

Center for Strategic and International Studies

## Online Event

# “The Reality of Rolling Out COVID-19 Vaccines”

DATE:

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FEATURING:

**Henrietta Fore**

*Executive Director, UNICEF*

**Charles Akataobi,**

*Epidemiologist/Field Coordinator,  
African Field Epidemiology Network (AFENET), Nigeria*

**Martha Ngoe,**

*Bureau Chief for International Vaccination and Travel Medicine and Sub-National  
Surveillance Officer, South-West Region, Ministry of Public Health, Cameroon*

**Shyam Raj Upreti,**

*Coordinator, COVID-19 Vaccine Expert Advisory Committee,  
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CSIS EXPERTS:

**Katherine E. Bliss**

*Senior Fellow, Global Health Policy Center, CSIS*

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*Transcript By*

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John J. Hamre:

Good morning, everyone. It's morning in Washington, D.C., but it may be midnight where you are. But we're delighted to have all of you join us for what's going to be a very important conversation. And this is a discussion about the reality of rolling out the Covid-19 vaccines around the world.

We're very privileged today. My role today is not only to welcome all of our panelists, and Katherine Bliss will take care of that, but my real special pleasure is to welcome Executive Director Henrietta Fore, who is the executive director of UNICEF. Now, I'm—you know, you should all know that I am the global president of the Henrietta Fore fan club. And I have been so excited—all weekend I've been looking forward to this. I don't have a chance to see her much these days because she's traveling the world on behalf of humanity. And it's such a splendid thing that she's doing. But I'll be brief, to say just a brief introduction.

You know, Executive Director Fore has the most perfect background to be leading UNICEF at this time. She had served—she's now the seventh executive director for UNICEF, a phenomenal organization. From 2007 to 2009, Executive Director Fore was the administrator of the U.S. Agency for International Development and the director of the United States Foreign Assistance. Now, that was perfect training, you know, for having background in the international community that reaches out to do very good things and important things for humanity. She earlier had served as undersecretary of state for management. So, she knows the architecture of internationalism so very well.

Most important, Henrietta Fore is the only person I know who made money, okay? She was the director of the Mint and she stamped out money left and right for many years. So this is a perfect training because right now she has to go raise money, you know, for this incredible mission. And so, from making money to raising money, Henrietta Fore is the perfect leader at this time. You know, people don't know, Americans don't know, we don't appreciate the enormous good that UNICEF does in the world. UNICEF is the largest administrator of vaccines in the world. It is the central partner to the global health community that actually provides for the foot soldiers in the field that get out and really put the shots in kids' arms and save millions and millions and millions of lives.

And it's that leadership that she's now bringing for UNICEF to this global campaign to try to get in the front of this terrible pandemic, Covid. Life is coming back to normal in Washington, but it is not coming back to normal around the world. And Henrietta Fore is leading that charge. And so, I'm so very grateful that she's here today and grateful for her work. Executive Director Fore, welcome. (Laughs.) Forgive me for my long introduction, but I just have so much I wanted to say about you. We're so pleased that you're with us today. Thank you.

Please, turn to you.

Henrietta Fore: Thank you very much, John. And it really is a great pleasure to see you. And thank you to and CSIS for programs that inform us, and educate us, and bring the world to us. So thank you very much. So today, this morning, for me also, I would like to talk a bit about how we think about ACT-A and COVAX, because it can sometime be confusing, and yet it's very interesting. It's a new model for the world, and we think an effective model. So let me begin.

In April 2020, the Access to Covid-19 Tools Accelerator, which we have given the acronym of ACT-A, was established in several global health partners so that we could respond to Covid-19 pandemic. It seeks to ensure fair and equitable access to new Covid-19 tools, particularly for low- and middle-income countries. ACT-A brings together different sectors, public and private, to innovate, to find solutions, to collaborate, and is at a scale never seen before. It is a global solution for a global problem. It aims to accelerate development, production, and delivery across three product categories—vaccines, therapeutics, diagnostics—all targeting COVID-19. And it aims to support a fourth cross-cutting pillar focused on health systems. Each pillar is defined by specific time-bound goals.

Now, COVAX is the vaccine pillar of ACT-A. And it is co-convened by the Coalition for Epidemic Preparedness Innovations, what we know as CEPI, Gavi, the vaccine alliance, WHO, and UNICEF. It aims to provide at least 2 billion doses of approved COVID-19 vaccines by the end of 2021, enabling participating economies to protect at least 20 percent of their populations, prioritizing frontline health workers and other high-risk groups.

So now let me move to UNICEF's role. UNICEF is engaged across all ACT-A pillars—for procurement, for country readiness, and for delivery. However, specifically for COVAX, for the vaccines, UNICEF plays a critical role in supply and country delivery. And you may say, why UNICEF? And it's because we currently move 2 billion vaccines a year for childhood immunizations—things like polio and measles.

So let me now turn to supply. UNICEF is in the COVAX procurement coordinator. It is the procurement agency for 82 countries that are a part of the advanced market commitment and that will get their doses procured with donor funding and 20 self-financing countries. Not only do we procure and supply vaccines, but syringes, syringe safety boxes, when a syringe is spent, and cold chain equipment to aid delivery. To date, 3.86 billion doses have vaccines have been secured and optioned through COVAX. And UNICEF has shipped 87 million doses to 131 participating countries.

