

Medicinal products supply chain in the Church Health Systems – access to the COVID-19 vaccine

Marlon Banda
Churches Health Association of



Presentation outline

1. Churches Contribution to Health Care Services in Africa
2. Challenges with Vaccine Access
3. Healthcare Supply Chains in Developing Countries
4. Supply Chain of Church Organizations
5. Church Role in Vaccination Uptake
6. Conclusions



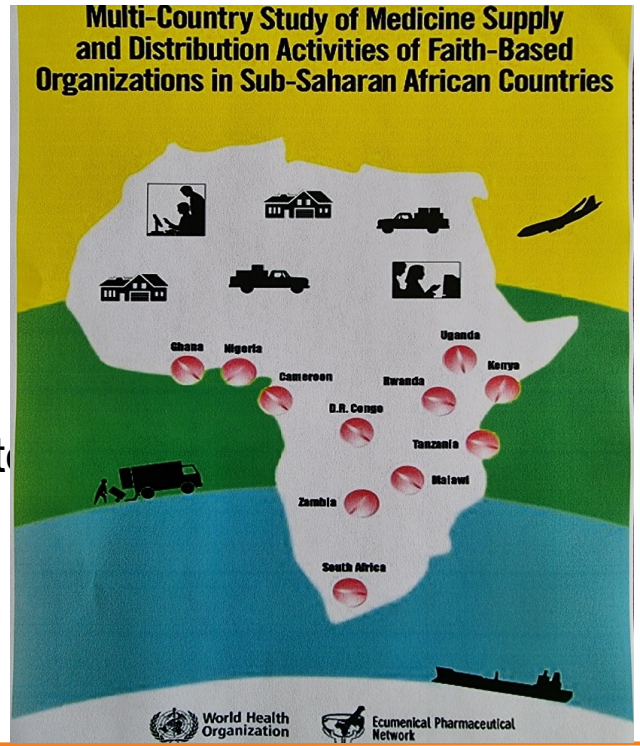
EPN



40 years of strengthening pharmaceutical services in church health systems

Churches Contribution to Health Care Services in Africa

- The Church provide between 25-60% of health services in Africa
- Church health services are delivered along small business-like models with either elected or nominated boards or committees to oversee their work
- Churches play a crucial role in increasing access to medicines, especially in rural and other remote areas of Africa



Challenges with Vaccine Access

Challenges in ensuring global access to COVID-19 vaccines: production, affordability, allocation, and deployment



Oliver J Wouters, Kenneth C Shadlen, Maximilian Salcher-Konrad, Andrew J Pollard, Heidi J Larson, Yet Teerawattananon, Mark Jit

The COVID-19 pandemic is unlikely to end until there is global roll-out of vaccines that protect against severe disease and preferably drive herd immunity. Regulators in numerous countries have authorised or approved COVID-19 vaccines for human use, with more expected to be licensed in 2021. Yet having licensed vaccines is not enough to achieve global control of COVID-19; they also need to be produced at scale, priced affordably, allocated globally so that they are available where needed, and widely deployed in local communities. In this Health Policy paper, we review potential challenges to success in each of these dimensions and discuss policy implications. To guide our review, we developed a dashboard to highlight key characteristics of 26 leading vaccine candidates, including efficacy levels, dosing regimens, storage requirements, prices, production capacities in 2021, and stocks reserved for low-income and middle-income countries. We use a traffic-light system to signal the potential contributions of each candidate to achieving global vaccine immunity, highlighting important trade-offs that policy makers need to consider when developing and implementing vaccination programmes. Although specific data points are subject to change as the pandemic response progresses, the dashboard will continue to provide a useful lens through which to analyse the key issues affecting the use of COVID-19 vaccines. We also present original data from a 32-country survey (n=26 758) on potential acceptance of COVID-19 vaccines, conducted from October to December, 2020. Vaccine acceptance was highest in Vietnam (98%), India (91%), China (91%), Denmark (87%), and South Korea (87%), and lowest in Serbia (38%), Croatia (41%), France (44%), Lebanon (44%), and Paraguay (51%).

Published Online
 February 12, 2021
[https://doi.org/10.1016/S0140-6736\(21\)00306-8](https://doi.org/10.1016/S0140-6736(21)00306-8)
 Department of Health Policy (OJW), WHO, Geneva, Switzerland
 M Salcher-Konrad MSc and Department of International Development (KCS), London School of Economics and Political Science, London, UK; UK (Prof A J Pollard), Department of Infectious Disease Epidemiology, London School of Hygiene & Tropical Medicine, London, UK (Prof H J Larson PhD), Prof M Jit PhD, Department of Health, Behavior, and Society, University of Washington, Seattle, WA, USA (Prof H J Larson), Health Intervention and Technology Assessment Program, Ministry of Public Health, Thailand (Y Teerawattananon PhD), Saw Swee Hoong School of Public Health, National University of Singapore, Singapore (Y Teerawattananon PhD)
 Correspondence to: Dr Oliver J Wouters, Department of Health Policy, London School of Economics and Political Science, London WC2A 3AE, UK. o.j.wouters@lse.ac.uk
 For more on COVID-19 mortality see <https://coronavirus.thebmj.com/>
 See Online for appendix 1

Introduction
 The COVID-19 pandemic has caused substantial excess mortality and plunged national economies into deep recessions.¹ Although the spread of the virus can be mitigated through physical distancing, face coverings, and testing and tracing—and potentially with therapeutics—the risk of outbreaks and disruption to economic and social life will probably remain until effective vaccines are administered to large portions of the global population to prevent hospitalisation and severe disease, and preferably achieve herd immunity to halt transmission of the virus.² Several COVID-19 vaccines have now been authorised or approved for human use, with many more in the late stages of clinical development. Yet having licensed vaccines is not enough to achieve global control of COVID-19; they also need to be produced at scale, priced affordably, allocated globally so that they are available where needed, and widely deployed in local communities (figure 1). These four dimensions of the global vaccination challenge are closely related, and the development and production steps have important implications for pricing, allocation, and public confidence.

