

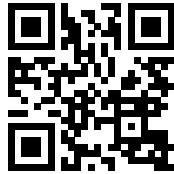
THE THREE COVID CRISES AND MULTISTAKEHOLDERISM Impacts on the Global South

Harris Gleckman



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PREFACE

In March 2021, Friends of the Earth International (FOEI) and the Transnational Institute (TNI) published '[COVAX: A global multistakeholder group that poses political and health risks to developing countries and multilateralism](#)'.

This follow-up report explores further the role of multistakeholderism (MSism) in the COVID crisis and situates COVID-focused multistakeholder undertakings in the overall strategy of the Global North toward the Global South. It looks at the way 'normal' healthcare markets with their economic, social, and gender inequalities have provided a platform for the global upsurge in COVID. The multistakeholder group, Access to COVID Tools Accelerator (ACT-A) and COVAX, its most public multistakeholder sub-group, has led to a proliferation of other multistakeholder groups that assert they are 'fighting COVID'. With this as a context, this new report classifies four types of responses made by powerful governments and businesses to the unequal world surrounding the spread of COVID.

Multistakeholder bodies are groups functioning outside the intergovernmental multilateral system but acting in many ways as if they were governing bodies. The membership of these groups are generally executives from TNCs and related business associations who bring together their associates in civil society, in government, in the UN system, in academia and in other public bodies to jointly work on a specific topic. COVAX is one such multistakeholder group that, interestingly enough, was convened largely by two other multistakeholder groups, GAVI and CEPI (the Coalition for Epidemic Preparedness Innovations). The World Health Organization (WHO) and UNICEF are junior partners in COVAX, reflecting COVAX and other health-oriented multistakeholder groups' efforts to marginalise the intergovernmental system.

COVAX's initial goal was to manage the distribution of COVID vaccines to 10 per cent of the population of 92 of the poorest developing countries and to re-organise key portions of the international vaccine industry in the process.

The first paper argued that COVAX was built more like a merchant bank, using capital provided largely from governments, to shape the global vaccine preparation industry and the Southern vaccine consumer market. It is also designed like a regular international trade association interested in establishing this vaccine market based on a health care system where one is required to pay for health. It also argued that COVAX was in fact designed to be a bit like a NATO to engage China and Russia in the next generation of soft-power geopolitical confrontations via the granting or not of vaccine access, prices and doses to specific countries and peoples. However ingeniously it was constructed, and however much it was cheered on by OECD governments and the Secretary-General of the UN, it was, the paper argued, unlikely contain the spread of COVID in the Global South.

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A. Introduction: The three COVID crises

On any given day, one hears a lot about the 'COVID crisis'. However, the expression 'COVID crisis' has markedly different meanings to different authors and speakers. Health policy makers and health activists need to think strategically about the best way to contest the impact of each type of 'COVID crisis'.

The 'COVID-19 crisis' and the 'SARS-CoV-2 crisis' refer directly to the spread of the virus, which moved from a non-human community into a human community or from a lab into a human worker, provoking the pandemic. The virus evolves into variants and moves without regard to geographical or political boundaries; it therefore cannot really be 'governed'. In this use of the term, 'COVID crisis', or more generally, 'the pandemic', is fundamentally a short-hand reference to a viral reality.

The second usage of 'COVID crisis' encompasses the social, economic, gender and political consequences that follow from the spread of the biological virus. It is fundamentally a reference to how the viral reality moves within pre-existing social and economic structures causing ill health, hospitalizations and death to people, largely in proportion to how the existing social and economic systems worked for or against them. Oxfam recently summarised this dynamic in the title of their annual report to the World Economic Forum as 'Inequality Kills'¹. When the system works against a community of people, it can result in only 10 per cent of a continent having the vaccine. When the system creates a privileged benefit for another class of people, it can result in free access to the second or third booster shots.

Key sectors of the Global South are adversely affected by the 'normal' operations of globalisation. The 'normal' inadequate practices of class-based medical care and the 'normal' requirement that health care is purchased drive the adverse impact on key sectors of the Global South. In this perspective, there is no need to take additional action: the 'normal' system means that hundreds of millions of people in the Global South and millions of people within the Global North will be adversely impacted by COVID, the biological crisis.

'normal'



The 'normal' operations of globalisation means, for example:

that most life-saving technologies are priced above the ability of millions to purchase them

that the control of the levels of production of medical technologies, vaccines and post-infection treatments available to developing countries is determined by TNC suppliers

that developing countries are often forced to finance emergency health care by increasing their indebtedness to international financial institutions

that actual health care for families and in hospital falls heavily on women and disproportionately on women of colour

that similar realities influence the access to COVID medical interventions for a significant number of people in developed countries

that the concurrent food, climate and financial crises restrict the opportunities to subsidise families and communities displaced by the consequences of the pandemic

The governance arrangement for this type of 'COVID crisis' are the 'normal' institutions of local authorities, national governments and the UN system. This second use of 'COVID crisis' should properly be termed the systemic COVID crisis.

The third usage of 'COVID crisis' is a reference to the consequences of actions taken by powerful actors (governments, the UN system, TNCs and their associated bodies) based on their own perception of their institutional priorities and interests. It reflects the use of power in response to the biological agent moving within pre-existing social structures. The governance issues here are the way that powerful actors act to intervene – or not – to alter the impact of the systemic COVID crisis. This type 'COVID crisis' can be termed the power COVID crisis.



power COVID crisis

In the power COVID crisis, the strategies of governments, the UN system, TNCs and their affiliated organizations reflect four different directions. They are:

- 1** Devising ways to 'use' the pandemic to **expand markets** and **political power**
- 2** Acting assertively to **prevent too many pandemic-related exceptions to globalisation rules and narrative** to become acceptable in 'normal' times
- 3** **Standing back** and just letting the 'normal' systemic practices impact large populations in the Global South and Global North
- 4** Using their capacities to **limit the consequences** of the systemic COVID crisis

In different times and places, governments, TNCs and the UN system have prioritised different types of responses to the systemic COVID crisis. There may be a fundamental difference between what power actors do and how they present these actions to the wider public. And, in different circumstances and at different times, these powerful actors can elect to use multistakeholder groups as a vehicle to implement their particular strategy. While powerful actors can use their leverage to shape events, their efforts do not always work as they intended, as those affected push back in unexpected ways.

The three different types of meanings of 'COVID crises' can apply equally to the use of the 'food crisis' the 'climate crisis', the 'care-giving crisis' and the 'biodiversity crisis'. People in the Global South and Global North face the cross-cultural impacts of the systemic COVID crisis with these other systemic realities.

A substantial number of people are working with civil society organizations, international organizations, multistakeholder groups and other institutions to face up to the challenge of the viral COVID crisis. Without their efforts the impact of the viral COVID crisis on the Global South would be far more serious, however, individual efforts are constrained by systemic structures of globalisation as outlined later in this report.

The systemic COVID crisis and the power COVID crisis are both socially created realities, and as anthropogenic realities they can be altered by human interventions. This study seeks to contribute to the understanding of these human-institutional arrangements and the development of specific recommendations for how these anthropogenic forces can be changed. While some of the characteristics of the systemic COVID crisis and the power COVID crisis apply to the international market for all health services, this paper explores only how the systemic and power COVID crises are operating in the current pandemic.

The first section of this paper elaborates on the four distinct types of power responses to the systemic COVID crisis. The second section explains how multistakeholder governance is one of the mechanisms used to implement these responses. The final section provides recommendations for how the health community, concerned government officials and other activists can counter each of the responses of the powerful to the systemic COVID crisis.



B. The four responses of the powerful to the systemic COVID crisis

1. Expand markets and the power of the currently powerful

One power option is to use the viral COVID crisis to capture additional markets or expand the power of OECD governments, TNCs and their allied institutions. Three cases illustrate this practice.

