

POLICY BRIEF

DELIVERING A PEOPLE'S COVID VACCINE IN INDIA

While the 7 June COVID-19 policy announcement is a step in the right direction, much more needs to be done to ensure access to a People's Vaccine. The new policy maintains the risk of pandemic profiteering by pharmaceutical companies at the cost of people's lives and continues to reserve a quarter of India's vaccine supply for the rich. 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. It must drastically increase the pace of vaccination with vaccines purchased at true cost prices, and distributed equitably prioritising those most at risk first. 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's 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 CONTINUED NEED FOR A PEOPLE'S COVID-19 VACCINE

In April 2021, Oxfam India and the FMES brought out a policy brief that made the case for a People's Vaccine in India. This responded to the announcement of a "liberalised and accelerated" Phase-3 strategy of COVID-19 vaccination. It asked for the vaccine to be distributed free of cost, centrally procured and distributed equitably. We also highlighted the need for a transparent vaccination policy and for the government to do what it takes to make vaccines available including exploring compulsory licensing and enhancing health budgets.

On 7 June, the Prime Minister of India announced several changes in India's vaccination policy, once again committing to centralised procurement of the vaccines, a price cap on sale of vaccines in private hospitals and their free distribution in the public sector to all above the age of 18 from 21 June. A month of implementation of this revised policy later, more needs to be done to deliver on a true People's Vaccine. This brief highlights the asks on vaccination in India using information updated as on 13 July 2021¹.

In terms of the current vaccination status, as on 11 July, India has administered the second highest number of vaccine doses behind China. Despite these impressive numbers, it had only fully vaccinated 5.3% of its population and another 22% are part vaccinated. Only 8 states have fully vaccinated more than 10% of their population, although there are glimmers of hope with Ladakh achieving 100% first dose coverage. Much more is needed to ensure universal vaccination through a People's Vaccine. The brief highlights some of the challenges of ensuring vaccination and draws some recommendations.

¹ This document draws on the earlier version of this brief "A People's Covid-19 Vaccine In India: No One Is Safe Until Everyone Is Safe" accessible [here](#).

INDIA'S DOMESTIC VACCINE POLICY

1. Opaque Vaccine Policy that Lacks Space for Adequate Citizen Participation in Decision-Making

India continues to lack a comprehensive vaccination policy that addresses all dimensions of the vaccination process. Vaccine announcements have been piecemeal through press releases or in response to court orders. The health ministry has refused to share information about the vaccine expert group and the process of ensuring safety and granting clearance to vaccines. Agreements with vaccine manufacturers have likewise not been disclosed. Contradictory statements have been made on issues like vaccine procurement information. The fight against the coronavirus has been hampered by absence of key data pertaining to vaccination including granular data on vaccine coverage (disaggregated by wealth quintile, social groups such as Scheduled Castes, Scheduled Tribes, Particularly Vulnerable Tribal Groups, Muslims, persons with disability and transgenders), efficiency and financial transparency. This has forced scientists to make representations to the Centre and file court petitions asking for government vaccine data. The National Health Authority has rolled out National Health IDs and the use of facial recognition for all persons who register for the vaccine using their Aadhaar numbers without ensuring adequate informed consent. Absence of credible independent information has pushed people to search the internet for answers, making them vulnerable to fake news.

As India prepares for the third wave, it is critical to prepare the public health system. Doing so requires sizeable increases in budget allocations to health given that India's health budget has been the fourth lowest in the world. The Indian Council of Medical Research (ICMR) had estimated that Rs 25,534 billion or 6.2% of GDP is needed to fight the COVID-19 pandemic in India. The 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 billionaires would be enough to pay for vaccination of everyone 18-45. This would be preferable to current plan of partly funding free vaccines from asset sales.

2. Emerging Vaccine Inequality

Vaccine availability has not been equal for Indians living in its various states and union territories. On average, richer states with a more educated population have vaccinated a larger percentage of their population. Only 1.75% in Bihar, 1.82% in Uttar Pradesh, 2.5% in Jharkhand, 3.26% in Assam, 4.37% in Chhattisgarh and 4.23% in Odisha are fully vaccinated. By mid-May, 30.3% of India's urban population had received at least one dose of the vaccine compared to 19.2% in semi-urban areas, 15.1% in semi-rural areas and just 12.7% in rural areas. This aggravates the risks for a third wave given that nearly 60% hospitals, 80% doctors, and 75% medical facilities are situated in urban areas. In May and June, rural areas having 65% of the population received only 51% of vaccine doses. While criteria for allocation of vaccines to states are known, the specific formula for allocations has not been shared leading to several states alleging unfairness in allocations made to their states.

