

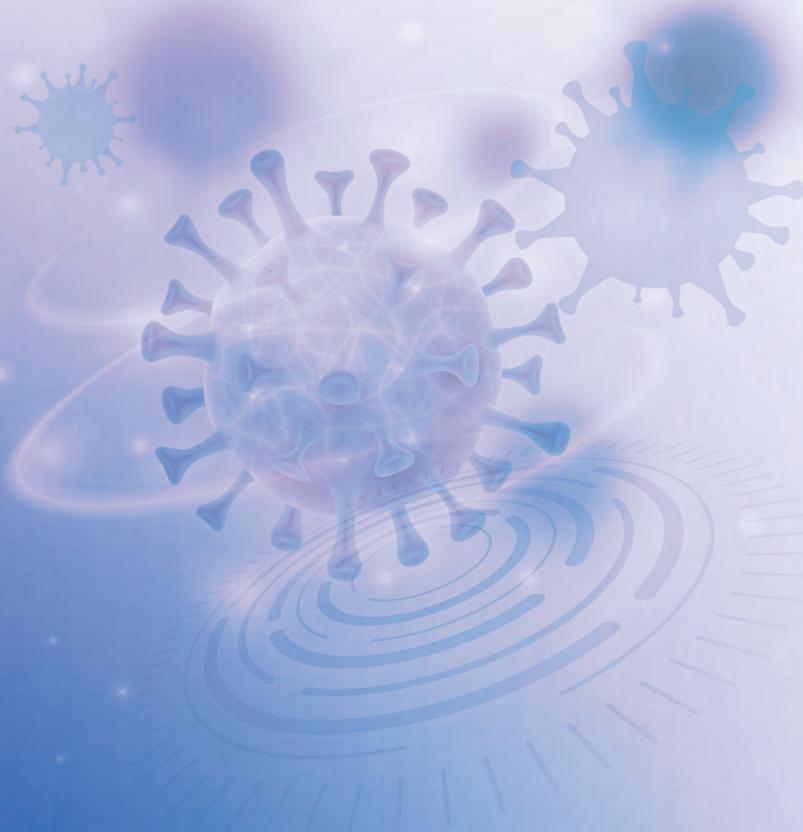


**ISER**

Facilitating Social Justice

INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS

# THE COVID-19 VACCINE AND UGANDA: TWELVE QUESTIONS TO POLICY MAKERS






# THE COVID-19 VACCINE AND UGANDA: TWELVE QUESTIONS TO POLICY MAKERS

## KEY TAKEAWAY

The country is yet to release a COVID 19 vaccination strategy despite its health system being overwhelmed by the number of COVID 19 cases and an increasing global display of vaccine nationalism which risks dwindling vaccine supplies. Scanty press briefings from the Ministry of Health and remarks by the President indicate that the country is looking to COVAX and developing a COVID 19 vaccine. We remain concerned about the country's readiness and the lack of timely substantive communication about access to COVID 19 vaccines. We pose twelve questions to policy makers and make the following recommendations.

1. Uganda should work with other lower-middle and low-income countries to push for a peoples vaccine and negotiate for waiver of patent rights.
2. Strengthen compulsory licencing and other provisions that would support access to vaccines and medicines in the Industrial Property Act.
3. Secure resources from the consolidated fund to supplement the doses that may be available through COVAX.
4. Negotiate for grants instead of loans from International Financial Institutions (IFIs) and bilateral donors.
5. Vaccine once available should be free at point of care.
6. Consult with VHTs and communities in preparation and develop a communication and community engagement strategy.
7. Share timely information regularly and honestly.
8. Recruit and train the health workforce.
9. Prioritize vulnerable groups during the initial stages of the vaccine particularly health workers, older persons and persons with pre existing conditions.
10. Ensure older persons without national Ids are registered expeditiously and ensure relevant data systems to identify beneficiaries are strengthened.
11. Put in place multi sectoral task force including lawyers, public health specialists, frontline health workers, officials from the Uganda Bureau of Statistics, National (NIRA), Ministry of Gender, Labour and Social Development, Civil society, and community voices as it develops national strategy for deployment of COVID 19 vaccine.
12. National Strategy for the Deployment of the COVID 19 vaccine should include activities to strengthen immunization throughout the life course, health services and health systems including traceability systems, monitoring and reporting systems.
13. Ensure/update functional cold storage, logistics and management systems.
14. Ensure regulatory system assessments are in place.
15. Government maintain strong stewardship of the process.
16. Regulate the private sector to ensure quality is maintained and profits are not prioritized over public health during vaccine distribution.