And, due to global supply shortages, the COVAX facility is now short over 200 million doses. Therefore, we've been very pleased with the announcement from global leaders for additional doses and pledges announced during the G-7 meeting. It really is an important step forward, and we urgently need vaccine doses now. So for country delivery, UNICEF leads the country readiness and delivery group with WHO. At the global level, we have developed guidance and tools for countries to help them introduce and scale up vaccine delivery. But we are also on the ground in over 100 countries.

And based on our longstanding experience with immunization, we provide technical assistance to countries to ensure that they have the systems and the people in place and trained to receive and scale up their vaccination program. As UNICEF, our comparative advantage is to: one, provide support in areas of in-country logistics; two, to work on vaccine confidence with the public; and three, to ensure that no one is left behind and that these vaccines also reach the populations living in humanitarian contexts. So now it is critical for all of us to be working together in solidarity and to ensure that all the priority groups in all countries have equal access to vaccines.

And why is this? First, it is for ethical reasons. There's a moral imperative to ensure that there is equal access to Covid tools, regardless of where you live or how rich you are. Second, for epidemiological reasons. No one is safe until everyone is safe. Without largescale joint action, the pandemic is likely to be more prolonged. As we have seen with the Delta and India South Asia, new waves will emerge with devastating consequences. New variants of concern are more likely to emerge, which could alter the trajectory of the pandemic and could also change the effectiveness of current arsenal of vaccines.

And third, for economic reasons. The global economy stands to lose as much as \$9.2 trillion U.S. if all countries cannot access Covid-19 tools. Even if advanced countries reach optimal vaccination levels by the second quarter of this year, we will lose up to \$4.5 trillion U.S. if vaccine rollout in developing countries and economies continues on its current trajectory. Investing in ACT-A COVAX makes sense—good investment sense.

So what will happen if we do not work together and find necessary actions? Let me highlight what this might mean for sustainable development and, of course, for children. For sustainable development, even before the pandemic we found that the world was off track in fulfilling the SDGs across a number of critical indicators. Covid-19 is having a devastating impact on all 17 SDGs, but especially for the most vulnerable, rolling the progress that we are making together. And for children, UNICEF is very concerned about the impacts of the Covid-19 pandemic, both short term and long term, on children's lives, and especially for the poorest, the most vulnerable, and the leaving of a legacy of increased inequality.

So let me share a few examples. We have evidence that essential services have been disrupted, as well as critical systems such as health, nutrition, water and sanitation, education, child protection, and social protections. For example, childhood immunization. While most countries have resumed delivery of routine immunization services, few have caught up and have reached their pre-pandemic coverage levels.

As you are all aware, education has also been severely disrupted during Covid-19. A recent UNICEF report finds that schools for more than 168 million children globally have been closed for almost a full year. Young girls especially will pay the heaviest price. And this is why we must work together and now to ensure equitable access to vaccines. But at the moment, we are far from this objective, and so let me share a few numbers.

Number one: To date high-income countries have, on average, administered vaccines to 60 per 100 people, compared with 0.9 per 100 people in low-income countries. That is the differential of 67 times. And second: Africa in particular has been left behind. So far, the continent has administered around 32 million doses as of June 1st, while worldwide over 1.9 billion doses have been administered. In other words, the Covid-19 vaccine inequality is much worse than already existing income inequality. And while we see progress in many countries now that they have started their vaccination programs, we have also found that there are implementation challenges.

So here are a few highlights: First, there is a lack of operational funding to plan and to deliver vaccines. Without these funds, countries face challenges to open up enough vaccination sites and have too-few qualified vaccinators to scale up the vaccination programs. And second, there is low confidence in governments and in the vaccine products, and that is hampering the rollout. We have seen a surge of misinformation and rumors online and offline. And we are observing vaccine hesitancy amongst health workers, but also among presidents and political leaders.

And third, with limited supply and visibility into when the next shipment is coming, many countries have reduced their short-term ambitions for their vaccine programs. Charles, Martha, and Shyam will all talk about their country experiences, but we now see two extremes in our world. Some countries have fully used up all of their doses and had to actually stop their vaccination programs due to a lack of supply. On the other hand, there are also several countries that had signaled that they would not be able to fully utilize their doses before the expiration date. And UNICEF and partners are working hard to support these countries to quickly export their excess vaccine doses to other countries who are in need and can utilize them.

So going forward, we will see a major increase in the number of doses that are shipped until the end of the year—something like a tenfold increase. While this is promising news, it will seriously challenge the weakest systems and will once again highlight the inequities and the urgent need to strengthen local primary health care systems. So in conclusion John, we must work together to build robust and resilient health systems, not only as a means to end the current pandemic, but to prepare for future pandemics while making sure that every person has access to the health systems that they deserve. Thank you very much.

