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WASHINGTON, DC

E-PAPER

Global perspectives on Covid-19 vaccination

Dealing with scarcity:
Equitable access to
Covid-19 vaccines
in Colombia



COLOMBIA

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Published by the Heinrich-Böll-Stiftung European Union, Brussels
and the Heinrich-Böll-Stiftung Washington, DC, June 2021

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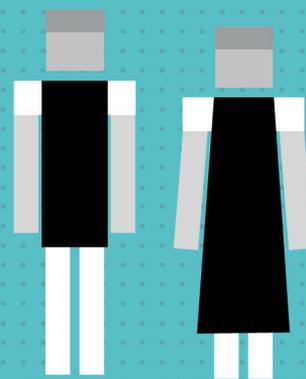
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COLOMBIA



GDP per capita in US

15,630.1 \$
(2019)



Overall population

50,339,443
(2019)

Population fully vaccinated

2021, June 14th

7.62 %



Population at least partially vaccinated

2021, June 14th

18.26 %



Vaccine doses allocated:

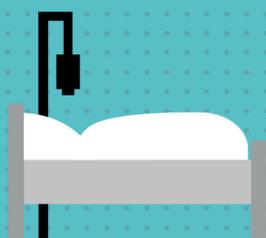
2,066,400

Astra Zeneca

Doses received:

2021, March 20th - 244,800

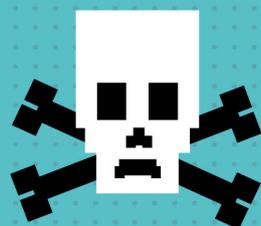
2021 April 25th - 912,000



Covid-19 cases

3,830,000

2021, June 16th



Covid-19 deaths

97,560

2021, June 16th

117,000

BioNtech / Pfizer

Doses received:

2021, March 1st - 117,000

Introduction

The global Covid-19 pandemic has hit the country strongly. As of May 13, Colombia ranks 12th worldwide in absolute positive cases and 10th in mortality. In February 2021, the Colombian government initiated a vaccination programme that brought hope to the people. However, the deployment of such a programme has faced many difficulties, which raises concerns about whether it will be possible to achieve herd immunity by the end of 2021.

This article presents an overview of the vaccination programme in Colombia and some recommendations for international actors to speed up the process and guarantee equitable access to vaccines. The article is divided into two parts. The first one presents an overview of the situation in Colombia and analyses the vaccine programme implementation. This section will also explore the current acceptance of the vaccine and the economic benefits that a successful vaccination programme could bring to the country. The second part will develop some of the expectations with regard to international actors, so as to promote international cooperation regarding access to vaccines. This section will analyse two scenarios: the waiver on intellectual property rights currently discussed in the World Trade Organization, and the COVAX initiative. We will argue that both forms of cooperation are complementary and that international actors, notably high-income countries, should support both strategies.

Overview of the pandemic and state of the vaccine programme

On March 6, 2020, the Colombian Ministry of Health and Social Protection (MHSP) announced the [first case of Covid-19](#) in the country, a young student that had returned to the country from Italy. By May 13, 2021, the National Institute of Health (INS) had [registered](#) 3,048,719 total positive cases in the country, from which 2,859,627 (93.8 %) had recovered and 79,261 (2.6 %) had died from the new disease. At the time of writing, Colombia ranks [12th in the world](#) according to the Johns Hopkins University Coronavirus Resource Centre in absolute positive case reports. As in other parts of the world, [fatalities are more common in the population aged 60 years and over](#).

As for the vaccine programme, the country is highly dependent on vaccine imports. Colombia lost its vaccine-manufacturing capacity in the late 1990s [after several budget restrictions to science and technology](#) that impacted the INS, the institution in charge of manufacturing different types of vaccines against yellow fever, rabies, tuberculosis, diphtheria, pertussis and tetanus. Today, there is no public or private vaccine manufacturing in the country. Instead, Colombia relies on the Pan-American Health Organization's (PAHO) [Revolving Fund for Vaccine Procurement](#), the only regional collective mechanism that allows the country to acquire most of its [public vaccine portfolio](#).

