



A PHM Policy Brief

Unpacking the COVAX black box

June 2021

1. What is Covax?

The “COVID-19 Vaccines Global Access Facility”, abbreviated to ‘COVAX’, is a global facility for equitable access to COVID-19 vaccines.

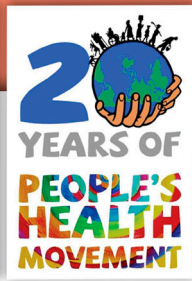
Covax is sponsored by most rich nations, global health partnerships, private philanthropies and pharmaceutical industry. This was their response to make vaccines against COVID-19 disease available to all as a global public good and a basic human right.

However, Covax has been unable to deliver on its promises; its failure was rooted in its genesis and design.

The Access to Covid-19 Tools Accelerator (ACT-A)

Covax is part of the Access to COVID-19 Tools Accelerator (ACT-A). The Accelerator was initiated in April 2020 with some of the leading global health players including the World Health Organisation (WHO), Bill and Melinda Gates Foundation (BMGF), the GAVI Alliance, Consortium for Epidemic preparedness (CEPI) and other organisations ([more](#)). ACT-A has four pillars – diagnostics, therapeutics, vaccines and health systems. The diagnostics arm is led by Foundation for Innovative New Diagnostics (FIND) and Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM); the therapeutics arm is led by Unitaid and Wellcome Trust; the vaccines arm (including Covax) is led by CEPI and GAVI and the health systems arm is led by World Bank and GFATM. The Accelerator is constituted as a multi-stakeholder partnership including UN bodies, private philanthropies and pre-existing public-private partnerships. It reflects a significant shift away from multilateralism.





2. Why a policy brief on Covax?

Arresting the spread of COVID-19 depends on universal vaccination to interrupt transmission.

Understanding the design failings of Covax is critical to mobilizing around a new global strategy based on the sharing of knowhow and the scaling up of local production; a strategy which treats vaccines, and other COVID-19 related technologies as global public goods.

In the early months of the pandemic and facing a global demand for universal vaccination the international pharmaceutical industry ('Big Pharma') with their supporting countries rushed through an approach which promised that the needs of poorer nations would be met within the existing market paradigm of private enterprise and patent monopolies.

But this has not happened.

The failure of Covax reflects fundamental contradictions between equitable and universal access to global public goods versus privatized knowledge and the unbridled pursuit of profit; between global governance based on multilateralism and public accountability versus a regime dominated by rich countries and corporate elites.

3. How is Covax governed?

Covax is directed by GAVI, the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI), and the World Health Organization. All three of these are heavily funded by the Bill & Melinda Gates Foundation (BMGF) a corporate philanthropy, which is one of the main drivers behind the whole initiative. The office of the Covax Facility is situated in the GAVI Secretariat, and the Board of GAVI has "ultimate responsibility for decisions and effective implementation of the Facility"

GAVI and CEPI are public private partnerships; the latter was established in 2017 at Davos. WHO does not have a leadership role in Covax.

The Covax coordinating mechanism has representation from International Federation of Pharmaceutical Manufacturers & Associations, and Developing Country Vaccine Manufacturers' Network. Civil society is represented by International Rescue Committee – an aid organization whose governance is currently under a cloud. There is no representation from the countries which are beneficiaries, patients' bodies, scientists or other important stakeholders. This multi-stakeholder approach, marginalizes the role of sovereign states and their representative global institutions and privileges the participation of global institutions, dominated by rich nations, pharmaceutical companies and private



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philanthropies, despite the obvious conflicts of interest.

4. How did Covax Plan to deliver affordable vaccines?

The Covax Facility is based on two sets of 'advanced purchase agreements': one set of agreements between GAVI and the vaccine suppliers (currently six main suppliers), and one set of agreements between GAVI and participating countries.

The agreement between GAVI and the vaccine

suppliers specify a price and a total volume (of individual doses). The total volume of doses which GAVI agrees to buy, from all suppliers, has been targeted to cover up to 20% of the total population of participating countries.