Katherine E.  
Bliss:

Thank you, Henrietta Fore, for your overview of the work UNICEF is doing globally and at the country level to support the procurement and distribution of Covid-19 vaccines, both through COVAX and the ACT Accelerator, and by helping countries prepare for the challenges of delivering vaccines to their populations. I am so pleased that you were able to join our conversation today.

I am Katherine Bliss, a senior fellow with the CSIS Global Health Policy Center. And as Henrietta Fore emphasized in her opening remarks, turning the tide on the Covid-19 pandemic globally depends to a very great extent on an equitable global distribution of Covid-19 vaccines. Last spring, in 2020, when COVAX was established as the vaccine pillar of the ACT Accelerator, it was to give all countries access to what, at that point, were vaccines still in development. Now there are several vaccines available, both through COVAX and on the open market, but equitable access, particularly for the lower and lower-middle income countries, has been elusive, with supplies limited.

Nearly 200 countries have started delivering Covid-19 shots to their population. But as Henrietta Fore emphasized, coverage rates vary considerably. The high-income countries have secured many millions of doses of vaccines with high rates of coverage, and nearly 50 percent of all people who have received at least one dose of Covid-19 vaccine are from Europe or North America.

Last weekend the G-7 countries pledged to donate hundreds of millions of doses to lower-income countries through COVAX and through bilateral mechanisms. But that's not enough to cover the gaps in supply. And supplies are only part of the equation. The planning, training, delivery, and demand for vaccines are equally important elements to consider. And so here, to join the conversation with Henrietta Fore, and to share their views and perspectives on the reality of rolling out country—or, rolling out Covid-19 vaccines at the country level, are three experts with deep experience in managing immunization programs, training health workers, and responding to outbreaks of infectious diseases.

Dr. Charles Akataobi is an epidemiologist and field coordinator with the African Field Epidemiology Network based in Nigeria. And he brings a background in preventing and responding to disease outbreaks, including Ebola, cholera, and polio, to his work leading training and technical support to community health programs, in responding to the outbreak of Covid-19 in Nigeria, and delivering Covid-19 vaccine.

Ms. Martha Ngoe is the bureau chief for International Vaccination and Travel Medicine within the Ministry of Public Health in Cameroon, where she supports the ministry's work as an epidemiologist and provides technical assistance to communities seeking to implement and strengthen immunization services, including the delivery of Covid vaccine.

And Dr. Shyam Upreti is the coordinator for the Covid-19 Vaccine Expert Advisory Committee with the Ministry of Health and Population in Nepal. He brings his experience as the head of the Expanded Program on Immunization and a focus on child health to his efforts to support the response to the Covid-19 outbreak and the rollout of Covid-19 vaccine. So thank you all for joining the conversation today, and thank you Henrietta Fore for setting the stage for our discussion.

So, Charles Akataobi, let me start with you, if I could. You know, as of last week Nigeria had administered at least one dose of Covid-19 vaccine to just 1 percent of the population. So I wanted to ask you to start out by saying, you know, or telling us a bit about the status of vaccine delivery in Nigeria. You know, beyond COVAX, has Nigeria worked with the African Union to secure additional doses? And while waiting for vaccines to arrive, what activities have you been undertaking in training health workers at the district and local level to begin to prepare for their distribution?

Charles Akataobi: Thank you Katherine for the very good questions. I'm really very grateful to Executive Director Fore for setting the stage, especially for the COVAX facility that gave Nigeria the initial close to 4 million doses that we used for our first dose. And courtesy of her and what she's doing in UNICEF, I'm fully vaccinated with the two doses, and many frontline health workers are also. So I really want to say thank you.

Just to answer directly to your question, so we learned a lot of, we got a lot of experience from the first dose. And one of the things we tried to do prior to getting the vaccine was try to build capacities in anticipation of the vaccine. Now when we rolled out, we also identified the fact that there were still shortage of capacities especially at the lowest level, the vaccine delivery points. And these local shortage of capacity cut across various technical components and across different technical components, including distribution, last-mile delivery of the vaccines.

So what we have done was draw from those experiences, especially based on reports from senior level and lower level supervisors who were in the field, including I, myself. So stepped back to review some of those challenges that we had in the initial phase. And one significant challenge was that we developed a new database that allowed people to be quickly scheduled for the vaccines. So we developed what we call the Electronic Management of Immunization Data, EMID, in Nigeria, courtesy of Covid vaccine introduction. So that platform allowed people to pre-register, schedule themselves, so that we can also avoid crowding at certain delivery points.

So people scheduled themselves in an interim of two hours, for this is our daily vaccination period. And so there had been some glitches, because that was rolled within the timeline of the vaccination. So we tried to address those glitches, and those have given us, that has helped us to address some of the needs for which we've reviewed our training materials, preparatory to receiving another batch of vaccine. Now again, we are going to have rollout teams because we're expecting larger, more doses of the vaccine. So we're going to be co-opting new teams. And those new teams need their capacities to be built. So we have training materials developed and structured.

So we have a three-tiered government system for health management: national, states, and district or LGAs. So, at the national level, we have developed a virtual training platform given the level of participants we are expecting at that level. And that helps us to manage costs and also reduce physical contacts. But at the lower level, we are going to be having physical trainings for those persons. And then we've also tried to review our training materials downward to focus primarily on the core things that we'll need to be doing in the field.

