## Open letter to the United Nations

## Health Inequity during the Pandemic: A Cry for Ethical Global Leadership

**H. E. Mr. Antonio Guterres,**
**Secretary General of the United Nations**

As public health and healthcare, scientific, academics, and related institutions, we are gravely concerned about the escalating impact of the COVID-19 pandemic among already vulnerable and marginalized populations worldwide. Media reports are surfacing of higher infection rates and mortality in underserved populations. From New York to New Orleans and Chicago in the US, to the shocking pictures of bodies lying in the streets in Ecuador, we see a prelude of the coronavirus impact in low- and middle-income countries, home to more than 80% of the world's population.

Disadvantaged and marginalized populations are more at risk to become infected. They have increased risk of exposure due to overcrowding in dwellings and neighbourhoods, have less access to basic sanitation, are more likely to use public transportation and have jobs that do not allow them to work from home. Additionally, in many parts of the world, everyday challenges of a precarious life may outweigh perception of risks presented by the coronavirus pandemic, making people less likely to engage in preventive measures, many of which—like social distancing and frequent handwashing—are luxuries they simply cannot afford.

When infected, marginalized people are more likely to evolve to severe cases as they suffer disproportionately higher rates of chronic diseases, obesity and malnutrition. They are also less likely to have access, if any, to testing and treatment, including hospitalization and intensive care, since hospitals in their communities are already inadequately staffed and resourced and in many, care implies high out-of-pocket expenses. For the most vulnerable citizens of the world, all these factors increase the likelihood of dying.

Despite ominous warnings, most health systems are not prepared to deal with a pandemic of this magnitude, a situation exacerbated by the for-profit model where health is treated as a commodity and not a basic human right. Common challenges include severe deficits in numbers of qualified health personnel, hospital infrastructure and equipment, hospital and ICU beds, personal protective equipment (PPE), testing supplies from swabs to reagents, means for quality control of tests, and access to medicines (even if experimental). If Chinese, Italian, Spanish and US healthcare systems are being overwhelmed, we can only imagine the impact in less affluent countries.

This situation has brought out the best in human nature, namely solidarity. Many stories circulate on kind neighbourly support, and commitment of frontline healthcare workers and of those who maintain essential services during lockdown. However, we are also witnessing the worst responses, from hoarding of food staples and hygiene supplies by people blind to the needs of others, to hoarding of PPE, laboratory tests, medicines and ventilators by wealthy nations, frantically outbidding each other. In the same nations, the media reveal plans to secure patents and benefits from effective vaccines and life-saving drugs, as we saw 30 years ago with HIV/AIDS. This hoarding frenzy is in response to panic, but is also coupled with an attempt to extract profits from the crisis. So, we must ask: What will happen to those who do not have the economic muscle to outbid the big players? Will the scenarios for them be still more bleak as new medicines and vaccines are developed?

Hoarding should be condemned in the strongest terms. In a time of shared anguish like this, we should be able to step back and unite in solidarity, so that everybody has at least a better chance at surviving this universal, yet unequal threat, which will have an unfair impact depending on where one lives.

We propose that the UN Secretary General provide the necessary support to the World Health Organization (WHO), by creating a multi-sector "Global Health Equity Task Force" to confront the impact of the COVID-19 pandemic in its full health, socio-demographic and economic dimensions. The Task Force would act to support coordination with pertinent UN bodies, including the Inter Agency Standing Committee COVID-19 Outbreak Readiness and Response, the Economic and Social Council (ECOSOC) and, if needed, enlist the support of the Security Council and the General Assembly.

The Task Force, housed within WHO, would be charged with taking the necessary steps to exert needed global leadership for a comprehensive, equity-focused response to the pandemic, guided by the ethical principles of justice, beneficence and nonmaleficence and the Universal Declaration of Human Rights. It would encourage international cooperation towards fair allocation of resources to all countries according to need.

The Task Force would develop necessary international norms to support regional production of quality generic medicines, supplies and equipment. Consistent with Sustainable Development Goal 3 of the 2030 Agenda (*Ensure healthy lives and promote well-being for all at all ages*), these norms should abolish patents for any pandemic-related supplies, equipment, medicines and vaccines. It should support quantification and forecasting of needs, taking measures to safeguard an equitable and viable global supply chain with the necessary logistical support.

It would concentrate on development of enhanced recommendations on preparedness and response, to increase surge capacity modalities to meet the needs of our highest-risk, most vulnerable populations worldwide, including communities living in poverty; those with high prevalence of co-morbidities; racial, ethnic and religious minorities; and people living in shelters, detention centers, immigration camps and conflict zones.

The Task Force should also advise countries and regions on coordinated, fair and equitable de-confinement strategies, while laying the foundation and promoting steps to strengthen universal health systems globally and to minimize the appalling economic and social disparities that have led to this magnified inequity in COVID-19 outcomes.

Mr. Secretary General, the organizations who sign this letter ask Your Excellency to grant our request and involve the pertinent bodies and programs of the United Nations, in order to support efforts to prevent the disastrous effects expected by the arrival of the pandemic to the world's most disadvantaged and marginalized people. The sheer magnitude of the impact of this pandemic requires bold interventions to protect those most in need.