Two subsets of agreements are struck between GAVI and participating countries; one for the 90+ 'self-funded countries' (upper middle income and high income countries who are self-funding their Covax procurements), and another one for 92 'funded countries' (low income and lower middle income countries).

The agreements with self-funded countries generally specify a price range, recognising that the agreed prices of the actually effective vaccines to be delivered may vary. Self-funded countries are required to pay a down payment, of around 10% of the total agreed purchase, up front.

The Covax facility depends on donor funding to pay for vaccines for the funded countries. This arrangement is referred to as an Advance Market Commitment (AMC) and the 92 recipient countries are often referred to as the AMC countries.

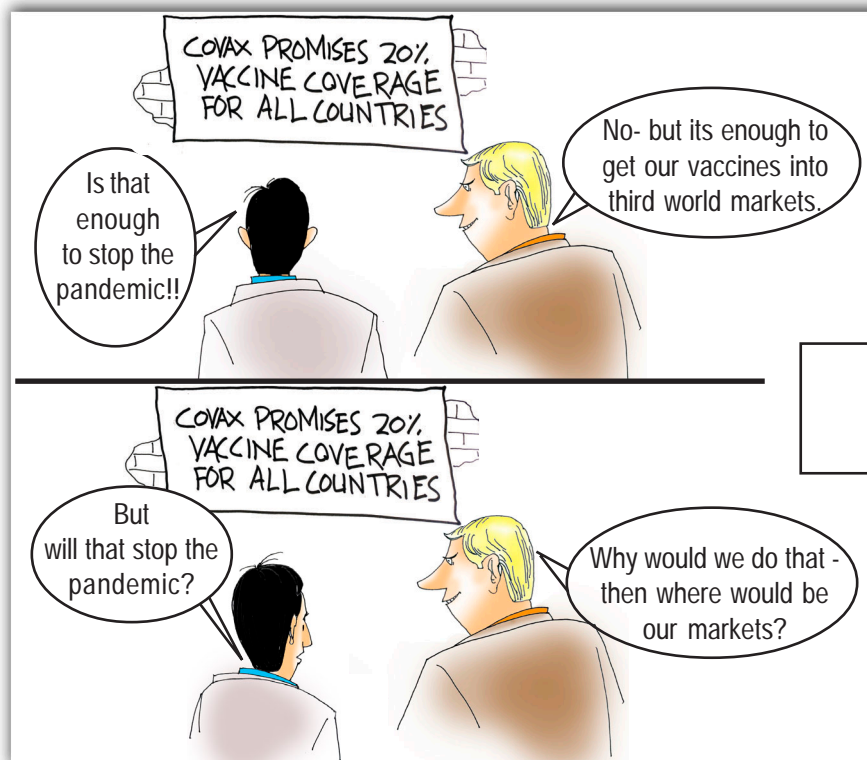
The June 11 [design document](#) indicates that vaccine suppliers will be asked to restrict their prices to "validated cost of production plus a small margin". However, the document also notes that suppliers may insist on tiered pricing (higher prices for higher income countries). The relationship between the price that is agreed between GAVI and the vaccine supplier and the price actually charged when supplies to individual countries are delivered is quite obscure.

It is understood that the Covax facility will only operate while the pandemic lasts. After participating countries have been supplied with the agreed doses all supply arrangements (prices, volumes and delivery dates), for the remaining 80% doses, will revert to bilateral arrangements between individual countries (or purchasing consortia) and vaccine suppliers.

5. What does Covax promise?

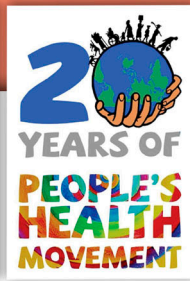
Covax has committed to delivering 2 billion doses by the end of 2021. An additional 950 million doses would be procured by self-financing countries through this facility. Covax estimates that the average price for full vaccination of an individual will be about \$US3.20, and the overall costs at \$US18.1 billion.

