

All India Peoples Science Network (AIPSN) Position Paper

On Second Wave of Covid-19 Pandemic in India

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[India is well and truly into a brutal second wave of the Covid-19 pandemic](#). Daily cases are skyrocketing to unprecedented heights, and are now the highest of all countries, while total cases have taken India to second place worldwide overtaking badly hit Brazil. For the sixth day, India had record numbers of daily cases over 1 lakh, [reaching 1, 61,736 new cases on 13 April](#), far higher than the record high of 97,894 new daily cases on 16 September 2020 during the first wave. Going by current trends, India is likely to reach even higher daily case rates, with these new highs prevailing for a prolonged period, unless strong and effective steps are urgently taken. Mortality and hospitalization rates are on the rise dangerously in parts of the country and [show a worrying trend overall](#).

Accept responsibility; don't blame the people and States

A very belated high-level [meeting at the PMO](#) a week ago “emphasized that the reasons for the sharper rise in cases could be mainly attributed to the severe decline in compliance of Covid-appropriate behavior primarily in terms of use of masks and maintaining ‘2 Gaj ki Doori’ [two yards distance], pandemic fatigue and lack of effective implementation of containment measures at the field level.” This analysis blaming the people and the States for this crisis, and repetition of the same charge by other high officials, is disingenuous, hypocritical and even dangerous, serving only to enable the Centre to evade responsibility for the present situation and give itself an excuse for future inaction or failure. It is evident even to a casual observer that broad sections of the people all over the country have become extremely lax as regards masking, maintaining physical distancing and avoiding crowded spaces especially indoors. However, this begs the question: what was the Government doing to tackle this and prevent the inevitable consequences of a second wave, and did not the Government itself encourage this laxity?

As public health experts have [pointed out](#), the period when cases were sharply declining reaching a trough or low point of [9,121 on 15 February](#), provided the best opportunity to attack the virus through vigorous containment and mitigation actions including expanded vaccinations, but the Government lowered its guard and missed this chance. Meanwhile, encouraged by signals from the Centre, authorities everywhere relaxed all restrictions, with offices, cinemas, restaurants, malls, passenger airlines and public transport all functioning at full capacity virtually in a pre-pandemic “life as usual” mode. Learning from the first wave, it is important that measures are taken through a partnership between the Centre and States, with the Centre providing evidence-based guidelines and financial as well as other assistance, with the Centre not making efforts to shift blame to States while withholding essential supplies and co-operation on many fronts.

Experience of different countries has repeatedly underlined the importance of continued vigilance and ensuring Covid-appropriate behavior during periods of declining cases. However, the Government itself suggested, through its [National Covid Supermodel](#), that cases in India had peaked by October 2020 and would be under control by February 2021, and led to widespread lowering of guard. Even today, in the midst of this dangerous second wave, huge crowds are attending potentially super-spreader events such as the massive gatherings at the [Mahakumbh Mela](#), and packed rallies

and road shows during the State elections frequently addressed by the topmost Government leaders who are themselves responsible for Covid-19 control measures. No guidelines have been issued, no efforts at enforcement of Covid norms are being made, and the few mild public appeals seem like a mere a formality. It would appear there is no pandemic in India!

Additional epidemiological data and further analysis is required to arrive at any firm conclusions as to reasons behind this second wave, and precautions required to be taken in the future.

Understand role of variants, expand gene sequencing

There is considerable discussion, albeit so far without adequate evidence or data, about one particular reason that may be contributing to this second wave, namely Sars Cov2 virus variants which may be more infectious, or deadlier, or even provide a “vaccine escape” i.e. being resistant to vaccine-induced immunity. It is well known that viruses mutate to combat increasing immunity in the host population due either to widespread prior infections or vaccination. The major internationally known variant strains or lineages are the so-called UK variant (B.1.1.7), which ravaged Britain and has now emerged as a dominant strain in the US and may even [lead to more deaths](#), the South African variant (B.1.351) and the Brazilian variant (P.1.). All these variants have been observed in India. Of around 10,787 samples from 18 Indian states analyzed by labs involved with the [Indian SARS-CoV-2 Consortium on Genomics \(INSACOG\)](#), 771 variant cases were detected comprising 736 UK (336 in Punjab alone), 34 South African and 1 Brazilian variant. Maharashtra has shown a worryingly large number of cases (202 of the above sample) with a “double mutation” (E484Q and L452R), now assigned a distinct lineage B.1.617.

