

Transparency and Equity in COVID-19 Vaccine Distribution in Latin America and the Caribbean

Key Questions to Address Gender and Diversity Issues

As countries move forward in the preparation of COVID-19 vaccine distribution plans in Latin America and the Caribbean (LAC), it is critical that these plans are carried out in a transparent and equitable manner. Each country will determine its prioritization criteria based on the risks of mortality, exposure, and transmission of COVID-19 of certain population groups. If a vaccination strategy heavily weighs avoiding mortality, older adults will likely be prioritized. Large differences in vaccination rates between age groups may be expected under many vaccination schemes; however, large differences based on ethnicity, race or gender are likely to be perceived as an indication of exclusion rather than the intended outcome. During each of the stages of the vaccination plan, countries should deter elite capture of the vaccine that leaves out the most vulnerable populations.

While we show how equity can be applied in the design of prioritization plans, this document focuses on how transparency and equity can be ensured within the prioritization schemes established in each country. It raises key questions and actions that can inform transparency and equity in the deployment of COVID-19 vaccines during prioritization, monitoring, and execution of vaccination plans. It is essential to facilitate access for vulnerable groups and ensure that race, ethnicity, gender, immigration status and disability are not an obstacle to vaccination.

This note was written by Suzanne Duryea and María Antonella Pereira with the inputs of Judith Morrison, Carmiña Albertos, Anne-Marie Urban, Bill Savedoff and Marcella Distrutti

Why is it important that vulnerable populations have access to vaccinations against COVID-19?

Although country-specific data regarding COVID-19 morbidity and mortality rates remains scarce, some common patterns have been demonstrated where the disaggregation by sociodemographic groups has been realized. **Older adults, particularly males**, have the highest probability of severe disease and death from COVID-19.¹ **Women** are over-represented in front-line health jobs with higher exposure rates to COVID-19. In Colombia, case mortality rates are higher for Afro-Colombians and Indigenous Colombians (3.24% and 3.19% respectively) compared to the overall case mortality rate of 2.54%.² For Brazil, the mortality rate of hospitalized patients with COVID-19 is higher for Afro-Brazilians (33.7%) than for the white population (30.3%).³ Studies that have examined the higher rates of mortality for **African descendants** versus whites in the US have found that the differences are partially explained by the higher probability of infection associated with structural characteristics of inequality such as the density of residential settings.⁴ **Indigenous peoples, people with disabilities**, and **migrants** are at increased risk of morbidity and mortality from COVID-19 due to structural disadvantages. These include pre-existing health conditions, limited access to basic health services, and possible overcrowding conditions.⁵ **LGBTQ +** people are also at high risk, as they have been found to be [more prone to various types of cancer](#) and HIV and [face significant barriers to accessing health care](#).



¹The death rate from infection increases dramatically after age 50 (Mallapaty, 2020). For example, the probability of dying was less than 0.1% in Spain and Geneva for all ages under 50, but 7.2% for those over 80 in Spain and 5.6 for those over the age of 50. 65 years in Geneva. In the US, the population over 55 years old accounts for 92% of deaths from COVID-19, although they are only 1/3 of the general population.

²Author's calculations using [this data](#) consider deaths up to early January 2021. .

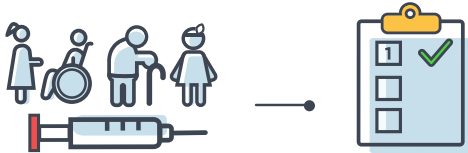
³Since the total number of positive COVID-19 cases is not reported, it is not possible to calculate the case mortality rate for Brazil. Mortality rates among those hospitalized are much higher than among all cases.⁴ (Zelner, 2020).

⁴(Zelner, 2020).

⁵(Duryea et al., 2020) and (Cotacachi & Grigera, 2020) and (Mazza, 2020).

PRIORITIZATION

During the prioritization stage in the distribution of COVID-19 vaccines, there are a number of questions and actions that can promote transparency and equity.



Key Questions

How can equity in the distribution of the vaccine be addressed within the prioritization scheme of each country?

