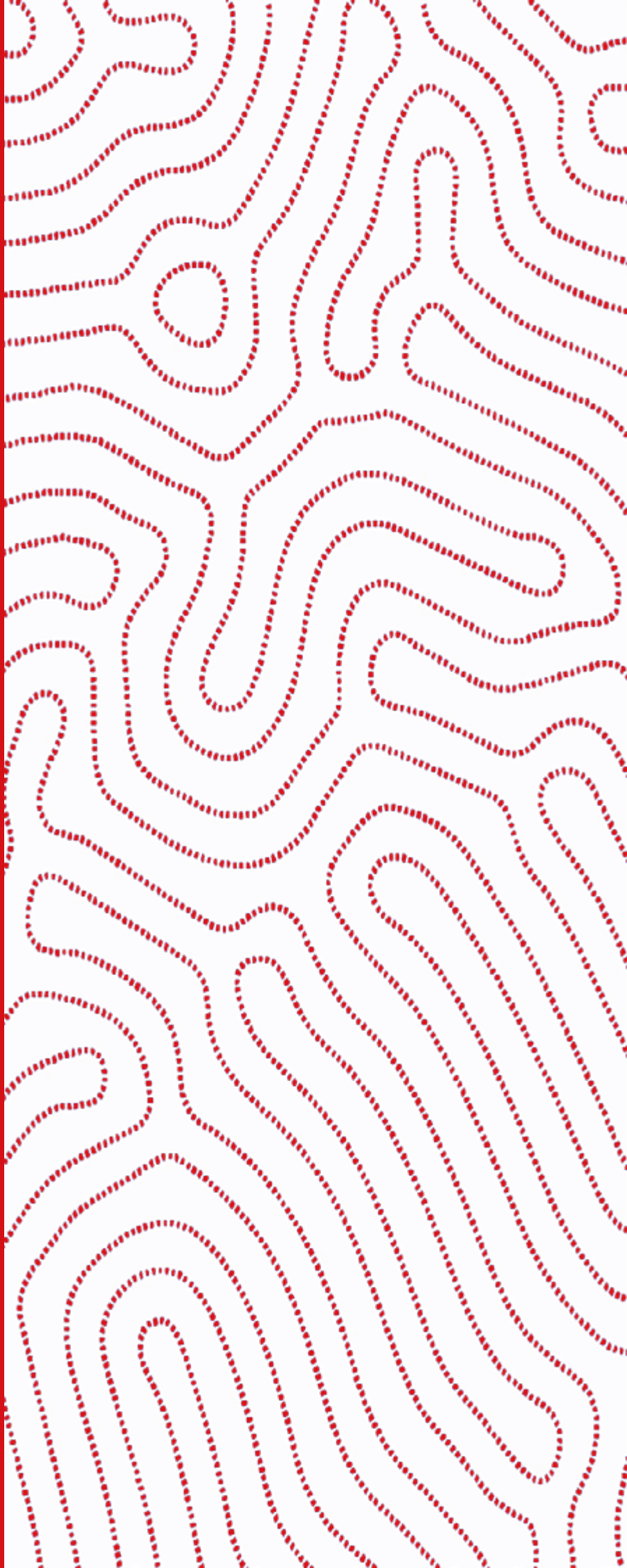



COVID-19 VACCINE ACCESS IN ASIA

WORKSHOP REPORT

ASIA CATALYST
APN+
TREAT ASIA





Information about the COVID-19 Advocacy Project, including workshop slides and a C-19 vaccine brief (in both English and Thai), are available online at <https://asia-catalyst.org/resources/covid-19-vaccine-information-and-advocacy-project/>

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FOREWORD

PERSPECTIVES FROM ASIA CATALYST AND ASIA-PACIFIC NETWORK OF PEOPLE LIVING WITH HIV (APN+)

ASIA CATALYST

Thirty years of transnational AIDS activism taught us a lot about systems of oppression and the need for collaborative long-term strategies to confront and overthrow them, particularly around the issue of access to essential medications. The right to health belongs to all people globally, but Pharma greed and profiteering, supported by the self-interest of rich countries and enabled through bully tactics, prevented poorer countries from asserting their rights to address local HIV epidemics through locally-made or imported generic drugs. The resulting delay in access to treatment led to millions of premature deaths.

Starting in the 1990s, we transnational activists committed to a long-term fight to ensure this lag in access to life-saving treatment across the global north and south divide wouldn't happen again. We stood up in global solidarity when the hepatitis C virus (HCV) cure became available, fighting for affordable access for all. We made huge strides: many in our communities who needed HCV direct-acting antivirals got generic versions quickly and overcame their disease, thanks to strong community-led advocacy.

Today we are confronting another global inequity: access to COVID-19 vaccines, which in new and unimaginable ways are being kept from those most in need. Once again, we see old problems - greed and self-interest- prevailing over a holistic, equitable vision for global health. As activists, we have a wealth of resources and collective power to bring to bear, namely our solidarity, and our long-term vision for structural change. Thanks to allies who help us understand the problem at hand, we have the right information and tools for our advocacy targets. Today we begin this work together as a region, across our networks, and in honor of all the friends we lost because we couldn't make these critical changes in time. We'll never give up hope nor the fight for human rights and health for all.

Karyn Kaplan, Executive Director, Asia Catalyst





APN+

This is a difficult year for all of us. We know that COVID-19 is about much more than vaccines, and the issues with vaccines are very complicated. Communities are important to the COVID-19 response; consulting with them is the only way governments can learn about gaps in, and barriers to, vaccine rollout.

In the past, treatment literacy was the key to HIV treatment access. Now, literacy is the way to challenge myths, misinformation, how we see things, and what we believe. Many people living with HIV who were reluctant to take vaccines are now vaccinated. Peer-to-peer education is really helping to address this issue. We know that there are still many people who do not want to get the vaccine; we need to continue to educate our communities so that they have information to make the right decisions for their health.

The aims of the workshop are to build capacity on key issues related to COVID-19 vaccines, understand UN initiatives, and address legal issues that we are familiar with from HIV work, such as consent, confidentiality and access to vaccines, and the impact of patents. It is important that we understand all these issues and how they are playing out in the context of COVID-19 vaccines.

Shiba Phurailatpam, Regional Coordinator, APN+





ABBREVIATIONS

ACT-A Access to COVID-19 Tools Accelerator

APN+ Asia-Pacific Network of People Living with HIV

ART antiretroviral therapy

ARV antiretroviral

C-19 COVID-19

CBO community-based organization(s)

CEPI Coalition for Epidemic Preparedness Innovations

CL compulsory license(s)

COVID-19 coronavirus disease 2019

CSO civil society organizations

C-TAP COVID-19 Technology Access Pool

CPTPP The Comprehensive and Progressive Agreement for Trans-Pacific Partnership

EU European Union

FIND Foundation for Innovative New Diagnostics

FTA Free Trade Agreements

Gavi Global Alliance for Vaccines and Immunizations

GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria

HCV hepatitis C virus

HIC high-income countries

HIV human immunodeficiency virus

HPV human papilloma virus

IP intellectual property

KVP key and vulnerable populations

LDC least-developed countries

LGBTQI lesbian, gay, bisexual, transgender, queer, intersex

LIC low-income countries

LMIC low-and middle-income countries

NGO non-governmental organization

PLHIV people living with HIV

PPE personal protective equipment

PrEP pre-exposure prophylaxis

PVA People's Vaccine Alliance

SI Serum Institute

TB tuberculosis

TREAT ASIA Therapeutics Research, Education, and AIDS Training in Asia

TRIPS Trade-Related Aspects of Intellectual Property Rights

UK United Kingdom

UMIC upper middle-income countries

US United States

WHO World Health Organization

WTO World Trade Organization



ACKNOWLEDGEMENTS

Our two-day virtual workshop, held on 17-18 August 2021, was organized by Karyn Kaplan, (Executive Director, Asia Catalyst) and Kajal Bhardwaj, Gisa Dang, Kanya Benjamineepairoj and Tracy Swan (consultants to Asia Catalyst), with technical and IT support from Jessie Torrisi (Asia Catalyst) and Ruod Ariete (consultant to Asia Catalyst); and notes were taken by Muanfun Tangpinijkarn.

This report is a summary of the workshop and ensuing community advocacy discussion, which aimed to lay groundwork for building a community-centered, gender-equitable framework for access to COVID-19 (C-19) vaccines (and other medical products) in South and Southeast Asia. It was written by Tracy Swan, and edited by Karyn Kaplan, Gisa Dang, and Kanya Benjamineepairoj, and designed by Chloe Forette.


WORKSHOP OVERVIEW

Using a key populations and human rights lens, the workshop focused on identifying gaps in and barriers to vaccine access. It showcased the work of, and recommendations from community-based organizations (CBOs) on how to eliminate those barriers. Country profiles from Bangladesh, China, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, the Philippines, Thailand and Viet Nam described the current COVID-19 situation and its impact on key¹ and vulnerable populations (KVP), approved vaccines and their pricing, and eligibility for and obstacles to vaccination.

The workshop covered:

- Vaccine inequity
- The failure of voluntary mechanisms in increasing access to medical products
- The impact of Free Trade Agreements (FTA) on access to medical products
- Intellectual property (IP) barriers
- Current civil society campaigns and international initiatives to increase access to C-19 vaccines
- Ethical and legal issues around C-19 vaccines
- Human rights in the context of C-19
- Decolonizing the C-19 response
- Ensuring that communities are at the heart of the C-19 response

1. Key populations are groups of people (sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs, and people in prisons and other enclosed settings), who are particularly vulnerable to, and disproportionately affected by HIV, due to marginalization and structural factors such as stigma, discrimination, violence, human right violations, and criminalization. Vulnerable populations are at greater risk of poor physical health due to disparities in physical, economic, and social status, including, but not limited to people with chronic illnesses and people with disabilities; migrants, refugees and internally displaced people; the elderly, infants and children; homeless people and those living in poverty. People who are members of key and/or vulnerable populations often lack access to health services.



The global HIV experience has unmistakably demonstrated that public and individual health initiatives will fail unless they are grounded in human rights and able to reach people who are members of the most affected: KVPs. But in the world's frantic scramble to secure and administer C-19 vaccines, human rights have been violated and the perspectives, wisdom, and needs of people who are members of KVPs are being left behind.

Our workshop was created for health and human rights activists working on COVID-19, with the main purposes of providing essential information for advocacy, bringing important human rights and other issues and perspectives to light, and by directly involving people and groups that have been left behind. While limited by time constraints, scheduling conflicts, connectivity issues, and other life circumstances, we proudly offer this summary as a commitment to the above purposes, and as a record of this successful transnational collaboration during a uniquely painful and challenging time in our world's history.

Methodology

This report draws on presentations and discussions from virtual meetings organized by Asia Catalyst, APN+ and Therapeutics Research, Education, and AIDS Training in Asia (TREAT Asia) in August 2021. It summarizes a two-day workshop for community and vaccine access activists, and a post-workshop community advocacy dialogue led by APN+.

Presentations were rearranged for context and do not follow the order of the original workshop agenda. Summaries of the presentations are based on the voices of the presenters and represent their point of view at the time of the workshop.



COMMUNITY VOICES

As with HIV, the C-19 pandemic affects us all. But COVID's impact has been far harsher in low- and middle-income countries (LMIC), and on people who are poor, marginalized, and vulnerable. Vaccine inequity, driven by IP barriers, continues to threaten the lives of millions of people while allowing the pandemic to rage on.

The HIV experience showed us the power of communities, who formed groups and networks dedicated to self-support in the face of neglect and discrimination while powerfully fighting for broad changes in policy, funding, legislation, healthcare funding and delivery and the IP systems to meet these needs and to change systems – such as healthcare – for positive social impact beyond HIV.

After our workshop, APN+ held community advocacy discussions with workshop participants, where they answered key questions on addressing the pandemic. We chose to open the report with these discussions.

Community Responses to Key Questions

What are the main advocacy issues related to C-19 vaccine access for people living with HIV (PLHIV) and key population groups?

- Unmet need for national campaigns with joint regional voices to support/amplify local campaigns, and a platform for networks to share information
- International support to prevent and stop crackdowns on non-governmental organizations (NGOs)
- More funding is needed for community-based and community-led work, including for supporting communities and people through and after lockdowns; provision of peer-led, culturally and linguistically competent C-19 vaccine information; supporting vaccine uptake (helping people register, taking them to appointments), and vaccine distribution
- Lack of differentiated vaccine delivery models, such as: expanding into ART (antiretroviral therapy) clinics, mobile sites and CBOs
- Governments are not transparent about vaccine procurement and their supply chains, which contribute to vaccine shortages in many countries. When procurement is delayed, such as in Viet Nam and Thailand, most vaccines have already been sold to high-income countries
- Stigma and discrimination still exist in healthcare facilities, due to a lack of understanding among healthcare practitioners about PLHIV and key populations. Stigma and discrimination will delay achievement of herd immunity

What are necessary activities for PLHIV and KVP to support C-19 vaccine access, especially concerning the inequity faced by many developing countries?

