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POLICY BRIEF

A PEOPLE'S COVID VACCINE IN INDIA: NO ONE IS SAFE UNTIL EVERYONE IS SAFE

The people of India are paying the deadliest price for today's national and global vaccine scarcity and inequality. As infection and death rates soar and overall COVID-19 vaccination rates dip, the Government of India's new COVID-19 vaccine policy steps back from its commitment to provide free COVID-19 vaccines for all; abandons priority access according to need; and ushers in the risk of pandemic profiteering by pharmaceutical companies at the cost of people's lives. The removal of price controls and the large-scale delegation of vaccine procurement to State governments means over a quarter of already insufficient State health budgets may have be diverted to purchase vaccines and has pitched states against each other in the quest of scarce vaccines. The government policy to enable private hospitals to purchase already scarce vaccine supplies at prices amounting to at least 43% of the monthly income for the bottom fifth of India's population will further drive up inequality as those who can afford, regardless of need, will jump to the front of the vaccine queue. At the same time, vaccine scarcity in India is exacerbated by rich country governments at the global level continuing to block proposals by India, South Africa and 100 other developing countries to temporarily lift the intellectual property (IP) barriers standing in the way of a large scale up in COVID-19 vaccine production.

The Government of India needs to announce a detailed and transparent COVID-19 Vaccine policy arrived upon in consultation with state governments and the people of India; drastically increase the pace of vaccination with vaccines purchased at true cost prices centrally, and distributed equitably prioritising those most at risk first and free of charge to all. The central government must do whatever it takes to upscale manufacturing including exploring compulsory licensing and leveraging India's large scale vaccine manufacturing capacity to address shortages. Other countries need to support India in its proposal for temporary relaxations to certain intellectual property provisions under the TRIPS Agreement of the World Trade Organisation for all COVID-19 technologies; ensure the vaccine science and know-how is shared with the World Health Organisation's COVID-19 Technology Access Pool (C-TAP) and lift bans on exports of essential ingredients for vaccine manufacturing.

THE NEED FOR A PEOPLE'S COVID-19 VACCINE

The Coronavirus is threatening all of us. The virus has already killed millions and risks pushing half a billion people into poverty. For decades, the Government of India has dramatically neglected its public health system with one of the lowest levels of public health funding in the world. The people of India are now paying the highest price—the fragile and weak health system cannot protect or save all those affected by this pandemic and the death toll is soaring. While a massive upscale in government funding for health is urgently needed, in this emergency context immediate rapid deployment of vaccines is essential to reduce suffering and death, alleviate the pressure on the healthcare system and accelerate the re-opening of society. Doing so is not just morally imperative, but time critical. A recent survey by

the People's Vaccine Alliance found that two-thirds of epidemiologists think that we had a year or less before the virus mutates to the extent that the majority of first-generation vaccines are rendered ineffective and new or modified vaccines are required. The WHO has rightly asserted that, "with a fast-moving pandemic, no one is safe, unless everyone is safe". Delaying vaccine access will also only increase inequality and the social and economic costs of the pandemic. The current scarcity of vaccines is artificial and avoidable. Urgent action is needed at the national and global level to address vaccine scarcity and inequality. The support of the US Biden administration for a global waiver on patent protections for COVID-19 vaccines offers hope for addressing vaccine shortages and vaccine inequality globally.

Vaccination is the best and most effective way to protect people and end the pandemic across the world. The People's Vaccine Alliance (PVA), a movement of health and humanitarian organizations, world leaders, health experts and economics, has been calling for COVID-19 vaccines to be made available to everyone free of charge and distributed according to need and not ability to pay. Oxfam is a founding member and strong supporter of the People's Vaccine Alliance.

INDIA'S COVID-19 DOMESTIC VACCINE POLICY

On 16 January 2021, India launched the world's largest COVID-19 vaccination drive. Across its first two phases, the central government introduced free vaccination of frontline workers and those over 45 years of age. The government has highlighted that India has been the fastest to administer 140 million vaccines. On 4 May it had administered 157.75 million doses, only behind US and China in terms of numbers, despite having a relatively weak public health infrastructure. However, while the sheer numbers are high, they are far from what is needed to provide herd immunity.