So, in a nutshell, I think the country is on track and are preparing to receive the second batch of vaccination. And then hopefully by June 25th, we should be completing the rollout of the first phase, where a lot of people expect to get their second shot for the—for the Covid-19 vaccine there. Thank you.

Ms. Bliss:

Thank you.

So, Martha Ngoe, let me—let me turn to you. Charles Akataobi has, you know, emphasized the work that in Nigeria has been taking place in order to, you know, really develop the ability to schedule people, rolling out technology and data systems to begin to prepare for and undertake the delivery of vaccines. You've been focusing your work at the regional level in Cameroon, where less than 1 percent of people have been able to access doses so far. And, you know, I just want to ask you to say a bit about the status of vaccine deliveries in the region where you've been working. Do your facilities, you know, have the storage necessary? And are health workers confident they

have the training that they can deliver them? What do you see as the greatest opportunities and needs in the region where you are?

Martha Ngoe: Thank you, Katherine, for the questions. I also want to thank my colleague Charles from Nigeria and the director who said the piece.

I think, yeah, I've been working on the regional level. That is a subnational level, where we have—at our level we have 18 health districts in the region. And so far, we have been having up to last Friday the 18th, we have had 2 percent coverage of the vaccination for Covid-19. So far, the delivery status on the 11th of, from the 11th to the 17th, because Sinopharm first of all came to the country, and then on the 17th we had also the AstraZeneca under the COVAX facility. So in all for the region we had 183 doses of the vaccine that were administered—that was delivered for the region.

And the main criteria for selection of the facilities for vaccination throughout the country was that they have a functional cold chain. So for the southeast region, where I work, we have 23 vaccination sites. So all of them have a functional cold chain that can be able to store this vaccine because we don't need the ultra-cold chain to store these vaccines. These vaccines can be stored within plus 2 and plus 8 degrees, which is what's normally used for the routine immunization.

For this region 185,000 people were targeted for the Covid-19 vaccination based on the fact that this had a population that were greater than 18, including health care workers and people who underlying risk factors such as diabetes, hypertension, and the rest. So this was the target. And so far, so good. This has been—as I said, it's been successful, in spite of the fact that there is a lot of hesitation, misinformation, and rumor.

And southeast has been one of the regions in the country where it is a humanitarian setting. That is, we have this crisis that has been going on, this is a political crisis, for the past four years, since—it's almost getting to six years—since 2015. It has not been easy. I pulled from the record we had last week from the national platform, the southeast region is the last, the least region that has vaccinated for the whole country, with the four region—four health districts out of the 18 health districts still to start—yet to start their vaccination against Covid-19. All this due to the insecurity, because there's a lot of insecurity.

So mainly those areas that have been able to vaccinate, these are areas that at least people are considering the safe havens, and most inhabitants of the other places flee to these other parts of the region. So far, just over slightly 2,000 people have been vaccinated as a guess. There are over 185,000 that has been targeted for the Covid vaccination.

And as to what are the greatest needs? We see already that from the time the vaccine was introduced in the country—the vaccine was delivered in the country on the 11th of April. And by the end of April, we started already vaccinating in our region. I work also as a frontline worker. I'm directly involved in administering the vaccine. I can say for those—for the time the vaccine came there was no time to set up the minimum conditions for vaccine introduction. So we barely had, we did not even have the registers, for example. They had copy of the register. We are still to get into the electronic registry. So even the hard copy, we just had to improvise.

If we could capture the indicators, even the vaccination card, everything—those things were not available. Even the training for the health workers to administer this vaccine, these trainings only came two weeks after. And there was a lot of inconsistency in this training. So there was a big lapse even in the communication. There was little time to scale up communication. And we know in case where we have misinformation and rumor communication plays a vital to especially help promotion. But this was not the case.

So we—it was really a challenge. It's still really a challenge because without effective communication, I don't think we can go anywhere with this Covid-19 vaccine rollout in the region, which already does not have confidence in the government. That is why we have this political crisis. And then secondly, with the rumor and misinformation we just have everywhere with the social media making matters to be worse. So what we really need is that communication to be scaled up, and that the communication should not be that kind of a generalized communication.

Because earlier we see also that health workers were really targeted for the first phase. But health workers turned out to be the most hesitant group. And interestingly, we see community members coming up more than the health workers. So like yesterday we had a meeting, and we were talking about the strategies to reach out to these health workers. It should be a kind of targeted communication, and not just generalized. For example, what do the medical doctors need to know about the Covid-19 vaccination? Because not all of them are involved in immunization, but yet they have to take this vaccine because they meet with people on daily basis. So there's a kind of communication that should be focused to them.

What should the nurses know? What should the lab scientists, the technician know, and so on—the paramedic staff and everybody? It should be a kind of targeted communication, beginning from the—they have a national order. So, using the national order to mobilize these people and see how these people can be really sensitized about importance of this vaccine, because one of the challenges here is that this is a region of over 3 million people. But I think our Covid vaccine—Covid disease for the diagnosis data for those with the rapid diagnostic test, we don't have more than 200 cases in the region.

