Achieving Global Vaccine Equity

The U.S. government can and must lead the charge for the equitable and efficient distribution of vaccines throughout the world.

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BACKGROUND

The approval and rollout of vaccines to protect against COVID-19 has provided the world with some relief and hope after more than a year of disruption and grief. Globally, the disease has marked over 216 million cases and killed nearly 4.5 million (although actual numbers are likely multiple times higher than official counts).[1] As the pandemic has left no country or community unaffected, the impacts on already poor and vulnerable communities have been disproportionately worse.[2] Our global health and economic security lie in the balance. While the United States has been a leader in helping to vaccinate the world, there is still much more to do to reach the estimated 4.8X return on investment as the global economy recovers.[3] Alternatively, we will be left to stand by as a largely unvaccinated world continues to navigate this pandemic; the global economy already lost over $2.4 trillion in 2020 due to loss of tourism alone, and it stands to lose as much as $9.2 trillion by the end of the pandemic. [4][5]

Reaching herd immunity against COVID-19 through vaccination is the only ethical and life-saving approach to ending the pandemic, requiring an estimated 11 billion doses to vaccinate 70% of the world's population (assuming two doses are given per person).[6] Yet inequalities in access to vaccines is staggering: 82% of the world's COVID-19 vaccine supply has been administered to high income and upper-middle income countries; 57% of high-income countries' populations have been vaccinated, compared to just 2% of low-income countries.[7, 8] As of July 7, 2021, low-income countries had received just 1% of the estimated 3.3 billion vaccine doses administered worldwide, and deals made by wealthy nations to secure vaccines for their own populations have driven up prices and potentially delayed COVAX deliveries.[9] At the current rate of vaccination, it is estimated to take 4.6 years to reach herd immunity globally.[10] The constant mutation of the virus makes a case for drastically increasing the rate of global vaccination.[11]

EXISTING EFFORTS

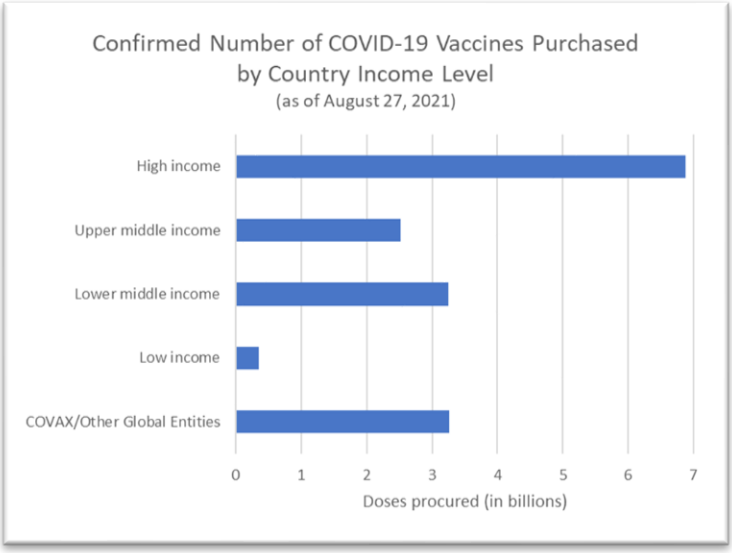
The ACT-Accelerator is well into its second year of operation, celebrating its scientific advances to confront COVID-19 along with the history-making collaboration of global health organizations, governments, foundations, civil society, scientists, and the private sector. However, as of August 13, 2021, with $18.1 billion committed to its efforts, the ACT- Accelerator was still short $16.6 billion to develop and deliver tests, treatments, and vaccines needed to bring COVID-19 under control.[12] Fully financing the ACT-Accelerator for 2021 would cost less than 1% of what governments are spending on stimulus packages to treat the consequences of COVID-19.[13]

We commend the USG for its pledge of $4 billion toward the global vaccine campaign[14] and the broader $10.8 billion committed toward the international COVID-19 response. We also support the U.S. commitment to share 500 million vaccines with other countries, of which 110 million have been shared.[15; 16] The U.S. will also draw on at least $100 million in existing regional vaccination efforts focused on

immunization to boost capabilities and work with the Quad countries to achieve expanded manufacturing of safe and effective COVID-19 vaccines.[17]

However, existing funding and efforts are still not enough to meet the evolving needs caused by the pandemic. Gavi and WHO estimates an additional $6.8 billion will be needed for COVAX to procure the doses necessary to reach the 2 billion doses by the end of the year,[18] and additional funding will be required to ensure vaccines become vaccinations.