- Advocacy to the government to ensure all people have access to C-19 vaccines
- Advocate for the government to produce materials on C-19 vaccine literacy, including on IP issues. Based on our HIV experience, the community should be empowered to be the government's allies

- The World Health Organization (WHO) must provide information on C-19 and vaccines for adaptation and dissemination through peer-to-peer sharing, to counter misinformation and overcome the inequity that communities often experience. Peer-to-peer information sharing should also cover IP barriers (using simplified information), so that community members have a better understanding of these issues
- Advocate for the prioritization of PLHIV and key populations for C-19 vaccines and to generate evidence of the benefits of C-19 vaccines for people in these groups
- Provide financial support for hospitalization and healthcare, including nutritional needs
- Implement C-19 awareness campaigns, especially in rural areas
- Advocate to oppose vaccine passports until all people in the country are vaccinated, with provisions for people who cannot be vaccinated due to allergies and other underlying conditions. When vaccine passports become a requirement for travel, employment, and rations, social inequity will increase
- Data collection, and evidence generation for advocacy
- Provide C-19 prevention materials – masks, sanitizers, soap, and personal protective equipment (PPE) kits

Which donors are providing support for C-19 related activities and what activities are being supported? Which other donors should be approached?

- GFATM in India, Myanmar and Nepal (for PLHIV and key populations) - PPE kits, nutrition, human resources and machines (GeneXpert) at a few government-run diagnostic sites
- United Nations Population Fund and Family Planning Association in Sri Lanka – prevention kits (proposal for setting up a care centre to the Global Fund)
- PEPFAR/USAID, AIDS Healthcare Foundation; the European Union (EU) could be approached

What advocacy strategies should PLHIV and key population groups adopt to ensure funding from donors for C-19 related activities?

- Community Mobilization on the ground at country level
- Demand generation activities
- Evidence generation
- Advocacy on key issues - work on patent/FTA barriers; removal of citizenship/ID card related barriers for access to services
- Donor/Stakeholder outreach
- Donor mapping per country

What should be the role of regional community groups in providing support to national groups?

- Adapt available information into local languages
- Resource mapping and funding for local groups

COMMUNITY KNOWLEDGE

The workshop focused on overcoming IP and other barriers to C-19 vaccine access; presentations describing these barriers are summarized here.





IP BARRIERS AND C-19 VACCINES

Kajal Bharwaj

Kajal Bhardwaj is a global leader in the access to medicines movement; she is a lawyer who has been working on health and human rights for over a decade.

As the HIV community, we have been fighting this battle on intellectual property and patents for 20 years.

Kajal Bharwaj

What is the World Trade Organization (WTO)?

The WTO, which was established in 1995, has 164 country members (not all countries are members, but most of the countries in this region are members). It sets agreements on global trade (several have been signed), has a strong enforcement mechanism and settles disputes. Countries are desperate to get WTO approval before moving ahead to suspend patents and IP on C-19 medical technologies.

What is the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement?

Although it was intended to open up trade, the TRIPS agreement obliges governments (except in least-developed countries [LDC]) to create monopolies on IP for various things - including medical technologies. Under the TRIPS agreement, all WTO members must provide patents for 20 years.

The same rules apply to everything: mobile phones, televisions and medical technologies. Devised by E. Pratt, former CEO of Pfizer, who proudly described it as resulting in part from "...the hard-fought efforts of the United States (US) government and US-based businesses, including Pfizer," the TRIPS agreement covers copyrights (which impact how we access research and scientific literature), trademarks, including service marks, geographic indicators, industrial designs, patents, layout designs for integrated circuits and undisclosed information, including trade secrets. The TRIPS Agreement has made sure that health technologies and the IP around it remain closed, and in the hands of Big Pharma.

What is Patent Evergreening?

A different dose or form of an existing medicine can be patented (called evergreening), which extends protection for an additional twenty years.

What is the *Doha Declaration*?²

We affirm that the (TRIPS) Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health, and, in particular, to promote access to medicines for all.

WTO Ministerial Declaration on TRIPS Agreement and Public Health, 14 November 2001

Twenty years ago, we faced the same situation with the HIV pandemic. There was treatment available, but it was in the control of a few multinational pharmaceutical corporations and very few people had access to life-saving treatment. Today, we have millions of people on treatment, thanks to the hard-fought battles of developing country governments and most of us, as treatment activists, who said we have the TRIPS Agreement and monopolies, but there are still a lot of things that governments can do to improve access to medical technologies, such as compulsory licenses (CL), and refusing to grant patents on frivolous applications.

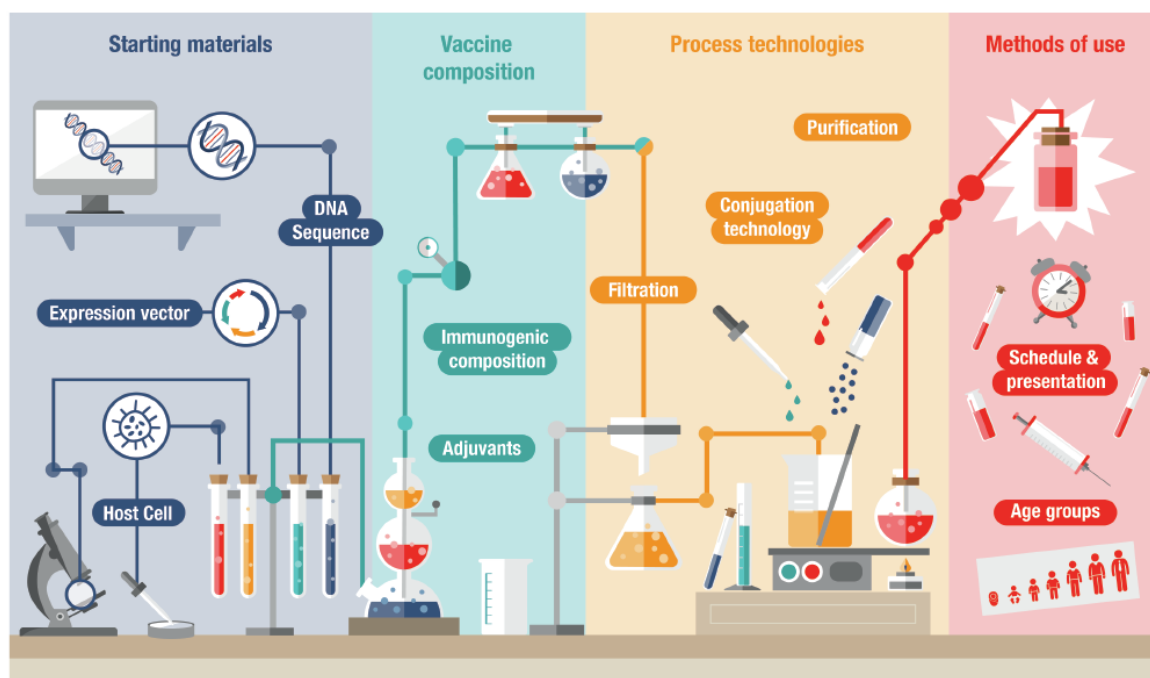
Concerns about the impact of patent monopolies on public health led to the 2001 *Doha Declaration*. The *Declaration* affirms the rights of governments to address public health needs by using TRIPS flexibilities (such as CLs, which allow countries and people other than the patent holder to make, sell, import, or use a patented product or process without the patent owner's consent; parallel importing, which allows countries to import generic products, and applying rigorous patentability criteria). Implementing these TRIPS flexibilities has been challenging, because countries who have used them were subject to political and legal backlash from the US and the EU, and multinational pharmaceutical corporations.

Patents and C-19

Patent monopolies cover - and prevent access to - more than medicines, including masks, ventilators, and diagnostic machines. Hospitals struggled to keep C-19 patients alive with ventilators that required an individual valve for each patient. A valve shortage in hard-hit Italy led researchers to create lifesaving, 3-D versions that could be produced quickly and inexpensively; they were threatened with legal action for patent infringement. In the US, the Governor of Kentucky criticized the 3M corporation for refusing to release their patent on N95 respirators despite shortages of and urgent need for personal protective equipment.

2. https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm

As HIV activists, we haven't focused on vaccines; during the past year, we have discovered that there are, thousands of patent applications and patents have been filed on C-19 vaccines (Including those in development) worldwide. Companies patent everything – and every process involved with developing and manufacturing vaccines. There are even patents on the age groups to whom vaccines can be given.



Source: MSF Access Campaign, A Fair Shot, 2017. Available from: https://msfaccess.org/sites/default/files/2018-06/VAC_report_A%20Fair%20Shot%20for%20Vaccine%20Affordability_ENG_2017.pdf (accessed 6 October 2021).

What are Trade Secrets?

We are not just talking about patents anymore: we are fighting the battle for access on many fronts. TRIPS also covers trade secrets – such as the recipe for Coca-Cola, which is considered the biggest secret. Trade secrets have become really important during the pandemic. They allow pharmaceutical corporations to withhold essential information necessary for discovering, creating, testing and manufacturing diagnostics, medicine, vaccines and other medical devices; starting materials; cell lines; genomic data and other biological materials. Even negative information on efficacy of vaccines and treatments can be held as trade secrets – preventing other companies from knowing how to avoid failed approaches.

What is a Voluntary License (VL)?

The VL model allows pharmaceutical corporations to decide who can produce and supply drugs. It has been a failure for HIV treatment access, because it leaves out most upper-middle-income countries (UMIC). During the pandemic, Gilead Sciences issued a VL on their C-19 treatment, remdesivir, which was a poor choice, because the WHO Solidarity Trial found that it was ineffective.³ Multiple companies in Egypt, India and Pakistan signed the VL. But as soon as the C-19 surge began in India, the country could not produce enough remdesivir for itself. The idea that Indian companies would be able to provide remdesivir throughout the world is ludicrous and demonstrates the failure of the VL model in a pandemic; we need production across the world.

Why Multiple Sources for Vaccines and Other Medical Technologies are Needed?

Multiple producers in multiple countries are needed to provide vaccines for the entire world; we cannot rely on just a few of them.

A large amount of public funding has gone into development of C-19 vaccines - but a lot of this money has wound up in private hands. AstraZeneca is a great example: the vaccine they manufacture comes from Oxford University and was developed with public money from the United Kingdom (UK). The vaccine was supposed to be open access, but it wound up going to AstraZeneca. Although the company said they were using “no-profit” pricing, the EU got the lowest prices for the vaccine (US \$2.15 per dose), while Uganda, an LDC, paid US \$7 - \$8 per dose.

The Serum Institute (SI) of India got public funding and money from the Gates Foundation to produce Oxford/AstraZeneca vaccines for the world. Soon afterwards, Indian treatment activists were embarrassed to discover that most of these vaccines were going to developing countries at high prices, via bilateral deals instead of being distributed through COVAX. When India got hit by the Delta variant, SI stopped importing vaccines because of domestic need.

Progress on Access During the Pandemic

Our governments do have the power to challenge Big Pharma's monopolies. During the pandemic, Israel issued a CL on lopinavir/ritonavir (an HIV protease inhibitor) – although it turned out to be ineffective against C-19, AbbVie announced that they would not enforce patents on this product, which could increase access to affordable generic versions of the drug. Russia and Hungary have issued CLs on remdesivir, and civil society groups in Argentina and India have filed patent oppositions on C-19 treatment. Some countries have voted to suspend patent protection during the pandemic, including Brazil (where it has passed in the Senate but may not ultimately be enacted).

Campaigns for suspending TRIPS are underway, but there are also Big Pharma-funded counter campaigns across the world. Beyond C-19, we are going to need access to medical technologies for HIV, tuberculosis (TB), and other conditions. The biggest lesson is what we've learned over the last 20 years: our governments are not going to take on Big Pharma, it is up to us to take them on.

3. <https://www.who.int/news/item/15-10-2020-solidarity-therapeutics-trial-produces-conclusive-evidence-on-the-effectiveness-of-repurposed-drugs-for-covid-19-in-record-time>

THE TRIPS WAIVER

Chee Yoke Ling, Third World Network

Chee Yoke Ling is the Executive Director of Third World Network. She is trained in law and has worked on public health and access to affordable medicines since 2000.

"We talk about so-called rights, but IP is a privilege, it is a monopoly that the law creates. Using the term 'rights' for IP is a problem; it has shifted how people think. IP rights are not the same as the right to health, but when we announce a CL or a patent opposition, some people will say to us "how can you violate the rights of these companies that spend so much money and work so hard to give us these medicines?"

