

**A RACE AGAINST TIME: DEPLOYING VACCINES  
AND ADDRESSING THE DISPROPORTIONATE  
IMPACTS OF COVID-19 IN LATIN AMERICA AND  
THE CARIBBEAN**

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**HEARING**

BEFORE THE

SUBCOMMITTEE ON  
WESTERN HEMISPHERE, CIVILIAN SECURITY,  
MIGRATION AND INTERNATIONAL ECONOMIC  
POLICY

OF THE

COMMITTEE ON FOREIGN AFFAIRS  
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# **A RACE AGAINST TIME: DEPLOYING VACCINES AND ADDRESSING THE DISPROPORTIONATE IMPACTS OF COVID-19 IN LATIN AMERICA AND THE CARIBBEAN**

**Thursday, May 13, 2021**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON THE WESTERN HEMISPHERE,  
CIVILIAN SECURITY, MIGRATION, AND INTERNATIONAL  
ECONOMIC POLICY,  
COMMITTEE ON FOREIGN AFFAIRS,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:04 a.m., in room 2172, Rayburn House Office Building, Hon. Albio Sires (chairman of the subcommittee) presiding.

Mr. SIRES. Good morning, everyone. Thank you to all witnesses for being here today. This hearing, entitled “A Race Against Time: Deploying Vaccines and Addressing the Disproportionate Impacts of COVID-19 in Latin America and the Caribbean,” will come to order.

Without objection, the chair is authorized to declare a recess of the committee at any point, and all members will have 5 days to submit statements, extraneous material, and questions for the record, subject to the length limitation in the rules. To insert something into the record, please have your staff email the previously mentioned address or contact subcommittee staff.

As a reminder to members joining remotely, please keep your video function on at all times, even when you are not recognized by the chair. Members are responsible for muting and unmuting themselves, and please remember to mute yourself after you finish speaking.

Consistent with H. Res. 8 and the accompanying regulations, staff will only mute members and witnesses as appropriate when they are not under recognition, to eliminate background noise.

I see that we have a quorum, and I now recognize myself for opening remarks.

I have dedicated much of my 15 years in Congress to deepening the United States’ engagement in the Western Hemisphere. So, it has been deeply painful to see the devastating impact of the COVID-19 pandemic in Latin America and in the Caribbean.

The region has less than 10 percent of the world’s population, but has accounted for almost 30 percent of the world’s deaths. An estimated 22 million people in this region were pushed back into poverty last year, effectively eroding many of the region’s gains in economic development over the last two decades.

The pandemic's impacts have been especially severe for women in the region, who have been 44 percent more likely than men to lose their jobs. The pandemic has also created nightmare scenarios for many women who have been forced to shelter with their abusers. In Mexico, Argentina, Colombia, calls to domestic violence hotlines have skyrocketed.

As we think about the lessons we should learn from this pandemic, I believe one of them is that the epidemic of domestic violence must be addressed with the urgency it deserves. The U.S. Government should incorporate efforts to combat and prosecute domestic violence into our foreign assistance programming throughout the regions.

We have also seen how this pandemic is undermining democratic governance, reducing citizens' trust in government, and leading to greater political instability.

The current situation in Colombia, the United States' strongest ally in Latin America, provides a grave foreshadowing of the kinds of unrest we may see throughout the region if we cannot work quickly and effectively to get this pandemic under control.

Last Congress, we held two hearings to examine the impact of the pandemic in Latin America and the Caribbean and the U.S. Government's response. In July 2020, when we hosted the Acting Assistant Secretary, Ambassador Kozak, we discussed with him the urgent need in the region for more personal protective equipment and masks. Today, that urgent need is vaccines. I ask President Biden, Vice President Harris, and their administration to answer the call.

The U.S. is expected to have over 400 million excess vaccines, even if we vaccinated every adult in the United States—even if we vaccinated every adult in the United States. In New Jersey, more than 7.7 million doses have been administered already, and I am working hard to ensure everyone in my district can easily get access to a vaccine. But the truth is that none of us will be fully safe from this virus until we all are. Time is of the essence, and we cannot afford any further delays.

The P.1 and other variants are making it even more difficult to contain this virus. That is why I have joined with my colleagues, including Congressman Castro and Chairman Meeks, in calling for Latin America and the Caribbean to be prioritized for vaccine distribution. The Caribbean in particular cannot be forgotten. I am glad we have started to send some vaccines to Mexico, but our neighbors in the Caribbean and in Central America should also be at the top of the list.

In the coming months, we must go beyond shipping excess vaccines or working with countries to pay for them to also supporting vaccine distribution and delivery. It should be U.S. policy to promote vaccine equity and ensure that the indigenous groups, women, and people of African descent, who have been hit especially hard by the virus, are prioritized in vaccination outreach efforts.

Looking ahead, we should be assessing how we can leverage the United States' expertise in the private sector and in our government-funded research institutions to help strengthen health systems throughout the region.

My hope is that, in the wake of the pandemic, the United States bonds with this region will help emerge stronger than ever before. I look forward to working with my colleagues, on a bipartisan basis, to advance that goal.

Thank you. And I now turn to the ranking member, Congressman Green, for his opening statement.

Mr. GREEN. Thank you, Mr. Chairman. And I want to thank our witnesses for being here today. As the United States begins to reopen and once all Americans have had a chance to receive the COVID-19 vaccine, we must prioritize vaccine assistance to our neighbors in the Western Hemisphere.

China and Russia are advancing powerful disinformation campaigns in Latin America against American vaccine efforts and, of course, the pandemic's origins. In particular, the CCP is exploiting the region's health and economic vulnerability to promote its foreign policy priorities. They are leveraging the public health crisis for investment opportunities and pressing Taiwan's allies to sever diplomatic relations.

Unfortunately, it seems to be working. Just this week, President Juan Orlando Hernández of Honduras, an enduring ally of Taiwan, announced that his country may open a commercial office in China. He said that the CCP wanted a, quote, "diplomatic bridge," end quote, before Honduras could buy their vaccines.

According to an article in Financial Times titled, quote, "Chinese jabs dominant Latin American vaccination campaigns," end quote, China has shipped more than half of the 143.5 million doses of vaccines delivered to the region's 10 most populous nations.

Yet, worldwide, the United States is by far the largest donor. However, because we are funding this through the multilateral initiative COVAX, the Chinese Communist Party can make it seem like they are the most generous.

As China and Russia fill the vacuum in Latin America and the Caribbean with their suspect vaccines, many are resorting to a new trend called COVID shot tourism. Travel agencies are advertising trips to the United States to get the shot. One ad in Mexico says, quote: "Want the COVID-19 vaccine? Have a U.S. Visa? Contact us," end quote.

Demand has soared and prices have increased by as much as 40 percent for flights from Mexico to the United States, as thousands from across the Americas try to get their shot here. States and cities are responding. On May 6th, New York City's government tweeted a quote: "Welcome to New York, your vaccine is waiting for you. We will administer the Johnson & Johnson vaccine at iconic sites across our city," end quote.

Our friends in Latin America are right to distrust the Chinese vaccines. As a physician, I know that the safety of the CCP vaccines, such as Sinovac and Sinopharm, is questionable at best and their efficacy is extremely poor.

Even the director of the Chinese Centers for Disease Control and Prevention admitted that their vaccines do not have high protection rates. Additionally, according to liberal human rights watch, the CCP has detained vaccine safety advocates, censored information critical of the Chinese vaccines, and spread propaganda and disinformation regarding Western vaccines. Does this sound like a

regime that is confident about the safety and efficacy of its vaccines? Of course not.

Why should the United States—or what should the United States do to help our neighbors to the south and counter China’s malign vaccine diplomacy? For starters, vaccines distributed using U.S. taxpayer money must be branded as U.S. assistance to counter CCP and Russian disinformation.

The people of the world must know that it is not communism but freedom that is bringing these vaccines, reliable vaccines to the world. We also should be prioritizing aid to Latin American and Caribbean Nations, many of whom are struggling with COVID outbreaks and have historically been forgotten.

Finally, we need to protect American intellectual property. America’s IP laws have helped foster life-saving innovation, including the miraculous success of former President Trump’s Operation Warp Speed. Waiving our IP protections would endanger American jobs and enable the CCP to profit from America’s hard work and investment.

I urge the Biden administration to incorporate these critical points in any strategy of COVID foreign aid. We cannot let Russia, China, or any of our adversaries benefit from a global health crisis. The world is crying out for America’s help, and America must answer, America must lead.

Thank you, Mr. Chairman, and I yield.

Mr. SRES. Thank you very much, Ranking Member Green.

I will now introduce Dr. Arachu Castro. She is the Samuel Z. Stone Chair of Public Health in Latin America and the director of the collaborative group for health equity in Latin America at Tulane School for Public Health and Tropical Medicine. Her research focuses on health equity, women’s health, and early childhood development.

Prior to joining Tulane in 2013, she was associate professor of global health and social medicine at Harvard Medical School. She holds a Ph.D. in social sciences and health from the University of Barcelona, and Ph.D. in ethnology and social anthropology from the School of Advanced Studies in the Social Sciences in Paris, and a master’s of public health degree from Harvard School of Health.

Dr. Castro, we welcome you to our hearing.

We will then hear from Ms. Tatiana Bertolucci. She serves as the regional director for CARE USA’s Latin America and the Caribbean program. Ms. Bertolucci has been working with CARE since 2012, and her expertise include issues—

Ms. Bertolucci has been working with CARE since 2012, and her expertise include issues of governance, gender justice, and participatory budgeting. She holds a master’s degree in Latin American studies from the Universidad Autonoma de Madrid and has a specialization in communications and culture from Sao Paulo University.

Ms. Bertolucci, thank you for joining us today.

Finally, we will hear from Dr. Evan Ellis. He is a research professor of Latin American studies at the U.S. Army War College Strategic Studies Institute, where he focuses on the region’s relationship with China and other non-Western Hemisphere actors. He previously served on the Secretary of State’s policy planning staff,



with responsibility for Latin America and the Caribbean and international narcotics and law enforcement issues. Dr. Ellis holds a Ph.D. in comparative politics from Purdue University.

Dr. Ellis, thank you for joining us today.

I ask that the witnesses to please limit your testimony to 5 minutes and, without objection, your prepared written statements will be made part of the record.

Dr. Castro, you are recognized for your testimony.

**STATEMENT OF ARACHU CASTRO, PHD, MPH, SAMUEL Z. STONE ENDOWED CHAIR OF PUBLIC HEALTH IN LATIN AMERICA, DEPARTMENT OF GLOBAL COMMUNITY HEALTH AND BEHAVIORAL SCIENCES, TULANE UNIVERSITY SCHOOL OF PUBLIC HEALTH AND TROPICAL MEDICINE**

Dr. CASTRO. Thank you, Mr. Chairman Sires, for inviting me to testify today. My comments complement the written statement that I submitted earlier this week. As you mentioned, the pandemic is creating great human suffering in Latin America and the Caribbean. Almost one million people have died of COVID-19.

Latin America has also suffered the largest economic contraction among low-and middle-income regions, and thousands, millions of people have gone back to extreme poverty. According to the Economic Commission of Latin America and the Caribbean, it is expected that people living in extreme poverty are going to increase from 7 million to 8 million.

As in the United States, the social determinants of health have come to the fore. Indigenous and African descendant communities and those in the lowest income groups are the most affected, both by the coronavirus itself and by the economic consequences of the pandemic.

This pandemic has also brought to light the fragility and underinvestment of health systems and of essential public health functions, such as epidemiological surveillance. There is a shortage of ICU beds, personal protective equipment, oxygen and health workers. If that were not enough, around 9,000 health workers have died of COVID-19 in the region, most of them female nurses.

Most health systems have not been able to both respond to COVID-19 cases and maintain essential health services for events that happen every single day, such as complicated childbirth, diarrhea and pneumonia among children, and sexual violence. As a result of the disruption of essential health services, maternal and child deaths are increasing by the thousands.

In 2021, hospitalizations and mortality rates due to COVID-19 have increased among all age groups, and particularly among those under the age of 60. New coronavirus variants have greater transmissibility and greater mortality. Millions of vaccines are needed as soon as possible, and they need to be distributed with ethical and epidemiological principles.

Most countries in the region have procured vaccines through COVAX, an international solidarity mechanism, and also through bilateral agreements with vaccine developers from the United States, the European Union, the United Kingdom, Russia and China. However, as of last Friday, less than 5 percent of the population in the region is fully vaccinated. At this slow vaccination

rate, it is going to take a very long time to bring the pandemic to an end.

There are different mechanisms to increase the delivery of vaccines in the region: One, donating vaccines to COVAX immediately; two, financing the logistics of vaccine rollout immediately; three, engaging other countries to support the intellectual property waiver of the upcoming World Trade Organization meeting and to redesign obsolete IP laws.

The successful precedent with antiretroviral therapies to treat AIDS is proof that collaboration can help boost drug and vaccine discovery and manufacturing in the near and long terms and pharmaceutical companies are doing very well despite the collaboration.

No. 4, collaborating with Latin American and Caribbean countries through technology transfer agreements to increase the development and manufacturing of messenger RNA vaccines to respond to the current and future pandemics.

And number 5, reengaging with the region to help improve epidemiological surveillance and help strengthen health systems through the Centers for Disease Control and Prevention and through the Pan American Health Organization.

Thank you for your attention.

[The prepared statement of Dr. Castro follows:]

Arachu Castro, Ph.D., MPH  
 Samuel Z. Stone Endowed Chair of Public Health in Latin America  
 Tulane University School of Public Health and Tropical Medicine

Subcommittee on the Western Hemisphere, Civilian Security, Migration, and International  
 Economic Policy, United States House of Representatives

May 13, 2021

**A Race Against Time: Deploying Vaccines and Addressing the Disproportionate Impacts  
 of COVID-19 in Latin America and the Caribbean**

In Latin America and the Caribbean, a region inhabited by 8.5% of the world's population, 29.9 million people have been diagnosed with COVID-19 (19% of world cases) and 951,710 have died of the disease (29% of world deaths) as of May 7, 2021.<sup>1</sup> Mortality among males has been greater than among females.<sup>2</sup> The number of deaths per population is higher than 100 per 100,000 in Brazil, Peru, Mexico, Colombia, Argentina, Panama, Chile, and Ecuador,<sup>1</sup> as shown in **Table 1**. With an average of 20 deaths per 100,000 population, Caribbean island countries and territories have experienced a smaller proportion of deaths than the rest of the region.<sup>1</sup> Not included in these statistics are the thousands more—including women of reproductive age, adolescents, and children—who are estimated to have died due to the disruption of essential health services, the decrease in the use of these services for fear of acquiring COVID-19, and other indirect effects of lockdown-related measures that affect women disproportionately.<sup>3,4</sup>

The sharp increase in unemployment and loss of income caused by the pandemic has particularly affected informal workers, deepening social and economic inequalities and increasing poverty in Latin America and the Caribbean.<sup>5,6</sup> These difficult conditions prevent people from attaining their best health potential and lead dignified lives,<sup>7</sup> further increasing health equity gaps in the region.<sup>8</sup> In a national antibody seroprevalence study conducted in Brazil in 2020 (before the availability of the COVID-19 vaccine), the researchers found the highest prevalence of COVID-19 infection among indigenous and Afro-Brazilian populations compared to other ethnicities and among those in the lower socioeconomic positions.<sup>9</sup> Similar trends along the social gradient exist throughout the region.<sup>8,10</sup>

In 2020, most hospitalizations and mortality in Latin America and the Caribbean occurred among those 60 years and older.<sup>11</sup> In 2021, however, data from Brazil, Chile, Paraguay, and Peru show that ICU and non-ICU hospitalizations and mortality rates have increased among all age groups, particularly among those younger than 60—whose hospital lengths of stay are longer than among older adults.<sup>11</sup> If severe COVID-19 cases are expanding to younger population groups, possible causes are the greater transmissibility and greater mortality of the new SARS-CoV-2 variants reported in Brazil, Peru, and elsewhere in the region.<sup>12</sup> The additional stress that the new variants can cause to already overstretched health systems is compounded by the direct effect on the health workforce: in 24 countries that report data, 7,449 health workers had died of COVID-19, as of May 7, 2021, among more than 1.3 million cases in Latin America and the Caribbean,<sup>13</sup> on January 31, 2021, among those aged 40 to 59 in the Americas, 74% were women.<sup>2</sup>

Table 1: COVID-19 cases and deaths, in total population and per 100,000, as of May 7, 2021

Subregion and country or territory	Population 2021	COVID-19 cases	COVID-19 cases per 100,000 population	COVID-19 deaths	COVID-19 deaths per 100,000 population
<b>Mexico and Central America</b>					
Belize	404,915	12,686	3,133	323	80
Costa Rica	5,139,053	265,486	5,166	3,365	65
El Salvador	6,518,500	70,255	1,078	2,150	33
Guatemala	18,249,868	233,696	1,281	7,695	42
Honduras	10,062,994	218,330	2,170	5,585	56
Mexico	130,262,220	2,361,874	1,813	218,657	168
Nicaragua	6,702,379	5,575	83	183	3
Panama	4,381,583	366,762	8,371	6,258	143
<b>Subtotal</b>	<b>181,721,512</b>	<b>3,534,664</b>	<b>1,945</b>	<b>244,216</b>	<b>134</b>
<b>South America</b>					
Argentina	45,605,823	3,118,134	6,837	66,872	147
Bolivia	11,832,936	316,153	2,672	13,182	111
Brazil	213,993,441	15,082,449	7,048	419,114	196
Chile	19,212,362	1,235,778	6,432	27,021	141
Colombia	51,265,841	2,968,626	5,791	76,867	150
Ecuador	17,888,474	398,921	2,230	19,137	107
French Guiana	306,450	20,366	6,646	104	34
Guyana	790,329	14,037	1,776	314	40
Paraguay	7,219,641	294,233	4,075	6,974	97
Peru	33,359,416	1,839,465	5,514	63,519	190
Suriname	591,798	10,933	1,847	214	36
Uruguay	3,485,152	216,146	6,202	3,032	87
Venezuela	28,704,947	205,181	715	2,263	8
<b>Subtotal</b>	<b>434,256,610</b>	<b>25,720,422</b>	<b>5,923</b>	<b>698,613</b>	<b>161</b>
<b>Caribbean</b>					
Anguilla	18,424	99	537	-	-
Antigua & Barbuda	98,728	1,232	1,248	32	32
Aruba	107,195	10,737	10,016	100	93
Bahamas	396,914	10,773	2,714	212	53
Barbados	287,708	3,931	1,366	45	16
Bermuda	72,009	2,434	3,380	30	42
Bonaire	20,104	1,547	7,695	16	80
British Virgin Islands	38,172	219	574	1	3
Cayman Islands	63,103	548	868	2	3
Cuba	11,326,616	114,912	1,015	722	6
Curaçao	164,796	12,222	7,416	113	69
Dominica	74,321	175	235	-	-
Dominican Republic	10,953,714	270,600	2,470	3,523	32
Grenada	113,015	161	142	1	1
Guadeloupe	400,013	15,429	3,857	236	59
Haiti	11,402,528	13,164	115	263	2
Jamaica	2,973,462	46,588	1,567	803	27
Martinique	374,743	11,490	3,066	87	23
Montserrat	5,404	20	370	1	19
Puerto Rico	2,828,246	134,888	4,769	2,367	84
Saba	1,933	7	362	-	-
St Eustatius	3,138	20	637	-	-
St Kitts and Nevis	54,166	45	83	-	-
St Lucia	184,401	4,654	2,524	75	41
St Maarten	44,418	2,250	5,066	27	61
St Vincent & the Grenadines	111,269	1,912	1,718	12	11
Trinidad & Tobago	1,403,374	12,720	906	196	14
Turks & Caicos Islands	57,022	2,402	4,212	17	30
<b>Subtotal</b>	<b>43,578,936</b>	<b>675,179</b>	<b>1,549</b>	<b>8,881</b>	<b>20</b>
<b>TOTAL</b>	<b>659,557,058</b>	<b>29,930,265</b>	<b>4,538</b>	<b>951,710</b>	<b>144</b>

Source: World Health Organization, [Coronavirus Dashboard](#), 2021.<sup>1</sup>

### Access to the COVID-19 vaccines

The limited capacity to develop novel vaccines in the region is why most countries have negotiated access to COVID-19 vaccines through bilateral agreements with vaccine developers while participating in the COVID-19 Vaccines Global Access (COVAX) facility—the vaccine pillar of the Access to COVID-19 Tools Accelerator (ACT).<sup>14,15</sup> Launched in April 2020, ACT was created to promote the equitable distribution of tests, treatments, and vaccines between and within countries by pooling public and private resources to invest in scientific discovery and strengthen health systems. COVAX is co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi (The Vaccine Alliance), and the World Health Organization (WHO).

