

# BREAK THE BLACK BOX:

Issues in the  
Use of Chinese  
Vaccines in the  
Philippines

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VACCINE EQUITY, TRANSPARENCY, AND ACCOUNTABILITY IN ASIA:  
Realities and Dilemmas

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## PART I: INTRODUCTION

Under the populist President Rodrigo Duterte, the initial response of the Philippines to the COVID-19 emergency can be summed up, fairly, as “spectacular failures, mismanaged pandemic” (Arguelles, 2021). However, despite falling just short of the mid-2022 deadline set by the World Health Organization (WHO) for vaccinating 70% of the target population, the Philippines rolled out a vaccination program under Duterte (March 2021 to June 2022), continued under his successor President Ferdinand Marcos Jr (since July 2022), which can be considered, altogether, as a qualified success. “I would say a partial success or a partial victory”, health reform advocate Dr Anthony Leachon said, “because we could have done better in terms of our response through agile leadership” (A. Leachon, personal communication, 21 February 2023). In spite of this partial success, however, the Philippine government’s handling of Chinese-made vaccines proved deeply problematic.

### 1.1. State and trends of COVID-19 and vaccination in the Philippines

From 2020 to 2022, the Philippines experienced four COVID-19 waves. Each was worse than the previous one — until the fourth one, when vaccinations reached a critical mass. Different indicators could be used to trace the trajectory of the COVID-19 pandemic and measure the impact of vaccination in the Philippines. One is the number of new cases per day, which clearly reflects the four surges, with each succeeding wave reaching higher peaks than the previous one. A second is the number of deaths per day, which shows not only the deadly consequences of infection but, beginning with the fourth wave, the real benefits of vaccination. Table 1 tracks the daily peak of those two indicators for each wave.

**Table 1: COVID-19 waves and the impact of vaccination**

|                                   | Peak daily cases | Peak daily deaths |
|-----------------------------------|------------------|-------------------|
| Initial wave (July-October 2020)  | 3,352            | 93                |
| Alpha/Beta wave (March-June 2021) | 10,978           | 181               |
| Delta wave (August-November 2021) | 20,668           | 364               |
| Omicron wave (January-March 2022) | 35,594           | 151               |

Source: Terminal Report, Task Force T3, based on DOH data

What explains the drastic fall in peak deaths in the last surge? When the fourth wave started in January 2022, the Philippines had already fully vaccinated 61% of its target population.<sup>1</sup> Vaccination works; it saves lives. As of 14 February 2023, Department of Health (DOH) data showed that the Philippines had recorded a total of 4,074,821 COVID-19 cases, with a death toll of 65,968. The fatality rate for those infected was 1.6% — higher than the global average of 1%, but down from the country's 1.8% at the start of 2022 and 1.9% at the start of 2021.<sup>2</sup>

### 1.1.1. Vaccine policy

The Philippine National Deployment and Vaccination Plan for COVID-19 Vaccines<sup>3</sup> lays out the road map for the national vaccination program. The plan, codified in DOH Administrative Order 2021-0005 dated 12 January 2021, was the work of many government offices, with important inputs from civil society and the business community (Department of Health [DOH], 2021a).

The program was launched officially on 1 March 2021 — just one day after the first batch of COVID-19 vaccines, some 600,000 doses of Sinovac, arrived in the Philippines from China. Four features characterize the conduct of the still-ongoing program.

**(A) The vaccines were procured through a portfolio approach.** Recommended by business community representatives as a necessary risk-mitigation strategy to diversify the country's possible sources of vaccines, the approach recognized that “there is a very limited global supply of vaccines where every country in the world is seeking to gain access to vaccines and where 80% of available supply has already been taken by the richest countries” (DOH, 2021a). The portfolio approach managed the uncertainty of vaccine supply by simultaneously negotiating with different suppliers, even as the government worked closely with the WHO to receive a considerable volume of vaccines through the COVAX facility. “The reality of the situation called for us to be pragmatic”, said a health industry executive (P. Borromeo, personal communication, 5 January 2023). Guillermo Luz, chief resilience officer at the Philippine Disaster Resilience Foundation, said the portfolio approach was like “playing the numbers”. He said: “We opted for a portfolio approach so that we wouldn't be caught short and at least we had assumed that by going to a portfolio, we'll have not only different supply but different delivery schedules, depending on the vaccine” (G. Luz, personal communication, 28 December 2022). Philippine participation in the COVAX facility was an essential component of the country's portfolio approach. Classified among the Advance Market Commitment countries, the Philippines received 74,228,930 doses from COVAX between 2021 and 21 December 2022. As a result

<sup>1</sup> Defined, by the national government using the WHO's lowered standard, as 70% of the total population. The estimate of 61% is from the Task Force T3 Terminal Report, based on DOH data.

<sup>2</sup> The statistical breakdown by political regions, however, shows some cities or provinces with disturbingly high fatality rates, as high as 4.8% in Cebu province, or even 5.1% in Aurora province.

<sup>3</sup> Available as a resource for local governments on the DOH website, at <https://doh.gov.ph/sites/default/files/basic-page/The%20Philippine%20National%20COVID-19%20Vaccination%20Deployment%20Plan.pdf>.

of its arrangements, in 2021, the first year of the rollout, the Philippines was able to procure an adequate supply of vaccines from seven different manufacturers.<sup>4</sup>

**(B) The rollout was based on a set of priority groups selected by the national government.** The prioritization framework was designed to meet three objectives: reduce mortality and preserve the country's health system capacity; stem the transmission of the coronavirus and minimize disruption to social and economic activity; and prepare for the return to normalcy. It identified a total of 12 categories of eligible individuals (see Table 2). The highly stratified scheme proved “complicated” and even at times “confusing” during the rollout (M. Torres, personal communication, 28 December 2022), but it also achieved the protective coverage (complete doses) of some of the most vulnerable sectors, including health care workers (100%) and senior citizens (79.47% of target population as of 6 February 2023) (DOH, 2023a).

**Table 2: Priority groups for vaccination**

|                               |  |   |
|-------------------------------|--|---|
| A1 Frontline health workers   | B1 Teachers and school workers                   | C Rest of the population not otherwise included |
| A2 Senior citizens            | B2 All government workers                        |   |
| A3 People with co-morbidities | B3 Essential workers                             |   |
| A4 Other frontliners          | B4 Groups with higher risk (PWDs, <i>et al</i> ) |   |
| A5 Indigent population        | B5 Overseas Filipino Workers (OFWs)              |   |
|                               | B6 Other remaining workers                       |   |

Source: DOH Department Memorandum 2021-0099, dated 23 February 2021, revising the original categories listed in the Philippine National Deployment and Vaccination Plan for COVID-19. For further discussion, see 3.1. Priority Groups, below.

**(C) The vaccines were administered mainly through various local governments,** at the provincial, city or municipality, and barangay<sup>5</sup> levels. The private sector companies that had purchased vaccines in a tripartite arrangement with the national government and pharmaceutical manufacturers also played a key role, but local governments had “an absolutely critical role” in the vaccination program. The rollout was “so dependent on [local governments]” (G. Luz, personal communication, 28 December 2022). As of 12 February 2023, the Philippines had administered 166,344,295 doses — mostly through local governments.

<sup>4</sup> In order of date of first delivery: Sinovac, AstraZeneca, Sputnik, Pfizer, Moderna, Janssen, and Sinopharm.

<sup>5</sup> The latest update from the Philippine Statistics Authority, dated 8 November 2022, set the number of provinces at 82, the number of cities at 147, the number of municipalities at 1,487, and the number of barangays at 42,047.

**(D) The vaccination program relied on communications support from both the government and the private sector.** Massive and coordinated information programs conducted by the government and the private sector educated the public about COVID-19 vaccination, addressed the challenge of vaccine hesitancy, and significantly shaped public opinion. The issue of information accessibility is discussed in greater detail in Chapter 2, below.

### 1.1.2. Available vaccines

In 2021, 12 vaccines received emergency use authorization (EUA) from the Philippine Food and Drug Administration (FDA) (see Table 3).