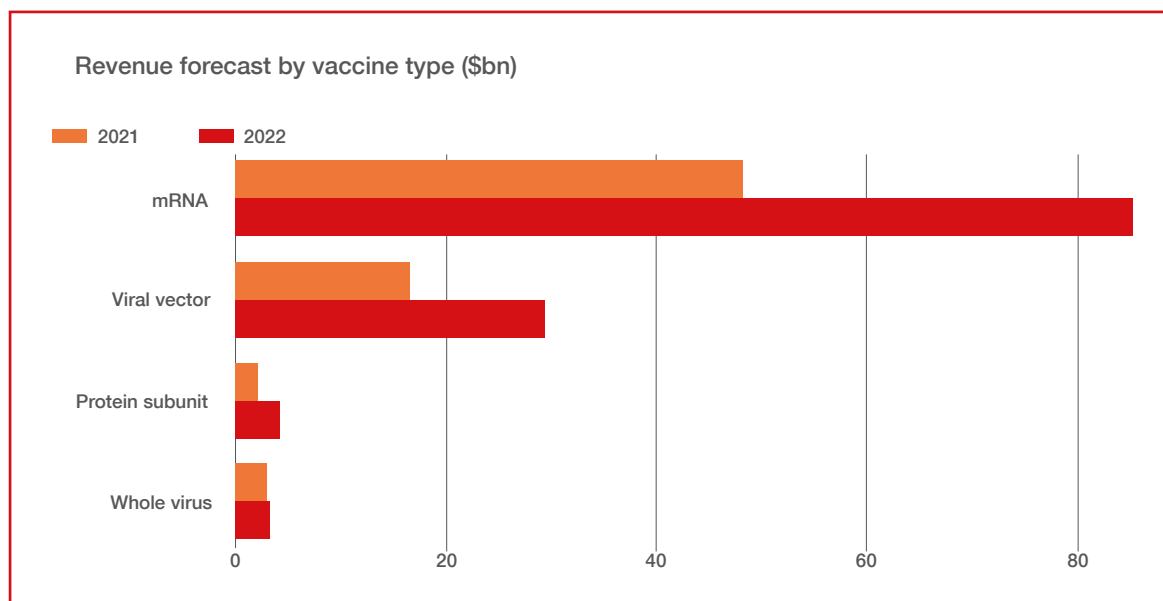
Chee Yoke Ling

C-19 Profiteering

The COVID-19 pandemic has been highly profitable for the pharmaceutical industry.

PFIZER	MODERNA
In Q1 of 2021, COVID-19 vaccine revenue reached US \$3.5 billion, which was 25% of the company's total revenue, although it was developed by BioNTech, a German company.	Founded 11 years ago and did not bring a single product to market or make a profit before the pandemic; Moderna got millions of dollars from the US government to help develop their C-19 vaccine.
The 2021 revenue forecast was increased by 73%, from US \$15 billion to US \$26 billion – but actual revenue is expected to be higher due to new contracts for booster doses.	Expected sales of US \$18.4 billion in 2021, most from the US, because the Trump and Biden administrations have invoked laws to ensure that most domestically-produced goods stay in the country.
The two-dose C-19 vaccine is priced at US \$39 in the US and US \$30 in the EU.	Over 12 months, during 2020 – 2021, the share price increased by 332%.
In August 2021, the EU price increased by 25% (from €15.50 to € 19.50) in the 2021-2023 contract for booster doses.	The two-dose C-19 vaccine is priced at US \$30 in the US and US \$36 in the EU, which is a benchmark for the rest of the world.
	In August 2021, the EU price increased by 10% (from US \$22.60 to US \$25 per dose; the original price of US \$28.50 was lowered because of the large volume order.

Sales of mRNA vaccines expected to boom



Source: Financial Times. Available from: <https://www.ft.com/content/d415a01e-d065-44a9-bad4-f9235aa04c1a>. Accessed 20 October 2021.

The TRIPS Agreement

The TRIPS Agreement created the right to impose 20-year minimum patent monopolies on products, processes and technology that meet certain criteria. Each country has its own standard for granting patents; some are weak and allow evergreening. One medicine can have thousands of patents. This has created monopolies that go on for 20 years and beyond. We all have to comply with these rules, except for LDC, after a lot of fights led by civil society and governments.

The other important area in the TRIPS Agreement is undisclosed information, or what we call “trade secrets.” There is no time limit on trade secrets and “know-how” (for example, the extra step that is not shared and thus prevents us from being able to make a drug). Even if there is no patent, this protection can go on forever.

TRIPS flexibilities are exceptions meant to limit monopolies, and with the aim to create a balance between private and public rights, such as CL and VL from IP holders, which have been a failure in terms of both public health and access to affordable medical products (including for HIV, hepatitis C virus, and vaccines). All of you have fought for access to HIV drugs, we know how hard that fight is. We have to push and push for our governments to give a CL; politically, it is so difficult, even though legally this is part of the TRIPS agreement. The law allows for a broad range of reasons to issue a CL. Even when governments want to issue one, oppositional pressure from Pharma, the US government, and the EU can be very strong.

VLs are a failure for access to treatment. One of the concerns we have with C-TAP and the other technology pools is that they rely on the voluntary nature of Pharma—which does not exist. We have seen in the last few weeks that there are vaccine stockpiles in the rich countries, which are reaching their expiry dates – they are throwing away these vaccines, which is criminal.

The TRIPS waiver

Given this backdrop, in October 2020, India and South Africa jointly submitted a proposal to the WTO TRIPS Council to temporarily waive IP rights on medical products to prevent, contain, and treat C-19. The WTO TRIPS Council has issued waivers before; it is built into the system. The Council makes decisions by consensus, so a single country can block a proposal.

When we talk about the TRIPS waiver, we talk about removing IP barriers, and having the freedom to operate, manufacture, sell, import, export, and use medicines. We need to cover a whole range of IP. Even the package insert that tells you when and how to take your medicine, and its side effects, is under copyright, which lasts for 50 years - plus the lifetime of the creator. Industrial design is also protected; the 3M mask, for example, has more than 200 patents.

We want a waiver to remove legal uncertainty. When Russia issued a CL on remdesivir, Gilead took them to court to challenge it. We do not want to go country-by-country using the existing TRIPS flexibilities, with Pharma threatening, or actually filing lawsuits. We want to remove this pressure from research institutions, drug manufacturers, and our local governments, who will have to invest, so that they are confident in doing so.

The Revised TRIPS Waiver Decision for Negotiations (25 May, 2021)

1. The obligations of Members to implement or apply Sections 1, 4, 5 and 7 of Part II of the TRIPS Agreement or to enforce these Sections under Part III of the TRIPS Agreement, shall be waived in relation to health products and technologies including diagnostics, therapeutics, vaccines, medical devices, personal protective equipment, their materials or components, and their methods and means of manufacture for the prevention, treatment or containment of C-19.

2. This waiver shall be in force for at least 3 years from the date of this decision. The General Council shall, thereafter, review the existence of the exceptional circumstances justifying the waiver, and if such circumstances cease to exist, the General Council shall determine the date of termination of the waiver.


The global campaign supporting the TRIPS waiver includes civil society organizations (CSO), patient groups, representatives from academia, and other eminent people, parliamentarians, big name political leaders and international organizations, such as Médecins Sans Frontières and WHO – its Director General, Dr. Tedros Adhanom Ghebreyesus, who said “If not now, when?”

For more information on the TRIPS waiver, and updates on its progress, see:

Compilation of selected WTO documents, reports on TRIPS Council, campaign statements and reports: https://twn.my/title2/intellectual_property/trips_waiver_proposal.htm

MSF Access Campaign: <https://msfaccess.org/>

Feminists for a People's Vaccine: <https://feminists4peoplesvaccine.org/>



In May 2021, the US announced its support for waiving IP on C-19 vaccines, but it has not done much since then. But they are not pushing for it, and the EU, Switzerland, and the UK are taking a very hard line – the EU has made a distracting alternative proposal, suggesting voluntary measures that we know do not work. A lot of campaigning needs to be done to counter Big Pharma, which was surprised by the strength of the global campaign for the waiver. Big Pharma is spending millions of dollars to oppose the waiver, and threatening governments who support it. The campaign must be sustained; we cannot relax.

By August 2021, there were 104 co-sponsors and supporters, 64 from LDCs and developing countries - notably, Asian supporters are: Bangladesh, Cambodia, Laos, and Myanmar (through the least-developed country group), and India, Indonesia, Malaysia, and Pakistan), but the EU, Switzerland, and the UK continue to block negotiations, and there is strong opposition from large pharmaceutical corporations.



FREE TRADE AGREEMENTS (FTA) AND THEIR IMPACT ON ACCESS TO MEDICINES

Chalerm Sak Kittittrakul, AIDS Access Foundation

Chalerm Sak Kittittrakul, or Jockey, is the Project Manager for Access to Medicines at AIDS Access Foundation. He is also the Coordinator for FTA Watch. He is based in Bangkok, Thailand. His work focuses on how to make use of TRIPS flexibility measures and opposing TRIPS plus provisions in FTA negotiations, to promote access to essential medicines at affordable prices.

In the past, we have seen millions of people die from HIV, TB, and hepatitis C – and now, from C-19. IP is at the root of this problem. The system is broken; it must be fixed. We have to remove barriers, not just go disease by disease.

Chalerm Sak Kittittrakul

The Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP)

FTAs can have a chilling effect on access to affordable generic medical products. You cannot focus on a single chapter of an FTA, such as the section on IP, because other parts of it may have an impact on access – the devil is in the details.

Seven of 11 country members have ratified the CPTPP, and it has been enforced since 2018. Thailand is not a member of the CPTPP yet, but to boost its economy, the government is thinking about joining the Agreement. We have concerns about the CPTPP's impact on CLs, so we have been working to stop the government from joining it.

Although the IP chapter of the CPTPP mentions that countries can enforce CL (according to the TRIPS Agreement), Annex 9-B 3(b) of the agreement's Investment Chapter says that you can only use a CL under rare circumstances. This could allow the private sector, and foreign investors, to sue countries that use CLs to make medicines affordable for their people, making it even more difficult for countries to use a CL.

The CPTPP has other provisions that will make access to medicines more difficult, such as data exclusivity (which prevents generics manufacturers from demonstrating bioequivalence to originator drugs; instead, they must do their own clinical trials to register a generic version of an existing drug).

Patent Linkage

Another TRIPS-plus provision is called patent linkage; this allows patent monopolies to be extended beyond 20 years. Patent linkage involves two unrelated systems. If you want to sell drugs or vaccines in Thailand, your products must be approved by the Thai FDA. Drug registration is a public health function: regulators review safety and efficacy data on drugs and vaccines before they enter the market to protect consumers.

Patents fall under the work of the Ministry of Commerce's IP Department. Their job is to look at patentability criteria⁴ to protect business interests through monopolies. Unlike registration, patenting drugs – or anything else – is voluntary. The CPTPP tries to link these two systems together. Under the CPTPP, the Thai FDA must inform patent holders that a generics company wants to register one of their drugs, and it allows enough time and opportunity for the originator and generics companies to come to an agreement. This TRIPS-plus provision will delay or block registration of generic drugs and biosimilar vaccines in Thailand.

An academic group looked at access to medicines and patents in Thailand and assessed the impact of ratifying the CPTPP. In 1987, domestically produced medical products made up 69% of all medical expenditures. After Thailand signed the TRIPS Agreement, it became easier to file patents in the country. Consumption of domestic products dropped to only 31% in 2019. The researchers looked at the IP and government procurement chapters of the CPTPP, predicting that if Thailand was a CPTPP member, its dependency on imported drugs would increase from 60% to 89% by 2049, and that Thailand's medical expenditures would increase by billions of dollars, while sales of locally produced products would be significantly reduced, which would undermine the capacity of local manufacturers.

COVID-19

34 million die from **HIV**
1.4 million die from **TB**
399,000 die from **HCV**
Intellectual Property

MEDICINES INEQUALITY

AIDS ACCESS
make medicines affordable
END UNFAIR MONOPOLIES

4. In Thailand, to patent a product, it must be new; involve an inventive step, and be capable of industrial application.

COMMUNITY CONTEXTS

Perspectives from Key and Vulnerable Populations



OVERVIEW

**Midnight Poonkasetwattana,
Executive Director, APCOM, Thailand**

We cannot see the end of this tunnel unless we have vaccine access for everyone.

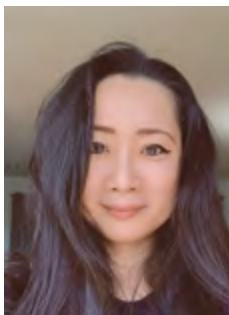
Midnight Poonkasetwattana

While the C-19 pandemic created hardships for nearly everyone, KVP faced numerous and specific struggles during the pandemic. Representatives from certain KVPs shared their experiences, needs and recommendations for addressing them.

Cross-cutting barriers revealed during this session were:

- Exclusion from governmental responses to C-19
 - ▶ Notably, sex workers and migrants have not been included in government assistance schemes
- Requirement for national ID to register for vaccination
 - ▶ This excludes migrants from vaccination
 - ▶ In some countries, women must rely on permission from men to get a national ID card
- Lack of information – and misinformation about vaccines
 - ▶ Information, when available, is often overwhelming and difficult to understand
- Technology is a barrier to vaccine access
 - ▶ Many people do not have a smart phone or computer
 - ▶ Many people do not know how to use smart phone apps or computers
 - ▶ People cannot afford data
- Mistrust of hospitals and other official facilities
 - ▶ Transgender people are often forced to identify and be grouped as male or female; they face stigma and poor treatment from healthcare staff
 - ▶ People who use drugs are not comfortable in hospitals and other official facilities; they prefer to seek services at CBO
- Need for mental health services
 - ▶ 60% of LGBTQI surveyed by APCOM people reported mental health issues
 - ▶ Lack of mental health care has been a huge issue for female sex workers
- Lack of access to non-C-19 health services due to lockdowns and closures
- Gender-based violence, and abuse
 - ▶ Especially occurring among LGBTQI people and female sex workers

FEMALE SEX WORKERS



Some of the red-light districts [in Bangkok] are completely deserted... an image I never imagined. Behind the scenes, you wonder what has happened to the people that used to work there, and their families and kids.

