global Fund, the World Bank, Unitaid, Wellcome Trust, Gavi, CEPI, and later, civil society and community representatives meeting weekly to discuss, contextualise, and deploy SARS-CoV-2 commodities and work on health systems deficits affecting uptake of those commodities.

Formed less than three months after the WHO announced that the novel coronavirus (which we now recognise as SARS-CoV-2 or Covid-19) was a Public Health Emergency of International Concern (PHEIC), the ACT-A consisted of four pillars — the vaccines pillar (which housed the COVAX delivery mechanism), diagnostics pillar, therapeutics pillar, and the health systems connector — and was launched in April 2020 at an event co-hosted by WHO's DG, the President of France, the President of the European Commission (EC), and the Bill & Melinda Gates Foundation (WHO, 2020a). In the coming days and weeks, pillar co-lead agencies (Global Fund and FIND for the diagnostics pillar; CEPI and Gavi for the vaccines pillar; Unitaid and Wellcome Trust for the therapeutics pillar, and WHO/World Bank for the health systems connector) worked to draw up some parameters and goals for 2020.

At around the same time as priority-setting activities, the pillars worked to incorporate civil society representation. This proved easier in pillars led by agencies with more of a robust history working with civil society. Civil society was first integrated into the therapeutics pillar, after one of the co-leads, Unitaid, approached several Community Service Organisations about representation. Global Fund Advocates Network and STOPAIDS co-ordinated the appointment of interim representatives while a selection process was devised. Similar processes were initiated and quickly adopted in the diagnostics pillar, then the health systems connector (later revised to the Health Systems and Response connector), and finally — after much back and forth — the vaccines pillar, which would

later house the COVAX, which would procure and deliver vaccines to some countries.

The priority- and target-setting process began. A 28 May 2020 call on the diagnostics pillar among all partners (dubbed the "Dx Partnership Calls") was held and was attended by, inter alia, Soji Adeyi who was the then-Director of Health, Nutrition, and Population Global Practice at the World Bank; Peter Sands, Executive Director of the Global Fund; Greg Widmyer, Director, Health Product Delivery and Market Dynamics at the Gates Foundation; the French Ministry of Foreign Affairs; and civil society representatives (myself, representing Health Poverty Action); and Carolyn Gomes (representing the Global Fund Developing Country delegation). This call discussed several strategic objectives, including the development of 2-3 fit-for-purpose affordable antigen RDTs, the need to procure 500 million tests over 12 months, and the need to increase country preparedness and readiness in terms of capabilities for both automated and manual PCR tests. At this meeting, Widmyer raised an important point — that there was a need for a joint Vx-Dx and Vx-Tx strategy, that is, "test and vaccinate" and "test and treat" strategies: "We need to ask: how does diagnostics drive smart action in other pillars?"

His observation was astute and necessary; whether it was heard and translated into action was a completely different matter which I will revisit later in this chapter.

Also at this meeting, I took the floor to raise my concerns about the Global North/Global South imbalance in these calls. Attendees were predominantly those with Global North passports from global health agencies based in the North. This was intuitively a problem for me and other key experts precisely because of the neocolonial nature of the global health architecture — the notion and practice of Global North Geneva/New York-based bureaucrats operating without the technocratic and real-world knowledge that Global South experts have — and how in numerous other spaces this often had translated into a distortion of priorities, poorly informed execution, and a lack of buy-in from Global South governments. The chairperson agreed to receive nominations for Global South expert membership. However, through its operation, the ACT-Accelerator

was plagued by geographic imbalance and decision-making that was insufficiently inclusive of LMIC experts and country input.

COVAX was set up in April 2020 (Loft, 2022), and over the next few months began target setting, country discussions, and procurement for deployment. It was in these initial meetings that the "20% coverage in COVAX Advance Market Commitment (AMC) countries by the end of 2021" target was set. In one COVAX call held on 8 September 2020, civil society and COVAX leads, including Seth Berkley (the then-Executive Director of GAVI), Soumya Swaminathan (the then-WHO Chief Scientist), and Richard Hatchett (the Chief Executive Officer, CEPI). Seth Berkley provided the first presentation — commenting on the high risk of failure in vaccine development and the need to scale up processes to industrial scale before clinical trials begin.