**Table 3: Vaccines granted EUA by the Philippine FDA**

| Vaccine   | Date of EUA | Headquarters of manufacturer   |
|---|-------------|--|
| Pfizer-BioNTech/Comirnaty COVID-19 mRNA Vaccine (nucleoside modified); hereafter, Pfizer                | 14 Jan 2021 | US; vaccines tested for EUA supplied from Belgium                      |
| ChAdOx1-S[recombinant] VAXZEVRIA (COVID-19 Vaccine AstraZeneca); hereafter, AstraZeneca                 | 28 Jan 2021 | UK; vaccines tested for EUA supplied from South Korea, Thailand, Italy |
| SARS-CoV-2 Vaccine (VeroCell), Inactivated [CoronaVac] (Sinovac); hereafter Sinovac                     | 22 Feb 2021 | China  |
| Sputnik V Gam-COVID-Vac; hereafter, Sputnik V   | 19 Mar 2021 | Russia   |
| Janssen COVID-19 Vaccine (Ad26.COVID-19S (recombinant)); hereafter, Janssen                             | 19 Apr 2021 | Belgium  |
| COVID-19 mRNA Vaccine (nucleoside modified) [COVID-19 Vaccine Moderna]; hereafter, Moderna              | 5 May 2021  | US; vaccines tested for EUA supplied from Spain                        |
| Whole Virion, Inactivated Corona Virus Vaccine [Covaxin]  | 21 Jun 2021 | India  |
| COVID-19 Vaccine (VeroCell), Inactivated [COVID-19 Vaccine Sinopharm (Wuhan)]; hereafter, Sinopharm     | 19 Aug 2021 | China  |
| Sputnik Light COVID-19 Vaccine; hereafter, Sputnik Light  | 20 Aug 2021 | Russia   |
| COVID-19 Vaccine (VeroCell), Inactivated [COVID-19 Vaccine Sinopharm (Beijing)]; hereafter, Sinopharm   | 10 Sep 2021 | China  |
| COVID-19 Vaccine (VeroCell), Inactivated [COVID-19 Vaccine Sinopharm (Hayat-Vax)]; hereafter, Sinopharm | 7 Oct 2021  | China  |

|  |             |       |
|--|-------------|-------|
| SARS-CoV-2 rS Protein Nanoparticle Vaccine [Covovax] | 17 Nov 2021 | India |
|--|-------------|-------|

Sources: Philippine Food and Drug Administration (<https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/>); DOH FAQs (<https://doh.gov.ph/vaccines/know-your-vaccines>).

The government settled on seven vaccines in its portfolio approach. The two from India fell through for different reasons; the two from Russia needed to be reconfigured from a two-dose to a single-dose vaccine;<sup>6</sup> the three variants of Sinopharm were treated as one in the government's tabulation. In general, negotiations for all non-Chinese vaccines involved the participation of the private sector, but the negotiations for the Chinese vaccines were limited to top government officials. Table 4 lists the vaccines with initial number of doses and date of first delivery to the Philippines.

**Table 4: First deliveries per vaccine**

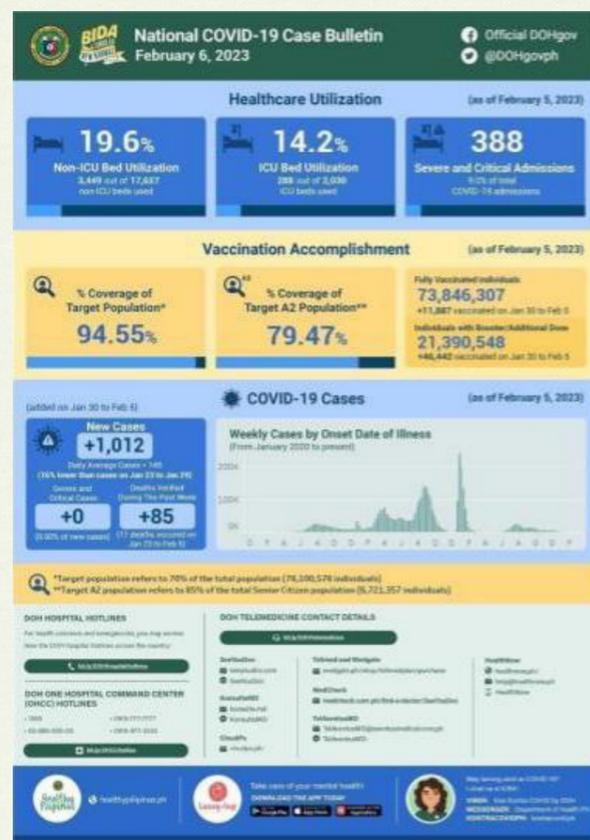
| Vaccine     | Number of doses in first batch (estimated) | Date of first delivery |
|-------------|--|------------------------|
| Sinovac     | 600,000                                    | 28 Feb 2021            |
| AstraZeneca | 487,200                                    | 4 Mar 2021             |
| Sputnik V   | 15,000                                     | 1 May 2021             |
| Pfizer      | 193,050                                    | 10 May 2021            |
| Moderna     | 249,600                                    | 27 Jun 2021            |
| Janssen     | 1,606,000                                  | 16 Jul 2021            |
| Sinopharm   | 100,000                                    | 11 Aug 2021            |

Source: Various newspapers

By 21 December 2022, COVAX recorded that the Philippines had accumulated a total of 251,342,200 doses. Almost 30% of those were donated through the COVAX facility.

<sup>6</sup> The reconfiguration was needed because it was "a complicated vaccine to administer [...] unlike all vaccines, when you have the two doses, first and second dose were identical formulations. In Sputnik, the first dose and the second dose had slightly different formulations, so they were distinguished as a red cap and a blue cap, so you can't take two blues or two reds. You know you gotta take one of each." (G. Luz, personal communication, 28 December 2022).

**Figure 1: The government’s weekly case bulletin**



Source: 6 February 2023 Case Bulletin, DOH

According to the 6 February 2023 case bulletin (Figure 1) of the DOH, 73,846,307 individuals had been fully vaccinated (either through two-dose vaccines like AstraZeneca or single-dose vaccines like Janssen or the reformulated Sputnik Light). This total is equivalent to 94.55% of the target population. Including first, second, and booster doses; the total number administered by the Philippine vaccination program, as recorded by DOH, was 166,344,295 as of 12 February 2023 (DOH, 2021b).

The portfolio approach to vaccine procurement was a success in ensuring mass vaccinations, but it led to an oversupply of doses by the end of 2022. The total number of unused doses may reach over 50 million; the Philippine Senate is investigating why at least 44 million doses expired before they could be used (Africa, 2022).

Those involved in the design of the vaccine procurement plan defend the portfolio approach, however, arguing that oversupply of vaccines is a positive outcome, considering the initial uncertainty, in late 2020 and the first half of 2021, over whether the Philippines would have a sufficient supply. “Because one thing with vaccines and immunity in general, if we don’t get up to a high number, you know that herd immunity number, if you vaccinate too few, you still have the risk of spread”, said Luz, who spearheaded Task Force T3.<sup>7</sup> “So we have to go big, go large” (G. Luz, personal communication, 28 December 2022).

Addressing late 2021 purchase orders for Chinese vaccines, which were still coming in the tens of millions of doses despite delivery commitments already signaling a sufficiency in supply, AC Health’s Paolo Borrromeo said, “We could have scaled back on the Chinese vaccines” (P. Borrromeo, personal communication, 5 January 2023).

## 1.2. Research methodology

This research relied on key informant interviews with private sector and government actors (Table 5), but its timing (late 2022 and early 2023) coincided with the Senate investigation; national government officials approached for this report consequently declined to be interviewed. In the words of one official: “we have been advised to recuse while there is still a Senate investigation ongoing” (Name withheld on request, personal communication, 5 January 2023).

