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'In principle almost 100% will require vaccination ... It should mean that everyone has an entitlement'

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Rema Nagarajan

Rema Nagarajan is with the Times Insight Group, which has a mandate to look at stories beyond and behind the headlines. She writes

Mass vaccination policy to combat Covid involves trade-offs. ***Rema Nagarajan*** *spoke to* ***T Sundararaman****, global health coordinator, People's Health Movement, and former*

mostly on development issues like health and ... MORE

executive director, National Health Systems Resource Centre, about the issues involved:

From a public health perspective, what are the key principles around which vaccination should be organised?

The first principle is universal vaccination, since everyone is at risk. But universal should mean that everyone has an entitlement to get the vaccination and not that it be made mandatory. Second principle is that because the entire population has to be covered and the supplies will take time to reach, prioritization is essential on the basis of greater

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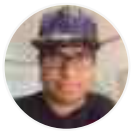

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risk such as age, co-morbidities and frontline workers, though there is not enough clarity on who are included in the frontline worker category. But risk also varies with occupation and marginalization. During the lockdown, the nation was demanding a higher degree of restriction on occupations such as vegetable vendors, fish sellers, sanitation workers, and construction workers. Certain population groups, like those using public common toilets or migrants or prisoners, were also known to be at higher risk. This must inform priority in access to vaccine. To the extent that vaccination prevents transmission, such a policy would help mitigate a very likely second wave. But even on grounds of greater individual risk, these

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sections must get a priority.

The third principle is acknowledging and addressing latent need. Need/risk, does not get reflected in demand for services. Those at highest risk may be unaware, may be afraid, may face stigma or may have no user-friendly access points. Currently, other than for health workers, registration in Co-WIN is the main device for prioritization. Though in principle anyone can register on Co-WIN, in our social context it will play out in a highly iniquitous way. Utilization through this channel is currently more by men, more from urban areas and more with other forms of privilege. It becomes the duty of the government to acknowledge this problem and reach out to those with greater risk both in the interest of

population health and in their individual interest. Responding to latent demand requires a huge emphasis on public service delivery. Currently no such plans are visible.

When we say universal, are we saying 100% of the population needs to be vaccinated?

Yes. The roll out will take place over time, but in principle almost 100% will require vaccination. Even when we have crossed the so-called herd immunity threshold for preventing epidemic spread, disease incidence will continue in an endemic form. Even if only a small proportion of those infected get fatal forms of the disease, this is true for many diseases, and is no argument against vaccination. Obviously, some people may not be so much at risk and may not come

forward. We can come to them in good time and we need not mandate it. But the principle is that no one who wants vaccination should be refused it and that it should be available and affordable, if not free of charge.

If we don’t mandate, will enough people come forward to take it especially as fear reduces with number of infections going down?

We have to educate people. Making it mandatory would be a serious error. An analogy is access to contraception. This is an entitlement, but the moment we make it mandatory we shift responsibility to the most vulnerable, depriving them of other entitlements. The three-child norm was used to penalize many women

when the truth was that many of these women get pregnant while waiting in queue to get sterilization services. The whole system is in denial of such supply side failures and it is convenient to attribute the failure to the victim. Compulsion, that too with penalties for non-compliance, is neither feasible nor desirable. We've also learnt from the polio and other immunizations that persuasion may take more time, but creates less resistance and it works well enough Also we require willing cooperation in the follow up and perhaps in revaccination later.

Many governments are tying international travel and access to public services or public spaces to vaccination certificates. Would you count that as coercion

or as necessary?

Again, it is in relation to risk. Certification would help in international travel by making quarantine less stringent or unnecessary and preventing re-introduction where it is eliminated. For yellow fever, for example, we have been having mandatory vaccination requirement for flying to or from some countries. Within the nation, some occupations have a much higher risk of spreading like hotel or transport staff, who if infected can become super-spreaders. So as a public safety measure, these workers must be given priority in access through special vaccination outreach with certification. But extending this logic to anyone wanting to travel in trains or eat a hotel would be a denial of rights, since access for

these sections has not been worked out. Also, we do not yet know for certain that vaccination breaks transmission, though it’s a reasonable expectation that it would at least lower it. There are no easy answers that would cover all situations. There are ethical conundrums here, but consultative decision making guided by these principles could take us forward.

If it’s not being made compulsory, how do we reach out to the entire population?

One obvious answer is the importance of persuasion, through good quality health education. But it is also a lot about the organization of services. Work places as routes of accelerated access would be easier for public sector enterprises like railways,

and in larger companies. In the last decade, the ESI coverage has been extended to many sections of unorganized workers with labour contractors being required to pay the premium. This could be leveraged to make employers feel responsible for and facilitate access to vaccines for all their staff, including daily wage and indirectly paid staff and their family members. The link with social security is useful in itself and increasingly such vaccination and lock-down relief measures should be built into social security schemes. This would go a long way in addressing latent need- and also in restarting and stabilizing the economy. Trade unions and workers associations could also facilitate, especially in unorganized sectors.

In rural areas and in the agriculture sector, the PHC network would have to draw up vulnerability maps of those most at risk and a considerable degree of the service delivery would have to devolve to these institutions.

But to achieve this in both urban and rural areas, public service delivery would have to be strengthened, mainly through considerable increase in the human resources deployed. The fear, almost panic that public health professionals have, is that in this drive to reach covid vaccine to all, we may undermine routine child immunization. That would be an unpardonable lapse.

