

# How to eradicate ‘vaxtortion’ before the next pandemic –

## Recommendations for building transparency and accountability into the Global Accord on Pandemic Prevention, Preparedness and Response



### BACKGROUND

#### Corruption and lack of equitable access during the COVID-19 pandemic

Pandemics and emergencies expose weaknesses and gaps in health systems. If not addressed, these weaknesses and gaps create risks and opportunities for corruption which can undermine the response and deprive people of health care or even worse their life.<sup>1</sup> The COVID-19 pandemic, unfortunately has not been different. Corruption and opacity have hampered the pandemic response, resulting in a lack of equitable access to personal protective equipment (PPE), diagnostics, vaccines and most recently treatments<sup>2</sup> both within countries, and between countries.

There have been a multitude of reports of corruption related to:

- **theft**<sup>5, 6</sup> e.g. 1,085 vaccines meant for inmates at an Indonesian prison suspected stolen and sold to the public
- **opaque public procurement of PPE**<sup>7</sup> e.g. investigations into procurement of COVID-19 items by the Kenya Medical Supplies Authority revealed several irregularities in the procurement process where for example no evidence was provided to verify that the negotiated prices were guided by a market survey.<sup>8</sup>
- **queue jumping** by individuals for faster access to vaccines, either through favouritism or falsely claiming to be front-line health workers (e.g. one pharmacist based in the United Kingdom reported turning away “dozens” of people a week who have lied about their eligibility.)<sup>9, 10</sup>

In addition to these reports of corruption, the response has also faced challenges with a lack of safeguarding equitable access. A lack of transparency in bi- and multilateral advance purchase agreements and limited mechanisms and international standards to protect against vaccine nationalism have contributed to inequitable access to COVID-19 vaccines. Purchasing patterns mirror those observed during the 2009 H1N1 pandemic where high income countries initially purchased and stockpiled as much vaccine as was manufactured.<sup>11, 12</sup> Governments in high income countries

- **pricing or access to personal protective equipment**<sup>3</sup> e.g. price of face masks in South Africa inflated by up to 748 per cent<sup>4</sup>

**“The money lost to corruption from global health budgets, if re-gained, covers the commitment made by UN member states to achieve universal health coverage by 2030.”**

have procured up to seven times the supply needed to vaccinate their population, administering fourth or fifth booster doses to non-priority groups when many low- and middle-income countries had vaccinated less than 10 per cent with a first dose.

Our own [research](#) on transparency in the development and procurement of COVID-19 vaccines found disturbing trends of poor transparency in clinical trials as well as in contracting for the supply of vaccines. Only 10 per cent (12 of 86) registered clinical trials shared clinical trial protocols and only 6 per cent (13 of 183) of COVID-19 vaccine procurement contracts were publicly available.

TI has also received multiple reports of people being denied relief aid in the first wave of the pandemic in countries including, Nigeria, Rwanda, Sri Lanka and Zimbabwe<sup>13</sup>, and of having to pay bribes to access to vaccines.<sup>14</sup>

The difficulties in ensuring an equitable and transparent response to COVID-19, at both national and global levels demonstrate the need for stronger principles, standards and legal frameworks for engagement. Such mechanisms will support governments in their response, and allow for greater oversight. Doing so will not only improve future pandemic responses, but also strengthen national health systems.

## The Global Accord on Pandemic Preparedness

In March 2021, 25 heads of government and international agencies (including the World Health Organization) came together in an extraordinary joint call to build a more robust global health architecture that will protect



**Only 10%**  
registered clinical trials shared  
clinical trial protocols

future generations.<sup>15</sup> In December 2021, the World Health Assembly established an intergovernmental negotiating body (INB) to draft and negotiate a convention, agreement, or other international instrument to strengthen future pandemic prevention, preparedness and response. Through intermediary steps (including a discussion about the working draft on 1 August 2022), the INB (which consists of members from Brazil, Egypt, Japan, South Africa, Thailand and the Netherlands<sup>16</sup>) is expected to deliver a progress report to the 76th World Health Assembly in 2023 and the final outcome for consideration by the 77th World Health Assembly in 2024.<sup>17</sup>

To ensure this international instrument will effectively strengthen future pandemic prevention, preparedness and response, there is a need to address the hidden challenges which have limited transparency and accountability in the response to the COVID-19 pandemic.

## THE HIDDEN CHALLENGES

### 1. Lack of transparency in research and clinical trials

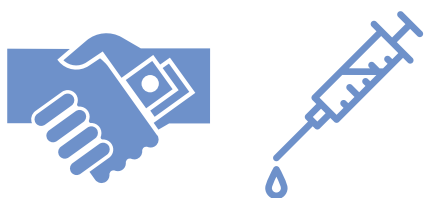
Reporting guidelines during emergencies vary between jurisdictions. During a global emergency, a lack of consistency on the timeframes for reporting, and what information is released, makes it difficult for governments to make decisions.

The TI report “[For Whose Benefit](#)” published in May 2021, found that clinical trial results for development of a vaccine against COVID-19 had only been announced for 45 per cent of the total registered clinical trials, with two developers having made no trial results public. 41 per cent had no published data analysis, meaning that only top-level results were provided through a press release, press conference or media report, with minimal data.