Task Force T3’s comprehensive Terminal Report (Dayrit *et al*, 2022) was a crucial resource in the research; it documented the different aspects of the task force’s work, which began well before and included far more than the vaccination rollout. The research also relied on a close study of both raw and aggregated data collected by the DOH, the Philippine FDA, and the COVAX facility — and it was supplemented by a reading of recent related academic literature and relevant government documents. The UN Development Programme-commissioned study on health communication in the Philippines (Ligot *et al*, 2021) also proved useful.

**Table 5: Key informants interviewed**

| Name            | Occupation                | Affiliation   | Date of interview | Method of interview                    |
|-----------------|---------------------------|---|-------------------|--|
| Paolo Borrromeo | Health industry executive | AC Health; Task Force T3                                  | 5 Jan 2023        | Recorded Zoom                          |
| Beverly Ho      | Lead, DOH communications  | DOH   | 8 Feb 2023        | Recorded Zoom, with follow-up on Viber |
| Anthony Leachon | Health reform advocate    | Past president, Philippine College of Physicians          | 21 Feb 2023       | Recorded Zoom                          |
| Dominic Ligot   | Data scientist            | CirroLytix Research Services; lead author, NEDA/WHO study | 23 Feb 2023       | Recorded Zoom                          |

<sup>7</sup> Task Force T3 was an initiative of the Philippine business community in response to the pandemic. It was formed to organize a community feeding program that, according to its own Terminal Report, served 14.3 million persons during the first lockdown, in March to April 2020. It was then invited by the government to coordinate with the Inter-Agency Task Force for the Management of Emerging Infectious Diseases as the representative of the private sector. By all accounts, including those of government officials, Task Force T3 played a crucial role in helping procure the vaccines and then in distributing them.

|                            |                            |  |             |               |
|----------------------------|----------------------------|--|-------------|---------------|
| Guillermo Luz              | Business community liaison | Philippine Disaster Resilience Foundation; Task Force T3 | 28 Dec 2022 | Recorded Zoom |
| Margot Torres              | Marketing executive        | McDonald's; Task Force T3                                | 28 Dec 2022 | Recorded Zoom |
| Jerry Treñas               | City mayor                 | Iloilo City  | 16 Jan 2023 | Recorded Zoom |
| Name withheld upon request | Government official        | National government                                      | 5 Jan 2023  | Viber message |

## PART II: ON INFORMATION ACCESSIBILITY

Public access to information about vaccines was hampered by a self-inflicted wound; after taking office in 2016, the Duterte government was confronted with a controversy over an earlier drug. Dengvaxia, a Sanofi drug, was the first dengue vaccine approved for use; over 800,000 Filipino children had been inoculated with it by November 2017, when Sanofi announced that the vaccine increased the risk of serious dengue for seronegative individuals (Mendoza *et al*, 2021). The Dengvaxia controversy, fanned into a long-running primetime scandal by government officials, inevitably had an impact on COVID-19 vaccine acceptance.

In May 2021, the Social Weather Stations survey organization conducted a nationwide survey on public attitudes about vaccination. The results were worrying: 33% of respondents said they were unwilling to be vaccinated (26% who “will surely not get it” and 7% who “will probably not get it”), while 35% said they were uncertain (Social Weather Stations, 2021). Social Weather Stations conducted three more surveys in 2021, with increasingly vaccine-positive results (see Table 6). In June, at the tail end of the second wave, the number of unwilling was down to 21%, and the number of uncertain to 24%. In September, in the middle of the third wave, the number of unwilling dropped further, to 18%, as did the number of uncertain, to 19%. In December, the numbers dropped to single digits: only 8% unwilling and 6% uncertain (Social Weather Stations, 2021). Altogether, these four Social Weather Stations surveys in 2021 tracked the decline in vaccine hesitancy, and were used as a measure of success by both the government and the private sector communication campaigns. In particular, both campaigns saw the surveys as measuring the impact of information on vaccine hesitancy.

**Table 6: Dramatic drop in vaccine hesitancy, in 2021**

| May 2021 | June 2021 | September 2021 | December 2021 |                                    |
|----------|-----------|----------------|---------------|------------------------------------|
| 26%      | 18%       | 14%            | 7%            | Will surely not get vaccinated     |
| 7%       | 3%        | 4%             | 1%            | Will probably not get vaccinated   |
| 35%      | 24%       | 19%            | 6%            | Uncertain about getting vaccinated |
| 9%       | 9%        | 6%             | 3%            | Will probably get vaccinated       |
| 23%      | 36%       | 23%            | 33%           | Will surely get vaccinated         |
| N/A      | 7%        | 10%            | 13%           | Vaccinated with one dose           |
| N/A      | 3%        | 25%            | 38%           | Vaccinated with two doses          |

Source: Social Weather Stations ([www.sws.org.ph](http://www.sws.org.ph))

## 2.1. Online portal

The official website of the DOH serves as the online portal for pandemic response,<sup>8</sup> with several sub-sites. Table 7 summarizes the categories of COVID-19 case, vaccination, and policy information available from the DOH and the FDA.<sup>9</sup> All COVID-19 case and vaccination data is channelled through the DOH but, as this matrix shows, the information is shared in different ways, with varying levels of availability. The dates of data released also vary, even within the DOH website.

**Table 7: Information matrix of online sources**

| Information need                      | Website    | Sub-site  | Feature  |
|---------------------------------------|------------|---|--|
| COVID-19 cases                        | doh.gov.ph | <a href="https://doh.gov.ph/covid19tracker">https://doh.gov.ph/covid19tracker</a>   | Interactive  |
| COVID-19 deaths                       | doh.gov.ph | <a href="https://doh.gov.ph/covid19tracker">https://doh.gov.ph/covid19tracker</a>   | Interactive  |
| COVID-19 case bulletin                | doh.gov.ph | <a href="https://doh.gov.ph/bulletin">https://doh.gov.ph/bulletin</a>   | Infographic format   |
| COVID-19 policies                     | doh.gov.ph | <a href="https://doh.gov.ph/COVID-19-policies">https://doh.gov.ph/COVID-19-policies</a>   | Reverse chronological order  |
| COVID-19 vaccination: doses           | doh.gov.ph | <a href="https://doh.gov.ph/vaccines">https://doh.gov.ph/vaccines</a>   | Dashboard (part 1)   |
| COVID-19 vaccination: doses, local    | doh.gov.ph | <a href="https://doh.gov.ph/vaccines">https://doh.gov.ph/vaccines</a>   | Dashboard (part 2)   |
| COVID-19 vaccination: priority groups | doh.gov.ph | <a href="https://doh.gov.ph/vaccines">https://doh.gov.ph/vaccines</a>   | Dashboard (part 3)   |
| COVID-19 vaccines                     | doh.gov.ph | <a href="https://doh.gov.ph/vaccines/know-your-vaccines">https://doh.gov.ph/vaccines/know-your-vaccines</a>   | FAQs; infographics (but only eight vaccines)                               |
| COVID-19 vaccines with EUA            | fda.gov.ph | <a href="https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/">https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/</a> | Detailed medical and technical information; nine brands, total 12 vaccines |
| COVID-19 drugs with EUA               | fda.gov.ph | <a href="https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/">https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/</a> | Detailed medical and technical information; three drugs                    |
| COVID-19 updates                      | fda.gov.ph | <a href="https://www.fda.gov.ph/fda-covid-19-updates/">https://www.fda.gov.ph/fda-covid-19-updates/</a>   | Reverse chronological order  |

<sup>8</sup> <http://doh.gov.ph>

<sup>9</sup> <https://fda.gov.ph>

|                                       |            |   |  |
|---------------------------------------|------------|---|--|
| COVID-19 vaccination: doses           | fda.gov.ph | <a href="https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/">https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/</a> | Summary at bottom of page  |
| COVID-19 vaccine adverse reactions    | fda.gov.ph | <a href="https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/">https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/</a> | Periodic reports; downloadable as PDF                                |
| COVID-19 vaccination: doses per brand | fda.gov.ph | <a href="https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/">https://www.fda.gov.ph/list-of-fda-issued-emergency-use-authorization/</a> | Periodic report Table 2 has per-brand dose data; only seven vaccines |

Source: Official websites of the DOH and the Food and Drug Administration.