Soumya Swaminathan then presented the proposed vaccine Allocation Framework, that health and social care workers and high-risk adults be prioritised at country-level for vaccinations, and that countries were to receive additional doses to cover 20% of their population. Countries would be invited to join the COVAX either as self-financing members or AMC facility members, the LMIC members of the latter of which would receive vaccines financed through donor contributions, as well as enter into binding financial commitments that would take them to 20% coverage. Swaminathan also presented indicative prices of the Covid-19 vaccines. It was at this point that Brook Baker — who is a professor of law at Northwestern University in Boston and Senior Policy Advisor at Health GAP, a CSO working on global access to medical technologies, and who always had astute observations and questions that dissect the nitty-gritty details of policy proposals — took the floor to ask what considerations, data, and studies had been done which brought the COVAX to 20%. Crucially — Baker was concerned about potential inequity, profiteering by industry, and potential vaccine nationalism. He may have been clairvoyant.

After a conversation with a diplomat from Palau, I was extremely concerned about the prices offered to small island states, raising a question as follows: "Some small island states have indicated that vaccine prices indicated to them are high-income prices. Why

is COVAX taking the restrictive World Bank definition of income levels? This is just one example of the injustice resulting from tiered pricing approaches."

I do not recall having received an answer for this question — nor was any answer scribbled in my notes. I can only offer my interpretation on this point — that as CSOs we certainly offered a perspective from countries which lent nuance and contextualisation to high-level targets, and that the architecture at that stage had not done that independently. We also raised concerns as to why ACT-A CSOs had not been asked to input or co-create these documents, and we were told that feedback was welcomed on final versions of documents. This certainly points to the tokenistic engagement of civil society on many parts of the ACT-Accelerator — ultimately successful interventions leverage upon the value and diversity of civil society expertise, and this will need to be integrated and elucidated in responses for future pandemics.

During this call, my CSO colleagues asked whether there would be transparency around agreements with manufacturers, including whether — for accountability purposes — they would be publicly available. Richard Hatchett responded stating that "appropriate levels of discussion" could be held due to specific levels of "commercial confidentiality" in the agreements. To his credit — he reached out to me after the meeting stating that he would be happy to continue conversations on the matter and was committed to communication and conversations with CSOs, and while we did not always agree — Hatchett was always more accessible to me and other CSO colleagues compared to Seth Berkley.

On 8 December 2020, we (ACT-A CSOs) attended a vaccines pillar briefing chaired by Susan Brown, the then-Director of Public Policy Engagement at GAVI, and attended by CSOs (including Red Cross Afghanistan, Health GAP, Population Services International (PSI)), academics, and key technical leadership of the COVAX, including Ann Lindstrand, head of the vaccine and register unit of the WHO. Among the key updates were that there were 97 countries and territories that were fully self-financed and 92 AMC countries that a Vaccine Introduction Readiness Assessment Tool (VIRAT) (WHO, 2020b) would be rolled out to. These countries would also be

provided a guidance package on acceptance and demand and a detailed supply and logistics guide. The VIRAT contained fields where countries could indicate "yes" or "no" as to whether they had, *inter alia*, identified a master list of service providers who could effectively deliver Covid-19 vaccines to various target populations, assessed dry storage and cold chain capacity at all levels, and had designed a demand plan to generate confidence, acceptance, and demand for Covid-19 vaccines which included advocacy, communications, social mobilisation, community engagement, and so forth (WHO, 2020b).

We were also informed during this call that countries could apply for cold chain infrastructure support through World Bank or GAVI funding, which precipitated a question from me on how many countries had thus far asked for cold chain infrastructure support. Mike Brison, the then--Lead for Covid-19 Vaccine Delivery on the Health Support and Infrastructure Services team at GAVI responded, stating that "UCC (ultra cold chain) technical assistance is a key challenge. There is a growing body of experts we are looking to draw expertise from to figure out how to mobilise to help these countries. Because the window has only opened yesterday for UCC support, only five countries have applied so far. The process is ongoing, and we expect more (applications) and the specific nature of those requests will be clarified in 2-3 months' time. We are looking at a lead time of 3-6 months to deploy equipment, and we will be prioritising cold chain support towards 56 GAVIi-eligible participants." His comments illustrate the monumental challenge that existed in vaccine delivery, occurring while flight routes were shutting down, but also to the infrastructure and health systems challenges that pre-existed the Covid-19 pandemic.