### 2. Lack of equitable access

That access to COVID-19 vaccines has been highly inequitable at the global level is well known. However, what is not known is how equitable the access to vaccines has been within many countries. There is limited insight into equity on in country access to COVID-19 vaccines, limiting the ability to effectively plan and distribute vaccines. However, where information is available it is concerning:

In Uganda, as of the 5th November 2021 only 15.6 per cent of those in vaccine priority groups had received a second dose. These included health workers, teachers, security personnel, those aged 50 years and above and those below 50 years with co-morbidities. In September 2021, the Ministry published data on the vaccination rates



## 9.3% of 6,120 respondents in Uganda reported paying bribes to access COVID-19 vaccines

of those individual priority groups. At that time, only 35.5 per cent of health workers and 8.8 per cent of those above 50 years had been fully vaccinated. By comparison 83 per cent of health workers and 82.3 per cent of the elderly in EU/EEA countries were fully vaccinated in September 2021.<sup>18</sup>

Research by TI in Bangladesh, Uganda, and Zambia found corruption, lack of transparency, and misinformation to be the leading barriers hampering individual's access to COVID-19 vaccines. 9.3 per cent of 6,120 respondents in Uganda reported paying bribes to access COVID-19 vaccines (individual districts varying between 2.1 per cent to 25.8 per cent). Personal connections were used to access vaccines by on average 20.5 per cent and 4.8 per cent of respondents in Uganda and Zambia, respectively. However, for some health facilities this ranged up to 93 per cent.<sup>19</sup>

Acts of sexual extortion (sextortion) are even less likely to be reported; social and power structures often stigmatise those who report or speak out about such acts. TI has not received any reports of sextortion during our monitoring of the COVID-19 vaccine rollout in Bangladesh, Uganda and Zambia. However, evidence shows that this is a gendered effect of corruption in the health sector.<sup>20,21</sup> TI's [Global Corruption Barometer surveys](#), conducted prior to the pandemic in 2019 found that in Latin America and the Caribbean<sup>22</sup> as well as the Middle East and North Africa<sup>23</sup>, one in five people have experienced sexual extortion when trying to access basic services or know someone who has.

Public insight has been hampered as data on vaccination progress have not been shared consistently, and more importantly, not disaggregated by priority or vulnerable groups. Transparency is key to building the knowledge and trust needed to achieve adequate support for equal access to vaccines, within and between countries, in addition to countering misinformation which feeds into vaccine hesitancy – a concern highlighted by 132 United Nations member states.<sup>24</sup>

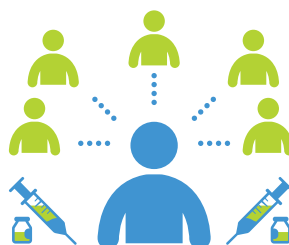
### 3. Limited mechanisms to enhance transparency and accountability

As of [May 2021](#), only six per cent of vaccine contracts between developers and public buyers were published through formal channels. Our [research](#) found that upper-middle income countries like South Africa paid an average of 25 per cent more per contract than high income countries like the United States for the AstraZeneca COVID-19 vaccine. In some cases, buyers also had to sign up to restrictive clauses- requiring new legislation to be passed before vaccines could be delivered. This slowed down the pandemic response in some countries.

A global pandemic needs a global response. However, inequitable access to vaccines has resulted in the response being anything but equitable. A lack of transparency in vaccine contracts has made it difficult for purchasers to negotiate prices (for example paying more than other purchasers for the same vaccine), ultimately putting manufacturers in the driving seat. Only one of 182 (0.5 per cent) of the analysed vaccine procurement contracts was published by buyers without redaction. The vast majority of contracts had large sections redacted that are of critical public interest, price per dose and delivery timetables.

Women's roles in leadership and decision making have also been limited. Despite making up 70% of the health workforce only 25% of senior roles are held by women.<sup>25</sup> During the pandemic only 3.5% of national COVID-19 task forces had gender parity and 85% had majority male membership.<sup>26</sup>

The lack of insight and understanding of the composition of task forces responsible for managing the response to the pandemic at the national and global level has also been a challenge. For example, an analysis of 87 countries found information regarding task force composition and membership criteria not easily publicly accessible for the majority of United Nations Member States and therefore impeding the ability to hold countries accountable to previously made commitments.<sup>27</sup>



Personal connections were used to access vaccines by on average 20.5% and 4.8% of respondents in Uganda and Zambia

# Recommendations for the global accord



To ensure no one is left behind in the response to future pandemics, it is critical that we learn from the COVID-19 pandemic and put in place processes which will ensure that the most vulnerable or high-risk groups are not once again left behind due to their socioeconomic status, literacy, or access to information.

## A TRANSPARENT AND ACCOUNTABLE PANDEMIC PREPAREDNESS ACCORD MUST ENSURE:

- ✓ WHO guidance on publishing clinical trials data and reports should define reporting timeframes.
- ✓ Full contracts for purchases of medical products should be released by buyers within 90 days of conclusion of the agreement.
- ✓ Mechanisms which support transparent procurement (e.g. open contracting, beneficial ownership registers, live audits) and data sharing (e.g. infection rates and vaccination progress of priority and vulnerable groups) must be built in to emergency response frameworks.
- ✓ Gender sensitive whistleblower mechanisms are built into country emergency preparedness planning, along with whistleblower protection.