So it's really difficult for people to believe that it's a disease, and then the acceptance rate to be effective, acceptance rate of the vaccine.

So I'm telling you that we've been doing outreach to meet the people. And they tell us that, my daughter, this disease does not exist in Cameroon, so don't bother me about a vaccine. And I also think that makes matters worse is also that adult life hood vaccine in Cameroon, I think it is this year that the government is really taking serious, beginning this year, because all what people knew about vaccine was for infants, zero to nine months. So it is important to communicate all this to the people.

And then I think also what we need is infrastructure, human resources. Because the same people we have—always have the problem of staffing. The country always has facilities understaffed. And there are these same people that are on the staff, they are there with the routine immunization for kids, for infants. They are still the people to attend to adults for the Covid-19. So it's a bit challenging also. And there is still infrastructure, like I said one or two facilities for supervision. And I could discover that where the infant vaccination is taking place is the same place that the Covid-19 vaccination is taking place. There is no room, there is no space to separate this activity.

And then, lastly, what I think the region also needs, as well as the country, is a proper committee to manage AFI. I am part of the committee at the regional level, but I tell you it is not complete because the people from the community are not represented in that committee. So I think communication also will involve these people. If they are part of the committee, it becomes transparent, and they take the information back to their community. And this helps also to debunk some misinformation and rumors and increases acceptance rate of the vaccine. Thank you.

Ms. Bliss: Martha Ngoe, thank you.

Shyam Upreti, let me turn to you. You know, Martha Ngoe has just, you know, emphasized some of the challenges around shifting from a focus on, or not shifting from a focus on children and routine immunizations but, you know, building on that and really focusing on adults. You know, over the past few months Nepal has faced a surge of Covid-19 cases, while also addressing flooding, and landslides, and working to secure doses of vaccine. The country has administered I think doses to roughly 10 percent of the population. But, you know, could you say a bit about what you're seeing in terms of the demands on health workers and the health system's preparedness to administer doses of vaccine to adults? And what are you seeing in terms of the status of planning for ensuring delivery to remote or hard-to-reach areas, including those affected by the recent floods?

Shyam Raj  
Upreti:

Thank you very much. First of all, I'd like to thank the CSIS organizer for giving me the opportunity to share the Nepal experience in the broader context. And again, really, thanks to the executive director for a very useful keynote address.

So in the Nepal situation, I think that the immunization program in Nepal is very much strong and well-established. We have a network of vaccinators from the center to the periphery, around 8,000 vaccinators. So they are in each and every place. And these vaccinators are supported by the community health premier volunteers. They are around half a million. So this network is very strong. And they are trained people. They are trained. And during the Covid-19 vaccination also, we have even trained them. So this is the way the system is working.

Second, the transportation has a network. I'm talking about the vaccine storage and the distribution network from central to province, and province to district. And you have a subset – (inaudible) – also. So vaccine distribution is well working. And what you said about the landslide, all the things, but in such a time when there is a crisis, that time I think usually the immunization system has been hard for some time. So, until there is a humanitarian crisis. So that way, the Nepal vaccine network is very strong. We have the trained health worker inside every—(inaudible). So any vaccine—adult or children vaccine—it's really easy for Nepal to roll out all over the country.

Ms. Bliss:

So, Henrietta Fore, let me turn back to you. Charles Akataobi, Martha Ngoe, and Shyam Upreti have all, you know, presented, you know, some country snapshots. But, you know, UNICEF is really working at a global level. It's long procured vaccines for the Gavi-eligible countries. But now, as you said, through COVAX is handling procurement for the advanced market commitment countries, a set of the self-sustaining countries. And, you know, at the same time really kind of the shift from a focus, you know, on childhood immunizations to adult. What has that expansion been like for the staff and the organization? And, you know, beyond working on the procurement of vaccines themselves, you know, what activities—how is UNICEF really, you know, working with countries to deliver those vaccines to adults in a way that might be different than the work with children?

Mr. Upreti:

It's a very important question. turn to In Nepal, I think this culture of working as a team, like at the WHO we work together under the leadership of the government, so there's a joint plan, we work together. What UNICEF, I think for the long time they are supporting in vaccine logistics. So these are—their support is excellent in the immunization system. So vaccine logistics system, distribution, and they're supported by UNICEF. But Covid-19 vaccine also they conducted, supported and conducted, an assessment of dry space and coastal space, and where are the gaps in the coastal space. So

actively we plan, we made an improvement plan. Based on that improvement plan, we have developed, and we have expanded our cold-chain system.

And—(inaudible)—the COVAX application, the UNICEF country of Nepal has supported the government of Nepal in preparing the COVAX application for—(inaudible). So that applications already accepted, so maybe by July we'll have the improvement ready for Nepal. So with that support, Nepal will add about 19 walk-in coolers, around 42—(inaudible). So that will expand the capacity of the cold chain all over the country, from the central to province and the district level.

