Online Event

“A Global Approach to COVID-19 Vaccination”

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FEATURING:
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Anuradha Gupta,
Deputy CEO, Gavi, The Vaccine Alliance

Jeremy Konyndyk,
Senior Advisor, Office of the Administrator, U.S. Agency for International Development

Muhammad Ali Pate,
Global Director, Health, Nutrition and Population Global Practice, World Bank and Director, Global Financing Facility for Women, Children and Adolescents (GFF)

Julie L. Gerberding,
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Good afternoon, evening, morning, wherever you happen to be. I’m J. Stephen Morrison. I’m a senior vice president at the Center for Strategic and International Studies in Washington, D.C., where I direct the Global Health Policy Center. Welcome to this timely gathering, organized by the CSIS Commission on Strengthening America’s Health Security, entitled “A Global Approach to COVID-19 Vaccination.” If you’re going to take a break from the impeachment trial, this is the event to select.

This event is part of a series of public discussions the commission is holding over the next few months on global immunization programs in the COVID-19 context, and the links to health security and U.S. national security. A previous session on January 29th looked at sustaining routine immunizations while preparing for COVID-19 rollout. The next session will focus on U.S. support for global immunizations and COVID-19 vaccines. Subsequent to that we will also examine country experiences and the issue of equitable distribution of the vaccines later in the spring.

We’re thrilled that our commission co-chair Julie Gerberding will preside today. She’s executive vice president and chief patient officer at Merck, and former CDC director. We’ve assembled a remarkable group of speakers today, whom Julie will introduce momentarily. A personal, special thanks to each of them, who remain close friends of our program. Norwegian Ambassador John-Arne Røttingen, Anuradha Gupta from Gavi, Muhammad Pate World Bank, and Jeremy Konyndyk from USAID. And a special thanks to my colleagues who put this together – Katherine Bliss, Michaela Simoneau, John Monts on the CSIS production team; and also from the Norwegian embassy Sigri Stokke Nilsen was very instrumental in organizing our opportunity to bring in Ambassador Røttingen. So thank you all for being with us. I hope you enjoy this. We have a lot on our program.

Over to Julie Gerberding.

Thank you, Stephen. And thank you, everyone, for joining us. Steve, I really want to give you a personal note of thank you for your leadership of this whole focus area for CSIS, and certainly your support for the commission. I think I can speak on behalf of my co-chair Kelly Ayotte that we really are in awe of your leadership. And your ability to bring together such august leaders as we are enjoying on our panel today is just one piece of that. So thank you, Stephen. Thanks to your team.

I have the distinct honor of introducing our panelists today with a little bit of background about the activities of COVAX, how it fits into the broader ACT accelerator effort, and kind of the stage setting for the really important topics that we’re going to take on as we go forward today. For those who aren’t familiar with the background for all of this, the ACT accelerator was started last year in response to the pandemic as a mechanism to bring
together the community of entities on a global basis who needed to collaborate in creating the tools to combat the pandemic.

The ACT accelerator’s focusing in five main areas – on tests, on treatments, on vaccines, on health system strengthening, and then of course around all of that is the access and allocation, a major focus of our discussion today as we move into the vaccine pillar. And the COVAX facility, which is really the manifestation of that pillar of the overall ACT accelerator.

So it is amazing, and I think in a testimony to the advances that science has been able to create over the past many years but also the intense collaboration, commitment, and investment on the part of a number of private sector partners as well as governments, that we have so many vaccines advanced this far in such a short time in the pandemic. It’s almost miraculous. But advancing vaccines through the pipeline and even scaling their manufacture is just a piece of the problem. We also have – the final hurdle in all of this is how do we get vaccines allocated, delivered, and trusted by the people who need them the most? Daunting challenges for all of this.

So let me say a little bit more about COVAX. COVAX was launched in April of last year, of course, in response to the pandemic. The idea of COVAX is to really coordinate the requirements for vaccine development, procurement, and deployment. The governance is coordinated by Gavi, The Vaccine Alliance, the Coalition for Epidemic Preparedness Innovation, CEPI, and the WHO, the World Health Organization. The COVAX facility is inclusive of the research, the development, and the manufacturing of the vaccine candidates, but also acts to help negotiate their pricing and the fair allocation decisions.

The priority startup aim is to have 2 billion doses available by the end of 2021, which we predict would go a long way to protecting the highest risk and the most vulnerable people, as well as frontline health workers around the world. This is a challenge. Everyone understands that. But I think, you know, we can be cautiously optimistic based on what’s happening in the first quarter of this year that we are now underway toward this goal. Science is on our side certainly, as I’ve said.

On the other hand, Mother Nature isn’t necessarily on our side. And as we learn more about the virus, its drifting, and what that may mean in terms of the requirement for changes in the 1.0 vaccines or additional doses of vaccines, this is probably going to be a moving target. And we’re going to have to think ahead of that curve in the scenarios that might influence our ability to accomplish what we hope COVAX will be able to do.

Just by way of a little context, right now there are 190 – soon be 191 economies participating in COVAX, once the U.S. government completes its commitment. These include 92 countries with advanced market purchase
agreements. I think it’s fair to say that the announcement of the indicated implementation of allocation – and when I say indicated – indicative distribution what I really am talking about the intent to allocate doses when they’re available and authorized.

For the first part of this year, 240 million doses of the Oxford AstraZeneca vaccine licensed to Serum Institute of India, 96 million doses of the AZ Oxford Gavi advanced purchase agreement doses, and 1.2 million of the Pfizer Bio and Tech doses have been evaluated through this indicative distribution model already. So that’s good news. It means people can plan or at least have some scenario planning that’s reality based. But again, that is a long way from the 2 billion doses we hope to have available by the end of this year.