Two DOH sub-sites are specific to vaccines. The first hosts the COVID-19 Vaccination Dashboard,<sup>10</sup> which summarizes the total number of vaccine doses administered and offers three types of statistical breakdown: by type of dose (first, second, or booster); by political or administrative region; and by priority group. However, there is no information, whether aggregated or disaggregated, on dose administration per vaccine brand. Helpful infographics on the first eight vaccines approved for emergency use are posted, designed for easy reading and easier sharing. As of 15 February 2023, however, the inventory has not been updated to reflect the other vaccines that have since been approved. The second sub-site is only a set of irregularly updated lists of vaccination sites, on Excel worksheets.<sup>11</sup>

The DOH website is the main portal, but it does not include all important information regarding vaccines. The main source for information on vaccines and drugs, including approval status and product details, is the Philippine FDA website. The DOH website (the entire site, not just the COVID-19 sub-sites) has seen increased traffic during the pandemic: on December 2022, it recorded 2.3 million visits, up from 1.9 million visits the previous month, with each visit averaging almost 16 minutes — multiples of what established news websites generate.

The DOH has an active presence on social media too. On Facebook, it has 8.4 million followers; on Facebook Messenger, 5.8 million likes; on the Viber chat app, 1.8 million subscribers (compared to one million subscribers to the WHO Viber channel); and on Twitter, over 757,000 followers. On the more video-based platforms, the Department has a modest-sized footprint: over 71,000 subscribers for its YouTube channel; and over 63,000 followers on TikTok. On LinkedIn, the Department has almost 14,000 followers.<sup>13</sup>

These numbers suggest that while the platforms where the DOH is present allow for sharing of video, the majority of its audience remains highly text-oriented. In this sense, the DOH portal's use of text-based infographics (such as the now-weekly case

<sup>11</sup> <https://doh.gov.ph/COVID-19-vaccination-sites>

<sup>12</sup> <https://www.semrush.com/website/doh.gov.ph/overview/>

<sup>13</sup> Data, retrieved from the respective social media channels of the DOH, are as of 15 February 2023.

bulletins and the vaccine brand FAQs) is conducive to the reading and sharing of detailed information that individuals might be looking for in the middle of a pandemic. While a lot of information is accessible on the DOH website, and some of the interactive features allow site visitors to customize the information they would like to see, the website does not contain any information on the procurement cost of the vaccines or classify the vaccines according to how they were procured.

## 2.2. Information campaigns

The communications response to the pandemic would have been inadequate, and information about vaccines accessed less, if the national government had adopted only a pull strategy. Even sub-sites such as the COVID-19 Tracker, which allows site users to interact with data, would not have been sufficient to attract people. Both the government and the private sector conducted massive information programs, initially separately and then in coordination. At first, they separately encouraged vigilance and the adoption of public health protocols amid great uncertainty; later, they worked together to encourage vaccination as the primary solution; and finally, in coordination, they encouraged responsible attitudes for living with the coronavirus. These push strategies helped redefine public attitudes about the pandemic and the value of vaccination.

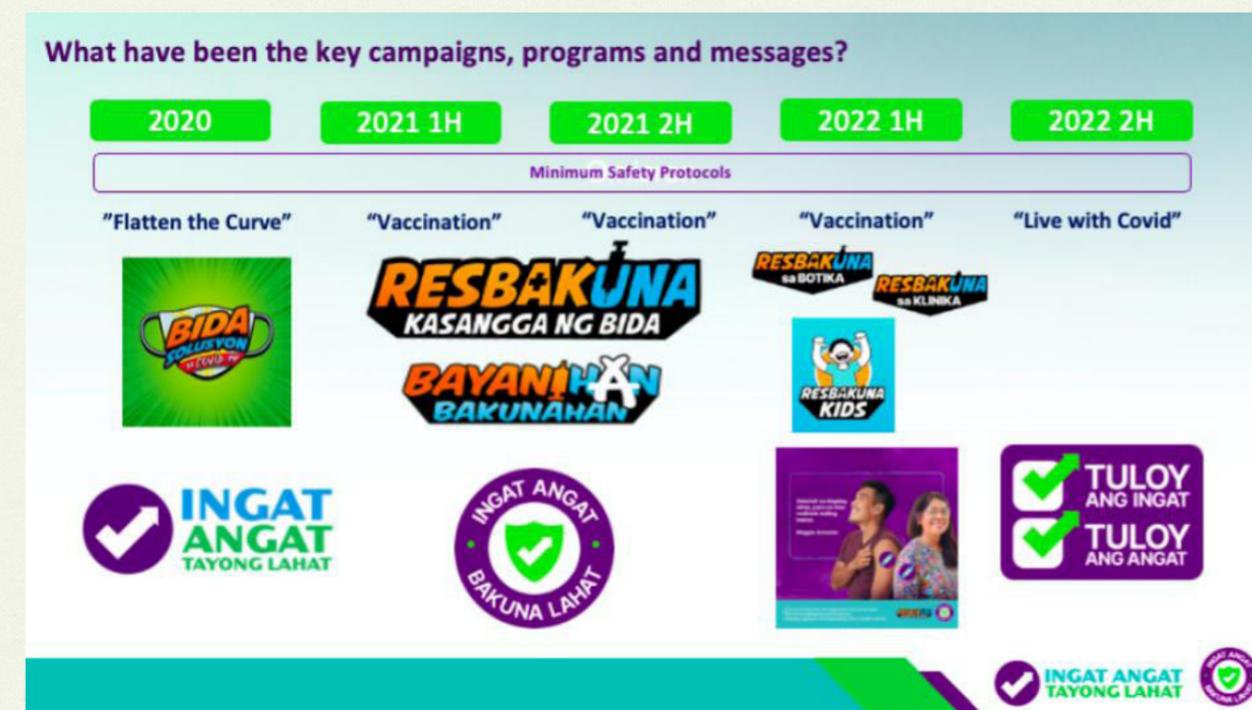
“That’s the first breakthrough for us. It’s recognizing that when we do market segmentation, there’s room for two parallel campaigns to go”, DOH Undersecretary Beverly Ho said, referring to the different audiences targeted by the private sector campaign and by the government’s own communications campaign, which she led. “It was so clear to us that the demographics that they [the private sector] want to reach is not the demographic that is typically who the government needs to reach. And always, naturally, the DOH campaign will veer towards the bottom 60% of the population” (B. Ho, personal communication, 8 February 2023). Margot Torres, who joined Task Force T3 to head the communications side, said the same thing: “The DOH, their focus is the masses [...] For the private sector, we talked to the AB Broad C” (i.e., A, B, and C) (M. Torres, personal communication, 28 December 2022).<sup>14</sup>

Despite missed opportunities in the first phase, and some shortcomings in implementation, the two information programs proved to be successful, and they may be useful and applicable in other situations. Of note, the true value of the communication campaigns may have been obscured by Duterte’s late-night rants on television, which created the impression that the national pandemic response was *ad hoc*, unscientific, and political (Hapal, 2021). Figure 2 gives an overview of the simultaneous, multi-phase campaigns conducted by the national government (the

<sup>14</sup> The Philippine consumer market is traditionally classified into five classes, from high-income A to the poorest E. The December 2019 survey of Social Weather Stations determined that classes A, B, and C account for 7% of the country’s population, class D (or the masses) for 75%, and class E, 18%. See <https://www.pids.gov.ph/details/news/in-the-news/counting-the-social-classes>.

green, orange, and blue icons) and the business community (the purple icons) over the course of the pandemic.

Figure 2: Parallel information campaigns by government and private sector



Source: *Ingat Angat Bakuna Lahat Final Report*

A new law which took effect a year before the pandemic started, the Universal Health Care Act, required the upgrading of the DOH’s Health Promotion and Communication Service to a Health Promotion Bureau. The timing of this restructuring, which included a bigger budget for health promotion that was guaranteed by law, coincided with the pandemic.