Two other things. In addition, UNICEF had assisted the government of Japan to improve the cold-chain system of Nepal. So the government of Japan is supporting Nepal to improve the cold-chain system in Nepal through initiative. So, you know, the first part is the initial support in the cold-chain system. And they are supporting in the development, the planning of vaccine distribution, and the monitoring of the vaccine stock at the—(inaudible)—level. So that one is important. During Covid vaccine they supported with transport of the vaccination team and the monitor from central to province and down level. So these are important support provided by UNICEF Nepal in term of the vaccine logistics.

Second very important component that supported is to increase the vaccine confidence. So they supported the government to develop the communication plan. They support the government to conduct many advocacy meeting with the media and with the professional organization. So they have supported the government to develop different media messages to be given in the different media. And other reporting they are doing is the media monitoring, social media monitoring. And I think—(inaudible)—they are addressing the impact to government and sit together and correct the other items. So that way the UNICEF Nepal country office is really supporting the routine immunization and also this Covid-19 vaccination.

Over.

Ms. Bliss: All right. Thank you very much.

We're starting to see some questions come in from the audience, but Henrietta Fore, I want to just turn to you to ask you to say a bit about what this expansion has been like for UNICEF globally. And also, you know, all of our speakers have really touched on this issue of vaccine confidence and the work that UNICEF has done to support the vaccination demand hub and others that's been so important. So let me ask you to say, you know, a bit about that work at the global level.

Ms. Fore:

So thank you, Katherine. And as Shyam has just said, there are lots of complexities when you're on the ground. But one of the first ones that you come to is how to finance it. And I think for us globally, as UNICEF, if you are doubling the number of vaccines that come through your doors and the amount of personal protective equipment, diagnostic kits, other things that are just needed urgently by the world at large, financing immediately comes to mind for UNICEF, just as it comes to mind in a Nepal, a Cameroon, or a Nigeria.

So getting advanced market commitments out means that you have to have some money in the bank that you can say to a manufacturer, yes, we will buy 500,000 doses, or 200 million doses of your vaccine when it is ready, and we need it shipped on these terms. So creating good public-private partnerships is one of the most important things that we have learned about in UNICEF during this pandemic. We already had good public-private partnerships, but we need more of them. They need to be faster, more effective, more at scale. And funding is really important for both the country level, as Shyam just mentioned, but also for UNICEF at the global level.

There's a second area that we have seen a lot of need for, and it's something that Charles spoke about. Digital health is coming. It's coming to every country. But not every country as yet can afford it or can put it in place. Shyam mentioned planning. It's very important, but you'd like to be able to use some of the digital tools that are now available. So we see that there are some initiatives globally—such as connecting every school to the internet, which would allow every village to be connected, which would allow every hospital or primary health clinic to be connected. And these kinds of digital tools can help the world in this pandemic and in the next one. Primary health care can use digital innovations. And so innovations that are both frugal and innovations that are very sophisticated but give you platforms as a country will be very important.

And then, Katherine, to your point about vaccine hesitancy and how the populations response, so Martha's comments about Cameroon is something that we are hearing from countries all over the world. And it is particularly strong in countries that have not seen vaccine rollouts. So the longer we wait as the world the more the misinformation gathers, the more the concerns and worry. We are hearing in some rural villages that they think that Covid is just in urban centers. We are hearing in others that they think it is just an adult person's disease, it doesn't catch children. But it does.

So what Shyam has mentioned about Nepal is what we would hope to do in every country, which is to work with the government, to build trust among the people, and to make sure that everyone realizes that vaccines save lives and they should come in and be vaccinated. But we're going to need a lot more public-private help. So we're going to need handbills on buses, at bus

stops. We're going to need them everywhere. We need businesses to tell their employees that they should get vaccinated, and to tell their friends and their families, and to bring their families in for vaccinations, and to get this out on radio, and on television, and on digital phones. We'll just need every possible way to talk to the populaces about confidence in vaccines.

Ms. Bliss: Thank you.

So, you know, thinking about this question of vaccine confidence at the country level, Charles Akataobi, I want to come back to you for a second. You know, given the limits on supplies of COVAX-provided vaccines—you know, with the surge of infections earlier in India, the stoppage of exports—Nigeria began rationing doses of the AstraZeneca product, asking people to wait on the second doses until later this year. Last week the National Primary Health Care Development Agency noted that the rationing was no longer necessary, and a second shipment is expected in August. But as Henrietta Fore has just said, you know, the longer that there's a wait, that allows more time for concerns and misinformation to be generated.

So I wanted to ask you to say a bit about what you're seeing in terms of the demand for vaccines in Nigeria, and how have health workers and the elderly—who've been prioritized in that first portion of the campaign—how have they responded? And what messages and communications that, you know, all of the speakers have mentioned, you know, what kinds of communications are you seeing as most effective, particularly for those groups?

Mr. Akataobi: Okay. Thank you very much. So just to highlight that vaccine hesitancy that was talked about by Martha, and which ED Fore had also reiterated, actually caused a lot of concern. Nigeria was not spared. And so one of the things that helps Nigeria, for one, is that we've had a long round with polio. So we sort of had structures in place, including UNICEF-supported communication platforms at the rural and community levels. So one of the things that we really did was try to leverage those things. So we tried to sort of use polio resources to support Covid-19 vaccination. And that helped significantly.