## 1. Greater transparency in research and clinical trials

### RECOMMENDATION

Timely publication of clinical trial data and reports in emergencies is important to avoid duplication, enable independent re-assessment and build public trust and confidence.

#### a. WHO guidance on publishing clinical trial data and reports should:

- Include an amendment on health emergencies;
- Define the timeframe for publication of clinical trials results related to emergencies, ideally 30 days.

#### b. Define the timeframe for complete clinical study reports to be made available within 60 days of approval for all medical products related to emergencies.

### EXPECTED OUTCOME

- Increased trust in health systems and global, regional and national emergency response mechanisms.
- Access to information about the development of vaccines and treatments.
- Avoid duplication of efforts, enable independent re-assessment and build public trust and confidence.

## 2. Safeguard mechanisms which enhance equitable access

### RECOMMENDATION

#### Procurement

- a. **Expand the COVAX approach** and develop global or regional pooled procurement mechanisms for equipment and medicines.
- b. **Establish a WHO medicines pricing database** where countries can anonymously report prices paid for medicines, vaccines, and supplies.

#### Coordination

- a. **Ensure an equal representation of high, middle- and low-income countries are invited to participate in planning** of the technical and financial support during the response to a health emergency.

#### Monitoring and reporting

- a. **Establish a data clearing house** (e.g. hosted by WHO) responsible for the collection and validation of published data in health emergencies.
- b. **Include indicators from national whistleblowing mechanisms as part of monitoring the global pandemic response** (e.g. number of reports received gender disaggregation of who reported).
- c. **Strengthen regulations and introduce minimum standards for disaggregated reporting** at global, regional and national levels of key data e.g. vaccination progress of priority and vulnerable groups to improve oversight.
- d. **Empower independent CSOs to support monitoring** of health emergency response at global, regional, national and subnational level. Put in place mechanisms which safeguard a minimum threshold of involvement of CSOs in all countries.
- e. **Ensure service centres are gender sensitive-** consider needs of men and women who may want to be separated due to religious or cultural reasons; women who are pregnant, have childcare or household commitments; as well as other gender, age or socio-economic/professional groups. They may need particular support e.g. flexible opening hours, translation services or outreach programs.

### EXPECTED OUTCOME

- Increased trust in health systems and global, regional and national emergency response mechanisms.
- Equitable access to vaccines, treatments and technologies e.g. based on need and not ability to pay or political context.
- Actual country needs and priorities are met resulting in more effective use of resources.
- Increased equity in pricing, and ability of governments/purchasers to negotiate prices.



Hejranh Nakwadda/Xinhua/Alamy Live News

A man receives a dose of COVID-19 vaccine at Kololo Ceremonial Grounds in Kampala.

### 3. Strengthened mechanisms for accountability and transparency

#### RECOMMENDATIONS

##### Procurement

- a. Include transparent procurement mechanisms** (e.g. open contracting, establishment of beneficial ownership registers, live audits) in emergency response frameworks.
- b. Full contracts for purchases of medical products should be released by buyers within 90 days of conclusion of the agreement.**
  - a. These should transparently contain key contractual details, including price per dose, extent and length of indemnification, provisions detailing what happens should either party renege on the agreement, quantity purchased and delivery schedules.
  - b. Should the need for redaction be paramount, all redactions should be clearly marked with the reason for redaction. Justifications should be specific to discrete sections of the contract, not blanket explanations.

##### Coordination

- a. Increased transparency and gender parity** in emergency health task forces.
- b. Require gender sensitive whistle blower mechanisms and mechanisms for protection of whistle blowers to be part of all countries ‘emergency preparedness plan’,** including but not limited to health workers supporting the response as well as the public. Ensure that all genders are able and feel safe reporting corruption or concerns through the use of diverse reporting mechanisms (e.g. anonymous SMS or tollfree reporting lines, centres with staff or written submission).

#### EXPECTED OUTCOME

- Increased reporting of corruption and concerns of corruption.
- Whistleblowing during an emergency response is destigmatized.
- Increased equity in pricing, and ability of governments/purchasers to negotiate prices.
- Targeted efforts in areas or among population groups who either have difficulty accessing services, or who need additional support to be able to make an informed decision about treatment or prevention e.g. vaccines, are strengthened.
- Increased accountability of governments and the private sector in emergency preparedness and response.
- Increased trust in the global and national response to health emergencies.
- Improved coordination and use of resources in health emergency response.
- Improved value for money in investments in health systems.
- Corruption risks such as bribery, fraud and embezzlement are prevented.

#### CONCLUSION

In order to ensure a global accord on pandemic prevention, preparedness and response for future pandemics is effective and ensures an equitable response, the INB must apply learnings from the hidden challenges which have prevented an equitable response to the COVID-19 pandemic. **A global accord for pandemic preparedness needs to safeguard transparency and accountability.**

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