For Big Pharma and related medical industries, the pandemic is a very significant market opportunity. No other medical necessity – in fact no other category of manufactured product or service – is needed by approximately 80 per cent of people on the planet within a very limited time frame, if one is to sharply reduce the spread of COVID and the opportunity for additional variants. A good proportion of the world population may need a follow-up booster, which adds a second marketing opportunity. There is a need for preventative medical supplies, for diagnostic testing, for post-infection treatments and resources to counter the economic and social-ripple impacts. With such a potential market, major transnational actors can extend their political and economic power. The World Economic Forum summarised this approach on its COVID Action Platform website as ‘protect people’s livelihoods and facilitate business continuity’.²

The second example is the use of COVID vaccines in the geo-political competition between the West and Russia, China and India, each using the terms of supply and prices for vaccines and related COVID services and products to decide which countries to pull into their orbits. The geopolitical battle is even being carried on at the WHO and by the EU, which has granted travel rights to Europe based on the origin of the vaccine shot and whether the EU accepts the authority of vaccine certificates from selected Global South countries. For Russia and China, the supply of free or discounted vaccines (called Sputnik V by the Russians) represents an opportunity to showcase that their political, economic and ideological system is superior to that of the West. For India, a new geopolitical player, the distribution of vaccines by their national firm, whose business prior to COVID was as the leading supplier of vaccines to the Global South, was first a point of national pride and then a victim of vaccine nationalism within India.

The third example of using the systemic COVID crisis to expand power for the already powerful is the new corporate and COVAX insistence that government purchasers agree on vaccine liability waivers as a pre-condition for negotiating purchase agreements. In OECD countries, manufacturers are liable for damages from their products if inadequate care was taken in the design, production or distribution of the product. Vaccine manufacturers and COVAX turned this OECD-wide practice upside down. They insisted that they would refuse any liability from defects related to the vaccines before even negotiating the details of the vaccine purchase. In the case of South Africa, the manufacturers demanded that state assets (buildings, military equipment,

national financial reserves) be collateral to exempt vaccine manufacturers from any suits from South African citizens. While the national parliament effectively blocked the use of state assets as collateral, South Africa was forced to accept state liability in place of manufacturer liability³. Similar vaccine liability waivers, called Indemnification and Liability Agreements, were also demanded from Latin American governments. COVAX itself is now 'offering' its own identification and liability insurance option.⁴ Big Pharma has now engaged the US Administration, other OECD countries and the UN Secretary-General⁵ to put pressure on countries in the Global South for the industry's commercial interests.

2. Prime goal is to protect globalisation, not to prioritise health services

The second set of choices for powerful actors is to move to pre-empt any pandemic mitigation steps that might endanger the rules of globalisation or re-shape the global narrative about globalisation after the current pandemic. Three cases illustrate the pre-emptive protection of globalisation practices.

A large group of countries have prompted a battle at the WTO with the demand that there should be an intellectual property (IP) waiver for COVID technologies. One of the key arguments against granting this pandemic-crisis waiver is that, if the COVID pandemic could 'waive' IP restrictions, then the recognition of systemic hunger crisis, climate crisis or biodiversity crisis could prompt developing countries to ask for additional IP waivers and thus undermine the legitimacy of the whole IP system. 'Normal' WTO rules require all members to agree on a specific waiver. Some OECD countries, which have announced 'support' for a waiver, are using this leverage to narrow any possible waiver so it would be almost impossible to implement.⁶

A second example is that COVAX, as a multistakeholder body, and other multistakeholder distributors of COVID-related products and services, have a fundamental operating assumption that, even in a pandemic, medical care must be purchased by those in need.⁷ The strong message is that countries and peoples need to accept this assumption in order to be given priority in accessing COVID-related products and knowledge. This insistence on payments for health undermines the global push to declare health a global public good, one that should be available to all irrespective of country, class, ethnic, gender or other standing. It also overrides the scientific clarity that without a global effort to vaccinate a significant proportion of all potential carriers, COVID cannot be contained globally, as it will continue to generate new variants.

Actions in oxygen markets exhibit a third form of how the preservation of 'normal' business practices is considered more important than the need for emergency medical exemptions. The oxygen industry, a sub-sector of the industrial gas industry, generally supplies gases as a commercial commodity. However, oxygen is also a medical product necessary for the effective treatment of serious COVID. The supply of oxygen to health care facilities is delivered with long-term, legally binding contracts. Some of these contracts prevent hospitals from purchasing oxygen from other firms or allow for a supplemental technology for on-site local oxygen extraction. Some oxygen firms in developing-country markets are insisting in maintaining the authority of these contract provisions and using their market-dominant positions to disparage small and medium-sized local oxygen enterprises, even in the face of the extraordinary increased need for medical oxygen during the pandemic.⁸

3. The stand-back approach

A third set of choices for powerful actors is a passive approach. Let the systemic COVID crisis 'play out' – even at the cost of preventable mass death, and the short-term disruptions to global value chains. Some may even see longer-term opportunity in this to 'reinvent globalisation'⁹, to use the crisis as advantage in global capitalist competition. The extreme version of this stand-back approach is denialism. It runs counter to the follow-the-science approach, which clearly warns that COVID variants will naturally evolve and that other pandemics can occur unless positive steps are taken in the area of public health. If one pretends COVID is not a health threat there is little need to take public action. The stand-back approach has, of course, parallels in the climate, biodiversity and food crises.

For effective use of the stand-back approach, it can be useful to have some highly visible associated projects that can convey the illusion that powerful actors appear to be acting to mitigate the seriousness of the crisis. Enter COVAX. From a global governance perspective, the stand-back approach aligns well with the shift to volunteerism in global governance – that is, each government and each TNC can decide for themselves how they wish to respond (or not) to a given deadly global crisis.

4. Mitigating the consequences of the systemic COVID crisis

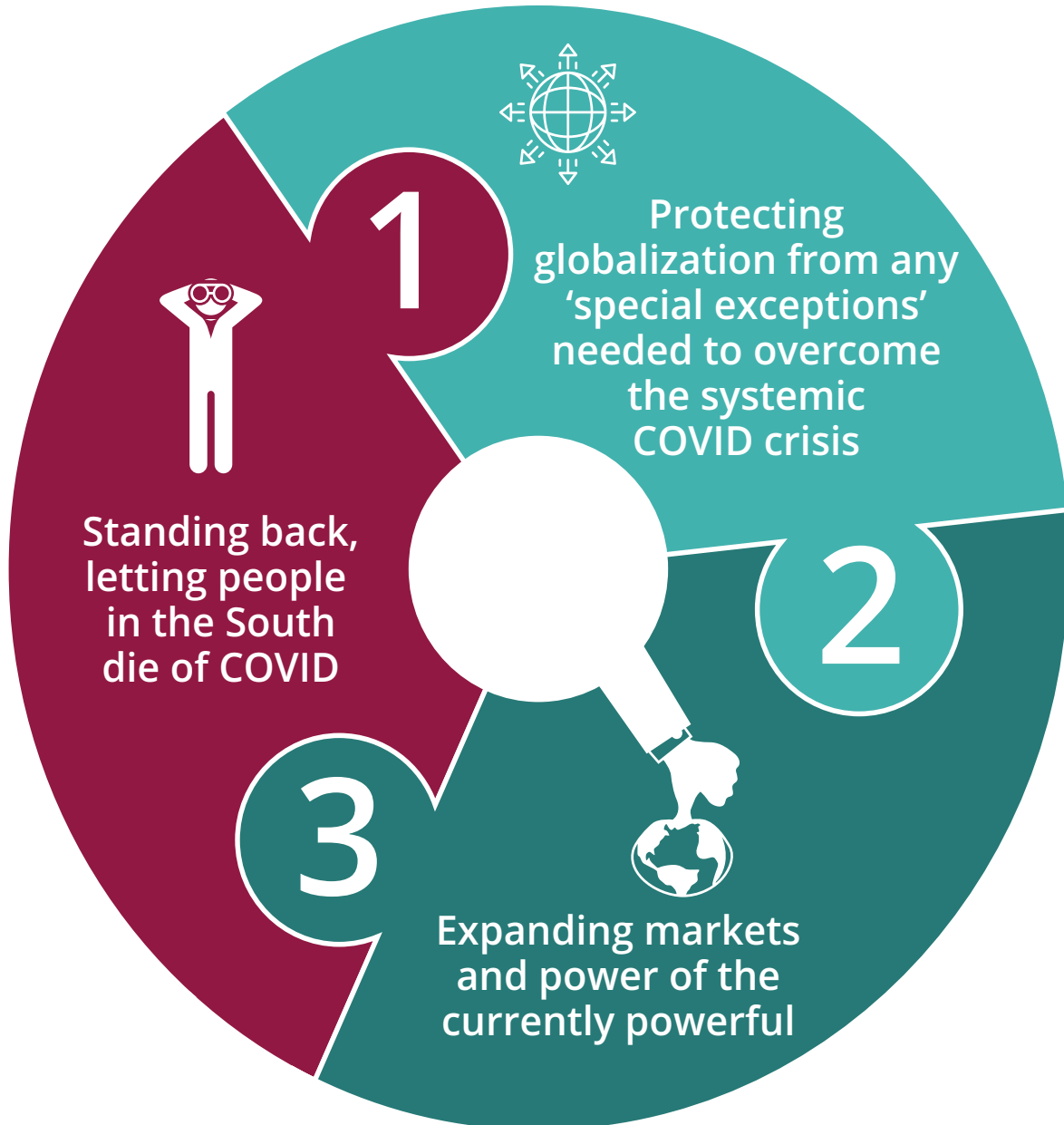
There is a range of actions that powerful actors could undertake to intervene meaningfully with systemic COVID, if the first priority is that human health were a global public good.

