COMMUN VII

2022 | Commonwealth School, Boston

WHO: Equitable Vaccine Distribution

Background Guide

Chairs: Bella Wright '24, Genevieve Robinson '24, and Ben Summey '24

Welcome Letter

Dear Delegates,

Thank you for choosing to be a delegate on the COVID-19 Vaccines Global Access committee (abbreviated as COVAX). COVAX is a global initiative co-led by the GAVI Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI), and the World Health Organization (WHO). The goal of COVAX is to create an equitable and fair distribution of COVID-19 vaccines, tests, and treatments for low-to-middle-income countries and level the playing field so that each country is given equitable access to doses and other resources to combat COVID-19. This means that no countries are left behind, and the pandemic can be globally mitigated instead of reduced in a select amount of higher-income countries.

This committee is run by three chairs, and as sophomores, COMMUN VII will be our first time experiencing COMMUN, so we thought it would be best to introduce an important and relevant topic for the conference that not only affects the entire world, but is important within international discussion to create understanding and cooperation across the globe. While 61% of the worldwide population has been administered at least one dose, with 24.3 million additional doses being given each day, there are still harsh disparities present between different areas of the world in regards to access to vaccines, accurate education and information around vaccines, and the rates of vaccine hesitancy.

It is often the case that higher rates of vaccinations are correlated with higher income countries, while low-to-middle income countries tend to not have access to the same resources, and thus cannot adequately administer the doses required to generate a safe and healthy population to combat COVID-19, with Oxford reporting that around only 10% of people in low-income countries have received at least one dose of the vaccine. Compare this to the United Arab Emirates, a very developed country, which has around 99% of its citizens receiving one dose, and 95% fully vaccinated, while many nations in Eastern Europe, Africa, and the Middle East have immensely lower rates — the Democratic Republic of the Congo is a very polar example of this, reporting less than 1% of its population even having received one dose of the vaccine, and near zero percent at full vaccination. This, in combination with the increasing rates of vaccine hesitancy in countries that already have abundant vaccine resources and education, is what COVAX aims to eliminate, by coordinating with countries worldwide and delivering and distributing doses equitably.

We acknowledge that vaccine equity as a global issue is extremely intricate and complicated, and we're so excited to hear from you in the spring. If you have any questions or concerns about our committee, please don't hesitate to reach out to any of us:

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UNESCO: Equitable Vaccine Distribution

> "Developing a vaccine against COVID-19 is the most pressing challenge of our time — and nobody wins the race until everyone wins"
>
> *-COVAX Mission Statement*

Problem Statement:

COVAX is committed to ensuring that countries across the globe approach the distribution of vaccinations against COVID-19 with fairness, rather than format it as a contest to see which country can get their population the highest vaccination rates in the shortest amount of time. While some countries already have an advantage compared to others in terms of population vaccine rates, as mentioned before, COVAX offers a diverse and actively managed portfolio of vaccines, with the intention of rebuilding economies and providing adequate amounts of doses for each country's population to effectively handle the pandemic.

Background: "A Brief History on COVAX"

COVAX is one of four "pillars" launched by the Access to COVID-19 Tools (ACT) accelerator via the World Health Organization (WHO) in April 2020. Along with the Diagnostics pillar, the Therapeutics pillar, and the Health Systems Connector, COVAX acts as the fourth Vaccine pillar, built with the intention of distributing vaccines for the COVID-19 virus equitably across all countries with accountability, which is done by ensuring legally-binding documents and contracts with pharmaceutical companies and manufacturers, as well as countries for financial pledges, to ensure money and vaccines are managed adequately.

COVAX ensures equity by making sure lower-income funded nations, who would otherwise be unable to afford these vaccines, can get access to the necessary resources

required to purchase and acquire vaccines to help diminish the spread of the virus and contain the pandemic in each respective country. Without COVAX, more citizens, especially in lower and middle-income countries, would be at risk of getting and spreading the virus, leading to hospitalizations, and in the most extreme cases, death. Ultimately, COVAX "serves as an invaluable insurance policy to protect their citizens, both directly and indirectly," and helps lessen the risk of COVID-19 across the globe where it is successful.