CURRENT CHALLENGES TO VACCINATING LOW-INCOME COUNTRIES



Source: Launch & Scale Speedometer, https://launchandscalefaster.org/covid-19/vaccinepurchases

Supply of vaccines may be outcompeted by wealthy nations. The COVAX facility has already procured and distributed over 224 million doses of COVID vaccines to 139 economies worldwide, with an expectation to deliver 2 billion doses by year end.[19],[20] However, as Henrietta Fore, Executive Director of UNICEF explains, "[T]his is no time to celebrate; it is time to accelerate. With variants emerging all over the world, we need to up global rollout."[21] This is predicated on additional supply of doses that COVAX will be able to procure. However, high-income countries bilaterally securing and purchasing these doses has pushed others out of the market, driving up the cost and delaying the delivery timeline of the vaccine. Currently wealthy nations have secured 6 billion of the estimated 8.6 billion doses that will be produced by year end.[22, 23]

Getting vaccines from port into people arms. While COVAX is an extremely valuable system for the procurement and delivery of vaccines, it is only set up to get vaccines to the point of entry. The act of getting the vaccine into the arms of willing individuals who may live in remote outposts, or conflict zones, is quite another undertaking. Currently, the WHO estimates that as of 2018, 74 of 194 WHO member states had no adult vaccination program for any disease, which will require immunization registries for adults, as well as the storage, delivery, and waste management systems needed to administer vaccines at this scale.[24; 25] A joint readiness assessment conducted by the World Bank, WHO, UNICEF, the Global Fund, and Gavi in November 2020 in more than 100 low and middle-income countries found that while 85% of countries have developed national vaccination plans, only 30% have developed processes to train the large number of vaccinators who will be needed for the

campaign and only 27% have created social mobilization and public engagement strategies to encourage people to get vaccinated.[26]

As the CARE report, "Our Best Shot: Women Frontline Health Workers in other countries are keeping you safe from COVID-19" estimates, "for every $1 a country or donor government invests in vaccine doses, they need to invest $5.00 in delivering the vaccine."[27] This includes the costs associated with funding, training, equipping, and supporting health workers—especially women—who administer vaccines. Further, campaigns will have to include education, connecting communities to health services, and building the trust necessary for individuals to get vaccines.[28]

Vaccine hesitancy may be higher in low-income countries. The lack of vaccine acceptance in some African countries has caused some governments, such as Malawi, Senegal and South Sudan, to have to destroy expired doses.[29] A 15-counrty survey conducted in December 2020 by the African Centres for Disease Control and Prevention showed that a predominant majority (79% average) of respondents in Africa would take a COVID-19 vaccine if it were deemed safe and effective.[30] There is still variance, however, where one study reported a 56% acceptance rate from the Democratic Republic of the Congo, with concerningly low rates among health-care workers; a 15% COVID-19 vaccine acceptance rate among a relatively young adult cohort in Cameroon; and 86% of participants in a unpublished survey done by the Rwanda Biomedical Centre in November, 2020, documented that were willing to take a government-approved COVID-19 vaccine.[31] Additionally, there were substantial differences in acceptance rates within the DRC: as high as 84% in one province and less than 40% in others.[32] In general, "[r]espondents who are older, those who know someone who has tested positive for COVID-19, and those who live in rural areas are more inclined to take a COVID-19 vaccine than younger people, those who have not seen COVID-19 affect anyone, and those living in urban areas."[33]

Hesitancy is also driven by mis- and dis-information campaigns aimed at anti-vaccination. A study done by the Boston Medical Journal found that the prevalence of foreign disinformation activity was "highly statistically and substantively significant" in predicting a drop in average vaccination rates.[34; 35] For COVID-19 specifically, conspiracy theories have reached top government officials, where Tanzania's President John Magufuli dismissed COVID-19 vaccine as "dangerous for our health," and has not accepted any COVAX doses for his country.[36] The president of Madagascar has touted an untested herbal remedy for COVID-19. Conspiracy theories abound, including that the COVID-19 vaccines are designed to quell Africa's population growth.[37]

POLICY RECOMMENDATIONS

Catholic Relief Services (CRS)' work is rooted in the principles of human dignity and the preferential option for the poor and vulnerable. We believe it is essential for these values to be reflected in the equitable global distribution of COVID-19 vaccines. Our collective well-being depends on the health and well-being of our entire global family.

The U.S. has a moral imperative to help those around the world and historically, administrations and members of both political parties have believed that international efforts to alleviate suffering, reduce poverty and promote peace align with U.S. moral values and fosters good will around the globe. In addition, the interconnectedness of the world has been on full display during the pandemic and as UN Deputy Secretary-General Amina Mohammed noted, "no one will ever be truly safe until everyone is safe."[38]

Stemming the spread of the virus through a comprehensive plan for vaccine procurement and distribution in low-income countries will be critical for getting back on track for positive development trajectories. It is essential that the USG leverage its policies, programs, funding, and diplomacy to facilitate the equitable, effective, and efficient distribution of vaccines to individuals around the world. This is not only the right thing to do, but also a key element to ensuring U.S. security now and for the near future.