On the international level: powerful actors could properly fund a UN humanitarian relief effort that covers not only the costs of COVID diagnostics and medical interventions but also mitigates the economic and social disruptions to life from the viral COVID pandemic and underwrites the UN system in coordinating these interventions. Governments and the UN system could implement the internationally agreed-upon sustainable development health goals and begin to support the Global South in building quality health care systems.

On a national level: governments could properly operate public health services, supported by social safety nets and social protections so as to minimise the commercialization of health care while they also establish effective health regulatory structures that guide all levels of medical commercial actors.

Any of these four different power responses can also have impacts on each other. Some of the efforts to protect globalisation can also enhance COVID-related market expansion and equally some of the stand back strategic responses to systemic COVID keeps open the door for 'normal' globalisation continuing to be seen as an acceptable response to the pandemic and other mega-crises. The next public platforms to witness the interaction of these systems will be the forthcoming revision of the WHO's International Health Regulations, the negotiations for a pandemic treaty,¹⁰ and the UN's 2023 Summit for the Future.

When the powerful say they are
'FIGHTING COVID'
in the **GLOBAL SOUTH**
they mean





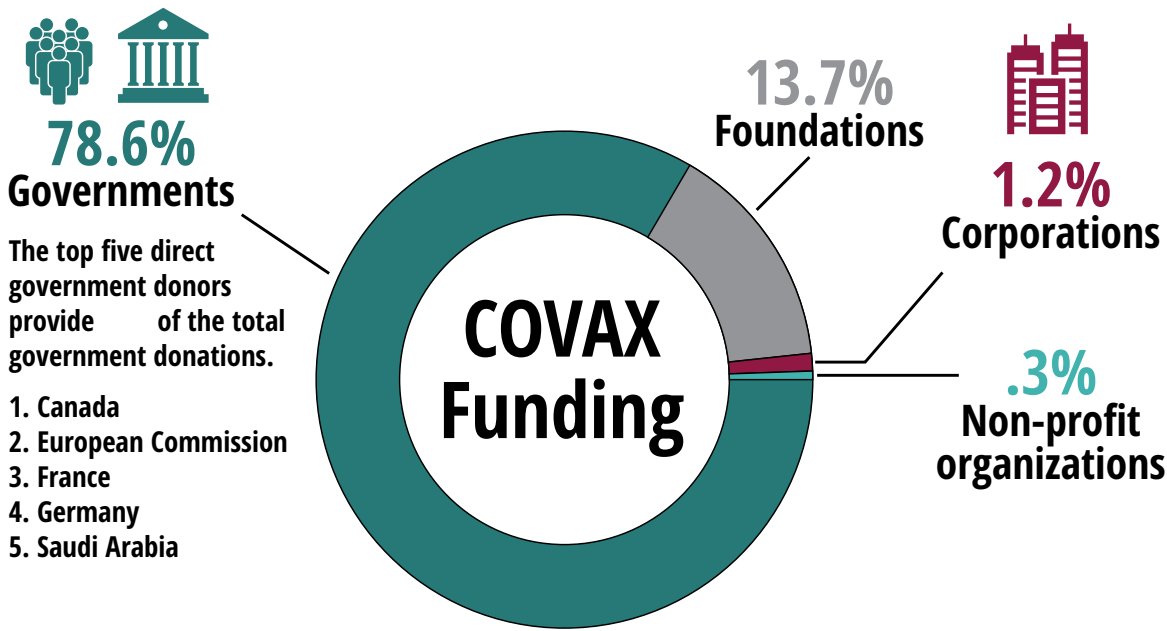
C. Multistakeholderism: A new governance tool from the North

Multistakeholder governance (MSism) at the international level introduces a fundamentally new governance platform for responding to global tensions, one which has a number of important benefits for powerful governments and businesses. By design, multistakeholder participants can exert governing power but they, unlike national states, have no formal requirements for responsibility, no obligations and no liabilities. This diffusion of responsibility, obligation, and liability – who is really accountable – makes the multistakeholder form of governance appealing, particularly in complex crisis situations. In a multistakeholder group all the participants can point responsibility fingers at all the other participants in the group, effectively precluding public or institutional accountability.¹¹

One of the key advantages of MSism is that the structure introduces TNCs, their associates and other non-state actors directly into the leadership of the global response.¹² This further marginalises governments in general and intergovernmental forums from taking the political leadership on a global crisis. If governments working through the UN system did take a leadership role, they might advocate for a higher moral position, a regulatory or quasi-regulatory response or take steps that encourage greater civil society and social movements involvement in responding to a global crisis.

MSism also allows powerful governments and TNCs to say something is being done in conjunction with a diverse set of other actors, knowing all the while that the MSism structure cannot fully address a systemic crisis. In this sense, a prominent multistakeholder group can function as an illusion for the wider public, an illusion that is often necessary to gain maximum benefit of their overall strategic response. One key way that this illusion can be created is by states and large private foundations shifting their financial support from UN humanitarian funding processes to ones administered by a multistakeholder group. As multistakeholder groups, like COVAX, now have a call on government funding, it can redirect public attention for the response to the multistakeholder group and away from the WHO's and the UN's long-standing systems for managing humanitarian crises.

Where is COVAX getting the money for its program?



Governments should be funding a WHO body, not giving a multistakeholder group the power to decide which developing countries get the vaccine.

Data for the first year of COVAX – source: ‘COVAX: A global multistakeholder group that poses political and health risks to developing countries and multilateralism’, Friends of the Earth International and TNI, March 2021.

For UN system leaders, knowing that OECD governments are not likely to significantly fund necessary intergovernmental interventions in viral or systemic COVID, making alliances with multistakeholder groups, TNCs and their associated organizations is a way to do something – anything – more than their normal activities. In the process the UN system provides effective public cover for governments and TNCs participating in multistakeholder COVID-associated projects and relieves pressure to make COVID-motivated exceptions to the ‘normal’ globalisation rules. Actions by the UN Secretary-General, by the Director-General of WHO, by COVAX and by some OECD governments have encouraged other Global North consortia to create or re-focus existing multistakeholder groups to ‘fight COVID’ for their own political and commercial reasons.

MSism is also a very flexible governance structure. As explained in the next section,¹³ MSism can be used to deliver specific projects, set policy goals, define new market standards and manage institutional financing.



D. Expansion of MSism claiming to ‘fight COVID’

1. Expand markets and the power of the currently powerful

In the context of the systemic COVID crisis, multistakeholder structures have become a leading vehicle to expand commercial markets and power, particularly in the Global South. Multistakeholder structures have played this role along the complete supply chain for COVID-related medical products.

Personal protective equipment (PPE), COVID testing technologies, syringes, vaccines, hospital and home oxygen and genomic mapping technologies for COVID variants are all necessary medical services and products. The global effort to supply these products and services for COVID relief has two branches: the firms that manufacture and distribute the products and services, and a multistakeholder body that aims to coordinate access to these products and services for a significant share of the population in the Global South. The lead multistakeholder body for the latter function, Access to COVID-19 Tools Accelerator (ACT-A), was launched in April 2020.