Led by the new Health Promotion Bureau, the government launched its BIDA (Filipino for “hero”) campaign as the right way to beat the “CONtraVIDa” (Filipino for “villain”), COVID-19. This was, as it turned out, only the first campaign. The name itself reflects the limited objective: BIDA is an acronym that, in colloquial Filipino, lists the four basic anti-COVID protocols (wear masks, wash hands, keep a meter’s distance, know what’s fact and what’s not). The second campaign focused on vaccination, promoting the benefits of vaccines and encouraging the public to get vaccinated. This time, the government — in coordination with the private sector’s own communications campaign — launched what it called its RESBAKUNA initiative (the name is a punny portmanteau, merging the image of the Defender, or “resbak” in slang, and the necessity of the vaccine, or “bakuna” in Filipino).

The DOH vaccination campaign offered the public a potent mix: a cocktail of persuasion (e.g., celebrity endorsements), nudges (e.g., free shuttles and pop-up

vaccination sites), and incentives (e.g., discounts from participating stores for those with proof of vaccination).

The private sector, through Task Force T3, conducted its parallel communications campaign from May 2021 until the end of 2022 to increase public acceptance of vaccination. It built on the success and the lessons learned from its first campaign, called “Ingat Angat Tayong Lahat” (colloquially, All of Us Will Take Care, All of Us Will Rise Again), which ran in the last quarter of 2020. The second campaign, conducted in coordination with the government’s Resbakuna drive, was called “Ingat Angat Bakuna Lahat” (To Take Care and Rise Again, Let Us All Get Vaccinated).

Torres, the managing director of McDonald’s Philippines who served as communications lead for Task Force T3, applied “contextual messaging” to the different challenges of the vaccination phase. She divided the vaccination rollout into three sub-phases. “When supply is low and demand is low, we focus messages on reasons why we should consider getting vaccinated [...] When supply and demand increase and when throughput (the job rate) becomes critical, we focus the message on the arrival of vaccines as a symbol of hope, on the increasing number of Filipinos getting vaccinated, and on the safety and efficacy of the COVID vaccine. When demand outstrips supply, we continue to reassure the unvaccinated about the safety and effectiveness of vaccines” (Torres, 2022).

The private sector’s information program also offered the public the same attractive cocktail, including celebrities posting their vaccination photos on social media, on-ground activation events, and discounts from some 200 restaurants. Other players were active in the mix. For instance, the UN Development Programme, working closely with the country’s economic planning agency, the National Economic and Development Authority (NEDA), commissioned a study on vaccine acceptance and health communication just as the vaccination rollout started. Among other outcomes, it recommended ways in which the communication campaigns for the vaccination program could be improved (Ligot *et al*, 2021).

“The big win that NEDA found was, It’s not a one-size-fits-all situation. Geographically, some areas are ahead of others, some are behind [...] There were some areas which are self-admitted hesitant but somehow were getting vaccinated, and vice versa. There were some areas that were kind of lagging in vaccination, but said on average ‘we’re actually [for] acceptance’ [...] And then using combinations of that information, we were able to break the population down into the usual market segments” (D. Ligot, personal communication, 23 February 2023).

Another finding had direct relevance to government conduct: “People felt that supply was being manipulated, because of preferential treatment, so that that crept up but that was highly correlated with side effects. So people didn’t want bad vaccines, at the same time trust in the government was also a factor. If they feel it’s being rigged, they won’t even bother” (D. Ligot, personal communication, 23 February 2023).

## PART III: ON ENSURING EQUITY

The Plan summarizes its classification scheme in determining priority groups: “The primary goal in identifying the eligible population and vaccination is to directly reduce morbidity and mortality and maintain most critical essential services. The secondary goal is to control transmission and minimize disruption of social economic and security functions. And lastly, the tertiary goal is to resume the country’s essential activities to near normal. These goals guided the selection of priority eligible groups.” (DOH, 2021a).

The Plan classifies the “priority eligible population” into 12 categories, with five groupings under A, six under B, and the rest of the population under C. Originally, the five Priority A groupings were determined to be as follows: A1, frontline health workers; A2, indigent senior citizens; A3, other senior citizens; A4, remaining indigent citizens; and A5, uniformed government personnel.

One month after the Plan was released, the Priority A classifications were changed,<sup>15</sup> ostensibly in an effort to clarify the categories but in reality because the original classifications were rushed (Ranada, 2021). The indigent population was moved down from A4 to A5; the original category A5 was expanded from uniformed personnel to frontliners in essential sectors, both public and private; and the expanded category was moved up to A4. All senior citizens were included under A2, and persons with co-morbidities were classified as the new A3 (see Table 2).

At that point in the pandemic, it had become clear that individuals 60 years and older were disproportionately vulnerable to the worst effects of COVID-19. A UN policy brief on the effects of COVID-19 on older persons warned of precisely that special risk (“The impact of COVID-19 on older persons,” May 2020). In July 2021, the WHO raised the alarm, saying “The elderly are at the highest risk of the most severe outcomes of COVID-19. Seven out of 10 COVID-19 deaths in the Philippines are from this group” (World Health Organization, 2021). As of 14 February 2023, a disturbing 61% of all COVID-19 deaths, or over 40,000, were senior citizens.

The rationale for including persons with co-morbidities as a separate priority category was easy to understand, but determining exactly which pre-existing conditions qualified as co-morbidities and which proof of co-morbidity qualified as legitimate was harder to define. Two more DOH memoranda, issued a week apart, elaborated on the criteria for inclusion in the category.<sup>16</sup>

<sup>15</sup> Through DOH Department Memorandum 2021-0099.

<sup>16</sup> DOH Department Memoranda 2021-0157 and 2021-0175.

The COVID-19 Vaccination Dashboard as of 12 February 2023 (Table 8) showed that 48.6 million individuals classified as Priority A had been fully vaccinated, or about two-thirds of all fully vaccinated individuals in the Philippines.

**Table 8: Number of Priority A individuals fully vaccinated**

| PRIORITY GROUP BREAKDOWN |  |                          |  |   |                              |                                  |
|--------------------------|--|--------------------------|--|---|------------------------------|----------------------------------|
|                          | A1<br>Frontline Healthcare Workers,<br>Expanded Pop. | A2<br>Senior<br>Citizens | A3<br>Persons w/ Comorbidities,<br>Expanded Pop. | A4<br>Frontliners in<br>Essential Sectors | A5<br>Indigent<br>Population | B&C<br>Rest of the<br>Population |
| FIRST DOSE               | 2,961,460  | 5,433,008                | 8,042,865  | 19,544,880                                | 9,258,674                    | 25,792,411                       |
| COMPLETE DOSE            | 3,026,501  | 6,931,078                | 9,472,142  | 19,735,037                                | 9,487,939                    | 25,207,406                       |
| BOOSTER DOSE             | 1,819,298  | 2,769,860                | 3,107,151  | 7,025,326                                 | 2,141,195                    | 4,588,064                        |

Over 48.6 million individuals belonging to the five Priority A categories have been fully vaccinated, as of 12 February 2023. Source: COVID-19 Vaccination Dashboard; the first row is first dose, the second is full dose, and the third is booster dose (<https://doh.gov.ph/vaccines>).

The weekly (formerly daily) case bulletin issued by the DOH includes four highlights related to the vaccination program: percentage of target population fully vaccinated, percentage of senior citizen target population fully vaccinated, total number of individuals fully vaccinated, and total number of individuals vaccinated with at least one booster dose (it also includes the number of individuals added to the fully vaccinated total in the preceding week and the number of individuals administered at least one additional dose in the preceding week). The emphasis on the vaccination of senior citizens is welcome, and can be the basis of a new, shorter-term information drive. In the case bulletins, however, there is no information related to vaccine brands.

### 3.2. Economic recovery as priority

Vaccines are not administered in a vacuum. Geography matters, especially in an archipelago like the Philippines, particularly because most vaccine shipments are received only in the main airport, located in Metropolitan Manila. How did the deployment plan strategize the geographical distribution of the vaccines? Which provinces, cities or municipalities, or barangays were prioritized?

