REFLECTIONS

The fourth dose: My "me-first" experience

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Abstract

Vaccine inequality is the biggest obstacle to curbing the Covid-19 pandemic and accelerating socio-economic recovery in the developing countries. Many people, including myself, living in developing countries, were initially inoculated with the WHO-approved vaccines unwelcome to developed countries, such as Sinovac. Presently, governments in developing countries are offering the third and fourth doses of mRNA vaccines to facilitate cross-border travel. This creates a devastating burden on ongoing Covid-19 vaccination in developing countries, increasing the injustice and inequality between the developed and developing countries. Here, I share my thoughts as a public health specialist while I was receiving the fourth dose of the Covid-19 vaccine to fulfil travel requirements.

Keywords: *Covid-19 vaccine, number of doses, vaccine inequality, injustice*

"Are you sure you want a fourth jab?" A colleague of mine called while I was going to get the fourth dose of Covid-19 vaccination. "Yes I am leaving home" I replied. "I feel something bad will happen." – maybe the fear of adverse effects like headache, myalgia, chills, and shivers that I suffered after the third dose was worrying her. However, being a medical doctor I was not concerned about the adverse effects. I was more anxious about the ethics of getting a fourth dose while many people in developing countries haven't even received their first dose yet.

My work at an oncology hospital ensured that I got two doses of inactivated viral vaccine – Sinovac, the only available Covid-19 vaccine at that time in Turkey – with an interval of 28 days between the doses in January - February 2021. This is when vaccines developed in western countries were reserved to meet their own populations' demand, while China was sending millions of vaccine doses to the developing countries out of generosity, commercial considerations, or to increase its political influence. Chinese vaccines, unwelcome in the West, were successful in gaining the trust of politicians and policymakers of many countries even before the clinical trial results were available [1,2].

The race for coronavirus vaccine safety and efficacy trials showed that mRNA-based vaccines were more effective. Additionally, clinicians in my social setting, tend to trust vaccine clinical trials, quality control standards, and research approval conducted in western countries.

The Turkish Ministry of Health (TMoH) approved a voluntary third dose of BioNTech to those who had previously received two doses of Sinovac, and my thirst for the mRNA-based vaccine was quenched on July 3, 2021. The thing that bothered me about the fourth dose (second jab of BioNTech) was not about efficacy but its necessity for international travel — at that time most western countries recognised only Pfizer/BioNTech or AstraZeneca for cross-border travel [3]. On August 16, 2021, the TMoH announced a fourth dose of vaccine for those who wished to travel abroad [4]. This decision was not based on any clinical recommendation but rather on "travel recommendations" issued by western countries.

On August 28, 2021 – the day of my fourth jab – only 1.8% of the population in low-income countries had received at least one dose of vaccine [5]. Indeed, just 47% of the Turkish population was fully vaccinated with two-doses on that day [6]. I knew that every person in the world needs to be immunised to end this pandemic or at the very least, the 70% vaccination milestone had to be passed in a community to normalise socioeconomic and educational activities. I had studied the topics of scarcity, rationing, equality, and justice in health economics and bioethics classes to become a public health specialist, but failing to apply them on that day seemed like "public health malpractice" to me. It was distressing to know that the fourth dose that I was to receive if given to someone not immunised could prevent infection in one among 650 thousand people infected daily and save one in 7 thousand lives lost daily due to Covid-19 [7].

Undoubtedly vaccine inequity is the biggest obstacle to limiting this pandemic and accelerating socio-economic recovery in developing countries [8]. Vaccine inequity exists between North an South as well as between the socioeconomically developed and undeveloped local regions within countries. This "glocal" inequality would increase

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further with the third and fourth doses of vaccine being offered. Undoubtedly, Covid-19 vaccine inequality would prolong the pandemic, undermine economic recovery, and threaten progress in achieving the Sustainable Development Goals. In the era of global interdependence, both the developed and developing countries would suffer the consequences.

Covid-19 vaccine is relatively costlier than other vaccines in routine immunisation programmes. The prices of best-selling vaccines were further raised after the developed countries secured the supplies for booster shots [9]. The Government of Canada has secured up to 409 million doses of vaccines for its 38 million population [10]. The price per Pfizer dose was raised from 15.50 to 19.50 [9]. In addition, mass vaccination is a huge strain on health systems in developing countries, lacking in adequate infrastructure and healthcare workforce. The adaptations in the national health system for the prevention and care of Covid-19 were at the cost of undermining routine immunisation and essential health services [11]. The additional vaccination for travel purposes would have a devastating impact on ongoing Covid-19 vaccination and the opportunity to recoup the healthcare gaps in these countries would be lost.