COVAX signs advanced purchase agreements with vaccine manufacturers, with either a flat or a tiered pricing mechanism, with the expectation that they will produce enough doses for low- and middle-income countries.<sup>16</sup> Countries participate in COVAX as donor-dependents with advance market commitments (AMCs) or as self-financing participants (SFPs). The ten AMC countries in the region are Bolivia, Dominica, El Salvador, Guyana, Grenada, Haiti, Honduras, Nicaragua, Saint Lucia, and Saint Vincent and the Grenadines.<sup>14</sup> SFP countries include: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, Guatemala, Jamaica, Mexico, Panama, Paraguay, Peru, Saint Kitts and Nevis, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.<sup>14</sup>

Outside of the Americas, UNICEF's Supply Division is the procurement agent. The Pan American Health Organization (PAHO), which is the WHO Regional Office for the Americas, serves as the COVAX procurement agent for the region through its Revolving Fund for Vaccine Procurement,<sup>17</sup> which operates in the region since 1979 as part of PAHO's technical cooperation.<sup>18</sup> Thus far, all vaccines procured through COVAX are from vaccine developers AstraZeneca-Oxford (United Kingdom and Sweden) and Pfizer-BioNTech (United States and Germany); Moderna (United States) announced on May 3, 2021, an agreement with COVAX to supply 500 million doses to AMC countries.<sup>19</sup> Since March 1, 2021, countries in the region have received 11.9 million vaccine doses through COVAX,<sup>14</sup> and the goal is to distribute 280 million doses by the end of 2021.<sup>15</sup>

Argentina, Chile, Costa Rica, and Mexico started their COVID-19 vaccination programs through bilateral agreements at the end of December 2020, with other countries following suit.<sup>15</sup> Many governments have negotiated these deals, in addition to participating in COVAX, to guarantee vaccine availability within their national borders. Brazil, Chile, Colombia, Ecuador, Mexico, Uruguay, and El Salvador have signed deals from both Pfizer-BioNTech and Sinovac (China), whereas Mexico has also reached agreements with CanSino (China) and Gamaleya (Russia). Honduras has signed with Moderna, Janssen (United States), and Gamaleya; Argentina with Sinopharm (China) and Gamaleya; Bolivia with Pfizer-BioNTech, Sinopharm, and Gamaleya; Paraguay with Bharat (India), Sinovac, Sinopharm, and Gamaleya; and Peru with Pfizer-BioNTech and Sinopharm. In addition to COVAX, Belize and Dominica have signed with Sinopharm; Nicaragua and Saint Vincent and the Grenadines with Gamaleya; Panama with BioNTech; and the Dominican Republic with Sinovac. The other AMC and SFP countries have not engaged in bilateral agreements.<sup>14,20</sup>

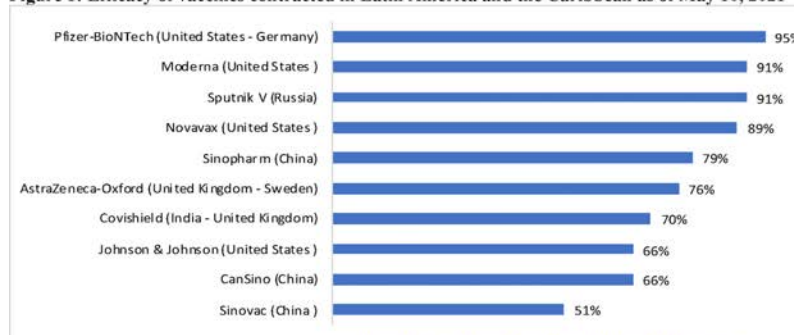
Despite the diversification of vaccine sources, access to COVID-19 vaccines is uneven throughout the region. As shown in **Table 2**, only 4.5% of the regional population is fully vaccinated and 12.2% is partially vaccinated as of May 7, 2021.<sup>20</sup> The sovereign nations with the highest coverage of vaccination are Chile (36.4% fully and 80.0% fully or partially), Uruguay (21.9% and 56.9%), and Dominica (13.8% and 39.1%).<sup>20</sup> In Mexico and Central America, 0.4% are fully vaccinated and 12.3% partially, whereas in South America it is 6.3% and 12.6%, respectively. In the Caribbean, the coverage is 4.3% and 7.6%, respectively.<sup>20</sup>

Haiti and Venezuela have not yet started to vaccinate their populations—Haiti reportedly having turned away in April 2021 a shipment of vaccines procured through the COVAX facility<sup>21</sup> and Venezuela due to lack of servicing its down payment.<sup>22</sup> Cuba did not participate in COVAX due to limitations in currency exchange,<sup>22</sup> instead deciding to invest in the development of their own vaccines. On May 7, 2021, Cuba authorized the emergency use of two local vaccines starting right away; by August, they plan to produce enough doses to vaccinate the entire population, which is expected to be completed by the end of December 2021.<sup>23</sup>

Despite current efforts to procure vaccines through different mechanisms, the region is far from reaching its targets and overcoming the crisis. Effectively controlling the COVID-19 pandemic in the region and the rest of the world requires the deployment of a systematic vaccination strategy. That is, a plan that immunizes at least 67% of the population of every country—the estimated herd immunity threshold above which virus transmission is contained<sup>24</sup>—before new variants that are more transmissible and more lethal reduce the efficacy of vaccination efforts.

Effective vaccination strategies also follow ethical and epidemiological principles that prioritize population groups more exposed to the coronavirus (such as health care workers), the elderly, and those with chronic health conditions.<sup>25</sup> Additionally, vaccines contracted in the region have different efficacy, shown in **Figure 1**. Countries and territories relying on the least efficacious vaccines may face challenges immunizing their populations and bringing transmission to an end.<sup>26</sup>

**Figure 1: Efficacy of vaccines contracted in Latin America and the Caribbean as of May 10, 2021**



Source: Americas Society/Council of the Americas, [Timeline: Tracking Latin America's Road to Vaccination](#), 2021.<sup>15</sup>

Table 2: COVID-19 vaccination coverage, in total population and percentage, as of May 7, 2021

Subregion and country or territory	Population 2021	Fully vaccinated (number)	Fully vaccinated (%)	Partially vaccinated (number)	Partially vaccinated (%)	Not vaccinated (number)	Not vaccinated (%)
<b>Mexico and Central America</b>							
Belize	404,915	1,547	0.4%	46,067	11.4%	357,301	88.2%
Costa Rica	5,139,053	345,153	6.7%	605,099	11.8%	4,188,801	81.5%
El Salvador	6,518,500	124,073	1.9%	950,691	14.6%	5,443,736	83.5%
Guatemala	18,249,868	2,260	0.0%	180,072	1.0%	18,067,536	99.0%
Honduras	10,062,994	2,958	0.0%	66,345	0.7%	9,993,691	99.3%
Mexico	130,262,220	-	0.0%	19,951,121	15.3%	110,311,099	84.7%
Nicaragua	6,702,379	-	0.0%	146,698	2.2%	6,555,681	97.8%
Panama	4,381,583	263,974	6.0%	467,692	10.7%	3,649,917	83.3%
<b>Subtotal</b>	<b>181,721,512</b>	<b>739,965</b>	<b>0.4%</b>	<b>22,413,785</b>	<b>12.3%</b>	<b>158,567,762</b>	<b>87.3%</b>
<b>South America</b>							
Argentina	45,605,823	1,191,546	2.6%	7,399,515	16.2%	37,014,762	81.2%
Bolivia	11,832,936	257,840	2.2%	715,006	6.0%	10,860,090	91.8%
Brazil	213,993,441	15,032,654	7.0%	30,869,414	14.4%	168,091,373	78.5%
Chile	19,212,362	6,993,123	36.4%	8,374,316	43.6%	3,844,923	20.0%
Colombia	51,265,841	2,136,171	4.2%	3,769,535	7.4%	45,360,135	88.5%
Ecuador	17,888,474	256,328	1.4%	920,338	5.1%	16,711,808	93.4%
French Guiana	306,450	8,312	2.7%	19,867	6.5%	278,271	90.8%
Guyana	790,329	7,153	0.9%	153,295	19.4%	629,881	79.7%
Paraguay	7,219,641	14,621	0.2%	144,339	2.0%	7,060,681	97.8%
Peru	33,359,416	655,127	2.0%	1,285,791	3.9%	31,418,498	94.2%
Suriname	591,798	82	0.0%	41,205	7.0%	550,511	93.0%
Uruguay	3,485,152	762,532	21.9%	1,222,137	35.1%	1,500,483	43.1%
Venezuela	28,704,947	-	0.0%	-	0.0%	28,704,947	100.0%
<b>Subtotal</b>	<b>434,256,610</b>	<b>27,315,489</b>	<b>6.3%</b>	<b>54,914,758</b>	<b>12.6%</b>	<b>352,026,363</b>	<b>81.1%</b>
<b>Caribbean</b>							
Anguilla	18,424	2,992	16.2%	7,188	39.0%	8,244	44.7%
Antigua & Barbuda	98,728	66	0.1%	30,763	31.2%	67,899	68.8%
Aruba	107,195	23,787	22.2%	55,143	51.4%	28,265	26.4%
Bahamas	396,914	-	0.0%	36,314	9.1%	360,600	90.9%
Barbados	287,708	25,466	8.9%	75,148	26.1%	187,094	65.0%
Bermuda	72,009	25,033	34.8%	32,948	45.8%	14,028	19.5%
Bonaire	20,104	5,283	26.3%	12,398	61.7%	2,423	12.1%
British Virgin Islands	38,172	1,012	2.7%	10,007	26.2%	27,153	71.1%
Cayman Islands	63,103	32,237	51.1%	37,062	48.9%	(6,196)	0.0%
Cuba	11,326,616	-	-	-	-	11,326,616	100.0%
Curaçao	164,796	31,127	18.9%	76,122	46.2%	57,547	34.9%
Dominica	74,321	10,239	13.8%	18,801	25.3%	45,281	60.9%
Dominican Republic	10,953,714	807,263	7.4%	1,389,890	12.7%	8,756,561	79.9%
Grenada	113,015	4,494	4.0%	13,262	11.7%	95,259	84.3%
Guadeloupe	400,013	7,574	1.9%	16,639	4.2%	375,800	93.9%
Haiti	11,402,528	-	-	-	-	11,402,528	100.0%
Jamaica	2,973,462	1,602	0.1%	143,656	4.8%	2,828,204	95.1%
Martinique	374,743	9,821	2.6%	33,467	8.9%	331,455	88.4%
Montserrat	5,404	759	14.0%	1,302	24.1%	3,343	61.9%
Puerto Rico	2,828,246	852,386	30.1%	1,189,868	42.1%	785,992	27.8%
Saba	1,933	1,300	67.3%	-	0.0%	633	32.7%
St Eustatius	3,138	-	0.0%	-	0.0%	-	100.0%
St Kitts and Nevis	54,166	277	0.5%	13,281	24.5%	40,608	75.0%
St Lucia	184,401	6,690	3.6%	24,653	13.4%	153,058	83.0%
St Maarten	44,418	9,956	22.4%	14,678	33.0%	19,784	44.5%
St Vincent & the Grenadines	111,269	1,730	1.6%	12,657	11.4%	96,882	87.1%
Trinidad & Tobago	1,403,374	480	0.0%	58,897	4.2%	1,343,997	95.8%
Turks & Caicos Islands	57,022	12,083	21.2%	17,932	31.4%	27,007	47.4%
<b>Subtotal</b>	<b>43,578,936</b>	<b>1,873,657</b>	<b>4.3%</b>	<b>3,322,076</b>	<b>7.6%</b>	<b>38,380,065</b>	<b>88.1%</b>
<b>TOTAL</b>	<b>659,557,058</b>	<b>29,929,111</b>	<b>4.5%</b>	<b>80,650,619</b>	<b>12.2%</b>	<b>548,974,190</b>	<b>83.2%</b>

Source: Pan American Health Organization, [COVID-19 Vaccination in the Americas](#), 2021.<sup>20</sup>



### **Expediting the delivery of COVID-19 vaccines**

There are different mechanisms to increase the delivery of COVID-19 vaccines in Latin America and the Caribbean. In the short term, donating excess vaccines to COVAX and financing the logistics of vaccine rollout can immediately increase vaccine coverage. Engaging other countries to support the intellectual property waiver at the upcoming World Trade Organization meeting and to redesign intellectual property laws can help boost vaccine discovery and manufacturing in the mid- and long-terms.<sup>27,28</sup>

The United States government can also undertake plans in collaboration with Latin American and Caribbean countries to increase the development and manufacturing of vaccines. These plans could start in Brazil and Mexico, the two largest countries in the region, both of which have existing manufacturing plants for vaccine production. The Oswaldo Cruz Foundation (Fiocruz)'s Institute of Drug Technology (Farmanguinhos)<sup>29</sup> and the Butantan Institute<sup>30</sup> are the largest pharmaceutical manufacturers in Brazil and are linked to its Ministry of Public Health. They have partnered with AstraZeneca-Oxford and Sinovac, respectively, to produce a total of 209 million COVID-19 vaccines<sup>31</sup> with imported active pharmaceutical ingredients (APIs) from China; they expect to receive the technology to produce their own APIs later in 2021. The National Institute of Allergy and Infectious Diseases (NIAID) could also assist Fiocruz in developing mRNA vaccines and transferring technology for future vaccine needs, facilitated by the waiver of intellectual property rights. In Mexico, private laboratory Liomont has partnered with AstraZeneca-Oxford to produce vaccines with APIs manufactured in Argentina's mAbxience, another private manufacturer;<sup>31</sup> however, issues with the certification process in Mexico have halted vaccine production.<sup>32</sup> The United States' involvement through technology transfer agreements, human resource training, and leveraging regional supply chains could help increase production capacity in a region with a population of 660 million and insufficient vaccine development capacity.

### **Strengthening epidemiological surveillance and health systems**

In most of Latin America and the Caribbean, the segmentation of health services, the concentration of human resources and medical technology in a few urban hospitals, the under-financing of primary health care and epidemiological surveillance, the limited use of digital health technologies, and the lack of coordination between the different levels of care have weakened the coordination of national response actions.<sup>4</sup> Reengaging with the region to help improve epidemiological surveillance systems through the Centers for Disease Control and Prevention (CDC) and help strengthen health systems through the Pan American Health Organization are measures that can improve the lives of millions and the standing of the United States in the Latin American and Caribbean region.



## References:

1. WHO. Coronavirus Dashboard. Available at: <https://covid19.who.int>. Geneva: World Health Organization; 2021.
2. PAHO. COVID-19 Health Outcomes by Sex in the Americas. From January 2020 to January 2021, <https://iris.paho.org/handle/10665.2/53372>. Washington, DC: Pan American Health Organization; 2021.
3. Castro A. Maternal and child mortality worsens in Latin America and the Caribbean. *Lancet* 2020; **396**(10262): e85.
4. Castro A. Challenges posed by the COVID-19 pandemic in the health of women, children, and adolescents in Latin America and the Caribbean. UNDP Latin American and the Caribbean, COVID-19 Policy Documents Series Number 19, September 2020. Available at: [https://www.latinamerica.undp.org/content/rblac/en/home/library/crisis\\_prevention\\_and\\_recovery/de-safios-de-la-pandemia-de-covid-19-en-la-salud-de-la-mujer--de.html](https://www.latinamerica.undp.org/content/rblac/en/home/library/crisis_prevention_and_recovery/de-safios-de-la-pandemia-de-covid-19-en-la-salud-de-la-mujer--de.html). New York: United Nations Development Programme; 2020.
5. ECLAC, PAHO. Health and the economy: A convergence needed to address COVID-19 and retake the path of sustainable development in Latin America and the Caribbean. Available at: <https://www.cepal.org/en/publications/45841-health-and-economy-convergence-needed-address-covid-19-and-retake-path>. Santiago: Economic Commission for Latin America and the Caribbean and Pan American Health Organization.; 2020.
6. ECLAC. Employment Situation in Latin America and the Caribbean. Employment trends in an unprecedented crisis: policy challenges. Available at: <https://www.cepal.org/en/publications/46309-employment-situation-latin-america-and-caribbean-employment-trends-unprecedented>. Santiago, Chile: Economic Commission for Latin America and the Caribbean; 2020.
7. PAHO. Just Societies: Health Equity and Dignified Lives - Report of the Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas. Available at: <https://iris.paho.org/handle/10665.2/51571>. Washington DC: Pan American Health Organization; 2019.
8. Coates A, Castro A, Marmot M, Mujica OJ, Eijkemans G, Victora CG. Just societies: A new vision for health equity in the Americas after COVID-19. *Rev Panam Salud Publica* 2020; **44**: e137.
9. Horta BL, Silveira MF, Barros AJD, et al. Prevalence of antibodies against SARS-CoV-2 according to socioeconomic and ethnic status in a nationwide Brazilian survey. *Rev Panam Salud Publica* 2020; **44**: e135.
10. Castro MC, Gurgenda S, Macario EM, Franca GVA. Characteristics, outcomes and risk factors for mortality of 522 167 patients hospitalised with COVID-19 in Brazil: a retrospective cohort study. *BMJ Open* 2021; **11**(5): e049089.
11. PAHO. COVID-19 Epidemiological Alert: Increase in hospitalizations and deaths among patients under 60 years of age. Available at: <https://www.paho.org/en/documents/covid-19-epidemiological-alert-increase-hospitalizations-and-deaths-among-patients-under>. Washington, DC: Pan American Health Organization; 2021.
12. Phillips T, Collins D. Brazil's 'rapid and violent' Covid variant devastates Latin America, <https://www.theguardian.com/world/2021/apr/23/brazils-rapid-and-violent-covid-variant-devastates-latin-america>. *The Guardian*, April 23 2021.
13. Personal communication, May 10, 2021.
14. PAHO. COVAX vaccines COVID-19 deliveries in the Americas, <https://app.powerbi.com/view?r=eyJrJoiMjA5ZDAxMmEtYTljNC00M2I0LWE5MjUtYWQzZGQxNDc4OThhIiwidCI6ImU2MTBjNzljLTJlYzAtNGUwZi04YTE0LTFlNGIxMDElMTlmNyIsImMiOiR9>. Washington, DC: Pan American Health Organization; 2021.

15. Horwitz L, Zissis C. Timeline: Tracking Latin America's Road to Vaccination. Available at: <https://www.as-coa.org/articles/timeline-tracking-latin-americas-road-vaccination>. May 10. New York: Americas Society/Council of the Americas; 2021.
16. GAVI. GAVI approach creates tiered pricing for vaccines. <https://www.gavi.org/news/media-room/gavi-approach-creates-tiered-pricing-vaccines>; GAVI The Vaccine Alliance; 2020.
17. WHO. COVAX. <https://www.who.int/initiatives/act-accelerator/covax>. Geneva: World Health Organization, ; 2020.
18. PAHO. PAHO Revolving Fund. <https://www.paho.org/en/revolvingfund>. Washington, DC: Pan American Health Organization.
19. Gavi. Gavi signs agreement with Moderna to secure doses on behalf of COVAX Facility. Available at: <https://www.gavi.org/news/media-room/gavi-signs-agreement-moderna-secure-doses-behalf-covax-facility>. May 3. Geneva: Gavi The Vaccine Alliance; 2021.
20. PAHO. COVID-19 vaccinations in the Americas. Available at: [https://ais.paho.org/imm/IM\\_DosisAdmin-Vacunacion.asp](https://ais.paho.org/imm/IM_DosisAdmin-Vacunacion.asp). Washington, DC: Pan American Health Organization; 2021.
21. Beaubien J. One Of The World's Poorest Countries Has One Of The World's Lowest COVID Death Rates. <https://www.npr.org/sections/goatsandsoda/2021/05/04/992544022/one-of-the-worlds-poorest-countries-has-one-of-the-worlds-lowest-covid-death-rat>. *NPR*, May 4 2021.
22. Personal communication, March 10, 2021.
23. Alonso Falcón R, Figueredo Reinaldo O, Sifonte Díaz YJ, et al. Prometedores resultados de candidatos vacunales cubanos: Comienza en mayo intervención con Abdala y Soberana 02 en grupos y territorios de riesgo [Promising results of Cuban vaccine candidates: Intervention with Abdala and Soberana 02 in risk groups and territories begins in May]. Available at: <http://www.cubadebate.cu/noticias/2021/05/10/ofrecen-detalles-sobre-fase-ii-de-ensayo-clinico-con-soberana-plus/>. *CubaDebate*, May 7 2021.
24. Sabino EC, Buss LF, Carvalho MPS, et al. Resurgence of COVID-19 in Manaus, Brazil, despite high seroprevalence. *The Lancet* 2021; 397(10273): 452-5.
25. WHO. WHO SAGE Roadmap for Prioritizing Uses of COVID-19 Vaccines in the Context of Limited Supply. Available at: <https://www.who.int/publications/m/item/who-sage-roadmap-for-prioritizing-uses-of-covid-19-vaccines-in-the-context-of-limited-supply>. Geneva: World Health Organization; 2020.
26. In clinical and real world trials, China's Sinovac underperforms. Available at: <https://www.economist.com/graphic-detail/2021/04/15/in-clinical-and-real-world-trials-chinas-sinovac-underperforms>. *The Economist*, April 15 2021.
27. Garrett L. Stopping Drug Patents Has Stopped Pandemics Before. Available at: <https://foreignpolicy.com/2021/05/07/stopping-drug-patents-pandemics-coronavirus-hiv-aids/>. *Foreign Policy*, May 7 2021.
28. Okediji RL. With a Covid-19 vaccine patent waiver likely, time to rethink global intellectual property rules. Available at: <https://edition.cnn.com/2021/05/07/opinions/covid-vaccine-patent-waiver-as-equals-intl-cmd/index.html>. *CNN*, May 7 2021.
29. Institute of Drug Technology (Farmanguinhos). <https://portal.fiocruz.br/en/unidade/institute-drug-technology-farmanguinhos>.
30. Butantan Institute. <https://butantan.gov.br/instituto-butantan/about-us>.
31. Duke University. Launch and Scale Speedometer, Vaccine manufacturing. <https://launchandscalefaster.org/covid-19/vaccinemanufacturing>. 2021.
32. Smink V. Vacunas contra la covid-19: qué pasó con los millones de dosis de AstraZeneca que México y Argentina prometieron producir en América Latina [Vaccines against covid-19: what happened to the millions of doses of AstraZeneca that Mexico and Argentina promised to produce in Latin America]. Available at: <https://www.bbc.com/mundo/noticias-america-latina-56923216>. *BBC News Mundo*, April 29 2021.

