

REGIONAL SYNTHESIS REPORT

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

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PART I: INTRODUCTION

While the COVID-19 pandemic has affected everybody, it has also laid bare — and introduced — country-specific socioeconomic and political challenges. Beyond showing existing inequalities, social stratification has been further magnified through differences in access to pandemic-related protection, services, and information. The pandemic created a crisis in which public health infrastructure struggled to cope with the high demand for healthcare services, leading to a gap in vaccine equity. The severity of this crisis is even more alarming in the most vulnerable and least-developed countries.

On a global scale, there was a stark difference in access to COVID-19 vaccines between the Global North and Global South. With most vaccines initially developed and produced by only a handful of countries, the rest of the world had to rely on existing diplomatic ties, purchasing power, and donations to access these vaccines. Meanwhile, observable inequities between populations at the subnational level, exacerbated by socioeconomic, geographic, and citizenship status, resulted in further uneven access to COVID-19 vaccines. Different countries have implemented different strategies for the distribution of COVID-19 vaccines. Some have kept vulnerable and marginalised populations in mind, whereas others have implemented generalised vaccine distribution and inoculation strategies without considering vulnerable and marginalised populations. This has caused some countries to be far ahead of others in terms of vaccination rate and equity.

Given these challenges, the Innovation for Change - East Asia Hub (I4C-EA) took the initiative to conduct two online learning spaces with field experts and civil society representatives from South Asia, East Asia, the Pacific, Africa, and Europe to discuss global and regional trends related to COVID-19 vaccine inequity, diplomacy, transparency, and accountability. These sessions in July 2022 highlighted the nuances of the COVID-19 vaccine equity situation across countries, and identified common issues and trends, such as uneven and inequitable access to COVID-19 vaccines, and concerns about the affordability and manufacturing rights of vaccines developed using public funding and philanthropic support. Subsequently, a three-day co-creation workshop was conducted with engaged civil society representatives from South Asia, East Asia, and the Pacific in August 2022. These developments have shaped the current framework and scope of this study presented in this report.

This report contains reports from 11 countries across three subregions of Asia: Southeast Asia, South Asia, and Central Asia (see Table 1). It captures the lived experiences and data-backed realities of COVID-19 vaccine equity. It looks at trends and similarities across focus countries, while capturing each country's unique experiences and situations. It also takes a special look at how COVID-19 vaccines made by China-based manufacturers have figured in the issues of vaccine access and equity, China's influence in these 11 countries, and how its vaccine diplomacy works in each.

Table 1: 11 countries in three subregions

Subregions	Countries
Southeast Asia	Cambodia Indonesia Philippines Thailand Timor-Leste
South Asia	Afghanistan Bangladesh India Nepal
Central Asia	Kazakhstan Mongolia

Using primary data — interviews and focus group discussions (FGD) — and secondary data, the 11-country research investigates vaccine information accessibility, equity, transparency, and accountability of vaccine procurement during the COVID-19 pandemic. This study has the following five objectives:

1. To contribute to the global campaign for vaccine equity
2. To examine the distribution and procurement of Chinese-made vaccines in 11 countries across three Innovation for Change regions (East Asia, focusing on Southeast Asia; South Asia; and Central Asia)
3. To explore the extent to which countries in the three subregions relied on Chinese-made vaccines at the start of the global vaccination campaign
4. To research the transparency of Global South governments' procurement processes
5. To assess the impact of reliance on Chinese-made vaccines

Experience with COVID-19

There were human rights issues that went unaddressed during the pandemic. In Mongolia, the National Human Rights Commission of Mongolia (NHRCM) and civil society reported that human rights violations led to the resignation of some government officials. However, some, such as the World Health Organization (WHO), regarded Mongolia's early containment strategy as successful. Some common issues and trends emerged among the 11 countries in their experiences with COVID-19.

1. In all 11 countries, governments have responded to the pandemic with some form of stringent lockdown at various levels and in different waves, especially as subsequent variants hit. Countries, including Mongolia, Thailand, Kazakhstan, and Timor-Leste, have declared emergencies. The use of an Emergency Decree in Thailand gives a wide range of powers to the state with limited liability, which creates a decisive centralised decision-making apparatus that makes it difficult to hold the government accountable.
2. Notwithstanding differences in economic status, all countries face constraints on their local capacities to recover from the pandemic.
3. The pandemic has severely affected already marginalised groups that lack access to resources in most countries, including India, Thailand, Timor-Leste, and Afghanistan. For example, the disabled population in Afghanistan was initially excluded from groups prioritised for vaccination.

Vaccination measures

There were similarities in the vaccination measures of the 11 countries as follows:

1. The governments of all 11 countries have some form of vaccination strategy or plan for government ministries or agencies to spearhead across different portfolios. In most cases, it is centralised.
2. The vaccination plans of all countries have specified priority groups, but they are not uniform in which groups they prioritised or how they ranked these groups.

