Covid-19 vaccination among people with disability—Statement from the iADH scientific committee

Scientific evidence is the best resource available to make health decisions either at individual or at community levels. To build such evidence, time is a key factor. The COVID-19 global pandemic has challenged scientists’ and clinicians’ ability to produce and test sufficient sound evidence regarding different strategies to limit the spread of coronavirus and its consequences. Having scrambled in the dark at the beginning of the pandemic, the facts are now becoming clear. We benefit day by day from the innovations and understanding that science has brought to the front line in the war against COVID-19. The bulwark of our ongoing defenses against this viral enemy is vaccination. The evidence shows great promise that COVID-19 vaccination conveys many individual and population-level benefits (see Box 1).

It remains that most of this evidence comes from general population data, due to exclusion from research for people with disability, severe mental illnesses and other high-risk vulnerable populations. This lack of evidence may result in additional barriers to predictable and successful vaccination among vulnerable groups, who already tend to be less likely to avail of immunization services in general, for reasons that are not fully understood.

The pursuit of health equity for vaccine guidance requires a roadmap to navigate health inequities with interventions that uphold the ethical principle of justice with the socially just distribution of limited resources. It should be applied within and between countries and regions so that supplies of COVID-19 vaccines are effectively distributed globally based on a gradient of risk rather than a gradient of wealth. With this in mind, it is known that adults with wide a range of disabilities and medical conditions, who typically attend special care dental teams, are at higher odds of hospitalization and mortality due to COVID-19 infection than the general population. In fact, so great is the increased risk to our population with disabilities that in England, 60% of people who died from COVID-19 in 2020 had a disability. Personnel working with populations requiring Special Care Dentistry must advocate the effectiveness of vaccination for all people to ensure equitable outcomes for the world’s most vulnerable citizens.

This requires advocacy and the iADH would like to add its voice to support prioritization of people with disabilities

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**BOX 1 What evidence supports COVID-19 vaccine use?**

- All COVID-19 vaccines validated by the WHO demonstrated efficacy (range 65%–95%) against symptomatic, laboratory-confirmed COVID-19 in adults ≥18 years; high efficacy (≥89%) against COVID-19 severe enough to require hospitalization and COVID-19-associated death. No head-to-head trials have compared efficacy between vaccines.

- All these COVID-19 vaccines appear to be effective (range 74%–95%) and safe and double-dose vaccination is recommended. However, more research is needed to investigate the long-term efficacy and safety of the vaccines and the influence of dose, age, and production process on the protective efficacy.

- All the COVID-19 vaccines that have published the data of phase III clinical trials have excellent efficacy, and the risk of adverse events is acceptable. The mRNA vaccines appear to be the most effective against COVID-19, with the risk and grade of adverse events being minimal, compared to that of severe symptoms induced by COVID-19.

- The adenovirus-vectored and mRNA-based vaccines for COVID-19 have the highest efficacy after first and second doses, respectively. However, the mRNA-based vaccines have higher side effects. Remarkably few people have experienced extreme adverse effects, and all resulted in stimulated robust immune responses.

- Transmission risk is likely to be substantially reduced among vaccinated people.
for vaccination, based on the existence of risk factors/co-
morbidities.11–16

1  FUTURE CONSIDERATIONS

“Normal life” is still a long way off and it appears that
COVID-19 will remain in circulation for years to come.
Advice is emerging about how to handle the next stage of
the pandemic, as vaccination or herd immunity is unlikely
to halt the virus and the World Health Organization has
warned that COVID-19 may never go away. There have
been calls for wider distribution of and enhanced co-
ordinated vaccination and testing regimes including rapid
testing systems, and yearly boosters for those most at risk.
Positive measures must be taken across a range of areas to
ensure that all groups of people with disabilities transition
out of the emergency phase on an equal basis with each
other and the rest of the population. The alternative risks
a permanent erosion of the human rights and equality of
people with disabilities.

COVID-19 has already given rise to significant risk of
discrimination and the undermining of rights for persons
with disabilities. The pandemic has clearly highlighted
that if an equal standard of dignity and participation is
not met in ‘normal’ times, it rapidly becomes a casualty in
times of crisis. Experience and evidence suggest that col-
lective living arrangements and congregated care settings
render vulnerable people more susceptible to COVID-19.
Furthermore, many with disabilities who live at home
encounter environmental and behavioural factors, on top
of their compromised health conditions, that increase the
risk of contagion, complications and hospitalisation.

At this time of global vaccine inequity, people with dis-
abilities are not consistently recognized as a vulnerable
group in emerging documents, which continue to focus on
age, immune status, and profession. Priority lists should be
responsive to new data and feedback from disability orga-
nizations to ensure that they give sufficient priority to peo-
ple with disabilities and their support networks, such as
personal assistants, family careers, and people working in
disability-related services.17

The IADH recommends that an equality-based approach
be taken to build a transition out of COVID-19 that is
fully inclusive to the needs and wishes of people with dis-
abilities18 and includes clear messages and information
in a variety of formats. The vaccine rollout must not exac-
erbate existing inequalities. Strategies should be devised
through consultation with people with disabilities in order
to assure that they are affordable and accessible and reach
people with disabilities in rural and isolated areas.

Health reforms are needed within the public health
arena to ensure recruitment of people experienced in deliv-
ering care to people with disabilities and that are willing
and able to deliver a rolling vaccination strategy across the
whole population, leaving no-one behind.

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[Correction added on October 26, 2021, after first online
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