Mr. SIREs. Thank you very much. I now turn to you, Ms. Bertolucci, for your remarks.

**STATEMENT OF TATIANA BERTOLUCCI, REGIONAL DIRECTOR  
FOR LATIN AMERICA AND THE CARIBBEAN, CARE INTER-  
NATIONAL**

Ms. BERTOLUCCI. Chairman Sires and Ranking Member Green and distinguished members of the committee, thank you for the opportunity to testify today as you examine the challenges and impacts of the COVID-19 pandemic in Latin America and the Caribbean.

These are critical issues, and I am really thankful for the committee's attention to them. CARE has provided the development, assistance and humanitarian relief in the region for over 65 years. We are currently responding directly or through partners in 12 countries, focusing on fighting the structural causes of inequality, supporting the most vulnerable populations, especially indigenous and afro-descendant women and girls and migrants and refugees.

When the COVID-19 pandemic hit, Latin America was facing a major humanitarian crisis. More than 5 million people had fled Venezuela. In Central America, people exposed to violence, hunger, and the effects of climate change were forced to leave their countries. And in Haiti, millions were facing food insecurity.

The impacts of the pandemic were deepened by the region's structural challenges and at the same time exacerbated the region's inequalities, making the humanitarian needs even more severe.

CARE is witnessing them firsthand, as in the story of Maria, a 29-year-old owner of a food post in Honduras that told us, in her words, we have been locked up and I have not been able to sell my products, because I have to go to the market and right now I am not able to do so. We had help these past days, but I am afraid we will not die of COVID, we will starve.

Or Mercedes, a 36-year-old Venezuelan woman living in Colombia, that told us, the hostel we were sleeping at was shut down by the government because of social distancing. Now myself and my two kids are on the street with no place to sleep, with no chance to have any income because everything is closed, and with no way of protecting ourselves from this disease or from people.

It is for the many stories like those that my testimony today focuses on the secondary and long-term impacts of the crisis. The International Monetary Fund predicts that the region will face a contraction in its economy of 7 percent. Then unemployment rates are rising and reached 10.7 percent at the end of 2020.

Lack of employment, together with the impacts of climate change, political instability, and income inequalities drive the tremendous poverty growth. Twenty-two million people moved into poverty just last year.

We are also seeing food insecurity and malnutrition growing. According to the World Food Programme, the region is expected to see a 269 percent rise in the number of people facing severe food insecurity. Sixty million already do not have—sorry, 60 million people do not know where they are going to find their next meal, and

women are already eating fewer meals to leave more food for their children.

Access to health and education has also worsened. With fragmented and unequal health systems, the region is ill-prepared to handle a health crisis of the scale of COVID-19. Also, 95 percent of the children are out of school because of COVID. The majority of them do not have access to internet, so they do not benefit from online learning. The caregiving burden is higher for women that are often responsible for the childcare, and for girls that are tasked with taking care of their younger siblings and have less time for their own education.

As the secondary impacts of COVID take their toll, thousands of people have been forced to flee their homes and face higher risks with the closure of borders. Informal migration routes expose women to higher rates of sexual exploitation, abuse, and human trafficking.

Finally, the rise in gender-based violence and the disproportionate rise in unpaid care work for women are two trends that are putting women's lives and futures at significant risk.

To address these challenges, CARE urges the U.S. Government to prioritize five key areas in its policy and assistance strategy for the region: One, ensure fast and fair delivery of COVID-19 vaccines to the last mile and sustainable health system strengthened by prioritizing investment in frontline and community health workers.

Two, elevate humanitarian diplomacy and funding within the U.S. strategy in the region, including facilitating durable solutions to displacement.

Three, ensure U.S. humanitarian and development investments have a clear gender focus and support women and girls, including through continued support for sexual and reproductive health and for gender-based violence prevention and response.

Four, engage with and support regional governments to ensure safety nets are accessible to the most vulnerable populations now and to improve their resilience throughout the years.

And five, direct resources to strengthen the capacity of locally led and especially women-led organizations, and prioritize economic empowerment for women and vulnerable groups to bolster resilience and capacity to respond to the current and future crises.

Thank you very much.

[The prepared statement of Ms. Bertolucci follows:]

Ms. Tatiana Bertolucci  
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CARE USA

Testimony Submitted to the House Foreign Affairs Committee - Subcommittee on the Western Hemisphere, Civilian Security, Migration, and International Economic Policy

“A Race Against Time: Deploying Vaccines and Addressing the Disproportionate Impacts of COVID-19 in Latin America and the Caribbean”

May 13, 2021

Chairman Meeks and Ranking Member McCaul, Subcommittee Chairman Rep. Sires and Ranking Member Green and distinguished members of the Committee, thank you for the opportunity to testify today as you examine the challenges and impact of the COVID19 pandemic in Latin America and the Caribbean. These are critical issues, and I am thankful for the Committee's attention to them.

My name is Tatiana Bertolucci, and I am the Regional Director for Latin America and the Caribbean at CARE USA. CARE began its story nearly 75 years ago when a small group of dedicated Americans sent the first CARE packages overseas to survivors of World War II. Today, CARE works in 100 countries around the world to address the root causes of suffering and to provide lifesaving humanitarian assistance to people in need. CARE's work focuses on women and girls because our experience has taught us that we must help communities address gender inequalities between women and men to respond effectively to crises and their underlying factors.

Before I begin, I would like to take this opportunity to thank this Committee and Congress for the continued bipartisan commitment it has shown to development and humanitarian assistance. Specifically, U.S. global leadership in providing support to respond to the pandemic in low-and-middle income countries has been critical to saving lives and spurring other donor countries to rise to meet this global challenge. Helping those in need around the world is not, and has never been, a partisan issue. CARE is grateful to have such strong champions on both sides of the aisle.

#### **Introduction and Overview**

The Latin America and the Caribbean (LAC) region has historically faced formidable challenges. It is the most unequal region in the world, with the top 10 percent owning more than 70 percent of the region's wealth, and faces high levels of social and political conflict, increasing rates of criminality and corruption, deterioration of human rights, and pressing humanitarian situations, all combined with persistent population flows and economic decelerations over the last few years.

Challenges faced by the region can often be traced back to structural issues as root causes: socio-economic inequality and persistence of poverty in the context of exclusive economic growth; cultural patterns that reinforce the patriarchal, racist and violent systems historically imposed in the region; the

unfair distribution of care work due to gendered division of labor that limits opportunity for women and girls; and poor governance and corruption linked to the concentration of power.

These issues are exacerbated by climate change and the region's high vulnerability to natural disasters – the impacts of which could be seen in the latest hurricane season when storms ETA and IOTA hit Central America less than 15 days apart; the digital revolution and digital inequality that the most impoverished populations in the region face; the changing scenarios of commercial and financial flows and impacts of the global economic crisis in a region economically dependent on the extractive/primary industry; and demographic changes.

Against this contextual backdrop, when the COVID-19 pandemic hit Latin America in 2020, the region was already facing major humanitarian crises including: the Venezuelan crisis that, as of spring 2020, had driven at least five million people to neighboring countries and exposed almost nine million people to high levels of food insecurity; the Central America crisis where people, exposed to violence, hunger, the effects of drought and climate change as well as limited opportunities to make a living, were forced to leave their hometowns and countries; and the food security crisis in Haiti where millions could not meet their minimum food requirements.

The impacts of COVID-19 in Latin America were deepened by the region's structural challenges and, at the same time, unveiled and exacerbated the region's inequalities and issues, making the humanitarian needs even more severe.

CARE witnessed this when Maria\*, a 29-year-old informal worker and owner of a food post in Honduras, told us, "We have been locked up and I have not been able to sell my products because I have to move to the market to buy supplies and right now, we are not able to do so. The grocery store has helped us avoid going hungry these past days... but I am afraid we will not die of COVID, we will starve."

Another informal sector worker in Ecuador told us, "I am already skipping breakfast and dinner, so the kids have more to eat, but I don't think we are going to make it. If I go to work, I have no one to leave the kids with, they are out of school now and are not having lunch. If I don't go to work, I don't make money and can't buy any food. It sounds crazy, but in the middle of all this, with all these people dying, getting sick feels like the least of my concerns right now."

Or when Mercedes, a 36-year-old Venezuelan woman living in Colombia with her children, told us she did not know where she was going to spend the night. As she said, "the hostel we were sleeping at during the past few days was shut down by the government, because it could not guarantee social distancing. Now, myself and my two kids, are on the street, with no place to sleep, with no chance to have any income because everything is closed, and with no way of protecting ourselves, from this disease or from people" – demonstrating the even higher level of vulnerability and risk that migrants and refugees were exposed to as Latin American countries tried to respond to the crisis.

As of April 14, 2021, the LAC region had almost 26.7 million confirmed cases (19.3 percent of cases worldwide) and over 846,000 deaths (28.4 percent of deaths worldwide) even though the region has only 8.3 percent of the world's population. A University of Washington COVID-19 projection model (updated April 8, 2021) forecasts deaths in the region could reach 1.2 million by August 1, 2021.

LAC countries have varied in their responses to the COVID-19 crisis with the majority declaring some form of a state of emergency and adopting preventive measures to limit transmission. Many have activated social security systems and safety nets, but these resources are not able to respond to the level needed and are often inaccessible to vulnerable communities including migrants and refugees. The pandemic is having widespread economic, social, and political effects on the LAC region, that will endure in the long



term. The pandemic has forced Latin America 20 years back in time, turning back advances the region had made in poverty and inequality reduction in the 90's and early 2000's.

#### The Secondary and Long-term Impacts of COVID-19 in LAC

Beyond the issue of vaccines, as mentioned above, COVID-19 has deepened and unveiled the structural inequalities of Latin America and the Caribbean, and increased the risks and needs faced by the most vulnerable populations in the region: women and girls, indigenous and afro-descendants and migrants and refugees.

As Marc Lowcock, United Nations Emergency Relief Coordinator puts it, "It has been clear for some time that it is not the virus itself doing most harm in vulnerable countries. It is the secondary impacts of the subsequent lockdowns and global recession – rising food prices, falling incomes, drops in remittances, interrupted vaccination programs, school closures. They all hit the poorest people in the poorest countries hardest." Latin America is no exception and it is on these "secondary impacts" that I will focus the remainder of my testimony today.

#### Impact on Employment and Poverty

Before the pandemic, the International Monetary Fund (IMF) projected 1.6 percent economic growth for the region in 2020. However, this forecast was revised in April 2021, and now, a contraction of 7.0 percent is predicted.

The economic contraction is visible in the rise of unemployment. The unemployment rate in the region reached 10.7 percent at the end of 2020, 2.6 percentage points higher than in 2019, according to the United Nations Economic Commission for Latin America and the Caribbean (ECLAC). The biggest hits have been seen in the informal, services, and tourism sectors, all of which employ majority women, making women, together with informal workers, youth and migrants, the most impacted by unemployment.

Lack of employment and income generating opportunities, together with the impacts of climate change, political instability, and income inequalities drive and reflect the tremendous poverty growth in the region. In March 2021, ECLAC reported that 22 million people in Latin America moved into poverty in 2020, with overall poverty rising to 33.7 percent from 30.5 percent in 2019. A total of 78 million people were in extreme poverty in 2020, the highest level in the 20 years.

The majority of those likely to slide into poverty will be women, girls, and LGBTQ+ people, especially from at-risk and marginalized groups – such as indigenous and afro-descendants.

#### Impact on Food Security and Malnutrition

Food security and malnutrition are immediate concerns in the region. Between 2016 and 2018, 69 million adult women and 55 million men in LAC experienced food insecurity. According to the World Food Program, the region is set to see a 269 percent rise in the number of people facing severe food insecurity bringing the total number of people who don't know where their next meal is coming from to 16 million, which is up from 4.3 million in 2019.

In Central America, 3.2 million people need food assistance in Honduras, 60,000 households have been identified for food assistance in El Salvador and a CARE Needs Assessment in Guatemala found that 64 percent of families across 95 percent of communities assessed do not have sufficient economic resources to meet basic food needs in the context of COVID-19. In Colombia, an additional 800,000 people need

emergency food, and 85 million children are cut off from school feeding programs. Haiti, Venezuela, Ecuador and Peru are also facing extreme challenges.

In this context, women are already eating fewer and less nutritious meals to leave more food for their children. At the same time, in some countries, health services have stopped basic screening and treatment for malnutrition amid the pandemic.

#### Impact on Access to Health

With fragmented and unequal health systems, the region is ill-prepared to handle a health and human crisis of the scale of the COVID-19 pandemic. Lack of access to quality health care and information is especially acute in rural and remote areas. Before COVID-19, 30 percent of people in the region were unable to access health care because of cost, and 21 percent could not access these services because of distance to a provider. Women and girls are particularly impacted as, when responding to pandemics, many governments tend to redirect funds from sexual and reproductive health services and maternity health. There are already reports of increased maternal mortality rates in some countries.

We have also seen migrants and refugees experience exacerbated xenophobia and denial of services during the pandemic in some health centers, justified by the “need to protect our own population.”

#### Impact on Access to Education

Despite significant progress in increasing enrollment and access to marginalized communities, education remains a challenge in LAC and is being highly impacted by the consequences of the pandemic.

Before COVID-19, there were significant gaps. According to UNICEF, 12 million children and adolescents ranging between ages 7 to 18 are out of the educational system. Approximately, 23 million indigenous women already faced unequal access to education and over eight million children and adolescents under 14 were at risk of exclusion due to a disability.

In the wake of the COVID-19 pandemic, the region is experiencing an unprecedented education crisis that requires immediate action to mitigate and reverse learning losses. Only nine percent of the poorest communities have access to internet in the region, usually mobile data of low bandwidth. With education moving to online platforms, these communities are facing even higher levels of exclusion. Beyond that, with 95 percent of children in the region out of school because of COVID-19, the care-giving burden is even higher for women as they are often seen as solely responsible for childcare. As young girls staying home are tasked with caring for younger siblings, they have less time to spend on their remote schooling, which will widen the education gap.

#### Impact on Displaced Populations

Millions of people throughout the region have also been forced to flee their homes and communities. Female migrants, refugees, internally displaced, asylum seekers, and returnees have the highest risk and no safety nets.

Due to the structural crisis in Venezuela, approximately nine million people are in need of humanitarian aid inside the country and more than 5.4 million people have fled to neighboring countries, including Colombia, Peru, Ecuador, and beyond. However less than half of these vulnerable people have documentation and residency permits that grant them access to basic services including healthcare or the opportunity to work in the formal sector. COVID-19 has created inhospitable conditions in many host



countries, either due to the closure of temporary hostels because of social distancing standards; increased xenophobia (in many countries, Venezuelan migrant and refugees were accused of “bringing the virus”); and lack of income-generating opportunities due to lockdown measures, among other reasons. Many have had to uproot their lives and tried to return to Venezuela, but border closures have put their lives at further risk and many turn to smuggling routes and irregular crossings to get back.

In Central America, thousands of vulnerable people are fleeing Honduras, Guatemala, and El Salvador in an attempt to leave poverty and violence to look for better living conditions elsewhere. As a result, with the fastest-growing population of migrants and refugees in the world, the LAC region is struggling to meet the assistance and protection needs of people on the move. As the secondary impacts of COVID take their toll, jobs are drying up, remittances to families back home are dropping, and many people are prematurely returning to their home countries despite the persistent lack of safety and opportunities to thrive, compromising their right to a voluntary, safe, and dignified solution to their displacement. Quarantine centers across the region also tend to be overcrowded and unsafe.

Women and girls are even more vulnerable, as informal migration routes expose them to higher risks of sexual exploitation, abuse and human trafficking. CARE’s Rapid Gender Analysis on the Venezuela crisis showed that women were obliged to exchange sex for money and/or food as a coping mechanism before the pandemic. As a result of the pandemic we are, unfortunately, seeing this trend grow.

#### Impact on Gender Equality and Rates of Gender-Based Violence

The region faces dire levels of gender inequality, which have been compounded by the COVID-19 pandemic. Approximately 55 percent of women do not have their own income, or their salaries are lower than a minimum wage. For every 100 monetary units received by men, women receive 83.9 on average. Women also work more hours a day and receive less pay for work of the same value in addition to being overrepresented in informal work and spending more hours doing domestic work. The region also presents the highest rates of violence against women and femicides in the world.

As mentioned above, the COVID-19 pandemic has exacerbated the vicious cycle of poverty and exclusion of women and girls in the region, and it is fundamental to understand the many ways in which this crisis increases gender inequality to design and support an effective response. Beyond the above, I want to highlight two other specific challenges for women during the COVID-19 pandemic:

1. Gender based violence is rising. Gender-based violence (GBV) is increasing, and women’s ability to access services is decreasing. Countries report calls to domestic violence hotlines rising between 18 and 100 percent. Many GBV clinics and mobile services were suspended in quarantine and, as there are fewer bystanders on the streets and businesses closed, women are facing increasingly unsafe conditions as there are fewer places to go for help when GBV happens in public. Also, due to lockdown measures, women are now spending even more time with their aggressors, and under tighter control, which makes asking for help even more difficult.
2. Unpaid care work is disproportionately rising for women. Women already handled 1.7 times more unpaid care work than men in LAC, and this unpaid work represents up 15-25 percent of national GDPs in the region. In Guatemala, women spend 18 percent of their time on unpaid work, 9 times more than men. This increases when people are sick; in Mexico, women spend 29 hours a week caring for sick family members, compared to 13 hours a week for men. The effect is larger in poorer families with larger household sizes and is one of the key reasons why women are even more marginalized during the pandemic. The disproportionate burden of care-giving limits

women's time and ability to participate in paid, income-generating activities, further widening the poverty gap between men and women and having long-term implications for development and equality.

#### The Role of CARE and Other NGOs

CARE has been working in Latin America and the Caribbean for over 65 years. We are currently responding to the humanitarian crises, directly or through partners, in Colombia, Cuba, Ecuador, Haiti, Honduras, Guatemala, Peru, Nicaragua, Costa Rica, Brazil, Venezuela and Mexico. Our work in the region focuses on fighting the structural causes of inequality and supporting the most vulnerable populations – especially indigenous and afro-descendant women and girls and migrants and refugees.

At CARE, we believe it is fundamental to keep human rights and social justice at the center of the economic recovery plans aimed towards a sustainable future. As such, women and girls, economic justice, and equal access to resources and opportunities must be central. It is important to include women and girls in decision-making at all levels, shifting focus towards policies and measures that prioritize women and girls and strengthen gender equity.

Nonprofit organizations play a critical role in supporting the response and long-term development through funding and technical capacity, advocating and supporting governments when possible, and in strengthening local civil society. Any effective, long-lasting and sustainable effort in the region, to fight both the primary and secondary impacts of COVID19 pandemic, as well as to ensure a fast and fair vaccination process, needs to be based in alliances and coordinated work between the international cooperation systems, local civil society, and national and local governments.

#### Key Recommendations

CARE urges the U.S. government to prioritize five key areas in its policy and assistance strategy for the region:

##### **1. Ensure fast and fair delivery of COVID-19 vaccines to the last mile and sustainable health system strengthening by prioritizing investment in frontline and community health workers.**

Achieving equitable vaccine delivery and inoculation will ultimately be essential to ending the pandemic and a successful recovery in LAC. Comprehensive global vaccination efforts will also be essential to achieving herd immunity and economic recovery in the United States as well as worldwide. Getting this right means both providing adequate funding and taking an approach to vaccine delivery that is smart and effective.

Frontline and community health workers are the lynchpin of effective vaccine delivery - ensuring shots in arms of the most vulnerable as well as providing education and outreach to overcome vaccine hesitancy - and yet they are routinely overlooked and chronically underfunded. As a result, last-mile delivery all over the globe is failing. Ultimately, vaccines are useless without proper delivery systems that, to be effective, must include equipping, paying, training, and supporting frontline health workers, 70 percent of whom are women and half of whom are unpaid. CARE's analysis shows that for every \$1 spent on vaccine procurement, the cost of effective delivery is \$5. The major multilateral mechanism for supporting global vaccination, the ACT-Accelerator, is critical for ensuring equitable vaccine distribution however it was never designed to cover the full cost of vaccine delivery on the ground. Countries throughout Latin

America with already weak and chronically underfunded health systems will not be able to cover these costs through domestic financing. To ensure efforts to acquire vaccines in LMICs are not wasted due to an inability to deliver them, future U.S. investment in vaccine equity must support health systems strengthening efforts through the USAID Office of Health System Strengthening and other development and humanitarian response programs focused on frontline and community health workers.

**2. Elevate humanitarian diplomacy and funding within the U.S. strategy in the region, including by facilitating durable solutions to displacement.**

The U.S. should provide assistance proportional to other crises of the same magnitude including additional resources to specifically address the secondary impacts of COVID-19. Likewise, the U.S. should ensure support for efforts to allow vulnerable displaced communities to be able to access documentation, health, education, and employment in host countries- particularly those with irregular status who are at heightened risk of protection violations. The U.S. must work closely with governments throughout the region, as well as the World Bank, InterAmerican Development Bank, UNHCR, and IOM, to strengthen and harmonize international protection systems and improve migratory regulations that uphold the rights of displaced populations throughout the region. More predictable, multi-year financing to support refugees and host communities and promote medium- and long-term solutions is critical.