So I think it’s fair to say that the rollout of this first year of vaccine, working out the complexities of these procurement, payment, pricing, and allocation schemes, and most importantly investing in the systems necessary to deliver them, is a daunting challenge. We have never accomplished anything like this on this timeline in the history of the world. So kudos to the incredible commitment of the teams of people around the world who are working on it, but also to the expertise of our panelists who are contributing in various ways to the success of this effort.

So without further ado, I’d like to introduce the panelists. Each of them are going to say a few words and then we’ll have some open-ended questions and answers and discussion among the panel. And please use the function to submit your questions, because we will try to be as inclusive as we can of the things that our audience is focused on.

So we have as our first – our first panelist – (coughs) – excuse me – John-Arne Røttingen – I have a hard time with your last name, Ambassador – who is a dear friend and has been at the health ministry in Norway, but is also a special advisor to the WHO for these issues, and a colleague in the public health world. The ambassador has been a long-time champion of infection control, infection containment, and various other public health measures during his evolution in Norway. But he’s going to take on the overall topic of how are we doing, what can we expect to accomplish through this effort, and what has to be true to bring the promise of our vaccine technologies to the people who need them.

Thank you so much, Julie. Thanks a lot. And I would also like to extend my thanks to Steve and the team. It’s actually four years since I was here at CSIS, just in the aftermath of the Ebola outbreak in West Africa, and had the opportunity to try to mobilize for CEPI, the Coalition for Epidemic Preparedness Innovations, as just mentioned by Julie now a part of the COVAX partnership, the COVAX pillar of the ACT-A partnership. So it’s great to be back. And I really am very hopeful as well to be back in the United
States given the new administration and given the very clear and strong signals from U.S. government.

So Julie has already excellently set the stage for both ACT-A and COVAX. And in many ways, I would say that this overall partnership is unprecedented in addition to the sort of the scientific deliveries that have been actually happening over just less than a year, because this is an example of a partnership where in many ways from bottom up, from the individual organizations, they came together, they saw that they could deliver more collectively than actually each one of them could do alone.

And that was then linked to a very clear top-down call for action from heads of state, G-20, the World Health Organization. And that met in sort of forming the ACT Accelerator, as Julie said, in April. In addition to the vaccine pillar we have heard about, the three organizations – Gavi, CEPI, and WHO – we have on the diagnostic side defined the PDP, developing diagnostics together with the Global Fund. They are helping both to develop rapid tests, as well as making sure that they can be delivered at large scale. And by procurement, by making sure that we – there is a demand for rapid tests and these things, we can also reduce price. And that has already been achieved. The price of these rapid tests have been halved during the work so far.

Then, on the therapeutics side, we have Unitaid and Wellcome Trust, and also with the Gates Foundation, both making sure that we early on have learned from the work we do in the chemical world, the repurposing of drugs, identifying most hopeful drugs – and among them includes dexamethasone, an old drug, a steroid – but also making sure that we actually can deliver oxygen and the very basic support need – patients need to survive when they have the most severe form COVID-19. And then also represented here is the Health Systems Connector. The World Bank together with the World Health Organization and the Global Fund making sure that we can also deliver the other tools necessary, and also implement them in an integrated way in health systems.

ACT Accelerator has already actually achieved quite a lot on the ground. We are on track to deliver 2 billion vaccines, just described by Julie. I think that’s fantastic. We have delivered 350 million rapid tests. And the goal is to expand that sizably now into 2021. Governments have committed. Altogether there has been a commitment of $6 billion U.S. to this collective enterprise from quite a broad group of contributors – not only including sovereign states but also including foundations, including companies, and individuals. And that’s also unprecedented in such a short time. And in addition, we are waiting here – and we may hear more about that later in this panel – but $4 billion indicated by the U.S. government to go for COVID-19 vaccines and vaccinations, which is also very promising.
But we are, as Julie also said, in a bit of an uncertain time. On the one hand, we have a very positive change that we now can actually start and have started rollout of vaccines. And we have entered the era where we actually can start to prevent. But of course, the supply is limited and we need to work on that. And that we will discuss in the panel today. Secondly, we see the emergence of virus – viral variants. One is just a natural evolution of the fact that this is a new virus. It is gradually adapting to the host – the human host. And it means that the more people it infects, the more is the chance of that becoming more effective. So we see the virus with higher ability to replicate, higher ability to transmit, and also somewhat higher severity in some patients.

So that’s a concerning factor. And we see in addition that some of these viral variants may escape, at least partly, the tools we have developed – some of the vaccines, some of the monoclonal antibodies that are also key for treatments. So I think this really demonstrates it’s now an unprecedented moment to do what is even more difficult than developing and approving vaccines in less than a year. And that is to scale this up globally or global rollout. And that’s really now the task of ACT-A. We have just revised – and I should say we because I’m really here representing the President of South Africa Ramaphosa and the prime minister of Norway because they are leading the facilitation council of ACT-A. And together with around 35 other members, the facilitation council has the oversight of making sure that we can mobilize politically, strategically, and also financially towards these goals.

I talked about six-plus, potentially 4 billion raised. But we need in total $27 billion to fund this program for 2021. That’s a huge amount. But when we know that the same countries have invested $12 trillion in economic stimulus packages – which is really important for our economies – if you do the calculations at least around 30 billion (dollars) is actually just a quarter of a percent of that total economic policy stimulus. So if you know, this is the most effective, most cost effective, the best return on investment, the best multiplier effect of any economic policy tool, my message today is really we need to do this together collectively. And I’m so glad that the U.S. is back on the stage. Back to you, Julie.