As countries rushed to be the first to release the vaccine, which offers an unprecedented opportunity to mitigate the pandemic, it is tempting to think “Help is on the way.” But is it? Members of Parliament, for instance, following the death of MPs and the second Prime Minister, simply asked when Uganda will get the vaccine and seemed to be assuaged by the Prime Minister’s response that in March 2021. As if it is guaranteed that the country will get the vaccines it needs in the first place and it is simply a matter of when. The President has briefly mentioned the country’s scientists are developing a vaccine but has provided scanty detail. As civil society, we are asking a few more questions.


## 1. Will the Vaccine work here?

Vaccines like the ones developed by Pfizer (Comirnaty COVID 19 mRNA), which is the [first vaccine listed for emergency use by WHO](#), meeting its criteria for safety and efficacy, needs to be kept at cool temperatures. Would that affect efficacy and distribution here? Are places in the countryside able to meet the cold storage requirements? Moreover, there is talk of a new COVID 19 strain in South Africa and the UK, that is more contagious, raising questions of whether the vaccine will be just as effective. Has it spread to Uganda and will it affect the efficacy of vaccination?

## 2. What is the country’s COVID 19 vaccine plan?

To date, beyond scanty information presented here and there, there has been no discussion of the country’s COVID 19 vaccine plan. Uganda submitted an application to [COVAX](#) on 7 December 2020. Essentially COVAX, which is the vaccine pillar of the Access to COVID-19 Tools (ACT) Accelerator, is a commitment coordinated by Gavi, the World Health Organization and CEPI that aims at fair distribution of the vaccine to protect people in all countries. The COVAX Facility through which self-financing economies and funded economies can participate enables countries to commit money and pool purchasing power to secure manufacturing capacity from the vaccine manufacturers and negotiate their pricing. Within this also sits an entirely separate funding mechanism, the Gavi COVAX Advance Market Commitment (AMC), which will support access to COVID-19 vaccines for 92 lower-middle and low-income economies. So far COVAX has secured [870m doses](#) (170 AstraZeneca/Oxford, 500m Janssen candidate; 200 million doses from Serum Institute of India (SII) for- with options for up to 900 million doses more - of either the AstraZeneca/Oxford or Novavax candidates, 200 million doses of the Sanofi/GSK vaccine candidate) to be shared between 92 lower income countries and is targeting 2 billion doses by the end of 2021. It also has a first right of refusal for a potential combined total of over 1 billion doses in 2021.

However, COVAX will only allow low-income countries like Uganda to get what is left over when rich countries have purchased the vaccines. [Research](#) by Oxfam found that nations, which comprise 14% of the world population, own 53% of the vaccines most likely to work. In other words, if you are a low-income country, you are left to beg for crumbs. For example Canada, which has bought five times the number of vaccines it needs, more than ten doses per citizen, says it will share the left overs. Nearly a quarter of the world won’t get the vaccine by 2022. A COVID 19 vaccine should be



a public good. Billions of us in low-income countries should not have to wait for leftovers.

Even if we get the vaccine through COVAX, it will not be enough. No country will receive enough doses to vaccinate more than 20% of its population. The Permanent Secretary Ministry of Health indicated that from COVAX, Uganda will get 9 million doses in the first phase and nine million in the next phase. Since it is a dual dose, COVAX allocation will only cover 9 million of the 46 million so slightly more than 19%. This is not enough to achieve herd immunity, which requires a significant percentage of the population to be vaccinated. It would be misplaced to rely only on COVAX, whose fate beyond 2021 remains uncertain.

