**ACT-A Communities & Civil Society Platform Call**

* **Date**: 6 August 2020
* **Organizers and co-hosts**: Global Fund Advocates Network (GFAN) and WACI Health
* **Purpose**: Follow-up to an 18 June 2020 call for civil society (CS) and communities interested in learning about the ACT-A and to provide updates on developments and opportunities regarding civil society representation and engagement.

*Summary of key discussion points[[1]](#footnote-1)*

**1. Overview of the Access to COVID-19 Tools Accelerator (ACT-A)**

* ACT-A was launched in May 2020. It is intended to be a time-limited partnership of global health actors, private sector and civil society partners, and other stakeholders. Its stated primary commitment is for ***equitable global access to innovative tools for COVID-19 for all***.
* ACT-A’s work is currently organized into four categories, or ‘pillars’: diagnostics, therapeutics, vaccines, and a cross-cutting health systems connector. The World Health Organization (WHO) provides overarching coordination and support. Other global agencies are leading on the individuals pillars: **vaccines** – CEPI and Gavi: **therapeutics** – Wellcome Trust and Unitaid; **diagnostics** – the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the Foundation for Innovative New Diagnostics (FIND); **health systems connector** – Global Fund and World Bank. Each pillar has a number of working groups/workstreams within it.
* The ACT-A Communities & Civil Society Platform was formed shortly after ACT-A’s launch. Its main initial focus has been on ensuring that CS and communities are represented in all pillars and working groups. The platform aims to support those representatives once they are selected by providing a space for information sharing, consultation and advocacy involving them and CS and communities more broadly.

**2. Update on Platform’s work**

* The Platform in July coordinated the drafting of a sign-on letter making the ‘business case’ or rationale for why civil society (CS) and communities add value and should be embedded within the vaccines pillar in all respects, including in all decisions and considerations regarding vaccine development. That advocacy letter had 175 signatures at the time copies of it were sent to all Board members prior to the 30 July Gavi Board meeting.
* GFAN and WACI Health have launched a **website (**[**http://covid19advocacy.org**](http://covid19advocacy.org)**)** to try to start getting resources and information consolidated online in one place for the Platform.
* Two selection processes for CS/communities representatives are underway. The deadline for identifying representatives for the therapeutics pillar is 9 August, although efforts are being made to get some additional time in order to find and include more people who are living with/have had COVID-19. The deadline is 14 August for the full selection process for the diagnostics pillar, which ideally also will include people who are living with/have had COVID-19.

**3. Update on engaging people living with/who have had COVID-19**

* The Platform acknowledges the importance of ensuring the direct engagement in ACT-A representation of people living with/who have had COVID-19 and a distinct group within that of people with impacts from the virus over a long period of time (‘long COVID’). This is part of a broader effort to have their voices heard and influence ACT-A decisions. A guiding principle is to try to ensure that meaningful involvement is global and from all regions.
* The therapeutics and diagnostics pillars are the main initial priorities for representation of those affected by COVID-19. Efforts in general for CS and communities representation are much further behind with the other two pillars.
* Emerging groups and peer-support networks of people living with/who have had COVID-19 can be found across Facebook and other social media platforms. Most activity is in places where the epidemic has hit hardest to date (e.g., the US, UK and South Africa), but groups are emerging elsewhere as COVID takes its toll more broadly.
* The Platform organizers have had discussions with people from ACT-A and COVID-19 groups about ***what ‘meaningful engagement’ could mean and how participation could be facilitated most effectively***. Components could include special efforts to bring representatives up to speed on the ACT-A, its structure and associated technical information; accommodations to take into account health issues of many COVID-affected individuals (e.g., selecting alternate reps in addition to main ones); and funding support for representatives, many of whom are facing dire economic situations and prospects themselves due to poor health or other effects of the pandemic and responses to it. Potential targets for requests for funding support include lead ACT agencies and international NGOs.
* As part of these processes, the Platform plans to undertake a mapping to ensure it is connecting with groups of people living with/who have had COVID-19 and understands their needs and priorities. Part of this includes thinking about communications channels as well.