Thank you for that. And we’ll come back to this issue of the total financing that we need to pull this off in a moment. Thank you.

Our next panelist is Anuradha Gupta, who many of you know as the deputy chief executive officer of Gavi, The Vaccine Alliance. She joined Gavi in 2015 and has really been a champion of many important dimensions of Gavi, but in particular putting equity and gender at the forefront of the decisions that are made there, and certainly bringing that dimension to the whole conversation about Gavi, Gavi’s role in COVAX, and what we can learn from Gavi as we look forward to the allocation and equitable distribution of the tools we have in the context of the pandemic.
So, Anuradha, I know one of the things that you're keeping your eye on is that equitable distribution, with the stated aim of assuring that 20 percent of the high-risk populations in all of the participating countries would have access to vaccine. So can you tell us what has to be true and how you see our approach to achieving that objective?

Anuradha Gupta: So thank you, Julie. And let me first begin by highlighting the growing nexus between equity and health security. And most of you are aware, Gavi is very focused on advancing equity in immunization. However, in this highly interconnected world, in which all the new pathogens are spreading really fast from one country to another, Gavi has also been at the forefront of health security. And that is why when COVID pandemic engulfed the world early last year, we really had no time to lose to rally support for this global effort, which is now called COVAX. Basically, to ensure swift, fair, equitable distribution of COVID vaccines.

And we have, and would continue to argue, that no one is safe until everyone is safe. And that it is in the interest of advanced economies to fully back COVAX with their voice, money, and actions. You are aware that we are administering the COVAX facility. And of course, we are hugely helped by our experience of being the single largest procurer of childhood vaccines, and our tremendous expertise in innovative finance, global pulling of demand, and also incentivizing large-scale manufacturing of vaccines at highly, highly affordable prices. And actually, it is this comparative advantage that has helped us bring together 190 economies, encourage their demand pulling and pool procurement, and offer volume guarantees which are backed by advanced market commitments.

You mentioned the deal with Serum Institute of India. In fact, it was $300 million in prefinancing that helped Serum Institute of India ramp up production, which has resulted in a supply agreement with COVID for more than a million doses of AstraZeneca and Novavax enterprise, which is capped at $3 per dose. We are, of course, concerned about bilateral deals. But I think the good news is, as you said and Ambassador John said, that COVID has, despite bilateral deals, already secured more than 2 billion doses of a diverse portfolio of vaccines. And more deals are in the negotiation.

If we now succeed in putting these two billion shots into the arms of high-risk and vulnerable populations in an equitable manner in every country within this year, I really think we could change the course of this pandemic. We are, of course, expecting that supplies to countries will commence in a few weeks, and then ramp up in the second quarter of the year. However, ultimate success would also depend on how countries build public confidence and use limited and free supplies in a highly planned manner, force-targeting those who need these shots the most.
And finally, as the ambassador also said, COVAX would need more money to accomplish its mission. So among COVAX participants, 92 countries face very tough fiscal challenges. And that is why we have set up COVAX AMC. We have, of course, succeeded in raising $6 billion. And we are very thankful to the generous support by the new U.S. administration, which has pledged $4 million. But we, of course, need much more funding. And I would argue that the case to invest in vaccine equity is very compelling from the perspective of global health security, but also as an economic and moral imperative.

Globally economy stands to lose as much as $9 trillion in case developing countries do not get access to COVID vaccines. And we should not forget that an additional 150 million people may slip into extreme poverty by the end of this year. And this is not a small catastrophe. Advanced economies have already spent trillions of dollars on pandemic-related stimulus packages – as the ambassador highlighted. And yet, it is insufficient. And on the other hand, we see that poorer countries have very little capacity to provide any similar assistance to their people.

So in my opinion, time is of the essence. Any delay would mean prolonging the pandemic with debilitating consequences for the whole world. More transmission means more variants, more adaptations of vaccines, potentially more boosters, more need for funding, more time for the economic recovery, and meanwhile more poverty, more hunger, more deaths. Not just from COVID, but also disruption of essential services and reversal of decades of hard-won deals, something that a beleaguered world can ill-afford. And I would stop here.

Anuradha, thank you for that sobering reality check, but also in a sense a call to action. So I really take your comments to heart.

Our next panelist is Dr. Muhammad Pate, who is the global director of the Health, Nutrition and Population Global Practice at the World Bank. And is also the director of Global Financing Facility for Women, Children and Adolescents, based in Washington. Dr. Pate was until recently the CEO of Big Win Philanthropy, which was based in the U.K. And prior to that, he’s had a number of important leadership positions, including that of minister of state for health in the Federal Republic of Nigeria.

So, Muhammad, you know, here you are at the Bank. The Bank has made a commitment of, I believe, $12 billion to help support countries’ procurement of vaccines and supplies for immunization programs. That in and of itself is a daunting challenge, to figure out how to allocate that resource, how to get the funds to flow through various government systems. Can you tell us a little bit more about how that will be organized and how you will go about adjudicating the complex decisions and processes that have to be bridged in order to make this a reality? And thank you for joining us.
Thank you, Julie. Before I respond to your question, let me just sort of extend a little bit of what Ambassador as well as Anuradha mentioned. Inequality undermines health security. But health security also undermines economics and national security. We’ve seen that in the pandemic. And I think it behooves all of us to come together in order to solve it, because the three are interconnected.