By 4 May only 2.11% of people in India were fully vaccinated and just 9.32% had received one dose. Despite this low level of coverage, in April, the government announced a "liberalized and accelerated" Phase-3 strategy of COVID-19 vaccination in which the government stepped away from its commitment to free universal vaccination with distribution based on need and risk and announced that everyone over the age of 18 was now eligible for vaccination. While 22 state governments have signalled their intention to vaccinate everyone free of cost, the removal of price controls means affordability of vaccines for the state governments is a grave concern. Vaccine shortages also mean that only six states began vaccination of those above 18 years of age and have done so on a very small scale. Overall rates of vaccination appear to be stalling and shortages are expected to continue until at least July-end. By some estimates, it would take India 2.4 years to cover 75% of its population.

This brief is updated with information as of 5 May 2021 and reviews India's vaccine policy against the central principles of a People's Vaccine.

1. STEPPING AWAY FROM COVID-19 VACCINES FREE OF CHARGE

Vaccines are global public goods, and it is the constitutional responsibility of the Government of India to provide them for free to everyone. Right to Health flows directly from Article 21 (Right to Life) of the Indian Constitution. India's National Vaccine Policy enables access to free vaccination through its Universal Immunization

Program (UIP). For all other national vaccination efforts the funds have come from the centre and have been largely free for India's citizens. India's National Vaccination Policy (2011) requires vaccines to meet UIP goals and follow centrally-procured General Financing Rules (GFR). There is no reason to treat COVID-19 vaccination outside of the vaccination policy framework.

India had initially declared that the vaccine would be free across the country and paid for by the PM CARES Fund and central government funding. The policy was aligned with global evidence that free vaccination is key to success and to the free COVID-19 vaccine policies of other nations including the US, UK, Japan, France, and China. Of huge concern is that the government appears now to be walking back from this commitment. India's Supreme Court has said that India's vaccine policy appears to be "detrimental to right to public health". While the central government will continue to provide vaccines free of charge to those above 45, vaccine manufacturers are now free to sell 50% of their doses outside of central government with states and the private sector now able and encouraged to buy direct. The government has also passed responsibility to state governments to vaccinate those between 18 and 45. The policy has, furthermore, removed price controls on vaccine manufacturers and state governments and the private sector are able to procure and charge for the vaccines.

The 'liberalised' vaccine policy means the government has not placed a cap on the vaccine price that manufacturers can charge either state governments or the private sector. With so few manufacturers supplying vaccines this has created a producer-declared monopoly price. The Serum Institute of India (SII) has fixed prices for its vaccine (Covishield/AstraZeneca) at Rs 300 per dose to states and Rs 600 per dose to hospitals. This is double and triple what the central government has paid until now. Bharat Biotech has priced its vaccine (Covaxin) at Rs 400 per dose for States and Rs. 1200 for private hospitals (this is 2.5 and 8 times what that central government has been paying, respectively). Dr Reddy's (which will distribute the Russian Sputnik V) have not made a formal announcement yet. Sputnik V vaccine is anticipated to cost Rs. 750 per dose and would likely be available from end-May. Pfizer has reportedly also offered the vaccine to India at a not-for-profit price although lack of transparency means this is impossible to verify. The Johnson & Johnson COVID-19 vaccine is expected to be imported by July at an unspecified rate. Even the Swadesh Jagran Manch has described the vaccine rates in the private sector as "exorbitant."

While 22 States have said they will continue to provide vaccines free of charge, the high prices charged by manufacturers raise considerable concerns about the affordability of these commitments when state governments are facing increasing emergency costs associated with the pandemic. Vaccine prices in the private sector would be prohibitively expensive for an even larger portion of the Indian population and significantly discriminate against the poor.

If only the price quoted by the private provider was passed on to the patient, an Indian family with 3 adults will have to pay Rs. 3600 in a private hospital for a full course of the Covishield Vaccine or Rs. 7200 for Covaxin. This amounts to 24% of its monthly income for the former and 48% for the latter, not counting any service charges or other overheads charged by the hospital. For the bottom 20% of households, this burden will be 43% and 86% of their monthly income respectively. For the top 20%, this number will be 12% and 24% of the household monthly income.

