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Viewpoints

Vaccine equity or health equity?

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Low rates of COVID-19 vaccination in the countries of sub-Saharan Africa have dominated many discussions around the African pandemic response, prompting calls for 'vaccine equity', understood as equal access to and uptake of COVID-19 vaccines. The World Health Organisation (WHO) has characterised this through the catch-phrase "No one is safe (from COVID-19) until everyone is safe"[1] (a nonsense statement as it implies that the immune, through vaccination or infection, are still not safe). In response, by January 2022, an unprecedented mobilisation of international, private and public funders have galvanised commitments of $13 billion for COVAX, the primary COVID-19 funding vehicle.[2] In context, this is over four times the annual WHO budget.[3]

However, investing far more in COVID-19 vaccination than any other disease (i.e. diverting resources), for a mass vaccination campaign of unprecedented breadth and rapidity, is a high-risk strategy.[4] In low- and middle-income countries, diseases such as malaria, tuberculosis and HIV/AIDS affect younger populations, and their burdens are greater, and growing.[5] Sub-Saharan Africa has a young population, as 50% are below 19 years of age,[6] and known comorbidities (obesity, hypertension, diabetes mellitus) are relatively infrequent, reducing vulnerability to severe forms of COVID-19.[7] Further, naturally-acquired immunity following infection is high in the African region,[8-10] greatly limiting potential vaccine benefit. Data indicates that vaccine efficacy is also time-limited,[11-13] especially regarding the arrival of new variants.[14,15] Beyond vaccine cost, their deployment will weigh heavily on resource-limited health systems. It is not easy to see such resource allocation being repeated indefinitely for boosters. These concerns raise questions regarding the legitimacy of the two justifications for mass vaccination in these populations, 'equity' and protection of others.

'Equity' is a crucial objective of public health policies. It addresses the causes of health inequalities or disparities that are avoidable, unnecessary, and unjust.[16] It means fairness or justice in the way people are treated, *depending on their respective needs and preferences*. This does not mean equal access to a specific pharmaceutical, but equal opportunity for a healthy and long life. To an African newborn, teenager or young mother, this may mean completing the full childhood vaccine schedule, anti-malaria therapy or birthing support. To an elderly diabetic Westerner, this may mean equal access to COVID-19 vaccination.[17] Vaccinating an African COVID-immune teenager at the cost of resources otherwise available for malaria or tuberculosis for the sake of 'equity' with triple-dosed senior Westerners is not true equity. It is diverting resources from services promoting equity, and reducing access to appropriate care, without even significantly inhibiting transmission to others.[18] Focusing on 'equity' in vaccine distribution, while needs are so vastly different, will promote inequality in the short run. It also does nothing to build resilient health systems and promote universal access to essential health services over the longer term,[19,20] despite frequent rhetoric to the contrary.

Therefore, we plead for a re-think of COVAX and mass COVID-19 vaccination in low- and middle-income populations, especially in the sub-Saharan African context. Indeed, equity is vital in public health and must be defined in terms of the health needs of each population, community, and individual, not as a one-size-fits-all blanket approach to healthcare. In becoming caught up in such a misinterpretation of the term, the humanitarian community risks doing great harm to those at the highest health risk and increasing existing health inequalities. Mass-vaccinating young Africans against COVID-19 will not address the growing disease burdens resulting from earlier lockdowns, rising child marriage, or growing poverty. On the contrary, targeting COVID-19 vaccination to those genuinely at risk (immunosuppressed, elderly and uninfected individuals with comorbidities) and transforming the vaccine pledges to 'equality' cash commitments to finance these populations' real priorities – including strengthening primary healthcare capacities and systems to enable universal health coverage of essential health services, based on a local appreciation of what those essential services are – would comprise real equity and sustainability. Respecting and responding to local priorities would address the growing appearance of neo-colonialism and paternalism that a forced external 'solution' blind to regional need inevitably presents.

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CONTRIBUTIONS

Both authors participated in all stages of the manuscript preparation, provided critical feedback on the manuscript and have agreed to be accountable for all aspects of the work

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