Jennifer Ho (panel moderator), APCASO



Meena Saraswathi Seshu is the General Secretary of Sampada Grameen Mahila Sanstha [SANGRAM], a health and human rights NGO based in rural Maharashtra and Karnataka in India. SANGRAM works to address social inequality, and to promote justice amongst marginalized communities, who are discriminated against because of sexual preference, sex work, HIV status, gender, caste, and religious minority. SANGRAM is a women-centered organization, with a focus on building solidarity.

Sex workers need to be recognized as a high-risk group, because their work depends on physical connections – social distancing is a joke if you are doing sex work.

Sex workers have zero income; they cannot pay for childcare. Formerly, their children lived in hostels, but the pandemic forced families to co-habit. Now these women fear that their children will learn that their mothers are sex workers. There is more violence now, not just from the police and bad clients, even from family members. In Nepal, after the brothels closed during the pandemic, sex workers were evicted, and were outed to the police by their landlords. In Sri Lanka and other countries, sex workers have been excluded from the response to C-19. Mobility – which sex workers depend on – has been stopped.

Sex workers face the fear of getting C-19, and lack of access to medical care for non-COVID-related issues. They have no money for private healthcare, and no place to go for it. They are not even on the agenda for vaccination; most are migrants and don't have ID papers.

We need lots of help at the vaccine centers, and free vaccination without identification papers. India has put everything on smart phone apps, but people may not have cell phones or know how to use them. There are no walk-in vaccine centers. You register and wait endlessly. They are not giving out vaccination certificates, which are required for travel. Sex workers cannot download them. We are only thinking of lockdowns, and how to get the economy going, we are not trying to think of the help that people need.

LGBTQI PEOPLE

Midnight Poonkasetwattana, Executive Director, APCOM



Midnight Poonkasetwattana is the Executive Director of APCOM, based in Bangkok, working in multi-sectoral partnerships with governments, donors, the United Nations, development partners and, most importantly, the community and civil society organizations working on advancing sexual orientation, gender identity, gender expression and sex characteristics rights, and alleviating HIV in Asia Pacific region.

We need to ensure that information is going to communities, that community leaders are part of those conversations, and that they understand the changing information about C-19 vaccines. We need to address concerns among PLHIV. Everyone must have access to safe, high-quality vaccines in a fair and quick manner.

We have been working to connect communities and bring them together. We discuss some of the issues they are facing, and how to tackle LGBTQI human rights and access to HIV services together.

Community-based settings that provide HIV care have had difficulty maintaining operations, such as HIV testing for KVP, reliable access to antiretroviral therapy (ART) and HIV pre-exposure prophylaxis (PrEP) - it has been very difficult.

We wrote a letter to WHO asking for more inclusive, LGBTQI-led strategies for social inclusion, and research on what is happening on the ground to inform them.

APCOM Resources

https://www.apcom.org/wp-content/uploads/2021/03/Report_Highlighting-COVID-responses_v8.pdf

https://www.apcom.org/wp-content/uploads/2021/01/CoronaAPCOMpassion_Brief_v3.pdf

https://www.apcom.org/wp-content/uploads/2021/06/Report-Khormoon_v5.pdf

<https://www.apcom.org/open-letter-to-who-to-integrate-effects-of-covid-19-on-the-lgbtqi-communities-gets-response-from-director-general-dr-tedros-adhanom-ghebreyesus/>



MIGRANTS

Wasurat Homsud, Senior Program Officer at Raks Thai Foundation

Wasurat Homsud has been the Senior Program Officer (Migrant and Mobile Population Program) at Raks Thai Foundation for five years. He has worked to promote good quality of life, and equal rights for migrant populations in Thailand. In response to the C-19 epidemic, Raks Thai and partners are adapting their existing health interventions to be integrated with C-19 services for migrant communities.

A lot of migrants are being left behind - they lack full access to C-19 testing, vaccination and treatment services. Many have lost their jobs, and have no money for food and housing, and the government has not provided subsidies for them. They face stigma and discrimination in Thailand, especially during the second wave of C-19; Thai people see them as responsible for bringing C-19 into the country.

Migrants face challenges to vaccination. Fear and misinformation about C-19 vaccines are common. Only 7% of migrants have gotten a first dose (versus 25% of all Thai people). Only documented migrants have access to the vaccine, but their employers must register them. You need an ID number and registration to be vaccinated. People have to self-pay for vaccination through the private system, but they still need an ID to register in Thailand. As of now, there is no channel for undocumented migrants to register for vaccines.

We need political commitment - instead of enjoying their low-wage labor, governments need to realize that migrant workers contribute to the economy; they should not be excluded from government schemes. We need to empower and strengthen migrant communities, so they can take care of themselves.



TRANSGENDER PEOPLE

**Prempreeda Pramoj Na Ayutthaya,
Vice President, Rainbow Sky Association of Thailand**

Born in Bangkok, Prempreeda Pramoj Na Ayutthaya (She, her, hers) holds an MA in Social Development from Chiang Mai University, and an MA in Health Social Sciences from Mahidol University. Both her master's theses were concerned with rights for sexual minorities, especially transgender people.

During the first phase of the pandemic, I did not hear about transgender people who had C-19 – they looked after themselves, because they feared healthcare facilities. They heard that if they had to go to the hospital, they would have to disclose that they are transgender. They did not know which section they would be admitted to. Transwomen don't want to get admitted into the male section; they face stigma and bad treatment from the medical staff.

Transgender people have concerns about drug interactions between ARVs and their hormone treatment - which they must rely on for the rest of their lives, and between C-19 vaccines and hormones. There is no information on, or research about potential negative consequences.

Transgender people have fought hard to get hormone treatment, but during the pandemic it was cut off every month or every three months- several clinics were closed, and people could not travel. Some transgender people have had to rely on private clinics - they had to ask about clinics in their own neighborhood, and negotiate access to hormone treatment, since prices vary from clinic to clinic.

PEOPLE WHO USE DRUGS

Kanya Benjamaneepairoj, Consultant

During focus groups with people who use drugs, they reported that information provided on C-19 vaccines is too formal and overwhelming for them. They need simpler information that is easier for them to understand. They don't feel comfortable going to hospitals or other public facilities; familiar surroundings make them more comfortable. They prefer to get vaccinated at their own network site, or at CBO that serves them. Thailand is using phone- or internet-based vaccine registration, and people may not have a phone or be able to afford data; the government should make sure that everyone can be included in the vaccination process.

HUMAN RIGHTS, VACCINE HESITANCY, LEGAL AND GENDER-BASED PERSPECTIVES



HUMAN RIGHTS

Gisa Dang, Consultant for Matahari Global Solutions and Treatment Action Group



Gisa Dang is a health and human rights professional with a focus on the right to participation, right to health, and right to science. She has expertise in experiential learning, organizational management and advocacy, and the UN human rights system. As consultant with Matahari Global, her work includes strategy development, racism in global health, and human rights research.

The right to the highest attainable standard of physical and mental health is as relevant to C-19 as it is to HIV.

Gisa Dang

Human rights (such as the rights to privacy, knowledge, access, self-determination, non-discrimination, equity, and freedom from torture) are indivisible, and interdependent; you cannot realize one right while you are infringing on another. A positive contribution to the realization of one human right will also have a positive impact on other human rights.

GIPA, the greater involvement of people living with HIV/AIDS, has come about through advocacy; it is based on human rights, including the rights to health information and participation.

The right to benefit from scientific progress and its applications - also called the right to science - addresses IP, open science, and government support. It covers all types of science, addresses participation in the process of science, scientific policy making, access to research data, healthcare benefits, medicines, and the responsibility of governments to ensure an enabling environment for research and development - and that the results are available to people.



VACCINE HESITANCY: A MYTH OR REALITY?

Sarojini Nadimpally,
SAMA Resource Group for Women and Health, India

Sarojini Nadimpally is one of the founders of SAMA Resource Group for Women and Health, and the Coordinator of Gender justice circle of People's Health Movement Global. She works at the intersection of public health, human rights, women's health, and marginalization. She has led several studies, fact-findings and advocacy over the past two decades on health systems, medical and reproductive technologies, conflict and health, and access to medicines; ethics in clinical research, and is currently looking at the pandemics from a gender, equity and intersectionality lens. She was appointed by the National Human Rights Commission, as a Member of an Expert Committee to assess the impact of C-19, and to provide recommendations to the government.

Communities have been front-and-center in the fight for access to HIV prevention and treatment, and they can play a key role in the response to C-19.

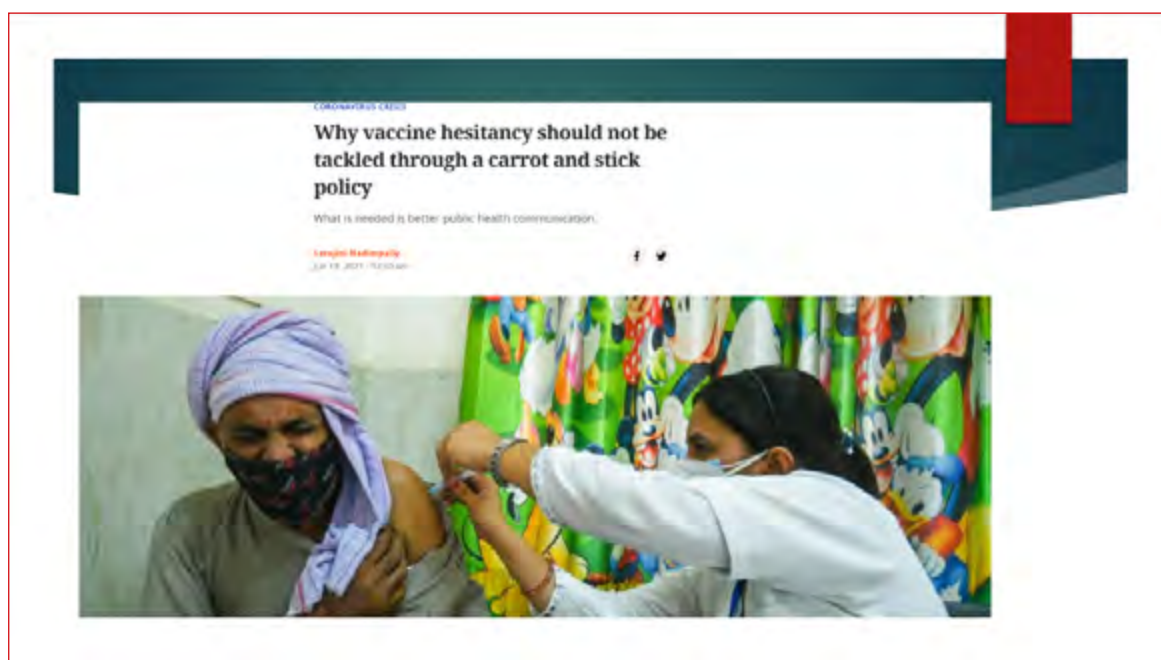
Sarojini Nadimpally

Several factors drive C-19 vaccine demand, including fears and uncertainty about the pandemic (especially among immunocompromised people), competition between countries, the influence of the pharmaceutical industry, and vaccine mandates. In contrast, vaccine hesitancy is a social, cultural, economic, and political phenomenon which is not limited to C-19 vaccines. It has been triggered by a deadly vaccination campaign to protect children in the Philippines from the dengue virus; false reports that the measles, mumps and rubella vaccine causes autism; unfounded reports about the safety of the human papilloma virus (HPV) vaccine in Japan, and an unethical HPV vaccine trial in India. The trial was run by the non-profit, US-based Program for Appropriate Technology in Health, involving 23,000 girls; it was halted after seven girls who had received the vaccine died from various causes (drowning [1]; snakebite [1]; suicide [2]; malaria complications [1]). The cause of two deaths was uncertain.

Vaccine hesitancy has been fostered by the rapid development of C-19 vaccines; criteria for fast-track approval and emergency use authorization; concerns about serious and/or lasting side effects; the inability to work; weak or non-existent post-marketing surveillance systems; policy changes around dosing schedules; funding from pharmaceutical corporations; negative experiences with healthcare; the failure to involve communities and civil society in vaccine policy development and implementation, and rumors and misinformation spread via social media (post-vaccination death and infertility). Barriers include lack of access to appointment-booking and vaccination sites, due to disability and/or the digital divide; gendered decision-making in households; public sector costs (transport and time off work), and high vaccine prices (in the private sector); logistical barriers; inadequate supply, and political pressure and/or coercion.