Key Actions



Establish a community vulnerability index to COVID-19 that informs the vaccination plan.

- In addition to prioritizing vaccines at the individual level, governments can prioritize vaccinations at the community level based on vulnerability to COVID-19. In other words, the distribution of vaccines can be prioritized in communities with populations more vulnerable to COVID-19. A vulnerability index to COVID-19 can be constructed at the geographic level (with municipal or census data) using a combination of demographic variables, household risk factors (overcrowding and poverty) and measures of the capacity of the health system.⁶
- Given that indigenous and Afro-Descendant communities tend to have higher poverty rates, higher mortality rates from COVID-19, higher rates of overcrowding and lower access to healthcare, community vulnerability indexes are highly correlated with race and ethnicity. Hence, community-level targeting is a critical tool for promoting vaccine equity.
- To avoid the exclusion of homeless people, migrants and other marginalized populations during the deployment, some countries are directing vaccines to vulnerable communities with criteria that do not require verification of residence or legal migratory status, just simply an official document that verifies age. Place of residence can be self-reported, but without requiring documentation.

⁶ Where available, geographic COVID-19 mortality data can be used for this purpose

MONITORING

Monitoring and reporting on the vaccination plan are essential for transparency. Through rigorous monitoring, it is possible to confirm if vaccines are reaching vulnerable populations and if gaps are observed, take corrective action.



Key Questions

Will the country have a system to monitor in real time the implementation of the prioritization criteria and to demonstrate that vaccines are reaching intended populations?

Are gender, race, and ethnicity considered among the data required in the information system to monitor vaccine distribution?

If large gaps based on gender, ethnicity or race are observed among the first 20% of the vaccinated population, how will the selected criteria for prioritization be maintained and justified as transparent and equitable?⁷ Will prioritization criteria be periodically evaluated and modified to adjust for equity in distribution?

Key Actions



Monitor vaccine distribution in real time with equity indicators through an information and monitoring system.

- An information system can report real-time progress in vaccination coverage. The collection and presentation of information disaggregated by gender, age, ethnic origin and race, level of education and municipality of residence can provide transparency on the implementation of the vaccination plan. Sensitive personal information such as name should not be reported.
- Even well-designed vaccination plans need updating after monitoring interim results. The probability of being vaccinated in the United Kingdom was found to be twice as high for whites as for people of African descent⁸ with large gaps also found in the United States by race and ethnicity⁹. These results have prompted additional efforts to vaccinate vulnerable populations who are often concentrated residentially. Some states in the United States are constructing “hot maps” which plot real-time vaccination rates and trends in COVID infections by postal codes. The dynamic mapping allows effective course correction, for instance, by increasing the presence of vaccination sites in communities where vaccination rates are low and transmission rates are trending up, and distributing through trusted community organizations.

⁷ If the prioritization scheme focuses heavily on avoiding mortality, it would not be unexpected to find a large vaccination gap by gender given the significantly higher mortality rates for men. Where data has been disaggregated by race, death rates from COVID-19 cases have been higher for Afro-descendant people than the overall population (Colombia and Brazil). Long delays in vaccination rates for Afro-descendant people could indicate difficulties in distribution and acceptance.

⁸ (Griffin, 2021)

⁹ (Ndugga et al., 2021)



- Some people may not want to report their ethnic-racial identity out of fear of discrimination, including concerns about receiving a lower quality vaccine. With the aim of minimizing the amount of missing information on race/ethnicity, it is possible to follow-up on ethnic-racial identity and other omitted information after the final dose of vaccination, always respecting the right to not respond.
- It is essential to communicate the progress of the vaccination process and the fulfillment of prioritization criteria in real time with the national population as part of a broader communicational strategy of transparency. This can be shared through various communication channels including television, radio, and on websites.

EXECUTION

Communication

Key Questions

Will the communication campaign be culturally appropriate and available in diverse languages, including indigenous languages, and accessible formats (eg, accessible website, subtitles, sign language interpretation, text messages, etc.)?