Background: "A Brief History on Vaccine Equity"

The belief that each country should be responsible for buying and administering vaccines for its own people originates from a history of wealthier countries obtaining vaccines at the cost of less powerful ones. Vaccines have thus become more of a market commodity than a public health necessity as a result of this. For example, during the HIV pandemic, which began in 1981, access to ART (antiretroviral therapy, or antiretroviral drugs) was severely limited in less developed nations due to unaffordable prices. The pharmaceutical industry has financed these vaccines for many developing countries, meaning the spread of ART is heavily reliant on their generosity.

More examples of this happening include the flu pandemic in the 1920's, in which developing countries had a larger death toll than those with better access to the vaccines that were developing in Europe and the United States. Although these vaccines did not by any means make one immune to contracting the flu, recent studies have shown that they may have led to a lower rate of hospitalization as they lowered the rate of infection with pneumonia after contraction of the flu. During the 1918 flu pandemic, developing countries such as India, losing 5.2% of its population, and Kenya at 5.8%, had extremely high death tolls (as opposed to the United States, which lost about 0.6%, or the United Kingdom at around 0.2%).

Another instance of inequitable distribution of vaccines includes the re-emergence of the swine flu in 2009. Leaders of developing countries were determined to buy and distribute vaccines to their citizens with as much efficiency as possible, but even after WHO and the United Nations appealed for donations so that these countries could be

equitably distributed vaccines, the developing world was still left with an inadequate vaccine supply to cover their populations.

Other examples include the 1953 cholera pandemic, the Asiatic flu in 1957, the flu pandemic in the 1970's and measles, which still persists today in many parts of Africa. We can see here how vaccination and general healthcare has historically been much less accessible to people in developing countries, effectively making it harder for these countries to develop and has worsened these citizen's living conditions.

Recent Developments

Under the Biden administration, The United States and the other G7 nations have pledged support for global vaccine procurement through the COVAX initiative. COVAX distributes vaccines to lower and middle-income countries and intends to immunize at least 40% of the population of every country by the end of 2022 and 70% by June of 2023. So far, COVAX has raised upwards of $10 billion and has distributed 240 million doses to 139 countries within a six month period, and has arranged legally-binding commitments to secure nearly 4.5 billion doses of the vaccine, according to the WHO, and COVAX's latest "Supply Forecast" predicts it will reach its milestone of 2 billion doses being released for delivery in the first quarter of 2022. In addition to this, it expects to get approximately 1.2 billion available for lower income economies, which is enough to protect 20% of the population, or 40% of all adults.

With global vaccine production at 1.5 billion doses per month, we have enough to reach these goals. The most pressing issue now lies in inequitable distribution, rather than in supply. The World Health Organization is focused on distributing these vaccines to the people who need them most, focusing on health workers, the elderly, and other at-risk groups.

COVID-19 Vaccine Hesitancy & Refusal

Vaccine hesitancy, for various reasons, has become a defining theme in the COVID-19 pandemic. Firstly, it is important to distinguish between vaccine hesitancy and vaccine refusal, the latter typically having deeper cultural and political undertones and often being much harder to overcome. Recurring arguments among the communities that refuse (that are not grounded in the history of the medical system imposing harmful practices on specific groups) include the idea that the side effects of vaccines are worse than the actual disease, the idea that vaccines cause disease and the idea that vaccine mandates infringe on civil liberties (and other issues with religious beliefs).

Discussion

Theories on the Side Effects of Vaccines

The theories that the side effects of vaccines are worse than the actual disease and that vaccines cause disease have existed since the 19th century, and are being spread widely on the internet. This idea is the result of widespread disinformation in regards to vaccines that is likely sparked by mistrust in the government and medical system. Different falsehoods like these about the COVID-19 vaccine and its side effects have little to no basis in fact, and have been spread widely on social media in the past year, unfortunately gaining a bit of traction

Civil Liberties and Vaccine Mandates

The issue of infringement upon civil liberties in regards to vaccine mandates is a more complicated one. Many feel as though vaccine mandates violate their civil liberties and individual rights to bodily autonomy. This becomes more complex when the issue of religion is introduced. The question of religious exemptions to vaccine mandates has become urgent recently, forcing clergy to take stands for or against excusals. Some religious leaders are pushing back against this idea and trying to mitigate people's concerns about vaccines, while others are helping churchgoing employees get religious exemptions to vaccine mandates for businesses. These religious exemptions are allowed in 44 states and typically require the employer to vouch for the employee's sincerely held religious beliefs. Integrity issues have arisen as a result of this; religious exemptions have been granted to people whose concerns were not actually religious, but are rather in regards to possible side effects.