Incentives and disincentives for vaccination are a slippery slope, and they do not address equitable access. They are not a substitute for providing reliable information about vaccines. They create conditionalities for access, rather than addressing questions, concerns, and fears about vaccination. Linking food- and social security- based incentives to vaccination, especially for vulnerable populations, is questionable from a human rights perspective, and impinges on their rights. Vaccine mandates increase hesitancy. It is unethical to deny people their right to work, particularly when access to vaccination is unequal.

Governments need to invest in their people by addressing gender gaps, providing better healthcare, education, and economic and political opportunities – and by taking adequate and just actions that enable people to make informed decisions about vaccination, while working in partnership with civil society, community leaders, frontline workers, healthcare providers and the media. Steps to address vaccine hesitancy and increase uptake include: providing regionally - and culturally-appropriate information in local languages and dialects; addressing community experiences, concerns, and fears (especially among KVP), crossing the digital divide, and reaching people with mobility issues.





LEGAL ISSUES THAT COMMUNITIES SHOULD BE CONCERNED ABOUT

Veena Johari, Courtyard Attorneys

Veena Johari is a lawyer based in India and has a small public interest legal firm called Courtyard Attorneys. She has been working on issues relating to access to medicines, human clinical trials, issues relating to women, public interest issues, human rights for over two decades. Over the course of a decade as part of the litigation team at the Lawyers Collective, she filed or supervised nearly 600 cases filed on behalf of people living with HIV and key populations from 1998 to 2008. Over the past decade she has been involved in opposing patents on pharmaceutical drugs. She also sits as a legal expert on Institutional Research Ethics Committees in Mumbai.

We need evidence-based public health leadership – where there is accountability and transparency, and data are shared – and policies are based on scientific data, not political whims. We must come out of C-19 stronger, by respecting human rights and upholding social justice.

Veena Johari

The pandemic has brought many legal and ethical issues to the forefront, especially abrogation of human rights and individual freedom for public health and the greater good. Was this justified, and done in the least intrusive manner, or did authoritarian governments and the attitudes of people in power lead to long restrictions on people? Can confidentiality breaches, inequity and discrimination be justified in the name of the greater good - and for public health?

The legal issues that have emerged with C-19 vaccines include confidentiality, informed consent, compensation for serious/adverse events, voluntary versus mandatory, transparency, information, knowledge, and data. Pharmaceutical corporations have been working without transparency and accountability.

C-19 Testing

Breaches of confidentiality, lack of counseling, and forced quarantine make people fearful of getting tested for C-19; positive results may go to the authorities first, not the person waiting for their result. In some places, posters announcing quarantine have been put up where people who had a positive test result live; contact tracing is not done thoroughly in some places, and police have used excessive force – even beating people – while implementing public health measures.

Vaccine Passports

There are inequities in vaccine distribution, access, and affordability. Vaccines are often out of stock or available only briefly. These shortages mean that only a small percentage of the population can be vaccinated. They are caused by a lack of local producers.

Are vaccine certificates and passports just and fair? Who gets access to vaccines, who is prioritized for them, and who is being left out? What about people who have recovered from C-19, and have antibodies? What about people who cannot get vaccinated because they are allergic to something in the vaccine, or due to religious or other medical reasons – or any reason? Many services can only be used by vaccinated people although they may still be at risk for or infected with C-19.

Vaccine Mandates

Mandating vaccines creates social stigma for those who cannot get vaccinated. Forcing people to disclose the reason why they are unvaccinated is a violation of their confidentiality, and it fosters production of fake vaccination certificates. Voluntary vaccination, and clear, accurate information about vaccine risks and benefits can dispel rumors and myths, which helps people make decisions about protecting themselves and others from illness.



Informed Consent

Informed consent is essential: people need to be fully informed about potential short- and long-term side effects, including those that are rare and/or serious, so they can seek medical attention when necessary.

Compensation for Serious/Adverse Events

During clinical trials, participants are compensated for any serious or adverse events. After vaccines are approved, there is no provision for compensation. Emergency use and full approval for vaccines should include provisions for compensation for serious/adverse events from vaccines. Pharmaceutical companies have been demanding that governments indemnify them, making them responsible for compensation for serious/adverse events, but no post-vaccination data is being collected.

Lack of Transparency

Lack of transparency has been a consistent issue across C-19 trials, and in post-marketing surveillance. Governments have cited confidentiality in response to “Right to Information” requests, or said that the information relates to a third party, making it difficult or impossible to obtain. There is no transparency about the names and qualifications of people serving on committees that follow post-vaccination adverse events, the type of data that is collected, how it is analyzed, and the criteria for deciding whether an adverse event is related to the vaccine. Data from some C-19 vaccine trials has not been publicly available, and the basis for granting emergency approval is unclear. It is difficult to find information on post-marketing trials for C-19 vaccines in some countries.

Governments and Pharmaceutical Corporations Need to Act Ethically

Although public funds were used to develop C-19 vaccines, no information about contracts, procurement, pricing, and their roll-out has been provided to the public. Pharmaceutical corporations have been hoarding knowledge that is desperately needed to stop the pandemic, while making unfair bilateral deals, refusing to disclose pricing, making exorbitant profits, and extortionate demands for protection from liability.

Demands for Addressing Ethical and Legal Issues Relevant to C-19 Vaccines

- Implement public health measures that are based on evidence, draw from experiences of successful programs, respect people's rights, include informed consent, and protect confidentiality
- Ensure equitable vaccine distribution by including non-citizens and people who do not have identity cards, removing gender-based access barriers, and do not rely solely on digital platforms
- Governments should expand access to C-19 vaccines through compulsory licensing, revoking or opposing their patents, sharing "know-how", and controlling costs to enable production by domestic and other manufacturers
- Support community outreach to provide honest, clear, and accurate information on benefits and risks of C-19 vaccines
- Require informed consent, and an explanation of adverse events before vaccination, and compensate for adverse events
- Stop discrimination by classifying people based on their vaccination status
- Provide information, and use all preventive measures to reduce the risk of C-19 infection
- Balance individual rights and public health by using the least-intrusive measures

C-19 VACCINES: DEVELOPING A GENDER, EQUITY AND ACCESS FRAMEWORK

**Aakriti Pasricha and Neelanjana Das,
SAMA Resource Group for Women and Health**



Aakriti & Neelanjana are working presently with Sama Resource Group for Women and Health on issues of public health importance, gender, health rights from a feminist, intersectional, and social justice approach.



The pandemic calls for a Feminist response because it has had a disproportionate effect on people, based on social position. In India, where many front-line and domestic workers are women, 46% of women versus 53% of men have been vaccinated.

Aakriti Pasricha

We have been developing a gender, equity, and access framework for C-19 vaccines, using an intersectional lens to include – and dismantle – the confounding effect of multiple forms of inequality (race, caste, class, and gender). There has been a lack of intersectional, gender-responsive policies across the globe.

We focus on multiple identities (education, family and immigration status, race, ethnicity, Aboriginality, gender, age, occupation, sexuality, ability, religion, language, geographic location, heritage, history) that highlight oppression and privilege.

The Feminist response is a recognition of gender as a social construct; as a system of social stratification, and an institution that structures every aspect of life, because it is embedded in the family, the workplace, the healthcare system, and the state, as well as in sexuality, language, and culture. This response locates the pandemic in the context of socioeconomic, neoliberal globalization, corporatization of healthcare, trade and Pharma policies, authoritarian politics, climate justice, and racialized and communalized health system responses.

The Feminist response focuses on equity, equality, non-discrimination, privacy, and confidentiality, as well as values that disrupt access to them and enable those that do, with the response centered on the most vulnerable people. We look at gaps between policy and responses to see who is being left behind and ensure that they do not remain so.

For more information on SAMA's work and to access their publications, see:

<https://samawomenshealth.in>

An Intersectional Feminist Response

The components of an intersectional feminist response are:

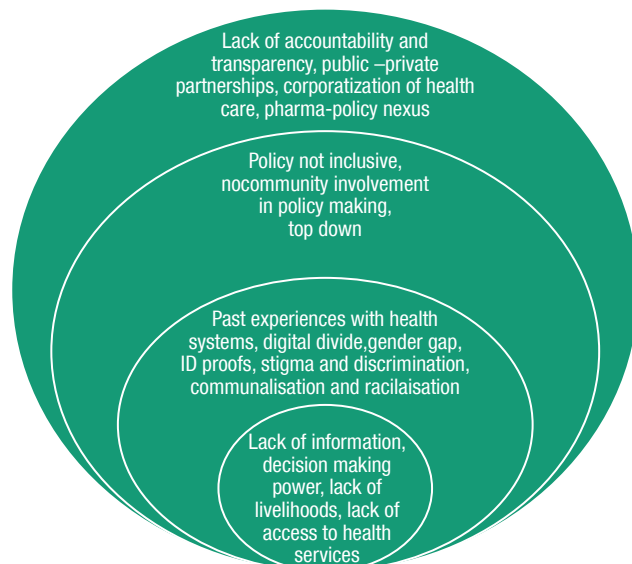
- Amplifying and empowering the voices of the marginalized
- Emphasizing the right to life and health, and rights of communities first, and how this interacts with other rights
- Recognizing the inherent inequities that exist in the predominately neo-liberal, corporate-controlled, technocratic world that we live in, and demands and advocates for equity in response
- Analyzing the complete erosion of democratic processes, and that there is no protection of the human rights of citizens, especially those from marginalized sections
- Analyzing global responses, learnings, and calls for ethical actions

Source: Resource Group for Women and Health

Problem analysis –

Women and young girls from marginalised sections, frontline workers, migrants, PLHIV, women & trans people in prisons; those marginalised by gender, sexuality, sexual orientation; work; by race, religion, caste and ethnicity, disability, age, occupation, citizenship, etc.

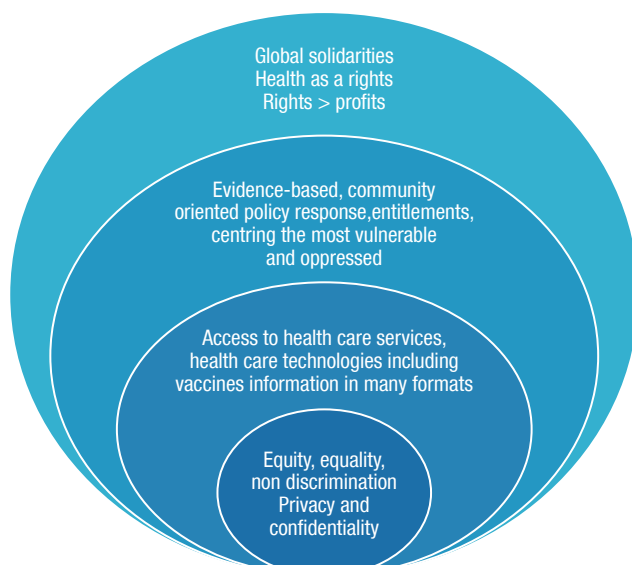
– getting equal access to testing, treatment and safe vaccines?



Core pillars of a feminist response

However, there is no one feminist way of understanding and responding.

A framework that emerges with inputs from our diverse realities will help us to engage at the local, national and global level.



GLOBAL AND REGIONAL RESPONSES TO COVID-19



KEY GLOBAL INITIATIVES FOR ACCESS TO C-19 MEDICAL TECHNOLOGIES

Dinah Fuentesfina
People's Vaccine Alliance and Dr. Stephen Chacko, WHO



Dinah Fuentesfina is ActionAid's International Campaign Manager and Co-convenor of the People's Vaccine Alliance- Asia. She also co-chairs the Campaign and Media Group of the People's Vaccine Alliance globally.



Dr. Stephen Chacko is a medical doctor from India with a post-graduate degree in public health from John's Hopkins University, USA. He has been working in immunization-related areas in the field for over 18 years in four WHO Regions (AFRO, EMRO, EURO and SEARO). He has extensive experience in the design, field implementation, monitoring and evaluation of immunization programs, surveillance and control of communicable diseases. Since June 2018, Dr. Chacko has been working in the WHO country office Myanmar as team leader for the Immunization Program. Before moving to Myanmar, he worked at various WHO offices including Bangladesh, Tajikistan, Uzbekistan, seven African countries, and India.

The PVA is calling for free-of-charge COVID-19 vaccines for everyone, everywhere, which are distributed according to need – without exception. Developing countries are left to bid in the open market, paying high prices for small amounts of vaccines, while rich countries have purchased most of the world's supply. They have three times the amount they need and are delaying supplies to developing countries, fiercely defending pharmaceutical company monopolies on vaccines, and distracting from real solutions with charitable measures that are inadequate, such as COVAX and donations.

Dinah Fuentesfina

What is the People's Vaccine Alliance (PVA)?

The PVA is a global movement for a People's Vaccine, not a for-profit vaccine, urging that safe and effective C-19 vaccines are available to all people, in all countries, at no charge. The People's Vaccine Alliance in Asia is a loose alliance of over 150 organizations. Asia is the fastest growing and most active region. For more information on the PVA, see: <https://peoplesvaccine.org>. There is an Asia chapter of the PVA (contact Mustafa.Talpur@oxfam.org and Dinah.Fuentesfina@actionaid.org to join forces for making vaccines available to those who don't have access).