Six stages should be considered for Covid-19 vaccine deployment: a) approval; b) acquisition; c) delivery and distribution; d) prioritisation; e) administration; and f) monitoring. The *approval stage* is the obtainment of authorisation from a sanitary authority for importing and administering a pharmaceutical product in each country. By May 13, 2021, the Colombian National Food and Drug Surveillance Institute (Invima) had issued [four Emergency Use Authorizations](#) for vaccines in 2021: Pfizer/BioNTech (January 6), Sinovac (February 3), AstraZeneca/Oxford (February 23) and Janssen (March 25). Invima has also authorized [four clinical trials](#) that included the vaccine prospects from AstraZeneca/Oxford and Janssen and ongoing trials from Clover Biopharmaceuticals and CureVac.

Vaccination acquisition is the stage in which a country obtains a formal agreement to receive a given number of vaccines from a developer, manufacturer or intermediary. The Colombian government created a vaccine portfolio from multilateral and bilateral agreements. On the multilateral side, the MHSP announced on July 28, 2020, that it had [joined the COVAX Facility as a self-financing country](#). According to the Ministry, Colombia committed to acquiring [20 million doses for 10 million people](#). On the bilateral negotiation side, the Colombian government has announced agreements for Covid-19 [vaccines with five developers](#): Pfizer/BioNTech (10 million doses), AstraZeneca/Oxford (10 million doses), Janssen (9 million doses), Moderna (10 million doses) and Sinovac (7.5 million doses). On May 13, 2021, the Moderna vaccine did not have Emergency Use

Authorization in Colombia. The multilateral and bilateral agreements will provide [66.5 million vaccines](#) in total, which will be enough, in theory, to cover [37,750,000 people](#), or 70 per cent of the Colombian population, by the end of 2021. However, as global production is scarce, there is not yet clarity on when those doses will be received.

The next stage of the vaccine deployment process is *vaccine delivery and distribution*. Once a country has an agreement, it will start receiving doses from developers and manufacturers. Colombia was confirmed to receive 2,066,400 doses of the AstraZeneca/Oxford vaccine in the [COVAX First-Round Allocation](#) announced on March 3, 2021, and 117,000 additional doses of the Pfizer vaccine from an exceptional distribution to 18 participating countries. By May 13, [the country had received 1,273,800 vaccines from the COVAX Facility](#), 117,000 doses of the Pfizer vaccine from the exceptional distribution, and 1,156,800 doses of the AstraZeneca/Oxford vaccine from the regular allocation. This represents 58.3 per cent of the total amount that is supposed to be delivered by May 2021, and there is no available information on when more doses will be delivered.

On deliveries from bilateral agreements, by May 13, 2021, Colombia had received [9,587,224 doses](#), representing 20.62 per cent of those commitments. Between February and May 13, the government had received 3,587,220 doses from Pfizer and 6,000,004 doses from Sinovac. Multilateral and bilateral agreements account for [10,861,024 doses](#), which represent 16.3 per cent of the total vaccine procurement goal. Although the Office of the President calculates that by the end of May 2021, [Colombia will have received 14 million vaccines](#), current figures cast doubts on whether such a goal will be achieved, as the agreements and their content, including delivery date, are [classified](#).

The next stage is *vaccine prioritisation*. Once vaccines are received, the national government distributes them among local health authorities and vaccination centres to be administered following a priority framework. In December 2020, the MHSP announced a [National Vaccination Plan Against Covid-19 \(NVPC\)](#) that established free vaccine access for everyone older than 16 years old, but using a priority-setting approach. The plan covers all inhabitants of the territory, including foreigners with regular status (a permit granted by the migratory authority of Colombia when a foreign person arrives in its territory).¹

1 It is difficult to know whether this plan is actually being carried out in a satisfactory way, as there is no centralised and publicly available information. This aspect will be discussed further in the *monitoring* stage.

The plan includes two phases and five steps, each with different priority groups based on the roadmap for priority-setting presented by the Strategic Advisory Group of Experts on Immunization (SAGE) of the World Health Organization (WHO). The [NVCP](#), which was revised in February 2021, states that the *first phase* would be focused on reducing mortality and consists of three steps:

1. Health personnel exposed to Covid-19 and population over 80 years old.
2. Population over 60 years old, other health workers, and traditional doctors and ancestral healers.²
3. Population between 16 and 59 years old that has comorbidities, schoolteachers, institutional caregivers, police and military officers, prosecutors, the indigenous guard, and funeral-home workers.

For the *second phase* of the plan, two steps, are included:

4. Incarcerated population and prison officials, firefighters, lifeguards, homeless population, air traffic controllers, and pilots.
5. The rest of the population aged 16 to 59 years.