So in terms of the Bank’s response, very early in this pandemic the Bank realized that this was something that required huge and unprecedented level of capability for the Bank itself to support client countries to respond to the health, social, and economic consequences of this pandemic. And it announced a large package of support for countries. And in health, the initial support was built on a framework we called the MPA, multiphase approach framework, that put $6 billion initially for emergence response, to protect frontline workers, to get the essential equipment that is needed to strengthening health systems, and anticipated vaccines, diagnostics and therapeutics will become available.

So that framework in early April was approved and started to provide really intense support for countries. More than 110 countries have been able to access those resources. More than half of those resources have already been dispersed or committed in terms of live, immediate support for countries to rise up to the occasion. Now as the discussions on ACT-A and COVAX unfolded, to which the Bank is a core part of that effort, we realized that there would be need for additional resources from the multilateral financing industries to complement what the global mechanism that is being put together will be able to provide to countries.

So in October the Bank’s board approved additional financing of $12 billion. So, all in all, $18 billion in terms of the health support from the World Bank, $12 billion of additional financing, 6 billion (dollars) for IDA countries and 6 billion (dollars) for the IBRD countries within their envelopes – within their lending envelopes for IBRD, but also within their allocations for the IDA countries. Now, that was to finance the procurement, but also the delivery because, as we know it’s only buying the vaccines. The implementation, the execution, the deployment of the vaccine is equally important for us to be able to get the full benefit of it. And to do it well building health systems, which we know that the secondary health crisis that the COVID pandemic unleashed is also wreaking a lot of havoc in terms of lives lost.

So that’s the framing of the 12 billion (dollars) that the Bank has put in. Now, to get countries moving since October we have worked with WHO, UNICEF, Gavi, Global Fund and ourselves collectively have sent letters to more than 126 – 140 countries actually, that we’re working together to assess their readiness so that they have deployment plans. As we expect, 123 of those countries have completed at least one readiness assessment and have begun their deployment plans. The gaps that would be identified
can be locked in even before the vaccines arrive in countries. You don’t start preparing for vaccines when the vaccines are at the airport.

So things like having the policies in place, making sure that the allocation criteria are fair and equitable, the cold chain infrastructure, logistics, the community engagement, the regulatory reform. All of those elements before the vaccines come. So we’ve deployed a lot of effort, together with the partners that I’ve mentioned, in this direction. And as we speak, more than almost 35 countries are in our pipeline in terms of accessing those resources in a way that is complementary to COVAX. The ones that will be approved tomorrow, for example, all of them are really building the Bank’s financing on top of what they will be able to get 100 percent subsidized through COVAX. And in addition, getting support on the delivery, on the exit, on the implementation of the vaccination campaigns in their countries.

And through the Global Financing Facility, which is a multinational trust fund hosted at the Bank, we’re also thinking that whole financing to ensure that the essential health services that are critical are also supported, even as we roll out vaccines. And here, Norway has been a very key partner, as well as several other partners in that direction. So that’s the way we are thinking of the Bank’s support, that it’s complementary within the context of COVAX but also within the broader ACT-A alliance, which we have been part of since the very beginning.

Julie L. Gerberding: Muhammad, thank you for that. And I want to just add a more personal perspective in your role on the Global Financing Facility for Women, Children and Adolescents, the GFF, which is something that my own program at Merck – the Merck for Mothers or Amnesty for Mothers in other parts of the world, has been participating in. It gives me confidence, because that particular innovative financing mechanism has really taught us a lot, but also has made a tremendous impact. So what you’re doing through the Bank, you know, along the lines of financing for COVID I think is – the GFF portends a good prognosis for what you’ve taken on. And I just really appreciate that support.

We’ll move to our last new panelist. Jeremy Konyndyk is a senior advisor on COVID-19 to the administrator of the USAID, the Agency for International Development. And I’m just going to say right now that Konyndyk is a hard name to pronounce. So is Gerberding. So I hope you all understand that we are very well-intentioned here but I apologize if I have made mistakes in proper pronunciation. I practiced, but I think I have failed you, Jeremy.

At any rate, Jeremy was a former senior policy fellow at the Center for Global Development, where he focused his research on humanitarian response, policy reform at USAID, and global outbreak preparedness. I can’t think of anyone really more prepared and more qualified to engage on these topics. But I’m also – as an American I’m extremely proud that the
Biden administration has stepped up to really engage with COVAX, with Gavi, with the WHO, and through bilateral channels. So I think we’ll all be interested in your remarks on our priorities from a U.S. perspective for COVAX, how our investment for procurement and distribution through Gavi will be channeled, and what kinds of additional commitments might we look forward to from the U.S. government. So thank you, Jeremy.

Jeremy Konyndyk: Thanks so much, Julie, for that generous introduction. And I’ve heard every variation of my last name, so don’t worry. (Laughter.) So and thank you also to Steve and CSIS for organizing this. It’s a really timely and important discussion.

On behalf of the new administration, I am – I share all of your enthusiasm for the U.S. really returning to the table in a strong way in the fight against the global dimensions of this pandemic, in addition to obviously the serious domestic situation that we have right now in the United States. President Biden is extremely committed to fighting this pandemic as a global pandemic and fighting it in a global way.

And, you know, a few – just a few initial signs of that, you can already see one of the first actions that he took as president on the afternoon of January 20th was returning the United States to the World Health Organization. The following morning at the World Health Organization executive board meeting Dr. Anthony Fauci announced that the U.S. would be joining COVAX and the ACT Accelerator platform. And as several other panelists have mentioned, the U.S. is also teeing up some very significant support.

So we are with the generous support of Congress through an appropriation at the end of last year, we are – you know, we will be committing funding to Gavi over the next two years. And that’s – it’s wonderful to have that funding in hand. So there will be more – I don’t want to get out ahead of the process on kind of the specifics of that yet, because we’re still working that through, but we – you know, we are really grateful to have that – you know, be able to provide those resources to Gavi over the next two years for the important work of COVAX.