**4. Updates by pillar**

**4.1 Health system connector**

* The health system connector is intended to be a cross-cutting area of work involving and linking the three main pillars but not duplicating what they are doing. It has seven workstreams, each of which has focused lately on narrowing its scope of work and identifying actions and deliverables. The seven workstreams are: health financing, community-led response, protecting frontline health workers, integrated data management, supply chain, private sector, and clinical care. They are currently at different stages in their planning and actions.
* The input of CS and communities is relevant and important across all workstreams. The sector has an especially vital leadership and action role in the community-led response workstream, which has identified addressing information, knowledge management, and leveraging existing country platforms for community engagement as three key focus areas.
* In an effort to support some ACT-A ‘quick wins’, the health system connector is initiating a country-level approach discussion in which 3–6 countries are identified to draw up an actionable road map for COVID-19 tools. Another ‘quick win’ centres on creating a survey to help selected countries identify immediate needs.

**4.2 Therapeutics**

* Workstream 1 is surveying the landscape for promising therapeutics, work that has included focusing on a couple of drugs that have shown some benefits (remdesivir and dexamethasone). Gilead’s control and pricing issues are a concern regarding broad access to remdesivir, although it has issued a voluntary license for sale in lower-income countries. A generic version is available but it is still highly priced. Regarding dexamethasone, it already is largely available in richer countries and Unitaid and other groups are seeking to get additional supplies so it will be more available in poorer ones.
* Workstream 1 is also paying attention to monoclonal antibodies, for either (or both) treatment and prevention purposes. Some antibody compounds are in position to be approved relatively quickly. A key concern will be price and availability in middle-countries (MICs) and low-income countries (LICs).
* Workstream 2 (market readiness) is trying to anticipate what kinds of interventions might be needed to ensure quality products in LICs and MICs. This is where issues such as intellectual property (IP), supply guarantees, and direct support to partnerships to scale up supply come into play.
* CS reps to the various workstreams of this pillar are seeking to increase communications among different workstreams and to set up a mechanism to get regular input from colleagues living with/who have COVID-19.
* To date, the therapeutics pillar has raised only about 10% of the budget needed to secure the supplies needed to accomplish its main goal – to have all MICs and LICs have access to all therapeutics that are identified and needed. One approach to address this might include looking at how money will be allocated through the other pillars (e.g., vaccines and diagnostics) and try to get funds for triggering a favourable market for supply of therapeutic options in LICs and MICs.

**4.3 Diagnostics**

* Several linked and complementary goals have been articulated in the pillar, including:
  + To increase access to molecular viral tests, including the establishment of a diagnostics consortium to arrange bulk purchase of testing supplies for LICs.
  + To support the development, introduction and affordability of a new antigen test that would produce faster results. Ideally at least 75% of testing demand in LICs and MICs would be met with these point-of-care (POC) tests that could deliver results as quickly as 30 minutes.
  + To get a very affordable test, e.g., around $5 or even as low as $1 apiece.
* A key issue in the pillar that needs to be decided is whether to prioritize/supply antigen tests that are device-based or can be self-read. Device-based is more expensive but has more direct and immediate connectivity for clinical care, epi tracing, etc.
* About 70 expressions of interest (EOIs) have come in to date, and are being screened down to 30 or so. The goal is to have 3 or 4 suppliers to have 300 million total tests for LICs by the end of 2021.
* An overarching issue for CS and communities (and advocacy more generally) re diagnostics is the possibility that the majority of tests will be seized and used by richer countries, thus further delaying access in poorer ones. Not a lot solidarity has been expressed; national and regionalism in terms of rushing to get products is already evident in actions by the US, Europe, Japan, etc. This heightens the responsibility and role of CS and communities to consider how to talk about the ACT-A’s equitable access mandate and then use technical information to advocate for it to be a reality.
* Modelling was done (and released in early July) to make the case for focusing on diagnostics stronger and clearer within the broader COVID-19 response. This helped to develop messaging and advocacy tools to improve communications around the issue. Key messages include that diagnostics are critical for supporting health care workers everywhere, for showing what therapeutic needs might be, and for preparing effectively and efficiently in all epidemic responses (e.g., making decisions about lockdowns). This modelling and messaging is an example of something CS has been involved in already.