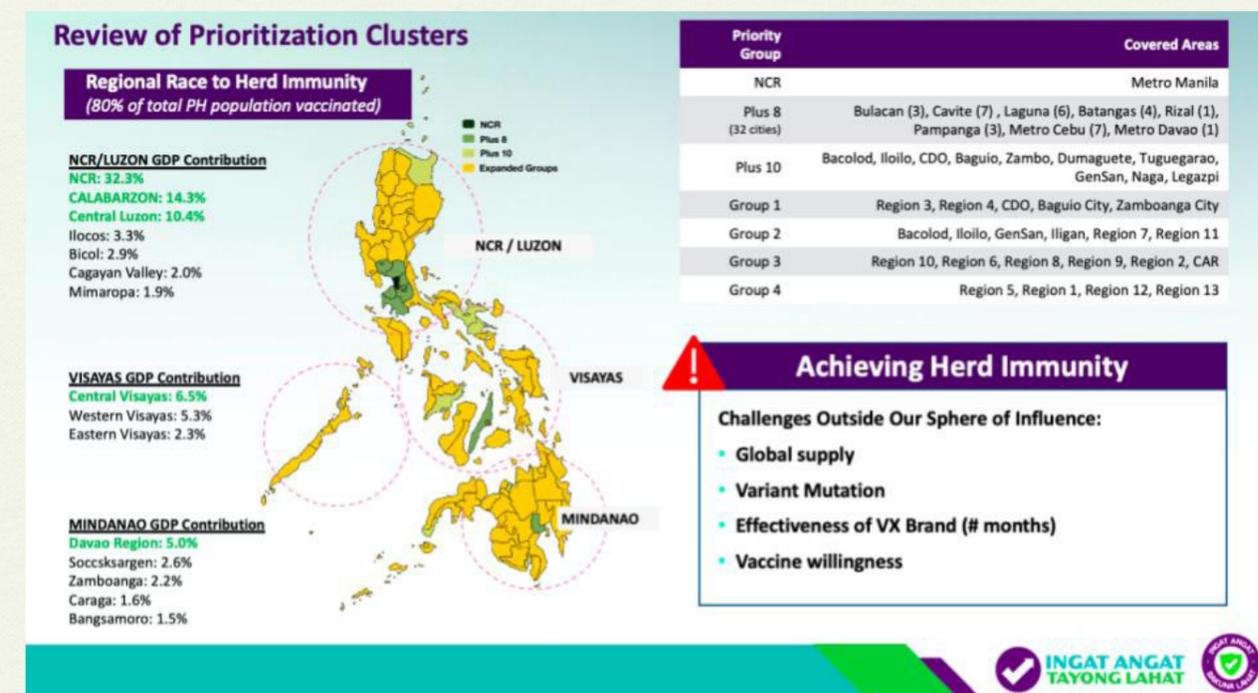
In reality, economic factors played an important role in the “identification of geographical areas” for the distribution of vaccines. There is considerable overlap between the high-burden locations and the country’s most economically active areas. The National Capital Region (NCR), or Metropolitan Manila, is the hardest-hit administrative region in the country, in terms of number of cases and number of deaths. It is also the most economically active region, accounting for about a third of the gross domestic product. The overlap can be explained by many factors related to economic activity: denser population centers, bigger and more crowded

transportation hubs, and a greater number of transit points and logistics distribution centers.

In the actual deployment of the vaccines, as they arrived in tranches, the Plan followed a framework that sought to strike a balance between public health priorities and economic concerns. Figure 3 reproduces a key slide from the communications team of Task Force T3, which shows the graduated scheme of priority areas, starting with the NCR alone, then NCR plus eight provinces, then those plus ten other provinces, and finally Expanded Groups 1 to 4, or the rest of the regions. It also indicates the GDP contribution of each region.

In sum, along with health priorities, one of the objectives of the vaccination program was to stimulate economic recovery. Factors such as contribution to GDP were used to determine where the vaccines went; the priority areas (upper right in Figure 3) were also the areas with high contribution to GDP.

**Figure 3: Economic factors also helped determine where vaccines went**



Source: *Ingat Angat Bakuna Lahat Final Report*

It is unclear whether those involved in the design, planning, or execution of the vaccination rollout acted in terms of an urban-rural dynamic, but the economic framework that ended up driving the physical allocation of vaccines inevitably reflected an urban-rural divide. The most economically active areas were often the hardest-hit by the pandemic; they also tended to be highly urbanized.

Iloilo City Mayor Jerry Treñas is one of those local government officials outside of the NCR who felt, in his words, like “a second-class citizen” because his city was low on the priority list. “They cannot explain why”, he said. “I was already inquiring from

them why Iloilo was not included in the priority areas.” Treñas believes that he was reelected in the May 2022 elections because his constituents shared the sense that “we were second-class citizens” and that he had stood up for them (J. Trenas, personal communication, 16 January 2023).

The argument can be made that the application of this economic framework ended up sacrificing vaccine equity — that, for instance, the indigent population in a province with many industrial parks was treated differently from the indigent population in a province more dependent on agriculture. To resolve that argument, a close study to compare and contrast economic activity indicators per region with COVID-19 data is needed.

## PART IV: ENSURING SELF-RELIANCE, TRANSPARENCY, ACCOUNTABILITY

The Philippine pandemic response in the first year of the public health emergency was marked by what medical anthropologist Gideon Lasco called “medical populism” (Lasco, 2020). Duterte personalized the coronavirus, turned the public health crisis into a public security issue, and cast his lot, and that of the country, with China and Russia.<sup>17</sup> While this populist approach continued until the end of Duterte’s term, the rollout of the vaccination program in 2021 and its continuation into a third year — during the Duterte administration — turned out to be, by and large, effective.<sup>18</sup>

### 4.1. The black box

Unlike its negotiations with Western, Russian, and Indian vaccine suppliers, as well as the open nature of the COVAX processes, the Philippines’ negotiations with Chinese vaccine suppliers were limited to select officials. “That’s a black box to me”, Borromeo said (P. Borromeo, personal communication, 5 January 2023). “We were not privy to the discussions”, Luz said, adding that it was common knowledge that the Duterte administration “was very pro-China” (G. Luz, personal communication, 28 December 2022).

Leachon, who once served as a special adviser to the inter-agency task force coordinating the government’s pandemic response but has since turned into a critic of that same response, expressed “surprise” at the government’s preference for Chinese vaccines. “I wonder about our preference, because they [the Chinese vaccines] are not well-known. And they have a low efficacy rate on paper. We had a choice. We had the money at the time. So the \$64 question: Why didn’t we do the right thing?” (A. Leachon, personal communication, 21 February 2023).

The metaphor of the black box can be extended to the Philippine government’s special relationship with China, and the largely opaque manner in which the Chinese government’s involvement in the Philippines’ official pandemic response was treated.

<sup>17</sup> Much can be said about the Duterte administration’s wrongheaded, *ad hoc*, and deadly populist response to the pandemic, but the situation in the first few months can be summed up by an extraordinary statement from the Senate of the Philippines. Matters had grown so bad the senators called on the Secretary of Health to resign (18th Congress - Senate Resolution No. 362 - Senate of the Philippines, 5 May 2020).

<sup>18</sup> According to the Philippine government, the Group of 20 or G20 countries named it an “example country” for its vaccination program (Servallos, 2022); institutions like the WHO (“Remarkable”: WHO Exec Commends PH COVID-19 Vaccination Program, 2021) and the World Bank (Pasig City: A COVID-19 Vaccination Success Story,

This lack of transparency was a failure of the Duterte government, but the Marcos presidency which succeeded it in the second half of 2022 has also failed to ask its predecessor government to come clean or set the record straight. The black box is defined by four failures in transparency and accountability:

**(A) Special treatment for China.** From the start of the pandemic, the Philippine government was reluctant to impose any restrictions or sanctions on China, which reported the first known case of the novel coronavirus. Initial appeals to ban inbound flights from China were dismissed, both by President Duterte (“it would not be fair”) and his Secretary of Health (there would be “political and diplomatic repercussions”). The government announced a shortage of face masks for domestic use just a few days after it had both donated and sold face masks for use in Wuhan and other parts of China. In March 2020, the DOH disclosed that it had discarded test kits made in China because of their low accuracy (40%); it retracted the statement the next day, after the Chinese embassy complained (Valenzuela, 2020; Lasco, 2020).

In his sixth and final State of the Nation Address, in July 2021, President Duterte gave effusive thanks to Chinese President Xi Jinping for assuring him early on that China would send vaccines to the Philippines. “That debt of gratitude cannot be repaid”, he said (Ybiernas, 2022). This sense of indebtedness must have been a factor in President Duterte’s consistent refusal to turn China into the “other”, the enemy, as his populist politics required, unlike Donald Trump in the US and Jair Bolsonaro in Brazil (Lasco, 2020). It is also likely the reason he “anchored the nation’s COVID-19 recovery on the development of the Chinese vaccine” (Teehankee, 2022).

**(B) Premature and still-unexplained use of Chinese vaccines.** The day after Christmas in 2020, Duterte made a startling announcement. He said that some officials and soldiers belonging to the Presidential Security Group, the military unit that is the presidential protective security service, had been inoculated with the Sinopharm vaccine. At that time, no vaccines had been granted any authorization, whether for emergency use or for compassionate purposes, in the Philippines. The Secretary of National Defense admitted that the vaccines had been “smuggled” in (Reuters, 2020). Two months later, in February 2021, the Philippine FDA granted the Presidential Security Group a “compassionate permit” to import 10,000 doses of Sinopharm — many months before the FDA gave the vaccine the EUA that allowed it to be deployed nationwide (Ranada, 2021b). To this day, the government has failed to issue a comprehensive explanation that answers the most important questions: who was vaccinated; did Duterte approve the vaccination; how were the vaccines brought in; why were health and FDA officials kept in the dark? (Tomacruz, 2021).

Also early in 2021, a prominent civic leader of the Filipino-Chinese community in Manila said she had learned that some 100,000 Chinese nationals residing or working in the Philippines, many of them part of the controversial Philippine Offshore Gaming Operators industry, had already received Chinese vaccines as early as November 2020 — again, despite the lack of official approval. “Her exposé confirmed what many suspected would be a thriving black market for COVID-19 vaccines” in the country (Mendoza *et al*, 2021). These false starts of the country’s vaccination program prompted multiple news cycles and provoked much discussion on social media; they

may have fed into public concerns about President Duterte’s close relationship to China and increased the public’s brand skepticism about Chinese vaccines, reflected in the Social Weather Stations survey of May 2021 (Cabato, 2021).

**(C) Officials’ ignorance of decisions and details involving Chinese vaccines.** The controversies involving Chinese-made vaccines were compounded by a lack of transparency, not only between the government and the anxious public, but also among government officials. No DOH or FDA official was informed about, was consulted on, or approved the early vaccination of the Presidential Security Group. “Definitely somebody did something wrong. With the FDA law, it says it is illegal to import, distribute, manufacture, use unregistered drugs”, the FDA director-general said. The defense secretary said he had not known about the vaccination (but nevertheless justified it as necessary for the “protection” of the President). The President’s spokesperson said he wasn’t aware either, and put the responsibility back with the military: “They must be privy to that information. I was not.” (Mendoza *et al*, 2021; Reuters, 2020; Luna, 2021; Tomacruz, 2021).

When the FDA issued a compassionate permit allowing the importation of 10,000 doses of Sinopharm for the use of the Presidential Security Group in February 2021, the President’s spokesperson again did not know the most important details (Ranada, 2021b). The Secretary of the President’s Cabinet, who served for a time as spokesperson for the pandemic response, also confessed ignorance about who had taken the unregistered vaccine before: “I really don’t know the details” (Panti, 2021). A study on “the politics of COVID-19 vaccine confidence” concluded: “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” (Sabahelzain *et al*, 2021).

**(D) A corruption scandal involving pandemic funds.** As the vaccination rollout gained momentum in 2021, the news broke that a new, under-capitalized company with links to a Chinese businessman close to President Duterte had: (a) cornered the funds reserved for the pandemic response; (b) overpriced medical supplies it sold to the government; and (c) supplied substandard goods. Pharmally Pharmaceutical Inc. was established only in 2019 with a paid-up capital of about USD11,000, but it was awarded over USD157 million in government contracts. “Another close associate of Duterte was also linked to the Pharmally corruption case. Chinese businessman Michael Yang, Duterte’s friend and former economic adviser, was identified as the financier and guarantor of Pharmally” (Tana, 2022).

The blue ribbon committee of the Philippine Senate, chaired by an erstwhile ally of President Duterte, conducted 18 hearings into the Pharmally scandal; nine senators (two short of the number necessary to raise the committee findings to the Senate as a whole) issued a report that concluded, among other findings, that President Duterte had “betrayed public trust”. The President had vociferously defended Pharmally and barred government officials from testifying at the Senate hearings. (Tana, 2022; Teehankee, 2022). “The Pharmally scandal has become the most prominent allegation of corruption against the Duterte administration” (Teehankee, 2022).

## 4.2. Vaccination by brand

The FDA's website is the only official government website that provides information on dose administration per vaccine — but in an incidental way. Nestled in the regular and cumulative reports on adverse reactions to vaccination (“Reports of Suspected Adverse Reaction to COVID-19 Vaccines”) is a table that includes data on vaccine distribution by brand. The latest available is the December 2022 report, which covers the vaccination program 1 March 2021 - 31 December 2022 (Table 9).

**Table 9: Doses administered, per vaccine brand**

| Vaccine                   | Date Started   | Doses Administered |
|---------------------------|----------------|--------------------|
| Sinovac                   | 1 March 2021   | 46,282,118         |
| AstraZeneca               | 7 March 2021   | 22,135,341         |
| Sputnik V / Sputnik Light | 4 May 2021     | 1,115,882          |
| Pfizer                    | 13 May 2021    | 72,245,351         |
| Moderna                   | 30 June 2021   | 19,609,498         |
| Janssen                   | 20 July 2021   | 7,200,829          |
| Sinopharm                 | 25 August 2021 | 1,038,476          |

Source: [fda.gov.ph](https://www.fda.gov/ph)

The two Chinese vaccines have contrasting records. Sinovac, the first vaccine to arrive in the country, is the second most used among the seven vaccines deployed in the program, at over 46 million doses; Sinopharm, the last to be deployed, is seventh, at a little over one million doses.

It must be noted, however, that the data on per-brand vaccination available on the FDA site differs from the vaccination information provided on the DOH website in one important respect: the totals do not match. The DOH reports that, as of 3 January 2023, a total of 165,904,800 doses had been administered; the FDA November 2022 summary, prepared more than a month earlier, reports a higher total of 168,816,023 doses.

The FDA reports on adverse cases — which were released weekly from March 2021 until June 2022, then fortnightly in July and August 2022, and then finally monthly starting in September 2022 — used to include data on first, second, and booster doses on a per-brand basis, but no longer do.

For instance, in the 10 July 2022 report, the last to include such information, the breakdown shows that less than one million individuals used either of the two Chinese vaccines for booster doses, while about 12 million of the 16 million individuals who had taken either one or two booster doses at that time chose either Pfizer or Moderna (Table 10). Since the 25 July 2022 report, the per-brand information has been limited to the total number of doses administered.