India does not maintain records of people vaccinated disaggregated by income or social group which would be critical to tailoring strategies to the specific population needs. The IANS-Cvoter COVID tracker survey suggests Scheduled Tribes have got the highest number of both shots of the COVID Vaccine while Dalits and Muslims come at the bottom of the list. COVID-19 vaccination per million population in tribal districts is higher than the national average, with 128 out of 176 tribal districts performing better than all India vaccination coverage, witnessing more walk-ins and a better gender ratio for those vaccinated. Only 21.3% of Delhi's Informal workers have received the first dose of the vaccine. Issues remain with enrollment of other vulnerable groups like the mentally ill or those lacking a legal guardian; the Supreme Court has questioned whether allocations to States take into account migration patterns.

India has vaccinated 17% more men than women and the gap is widening. In one analysis, more men were vaccinated in 620 of the 729 districts. Challenges to women's immunisation include misinformation about impact on women's health, mobility challenges and limited online access. As of 30 June, transpersons accounted for 0.01% of those vaccinated, covering 11.45% of the total transgender population; the share of those fully immunised is not known.

Vaccine rollout should continue to prioritize those most at risk of severe outcomes of infection; the ICMR has estimated that vaccinating priority groups could reduce COVID incidence by 20.6% and deaths by 29.7%. The Centre has prioritised vaccination of healthcare workers, frontline workers, citizens over 45 years of age, and citizens due for their second dose. However, only 56% of healthcare workers are fully vaccinated and 47% of frontline workers have been fully vaccinated. Guidelines for frontline workers needs to be expanded to include teachers (critical for ensuring reopening of schools), banking staff, journalists, caregivers of persons with disabilities, domestic workers and other relevant categories. Only 43% of those above 60 years and 37% of those above 45 years have received both shots of the vaccine; end June saw a 75% fall in average vaccination rates of those above 60 years since the peak in March. 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 characterised the pandemic.

In this context, it is critical to examine the decision to set aside a quarter of vaccine doses for sale in private hospitals. An Indian family with 3 adults will have to pay INR 3600 in a private hospital for a full course of the Covishield vaccine or INR 7200 for Covaxin. This amounts to 24% of their monthly income for the former and 48% for the latter. For the bottom 20% of households, this burden will be 43% and 86% of their monthly income respectively. Thus, only the rich can really afford these rates.

While India has effectively legitimised the rich jumping the COVID-19 vaccination line, this was taken very seriously in other countries. Peru's health and foreign ministers and its former president were placed under criminal investigation after reports of officials receiving vaccine doses before the national immunisation programme began surfaced. Argentina's health minister had to resign after reports that he used his connections to get ineligible VIPs vaccinated. The World Bank threatened to withdraw support for Lebanon's vaccine in the face of MPs receiving the vaccine out of turn. Setting aside a quarter of India's vaccines for the rich at a time of shortages compromises the focus on these groups.

An implication of only 75% of the population receiving a free vaccine is that the remaining population, 240 million people, can afford to pay for the vaccine at the stipulated rate. Estimates suggest that post-pandemic 2 million in India are in the high income category, 16 in the upper-middle income and 66 in the middle income category. This reservation, therefore, will not only promote inequality, but contribute to vaccine shortages.

Private hospitals are, furthermore, not distributed equally in the country. Several states including Rajasthan, Chhattisgarh, Kerala, Odisha, Tamil Nadu and Jharkhand have urged the centre to reduce the share of vaccines delivered in private hospitals to avoid exacerbating vaccine shortages. Odisha and Jharkhand have asked for a cap of 5% mirroring the share of the private healthcare sector; Chhattisgarh and TN have asked for a 10% cap to mirror the number of doses currently administered. Rajasthan has asked for all vaccines to be given to the state government as per need. A case has also been filed in the Supreme Court challenging this decision. Private hospitals delivered only 7.5% of doses in May; the public sector provided over 95% of all vaccines in almost 80% of districts and their share was less than 1% in half of the districts. 80% of doses administered in the private sector in May were distributed in Delhi NCR, Mumbai Metro, Bengaluru and Hyderabad alone; 50% of vaccine doses were monopolised by only nine hospital chains. Five states that are home to 27% of India's population accounted for 75% of the private vaccine doses administered.

Equity issues prevail in states with a high share of private hospitals. One analysis of data for Delhi showed that it had more sites and slots of free vaccines but most of these lacked doses. When slots became available, these were available only briefly on the day preceding their delivery. In contrast, 74% of the doses available on CoWIN were for paid doses which were also available days in advance. While 15.9% free sites had doses available, 89% of paid sites had vaccines. For Delhi's poor, the chance of finding a free vaccine could be as low as 2%. This shortage has in turn resulted in a cottage industry of telegram groups, bots and apps to aid the more tech-savvy and financially better off to find elusive free vaccine slots. The wealth and digital divide continues being a vaccine divide, despite the opening up of the option for walk in registration.