As the world adjusts to the COVID-19 pandemic, most COVID-19 dashboards have stopped updating. This created challenges for the researchers to obtain updated data on the fully vaccinated rate for the eligible population. Not all data found by the researchers are disaggregated and updated. Hence, some countries have unconfirmed data, while others have to rely on the limited information provided by alternative sources. For instance, Kazakhstan has no particular figure for its vaccinated eligible population. Moreover, while full vaccination generally refers to two doses, in the Philippines, it also covers those who got the single-dose vaccines like Janssen (J&J) and Sputnik Light.

According to WHO data, as of February 2023, 15 million vaccine doses had been administered in Afghanistan, with 13.4 million people having received at least one dose (34.5%) and 12.7 million considered fully vaccinated (32.6%). In Bangladesh, over 115 million people received two vaccine doses in 2022. In Nepal, as of January 2023, 22,327,169 people, or 76.5% of the total population, had been fully vaccinated. In Mongolia, the fully vaccinated percentage was 85.7% as of 6 January 2023, with an eligible population of 2.5 million. In Thailand, as of 10 February 2023, vaccination coverage stood at approximately 78% population coverage of two-dose programs, and slightly more than 50% booster coverage (third dose or more). As of 13 February 2023, Timor-Leste has made good progress with 2,011,703 doses delivered to around

798,020 people, meaning it has achieved around 60.53% two-dose vaccination. Some countries have adopted different approaches to vaccination. For instance, in the Philippines, four features characterise the vaccination program: (1) vaccine procurement through a pragmatic, diversified portfolio approach, as recommended by business community representatives, in order to minimise the risk of vaccine supply failure; (2) rollout based on priority groups selected by the national government; (3) vaccines being mainly administered by local governments; and (4) communication support from the government and the private sector. In some countries, such as Indonesia, Cambodia, and Timor-Leste, leaders were influential in overcoming vaccine hesitancy at the beginning of the vaccination program by receiving the first jab in public.

A focus on Chinese-made vaccines

Except India, all 10 research focus countries have received Chinese-made vaccines. India's inclusion in this research, however, has added to the nuances of exploring the factors leading to Chinese vaccine diplomacy in these countries. As indicated in the India report, India launched its Vaccine Maitri Campaign and "Neighbourhood First Policy" to contribute towards Global South vaccine equity. Along with this, India, in alliance with the United States (US), Australia, and Japan under the Quadrilateral Security Dialogue ("Quad"), has attempted to fill the vaccine gap with the hope of changing geopolitical tides in its favour. However, India has been unable to deliver on its aspirations or promises. By contrast, China has met this vaccine access gap in South, Central, and Southeast Asia. This dilemma of vaccine equity reveals how geopolitical contestation has impacted international vaccine equity: vaccination has become a strategic commodity rather than a global public good, as countries that can afford to produce vaccines use vaccine diplomacy to pursue their national interests and geopolitical gains.

Countries such as Bangladesh, Timor-Leste, Kazakhstan, Nepal, and Afghanistan have relied on external assistance, donor countries, international organisations such as the United Nations Children's Fund (UNICEF), and the WHO, and initiatives such as COVID-19 Vaccines Global Access (COVAX) to ensure sufficient vaccine supply. Timor-Leste has relied on AstraZeneca and Sinovac vaccines — the former supported by major donor countries such as Australia, the U.S., and New Zealand, and the latter supported by China.

China has emerged as the largest vaccine supplier to most countries covered by this research, including Indonesia, Bangladesh, Timor-Leste, Cambodia, and Afghanistan. Bangladesh has relied heavily on Chinese-made vaccines, with Sinopharm and Sinovac comprising approximately 87.7% of all the vaccines it received until June 2022. As a non-vaccine manufacturing country, Cambodia has received Sinopharm and Sinovac from China in two formats: donation to and purchase by the Cambodian government. There are 13 types of vaccines in Indonesia, five made by or in cooperation with Chinese companies. Owing in part to India's inability to provide vaccines to Bangladesh and Afghanistan as promised, China has become the largest vaccine supplier in South Asia. Limited by the "two-neighbour" problem, Kazakhstan, being geographically and

economically close to Russia and China, has been dominated by Russian and Chinese vaccines. This has prevented Kazakhstan from diversifying its inventory of vaccines to include those from Western countries. For low-income countries, such as Afghanistan, acquiring enough vaccines to vaccinate their populations has been challenging; Afghanistan has relied on COVAX and other countries, including the US and China. However, after the US and North Atlantic Treaty Organization (NATO) forces withdrew from Afghanistan in August 2021, leading to the return of the Taliban, China grabbed the opportunity to fill the vaccine gap. It is also noteworthy that although China has made major donations to most countries under this research, there have been some adverse reactions to this from communities in these countries such as in Cambodia, Timor-Leste, and Kazakhstan.

The findings of this research are divided into three main sections: information accessibility; vaccine equity; and self-reliance, transparency, and accountability. The similarities and differences among the 11 countries are discussed in each section, before a conclusion and list of recommendations.