Once vaccines are distributed and appointments allocated, the next stage is *vaccine administration*. The [first vaccine](#) was administered on February 17, 2021, to Verónica Machado, Chief Nursing Officer at Sincelejo Teaching Hospital. Since then, and up to May 13, 2021, [Colombia has administered 6,851,163 doses for 4,238,607 people](#), meaning that 2,612,556 people have received a second dose. The NVCP aims to vaccinate [35,734,649](#) people, but it has only reached 11.9 per cent of the target population two months after the official start of the vaccination programme. At this pace, the goal of vaccinating 70 per cent of the population by the end of 2021 will not be reached. According to Our World in Data, the [daily vaccine doses administered per 100 people](#) in Colombia was 0.31 doses per 100 people by May 13, 2021, compared to Uruguay (0.79), Chile (0.64), Brazil (0.2), Argentina (0.31) and Mexico (0.31).

The vaccination deployment process does not stop during the vaccine administration stage. It is vital to have information about each step in the process to identify bottlenecks and opportunities. Therefore, it is crucial to consider the *vaccine monitoring* stage. The country provides information about the rollout and the different characteristics of the people who have received it. Unfortunately, by May 13, 2021, Colombia did not have a centralised public information system that allows citizens to know in detail the characteristics of people vaccinated among regional and local administrative entities.

2 At least 1.9 million Colombians belong to indigenous communities according to the 2018 National Census. Decree 1953 of 2014 established an Intercultural Indigenous Health System (SISPI) that recognises the role of traditional doctors and healers in the provision of health services for indigenous people.

There is still no information about vaccine administration by gender, age, profession, migration status or type of vaccine received. This is a worrisome situation for many vulnerable communities that bear the inequity in vaccination access. For instance, there is no reliable information available to confirm if migrants are being vaccinated, despite their eligibility in the current stage of the NVCP. The vaccination programme requires an ID number to be part of the waiting list that the national and local governments organise to allocate appointments, a process that becomes an administrative [barrier for migrants that have not achieved regular status](#).

Acceptance of the vaccine

In general, Colombians have a positive image of the Covid-19 vaccine. The National Administrative Department of Statistics published the results of a recent [survey](#) about confidence in the vaccine, in which 70 per cent of the people confirmed they would get vaccinated if they were allowed to do so. Nevertheless, some people still have a negative perception of the vaccine. Misinformed groups or individuals deliberately spread erroneous or false information about Covid-19 vaccination. Furthermore, 6 per cent of the population surveyed answered that they were not worried about the new virus, 52.1 per cent considered that they were somehow worried about it and [38.4% revealed that they were very concerned](#) about getting sick from the virus.

In March 2021, the Colombian government launched a media campaign called "[Let's get vaccinated and live again](#)" (in Spanish "Vacunémonos y Volvamos a Vivir") that had the mission of countering misinformation around Covid-19. The MHSP has held different [webinars with experts](#) that reiterate the positive message around the vaccines and in which several celebrities participated.

The vaccine is not compulsory in Colombia. All persons have the right to be informed about the vaccine, and they have the right to either consent or refuse to get the jab.

Expected consequences of the vaccine deployment for the Colombian economy

As in most countries around the world, the pandemic has harmed the economy. According to the National Administrative Department of Statistics (DANE), [the Colombian economy shrank 6.8 per cent of GDP in 2020](#). At the beginning of the pandemic crisis, more than 20 per cent of the economically active population was unemployed. One year later, the unemployment rate is still over [fifteen per cent](#). In 2020, [21,021,564 Colombians were poor](#), which means that 42.5 per cent of the Colombian population are below the minimum per capita income needed to acquire a basic basket of food and non-food goods

and services. The poverty rate has increased by 6.8 percentage points in the last year. The population living in urban areas was the most affected. In the following years, the Colombian state has an urgent and essential task on its hands to mitigate the effects of the economic crisis on the population.

The pandemic did not impact all Colombian regions in the same manner. In cities such as Cartagena, on the Caribbean coast, [60.5 per cent of the households had access to less than three meals a day](#). Before the pandemic, 81.9 per cent of Cartagena households had access to three or more meals a day. [Unemployment rates](#) are higher than the average in cities like Cúcuta (22.3 per cent), Quibdó (22.1 per cent) and Ibagué (21.5 per cent). Likewise, the pandemic has hit some groups economically more than others. While unemployment is still high, [women's labour participation decreased even more highly](#), especially among Venezuelan migrants and [afro-descendants](#).