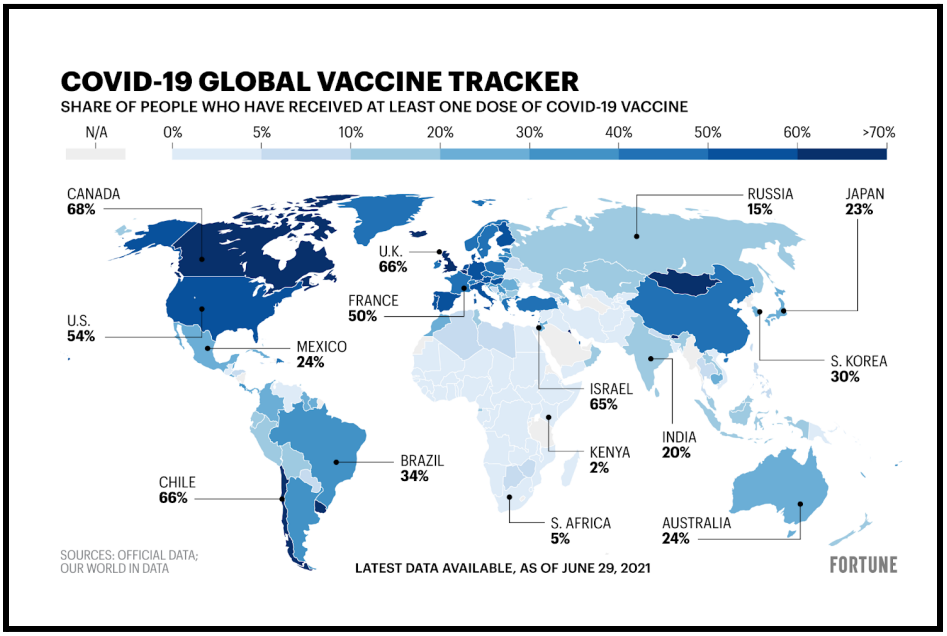
Mistrust of Medical System from a Racial Standpoint

A general mistrust of the medical system exists in some racial groups, due to specific historic instances in which these groups have been targeted. Two examples of the medical system targeting specifically the Black community include the Tuskegee Syphilis Study, in which Black men were used in a study to record the "natural history of syphilis" without their informed consent, and the mistreatment of Black women by gynecologists including J. Marion Sims (now considered the father of gynecology), who performed research experiments on Black women without anesthesia or informed consent. This lack

of institutional trust stems from a variety of factors, also including the inconsistent information and recommendations from the scientific community at the beginning of the pandemic. Racial and ethnic minority groups have been historically prevented from having equitable opportunity for economic, physical and emotional health and this is being highlighted by the fact that COVID-19 is disproportionately affecting these groups in terms of infection, hospitalization and death.

Vaccine Distribution in Developing Countries

The issue of racial and ethnic minority groups historically having less access to healthcare affects equity on a larger, more international scale as well. More developed countries have healthcare infrastructure that allows the fast manufacturing, acquiring and distribution of doses. This means that developing countries have lower rates of vaccine distribution and therefore higher rates of infection. The graph below shows the share of people who have received at least one dose of the COVID-19 vaccine as of June 29, 2021 and highlights that developing countries have lower rates of vaccination.



Additionally, companies like Moderna, who made an estimated $18 billion from their COVID-19 vaccine production in 2021, have been condemned in their alleged for-profit system. Numerous attempts have been made by public health officials across the globe to gain access to patents or arrange deals with Moderna for their formulas, recipes, and techniques for vaccine development, so that the worldwide effort can be accelerated at a much higher pace, but Moderna has often ignored or rejected these requests, choosing to proceed in whatever way the company deems fit for its vaccine production.