**3. Ensure U.S. humanitarian and development investments have a clear gender focus and support women and girls, including through continued health support for SRHR and not redirecting funds as well as through ensuring GBV funding, systems, and protection.**

COVID-19 response and recovery programming must:

- Ensure all COVID-19 response provide trauma-informed, women-friendly, actively inclusive environments. Support should enable access to healthcare services for women and girls, historically marginalized groups such as indigenous and afro-descendant population and the most at-risk groups. Additionally, GBV and SRH services must be considered essential services that cannot be deprioritized in pandemic response.
- Ensure any and all telehealth services, and/or telehealth service plans, take the gender data gap into account and include specific messaging, campaigns, and data support plans for reaching women and marginalized people who do not usually have internet access or smartphones.
- Recognize and address the care work – paid and unpaid – including household and paid sector activities. Care workers – both paid and unpaid – should be recognized as essential workers and supported to carry out their work safely, including measures to ensure such care arrangements can continue safely, and are included in cash transfer programs and/or other sectoral humanitarian supports.
- Ensure women's, marginalized and at-risk groups access to Information Communication Technology is considered an essential, life-saving service, both during response and throughout recovery. Collaborate with grassroots women's groups and civil society women's organizations to ensure alternative community-based mechanisms are put in place for survivors who do not have access to the internet or smart phones.

**4. Engage with and support regional governments to ensure safety nets are accessible to the most vulnerable populations, not only in the short-term for the COVID-19 recovery but also for the long-term resilience.**

Governments in the region rushed to enact COVID-19 response and rollout safety nets, but more must be done to ensure that safety nets are available for the most vulnerable members of society, including refugees, female-headed households, domestic workers, and others in the informal economy who are often overlooked. As a first step, there must be an understanding of the needs of the most marginalized; this requires prioritizing data collection about, and in support to, groups who are underrepresented in current analysis data but who are the most vulnerable and disenfranchised, such as LGBTIQ+ people; homeless, migrant, refugee, and displaced women; indigenous and Afro-descendant women and girls; and others.

**5. Direct resources to strengthen the capacity of locally-led and specifically women-led organizations and prioritize economic empowerment for women and vulnerable groups to bolster resilience and capacity to respond to current and future crises.**

At an individual level, immediate relief assistance can support long-term response and recovery strategies by providing targeted cash assistance and income-generating activities. This should include specific programs to re-orient income-generating activities in the immediate and long-term, ensuring equal or enhanced employment opportunities, and addressing unequal burdens of care in both immediate response and recovery.

At a systems level, the U.S. can partner with diverse women and LGBTIQ+ organizations and support their participation and leadership as a cornerstone of effective COVID-19 response. Local women's organizations throughout the region, many of whom CARE prioritizes partnering with, are the best positioned to ensure resources reach those with the greatest need, to develop response plans that will be effective based on local context, and to lead sustainable, long-term change as a part of recovery. Response agencies should engage a range of women's and LGBTIQ+ organizations, human rights defenders, and activists in all planning and response efforts – from local to national and regional levels – as key decision-makers and leaders.

Thank you Congressman Sires, Green and all distinguished Members. I look forward to your questions

Mr. SIREs. Thank you very much.

We now recognize Dr. Ellis. You are recognized for your testimony.

**STATEMENT OF R. EVAN ELLIS, PHD, LATIN AMERICA RESEARCH PROFESSOR, STRATEGIC STUDIES INSTITUTE, US ARMY WAR COLLEGE**

Dr. ELLIS. Chairman Sires, Ranking Member Green, distinguished committee members, thank you for this opportunity. I will summarize my written testimony.

No region in the world is more directly connected to U.S. security and prosperity than is Latin America. The region has recorded approximately the same number of COVID-19 cases as the United States, yet have 50 percent more deaths, over 960,000 as of May 11.

The region's large informal sector and often marginal small businesses have made its population particularly vulnerable to both contagion and the adverse economic effects of fighting the spread of the virus. The region's GDP declined by 7.7% in 2020. Many small businesses bankrupted by the pandemic are gone permanently.

This past week's violent protests in Colombia, the burning of Guatemala's Parliament last November, and other unrest across the region highlight that both Latin America's people and their governments are at their limits.

Indeed, as a result of COVID-related spending, government debt in the region went from 68 percent to 77 percent of GDP since last year alone.

The region's governments have been unable to obtain and distribute adequate quantities of vaccines, either directly through contractors or through COVAX. Only two countries in Latin America, Chile and Uruguay, have vaccinated more than 20 percent of their populations.

China, Russia, and even Cuba, as Ranking Member Green noted, have stepped into the breach. The PRC is currently supplying vaccines to at least 12 Latin American countries. This represents 85 percent, I repeat, 85 percent, of vaccines received by Chile to date, 82 percent of vaccines received by El Salvador to date, and 75 percent of vaccines received by both Brazil and Uruguay.

At least 10 Latin American and Caribbean countries are using Russia's Sputnik V vaccine, including Venezuela, Nicaragua, Bolivia, Argentina and Mexico.

The PRC is using access to its vaccines to promote its interests in other areas, as Ranking Member Green noted. Following PRC vaccine promises, both Brazil and our ally the Dominican Republic reversed their prior public commitments to exclude Huawei from their 5G networks, and in Paraguay the PRC tried unsuccessfully to use vaccines to get the Abdo Benitez government to abandon diplomatic relations with Taiwan. And their maneuvering with Honduras has also been noted by Ranking Member Green.

Nonetheless, China's vaccines have had efficacy problems. Chile's government bet on Sinovac to get shots to more of its population than any other country, but Sinovac turned out to have only 3 per-

cent efficacy after the first dose, allowing the virus to continue spreading.

China's marketing of its vaccine contributions masks a less positive reality. The PRC sells, rather than donates most vaccines.

Indeed, the PRC set up a \$1 billion loan fund to help Latin American countries buy its vaccines, just like the PRC, loans money to the region to hire Chinese companies in other areas.

The Chinese have, however, aggressively marketed their vaccine rollouts. They have turned just about every vaccine delivery into a photo op on the airport tarmac. Such marketing creates the false impression that, in the face of U.S. indifference, the PRC is generously saving our neglected neighbors.

The Russians, for their part, have had production problems, resulting in only limited deliveries of Sputnik V. Even Cuba has gotten into the vaccine game now with its "Sovereign 2" and "Abdala" vaccines.

It is in our strategic interests to help our neighbors to more rapidly and effectively vaccinate their populations. First, the United States will have vaccine to distribute. As of May 12th, 58.7 percent of the U.S. population, according to the CDC, have received at least one dose, with more vaccine in the pipeline.

Second, controlling the virus in Latin America is important to minimize the risk of mutations or variants, such as the previously noted P.1 variant in Brazil, and their transmission to the United States, especially given the high level of U.S. personnel interchange with the region.

Third, helping control COVID in the region is arguably a necessary precondition to ease migratory pressures and alleviate socioeconomic stresses that could help bring antidemocratic populist governments to power, further opening the door to worrisome forms of engagement by China, Russia, and Iran.

Fourth, U.S. vaccine leadership strengthens our neighbors' goodwill to work with us in other areas that we value, while fighting China and Russia's false and self-promoting narratives.

I, thus, respectfully recommend the following: First, that we donate, not sell, significant quantities of vaccines from proven Western manufacturers, highlighting U.S. generosity in contrast to Chinese profit-seeking.

Two, in addition to COVAX, we should work directly with trusted Western manufacturers to obtain additional vaccines for the region.

Three, where accepted by partner governments, we should provide logistic support for the transport, storage, and distribution of the vaccines, possibly even using the U.S. military, where appropriate, complemented by international observers and NGO's, thus reducing the risk that vaccines will be diverted or used by local elites to support their own interests or enrichments.

Thank you for your time and interest. I welcome the committee's questions.

[The prepared statement of Dr. Ellis follows:]

A Race Against Time: Deploying Vaccines and Addressing the Disproportionate  
Impacts of Covid-19 in Latin America and the Caribbean

R. Evan Ellis, PhD

Latin America Studies Professor

U.S. Army War College Strategic Studies Institute

Testimony before the U.S. House of Representatives

Subcommittee on the Western Hemisphere, Civilian Security, Migration, and  
International Economic Policy

May 13, 2021

Chairman Sires, Ranking Member Green, distinguished members of the House Foreign Affairs Western Hemisphere Subcommittee, thank you for the opportunity to share my work with you today regarding the impact of the Covid-19 pandemic in Latin America and the Caribbean, and the importance of U.S. leadership in helping our neighbors in the region vaccinate their populations.

The opinions I express here today are my own, and do not necessarily represent my institution.

**Why it Matters**

As the members of this committee understand, no region of the world is more directly connected to U.S. security and prosperity, than is Latin America and the Caribbean. Covid-19 is not only a public health crisis for the region, but it is imposing severe, long-term stresses on its socioeconomic structures and political stability. It matters to us, in the United States, not only because of the grave suffering of our neighbors, but because it affects the United States, through the potential emergence and transmission to the U.S. of virus mutations, through U.S. investments in the region and supply chains that depend on it, and through the immigration to the U.S. of those for whom the pandemic has helped to make life in their homes unsustainable. The dynamics of the pandemic in Latin America and the Caribbean further affects the U.S. through its impacts on criminal networks, such as those that bring fentanyl and other drugs to the U.S., killing 81,000 of those living here last year,<sup>1</sup> evolving and strengthening those networks, and diverting the limited resources of our neighbors' police and security forces to combat them. The pandemic further affects the U.S. by weakening governance in the region in ways that contribute to safe spaces for criminal and terrorist groups that would harm the United States, and by precipitating political crises that help to bring to power anti-US populist leaders, less willing to cooperate with the U.S., and who permit criminal and other malevolent actors in their countries, and who open the doors for troubling forms of cooperation with extra-hemispheric U.S. rivals such as China, Russia, and Iran.

Although Latin America and the Caribbean have reported approximately the same number of Covid-19 cases as the United States, the region has suffered 50% more deaths—over 930,000.<sup>2</sup> The region's large informal sector and often marginal small businesses has made its population particularly vulnerable to both contagion and the adverse economic effects of measures to control the virus. The United Nations Economic Commission on Latin America and the Caribbean (ECLAC) estimates that the region's GDP declined by 7.7% in 2020,<sup>3</sup> yet the damage is also long-term. Many of the Latin American small businesses bankrupted by pandemic-related closures are permanently gone, and their owners and employees have been displaced. ECLAC estimates that it could require as much as a decade for employment to return to pre-pandemic levels.<sup>4</sup>

Compounding the problem, governments in the region are rapidly running out of money to deal with both the continuing crisis, and the long-term needs of their people. In just a year, the expenditures of Latin American and Caribbean governments to combat the pandemic and protect their populations from the economic effects has ballooned public debt in the region from 46% to 55% of GDP.<sup>5</sup>

This past week's violent protests in Colombia,<sup>6</sup> the burning of Guatemala's Parliament building last November 2020,<sup>7</sup> and a range of other unrest across the region highlight that both Latin America's people, and their governments, are at their limits.

Such conditions make it clear that, even more than the U.S., the region desperately needs to vaccinate its population to bring the pandemic under control and rebuild an adequate, secure, and sustainable basis of life for their people. To date, however, the region's governments have been unable to obtain and distribute adequate quantities of vaccines, either directly from the producers, or through the World Health Organization Covax facility.<sup>8</sup> As of last week, only two countries in Latin America, Chile and Uruguay,<sup>9</sup> had vaccinated more than 20% of its populations.<sup>10</sup>

#### **China, Russia and Cuba Filling the Void**

In the context of such great need, and with the U.S. to date providing little vaccine support beyond its contributions to COVAX, China, Russia, and now even Cuba have stepped into the breach.<sup>11</sup>

Relatively early on, PRC-based companies began conducting Phase 3 vaccine trials in the region, including in Brazil,<sup>12</sup> Argentina<sup>13</sup> and Peru,<sup>14</sup> setting the stage to provide significant portions of their vaccine to those countries, and effectively marketing them to other desperate for a vaccine, such as Chile. The PRC is currently supplying its Sinovac, Sinopharm, and CanSino vaccines to at least 12 Latin American countries.<sup>15</sup> Chinese vaccines currently account for 62% of the total vaccines contracted for by Chile, 45% of Peru's vaccines, and 30% of Argentina's.<sup>16</sup>

In the case of Russia, at least 10 Latin American and Caribbean countries have accepted its Sputnik V vaccine, including anti-US populist regimes in Venezuela,



Nicaragua, Bolivia, Argentina and Mexico. In April, Argentina began producing Sputnik V locally.<sup>17</sup>

In both Brazil and the Dominican Republic, the PRC used expedited access to its vaccine to persuade those governments to reverse prior decisions to exclude the Chinese telecommunications company Huawei from participation in 5G auctions. In Paraguay, the PRC tried (unsuccessfully) to convince the government of Mario Abdo Benitez to abandon diplomatic relations with Taiwan for expedited vaccine access.

Sinovac is currently looking to set up a vaccine manufacturing facility in South America.<sup>18</sup> While a seemingly logical step to help the PRC produce more of its vaccine locally, as with other parts of its growing business footprint in the region, doing so would also potentially help Chinese companies to gain access to the Western medical technologies in areas that the low efficacy levels of their vaccines<sup>19</sup> suggest that they may be lacking.

In some countries like U.S. allies Chile, Colombia, and Brazil, the PRC has had an impact by getting the vaccine to the country more rapidly, in greater quantities than Covax or direct shipments by Western firms. In Brazil, for example, 75% of vaccines administered so far have reportedly been from PRC-based companies.<sup>20</sup> Nonetheless, China's vaccines have had problems with efficacy. In Phase 3 trials in Brazil, the Sinovac vaccine demonstrated an effectiveness of barely 50%.<sup>21</sup> The use of Sinovac as the principal vaccine in Chile became problematic, with infections there continuing to rise there despite high vaccination rates achieved by the Chilean government, which had relied predominantly on the Chinese vaccine. Data showed that the Sinovac vaccine there had a mere 3% efficacy after the first dose.<sup>22</sup>

As noted previously, China's marketing of its vaccine contributions in the region masks a less positive reality. To date, the PRC has actually delivered only limited quantities of vaccine, and sells, rather than donates, most of that. In Brazil, China has reduced the amount of vaccine material it plans to send to the Butantan institute for local Brazilian production of the Sinovac vaccine, citing administrative difficulties.<sup>23</sup>

Vaccines, in some way, have become another commercial opportunity for the PRC, resembling Chinese patterns of behavior in other sectors. Indeed, the PRC set up a \$1 billion loan fund to help Latin American governments buy made in China vaccines,<sup>24</sup> just like it loans Latin American governments money to build infrastructure projects with its own companies, equipment and workers.

The Chinese have, however, aggressively marketed their vaccine rollout, turning every delivery of Chinese vaccines into a photo op, with the recipient's national leader or other senior officials typically receiving the Chinese aircraft on the tarmac as boxes of visibly marked Chinese vaccine are rolled down the cargo ramp.<sup>25</sup> Such marketing creates the false impression that, in the face of U.S. indifference toward the fate of the region, the PRC is generously saving its Latin American friends from the pandemic. In El Salvador, whose government is paying to buy two million doses of Chinese vaccine, its President Najib Bukele enthusiastically thanked "President Xi Jinping and the Chinese people"<sup>26</sup>

for donating 150,000 doses, complimenting the two million paid for.<sup>27</sup> Similarly, in the Dominican Republic, where the government paid the Chinese \$19 million for a million vaccine doses,<sup>28</sup> the air cargo shipment from China was carried with great fanfare by sympathetic local papers, with staged photos of banner-bearing Chinese workers sending the plane off.<sup>29</sup> As in El Salvador, China's publicity for the Dominican Republic highlighted the 50,000 "extra doses" that the Chinese had thrown in for free with the shipment.<sup>30</sup> A Dominican colleague of mine put the act into perspective, referring to the extra doses as the "ñapa," the token gift that Dominican shop owners give to their customers to thank them for their business.<sup>31</sup>

The Russians, for their part, have had temporary production and logistics problems that have delayed their ability to get significant quantities of their flagship Sputnik V vaccine to Latin America and elsewhere.<sup>32</sup> By contrast to the Chinese, however, the Russians have been able to highlight that the efficacy of Sputnik V has been found by an "independent medical journal" in Phase 3 trials to be 91%<sup>33</sup> (although Argentina's President Alberto Fernandez famously contracted the disease despite having received the full two dose Sputnik V regimen).<sup>34</sup> Russia claims that its new vaccine, EpiVacCorona, is even more effective.<sup>35</sup>

Even Cuba has gotten into the vaccine game in the region, with two offerings, developed with Iranian assistance, "Sovereign 2" and "Abdala."<sup>36</sup> Not surprisingly, Cuba is using its ally Venezuela for clinical trials.<sup>37</sup> Its vaccine, like those of Russia and China, is expected to go primarily to anti-US regimes and those unable, for various reasons, to get access to Western vaccines,<sup>38</sup> creating opportunities for the communist Cuban government to both advance its political agenda and earn revenue, as they have with their doctors and other medical programs.

#### **Why the U.S. Should Help**

As the United States now achieves vaccination of the majority of its adult population, it is in our strategic interest, as well as the right thing to do, to help our neighbors to the South to move past the pandemic by more rapidly and effectively vaccinating the majority of their populations.

First, the United States will increasingly have the vaccine to spare. As of May 5<sup>th</sup>, according to the Centers for Disease Control and Prevention, 45.3% of the U.S. population had received at least one vaccine dose,<sup>39</sup> with much more in the pipeline.

Second, as noted previously, controlling the virus elsewhere in the world, is critical to minimize the risk of mutations, which are more probable in areas in which virus spread is greater.<sup>40</sup> Mutations which may be resistant to existing vaccines in Latin America and the Caribbean are, of course, of particular concern for the U.S. This is because the region's high natural rate of personnel interchange with the U.S. for commerce, tourism, and family, increase the risk that mutations in the region may be quickly passed to the U.S.

Third, helping control Covid-19 in the region is a powerful and necessary vehicle to stabilize Latin American economies and ease the previously noted severe pressures on their social fabric, governance and political stability. Indeed, doing so is arguably a necessary precondition to address the root causes of immigration to the U.S., which is driven not only by economic need, but insecurity and the impacts of sustained political chaos and violence, all of which are compounded by the virus continuing to spread and wreak economic and other effects on the region.

Fourth, U.S. vaccine leadership is a powerful, cost effective way to strengthen goodwill and cooperative relationships with the U.S., while inoculating the region against the false narrative of China and Russia coming to the rescue of our neighbors in the absence of help from a privileged, self-absorbed U.S. While the United States has generously committed \$4 billion to the COVAX facility,<sup>41</sup> it has received almost no recognition in the region for such efforts, both because Covax by design does not promote its key donors like direct deliveries by China and Russia do, and because deliveries under COVAX to date have been limited.

#### **Recommendations:**

I respectfully recommend the following for an aggressive, U.S.-led vaccine campaign in the Americas:

1. Donate, not sell, significant quantities of vaccines from proven Western manufacturers, creating an opportunity to highlight U.S. generosity, by contrast to Chinese profit-seeking through vaccine sales.
2. In addition to continuing to work through the Covax facility, employ existing and possibly additional direct arrangements with vaccine manufacturers, where feasible, to obtain the additional vaccine for the region.
3. To the degree possible and accepted by partner governments in the region, provide logistic support for the transport and distribution of the vaccine in the region. Depending on the vaccine(s) chosen, could include cold storage, and other medical infrastructure in short supply, particularly in more remote parts of the region. Where acceptable to and desired by our partners, the U.S. could also help to directly transport, distribute, and even support the administration of the vaccine to local populations. As with the U.S. support to the response against Ebola in Africa, and where acceptable to and desired by our partners, the U.S. military, and trusted partner militaries, may have useful resources to bring to bear. Any such distribution operations, where possible, should also be accompanied by international observers and supporting NGOs to reduce the possibilities that distribution of the U.S. vaccine could be diverted, or done by local elites in ways that advance their own political interests, or personal enrichment.