But then—so initially there were also those—not initially, there still is. But there were a lot of rumors that against the vaccination and the Primary Health Care Development Agency in Nigeria, which manages immunization, focused initially on the general populace. We had thought that it was a given that the health workers would actually accept vaccines. So when the rollout came, again, we had prioritized based on the quantity of expected vaccines that we were going to first vaccinate health workers and frontline officers. So we had four phases to be rolled out as we did at—(inaudible).

And so in the first phase we had prioritized health workers and frontline workers for the COVID-19 vaccination. And frontline workers include not health workers that are on the frontlines, like the military, paramilitary, and others. And in the second phase we prioritize the elderly. Then later we were targeting people that were between 18 and 50 but that had comorbidities. And then subsequently, the remainder of the population within the age brackets that had no comorbidities.

But by the time we rolled out, we found a lot of hesitancy even among health-care workers. So we had to, and just like the ED said, we had to now change our communication strategy. We had to do a lot of unique—(inaudible)—with private-sector-driven organizations. We had to identify key communication channels in organizations. We are most—(inaudible)—health workers—(inaudible). And then we had to find strategic ways to communicate to them using their communication structures internally, which they had a lot of confidence in. For health workers, we have to reach out to the Association of Health Workers at the different levels of health administration to talk to them and also try to bring to their perception the risks associated.

You know, Shyam did mention, and I think Martha did say, there's actually low risk perception in many of the developing countries, including Nigeria. And so we have to find a way, using pictorials and videos of those who actually had the disease, a lot of whom were health workers, to now re-strategize our communication. And that did help a lot. So we, I think over time. And then we did also use head of organizations publicly receiving the vaccines, because this was actually a way to promote it. So we had the President receive, the Vice President. And then in hospitals, like teaching hospitals, we had the CMDs of those hospitals publicly taking the vaccine. And so that gave a lot of reassurances to other health workers in the world of the health system to see people, our leaders, can take this.

So we used those pictorials to form communications, short communications that were sent out as SMS messages, public service announcements. We also engaged social media influencers, because we also saw that social media was actually promoting a lot of negative communication based on rumors. So we had strategic teams that worked with social media influencers that had a lot of followers to debunk some of those rumors with valid scientific evidences from WHO, UNICEF, CDC, and all of that, and also those things that were originated internally. So this has helped significantly to communication in the country.

But I want to really give a lot of kudos to our preexisting polio structure. Even at the onset of rollout we had the challenges of shortage of health workers, just like Martha did mention in Cameroon. So what we did was reach out to reengage some of those who had worked with polio who were

being laid down because of the reduction in polio financing. So we reengaged them for the COVID vaccination. And they did bring some of those experiences, and that has helped significantly. We've not been able to deal with all the challenges. We still have pending hesitancy, especially in the general public. But significantly, among the prioritized target population in the initial first phase, significantly, we've been able to make some landmark achievements.

Thank you.

Ms. Bliss: Thank you.

Shyam Upreti, let me turn back to you. We've had a question come in from the audience, you know, asking about the challenges of reaching out to populations that may have, you know, language differences, border populations that may, you know, have—not share the same cultural affinities or, you know, and also just challenges of reaching populations that may be, you know, very remote or outside of sort of access to normal government services. Could you say, you know, a little bit about how, you know, some of the existing and previous work that you've done through the expanded program on immunization addressed some of those challenges, and what the thinking is currently in Nepal?

Mr. Upreti: Thank you. Actually, Nepal come to a stage of micro-plan in each and every village for routine immunization. So what the micro-plan is, is the deployment and involvement of the local community and locally marginalized community also. They all sit together and develop the micro-plan. Same thing happened in the Covid vaccination also. Before vaccination, each and every village developed a micro-plan with the consultation of the local government, marginalized community, community health volunteers. That way the low-covered area aren't left out or dropped out area was clearly delineated. And based on that, the targeting that area plan was developed. That's the important thing.

Second, for the media, we develop the media in different regional languages because in Nepal there are different regional languages or the ethnic languages. So we developed or we translated the national Nepali language – all these media things—to the local languages. And that was given in the paper media, even in the local FM radio. So that way it reach to the unreached—(inaudible). Another very important thing for Nepal is because we have got female community volunteer in each and every community. So in that community, this volunteer knows each and everybody in a community because she is from local community. That way we can reach the unreached or some marginalized community through that channel also. So this is the mechanism in Nepal. We are reaching the unreached. And even the

polio vaccine also, we use the same mechanism to reach the marginalized communities.

Over.

Ms. Bliss: Thank you.

Let me—Martha, let me turn to you again on this question of reaching out to communities that may not have as much trust in the government. You mentioned that the region where you've been working is, you know, has had a four-year process of conflict and sort of a lack of trust in overall public services. And at the same time, you know, a recent survey of some 2,500 adults in Cameroon late last year showed that a very high percentage were hesitant to get a Covid-19 vaccines. Concerns about clinical trials and motives of pharmaceutical companies really underpinning people's fears. You know, this question of misinformation has come up. You know, what do you see as the best messages or communications to really reach those populations that already have such concerns about government services in the first place?

