ACT-A: "The international architecture did not work for us"

A new evaluation has delivered a devastating verdict of the global mechanism to provide the tools to control the COVID-19 pandemic. Ann Danaiya Usher reports.

At a time of desperate uncertainty, the Access to COVID-19 Tools Accelerator (ACT-A) was established in April, 2020, just 3 months after WHO declared COVID-19 as a Public Health Emergency of International Concern. Consisting of ten UN agencies and global health organisations, The World Bank, Wellcome, and the Gates Foundation, ACT-A aimed to develop health products for COVID-19 and to ensure their equitable distribution, while helping health systems with delivery.

The first comprehensive evaluation of ACT-A, commissioned by the Facilitation Council of the ACT-A and carried out by the Berlin-based Open Consultants, published on Oct 11, 2022, has delivered a devastating review of the effort. Based on 101 interviews with key informants, it concluded that the design was "top-down" and several aspects were misconceived. ACT-A afforded too much influence to donors and corporate partners, global targets were not met, and low and middle-income countries (LMICs)—the purported beneficiaries of the scheme—were excluded from conceptualisation. It documents particular dissatisfaction with ACT-A in Africa and Latin America.

The report recognised that ACT-A was the first global initiative of its kind, forged in the context of a fragmented global health architecture and an unprecedented health emergency. Bruce Aylward, who coordinates ACT-A at WHO, has previously described the situation: "We [were] operating in an environment where there [were] no rules of the game. And any rules that were put in place were flaunted."

However, while the report concluded that it was the "best possible structure" given the circumstances, ACT-A failed to deliver on its main goal: equity. "Almost two-thirds of respondents (65·3%) think that the operating model should not be replicated."

The absence of meaningful engagement of LMICs and regional bodies was a "strategic mistake" and resulted in a lack of ownership and affected the delivery of COVID-19 tools. No LMIC government was involved in the creation or initial governance of ACT-A, the report states. Representatives from African regional organisations reported that they "quickly lost interest in participating in the working groups" because they did not feel that their views were heard.

The Facilitation Council, a body established in September, 2020, to lead and guide the ACT-A, attempted to remedy the situation. Co-chaired by Norway and South Africa, the council initially had 26 country members with only one other from Africa—Rwanda. In late 2021, five country representatives from Africa were added to the council: Cameroon, Egypt, Malawi, Nigeria, and Uganda. But this adjustment was too little, too late.

"Inclusion is not a tick-box exercise, nor an afterthought," said Githinji Gitahi, CEO of AMREF. "It was a major gap for ACT-A not to have centred the inclusion agenda because it was for the benefit of LMICs that it was set up." This sentiment is echoed by Lawrence Gostin, Director of the O'Neill Institute for National and Global Health Law, Georgetown University, Washington DC, USA. He said that although ACT-A was the most innovative idea ever conceived to address equity in a pandemic, it "failed to listen to the voices of low-income countries and civil society. It failed to account for the greed of high-income countries in hoarding scarce vaccines and other medical resources."

The ACT-A comprised three vertical pillars for the development and procurement of vaccines, therapeutics, and diagnostics. A fourth pillar aimed at strengthening health systems was added as an afterthought. The report identified shortcomings with all the pillars, resulting from a combination of unbalanced distribution of scarce resources and inappropriate design.

Collectively, ACT-A raised US$23·5 billion from donors, which, although significant, was less than half of the minimum requested amount. These funds were heavily skewed in favour of the vaccine pillar, which received more than $16 billion.

By contrast, the therapeutics pillar received just $1·8 billion of $9·1 billion requested. The report credits the pillar with supporting research that identified dexamethasone as the first life-saving therapy for COVID-19. But by the end of 2021, of the original delivery target of 245 million doses, only 21·6 million units of dexamethasone had been shipped. Ayoade Alakija, WHO's Special Envoy on ACT-A, has pointed out that Africa has still not received a single dose of Pfizer's COVID-19 treatment, Paxlovid. The diagnostics pillar, which made substantial contributions to the development of COVID-19 tests, delivered only 97 million of the 500 million planned tests for LMICs.

The health systems pillar was considered to be largely dysfunctional; most respondents said it was "misconceived" and failed to deliver. Gitahi said "vaccines were given priority, but the wider health systems were not. Vaccines do not deliver themselves, so this approach only addresses one half of the equation." The report attributed problems in the health systems pillar to an absence of funding and to the "discordant views and approaches" between The World Bank and WHO, which oversaw the work.