Since April 2020, the government has expanded social programmes and employment protection worth [1.3 per cent of 2020 GDP](#). During this period, the government's flagship programme to help poorer and vulnerable households, the 'Programa de Ingreso Solidario' (PIS in Spanish), was established as a monetary non-conditional transfer to the population at risk not covered under other social programmes. While PIS had some positive impacts on the households that received it, [civil society movements have denounced](#) the programme for providing minimal monetary aid to supply basic needs and still having an exclusion error due to the targeting instruments and other implementation problems. Despite these drawbacks, DANE pointed out that this programme, together with other state aid, could [help reduce poverty in rural areas of the country during the pandemic](#).

A fast and rigorous implementation of an ambitious vaccination plan would accelerate the economic recovery due to the high rate of labour informality, self-employment, and small and medium size businesses affected. In a scenario of declining infections, rising vaccinations and limited lockdowns, the International Monetary Fund (IMF) estimates a gradual recovery this year. However, [GDP would not return to pre-pandemic levels until the end of 2022](#). Other national experts point out that the [recovery could take 5.2 years](#), depending on government decisions. In any case, access to sufficient vaccines for at least 70 per cent of the population is a necessary condition to guarantee the success of the vaccination programme and an economic recovery plan. More considerable efforts regarding the coverage and speed of the vaccination plan to reduce infections, save lives and reduce lockdowns, while at the same time maintaining critical financial support to households and the implementation of infrastructure programmes, will undoubtedly contribute to Colombia's recovery. Also, the IMF points out that Colombia's effort to integrate Venezuelan migrants into the economy should raise the country's potential growth in the midterm. Currently, around [1.7 million Venezuelan migrants are living in Colombia](#).

In March, Colombia's government proposed a bill on tax and public spending reform. Part of the proposals included social programmes such as a guaranteed basic income for vulnerable households and subsidies for job creation. However, the proposal had regressive implications that were especially felt by Colombia's middle class. The reform, along with other problems such as assassination of social leaders, police brutality and economic inequality, among others, raised the indignation of the population. At the time of writing this article, Colombia had been on strike for fifteen days. Given the blockades, new problems were added to the current situation in the country during the pandemic, such as the lack of supply in urban supermarkets, the loss of crops and other agricultural products, and the difficulty of transportation. Likewise, the country is passing through the third peak of the pandemic with health services capacity at 99 per cent. Without adequate and pertinent actions on the part of the national government to reconcile with the population, the recovery of the Colombian economy may take much longer than estimated.

Expectations for international actors

As we have seen, both the public health situation and the economic recovery in Colombia are dependent on the quick implementation of the vaccination plan. However, like many other middle- and low-income countries, Colombia is facing difficulties in accessing vaccines. According to official figures, 83 per cent of all Covid-19 vaccines have been administered in high and upper-middle-income countries, including Colombia in the latter group, while only 0.1 per cent of doses have been administered in low income ones. Many low-income countries have not yet reported one single jab.

With just a few companies producing the vaccines for the whole world, there is a substantial scarcity of vaccines in the market. Most countries have faced the problem with a nationalistic approach by purchasing even up to five times what is required to vaccinate their entire population, or by keeping the production of vaccines made within their territory to themselves. This has led to very unfair situations in which healthy young people from rich countries have already received their second jab, while frontline health workers from developing countries have not yet received any. The WHO director has called this a "catastrophic moral failure" that will be paid for with the lives of the world's poorest inhabitants; others have simply called it "vaccine apartheid".

Although most pandemic-related global actors have called for the need to strengthen international cooperation as the only way to succeed in the race against the virus, they frequently disagree on the best tools to achieve it. The following section will focus on two scenarios that would facilitate cooperation and equitable access to vaccines and how they may be helpful to increase the number of vaccines in low- and middle-income countries. For each of them, we will present some of the expectations for international actors

Intellectual property laws at the World Trade Organization

Many have claimed that the current vaccine scarcity is actually artificial, resulting from the Intellectual Property (IP) regime. The IP legal framework established in the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement allows companies to enjoy exclusive rights over their products for an extended period and makes it impossible for other companies to produce vaccines without risking a legal claim. In October last year, India and South Africa proposed to the World Trade Organization (WTO) that member countries waive patents on Covid-19 vaccines and other technologies to increase vaccine production. Such a waiver would last for one year or until herd immunity is reached in most countries.