Can we afford to spend over half our national health budget on vaccination. Is that

sustainable given this is not the last pandemic?

India's national health budget, as a proportion of GDP and of total health expenditure, is among the lowest in the world. So, we have the fiscal space. Further, public health services must be designed with a planned excess capacity (surge capacity) that can address pandemics. This virus has fortunately had a low case fatality rate. We may not be so lucky next time. As we have seen with the covid response, private health services have, even when empanelled under PMJAY, played a very limited role in responding to such a crisis. Such public service readiness would reduce the costs of vaccine delivery, which is now a considerable issue. And we need a formal recognition of vaccines and diagnostics as public

goods, free of patent barriers to affordable production, and with adequate publicly administered domestic manufacturing capacity, so that profit mark-ups are limited.

No other country is selling vaccines. What kind of public health policy allows distributing vaccines for payment through the private sector?

There are two reasons for private sector participation. One is because public system capacity to vaccinate is limited and additional service delivery capacity is required. But here, because it is an extension of public service delivery, the emphasis will remain to actively reach out to those most in need who would require free services with government reimbursement of costs

to the hospitals. Many not-for-profit hospitals and motivated providers would be willing for such participation. However, currently such partnerships are not in place.

The current approach of fixing the fee at a modest Rs 250 per dose, and making it available through private providers is able to respond to the demand from more aware and privileged sections. To make the privileged wait their turn, in a context where demand is yet to pick up, is bad strategy. In any case, prioritization through Co-WIN allows preferential access without having to declare it as such. As of today, in many empanelled corporate hospitals, demand as expressed through Co-WIN is so low that those who seek vaccination can get it on

a walk-in basis and then get assistance from a help desk to register in Co-Win. It is however good that even for such sections the price is fixed, the arrangement well publicized and regulated, prioritization adheres notionally to some public guidelines and most important that the procurement and supply of vaccines to the private provider is through the government. If these forms of public administration of private delivery are relaxed and direct procurement and independent pricing were allowed, it could be quite damaging.

It would be interesting to see how allocation between sectors and between hospitals plays out as demand rises. As of today, over 90% of vaccination is reported to be in the public sector, but this is reflecting

vaccination of health workers. The public sector has no strategy in place for how it plans to reach out to the rest of the population, and the current private sector partnership or Co-win would be of little help for this.

Isn’t the shortened approval process for the vaccines continuing to create vaccine hesitancy even among those most in need like health workers and even the elite?

True. Hasty approvals have created vaccine hesitancy in these sections, especially with respect to the indigenous covaxin, which was approved even before interim phase results were available. In principle, all medicines, including vaccines, should be approved only after phase 3 trials are

published in a peer-reviewed journal. Due to the pandemic urgency, this threshold was relaxed to give emergency use authorization once interim reports of phase 3 were made available. However, publication of full phase 3 results must take place within three months. Further given the sample sizes used, the limited India-specific data, gaps in knowledge with respect to infectivity and duration or protection and now the rise of mutant strains, it would be important to insist on a continued post-introduction study and come out with more complete findings and a larger sample periodically. Genomic surveillance with feedbacks/reference samples to diagnostics and vaccine manufacturers is also

important. Finally, newer vaccines being introduced should await full phase 3 results.

Can the health system scale up without affecting routine immunization and services?

It cannot. And here is the real danger. The recruitment of private services could help in some urban contexts, but this will not solve the access problem. In many areas of high need, child immunization rates are already quite low, and private sector has little presence. There has to be an expansion of public service delivery capacity. There is no getting away from this, and the sooner all stakeholders realize this the better. We should be worried not only about routine immunization, but also about set-backs to care in pregnancy and

care for TB, HIV etc, where coverage rests largely on public services.

Do you think the emphasis on Co-WIN registration despite its glitches could slow down vaccination and shift focus to just data gathering?

This is not just about software glitches. There are institutional issues. To get onto Internet, to upload the documents, … it is much more difficult for the poor, for the migrant worker, for the vegetable vendor, for the headload worker. Those who can navigate the system are likely to be more privileged.

Also is the Co-Win geared to enabling user follow up and post-marketing surveillance, or is it only about creating a queue for getting the vaccine? Even for the latter, reports are that it’s not very

effective, We need more information on these aspects. This excessive reliance and projection of Co-WIN (with or without Aadhar) as solving the problem of prioritization, guiding rational allocation and enabling post-marketing surveillance all at one go is misleading. Many states are managing with parallel arrangements.

What about the fear of data security as far as Co-WIN is concerned? After all, theoretically, they will be collecting data from almost the entire population.

Such fears are real. There is a bill pending before Parliament on data privacy and this needs to be improved and then adopted. The current data management policy authored by the Niti Aayog is insufficient for this purpose. However, at

this point of time in India, there are many parallel digital health information systems, which carry a similar threat, but their effectiveness and use has so many gaps- that the threat remains notional. Arogya Sethu is a recent example.

Co-WIN data gathering is said to be to generate a health-ID for the National Digital Health Mission. Is it ethical to generate such an ID without explicitly informing the people registering?

Clearly it would not be ethical to do so. It's also a needless distraction from the main objectives that this system should serve. Especially when the capacity of the co-win system to serve its main purposes is yet to be established.

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