The world's uncoordinated approach is worsening existing inequity; we need a global strategy and plan for ending the pandemic. Currently, high-income countries (HIC) have administered 50 times the number of vaccine doses than low-income countries (LIC).

WHO has set targets for vaccination and equitable access in all countries: by September 2021, 10% of the global population should be vaccinated, reaching 40% by December 2021.

Dr. Stephen Chacko, WHO

What is the Access to COVID-19 Tools Accelerator (ACT-A)?

The ACT-A was set up by the Coalition for Epidemic Preparedness Innovations (CEPI), the Foundation for Innovative New Diagnostics (FIND), the Global Alliance for Vaccines and Immunizations (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNICEF, the WHO and others to provide a fair allocation framework for C-19 prevention, testing and treatment; with the goal to distribute two billion vaccine doses, 245 million treatment courses and 500 million diagnostic tests by 2021.

What is COVAX?

The COVAX facility is the ACT-A's vaccines pillar. It is co-led by CEPI, Gavi and WHO, with UNICEF as a delivery partner, aiming to provide global equitable access to C-19 vaccines.

COVAX's objective is to offer enough C-19 vaccines for 20% of the population of every country at no charge (and to provide subsidized vaccines for countries who wish to procure them). For more information about COVAX, see: <https://www.who.int/initiatives/act-accelerator/covax>

What is the COVID-19 Technology Access Pool (C-TAP)?

C-TAP was launched by WHO (and partners) as a global resource, and to increase the supply and local production of C-19 diagnostics, vaccines, treatments, and other health products. C-TAP provides companies who develop these health products with a place for sharing their IP and know-how through public health-driven voluntary, non-exclusive and transparent licenses.

For more information on CTAP, see: <https://www.who.int/initiatives/covid-19-technology-access-pool>

DECOLONIZING GLOBAL HEALTH

Dr. Fifa A Rahman



Dr. Fifa A Rahman has over 12 years of experience working in global health. She is presently a permanent NGO representative on the WHO Access to COVID-19 Tools Accelerator Facilitation Council and Diagnostics Pillar (or in short, ACT-Accelerator). She is Principal Consultant at Matahari Global Solutions, working on projects on the right to health for Amnesty International, and on developing a five-year strategy for the Global Coalition of TB Activists.

Decolonizing requires constant pushing. People just don't know what they don't know. We need to engage people from the global South.


Dr. Fifa A Rahman

There is something fundamentally flawed about how the architecture of global health works. It's clear that this system is inequitable, and that voluntary systems are not working. Promising to provide vaccines to only 20% of the population of LMIC is inequitable - who decided on this figure, while countries in the global North are planning boosters?

A key issue is that there is very little involvement of LMIC in COVAX. It is led by white men from the Global North, and priorities become distorted. During my first meeting of the Access to COVID Tools Accelerator (ACT-A), I noticed that there was only one other Brown person (Olusoji Adeyi, Director of the Health, Nutrition and Population Global Practice at the World Bank Group) out of the 70 on the call. I asked why there were only two of us – and I have done this multiple times during the last year and a half.

Only recently have we had presentations from experts on the ground, and in-country. Every time these people join our calls, you realize what has been missing from the C-19 response. For example, COVAX is giving countries very little lead time before their vaccines arrive - this lack of transparency is problematic. Doses that were sent to the Democratic Republic of Congo and South Sudan were returned to COVAX, because the ACT-A's tools for estimating vaccine readiness were not accurate enough. If there were experts from LMICs in the working groups this would not be happening, because they could identify problems.

It's not easy to call out things based on race. We have to ensure that participation of Black and Brown people is not tokenistic, and that the right Black and Brown people have to be included. The world rejoiced when the first Black woman was appointed to



head the WTO – but we don't see things moving there. We have to keep calling out the absence of Black and Brown people, because there is white supremacy throughout the global health architecture, and a lot of people do not know how to talk with Black and Brown people. A lot of white people in global health just do not understand how colonial it is.

Recent efforts have paid off, but they are not enough. We need to be involved in co-creating documents, and in designing strategies from the beginning. As an example, during a meeting of the country support working group of the ACT-A's Diagnostics Pillar, we discussed designing an advocacy strategy, which UNICEF was leading. They produced an advocacy strategy that identified people to target. We, as civil society, had to ask what the advocacy messages were, since we must target countries that are suppressing testing, and countries that are viral load testing loyalists and do not like rapid tests, and noted that there are different messages for countries. UNICEF did not know this – they said they needed to go back to the drawing board to work on the strategy – by themselves. We had to tell them that if they wanted to de-colonize, they had to let us co-create. If we are not involved from the start, you won't benefit from our expertise.

C-19 IN THE ASIA-PACIFIC REGION

Dr. Salil Panakadan, UNAIDS

Dr. Salil Panakadan is a public health physician working for UNAIDS in the Asia Pacific Regional Office in Bangkok as a senior Regional Adviser. He looks after the C-19 and HIV Prevention and Treatment portfolios for the regional office. He has been working in this field for about three decades, and has been based in India, China, Bangladesh, UNAIDS headquarters, and now, the Regional Office in Bangkok. His priority has been to work for affordable access to comprehensive, rights-based services and products for key populations, as universal health care is rolled out, and interest and funding declines for the HIV response.

Clearly, no lessons have been learned from the movement for access to HIV antiretrovirals (ARV). Stockpiling, booster doses, and price increases are challenges for access to vaccines, although there is a clear case for re-distributing them to prioritize countries and populations.

Dr. Salil Panakadan

Globally, the Delta variant is causing most new infections. Delta has been found in 135 countries; it is moving fast and causing challenges in most of the world. The WHO African and Eastern Mediterranean regions are the most vulnerable to rising infection rates. Infection rates are also rising in the WHO Western Pacific region.

Globally, 4.7 billion vaccines of C-19 doses have been administered to date. Although this is a very impressive number overall, when you look at the number of vaccines administered per 100 people by country, inequity and maldistribution become clear: 50 times more doses have been administered in HIC than in LIC. If you look at LIC, only 1% to 2% of people in these countries have gotten at least one dose of a C-19 vaccine; in UMIC, over 30% of people have gotten at least one vaccine dose, while 50% to 60% of people in HIC have been given at least one dose. Vaccine wastage is another big issue. Criminally, HICs have been stockpiling vaccines, and cannot use them before they expire.

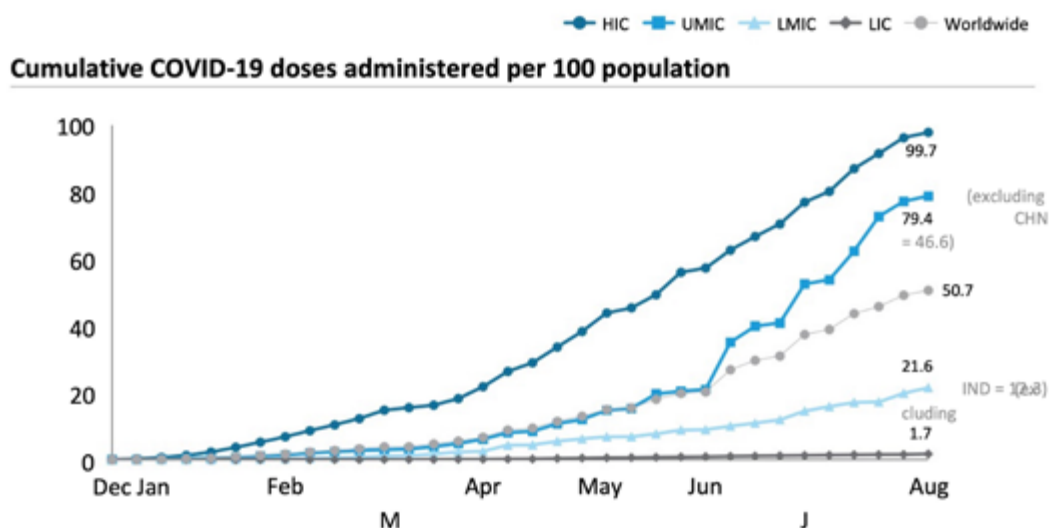
Last month, at the International AIDS Society conference, an increasing scientific consensus emerged - that PLHIV, regardless of CD4 cell count, are at significantly increased risk for severe illness and mortality from C-19 (other factors such as older age, being male, and having diabetes and/or hypertension add to this risk). The scientific evidence calls for prioritizing PLHIV for C-19 vaccines, yet only five countries in the region (Fiji, India, Indonesia, the Philippines – where vaccination rates among PLHIV are low despite prioritization - and Viet Nam) have prioritized them. There is not much information on vaccine coverage among PLHIV in the region.⁵ UNAIDS wants to work closely with national PLHIV networks, to get more information on vaccine access, prioritization, and coverage among PLHIV to support advocacy.

5. (Except for a dynamic online platform for PLWH in China, where 31% of participants reported having at least one dose; a similar platform in Cambodia, where 22% of PLWH had at least one dose, and in Fiji, where there are very few PLHIV; at least 90% of them were vaccinated).

High income countries have administered >50x more doses per population than low-income countries

DATA AS OF 5 AUGUST 9:00 AM CET

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Pharmaceutical monopolies control vaccine access; we need to fight this as we move forward. Not all LICs support the TRIPS waiver; we need to work to build broad public support, and work with the media to change the narrative about the larger causes of vaccine inequity, and what needs to be addressed.

UNAIDS continues to work with PLHIV and key populations to track vaccine access and prioritization policies. We need more information. Please work with us, share information, and join forces to advocate for and demand what people need. Revive activism for vaccines and beyond!

COUNTRY PROFILES

Country profiles covered the state of the pandemic as of August 2021; pandemic-related challenges faced by people who are members of KPV, and the barriers they encounter; groups that are being left behind; approved/available vaccines, and their pricing (when available), and local vaccine development and production. Each speaker provided recommendations to improve access to, and uptake of vaccines.



Myanmar Country Profile

Myanmar has a very diverse ethnic population of 54 million people.

The national health system cannot cover areas where our ethnic populations are.

During the first and second waves of C-19, the previous democratic government, which was managing the response, included the ethnic populations. Since the military coup in February 2021, cases and deaths have increased (although deaths are underreported because many people have died in their homes). The political situation is related to the severity of the pandemic.

We don't have data on C-19 cases or deaths among PLHIV, but we have seen that PLHIV and key populations are facing challenges to accessing ART, and regular and emergency health care. People do not know how to get admitted into the hospital, because they must get several approvals from different authorities – and PLHIV face barriers to essential medicines, because of high prices. There is a shortage of healthcare and social workers; many have been arrested by the military government, and others fear for their safety.

Before the coup, the government ordered 1.5 million vaccine doses from Sinopharm and Sinovac, and asked Gavi for vaccines (we don't know the outcome of this request). The previous government planned to vaccinate 40% of the population, but the plan did not proceed after the coup. The current government has not been transparent about what they are paying for the vaccines. The people don't need to pay for vaccines now, but we do not know if they will still be free-of-charge. After the coup, Covishield was approved, and is being sold online in the private market, where different prices are being charged. Some private clinics are selling vaccines for US \$120.

Over a million people have gotten their first dose, and 3.2% of the population has been fully vaccinated. But we don't know how many of them are in the military versus the general population. Eligibility criteria were changed by the new government, but people don't trust the government system, so they don't join the immunization program, which is now vaccinating whoever comes to the clinic.

BANGLADESH

Dr. Asifur Rahman, Ashar Alo Society



Dr. Asifur Rahman, from Bangladesh, works as Health Personnel, with a demonstrated history of working in different areas of public health (Epidemiology, Global Health, Telemedicine, Healthcare Management, Health Systems, Immunization, Nutrition, HIV/AIDS and TB). Dr. Rahman holds MBBS and MPH degrees, and has held positions with the WHO, BRAC, and Save the Children. At present, Dr. Rahman is the Program Coordinator (TB Control Program) at Ashar Alo Society Bangladesh.

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
Cases are declining	<p>Impacts: Access to ART has been compromised; medical follow-up has been hampered; economic hardship</p> <p>Barriers: lack of knowledge about vaccines, and fear of them</p>	People under age 18, people who do not have a national ID card	AstraZeneca (government price: US \$5); Pfizer (government price: US \$70); Moderna, (no pricing information); Sinopharm (no pricing information); given free-of-charge through public system; not authorized for use in the private system	Globe Biotech Limited waiting for approval to open phase I trial of Bangavax
<p>Recommendations</p> <p>Increase public awareness of vaccines</p> <p>Access to vaccine centers should be easy and safe</p> <p>Provide a free flow of accurate information</p> <p>The government should provide proper supervision and monitoring of the vaccine program</p>				

CHINA

Thomas Cai

China				
Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
Epidemic is worsening, although the number of cases is low	Impacts: disruptions in medical follow-up, consultations and laboratory monitoring; ARV stockouts in early-to-mid 2020 Barriers: concerns among PLHIV about vaccine safety and efficacy	People under age 12	Can Sino, Cho Cell, Sinovac, and VeroCell, vaccines are given free-of-charge; no information on pricing	A fifth Chinese vaccine is expected to be approved in October
Recommendations Mandating vaccines for work, traveling, and school makes people feel disrespected - don't force vaccination; give people information about vaccines				

INDIA

Manoj Pardesi

Manoj Pardesi, from India, is the General Secretary and founding member of the National Coalition of PLHIV in India (NCPI+). He has worked in the field of HIV for over 24 years. He has collectivised People Living With HIV, worked with government, non-governmental, bilateral, and funding agencies, and facilitated policy and legal changes that protect rights and meet the needs of PLHIV.