2021: Inequity abounds

The ACT-Accelerator was a platform pieced together in haste. At various times in meetings numerous actors, including CSOs, sheepishly admitted to riding the bicycle that was the ACT-Accelerator while trying to fix it. The result is a keen understanding that we must be more prepared for the next pandemic and more realistic about the realpolitik around how rich countries behave,

and how corporations behave. The following are illustrative examples of key equity issues that unfolded in the ACT-Accelerator *vis-à-vis* vaccines and self-testing, albeit there were also numerous inequities that occurred *vis-à-vis* Paxlovid, oxygen access, and the failure of the ACT-Accelerator to integrate a strong health systems approach.

Vaccines: Supply constraints, hoarding, and a failure to account for local context

In January 2021, the AMC Engagement Group on the COVAX, chaired by Lia Tadesse, the Minister of Health for Ethiopia, held its first meeting, beginning with co-chairs stating their priorities for COVAX and vaccine access. Of note was the intervention by the then-Minister of Foreign Affairs of Indonesia, who underlined three priorities, namely 1) transparency, inclusiveness and ensuring transparent processes within the AMC Group; 2) certainty on key issues such as the number of vaccines available, timelines and regulatory issues; and 3) solidarity and international cooperation to ensure a fair and equitable access to the Covid-19 vaccine for all (GAVI, 2021). The story that unfolded is well-known — in March 2021, the Serum Institute of India needed to reserve its supplies for India and suspended its supply to COVAX (Findlay et al., 2021) (Agencies, 2021). Throughout 2021 it became clear that rich countries were hoarding much more vaccines than they needed, to the detriment of the Global South. According to one article:

> The G7 and European Union combined have 769.8 million vaccines to spare this year, even if 75% of the population is vaccinated and 20% gets boosters (which assumes a three-fold increase in the daily vaccination rates), plus 10% is set aside for waste
>
> (Goldhill, 2021).

Many countries had had enough. The Malaysian Minister of Health in a June 2021 World Bank event slammed rich countries for hoarding

and said that the COVAX was an "abysmal failure" (Zahiid, 2021). Countries derided poor transparency on the platform, with one Latin American country stating that GAVI stated that they were having issues with producers but that no precise answers were given as to when vaccines would be delivered (Furneaux et al., 2021). Libyan officials said a meeting request to Seth Berkley was met with silence. A Pakistani official said that COVAX would "sometimes not pick up the phone", and Sabin Nsanzimana, the DG of the Rwanda Biomedical Centre and now the Rwandan Minister of Health, said COVAX had given his country just a days' notice of a shipment arriving. An external evaluation of the ACT-Accelerator would later find that "accountability and transparency were not sufficiently promoted by the ACT-A model" (Open Consultants, 2022). Seth Berkley would later say that he suspected that companies were prioritising their wealthy customers over COVAX and that activists "should have invested more effort into asking companies to be more transparent on their vaccine supply rather than asking for a TRIPS waiver" (Ravelo, 2023).

And while supply was a massive issue, there was also a fundamental issue contained in the architecture of the ACT-Accelerator that had not been addressed. In April and May 2021, news emerged of the Democratic Republic of the Congo (DRC) (Jerving, 2021) and South Sudan returning vaccine doses to the COVAX. The question is, why would countries return vaccine doses to the COVAX right in the middle of the acute phase of the pandemic? One colleague based in DRC told me that the COVAX had not engaged provincial health leadership and had not sufficiently leveraged the expertise of community health workers that had been mobilised and trained for the Ebola response. One article pointed to "strong levels of vaccine hesitancy and gaps in the DRC health system that limit the country's capacity to roll out vaccines quickly" (Jerving, 2021). And while the term "hesitancy" does not sit well with me because it was a narrative pitched by Pfizer's Albert Bourla (Hossain et al., 2021) amplified by Global North entities, and eventually co-opted by Global South entities to explain away a situation where communications campaigns simply had failed to address the legitimate concerns and questions that people had about vaccines, it became clear

that there were multiple contextual factors that were preventing vaccine uptake. The next question was, did DRC's VIRAT indicate to the COVAX that it was not ready to deploy?