We also want to be – we want to be clear that the fact that the U.S. has this money does not let other donors off the hook. So we are – we are late to the game, but it’s very important to us as well that as we are going form sort of, you know, no commitment to COVAX to a very large commitment to COVAX, that we are also engaging with other donor countries to use that funding to increase everyone’s level of ambition with regard to COVAX, not so simply kind of plug the existing gaps in fundraising and let everyone else off the hook. And we’ll have – we’re trying to come up with some creative engagement on that and working with Gavi on that.

We are – we are also, you know, in the early stages still, but figuring out how we will – how we will address our posture globally to really take on
this pandemic in a comprehensive way. And as Anuradha said, this is – you know, we often say no one is safe until everyone is safe. And that’s more than just a slogan. It really needs to be the centerpiece of our policy on the pandemic. And I think that the variants that – the issue with the variants that we’ve seeing over the last few months really underscores the stakes here. This is an outbreak – this is a virus that has been with us for just over a year now.

And in that year, we have seen multiple variants emerge that have enhanced the risk of this – of this virus, including, based on some of the recent data out of South Africa, potentially compromising one of the major global vaccine candidates, or at least, you know, having – showing potential to do that. Also other strains showing potential to be more transmissible and possibly more severe. So you know, if that’s what’s happened in a year, and a year when global transmission was probably lower than it might be in the year ahead, then we face real risks the longer that this outbreak goes unchecked – this pandemic, rather, goes unchecked globally.

So we really all need to redouble our efforts and enhance both the scale but also the speed of global vaccination efforts. So as we are thinking about how to do that, and we haven’t figure it – you know, figured out every aspect of the new U.S. policies yet, you’ll be surprised to hear – (laughs) – but we’re working hard at it, three issues that are really at the forefront of our mind that I want to highlight.

The first is equity. So today President Biden announced a new Health Equity Task Force for the U.S. response. And we are applying a similar equity lens to the global response. And we are really focused on ensuring that as – and working with COVAX and with other global partners – to ensure that as vaccines are made available in other countries, that countries are distributing those in an equitable way. And in a way that goes to – targets marginalized populations, whether that is politically marginalized people who are citizens of the state, whether that’s refugees and IDPs, ensuring that there is equity in the prioritization in the distribution of doses within countries, just as we are trying to do in the U.S. And, you know, it’s a struggle. So it will take some work.

The second piece that we are really prioritizing is country readiness and delivery. We are hearing from many of our USAID missions around the world a lot of concern about country readiness to deliver a population-level vaccine program. And, you know, here again we can look to the United States to see what the challenge of that is. Even in our own countries we are really struggling, states have struggled, the federal government is working through a lot of challenges on this right now. So it’s not an easy thing. And most of the excellent vaccine work that the global health community does is focused on subsets of populations, not the entirety of populations.
And so here we really need to do a simultaneous mass vaccination of the entire world as quickly as possible. That is a pretty unprecedented challenge and will require a lot of support to country readiness. So it’s encouraging to hear the sort of things that Muhammad was talking about that the World Bank will be doing. It’s certainly a priority for us USAID. And we are looking at both using some of the new funding that the president has requested from Congress in the emergency package, as well as realigning some of our existing resources to support that.

And then finally, you know, a point that we know from past vaccination challenges and past outbreaks, but I think really bears repeating, is that this cannot only be about COVID-19. We also need to understand the wider health context that people are living within in their countries. You know, we have seen with polio – and there was an article in The Wall Street Journal just in the past few days about how in Pakistan there is – there is some hesitancy around polio vaccination because it’s the only kind of support people are being offered.

And so if you have someone who has a variety of health needs and the only one that the global health community is supporting them for is a particular disease vaccination, that’s not going to be well received. We see that same dynamic in eastern Congo with Ebola vaccination. Villages that had not hear from the government or heard from the World Health Organization or health NGOs for decades suddenly, you know, we’re having vaccine teams just to give them a COVID – or, sorry – an Ebola vaccine. Well, we need to be more comprehensive. We need to understand that for people to receive this and accept this it needs to speak to them and support them where they are in their broader constellation of health needs, not just the ones that are kind of the flavor of the month or the year.

So all of those are major priorities for USAID as we move forward on this. Thank you.

Julie L. Gerberding:

Thank you. It’s good to hear that level of commitment and also the frontline priorities that you have been emphasizing in terms of understanding the context in which this vaccine program is delivered, and how it ranks in priority with other issues at the country level – something we easily forget.

So we’ve heard from our four panelists, who obviously are very serious, committed experts, and I think who have painted a pretty sobering reality of the challenges with some optimism in the surround sound space. If I were going to paint a word picture of the assembly of your remarks, I think the most dominant word that I heard was “equity.” And I think that’s really important. One dimension of that that I wanted to – and I’ll probably start with you, Anuradha, on this but other please chime in.

And that is while we are gaining confidence that we’ll have doses of vaccine sufficient to meet the high-level objectives, there is a disequilibrium in what
vaccine is going where. First of all, among the highest income countries, 75 percent of them have started vaccination, whereas among the lowest income countries less than 10 percent have started the vaccination program, and the upper and lower middle income countries are somewhere in between those. So there’s an inequitability in time to initiate the vaccine program.