Covax *does not commit* to delivering the vaccines needed to vaccinate the whole population in each of the AMC countries. It is only committing to the 20% 'priority population' and a maximum of 30% if it is able to raise additional funds going into late 2022.



Even the 20% is subject to the extent to which Covax is able to raise funds and secure stock, which, given competition amongst vaccine buyers for limited supplies, makes it a difficult task. Beyond the 20% Covax has no commitment and is suggesting either a bilateral agreement by countries with the vaccine manufacturers or via a 'cost sharing' arrangement (under which the 92 AMC countries would raise funds through multilateral development banks for cost-sharing procurement through Covax).

Officially its [objective statement](#) is quite



cautious: “to ensure that vaccines are developed as rapidly as possible, manufactured at the right volumes without compromising on safety and delivered to those that need them most”. The “right volumes” does not appear to address the objective of herd immunity.

6. Why is this promise not good enough?

For countries to interrupt the spread of COVID-19, the level of ‘herd immunity’ required is

procurement for full immunisation for the poorer countries. If Covax were allowed to morph into a bulk procurement agency for the full immunisation needs of low, and lower-middle income countries it would be able to exercise significant pricing power as a monopsonic purchaser (and would come under strong pressure to do so).

By restricting Covax to 20% and limiting the life of Covax to the duration of the pandemic the commercial interests of pharma have been preferred over the needs of the developing countries. Once the pandemic is declared over vaccines will continue to be required (to manage endemic COVID-19), but they will

have to be procured on the open market. Due to their control over supply in the face of continuing demand, the pharma companies will be in a strong position to set prices. A peek into the way market mechanisms are unfolding can be seen in how Pfizer has [gradually increased its prices for the vaccines](#) delivered to European Union beginning with USD12 and then to 15USD and now at 23USD per dose. If the EU is subjected to such pressure one can imagine what it would be for poor countries whose only option will be bilateral agreements with the vaccine manufacturers.



estimated at a minimum of 70 to 80% of the population (although the emergence of new variants creates further uncertainty). The Covax 20% limit appears to have been deliberately struck to serve the interests of the rich countries and the big vaccine manufacturers.

The 20% limit has had the effect of protecting vaccine supply to allow the rich countries to achieve full immunisation while appearing to address the needs of poorer countries.

The 20% limit has also protected the market position of pharma with respect to

7. Lofty promises obscure design failure

Despite its modest objectives and the naked protection of the interests of the rich countries and of big pharma, quite extraordinary [claims](#) are made for Covax including: *“It is the only truly global solution to this pandemic because it is the only effort to ensure that people in all corners of the world will get access to COVID-19 vaccines once they are available, regardless of their wealth”* and *“..thereby making a very real impact towards stopping the spread of the*

pandemic by end 2021". Such promises are directed to reassuring governments and communities that Covax will take care of their requirements.

Vaccinating 20% of the population would hardly take care of the epidemic but it was inevitable, from the way Covax was designed and implemented, that meeting the needs of developing countries would be deferred as necessary to preserve supplies for full vaccination of the rich countries. Covax is nowhere near to delivering even on its modest objectives. As against the 2 billion dose promise, it has currently delivered a mere 83 million doses (with half of 2021 already over).

The funds raised for Covax fall far short of what is required. As against the 18.5 billion dollars it targeted it has raised only 8.5 billion dollars.

Meanwhile, the rich countries have stockpiled vaccines far above their immediate requirements. Many big pharma companies like Pfizer and Moderna have either no deal or very small deals with Covax and AstraZeneca, which received so much public financing and technical support, has been unable to honor its delivery schedules.

8. From pandemic to endemic

COVID-19 will remain a public health challenge for the foreseeable future.

Even assuming that all countries will achieve high levels of immunity during the pandemic a continuing vaccination program will be needed: for booster immunization; to immunize children yet to be born; and to address the changing immunogenicity of the emerging variants.