While countries from the Global South have supported the initiative, countries in the Global North, including the United States (US), the European Union (EU), Canada, the United Kingdom (UK), Norway, Japan and Australia, have consistently opposed these efforts. Some of the arguments supporting their position, which are also shared by the industry, state that the problem of scarcity does not only depend on the intellectual property regime but on the [existence of know-how, technology, expertise and biological samples](#), which are not available in most countries. Moreover, the [pharmaceutical industry](#) states that intellectual property rights are crucial to ensure that investment in innovation and science has a safe return, and that diluting that legal framework may be counterintuitive to get inventors and investors engaged in future pandemics.

Advocates for the waiver have explained that [intellectual property laws are not the only barrier](#) to access to Covid-19 vaccines. Access to technology and know-how should also be available to increase production. However, waiving patents is an essential first step that will surely contribute to overcoming the barriers to access. Moreover, as for the argument on investment return, further analysis shows that research on Covid-19 vaccines has largely benefited from public funding. In the US, six vaccines have received [\\$12 billion US from public funding](#). In the UK, [research](#) has shown that around 95 per cent of all the funding used to create the AstraZeneca vaccine was public. Thus, securing monopoly rights for just a reduced number of industries over the invention of a vaccine, to which the public itself has already contributed, may be excessive.

Lastly, there are legal reasons in favour of a temporary hold on intellectual property rights. A statement from March 2021 by the Committee on Economic, Social and Cultural Rights on unaffordable universal vaccination for Covid-19, international cooperation and intellectual property, emphasised that states have a ["duty of international cooperation and assistance to ensure access to vaccines for Covid-19 wherever needed, including by using their voting rights as members of different international institutions or organizations, including regional integration organizations such as the European Union."](#) As most countries have signed or ratified the Convention

on Economic, Social, and Cultural Rights, this statement comes as an authorised recommendation to take action. Similarly, the [Inter-American Commission on Human Rights](#) has also called for states to secure equitable access to vaccines, goods and health services, and to cooperate in their access through the support of COVAX, the Covid-19 Technology Accelerator Pool (C-TAP) and other relevant global tools.

On May 3, the US declared it will support the waiver on patents and facilitate discussions within the WTO. This was a game-changer in the discussion that opened a crack within the EU's position. Following this statement, representatives from [Spain, Russia, Italy and Greece](#) declared they will also support the waiver, while the President of the European Commission declared that "[t]he EU is also ready to discuss". The WHO Director-General Dr Tedros Ghebreyesus called this a "[historic decision for vaccine equity](#)". However, Germany, France and Switzerland are still sceptical about the proposal. The Chancellor of Germany, Angela Merkel, stated that "[t]he limiting factors in the production of vaccines are the production capacities and the high-quality standards and not patents" and that "[t]he protection of intellectual property is a source of innovation and must remain so in the future". According to Germany's Health Minister, "[t]he main issue is not patent protection but production capacity". These arguments mirror the ones from the industry that were discussed above and align with the 'third way' proposed by the WTO Director-General Ngozi Okonjo-Iweala.

The "third way" consists of encouraging *voluntary non-exclusive license* agreements between companies. This proposal has been supported by Australia, Canada, Chile, New Zealand, Norway, Turkey and Colombia. As with any voluntary measure, the problem with this initiative is that it requires the will of the industry to get involved. Although this option has always been available, so far the only companies that have accepted such an agreement are AstraZeneca and Novavax with the Serum Institute of India. Other companies have refused to agree on voluntary licenses when asked by other companies interested in copying their production. For example, Johnson & Johnson (J&J) [refused to agree on a voluntary license](#) of the vaccine Jansen, despite the Canadian company Biolyse Pharma Corp. offering it five per cent or more of royalties if it agreed on a voluntary license. Such a deal would have resulted in the production of 20 million doses additional to the ones already produced by J&J. Some trade analysts argue that [after the US backed the waiver proposal, pharmaceutical companies may now be more open to sharing technology in a voluntary manner or for a reduced charge](#). However, apart from AstraZeneca and Novavax, no company has announced the negotiation or beginning of voluntary licences so far.