In addition, there’s an inequity in which vaccines are available where. We know, for example, that the Russian vaccine is being used almost entirely in the lowest-income countries whereas the Pfizer and Moderna vaccine are used almost entirely in the high-income countries right now. So, you know, we have sort of this inverse correlation. And I think it’s understandable why things have evolved in this direction, and yet that’s one of the main goals of COVAX, is to try to balance that equilibrium. So I’ll start with you, and maybe we can talk about what can we do to try to rebalance that portfolio and improve the overall availability of vaccine for the highest-risk people.

Anuradha Gupta: So thanks, Julie. And I think this is a very important issue, that when we talk about equity, you know, there are multiple dimensions to this whole puzzle of equity. So first is really making sure that the rich and non-rich countries have access to vaccines in much the same fashion, right? So that, of course, at the macrolevel we have already spoken about that. But if we just sort of dive a bit deeper, then I would say there are a couple of things. One is the timing issue, as you said. You know, and timing is important. So in some countries, vaccination has started and in many other countries vaccination is yet to start. And I think that’s not something that we think is good, right?

So we really need to now get vaccines out as quickly as possible to all countries. And that is why we are now hopeful that in the end of February at least some doses would start to get into countries, and with a ramp up in March. But of course, there are several assumptions there, right, that manufacturing would be on track, you know, regulatory approvals would be obtained in real time, shipping doses to countries would not be an issue, countries would be ready then, you know, to roll them out, and that there would be vaccine confidence. So one is the timing issue.

To me, the second is also the speed issue, right? That sort of what is – what is the speed with which first we access doses and then get them out to countries, but then also the speed at which countries are able to vaccinate their populations? And we have seen that in the first wave of countries where vaccination has already started there have been many hiccups, right? And there are several countries where vaccination rates are really low. So Israel is one of those countries, you know, where we see now more than 50 percent of vaccination coverage, but there are others which are at 2 percent, 3 percent, you know. Also some cases of 100 percent.
So I just think then we’re focusing attention on country readiness. And when we are talking about lower-income countries, this is going to become a very big challenge. And this speaks to then the issue of product choice and product mix. So we know that Pfizer is a product which has certain special requirements which a lot of countries simply cannot provide for. And that is why when the first wave of countries was being considered, you know, for Pfizer rollout, actually the number of countries that were prepared or that were deemed ready to actually roll out Pfizer was very small. So 18 countries in the first wave. Though, you know, there was interest from countries, but it wasn’t backed by readiness.

Then to me the last dimension really is scale. You know, so there are countries which now, of course, you need to vaccinate 75-100 percent of their population. I mean, the target is 100 percent. Now, it depends on how many people actually come forward and to finally take the vaccine. But within COVAX, we are sort of hoping that we will do at least 20 percent, and more if we get funding. But the question is whether that is enough, right? So and that may still leave a very big gap in these countries, and still continue to pose a challenge in terms of equity. So I really think in terms of our product mix just making sure that the products that we buy and procure actually also match the infrastructure that exists in different countries. And of course, then epidemiology is going to become a very immediate consideration if there are variants. Over.

Julie L. Gerberding: Yeah. John-Arne, I think related to this is that last mile consideration. It’s the last mile and the last inch. And, you know, we have put so much investment in vaccine development and manufacturing. Have we invested in health system strengthening and really building up the ability to move these vaccines into the arms of the people who need them?

John-Arne Røttingen: I think unfortunately the simple answer is no. And there has been a lot of costing studies done on what needs to be done to actually cover that gap of just the very basic level primary health care service in low- and middle-income countries. And those costs are huge. And of course, now that we really need that system to deliver, as Jeremy indicated, and we need – because we need trust in the population. And we cannot just come in with one intervention and say, now you need to get this.

We actually need to deliver a holistic service of health care, build trust, and where vaccines is a part of that totality. So I think this also speaks actually to a much wider, broader agenda. That’s a hard task to really deliver at the same time, but I think we should be mindful of that. And the way we operate now in the pandemic should, in a way, wave the way for scaled broader system strengthening and integrated primary care services.

But I just would like to mention briefly on the balance, because the only way to balance is to increase supply. Because it’s very unrealistic to redistribute in any way. And we need – we need a lot – a high leverage of
coverage due to the situation we have seen emerging. And then I think it’s really important to use all the resources we have and all the candidates that are being developed. As you know, I lost count when WHO started to have more than 200 vaccines on, yeah – (laughs) – on the list of the vaccines under development, and more than 50 – I guess now more than 60 are in technical development. Of course, not all of them will reach the market.

But many have actually started reaching individuals without having – with us without having the ability to actually assess the data and see whether they are of sufficient quality. They may be good vaccines. And the point I think to really now invite all actors – and by that I mean countries like Russia, China, all manufacturers – that they have the ability and opportunity to get their products assessed in the normal way together with other products, so that they can maximize actually rollout. But to give, yeah, the same quality bar and standard to everyone, I think that is really important and it’s a part of global solidarity to make everyone also allowed to contribute.

Julie L. Gerberding: Just a point of clarification, the current 23 billion (dollar) gap in funding for the facility, does that include the resources necessary for this systems of vaccination? Or are additional resources needed to strengthen the actual immunization programs that are necessary, particularly for adults since we don’t have adult immunization programs in most countries?

John-Arne Røttingen: We need additional funding in countries and with the support of multilateral development banks, like the World Bank, to deliver the full program, definitely. So that is not fully costed, partly because it’s so difficult and hard to cost at a global scale. And I think it needs to be done domestically with those understanding their own context. But the World Bank and the World Health Organization are now working together to assess country readiness, and really see in detail the national plans for rollout. And then we can identify the gaps, the hurdles, the bottlenecks, and make sure that we can invest contextually in what is needed in every individual country.

Julie L. Gerberding: Muhammad, maybe I’ll ask you to follow up on that then in terms of, you know, what do you see as the gap for the last mile, last inch service delivery?