3. Need To Strengthen Planning And Delivery Of Vaccination And Lay Down Clear Accountability Mechanisms

Amidst a complex and rapidly changing vaccination guidelines, it is essential to lay down clear lines of accountability. Several breaches of government guidelines for vaccination have been reported including mixing of doses and non-adherence with distancing guidelines at vaccination sites. It is critical to strengthen training of frontline staff and improve monitoring of delivery. The government needs to remove barriers in the form of distance, technology, and convenience that delay vaccination. Robust district-level planning and platforms for collaborative learning of district administration and health workers to support vaccination are critical. Spatial targeting may be needed by prioritising vaccination in areas adjoining pockets of high infection to prevent spread; trends of PCR and rapid antigen tests from sentinel sites can be used to provide alerts for upcoming outbreaks, allowing vaccines to be deployed responsively to those areas.

A more targeted bottom-up approach is needed to ensure vaccination nearer to people's habitations, especially in high coronavirus prevalence areas is desirable. Walk-in vaccinations have been behind the relatively high vaccination rates seen in tribal areas and the decision to open this option for everyone should enhance vaccination. Reliance on facilitators such as health workers or ASHAs and enhancing on-site registration and vaccination would help address hesitancy. Using existing listings of eligible persons like electoral rolls or other records could also facilitate saturation of vaccination coverage. One may need to reconsider the timing of the vaccination which is open between 9-5 PM, which means India's informal workers have to lose a day's wage to get vaccinated.

Enhancing capacities of India's 150,000 sub-centres lies at the heart of the solution of successful vaccination in rural areas. This involves enhancing availability of trained personnel, enhancing cold-chain and transportation facilities to support outreach to adjoining areas with the vaccine. However, this needs to be extended to more populations and vaccination taken closer to people's habitations. Vaccination camps should be held within the village, given that even primary and community health centres are 15-30 km away from many villages. A good start has been made by providing near to home vaccination centres for persons with disabilities and the elderly. Use of mobile vans in remote and under-served locations to deliver vaccines could be explored; use of boats for delivering vaccines in remote areas has been done in West Bengal and Bihar. Kolkata is piloting a home-based vaccination programme for the elderly, infirm and terminally ill who are unable to go outside their homes to get vaccinated; Maharashtra is proposing a similar pilot. These could be scaled to other locations.

WHO currently does not recommend vaccination for children below 16 years of age, but tests of vaccine candidates is underway and India is expected to start vaccination of 12-18 year old children by September or October with the Zydus vaccine. It is time to start planning for vaccination given the scale of the task (40% of the population is under 18 years of age) and more strenuous cold chain requirements of this vaccine. Until then the best option to prevent paediatric COVID is to vaccinate parents and other contacts.

Oversight is needed over private vaccination centres. Clear standard operating procedures are needed for setting up outreach vaccination centres being run by private hospitals. There have been reports of overcharging in private hospitals causing the government to introduce a price cap of INR 150 as service charge over and above the manufacturer's cost. A recent survey found that 23% citizens paid more than INR 1000 for a single dose and 3% paid more than INR 2000. 73% citizens wanted private hospital service charges to be capped while 79% citizens want state governments to prohibit private hospitals from levying a registration fee for COVID vaccine. The government has acceded to these peoples wishes, but it would be critical to track conformity with this provision.

4. Addressing Vaccine Hesitancy And Dealing With Misinformation

According to the latest IANS-CVoter COVID Tracker, 80% of India's citizens support vaccination, almost 10% higher than the sentiment in the USA. A survey held in May showed that 60% of those in rural towns reporting being unable to take the vaccine despite being willing to do so; 63% did not know how to register on the CoWin app and 42% felt the centres were too far away. Improving mechanics of vaccine delivery should improve vaccine uptake.

In another urban survey, 24% of those who are yet to be vaccinated stated that they were not convinced that currently available vaccines provide enough protection from the latest and future variants and would rather wait until different vaccines become available. Delays in making Covaxin phase 3 trial data available and dismissing requests for information as unpatriotic may have contributed to negative views of vaccination. Another 23% respondents felt that a prevailing medical condition prevents them from taking the vaccine while another 12% said they don't plan to take a shot yet amid concerns over side effects. Enhancing flow of medical information about vaccine side effects and contra-indications would be important.