However, insufficient information is available as of now to draw any firm conclusions about the impact of these variants. Also, not enough is known about the efficacy of different vaccines in protecting against these variants, although some available [information suggests](#) that the Oxford-AstraZeneca or Covishield vaccine provides good protection from the UK variant but not from the South African variant. [INSACOG has been beset with difficulties and only 7,664 samples – less than 1% of the total positive samples since January 2021 through March 18, 2021 – have been sequenced.](#) It is important that India significantly expands genetic testing across the country and correlates findings with epidemiological data in order to obtain a better understanding of the dangers posed by these variants. There is therefore need for more laboratory and field studies regarding the efficacy of Covishield, Covaxin and other vaccines likely to be used with respect to these variants.

Increase testing, tracing and surveillance

It is important to note that the main public health response to the present second wave, irrespective of these variants and other factors, remains broadly the same as was advocated earlier, but learning from missteps and experience during the first wave. [India needs to vigorously test, trace, isolate and treat infected persons](#), besides putting in place decentralized, locally relevant and evidence-based surveillance and containment strategies. Test positivity rate in the first wave was highest at around 12.7% on 20 July 2020, about 8.7% at the case load peak around 20 September 2020 and was at its lowest at 1.6% on 15 February 2021. Today [all-India average test positivity rate](#) is high at 11.4% on 12 April 2021 showing inadequate testing, and rising continuously. Testing needs to be ramped up significantly, with emphasis on RT-PCR tests, so as to uncover infections

more quickly. At the same time, testing needs to be strategic, targeting contacts of positive cases and symptomatic cases in clusters identified through community surveillance and contact tracing.

Contact tracing was the weakest aspect of the response by governments at the Centre and most States during the first wave, with the Aarogya Setu App proving to be [ineffective](#), and badly needs to be strengthened now. Tracing all contacts quickly, testing and then isolating them if infected, is essential for quick containment of the spread of the disease, along with community-level surveillance measures to identify potential hot spots. Decentralized evidence-based approaches with community participation would be most effective. All available human resources need to be mobilized for this, going beyond health workers and the police who may have enough on their hands, and tapping NDRF, home guards, educated youth and other volunteers, and civil society organizations, all with proper training for the purpose. Data relating to contacts traced, tested and isolated should also be included in daily reporting dashboards of State governments along with cases, tests, deaths etc, since this would act as a monitoring mechanism as well as motivation to perform better.

Address Vaccine shortage & Equity

There is a seriously mistaken tendency among authorities, and also some commentators, to look to vaccines as a silver bullet to tackle the pandemic and bring this second wave to an end. [India is currently vaccinating an average of 3-4 million persons per day and has so far administered around 85 million doses](#). While this may look good in absolute numbers, especially for a developing country, India's vaccinations per capita rank well below the global average. [Many States are also complaining of shortages in vaccine supply from the Centre](#).

It also needs to be emphasized that India will take at least another 55 days at present rates to administer at least one dose to the original target of 300 million persons for this phase, not counting the additional recipients due to inclusion of all above the age of 45 years in the eligible group. That still leaves a huge gap of several hundreds of millions of doses requiring to be administered even if those under 18 years are not counted. Clearly, India cannot just wait for vaccinations to be completed and must press on urgently and effectively now with the public health measures discussed above.

There is [much information](#) available, albeit scattered and mostly anecdotal at present that a class divide is emerging in India's vaccination drive, in cities as well as in many rural areas in the country. Those missing out on vaccinations say they do not know where vaccines are being administered, how to get vaccinated, how to enroll for vaccinations, that they do not have smart phones etc. These deficiencies need to be urgently rectified by suitable modifications in the vaccination strategy, especially by taking the vaccines to eligible populations at community level and conducting widespread communication campaigns on the vaccination drive. Continuing vaccine hesitancy also needs to be overcome.