PART II: RESEARCH FINDINGS

Section 1: On information accessibility

Limited information on vaccine procurement and donations

No country has comprehensively reported good practices for obtaining information about procured or received COVID-19 vaccines. In Kazakhstan, there is no information on available vaccines and no other information on procurement volume, price, or sources of supply. In Timor-Leste, it remains a challenge to access updated information about the number of people who have received vaccines and the type of vaccine used. In Bangladesh, neither the Surokha app nor the national dashboard includes vaccine price, batch number, expiration date, or waste information; this information is confidential and only accessible by filing a right to information (RTI) application under the Right to Information Act of 2009, which can take months or years to process. In Thailand, the government has never publicly disclosed vaccine delivery records, distribution data, existing vaccine stock, vaccine expiration or wastage information, or expenses incurred during vaccine procurement. Local media outlets have submitted requests but received no responses.

In Indonesia, despite there being policies targeted at the vaccine procurement process, such as the Presidential Regulation (Perpres) on COVID-19 Vaccine Procurement and the Vaccination Programs and the Health Ministerial Regulation (Permenkes), these policies, while being implemented, do not oblige responsible government agencies to disclose public information. For instance, the responsibility of government institutions to disclose information on vaccines is not specified.

In Mongolia, detailed information, including about vaccine procurement, distribution, availability, expiration, and wastage, was not available in government portals. Only limited information on vaccine procurement, distribution, and availability was included in the statements of government officials, and only statistics on vaccination progress and vaccination centres are publicly available. In Nepal, for months, there was little information on the vaccines being provided and no breakdown of how many people had received each vaccine, along with details about the vaccines, doses of each administered, manufacturers, and expiry dates. This information was eventually incorporated into daily updates; however, until then, the public had to rely primarily on news reports. In Cambodia, there is no detailed breakdown of procurement, donations, and related incurred costs, such as storage and maintenance. Moreover, sources of the total figures of vaccines received, doses remaining, wastage, expiry dates of vaccines, and medical waste management are not publicly available in one portal or location.

Dissemination of vaccine information

All 11 governments have used digital and information technologies during their pandemic responses. They each have at least one leading website portal and application tool for some information related to the COVID-19 vaccine. The difference lies in how these portals and tools cover information that is accessible to the public. Some have proven to be effective, whereas others have proven to be detached from actual grassroots needs. In India, for instance, technology is considered a key enabler of citizens' access to information: information on vaccination is disseminated using both an app and national application tools (namely, Co-WIN and state-developed apps such as the GOK Direct-Kerala), strengthening information accessibility at the state level. Some countries are heavily dependent on social media, such as Cambodia, where there are almost 12 million Facebook users out of a population of 16 million. The Facebook pages of the Cambodian Prime Minister and the Ministry of Health were the official sources of pandemic-related information.

Some countries have gradually improved their systems to share data and information more comprehensively. For instance, in Bangladesh, information was initially limited to a few topics, such as a vaccination centre's name, the total number of dosage recipients, and the proportion of male and female vaccine recipients. However, more information was made available later, including the distribution of different vaccines (e.g., AstraZeneca-Covishield, Sinopharm, and Pfizer) and the centres where they were provided. Some countries, such as Bangladesh, also include the local language (e.g., Bengali), apart from English, in their public web portal. Likewise, in Kazakhstan, all central information about COVID-19 has been organised on a web portal and made available in Kazakh and Russian languages.

Other actors also have played essential roles in information accessibility. For instance, in Cambodia, especially in rural areas, village leaders went door-to-door to inform household members about the date, time, and documents required to be brought along when going for vaccination. The government and the private sector conducted massive parallel information programs in the Philippines, and these strategies helped redefine public attitudes about the pandemic and the value of vaccination. In Kazakhstan, in light of the government's lack of information campaigns, civil society groups and various entities filled gaps. For instance, doctors made the Instagram page MedSupportKz, which provides information about all of the COVID-19 vaccines, what types of vaccines are available, and how each vaccine works; it also posts replies to questions about mass vaccination measures by the government, revaccination necessities, and consequences of vaccination. Information is provided in both Russian and Kazakh languages.

Barriers to vaccine information accessibility

There have been similar barriers to information accessibility across all 11 countries, as identified in this research. For instance, information being disseminated does not include scientific information to assure public confidence of vaccines' safety, which has repeatedly led to misinformation and

disinformation. It also lacks disclosure on how COVID-19 vaccines are being made accessible to marginalised communities, migrants, refugees, and stateless persons. Limited access to the Internet, social media, and conventional media is another barrier. In Timor-Leste, Internet penetration is less than 50%. At the same time, not all Timorese in rural areas have access to national media such as television.

Some barriers are more context specific. For example, although authorities have provided briefings in Bangladesh, the same information is not publicly available on government websites. Sometimes, journalists had to confidentially gather information from unnamed sources. In countries where media freedom is restricted, such as Cambodia, government agencies have designated officials to handle the press, whom reporters can call for interviews. However, efforts to seek further clarification and explanation of government agencies' public announcements are not informative as reporters are usually fed with the same publicly available information; restrictions were imposed because local authorities wanted to control the news narrative and avoid chaos among the public.

