



Vaccine Reallocation Policy brief

A number of HIC countries have secured sufficient COVID-19 vaccine doses to begin reallocating a portion of those doses rapidly with low- and lower-middle-income countries (LICs and LMICs). A few HICs, including [Norway](#), Canada, the [EU](#)¹ and the [US](#), have already announced that they will share vaccine doses with other countries through COVAX, but there was no clear timeline at the time of writing. Norway's Minister of International Development Dag Inge Ulstein announced in January 2021 that Norway will reallocate COVID-19 vaccine doses through WHO and ACT-A to and that this would happen [at the same time as domestic vaccinations](#). Some HICs were named as recipients of COVAX vaccines themselves in the publication of COVAX's [Interim Distribution Forecast from 3 February 2021](#). A decision COVAX took early on was to allow HICs to order vaccines through COVAX. While HICs are therefore within their rights to claim vaccines from COVAX, we want all countries to reflect the spirit of ACT-A by ensuring frontline workers and the most vulnerable in LICs and LMICs are prioritised by COVAX before delivering vaccines to self-financing HICs - especially those that have coverage through bilateral deals. As Gavi CEO Seth Berkley said COVAX's most important role is to "supply vaccines for countries that otherwise wouldn't get access".² HICs that have bought the majority of vaccines have a responsibility to their own populations to help all countries vaccinate at least 20% of their populations in 2021, starting with health care workers and the most vulnerable since this action will quicken the timeline for gaining control over this pandemic globally.

Recommendations

1. *HICs should prioritise the equitable global distribution of vaccines by **sharing COVID-19 vaccine doses as soon as possible in parallel to the vaccine roll-out in their own country - especially those with excess doses.***
2. *'Slot swaps' should be undertaken whereby HICs reallocate some of their existing orders immediately, ordering replacement vaccines to arrive later in the year, effectively giving their earlier 'slots' to COVAX to help provide vaccines in early 2021 for LICs and LMICs to close the current acute gap in supply which is likely to last until at least mid-2021.*
3. ***Vaccine reallocations must be made in addition to fully funding the [Access to COVID-19 Tools Accelerator \(ACT-A\)](#), and pledges should be made as soon as possible.***
4. ***Reallocations should be made through COVAX to ensure the most equitable, effective allocation, and to ensure a coordinated approach.***
5. ***All reallocations must clearly adhere to the [COVAX Principles for Sharing COVID-19 Vaccine Doses](#) - safe and effective, early availability, rapidly deployable, unearmarked, substantive quantity - and in line with the [WHO Fair Allocation framework](#). HICs should fund the transfers.***

¹ Under the EU Scheme, other countries will be able to buy excess doses off Member States who are willing to do so. In the case of the Western Balkans, the EU set up a grant so that these countries can buy vaccines using EU money.

² <https://www.bbc.co.uk/news/world-us-canada-55932997>

6. **HICs and manufacturers should ensure contractual provisions in bilateral deals to allow for vaccine reallocation as early in the process as possible, and should seek to actively accommodate allocation scenarios within bilateral contracts.**
7. **The ACT-A Facilitation Council should agree that all HICs participating in COVAX that have covered the needs of their populations through bilateral deals should reallocate their COVAX self-financing doses to the COVAX AMC to go to LICs and LMICs, so that COVAX increases its chances of vaccinating at least 20% of people in LICs and LMICs in 2021.**