The need to share knowhow and scale up local production will be with us into the medium and long term.

9. Are Covax deals transparent? Do we know enough to assure ourselves that the deals are in public interest?

There is much about Covax deals with Big Pharma that is shrouded in secrecy:

- We do not know the delivery schedules and quantities that Big Pharma has promised to countries and to Covax. It is clear that supply to rich countries is being prioritized and supply to weaker countries through Covax and through direct procurement is being pushed back.
- We do not know what prices Covax is paying for the vaccines and or the prices that self-funded countries will be paying.
- We do not know what prices the US and Europe are paying. It is likely that the larger and richer countries will get a better price because of their stronger

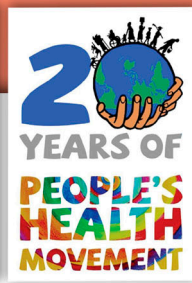
"In January, I spoke about the potential unfolding of a moral catastrophe. Unfortunately, we are now witnessing this play out. In a handful of rich countries, which bought up the majority of the vaccine supply, lower risk groups are now being vaccinated... in low and lower-middle income countries, vaccine supply has not been enough to even immunize health and care workers, and hospitals are being inundated with people that need lifesaving care urgently. **At present, only 0.3% of vaccine supply is going to low-income countries. Trickle down vaccination is not an effective strategy for fighting a deadly respiratory virus.**"

The WHO-DG during a COVID 19 Briefing on 14th May 2021



negotiating position. Vaccines manufactured in India are available in the Indian market at a costlier rate than sold abroad.

- We do not know how much of the innovation in new vaccine platforms has been paid for and undertaken by the pharma companies. This claim is used to justify higher prices and profits but much of the research has been done by public universities and supported by public financing.



- We do not know how much of its own capital big pharma has invested in scaling up manufacture and how much has come from the public purse. Vast sums of public money in direct grants and generous advance purchase agreements have contributed to the scale up but the relative contribution remains obscure. It appears that that each dose of the vaccine has been paid for - by the public – three times: first as input subsidy, second time as price and thirdly through **tax avoidance**.
- We do not know the terms and



“There is much about Covax deals with Big Pharma that is shrouded in secrecy: About prices, about R& D financing, about licensing and agreements, about the role of Gates Foundation...”



conditions of voluntary licensing that big pharma is giving out, nor has Covax bargained for intellectual property rights or technology transfer. We do know that Gates Foundation persuaded Oxford University to abandon its original commitment to a patent and profit free vaccine and sign up with AstraZeneca, the largest supplier to Covax.

- We do not know that whether key decisions are prejudiced by conflicts of interest. We know that Gates Foundation and the Wellcome Trust have investments in Big Pharma - but we do not know how such conflicts of interest are being managed.

9 Lofty promises but design and implementation has been shaped by vested interests

As a bulk purchaser Covax, was supposed to get better prices than individual countries

This failed because big manufacturers like Pfizer and Moderna, were facing strong demand from the rich countries and were able to control supply to keep prices high. They had no need for Covax. Others like AstraZeneca did join Covax but they also were facing strong demand from the rich countries and had no incentive to give preference to Covax.

The creation of Covax was based on repeated assurances that the rich countries would contribute the necessary funding to purchase vaccines for the 92 least developed nations:

There was no binding treaty, just voluntary commitments. Faced with the crisis in their own countries, few rich countries have lived up to their commitments.

Part of the Covax promise was that once financing was assured pharma companies would be under an incentive to scale up manufacture to meet the demand, vaccine supplies would increase and costs would go down.

On the contrary the upscaling of supply has lagged far behind global need, partly through manufacturing mishaps and input shortages but also because it has been in the interests of the manufactures to control supply.

Covax never included any provisions to scale up manufacturing, including support for technology transfer.

10. How have the interests of Big Pharma trumped the needs of the developing world ?

Covax enables Big Pharma to make huge profits.