ACT-A can properly be seen as a counter-move to the WHO’s initiative to generate a multilateral-led effort to induce COVID-related manufacturers to provide ‘emergency’ COVID medical support to developing countries. This programme, called COVID-19 Technology Access Pool (C-TAP), was supported by over 30 WHO member governments and later approved at the 2020 World Health Assembly. However, it did not get support from the industry or from most OECD governments. As such, it may well have had the effect of forcing WHO to work with multistakeholder-led COVID focused bodies.¹⁴

According to ACT-A, The co-conveners and partners of ACT-Accelerator bring world-class knowledge in research and development (R&D), manufacturing, policy development, regulatory procedures, market shaping, procurement and delivery.¹⁵ From this perspective defining the new COVID-related market opportunities involves bringing together experts not only in the definition of sub-markets and the logistics of procurement and delivery but also the revamping of regulatory approval processes and the investment on research and development and manufacturing facilities. What is missing from the participants in this ACT-A global coordination body, as well as from its sub-sector bodies, are representatives selected by associations of nurses, doctors, community health care centres, social movements, voluntary health workers and other on-the-ground developing country organizations. What is also missing from the ACT-A coordination process is any commitment to frequent public reporting, public hearings or a formal link to the intergovernmental World Health Assembly.¹⁶



The parent multistakeholder body ACT-A¹⁷ coordinates:



another multistakeholder group, the **Health System and Response Connector**, for access to PPEs and country-specific health system requirements



the distribution of diagnostics by a second multistakeholder group led effectively by the multistakeholder group, **Foundation for Innovative New Diagnostics (FIND)**



the distribution of vaccines via a third multistakeholder group (**COVAX**)



enhanced access to therapeutics (treatments) by a fourth multistakeholder group, led by the funding groups, **Unitaid and the Wellcome Trust**

In ACT-A parlance, this work is organised into four pillars:

1. the diagnostics pillar (Dx),

2. the therapeutics pillar (Tx),

3. the vaccine pillar (Vx) and

4. the Health System & Response Connector (HSRC)¹⁸ on country-specific health systems and access to PPE.

The four pillars are complemented by the WHO's assigned work on 'global equitable access and allocation'. ACT-A leadership is funded by four sources (the Bill and Melinda Gates Foundation [BMGF], Unitaid,¹⁹ The Global Fund to Fight AIDS, TB, and Malaria [GFATM], and the Wellcome Trust), two UN-system organizations (WHO and the World Bank), two key participating organizations (CEPI²⁰ and FIND²¹), and 'private sector partners and other stakeholders'.²² The roles of individual actors in ACT-A and its pillars are summarised in annex Table 1. ACT-A's operating budget for 2021-22 is \$23.4 billion.²³ As a point of comparison, the core two-year budget for the WHO for 2020-2021 was \$5.84 billion.²⁴

Table 1: Institutional leaders within the ACT-A structure

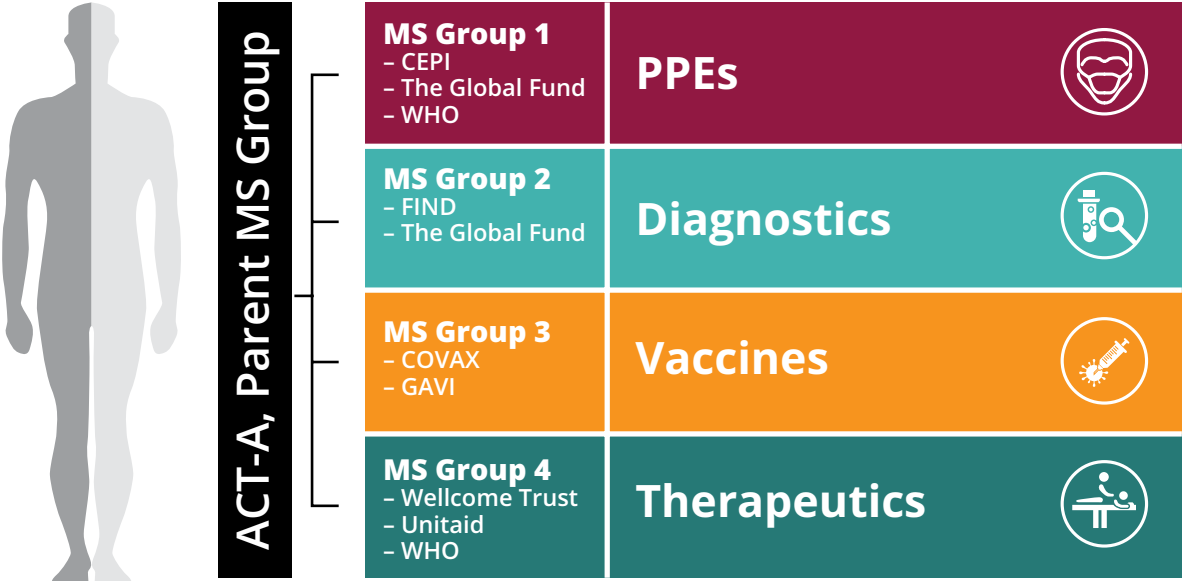
Organization	Type of organization	Via an ACT-A COVID MSism groups (pillars and ACT-A workstreams chaired by organization)
African CDC	Regional health body	Dx – country preparedness workstream
Bill and Melinda Gates Foundation (BMGF)	Private foundation	Dx – R & D of tests and digital tools workstream Dx – strategic private sector engagement Tx – Rapid evidence assessment workstream
CEPI	Multistakeholder group	HS&RC – convenor
FIND	Multistakeholder group	Dx – convenor Dx – market readiness workstream Vx – development and manufacturing
GAVI	Multistakeholder group	Vx – convenor Vx – COVAX Facility and COVAX AMC
Global Financing for Women, Children, and Adolescents (GFF)	Multistakeholder global partnership housed at the World Bank	HS&RC
Global Fund Advocates Network (GFAN)	Public-private partnership and international financing institution	Dx – strategic private sector engagement workstream
Imperial College London	University	Dx – data foundation & modelling
Mayo Clinic Labs	TNC – supplier of lab tests	Dx – strategic private sector engagement workstream
PAHO	Regional health body	Dx – country preparedness workstream
Praesens	TNC – digital sector	Dx – R & D of tests & digital tools workstream
Symphony Capital LLC	TNC – private equity	FIND
The Global Fund	Multistakeholder group	Dx – convenor HS&RC – convenor Dx – supply workstream Tx – procurement and deployment HS&RC
UNICEF	IGO	Vx
Unitaid	Multistakeholder funding group	Tx – convenor Dx – market readiness workstream Tx – market preparedness
Water Street	Private investment firm	Dx – strategic private sector engagement workstream
Wellcome Trust	Private foundation	Tx – convenor Tx – Rapid evidence assessment workstream
World Bank	International financial institution	HS&RC – convenor Dx – data foundation & modelling
World Economic Forum (WEF/Davos)	Corporate multistakeholder body	Dx – strategic private sector engagement workstream
World Health Organization	Intergovernmental organization	Vx – convenor HS&RC – convenor Dx – supply workstream Tx – procurement and deployment Vx – policy and allocation

Source: ACT-A How It Works at 6 April 2021, [https://www.who.int/publications/m/item/what-is-the-access-to-covid-19-tools-\(act\)-accelerator-how-is-it-structured-and-how-does-it-work](https://www.who.int/publications/m/item/what-is-the-access-to-covid-19-tools-(act)-accelerator-how-is-it-structured-and-how-does-it-work), (accessed 24 January 2022).

The ACT-A Principals Cooperation Group coordinates the four pillars. It consists of the leadership of each pillar, UNICEF, the Bill and Melinda Gates Foundation and ‘industry associations’,²⁵ and the ACT-A Facilitation Council. The ACT-A Facilitation Council is co-chaired by the governments of Norway and South Africa and co-hosted by the WHO and the European Commission. It is comprised of the ACT-A founding-donor countries, major market-shaper countries and current chairs of regional cooperation groups, with non-governmental partners (the Bill and Melinda Gates Foundation, Wellcome Trust, World Economic Forum), and the World Bank (observer), with standing invitations from select ‘civil society organizations, communities, and industry.’²⁶ Note that ‘major market-shaper countries’ is a designated group in this multistakeholder body and that the Bill and Melinda Gates Foundation, the Wellcome Trust and the World Economic Forum are seen as NGOs.