Will the dissemination of information be coordinated with indigenous authorities and civil society organizations that have close ties to various population groups that may be more difficult to reach, including those who work with vulnerable LBGTQ + populations?

Three aspects should be considered in the execution stage of vaccination plans against COVID-19: communication strategy, protocols and accommodations that allow access to vaccination for vulnerable populations, and consent mechanisms for diverse populations. People with disabilities, Afro-descendants, indigenous people, women, LBGTQ + people, and migrants need to be informed about the vaccination plan, be able to access the vaccine without obstacles within the prioritization scheme, and give their voluntary and informed consent to the vaccine. Below are key questions and actions for the execution stage that can facilitate transparency and equity in vaccine distribution.

Key Actions

 **Develop an inclusive communications campaign about the vaccination process.** The campaign must include two fundamental aspects:

1. The campaign's messaging must be culturally adapted, clear and communicated through respected and reliable community members.

In communities with doubts about the efficiency, safety or importance of the vaccines¹⁰, it is especially important that the content of communication campaigns reflect local practices and traditions.

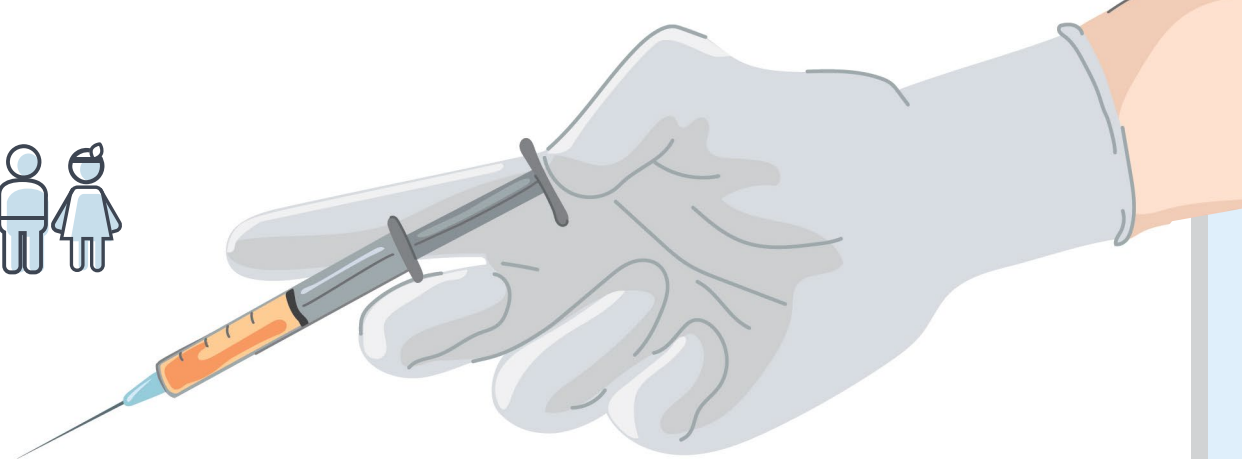
- A community consultation process in indigenous communities can help understand how intercultural beliefs and practices relate to the vaccine (s), so that they influence communication campaigns and how health workers can effectively communicate the information on the importance of vaccination. Information on vaccination can be communicated by indigenous authorities..
- Information can be disseminated through community leaders and civil society organizations that have strong ties to diverse populations that may be difficult to reach, including leaders/organizations that work with vulnerable LBGTQ + populations and migrant populations. This can help combat hesitancy and misinformation around vaccination.¹¹
- It is crucial to develop clear messages targeted to women who are pregnant, looking to conceive or breastfeeding.
- Ensuring a diverse representation in communication materials is a priority, including the representation of indigenous peoples, Afro-descendants, women and people with disabilities.

2. Communication materials must be accessible.

- It is important to create accessible materials for people with disabilities on how to access vaccination, for example, through websites accessible to screen reader users, captioning and sign language interpretation in multimedia and live television, the use of text messages, among others.
- Likewise, materials must be created in indigenous and other diverse languages, which consider the cosmovision of indigenous peoples.
- Ideally, there should be multiple methods of accessing information including through television, radio, websites or text messages.