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
Epidemic waning after the Delta variant-driven second wave	<p>Impacts: Disrupted access to HIV care and treatment; stress due to loss of income /employment; fear of C-19</p> <p>Barriers: Fear of stigma and discrimination, due to gender preference, sex work, sexuality, and HIV status; PLHIV fear exposure to C-19 at vaccine centers, and fear disclosing their HIV status to obtain the vaccine; concerns about adverse events from the vaccine among people on ART and/or treatments for HIV-related complications, and opportunistic infections</p>	Women, homeless people, prisoners, and trans-gender people; the digital divide has left people without smartphones behind	Government pays Rs 150 (US \$2); vaccines are free of charge through the public system for Covaxin, Covishield, Sputnik V (J & J authorized but not yet available). Private system: Covaxin Rs 1410 (US \$19) per dose; Covishield Rs 780 (US \$10) per dose; Sputnik V Rs 1145 (US \$15) per dose	Covaxin; Bharat Biotech and Indian Council of Medical Research) are also co-developing a nasal vaccine, in ongoing trials; Zydus has completed a phase III trial of its DNA-based vaccine and applied for approval; Biological E's protein sub-unit vaccine is in ongoing trials; Genova's mRNA vaccine in trials

Recommendations

Improve vaccination access by eliminating on-line registration, long lines and waiting time for vaccines, stock-outs, and the need to register for a second vaccine dose

Address concerns about confidentiality, stigma, and discrimination among PLHIV/key populations

Provide information to increase vaccine literacy and preparedness, and address myths and misconceptions about C-19 vaccines

Promote peer-led vaccination drives

Provide peer-led, pre-and post-vaccination counseling for PLHIV, and other members of key populations

Provide affordable vaccines through the private sector

Generate data on vaccine access, uptake and efficacy

INDONESIA

Aditya Wardhana, Indonesia AIDS Coalition (IAC)

Aditya Wardhana, from Indonesia, is the founder and executive director of the NGO, Indonesia AIDS Coalition. He also led the Indonesian Affordable Medical Coalition, which focuses on advocacy to improve people's access to needed health services.

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
Cases have spiked significantly since early July, spreading outside of Java, and on Bali, and to remote islands and areas	<p>Impacts: Disrupted healthcare; fear of seeking health services; job and income loss; psychological stress; increased gender-based and intimate partner violence; lack of social interaction; confinement and fear of C-19</p> <p>Barriers: HIV is considered as a co-morbidity; PLHIV must have CD4 cell count and viral load test results to be vaccinated; requirement for ID card, especially for PLHIV, transwomen, and key populations; worry about vaccination and co-morbidities; lack of belief in vaccine efficacy and the halal status of vaccines; fear of side effects; difficulty with transportation to vaccine centers; lack of education for healthcare providers.</p>	Marginalized people, especially those who do not have an ID card	<p>Government / public system free of charge (AstraZeneca, Novavax, Pfizer/BioNTech, Sinovac)</p> <p>Private system: Cansino, Moderna, Sinopharm (US \$60)</p>	Vaksin Merah Putih Research from six institutions; currently in approval and permit stage; Mass production and distribution by PT. Bio Pharma in January 2022
<p>Recommendations</p> <p>Use differentiated service delivery- provide facility-based, mobile, and static vaccination sites</p> <p>Encourage local production, especially of mRNA vaccines</p> <p>Create user-friendly vaccine registration system that does not require an ID card</p> <p>Expand and scale up information on vaccines, including updates on registration processes and requirements</p> <p>Follow and monitor the status of the TRIPS waiver proposal</p> <p>Strengthen and expand vaccination campaigns in collaboration with influencers, religious and public leaders</p> <p>Roll-out boosters for healthcare workers</p>				

MALAYSIA

Ed Low, Positive Malaysian Treatment Access and Advocacy Group



Edward Low from Malaysia is the Director of Positive Malaysian Treatment Access & Advocacy Group (MTAAG+). He graduated from Chartered Institute of Marketing (C.I.M), and was a former Sales Engineer. Since 1998, he has been actively volunteering to advocate for treatment, care, and support in national patient groups. He has also been a founding member of MTAAG+ since 2015, focusing on a rights-based project on basic research on medicines, training for the community, and campaigning for access to public medicines. As a Person Living with HIV for 25 years, he has been empowering through his work as a full-time activist and advocate through international conferences.

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research / production
Cases and deaths are increasing	<p>Impacts: Income and job loss among many daily-wage workers and small business owners; increased isolation, depression, suicide attempts and use of amphetamine-like stimulants; travel restrictions, and fear of going to clinics limit access to HIV testing and other services</p> <p>Barriers: Long wait for vaccination for everyone, especially people living with AIDS, who must consult with their doctor before vaccination</p>	Adolescents ages 12-18	<p>AstraZeneca, CanSino, J & J, Moderna, Pfizer, Sinopharm, Sinovac, are free-of-charge; the government pays US \$18.40 for vaccines</p> <p>In the private system, Sinovac costs US \$83</p>	<p>The Institute for Medical Research at University Putra Malaysia and the Veterinary Research Institute are developing an inactivated virus-based vaccine; the Institute for Medical Research is developing an mRNA vaccine</p>
<p>Recommendations</p> <p>Remedy instability in vaccine supply caused by advanced orders from high-income countries</p> <p>Support the TRIPS waiver</p> <p>Stop vaccine nationalism</p>				

MYANMAR

In-country speaker

Our Myanmar presenters are unnamed for their safety.

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
Country has faced a first and second wave of C-19, in September 2020 and July 2021	<p>Impacts: Healthcare including hospitalization for emergencies, has been disrupted and people are experiencing economic hardship due to loss of income and inflation – and the high prices for essential medicines and oxygen</p> <p>Barriers: Lack of healthcare workers (since the military government has arrested many of them); vaccines only offered through government or private hospitals- which are expensive; no NGOs deliver them; lack of cross-border services</p>	Ethnic minorities and displaced people and those in border areas; KPV; activists and people who participate in civil disobedience	<p>Pre-coup (February 11, 2021) The government purchased 1.5 million doses of Covishield (at US \$2.50 each); provided free-of-charge through the public system. Private-system pricing was being planned. Post-coup: The government purchased 4 million doses (at unknown prices) from Sinopharm and Sinovac (an additional 2 million doses were donated); provided free-of-charge through the public system, but future pricing is not known. Some private clinics offer Covaxin at US \$120 per dose</p>	N/A
<p>Recommendations International donors need to support locally-based civil society organizations that provide health care, because they are more likely to take risks to provide services Provide direct support for Ethnic Health Organizations, through work with trusted implementing bodies UN agencies should ensure the safety of healthcare and social workers, initiate vaccination programs, provide immediate responses to urgent issues, such as shortages of oxygen, healthcare and social workers and inadequate health facilities Policymakers in neighboring countries need to support the desire of people in Myanmar, who want to control C-19 to stop it from mutating and spreading among migrants, and to provide cross-border support for Ethnic Health organizations</p>				

NEPAL

Rajesh Didiya, National Association of PLHIV



Rajesh Didiya from Nepal is the President of the National Association of People living with HIV/AIDS (NAP+N) in Nepal. Rajesh belongs to the Indigenous group known as Newa Peoples in Nepal. Rajesh is a ex-drug user who has been living with a compromised immune system since 2003, and has been working for community betterment from last 17 years, witnessing all aspects of HIV work, and understands the social dynamics of each area.

Nepal / Rajesh Didiya, National Association of PLHIV

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
Cases are increasing to a record high	Impacts: Lack of income; decreased access to health services; worsening mental health Barriers: Not enough vaccines for everyone; fear of side effects from the vaccine	People under age 45 who are not healthcare workers, civil servants or staff of financial institutions, poor and marginalized people;	Covaxin, J & J, Sinopharm, Sinovac and Sputnik V are available free-of-charge; government took loans of US \$240 million to finance them; no pricing information	N/A
Recommendations Explain where PLHIV fall under vaccine prioritization; currently only people over age 45 years are being vaccinated and PLHIV have to wait for their age group to become eligible Prioritize PLHIV and people who are members of key populations for vaccination				

PAKISTAN

Asghar Satti, APLHIV

Ashghar Satti, from Pakistan, is a national coordinator for the national network of people living with HIV and associated key populations, known as the APLHIV-Pakistan. He has played a key role in transforming the APLHIV into a vibrant organization, which is well placed at the policy and decision-making corridors. He has been instrumental in sensitizing national and provincial programs about the need for, and importance of engaging communities in key population service delivery, and their engagement in all processes related to HIV response. His advocacy remained significant for the initiation of community-based services in Pakistan. He also represents the PLHIV Constituency in CCM, and is a member of the steering committee and board of APN+.

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
N/A	<p>Impacts: Lockdowns limited access to HIV prevention and testing services and ART and caused/aggravated socio-economic issues</p> <p>Barriers: Requirement for national ID, which many people who use drugs do not have; lack of awareness about vaccinating PLHIV; guidelines for PLHIV specifying that they should receive an mRNA vaccine, which also create stigma, discrimination and fears about confidentiality since PLHIV need to show proof of their HIV status; mRNA vaccines are often not available in small cities and towns; C-19 denial and myths about vaccines and belief that ARVs prevent C-19</p>	People who do not have national ID	Cansino, Moderna, Oxford/AstraZeneca, PAKVAC, Pfizer/BioNTech, Sinopharm. Sinovac, Sputnik V are available at no cost; no information on pricing	PAKVAC, a locally produced version of China's single-dose Cansino vaccine
<p>Recommendations</p> <p>Implement vaccination camps for PLHIV</p> <p>Provide C-19 vaccines at ART centers</p> <p>Provide mobile vaccine sites for people who are members of key populations</p> <p>Vaccinate people who do not have national ID</p>				

PHILIPPINES

Arnold A. Rañada, RSW

Arnold Rañada and Emerson Arriola from the Philippines: Arnold Rañada is a registered Social Worker in the Philippines. He is a volunteer social worker and part of the Technical Working Group of Pinoy Plus Advocacy Pilipinas Inc., the pioneer organization of PLHIV in the Philippines. Emerson Arriola is the Project Coordinator of PLHIV Response Center of Pinoy Plus Advocacy Pilipinas, Inc., under its project ion “PLHIV Response Center” (PRC). The PRC is a communication and coordination platform that provides information about HIV services and other medical needs for the general population and key populations, such as MSM, PWID, transgender people, sex workers and PLHIV.

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
Cases are increasing; they are near their highest-ever level	<p>Impacts: Delayed access to HIV testing and ART; switching to telehealth has lowered quality of healthcare services</p> <p>Barriers: Lack of clear, PLHIV-specific vaccination guidelines, and confusion among PLHIV about what is required to get vaccinated; need for PLHIV to obtain clearance from a doctor, including a CD4 count, although doctors are unavailable; lack of clear information about C-19 vaccines and their side effects; cost of transportation to, and on-line or on-site registration for, and confidentiality at vaccine centers</p>	N/A	Bharat Biotech (Covaxin), J & J, Moderna, Oxford/ AstraZeneca, Pfizer/ BioNTech, Sinopharm, Sinovac, Sputnik V; the government estimates that it will pay PHP 1,300 (US \$26) per person for full vaccination	N/A
<p>Recommendations</p> <p>Provide vaccines to PLHIV at their treatment hubs</p> <p>Standardize criteria and requirements for C-19 vaccines among PLHIV</p>				

THAILAND

Kanya Benjameepairoj, Consultant

Kanya Benjameepairoj (or Yu by her nickname) is from Thailand. She is a consultant to Asia Catalyst. She is an international development professional, who works with government executives and community-based organisations at the international and national level, to improve public policy in healthcare and financing. Kanya holds an MPH in health policy and sciences from the French School of Public Health, and a BA in Social Science from Mahidol University International College.