Each pillar within the ACT-A multistakeholder structure has a different governance system, strategies and exhibits, and, in its own way, different features of multistakeholder governance. They do have, however, common features – they marginalise the decision-making and operational parts of the UN system; they are closely connected to TNCs, which have a financial stake in a given medical technology; and they seek finances to implement their goals either from sources that traditionally funded multilateral projects or from increased debt obligations of recipient countries.

MSism ‘FIGHTING COVID’



The characteristics of each pillar and the lead multistakeholder groups 'fighting COVID' are described below.



MS GROUP 1: Personal Protective Equipment and the Health Systems & Response Connector (HSRC)

Personal protective equipment (PPE) includes masks, gloves, safety glasses and shoes, earplugs or muffs, hard hats, respirators, coveralls, vests and full body suits. The value of the global market for PPE due to COVID is estimated to be \$198.4 billion by 2026.²⁷ Given population size and relative purchasing power, the value of the share of this PPE market in the developing world could easily be \$100 billion by 2026.²⁸

The HSRC group is co-convened by two financing bodies (The Global Fund and the World Bank) and two UN system bodies (the WHO, and in a secondary role, UNICEF). HSRC has a seven-part structure with a 'private sector' team led by the World Bank. The HSRC has two distinct functions – it has been assigned responsibility for providing high-quality PPE to over 2.7 million health and care workers²⁹ and it has overall responsibility for integrating ACT-A tools into existing health care delivery systems of the 92 poorest developing countries.³⁰ In the latter function, the HSRC seeks to strengthen national response mechanisms and overcome health system bottlenecks. Its priorities are to work with governments 'in planning, financing, and tracking delivery against targets [and] provide coordinated technical, operational and financial support to countries'.³¹ To do this, HSRC works to restructure national health systems and to assist them in getting grants and concessional lending to adapt national health care systems for other ACT-A tools.

For the PPE function, the ACT-A Strategic Plan for October 2021 – October 2022 is noticeably silent on how the HSRC will deliver PPEs to health workers in the 92 countries. Given the leadership of this multistakeholder group by the World Bank and The Global Fund, and the terms of reference for intervention in the national health care systems cited above, it would be reasonable to assume that this goal and the related expansion of the market would be met, if it is met at all, by increased debt or grants to developing country institutions.



MS GROUP 2: Diagnostics and Testing and FIND (the Dx pillar)

The Dx pillar is focused on providing COVID testing and analysis equipment to the designated developing countries. ACT-A estimates that 50 per cent of the world's population has little or no access to basic diagnostics. The Dx target for 'equitable access' to COVID tests is 100 tests/100,000 population/day in 144 countries. To meet this goal, ACT-A estimates that additional market purchases of \$6.984 billion per year are necessary.³² The 'equitable access' claim is not credible, as current testing in OECD countries is 50–200 per cent higher.³³



Why has COVAX failed to deliver?

MEDIA NARRATIVES

Two candidate explanations have been offered in the public media.

One is that COVAX is **under-staffed** and massively misunderstood the realities of the **weak healthcare systems around the world** – the complexities of coordinating between vaccine manufacturers, the international logistics systems, Southern governments and Southern hospitals and clinics.

The other explanation is that **COVAX didn't fail**. Northern governments and TNCs failed to properly transfer sufficient resources to COVAX because of vaccine nationalism and because even the 10 per cent threshold was too great for existing aid budgets. Both public explanations have credibility, but there are two other highly relevant explanations.

UNSpoken FAILURES

The first unspoken structural failure is that COVAX sought to join other multistakeholder bodies like GAVI in undermining the universal character of the WHO, and that significant segments of government agencies and the public were not on-board with this 'takeover'.

A second unspoken failure of COVAX is that it sought to re-align the global market of vaccine manufacturers and distributors by assuming that major governments would provide them with a massive pool of capital from advanced-purchase agreements. A third unspoken failure of COVAX is that it made the operational assumption that the best way to get vaccines to the target 92 countries was by delivering finished-product vaccines rather than delivering the knowledge and technology to allow these countries to make their own medical supplies. A third unspoken failure was that COVAX functions, in part, as a public illusion that the North was really committed to preventing the spread of COVID in the Global South, an illusion that was reflected in formal statements at the World Health Assembly.

The Dx pillar is led by FIND and GFATM.³⁴ FIND is itself a multistakeholder group involving corporate executives, government representatives, academics, a multistakeholder funding group and an international journalist.³⁵ Both organizations have a long history of health care delivery in developing countries, pre-dating the start of COVID. The Dx pillar has seven sub-groups, including a 'strategic private sector engagement' work stream led by the World Economic Forum; the Bill and Melinda Gates Foundation; Mayo Clinics Labs, a commercial supplier of lab testing services; and Water Street, which describes itself as 'a strategic investor in healthcare'.³⁶

One feature of MSism is to accept the reality of an element of a systemic crisis and build public attention for this reality. FIND, on behalf of Dx, does this via a well-developed educational and marketing programme calling attention to the severe shortage of COVID testing supplies in developing countries. But, as with other multistakeholder groups, its overall solution is to propose expanding investment in relevant markets, increasing international grants from OECD countries and adding to the debt burdens for developing country governments.



MS GROUP 3: COVAX and vaccines (the Vx pillar)

The Vx pillar, led by GAVI, CEPI and the WHO, has four sub-groups including a ‘development and manufacturing’ task force led by CEPI. The overall operating system for COVAX and its supervision by GAVI and CEPI (the Coalition for Epidemic Preparedness Innovations) are presented in the FOEI/TNI March 2021 report.³⁷ By its own 2021 reports, COVAX has not met its minimalist target of vaccinating 10 per cent of the population of its target 92 countries.

Since the first report, there have been four important changes in COVAX’s functioning. COVAX has upped its target from 10 per cent of the population in the 91 LMIC countries to be in line with WHO’s target of 70 per cent; COVAX has pushed back its announced vaccine goals from the end of 2021 to well into 2022; and COVAX has received substantially more ‘donations’ from OECD Aid agencies. They have also established a third window (see the next section).



MS GROUP 4: Treatments for COVID (the Tx pillar)

The therapeutics pillar of ACT-A seeks ‘to advance research for effective treatments, support countries to optimise clinical care, including use of corticosteroids and medical oxygen for severe and critical patients, [and] introduce new therapies, once proven effective...’.³⁸ This multistakeholder group is co-convened by Unitaaid and the Wellcome Trust working with the WHO, The Global Fund and the Bill and Melinda Gates Foundation.

The market for COVID treatments is likely to grow dramatically, including demand for oxygen suppliers for severe COVID and the newly approved pharmaceutical products that treat early stage COVID.



oxygen

Oxygen is the essential part of any treatment of severe COVID.

In May of 2021, Médecins Sans Frontières (MSF) described the importance of having medical oxygen supplies to respond to COVID-19 in this:

- ‘Oxygen is the most critical medicine for people with severe COVID-19, yet **its supplies are unstable in many countries.**
- **People in low- and middle-income countries are last in line** for both preventive COVID-19 vaccines and stable medical oxygen supplies – leaving people to get sick and die.
- Governments must invest in **stable oxygen supply chains**, including providing more concentrators, and regulating the price of oxygen’.³⁹

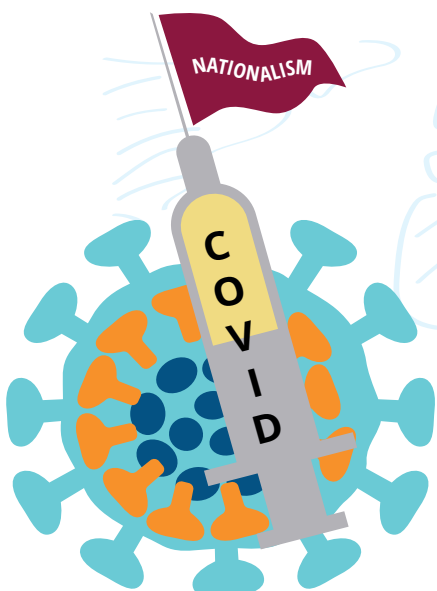
PATH.org, a multistakeholder group of public institutions, businesses, investors and community groups focused on global health interventions, quantified the oxygen shortfall by noting that ‘approximately 15 per cent of all people with COVID-19 require oxygen support. In LMIC [lower- and medium-income countries] an estimated half a million people require 1 million cylinders of oxygen every day. Countries around the world – such as Brazil, India, Jordan, Nigeria, Pakistan, South Africa, Zimbabwe and more – are reporting oxygen shortages on a daily basis’.⁴⁰

In response to these shortfalls, the COVID-19 Oxygen Emergency Task Force was created. The task force, associated with the Tx pillar, is led by Unitaid, an intergovernmental funding body, and the Wellcome Foundation, a private grant-making organization. Other members include two other funding bodies (the Bill and Melinda Gates Foundation and the Global Fund); three multistakeholder groups (Clinton Health Access Initiative [CHAI], the Every Breath Counts Coalition and PATH); a major healthcare civil society organization (Save the Children), a major health industry benchmarking civil society organization (Access to Medicine Foundation)⁴¹ and four UN-system bodies (the WHO, UNICEF, The World Bank and the UN Office for Project Services).⁴²

The task force has coordinated with its members to assist medical establishments across the Global South to obtain oxygen supplies and to arrange for better delivery arrangements for patients. The task force has focused on arranging grants and loans from OECD governments, the World Bank, regional development banks and private foundations to allow local health authorities to purchase additional oxygen.