The financial burden, as is to be expected, will be significantly higher in rural areas (31% for Covishield) compared to urban areas (16%). A substantial share of India's population is thus potentially priced out of purchasing the vaccine.

2. IT IS NOT BEING PURCHASED AT TRUE COST AND ALLOWS UNDUE PROFIT

The government in its statement to the Supreme Court has justified not setting the cost of the vaccine as aimed towards "creating an incentivised demand for the private vaccine manufacturers in order to instil a competitive market resulting in increased production of vaccines and market driven affordable prices for the same". However, having a single point of vaccine procurement has been recommended by the National Expert Group on Vaccine Administration for COVID-19. It is difficult to understand the advantages of forcing India's states to compete with each other and against private hospitals thus fracturing India's bargaining power and lowering the leverage of bulk, centralised procurement to maximise volume while driving prices down. Indians will in all probability pay more than they should.

Interestingly, the new price of the Covishield vaccine chargeable to states is equivalent to the USD 5.25 that South Africa was charged for the same vaccine. South Africa's price was reported by SII as the Upper Middle Income country rate while India is classified as a lower middle-income country. Meanwhile SII is charging lower middle income Bangladesh USD 4. Oxfam is opposed in any case to such arbitrary tiered pricing, especially for what is supposed to be a 'not for profit' vaccine (see below), but this higher rate for India constitutes a failure on the governments' part to drive down prices for a domestically produced vaccine. The price SII will charge private hospitals has been criticized as being the highest in the world for the AstraZeneca vaccine. SII has issued an unsatisfactory and incomplete explanation for the same; there is a lack of transparency in the fixation of rates for both SII and Bharat Biotech.

While vaccine manufacturers cited the need to recover costs as a reason for hiking the price of the vaccine, their development has actually been the result of substantial investments by the public sector via academic universities, funds from governments and other philanthropy foundations. AstraZeneca vaccine research has been 97% publicly funded. Private Pharma companies also benefitted from prior public research and reduced costs of clinical testing because of more unpaid volunteers for trials. AstraZeneca's agreement with Oxford University was on the condition that it will not profit from sales of its vaccine while coronavirus remains a pandemic. On 30 April 2020 both parties committed to "operate on a not-for-profit basis for the duration of the coronavirus pandemic, with only the costs of production and distribution being covered". This pledge was reiterated in June when it signed its agreement with SII, Coalition for Epidemic Preparedness Innovations (CEPI) and GAVI (Global Alliance for Vaccines and Immunisation) that committed it "to ensure broad and equitable access to Oxford's vaccine across the globe and at no profit". The latest move to raise costs appears to see SII move away from this commitment and raise considerable cause for concern about the failure of AstraZeneca to follow through on its commitment to no profit through its global supply chain.

Even at the initial central government price SII and Bharat Biotech were projected to make a significant 40-50% earnings before taxes as they did not incur significant

research and development costs and given high sales of vaccines. SII has been expected to generate USD 4 billlion in revenue globally through COVID deals. While public criticism of the high prices SII previously announced for state governments forced the company to make a marginal reduction from Rs 400 to Rs 300 per dose, the profitability of even the initial central government price was confirmed by SII's Adar Poonawalla. He said, "Is it still profitable today, on a per dose basis? Yes, absolutely". "…I would not say we are not making any profits, but we have sacrificed what we call super profits," he added. He also said that the SII would be content with normal profits only for "a temporary period". On super profits, he said, "We can always make those profits after a few months." Even based on so-called normal profits SII and its owners personally have made considerable sums.

According to media reports, SII's Cyrus Poonawalla's wealth almost doubled, rising by 85% in the first five months of the pandemic increasing to USD 13.8 billion. His wealth grew the fastest among Indian billionaires and fifth largest in the world during the pandemic based on Hurun Research. SII has clearly been making substantial profits even on the initial central government rates. These profits are only set to increase further now despite the fact that we are in the middle of a record wave of infections and deaths that has devastated the livelihoods of much of India and causing nationwide economic loss.