VIRATs (readiness assessments) were rolled out to more than 100 LMICs in November 2020, and according to a March 2021 World Bank publication, the majority of countries had not developed processes to train vaccinators, nor had they developed social mobilisation and public engagement strategies to encourage people to get vaccinated. An excerpt from the report reads as follows:

> The assessments reveal that while 85% of countries have developed national vaccination plans and 68% have vaccine safety systems, only 30% have developed processes to train the large number of vaccinators who will be needed for the campaign and only 27% have created social mobilization and public engagement strategies to encourage people to get vaccinated. Given the worrying vaccine hesitancy levels, strategies to generate confidence, acceptance and demand for the vaccine are urgently needed
>
> (World Bank, 2021).

It was clear that a predominantly commodities-based approach to vaccines was not going to work. Any mechanism that had sufficient Global South expertise integrated and present throughout meetings would have been able to communicate this. This was something I kept saying in multiple meetings, like a broken record. This allows us to segue into the next section of this chapter — on the key elements needed in future pandemic mechanisms, including the proposed WHO Medical Countermeasures platform.

Self-tests: Ideological failures and poor co-ordination

Self-tests remained largely inaccessible in the Global South, owing to a combination of conservatism and paternalistic attitudes at

the global, regional, and national decision-making levels and poor regulatory capacity at the regional level. As self-testing became widely available in the Global North — including in the UK where I live from 9 April 2021 for free on the NHS (UK Government, 2021) — progress on self-testing on the ACT-Accelerator was progressing extremely slowly, and not for want of trying. WHO Guidelines for self-testing needed to be issued before large procurers like Global Fund and UNICEF could make purchases for the countries they work in, or risk rejection/non-acceptance of supplies. The reality was that many countries in the Global South remain reliant on the WHO for regulatory approval and quality assurance of products (including self-tests). While the WHO has robust technical expertise on quality assurance, the responsible unit on product prequalification is small and underfunded, and especially during a fast-moving pandemic, lacked capacity to review the large number of dossiers from diagnostics manufacturers, many of which were of poor quality (PVA, 2023).

Throughout 2021, ACT-Accelerator civil society and community representatives, the Global Fund, FIND, the Gates Foundation, and even key actors within the WHO, were pushing against a select few diagnostics decision-makers within WHO and who were concerned about whether communities in the Global South knew how to "link to public health action" (Rahman et al., 2022) after a self-test and concerns about the "trustworthiness" of WHO in recommending self-tests without comprehensive studies into feasibility, acceptability, and public health value of self-testing in communities. Some officials were concerned that there was a lack of randomised controlled trials and meta-analyses on Covid-19 self-tests — and we argued against this rigid and binary view of what constituted scientific evidence — drawing them to examples of self-testing in HCV and HIV, and in pregnancy. Notably, we would not be paternalistically gatekeeping access to pregnancy tests fearful of women not knowing what the next steps were.

While meetings pushing for self-tests occurred throughout the year, a pivotal meeting occurred on 11 November 2021 with key decision-makers in global health agencies and with WHO officials involved. The above points were raised by assorted WHO technical

staff members, precipitating angry responses from multiple agencies and from civil society. In the Zoom chat, I typed (verbatim):

> So I think what's important here is to ask how trustworthiness is impacted by delay. In the start of the pandemic, we obviously heard WHO's own Mike Ryan say that "speed trumps perfection" in the pandemic response - and while I understand why systematic processes like this exist, the implication of this delay is that self-testing is OK for Germany and UK but not for LMICs. Also concerned about some of the language coming out from WHO staff on this that "we don't know whether people will link to treatment". And we do in the global north? People should be allowed to self-test even for managing their own risk to their families, as what is happening in our homes in the UK. Some of this language mirrors some of the language of distrust in the HIV world as well - and it is really quite racist. Third is that I hope that equity is taken *really* seriously on this because the approach is really quite stark. We have self-tests in our homes in the UK. But not in Zambia, in Laos, in Peru. That's problematic.