Why protecting others helps protect ourselves

The early reallocation of vaccine doses to help achieve global access to COVID-19 vaccines is the right thing to do, **not only ethically and to [meet human rights obligations](#), but also strategically**. As numerous studies have shown, our success in terms of health, prosperity and the ability to live freely without the social constraints of anti-COVID measures depends on all countries ending the acute phase of the pandemic in the same timeframe. Acting globally and swiftly will save lives and money in the longer term. According to the [Northeastern University study](#), if wealthy countries stockpile vaccines, we will see nearly twice as many deaths than if vaccines were distributed equally across the globe. According to an [ICC](#) report released on January 25, vaccine nationalism could cost rich countries US\$4.5 trillion. Key advanced economies that would be most impacted include many European countries (including Belgium, France, Germany, the Netherlands) Norway, Switzerland, the United Kingdom and the US, who might lose up to 3.9% of their GDP compared to a scenario in which vaccines are distributed on a globally coordinated basis. The recent emergence of **rapidly-spreading variants** has also made clear that we cannot let our guard down and continue to let the virus spread freely in any country - this would significantly increase the risk of mutant strains, which are already on the increase. Our full recommendations on vaccine reallocation are as follows:

1. **Doses must be shared and allocated now, in parallel to the vaccine roll-out in HICs, in order to fill the global access gap.** Reallocated doses should be made available as early as possible in 2021, and ideally concurrently by the sharing country as it receives vaccines to increase equitable access and have maximum impact. Dose-sharing countries should facilitate authorisations, so that doses are shipped directly from the manufacturer with universal labelling and packaging, allowing rapid deployment and maximizing shelf-life.
2. **'Slot swaps' should be undertaken** whereby HICs reallocate some of their existing orders immediately, ordering replacement vaccines to arrive later in the year - effectively giving their earlier 'slots' to COVAX to help provide vaccines in Q1-Q3 2021.
3. **Dose reallocations should be made in addition to fully funding ACT-A - not instead of.** ACT-A is our greatest hope to end the crisis as quickly as possible. It is the only global mechanism to ensure global equitable access to all COVID-19 tools - diagnostics, therapeutics, and vaccines - and will invest in health systems strengthening. ACT-A urgently requires US\$14.2 billion by Q1/Q2 of 2021, as part of their overall US\$27.2 billion funding gap in 2021. Investments should also be made to ensure all countries are better prepared to effectively address future pandemic threats

including through strong research capacity, development, and delivery of tools for emerging infectious disease threats.

4. **Dose reallocations should be made through COVAX to ensure the most equitable, effective, and coordinated approach.** COVAX has begun rolling out the vaccines in its portfolio, and is ready to accept reallocated doses. COVAX is our best chance to ensure an equitable and coordinated allocation, taking into consideration the global picture, and ensuring vaccines get where they are needed. Donors should thus take every possible action to ensure doses are allocated through COVAX.
5. **All reallocations must clearly adhere to the [COVAX Principles for Sharing COVID-19 Vaccine Doses](#) and in line with WHO's [Fair Allocation Framework](#):**
 - **COVAX sharing principles** that vaccines must be safe and effective, prioritise early availability, be rapidly deployable, unearmarked, and of a substantive quantity must be adhered to. Early dialogue with COVAX and manufacturers will be essential to ensure adherence, and to facilitate planning and avoid disruptions.
 - **The WHO Fair Allocation Framework** must be respected so that an initial proportional allocation of doses is made to countries until all countries reach enough quantities to cover 20% of their population. A follow-up phase will expand coverage beyond 20% to other populations. If severe supply constraints persist, a weighted allocation approach would be adopted, taking account of a country's COVID-19 threat and vulnerability.
 - **Doses that have already been bought must be donated and not resold to COVAX.**
6. **HICs and manufacturers should ensure contractual provisions in bilateral deals to allow for vaccine reallocation,** and should seek to actively accommodate reallocation scenarios within bilateral contracts.
7. **The ACT-A Facilitation Council should agree that all countries participating in COVAX which also procure doses from other sources, reallocate their COVAX self-financing doses to the COVAX AMC for the benefit of LICs and LMICs, so that it can contribute to reach COVAX's target of vaccinating at least 20% of people in LICs and LMICs in 2021 more quickly.** Although HICs can in principle order vaccines through COVAX, they must refrain from drawing on the COVAX supply of vaccines, at least in the first phases of the vaccine rollout, to ensure enough supply is available to LICs and LMICs.