**4.4 Vaccines**

* CS/communities have no engagement yet as representatives in this pillar. As a result, there is limited information on active work re the individual workstreams.
* At the 30 July Gavi Board meeting, some Board members reportedly have said there is no need for CS/communities engagement. CS has pushed back and threatened to go public. Ultimately, there was agreement at the Board meeting to accommodate CS representatives to some extent, but no decision has yet been agreed as to which working groups or workstreams would have them. Among the claims by sceptics of CS/communities engagement is that the sector does not have the right skills set or expertise to participate meaningfully.
* Gavi CS delegations have continued to push the Gavi Secretariat to accept and facilitate full CS/communities engagement in the pillar. There is a need for all involved in the Platform to do more to push for this as well.
* Several notable and relevant content discussions occurred during the Board meeting. Among those are areas where CS and communities are likely to want to engage, including vaccine affordability and expense (i.e., price per dose); concern that multiple doses could make everything much more complex and expensive; IP arrangements (including how and when to use flat and tier pricing); allocation framework; and the possibility that manufacturers could raise prices and be less accommodating a year or more down the line after the products are first introduced.

**5. Q&A input: selected requests for Platform attention**

* ***Diagnostics reliability***. Antigen and antibody tests had not been highly reliable to date. In addition to focusing on different modalities (e.g., POC), the diagnostics pillar could/should focus on getting truly reliable tests as well.
* ***Reaching and supporting people with ‘long COVID’.*** Distinct diagnostics might be needed to identify people with ‘long COVID’. This seems important for their care and support as well as in response to observations that viremia is changing over time among them as they continue to experience symptoms and impacts. From a therapeutics perspective, many people experience this disease as a multi-organ syndrome and not just one affecting the lungs. Thus, the therapeutics pillar is encouraged to look at treatment and care from the widest perspective possible.
* ***Equitable access to diagnostics***. Wealthier countries already seem to be hoarding diagnostics and leaving little for developing countries. CS/communities representatives already in place (e.g., in the therapeutics and diagnostics pillars) have begun taking steps toward making a stronger case that equitable access is not being discussed at a high level across ACT-A despite being a core mandate. These conversations and efforts ideally will become stronger and have more impact after all CS/communities representatives are in place.
* ***Youth participation and engagement***. Young people and their organizations are encouraged to apply for positions within the ACT-A pillars (information is available on the Platform website). Another entry point is to reach out to selected representatives and bring to them the ideas and issues of students and other youth.

**6. Communications and collaboration**

* Mapping is being undertaken to ensure that the Platform is connecting and communicating with as many CS/communities groups as possible. A Google group will soon be set up for people to sign up for. Advocates are urged to share with their networks and communities more widely to ensure more who are interested can be kept up to date.
* Collaboration and information-sharing with others from the CS sector working on COVID-19 issues is a top priority across the Platform. The mapping work also aims to identify those groups and structures. One example is the COVID Advocates Advisor Board, which focuses primarily on research advocacy vis-à-vis COVID-19. (Details are available at [www.avac.org/blog/avac-itpc-tag-and-global-partners-launch-new-covid-advocates-advisory-board](file:///C:\Users\FirstNameHere\Documents\ICSS%20and%20GFAN\GFAN,%202020\GFAN%20Strategy%20Development%20support\Covid%20work,%20ACT-A\www.avac.org\blog\avac-itpc-tag-and-global-partners-launch-new-covid-advocates-advisory-board) and <https://covidadvocates.org>.)

1. More detailed and additional information about the call is available on the Platform’s website, including the full recording of the call and slides of some of the presentations. <http://covid19advocacy.org/calls-details-and-notes/> [↑](#footnote-ref-1)