The weakness in vaccinating health workers and frontline workers, the first in the eligibility queue, also needs to be overcome urgently. [Reports suggest](#) that around one-third of health workers have not been vaccinated, for whatever reason. Having noticed some misuse of the priority facility for health workers, the Government has [recently closed](#) the enrollment of health workers for vaccination. Instead of taking punitive action against health workers by closing their enrollment for vaccination, Government should rectify the enrollment system and block loopholes, while actively persuading health workers to get vaccinated.

Scale-up Vaccine production and availability

These vaccine numbers show that, quite apart from complaints by several States about vaccine shortages and lack of timely supplies from the Centre, requirement for vaccines is currently greater than supply and likely to remain so over the next few months. According to reports, [Serum Institute of India \(SII\) is producing around 21.6 lakh doses of Covishield daily or 648 lakh \(64.8 million\) doses per month. Bharat Biotech is manufacturing around 1.6 lakh doses of Covaxin daily \(4.8 million doses per month\).](#) The total production is therefore enough only for 23 lakh doses daily, much below even current vaccination rates, leave alone an expanded vaccination drive. Therefore the Government needs to urgently take steps to boost manufacturing capacity. For instance, both the above manufacturers have requested the Government to finance expansion of production significantly and quickly. SII has said it could ramp up production of Covishield to 200 million doses per month if such financing is made available, and. Bharat Biotech says they could scale up production of Covaxin to around 7 times current levels or to about 33.6 million doses per month.

All those who are clamoring for on-demand vaccinations for the entire adult population should keep these supply chain constraints in mind. At the same time, the suggestion from several hospitals and doctors that those between 18 and 45 with serious co-morbidities should also be brought within the eligibility criteria for vaccinations need consideration.

At the same time, the Government should also take several other steps to ramp up availability of vaccines. At the time of writing, the [Russian Sputnik-V vaccine](#), which has a proven high efficacy against the SARS Cov2 virus and has also undergone bridging trials in India, [has been given emergency use approval by DCGI](#) after a prolonged wait while being repeatedly asked for additional data. This contrasts sharply with the rapid pace with which Bharat Biotech's Covaxin was approved, without even waiting for efficacy data. This is not to argue for similarly cutting of corners for Sputnik-V or other vaccines, but Government should help to expedite the process. Sputnik-V is not prohibitively expensive, unlike the Pfizer and Moderna vaccines, and can be stored in ordinary refrigerators in powder form, and can therefore form an important part of India's vaccination programme. Russia Direct Investment Fund (RDIF) has also tied up with 6 Indian vaccine manufacturing companies to together produce around 650 million doses. However, since this production in India will take time, Sputnik V will initially be fully imported from Russia. Again, at the time of writing, Government has decided to invite those vaccines approved by WHO and by regulators in the US, Europe and Japan to apply for approval in India without having to undergo bridging trials, stating that close watch would initially be kept on safety aspects before large-scale roll out.

Care should be taken to ensure that modalities of import, pricing and distribution are designed in such a manner as to not accentuate the present class divide in vaccine access, and that a dual-access does not emerge where the well-off have ready access to a wide variety of vaccines through private facilities by virtue of their ability to pay higher prices, while the poor struggle to access vaccines due to lack of paying ability and poor access to information.

Address Licensing/ IP issues

It is unfortunate that despite this good track record of assisting the global vaccination effort despite high , India has not pushed back on high-income countries such as in the US and in EU countries who have hoarded vaccines at the cost of other especially poorer countries.

India recently participated in a Meeting of the Indo-Pacific Quad grouping comprising the US, Australia, Japan and India. Among other things, the Meeting discussed a major Quad role in enhancing vaccine supplies for the Indo-Pacific region through an agreement under which the US would provide vaccine know-how and share financing with Japan, India would take responsibility for manufacture and Australia would handle logistics for supply of 1000 million doses to the region by end of 2022. Unfortunately, India did not use the occasion to raise the issue forcefully with the US, merely [stating afterwards that](#) the matter is sensitive and is being discussed with the US bilaterally. India must push the US strenuously in this regard; otherwise the “strategic partnership” would mean little.