Dr. Martin Freide, an official of the World Health Organization, has stated, “We would love to get a discussion with Moderna, about a license to their intellectual property

— this would make life so much simpler, but for the moment all attempts have resulted in no reply," and Candice Sehoma, the South Africa advocacy officer for the international humanitarian organization, Doctors Without Borders, has also stated, "By choosing to ignore global public health initiatives and go its own way, Moderna has made it clear that it is much more interested in raking in grotesque profits than in contributing to the global vaccination effort to save lives."

Moderna, and other pharmaceutical companies alike in vaccine development and production, are making the global process for vaccine equity much more difficult by withholding information from government and humanitarian organization officials to maximize the amount of money they make each year from their distribution and sales of vaccines.

Overcoming Vaccine Hesitancy

It is crucial that, to overcome current rates of vaccine hesitancy, trust in the scientific community is rebuilt. Community-based initiatives and creating connections between the scientific community and the leaders of smaller communities are necessary strategies to instill this trust. Ensuring that everyone has fair and just access to COVID-19 vaccination is another important step towards health equity.

The CDC has created a plan for ensuring that everyone has equal access to COVID-19 vaccination. Through communication with marginalized communities, the CDC is creating tools and resources to respond to the concerns of these communities and share accurate information about COVID-19.

Bloc Positions:

As part of the Group of Seven (G7), multiple North American and Western European nations have pledged to immediately share at least 870 million doses of COVID-19 vaccines with the United Nations' global immunization efforts. Beginning as an incredibly important pledge for the future of vaccine distribution, COVAX gave continued support for the group's aid in significantly exporting vaccines by promoting voluntary licensing and not-for-profit global production. However, numerous humanitarian charities and organizations have been critical of the G7 pledge, as while the group is composed of some of the world's wealthiest nations, some believe the pledge does not go far enough: Agnès Callamard, the Secretary-General of the human rights organization Amnesty said, "Pledging to provide one billion doses is a drop in the ocean and wouldn't come close to

covering the population of India, let alone vaccinating the world's population. It is nowhere near enough and fails to address the root issues at play. Not only is it unambitious but smacks of self-interest, particularly considering data suggests G7 countries will have three billion spare doses surplus to requirement by the end of the year."

China alone pledged more than double what the entire G7 group has collectively, committing to donate around 2 billion doses and an additional $100 million in aid for global distribution of the vaccines to COVAX. Chinese top-leader Xi Jinping has said, "China will continue to do everything it can to help developing countries cope with the epidemic," placing China's commitment in direct opposition to that of the United States, a recurring competitor to China, which individually sent over 100 million doses abroad and purchased another 500 million to be distributed through COVAX in 2021. The WHO additionally clarified that it was not clear when the donations would come, or whether China's pledge was reflective of vaccine sales rather than direct donations to COVAX.

While vaccine pledges from industrial nations are important for global contribution, the WHO is insistent that to bring the pandemic under control, an additional 11 billion doses are required to be purchased, distributed, and administered across the world. While vaccine administration in countries like the United States may be free, its development by pharmaceutical companies like Pfizer and Moderna are largely for-profit, making it even harder for lower-income countries to purchase vaccines for their citizens, forcing other nations to designate funds. For example, in November 2021, ReliefWeb, the humanitarian information portal, reported that vaccine development companies were estimated to produce pre-tax profits of around $34 billion, with people such as Anna Marriott, Health Policy Manager at the Oxfam charity organization saying, "It is also a complete failure of government to allow these companies to maintain monopoly control and artificially constrain supply in the midst of a pandemic while so many people in the world are yet to be vaccinated," and in May 2021, the New York Times additionally reported that, "The World Health Organization figures make clear that Pfizer has provided minimal help to the world's poorest countries". These nations are overwhelmingly of higher-income compared at a global scale, and make vaccine distribution much harder as the number of intermediaries between pledges and acquisition of doses increases.

Questions:

1. How can COVAX place pressure on higher-income countries to distribute more vaccines globally, rather than creating pledges that are not adequate?
2. How can COVAX allocate resources that contribute to lowering vaccine hesitancy, and what strategies can COVAX implement to instill greater trust in vaccine administration?
3. How can countries balance vaccine distribution for their own citizens individually while still contributing to the global immunization effort against COVID-19?
4. How should the WHO go about addressing and assuaging historically based concerns that racial groups might have in regards to vaccines?

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