### 3. What is the plan to get the country sufficient doses?

The President, in his address to the nation, announced the country is developing a COVID 19 vaccine but has not provided substantive information on progress. For example whether trials are being conducted or any other information. The only information the Ministry has released is that apart from COVAX, it is exploring a traditional vaccine from China.<sup>1</sup> However, Chinese firms developing the vaccine have not been transparent about data or efficacy trials and yet this is necessary to ensure quality is upheld. So far Sinopharm's COVID 19 vaccine has been approved in China reporting a 79% efficacy rate compared to the efficacy rate of other COVID-19 vaccines, namely those developed by Moderna is 94.1% and Pfizer/BioNTech is 95%. Moderna Inc, which has already agreed to sell to Canada, EU and the United States of America, has disclosed it does not plan to distribute in South Africa, a likely indication of a reluctance to distribute to Africa and possibly indication of vaccines supplies for Africa dwindling. India has barred the export of Oxford University Astra Zeneca Covid 19 vaccine for months despite the Serum Institute in India being contracted to make 1 billion doses for developing countries further delaying the export of vaccines to COVAX. The European Union has been approaching this as a bloc and is supporting Pfizer-BioNTech and other companies with candidate vaccines counting on having more than two billion doses of vaccine available for all 450 million Europeans and their neighbors if all vaccine candidates are approved. It is unclear whether the African Union plans to do the same. As we witness increasing vaccine nationalism, we need more concrete details of the government's plans to obtain sufficient doses.


### 4. How much will we be paying for each dose?

The Serum Institute will be selling Astra Zeneca to the Indian government at USD \$2.74 per dose after which prices will be higher and will later sell it to the private market at USD \$13.68. The EU will pay 1.78 Euros for the Oxford/AstraZeneca vaccine (compare this to the US paying 4 dollars a dose). For Pfizer/BioNTech, which is among the first to have been approved and is being rolled out in the UK, Belgium will pay 12 Euros for 5 million shots while the EU will pay 15.50 Euros and the most expensive among the vaccines so far is 18 Euros for the Moderna vaccine (compare this to the US paying 15 dollars).

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<sup>1</sup> Ministry of Health, Press Statement on Access to the COVID 19 Vaccine, 2 January 2021.






How much will Uganda be paying? So far the Ministry of Health in a media interview has merely indicated we need 405 million USD to get AstraZeneca without disclosing how much we need per dose or whether this amount is solely for vaccines or the cost of vaccination. It has further indicated that Government will co finance COVAX at 10-11 million USD. Will Uganda be paying for this as a self-financing participant yet we are a low-income country?

The lack of transparency around how much countries pay per dose is concerning. Belgian Minister (budget state secretary) recently irked the drug manufacturers when she tweeted the EU COVID vaccine price list. In response to this, drug companies complained of a breach of confidentiality, noting prices were covered by confidentiality clause in contract with European Commission. COVAX similarly lacks pricing transparency. Having drug and vaccine prices as commercial secrets guarded by confidentiality clauses enables a system that impedes access to medicines. Why are the prices of vaccines supported by tax payers money not in the public domain?

## 5. How will COVID 19 vaccines be paid for?

The World Bank [has approved](#) 12 billion dollars for vaccines and [offers](#) low income countries like Uganda the ability to apply for loans under the Bank's first track emergency response to purchase the vaccine under the assumption that the allocation it will receive under COVAX will be insufficient. This raises the question, [should low income countries like Uganda, already at a risk of debt distress, be financing a vaccine, which has been publicly financed, through loans?](#) According to [MSF](#) reports more than \$4.4-billion of public and philanthropic funding was spent on vaccine candidates. Moderna's vaccine was developed with 2.5 billions USD funding and orders from the US government Operation Warp Speed. The UK spent considerable amounts of money in development of vaccines like AstraZeneca which is reported to have received more than 1.3 billion USD of public funding.