Another option that has been discussed to accelerate vaccine production is the application of *compulsory licenses*. These are agreements in which states may force companies to share their knowledge, usually in exchange for some monetary compensation. The problem with this option is that it requires the approval of domestic institutions and the following of procedures that may be complex and time-consuming. For example, most legislation requires states to have offered the company a voluntary license previously; only if that process fails could a process for a compulsory license be initiated. Another

difficulty is that the license usually does not include all the other trade secrets and know-how needed to secure production, so they may not always be enough to secure increased production. Moreover, compulsory licenses are to be applied, in principle, only by countries that have registered their patents and do not produce products primarily for export. This means developing countries could hardly benefit from this option. For example, suppose a country such as Canada obtains a compulsory license. In that case, any vaccines produced could not be exported to a third country unless such a country had participated in the process of licensing and notified the WTO. Recently, [Bolivia notified the WTO of its interest to use this mechanism](#) in order to import vaccines from a Canadian company. However, the license has yet to be approved by the Canadian government through an internal mechanism that some have called a “[procedural labyrinth](#)”. If successful, this will be the first case in which this mechanism is used to access covid vaccines. However, it is still too soon to see if it actually works within a reasonable timeframe.

The difficulties of implementing either voluntary or compulsory licences make the waiver on patents the best option to increase production in the medium term. However, it is important to take the recent wave of support for this initiative with a pinch of salt. In order to work, it should include not just the vaccine but all the medical products necessary to tackle the virus, as there are still many regions of the world where dissemination of the virus is rampant and treatment of sick people is urgently required. This should include medicines, respirators and others. Moreover, the waiver should be available for the necessary time to control the pandemic in all regions of the world, which may be longer than a year.

Finally, the waiver on patents must be accompanied by other measures such as an increase in the number of vaccine exports from some producer countries and avoiding export bans. When [comparing the vaccine production with the exports in different countries](#), it is worth noting that the US and the UK have kept most of their production for themselves. Of the 164 million doses produced in the US in March 2021, none have been exported. The same scenario happened in the UK, where 16 million doses were produced but none were exported. In contrast, China, India and the EU exported more than 40% of their production in the same period. It is important that all countries approach the vaccine problem from a cooperative approach and not just from a nationalistic one. This means producer countries such as the US and the UK must be open to sharing their production with the rest of the world in an equitable manner. Such a measure is not just compatible with the idea of a patent waiver but is also consistent with the idea of cooperation and equitable access to vaccines.

Colombia has experienced difficulties accessing a reduced market of vaccines when competing with rich players that have greater economic capacity and political influence. As previously mentioned, almost two months after the initial start of the vaccination campaign, it had just reached 11.9 per cent of the population. Although the Minister of Health has stated that the goal of vaccinating 70 per cent of the population

(approximately 35 million people) will be reached by the end of the year; the speed of the vaccination programme casts doubts on this projection, with it being more likely that [this will not be reached until 2023](#).

The government of Colombia has chosen not to support the waiver and, instead, supports the “third way” of voluntary licenses, together with some of the most developed countries. This is an unacceptable position that does not take into account the reality of the country and does not show solidarity with other countries from the Global South that are in a worse situation. [Organisations from civil society made a formal request to the Colombian Government to support the waiver](#) as a necessary way to accelerate the production of vaccines worldwide and guarantee its equitable access. We hope that countries in the Global North, particularly Germany, the EU as a block and the Colombian government, can reconsider their position and support the temporary waiver of patents until we can control the pandemic. This comes not just as a moral expectation but also as an imperative supported by public health, economic and legal reasons. Moreover, we hope that rich countries and vaccine producers, such as the US and the UK, increase their vaccine exports to the rest of the globe.

International cooperation and the COVAX initiative

Together with some western countries and private philanthropists, the WHO has materialised their cooperation efforts through the creation of [COVAX](#), a global collaboration mechanism designed to accelerate the development, production and equitable access to Covid-19 tests, treatments and vaccines. One of its goals is to create a pool of two billion doses by the end of 2021, from which 1.3 billion doses will go to low- and middle-income countries. It is expected that this mechanism could help countries to vaccinate up to 20 per cent of their population in the long term. Colombia is a self-financing participant, meaning that it will buy doses at a specific price. According to the [Interim Distribution Forecast of the mechanism](#), published on February 3, 2021, 2.6 million doses were assigned to Colombia for purchase, but not all doses are available.