Crucially, at that stage, many across rich countries still did not know how to access Paxlovid but were not prohibited access to self-tests on account of this fact. Communities across the Global North were allowed access to self-tests because their governments and scientific decision-makers believed they had the right to know their status and take measures within their own homes to protect their families.

An op-ed written by key members of ACT-Accelerator CSOs precipitated a bilateral meeting with the WHO DG, Tedros Adhanom Ghebreyesus, who agreed with us. Culminating from this meeting and immense pressure from multiple other agencies, the WHO released Covid-19 self-tests guidelines in March 2022 (WHO,

2022b), enabling large procurers to begin purchases and supplies. Many countries in the Global South had to wait for supplies from large procurers, and that was contingent on WHO guidance. Strengthened regulatory capacity at regional levels will enable greater agility, and better adherence to equitable access principles as applied to testing and the right to know one's status.

The issue of accessibility of self-tests could have probably also benefited with cross-pillar discussions and co-ordination. Earlier in this report, it was discussed how Greg Widmyer from the Gates Foundation suggested the need for joint pillar discussions to drive "smart action" in other pillars in May 2020. While joint pillar discussions eventually became more frequent, the first joint therapeutics and diagnostics meeting was only held for the first time on 23 September 2021, a full year and four months after the first time it was suggested.

What is needed for the next pandemic: Lessons from the ACT-Accelerator

Equal intellectual partnership of LMICs in a revamped and inclusive governance structure

In February 2022, CoVDP was established. Led by Ted Chaiban from UNICEF, the CoVDP would work in partnership with countries, CSOs, INGOs, and UNICEF country offices. As time passed, it became clear that the CoVDP was what was needed for uptake but what should have been established at the inception of the ACT-Accelerator. Work under the CoVDP established that in the DRC, for example, trusted influencers were church leaders and that when church leaders were engaged, people would want to get vaccinated, but because vaccination centres were often too far away from homes, there was a need for mobile vaccination centres to be placed right outside the churches (Matahari Global Solutions, 2022). CoVDP work by UNICEF South Sudan, for example, unearthed why women were not getting vaccinated — it was because Covid-19 vaccinations were rolled out in large hospitals far away from where women congregated and that there were gendered/patriarchal factors at play, such as women still needing permission from male partners

and guardians for any healthcare decisions. UNICEF South Sudan and the Ministry of Health then put in multi-layered interventions to increase vaccine uptake among women.

All these require equal intellectual partnership of LMICs in the architecture of any pandemic response mechanism. One cannot have an effective deployment with a predominantly Global North-led platform. Democratisation of expertise and geographic parity in governance of any mechanism is not a function of "wokeness", whatever that means, or tokenism or something global health entities do to tick their diversity, equity and inclusion (DEI) boxes. If your platform is not diverse and does not leverage the expertise within countries, it will fail on grounds of inefficiency, poor political buy-in, and poor local contextualisation.

This was well-documented by Global South actors. Devex quoted me as follows: "Fifa Rahman, a civil society representative with ACT-A, says a key drawback of the mechanism is the failure to integrate LMIC expertise in equal intellectual partnership." (Byatnal & Ravelo, 2022). In The Lancet, Pascale Ondoa, Director of Science and New Initiatives at the African Society of Laboratory Medicine, headquartered in Addis Ababa, Ethiopia, said, "the current format of the consultations could be improved to provide the right enabling environment for LMICs to bring their priorities forward and shape the agenda." The article further said that Ondoa hopes that the participation of LMICs and indigenous African health institutions becomes more prominent in the ACT-A decision process (Usher, 2021). In another article, Olusoji Adeyi, former senior adviser for human development, World Bank said that "in the fullness of hindsight, it is now eminently clear that the power structures have favoured the Global North over the Global South" (Banco et al., 2022).