The emergence of rapidly-spreading, potentially vaccine-resistant, COVID-19 variants also highlights the need to **strengthen all countries' health systems and their capacity to detect** new COVID-19 strains so they can rapidly be contained. It shows that, although essential, vaccines are not the only solution to the pandemic and that global access to all COVID-19 tools, including therapeutics and diagnostics, must be urgently deployed.

ANNEX: [Principles for sharing COVID-19 vaccine doses with COVAX](#), 18 Dec 2021

COVAX is a bold international initiative to ensure fair and equitable access to COVID-19 vaccines for all countries regardless of wealth. The COVAX Facility (Facility) is responsible for securing the vaccines. Donors have contributed an initial US\$2.4bn for the Gavi COVAX Advance Market Commitment (AMC) to accelerate access to safe, efficacious, and early doses of COVID-19 vaccines. Gavi is seeking at least US\$4.6bn in additional funding in early 2021 to ensure the purchase of COVID-19 vaccines for at least 20% of the population of all AMC-eligible economies in 2021. Access to early doses will enable these countries to build capacity to roll out vaccines and immunize their health workers and highest risk populations as soon as possible. Given the increasing number of emergency use authorizations for COVID-19 vaccines by stringent regulatory authorities (SRAs), some countries have secured sufficient doses to begin **sharing** a portion of those doses rapidly with other countries. Consequently, the Facility is accelerating its work with potential dose-sharing countries, and vaccine manufacturers, to include these doses in the Facility and facilitate their equitable global distribution. These shared doses will complement the early doses procured through the Facility. They can accelerate the Facility's goal of ensuring participating countries – primarily AMC-eligible countries, but potentially others – achieve coverage of up to 20% of their population as soon as possible in 2021 and can expand coverage beyond that in 2021. To maximize impact, the Facility promotes the following **principles** for shared doses:

- 1. Safe and effective:** shared doses must be of assured quality with, at a minimum, WHO prequalification/emergency use listing or licensure/authorization from an SRA. Vaccine doses could be transferred to countries most rapidly if they are already in the COVAX Portfolio; other vaccines can be considered if they meet WHO's Target Product Profile and the standards set by the Independent Product Group for vaccines in the COVAX portfolio.
- 2. Early availability:** shared doses should be made available as soon as possible and ideally concurrently by the sharing country as it receives vaccines to increase equitable access and have maximum impact. Dose sharing should begin very early in 2021. Doses provided later in 2021 and beyond could still help increase coverage in countries and impact the pandemic.
- 3. Rapidly deployable:** sharing of doses should be signalled as early as possible in the manufacturing process, with the dose-sharing country facilitating authorizations, so that doses are shipped directly from the manufacturer with universal labelling and packaging, allowing rapid deployment and maximizing shelf-life.
- 4. Unearmarked:** to facilitate equitable access and in keeping with COVAX's allocation mechanism, doses should not be earmarked for specific geographies or populations.
- 5. Substantive quantity:** shared doses should be of sufficient and predictable volumes to have a substantive impact in achieving the goals of the Facility.

Shared COVID-19 doses would ideally be fully paid for by the dose-sharing country, including ancillary costs where possible. When shared vaccines are being provided to AMC-eligible economies, the Facility may also consider contributing to the costs of doses or options for doses at Facility prices (for example, for doses that are available early in 2021). These principles will be implemented in consultation with dose-sharing countries and vaccine manufacturers. In keeping with the Facility's goals, principles, and operations, the Facility will ensure that shared doses are distributed equitably, effectively, and transparently through the COVAX Allocation Mechanism. In parallel, COVAX is supporting AMC-eligible economies to optimize readiness for vaccination and ensure that 'no dose sits idle'. For AMC-eligible economies, shared doses would be eligible for the Indemnity and Liability provisions for these economies. **The COVAX Facility welcomes commitments by potential dose-sharing countries and manufacturers to adopt these principles, which are in line with the overall principles of COVAX, and to partner with COVAX to provide additional doses for equitable distribution.**