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- <sup>1</sup> "Overdose Deaths Accelerating During COVID-19," Center for Disease Control, December 17, 2020, <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>.
- <sup>2</sup> "WHO Coronavirus Dashboard," World Health Organization, Accessed May 7, 2021, <https://covid19.who.int/>.
- <sup>3</sup> "Latin America and the Caribbean Will Have Positive Growth in 2021, but It Will Not Be Enough to Recover Pre-Pandemic Levels of Economic Activity," ECLAC Official Website, December 16, 2020, <https://www.cepal.org/en/pressreleases/latin-america-and-caribbean-will-have-positive-growth-2021-it-will-not-be-enough>.
- <sup>4</sup> "Employment Situation in Latin America and the Caribbean. Employment trends in an unprecedented crisis: policy challenges," ECLAC Official Website, November 2020, <https://www.cepal.org/en/publications/46309-employment-situation-latin-america-and-caribbean-employment-trends-unprecedented>.
- <sup>5</sup> "Fiscal Panorama of Latin America and the Caribbean 2021: Fiscal policy challenges for transformative recovery post-COVID-19," ECLAC Official Website, April 2021, <https://www.cepal.org/en/publications/46809-fiscal-panorama-latin-america-and-caribbean-2021-fiscal-policy-challenges>.
- <sup>6</sup> "Protestas en Colombia: las imágenes que dejan los violentos enfrentamientos entre manifestantes y policía," *BBC News*, May 6, 2021, <https://www.bbc.com/mundo/noticias-america-latina-56910572>.
- <sup>7</sup> "Las protestas en Guatemala que provocaron un incendio en las instalaciones del Congreso," *BBC News*, November 21, 2020, <https://www.bbc.com/mundo/noticias-america-latina-55031616>.
- <sup>8</sup> See Maria Cheng and Aniruddha Ghosal "Unwilling to wait, poorer countries seek their own vaccines," *AP News*, February 6, 2021, <https://apnews.com/article/business-honduras-coronavirus-vaccine-coronavirus-pandemic-central-america-16d7d06f031c89aaf37a4306747b9128>.
- <sup>9</sup> Henrik Pettersson, Byron Manley, Sergio Hernandez and Deidre McPhillips, "Tracking Covid-19 vaccinations worldwide," *CNN*, May 7, 2021, <https://www.cnn.com/interactive/2021/health/global-covid-vaccinations/>.
- <sup>10</sup> Luisa Horwitz and Carin Zissis, "Timeline: Tracking Latin America's Road to Vaccination," *Americas' Society / Council of the Americas*, May 3, 2021, <https://www.as-coa.org/articles/timeline-tracking-latin-americas-road-vaccination>.
- <sup>11</sup> Dave Lawler, "Latin America turns to China and Russia for COVID-19 vaccines," *Axios*, March 2, 2021, <https://www.axios.com/russia-chinese-vaccines-latin-america-us-mexico-86a9daf5-4d39-421b-958a-40a457513e1c.html>.
- <sup>12</sup> "Sinovac: Brazil results show Chinese vaccine 50.4% effective," *BBC News*, January 13, 2021, <https://www.bbc.com/news/world-latin-america-55642648>.
- <sup>13</sup> "Argentina joins Chinese coronavirus vaccine trial, maker says," *Reuters*, August 22, 2020, <https://www.reuters.com/article/us-health-coronavirus-vaccine-sinopharm/argentina-joins-chinese-coronavirus-vaccine-trial-maker-says-idUSKBN25I0CZ>.
- <sup>14</sup> "Wang Yi hails Peru's decision to test Chinese vaccine in phase 3 trial," *CGTN*, November 6, 2020, <https://news.cgtn.com/news/2020-11-06/Wang-Yi-hails-Peru-s-decision-to-test-Chinese-vaccine-in-phase-3-trial-VbJStPV2Tu/index.html>.

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<sup>15</sup> Horwitz and Zissis, 2021.

<sup>16</sup> Horwitz and Zissis, 2021.

<sup>17</sup> "Argentina Produces Russia's Sputnik V Vaccine in Regional First," *U.S. News & World Report*, April 20, 2021, <https://www.usnews.com/news/world/articles/2021-04-20/argentina-produces-russias-sputnik-v-vaccine-in-regional-first>.

<sup>18</sup> "Chinese vaccine developer eyes production in Chile," *Mercopress*, May 5, 2021, <https://en.mercopress.com/2021/05/05/chinese-vaccine-developer-eyes-production-in-chile>.

<sup>19</sup> Samantha Pearson, Luciana Magalhaes and Chao Deng, "Chinese Covid-19 Vaccine Far Less Effective Than Initially Touted in Brazil," *The Wall Street Journal*, January 12, 2021, <https://www.wsj.com/articles/chinas-sinovac-covid-19-vaccine-is-50-4-in-late-stage-brazil-trials-11610470581>.

<sup>20</sup> "Brazil's Butantan expects less COVID-19 vaccine input from China," *Reuters*, May 6, 2021, <https://www.reuters.com/article/health-coronavirus-brazil/brazils-butantan-expects-less-covid-19-vaccine-input-from-china-idUSL1N2MT157>.

<sup>21</sup> Yen Nee Lee, "Brazil researchers now say China's Sinovac vaccine is 50% effective — lower than announced earlier," *CNBC*, January 12, 2021, <https://www.cnn.com/2021/01/13/chinas-sinovac-vaccine-reportedly-50point4percent-effective-in-brazilian-trial.html>.

<sup>22</sup> "Chile Covid-19 vaccination drive adds to Sinovac efficacy data," *South China Morning Post*, April 9, 2021, <https://www.scmp.com/news/china/science/article/3128886/chile-covid-19-vaccination-drive-adds-sinovac-efficacy-data>.

<sup>23</sup> "Brazil's Butantan expects less COVID-19 vaccine input from China," 2021.

<sup>24</sup> Karol Suarez, "China offers \$1 billion loan to Latin America and the Caribbean for access to its Covid-19 vaccine," *CNN*, July 23, 2020, <https://www.cnn.com/2020/07/23/americas/china-billion-vaccine-latin-america-coronavirus-intl/index.html>.

<sup>25</sup> "China's Sinopharm vaccine arrives in Bolivia," *CGTN*, February 25, 2021, [https://www.youtube.com/watch?v=vd2vUDT\\_Mpk](https://www.youtube.com/watch?v=vd2vUDT_Mpk).

<sup>26</sup> "El Salvador President thanks China for CoronaVac vaccine donation," *Prensa Latina*, April 7, 2021, <https://www.plenglish.com/index.php?o=m&id=66076&SEO=el-salvador-president-thanks-china-for-coronavac-vaccine-donation>.

<sup>27</sup> "China to donate 150,000 Sinovac COVID-19 vaccine doses to El Salvador," *Reuters*, April 4, 2021, <https://www.reuters.com/business/healthcare-pharmaceuticals/china-donate-150000-sinovac-covid-19-vaccine-doses-el-salvador-2021-04-04/#:~:text=El%20Salvador's%20President%20Nayib%20Bukele,jabs%20his%20government%20already%20purchased>.

<sup>28</sup> "El país negoció mejor precio por las vacunas chinas," *Listin Diario*, March 18, 2021, <https://listindiario.com/la-republica/2021/03/18/661692/el-pais-negocio-mejor-precio-por-las-vacunas-chinas>.

<sup>29</sup> Melbin Gomez, "Despegó en China avión con más de un millón de vacunas contra COVID-19 con destino a RD," *Diario Libre*, March 17, 2021, <https://www.diariolibre.com/actualidad/despego-en-china-avion-con-mas-de-un-millon-de-vacunas-contra-covid-19-con-destino-a-rd-NC25053079>.

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<sup>30</sup> Gomez, 2021.

<sup>31</sup> R. Evan Ellis, "Chinese Engagement with the Dominican Republic – An Update," *Global Americans*, May 7, 2021, <https://theglobalamericans.org/2021/05/chinese-engagement-in-the-dominican-republic-an-update/>.

<sup>32</sup> Daria Litvinova, "Russia scores points with vaccine diplomacy, but snags arise," *AP News*, March 7, 2021, <https://apnews.com/article/europe-global-trade-middle-east-diplomacy-moscow-e61ebd3c8fe746c60f5ecc1ec323c99a>.

<sup>33</sup> Ian Jones and Polly Roy, "Sputnik V COVID-19 vaccine candidate appears safe and effective," *The Lancet*, February 2, 2021, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)00191-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00191-4/fulltext).

<sup>34</sup> Claudia Rebaza, Jaide Timm-Garcia and Caitlin Hu, "Argentina's President tests positive for Covid-19 after vaccine," *CNN*, April 4, 2021, <https://www.cnn.com/2021/04/04/americas/argentina-alberto-fernandez-covid-19-sputnik-vaccine-intl-latam/index.html>.

<sup>35</sup> "Russia's second vaccine '100% effective', watchdog tells media," *Reuters*, January 19, 2021, <https://www.reuters.com/article/us-health-coronavirus-russia-vaccine-vec/russias-second-vaccine-100-effective-watchdog-tells-media-idUSKBN29O151>.

<sup>36</sup> "Cuba punches above its weight to develop its own Covid vaccines," *The Guardian*, May 4, 2021, <https://www.theguardian.com/world/2021/may/04/cuba-covid-vaccines>.

<sup>37</sup> "Venezuela to begin clinical trials of Cuba's Abdala vaccine candidate," *Reuters*, May 3, 2021, <https://www.reuters.com/world/americas/venezuela-begin-clinical-trials-cubas-abdala-vaccine-candidate-2021-05-03/>.

<sup>38</sup> Patrick Oppmann, "Inside Cuba's race to vaccine sovereignty," *CNN*, March 31, 2021, <https://www.cnn.com/2021/03/31/americas/cuba-vaccines-covid-phase-three-intl-latam/index.html>.

<sup>39</sup> "COVID-19 Vaccinations in the United States," Centers for Disease Control and Prevention Official Website, Accessed May 7, 2021, <https://covid.cdc.gov/covid-data-tracker/#vaccinations>.

<sup>40</sup> "About Variants of the Virus that Causes COVID-19," Centers for Disease Control and Prevention, Official Website, April 2, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/transmission/variant.html>.

<sup>41</sup> "Fact Sheet: President Biden to Take Action on Global Health through Support of COVAX and Calling for Health Security Financing," The White House, Official Website, February 18, 2021, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/02/18/fact-sheet-president-biden-to-take-action-on-global-health-through-support-of-covax-and-calling-for-health-security-financing/>.

Mr. SIREs. Thank you, Dr. Ellis.

We will now go to questions.

I have been advocating for a number of months for the U.S. to donate excess vaccines to the region. I was happy to hear the White House's announcement that the U.S. will share 60 million doses of the AstraZeneca vaccine with the world.

Dr. Castro, how should the United States prioritize where vaccine doses are sent within Latin America and the Caribbean?

Dr. CASTRO. Throughout the region, there is an uneven distribution of vaccines. And we should follow epidemiological priorities to start to deploy vaccines.

One mechanism is through COVAX, which already—so the Revolving Fund is distributing vaccines, and there could be an agreement to make sure that those vaccines are first distributed where they are needed the most.

Usually, that entails the cities that are highly dense with populations where transmissibility occurs more rapidly. But, first of all, I would start with healthcare workers, who are the most exposed to the virus, following people who are the elderly and those with chronic conditions.

Mr. SIREs. Thank you. The COVID-19 pandemic has worsened a humanitarian crisis in Latin America and the Caribbean due to pervasive inequality, fragile health systems, and corruption.

Ms. Bertolucci, where is the U.S. assistance most needed right now?

Ms. BERTOLUCCI. Thank you for the question. We do need to focus the U.S. assistance, both the humanitarian response but also the support, to fighting the root causes that are making people more vulnerable to this crisis that I mentioned in my testimony.

That support is needed especially in Central America, responding to many of the crises that I mentioned, but also in South America, supporting the countries receiving the Venezuelan refugees and migrants and even Israelites south.

Finally, as you mentioned, Representative, the Caribbean must not be forgotten, as they are facing already food insecurity, especially in Haiti. And also, we are expecting a very difficult hurricane season that is starting right now, which will increase the humanitarian needs in the region.

Mr. SIREs. Thank you.

Dr. Ellis, I have said for a long time that if we do not pay attention to our own hemisphere, countries like Russia and China will fill the void the U.S. is leaving. They have taken advantage of this during the pandemic, offering almost every country in the region vaccines.

How do we combat that, Dr. Ellis?

Dr. ELLIS. That is an excellent question, and I fully support your observation, Mr. Chairman, regarding the importance of the hemisphere. I think, No. 1, it is important. The United States has been very generous. This administration, as you know, has committed \$4 billion to COVAX.

Unfortunately, the Chinese play, as Ranking Member Green noted, a much better game, in terms of claiming credit for the vaccine. I think it is important that we take advantage of private sec-

tor mechanisms and existing contract mechanisms to get more vaccine directly, both the surplus vaccine that we have and others.

We also need to do a better job in engaging with the region to emphasize the efforts that we are doing. And, frankly, beyond that, I believe that we need to sustain the investment in the region to continue to push back against the grave socioeconomic and other conditions that have been unleashed by the virus, not only the economic conditions, but there are also pressures for public insecurity and other things that will continue to push regimes to open the door for the expansion of new populist governments that traditionally have further created opportunities for China and Russia to advance in the region.

There are a lot of pressures, both fiscal pressures and other pressures for that Chinese advance. And so we need to be a better friend and ally, supporting, strengthening governments' initiatives as well as the vaccine rollout themselves, Mr. Chairman.

Mr. SIRE. Thank you. I now recognize Congressman Green.

Mr. GREEN. Thank you, Mr. Chairman, and really appreciate your leadership here on this. I also want to cite that I appreciate your continuing to advocate that we share our vaccines with our friends in Latin America.

We have seen actors like the Chinese Communist Party, Russia, and Iran wage very intentional campaigns to undermine the Western vaccine effort. They are raising questions about the origins of the pandemic, shaping the narrative there.

Dr. Ellis, how do these disinformation campaigns affect public health response efforts in Latin America?

Dr. ELLIS. Thank you. It is an excellent question.

First of all, it creates the impression that the rollout of the Chinese vaccine is adequate. This was a problem in Chile. Again, due to the limited efficacy of those vaccines, despite Chile leading the campaign in vaccinating its country in the region, it discovered that the virus was continuing to spread.

In addition, the impression of China and Russia, as I noted, coming to the supposed rescue of the region creates the narrative that the United States is not there, the United States does not care, and that undermines our efforts to engage with our allies in other ways, whether it is promoting our agendas of democracy and human rights or free markets and open governments.

And finally, it opens the door for cooperation with the Chinese in other areas. Some of those areas, as you noted, sir, include, for example, the pressure, in order to obtain more vaccine, to open up the market for, for example, Huawei and 5G, which creates a very serious intelligence and opportunities for the Chinese that can even put the autonomy of member governments and their leaders at risk.

It also puts our ally Taiwan in a very precarious position, as you noted, sir, with respect to both what is happening in Honduras and Paraguay and pressures elsewhere.

And traditionally, as we have seen already with El Salvador, which is launching a major new program with the Chinese this week, as well as Chinese advances in the Dominican Republic and Panama, those open doors for the Chinese that lead to dramatic expansion of Chinese commercial presence, which has a silencing ef-



fect and often an antidemocratic effect, in addition to, again, helping open the door for further populist governments that, again, has a mutually reinforcing effect of creating even more opportunities for the Chinese in other areas.

Mr. GREEN. So how do we push back on this, and how do we recruit some international partners to help us in fighting this disinformation campaign?

Dr. ELLIS. If that is for me, sir, an excellent question. First of all, I believe that we need to be very careful in not trying to tell the region that they are not allowed to economically engage with the Chinese. We believe in the principles of free market and, obviously, you know, principles of autonomy of states.

But there is a lot more that we can do with respect to promoting principles of good governance, pushing for transparency, which makes it more difficult for countries, for elites in the region to engage with Chinese in under-the-table deals which ultimately benefit those elites and the Chinese without benefiting the populations.

We need to help our countries in the region fight corruption and also strengthen their ability to implement solutions that involve level playing fields, rule of law, objective public planning, to prevent situations like what happened in Panama, where the previous government of Juan Carlos Varela signed up for a \$4 billion bullet train, spending the Panamanian people's money, for something that wasn't even in the government's long-range plan.

We need to help our governments in the region to enforce their own laws under their own sovereignty, so that Chinese companies can operate on a more level playing field.

And, frankly, we need to bring to bear more resources with respect to studying performance of the Chinese, in terms of looking at the long, long record of where the Chinese companies have not lived up to promises, where they have had problems with local communities, where they have had environmental issues and other things.

Because, at the end of the day, we need to give data-driven reasons why our partners should not accept those false promises and why democratic, free market solutions are the most viable path for their prosperity and development and, of course, to ours, because we are deeply connected to the region.

Mr. GREEN. I only have a few seconds left, but I would love to get a response in writing back from all of our witnesses today on the following question: You know, Congress passed \$15 billion in aid through supplemental appropriations.

I would like to know how State, USAID, and the NGO's are responding to that. Are they doing a good job with that aid? Is it being appropriately administered? And since my time is now up, if I could get those answers in writing, that would be helpful.

And thank you, Mr. Chairman. I yield.

Mr. SRES. We now recognize Congressman Castro.

Mr. CASTRO OF TEXAS. Thank you, Chairman.

Ms. Bertolucci, thank you for your testimony today. As you have stated, the COVID-19 pandemic has exposed existing structural challenges and exacerbated inequalities affecting vulnerable populations across Latin America. This is certainly true for migrants

and refugees, who have been displaced across the region and may lack access to healthcare and recourses to obtain a COVID-19 vaccine.

So I wanted to ask you, how can the United States work with Latin American countries and civil society organizations to make sure migrants and refugees receive the COVID-19 vaccine?

Ms. BERTOLUCCI. Thank you so much for this question. I believe there are several things that the U.S. can do to support the governments. The first one has been very much discussed right now, which is ensuring a fast and fair distribution of vaccines, augmenting the capacity of the several States in Latin America to have availability of vaccines and, therefore, not having to choose who are they vaccinating and who are they excluding from this process.

We need to also advocate and guarantee that not only the vaccines reach the countries, but also that the health systems are strengthened and the frontline workers and community health assistants are strengthened so that the vaccine can be distributed to the most remote communities, to the communities that are on the borders or walking through Latin America, which is a reality for the Venezuelans, for instance, and also make sure that we are looking at the most vulnerable populations as part of the targeting and strategy for the vaccines.

Finally, focusing only on vaccines will not solve the huge displacement and needs that the migrants and refugees have at this moment in Latin America. So we do need to step up on our humanitarian response and humanitarian funding, to make sure that they have not only access to health but access to food security, access to education, and access to the basic protection, especially for women and girls.

So those are some of the areas that I believe the U.S. could invest to support migrants and refugees in the region.

Mr. CASTRO OF TEXAS. Thank you.

I have a question for Dr. Castro. Thank you for being here today as well. And I agree with your statements on the importance of donating excess vaccines to Latin America and of supporting the intellectual property waiver at the upcoming World Trade Organization meeting.

During your testimony, you also mentioned the possibility of having the U.S. Government work with the governments of Mexico and Brazil to expedite their manufacture and development of COVID-19 vaccines. I think that this is a great idea, and it could be a long-term plan for generating sufficient COVID-19 vaccines for the entire region's population.

So I wanted to ask you, can you explain how assisting Mexico and Brazil in the manufacturing of COVID-19 vaccines could help the region in their long-term recovery from the coronavirus pandemic, and what are some of the steps the U.S. Government needs to take to make this a reality?

Dr. CASTRO. Thank you, Representative Castro, for your question. Indeed, Brazil and Mexico have the largest populations in the region, and they also have plants where they are producing vaccines. However, they do not yet have the technology needed to produce vaccines such as those that have Messenger RNA.

And that is where the United States can be very helpful, given that two of the most efficacious vaccines are based in the United States, and those are Moderna and Pfizer. And Moderna has been produced mostly with taxes from the taxpayers in the United States, and it would be a great idea if the National Institutes of Health, which has contributed vastly to the production of the Moderna vaccine, could come to agreement with researchers in Brazil and in Mexico to transfer that technology.

And that technology can help produce vaccines for the current vaccine; but because the mRNA is a new technology, it could also be very useful to treat future diseases—I mean, to treat diseases in the future and also to produce vaccines for upcoming pandemics.

So I believe that collaboration between the United States with the NIH and through vaccine developers such as Moderna and Pfizer working in collaboration with, for example, the Fiocruz in Brazil, which has a very long tradition of producing medicine and vaccines. There is also the Institute Butantan in Brazil.

And there is an agreement between Argentina and Mexico, where part of the initial product for the vaccine are produced in Argentina and then they are finished in Mexico. And that is also an agreement that could be potentiated so that more vaccines are being able to be produced. Again—

Mr. CASTRO OF TEXAS. Well, thank you. Thank you.

Ms. BERTOLUCCI. You are welcome.

Mr. CASTRO OF TEXAS. My time is expired, but I appreciate it.

Mr. SIRES. Thank you.

We now recognize Congressman Pfluger.

Mr. PFLUGER. Thank you, Mr. Chairman, for this important hearing. And I appreciate your comments, especially on the rise of the influence of the Chinese Communist Party and of Russia.

And so I would like to focus my questions first, Dr. Ellis, with you. We have seen how actors like the Chinese Communist Party, Russia, and Iran are waging campaigns to undermine Western vaccine efforts and legitimate questions about the origin of the pandemic.

So how do these disinformation campaigns affect public health response efforts, and what other efforts, disinformation efforts exist in Latin America?

Dr. ELLIS. Thank you very much, Congressman, for the very important question.

With respect to the efforts, obviously, they undermine the United States' position in a number of different ways. No. 1 is it contributes to the undermining of goodwill toward the United States and, thus, the sense that the United States is a key partner and what the United States stands for is the right way to go in the region.

In many ways, it contributes to a form of moral equivalence, the desire in the region to take the Chinese money in various other commercial endeavors. And if one can think there is somehow a moral equivalence or U.S. neglect then why not take the Chinese money, thus taking the elites down a very troubling path that leads them into dependence on the Chinese companies, because at the end of the day the Chinese are seeking to get their value-added out of their commercial endeavors.

In my judgment, the Chinese and the Russians and others are playing a slightly different game here. The Russians have been more actively involved in trying to spread false rumors and sow discontent and play up stories on, you know, the internet to undermine our best allies.

The Chinese have been particularly pressing, doing everything that they can to suppress information about the Wuhan origins of the coronavirus and the investigations into the origins, obviously, in the Wuhan virology lab. And so it has become very clear that anyone who raises that question, even our allies outside of the region, the Australians, when they dared to raise those questions were, you know, subject to very harsh economic reprisals.

And so I think not only is it undermining the U.S. position and delivering the region more rapidly into an economic dependence on the Chinese, but it also shows the way in which it is not just about economics. Overall, it is about things that both Republicans and Democrats, I think, hold dear. There is a self-censorship effect. There is a silencing effect, anything that is objectionable to the Chinese. And the more that we see Chinese power and dependence grow, I think we will see an undercutting of the U.S. position and our values, that we fight for in the region.