Ultimately, this is an issue related to entrenched colonialism in global health architectures and governance, and something different is needed for the next platform on pandemic response. It should be noted here that in the ACT-A Evaluation: "Two-thirds of survey respondents (66.0%) agreed that ACT-A's operating model was the best possible structure at the time of the launch… For the next pandemic, only 34.7% of survey respondents would replicate

ACT-A's operating model –that is, four pillars and an informal coordination structure" (Open Consultants, 2022).

Geographic parity in the platform as well as regional implementation can also go a long way in mitigating paternalistic attitudes towards communities in the Global South –- as presented in the section on self-testing.

Co-creation of decisions with civil society

Integration of civil society occurred more seamlessly in some pillars of the ACT-Accelerator versus others. The therapeutics pillar included interim civil society representatives in some of their earliest working group meetings, largely an informal initiative of Unitaid staff members who believed that CSO opinions were necessary to ensure effective therapeutics interventions. Then diagnostics, health systems, and after much wrangling, vaccines. It is my reading that the ease of integration of CSOs into working groups depended greatly on the character of the co-lead organisations and the nature of their own experience with CSOs. I remember clearly one of the members of the senior leadership of one of the vaccines pillar co-leads stating he was worried CSOs "would be disruptive" — illustrating to me that he had a binary perception of civil society as rabble rousers and troublemakers — which we are, although some of us do this through strategic influencing and research, and others by loud and critical interventions. We also build meaningful partnerships with our colleagues in global health agencies and contribute intellectually — and it remains quite shocking to me that some view our ways of working as acutely different than theirs, or that it shocks them that we went to the same schools that they did. The work of CSOs is valuable and necessary, and they operate as a check and balance to binary viewpoints.

I asked Karrar Karrar from Save the Children, a CSO representative on the ACT-Accelerator, why the inclusion of civil society in the COVAX occurred so slowly. In his words:

> In achieving speed and scale of COVAX operationalisation, effective CSO integration took a little longer than other pillars of ACT-A. The early phase of COVAX operations surrounding contract negotiations and other politically sensitive decisions with governments, donors and industry required a huge degree of trust and confidentiality on the part of all partners. I suspect given the critical response of some sections of the CSO community towards COVAX's design and model of operation, this naturally led to reservations as to whether CSO's could be trusted with that information. I believe this led to an underlying tension which meant that we never really achieved truly effective CSO integration. In my opinion this was a shame as the voice of CSO's as an accountability mechanism could have been used strategically by COVAX leads early on when that public pressure could have eased some of the early supply bottlenecks.

Co-creation of ACT-A decisions with civil society largely depended on personal relationships with co-lead agencies and senior management within them. Future pandemic countermeasures mechanisms must ensure that documents and positions are not fully curated before they come to civil society, but that CSOs are viewed as technical and intellectual partners from the outset. At the same time, we acknowledge our faults — CSOs too need to invest more time in identifying and investing in representatives who are able to centre local expertise, deconstruct poor arguments, encourage accountability in CSO engagement, and understand how strategic influencing works.

A new TRIPS order

Access to pandemic tools was compromised by maximalist intellectual property and the actions of countries who were intent on delivering a TRIPS decision that was not as effective as it should

be. In addition, some of the co-lead agencies simply did not believe intellectual property was a factor in access to pandemic tools, (Ravelo, 2023) contrary to the testimony of experts with centuries of cumulative experience on intellectual property. The European Commission too was against any kind of TRIPS waiver, "suggesting that sharing intellectual property would not immediately speed up manufacturing" (Human Rights Watch, 2021).

Managing the corporate loyalties of certain actors will be impossible without the shifting of the IP power dynamic to the Global South. Before the next pandemic arrives, countries will need robust strategies on both ensuring Global South development of pandemic tools and in establishing a new TRIPS order at the national level with levels of IP that makes sense for the country.

