COVID-19 Vaccines: Is equity between North and South still possible?

Heba Wanis

Abstract

This article explores global vaccination inequity and wether equity in this regard is achievable between North and South. It covers the challenges faced by health systems in the region during the pandemic, issues of equity in access to the vaccine, and the developments and barriers relevant to vaccine production in the South. This article is based on the discussion during our centre's webinar "Decolonising Access to Health, Addressing Vaccine Inequity in MENA" on 2 September 2021.

Keywords: MENA Region, Right To Health, Vaccination Inequity, Social Justice, Crisis Prevention & Recovery

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The global supply of COVID-19 vaccines has been controlled by countries with financial and political means, leaving behind most of the world's developing regions, including the Middle East and North Africa (MENA). Almost 75 percent of the approximately 5 billion vaccine doses administered globally have been used by just 10 countries.[1]

The global vaccination targets set by the World Health Organisation (WHO) are to have countries vaccinate at least 10% of their populations by the end of September 2021, at least 40% by the end of 2021, and ultimately 70% of the world's population by the middle of 2022.[2] These targets are overly ambitious in light of the current global situation.

At the beginning of the pandemic, there were global calls, led by the WHO, for collective action to minimise vaccination disparity between countries so that their economies and purchasing power would not be the determinant of access. Despite that, governments sought to secure their stocks of vaccines, mostly through bilateral advance purchase agreements, some of which agreed long before clinical trials were concluded. Some countries have even ended up with millions of surplus doses. The result is the situation which are currently facing: a North-South divide, unfortunately making vaccine inequity a characteristic of the global response to COVID-19.

Regional public health challenges: health systems tested

The COVID-19 pandemic has tested the resilience of public health systems worldwide, including in the Eastern Mediterranean Region (EMR) where it exposed the fragility of medicine and vaccine supply chains.[3]

As a result of COVID-19, nearly 75% of essential health services experienced some level of disruption in the EMR, such as routine immunisations and chronic disease management, including cancer care.[4] Vulnerable communities in the region still lack social or financial protection which would otherwise give them access to healthcare services, and these include populations impacted by conflict and state fragility, refugees, migrants and those in the informal sector.[5] Besides, the economic conditions and high rates of poverty in the region are determinants of people's health. Nearly 77 million people in the region went through financial hardship in 2015 by spending more than 10% of their resources as direct out-of-pocket payments in relation to healthcare.[6]

That said, the MENA region has had its share of unequitable access to vaccines despite its 15 million confirmed COVID-19 cases and 278,000 deaths at the time of writing.[7] According to the WHO, low vaccination coverage in several countries in the Eastern Mediterranean Region (EMR), especially low- and lower-middle income ones, has become a concern, primarily due to limited deployment capacities. This is taking place at a time when countries such as Egypt, the occupied Palestinian territory, Somalia, the Syrian Arab Republic, and Yemen are reporting significant surges in COVID-19 cases and deaths.[8] Furthermore, disparity in vaccination rates exists within the MENA region. For example, the United Arab Emirates has fully vaccinated 79% and partly vaccinated 11% of its population, reaching a total coverage of 90%, while Syria has only fully vaccinated 1.1% of its population.[9] The African Region as well demonstrates flagrant vaccine inequity. Only 87 million doses have been administered in the African region, out of the 5 billion doses administered globally, which is less than 2 percent of the global figure. In Africa, only 4 countries could vaccinate at least 10% of their populations, whereas globally 140 countries reached that target.[10]

Vaccine nationalism: access for those who can afford it

Bilateral advance purchase agreements between high-income countries and vaccine companies have led to an imbalanced global distribution of vaccine doses. Rich governments have stockpiled vaccine doses that go beyond their national needs, thus depriving other countries of extra doses to cover their populations. Approximately 26 million unused doses of COVID-19 vaccines were reported in the USA in July 2021, which are enough to vaccinate 13.1 million people. This is in addition to significant quantities of Pfizer vaccine doses which were due to expire in August 2021. In the UK, doctors have also reported that thousands of Pfizer and Moderna shots had to be discarded for fear of their expiry. After vaccinating 80% of all above 16 years and administering boosters to high-risk groups, the UK will still have 219 million surplus doses at the end of 2021. In other words, vaccine purchasing orders by the UK led to a stock of around seven vaccine doses per capita.[11]

In a call to reduce vaccine inequity, the Director-General of the WHO has called for a global moratorium on booster doses until at least the end of 2021 in order for the world to achieve global vaccination targets.[12] He spoke against the widespread use of boosters for healthy people when health workers and at risk-people around the world are still waiting for their first dose.[13] The global state of fear of further outbreaks, as well as political pressures driven by the continued economic repercussions of the pandemic, have been in favour of administering booster doses.

