SDGHI Perspectives Essay Series - **COVID-19 A Year Later**

Vaccines in Southeast Asia

Leaving no one behind: Imperatives for Equity and Solidarity in COVID-19 vaccination programs

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April 2021

Situation in the Philippines

The Philippines has ostensibly the longest lockdown in the world [1] (day 393 [2] as of 11 April 2021) and grim milestones (28th and 29th globally for cases and deaths [3], respectively) have been reported. In my hometown, about 65 km south of Manila, the situation is not much better as town officials continue to report new cases daily, some recoveries and sadly several deaths (including a few in my own *barangay* or village).

Morbidity and mortality as well as transmission of COVID-19 can be reduced by consistently adhering to the correct implementation of mandated public health practices that include using a face mask *plus* face shield especially in public places, hand hygiene, physical distancing, limited time of interaction with persons residing in other houses and ensuring good ventilation [4, 5, 6]. In a country with weak health system capacities (too few health facilities with adequate laboratory capacity; insufficient number of adequately compensated health-related human resources; inefficient systems and infrastructure; lack of supplies and equipment, etc.) providing effective, affordable and accessible services for testing, tracing, isolation, treatment and care has become extremely challenging [7, 8]. It is important to note that the Philippines supplies health human resources to other countries including Singapore [9, 10]. Vaccines against COVID-19 offer protection to a certain extent but are not a substitute for the consistent use of other public health measures. Lockdowns with varying levels and kinds of restrictions have been imposed by government authorities [11] supposedly to protect the health and well-being of the Filipino people, but these lockdowns have sometimes unfortunately resulted in violence [12, 13].

Amidst the rise of cases in some other countries, the WHO Representative to the Philippines said on 19 March 2021 that the Philippines has "a very complex scenario" [14] and hypothesised that the surge may be due to (among others) the presence of COVID-19 variants [15]and so-called "vaccine optimism". Such vaccine optimism "may have led to lower compliance with health protocols resulting in more infections" [14] despite the currently very limited vaccine rollout in the country. As of 20 April 2021, seven weeks since the start of the program, 76% (1,353,107 administered 1st doses) and 12% (209,456 administered 2nd doses) of the total 1,780,400 available doses have already been administered for a total of 1,562,563 administered doses [16]. Similar observations around vaccine optimism were previously reported in the US and UK, where citizens became less cautious of their social behaviours as COVID-19 vaccination coverage increased [17, 18, 19].

Mann's [20] description of the AIDS epidemic as "3 distinct yet intertwined global epidemics" can be applied to the COVID-19 pandemic, wherein the first epidemic is of SARS-CoV-2 (the viral infection itself). Inexorably following the first, the second epidemic is that of the disease COVID-19 itself and the third epidemic includes the social, cultural, economic and political reactions to COVID-19. The pandemic and how individuals, families, communities, organisations and countries have responded to

it have sparked a worldwide catastrophe that stretches past 'mere' health effects to all facets of life. The impact of COVID-19 has aggravated inequalities particularly for groups who were already marginalised and excluded before the pandemic. The Social Weather Survey reported that the average joblessness rate in the Philippines for 2020 was a record high of 37.4% compared to 19.8% in 2019 [21] and the average hunger rate for 2020 was also a record high at 21.1% and double the average of 9.3% for 2019 [22].

The imperative for health equity and the need for solidarity

The World Health Organization has defined ***health equity*** as the "absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically" [23]. West-Oram and Buyx [24] defined ***solidarity*** as an "enacted commitment" to help other people with whom you recognise similarities even if such assistance entails bearing costs. The authors argued that evolving health threats (e.g., anthropogenic climate change, antibiotic resistance) could spur global solidarity, foster cooperation and establish global health infrastructures to address such threats together.

The equitable allocation of the COVID-19 vaccine is prefaced on present evidence of COVID-19 - transmission, susceptibility, risks of severe disease or death. In the Philippines, vaccination has been prioritised by groups starting from frontline workers, senior citizens, persons with co-morbidities, frontline personnel in essential sectors including uniformed personnel, indigent population in category A; teachers, social workers, government workers, essential workers, overseas Filipino workers and the remaining workforce in category B; and the rest of the Filipino population in category C [25]. However, there have been reports of privileged access [26] and what IBON Foundation has termed as "vaccine missteps" in procurement, budget, competition for vaccine supplies and lack of confidence in the government's vaccination program [27].

Current public health and clinical policies and recommendations at all levels from global to local must be flexible and updated amidst the availability of new evidence and shifting realities to address the imperatives of solidarity and equity.

UN Secretary-General António Guterres' has declared that "A COVID-19 vaccine must be seen as a global public good, a people's vaccine" [28]. In an increasingly interconnected and theoretically 'smaller and more similar world', the acute global shortage of COVID-19 vaccines has been exacerbated by vaccine nationalism and vaccine hoarding with wealthier nations pre-buying nearly three times more vaccines than they need to cover their entire populations [29]. Will the phrase "*No one is safe, until everyone is safe*" just remain as an exhortation or slogan?

Health is a fundamental human right. People and groups who experience health inequities lack political, social and economic power. Interventions such as vaccination programs need to be effective and sustainable and, thus, access to vaccines alone is insufficient, especially when vaccine confidence is generally low. Policies for COVID-19 should be based on transdisciplinary and evidence-based science and good public health. Sociocultural and behavioural realities, working together and communicating with each other are integral to a holistic response to the challenges of the pandemic. The so-called 'new normal' is not normal. We need to pivot our responses (priorities, policies, interventions, actions, behaviours) so that we can transition to what hopefully will be a '*Better Everyday*' in a just and humane society. Systemic changes (e.g., policy reform, changes in economic or social relationships) are imperative to help empower marginalised groups and ensure that **no one is left behind!**

About the author

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Professor Nina T. Castillo-Carandang is a Health Social Scientist and Professor at the Department of Clinical Epidemiology in the College of Medicine at the University of the Philippines Manila. Her career as a sociologist in the University of the Philippines began in the agricultural sciences campus (Los Baños) before she joined the health sciences campus (Manila) and went into the fields of health social science, clinical epidemiology and global health. Her current work looks at different facets of quality of life and the Filipinos' search for *Kagalingan* (well-being, happiness, and health). She has also been a Cross-Cultural/Diversity and Human Resources Development Consultant for various organisations. She has a Bachelor of Arts degree in Sociology (University of the Philippines Los Baños), a Master of Arts degree in Sociology (Ateneo de Manila University) and a Master of Science in Clinical Epidemiology (McMaster University). Her PhD in Social Sciences and Global Health was from the University of Amsterdam. Nina is currently a member of the WHO Social Science Working Group for COVID-19 and the National Technical Advisory Group (NITAG) for COVID-19 Vaccines.

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