## List of Institutions

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| 1 | World Federation of Public Health Associations - WFPHA |
| 2 | Latin American Alliance for Global Health - ALASAG |
| 3 | World Public Health Nutrition Association - WPHNA |
| 4 | African Federation of Public Health Associations - AFPHA |
| 5 | African Nurses and Midwifes Network - ANMN |
| 6 | Alliance of Public Health Associations in the Americas Region - APHAAR |
| 7 | Public Health Asia- Pacific Regional Liaison Office - APRLO |
| 8 | Caribbean Public Health Agency – CARPHA |
| 9 | European Public Health Association – EUPHA |
| 10 | Health Equity Network of the Americas - HENA |
| 11 | International Medical Society of the Latin American Schools of Medicine -SMI-ELAM |
| 12 | Latin American and Caribbean Association of Faculties and Schools of Medicine (ALAFEM) |
| 13 | Latin American Association of Collective Health – ALAMES |
| 14 | West African College of Physicians, WACP, Accra, Ghana |
| 15 | Academy of Medicine of the State of Rio de Janeiro – ACAMERJ / Brazil |
| 16 | Afrihealth Optonet Association [CSOs Network], Nigeria |
| 17 | Argentinian Association of Public Health – AASP / Argentina |
| 18 | Association of Health Economics - AES / Argentina |
| 19 | Brazilian Academy of Rehabilitation Medicine / Brazil |
| 20 | Brazilian Academy of Sciences - ABC / Brazil |
| 21 | Brazilian Association of Collective Health – ABRASCO / Brazil |
| 22 | Brazilian Centre of Studies of Health - CEBES /Brazil |
| 23 | Brazilian Mental Health Association – ABRASME/Brazil |
| 24 | Brazilian National Academy of Medicine - ANM / Brazil |
| 25 | Brazilian Society of Analytical Psychology / Brazil |
| 26 | Chilean Health Society / Chile |
| 27 | Chinese Preventive Medicine Association / China |
| 28 | Colombian Association of Public Health / Colombia |
| 29 | Community Health International Medical Projects for Sustainability, Seattle, WA, US |
| 30 | Cuban Association of Public Health / Cuba |
| 31 | Dominican Society of Public Health / Dominican Republic |
| 32 | Dr Uzo Adirieje Foundation (DUZAFOUND), Nigeria |
| 33 | Ecuadorian Society of Public Health / Ecuador |
| 34 | Ethiopian Public Health Association (EPHA) / Ethiopia |
| 35 | Latin American Faculty of Social Sciences (FLACSO CHILE) |
| 36 | Faculty of Health Sciences, Atacama University /Chile |
| 37 | Faculty of Public Health, University of São Paulo, Brazil |
| 38 | Fides et Ratio Academy / Brazil |
| 39 | Global Health International Advisor – GHIA / USA |
| 40 | Guatemalan Association of Public Health Specialists / Guatemala |
| 41 | India Critical Care Nurses Society, Mumbai / India |
| 42 | International Primary Care Respiratory Group, Scotland |
| 43 | Institute of Public Health of the Andrés Bello University /Chile |
| 44 | Institute of Social Medicine, State University of Rio de Janeiro – UERJ / Brazil |

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| 45 | Jungian Association of Brazil – AJB / Brazil |
| 46 | Kenya National Union of Medical Laboratory Officers – KNUMLO / Kenya |
| 47 | Latin American Institute for Peace and Citizenship - ILAPYC /Argentina-Panama |
| 48 | Liberia College of Physicians & Surgeons - LCPS / Liberia |
| 49 | Liberia Medical Dental Association / Liberia |
| 50 | Liberia Midwives Association/ Liberia |
| 51 | Liberia Nurses Association / Liberia |
| 52 | Liberia Society of Critical Care Nurses, LSCCN / Liberia |
| 53 | Medical Education Cooperation with Cuba –MEDICC / Cuba |
| 54 | Mexican Association of Public Health / Mexico |
| 55 | National School of Public Health, Fiocruz / Brazil |
| 56 | Near East Foundation / Mali |
| 57 | Nigeria Universal Health Coverage Actions Network (NUHCAN) / Nigeria |
| 58 | Panamanian Society of Public Health / Panamá |
| 59 | Pak One Health Alliance, Islamabad / Pakistan |
| 60 | Peruvian Network of Teachers and Training Institutions in Public Health –REDISP / Peru |
| 61 | Professores da UFRGS pela Democracia / Brazil |
| 62 | Public Health Association of Australia / Australia |
| 63 | School of Public Health Salvador Allende, Universidad de Chile / Chile |
| 64 | Slum and Rural Health Initiative / Nigeria |
| 65 | Solidarity Network in Defence of Life, Pernambuco / Brazil |
| 66 | SOS Sahel Ethiopia / Ethiopia |
| 67 | Uganda Public Health Association / Uganda |
| 68 | University of Wisconsin - Madison's Global Health Institute / US |
| 69 | Venezuelan Society of Public Health / Venezuela |
| 70 | Veracruzana Society of Public Health / Mexico |
| 71 | West African College of Nurses, Liberia Chapter/ Liberia |

## Coordination and Letter's Drafting Team

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