The complexity of website portals and vaccination apps is unfriendly for many. For instance, FGD participants in Dhaka and Chottogram, Bangladesh, said that most ethnic minorities and Rohingya refugees, who lacked Internet access and had not yet learned about online registration either could not register or had to get help from others to register at business-driven Internet facilities. The transgender community there was excluded from a registration process that required official IDs that these community members did not have.

There is no specific platform for COVID-19-related information in Afghanistan. Only designated Ministry of Public Health staff have access to vaccine information. Nevertheless, it should be noted that information was more accessible before the Taliban took power. After the Taliban takeover on 15 August 2021, it rarely shared any information on vaccination with either media or the public. It is also imperative to note that the general public's understanding of COVID-19 and readiness to take measures have been hampered by pervasive, widespread poverty and illiteracy. Many Afghans have simply been absorbed with other daily hardships.

Section 2: On ensuring equity

Barriers to vaccine information accessibility overlap with and can impact vaccine equity. For example, technological inequality was observed in all 11 countries. Low digital literacy and limited Internet penetration were common hurdles to realising equitability. This has contributed to limited vaccine information and led to a vaccine equity gap as adequate information was not received. In Thailand, the various digital channels for making job appointments, ranging from the official "Mor Prom" website and application to social security websites, hospital websites, telecom company websites and applications, various municipal government websites, private company Intranet, and other channels, have caused much confusion and anxiety among the public regarding which channel should be used to secure job appointments. In Nepal, differing digital access has further widened the rural-urban divide.

Equity issues within priority groups

All 11 countries had priority sequences that used a phased approach in their vaccination strategies. In all of them, supply constraints informed the vaccination policy. In Mongolia, information about such prioritisation was unclear from the start; the ministerial order of vaccination listed target groups without a precise priority sequence. The vaccination drives in most countries prioritised high-risk groups, including healthcare and frontline workers. The other priority groups include those exposed to illnesses, such as in Bangladesh. In Kazakhstan, the main priority groups are medical workers in infectious disease hospitals, emergency medical care, intensive care units (ICU), primary health care (PHC), emergency rooms of hospitals, and epidemiological services, as well as sanitary employees. In Thailand, older adults and immunocompromised individuals have had the highest priority. Notably, "teachers and other essential workers" and "disadvantaged sociodemographic subpopulations at higher risk of severe COVID-19" are among the groups considered high-priority in Thailand, though neither group is included in the WHO standards. Cambodia initially set out four priority phases, with the first phase targeting healthcare workers, frontline armed forces, police, and government officials. However, it changed its approach because of community cluster outbreaks, refocusing on high population density areas before moving down to less populated and remote areas.

In Afghanistan, the priority sequence is as follows: health workers, teachers in schools and universities, security personnel, prisoners and residents of women's shelters, people with comorbidities, people over 50, the nomadic population (30-50 years old), IDP camp residents (30-50 years old), returnees from neighbouring Iran and Pakistan (over 30), government and private employees working with crowds of people (over 18), and people living in the slums of big cities (over 18). This is interesting, as it includes marginalised groups. Even though Afghanistan has one of the largest populations per capita of persons with disabilities (PWDs) in the world, PWDs were not initially included in the priority list and only to be addressed with the arrival of the additional vaccines. The vaccination plan in the Philippines classified the "priority eligible population" into

12 categories, with five groupings under A, six under B, and the rest of the population under C. While senior citizens were included in Group A, the number of deaths in this group suggests that its members remained vulnerable; as of 14 February 2023, 61% of all COVID-19 deaths (over 40,000) claimed the lives of senior citizens. While most countries have a list of priority groups, the Philippines' report also raised another interesting concern: How do countries balance public health priorities and economic concerns? As indicated in the report, one of the objectives of the vaccination program was to stimulate economic recovery, so factors such as contribution to the gross domestic product (GDP) were also used to determine the allocation of vaccines. However applying this economic basis for prioritisation arguably sacrificed vaccine equity. 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.

In Nepal, development workers, diplomats, and journalists were ahead of the elderly, those with comorbidities, and frontline workers. Such decisions were heavily criticised; many believed such a move was for political gain. Nepal also had a significant rural-urban divide in access. Although just 20% of Nepal's population is urban, these people have had faster and easier access to vaccines.

Differing safety approaches meant that children were vaccinated in some countries and not others. In some countries, children under 12 years were also included in the vaccination groups. In India, the priority sequence is only until the age of 12. Bangladesh started its COVID-19 vaccination campaign for children ages 5–11 in August 2022. In Indonesia, vaccination targets include children ages 6–11.

Barriers to vaccine equity

Some countries, such as Indonesia and the Philippines, have opted for a decentralised approach, resulting in greater vaccine equity. In Indonesia, provincial, regency, and municipal governments — and sometimes even district and village administrations presided over vaccine distribution. In the Philippines, vaccines have been administered mainly through local governments at the provincial, city, municipality, and *barangay* (village) levels. Apart from local governments, private sector companies (including the private healthcare sector) have also been involved in some countries, such as Indonesia, India, and the Philippines. Indonesia's *gotong-royong* (or private-sector collaboration), proposed by the Indonesian Chamber of Commerce and Industry (KADIN), helps the government achieve herd immunity targets through a vaccination program. Such practices can allow for greater coverage, but they can also put vaccines out of reach as a result of rent-seeking by private actors. In India, for example, vaccination is chargeable in private hospitals, posing an economic barrier for poorer people. The issue of rent seeking motives has also been raised in Indonesia. The decentralised approach also raises questions about who should be responsible for ensuring the equitable distribution of vaccines. In India, the decentralised approach was reversed, state government quotas for vaccine procurement removed, the private sector's quota reduced to 25%, and the Indian government's quota increased to 75%, after a Supreme Court ruling emphasising the need for vaccine price neutrality and equitable distribution.