3. PUTS AN UNFAIR BURDEN ON STATES AND COMPROMISES INDIA'S FEDERALISM

Traditionally, vaccines are acquired by the Centre and distributed among the States. The decision to create two vaccine supply streams—for the centre and the states—marks a deviation from this historic precedent. Instead of using its bargaining power to procure the balance centrally, it has passed the responsibility to the states. The central government's pre-orders appear to be inadequate to cover the population. This will cost India—while early pre-order was priced at 150 per dose, new orders (for both centre and states) will cost twice as much. By making states responsible for the bulk of new procurements, the centre appears to have insulated itself from the resulting price.

Even if one ignores the question of the central government's responsibility for the delayed initial pre-order, this unanticipated massive expense will place a major financial burden on States for which they have not been forewarned and for which they are unsupported. They had less than a fortnight to find the resources, make necessary procurements and put in place modalities of distribution. It has also potentially pitched states against each other chasing scarce vaccine stocks and given manufacturers undue power to set prices and decide who gets to buy. SII's Poonawalla has fled India citing threats from the powerful.

States cannot afford the new costs particularly in the middle of the pandemic with vaccine competing with scarce oxygen and enhancement of the public health infrastructure. Estimates suggest that the total cost of vaccination in India, assuming everybody in the 18-44 age group was to use the state government supply route and use the cheaper Covishield vaccine, would be Rs. 475,658 million, or 26% of the total health spending of the states in 2020-21 as per CMIE data. The current policy of differential pricing for the Centre and States, and pushing the States to the market for its vaccines, would force India's poorer and more populous States to pay relatively

more. Bihar may need to pay Rs. 25,800 million to vaccinate 70% of its population as compared to Rs. 14,890 million to vaccinate Tamil Nadu. While both may need to divert funds from other essential expenditure to deliver free universal vaccination, the tradeoffs are higher for Bihar.

Vaccine allocations to states are also not in proportion of the emerging demand from those under 45 or the quantum of COVID-19 cases. In the absence of detailed government guidelines or framework for price control one can only assume that richer states, which can procure large amounts and those with large networks of private hospitals are likely to receive a higher proportion of doses. States closer to the site of production (potentially having lower transportation costs) may also benefit from cheaper vaccines.

4. RISKS PROMOTING VACCINE INEQUALITY

Failing to put the most vulnerable at the front of the line for COVID-19 vaccines risks exacerbating the gaping wealth, racial and ethnic disparities that have characterized the pandemic. While India has seen many reports of COVID-19 vaccination, this was taken very seriously in other countries. Peru's health and foreign ministers and its former president was placed under criminal investigation after reports of officials receiving vaccine doses before the national immunisation programme began. Argentina's health minister had to resign after reports that he used his connections to get ineligible VIPs vaccinated. The World Bank threatened to pull support for Lebanon's vaccine in the face of MPs receiving the vaccine out of turn. Instances of ineligible people receiving vaccines have been reported in India without concrete action taken.

The new strategy is fundamentally inequitable. As India's Supreme Court noted, "Discrimination cannot be made between different classes of citizens who are similarly circumstanced on the ground that while the Central government will carry the burden of providing free vaccines for the 45 years and above population, the state governments will discharge the responsibility of the 18 to 44 age group on such commercial terms as they may negotiate". The higher prices announced in the private sector incentivise selling to private hospitals over selling to states.

India has until now prioritised vaccination of essential service providers and vulnerable groups for which the central government continues to have responsibility include healthcare workers, frontline workers and those above 45 years. Ensuring a second dose of the vaccine for these groups needs to be prioritised. This list also excludes many vulnerable groups including teachers (critical for ensuring reopening of schools and thus addressing a year's learning loss), banking staff, journalists, migrant workers and those directly involved in the current response (e.g., crematorium workers). Teachers' vaccination is not prioritised despite over 700 teachers dying on election duty in Uttar Pradesh alone. No specific measures have been taken to prioritise vaccination of any of these categories.

