Vaccine Justice

A framework for urgent action to save lives and seed a new paradigm

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This document articulates a transnational framework for **vaccine justice**, to help guide the mutual shaping of Open Society regional and global initiatives related to the COVID-19 pandemic.

Staff of the Public Health Program have compiled this document based on joint work and thinking with multiple colleagues and partners, with the aim of facilitating global coherence to Open Society's approach to the vaccine and the issues it raises. Rather than proposing a specific global initiative, this document presents a framework of ideas that could evolve into specific regional and/or global proposals.

We have prepared this document in recognition of the shared sense of urgency across the network to continue responding to the pandemic as we undergo an organizational transformation.

The COVID-19 crisis has not impacted everybody equally, and nor will the massive "global" vaccination effort now underway. The impact of the disease, as well as the information and resources to confront it, are vastly inequitable across race, gender, caste, socio-economic status, and income level of affected countries and people.

Just as the concept of *reproductive justice* moves beyond the delivery of health services to address inequities of power based on gender and race, and just as *climate justice* moves beyond ecological preservation to address the inequitable effects of climate change in communities, the concept of *vaccine justice* seeks to address the racial, gender, and colonial roots of inequitable and profit-driven COVID-19 responses.

Vaccine justice recognizes that it is not vaccines that save lives, but rather vaccination programs, delivered in the context of comprehensive health systems and holistic community services that enable a full range of prevention, treatment, and participation for all.

Vaccine justice recognizes the historical misuse of public health technologies, and builds on Open Society's networks and partners to challenge and transform the dominant approach to development and manufacturing, financing, and delivery of diagnostics, vaccines, therapeutics (DVTs) and essential personal protective equipment (PPE) related to COVID-19. In so doing, it seizes on the inequities revealed by the current COVID-19 vaccine rollout to begin to build a pandemic response that goes far beyond inoculating people against a single disease.

Current vaccination efforts will mean that more than 85 poor countries will not have widespread access to coronavirus vaccines before 2023.[1] The global economic loss if governments fail to ensure developing economy access to COVID-19 vaccines is estimated to be $9.2 trillion, according to new research by the International Chamber of Commerce.

Without global solidarity and collective action to achieve herd immunity across the globe, vaccine access will be enjoyed by rich countries[2] and by rich people in low- and middle-income countries, failing to achieve either equity or economic recovery.[3] Poor, marginalized, racialized, and ethnic minority communities are experiencing a disproportionate death toll and economic burden while being cut off from public services, including mental health and well-being support. As vaccine disparities grow, these communities will be further stigmatized and blamed as vectors of infection.

Now is the time to act. The global impact of and global mobilization against the COVID-19 pandemic provide an opportunity for unprecedented forward motion on key issues of vaccine justice. This window will close as richer countries declare the worst of the pandemic "over" and as powerful interests consolidate their approaches.

1 https://www.eiu.com/n/85-poor-countries-will-not-have-access-to-coronavirus-vaccines/

2 Recognizing that roll-out of vaccine access in rich countries has also been uneven.

3 https://iccwbo.org/media-wall/news-speeches/study-shows-vaccine-nationalism-could-cost-rich-countries-us4-5-trillion/

This document identifies a **limited number of time-sensitive opportunities**, grouped into three categories to achieve tangible results in advancing vaccine justice in the next 24 months. These opportunities focus on COVID-19 directly, using the crisis and opportunity of the pandemic to push for broader systemic change.

The three categories relate to three interlocking and mutually reinforcing elements of an overall paradigm shift:

- First, we identify time bound opportunities to shifting the power over vaccine ***manufacturing and development*** from high-income countries to low- and middle-income countries.
- Second, we identify time bound opportunities to shift the model of vaccine ***financing and distribution*** from charity to shared good.
- Third, we identify time bound opportunities to shift the focus of vaccine ***delivery and uptake*** from overcoming individual "vaccine hesitancy" to addressing structural inequities.

Vaccine development and manufacture: from high-income countries to low- and middle-income countries

While the current pharmaceutical research and development system helped to produce effective COVID-19 vaccines quickly, the reality is that it also exacerbated inequalities in access and deepened dependency on drug corporations and wealthy nations to meet the health needs of the world's poor. A drug is once again seen as the cure to a virus that has not only revealed human physical vulnerability, but a system of intolerance and profit making.

Ten countries have administered 75 percent of all COVID-19 vaccines, and more than 113 countries have not yet received a single dose. Despite pledges for scientific cooperation, patent pooling and sharing of intellectual property in the interest of the public good, no high-income countries where vaccines are manufactured have joined the COVID-19 Technology Access Pool (C-TAP), launched by the WHO in partnership with the Government of Costa Rica and 40 Member States.

Despite massive public infusions of billions ($113 billion and counting) for the development of vaccines, corporate manufacturers have generally charged what the market will bear. They have entered into secret contracts with countries to protect their market share, and insisted that countries pass new laws to indemnify them against any liability—in some cases going as far as to demand embassy buildings and military bases as collateral. Just two of these companies, Pfizer and Moderna, are expected to post $32 billion in revenue in 2021.

China and Russia are both using vaccine access as a form of "soft power" to build diplomatic and business relations in Africa and Latin America. Essential, lifesaving commodities other than vaccines—including oxygen and medical grade PPE suitable for health workers—also remain out of reach for millions in low- and middle-income countries, restricted through monopoly sales agreements, stockpiling, and diversion of supplies to the highest bidder. With less than 1percent of vaccines used on the African continent having been manufactured *on* the continent, not surprisingly there is limited capacity in Africa for vaccine and PPE manufacture. Ninety-five percent of PPEs used in Africa are imported. Similar problems exist in Latin America, beyond Brazil.

Financing institutions and philanthropic efforts, including the World Bank Group's International Finance Corporation and the European Investment Bank, are providing billions in financing for pharmaceutical research and development and manufacturing, including in Africa. However, they have failed to challenge the monopoly power of vaccine manufacturers or to condition support on affordability of COVID-19 diagnostics, vaccines or treatments. While transfer of manufacturing capacity is increasingly discussed, no funder in the space besides the Open Society Foundations consistently brings affordability into the discussions.

Now is the time to push further—to catalyze new manufacture and development of diagnostics, vaccines and treatment centered in the low- and middle-income countries and on the premise of affordability as essential to the venture rather than something negotiated in secret or as an afterthought.

Open Society is poised to have tangible impact in this space, both through impact investing as well as through grant making, advocacy, and communications.

Anticipated results of Open Society's *impact investing* on vaccine development and manufacture could include:

- The first development and manufacturing facility for affordable (cost plus) COVID-19 diagnostics is established in Africa (Senegal), with capacity to supply West Africa and technology suitable for further diagnostic applications that are needed to address the growing levels of non-communicable diseases. An additional diagnostics manufacturing facility is established in Pakistan for distribution in the region and globally.
- A partnership with Oxygen Hub and Hewa Tele leverages the $1.6 billion in investment planned by ACT-A, World Bank, and EIB in next six months, to support the first affordable medical-grade oxygen manufacture and distribution in Africa (Kenya, Uganda, Nigeria, Ethiopia, Ghana, Senegal, and Nigeria), and the first African facilities producing affordable active pharmaceutical ingredients (Mauritius).
- A facility in India or Vietnam utilizes modular technology to produce affordable vaccines and biologics, with modular technology then optimized for use in Africa (Kenya or Senegal) in years 2-3.
- Three Africa-based investors co-invest with Open Society/SEDF in efforts to transfer development and manufacturing capacity to the continent and make affordability essential to their investment.

Anticipated results of Open Society's *grant making, advocacy, and communications* on vaccine development and manufacture could include:

- Senegal and Kenya, reacting to political opportunities and civil society demands, emerge as regional hubs of diagnostic, vaccine and therapeutic manufacturing capacity on the African continent. Key industrial policies are introduced creating an enabling investment environment, while at the same time government policies ensure affordability of locally manufactured health products.
- The African Centers for Disease Control becomes a global and regional leader fully capacitated and resourced to advise and direct countries on the building of regional manufacturing hubs committed to affordable diagnostic, vaccines and treatments on the continent.
- A continental advisory council of African donors (e.g., Dangote), politicians (the head of AU), scientists, and elders (e.g., Graca machel) works with the African Centers for Disease Control to guide and promote the decentralization of manufacture and increase African ownership of the effort.
- At least two impact investors or major philanthropic actors (e.g., Gates, Elma, Wellcome) make health product affordability essential to their COVID-19 investment decision making and due diligence.
- Civil society pressure ensures that the United States commits significant funding of and technology transfer to 2-3 vaccine manufacturing regional hubs potentially situated in South Africa and Indonesia.
- Civil society monitoring and advocacy moves leading Indian, Pakistani, and South Korean biomedical companies and manufacturers to commit to and implement affordable LMIC pricing for COVID technologies.
- The South Korean government translates rhetoric on COVID technologies as global common goods into policies that make sure Korean manufacturers price and distribute their products to make them accessible for LMICs.

Vaccine financing and distribution: from charity model to shared good

By the end of 2020, $93 billion of public money had already been spent on the development of COVID-19 vaccines and therapeutics.[4] Many more billions are now being dedicated to purchasing vaccines, either bilaterally from pharmaceutical manufacturers or via mechanisms like the Access to COVID-19 Tools (ACT) Accelerator, a global risk-sharing mechanism for pooled procurement and equitable distribution of COVID-19 vaccines.

To date, a total of $6.3 billion has been pledged to ACT-A's vaccine arm (COVAX) to support the financing of doses for 92 lower-income economies.[5] COVAX, however, faces stiff competition from high-income countries buying up doses, thus restricting the supplies available for pooled procurement and allocation, particularly for low- and middle-income countries, including in Latin American countries where case fatality rates are highest. COVAX, moreover, does not make terms of purchase or procurement transparent and has sidestepped calls to address the intellectual property restrictions that prevent manufacture and development outside high-income countries.

Critically, COVAX is only designed to supply around 20 percent of country doses, with countries required to look elsewhere for supplies, and the financing to procure the additional doses to achieve higher population coverage (for example, the 60-70 percent coverage level the African Union has set as part of its vaccination strategy). Some developing countries are supplementing their COVAX allocations with bilateral deals, while others, such as Thailand, are bypassing COVAX altogether, favoring bilateral deals, in which they have more control in negotiations.

There are strategic and political openings for Open Society to influence development banks and donors, as well as to change domestic vaccine financing modalities in 2022. All of these can help to increase access and equity in a global system that will otherwise follow a model where richer countries donate to the poorer, and middle-income countries are left to fend for themselves.

4 https://healthpolicy-watch.news/81038-2/

5 https://www.gavi.org/news/media-room/g7-backs-gavis-covax-amc-boost-covid-19-vaccines-worlds-poorest-countries

Open Society's action in this area could target *development bank financing*, *global health and development donors*, and *financing of mental health programs*, which face similar challenges with biopharmaceutical monopolies as vaccines.

Development Bank Financing

Development banks are partly filling the gap in financing from COVAX with multi-billion dollar financing to fund procurement and deployment of vaccines, most notably $12 billion from the World Bank Group for grants and concessional loans to low- and middle-income countries. The total development bank contribution currently stands at around $27 billion, most of which is yet to be allocated.

While this funding is welcome, it may also lead to hastily designed projects that fail to reach vulnerable and marginalized populations, and force countries to pay inflated costs for vaccines and decrease spending on the health systems to get those vaccines into people's arms. Pre-pandemic, many countries were already paying less on health systems than they were spending to service debt,[6] and for some countries vaccine financing will deepen that disparity.

Open Society has a time-bound opportunity to help ensure this rich stream of development funds translate into a more equitable COVID-19 response.

Notably, the World Bank's $12 billion for vaccine procurement and deployment is in its early days, with 93 of 100 projected projects yet to be approved or negotiated in the next twelve months.[7] Complemented by our current direct engagement with World Bank Board members and advisers, which has already influenced the board's approach, civil society groups across West Africa and Mozambique are poised to engage in dialogue on the design of these projects in country need support, as are groups and journalists able to investigate and monitor implementation.

Beyond vaccine access for vulnerable groups, whether these World Bank projects include financing for broader public service interventions like health worker salaries to support vaccination programs will also depend on individual

6 https://actionaid.org/publications/2020/who-cares-future-finance-gender-responsive-public-services#downloads

7 While the focus of this note is the World Bank funding envelope, an additional $1 billion from the Inter-American Development Bank, $9 billion from the Asian Development Bank, and $5 billion from the African Development Bank and African Export Import Bank (Afrexim) require additional scrutiny.

project design. As some countries will receive these funds through loans, and therefore incur additional debt amidst a debt crisis, these questions of whether projects will contribute to equitable access and how they will reinforce health systems will also fundamentally determine how countries assess the benefits of this financing.

Anticipated results of Open *Society's grant making, advocacy, and communications* on development bank financing and distribution of vaccines could include:

- World Bank and Inter-American Development Bank funds for vaccine procurement are deployed in country projects in Latin America, Eurasia, and Africa with the effective engagement of national level stakeholders, including civil society, helping to ensure greater equity of access of vaccines particularly for marginalized populations. This marks a sharp change in practice where there are barriers to entry for civil society.
- Vaccine allocation plans are designed to ensure access for vulnerable and marginalized populations as a condition for support, with specific focus on Latin America and Africa.
- Public financing for manufacturing COVID-19 diagnostics, vaccines, therapeutics, and essential personal protective equipment (PPE) will also include provision for ensuring equitable access to the products of that manufacturing, with a particular focus on the International Finance Corporation's $4 billion Global Health Platform.

Global Health and Development Donors

The limits of the COVAX model, rooted in a global health architecture that leaves control with high-income countries and donors, has inspired regional bodies such at the African Union to build their own agency and capacity when it comes to public health and pandemic response (see manufacturing section above). This is taking place just as global health activists, inspired by the Black Lives Matter movement and mobilized by the profound vaccine inequity between rich and poor countries, are calling for the "decolonization" of aid.

One arm of this movement, known as the "localization agenda," calls on donors and the UN system to acknowledge the contributions of local and national actors in health crisis management to increase the sustainability of their interventions and empower them to shape global health responses by defining local needs. Another is a campaign to reform and reframe aid as a system of Global Public

Investment, in line with the values of shared responsibility and global solidarity embedded in the SDGs.

The cracks in the aid architecture exposed by vaccine rollout have increased attention to both of these campaigns from bi- and multilateral agencies such as NORAD, FCDO, the Swiss Agency for Development Cooperation, and the OECD, and could use significantly more support to get to scale.

Critically, the rush to procure and distribute vaccines has exacerbated the potential of corruption in procurement financed nationally and by external aid. As national governments enter into procurement negotiations, it is critical that civil society groups are equipped to participate in the design of national vaccination programs. Due in large part to the ongoing funding partnership between PHP and EJP, COVID-related financing and procurement monitoring is now the focus of anticorruption efforts in Ukraine, Moldova, the Kyrgyz Republic, Kenya, the United Kingdom, Colombia, and Mexico.

Working in coalition with health advocates, journalists, and local communities, anticorruption groups are scrutinizing procurements at the national level in an effort to prevent derailment of donor and public funds and to document how the misuse of those funds erodes access to essential health services and increases inequality (building on the documentation of similar trends during Ebola). The expertise gained by many grantees in monitoring the procurement of diagnostics, therapeutics, and PPE can now be transferred to vaccines, an arena which is much more politicized (political leaders vaccinating their cronies and supporters first) and prone to corruption.

Anticipated results of Open Society's *grant making, advocacy, and communications* on donor behavior related to financing and distribution of vaccines could include:

- Civil society collectives such as The Kampala Initiative, the Global Public Investment Initiative, and the Network for An Empowered Aid Response, focus on vaccine justice as part of their strategy to shift narratives on and disbursements of global health aid, and succeed in having at least two bilateral agencies champion replacing a charity frame with one advancing global solidary and health as a public good.
- Donors make measurable commitments to "localize" aid by investing in local public health responses, resulting in at least two donor or major development partners (INGO or UN agency) championing the aid reform agenda.

- Health advocates leverage relationships with anticorruption groups, budget accountability activists, and investigative journalists to expose misuse of vaccine budgets, and the diversion of vaccines from highest risk or marginalized populations to national elites, with a particular focus in Latin America, Eurasia, and Africa.

Mental Health Financing

The same biopharmaceutical monopolies on knowledge and production that impede global vaccine equity also impede holistic and community-based responses to the interlinked issue of COVID-19 and mental health. The pandemic, its economic impact, and the social isolation visited upon people because of lockdowns have had a significant impact on mental health and well-being, with mental health and psychosocial support needs increasingly referred to as a silent epidemic or crisis in their own right.

Lack of access to appropriate supports in community-based settings is invariably stratified by race and class, and has a direct bearing on vaccine uptake. Global actors, including the Wellcome Trust (which has initiated a new priority area on mental health) and the Global Fund to Combat AIDS, TB and Malaria, have directed funds, or are being called upon to direct significant funds, to mental health in the coming months.

In May 2021, the Healthy Brains Global Initiative, a $10 billion financing mechanism will be launched at the World Economic Forum. New funds are also being launched at the U.S. National Institutes of Mental Health, and the World Health Organization will expand its global Special Initiative on Mental Health in the context of Universal Health Coverage over the course of this year.

The growing attention that the COVID-19 crisis has brought to mental health provides an opportunity to move the needle on financing for mental health at domestic levels, which is estimated to amount to less than 2 percent of total health spending currently. Because of COVID-19, as mental health and well-being are gaining more public attention, part of a vaccine justice agenda is to ensure that new and existing funding centers lived experience, recognizes the need for rights-affirming practices, and avoids the same overreliance on profit-driven pharmaceutical models that produce vaccine inequities.

There are significant upcoming opportunities for the Open Society Foundations to work with initiatives such as United for Global Mental Health and the WHO Special Initiative on Mental Health, to convene domestic and global stakeholders to examine the impact of finances diverted to vaccine procurement as a result of price-gouging, intellectual property restrictions, and global vaccine inequity on wider health equity and health systems goals.

Anticipated results of Open Society's *grant making, advocacy, and communications* on mental health financing in the context of vaccines could include:

- Targeted research interventions (e.g., by the Validity Foundation and/or Stanford Institute for Innovation in Developing Economies and the Impact Management Project) produce evidenced-based illustrations of the direct impact on vaccine uptake of not addressing mental health and psychosocial support needs, particularly by migrants, people of color, and low-income communities.
- Donor governments, development banks, and governments increase investment in non-pharmaceutical and non-biotechnological therapeutics and multi-sectoral responses that acknowledge the significance of psychosocial support in contributing to the sustainable recovery from COVID-19 (potential targeted opportunities at the 2021 Vaccine Summit and the G20 Leaders Meeting in October 2021).
- Organizations of people with lived experience of mental health conditions engage with broader health governance organizations and coalitions (including the Global Public Investment Initiative) to ensure civic participation in World Bank, African Development Bank, and Inter-American Development Bank decision-making and programming related to mental health.
- A 2022 convening of major multilateral, bilateral, and philanthropic funders of mental health and psychosocial support (such as the Wellcome Trust's new priority area on mental health, the Healthy Brains Global Initiative—to be launched at the WEF in May 2021—and the NIMH). Such meetings would also include multisectoral health funders (such as the World Bank and the Global Fund) to build consensus on supporting rights-based approaches to mental health, reflecting on the direct impact on vaccine uptake of not addressing mental health and psychosocial support needs and the significance of mental health and psychosocial support in long-term recovery from COVID-19.

Vaccine delivery and uptake: from individual hesitancy to structural equity

Media coverage and accepted narratives of "vaccine hesitancy"[8] obscure the structural and systemic barriers impeding access to COVID-19 prevention and care, and often fail to recognize the power of disinformation in creating wariness and doubt. Communities most at risk of COVID-19, including health workers, people in crowded and racially segregated neighborhoods, informal settlements, and refugee camps face barriers that go far beyond their acceptance, or not, of vaccines.

Lack of PPE, inadequate access to public services, overcrowding, and disinformation fuel both community infections and distrust. Quarantine enforcement and mobility restrictions have also fallen heavily on certain communities, while the deployment of immunity passports will continue to deepen marginalization and the digital divide, and restrict economic and social participation.

Multiple processes and campaigns—including the WHO Year of Health and Care Workers campaign and its Vaccine Equity Pledge; the G20 Leaders Summit and the WHO Pandemic Review Panel; and the World Economic Forum's Special Annual Meeting on Pandemic Recovery will in the next year conduct evaluations and set global guidance for the ongoing COVID-19 response. All of these efforts need to move beyond the dominant narrative that "we are all in this together" to name and address the needs and demands of communities that are most at risk, providing them a place at the table to craft successful responses to the pandemic.

A structural response to vaccine delivery and update could engage at least three key areas: *justice for health workers*; combating *disinformation to build vaccine confidence*; and *equity in urban COVID-19 responses*.

8 Defined by WHO as a "delay in acceptance or refusal of vaccines despite availability of vaccination services."

Justice for Health Workers

Women represent nearly 70 percent of the global health workforce, and in many countries health workers are disproportionately racial and ethnic minorities and migrants. The administration or delivery of vaccines depends on health workers. Yet, around the world health workers lack access to necessary tools and supports, quality PPE, and vaccines to do their work as safely as they can. At this point in the pandemic, there is an enormous need and a window of opportunity to increase access and demand justice for health workers.

Health worker justice in the context of COVID-19 is a multi-faceted challenge:

- Health workers are at greatly disproportionate risk of COVID-19, and in some countries at much higher risk of severe COVID-19.[9]
- The disproportionate risk is in large part due to lack of PPE, knowledge and protocols, and, increasingly, vaccines.
- Community health workers often lack recognition of worker status, which impacts access to PPE, vaccines, and supports.
- In a survey of 105 countries, almost half said they had insufficient PPE for health workers.[10]
- A systematic review showed a 23 percent prevalence of depression and anxiety, and a 39 percent prevalence of insomnia among health workers during COVID-19.[11]
- Violence against health care workers has increased during COVID-19.[12]

Health workers are organizing for the safety they deserve, and increasingly governments and multilateral institutions are listening. In September 2020, WHO issued a Charter on Health Worker Safety, pronounced 2021 the Year of Health and Care Workers, and launched a Vaccine Equity Declaration. These efforts recognize a core tenet of vaccine justice, which is that while we can manufacture billions of doses of vaccines, those vaccines are worth nothing unless they are correctly administered by health care workers who are treated with dignity.

9 https://oem.bmj.com/content/early/2020/12/01/oemed-2020-106731

10 https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

11 https://pubmed.ncbi.nlm.nih.gov/32437915/

12 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31858-4/fulltext

Anticipated results of Open Society's *grant making, advocacy, and communications* on vaccine justice for health workers could include:

- Local and national governments adopt and resource plans for increased access to PPE and vaccine prioritization for health workers.
- National governments in target countries recognize community health workers as workers, which is a necessary condition to access appropriate PPE and vaccines.
- WHO establishes meaningful targets and accompanying technical supports for its Year of Health and Care Workers campaign, including the Vaccine Equity Declaration.
- Health workers increase their own mobilization and collective demands for vaccine justice.[13]
- Global labor movements develop and expand campaigns for health worker justice.
- Global and regional health and labor institutions develop norms around health worker safety, which are transposed in national and local contexts.

Disinformation and Vaccine Confidence

Vaccine disinformation has emerged as a significant front in the effort against COVID-19. Disinformation has been shown to reduce vaccination intent[14] while also strengthening the hand of diverse enemies of open society.

Anti-gender actors spreading disinformation related to the bogus claim that COVID-19 vaccines contain aborted fetal tissue/cells, cause miscarriages or birth defects. Racist groups are using the legacy of racist medical malpractice (such as the Tuskegee syphilis experiment) to target Black communities in the United States with vaccine disinformation. Coordinated efforts linked to Russian intelligence suggest mRNA vaccines can alter human DNA and/or are a tool of mass surveillance or international conspiracies.

13 Building on existing PHP work like the emergence of the Nurses United and Nurses of Colour collectives in the United Kingdom and the mobilization of community health workers as champions for effective health systems in South Africa.

14 https://www.nature.com/articles/s41562-021-01056-1

There are many strategies to counter vaccine disinformation, from online fact checking operations to community-based efforts by faith leaders and health workers. “Conversion” narratives of people who have overcome disinformation, de-politicization of science by elected officials, modeling of norms by influencers such as religious leaders and ambassadors, and the provision of spaces for honest conversation about science have all been demonstrated to play important roles in addressing disinformation and helping to assure the success of vaccination campaigns.