Muhammad Ali Pate: Yes. No, before I respond to that just one of – reflecting one of the lessons I learned about a decade ago within the polio program in Nigeria is that lack of transparency undermines trust. And linked to the issue of equity that we started talking about, because of lack of transparency in terms of where the vaccines are, who has them, making that visible not only at the global level but also within countries will be very vital for maintaining – for earning and also maintaining the trust of populations to take the vaccines. So measurement of that and making it visible, because at the moment there are lots of numbers out there. I’m not sure that we have a full handle on
that. So transparency around vaccines globally is going to be a key part of regaining the trust of the populations.

On the issue of last mile delivery, that’s a big challenge. I think we’ve under-invested in basic health care systems. Frontline health workers, as we’ve seen in many countries, bore the brunt of this pandemic because even the basic protections weren’t really available initially. Now things have improved and through ACT-A and the resources deployed by some of the multilateral financing entities like the World Bank, I think we’re sort of seeing improvement in terms of our availability of some of those basic things. But this is a long game.

And we need to ensure that as we deal with this variant and what is unfolding ahead of us, that we actually build the health systems – the human resources at the front lines, the logistics and cold chain infrastructure, the information systems that are needed to track who is getting what and where. That will be vital for not only COVID but also other basic needs of population – reproductive health, family planning, treatment of pneumonia, other vaccine-preventable diseases. That’s what GFF is also trying to do uniquely around the essential health services agenda. That will be a key part of the overall piece. Otherwise, if we just isolate it I don’t think we’ll be able to succeed in the long run, because this is not just one off.

Now, Jeremy, you have a lot of experience with this frontline issue from the USAID, and even your previous role there. What do you think the most important thing the U.S. government, USAID can do to help accelerate uptake and trust, transparency at Muhammad said?

Jeremy Konyndyk: Yeah. Yeah, I think that point on trust and transparency is just so crucial. We see that in outbreak after outbreak. One of the biggest challenges with the Ebola outbreak in Congo a couple years ago was lack of trust in the population. And that just makes everything else considerably harder. And, you know, we’ve learned that lesson many times. I think we need to apply that on a global scale here.

You know, I think it’s a mix. So it’s very country-specific what’s needed to enhance readiness at a country level. Every country is in a different place. And I think it’s also very vaccine specific because there are – some of the vaccines – you know, obviously the Pfizer vaccine is very logistically intensive to manage and administer that in a proper way. And Anuradha said, only 18 countries have all the AMC and SFP countries and COVAX-qualified for that initial allocation. So if it were – you know, if you were talking about a vaccine that didn’t require intensive cold chain, it would be easier.

So I think what we – you know, what we need is to – it’s a fairly complex process of lining up vaccines with local and national capacity, understanding – as we get a better understanding how different vaccines
respond differently to different variants, and aligning that properly as well. But it’s just at the – you know, at the bottom line it’s going to take a lot of capacity and a lot of money rolled out very quickly. And so that is – you know, that’s going to be important for some of the funding within COVAX, to ensure that it’s not just buying vaccines but it’s also supporting country readiness. I think the World Bank funding is crucially important. We’re what we’re going to be able to do on the USG side. And a lot of technical advice. And so we’re looking at the kind of technical advice that we can provide through our USAID missions and in partnership with our CDC colleagues, of course, who have deep expertise in this.

And yeah, that – I think a mix of urgency, technical expertise, and an appropriate level of resources are going to be critical to actually making sure we can translate purchased doses into shots in arms.

You know, I know from the background of the pharmaceutical industry that there is an enormous and unprecedented amount of collaboration across companies going on. Just speaking for Merck, the conversations that we’ve been engaging in with our government, other governments, and other vaccine manufacturers who have authorized vaccines, to try to figure out how to flex our manufacturing capacity and do more to accelerate availability of these vaccines, is something going on mainly behind the scenes. But it is a very vibrant beehive of activity and passion.

But, you know, John-Arne, I’d just ask you, even with that the marketplace is pretty chaotic, and the pricing is hard to understand, predict, and probably manage in a rational way. How do you see this whole issue of sustainability of the marketplace evolving over, say, the next year or two?

Well, I think – also there actually I think we need more transparency. Our minister in the facilitation council meeting yesterday called for more transparency to actually increase trust and better improve coordination. And I think when you increase transparency you need to, in a way, be able to explain the reality you then see. And then I think we actually need some principles also on pricing. We believe that at the scale of the market we are talking about now the pricing for products for the 92 AMC countries needs to be equitable and preferably at the cost-plus pricing, so not profitable market. And then we should make sure that other countries should pay higher prices.

But that sort of transparency would actually require also a common understanding of basic principles, because otherwise they can be sort of – yeah. When transparency demonstrates inequity, I think we can also have a very uncertain situation. And I think of course COVID-19 itself is a security issue, definitely. But actually showing even more plainly in the globalized world we have – with the social media and everything – the inequities in access to technology is also in itself a security risk. So I think increased transparency is a prerequisite for trust, but actually it also really leads –
yeah, it tells us that we need to deliver on our promises, and we need to have some principles to start from. So that is an important task. And I think we should even consider engaging the Security Council in issues like this, because this is really one of the biggest problems of the world right now.

Julie L. Gerberding:

Yeah. I’m trying to touch on some of the questions that are coming in the chat and I have a really simple follow-up question for you, maybe. What are – what are the private sector contributions to COVAX? Are there private sector contributions? And is there a mechanism? And how can that be encouraged?