Windfall profits are being made by the vaccine companies with many of the company **CEO's becoming billionaires** and the shareholders being paid out

nearly 26 billion USD. Pfizer expects to make 15 billion USD sales from vaccines alone for 2021 with a profit of 4 billion USD. The CEO of the Serum Institute of India, Cyrus Poonawalla's wealth grew the fastest among Indian billionaires and fifth fastest in the world during the COVID-19 pandemic as he climbed 57 places to be the 86th richest person in the world as of May 31 2021. And this for a company which is far short of the delivery schedule due to production problems. The monopolies embolden companies to set the rules of the game. For instance, the three big pharma companies Pfizer, Moderna and Johnson and Johnson, indicated that they will revert to higher prices post-pandemic and that they will exercise the right to declare the end of the pandemic!!

Covax failed to gain leverage from the public financing for R& D to secure better prices. The Moderna vaccine received nearly 5.9 billion dollars but ironically is charging Covax the highest amounts of USD31 per course (two doses). The Pfizer vaccine has received close to 6 billion USD of public financing, Johnson and Johnson 2.9 billion USD, and Astazeneca close to 1.6 billion dollars. Further, in the innovation of the vaccine all the manufacturers have drawn on research done in public institutions with public financing.

Covax fails to use its financing power to secure at least part ownership over IP rights, for faster rollout of the vaccines but instead prefers to use it to negotiate 'better' prices and maintain the status quo of the patent regime.

11. Covax has not delivered. But has it harmed interests of LMICs?

The false hopes that Covax has raised has served to distract from more effective routes to solving the challenge of vaccine access.

In the initial stages of the pandemic, a sense of global solidarity was emerging. During this time, WHO proposed the COVID-19 Technology Access Pool (C-TAP) for the sharing of COVID technologies. This was a weak proposal since it was based on voluntary licenses and not on binding commitments. But even this was met with strong resistance. C-TAP was rebuked by the pharmaceutical industry and global health organizations and rich nations ignored it. -Covax was floated by GAVI, CEPI and BMGF as a counter

proposal which did not challenge the IPR model nor Pharma's insistence that its business model was not to be disturbed.

Similarly many countries were persuaded not to support the waiver of TRIPS conditions on the grounds that Covax would take care of their needs. This delayed the sharing of knowhow and scaling up of manufacturing globally.

The creation of the ACT Accelerator (including Covax) outside WHO was a deliberate strategy to exclude low and middle income countries from any role in the governance of the project while ensuring that private philanthropy and international pharma were centrally involved.

The failure to provide timely access to vaccines in LMICs means not only a huge loss of lives and

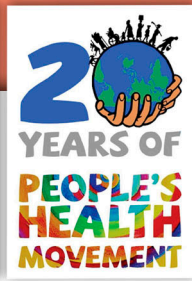


livelihoods but also the risk for the emergence of mutant strains that can create a new pandemic.

12. What are the alternatives to the problem of vaccine access and equity? And to realizing vaccines as a global public good?

An alternative approach has to be based on global solidarity and human rights. PHM calls on all civil society organizations and countries to unite to work on three parallel tracks to overcome the crisis. These are:

- Approval within WTO of the proposed waiver of TRIPS requirements in relation to all Covid technologies (See PHM's earlier policy brief on this)



- Creation of new arrangements to support wider access to Covid-related technologies and the development of widely distributed production capacity.

- Renewed focus on alternatives to the current extreme intellectual property regime including alternative (publicly funded and publicly accountable) approaches to innovation.

These challenges will be discussed in subsequent policy briefs.

13. What should we ask our governments to do to enable wider access to COVID-19 technologies, including vaccines?

1. Support the TRIPS waiver.
2. Support WHO initiatives to create regional technology transfer hubs and distributed regional production
3. Through WHO call upon all member states to insist on pharma joining a revised C-TAP based on mandatory open licensing
4. Insist on the publication of all the agreements between Covax and the vaccine manufacturers, and of data pertaining to prices and delivery of the vaccines.