These new antiviral and monoclonal antibodies treatments should be made available in the Global South. In preparation for this, the Tx Pillar is working on ‘designing an allocation process and mechanisms’ and ‘developing a governance structure to manage allocations’.⁴³ As of the drafting of this second COVID report (March 2022), it is not clear when these new Northern COVID treatment medications will be available in the Global South, nor what the prices of these treatments will be. The challenge is whether the inequitable distribution of COVAX-distributed vaccines will now be replicated with unequal access to these COVID medications.

Before the announcement of these COVID pills, the Tx pillar set a goal for themselves to distribute up to 100 million treatment courses for populations in low- and middle-income countries. With the newly approved COVID medicines, this goal again represents less than 10 per cent of these countries.



When the vaccine was first available in **OECD** countries
**THE POWERFUL CREATED
VACCINE NATIONALISM.**

As treatment pills are becoming available in **OECD** countries
**WILL THE POWERFUL NOW
CREATE COVID TREATMENT
NATIONALISM?**

ACT-A and its associated multistakeholder groups are not the only multistakeholder groups reacting to the systemic COVID crisis in ways that expand business markets and developed-country power.

Market Growth and The World Economic Forum’s COVID Action Platform

The COVID Action Platform of The World Economic Forum (WEF) has 28 multistakeholder groups that are said to be ‘fighting COVID’ (January 2022). The WEF is a privately run consortium of leading TNCs, whose executive director is a leading proponent of stakeholder capitalism and multistakeholder governance. A good number of the COVID Action Platform’s multistakeholder groups are focused directly on market expansion, such as expanding the market for financial technology and financial services, the vehicle sector, digital services, and ‘consumer wearable devices’ markets, stabilising supply chains for hand hygiene products and re-structuring African small- and medium-sized firms and African health care markets. The names and terms of reference of some of these WEF-hosted groups are in Table 2.

Table 2: Using the COVID crisis to expand markets and economic power as advocated by the World Economic Forum’s COVID Action Platform

WEF-hosted multistakeholder group	Self-declared terms of reference
Mobilising Hand Hygiene for All Initiative	Rebuild markets and catalyse supply chains to deliver robust yet affordable hand hygiene products and solutions. ⁴⁴
Pandemic Supply Chain Network	To create and manage a market network allowing the WHO and private sector partners to access any supply chain functionality and asset from end-to-end anywhere in the world at any scale.
Global COVID-19 Fintech Impact and Resiliency Study	To understand the impact of COVID-19 on fintech (financial technologies and instruments), the response of the global fintech industry to the pandemic and the immediate regulatory and policy implications as a result of economic volatility. ⁴⁵
Africa Growth Platform (AGP) COVID-19 Small Business Support Network	To provide a forum to coordinate and enhance collective action among various (African) stakeholder groups in order to maximise impact (of SME in the time of COVID). The AGP seeks to build on already-existing interventions of WEF partners and governments. ⁴⁶
COVID-19: Resetting Africa for Resilient Future	It is an exceptional opportunity to reset many aspects of (Africa’s) health, economic management and public sector priorities and decision-making systems. ⁴⁷
#WeAllMove: A universal open mobility match-making platform	To match mobility needs with mobility options critical (to responding to COVID), which holds the key for transitioning the world into a resilient new normal in mobility. ⁴⁸
Accelerating Digital Transformation for Long-Term Growth	A multi-year initiative that helps companies proactively embed stakeholder interests and sustainability into their digital growth and business transformations. ⁴⁹
Managing Epidemics with Consumer Wearables	Establish an ethical approach for public health stakeholders to respond to pandemics using insights from consumer wearable devices. ⁵⁰

Source: <https://www.weforum.org/platforms/covid-action-platform/projects> (accessed 10 January 2022).

2. Prime goal is to protect globalisation, not to prioritise health services

Before multistakeholder groups intruded in the global governance of emergencies, the prime method of responding to global or regional humanitarian crises was a UN system-led relief fund. These funds, which received the bulk of their financial resources from OECD country AID budgets, provided their services to those in need without costs. The Inter-Agency Standing Committee is responsible for coordinating all the separate parts of the UN system in these humanitarian interventions.

Amongst other characteristics, COVID-related multistakeholder groups condition their interventions on keeping medical care as a commodity to be purchased, even during a global pandemic. The primary source of financial resources for COVAX and other related ACT-A bodies are OECD governments' funds, which have been diverted from a traditional UN-led process. When a developing country's government lacks the resources to make the purchase, ACT-A bodies encourage the government to seek additional loans (i.e., acquire debt) from the international financial system. In this manner, dependency increases and the message is conveyed that a global pandemic is insufficient reason to provide health services as a global public good.

COVAX's first and second window are aimed at government buyers.⁵¹ A new third window, called the Humanitarian Buffer, aims to provide vaccines to those in refugee camps, war zones, in the process of migrating and in communities that are in conflict with their national government. One of COVAX's pivotal functions is to decide which of the 92 LMIC countries are to receive the available vaccines at any one time and determine the delivery, liability and use requirements for these vaccines. To make these decisions, COVAX has two internal task forces to determine who should live and who should die.⁵² To select the recipients of vaccines from the Humanitarian Fund, COVAX opted for a different decision-making system. COVAX decided 'to authorise' the UN's Inter-Agency Standing Committee to make these decisions.⁵³ The irony here is that the entire COVAX approach is premised on marginalising just this established intergovernmental relief system and now they are 'authorising' a body that they displaced to do the work for them.

ACT-A bodies are not the only multistakeholder groups 'fighting COVID' that are organised in such a way that they protect the underlying principles of globalisation and the narrative of a good free market for health care. Nor is it the only health-care focused multistakeholder group that acts to undermine the multilateral humanitarian and policy framework.

Securing Globalization and the World Economic Forum's COVID Action Platform

A second group of multistakeholder organizations in the World Economic Forum's COVID Action Platform is also designed to protect globalisation itself and weaken the potential leadership role of the UN system. Some of these multistakeholder groups are focused on using the COVID crisis to keep in place systems to facilitate trade, maintain business continuity, maintain business continuity, shape the post-COVID narrative about globalisation and influence the way gender issues are incorporated in COVID relief activities. The names and terms of reference of these WEF COVID Action multistakeholder groups are in Table 3.

