In Southeast Asia, as in other parts of the world, COVID-19 vaccines have become the object of desire for those who are impatiently waiting to be protected. In a region where there is scant expression of anti-vaccine sentiments and where initial worries among some Muslim groups have been calmed by halal certifications, the greatest concern is that there will not be sufficient vaccines for the entire population or not soon enough.

The task of covering the region's 673 million people is daunting because of purchasing and delivery challenges. As of April 17, Indonesia's 17 million doses, the highest number in the region, only covered 3.1 percent of its large population, while Singapore's 1.3 million doses covered 30 percent of its tiny population. Other Southeast Asian countries lagged far behind with 1.7 percent population coverage in Malaysia and less than 0.5 percent in Thailand, Laos and Vietnam.

Prospects are bleak for Southeast Asia according to a January Economist Intelligence Unit (EIU) report: with the exception of Singapore and possibly Vietnam, widespread vaccination will be achieved only in late 2022 by a few countries and by 2023 and beyond by the large majority.

Countries have employed various strategies to attain the needed supply: serving as trial locations, purchasing vaccines directly from the manufacturers, using the international COVID-19 vaccine-sharing program and developing and manufacturing vaccines under limited production sharing agreements or, as in Vietnam, under a home-grown scheme.

Still, they are struggling to obtain sufficient doses, let alone distribute them.

In some cases, this is due to government inertia and complacency with the country's low infection rates, but often Western countries' vaccine nationalism and even "hoarding", restrictive export regimens, and caution on unexpected side-effects have reduced and delayed delivery to the rest of the world.

Financial constraints have made some Southeast Asian countries dependent on China's "vaccine diplomacy" through donations and sales and on COVAX. The first option has been fraught with a lack of transparency and mistrust in the vaccines' efficacy, while the second has not performed as expected.

Faced with these limitations and trying to balance economic and health interests, governments are increasingly counting on partnerships with the private sector to bring in extra resources to "help the country achieve herd immunity" and finally reopen. Indonesia has launched the Gotong Royong (mutual cooperation) scheme, enabling companies to buy vaccine doses from the government to inoculate their staff and their families through private health facilities.

Although presented as win-win solutions, these programs raise multiple issues. To begin with, manufacturers require governments to purchase the vaccines, cover indemnification and take responsibility for possible adverse effects out of liability concerns. This implies an extra burden on already stretched public resources with little clarity on whether procurement for the private sector is going to be monetized or will subsidize private interests.

It is also unclear whether emergency use authorization allows for commercialization of the vaccines, since this would expose the manufacturers (and governments as the private sector's

guarantor) to liability claims. If the private sector is supposed to help the government accelerate distribution, one wonders why it cannot simply be enlisted for such a task in line with priorities set nationally and allowed to charge administration costs only, as Malaysia is contemplating.

Not to do so would represent a double standard and prioritization based on opportunity rather than need. For instance, in Indonesia, the stipulation that the Gotong Royong vaccines be different from those in the public program to avoid competition in itself creates differential treatment (here leaving aside judgment on which vaccines are best). Moreover, young employees of those selected companies will have access to a vaccine before older non-employees who more urgently need it. . