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The politics of Covid-19 vaccine confidence

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In the context of emerging COVID-19 virus variants, trends of vaccine nationalism, and multiple vaccine supply challenges, COVID-19 vaccine related uncertainties and challenges continue. Additionally, confidence in new COVID-19 vaccines is highly variable, with minority communities generally less trusting of not only the new vaccines, but also those who produce them and the governments buying and recommending them. How governments handle the COVID-19 response will be a key influencer of public confidence in and acceptance of COVID vaccination.

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Now, well into the second year since the World Health Organization declared that the Covid-19 outbreak in China had become a Public Health Emergency of International Concern (PHEIC) [1], the pandemic continues to disrupt the planet with multiple uncertainties. It has been a turbulent journey with new variants emerging — some more dangerous than others — to seemingly unexpected new outbreaks raging, and multiple new vaccines developed, but their delivery uneven. In addition, supply chains carrying not only vaccines, but crucial ingredients, have been interrupted while wealthy nations hoard the lion's share of supply.

Covid-19 vaccines have been increasingly looked to as the holy grail to provide the most promising efficient and

effective means of putting the pandemic behind us— especially given the lack of effective treatment against the SARS-CoV-2 virus. But politically motivated decision-making around the pandemic response more broadly, and vaccine decisions specifically, have created serious inequities triggering multiple calls for more fairness across the global response.

Reflecting on the global inequity in access to the new Covid-19 vaccines, WHO's Director-General, Tedros Adhanom Ghebreyesus warned that the world was verging on 'catastrophic moral failure' [2].

Alongside the ethical and logistical challenges of getting newly approved Covid-19 vaccines to those who need them most, equitably, there is a volatile landscape of vaccine confidence [3]. Across the various surveys being conducted locally and globally [4–6], willingness to get vaccinated by one of the approved Covid vaccines is dynamic, with ups and downs in willingness depending on the state of the pandemic threat and perceived risk, alongside various concerns around safety, and conspiracies propagating through social media.

Many of these drivers are not new to vaccine reluctance or refusal [7••]. Already two years before the newly available Covid-19 vaccines were approved for emergency use, the WHO had called out vaccine hesitancy as one of the ten top global health threats [8], but there are some unique issues around Covid-19 vaccines. One is that the Covid-19 vaccines were developed far more rapidly than expected and launched under an 'Emergency Use Authorization'. New vaccines by nature provoke more questions but, in the case of Covid-19 vaccines, the processes used to produce them are also new, having never been used for vaccines before, such as the mRNA platform. This overall sense of being rushed, and risking compromises around vaccine safety and quality, has particularly contributed to vaccine hesitancy.

External events beyond vaccine concerns around safety and efficacy also matter when it comes to both vaccine hesitancy and low confidence in general, as well as specific to Covid-19 vaccines. Personal and community histories, including memories of exclusion or unfair clinical or scientific practices as well as current marginalization, can undermine public trust and drive vaccine reluctance and refusal.

This paper will focus on three key external issues influencing Covid-19 vaccine confidence at a more political

level: (1) how governments handle the Covid-19 response more broadly, (2) populism, and (3) vaccine equity, particularly when it plays out as vaccine nationalism.

How government's handle the Covid-19 response

How governments handle the Covid-19 response more broadly is a key influencer of public confidence in vaccination. Research conducted in December 2020 by the Vaccine Confidence Project in collaboration with its polling partner, ORB International, found that across 32 countries the strongest indicator of willingness to accept a Covid-19 vaccine was confidence in the government's handling of the Covid-19 response [9]. If the government was perceived to be handling the pandemic response well, willingness to accept Covid vaccination was higher; for those who felt that their government was handling the response badly, their willingness to vaccinate was much lower.

In the case of the Philippines, for example, politicians' misuse of the Covid-19 response to strengthen their political profiles is one factor that has contributed to the erosion of trust in vaccines and vaccination [10]. The national government appeared to hold itself to a different standard than that for other Filipinos when it justified the use of a donated vaccine, which had not undergone regulatory evaluation and approval, for a select group of government officials and employees at a time when the government was unable to procure vaccines for the populace. It later admitted that vaccine deals had stalled because it had only been lately informed of the need for an indemnification law which required an indemnity fund [11].

In another instance, during the first quarter of 2021 when Covid vaccines started to enter the Philippines, the government was criticized as slow in rollout with insufficient vaccination targets being achieved, coupled with rising cases of Covid to levels of 10 000 plus per day. Politicians promoted and even distributed Ivermectin as a prophylaxis and treatment citing the urgency of public health crisis while going against scientific and legal restrictions [12].

The national government showed it was willing to make compromises in other cases. The Food and Drug Authority (FDA) Philippines granted the first Emergency Use Authorization (EUA) to the Chinese vaccine Sinovac with stipulations that it not be used for health frontliners, the elderly and those with comorbidities, effectively the top three categories of government prioritization. A public uproar ensued, and the FDA overturned its stipulations a few days later without explanation; by then, even those who wanted to be vaccinated had resolved to wait for a 'better' vaccine [13]. As all this trial and error unfolded on traditional and social media, along with disagreements

among public figures and experts, self-proclaimed and otherwise, confusion and vaccine hesitancy continue to grow.

Populism and Covid-19

Tensions between experts, authorities, and the public are not new to vaccines, and particularly play out in the context of populism. In 2019, an analysis which compared the Vaccine Confidence Index™ measures across the European Union member countries to voting behaviour, found that the proportion of people who voted for populist parties correlated significantly with low-to-no confidence in the importance, effectiveness, or safety of vaccines [14]. Earlier studies have also reported the influence of political affiliation on vaccine sentiments [15**].

Populism is described by Gugushvili *et al.* as 'pitting the 'common sense' of a virtuous people against expert knowledge. Its arguments often oppose public health measures that are based on evidence from research' [16].

As outlined in Larson's book *Stuck* 'From Italy's Five Star party to Poland's Law and Justice party (PiS), Trump, Brazil's far right populist Jair Bolsonaro, Turkish President Recep Erdogan, Joko Widodo in Indonesia, and India's Hindu-nationalist Narendra Modi, us-versus-them intolerance is back on the rise. It is 'the people' versus the political and financial elites, with medical and scientific experts seen as among those who are deemed elitist, speaking a different, inaccessible language and entwined with big business and pharma as well as politics' [17].

McKee *et al.* describe four common potential mechanisms that are used by populist leaders in handling the Covid-19 pandemic, including blaming outsiders and victims, contempt for institutions, denialism and suspicion of elites [18].

In another analysis of what author, Brett Meyer, terms 'pandemic populism,' he differentiates between types of populist leaders. 'Not all populists who have taken the virus seriously have responded the same way. Some have taken an illiberal response, assuming excessive emergency powers and/or using the crisis to crack down on political opponents.' Meyer identifies others, such as Modi, as being 'cultural populists'. 'For these (cultural populist) leaders, the crisis has offered an opportunity to draw cultural dividing lines with opponents to strengthen their own positions' [19].

Social scientist Gideon Lasco, who coined the term 'medical populism' and also explored its relevance to immunisation programmes [20,21**], took his analyses further in the context of the pandemic. He writes about medical populism and the politics of the Covid-19

response in Brazil, the Philippines, and the United States, distilling four key features of the populist leadership.

Lasco firstly names a ‘simplification of the pandemic’ as a characteristic, including ‘downplaying the virulence or severity of the outbreak (e.g. ‘It, promising quick fixes like an effective drug — e.g. hydroxychloroquine) or a forthcoming vaccine.’ Secondly, a ‘dramatisation of the crisis’ where politicians ‘dramatise the pandemic itself as an exceptional threat as a pretext to gain ‘emergency powers.’ He then lists, ‘forging of divisions’ where the public is pit against ‘others’ which include ‘powerful elites such as pharmaceutical companies, supranational bodies, the ‘medical establishment’ but they may also include ‘dangerous others’ like migrants that are blamed for the crisis and cast as sources of contagion.’ Lastly, he identifies the ‘invocation of knowledge claims’ as the fourth key characteristic of populist actors in the context of Covid-19. ‘In order to simplify and spectacularise crisis, and forge divisions, political leaders resort to making knowledge claims. In the case of Covid-19, these have included assertions about the virus’ origin (e.g. ‘It came from a laboratory in China’) . . . (to) . . . proposed cures and solutions’ [22].