Table 3: Using the COVID crisis to protect and expand globalization as advocated by the World Economic Forum’s COVID Action Platform

WEF hosted Multistakeholder group	Self-declared terms of reference
Enabling Trusted Information on Trade Facilitation and COVID-19	a joint effort to consolidate information, actions and initiatives adopted by key stakeholders to facilitate trade during the COVID-19 pandemic. ⁵⁴
COVID-19 Vital Supply Chains: Food System Security	to support companies to navigate immediate challenges with the goal of long- term system resilience and global food system security going forward. ⁵⁵
Redesign Trust: Blockchain, COVID-19 & Supply Chains of the Future	will allow stakeholders to connect across the world to collectively navigate and strategize in this new, uncharted territory and facilitate business continuity in the COVID and post-COVID times. ⁵⁶
COVID Social Sector Mobilization Platform	As the International Organization for Public-Private Cooperation, the World Economic Forum has been charged by the World Health Organization to accelerate multi-stakeholder action to combat coronavirus. ⁵⁷
COVID-19 Solidarity Response Fund	Calls on all COVID Action Platform partners to provide financial support to COVID-19 Solidarity Response Fund, a fund “created at the request of WHO by the United Nations Foundation in partnership with the Swiss Philanthropy Foundation”
Arts & Culture Global Solidarity Network	The Arts & Culture Global Solidarity Network [of the WEF] engages artists, cultural institutions and the broader cultural ecosystem to share lessons for navigating the crisis as a sector and to come together to help shape narratives of the world we want to live in post-COVID-19. ⁵⁸
Hour of Pride	multi-stakeholder project that brings together business and nonprofit leaders to promote their commitments to LGBTQI+ inclusion during the COVID-19 crisis. ⁵⁹

Source: <https://www.weforum.org/platforms/covid-action-platform/projects> (10 Jan 2022)

Who is leading the ‘governance’ of these COVID responses? It is not the WHO

The WHO has provided leadership in addressing the viral COVID crisis. However, both the WHO and the UN have exhibited weak global leadership in response to the systemic COVID crisis and the power COVID crisis. A good part of this weak response is that their governments’ members have so far been disinclined to strengthen the WHO and other parts of the UN system, even during the multiple global mega-crises. The future potential leadership role for the WHO from the governmental perspective is central to the upcoming deliberations over the International Health Regulations and the Pandemic Treaty.

The multistakeholder system around COVID is an exemplar, however, of how MSism is contributing to the marginalization of multilateralism and the UN system. As reflected in Table 4, the ACT-A multistakeholder groups describe the role of the UN system as mostly in support of multistakeholderism. UN system bodies are expected to handle ‘delivery’, ‘host’ parts of the ACT-A, ‘procure’ COVID products, assist leaders of pillar teams and ‘partner with’ ACT-A. As noted below, COVAX even ‘authorised’ a UN system body, the Inter-Agency Standing Committee

(IASC), to make decisions for them about potential recipients of the COVAX Humanitarian Fund. In spite of the number of references to the WHO and the Office of the Director General, only two of them reflect serious organizational influence – co-hosting the ACT-A Facilitation Council and the Principals Coordination Group. There are no references to the intergovernmental World Health Assembly. Actually, the only reference to any intergovernmental body is to the General Assembly, which hosted, ‘on the margins’, a COVID summit in 2020.

The sole exception to the UN system being seen as providing services to ACT-A are references to the international financial institutions: the World Bank, as a financing and administrative agency, and the IMF, as a government lending institution.

Table 4: UN system as seen from ACT-A

UN Body	How it is seen from ACT-A
WHO Secretariat and Office of the Director-General	Co-convenor of Vx (1); ‘procurement and delivery at scale’ in Vx (2); ‘leading on regulatory policy, product procurement and allocation, with country access and support, while supporting R&D efforts’ in Dx (1); ‘leading the policy and regulatory work’ in Tx (1); WHO Special Envoy’s ‘co-chair’, Principles Coordinating Group (3); ‘host’ of ACT-A Executive Hub (3); ‘co-host’ ACT Facilitation Council (3); ‘ambitious global coverage targets... established by WHO’ (4); Dx ‘with’ co-convenors (5); Tx ‘with’ co-convenors; (6) sole convenor of Access & Allocation pillar (7); ‘the global normative agency on health’ (9).
World Health Assembly	No references
UNICEF	‘key delivery partner’ (1); ‘procurement and delivery at scale’ in Vx (2); ‘lead agenc[y]’ (3); HSRC – ‘with’ co-convenors (8)
PAHO	‘procurement and delivery at scale’ in Vx (2)
UN General Assembly	‘hosted COVID-19 Summit’ (10); ‘Global Summit on COVID-19 hosted in the margins of the 76th General Assembly’ (11)
Inter-Agency Standing Committee – IASC	‘to authorise’ IASC to make decisions regarding the COVAX Humanitarian Fund
The World Bank Group	‘coordination on financing’ (14)
IMF	‘partner’ with HSRC (12); ‘Concessional financing ... complementary resource stream’ (13); ‘tracking and monitoring efforts’ (14)

Source: ACT-A Strategic Plan and Budget, October 2021 to September 2022, 28 October 2021, WHO publisher, ACT-Accelerator-Strategic-plan (2).pdf, (subsequently cited as ACT-A Strategic Plan); and WHO ‘What is the Access to COVID-19 Tools (ACT) Accelerators, how is it structured and how does it work?’, WHO website (subsequently cited as How Structured) (1) How structured, pg 1; (2) How structured, pg 5; (3) How structured, pg 6; (4) ACT-A Strategic Plan, pg viii; (5) ACT-A Strategic Plan, pg 14; (6) ACT-A Strategic Plan, pg 18; (7) ACT-A Strategic Plan, pg 20; (8) ACT-A Strategic Plan, pg 22; (9) ACT-A Strategic Plan, pg 26; (10) ACT-A Strategic Plan, pg 4; (11) ACT-A Strategic Plan, pg 27; (12) ACT-A Strategic Plan, pg 27; (13) ACT-A Strategic Plan, pg 46; (13) ACT-A Strategic Plan, pg 22.

To be clear, the multistakeholder groups described above also do not lead in governing the North’s response to COVID in the Global South. The key leaders in the West’s governance of COVID responses are first and foremost the TNC manufacturers and commercial distributors of COVID-related medical supplies, supported in complex ways by their national governments. The power of this leadership is reflected in [Pfizer’s extraordinary 2021 profits](#);⁶⁰ in [Johnson & Johnson’s decision to halt vaccine production](#) when they felt it was more remunerative to use their medical production facilities for other products in their portfolio;⁵⁹ in [AstraZeneca’s decision to override Oxford University’s public commitment to the free distribution of vaccine knowledge](#); in [Moderna’s year-long decision not to provide vaccines to COVAX or licence their technology in developing countries](#);⁶² and global firms’ decisions to enforce their no-alternate-purchase provisions in long-standing contracts. While the specifics of these actions have prompted public disquiet, they reflect the governance power of the key TNC manufacturers and distributors.

3. The stand-back approach in practice

The global reported death toll from COVID is 6.3 million people.⁶¹ The World Health Organization (WHO) estimates global excess mortality over the two years since January 2020 at 14.91 million people.⁶² This staggering number of deaths has already exceeded that of some of the worst wars of the past fifty years.⁶³ A cursory look at a map of rates of vaccination⁶⁴ shows Africa as standing out among countries with very low levels of vaccination. The WHO reports that 74 out of every 100 people in high-income economies [using the World Bank definitions of economies] have been fully vaccinated, while comparable numbers for the 28 lower income economies are just 16.59.⁶⁵ In lower-income countries, just 1.61 out of every 100 people has received a booster shot. This represents a major structural and systemic failure with severe consequences to people living in these countries.

Given this scale of deaths, the scientific knowledge that tells us public health matters, and the availability of technologies that could have prevented many of these deaths, the fact that Northern states (particularly the USA, and governments in Europe) chose to protect the profits of pharmaceutical corporations over saving the lives of millions of people in the South is callous in the extreme.

Indeed, given they know the consequences, one has to ask whether the stand-back approach is not tantamount to a silent war on those considered surplus to global capitalist requirements – the vulnerable, sick, old and poor, particularly those in the Global South. If so, this silent war joins – and has been compounded by – other silent wars marked by inaction, such as climate change, pollution, poverty and starvation. Great numbers of people are allowed to die – because they just don't count.

The nature of war evolves over history, and it is possible that what we have witnessed recently is the advent of silent wars. These are wars of inaction, they are won by standing back and letting 'surplus people' die – from pandemics and poverty, the effects of climate change and environmental damage. They are silent wars to uphold the status quo which inequality affords the richer parts of the world.

As with war, inuring people to mass death of this kind relies on de-humanization of the victims. They are the 'others' out there, far away. The same 'others' that are kept behind borders with aggressive, military-style barriers.⁶⁶ As with war, domestic elites need to be convinced that there are sound political and psychological reasons for letting others die – 'we have to look after our own first', 'we cannot set a precedent' (in waiving intellectual property rights). Some proportion of the population is also required to be complacent or distracted. Complacency comes with the 'I am alright, Jack' attitude, for example being offered booster shots, that diminish the availability of first shots for people elsewhere.⁶⁷ Distraction is achieved with mobilising, for example, concerns about how obligations to wear face masks or rules about social distancing may or may not abrogate civil liberties.