Vaccine hesitancy has also been fed by misinformation and rumours. In many instances, this is caused by a deep-rooted mistrust in the state combined with religious fatalism that has increased in the wake of the pandemic. In others, rumours have flourished in the absence of credible information. Making information accessible and more transparent decision-making would help to allay suspicions. A clear campaign against misinformation is also needed. Communication in local, particularly tribal, languages is key to create spread awareness of the vaccine and create demand for vaccination. More conventional campaign like TV spots could be explored.

It is critical to avoid invoking coercive measures to promote vaccination which would be counter-productive in the long run. Meghalaya's High Court has held that mandating vaccination as a condition for resuming one's business violates the fundamental rights as mandated under Article 19(1)(g) of the Constitution (Right to earn livelihood). In Uttar Pradesh, people reportedly have been threatened that their ration and MGNREGA wages will be withheld if they don't take the vaccine. Local political leaders, religious leaders and community elders could be involved in vaccination drives to build trust and serve as champions for vaccination. Steps to address misinformation about vaccination are also key. The National Media Rapid Response Cell (NMRRC) set up under the COVID-19 vaccine communication strategy needs to alert district collectors across India about vaccine fake news in real time. Governments can rope in celebrities, community leaders and mass influencers to generate credible voices for vaccination.

5. Failure To Prioritize Public Sector Production

India started its vaccination drive late; it only placed its first orders for 11 million doses in January. It aims to reach universal COVID-19 vaccination by end 2021 which calls for a procurement cum manufacturing target of 2 billion doses by end 2021. It has augmented its manufacturing capacity, allowed import of foreign vaccines and made pre-orders to meet this target. In May, the government projected the vaccine availability to be 2.16 billion doses; this has now been reduced to 1.35 billion in its June affidavit to the Supreme Court. This leaves India with a minimum deficit of 470 million to complete vaccination in the coming 180 days.

However, only 3 of 5 vaccines under production are currently approved for use (among the rest 2 are in early stage trials and 3 in late-stage trials) and there is no guarantee that India's bet on these new vaccines will pay off. Furthermore, the production numbers are more optimistic than the manufacturers' own estimates, suggesting India is overestimating its capacity. Not all vaccines produced in India will also be available for Indians considering Serum Institute of India's (SII) obligations to make vaccines available internationally. Lastly, manufacturers have begun researching the need for a third booster shot that could also focus on new variants which may further draw on manufacturing capacity. There are also grounds to think that the projected supply of Covaxin may be overestimated. Bharat Biotech has only supplied about 40 million doses in the last five months and will need to escalate its supplies by nearly nine times to fulfil the entire order of 480 million doses over the next six months.

Given the above it is unlikely that India will meet the manufacturing targets. The government, therefore, needs to augment manufacturing capacity by bringing in new players. India has almost two dozen vaccine production units and both the public and private sector have units that can potentially contribute to the expansion of local vaccine production. In the beginning of 2000s, 80% of India's vaccines for the Universal Immunisation Programme were sourced from the public sector. Today, 90% are sourced from the private sector at a higher cost.

The Integrated Vaccine Complex in Chengelpet, TN has the capacity to supply 585 million doses per year but while the construction and installation of labs was done in 2017, no vaccine production has taken place in the complex till now. This 904 crore unit needs another cash influx of INR 1500 million to start vaccine production. India has 12 public sector Pharma companies that, with support, could be brought in to augment manufacturing capacity.

This would entail sharing the intellectual property (IP) of the existing set of vaccine manufacturers thus augmenting supplies and reducing prices. Brazil's senate recently voted to approve a temporary breach of patents for COVID-19 vaccines, tests and medicines for the duration of the pandemic. Similar measures may be considered to be domestically given; Section 92 of the Indian Patents Act, 1970 empowers the Central government in case of "national emergency" "public health crises" or "extreme urgency" supply its citizens with generic versions of patented drugs. The Indian Council for Medical Research (ICMR), the government's medical research arm, holds the intellectual property jointly with Bharat Biotech (BB) and is entitled to a 5% royalty on Covaxin sales. ICMR's contract with BB is "not close-ended, it is open-ended in terms of sharing of technology. So, we are free to share the know-how with other companies." Such a compulsory license 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.

6. Failure To Address Pandemic Profiteering By Vaccine Manufacturers

The new vaccine policy caps the costs of the vaccine at the point of sale in the private sector, but fails to address the core problem of the price of the vaccine at the point of manufacturing. India intends to renegotiate the cost of the vaccine offering some scope for change.