Like me, many people in the developing countries were inoculated with the WHO-approved Covid-19 vaccines produced in the East, such as Sinopharm, Sinovac, and Covishield, "unacceptable" to the West. Every year millions of people from developing countries travel for work, education, family visits, and tourism to western countries. For instance, in 2019, more than 90,000 trips were recorded by Pakistani citizens to the UK [12]. Now the government of Pakistan allows booster doses at a subsidised price of 1270 Pakistani rupees (6.4) to facilitate cross-border travel of those who received two doses of the Chinese vaccine [13]. Meanwhile, the Government of Pakistan itself relied on donations and allocations from the World Health Organization-backed Covax/GAVI scheme that guaranteed fair and equitable vaccine access for developing countries [14]. Until August, 2021, Covax has delivered only 236 million doses to the developing countries [15], and the use of the third dose in these countries would widen the gulf between vaccinated and unvaccinated populations.

From a public health perspective, a key question is why are the WHO-approved inactivated viral vaccines used earlier not acceptable for facilitating cross-border movement in some countries? Why did European Union (EU) countries not welcome visitors who received the Indian Covishield vaccine [16] even though it is a version of the Oxford-AstraZeneca vaccine [17] used in the EU? From a public health viewpoint, the available evidence suggested that all types of WHO-approved vaccines show reasonable efficacy against symptomatic infection and severe disease after infection, and that mortality is higher among unvaccinated people. On the other hand, the available evidence also shows that the immunity level triggered by mRNA-based vaccine reduces after some point in time [18] and people vaccinated with it are also getting the infection [19]. In this context, the Covid-19 vaccine is one of the main measures, among others, to control cross-border spread of infection.

At present, attention is focused on vaccine efficacy, which means a reduction in symptomatic cases among specifically chosen vaccinated people in a controlled clinical trial. In reality, vaccine performance under real world conditions may differ due to many factors. It is "vaccine effectiveness" that measures how well vaccines work in real-world conditions to protect communities as a whole [20]. Phase VI trials to measure such effectiveness are still pending. Most country-specific entry restriction strategies are either based on fragmented information or copy what is applied in the leading countries. Perhaps, welcoming only recipients of certain Covid-19 vaccines is a modern policy of imperialism and will undermine indigenous mass vaccination strategies, besides creating a demand for a particular brand of vaccine in developing countries. Public trust in the available vaccines is vital for their uptake. With confusion and lack of trust in the locally–made available vaccines, people will not vaccinate, and wait till vaccines manufactured in the West become available to them.

In the end, I was unable to overcome my endless troubled thoughts, and I felt I was a burden on my health system. I am not only a doctor and public health specialist but also a human being, an economic migrant who desperately wants to meet his parent living oceans away. I finally rolled up my sleeve for the fourth dose — a pathway to international travel. My colleague who had accompanied me to the vaccination site said "You are safe now". For me, it was too early to quantify the probability of my safety, however, if I could have donated it to someone most at risk but without access it could have saved their life.

I had never taken a photograph of my vaccinations except for that dose. I shared my photo "4th dose and blessed" among my family and friend network with the hope that it could help the unvaccinated to overcome myths and fears of side effects. Surprisingly, many vaccine deniers not only agreed to vaccination but some also shared my experience of the 4th dose with others for advocacy. Indeed, this advocacy was the only thing that calmed my anxious mind. Some criticise the TMoH cocktail vaccine policy because it imposed a double burden on the economy and health system. Turkey launched its vaccination campaign in January 2021, the time when mRNA vaccine was available mostly in countries that produced it. In the era of global vaccine confusion, TMoH allowed 83 million citizens and four million refugees to boost their immunity and embark on international travel without any charge.

The growing global health inequity is indisputable, but one lesson I learned from this event is how firm and inevitable the architecture of inequality is sometimes. I hope sharing my "me-first" experience can help spark discussion for safer international travel, together with improving equitable global access to Covid-19 vaccines.

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