In many ways, the stand-back dimension of how the COVID pandemic has been handled at global level – the lack of international solidarity demonstrated on the part of Northern states, the callous disregard for human life in the South – is a generationally defining moment. It ushers in a legitimisation of inaction on that part of the richer world that does not bode well for the crises we are yet to face as a world, including more pandemics but, most seriously, the consequences of climate change. The message is that only those who can afford it, will be saved; only where we need people, will we save them.

4. Mitigating the consequences of the systemic COVID crisis

Governments, the UN system, civil society organizations and social movements could move the world toward a more humane response to pandemics. They could use their positions to mitigate the realities caused by the systemic COVID crisis. In a democracy, this is more than a viable public position.

Developed country governments could require manufacturers to distribute COVID preventative and treatment supplies and knowledge at no or little cost in the Global South. The voluntary initiative of the Texas Children's Hospital Center for Vaccine Development, which have offered their vaccine Corbevax as an open-source vaccine free to developing countries, could be a model for this intervention.⁶⁸ OECD governments can also use their regulatory authority to require manufacturers to significantly expand production capacities or to allow other manufacturers in the Global South to increase production of preventative and treatment supplies, eliminating the opportunity to inflate prices because of limitation of supply. OECD governments can also use their financing capacities (or re-purposed revenues in their military budgets) to purchase, at a marked discount, large quantities of prevention or treatment technologies and to have them delivered to key Global South cities, perhaps using their navies and air forces to do the international delivery.

Governments at the WTO could follow Oxford University⁶⁹ and FIND's innovative approaches to intellectual property.



Foundation for Innovative New Diagnostics (FIND)

FIND's position is:

To overcome common barriers to product availability, motivate some of the best biotechnology companies to innovate in high-tech diagnostics, and ensure affordability and access for public health sectors in low- and middle-income countries, we have adopted a segmented intellectual property (IP) policy... our approach to IP not only applies to patents, but also to copyrights, trademark, trade secrets and data rights... In general, we seek to:

- Provide freedom to operate for the development, manufacture and commercialization of diagnostic products and services for our target diseases, pathogens and populations;
- Minimise costs (e.g., from royalty burdens) to maximise affordability;
- Maximise freedom for others to use the outputs of our projects (including, but not limited to, data, algorithms, reagents including cell lines, software, know-how) for follow-on research.
- We work with our partners to ensure that all IP rights are clearly agreed and contractually defined at the start of each project. We will not enter into projects for which it is clear that IP may pose an insurmountable barrier to research, affordability or availability in resource-poor settings.⁷⁰

The Secretary-General could convene quarterly heads of state and government to formulate an all-of-multilateralism, all-of-government response to COVID. The UN system as a whole could assertively campaign for the recognition that health is a global public good, available irrespective of the ability to pay, geography, ethnic community or gender.

These are examples of actions that powerful actors could take to intervene meaningfully on systemic COVID, if the first priority was that human health were a global public good.

A number of leading forces in the Global North see the COVID crises as an opportunity to institutionalise multistakeholderism as a new form of governance and to sharpen the demarcation between the Global North and the Global South, and between elites in both regions and the 99 per cent of their populations. The actions taken – or not taken – by powerful actors in the context of the systemic COVID crisis can be countered by a number of different actions.

E. Governance counter-responses to the power COVID crisis



1. Counter the expansion of TNC markets and the power of the currently powerful

Global narrative

- Assert clearly that health is a public global good, not one that requires patients to pay directly for health care.
- Undermine in public discourse and media messages the World Economic Forum's call for stakeholder capitalism and the expansion of multistakeholderism.

Institutional responses

- Monitor the process of the access to COVID treatment pills in the Global South in order to prevent a repetition of the unequal access to COVID vaccines.
- Establish special exemptions from WTO and International Dispute Settlement Panels rules for actions taken by national governments in response to global crises.
- Seek national parliamentary support to mandate sharing of scientific medical know-how with the Global South and to suspend intellectual property regulations during the pandemic.
- Support technology and knowledge transfer North to South via the WHO's COVID-19 Technology Access Pool (C-TAP) and other similar programmes.
- Campaign to place profit controls on Big Pharma and all TNCs providing COVID-related products.
- Overturn exceptions from liability waivers that shift legal responsibility for COVID product damages onto Southern governments and institutions and support the cross-boundary liability provisions in the draft Binding Treaty on TNCs and Human Rights.

2. Prioritise global health services, not the protection of globalisation

Global narrative

- Delegitimize globalisation and its associated intellectual property, tariff, monetary and fiscal elements.
- Support efforts to protect political space for countries and peoples to make their own decisions, including on COVID health care, irrespective of geo-political considerations.
- Re-think the distribution of scientific knowledge, pluralise the innovation scene and avoid the imperial control of the knowledge economy.

Institutional responses

- Campaign that the WHO should have a formal seat in the WTO Council and have the legal capacity to declare when there is a global pandemic that they should suspend trade-and investment-related rules, now currently handled by the WTO Council or the International Dispute Settlement Panels.
- Return the locus of international decision-making from MSism to governments and multilateralism.
- Cancel least-developed country debt to free up nationally determined resources for health care and other necessary state support for those living around COVID.

3. Campaign against the stand-back approach

Global narrative

- Describe publicly the silent war characteristics of the systemic COVID crisis in all educational materials.
- Prevent the 'othering' of communities forced to migrate because of environment, climate, ethnic, gender or social violence.
- Identify publicly the race-based, gender-based and class-based consequences of the stand-back approach.
- Campaign against vaccine and treatment-pill nationalism and their public rationales.

Institutional responses

- Support the WHO's call to give priority for COVID vaccines to go to the Global South before using those vaccines for booster shots in countries with a high vaccination rate.
- Re-purpose resources in military budgets for health, climate, care support and hunger responses at home and internationally.

4. Actively intervene to mitigate the consequences of the systemic COVID crisis

Global narrative

- Increase transparency and disclosure in all multistakeholder projects asserting they are 'fighting COVID' or claiming to support the UN system and the Sustainable Development Goals.
- Develop educational and course materials on systemic crises and power response crises.
- Support strong and diverse health care systems in developing and developed countries.

Institutional responses

- Shut down COVAX and other multistakeholder groups that claim to be 'fighting COVID' and transfer their activities and resources to an expanded WHO emergency fund, supported by other parts of the UN system.
- Campaign for a pandemic emergency tax on TNC transactions to meet the costs of systemic COVID.

- Establish a UN system registry of TNCs and related institutions actively aggravating or seeking to benefit from a COVID-type crisis; such a registry could be used to discourage investments or debt from concerned citizens, pension funds and governments.

The systemic COVID crisis, like the climate crisis, inequality crisis, care-giving crisis and the biodiversity crisis, are part of a broader systemic reality. Some of the above actions can create momentum to fix the more egregious aspects of systemic COVID. Other recommended actions can expose more clearly the flaws in the globalisation narrative and motivate communities and social movements to engage in organising to make health care a recognised global public good.

In the current dynamics, the political COVID crisis is unfortunately continuing to push people in the Global South further from the people of the Global North, aggravating the distance between people of colour and white people, and exacerbating the burdens on care givers in all regions of the world.

From a human rights, democratic or socialist perspective there is no reason why these man-made institutions cannot be fundamentally changed to make life – human and non-human life – the centre of politics and the environment.

The North's 'fighting COVID' shares similarities with other Northern 'Fights'



Endnotes

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- 44 WEF and UNICEF
- 45 University of Cambridge and World Bank Group
- 46 28 partners, mostly international businesses, and including UN Women
- 47 16 partners, almost all international businesses
- 48 Six partners, five international transport firms and WEF
- 49 45 partners, all international businesses
- 50 53 partners, a mix of international business, universities, local governments, federal government agencies and the WHO
- 51 The first window is to allow large and medium-sized countries to buy their vaccines supplies via COVAX; the second window is focused on vaccine distribution to the World Bank's 92 low-and middle-income countries (LMICs).

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- 56 Partners are WEF, a research center, and logistics firm
- 57 WEF and Spring Impact, an organization created by a WEF Young Global Leader
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