And, frankly, you know, a region in which its leaders, its political leaders, its elites do not feel free to speak out or question the Chinese is not the type of region that we stand for nor that I think that many in Latin America want to live in.

So I think there is a lot more at stake than just the economics, but we certainly need to get the virus under control through vaccine leadership as well, sir.

Mr. PFLUGER. Thank you, Dr. Ellis.

Dr. Castro, I would like to just kind of ask you, through the lens that you are looking at, do you see, you know, some of the similar lines of effort through disinformation or vaccine diplomacy, and do you see them negatively affecting the various countries?

Dr. CASTRO. Thank you for the question.

The efficacy of the vaccines varies a lot, and my concern is that Sinovac has only 51 percent efficacy, and it is being distributed throughout the region. And the problem is that it is going to be more difficult to reach herd immunity with vaccines that do not confer a greater protection.

So there could be a disinformation in the fact that some people may think that all vaccines are equal, and that is not correct. So definitely, we need to make sure that the vaccines that are the most efficacious are the ones that are most widely distributed and to reach herd immunity, which would mean that about two-thirds of the population is vaccinated with efficacious vaccines. Thank you.

Mr. PFLUGER. Thank you very much.

And I appreciate all three witnesses and their testimonies for this important subject.

I yield back.

Mr. SIRES. I now recognize Congressman Levin.

Mr. LEVIN. Thank you so much, Mr. Chairman, for holding this really important hearing. It is my understanding that ten countries in Latin America and the Caribbean are eligible for vaccines

through COVAX-AMC and, of those 10 eligible countries, only Haiti is waiting still on any doses.

The Miami Herald reported last week that Haiti is supposed to get 756,000 doses of the AstraZeneca vaccine. According to the Pan American Health Organization—I am quoting—“Haiti is still in the process to finalize the arrangements that all the other countries have made to be able to receive these vaccines. Haiti is not paying for these vaccines, but the country needs to make some legal and administrative arrangements,” end quote.

The same Miami Herald report noted that in order to get the doses, Haiti’s Health Ministry must make sure personnel are trained, that there is a plan for storage, and that other logistical details are in order.

I am worried that this delay will be compounded by the COVID crisis in India, which had planned to send roughly 1 billion doses of AstraZeneca to COVAX before halting their exports. I know Haiti was slated to receive a portion of those doses too.

So, Dr. Castro, let me start with you. Are you able to share any additional details on why Haiti has not received any vaccine doses through COVAX yet?

Dr. CASTRO. Thank you for the question. The information that I have is through NPR. Last week, it was published that actually the Minister of Health of Haiti had told the Revolving Fund that they did not need the vaccines because the pandemic is not having such a large impact.

Of course, it is difficult to understand why there would not be more transmission of the coronavirus in Haiti, given all the very dire conditions in which most of the population live and given that it shares the island with the Dominican Republic, where thousands of people have died of COVID-19.

So I do not have additional information, but I can find out, I can find out and provide you with a written answer about this topic.

Mr. LEVIN. I would appreciate that. I have also heard reports that, you know, last month Haiti’s Ministry of Health voiced concerns about the AstraZeneca vaccine’s safety and asked Gavi to consider making a one-shot vaccine.

And so, I mean, do you have a sense that Haiti’s Ministry of Health is rejecting the AstraZeneca vaccine? Do you have that sense?

Dr. CASTRO. Well, what I read in the NPR reporting was that they did not want to receive the vaccines that COVAX, that the Revolving Fund was about to ship to Haiti. But, again, I will find out and provide you with a better answer.

Mr. LEVIN. All right. Well, thank you. I appreciate that.

You know, in recent months, many countries in the region have experienced setbacks to democracy and authoritarian efforts to undermine democratic institutions and significant social and political unrest.

On May 1, President Bukele’s allies in El Salvador’s Congress removed constitutional court judges and the attorney general and then proceeded a few days later to provide themselves blanket immunity for virtually any act of official corruption related to the pandemic.

President Bolsonaro in Brazil is being investigated for his government's severe mishandling of the pandemic, and Colombia is experiencing massive social unrest with human rights organizations having documented excessive use of force by police.

Dr. Ellis, how should the U.S. respond to democratic backsliding in the region made worse by the pandemic? What tools can we in Congress use to push back against these antidemocratic tendencies?

Dr. ELLIS. Congressman, you raise a very important point. And there are some very complex strategic tradeoffs that we have to obviously work with, remaining consistent, because at the end of the day it is really the fight to strengthen institutions and ensure democratic practices that is at the heart of what we stand for in pushing back against China.

And yet we need to be careful at critical moments that we do not inadvertently push allies into conditions in which we actually increase their risk of populist revolutions, or push them into the hands of China, thus liberating them from their constraints and dependence on the United States and, frankly, making things worse for their people.

But I think one of the key things you also brought up is with respect to the pressures and corruption that are really threatening not just public health but undermining the stability, the political and socioeconomic stability of the region, that creates very serious challenges for us.

Mr. LEVIN. All right. Well, I see my time is expired, Mr. Chairman, so thanks and I yield back.

Mr. SIRES. Thank you.

I now recognize Ms. Salazar.

Ms. SALAZAR. Thank you, Mr. Chairman, for holding this very important hearing. And, unfortunately, what we are hearing is very troubling. There is something called a race for vaccine diplomacy, and we are getting outplayed by China and Russia, from what we are hearing.

We invented the best vaccines in the world, but very few people know about it. We gave \$4 billion to the global COVID-19 relief through COVAX. We have given more than any other country, but most people do not have a clue that is happening.

While the American companies, Pfizer and Moderna, have saved millions and millions of lives, Russia and China are pumping questionable vaccines in Latin America and demanding political loyalty in return.

So we have worked miracles, literally miracles, yet China and Russia are taking the credit for it. So, in other words, we are getting outmaneuvered by communist propaganda that trades on power and destroys countries.

So they are eating our lunch, and we have no apparent strategy to counter this new form of aggression from China and Russia. China wants to own the Panama Canal. Russia is supporting Venezuela and Nicaragua dictators. And the vaccines are their new tool.

Look what they have done. We have just discussed it in this hearing. China is providing vaccines to Chile, Uruguay, and Brazil;

Russia to Argentina, Bolivia, Mexico and Venezuela. And where are we, the United States?

The good news is that by this July this country will reach a vaccine surplus. We will have more doses than people who need them in this country. In the meantime, we know that Latin America can't make the vaccine, but they desperately need one.

So there is a vacuum. If we do not fill that vacuum, China and Russia will. It will be us versus them and, obviously, we always bet on America. So that is what I am proposing. I am proposing to protect American intelligence property so we can make sure China does not get its hands on our most valuable technology of this hour.

We should deliver surplus vaccines directly to Latin America and put the American flag on every single vaccine dose we give out so everyone knows who is giving it to them, who is saving their lives, once again, like we have done for centuries, in exchange of nothing, just because we love the common good.

So I just wanted to ask you a couple of questions, Dr. Ellis. And thank you very much for coming and spending your time and giving us your knowledge. I just wanted to ask you, do you know that within the State Department there is a group called the Bureau for Crisis and Contingency Response, the CCR, who was able to fly dozens of planes across the globe carrying almost 200,000 vaccines to our diplomats so we could protect our diplomatic personnel. Are you aware of this group within the State Department?

Dr. ELLIS. Yes, ma'am. You raised a number of excellent points. I had the honor of spending an unforgettable year with my life on the Policy Planning Staff, and the State Department has capabilities across a range of different areas.

In addition to the things that we have for our own personnel to support U.S. Nationals, there are also a number of other tools, for example, through the Global Engagement Center, and others to more effectively push back against Chinese propaganda. We certainly need as much—

Ms. SALAZAR. Do you know that these people are there, and we could use them to fly millions of vaccines to Latin America after we have this surplus that everything indicates that we are going to have it by July?

Dr. ELLIS. I would have to do a more detailed look at the scalability of those current efforts. You know, there are probably a range of different tools that can be used including with the Department of Defense and some of those logistics capabilities that it has as well.

But, certainly, the State does have short turnaround, in-house tools to deliver limited quantities of vaccines and other logistics supplies of the region. I would have to look into the scalability of that effort.

Ms. SALAZAR. So that means that if the Biden administration has the willingness to help Latin America, we could fly and provide those extra vials, starting July when we have a surplus in this country? So it is just political willingness?

Dr. ELLIS. I think we can certainly, ma'am—I agree with you. We have the vaccine, and across our whole of government capabilities, we have a number of different instruments, as we found out re-

sponding to the Ebola crisis in Africa not too many years ago, as well as professional capabilities to move things quickly.

I saw State when they were moving personnel and rescuing them, getting out of harm's way as the virus took off in the region last year. So whatever that particular capability is appropriate to this, we absolutely have the capability and we increasingly have the surplus in vaccines.

Ms. SALAZAR. But do not you think it will be a good use to those—

Mr. SIRE. Thank you, Congresswoman Salazar.

Ms. SALAZAR [continuing]. I'm sorry. Thank you. I just want to put on the record, there is this article by Vanity Fair that says that we have the vials and we have the capability of distributing them. It is just willingness.

Thank you, Mr. Chairman.

Mr. SIRE. Thank you. Congressman Vargas is recognized.

Mr. VARGAS. Thank you very much, Mr. Chairman. I appreciate you very much having this hearing and, of course, the witnesses. I want to continue on with this line of questions because I think numbers matter here, though.

So how many extra vials do we have right now, and how many people are in Latin America? I mean, I was just looking up the numbers of some of these countries. So Brazil has over 211 million people, Mexico 127 million, Colombia 50 million. I mean, these numbers are huge compared to the vials that we have. Let's be frank. I mean, if we took all the extra vials right now and we sent them to Latin America that we have, how many would that be? Who can answer that?

Evan? Dr. Evan.

Dr. ELLIS. Congressman you make a good point with respect to the number that we may have in stores at this moment versus the question of what is in the pipeline and what will also be freed up for the pipeline based on certain decisions that we make. I do not have the specific number what we have in inventory right now, but my understanding—

Mr. VARGAS. Is it 400 million? We have 400 million vials ready to go?

Dr. ELLIS. What I believe, sir, is that if we make commitments through existing or justable commercial relationships with our existing Western-based manufacturers that we can keep that pipeline ramped up as our own demand in the United States ramps down so that in the coming—

Mr. VARGAS. You do not want to give me a number, though? Does anyone want to give me a number?

See, that is what I think the problem is we are talking about numbers that are small that we have and we are talking about gigantic numbers that they need. That is the problem. So even if we gave them all the extra vials—there is not that many extra vials, let's be frank. I mean, we do not have it right now. That is the problem.

I mean, you have, you know, 19 percent of the COVID-19 virus in the region, you have 8 percent of the population, but 8 percent of the population is huge. So at the moment we do not have enough. I mean, that is the reality.



The Chinese have been good, I think, about saying, hey, we will give this to you even though their vaccine is pretty crappy, but it is something so they will take it. We have to have the ability to give them some vaccines. I mean, that is the issue. And how do we do that? Dr. Castro, how do we do that?

Dr. CASTRO. Well, some numbers is through COVAX. The current goal is to provide 280 million doses by the end of the year. And if you take into account that most people because of the type of vaccines are going to need two doses, that means 140 million and for a population of 660 million. Of course, that 660 million includes children. And right now we are still going to—if they can, if it is safe to provide the vaccine. But it is true that we still need millions of doses to be delivered.

Mr. VARGAS. Now, I do have a concern that some of my colleagues on the other side of the aisle do is that COVAX-AMG is great, but the reality is that we do not—we should have on there, you know, provided by the United States of America. I do agree with that. That is something that we should insist on.

I mean, if we are providing the money to do this, we should get credit for it. And not because we want to get credit for it, but I think it is good for democracy. I think it is good for the people there to understand we are doing this because this is what free countries do, this is what democracy does, as opposed to the Chinese who do it for self-interest. They are doing it because they want something out of it. They want us to take their canals. They want to take their raw materials.

So I do think it is important when we provide these vaccines that they know that it is coming the United States of America. But at the same time we have to be realistic about it and understand that, you know, yes, we can fly down what we have right now, and you can, you know, get a very few people vaccinated, but the reality is it does not really cover the great majority of people there. We need a better plan. And that is what we have to come up with a better plan to figure out how do we help vaccinate everyone in Latin America that wants it? And hopefully everyone would want it, because we will not be safe until they are. Am I wrong about that?

Dr. CASTRO. You are right. We need to immunize even if everybody in the United States wanted to be vaccinated, and we achieved herd immunity, we would not be safe in the United States until at least two-thirds of the population in every single country in the world is vaccinated.

Mr. VARGAS. And that is why I think we do need this plan to try to figure out how he are we going to help Latin America and the Caribbean get fully vaccinated? I mean, it is interested to talk about these little things to send them a few vials here, a few times there. That is not the scale that we need. We need a plan that is really going to do the job.

I see my time is up, so I will yield back. Thank you.

Mr. SIRE. Thank you, Congressman. And I certainly agree with you to say on it, Made in the USA.

Well, thank you, again, for joining us today, to all the witnesses. I want to close today's hearing by once again urging the Biden administration to take immediate steps to support vaccine distribution in Latin America and in the Caribbean. I look forward to

working with Ranking Member Green and our colleagues to deepen U.S. engagement with our allies as we work to get this pandemic under control throughout the Western Hemisphere.

With that, this committee is adjourned.

[Whereupon, at 11:12 a.m., the subcommittee was adjourned.]

APPENDIX

**SUBCOMMITTEE HEARING NOTICE  
COMMITTEE ON FOREIGN AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
WASHINGTON, DC 20515-6128**

**Subcommittee on the Western Hemisphere, Civilian Security,  
Migration and International Economic Policy**

**Albio Sires (D-NJ), Chair**

May 13, 2021

**TO: MEMBERS OF THE COMMITTEE ON FOREIGN AFFAIRS**

You are respectfully requested to attend an OPEN hearing of the Subcommittee on the Western Hemisphere, Civilian Security, Migration and International Economic Policy, to be held in Room 2172 of the Rayburn House Office Building. Members who wish to participate remotely may do so via Cisco WebEx. The hearing will be available via live webcast on the Committee website at <https://foreignaffairs.house.gov/>:

**DATE:** Thursday, May 13, 2021

**TIME:** 10:00 a.m., EDT

**SUBJECT:** A Race Against Time: Deploying Vaccines and Addressing the Disproportionate Impacts of COVID-19 in Latin America and the Caribbean

**WITNESSES:** Arachu Castro, PhD, MPH  
Samuel Z. Stone Endowed Chair of Public Health in Latin America  
Department of Global Community Health and Behavioral Sciences  
Tulane University School of Public Health and Tropical Medicine

Ms. Tatiana Bertolucci  
Regional Director for Latin America and the Caribbean  
CARE International

R. Evan Ellis, PhD  
Latin America Research Professor  
Strategic Studies Institute  
US Army War College

**\*\*NOTE:** Witnesses may be added.

**By Direction of the Chair**

*The Committee on Foreign Affairs seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202/225-5021 at least four business days in advance of the event, whenever practicable. Questions with regard to special accommodations in general (including availability of Committee materials in alternative formats and assistive listening devices) may be directed to the Committee.*

To fill out this form online: Either use the tab key to travel through each field or mouse click each line or within blue box. Type in information.

## COMMITTEE ON FOREIGN AFFAIRS

Note: Red boxes with red type will NOT print.

MINUTES OF SUBCOMMITTEE ON Western Hemisphere, Civilian Security, Migration and International Economic Policy HEARING

Day Thursday Date May 13, 2021 Room 2172 Rayburn HOB

Starting Time 10:03am Ending Time 11:12am

Recesses 0 (\_\_\_\_ to \_\_\_\_ ) (\_\_\_\_ to \_\_\_\_ ) (\_\_\_\_ to \_\_\_\_ ) (\_\_\_\_ to \_\_\_\_ ) (\_\_\_\_ to \_\_\_\_ ) (\_\_\_\_ to \_\_\_\_ ) (\_\_\_\_ to \_\_\_\_ )

Presiding Member(s)

*Chairman Albio Sires*

Check all of the following that apply:

Open Session ☒

Executive (closed) Session ☐

Televised ☒

Electronically Recorded (taped) ☒

Stenographic Record ☒

To select a box, mouse click it, or tab to it and use the enter key to select. Another click on the same box will deselect it.

TITLE OF HEARING:

*A Race Against Time: Deploying Vaccines and Addressing the Disproportionate Impacts of COVID-19 in Latin America and the Caribbean*

SUBCOMMITTEE MEMBERS PRESENT:

*See attached hearing attendance form.*

NON-SUBCOMMITTEE MEMBERS PRESENT: (Mark with an \* if they are not members of full committee.)

*None*

HEARING WITNESSES: Same as meeting notice attached? Yes ☒ No ☐

(If "no", please list below and include title, agency, department, or organization.)

STATEMENTS FOR THE RECORD: (List any statements submitted for the record.)

*IFR, Sires on behalf of Dr. Arachu Castro*

*IFR, Salazar*

*QFR, Sires*

TIME SCHEDULED TO RECONVENE \_\_\_\_\_

or

TIME ADJOURNED 11:12am

Clear Form

Note: If listing additional witnesses not included on hearing notice, be sure to include title, agency, etc.

*[Signature]*  
Subcommittee Staff Associate

WHEN COMPLETED: Please print for subcommittee staff director's signature and make at least one copy of the signed form. A signed copy is to be included with the hearing/markup transcript when ready for printing along with a copy of the final meeting notice (both will go into the appendix). The signed original, with a copy of the final meeting notice attached, goes to full committee. An electronic copy of this PDF file may be saved to your hearing folder, if desired.

WHEM SUBCOMMITTEE HEARING

<i>PRESENT</i>	<i>MEMBER</i>
X	Albio Sires, NJ
X	Joaquin Castro, TX
X	Andy Levin, MI
	Vicente González, TX
X	Juan Vargas, CA

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## OPENING STATEMENT CHAIRMAN SIRES

House Committee on Foreign Affairs  
Western Hemisphere Subcommittee

Chairman Albio Sires (D-NJ)

Opening Statement – “A Race Against Time: Deploying Vaccines and Addressing the Disproportionate Impacts of COVID-19 in Latin America and the Caribbean”

Thursday, May 13, 2021

- 
- I have dedicated much of my fifteen years in Congress to deepening the United States’ engagement in the Western Hemisphere, so it has been deeply painful to see the devastating impact of the COVID-19 pandemic in Latin America and the Caribbean.
  - This region has less than ten percent of the world’s population but has accounted for almost thirty percent of the world’s deaths.
  - An estimated twenty-two million people in this region were pushed back into poverty last year, effectively eroding many of the region’s gains in economic development over the last two decades.
  - The pandemic’s impacts have been especially severe for women in the region, who have been 44% more likely than men to lose their jobs.
  - The pandemic has also created nightmare scenarios for many women, who have been forced to shelter with their abusers.
  - In Mexico, Argentina, and Colombia, calls to domestic violence hotlines have skyrocketed.
  - As we think about the lessons we should learn from this pandemic, I believe one of them is that the epidemic of domestic violence must be addressed with the urgency it deserves.
  - The U.S. Government should incorporate efforts to combat and prosecute domestic violence into our foreign assistance programming throughout the region.
  - We have also seen how this pandemic is undermining democratic governance, reducing citizens’ trust in government, and leading to greater political instability.
  - The current situation in Colombia, the United States’ strongest ally in Latin America, provides a grim foreshadowing of the kinds of unrest we may see throughout the region if we cannot work quickly and effectively to get this pandemic under control.
  - Last Congress, we held two hearings to examine the impact of the pandemic in Latin America and the Caribbean and the U.S. Government’s response.

- In July 2020, when we hosted the Acting Assistant Secretary, Ambassador Kozak, we discussed with him the urgent need in the region for more personal protective equipment and masks.
- Today, that urgent need is vaccines.
- I ask President Biden, Vice President Harris, and their administration to answer the call.
- The U.S. is expected to have over four hundred million excess vaccines, even if we vaccinate every adult in the U.S.
- In New Jersey, more than 7.7 million doses have been administered already and I am working hard to ensure everyone in my district can easily get access to a vaccine.
- But the truth is that none of us will be fully safe from this virus until we all are.
- Time is of the essence and we cannot afford any further delay.
- The P-1 and other variants are making it even more difficult to contain the virus.
- That is why I have joined with many colleagues including Congressman Castro and Chairman Meeks in calling for Latin America and the Caribbean to be prioritized for vaccine distribution.
- The Caribbean in particular cannot be forgotten.
- I am glad we have started to send some vaccines to Mexico, but our neighbors in the Caribbean and in Central America should also be at the top of the list.
- In the coming months, we must go beyond shipping excess vaccines or working with countries to pay for them to also supporting vaccine distribution and delivery.
- It should be U.S. policy to promote vaccine equity and ensure that indigenous groups, women, and people of African descent, who have been hit especially hard by the virus, are prioritized in vaccination outreach efforts.
- Looking ahead, we should be assessing how we can leverage the United States' expertise in the private sector and in our government-funded research institutions to help strengthen health systems throughout the region.
- My hope is that in the wake of the pandemic, the United States' bonds with this region will emerge stronger than ever before.



- I look forward to working with my colleagues on a bipartisan basis to advance that goal.
- Thank you, and I now turn to Ranking Member Green for his opening statement.