¹⁰ According to a survey carried out in several countries worldwide, it is shown that there is a significant percentage of the population that is undecided about vaccination against COVID-19. Around 17% of respondents in Brazil answered that they probably would not want to be vaccinated against COVID-19 or that they would definitely not want to be vaccinated; in Mexico the percentage is 18%, in Ecuador 20%, in Argentina 24%, in Chile 28%, in Peru 28%, and in Paraguay 49% (Wouters et al., 2020)

¹¹ Successful vaccination campaigns prior to the COVID-19 pandemic demonstrate that it is important to engage influential leaders to understand community concerns, increase trust, and combat rumors and misinformation (Wouters et al., 2020)



Key Questions

*Do people with disabilities face barriers to accessing the vaccine?
How will transportation, communication, accessibility at facilities,
or other barriers be addressed?*

*How will gender roles be considered, in that they affect, for
example, access and control of resources of women, men and
LGBTQ + people and their ability to access vaccination sites
(considering distances, hours of operation, time and costs involved,
security concerns, knowledge of service availability)?*

*Do traditionally excluded populations have equitable access
to vaccines (indigenous peoples, LGBTQ + people, areas with
high concentrations of Afro-descendants, areas with high
concentrations of migrant populations, remote communities)? Is it
feasible to support the provision of mobile vaccination services to
address potential diversity gaps?*

*How can vaccines be administered in remote areas, particularly
indigenous territories, in the most cost-effective way? How will
contagion be avoided during the vaccination process in these
communities? Has a community consultation process been planned
regarding the distribution of vaccines to indigenous peoples?*

Key Actions

Create accessibility protocols for vaccinations. This can include:

- Adapt and ensure that vaccination sites are accessible to people with physical and sensory disabilities, or that reasonable accommodations can be provided to facilitate access to the vaccine.
- Create a reasonable accommodation request protocol, so that people with disabilities can request reasonable accommodations before/during their vaccination appointment, such as the presence of a sign language interpreter, curbside vaccination, vaccination at home, Braille documents, among other accommodations.
- Create a protocol for requesting translators, so that indigenous peoples can request a translator before/ during the vaccination appointment, or that there is a guaranteed presence of translators or intercultural facilitators at certain times at specific sites.

Create mobile vaccination campaigns, that look to reach vulnerable populations and isolated communities. This can be useful for:

- People with disabilities that cannot travel to vaccination sites.
- Work in coordination with indigenous health services and in remote areas. This should be coordinated through the community consultation process.



- Afro-descendant communities with difficult access to health services.
- Women and LGBTQ+ people who may not want to travel long distances due to risk of violence.



Implement a consultation process with indigenous communities to develop vaccine distribution plans in specific communities.¹²

Consent must be ensured for the distribution of vaccines in communities and at the same time, measures must be taken to prevent the transmission of COVID-19 as a result of the distribution of vaccines. The consultation process can be helpful to:

- Facilitate the logistical aspects of distribution and avoid contagion. In LAC, there are indigenous cultures at risk of extinction, or that could face the threat of extinction from COVID-19. It is crucial to protect these communities. Given this reality, the entry of external health personnel during each stage can present a threat and significant logistical difficulty. Vaccinating entire indigenous communities can be considered to avoid contagion and, in turn, reduce logistical costs related to access to communities and preservation of vaccines.
- Coordinate the distribution of the vaccine through a community strategy with the community governance structures (their authorities) or NGOs working in remote rural areas.
- Establish methods of access to vaccination that are respectful of intercultural beliefs and practices.

¹² This action is also relevant to develop culturally adapted communication campaigns, obtain the consent of communities, for example, to the entry of health personnel into their communities, and guarantee the access of indigenous peoples to the vaccine. It is mentioned only once to avoid redundancy.

CONSENT



Key Questions

Are adults given the opportunity to consent to the vaccine rather than through a third party (in their own language, in accessible formats, directly to the person rather than through a non-official representative/ guardian)?

Are indigenous communities provided the opportunity to participate in voluntary, prior and informed consent (in their own language, in culturally appropriate formats, in coordination with indigenous authorities, and through community consultation processes)?