Vaccine hesitancy has been another issue in all 11 countries. Hesitancy in India is rooted in concerns about the safety and efficacy of indigenous vaccines. In the Philippines, public trust in COVID-19 vaccines was undermined by an earlier controversy over an unrelated drug, Dengvaxia. Distrust in the effectiveness of Chinese vaccines was significant in Mongolia, Cambodia, Timor-Leste, and Nepal. In Bangladesh, distrust of Chinese vaccines is also among the reasons for this, including based on misinformation. In Mongolia, due to a lack of substantial knowledge and information on various types of COVID-19 vaccines, people were hesitant to be vaccinated during the early stages of the vaccination program.

In Thailand, geographical distribution of vaccine coverage showed a clear pattern of inequality. As of December 2022, 54 of 77 provinces recorded more than 70% two-dose coverage, including 112% coverage in Bangkok (suggesting that a considerable number of non-residents travelled to Bangkok to get jobs). Another 19 provinces reported a 60–69% two-dose average, and the remaining four provinces reported less than 59% coverage. The four are among the poorest provinces in Thailand, and this relatively low vaccination coverage has the potential to exacerbate severe economic and social inequalities. The report identified five dimensions of vaccine equity: geographical, technological, and related to target groups and legal status. Poverty has also been identified as a factor affecting vaccine equity. The Thailand report indicates that the poorest populations in Thailand have tended to have less access to “alternative vaccines” (Sinopharm and Moderna, whose importation and administration was facilitated by the private sector) than residents of richer provinces. The “alternative vaccine” scheme has likely exacerbated, rather than alleviated, vaccine inequality in Thailand due to the imbalance of priorities between wealthier and poorer provinces.

Kazakhstan's combination of historical ties to Russia and economic dependence on China, while landlocked and sandwiched between the two, affected its diplomacy and the direction of its vaccine rollout. The majority of its vaccines were produced in Russia and China, and Sinopharm (from China) is the only vaccine approved by the WHO that is available to Kazakhstan citizens. Although Kazakhstan has produced its own vaccine, QazVac, the drug has faced opposition from some independent scientists and doctors, who cite safety issues. Owing to the unavailability of other vaccines, such as those approved by the WHO, Kazakhstan citizens have used “vaccine tours”, most commonly to the United Arab Emirates (UAE), Turkey, Croatia, and Bulgaria. The lack of vaccine choices has also pushed many citizens to receive vaccines from neighbouring Central Asian countries, such as Uzbekistan. These practices translated into inequality, as many lower-income people could not afford to do the same.

While most countries have faced shortages of vaccines, this has not been the case in the Philippines, where a portfolio approach involving multiple vaccine manufacturers has preempted a lack of vaccines. However, this approach ultimately caused an oversupply of doses, resulting in wastage. The total number of unused doses was estimated to exceed 50 million, and the Philippine Senate is investigating why at least 44 million doses have expired before they could be used. The vaccine distribution in some countries has also reportedly been warped by political influence. Many political parties involved in government coalitions have competed to manage vaccine

distribution in Thailand, leading to different channels of vaccine appointment registration that led to confusion and disrupted the priorities outlined in the country's vaccination strategy.

Vaccine equity for marginalised groups

Across all 11 countries, there has been significant inequity in vaccine distribution across gender lines and regarding marginalised groups — especially refugees and migrant workers. This has led to debates regarding discrimination.

Research for this report suggests that three factors have led to gender inequity in vaccination in India: a patriarchal structure that discriminates against women's right to access healthcare services, limited digital access for women, and misinformation about how vaccines can affect menstrual and women's sexual health. In neighbouring Bangladesh, a glaring disparity could be seen as sanitation workers, garbage collectors, cleaners, and other informal workers exposed to the virus were left behind in vaccination. This has also been the case for vulnerable groups such as indigenous people, people who live in slums, and the transgender community in Bangladesh. Despite the Thai government's announcement that it would implement a "non-discrimination" policy, many foreigners in Thailand, especially migrant workers, continue to face much more difficulty accessing vaccines than Thai nationals. In Cambodia, indigenous people, ethnic minorities, people with disabilities, LGBT+, entertainment workers, domestic workers, and people living with HIV/AIDS are not prioritised, leaving them even more vulnerable.