India is yet to finish vaccinating the vulnerable. Only 37% of India's 30 million health and frontline workers are fully vaccinated. Only 38% of people over 60 have received even one shot of the vaccine. The expanded vaccination mandate and shortages should not compromise the focus on these groups; India needs a separate queue for booking the second shot to ensure those eligible receive their shots within the

stipulated window of time to prevent wastage of doses. Odisha had to halt immunization in 11 of its 30 districts and Nagaland stopped giving the first vaccine shots in view of vaccine shortages. 18% respondents in a recent rapid survey found they or their close contacts could not obtain the vaccine when they went for booked vaccination in early April. The rationale behind the decision to jump directly to opening vaccination to another 600 million people irrespective of vulnerability and without ensuring adequacy of vaccine supply is unclear.

India does not maintain records of people vaccinated disaggregated by income or social group. It is lagging in immunising its women. So far, 52.18% of those vaccinated are men, while 47.8% are women. About 0.01% of the vaccines have been administered to transpersons.

Vaccine coverage has been highly unequal till now. While some 20% of the population of Himachal Pradesh has received the vaccine, only 4.67% of adjoining Uttar Pradesh received the shot. It is critical to prioritise vaccination in areas with higher COVD-19 prevalence rates and higher shares of vulnerable populations. Even more fine-grained analysis is needed to address emerging vaccination gaps opening among India's districts. It would appear that releases of vaccines to the states are not proportionate to the eligible population or the number of cases and deaths.

India also needs to reconsider the vaccine enrolment strategy. Successful vaccination drives are rooted in detailed district plans and social mobilisation strategies to reach vulnerable communities; these are missing this time around. The near complete reliance on on-line appointments for vaccination without providing for even walk-in facilities tends to exclude those who lack internet access, the elderly living alone, those with disability and populations such as homeless and pavement dwellers and those in institutions. Only 15% rural households have access to the Internet and only 24% of India's population has smartphones. A more targeted bottom-up approach is needed to ensure vaccination nearer to peoples' habitations, especially in high coronavirus prevalence areas. It is also unclear why alternative options of vaccination of the vulnerable, including door to door vaccination, has not been adequately explored. This strategy has been the backbone of India's successful polio vaccination drive and could be explored for the COVID-19 vaccine. Use of mobile vans in remote and underserved locations to deliver vaccines could be explored. Telangana government has been granted permission to conduct experimental drone delivery of the vaccine.

There are inherent risks of exclusion and privacy and safety of data in the proposal of introducing Aadhar-linked face recognition for vaccination. The National Health Authority has been rolling out National Health IDs for all persons who register for the vaccine using their Aadhaar numbers without ensuring adequate informed consent. As has been pointed out, the pandemic is not to stealthily bring in test technologies on the vulnerable, nor should it be used to compromise patients' privacy.

Of course, vaccine inequality prevails not only domestically, but globally. Rich countries with 16% of the world's population have secured 49% of the leading COVID-19 vaccines. Ten countries had so far administered 75% of all vaccinations which the UN Secretary General has described as being "wildly unfair". More concrete steps are needed to address vaccine hoarding by countries in the global north. Of the 383 million doses of COVID-19 vaccines administered globally to date, nearly 50% went to the US, EU, and UK, which together represent only 11% of the world's population. According to Bloomberg, the UK has enough doses under contract for current and future production to cover 340% of its population. By some accounts, Canada has bought more doses per head than anyone else—enough doses to vaccinate every single Canadian five times over. Poorer countries in the global south needs these vaccines, while these countries manifestly do not.

5. IS NON-TRANSPARENT AND DID NOT ALLOW FOR ADEQUATE CITIZEN PARTICIPATION IN DECISION-MAKING

The health ministry has refused to share information about the vaccine expert group, the process of ensuring safety and granting clearance to vaccines. This was also reflected in the opaque decision-making around the new policy. Reports suggest that no other country has allowed open-market sale of vaccines given that they operate under Emergency Use Authorisation (EUA) and have not been fully licensed in their countries of origin. In India, the Drugs Controller General of India (DCGI) has only given emergency authorisation to both Covaxin and Covishield which allows it to only sell to the government; both appear to still lack general marketing approval. Furthermore, the SII also said that the vaccines will eventually be available in "retail and free trade" i.e. in chemist shops, "post 4-5 months". It is unclear whether they have permission to do so.