Ms. Ngoe: Thank you, Katherine. I think, as I earlier said in the first part of the discussion with the data, I tried to back up with we already see that there is still a level of hesitancy with the people not having trust. But on the other side, on the other hand, I talked about involving the community in, let's say, the management committee of AFI (ph). This alone gives some kind of confidence back to the community that they are involved in what is happening. The information should be there in real time. We saw that little or no time was there to communicate with the people for a disease that they don't really see the burden around them. I come and tell them that they should be prevented through vaccines, the disease they don't know about, and they call and tell them about the vaccine. Or that you really have to expend all these things to these people.

For example, Sinopharm, first of all, which comes from the 11<sup>th</sup> of April, and at that time WHO has not approved Sinopharm as one of the vaccines to be used in an emergency. As opposed to, what do I expect in a vaccine from the COVAX facility? Because for vaccines to be approved by the government or be accepted by the government to be used in the country, that's the Sinopharm, AstraZeneca, Johnson & Johnson, and Sputnik. So of all the vaccines, why should it be that? And Sinopharm, that is still pending approval from WHO. That would first of all reach you. People thought that they are being used for the final phase of the clinical trials without consent. So this wasn't—(inaudible). And then AstraZeneca came in. AstraZeneca came in just a few weeks after what happened with the blood clotting, and rumor of blood clotting, and so on.

So all those—there was no time to communicate all these things to the people. Why even if you don't see the cases right at your doorstep, it's important for you to protect yourselves through the vaccine. So I think engaging the community at any level for vaccine implementation or rollout's really, really important because you cannot leave out the same people that you want them to be vaccinated in whatever planning you are doing. That cause for some kind of doubt, especially in a conflict zone like us. And then also the people also need to, like, reach assessment.

We need to—it all boils down to communication. They reach assessment as to the health workers, for example. The health workers, they are there. I think one of the reasons from our—(inaudible)—reassessment we have done, the health worker at the rural setting does not really see the cases of the Covid-19 as somebody in the urban sector. And—(inaudible)—for the health workers who have been vaccinated, who have accepted these vaccines, they are health workers who are based in the urban sector. Just 383 health workers have been vaccinated after two months of the vaccine rollout in the country, which is not a good thing.

So there really needs to be, to explain to them: these health workers don't only live in the health facilities where they work. They live in the community where they spend most of their time, and they come back to their place of work during the working hours. And so if you don't understand certain concepts, certain ideas, certain—they don't have certain logic of what is happening because of everybody's involvement in immunization, then we also affected the community. On the other hand, if the community is also involved in what is happening it may also affect the behavior of the health worker. So it's a two-way game. So nobody should be left behind. All of us have to move.

And then lastly, because life-hood vaccine has not been the case in Cameroon. These are people who have been living their normal lives. They have not been attached to vaccines. And now we come and tell them: this is Covid. It's killing people. And yet, they are not seeing the people and it's—(inaudible). They have been told about the importance of—(inaudible)—vaccine, including Covid-19 vaccine. So all this boils down the communication, our communication strategy—how we include our community, how we engage them in whatever intervention we do. The way we include them in interventions, I think that will determine the success rate. Thank you.

Ms. Bliss: Thank you.

Ms. Ngoe: Over.

Ms. Bliss: Thank you.

So, Henrietta Fore, you opened our session this morning with an overview of UNICEF's work at the global level and the local—how global needs and challenges have really evolved over the past year and a half of the epidemic, the pandemic. Let me turn to you for some final reflections, both on the state—the reality of rolling out Covid-19 vaccines and, you know, what you're most concerned about or optimistic about as you look ahead two to three years.

Ms. Fore: Thank you, Katherine. Well, I think what I'm most concerned about is that many of these countries have fragile health systems. And that for us as the world, to beat Covid-19, it's going to have to be multisectoral, as you mentioned in your opening remarks. So it is also getting routine immunizations, getting clean water and a bar of soap in a school, or in hospital, or in a clinic. And making sure that donors don't get too fatigued.

But we have a chance coming out of Covid and living through Covid to really reimagine the education system in our world and to use remote and distance learning. We have a chance to re-look at water systems so that we can have better hygiene and sanitation. And we have a chance to really look deeply into mental health. It's going to be a big issue, Katherine, all around the world coming out of Covid, but especially for the young generation.

So you have put your focus on the most important part, which is the country. And there was a question in the chat boxes from Stacy Gilbert (sp). The estimate is \$1 spent to procure a vaccine needs to be paired with \$5 for helping the health systems in a country. The local country is where the action is now. It is a race against time to try to keep the world healthy. And we can use the help of everyone. So anyone who can pitch in and help us we would appreciate. And we'd love to add some thoughts into the chats after this. But thank you very much, Katherine.

Ms. Bliss: Well, thank you. I want to thank Charles Akataobi, Henrietta Fore, Martha Ngoe, John Hamre, Shyam Upreti for joining the conversation this morning. Thank all of you in the audience for joining and participating in this discussion about the reality of rolling out Covid-19 vaccines. And thank you very much for participating in our conversation today. We are adjourned. Thank you.

(END)