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local re-search/ production
Cases have been increasing to record highs	Impacts: Income loss; access to medication; mental health issues. Barriers: lack of information, attitudes of healthcare providers; language (for migrants)	Homeless and Hill Tribe people, unregistered migrants	Government provides AstraZeneca and Sinovac (paying ฿151/US \$5.00 and ฿550/US \$17 per dose, respectively); for other vaccines, public system prices per dose: Covaxin: ฿660/ US\$ 19.78; J & J: ฿115.50-330/US \$3.50-US \$10; Moderna: ฿495- 1,221/ US \$15-US \$37; Pfizer: ฿223-775.50/US \$6.75- US \$23.50; Sinopharm: ฿330-1,179/US \$10- US \$35.72; Sputnik V ฿330/US \$10; Private system, per dose: Moderna: ฿1650/ US \$50; Sinopharm: ฿777/US \$7.50	Chulalongkorn University's ChulaCov19 in phase II; Mahidol University NDV-HCP-S in phase I
Recommendations Vaccines should be accessible, and provided to all people living in Thailand Improve the vaccine registration system The government should study strategies from countries that have achieved higher vaccination rates The government should purchase different vaccines; the ones they currently provide appear to be lower quality and less effective than other options				

VIET NAM

Do Dang Dong, Viet Nam Network of People Living With HIV (VNP+)

Dong Do Dang, from Viet Nam, is the chairperson of the Vietnam Network of People living with HIV (VNP+).

Coronavirus situation as of August 2021	Impacts on key and vulnerable populations and vaccination barriers	Who is being left behind?	Approved / available vaccines and prices	Local research/ production
Cases are declining in some provinces	Impacts: Disruptions in access to PrEP and ART, especially in lockdown areas; discontinuation of in-person counselling, adherence support, and testing for HIV and HCV; people also faced loss of income and difficulty getting food due to lockdowns.	People who have underlying conditions, and are allergic to vaccine components; people with cancer who are undergoing chemotherapy or radiation; people with thrombocytopenia; children under 12 years (the Pfizer vaccine will be available for children ages 12-17 in Q4 2021)	Vaccines are available free-of-charge through the government only – not through the private system; AstraZeneca; J & J (approved but not yet available); Moderna; Pfizer/BioNTech; Sinopharm; Sputnik V	Nanocovax, an mRNA vaccine from Nanogen Pharmaceutical Biotechnology JSC, and the Ministry of Science and Technology in phase III; Covivac, a viral vector vaccine from Nha Trang Institute of Vaccines and Biologicals, is in phase II
Recommendations It is extremely important for the community to advocate with the Ministry of Health to provide full information on the benefits of vaccination for PLHIV and key populations, and to prioritize them for vaccines. The best vaccine is the one that is given earliest.				



CUTTING THROUGH THE POLITICS - WHY WE NEED TO GET VACCINATED

Thomas Cai, AIDS Care China

This is a war between human society and the virus. WHO should consider working with community-based organizations. When the community does HIV treatment literacy and treatment advocacy, we translate highly technical information from WHO guidelines, and other publications, into community-friendly language. This needs to be done for C-19 immediately, to stop rumors and misinformation.


Thomas Cai

We have been suffering with C-19 for almost two years. It is a public health issue, but we can see a lot of politics in the whole process. Politics have been creating barriers for access to information and services. Human society has not been working in unity to fight the pandemic.

We have big problems with information; at this stage, we have new vaccines and we don't know which one is the best. At the moment, the government almost dominates all channels of information. The Chinese media talks about the side effects from Western vaccines, and how good vaccines made in China are. Western media criticizes Chinese vaccines, which confuses people, and there is no convincing voice to explain things to people. The politicians are not public health experts, instead of listening to their scientific advisors, they are serving their own agendas. Lack of transparency is a big issue, as we have seen over the last two days.

Procurement of, and prices for vaccines vary. Communities don't know how much their country is spending on vaccines, or what they pay for each dose. There is a lot of corruption, and budgets have not been used wisely. We don't see much volunteerism, even from non-governmental organizations. It's not like HIV, where CBOs did everything – testing, treatment referral, follow-up support, and care, Now, everything relies on governments.

Vaccination is not high-tech work. Many community health workers can do it. In some countries, we don't have enough nurses or medical staff, so they slow down vaccination campaigns. Why don't they mobilize NGO and CBOs to accelerate vaccination? Donors should support this.



We have a strong HIV movement and we have cultivated strong networks – but what about the other diseases? Human rights can only be delivered with community participation, transparency, and monitoring. CBOs are not just for protesting - we can deliver services, and play an important role in the government. This is a very important time, and a great opportunity for CBOs to demonstrate their value and importance, not just in HIV, hepatitis C and C-19, but in general.

How can we help people understand why the vaccine is important? Otherwise, rumors still block access to vaccination. Also, we can talk to governments, and tell them that we can do testing and vaccination. In Cambodia, we did not have access to rapid antigen testing. Our NGO started doing staff testing, and we found four people who had C-19; because they were vaccinated, they did not have symptoms. We told the Ministry of Health about this, and suggested self-testing to save money on expensive PCR testing – the government realized that people should have access to antigen testing, and the price dropped. CBOs can trigger changes.

HIV is a smaller community; C-19 is the whole country. What we need to do is pilot models to build awareness among people and push the government forward.



COMMUNITIES AND THEIR ROLE IN THE RESPONSE TO COVID-19

Loon Gangte

Loon Gangte is a treatment activist based in India. He has been living with HIV since 1997. In 1999, with four other people living with HIV, Loon co-founded the Delhi Network of Positive People (DNP+). Treatment activism is the core of Loon's work, which ranges from providing peer counselling and ensuring adherence to opposing patents on key HIV, TB and HCV medicines and advocating against free trade agreement negotiations that can threaten access to generic medicines. He is also the coordinator of ITPC South Asia. During the severe lockdown in India at the start of the pandemic last year, Loon and his colleagues travelled hundreds of kilometers on their bikes to deliver ARVs to PLHIV. Later, they braved police brutality at a street protest lasting several days and nights, to demand re-starting hepatitis C screening and treatment services that were suspended during the lockdown.

There is a big gap in vaccine access. The only people who can fill this gap are global activists like you and me. We have done it with HIV, and we can do it again.

Loon Gangte

Globally, approximately 23% of the population is fully vaccinated. In my country, India, only 10% have been vaccinated. If you look at the EU, the UK and the US, they have all vaccinated 50% of their populations – a few countries have vaccinated 60% of their people. This is the same trend as in the early days of HIV: the poor die, and the rich live. COVID has certainly benefited from the infrastructure that the global HIV community has built and upgraded over the decades - but we become victims of C-19.

If you look at vaccine politics, they are very similar to those during the early days of HIV treatment: only the rich countries are doing better, while LMIC have been harder-hit. We can use the same strategies that we used for HIV treatment access. There are lots of myths and misconceptions about vaccines. If we rely on the government, people in grass-roots communities won't be convinced. But if we talk face-to-face with them – peer education, which we did with HIV – we can convince them. Two sides of community work can bridge the gap in vaccine access: one on TRIPS, monopolies and politics, and one on breaking up C-19 myths and misconceptions, and spreading awareness on the ground.

It is very unfortunate that in this 21st century we have all the money, the resources, the technical know-how, and the active pharmaceutical ingredients. We lack nothing, except the active involvement of the global community of activists like you and me. There is no trick; we are experts in the same old strategies. When we apply them, we will see a big difference in C-19 vaccine access. I believe we are here not just for HIV, but for the public health of our peers, our nations and this world. Let's do it – let's teach the politicians, governments, and multinational companies. We have done it before, and we can do it again

ANNEX

COVID-19 VACCINE INFORMATION AND ACCESS IN ASIA WORKSHOP



Day One: 17 August

Session	Details	Speakers
Opening Session	WELCOME	Karyn Kaplan, Asia Catalyst Shiba Phurailatpam, Asia-Pacific Network of People Living with HIV (APN+)
Session 1: C-19 in the Asia-Pacific region	Presentations and discussion Moderator: Karyn Kaplan, Asia Catalyst	Session Objective: Overview of country-specific C-19 vaccine access and barriers, delivered by representatives from key populations and human rights groups
	<i>Vaccine Inequity in the Asia-Pacific</i>	
Country Reports	Thailand	Kanya Benjamaneepairoj, Consultant
	Bangladesh	Dr. Md. Asifur Rahman, Ashar Alo Society
	Nepal	Rajesh Didiya, National Association of PLHIV in Nepal (NAP+N)
	Myanmar	Asia Catalyst (presenters are unnamed for their safety)
	China	Thomas Cai, AIDS Care China
Session 2: Key Populations and Access to Vaccines	Panel + Q&A Moderator: Jennifer Ho, APCASO	Session Objective: Gain perspectives from, and learn about experiences of key populations in terms of C-19 vaccine access and barriers
	LGBTQI	Midnight Poonkasetwattana, APCOM
	Sex Workers	Meena Seshu, Sangram and National Network of Sex Workers, India
	Refugees and Migrants	Wasurat Homsud, Raks Thai
	Transgender People	Prempreeda Pramroj Na Ayutthaya
Session 3: Key Issues: Consent, Confidentiality, Indemnity, Adverse Events	Presentations and discussion Moderator: Kajal Bhardwaj	Session Objective: An overview of ethical and legal issues around C-19 vaccines, and country-specific overviews of barriers and access to C-19 vaccines from a key population lens
	Carrots and Sticks for C19 Vaccines uptake: Ethical concerns	N. Sarojini, SAMA
	C19 Vaccines: Legal Issues that communities should be concerned about	Veena Johari, Courtyard Attorneys
Country Reports	Vietnam	Do Dang Dong, Vietnam Network of People living with HIV (VNP+)
	Philippines	Arnold Rañada and Rommel Legwes, Pinoy Plus
	Indonesia	Aditya Wardhana, Indonesia AIDS Coalition (IAC)
Wrap Up		Kanya Benjamaneepairoj, Consultant

Day Two: 18 August

Session	Details	Speakers
Opening	Welcome back	Giten Khwairakpam, TREAT Asia
Session 4: Vaccine Access: International Landscape	Presentations and discussion Moderator: Kanya Benjamineepairoj	Session Objective: An overview of international initiatives for securing access to C-19 vaccines and country profiles on access and barriers to C-19 vaccines from a key-populations lens
	C-19 vaccine access: the role of WHO	Dr. Stephen Chacko, WHO (Yangon)
	The failure of voluntary mechanisms	Fifa Rahman, Matahari Global
	People's Vaccine Alliance Asia	Dinah Fuentesfina, ActionAid
Country Reports	Malaysia	Edward Low, Positive Malaysian Treatment Access & Advocacy Group (MTAAG+)
	India	Manoj Pardesi, National Coalition of People living with HIV (NCPI+)
	Pakistan	Asghar Satti, Association of People living with HIV - Pakistan (APLHIV)
Session 5: Vaccines and Intellectual Property Barriers	Presentations and discussion Moderator: Kajal Bhardwaj	Session Objective: This session will highlight the impact of TRIPS and Free Trade Agreements (FTA) on access to C-19 medical products, and cover current campaigns to broaden access to C-19 vaccines and other medical technologies
	IP barriers and C-19 Vaccines	Kajal Bhardwaj
	The TRIPS Waiver	Chee Yoke Ling, Third World Network (TWN)
	FTAs and C-19 Vaccine Access	Chalerm Sak Kittitrakul, AIDS Access, Thailand
Session 6: Looking Ahead	Presentations and discussion Moderator: Gisa Dang	Session Objective: This session will provide an overview of human rights in the context of C-19, exploring and deconstructing neo-colonial approaches to global health, and pushing for a community-centered and gender-equitable access framework
	C-19 and human rights	Gisa Dang, Independent Consultant
	How to decolonize the C-19 response	Fifa Rahman, Matahari Global
	C-19 Vaccines: Developing a gender, equity and access framework	Aakriti Pasricha and Neelanjana Das, SAMA
	Cutting through the politics - why we need to get vaccinated	Thomas Cai, AIDS Care China
Closing Remarks	Putting communities at the heart of the response	Loon Gangte, Delhi Network of Positive People (DNP+)
		Closing and Next Steps Karyn Kaplan, Asia Catalyst



Asia Catalyst promotes the rights of marginalized communities by supporting a vibrant network of advocates committed to ending stigma, discrimination, and criminalization. We strengthen civil society by providing training and resources for community-based organizations to become more effective and responsive to community needs, and to conduct rigorous human rights documentation and advocacy. We work side by side with grassroots activists to ensure that their voices are fully represented in local, national, regional, and global policymaking.



The ASIA PACIFIC NETWORK OF PEOPLE LIVING WITH HIV (APN+) is the regional network of people living with HIV in Asia Pacific region. Established in 1994, its membership is now drawn from more than 30 countries in the region. Currently, the APN+ secretariat office is located in Bangkok, Thailand. APN+ is active in responding to HIV- related stigma and discrimination, building capacity of people living with HIV and increasing access to treatment, including by fighting patents on medicine that minimize access.



Launched in 2001, TREAT Asia, amfAR's primary international program, has helped improve treatment and care in Asia and the Pacific and is regarded as a model of regional collaboration on HIV/AIDS. The TREAT Asia network includes 21 adult and 17 pediatric clinical sites in 12 and 6 countries respectively that contribute data to TREAT Asia's adult and pediatric HIV databases, conduct research, participate in TREAT Asia-led training programs, and share information and best practices.

TREAT Asia has been strongly involved in improving access to treatment, highlighting intellectual property barriers, viral hepatitis education, awareness, policy advocacy and treatment access work throughout the Asia-Pacific.