Uganda's debt burden is already close to being unsustainable. The [Bank of Uganda Monetary Policy](#) 2020 report shows the country's debt level is nearing crisis level at 56.5 trillion, 41% of GDP, the 21.7 % rise in debt from FY 2019/20 is mostly attributed to borrowing to mitigate COVID 19. This debt burden poses a substantial drain on public resources that will finance the associated increase in interest payments rather than go to financing development. The country should not take on further loans for COVID 19 vaccines. The government should pursue support from the World Bank, the African Development Bank, the European Union and other development partners to cover the remaining financing needs but through grants. These institutions should, in a show of international solidarity, make grants available. It should also begin to explore appropriations from the consolidated fund and we should already see this reflected in the budget estimates. Uganda should join other countries in continuing to put pressure on the IMF to issue new special drawing rights allocations to enable developing countries like Uganda to have the urgently needed fiscal flexibility in this crisis.



## 6. What is Uganda doing in conjunction with other low and middle-income countries to mitigate the Intellectual Property Issues that impede access to the vaccine?


We are yet to see global commitment to address the Intellectual Property(IP) issues that continue to impede countries' access to medicines as evidenced by HIV/Aids, Hepatitis. While Moderna has said it [would not enforce its patents and would license its COVID-19-related patents](#) with other vaccine manufacturers, it will not share its trade secrets. AstraZeneca will only make its vaccine [available on a cost basis until the pandemic is over](#) but has stipulated this will only be until July 2021. The World Health Organization has put in place a [COVID 19 Technology Access Pool](#) that seeks to increase access to medication through voluntary licencing and patent pooling. Licence holders agree to licence their patents to the medicine patent pool which sub licences the right to manufacture treatments like the vaccine to generic manufacturers there by increasing the supply of these medicines and lowering their cost. While a [Medicines Patent Pool](#) has been effective in increasing access to HIV medicines, C-TAP has not received strong backing from stronger economies. No company developing a vaccine has joined the (C-TAP) set up by the World Health organization. COVAX is yet to express support for the open licensing and pooling vaccine technology, without which it is difficult to fix the vaccine supply deficit. World leaders including notable economists, health advocates and elders have called for a Peoples vaccine and the sharing of technology so as to ensure a free and accessible vaccine to all but Uganda has not publicly joined this call.

An argument frequently cited in favor of product patents is that they incentivize innovation by providing a temporary monopoly, which allows companies to charge high prices to recoup the investment they made in the research and development of the drug. Essentially companies are granted a 20-year monopoly, which limits the supply and access to essential technologies. Yet we need to maximize production of these vaccines. Countries like South Africa, Kenya, India, Eswatini have [proposed](#) the TRIPs council to waive provisions of the TRIPs agreement and temporarily suspend intellectual property rights until widespread vaccination is in place in order to prevent and contain COVID 19. The United Kingdom in its [response](#) noted it was merely hypothetical to suggest that failing to waive IP for these vaccines would result in a barrier to accessing vaccines and treatments for COVID 19 and opposed the request to waive IP provisions, calling it an extreme measure. Yet, we saw this with the HIV/Aids Epidemic. In the 1990s, ARVs were not considered an option for people in low-income countries. Competition from generic drug producers drove ARV prices down from 10,000 USD to 100 USD per patient per year.

Countries like the UK instead push for flexibilities available in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement). Companies that hold patents can give permission to generic manufacturers to make, sell, or import the drug in a particular country, and thus bring prices down and expand manufacturing capabilities. Known as “voluntary licenses” they have serious limitations. The most blatant one is the fact that it depends on the good will of the company.

Countries could explore compulsory licencing, another TRIPs flexibility. Compulsory licences enable production of essential medicines and convince patent holders to reduce their prices.