## INFORMATION FOR THE RECORD FROM SIRES ON BEHALF OF DR. CASTRO

Arachu Castro, Ph.D., MPH  
Samuel Z. Stone Endowed Chair of Public Health in Latin America  
Tulane University School of Public Health and Tropical Medicine

Subcommittee on the Western Hemisphere, Civilian Security, Migration, and International  
Economic Policy, United States House of Representatives

June 28, 2021

### **A Race Against Time: Deploying Vaccines and Addressing the Disproportionate Impacts of COVID-19 in Latin America and the Caribbean**

#### **Follow up to May 13 testimony**

In Latin America and the Caribbean, the COVID-19 pandemic continues to have a devastating impact despite the deployment of vaccines. In the span of seven weeks between May 7 and June 26, 2021, the number of people diagnosed has grown from 29.9 million to 36.8 million and the number of deaths from 951,710 to 1,254,425.<sup>1</sup> This growth is disproportionately higher than in other parts of the world: during this period of time, the share of world deaths occurring in the region has increased from 29% to 32%, despite having less than 9% of the world's population.<sup>1</sup> The number of deaths per 100,000 population varies greatly within subregions: 25 in the Caribbean, 144 in Mexico and Central America (led by Mexico with 178 and Panama with 148), and 226 in South America (led by Peru with 573, Brazil with 237, and Argentina and Colombia with 200).<sup>1</sup>

During these seven weeks, the deployment of vaccines throughout the region has evolved unequally, as shown in **Map 1**.

Chile and Uruguay lead the way, with an estimated 100% population being at least partially vaccinated in both countries.<sup>2</sup> On the other hand, Haiti is the only country in the entire region without access to any vaccines.<sup>2</sup>

Support from the United States Government is critically needed to help deploy vaccines to Haiti and strengthen its health system. Other countries that are lagging in vaccination efforts are Nicaragua, Guatemala, Honduras, Venezuela, and Jamaica.

*Map 1: Percentage of population fully or partially vaccinated for COVID-19 in Latin American and Caribbean countries, as of June 25, 2021.*

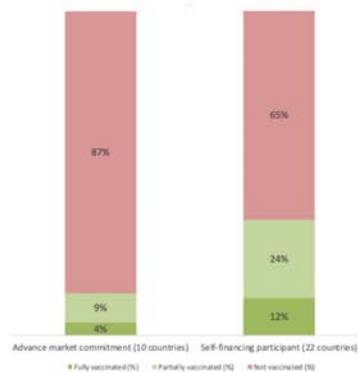


Sources: Pan American Health Organization, [COVID-19 Vaccination in the Americas](#), 2021<sup>2</sup> and [Our World in Data](#), 2021.<sup>3</sup>

To reach herd immunity in Latin America and the Caribbean, a region of 660 million population, an estimated 462 million people (70%) need to be fully vaccinated. Given that most countries in the region are distributing vaccines that require two doses, this translates to 924 million doses needed. Of these, 299 million have been administered. Therefore, there is a critical need to deploy an additional 625 million doses by the end of 2021 to reach this immunity threshold.

Although at least 13 countries in the region have engaged in bilateral agreements, all of them except Cuba participate in the COVAX mechanism to procure COVID-19 vaccines through the Pan American Health Organization (PAHO)'s Revolving Fund for Vaccine Procurement. Countries participate in COVAX as donor-dependents with advance market commitments (AMCs) or as self-financing participants (SFPs). Cuba has relied on their own vaccine development, and plans to vaccinate its entire population by the end of 2021.<sup>4</sup>

Figure 1: Percentage of population fully, partially, and not vaccinated for COVID-19 in Latin American and Caribbean countries according to their type of participation in the COVAX mechanism, as of June 25, 2021.



Due to a shortfall of donations to COVAX, of the 202 million requested doses for 2021 for the region, PAHO projects that only 33 million doses will be delivered by end of July and 10 million more by end of September, 2021.<sup>5</sup> This shortfall creates great inequity in vaccine access. As shown in **Figure 1**, the percentage of the unvaccinated population is greater in AMC countries (87%) than in SFP countries (65%).<sup>2</sup>

AMC countries include Bolivia, Dominica, El Salvador, Guyana, Grenada, Haiti, Honduras, Nicaragua, Saint Lucia, and Saint Vincent and the Grenadines.

Sources: Pan American Health Organization, [COVID-19 Vaccination in the Americas](#), 2021<sup>2</sup> and [Our World in Data](#), 2021.<sup>3</sup>

Haiti needs 16 million doses to reach herd immunity. Through COVAX, Haiti is expected to receive around 4.6 million doses, but none have yet reached the country and the first installment, comprised of around 130,000 doses, is not expected to arrive until late July or August, 2021.<sup>5</sup> In the meantime, the White House has pledged 1.5 million Pfizer-BioNTech doses,<sup>6</sup> but they have not yet been deployed. A partnership between the Subcommittee on the Western Hemisphere, the House Haiti Caucus, and the Pan American Health Organization could help speed up the arrival of vaccines in Haiti. PAHO's Revolving Fund has the experience and capacity to assist Haiti in ensuring the sustainability of immunization supply chains.

**References:** 1. WHO. Coronavirus Dashboard. Available at: <https://covid19.who.int>. Geneva: World Health Organization; 2021. 2. PAHO. COVID-19 vaccinations in the Americas. Available at: [https://ais.paho.org/imm/IM\\_DosisAdmin-Vacunacion.asp](https://ais.paho.org/imm/IM_DosisAdmin-Vacunacion.asp). Washington, DC: Pan American Health Organization; 2021. 3. Our World in Data. <https://ourworldindata.org/>. 2021. 4. Alonso Falcón R et al. [Promising results of Cuban vaccine candidates: Intervention with Abdala and Soberana 02 in risk groups and territories begins in May]. Available at: <http://www.cubadebate.cu/noticias/2021/05/10/ofrecen-detalles-sobre-fase-ii-de-ensayo-clinico-con-soberana-plus/>. *CubaDebate*. May 7, 2021. 5. John Fitzsimmons and Murat Öztürk (Pan American Health Organization). Personal communication, June 13, 2021. 6. Paul Farmer (Partners In Health). Personal communication, June 25, 2021.

INFORMATION FOR THE RECORD FROM REPRESENTATIVE  
SALAZAR

5/13/2021

Inside the Secretive Government Unit Saving American Lives Around the World | Vanity Fair

CORONAVIRUS

Inside the Secretive Government  
Unit Saving American Lives  
Around the World

A little-known team of medics and miracle workers—hidden deep  
within the U.S. Department of State—opens its doors to *Vanity Fair*.

BY ADAM CIRALSKY

MAY 6, 2021



Members of OpMed's Operation Icebox: TOP (L-R) Matthew Ferreira, veterinarian/epidemiologist, Katrina Mayes, biochemist/virologist, Laurean Pope, program analyst. BOTTOM (L-R): Taundria Cappel, program analyst, and Taylor Bunch, senior inter-agency coordinator. PHOTOGRAPH BY ADAM CIRALSKY.

**I**n a concrete hangar in Aguadilla, Puerto Rico, **Katrina Mayes** is working with precision and purpose. Wisps of smoke surround her, wafting off the dry ice she is using to jerry-rig a cardboard vaccine carrier. Her task: to create a vapor phase vent to moderate the temperature of the cooling container from around minus 80 degrees Celsius (for storing Pfizer's COVID-19 vials) to minus 15 degrees Celsius (to accommodate supplies of the Moderna vaccine).

At 29, the biochemist and virologist has spent much of her professional life indoors, where the U.S. government has entrusted her to handle some of the world's most lethal pathogens—including Ebola, Lassa fever, and Nipah viruses—at top-secret Biosafety Level Four facilities. “I shower six times a day,” she tells me. “I’m the cleanest person you’ll ever meet.” Her winning smile and gallows humor mask the gravity of her work, which has involved diffusing poison-laced letters that have been mailed to federal buildings.



Taylor Bunch and Katrina Mayes jerry-rig a cardboard vaccine carrier in Aguadilla, Puerto Rico. PHOTOGRAPH BY ADAM CIRALSKY.

On a Tuesday in March, her mission was just as urgent but more life-affirming. Dubbed “Operation Icebox,” Mayes was helping deliver nearly 200,000 doses of COVID-19 vaccine to American embassies, consulates, and other overseas posts scattered across six continents. It is a complex affair involving two dozen jets that are big enough to fly long distances—carrying ultra-low temperature (ULT) freezers—yet nimble enough to land on a variety of

runways. Mayes's colleague **Taundria Cappel**, a Guyanese émigré who began her government career as a secretary, oversees the entire operation—at age 30. “We are the MacGyvers of the State Department,” she explains. “People come to us with crises and we develop solutions.”

## A New Breed of Hero

With the violent departure of **Donald Trump** from the White House, a pandemic, economic dislocation, and police killings of Black people fueling a vast movement for social change, Americans have faced so much death, division, and denial over the last year that many now wonder whether government can ever again be viewed, at times, as an agent of change or a force for good. Then came the mass vaccination effort, revealing heroes across the country, embodying excellence and offering empathy and salvation like vestiges of a bygone era.

Those qualities are in ample supply inside an elite expeditionary medical force that you have almost certainly never heard of, but to which Mayes and Cappel belong. Buried within the U.S. Department of State, it is called Operational Medicine, “OpMed” for short. Its motto—attributed to Hannibal when told it was impossible to cross the Alps by elephant—is, *Aut inveniam viam aut faciam*: “I shall either find a way or make one.” Even before COVID reared its head, OpMed was finding ways to do all sorts of things, serving as the hidden hand behind daring and often dangerous operations to rescue Americans from peril abroad. “You’ll find more about highly classified military units on Google than you’ll find about OpMed,” a senior State Department official advised. “You tend to see the missions [in the press]. You just don’t see the unit.”

With codenames straight out of a spy or superhero franchise—Guardian, Sentinel, Anodyne, Hemlock, Solitude, Erudite, Presidium, and Fanion—the scope and solemnity of their work is vast: dispatching “medics with guns” to posts at risk of being attacked; embedding with rapid-reaction forces in response to life-threatening incidents worldwide; supplying weapons of mass destruction (WMD) countermeasures and mass-casualty triage gear to far-flung locations; running the world’s only multi-patient bio-containment flights (think ICUs in the sky) capable of evacuating and treating those infected with Category-A pathogens like Ebola and Lassa as well as less deadly but more contagious diseases such as COVID-19; and providing around-the-clock medical support to Secretary of State **Antony Blinken**,

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climate envoy **John Kerry**, U.N. Ambassador **Linda Thomas-Greenfield**, and Deputy Secretary of State **Wendy Sherman**.

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Preparing to load a Containerized Biological Containment System (CBCS) onto a Boeing 747. Many of the large-scale repatriation flights conducted by OpMed during 2020 had CBCS units onboard. COURTESY OF PHOENIX AIR GROUP.

In March, I asked the State Department for access to OpMed's chief, **Dr. William Walters**, and his team of doctors, scientists, logisticians, and veteran Special Forces medics. To my surprise, given the side-eye the unit gets in certain diplomatic quarters, the request was approved. Over the course of several weeks this spring, I shadowed Walters and company at facilities in the Florida, Puerto Rico, Washington, D.C. area, and aboard their special-mission aircraft as they barnstormed a series of nations in support of Operation Icebox.

What I found was a 64-member squad forged by tragedy with a mission set as diverse as its workforce, which, far from public view, has been doing hard things in difficult places. At the same time, however, the *op* in OpMed has ruffled feathers at State—America's oldest cabinet-level agency—where some foreign service officers worry that undertaking secretive, sophisticated international operations blemishes the art of diplomacy and should instead be the responsibility of the Department of Defense or the CIA or, frankly, anyone else. OpMed, even as it works to stave off threats to Americans abroad, is fighting a rearguard action at home.

## A Herd of Unicorns

OpMed emerged from the ashes of Benghazi, where, on September 11, 2012, militants attacked the U.S. consulate, killing America's ambassador to Libya, an information management officer, and two CIA contractors. The day's events rocked the national security establishment and prompted years of recrimination, congressional hearings, and blue-ribbon commissions. When the dust more or less settled, several findings emerged: First, Pentagon officials had long warned their counterparts at the State Department about the "tyranny of distance" in Libya and other parts of North Africa. Second, CIA medics on the scene in Benghazi played an indispensable role in saving the lives of gravely wounded diplomatic security personnel. Finally, an interagency panel of experts concluded that, in light of the "grossly inadequate" response time to evacuate the injured from Benghazi, "State



must ensure it has the capability to rapidly deploy crisis responders and evacuate [...] personnel in harm's way."

Responsibility for internalizing these lessons and bolstering the department's ability to treat its own fell in no small part to William Walters, who had joined State in December 2011 in what for nine months had largely been a role in search of a mission: managing director of operational medicine. He had served with the Army's most elite special operations unit and held the euphemistic title of deputy command surgeon for sensitive activities at the Joint Special Operations Command (JSOC). "They wanted a guy who understood the Pentagon but could also wear cuff links," he said with a laugh, recalling the clash of cultures. And yet Doc Walters, as he is known in the corridors of Foggy Bottom, quickly emerged as a contrarian (in a department that values consensus) and an egalitarian (in an organization that's been a bastion of elitism since 1789).

"This is the first interview I've ever done," Walters said when I asked why OpMed's work has remained in the shadows. "We're a back-office function until there's a crisis and then, you know, it comes forward. It solves what very quickly becomes a diplomatic and American-citizen-services problem and then goes back into the background to allow the organization to do its stock and trade, which is diplomatic engagement." From repatriating Americans—held hostage in places like Iran, North Korea, Syria, and Yemen—to averting a Benghazi redux when U.S. embassies are in the crosshairs, OpMed has responded to hundreds of crises. As one operative put it, "If you are overseas and something were to happen, we're probably the ones coming to get you."

Alongside Katrina Mayes, as she moves hundreds of doses of vaccine into cold storage, is **Matt Ferreira**. The pair are jokingly referred to as "Matrina," because they share a love of science and finish each other's sentences. Like Mayes, Taundria Cappel, and others in the unit, Ferreira, 32, is a multi-hyphenate: a doctor of veterinary medicine with a Master of Public Health degree from Johns Hopkins who specializes in the epidemiology of zoonotic diseases. "When I started [with OpMed], I feel like a lot of people didn't know what to do with me as a veterinarian," Ferreira remembered. "But then I started seeing reports of a mysterious pneumonia coming out of Wuhan. I said, 'That's in my lane,' and emailed Doc Walters. He said, 'What do you think it is?' I said it could be a novel coronavirus. He said, 'Keep an eye on it, keep sending updates.' That gave our office a head start."

Ferreira working in a -20 degree Celsius cold storage unit preparing COVID-19 vaccines for distribution to U.S. diplomatic posts worldwide. PHOTOGRAPH BY ADAM CIRALSKY.

Ferreira quickly learned that his colleagues act on, rather than ruminate about, problems—and that no job is beneath anyone in the squad, Walters included. In February 2020, Ferreira, the baby-faced New Jersey native, manned evacuation flights of American diplomats and citizens out of Wuhan, where he did every conceivable job short of flying the plane: checking people in, conducting safety briefings, maintaining the bio-containment unit, scrubbing toilets, refreshing passengers' masks, and serving them food and water. "On

the last Wuhan flight, the passengers passed a book back and forth and finally sent it forward,” he recalled. “They had written thank-you messages to all of us. It made the last five days of wearing PPE and no sleep worth it.”

Not everyone was effusive. Then president Trump reportedly was apoplectic when he learned, in February 2020, that OpMed and the Department of Health and Human Services (HHS) flew 328 Americans home from pandemic purgatory aboard the *Diamond Princess* cruise ship in Yokohama, Japan. Fourteen of them, the Japanese told U.S. officials as the evacuation was in high gear, had tested positive for coronavirus even though they appeared asymptomatic during the pre-flight screening. Walters and his HHS counterpart, **Dr. Robert Kadlec**, nonetheless elected to put everyone onboard. A cabin-wide plastic wall was installed to help segregate those exposed in a specialized containment area in the back of the 747—where, by design, air flows aftward. Senior HHS and State Department officials argue that there is no evidence that any of the COVID-19 evacuations—including Wuhan, the *Diamond Princess*, and the *Grand Princess*—served as amplifiers, resulting in secondary infections. Still, to Trump, the election-year optics were unforgivable. As he would later say of the *Grand Princess* repatriation effort, “I don’t need to have the numbers [of U.S. coronavirus cases] double because of one ship that wasn’t our fault.”

In a recently released report, the Government Accountability Office (GAO) took HHS to task because its component agencies—the Administration for Children and Families, the Office of the Assistant Secretary for Preparedness and Response, and the Centers for Disease Control and Prevention (CDC)—“did not follow plans or guidance delineating their roles and responsibilities for repatriating individuals during a pandemic—an event these agencies had never experienced.” It seems the OpMed-run repatriation flights were not the problem, but rather what happened once passengers stepped back onto U.S. soil—the point at which HHS is fully in control.

“We’ve created a herd of unicorns,” Walters beamed. Walters’s troops are not simply diverse in their skill sets, but also by background and lived experience. That makes OpMed something of an outlier in a department that has been criticized for what Politico **called** its “overwhelming and entrenched whiteness.” Secretary Blinken, to his credit, has **acknowledged** what he called a “problem [that] is as old as the department itself” that is “perpetuated by policies, practices, and people to this day,” and he recently appointed Ambassador **Gina Abercrombie-Winstanley** as State’s first chief diversity and inclusion officer. She would do well to visit OpMed, an office created under **Barack Obama’s** administration, in 2013, and expanded under Trump’s, that has long since embraced

President **Joe Biden's position** that prioritizing diversity, equity, inclusion, and accessibility is a national security imperative. Walters's team is 41% female; 37% Black, Indigenous, and people of color (BIPOC); and 44% identify as having a disability. Yet they remain outsiders at State, where there is an age-old pecking order: there are foreign service officers and then there are "others." No matter how diverse and capable they may be, the fact remains that OpMed is staffed entirely by others.

"Diversity of opinion and diversity of options," Walters responded when I asked about the net effect of his hiring practices. "There's no groupthink. There's not enough people that are similar to create groupthink." Having grown up in Auburn—a town of about 30,000 in upstate New York, where his parents owned a small construction company ("My dad was a bricklayer," he likes to say), little seems progressive about the 49-year-old with sandy blond hair and a military bearing. Nevertheless, he is an uncanny talent scout, and everyone in his unit has a story about how they were recruited.

Cappel was moonlighting as a medical scribe at Inova Hospital in Alexandria, Virginia—in hopes of beefing up her med school credentials—when the Guyana-born American was assigned to follow Walters on rounds in the ER. He told her he worked for one of the best medical organizations in the world and promised that if she joined him, it would *really* bolster her application. About nine years ago, she became OpMed's sixth overall hire. Cappel began as an administrative assistant, but in time was put in charge of Hemlock, a spooky program that outfits overseas posts with specialized countermeasures to contend with chemical, biological, radiological, and nuclear (CBRN) threats. She says that emigrating to the U.S. as a teenager armed her with important skills and an entirely different worldview: "Thinking outside the box is just a way of life. There's always another way or approach. And that's how we operate in OpMed." Walters noted that Cappel's capabilities and adaptability made her the obvious choice to run Operation Icebox, a mind-bogglingly complicated global logistics operation with very high stakes. "Speaking as someone who came from a developing country," Cappel said, "to have this opportunity to do something this important for Americans around the world, it means a lot."

Mayes first appeared on Walters's radar when she worked alongside him as a medical operations officer during a 2017 deployment to Iraq with the Maryland National Guard. In late 2019, he lobbied her to leave her lab at the National Biodefense Analysis and Countermeasures Center in Fort Detrick, Maryland, and board what one OpMed team member describes as a "pirate ship on the sea of diplomacy." She started in January 2020. "I come to work and immediately we roll right into the Wuhan evacuations," she recalled.

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Walters dispatched her to Travis Air Force Base near San Francisco, where she helped triage the hundreds of Americans that Ferreira and others in the unit were flying home.

"People who, from the outside, look at our operations, they may see it as chaotic, they may see it as reckless," a senior State Department official said while we were in the Caribbean observing vaccine deliveries across the Western Hemisphere. Guatemala's Pacaya volcano was erupting and the central airport was closed, forcing the team to improvise. The official compared their operations to a fireworks display: "When you talk to the person who's setting up the mortar tubes, it is an incredibly precise operation that, if you don't know what you're looking at, looks like beautiful chaos. When you dig into it, it's all about having the people, the talent, and the resources to make that beautiful chaos work exactly and precisely in a choreographed way." The metaphor encapsulates a sentiment I found to be pervasive among OpMed's workforce; namely, that they believe some senior State Department officials do not fully comprehend how OpMed operates, are incurious about how the beautiful chaos comes together, and yet are quick to take credit when it does.

Inside the G-III plane sent to rescue Bert Hewitt. An aeromedical biological containment system (ABCS) isolated Hewitt in a hot zone to prevent others from becoming infected. COURTESY OF PHOENIX AIR GROUP.

I got a taste of that in speaking with some at State who could barely disguise their contempt for the unit, begrudgingly acknowledged its effectiveness, and, even then, tried to attribute its successes to other elements in the department, which, coincidentally enough, are run and staffed by foreign service officers. Others said that they could not render a verdict on OpMed's effectiveness until the department completed "a 360-degree holistic look back." The diplomatic double talk was bizarre—all the more so when one considers how the unit is viewed by those it has rescued and repatriated.

