VACCINE ROLLOUT IN MALAWI

A PROGRAMME REVIEW

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COMPILED BY FOR EQUALITY WITH SUPPORT FROM THE COMMONWEALTH FOUNDATION

ABOUT THE PROGRAMME REVIEW

This Programme review seeks to provide an overview and analysis of the vaccine rollout in Malawi. Africa's largest-ever vaccination drive is well under way. All but one of Africa's 54 nations are rolling out COVID-19 vaccines and around 250 million doses have been given on the continent. Yet just 3% of the almost 8 billion doses given globally have been administered in Africa, and only around 8% of Africans are fully vaccinated, compared with more than 60% in many high-income countries.
Malawi rolled out the first phase of vaccination, targeting 20% of the eligible population, in March 2021. Malawi has administered at least 1,840,646 doses of COVID vaccines so far. Assuming every person needs 2 doses, that's enough to have vaccinated about 4.9% of the country's population. (Reuters, 2022) By November 2021, only appr. 6% of the population had received at least one dose and about 3% had been fully vaccinated.

This programme review falls under the Strengthening Protection-Cluster capacities for Policy and Programmes Review Project.
For Equality, with support from the Commonwealth Foundation, launched a series of interventions on Strengthening Protection-Cluster capacities for Policy and Programmes review.
The project comes at an opportune time when the need for gender responsiveness, accountability and transparency in COVID-19 funds usage and vaccine rollout programmes, has emerged as the key strategic issue.

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CONTEXTUAL BACKGROUND

Malawi declared a state of national disaster due to the COVID-19 pandemic on 20th March 2020 and registered its first confirmed coronavirus case on 2 April 2020. Through the review of policy documents from the Public Health Institute of Malawi, the Malawi Gazette, the Malawi Ministry of Health and Population, and the University of Oxford Coronavirus Government Response Tracker, it was clear that the Malawi response to the COVID-19 pandemic was multisectoral and implemented through 15 focused working groups termed clusters. Each cluster was charged with providing policy direction in their own area of focus. All clusters then fed into one central committee for major decisions and reporting to head of state.

By 1 January 2021, Malawi was experiencing a second wave of infections, and additional restrictions were placed on the population. Schools and workplaces were closed in many districts; large gatherings and public events were banned, but a full lockdown has been prohibited due to concerns around the implications on vulnerable populations. The impact of NPI on SARS-CoV-2 transmission in Malawi depends critically on the local context such as population behavior (including uptake of and compliance with such measures), population movement, and contact patterns (Malawi is over 80% rural and many rely on subsistence farming) and health system capacity.

The current COVID-19 pandemic has laid bare the structural inequalities and injustices that are deeply embedded in our social, economic, and political systems that were built from the exploitation of the world's poor and marginalized, especially women, girls, and LGBTQIA+ peoples. In many ways, the pandemic is unlike any crisis that has been experienced by the world before. It has so far upended economies, changing and disrupting social and mobility patterns and networks, breaking the dichotomy of formal and informal labor and redefining the concept of care work, essential work and who performs it.

In many instances, the patriarchal and gendered norms at home, at work, and in public spaces are being reinforced, evidenced by everything from the surge of domestic violence to the loss of income and livelihood of women who are often hired in casual, contractual, and short-term employment and the increase in women's burden of unpaid care work. It is likely that the economic, health, environmental, and social impact of this crisis will be felt for years to come.

Further to the inequalities and injustices spotlighted by the onset of the pandemic globally, the introduction of the vaccine has brought an added array of inequalities and gaps. While the hasty development of the vaccines speaks to humanity's ability to adapt to threats to our livelihood, the global distribution speaks to the great structural inequalities and injustices, between the rich and poor.

A comparison of the vaccine uptake in the rich countries and poor countries showed that approximately 60% of the population in higher-income countries had received at least one dose of a vaccine whereas only 1% of the population in lower-income countries had received a vaccine dose, by August 2021.

GLOBAL VACCINE ROLLOUT

G20 countries received 15 times more COVID-19 vaccine doses per capita than countries in sub-Saharan Africa, according to an analysis conducted by science analytics company Airfinity. This analysis exposed the severity of vaccine inequity between high-income and low-income countries, especially in Africa.

It found that doses delivered to G20 countries per capita are:

- 15 times higher than doses delivered per capita to sub-Saharan African countries;
- 15 times higher than doses delivered per capita to low-income countries;
- 3 times higher than doses delivered per capita in all other countries combined.

“Vaccine inequity is not just holding the poorest countries back – it is holding the world back,” said UNICEF Executive Director Henrietta Fore. “As leaders meet to set priorities for the next phase of the COVID-19 response, it is vital they remember that, in the COVID vaccine race, we either win together, or we lose together.”

Wealthy countries with more supplies than they need have generously pledged to donate these doses to low- and middle-income countries via COVAX but these promised doses are moving too slowly. Of the 1.3 billion additional doses countries have pledged to donate, only 194 million doses have been provided to COVAX.

African countries, in particular, have largely been left without access to COVID-19 vaccines. Less than 5 percent of the African population are fully vaccinated, leaving many countries at high-risk of further outbreaks.

The WHO wanted 40% of the world fully vaccinated by the end of 2021, meaning 40% of country populations fully vaccinated by Dec 2021.

Yet, only about 9% have been fully vaccinated in Africa.

SITUATIONAL ANALYSIS

AN ASSESSMENT OF THE VACCINE ROLLOUT IN MALAWI

The Malawian Government developed the National Vaccine Deployment Plan (NVPD) that was aimed to map out the vaccine rollout in the country. The deployment plan also aimed to provide a stepwise approach to building confidence to the COVAX team, WHO, UNICEF, and Gavi including multilateral and bilateral partners that vaccine doses and resources are being put to good use and more lives will be saved from this pandemic. Malawi is a member of the COVAX facility arrangement

The NVPD included a cost analysis as well as sources of funding, which included potential support from COVAX, Development partners, and loans from the African Union and the World Bank; descriptions of the priority groups to be vaccinated, an assessment of Malawi's capacity to vaccinate the country's population to meet the set WHO deadlines.

Furthermore, it was highlighted by the NVPD that a deliberate resource mobilization strategy will be developed to facilitate the execution of the deployment plan but also increase transparency and accountability to the Malawi citizenry. Both the public and the private including the faith-based organization were to be engaged in order to mobilize resources and reduce any inequalities in the distribution of the vaccines.

Malawi launched COVID-19 Vaccination in mid-March 2021, with the target to vaccinate approximately 60% of the population by December 2022. By November 2021, only appr. 5% of the population had received at least one dose and about 3% had been fully vaccinated. (KAP Study during COVID-19 Vaccine Rollout, Centre for Social Research, UNIMA, November 2021)

The target group for vaccination was selected on the acknowledgment that Malawi would be unable to procure sufficient vaccines to vaccinate the country's adult population.

According to the NVPD, the COVAX Facility targeted 20% of the country's population, which was app. 3,779,688 (NSO, 2021 population projection). Out of the 20%, 3% were health workers in public and private healthcare facilities, as the priority and frontline workers, then the elderly, and people with comorbid health conditions such as diabetes, hypertension, and HIV that increase the risk of developing severe COVID-19 disease and death. However, in the case of the short supply of the vaccine, the priority was to be health workers in hospitals that are treating COVID-19 patients.

The social workers to be targeted in the first phase were to also include the police, soldiers, and prison warders, who according to their work, are always in direct contact with groups of people and most difficult to keep social distance. These comprise 2.4% of the population.

By December 2021, Malawi had administered at least 1,847,917 doses of COVID vaccines so far. Assuming every person needs 2 doses, that's enough to have vaccinated about 5% of the country's population only. Despite Malawi receiving donations of the vaccine, the dosages have simply not been enough to cater to the entire population. As of June 2021, facilities across the country had run out of vaccines after vaccinating only 455000 people, out of over 12 million adult populations.

According to a study by the Ministry of Health to understand the low uptake of the vaccine outside of unavailability of the vaccine in some centers, the main reasons for the vast majority's unwillingness to get vaccinated included:

- Lack of trust in the vaccines as a result of limited awareness and societal myths
- Lack of accurate and necessary information on the vaccine

The study also indicated that respondents from the rural areas were least likely to opt for vaccination as compared to respondents in the urban areas, largely due to the lack of information made available to the rural areas.

Furthermore, of the respondents, 61% reported that they trust the vaccine moderately and very much while 39% reported that they did not trust the vaccine at all or trusted a little, thus, more males (70%) than females (54%) showed trust in the vaccine.

According to the study, the main barriers to accessing the vaccine included:

- Distance from vaccination sites
- Societal myths around the vaccine such as their effects on fertility.
- Fear of complications and side effects from the vaccine
- Lack of trust in the vaccine

While some were able to access the vaccine without any barriers, about 20% reported having received a form of incentive to get vaccinated, or a sanction if they did not.

On the brand of vaccines available to Malawi, 12% reported that they were concerned, primarily those within the urban areas.

MYTHS AND MISCONCEPTIONS

MISCONCEPTIONS ABOUT THE VACCINES INCLUDED:

- Side effects of being vaccinated against COVID-19: reports through social media that those vaccinated were experiencing side effects made some people decide not to be vaccinated.
- Once one is vaccinated, he or she will be very weak, that COVID-19 vaccines are poisonous, that people will die once they get vaccinated and that the body develops sores.
- Non-availability of vaccines: Few people vaccinated because vaccines were not available in the community, or they were not aware of the vaccines were not available at the clinic or that the health workers had not yet informed them about the vaccines.
- Vaccines are for children: vaccines are traditionally for children. COVID-19 vaccines are given to adults and this is strange, hence some do not go forth.
- Religious beliefs: Some religious leaders are the ones making people not get the vaccine as they link this to 666 as written in the Bible
- COVID-19 is not a problem: some reported that they have not yet had cases of COVID-19; others felt that COVID-19 does not exist
- No vaccines for other diseases yet: The signs and symptoms of COVID-19 are similar to other diseases to which people get cured and there are no vaccines yet for them.
- One can still get COVID-19 after being vaccinated: once one is vaccinated it is not a guarantee that you will not suffer from the disease.
- Health workers getting allowances: Many feared getting a false diagnosis of COVID-19 hence they could not go to the health facilities.

STRATEGIES AND BEST PRACTICES

RECOMMENDED STRATEGIES TO INCREASE VACCINATION RATES

- Conducting a comprehensive awareness program on COVID-19 vaccines
- Making COVID-19 vaccine compulsory
- Establishing health facilities where there are no facilities /Provide more health workers
- Providing evidence that the COVID-19 vaccine works
- Using someone who is vaccinated but never experienced side effects to convince others
- Making COVID-19 vaccine a requirement for people to get passports
- Conducting door to door vaccinations against COVID-19

BEST PRACTICES TO BE LEARNED

With strong government commitment and engagement from the outset, more than 40 countries finalized their National Vaccine Deployment plans before the first vaccines arrived. These countries have typically fared better than those with less developed or no plans.

In Botswana, which is one of the six African countries to reach the WHO global target of fully vaccinating 40% of its population by the end of December 2021, emergency operation centers at the national and district levels handled operational issues, such as coordinating transport.

Ethiopia, which has used 80% of its available vaccines, used a reverse logistics system to bring back vaccine doses from areas where they were underutilized and redistribute them to areas with higher demand, thereby avoiding the expiry of precious doses.

In Ghana, in addition to the focus on protecting the elderly, populations were prioritized for vaccination based on vulnerability and the potential risks of exposure on the job. Good planning also helped the country make use of innovative tools, such as drones, to reach far-flung communities.

VACCINE INEQUITY AND INEQUALITY

ANALYSIS OF THE GLOBAL VACCINE DISTRIBUTION IN COMPARISON TO THE VACCINE DISTRIBUTION IN AFRICA.

According to UNESCO, Equity can be defined as the process of being fair to men and women. To ensure fairness, measures must often be put in place to compensate for the historical and social disadvantages that prevent women and men from operating on a level playing field. Equity is a mean. Equality is the result

In the case of the COVID-19 Vaccine rollout globally, equity can then be defined as the equal distribution of the vaccine to meet the exact needs of each country. This would mean that companies charged with the development and supply of the various vaccines, would subsidize the cost of the vaccines based on countries financial and economic capability to afford enough vaccines for their country, this would also call for the involvement of higher-income countries and development agents to provide sufficient support -to low-income countries to afford sufficient vaccines for the country's population.

On 14th September 2021, the World Health Organization (WHO) Director-General, Dr. Tedros Adhanom Ghebreyesus stated that more than 5.7 billion doses have been administered globally, but only 2% of those have been administered in Africa.

Furthermore, Dr. Ghebreyesus, stated 'Of the 5.7 billion vaccines administered globally more than 80 % have been used by high and upper-middle-income nations although they don't count for half the world population'. The acquisition by the high and upper-middle-income countries of 80 % of the vaccines will not produce positive results instead there is a higher possibility of the virus making a comeback.

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According to the World Health Organization, Safe and effective COVID-19 vaccines were developed in record time. But the virus is moving faster than the global distribution of vaccines. The vast majority have been administered in high- and upper-middle-income countries. If these doses had been distributed equitably, they would have been enough to cover all health workers and older people globally.

WHO set a target for all countries to vaccinate 10% of their populations by the end of September. 56 countries effectively excluded from the global vaccine marketplace were not able to reach this target – and most of them in Africa.

Even more, countries are at risk of missing the WHO targets of vaccinating 40% of the population of every country by the end of this year, and 70% by the middle of next year.

Most manufacturers have largely spurned the opportunities to share technology and know-how and public health-oriented licensing, despite a number of mechanisms being set up including the COVID-19 Technology Access Pool and the mRNA vaccine technology transfer hub, which is now moving ahead in South Africa.

The global failure to share vaccines equitably is taking its toll on some of the world's poorest and most vulnerable people. New variants of concern mean that the risks of infection have increased in all countries for people who are not yet protected by vaccination.

"The longer vaccine inequity persists, the more the virus will keep circulating and changing, the longer the social and economic disruption will continue, and the higher the chances that more variants will emerge that render vaccines less effective." Strive Masiyiwa, AU Special Envoy for COVID-19.

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IN MALAWI, The vaccine rollout carries similar characteristics of inequity and ultimately, inequality.

Despite the Malawian Government developing the National Vaccine Deployment Plan as the strategy to ensure the vaccine distribution reaches the priority groups in the country, the reality resembles that of the global stage.

According to the statistics, a majority of the population who have clear access to the Vaccine are the urban population.
This includes access to accurate information about the vaccine, accurate responses to the misconceptions and myths about the vaccine; access to vaccination sites, and quality healthcare services.

It is worth noting that national vaccination sites are mainly in public hospitals and selected private healthcare facilities, all of which are located in the urban or peri-urban areas, that are already hard to reach for many of those residing in the rural and hard to reach areas.

In addition, it is also worth noting that over 60% of the country's population reside in rural areas that have limited access to public hospitals and quality healthcare facilities due to the long distances, lack of access to transportation an d resources to access safe transportation.

Based on the statistics, a conclusion can therefore be drawn that, despite having a clear strategy, the vaccine rollout has inadvertently prioritized the wealthy and the rich, and the population with easy access to accurate information and those presiding closer to the vaccination sites.

> **There are enough doses of vaccines globally to drive down transmission and save many lives if they go to the people who need them most around the world. Worldwide access to COVID-19 vaccines offers the best hope for slowing the coronavirus pandemic, saving lives, and securing a global economic recovery.**
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> **WORLD HEALTH ORGANIZATION**

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