To move us closer towards vaccine equity, the U.S. should:

1. ***Put equity first: Immediately share more vaccine doses and materials with LICs.*** The U.S. currently has a growing stockpile of vaccines. As of August 10, 2021, the U.S. had over 55 million doses of the vaccine in storage while only vaccinating approximately 900,000 people per day; meanwhile, more than 25 million unused doses are estimated to have expired in July 2021.[39; 40] The U.S. must prioritize ensuring that these lifesaving vaccines are not wasted and instead get in the arms of those who need it most – at home and abroad.
   The U.S. has committed to sharing 500 million vaccines with other countries (at a rate of 200 million per year). Only 110 million have been shared so far.[41;42] Of all G7 commitments made in June 2021, only 10% of doses have been delivered.[43]
   The U.S. must make it an urgent priority to meet and exceed its distribution goals. The goal of sharing 200 million doses this year is not sufficient. Some health experts suggest the U.S. should export 10 million vaccines per week.[44] We urge the USG to increase its goal significantly, accelerate the distribution timeline, and establish channels to safely and legally reroute vaccines that are set to expire if they remain within the U.S. The U.S. and other wealthy nations must not only deliver on their promises, but also demonstrate that purchases of vaccines targeting the unvaccinated here and providing boosters in America are not compromising the global effort.
   To be a credible leader at the COVID Summit and to address unfulfilled commitments across the G7, the U.S. must deliver.

2. ***Display global leadership in funding, sharing, and distributing vaccines equitably.*** The U.S. should provide additional funding and support to the ACT-Accelerator to ensure that the $4 billion contribution to COVAX for vaccine procurement and distribution gets vaccines into the arms of those who need it. Assert leadership on the global stage to prioritize and coordinate pandemic response funding and decision making, particularly through the COVID Summit and the G20. Prior to the summit, the U.S. must share a concrete implementation plan and have resolved key barriers imposed by U.S. -based vaccine manufacturers. In addition to the support for supplies through COVAX, the USG must provide support to holistic national plans that address both supply and demand. As the U.S. continues and increases investment, it must ensure accountability through transparency on how funding is spent.

3. ***Increase manufacturing capacity for vaccines globally.*** Ensure concrete action on the TRIPS waiver and technology transfer to speed and scale up the production of lifesaving vaccines by waiving the

intellectual property barriers to address immediate needs and invest in regional manufacturing hubs.[45]

4. ***Leverage diplomatic, economic, assistance and other means to ensure inclusion of the most vulnerable, including refugees, IDPs and the stateless into vaccine schemes***. The IASC estimates roughly 167 million individuals are at risk for exclusion from national vaccine plans due to conflict, natural disasters and displacement.[46] A WHO analysis of National Deployment and Vaccination Programs found that migrants, refugees and internally displaced people (IDPs) are not included in many countries national COVID immunization plans – 72% of countries did not include migrants, 61% did not include refugees and asylum seekers and 63% did not include IDPs.[47] We strongly support the Humanitarian Buffer created as part of COVAX, which has recently been reduced to a 5% set aside for vulnerable groups who are not included in National Deployment and Vaccination Plans – including staff in humanitarian contexts. However, while this buffer provides some relief and support, it is meant to be a "plan B" and is not enough to cover all vulnerable groups. It is essential that the USG use its leverage to push countries to include these groups into their national plans at the onset. Furthermore, the USG should encourage all countries to prioritize the most vulnerable people in their vaccine distribution plans.

5. ***Utilize faith groups and faith leaders to disseminate positive messaging for vaccine acceptance and to counter mis- and dis-information.*** Biomedical advances alone are insufficient to sustainably control a pandemic. "Considerations related to health infrastructure, local epidemiology, and responsiveness to local concerns and beliefs are critical for ending the COVID-19 pandemic."[48] Faith Based Organizations (FBOs) have a rich history of supporting health crises within their communities, notably including their well-documented success in promoting vaccinations against Polio in Nigeria in the early 2000s.[49]

   In general, local faith leaders tend to be trusted by their community, and therefore are an essential resource to encourage their congregants to receive vaccines and dispel any disinformation about the vaccine's safety or effectiveness. FBOs can be further utilized to help broker and support local ceasefires in conflict zones so that vulnerable people are able to get vaccinated. We encourage the USG to work with local faith actors, as well as support ongoing efforts by the United Kingdom to call for these vaccine ceasefires.[50]

6. ***Continue to strengthen health systems while distributing vaccines.*** As the world continues to address the acute needs of protecting and vaccinating people against COVID-19, it is more important than ever that we continue to strengthen the health systems, to prepare for the prevention and treatment of future pandemics and outbreaks. The U.S. should increase support to Global Health and invest in the Global Fund, which has been an indispensable vehicle to work towards ending AIDS, tuberculosis, malaria, and now COVID-19.

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