It is noteworthy that Bangladesh was one of the first countries in the world to vaccinate refugee children and adolescents. The government also signed a revised version of the National Deployment and Vaccination Plan (NDVP) that included the Rohingya population as a target group. As Bangladesh is one of the largest refugee-hosting countries in the world, research for this report focused on vaccine equity involving FGDs in Dhaka and Chottogram, where most ethnic minorities and Rohingya refugees are located. The findings indicate that the government has also attempted to vaccinate Rohingya refugees living in camps in Bangladesh and people in hard-to-reach places. The first and second doses of the vaccine were also given to vulnerable people, also known as the "floating population", and the government and foreign aid organisations allocated COVAX vaccines to immunise the Rohingya community living in Cox's Bazar.

Some efforts have been made in marginalised communities to address this issue. Community leaders and priests were crucial in vaccinating their communities in some marginalised communities, such as the Chepang and Muslims in Nepal. In Cambodia, as marginalised and vulnerable groups are stigmatised and have not been prioritised, civil society has played a vital role in advocating for vaccines to be available to them; trade unions have also played crucial roles in mobilising support for them. Migrant workers returning from Thailand were supported at borders by the International Organization for Migration (IOM), the WHO, UNICEF, and the government, but this response was situational rather than strategic, as it did not meet the real needs of specific groups.

Chinese vaccines and equity

Chinese vaccines have become the primary avenue for some countries in their strategies to increase vaccine equity. In Timor-Leste, the government formally asked the Chinese government to increase the supply of vaccines to support existing vaccine stocks. In Nepal, civil society likewise asked the Chinese government to do so. At the same time, resistance to Chinese vaccines has also been high. In some cases, this was because countries — such as Cambodia and the Philippines — were using them before they got the WHO's approval. When the vaccination campaign began in Cambodia, the government faced multiple challenges, including information about the adverse effects of Chinese vaccines and refusal to voluntarily obtain jabs, with people waiting for the arrival of WHO-approved vaccines. When non-Chinese vaccines arrived, the government faced other challenges, as these were not available at every site where vaccines were administered, and the public was eager to obtain them. Many countries have had debates about whether to use Chinese or non-Chinese vaccines, with implications for how much of their population gets vaccinated. To overcome the negative public sentiment, high-level officials have attempted to boost confidence by being publicly inoculated with Chinese vaccines.

These same issues arose in Mongolia, which has relied heavily on Sinopharm. For example, a small group gathered before the national Ministry of Health office, protesting that Sinopharm was in a phase III clinical trial and not approved by the WHO and voicing suspicion and nationalist sentiments possibly based on misinformation, that "Chinese vaccines received through humanitarian aid, will be used to vaccinate military personnel". In Nepal, the communities examined in the report expressed doubts about Chinese vaccines and preferred other vaccines, primarily due to the prevailing sentiment among Nepalis that Chinese-made products are inferior in quality and are not as trustworthy as those manufactured elsewhere.

Strategies to increase vaccine coverage

Different countries have used different approaches to increase vaccine coverage. The Government of Bangladesh has worked with other actors, including civil society groups, to address vaccine equity. In Thailand, civil society has played a crucial role in helping vulnerable groups access healthcare and vaccine registration, despite receiving no incentives or special assistance from the government. The Timor-Leste government has applied an entertainment-education approach in its vaccination campaign, with public figures such as national artists joining in efforts to encourage more people to get vaccinated. In Indonesia, some regional governments have provided gifts to encourage people to receive vaccines, including grocery packs, social assistance, and door prizes. In Mongolia, the government gave approximately USD18 for people to receive the first dose of the vaccine; however, this was also in the run-up to a presidential election campaign in June 2021, (likely) illustrating how governments have used the COVID-19 pandemic to their political advantage.

Section 3: On ensuring self-reliance, transparency, and accountability

Home-grown vaccines and self-reliance issue

Five of the 11 countries achieved greater self-reliance by producing vaccines (see Table 2). At the beginning of the COVID-19 pandemic, the Indian government recognised the importance of self-reliance, given its vast population and the potential difficulty of procuring vaccines from abroad for this population. The Indian government launched its “Atma Nirbhar Bharat Abhiyan”, (Self-Reliant India Campaign) allocating economic stimulus and comprehensive packages worth USD265 billion (Rs. 20 lakh crores) to support India’s fight against COVID-19. India also launched the Mission Covid Suraksha, (Covid Protection), to provide monetary support for indigenous vaccine development. Of the 12 vaccines approved in India, six are indigenously produced. One of them, Covishield, was developed by the Serum Institute of India (SII) with the foreign assistance of Oxford-AstraZeneca, Codagenix, and Novovax. Another, Covaxin, was developed by Bharat Biotech International Limited, in collaboration with the National Institute of Virology of the Indian Council of Medical Research (ICMR). However, there are lingering safety concerns regarding Covaxin. Subsequently, four indigenously produced vaccines have been released: ZyCoV-D, Covovax, Gemcovac-19, and iNCOVACC.