Initiatives seeking equitable access: a global disappointment

Several global access-related initiatives have been established and have gained international support, yet with disappointing delivery in terms of ensuring equity. One of the earliest initiatives towards equitable access was the COVID-19 Technologies Access Pool (C-TAP) adopted and hosted by the WHO in partnership with some international organisations. The C-TAP is an entity whose purpose is to enable holders of intellectual property rights and clinical data to contribute by giving access to such knowledge and technologies to third parties to develop and produce diagnostic tests, medicines and vaccines. It was welcomed by UN agencies and was launched in May 2020 with the support of 40 countries. However, since May 2020, not one vaccine originator has shared related technologies through this voluntary platform.[14] This was indeed indicative of the trend in major countries to act individually with respect to the provision of treatment and vaccines, each according to their respective economic capacity.

The COVAX Facility, which is the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator co-led by the WHO, is a global risk-sharing mechanism for pooled procurement and equitable distribution of COVID-19 vaccines. It seeks to provide global equitable access to vaccines worldwide through the provision of two billion doses by the end of 2021. COVAX has later established a mechanism to support access to COVID-19 vaccines in areas of humanitarian crises: COVAX Humanitarian Buffer. It is a 'last resort' measure to ensure access to COVID-19 vaccines for high-risk and vulnerable populations in humanitarian settings such as refugees, internally displaced persons, populations in conflict or those affected by humanitarian emergencies.[15]

Economically, the COVAX facility represents an opportunity for countries to protect the world economy – and consequently its interests – by supporting the immunisation of the populations of developing countries. Economic models developed to support this argument have demonstrated that countries that do not vaccinate 60% of their population by mid-2022 will suffer GDP losses totalling USD 2.3 trillion by 2025, with the MENA region bearing the second biggest losses after Asia-Pacific. Two thirds of projected losses will be borne by emerging economies, delaying their convergence towards advanced economies.[16] Another model showed that if the vaccine is not provided to the populations of developing countries, the world economy could incur a loss of up to USD 9.2 trillion, half of which would be borne by richer countries.[17]

Surprisingly, despite the ambitious mandate and promising potential of COVAX, bilateral deals between governments and vaccine manufacturers appeared to be more feasible. Moreover, COVAX has not received the political and media support it merits as an important global initiative.

So far, COVAX has shipped over 270 million vaccine doses to 141 participating countries.[18] In the meantime, the United States alone administers 3 million doses daily.[19] Through the COVAX Facility, the EMR has so far received 51.54 million out of the 89 million doses allocated to its countries.[20]

There is a need for vaccine donation from countries with surplus doses to those in need.[21] However, donating surplus doses might not be easy, because many surplus stocks are reaching their expiry date. This problem threatens to undermine donations from wealthy countries to the COVAX Facility, as well as the relatively high level of vaccine acceptance in low- and middle-income countries.[22]

Vaccine production in the South: developments and barriers

Vaccine manufacturers need to prioritise deliveries to low and lower-middle-income countries, and to eliminate export restrictions on vaccines and raw materials.[23] The Group of Seven (G7) committed to provide about 500 million doses in 2021. A total of 1 billion doses should be shared in 2021, of which at least 250 million should be made available by September 2021.[24]

Vaccine production capacity needs to be increased, particularly in the South, to supply domestic and global demand at affordable prices. Established pharmaceutical bases in developing countries have the capacity to host production of coronavirus vaccines. The MENA region has already witnessed some positive steps in terms of local production. Egypt is a prime example, where the government-run Holding Company for Biological Products and Vaccines embarked on a joint venture to locally produce Sinovac, with plans to cooperate with another European vaccine manufacturer.[25]

The most significant barriers to local production in developing countries are related to intellectual property rights of COVID-19-related knowledge and the necessary transfer of technology. To address this major barrier, negotiations are currently underway at the TRIPS Council of the World Trade Organisation (WTO) to waive COVID-19-related intellectual property rights in order to ensure effective responses at affordable prices, including diagnostic tools, vaccines, and medicines.[26] This proposal was initiated by developing countries led by India and South Africa.

Developed countries, particularly the EU, Japan, and Switzerland are opposing the TRIPS waiver.[27] Also, multinational pharmaceutical companies oppose this proposal under the pretext that IP rights are important to incentivise research and development in the pharmaceutical industry.[28] In fact, it is this incentive to innovate that is usually raised by owners of pharmaceutical technology to justify the importance of IP rights. However, it does not warrant this persistence on the use, or rather abuse, of IP rights, particularly at times of health crises, which call for countries to implement exceptional and legitimate procedures to protect the rights of their people. Thus, many developing countries are still defending their right before the TRIPS Council based on the principles of the TRIPS Agreement and on the grounds of global solidarity among world countries at times of crises.

The costs of inequity are immense at the political, social and geopolitical fronts, and radical transformational actions are necessary for the world to recover. These are unprecedented times that the world is witnessing. They are times of fast change and harsh realities, with many lessons to learn at both the national and global levels. The question remains: Is equity still possible?

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