The basis of fixation of the vaccine costs have not been disclosed or explained, particularly Covaxin. Reports suggest that this may have been derived from "the cost of hospitalisation due to COVID-19, which comes to the tune of Rs 5 lakh, the cost to the economy due to the pandemic and the future scope for innovation" along with the R&D costs. If so, the price is based on notional "value to patient" instead of true manufacturing costs. A recent report argued that the estimated production cost of a COVID-19 vaccine in India ranges between INR 30 and INR 80 per dose providing for a profit of 188% to 500% per dose at the central government rate; the margins rise to 1500% to 4000% per dose at the private hospital rate. When BB launched its vaccine, they promised that a bottle of water will "cost five times more than our vaccine"; instead, its private sector rate makes it the third most expensive vaccine in the world. Some experts estimate it should cost INR 40 per shot; others compare it with the costs of manufacturing the rabies vaccine which uses technology similar to that of Covaxin which is sold at INR 200 per dose.

Vaccines have relied on substantial investments by the public sector in India and globally. Private pharma companies benefited from prior public research and reduced costs of clinical testing because of more unpaid volunteers for trials. BB received funding and in-kind support for development of the vaccine and pre-clinical and clinical trials. Covishield is the Indian version of the AstraZeneca vaccine which was 97% publicly-funded. 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.

In 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 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". SII is now failing to live up to this contractual obligation. AstraZeneca has failed to follow through on its commitment to not profit throughout its global supply chain. It is time India ensured transparency in the agreement reached with vaccine manufacturers by making agreements reached public.

While much of India has been suffering from unprecedented loss of earning and a historic drop in GDP, SII and BB were projected to make a significant 40-50% earnings before taxes. SII's Adar Poonawalla confirmed that SII made moderate profits at the central government rate, but would only be content with normal profits 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. SII has been expected to generate USD 4 billion in revenue globally through COVID deals. It earned the highest profit among Indian companies in 2019-20 earning a net profit of 41.3% making it India's most profitable company. SII's Cyrus Poonawalla's personal 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.

INDIA'S POSITION GLOBALLY

Rich countries with 16% of the world's population have secured 49% of the leading COVID-19 vaccines. Ten countries had 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 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.

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 a hold on exports of the AstraZeneca vaccine and is unlikely to resume "Vaccine *Maitri*" until domestic demand eases. However, 35 countries, largely low and lower-income countries, have relied on India's vaccines and pre-payments have been made to SII for their delivery which are being 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 largely 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 have seen some important shifts with the US, France and Spain coming out in support of the waiver. 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 needs 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.

The central government must immediately—

- put in place a detailed, time-bound and transparent COVID-19 Vaccine policy and action plan arrived at in consultation with the States, experts and citizens at large and ensure transparency in contractual agreements reached by the government with the Pharma sector;
- roll back the compulsory reservation of 25% vaccines for private hospitals; vaccine allocation to private hospitals should never exceed their share in private health sector in a state

It must also at the earliest—

- ensure that the vaccine is purchased at low true cost prices by controlling profiteering by vaccine manufacturers;
- ensure vaccine availability including ramping up public sector vaccine manufacturing capacity including through compulsory licensing of vaccines;
- strengthen the public health system to be better prepared for the potential next wave of the pandemic

State governments must ensure

- fair allocation of vaccines that prioritises at-risk groups and addresses inequalities in access between various districts, genders and urban-rural differences;
- development of district-level plans that promote decentralised vaccination, involvement of local influentials, promotion of on-site registration and outreach to the most vulnerable where they live and work;
- roll out of clear communication cum outreach strategies to address vaccine-related hesitancy and myths, particularly in local languages;
- timing of the vaccination do not conflict with working hours by keeping centres open beyond 9-5 PM to enable India's informal workers to get vaccinated;
- that coercive modes of promoting vaccination are avoided;
- rope in celebrities, community leaders and mass influencers to generate credible voices in support of vaccination;
- expansion of the list of frontline workers to include teachers, domestic workers and those working in medical and grocery stores;
- that price caps on vaccines in private hospitals are enforced

District administrations must ensure

- setting up vaccination camps at the Panchayat level, enhancing on-site registration and reach the vulnerable where they live and work;
- steps to track and address inequalities in access between various blocks, gram panchayats, genders and locations in their jurisdiction and ensure targeted outreach to these populations;
- implementation of awareness campaigns through use of on-ground outreach, radio and IVRS to reduce vaccine hesitancy, particularly using regional languages/dialects;
- ensure that access to vaccination is unconditional (without any required documentation) in line with existing guidelines in the affidavit sent by the government to Supreme Court;
- enforcement of price caps set by the central government for private hospitals;
- no coercive measures are taken for vaccination

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

- Temporary relaxations for IP, 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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