Table 2: Home-grown vaccines

Country	Vaccine names
Afghanistan	-
Bangladesh	Bangavax ¹
Cambodia	-
India	Covishield ² Covaxin and Covovax ³ ZyCoV-D, Gemcovac-19, and iNCOVACC ⁴
Indonesia	IndoVac, AWcorn, and Inavac ⁵
Kazakhstan	QazVac ⁶
Mongolia	-
Nepal	-
Philippines	-
Thailand	HXP-GPOVac, Baiya SARS-CoV Vax 1, and ChulaCOV19 ⁷
Timor-Leste	-

In Indonesia, a state-owned company, Bio Farma, is responsible for conducting Research and Development (R&D) on vaccines and for commercial deals on vaccines, drugs, and medicines, together with the efforts of the National Agency of Food and Drug Control (BPOM). Indonesia has also locally produced three vaccines — IndoVac, AWcorn, and Inavac — with the involvement of some universities. This supports the country’s ambition to be self-reliant and not overly dependent on the vaccine production of foreign countries.

Thailand has had three concurrent initiatives: HXP-GPOVac, by the Governmental Pharmaceutical Organisation (GPO); Baiya SARS-CoV Vax 1, by Baiya Phytopharm, a clinical-stage biopharmaceutical company incubated by the C.U. Innovation Hub at Chulalongkorn University; and ChulaCOV19, by the Faculty of Medicine at Chulalongkorn University. Bangladesh, which is on the United Nations (UN) list of Least-developed Countries, is undergoing clinical trials for the Bangavax vaccine.

Several efforts have been made in Cambodia to promote self-reliance, which include financing the purchase of vaccines, as the government struggled to do so on its own. While depending on vaccines from bilateral counterparts and the COVAX facility, Cambodia also set up a working group to discuss and design its vaccine research and production plan, demonstrating a desire for greater self-reliance in the face of future pandemics. A task force was created under Cambodia’s Readiness for Future Vaccine Development and Production Plan to study the possibility of researching and manufacturing vaccinations. Prime Minister Hun Sen called for wealthy individuals in the country to donate their money to prepare to purchase vaccines whenever they were available on the market. This money was donated by private and wealthy individuals, civil servants, and others. This gesture was followed by senior government officials who donated salaries of three, six, or 12 months to the cause, including Hun Sen himself. However, this private donation by rich civil servants and others raises the issue of transparency and accountability for their monetary contributions.

The countries that have received vaccines through COVAX are Bangladesh, Timor-Leste, Indonesia, Mongolia, Cambodia, Afghanistan, and the Philippines. It is acknowledged in this report that there is a need to have more support for the Trade-Related Aspects of Intellectual Property Rights (TRIPs) waiver, given issues such as the lack of vaccines in most countries. For instance, Mongolia recognised its lack of vaccine self-reliance early and showed firm support for a TRIPs waiver for better vaccine access, especially in the Global South.

Policymakers have raised concerns about Timor-Leste’s reliance on vaccine-producing countries, as it is a small country that lacks financial and human resources.

¹ Not approved by WHO.

² Approved by WHO (granted emergency use).

³ Approved by WHO.

⁴ Approved in India, not approved by WHO.

⁵ None approved by WHO.

⁶ Approved in Kazakhstan, not approved by WHO.

Self-reliance also remains impossible for low-income developing countries like Nepal, which relies heavily on India, does not produce vaccines independently, and has little sway in global geopolitics. The government was forced to accept whatever was given by donors and multinational organisations.

Chinese vaccines and dependency

Agreements between China and Bangladesh on the purchase of Sinopharm and Sinovac vaccines in massive quantities illustrated how one country's dependency can be leveraged by another country for strategic or political gains. Around the same time that China sent Bangladesh 500,000 vaccine doses, it warned Bangladesh against joining the "Quad Alliance" (with Australia, India, Japan, and the US) or risking its bilateral relations with China. In addition, questions of favouritism — or unfair dealings, depending on one's perspective — were raised when Bangladesh's Cabinet Division claimed that vaccines cost USD10 per dose, even though China had sold the same vaccines to Sri Lanka for USD15 per dose. In Mongolia, approximately 90% of all vaccines received by 6 May 2021 were from China.

Research for this report strongly emphasises that Cambodia relies heavily on Chinese vaccines. The first batch of COVID-19 vaccines to arrive in Cambodia contained a Chinese-made vaccine not approved by the WHO at that time. Reliance on the Chinese vaccine was not only a priority, but the only viable option, for Cambodia to take precautionary measures against COVID-19, considering the scale of investment and donations from China in Cambodia, as well as Cambodia's already deteriorating relationship with the West, including the US and the European Union. In Thailand, the government's vaccine acquisition and distribution by the brand was plagued with a public outcry over the appearance of favouritism for inactivated virus vaccines from China (Sinovac and Sinopharm), as well as the purchase of viral vector vaccines (AstraZeneca) produced under contracts by the monarch's own company.

The metaphor of a black box is used in this report to refer to the Philippine government's special relationship with China and the largely opaque manner in which it publicly portrayed the Chinese government's involvement in its pandemic response. This lack of transparency was deemed a failure by the previous administration of President Duterte, but the Marcos presidency, starting in the second half of 2022, has also failed to ask its predecessor government to set the record straight. The black box is defined by four failures in transparency and accountability identified in the report: special treatment for China, premature and still unexplained use of Chinese vaccines, officials' ignorance of decisions and details of Chinese vaccines, and a corruption scandal involving pandemic funds.