Countries have rights under TRIPs to issue compulsory licences but they need to put in place enabling laws/make amendments to existing Intellectual Property laws to allow governments to exercise those rights. Moreover, compulsory licenses are often only issued after failed negotiations with a patent holder so this product by product approach is not effective during a widespread pandemic. Article 31 of TRIPs allows countries to issue compulsory licenses when they see fit, as long as they follow certain procedures. It is especially simple if there is a national emergency or other situations of extreme urgency or where public non-commercial use is involved. In these cases, countries do not need to follow certain procedural requirements, such as prior negotiation with the rights holder. But with rare exceptions, they are used for the supply of the domestic market. In other words, Uganda would have to think through how to produce them domestically. There is an export mechanism exception, the WTO General Council on August 30, 2003, agreed to allow exporters to override patents to supply member states that do not have manufacturing capacity but its rarely used. Navigating all this would take time, a luxury we do not have.

Uganda's Industrial Property Act, 2014 does have provisions that could support compulsory licencing for the COVID 19 vaccine but they are not sufficient. Article 60.3 of the Industrial Property Act, 2014 notes that the requirement to demonstrate that negotiation with the patent holder failed within a reasonable amount of time "shall be waived in the case of a national emergency or other circumstances of extreme urgency or where the application is based on anti-competitive practices; except that the registrar shall notify the owner of the patent as soon as reasonably possible of the waiver." Uganda should look to strengthen this legislation expeditiously to make full use of the TRIPs flexibilities. For example including a maximum duration for negotiations with patent holders. Burundi for example has a maximum duration of negotiation of 45 days for emergency life saving medication. Having legislation that makes full use of TRIPs flexibilities will be key even beyond the vaccine. Compulsory licencing, however, is a short-term second best solution.

## 7. How will government communicate about the vaccine?

The first time many Ugandans heard about the vaccine was when a letter with regalia of the Peoples Republic of China and signed by the Minister of Health requesting special exception for Chinese workers to receive the vaccine was leaked. It was only then that the Ministry of Health in response to public outcry noted that [Chinese firms would be allowed to export vaccines for their nationals](#) without indicating the fate of Ugandans. Later on, it indicated Uganda had applied for the vaccine through COVAX. It raises the question of whether the public would have had access to this information this year if the letter had not been leaked. The scanty information communicated is primarily on twitter and videos that appear after public outcry. For example at the start of 2021, the Permanent Secretary in a [media interview](#) simply stated the country would need 405 million leading to speculation about the cost per dose. After public outcry, the Ministry of Health issued another [press statement on 7 January 2021](#) backtracking that it was merely an estimate awaiting communication from COVAX facility. The information is yet to be placed on the Ministry of health website. There has been no presentation of a national COVID 19 vaccine strategy. When such critical information is communicated in this defensive, haphazard manner, it will be an uphill task



to convince communities to get it or to marshal enthusiasm to prevent COVID 19. There are already enough conspiracy theories that state otherwise. While this is playing out, the Ugandan government needs to rethink how it is conveying information about vaccines.

## 8. How will we engage communities?

We need an effective and large scale communication and outreach campaign. Are we, for example, planning to use Village Health Teams (VHT)? If so have we consulted them or do we simply, like we have done in the COVID 19 response, plan to tell people how it will be done rather than provide opportunities for them to meaningfully participate? A VHT recently noted how much further we would have gone with the COVID 19 response if they had been consulted from the onset and facilitated to be community champions. It was only in October that a community engagement strategy was formulated and it is yet to be fully implemented.