Among the most outspoken populist leaders questioning the relevance and safety of Covid-19 vaccines is Brazil’s president, Jair Bolsonaro, who announced that he would not take any Covid-19 vaccine even when it is approved [23,24]. He expressed his skepticism about the vaccine developed by China’s Sinovac, but also scorned the Pfizer BioNTech vaccine as saying they would not take responsibility for any adverse effects, adding that, in other words, ‘if you turn into a crocodile, it’s your problem’ [25].

Although mocked by the scientific and public health community, his words matter when it comes to vaccine confidence. A recent poll surveying trust in Covid-19 vaccines and trust in Brazil’s president, showed a correlation between vaccine refusal and trust in President Bolsonaro. About a third of the participants who said they always trust Bolsonaro were not willing to take the vaccine [26].

Vaccine equity or vaccine nationalism?

Beyond the influence of political leaders in building or breaking public confidence, is the additional issue of vaccine equity, particularly when it plays out as vaccine nationalism. Vaccine confidence is not only an issue of confidence in vaccines — the product — but also the processes around vaccines, including transparent and fair decision-making around vaccine allocations. Vaccine equity can be a trust builder, particularly among those who have been historically left out or marginalized. Vaccine inequities, on the other hand, can be a trust breaker or reinforce underlying distrust in global and national systems that are perceived to be unfair.

The rise of Covid-19 vaccine nationalism emerged in early 2020 when the USA pre-purchased its first vaccines to secure priority access for 100 million doses from a Sanofi-GSK collaboration for the now well-known ‘Operation Warp Speed’ [27]. (Following delays, the Sanofi-GSK candidate vaccine only moved into phase 3 trials only in May 2021.) [28]. The United Kingdom joined the USA in the race for vaccines by investing early in the Oxford University vaccine program. Regionalism also was in play when the European Union approved Covid-19 stimulus package of US\$857 billion for grants and loans. Under the umbrella of these investment agreements, the USA, European Union, United Kingdom and Japan secured access to about 1.3 billion of probable Covid-19 vaccine doses by August 2020 [29].

Canada, too, was called out for its vaccine nationalism, having bought among the highest number of vaccines relative to population need. Despite this, Canada faced various delays in their vaccine delivery and withdrew their commitment of doses to the COVAX, the Covid-19 Global Vaccine Access initiative.

COVAX in the meanwhile is falling significantly short of its aspired vaccine delivery goals due to a mix of manufacturing and supply issues and some countries prioritizing their own needs, restricting exports of not only globally needed vaccines, but crucial vaccine components for other country manufacturers. In addition, a number of high-income countries have made significant deals with vaccine producers, limiting the global supply [30].

Interestingly, some of the leaders who adopted a vaccine nationalistic stance were those who were criticized as having been among the worst in dealing with the Covid-19 crisis in their countries [17].

The pharmaceutical companies too had a role in nationalism trend. Sanofi stated that the USA had ‘rights to the largest pre-order of a vaccine.’ AstraZeneca also proclaimed priority access to vaccines for USA and UK [2,29].

An analysis by the RAND Corporation put the risks in economic terms, estimating that the cost of vaccine nationalism and consequent unequal access to Covid-19 vaccines would take a toll on the global economy at a cost of approximately US\$1.2 trillion a year in terms of GDP [31]. A more recent report by the IMF outlines an aggressive strategy—including vaccinations, diagnostics, and therapeutics—to end the pandemic, with a price tag of us\$50 billion, but an estimated gain of us\$9 trillion by 2025 [32].

But, once again, the challenge is political will.

In 2009, an article called ‘Good Politics, Bad Politics: The Experience of AIDS’ had some valuable insights to reflect on and as we choose our course to end Covid-19.

“Politics has been the main driver of action as well as inaction and denial...On the one hand, positive political action at both the grassroots and governmental levels has greatly enhanced the global response...Political action has also been an opportunity to correct underlying injustices and mobilize positive political momentum...On the other hand, politics has been a negative force at times, blocking important policy developments and evidence-informed action . . . particularly access to treatment in poor countries.” [33]

As called out by a group of religious leaders, NGO and UN organizations, “We have a choice: vaccine nationalism or human solidarity.” Their statement “No-one is safe until everyone is safe — why we need a global response to Covid-19” outlines a list of needs for a global, equitable supply of vaccines, declaring “equitable vaccine distribution is a humanitarian imperative” [34]. While arguably a humanitarian imperative, the reality of politics cannot be ignored.

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