Canadian Coalition for Global Health Research (CCGHR)
& Canadian Society for International Health (CSIH) Response
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The World Health Organization (WHO) proposal for a Global Allocation Framework for COVID-19 products: Global solidarity requires addressing the structural drivers of inequities
Response to Invitation for Feedback

The rapidly escalating COVID-19 pandemic is a critical risk to global health, prosperity and security. Confronted by an urgent and common threat, governments and international partners from all sectors have mobilized with unprecedented speed to support the search for effective diagnostics, therapeutics and, especially, vaccines. Because all people everywhere are vulnerable to the SARS-Cov-2 virus that causes COVID-19 disease, global demand for treatment and prevention products is anticipated to outstrip supply in the early phases. On June 18th, 2020 the WHO released a draft allocation framework to expedite control of the COVID-19 pandemic while ensuring fair and equitable allocation of COVID-19 products,[1] using the global distribution of a hypothetical COVID-19 vaccine as an example of how it could be applied.

Yet, we are not all equally vulnerable. Around the globe, the pandemic is exposing structural fragilities – poverty, governance deficits, weak social safety nets, poorly resourced health systems, social and economic exclusion—all of which disproportionately heighten vulnerability to the pandemic and amplify its negative impacts. **Responding to the socio-economic impacts of COVID-19 is a cornerstone of the UN strategy for a better recovery.[2] Canadian leaders in global health call upon the WHO and global partners to re-examine how the WHO Global Allocation Framework addresses the structural drivers of exclusion, inequalities and discrimination.**

Analysis: Allocation criteria proposed in the WHO Framework

The WHO Allocation Framework argues for prioritization of certain populations to achieve public health goals.[1] Taking the example of allocating a newly developed COVID-19 vaccine (or vaccines) among countries, the framework argues that strategic allocation will help to maximise health impact and prevent health systems from being overwhelmed, thereby improving overall well-being and mitigating the impacts of the pandemic on societies and economies.[1] The Framework proposes that **initial country shares of vaccines be determined by their proportions of three priority populations:**

1. Healthcare system workers (medical doctors, nurses, midwives, community health workers), estimated at 1% of the global population;

2. Adults >65 years old, representing roughly 8% of the global population;

3. Adults 30-70 years old, with specific comorbidities (cardiovascular disease, cancer, diabetes, obesity or chronic respiratory disease), representing approximately 15% of the global population.

Ethical justifications are offered for prioritising each of these populations. Health care workers are prioritised because of their contribution to the health and well-being of the community, and because they may serve as transmission vectors spreading the illness should they fall ill. Older adults and adults with co-morbidities are prioritised due to their higher risk of severe disease outcomes. An upper age limit is set on those with co-morbidities, to ensure that those who receive scarce vaccines are able to benefit.[1]

Although we agree that prioritisation is necessary, we are concerned that the criteria currently proposed risk compounding the disadvantages faced by the world's poorest populations. The share of healthcare workers is lower in low-and middle-income countries, and lowest in the most resource-poor settings.[5] The same pattern holds true for adults over 65 years of age, with the oldest high-income countries having proportions of adults over age 65 close to 30%, while the youngest, located overwhelmingly in sub-Saharan Africa, have shares of less than 5%.[4] Finally, the chosen comorbidities vary substantially among countries and regions and are lowest in the poorest countries.[5] Taken in the context of vast global inequities in health, the three priority areas privilege the world's already most-resourced populations.

The selection of co-morbidities is designed to reflect who is at highest clinical risk; however due to the history of how the pandemic has evolved, our medical knowledge is nascent. The majority of research on COVID-19 disease comes from the countries that have been first or most affected, such as China, the United States, and Italy. In these countries, the risk factors leading to severe complications and mortality include diabetes, heart disease (hypertension), chronic respiratory disease, severe obesity and immune deficiency.[6-9] Severe cases and deaths are concentrated in older age groups (65 years+) and, in some countries, in men. [6, 8-10] Health conditions in many LMICs countries differ sharply from those in countries from which current COVID-19 research originates. Key unanswered questions include the possible impact of COVID-19 when pre-existing conditions such as anaemia, HIV, tuberculosis, or undernutrition are prevalent. Shaped by co-morbidities and gender norms, the gender distribution of risks and outcomes may also be substantially different in LMICs. WHO promises that the approach will be fine-tuned based on "product characteristics".[1] **We recommend that the definition of priority populations at higher risk be responsive to emerging information on co-morbidities common in LMICs**.