India and South Africa also moved a [proposal](#) to the WTO in October 2020 calling for suspension of intellectual property rules and other obstructions to sharing of know-how especially to developing countries to enable the latter to manufacture vaccines, medicines and other medical products and hence to more rapidly bring the Covid-19 pandemic under control at least cost to their people. Regrettably, but true to form of the global North, the high-income countries notably the US, UK and EU [blocked](#) the proposal. In this case too, India did not actively pursue this proposal, which had the backing of the developing countries, either bilaterally with the US and other developed countries or in multi-lateral fora, revealing a possible lack of courage and determination to take on the leaders of global capitalism.

However, this demand by India points to another measure the Government could take in India so as to ramp up production of vaccines in India. The Covaxin vaccine was developed by the National Institute of Virology in Pune, a laboratory under the Indian Council of Medical Research, and productionized by the Hyderabad-based Bharat Biotech who put it into production. It is suggested that the Government take the initiative to work out arrangements for licensing other Indian manufacturers to produce Covaxin so as to augment total supply of this vaccine. Established public sector enterprises such as the Haffkine Bio-Pharmaceutical Corporation Limited, Maharashtra should also be included in this endeavor, putting aside the blind ideological opposition of the ruling dispensation to PSUs.

There is no compulsion to allow Bharat Biotech to retain a monopoly over the know-how for this vaccine, especially during this dangerous second wave of the pandemic, [just as India had joined South Africa to demand that vaccine developers and manufacturers in the developed countries give up their monopoly rights.](#)

Oppose misguided vaccine nationalism

In this connection, there is a wholly misconceived campaign being mounted, including by some political parties and sections of the media, that India should stop commercial and aid-based exports of vaccines so as to prioritize domestic needs. Even before this, the Government had [imposed some restrictions](#) on exports potentially undoing the goodwill earned earlier by free supply of vaccine to friendly developing countries and by its substantial contribution to the international Covax facility to supply vaccines to lower income countries. India has exported around 64.5 million vaccine doses, mostly of Covishield, since January 2021. [Of this](#), 10.5 million were free supplies to developing countries and UN peace-keeping forces, 18.2 million to Covax, and 35.8 million were commercial exports, again including under contractual agreements with AstraZeneca which has licensed the manufacture of Covishield in India. Notably, India has hugely benefited from the

transfer of technology from Oxford AstraZeneca to SII of a vaccine whose price has been deliberately kept low so as to benefit other developing countries. Supplies to Covax too are contracted and manufacturers like SII have received substantial advance funding under the Covax programme, so these actually should not be stopped or delayed, although [reports are](#) that India has slowed down supplies to Covax and also under its aid programme, causing anxiety among these recipients.

It should also be noted that India has received back around one-third of its supplies to Covax, since India too is a beneficiary country, and largest recipient, under Covax! The free vaccine supplies amounts to just 3 days of vaccination in India at present rates, and even the commercial exports are equivalent to only about 10 days' supply for vaccination in India. Therefore, stopping exports will not provide much relief from the demand-supply gap India is facing. Further, China and India are almost the only countries that are working to assist the global vaccination effort especially in developing and low-income countries, and it would be cruel and immoral to weaken or close down this endeavor in an extremely selfish display of vaccine nationalism, and that too for very little benefit. This is a record to be proud of not condemned. The point again is that what India needs to do now is to ramp up vaccine production by existing manufacturers, and by quickly approving the production and deployment of several other vaccines that are in the pipeline.

It is precisely [this kind of vaccine nationalism and related crass commercialism practiced by the US](#) which is one of the major factors preventing SII, Biological-E (licensed to manufacture the Johnson & Johnson vaccine in India) and other vaccine manufacturers in India to scale up production. These [manufacturers depend](#) on various raw materials and intermediates such as specialized bags, filters, cell culture media, single-use tubing and special chemicals from the US, which has imposed an export ban on all vaccine-related materials under its Defence Production Act. If India were to similarly restrict exports, it would have no moral authority to demand opening up of exports by the US or others.

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