For the **evaluation of ACT-A** see https://www.who.int/publications/m/item/external-evaluation-of-the-access-to-covid-19-tools-accelerator-(act-a)

For **Aylward's previous comments on ACT-A** see **World Report** *Lancet* 2021; **98:** 650–51

For more on **funding the pandemic response** see https://www.imf.org/-/media/Files/Publications/WP/2022/English/wpiea2022099-print-pdf.ashx

The vaccine pillar, COVAX, was managed by Gavi, CEPI, and WHO. The COVID-19 vaccine roll-out has been the fastest in history and unprecedented in scale, with 832 million doses delivered to LMICs in 2021 against a target of 950 million doses. By comparison, 822 million children were reached by Gavi through routine immunisation programmes between 2000 and 2019. Nevertheless, although high-income countries had access to an over-supply of vaccines early on, as of January, 2022, 34 of low-income countries still had a COVID-19 vaccine coverage of less than 10%.

Several key informants from Africa, including from African regional organisations and the African COVID-19 Commission, pointed to the inequitable global access to COVID-19 vaccines, arguing that COVAX largely failed. "I don't think the [COVAX] model can be considered a success", says Nathalie Ernoult, Deputy Head of Policy and Advocacy, Médecins Sans Frontières Access Campaign. "One size fits all is not suitable, and it didn't work."

COVAX was conceived as a procurement mechanism for the whole world, consisting of three arms: one to supply vaccines to wealthier countries, the so-called Self-financing Participants Facility; a Humanitarian Buffer to make vaccines available for people in emergencies; and one to supply vaccines to LMICs. The report concluded that the first two did not work.

The Humanitarian Buffer was meant to provide 50 million vaccines but it reached only 1·6 million doses, mainly due to problems with indemnification and liability. The self-financing arm of COVAX did not deliver as anticipated because high-income countries made their own deals with pharmaceutical companies instead of buying through COVAX. And upper-middle-income countries eligible to purchase vaccines through the self-financing facility, particularly in Latin America, were dissatisfied with its performance.

The former Peruvian Health Minister Victor Zamora Mesia concurred with this finding: "We were supposed to 'act' together. It didn't happen." He told *The Lancet* that Peru bought vaccines bilaterally from the Chinese manufacturer Sinopharm and began vaccinating at the beginning of February, 2021, whereas vaccines from COVAX only began trickling into the country in June, 2021. "As for the other tools—personal protective equipment, medical oxygen, and diagnostic tests, there was nothing…We understood very early in the pandemic, that we were alone. My colleagues in Latin America had the same experience. The international architecture did not work for us as a key element for responding to the pandemic."

The evaluation recommended dropping the self-financing participants mechanism in a future pandemic response. Gavi takes exception to this proposal. A spokesperson told *The Lancet*: "Without the upfront payments from self-financing participants, COVAX would not have had cash on hand to procure doses. This would have set equitable access back even further."

"This has not been an easy task by any means", the spokesperson said. "COVAX has had to innovate every step of the way, from building the model and raising money for it, to overcoming complex technical challenges, such as… securing scarce supplies in the face of hoarding and export bans."

A crucial gap identified by the evaluation was the failure of ACT-A to include medical oxygen as a treatment from the beginning. Oxygen was eventually placed in the health sector pillar, and was later moved to the therapeutics pillar following pressure from civil society organisations, led by the Every Breath Counts coalition. The evaluation stated that "it is unlikely that oxygen would have been neglected if LMIC representatives had been included in ACT-A".

Ramanan Laxminarayan, President of One Health Trust, New Delhi, India, said that countries also failed to recognise the importance of medical oxygen. "The lack of medical oxygen caused a significant number of deaths in India", he told *The Lancet*. "We had an entire year to prepare once we knew that this was a respiratory disease. Medical oxygen is a fairly simple intervention that could have saved many lives in the absence of vaccines or therapeutics. Nearly one-third of excess deaths due to COVID-19 worldwide occurred in India—4·5 million people—and most of these occurred before May, 2021, before the vaccines were deployed widely."

The report concluded that health systems strengthening cannot be done during an emergency. Laxminarayan agreed. "We need to think about these things to fix before the next pandemic. No accelerator can increase the number of health workers or build up a medical oxygen infrastructure", he said.

Overall, the evaluation recommended that for a future pandemic, instead of trying to provide tools for the whole world, the response should focus only on LMICs. To address the financing gap, the report recommended two mechanisms: an Advance Commitment Facility, along the lines of a proposal by Ruchir Argarwal at the International Monetary Fund and Tristan Reed at The World Bank. To ensure a fast and equitable global response in a future pandemic, this facility would have access to a credit line on day zero and an inclusive and accountable governance structure. In addition, the report recommended a complementary joint funding pool that would allocate based on needs.

Criticising the siloed approach to research and development across the three unevenly funded pillars, the report called for a joint platform for R&D that would link the three areas.

A spokesperson for ACT-A said that the agencies will be submitting their comments on the report to the council and explained "we know that the ACT-Accelerator experience has key learnings for strengthening the global health architecture for emergencies".

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