Concerns have long been voiced about the lack of transparency in the fine print of AstraZeneca's agreement to keep the vaccine not for profit. AstraZeneca's vaccine manufacturing agreements with Indian and Brazilian companies lack transparency about costs. There is no transparency in decision making about how rates are fixed. SII is marketing the same vaccine to GAVI at USD 3 a dose, compared to the upper middle income country rate of USD 5.25 for Indian states and USD 8 for Indian private hospitals. In contrast, the cost of the vaccine is USD 3-4 in the UK and US; this subsidised cost to the global north had been explained as being because these countries had contributed to vaccine development. Poonawalla has also pointed royalty due to AstraZeneca as a reason for him to charge enhanced costs for the vaccine. None of these claims have been substantiated and certainly seem to contradict the global non-profit commitment made by AstraZeneca. Issues of transparency also exist for the home-grown Covaxin; while Bharat Biotech claims to not have received government funding for the development of the vaccine, funding and in-kind support was provided for development of the vaccine and pre-clinical and clinical trials. Countries who have been able to pay upfront have benefitted at the expense of poorer, but more coronavirus-affected countries. The result is that many in India will be paying more than the richest countries of the world despite producing these vaccines domestically.

6. DOING MORE TO ADDRESS ROOT CAUSES OF VACCINE SHORTAGES

SII has stated that vaccine shortages would continue till July and manufacturing capacities were not enhanced due to absence of timely pre-orders by the government of India; reportedly the biggest order was only for 110 million doses adequate for only 4% of the population until new orders were placed by the central government only in late April for another 50 million. The government needs to bring in all available manufacturing capacity to ensure availability of the vaccine. Bringing in new players, however, would entail sharing the intellectual property (IP) of vaccine manufacturers. The US government's recent support for a temporary waiver of intellectual property at the WTO offers one way forward.

The government may consider temporarily allowing Pharma manufacturers to produce generic versions of patented medicines for the larger public good through a mechanism called compulsory licensing. Section 92 of the Indian Patents Act, 1970 empowers the Central government to make a declaration in the Official Gazette which would allow in case of "national emergency" "public heath crises" or "extreme urgency" supply its citizens with generic versions of patented drugs. The pandemic certainly qualifies as a national emergency under section 92 of the Patents Act. Such an arrangement for the COVID-19 vaccine could be cost-effective for the public and remain advantageous for the patentee in the form of license fee.

Brazil's senate recently voted to approve a temporary breach of patents for COVID-19 vaccines, tests and medicines as long as the pandemic lasts. Israel issued a compulsory license to import generic versions of Ritonavir, a coronavirus treatment and Canada amended its Patent act in March 2020 to allow quick issue of compulsory licenses. A compulsory license could bring to bear India's entire vaccine manufacturing capacity, particularly its vaccine making public sector units, to manufacture the vaccine thus augmenting supplies and reducing prices. Compulsory licenses should be accompanied by using all policy and legal tools to insist the vaccine technology and know-how is transferred from existing COVID-19 vaccine manufacturers. Compulsory licenses should be accompanied by measures to insist the technology and know-how is transferred from existing Indian COVID-19 vaccine manufacturers.

The limitations of closed door IP protected bilateral tech transfer partnerships between pharmaceuticals have been demonstrated by the AstraZeneca and Novavax agreements with SII. While a step in the right direction the vaccine originator company retains full control over the supply and can choose to deploy this to meet contractual needs outside of India. This is why non-exclusive licenses and open sharing of technology and know-how are preferable to achieve sustainable and sufficient vaccine access. The Indian government has taken some steps toward improving supply including bringing in Haffkine Bio-Pharmaceutical Corporation to manufacture Covaxin. India has also involved two central public sector units— India Immunologicals Limited and Bharat Immunologics and Biologicals Limited to manufacture Covaxin and discussions are also underway with Panacea Biotec. However, the requirement for availability of necessary infrastructure like Biosafety level-3 production facility will create significant delays in roll out. SII and the Government of India are also considering starting manufacturing Covishield and Covaxin outside India, the latter through a possible arrangement for technology

transfer. All options need to be explored urgently to ensure availability of vaccines for all.