A true equity and access lens

There is not one actor on the ACT-Accelerator that did not believe they were all focused on equity and access. However, the inequity of structures and biases inherent to all our backgrounds means that there were many blindspots. With self-tests, many laboratory-trained experts were overwhelmingly focused on the accuracy of tests over and above access. This often meant these decision-makers would deprioritise rapid tests, whether professional use rapid tests or self-tests. I dubbed these individuals PCR fundamentalists because they were pro-PCR at all costs, even though there were nomadic populations who by nature could not wait until the next day to get the PCR result and did not have an address or phone that you could forward results to. They were pro-PCR at all costs even for mums of six in South Sudan who lived a 40 minutes bus ride away from their nearest centre for PCR testing and faced the added obstacle of having to ask a male partner for permission to access healthcare. PCR fundamentalists and especially Global North PCR fundamentalists are viewing tests from a very binary worldview and thus cannot deliver real equity in access no matter their intentions.

The same applies to Paxlovid. An August 2022 report documented that doctors in rural healthcare centres in Haiti, Madagascar, and Nigeria having never heard of Paxlovid, despite it having received emergency authorisation at the US Food and Drug Administration

in December 2021 (Pfizer, 2021) and WHO calling for "wide geographical distribution" of Paxlovid in April 2022 (WHO, 2022c). An equity lens means several things here — that sufficient volumes be reserved for LMICs, that any intellectual property be waived instantly to enable generic competition and cheaper pricing, and that there is democratisation of information at the local level in languages people understand so that demand creation can come from the grassroots.

These examples illustrate how a true equity and access lens is not just closely related to ensuring diversity in expertise that you have in decision-making groups, but how diversity and geographic parity of experts is equally important and is not a function of some tokenistic tick in the box fanciful DEI process.

More agile and decentralised regulatory processes and guideline development

Regulatory and quality assurance processes at the international level, while technically robust, worked too slowly for fast-moving pandemic times. In addition, rigid processes for self-tests guidelines at WHO, a prerequisite for procurement by large procurers, focused heavily on what evidence specifically existed on Covid-19 self-tests, rather than self-tests for all diseases. Systematic analyses and meta-analyses were prioritised. While these studies hold value, this approach under pandemic times created additional bureaucracy for what was already an extremely late approval process for a document that was the single biggest barrier to large procurers making purchases. They also were largely irrelevant — at that stage there were many highly sensitive and specific self-tests being used in the Global North, having been approved by their stringent regulatory agencies.

More agile regulatory processes and guideline development processes require decentralisation. This means building capacity and establishing stringent regulatory authorities at regional bodies such as the nascent African Medicines Agency — and for large procurers being able to rely on guidelines developed by regional entities. In the meantime, WHO should also revise its guideline development processes during pandemics. While the quality of

evidence is extremely important, it should establish more agile processes and approaches to knowledge that take into account decisions made by stringent regulatory agencies, considerations of equity, and established knowledge about similar tests in other disease areas.

Health systems as a core investment

The ACT-Accelerator Health Systems and Response Connector was a failure. The ACT-Accelerator External Evaluation stated that "most key informants described the pillar as largely dysfunctional throughout 2020 and 2021" (Open Consultants, 2022) and indeed it was. Its working groups sat infrequently, and its scope initially focused predominantly on oxygen and PPE, which Hipgrave criticised in 2021 as "better described as components of clinical care" rather than fitting within the domain of health systems (Hipgrave et al., 2021).

In May 2021 my intervention at the 6th convening of the Facilitation Council, the body to which WHO Member States could — if they so desired — interrogate the inner workings of the ACT-Accelerator or share updates and concerns about their national responses, I pointed out the poor co-ordination and investments in health systems in the ACT-Accelerator, calling out specifically the return of vaccines from DRC to the COVAX due to "inaccurate assessments in vaccine readiness and insufficient engagement of local communities" (Rahman, 2021). Ultimately, health systems investments need to look at cold chain support, logistics, the mobilisation of community health workers, data systems that track who has been vaccinated and that can analyse which communities are being missed out, electrification of facilities, and reimbursements for community transport to vaccination facilities, among many key investments.

The next pandemic countermeasures mechanism must ensure a health systems focus. Commodities dumped in-country without health systems investments will result in the same story — commodities deployed in a suboptimal manner and with inequity for the most intersectionally marginalised communities.

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