Refocused vaccination campaigns are possible

Local planning will need to go hand-in-hand with equitable plans at the national and global levels

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Poornima and Ashok, 80-year-old parents of two and grandparents of three, have been hunkered down in their Mumbai apartment for a year. When a COVID-19 vaccine became available in March 2021, they went to the local hospital to get their first dose of the Serum Institute of India's Covishield vaccine – the vaccine that was supposed to save the world. Seeing long lines and not wanting to risk being infected while waiting to be vaccinated, they returned home. This happened again the next day before a very helpful staff member of the World Health Organization (WHO) stepped in to help, taking them to a health centre early one morning and making sure they did not have to wait in a line to get vaccinated. This played out again in April 2021 for their second dose. This couple was lucky.

Where the focus must be

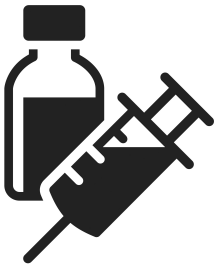
As we look ahead to what is promised to be a transition from a lack of vaccine supply to one of greater availability, the plan must be to prioritise people like the two octogenarians in Mumbai – older adults who remain unvaccinated, and very much at risk. Ensure we vaccinate them before we open vaccination to younger adults. This would prioritise people based on the risk of severe disease, and need – essential principles if we plan with justice in mind.

Local governments and municipalities should also prioritise vaccines for the historically marginalised by focusing through the lens of equity and justice. What does it mean to focus through a lens of equity and justice? It would mean ensuring that the vaccine roll-out does not result in avoidable differences in vaccine uptake – and hence preventable disease and death – between marginalised groups and the rest of the country. It would require prioritising the poor, religious minorities, socially disadvantaged castes, Adivasi communities, those living in remote areas, and women.

In Chhattisgarh

One example of an equity-focused vaccination plan came from the Chhattisgarh government. The plan prioritised ration card holders, specifically because they are poor, and often live in multi-generation, larger households, putting them at higher risk of infection. They also often lack access to mobile phones and the Internet, which are necessary to register for vaccination. Though the High Court asked that the plan be modified to provide vaccines to the general public alongside ration card holders, we would propose prioritisation of the marginalised when vaccine supply is limited in order to minimise the risk of severe outcomes due to COVID-19. WHO's strategic advisory group of experts on immunisation recommend prioritising sociodemographic groups at significantly higher risk of severe disease or death (for vaccination) in the context of limited supply (https://bit.ly/3pGy99C). We should ensure that we remove barriers to vaccination for the most vulnerable in India to minimise preventable disease and deaths.

India depended, and continues to depend on the AstraZeneca vaccine because it was stable in a refrigerator for longer periods than mRNA vaccines (https://bit.ly/3gv02Ny). Presumably, this was so that vaccines could be made available where freezers do not exist. But it also enables the vaccine to be transported in vaccine carriers, and taken to the people where they are. In Indian villages, Accredited Social Health Activists (ASHAs) and Auxiliary Nurse-Midwives (ANMs) have vast experience and expertise with campaign-style pulse polio vaccination and newborn vaccination; their expertise should be harnessed to take vaccines to villagers.



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Urban slums and neighbourhoods, where socially disadvantaged caste and community groups, and migrants from Adivasi communities often reside, have poor access to and low levels of trust in the health-care system. Vaccines should be provided in camps or door-to-door in such areas. Appropriately, local governments are considering providing vaccines to older adults in door-to-door campaigns. A similar approach – vaccination camps where people live and work – could also greatly enhance vaccine uptake among essential workers and the poor. We need to ensure that those who work for daily wages are able to get the vaccine without having to forego work or pay.

Adivasi communities also reside in remote and forested areas that are also being ravaged by waves of death, presumably due to COVID-19; vaccine distribution should be prioritised to districts where they live. In India today, perhaps the most marginalised are religious minorities, and, specifically, poor Muslim communities. Vaccine distribution should also be prioritised to Muslim-dominated tier-3 towns across the country. An explicit focus on justice would prioritise the engagement of trusted spokespeople to engage in effective risk communication with vulnerable and marginalised communities, and to build trust in the vaccine.

Women-only vaccine days

We need women-only vaccine days to ensure that women know that they are being prioritised. During the 1918 influenza pandemic, India was one of few locations where mortality was higher in women than in men (https://bit.ly/3gfc4vH), and we barely understand the drivers of this observation. In the current pandemic, it is very possible that if women are not explicitly prioritised, economic pressures to protect the (often male) breadwinner in families, and the historically marginalised stature of women in society, will end up resulting in gender inequities in vaccine uptake – early signs of exactly this have been recently reported.

Unfortunately, our data during the pandemic do not allow us to examine whether gender, caste, religious, and indigenous identities have impacted the risk of SARS-CoV-2 infection or death. Despite global calls for better surveillance (https://bit.ly/2TjQxZU), including among vulnerable groups, India does not regularly report even gender-disaggregated data. Despite crowd-sourced efforts to collect and make data available, reporting of geographic and other meta-data for tests conducted and sequenced samples is variable across laboratories and States. Better leadership to standardise and enforce meta-data collection and timely reporting is essential to inform data-driven interventions and prioritised resource mobilisation.

Equity and justice

Local planning will need to go hand-in-hand with a refocus on equity and justice at the national and global levels as well. Nationally, people have recognised that digital apps for registration are a recipe for inequity along age, gender, and economic dimensions, and reports have highlighted the plight of those on the wrong side of the digital divide. CoWIN data that are available to date (https://bit.ly/2RJWQFw) show that vaccination rates have been inequitable between tribal and non-tribal areas (https://bit.ly/2TY9qBU), for example. Going forward, let us focus on first doing no harm – get people vaccinated to save the lives most at risk. At the national level, the recent decision to procure vaccines centrally and make COVID-19 vaccines available free of cost through the public system goes a long way towards ensuring equity and justice. WHO has been tireless in its call for the urgent need for vaccine equity at the global level. In an ideal world, vaccines would be procured and equitably distributed to countries based on need through the COVAX facility (https://bit.ly/3pRoXPS). But instead, wealthy countries have once again, as during the 2009 H1N1 flu pandemic, secured more doses than they need to vaccinate every member of their population (https://bit.ly/3zmRa5a), and even pre-ordered booster doses (https://reut.rs/3pHT1NL). This leaves only poor countries to be dependent on supplies through COVAX, and they find themselves at the end of the line. This is a wake-up call for setting up vaccine distribution systems with equity in mind for the next pandemic. At this time, unfortunately, poor countries are at the mercy of the European Union and the United States, who need to donate vaccines now. They need to vaccinate the world alongside their own communities – they need to vaccinate grandparents everywhere alongside children and adolescents within their borders. Work during the 2009 H1N1 flu pandemic showed that willingness among the U.S. public to donate vaccines to the poorer countries was appreciable (https://bit.ly/3iAvnRU). Today as well, surveys show that U.S. public support for immediate donation of COVID-19 vaccine exists (https://bit.ly/3pIs9gx). Doses need to be donated to COVAX now so that they can be distributed to countries based on need. Every life matters in this world and world leaders need to follow the lead of WHO and embody global solidarity in this pandemic.

Refocused, rejuvenated local, national, and global vaccination campaigns are possible. Let us ensure that we plan now so that we get those shots in arms when they are available. Let us get to work in India.

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