Doing so requires sizeable increases in budget allocations to health given the severe challenges faced by the sector. India's health budget has been the fourth lowest in the world resulting in a vulnerable public health system whose frailty is visible at this time of crisis. India needs to strengthen the public health system to be better prepared for the potential next wave of the pandemic and expenditure on vaccines must be additional to increased investments in the health system itself. A one time 1.6% tax on the net worth of India's 827 billionnaires would be enough to pay for vaccination of everyone 18-45.

INDIA'S POSITION GLOBALLY

India is said to make 60% of the world's vaccines. It has so far shipped 66.3 million doses of COVID-19 vaccines to 95 countries and has contributed 21% of the world's COVID-19 vaccine supply. Under pressure from domestic demand, India has put in place an unofficial temporary hold on exports of the AstraZeneca vaccine and is unlikely to resume "Vaccine Maitri" before July. 35 countries, largely low and lower-income countries, rely on India's vaccines and pre-payments have been made to SII for their delivery which is now expected to be delayed by several months. Ramping up India's vaccine manufacturing is critical not just for India's but the world's fight against coronavirus.

India and South Africa have sought temporary relaxations for IP, patents and other such provisions laid out under the TRIPS Agreement of the WTO to ramp up manufacturing. This is being supported by over 100 low- and middle-income nations, who are calling on the World Trade Organisation (WTO) for a waiver of IP protections on COVID-19 products during the pandemic, a move so far opposed by the pharmaceutical industry and many high-income countries (HICs). Recent developments mean some important shifts with the US government, France and Spain all in support of the waiver at the time of publication.

India's proposal states that IP rights such as patents are obstructing affordable COVID-19 medical products. A temporary lifting of the IPR combined with a commitment to transfer technology and know-how preferably via the World Health Organisation's COVID-19 Technology Access Pool (C-TAP) would allow multiple actors to start production sooner, instead of having manufacturing concentrated in the hands of a small number of patent holders. This would need to be accompanied by addressing trade barriers and export restrictions that prevent the movement of vaccine components and vaccines and ensuring technology transfer to support manufacturing.

The United Nations Secretary General António Guterres said in February, "Vaccine equity is the biggest moral test before the global community" at this time. Temporarily lifting IP rights and doing what it takes to address gross global inequalities in vaccine access is critical for the world today.

WHAT INDIA NEEDS TO DO

Accordingly, we call on the Government of India to take action to ensure a people's vaccine.

Domestically, it must have detailed, time-bound and transparent **COVID-19 Vaccine policy and action plan** arrived at in consultation with the States and India's experts and citizens at large and ensure **transparency in contractual agreements** reached by the government with the Pharma sector. It must ensure:-

- That the vaccine is purchased at low true cost prices and provided free of charge to all
- Large-scale centralised vaccine procurement by the national government at regulated prices which do not financially cripple India's states or pitch them against each other in the quest of scarce life-saving vaccines
- Fair allocation of vaccines which prioritises at-risk groups, is sensitive to the existence of the digital divide and is able to reach the vulnerable where they live and work
- Enhance immediately financial outlays to public health and do what it takes to make the above happen through all possible steps including compulsory licensing of vaccines and ramping up public sector vaccine manufacturing capacity, and strengthen the public health system to be better prepared for the potential next wave of the pandemic

Globally, India needs to continue playing a global leadership role by demanding:-

- Temporary relaxations for Intellectual Property, patents and other such provisions under the TRIPS Agreement of the WTO to ensure free and equitable vaccines for all and including international support for the World Health Organisation's COVID-19 Technology Access Pool (C-TAP) to facilitate the pooling of IP and the transfer of technology to manufacturers in the global south
- Addressing Vaccine Nationalism by rich countries including lifting bans on exports of ingredients for vaccine manufacturing, and
- Redistribution of excess vaccine stocks from the global north

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