## 9. What is the plan for distribution?

To combat this pandemic, we need everyone who needs it to be able to get tested and ideally get vaccinated. We need to prioritize the most vulnerable. WHO Strategic Advisory Group of Experts (SAGE) values framework for the allocation and prioritization of COVID-19 vaccination calls for vaccination of health workers and those at high risk. COVAX first phase should have 3% of health workers and 17% of older persons and those with pre existing conditions. Laudably, the Prime Minister indicated that health workers and older persons with pre existing conditions will be the first to get it. That is a positive step but we need clearer criteria. **Do we have comprehensive data on older persons? Data on those at high risk? How will we avoid double counting those who are older and with pre existing conditions?** The World Health Organization in its guidance to countries on the COVID 19 vaccine mentions that sources of data could be bureau of statistics. Many older persons lack national ID numbers. What steps will the government take to ensure that they are not barred from accessing the vaccine due to the lack of biometric data? Has the government in light of WHO guidance classified different health worker categories based on assessment of risk; the policy for vaccination for each category; and strategies for managing non-compliance of health workers?

## 10. How ready are we as a country to distribute the vaccine, particularly in hard to reach areas?

To do this, we need supply chain and logistics management for vaccine storage handling, trained vaccinators. Has the cold chain requirement for AstraZeneca, which the Ministry indicated it would get through COVAX been sufficiently put in place?





## 11. Will the vaccines be free?

The vaccines should be free at point of care. This means the government should fully cover the cost otherwise we shall never be able to completely deal with the pandemic. While some countries have indicated insurance, doing so would not ensure adequate coverage since less than 1% of the population is insured.

## 12. What barriers to access will we create and inequities do we further entrench if we let the free market operate during distribution?

The Ministry of Health indicated they would use the private sector to distribute but this risks further entrenching inequality in access. As revealed by the country's approach to the private sector testing and treating COVID 19, the consumers are left with high costs that undermine the country's ability to mitigate the pandemic. There are concerns raised that private facilities may not be able to meet requirements for safe handling and distribution of the vaccine, for example cold chain requirements. A free market approach could also result in varied practices around vaccine handling and administration where some players compromise standards in order to improve their profit margin. Government needs to remain at the centre of this rather than outsource it to the private sector, and learn from the testing and treatment experience where costs for testing and treatment are only affordable by a few.

We are in a pandemic. This time we have the benefit of lessons from pandemics before. Countries and donors must come together, as they eventually did for HIV/Aids and create dedicated funding streams for the COVID 19 vaccine. We need to see decisive government action and proper planning. The government needs to consult communities as it comes up with plan for vaccine distribution and provide access to information. It needs to prioritize vulnerable individuals and communities when the vaccine is rolled out. We can't leave this to the market. No one is safe until everyone is.



## RECOMMENDATIONS

1. Uganda should work with other low income countries to push for a peoples vaccine and negotiate for waiver of patent rights.
2. Strengthen compulsory licencing and other provisions that would support access to vaccines in the Industrial Property Act.
3. Secure resources from the consolidated fund to supplement the doses that may be available through COVAX.
4. Negotiate for grants instead of loans from IFIs and bilateral donors.
5. Vaccine once available should be free at point of care.
6. Consult with VHTs and communities in preparation and develop a communication and community engagement strategy.
7. Recruit and train the health workforce.
8. Prioritize vulnerable groups during the initial stages of the vaccine particularly health workers, older persons and persons with pre existing conditions.
9. Ensure older persons without national Ids are registered expeditiously and ensure relevant data systems to identify beneficiaries are strengthened.
10. Put in place multi sectoral task force including lawyers, public health specialists, front line health workers, officials from the Uganda Bureau of Statistics, National Identification and Registration Authority (NIRA), Ministry of Gender, Labour and Social Development, Civil society and community voices as it develops national strategy for deployment of COVID 19 vaccine.
11. National Strategy for the Deployment of the COVID 19 vaccine should include activities to strengthen immunization through out the life course, health services and health systems including traceability systems, monitoring and reporting systems.
12. Ensure/update functional cold storage, logistics and management systems.
13. Ensure regulatory system assessments in place
14. Government maintain strong stewardship of the process.
15. Regulate the private sector to ensure quality is maintained and profits are not prioritized over public health during vaccine distribution



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