Anticipated results of Open Society’s *grant making, advocacy, and communications* on vaccine disinformation could include:

- Vaccine confidence increases in target countries as a result of community-based efforts.
- Faith leaders and ambassadors take greater responsibility and have access to increased tools and resources to increase vaccine confidence, including by engaging constructively with harmful influencers in their own communities.
- Pop-culture influencers engage in campaigns to address disinformation related to reproductive justice and the vaccine.
- Vaccine disinformation online is reduced significantly as a result of online fact-checking and other antidisinformation strategies.
- WHO implements its health research agenda for managing infodemics.

Equitable Urban Responses

Some of the most pronounced inequities and injustices related to COVID-19 vaccine delivery and uptake occur in urban settings, which are themselves more vulnerable to epidemic spread because of high density and patterns of housing, employment, and social clustering. Public health experts with experience in HIV, Ebola, and urban community health bring key insights to the COVID-19 vaccination effort about how to effectively reach communities with good reason to distrust government. These experts have particular experience in how to change urban health conditions locally, which also requires moving global actors to shape best practice and structural interventions to prevent health crisis in particular places.

Local context will determine the success and equity of vaccine delivery and uptake in urban spaces. Cities in Latin America, Europe, and the United States, where COVID-19 case fatality rates and deaths per 100,000 population are among the world’s highest, tend to stigmatize and include the most vulnerable.

COVID-19 vulnerability mixes with racial and ethnic segregation, xenophobia, and disinformation campaigns—whether targeting Roma, African Americans, or favela residents.

Countries where these factors have been shown to converge in urban spaces, and where we have a footprint, include Bosnia and Herzegovina, Bulgaria, Brazil, Colombia, the Czech Republic, Hungary, Montenegro, Mexico, North Macedonia, Slovakia, Ukraine, and the United States. In addition, South Africa and Indonesia are experiencing high fatality rates and are places where we have supported urban community health work.

Anticipated results of Open Society's *grant making, advocacy, and communications* on equitable urban responses in the context of vaccines could include:

- In at least five locations, urban communities marginalized by COVID-19 vaccination efforts use appropriate means, including grassroots uses of digital technology, to increase their access to COVID-19 prevention, treatment, vaccination and mental health support, document structural obstacles to COVID-19 control, and advocate for accessible public health system support.
- Lessons and recommendations are passed up to global actors shaping COVID-19 vaccine delivery and uptake (e.g., Gates Foundation, Resolve to Save Lives, Partners in Health) and, where relevant, actors shaping digital health information systems such as the World Bank Service Innovation team, World Health Organization pandemic review panel, and major global health non-profits.
- Attention to and effective remedies for structural determinants of COVID-19 vulnerability in cities are incorporated into global COVID-response agendas such as the UN guidance on COVID-19 in urban settings, the New Urban Agenda, and the related COVID-19 Campaign to take action in solidarity to the most vulnerable in cities and communities; the World Health Organization Pandemic Review Panel recommendations, and the UCLG Decalogue for the post-COVID-19 era.

Conclusion

Vaccine justice represents a niche for the Open Society Foundations in the crowded but increasingly inequitable spaces of vaccine development, manufacture, financing, distribution, delivery, and uptake. It engages questions of access in middle-income countries excluded from existing mechanisms. It takes us beyond narrow vaccine programs to include the pursuit of fair and inclusive responses to the COVID-19 pandemic, now and in the future.

Vaccine justice stands for the notion that the COVID-19 vaccine should enable people to realize their rights on an equal basis with others, not deepen existing inequality. It recognizes and seeks to rectify the histories of injustice that underpin inequitable access to vaccines and other COVID-19 prevention measures, as well as the practical consequences of this inequity.

The analysis and intended results of this paper represent the joint work of multiple thematic and regional programs and national and regional foundations over more than a year of responding to COVID-19. Some parts of this paper are necessarily more developed than others, due to the constantly evolving and fast-moving nature of the pandemic itself. Additional work is required to develop these ideas into concrete proposals for emergency reserve funds, regional strategies, and/or global initiatives, including work with learning and evaluation colleagues to further refine intended results into observable outcomes.

Just as public health is a measure of open society, so, too, is just progress on the COVID-19 vaccine.