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Working Upstream

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Canada is no global health leader on COVID-19 vaccine equity

In the 2018 *Lancet* Series on Canada's global leadership on health, the authors reported on measures such as the Feminist International Assistance Policy and concluded that "the world, more than ever, needs Canada's leadership on health".[1] Unfortunately, Canadian leadership on vaccine equity was an early casualty of COVID-19. A year into the pandemic, Canada's international image is that of a country who secured over ten doses of scarce vaccine per capita.[2]

Weeks after its vaccine portfolio made headlines worldwide, Canada remained silent on what would happen to its extra few hundred million projected doses; Prime Minister Justin Trudeau finally made a vague commitment to share surplus, not in an official policy but in a television interview.[3] Little has happened since. Canada has not responded to calls for immediate donations for health-care workers and the most susceptible abroad; despite releasing official timelines outlining when Canada will have more doses than it needs, Canada has not yet announced a corresponding timeline for sharing its excess supply.[4]

Canada's defenders will correctly note that the country has been a major financial contributor to the COVAX initiative and the Access to COVID-19 Tools Accelerator. However, COVAX would have worked far better had Canada (and other countries) not actively subverted the initiative through bilateral deals with vaccine suppliers, thereby pushing COVAX towards the back of the line for scarce global supplies. Writing a generous cheque is less meaningful when there is little to purchase.

Actions speak louder than Canadian officials' frequent recitation that no one is safe until everyone is safe. In February, 2021, despite explicit entreaties by WHO, Canada signed yet another bilateral agreement (its eighth), this time with the Serum Institute of India, a primary COVAX supplier. Around the same time, Canada also requested vaccines directly from COVAX in the first round of distribution, the only G7 country to do so. Although legally entitled to this request, bolstering its bilateral deals by drawing on this low supply at a time when countries dependent on COVAX had yet to receive a single dose should not be considered global health leadership. Canada's obfuscatory stance to the World Trade Organization on temporarily waiving intellectual property rights during the pandemic, even as the country rapidly amended its own domestic laws along similar lines, has also done little to burnish its global image.[5] The sad conclusion is that although the world desperately needs more vaccines, it does not need more of this kind of Canadian leadership.

ARH works for Doctors Without Borders/Médecins Sans Frontières Canada in a role relating to access to medicines. SM declares no competing interests.

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Working upstream

Michael Westerhaus

For more on the **Movement for Black Lives** see https://m4bl.org/

Health-care workers often conceptualise addressing the social and structural determinants of health as working upstream.[1] In response to the racial disparities of the COVID-19 pandemic and the Movement for Black Lives, health systems are acknowledging systemic racism, promoting implicit bias training, and screening for the social determinants of health. Although welcome, these changes will not achieve the social transformation necessary to eliminate health inequities. We must move even further upstream.

Water Protectors, working upstream on the Mississippi River in northern Minnesota, USA, provide a model of what this work entails. They are a mix of Indigenous and environmental activists who are resisting construction of the Line 3 tar sands pipeline. Line 3 will be able to move up to 915 000 barrels of tar sands oil per day across hundreds of water bodies and wild rice beds, a nutritious grain integral to the Ojibwe people (also known as the Anishinaabe people) that does not grow anywhere else in the world. The pipeline will traverse sovereign treaty territory where Ojibwe people maintain the rights to hunt, fish, gather, and practise cultural traditions. Chronic disease, carcinogenic pollutants, and climate change are the possible downstream consequences of Line 3 on the health of humans, land, and water.[2,3]

For more on **Line 3** see https://www.stopline3.org/#intro

In response, Water Protectors are acting to directly obstruct the flow of capital and challenge endless resource extraction. They lobby congress, protest in the streets, testify in courtrooms, implore divestment from banks funding pipelines, create camps on the basis of mutual aid, and physically impede construction.

Health-care workers and health systems seeking to erase health inequities can learn a great deal

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from the Water Protectors. First, addressing the social determinants of health requires dismantling the upstream systems of power that structure society, such as racial capitalism and settler colonialism.[4] Second, working upstream requires a collective, longitudinal pursuit of justice. The movement to resist Line 3 has been organising for 13 years, building restorative communities and germinating relationships of trust among multisectoral coalitions. Third, human and natural ecosystem health is inter-related and we must prioritise addressing climate change as essential health work. Fourth, just as some Water Protectors risk arrest or danger to their bodies, so too must health-care workers risk confrontation with power holders in our health-care and political systems.

In our efforts to deeply engage with the social determinants of health, Water Protectors, who prevent the destruction of life and assert the sovereignty of Indigenous people, are an exemplar of truly upstream health and healing.

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For more on **COVAX** see https://www.gavi.org/covax-facility

Vaccine scarcity in LMICs is a failure of global solidarity and multilateral instruments

To address COVID-19 vaccine scarcity, Ivan Sisa and colleagues[1] justify placebo-controlled trials in low-income and middle-income countries (LMICs), arguing that these countries have “less capacity to negotiate and purchase vaccines than do high-income countries” and that the global shortage can be overcome with more vaccine producers coming from such trials. We are concerned that this reasoning sets the wrong precedent because approving such a trial should show that evidence can only be reached with this design.[2] Furthermore, LMICs should not ignore the urgent need to increase production and distribution[3] of already efficacious vaccines.

In the interest of saving people’s lives, vaccine development demands working towards improved capacities on the road from discovery (free of patent restrictions) to manufacturing and equitable distribution. Therefore, clinical trials should be done simultaneously, engaging volunteers and researchers across a broad range of LMICs and high-income countries. Furthermore, study protocols should provide robust assurances that participants will have access to the vaccine when their priority group is eligible in the general population. Finally, emphasis should be made on other pressing issues, such as adopting low dead space syringes to prevent discarding residues, thus improving vaccine volume.[4]

Ensuring efficacious vaccines are made widely available and at fair cost, when high-income countries are hoarding up to five times what they need[5] and prices are speculative, would require making alliances with countries (eg, Brazil or India) with the capacity to produce generic vaccines, alongside efficient syringes, and means of storage and transportation. Notwithstanding, LMICs will need support from additional partners in other regions of the world.

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Global COVID-19 vaccine roll-out: time to randomise vaccine allocation?

The global COVID-19 vaccine roll-out might be the largest public health exercise ever done. COVAX, the vaccines access pillar of the COVID-19 Tools Accelerator, supported by WHO, UNICEF, and others, expects to deliver two billion doses to 190 countries in 1 year. At present, 13 vaccines have received approval in various jurisdictions. The roll-out provides an opportunity, unparalleled in human history, to learn about vaccines.