**Dan Honig** is one of them. An assistant professor at Johns Hopkins School of Advanced International Studies—who specializes in how organizational systems and management practices influence government performance—Honig and his family were trapped in Senegal last April when the West African country took drastic steps to address the pandemic. Having worked and advised governments and NGOs in both Africa and Asia, he sensed what was coming: "I hear closed borders, closed trade, economic difficulties, and I certainly hear the possibility of social unrest." The professor told me that even though his employer has top-tier medical evacuation insurance, he was told that only the U.S. government could get him, his wife, and their five-year-old son back to the States.

On April 3, 2020, the Honigs walked onto the tarmac at the airport in Dakar along with 147 of their fellow citizens. "I was looking up at the plane and it was a Kalitta Air flight. And I knew the name. [Conrad] "**Connie**" **Kalitta** is a drag-racer from Detroit who then started a charter company run out of Willow Run Airport in Ypsilanti, Michigan. And so, I'm looking out at this plane with the name of a Detroit former American Hot Rod Association champion on it, watching this guy in full personal protective equipment announce, "This is not a regular flight."

That guy was **Casey Roberts**, one of OpMed's Guardians. Like his brethren, he sounds like a character conjured up by a screenwriter. Roberts spent decades as a Special Forces medic. During a 2009 tour in Afghanistan, he was on a joint patrol with the French Foreign Legion in the Uzbun Valley when the Taliban dialed in an 82mm mortar on his position. Shrapnel pierced his tear duct and lodged in his sinuses. With blood running down his face and an eye swollen shut, Roberts patched up five of his comrades until reinforcements arrived. The Pentagon awarded him a Bronze Star (with V for Valor); the French gave him their equivalent, the Croix de la Valeur Militaire (Cross of Military Valor). He would go on to serve in Iraq, where he trained and equipped the country's Counterterrorism Service to battle ISIS. In 2018, he was working at Special Operations Command in Tampa when Walters met him at a conference and slipped him his card. Despite significant field

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experience, he nonetheless had to run the gauntlet to become a Guardian. That involves a six-month “green team” course put on by State’s Bureau of Diplomatic Security followed by seven weeks in Camden, New Jersey, where current and prospective Guardians work alongside trauma surgeons. The training is designed to mimic OpMed’s real-world responsibilities: treating patients in austere environments until they arrive at a facility with an acceptable level of care.

In the hours before landing in Senegal, Roberts had flown from Washington to Monrovia, Liberia, and back, repatriating 150 Americans in the process. He and his team sanitized the aircraft, showered, donned new PPE, and headed back to West Africa. Honig recalls Roberts fielding questions from the anxious and weary Americans assembled before him. “I’m honored to be able to help get you all home,” he told them. His calming presence and quiet professionalism left a profound impression on the professor and his fellow passengers. “Somebody started applauding and then everybody started applauding,” said Honig. Roberts too was moved: “That sent chills down my spine. To have a whole plane full of people clap and be supportive was amazing.” Reflecting on a career with its fair share of challenges, he expounded, “We all do stuff. But you ask yourself, ‘Did that thing I did make a difference?’ On that plane I could see the difference. I could see it on their faces. I’ll remember those missions for the rest of my life and think, That was good work.”

OpMed's managing director William Walters boarding a flight to oversee vaccine distribution in March 2021. PHOTOGRAPH BY ADAM CIRALSKY.

"The Bureau of Medical Services' Directorate of Operation—or 'OpMed,' as we call it—is a lifeline for the Department of State and the American people," Secretary of State Tony Blinken said in a statement to *Vanity Fair*. "Though perhaps lesser known outside of the Department, it's vital to our operations. That's because OpMed provides the platform and personnel to save American lives around the world, especially in times of crisis. During the early stages of the coronavirus pandemic, OpMed was integral to our evacuation and

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repatriation of 100,000 Americans to the United States as countries began locking down their borders.”

## A Tale of Two Tail Numbers

At 41,000 feet over the Caribbean, the Gulfstream III, on which I am traveling, is hardly the picture of luxury commonly associated with private jets. Matte gray on the outside with an interior that could best be described as utilitarian, the plane is known as 163, on account of its tail number. Along with its sibling, 173, it once belonged to the Danish Air Force, which used them for maritime patrols around Greenland. The “Gray Bird sisters” were later acquired by OpMed’s aviation provider, Phoenix Air Group (PAG), based in Cartersville, Georgia. In the years since, they have done some very heavy lifting.

On March 2, 2020, **Bert Hewitt**, a retired physicist, fell ill while on a trip to Bhutan. An avid hiker, Hewitt had stayed in touch with his family—8,000 miles away, in Maryland—via text. But when communication ceased, his three grown children grew worried. Worry quickly turned to dread when an internet search unearthed an article in the *Jakarta Post* describing how an unnamed 76-year-old American tourist had become Bhutan’s first confirmed COVID case. “This is where it got really scary for me,” explained Hewitt’s daughter **Catherine Miller**, who works as the director of care management at the University of Maryland Medical Center. “My dad is on the exact opposite side of the world, and I’m pretty sure that he’s dying.”

In Bhutan’s capital, Thimphu, Hewitt’s plight caught the attention of the king, who showered the American with presents—including a new television so he could watch his beloved Manchester United—and ensured that he received top-notch care, which included a team of 17 and a VIP ward. As fate would have it, Hewitt was diagnosed and treated by a California-born ER doctor named **Shankar LeVine**, whose eccentric Jewish parents had moved to India when he was a child and raised him in an ashram. (He later returned to the States for college, medical school, and residency.) “I remember having a conversation with Bert and [his partner] **Sandi [Fischer]** about when to intubate him,” LeVine told me. “He had said he didn’t want to be intubated if he was just going to die. And I said, ‘I don’t know what’s going to happen, but we know that the only chance you have is if we intubate you.’”

When her father went on a ventilator, Miller went into high gear: “I was really calling everyone I knew on the planet.” No one was willing to medevac a COVID patient, much less one in Bhutan. As a health-care professional herself, Miller noted, “I have done medical

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evacuations for other families either out of the United States or back into the United States, and I didn't know of Dr. Walters's team." That is, until a friend slipped her his phone number. "I remember the first time we talked, he said something like, 'It's going to feel like nothing is happening and then all of a sudden, it's going to be a go. And so, I just need you to be prepared for that.' And he was absolutely right. It felt like nothing was happening. And then all of a sudden, he and his team have put together this elaborate plan to go and get my dad."

OpMed dispatched a team to Bhutan in March 2020 to medevac Bert Hewitt, a retired American physicist, who was the kingdom's first COVID case. American officials have called the operation "One of the most complex medical evacuations in history." COURTESY OF PHOENIX AIR GROUP.

A team aboard 163 flew toward Bhutan's Paro Airport, which is so treacherous—with a short runway surrounded by 18,000-foot peaks—that only a handful of pilots are certified to land there. After picking up one of those aerial Sherpas in New Delhi, the G-III landed safely. LeVine and the crewmembers transferred Hewitt from an ambulance into an aeromedical biological containment system (ABCS) onboard 163, which then quickly departed. On its way back to Baltimore, the plane became a reverse clown car, taking on fresh pilots and oxygen during refueling stops in five countries, where officials refused to allow anyone or anything to exit the aircraft. LeVine said that State Department officials kept his team apprised of the plane's progress until word from Catherine finally arrived: "He's here and he's alive."

"The overall feeling that I got after this experience—and it will live with me for a long time," Catherine Miller marveled, "is that there are good people in the world who are willing to help strangers, which is not something that I think you find every day. And that is true of Dr. Walters as an individual and of his team and the entire country of Bhutan as well. So many people were fighting for me and my dad, and they had never met us." For his part, Hewitt, who has made a full recovery, says of those who came to his aid, "I feel incredibly grateful and I'm incredibly lucky. All the stars were aligned for me."

Hewitt's medevac, however, was less a matter of luck and more the product of prescient planning, innovation, and bold execution that can be traced back through four

administrations. In 2007, the Centers for Disease Control and Prevention (CDC), on the heels of two outbreaks (SARS-1 and Avian Flu), identified the need for a way to transport government employees who had contracted, or were exposed to, infectious diseases. PAG received the contract and set about creating something that had never before existed: an aerial ICU with negative pressure chambers to ensure that nothing from the hot zone—where an infected patient is housed—exposed any other part of the aircraft. What's more, the entire contraption needed to be small enough to fit inside the body of a G-III. It took four and a half years to build and relied on CDC for the science (how to protect people from pathogens), DoD for the equipment (to contain biological agents), and required certification by the Federal Aviation Administration (FAA) and the Department of Health and Human Services (HHS). But by the time the ABCS was completed in 2011, the epidemics that spurred its creation had subsided and the unit sat idle inside a hangar for years.

That all changed in July 2014, when the largest and longest Ebola epidemic in **history** broke out in West Africa. At the time, **Dr. Kent Brantly**, an American missionary, was in Liberia on the front lines treating the infected. Despite meticulous protocols for donning and doffing personal protective equipment (PPE), he contracted the virus, which at the time had a roughly 70% fatality rate. When the charity that employed him scoured the world for a plane to fly him back to the States in hopes of improving his long odds, only one quote came back: a South African company offered to take Brantly as far as Germany for \$1.3 million. Problem was, Germany—indeed the entire European Union—had little interest in accepting and treating an American with Ebola.

Casey Roberts, emergency management specialist, known within OpMed as a Guardian, repatriating American citizens from Dakar, Senegal, in April 2020. COURTESY OF OPMED.

As Catherine Miller would later do, Brantly's employer found its way to Doc Walters and OpMed, which flew him back to the U.S. aboard a Gray Bird kitted out with the never-before-used ABCS. It was a daring move that invited a torrent of criticism. "Ebola patient will be brought to the U.S. in a few days - now I know for sure that our leaders are incompetent. KEEP THEM OUT OF HERE!", Donald Trump—then a reality-show star—tweeted on July 31, 2014, before doubling down the following day: "The U.S. cannot allow EBOLA infected people back. People that go to far away places to help out are great—but must suffer the consequences!"

Three days later, Gray Bird 173 landed at Dobbins Air Reserve Base and with news helicopters hovering overhead, Brantly was taken in a medical convoy to Emory University Hospital in Atlanta, where he became the first Ebola patient ever treated in the U.S. Now living in Zambia, Brantly told me that until his brush with death, he was oblivious to OpMed's existence: "I owe a debt of gratitude—indeed, my very life—to Dr. Walters and the many others who pushed back against stigma, against bureaucracy, against public fear in order to show compassion to me at a time when I was completely vulnerable and helpless.

These people are heroes in the truest sense of the word [...] for the remarkable acts of courage and [for their] compassion in the face of the seemingly impossible. They represent the best part of what it should mean to be an American.”

As part of what is known as Program Solitude, OpMed has medevacked more than five dozen people infected with, or who had high-risk exposures to, Ebola and Lassa fever and managed to do so without causing a single secondary infection. President Obama recognized the accomplishment at a White House ceremony in February 2015: “Some worried about bringing the disease to our shores. But what folks like William [Walters] knew was that we had to make the decisions based not on fear, but on science. And he knew that we needed to take care of our heroes.... As William said, ‘We do the work we do to impact something bigger than ourselves.’ That’s the test of American leadership.”

That leadership was tested again the following year, when a power struggle between South Sudan’s president and former vice president devolved into days of mayhem on the streets of Juba that left more than 300 dead. With the U.S. embassy under threat, one of the Gray Birds, 163, flew out of D.C. with a six-person team.

Preparing to medevac injured and traumatized American citizens from Juba, South Sudan, in July 2016. COURTESY OF PHOENIX AIR GROUP.

In the wake of Benghazi, Walters had begun recruiting experienced combat medics from America's most elite special operations and special forces units to meet two needs. Some were dispatched for extended periods to embassies and consulates that were in high-risk places—like Baghdad, Damascus, and Peshawar—while others were attached to interagency counterterrorism teams. The former became known as Sentinels, the latter as Guardians.

"The breadth of knowledge which they bring to the problem is absolutely incredible," explains **Taylor Bunch**, 36, who joined OpMed as a Guardian and is now effectively Walters's right hand, overseeing, among other things, the unit's threat analytics division. He served two tours in Iraq with the Army's 1st Cavalry Division before joining the 3rd Special Forces Group, which sent him as a combat medic to Afghanistan. Like many veterans his age, he sees omens where the rest of us see misfortune. "My Special Forces team was Operational Detachment Alpha (ODA) 3322. On my second deployment in 2013, I got shot in our 22<sup>nd</sup> firefight." The bullet he took in the shoulder ended his military career and led him to transition to a civilian position as an instructor at the Joint Special Operations Medical Training Center at Fort Bragg, North Carolina, which is where Walters found him. "Iraq, Afghanistan—that's an easy environment to work in because you know, 'Here's your gun, here are your bullets, you're good.' To operate in a diplomatic environment that has a tactical threat is challenging. And so, [the Guardians and Sentinels] are the medical blanket, the conduit to medical evacuation, as well as tactical advisers to whether it be the ambassador or the security teams."

The operation in Juba demonstrated OpMed's agility and deep bench. While en route, the situation on the ground was deteriorating and the mission expanded from bolstering the embassy to rescuing civilians. About 30 foreign nationals had sought refuge at the Terrain Hotel less than a mile away from a compound housing peacekeepers belonging to the aptly named UNMISS (U.N. Mission in South Sudan). According to the U.N.'s own **assessment**, its forces stayed on base and ignored pleas from those barricaded inside the hotel.

With no one standing in their way, South Sudanese troops shot their way into the building, striking an American in the process. They then promptly grabbed a local journalist who had been working at a U.S.-funded radio station and executed him in front of his colleagues. At that point, the soldiers set upon their captives, and over the course of many hours, viciously assaulted them and gang-raped several of the women. When they were finally released and driven to the airfield, the group of American, Australian, and Filipino civilians were traumatized. Some of the injured sprawled out on stretchers inside *163* while others sat upright while they flew to Kenya for treatment. Like most of its work, OpMed's role in the Juba mission has never been revealed. Neither has the full extent of the horrors visited upon those they rescued, the details of which are simply too graphic to publish.

he sun was setting as the OpMed team flew back to the States from Haiti, having also delivered vaccine stocks to the Dominican Republic and Jamaica earlier in the day. Walters



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**T**had ruptured a bicep tendon while lifting one of the nifty yet unwieldy ULT freezers that Matrina and the others designed. “I’ve had the opportunity to serve three tours in Iraq with infantry and aviation units and spent over four years in Joint Special Operations Command. I have, over the years, had the opportunity to be at the forefront of a number of really important things,” he said staring out the window. “But I’ve never been prouder of anything I’ve done than bringing this team together—and then getting out of their way and letting them do just amazing work.”

An OpMed team preparing ultra-low temperature (ULT) freezers for Operation IceBox. Dr. Troy Glassman, Jimmy Algarin, Dr. William Walters, Samuel Bunch, Matthew Ferreira, Katrina Mayes, and Taylor Bunch. PHOTOGRAPH BY ADAM CIRALSKY.

Postscript: On April 19, 2021, Katrina Mayes closed out Operation Icebox by dispensing vaccine vials to the U.S. embassy in Singapore. All told, Mayes and her colleagues—with Cappel at the helm—flew 574,000 miles on 26 separate aircraft to 212 airports worldwide, supplying 190,544 doses of Pfizer-BioNTech and Moderna to 257 U.S. diplomatic posts. In

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the week that followed, they were called upon to help fortify the U.S. embassy in N'Djamena, Chad, where the country's president had died battling rebels, and then to source thousands of oxygen cylinders and transport them aboard a 747 to India, where the pandemic continues to rage. Not bad for a bunch of outsiders.

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## RESPONSES TO QUESTIONS SUBMITTED FOR THE RECORD

### Questions for the Record from Chairman Sires “A Race Against Time: Deploying Vaccines and Addressing the Disproportionate Impacts of COVID-19 in Latin America and the Caribbean” Thursday, May 13, 2021

#### Questions to Ms. Tatiana Bertolucci

1. According to the World Food Programme, the Latin American and Caribbean region is set to see a 269% rise in the number of people facing severe food insecurity, bringing the total to 16 million people up from 4.3 million in 2019. WFP is particularly concerned about Haiti, Central America, and Venezuela and Venezuelan migrants.
  - Where have you seen the steepest increase in food insecurity in the region and why?

The highest rates of food insecurity have been in rural areas. The pandemic obviously exacerbated an already challenging situation as it disrupted supply chains and limited people's ability to get the resources they needed. According to Panorama, a report issued by the United Nations, the most acute challenges were in Haiti, Venezuela, Nicaragua, Guatemala, and Bolivia. Honduras was also dramatically impacted following Hurricanes Eta and Iota. Our assessments also show that women are highly impacted as they eat less meals and of lower variety to leave more food for their families.

- How have humanitarian organization addressed food insecurity?

CARE has been proactive on this issue in this region for some time. As an example, CARE Honduras is working to reduce the impact of the food crisis on the lives of vulnerable families through its programs, with a focus is on women and girls who predominantly work in high-risk, informal, sectors and have a high dependence on natural resources for their livelihoods. Through its response activities during the COVID-19 pandemic and the two hurricanes, Eta and Iota in November 2020, CARE provided food support to 25,000 people. Another 7,137 (the majority of whom were women) received assistance in cash or vouchers to mitigate the socio-economic impacts associated with these crises. CARE is also providing support to enhance reactivate rural livelihoods and women's economic activities in rural and urban settings through the provision of seed capital, agricultural kits and technical support, with resilient crops and techniques to resist severe climate events, including the continued drought in the dry corridor. Our actions sought to reduce the risk of transmission of COVID-19, ensure access to safe water, reduce the risk of malnutrition amongst vulnerable groups, guarantee access to protection systems and psychological support for women survivors of gender-based violence, as well as meeting the immediate needs of food, shelter and livelihoods for the affected populations.

- How can foreign assistance best address immediate food needs?

There is a myriad of policies that can help alleviate food insecurity in these areas. Because many communities rely on small and family-owned farms, access to financial and non-financial assets are particularly important. Also critical are broad economic development and job opportunities, particularly for women, so that families can establish financial stability to meet their needs. Additionally, foreign assistance should focus on cash and voucher programs that allow

immediate relief to impacted families, immediate health needs including clean water and access to family planning resources, and design its programs with systems that promote the local market sustainability and activity.

2. As COVID-19 reduced mobility within and across borders, new policies restricted migrants' movement leaving many stranded across the region. Some were forced to return to the country they had previously fled or were attempting to flee.
  - What circumstances or risks are migrants facing as they leave their home countries, as they try to settle in host countries, or as they are forced to return still in the midst of a pandemic?

Migrants are facing multiple challenges as they flee their countries and attempt to settle in host countries. They are often fleeing because of a lack of economic opportunity or, even worse, human rights abuses, violence (including gender based) and crime. Their journeys are typically fraught with hardships including a lack of food, water, and shelter. Gender-based violence can also occur during these treacherous journeys and CARE RGAs have found that sex for food and sex for work are used as coping mechanisms. With the closing of the borders the irregular pathways have increased as well as the activities of exploitative groups that offer "border crossing services" usually in high-risk ways. These groups are also usually involved in criminal activities such as human trafficking or recruiting for criminal groups, which increases the vulnerabilities of women, girls and young women and men. LGBTIQ+ groups also report higher vulnerabilities to sexual exploitation. For these reasons, durable solutions and pathways to regularization are key, as well as guaranteeing health attention and COVID19 prevention and treatment for migrants and refugees in the host communities.

- How are countries maintaining health safety precautions while addressing the humanitarian needs of migrants and asylum seekers?

Countries are trying to manage the health challenges and humanitarian needs of migrants as best they can but it is a challenge in a pandemic. Even though many governments have re-affirmed the commitment to extend health services to migrant and refugees, the pandemic has surpassed the local capacity and xenophobia has been reported, with health centers denying services to migrants and refugees. Nevertheless, governments such as Colombia has increased the level of regularization to support Venezuelan migrants and refugees.

The US can play an important role in encouraging similar policies throughout the region and ensuring it's own policies uphold the rights of displaced communities seeking safety and services within the US as well.

#### **Questions to Dr. Arachu Castro**

3. As of May 4, the World Health Organization's COVAX facility had shipped over 53 million COVID-19 vaccine doses to 121 countries. Of those, over 11.5 million doses

were delivered to Latin America and the Caribbean. The Pan-American Health Organization has been in charge of procurement, delivery, and logistics for vaccines going to the region from the COVAX facility.

- Have the COVAX facility and PAHO been effective and efficient in supplying vaccine doses to countries across the region?
- What could the United States do to better support COVAX and facilitate faster delivery of vaccines through the COVAX facility, considering it has already donated \$2 billion with an additional \$2 billion by 2022 while working to secure additional donations from other countries?

*Dr. Castro did not respond in time for printing.*

4. The pace of vaccine deployment has varied greatly across countries in Latin America and the Caribbean. For example, by mid-April, Chile led the Western Hemisphere in vaccinations per capita and is still third in the world, having bought enough vaccines to inoculate its population twice over. Meanwhile, Haiti has yet to receive any COVID-19 vaccines after Haiti's health ministry raised concerns about the safety of AstraZeneca vaccines and the surge in India delayed production and delivery of vaccines to Haiti from the Serum Institute of India.
  - What factors account for the difference in the efficacy of vaccination plans across countries in the region?
  - How can the United States help to bridge the gap between countries that are successfully vaccinating their population and countries that need additional assistance to meet their needs?
  - What risks do such different success rates with vaccinations raise for global health security?

*Dr. Castro did not respond in time for printing.*