John-Arne Røttingen:

Yes. Both for ACT Accelerator and for COVAX there are private sector contributions in those. Global Citizen, together with International Chamber of Commerce, has started a large international campaign to mobilize private sector contributions. But I think we – in the end, I think private sector’s main contributions is really to deliver what they can. They deliver the technologies, they deliver the logistics, they deliver – so that we can actually use their technologies out in the field. So I don’t think we should expect too much of sort of cash donations from private sector that are – yeah, across sectors, of course, are also heavily hit by the pandemic.

But I think to – of course, it’s as a part of an overall picture. And in particular, we have said in the facilitation council around that that some industries have seen increased revenue streams due to the measures we have and the large digital platform companies and others. They should consider how they can contribute also by financial resources to our collective good.

Julie L. Gerberding:

And, Jeremy, kind of the yin of that yang is the surplus vaccine in some locations – for example, in the U.S. So if we end up having surplus vaccine, which is hard to imagine right now, since we’re all waiting for our first dose – but do we have a plan as a government in how we will reallocate or redistribute doses that are in excess? Other countries are, based on their procurement commitments, in a similar situation, where they have more doses than they have people in the country, for example?

Jeremy Konyndyk:

Yeah, and that’s something that we’re actively – we’re actively working to develop. You know, I think right now it’s a little bit premature. We’re still, and the federal government’s, at a point of saying no to states that need urgent doses of vaccines for high-risk populations. So we’re not – you know, we still have – we still have health care workers – frontline workers and high-risk populations who are – who are not covered in the United States. We are – you know, we are trying to figure out, you know, what is the point at which we will deem we would have a sufficient surplus that we could begin sharing, and then how to do that?
We don’t have something to announce yet, but it’s under very active discussion and, you know, because like a lot of other countries we have – we have – well, we’re on track to have overbought. When Warp Speed was being set up, we didn’t know which vaccine, if any, would hit. And so we bought up a lot of doses of many of them. Now multiple of them are proving successful. So that leaves us in the fortunate position of potentially at some point having some to share. But you know, at what point we will cross that threshold, we’re not quite sure yet.

Julie L. Gerberding:

Yeah. I think that’s true.

Anuradha Gupta:

Yeah. So I think it is not going to be a smooth road. There are going to several bumps, right? So, for example, we are under COVAX trying to put out 2 billion doses in countries, right? And we know that that’s not going to be sufficient. So we are going to really open the next year, you know, with a much higher demand in countries, right? So I think if the next few months could actually focus on finding new ways to accelerate and scale up manufacturing, that itself can make 2022 look better for the world.

The second thing is that if we could really avoid scrambling for doses. That also could help making sure that scarce supplies are at least sort of shared across countries in a much better fashion and a much more organized and coordinated fashion. So and of course, as has been said, partnerships I think are going to be critical, Julie. And we are seeing some very exciting partnerships – something that we would not have imagined in the past, right? Even vaccine manufacturers who compete with each other coming together actually say – and, you know, a match and mix kind of formulations and experiments that are being thought of. So I think 2022 – what we do in 2021 is going to lay the foundation for what 2022 is going to look like.

Julie L. Gerberding:

Thank you. Anyone want to add to that?

Muhammad Ali Pate:

I will say, I mean, we survived 2020. (Laughter.) So it’s only going to get better. In the U.S., elsewhere, all over the world. So 2022 will be much better, that’s what I think.

Julie L. Gerberding:

Well, we have had a robust discussion. And I feel we could carry this forward for a longer duration of time, but it is time to prepare the end of our panel. So I wanted to give our panelists one quick last word. If each of you can just give your soundbite of the most important thing you want
people to take away from this conversation, I think that will leave us with food for thought and hopefully be the thing that sticks in our mind. So I'll start with Jeremy this time, to go in kind of the reverse order.

Jeremy Konyndyk: Thanks, Julie. Yeah, I think – I think 2021 is going to be a race between the vaccines and the variants. And it will be absolutely incumbent on us, as Anuradha said, to scale up production while we're scaling up readiness, because we have to grow the pie not just share – we have to share it equitably, but also grow it so that we can actually – we actually can share it equitably. And, you know, the U.S. will be – will be heavily engaged in returning to our – you know, the customary role in helping to work with the rest of the world and leading that fight.

Julie L. Gerberding: John-Arne?

John-Arne Røttingen: Yeah. I think we are, as Muhammad said, in quite a good place, actually. And I think we are in a better place than we could have been because we acted fast, early. We spread the risks, as Jeremy mentioned. We needed to look – invest in several different vaccines. I think we need to continue actually with the same approach. We need more investments and we actually – we live in an uncertain era. We don't know what will happen in the next year. So we need to invest in many fronts, and then also, of course, invest to make sure that we can use the benefits of research and development that has been sort of delivered to us during this unprecedented year. So more funding, but do it in a wise way.

Julie L. Gerberding: Muhammad.

Muhammad Ali Pate: Nothing to add, just to say thank you to you, all the panelists, and Steve for organizing this. Nothing else to add. Thank you.

Julie L. Gerberding: And Anuradha, you get the last word

Anuradha Gupta: OK. So I would say unity, strength. Transparency builds trust. We are in it together. Together we can definitely do it. It’s time to act

Julie L. Gerberding: I think that’s a wonderful way to end the panel. And I really thank you all again for your expertise, but your incredible commitment. I think the caliber of capability that you all are bringing to the table from your different points of view and your different backgrounds really is inspiring and gives all of us hope that we will be able to get through these bumps in the road and end up in 2022 in a very different place than today. So, thank you. Steve, thank you and CSIS for a magnificent opportunity just to discuss some pretty tough issues. Thank you.

(END)