Transparency and accountability issues

The 11 country reports show similarities in their findings on vaccine transparency and accountability. Data on the COVID-19 vaccine supply inventory, procurement, and overall pandemic spending are limited in all 11 reports.

In Bangladesh, procurement irregularities and a lack of transparency have repeatedly been raised as causes of concern. This includes controversy and conflicting news regarding the expiration date of Pfizer vaccines, with one claim that the expired vaccines were returned and another that the WHO had permitted the prolonged use of the vaccines. No details regarding the procurement process for any brand were made public in Thailand, and Kazakhstan lacked clear procedures or publications on vaccine procurement or spending contracts. In all 11 countries, research indicated the lack of a mechanism to verify government data and disclosures related to COVID-19 vaccines, as well as a lack of subnational data on vaccination and the pandemic situation.

Without sufficient checks and balances in place, all of these countries faced the possibility of corruption. Due to price issues, diplomatic hurdles, and internal criticism, the Nepalese government appeared uninterested in disseminating procurement information. For instance, vaccine expiry dates were hidden, and Nepal signed a non-disclosure agreement with China regarding the price at which it purchased 10 million Sinopharm doses. Under the COVID-19 Law in Mongolia, the government can rearrange budget expenditures as it sees fit — as long as it does not exceed a budget cap — without parliamentary discussion and approval. Incidents such as highly budgeted procurements being announced for unusually short periods, caused public concern and called the integrity of processes into question.

Ensuring government accountability

COVID-19-related fiscal transparency and accountability have been criticised not only by experts and civil society, such as the media and academia, but also by opposition politicians. The media is vital as a watchdog to ensure vaccine accountability and transparency. In India, it has held the government accountable for issues of vaccine wastage, vaccine distribution across states, and various inequities. In Nepal, where the government has not been transparent about procurement and vaccine spending information, most information regarding vaccines in the public domain comes from local media, including exposure of corruption in procurement.

India's judiciary has also played a crucial role in ensuring government accountability. A Supreme Court decision triggered a change in the procurement process of vaccines when the budgetary constraints of state governments were raised. In Timor-Leste, the Aid Transparency Portal (ATP) is the central repository for all aid information, aiming to improve aid transparency, accuracy, and predictability, and to ensure that assistance is efficient and effective. In Nepal, with no official data on vaccine procurement provided by the government, civil society and non-governmental organisations (NGOs) consolidated their data from various sources, such as diplomatic releases and newspapers, to make the numbers more transparent.

PART III: CONCLUSION AND RECOMMENDATIONS

While all 11 countries have somehow managed to contain the spread of COVID-19 through their respective vaccination strategies, the pandemic has revealed the structural inefficiencies they must address in the long term to improve their preparedness for providing healthcare services and capacity to cope with further health emergencies.

This report highlights successes in some countries. For instance, Mongolia concluded that its vaccination program was implemented with relative success, with the crucial factor of access to vaccines enabling vaccination progress. Unfortunately, Mongolia's access to vaccine information, effective communication, and transparency regarding vaccine procurement are insufficient. Nepal's report indicated that the government had used various media to encourage citizens to vaccinate reasonably successfully. In the Philippines, while the populist approach was continued through the end of President Duterte's term, the rollout of the vaccination program in 2021 and its continuation into the third year of his administration turned out to be at least a partial success.

All 11 countries, except India, have relied primarily on Chinese vaccines for vaccine coverage. Chinese vaccines have generated common debates across countries, and their wide use has raised the question of whether China's vaccine diplomacy contributes more to the international public good or to China's diplomatic gains and soft power projection. The handling of Chinese-made vaccines has led to problems with procurement, resistance from people questioning the safety of the vaccines, and political influence affecting the actions of some governments, such as Cambodia and the Philippines.

While some recommendations are more context-specific across the 11 countries, many share generally applicable recommendations:

- 1. Strengthen public health infrastructure.** Ensuring that marginalised communities are included is essential for achieving health equity.
- 2. Strengthen self-reliance.** Cooperation with international organisations and donor countries is essential to ensure states' resilience. Efforts in favour of the TRIPs waiver on vaccines must be supported to move towards equitable vaccine access.
- 3. Ensure appropriate and timely communication of vaccination information to all, including marginalised groups.** This is crucial for ensuring vaccine equity. Strategic, well-funded, and coordinated information campaigns can help to shape public opinion. Language, cultural context, and societal nuances should

be considered when encouraging people to vaccinate and to overcome vaccine hesitation.

- 4. Employ transparency.** Governments should be transparent about vaccine procurement and donations. The development and availability of data are essential in many ways, and this can also enhance accountability and build public trust.
- 5. Exhaust all viable options.** Emergency-decree powers should be chosen only as a last resort, because they severely limit accountability and possibly make the government less mindful of public demands and outcries.
- 6. Decentralise and be inclusive.** Although the national government may have primary responsibility, public health emergencies must be inclusive and ensure that all stakeholders are meaningfully involved, even if this means devolving powers to local bodies.

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