Key Actions



Create consent protocols that consider that all information must be shared directly with the patient and that the patient is the only person who can consent to the vaccine. This is especially relevant for indigenous peoples and linguistically diverse groups (so that they can consent in their own language) and adults with disabilities (so that they consent to the vaccine themselves instead of through a non-official representative/guardian). This should involve:

- Training health professionals in guaranteeing the consent of indigenous peoples and people with disabilities.
- Create consent forms and mechanisms that are accessible, for instance, with the presence of sign language interpreters, forms in Braille, digital signatures, information in simple language, among others.
- Create consent forms and mechanisms in indigenous and diverse languages, for example, with the presence of translators.
- The community consultation process can be used to guarantee consent for indigenous peoples in the distribution of vaccines in their territories, and if necessary, the entry of health professionals foreign to the community.

Key Actions in Context

It is clear that all countries must be proactive in ensuring transparency and equity in the distribution of vaccines. However, each country has its own challenges regarding the distribution of COVID-19 vaccines. Governments must determine which actions are most relevant within their vaccination plans and adapt them to the local context. Some countries are already doing this:

Alaska, USA

In Alaska, much of the state is not accessible by car and the population is widely dispersed. The vaccination strategy consisted of partnering with indigenous authorities and indigenous health services, who directly received the vaccines for distribution to the indigenous population. Health personnel are traveling on snowmobiles, fishing boats, light aircraft, and water taxis to vaccinate the population. [Mobile vaccination campaigns and alliances with indigenous authorities](#) were implemented to minimize doubts and fear about the vaccine among indigenous peoples and facilitate the geographic reach of vaccination. The state has one of the highest vaccination rates in the United States.



Australia

The Australian Ministry of Health has developed an extensive communications campaign on the vaccination plan. As part of the initiative, the Ministry of Health has created [committees representing indigenous peoples, multicultural communities, and people with disabilities](#), which are supporting the Ministry in creating culturally adapted materials for these populations. In addition, the Ministry has announced that the general campaign materials, which include messages on television, radio and the internet, will be [translated into 15 indigenous languages](#).



Brazil

Among the priority groups for vaccination against COVID-19, the Brazilian government has [prioritized the vaccination of indigenous peoples living in indigenous territories, as well as traditional ribeirinha and quilombola communities](#). The Ministry of Health is sending the vaccines directly to the centers of the Subsystem for Indigenous Health Care that operate in health districts with a significant presence of indigenous communities (DSEI). The Brazilian government has kept a record of the vaccines distributed in these territories. At the national level, [50.4% of indigenous adults](#) have been vaccinated; In the DSEIs, vaccination levels of indigenous adults vary from 4.67% (in Kaiapó do Pará) to 86.96% (in Alagoas and Sergipe). In addition, it is worth highlighting the [information page](#) on vaccination against COVID-19 of the Subsystem for Indigenous Health Care, which contains the data on the level of vaccination in the DSEIs. The page is accessible and has a robotic interpreter in Brazilian sign language (Libras).



United Kingdom

The National Public Health Service (NHS) created an app that enables patients with auditory disabilities to make calls to the NHS in British Sign Language (BSL). As part of the initiative to increase accessibility in the access to vaccines in the UK, the NHS added the possibility of scheduling vaccination appointments via the [119 BSL line](#). In addition, the NHS has collaborated with [SignHealth](#), the UK's leading NGO dedicated to increasing deaf people's access to health services, to distribute information on COVID-19 and the vaccination process in BSL. These videos include a BSL interpretation of the [“Vaccination Guide for Women of Childbearing Age, Currently Pregnant or in Planning”](#) that was originally produced by the NHS.



As the countries of Latin America and the Caribbean launch their vaccination campaigns against COVID-19, it is essential that they implement measures to ensure transparency and equity in the deployment of vaccines. In this sense, countries must develop vaccination plans that seek to avoid elite capture of vaccines, and implement such plans with transparent monitoring, culturally adapted communication campaigns, accessibility in the vaccination process, and consent mechanisms.

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