Allocation criteria missing from the WHO Framework

In defining who is at risk, the WHO Allocation Framework focuses on clinical markers that influence risk of severe disease. Yet, poverty and other structural drivers place some individuals and groups at much higher risk of infection and poor outcomes. The WHO defines the social determinants of health (SDH) as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[11] These determinants are the root causes of health inequities, the differences in health status or the distribution of health resources among different populations that disproportionately advantage some groups over others.[11, 12] They are particularly important for understanding the multiple, systematic disadvantages faced by the poorest populations and countries. Even in relatively wealthy nations, epidemiologic data clearly indicate that groups already facing the greatest social and health inequities also bear the brunt of the pandemic (e.g., disproportionate cases and deaths among Black and other racialized groups).

Ability to prevent exposure to the SARS-Cov-2 virus differs sharply within and among countries. Deficient water, sanitation and hygiene infrastructure, high exposure to indoor and outdoor air pollution, crowding, poor quality or precarious housing, working conditions that promote occupational exposure, and less awareness of disease mechanisms are among the important factors that may make poorer individuals and countries more vulnerable and favour rapid disease transmission.

For those who fall ill, health system preparedness and response is also a critical concern. While the world average is 14.9 doctors, 32 nurses and midwives and 28 hospital beds per 10,000 people (and the

averages for countries with high human development are respectively 30.4, 81 and 55), countries with low scores on the human development index have only 2.1 doctors, 8 nurses and midwives and 6 hospital beds per 10,000 people.[13] Compounding problems of limited access to healthcare facilities, out-of-pocket expenditures are generally higher in countries with weak health systems. Weaker health systems have lower diagnostic and treatment capacity, limited access to personal protective equipment, and a higher likelihood of nosocomial infections. As COVID-19 mitigation efforts and cases surge, weak health systems are the first to forego provision of other essential services, with devastating consequences.[14]

Finally, due to the interplay of poverty and weak social safety nets, those who are most vulnerable have little ability to rebound from stresses caused by pandemic mitigation measures or illness. The poignant struggles of migrant workers around the globe over the last months are a case in point.

As the first wave of infection peaks in North America, and as subsequent waves of infection emerge in Asia and Europe, we are reminded that the second wave of the 1918 influenza pandemic killed more people than the first. In Africa alone where the first wave is still unfolding, by the end of 2020 up to 190,000 people could die of COVID-19, and an additional 44 million people could be infected.[15]

As the world engages in unprecedented containment, control and mitigation measures, COVID-19 will continue to hit poorer countries particularly hard, where new outbreaks expose and exacerbate inequity and vulnerability. As the pandemic and its cascade effects continue to unfold, even the best case scenarios leave the UN warning of global famines that could affect 250 million people by the end of 2020.[16] Here, those most at risk are in 10 countries affected by conflict, economic crisis and climate change, or who are in other complex humanitarian settings.[17] An ethical priority setting strategy must account for these factors.

The UN Sustainable Development Goals ask us to place equity at the heart of our actions. As we struggle to emerge from the pandemic, the design of economic and social policies such as the ACT Accelerator and the WHO Allocation Framework will play a critical role in shaping life chances.[18] By failing to address the structural drivers of health and disease, the WHO Global Allocation Framework may inadvertently exacerbate vulnerabilities. We fully agree that global UN coordination is required to ensure a fair and equitable response, but this should be grounded in a broader, more inclusive vision of health determinants and outcomes. We call upon WHO and its partners to work in solidarity to address the root causes of health inequities and ensure a better recovery for all.[2]

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