There are indeed moral, health and economic reasons to enhance cooperation among countries to achieve equitable access to vaccines. On the one hand, as all *human beings are equal in dignity*, access to vaccines should be decided based on public health, not on money. On the other hand, without speeding up the pace of vaccination compared to the contagious pace, the world is at constant risk that new variants of the virus appear, variants that could be more infectious or even resistant to the current vaccines. In fact, during the last months, new variants of the virus have already shown to be more contagious. It is not just a rhetoric mantra but a reality that “nobody is safe until everyone is safe.” Lastly, different economic studies ([ICC](#), [Duke Health](#), [Eurasia Group](#), [RAND](#)) have shown that the cost for wealthy countries of not supporting coordinated

access to vaccines is mammoth. According to the [ICC study](#), such costs range between 203 billion and 5 trillion US dollars.

However, it is not clear that the COVAX mechanism will be the silver bullet to secure equitable access for everyone, as it faces several problems. So far, [COVAX has raised more than \\$6bn](#), but another \$2bn is still needed to reach the target for 2021. Moreover, the initiative needs to improve with regard to the pace of the deliveries. Colombia was the first country in the region to receive vaccines through this mechanism. However, as mentioned above, by May 13, the country had only [received 1,273,800 doses](#) out of the 2.1 million made available by the mechanism and out of the 20 million that the country expects to obtain through it. At this pace, the goal of vaccinating at least 20 per cent of the population with this mechanism will not be reached in 2021.

These problems mainly depend on the lack of cooperation to fund and activate the mechanism, which still relies predominantly on Western countries. While the Trump administration refused to join COVAX, President Joe Biden has made a decisive U-turn by joining and leading the initiative. Nowadays, the US is the most important [funder](#) of the initiative, followed by the EU and the UK. In 2021, the EU [increased](#) its contribution to the mechanism to €1 billion. So far, the EU has contributed €2 billion, which includes individual European states such as Germany, which alone has contributed €970 million.

Some Eastern countries have been less active in supporting the COVAX facility, although new steps show an increasing involvement. In October 2020, China [announced](#) its intention to join the initiative and donate 10 million doses of its vaccine Sinovac, [which was included in the list of vaccines for emergency use by the WHO](#). Russia, another significant producer of vaccines, is still not yet part of the mechanism.

The world needs the strong support and cooperation of all countries to succeed in the race against the virus. On the roles of the US and the EU, it is essential to acknowledge their current support for this initiative. However, more could be done in terms of cooperation from these countries by progressively increasing their contributions in either money or kind. Moreover, on the role of other key participants, it is positive that countries such as China have decided to support the initiative actively. However, taking into account that it is the second largest producer of vaccines in the world, it could probably [do better and increase its contribution](#), both in terms of funding and supplies. Other key players such as Russia could show their interest in cooperation by joining the COVAX programme as soon as possible and supporting it economically.

Without denying the importance of this effort, the contribution of COVAX to equitable access to vaccines is limited. In the best-case scenario, developing countries will be allowed to obtain the vaccines necessary for 20 per cent of their population, but accessing the number of doses necessary to gain herd immunity will not be guaranteed until world production increases. We need the coordinated effort of all countries to increase production and that necessarily requires the temporary waiver of patents.

Conclusion

Improvements in public health and the economic recovery of every country facing this pandemic are dependent on a quick vaccine programme that guarantees the vaccination of at least 70 per cent of the population by the end of 2021. However, the global scarcity of vaccines is threatening this goal, remarkably, in low- and middle-income countries. We need to improve international cooperation to increase vaccine production and guarantee their equitable distribution. While COVAX can be an excellent instrument to facilitate access to a minimum of doses per country, it will not be enough to secure the doses required to achieve global herd immunity. This is the reason why a waiver on IP laws is urgently required. We need it as a first step to overcome the current barriers to access. In the medium term, we will also need knowledge and technology transfer that facilitate the production and distribution of vaccines, as well as medicines, diagnostics and personal protective equipment. Moreover, other measures, such as increasing the export of vaccines from producer countries to the poorest ones, are also required in order to guarantee equitable access. This article invites international actors to support the waiver on IP laws as soon as possible, as well as to share their production with the rest of the globe. Millions of lives are still at risk, particularly those from the most vulnerable groups, so the moment to act is now!

Imprint

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Place of publication: <https://us.boell.org/> | <http://eu.boell.org>

Release date: June 2021

Editor: Chris Meikle, Brussels

Illustrations: Pia Danner, p*zwe, Hannover

Layout: Micheline Gutman, Brussels

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