**Table 10: Doses administered, per dose or booster, per vaccine brand**

*Table 2. Distribution of reports of adverse reactions for each vaccine*

| Vaccine                  | Date started | Total vaccine doses administered <sup>a</sup> | Number of fully vaccinated individuals <sup>b</sup> | Number of individuals partly vaccinated | Number of individuals with first booster shot | Number of individuals with second booster | Total number of reports <sup>c</sup> | Reports of non-serious events | Reports of serious events |
|--------------------------|--------------|---|---|---|---|---|--------------------------------------|-------------------------------|---------------------------|
| CoronaVac                | 01 Mar 2021  | 45,866,668                                    | 21,949,708  | 1,048,633                               | 911,421                                       | 7,198                                     | 35,745                               | 32,496                        | 3,249                     |
| AstraZeneca              | 07 Mar 2021  | 21,941,778                                    | 9,052,395   | 775,829                                 | 3,047,938                                     | 13,221                                    | 36,826                               | 35,054                        | 1,772                     |
| Sputnik V/ Sputnik Light | 04 May 2021  | 1,108,354                                     | 531,994   | 44,955                                  | 338   | -   | 880                                  | 831                           | 49                        |
| Comirnaty                | 13 May 2021  | 59,553,924                                    | 24,506,757  | 2,264,752                               | 7,496,333                                     | 779,325                                   | 18,973                               | 16,888                        | 2,085                     |
| Moderna                  | 30 June 2021 | 19,209,276                                    | 7,343,374   | 514,028                                 | 3,854,017                                     | 154,483                                   | 6,158                                | 5,457                         | 701                       |
| Janssen                  | 20 July 2021 | 7,208,321                                     | 7,176,453   | -                                       | 31,868  | -   | 5,235                                | 4,187                         | 1,048                     |
| Sinopharm                | 25 Aug 2021  | 1,039,342                                     | 495,071   | 48,463                                  | 737   | -   | 404                                  | 325                           | 79                        |
| <b>TOTAL</b>             |              | <b>155,927,663</b>                            | <b>71,055,752</b>                                   | <b>4,696,660</b>                        | <b>15,342,652</b>                             | <b>954,227</b>                            | <b>104,221</b>                       | <b>95,238</b>                 | <b>8,983</b>              |

Data source: <sup>a</sup>VigiFlow, <sup>b</sup>NVOC daily report as of 10 July 2022  
Notes: Additional information may become available in individual cases, which may change the figures presented  
<sup>a</sup>An individual is considered partly vaccinated if they have received only one dose of a two-dose vaccine course. An individual is considered fully vaccinated if they have received a single-dose vaccine or both doses of a two-dose vaccine  
<sup>c</sup>Data concerning various vaccines are not directly comparable. COVID-19 vaccines profile varies, they have not been used for equal periods of time and they have been administered to number of people with different profiles including various age and sex.

Source: “Reports of Suspected Adverse Reaction to COVID-19 Vaccines”, 10 July 2022 report, Food and Drug Administration

It is curious that the DOH does not publish per-brand vaccination data, and that the public catches a glimpse of the per-brand breakdown only through a loophole, in the form of a recurring table in a regular report on adverse reactions. That the broken down data (number of doses per vaccine, classified according to first dose, second dose, first booster, and second booster) is no longer available suggests that the loophole has been deliberately tightened.

Why not bring out information per vaccine brand into the open? Undersecretary Ho said the reason was probably the lag time between two different sets of data. The aggregate data, which goes into the dashboard, is submitted by local governments every day. However, the more granular data which includes information on brands comes much later. “Definitely, there’s a gap in the length of time that the [local governments] are able to submit that.” It’s not that “we don’t have the data and we don’t want to present it that way, but the aggregates for the scorecard being given to everyone is the aggregate data, so we wouldn’t have the breakdown yet.” (B. Ho, personal communication, 8 February 2023).

This answer is sensible, but it does not suffice. Two years after the start of the vaccination rollout, the DOH still does not provide regular updates on brand-specific vaccination. It is possible that this relative lack of transparency (relative, because the information can still be extracted from the FDA website) is a vestige of the black box treatment involving Chinese vaccines. Whether by design or by accident, however, it does reinforce the main message of the vaccination program, that all vaccination works. Highlighting the differences between vaccine use could negate all that.

Regarding the fundamental assumption behind this research project, that it is in the country's best interests to develop a reliable pipeline to vaccines made in the Global South, Ligot struck a cautionary note: "When you look at it purely from a supply aspect, I would agree. But then there are two more factors to consider. One is the speed of innovation. There's a great distance between the Western vaccines and the Indian and Chinese vaccines. The second aspect is [it's] really hard to disentangle the role of government in all this. Even if the whole Sinovac-was-first situation may have come from a completely benign rationale, people can't help but suspect what's going on." He added: "People would be hesitant. 'I'm not going to get that crap, because I don't trust the government.'" (D. Ligot, personal communication, 23 February 2023).

## PART V: CONCLUSION

Despite a false start, and in spite of logistical shortcomings, the country's vaccination program succeeded in fully vaccinating 95% of the target population against COVID-19. Much remains to be done, including getting at least 70% of the target population inoculated with booster doses. As of 6 February 2023, the total number of individuals who had received at least a single booster was 21.3 million, or only about 27% of the target. The momentum of the vaccination campaign, unprecedented in scope and scale, may have slowed, but it persists. After Marcos Jr. took office in mid-2022, he appointed only a temporary officer in charge of the DOH, for a reason that was bizarre on its face: he said he would appoint a Secretary of Health once the public health situation "normalizes" (Corrales, 2022).

The immediate challenge is complacency. The number of new vaccinations every week is in the tens of thousands, a number that is considerable but nowhere near the peak. As a result, the percentage of fully vaccinated senior citizens has stayed stubbornly just below 80% for many weeks. The number of booster doses administered is stuck below 30%.

If the response to the challenge is to drive up the number of booster vaccinations, what can the Marcos government learn from the experience of the last three years? If the challenge is the outbreak of another pandemic, what can be done better, more efficiently, to save more lives? In particular, how can greater vaccine equity, accessibility, transparency, and accountability be assured?

The first lesson involves vaccine supply. As long as the Philippines continues to lack the industrial and financial capacity to produce vaccines of its own, it must continue to rely on a portfolio approach, minimizing the risk of supply failure by maximizing the number of possible sources. But the country's experience with the COVID-19 vaccination program suggests that seven vaccines is too many, and that a smaller number may be optimal.

It would be best, then, to **implement a smaller portfolio approach to vaccine procurement**. Dealing with seven vaccines in 2021 meant dealing with seven different supply chains, complicating the entire program. The negotiations with the vaccine manufacturers in 2021 also suggest that the Philippines must invest in closer working relationships with its potential vaccine sources. To ensure that the Philippines can enjoy the benefits of a vaccine made in Asia, say from China or Vietnam, or from Japan or Korea, it is necessary to develop both closer commercial relations with the manufacturers and closer diplomatic engagement with the governments in those countries.

The second lesson is related to the bureaucratic temptation to complicate processes or multiply categories. It would be best, for instance, to **simplify the prioritization framework**. A total of 12 categories, some with lengthy lists of sub-categories, is too many and too unwieldy. One lesson from the experience of local governments like Quezon City is that supply should be a dynamic factor in identifying priority groups (Escaño-Arias & Eleria, 2022). When vaccine supply is sufficient, vaccine access should be opened up; when supply becomes limited again, access should follow the prioritization scheme. A simplified framework should also include children as a separate priority group.

The third lesson is obvious to those who worked in the vaccination program. Even though the national government has the responsibility to enter into supply arrangements with vaccine manufacturers, and even if the business community may have the financial capacity to reserve vaccine supply, the distribution and administration of the vaccines largely depends on the work of local governments. Given this reality, it would be best to **include the local governments at the highest levels of planning and decision-making from the start**, through the various leagues (associations of provinces, cities, municipalities, and barangays) and in their own capacities. To prevent conflicts over prioritization of vaccine allocations, the distribution plan must be designed and agreed to well before the next pandemic.

The fourth lesson recognizes the paramount importance of sympathetic or cooperative public opinion. Vaccine hesitancy and vaccine brand skepticism diminish the possibility of public cooperation, which is necessary to a successful pandemic response. Strategic, well-funded, and coordinated information campaigns can help shape public opinion. To do so effectively, the government and the private sector, through the business community, should **cement their partnership in communications**, coordinating initiatives as soon as a public health emergency hits.

The fifth lesson is drawn from the sorry experience of unnecessary and unproductive secrecy that surrounded government decisions involving the use and purchase of Chinese vaccines. It is best to **practice transparency**. Vaccinating against a global scourge, fighting an invisible enemy, requires utmost trust between government and public. The fight has no space, or use, for the black box of secrecy.

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