In this Health Policy paper, we review potential challenges to success in each of these dimensions and discuss policy implications. To guide our review, we developed a dashboard (figure 2) to highlight the key characteristics of 26 leading vaccine candidates, based on the target product profiles for COVID-19 vaccines set by WHO.³ We focused on characteristics that distinguish individual vaccine candidates from one another. We used a traffic-light system to signal the potential contributions of each candidate to achieving global vaccine immunity, with the colour red indicating high risks to achieving widespread immunity, amber indicating medium risk, and green indicating little or no risk. Appendix 1 outlines the methodology for

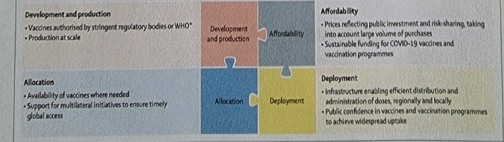


Figure 1. Four dimensions of an effective global immunisation strategy against COVID-19
 *Stringent regulatory bodies can approve vaccines or authorise their use in emergencies (eg, emergency use authorisation during public health crises, such as pandemics). WHO can grant emergency use listing (comparable to emergency use authorisation by a stringent body) or prequalification (comparable to approval by a stringent body). WHO publishes a list of stringent regulatory authorities.³

- Development and production
 - Vaccines authorized by stringent regulatory bodies or WHO*
 - Production at scale
- Allocation
 - Availability of vaccines where needed
 - Support for multilateral initiatives to ensure timely global access
- Affordability
 - Prices reflecting public investment and risk-sharing, taking into account large volume of purchases
 - Sustainable funding for COVID-19 vaccines and vaccination programmes

- Deployment
 - Infrastructure enabling efficient distribution and administration of doses, regionally and locally
 - Public confidence in vaccines and vaccination programmes to achieve widespread uptake

Healthcare Supply Chains in Developing Countries

PEOPLE
that
DELIVER

Healthcare Supply Chains in Developing Countries

SITUATIONAL ANALYSIS



- In most LMICs, medicines are distributed through three systems:
 - Public or government-run system
 - Private not-for-profit, largely faith-based and/or international NGOs
 - Private commercial
- Common challenges faced by LMIC supply chains are:
 - Limited capacity, often poor storage conditions
 - Limited transport capacity
 - Manual inventory record systems
 - Limited/poor data visibility and quality
 - Limited achievement of access to essential products for targeted populations

Supply Chain of Church Organizations

- Churches come together to operate cooperative supply chains, for example the Churches Health Associations of Malawi, Ghana, and Zambia.
- Capacity of supply chains varies, but in general have the similar challenges as Government supply chains
- The reach of services is similar to that of Government but is perceived to be of better quality
- The most important comparative advantage that FBOs bring to health service delivery in sub-Saharan Africa is moral and ethical standing

References:

1. Kaufmann, J.R., Miller, R. and Cheyne, J., 2011. Vaccine supply chains need to be better funded and strengthened, or lives will be at risk. *Health Affairs*, 30(6), pp.1113-1121.
2. Dowling, P., 2011. Healthcare supply chains in developing countries: situational analysis. Arlington, Va.: USAID| DELIVER PROJECT.
3. Widmer, M., Betran, A.P., Meriadi, M., Requejo, J. and Karpf, T., 2011. The role of faith-based organizations in maternal and newborn health care in Africa. *International Journal of Gynecology & Obstetrics*, 114(3), pp.218-222.
4. Gill, Z. and Carrough, M., 2008. Do mission hospitals have a role in achieving Millennium Development Goal 5?. *International Journal of Gynecology & Obstetrics*, 102(2), pp.198-202.
5. Lipsky, A.B., 2011. Evaluating the strength of faith: Potential comparative advantages of faith-based organizations providing health services in sub-Saharan Africa. *Public Administration and Development*, 31(1), pp.25-36.



Church Role in Vaccination Uptake

- The need to build a consensus about the order in which groups of the population will get access to the vaccine;
- Reduce any fear and concerns that exist in relation to vaccination and to create demand for vaccines
- Play a role in taking vaccines to people and in vaccination campaigns to reach scale

Conclusion – The Churches can play a role

- Global health community must *respond on multiple fronts* at once: expand the role of vaccine access beyond the traditional Government role to include a play for churches and other community organizations
- *Optimize deployment capacity* ensure both availability of vaccines to all populations who need, as well as rapid access through use of multiple stakeholders to reach communities
- *Identify and improve logistics capacity*, establishing new/extra capacity for accelerating access, where possible



Thank you!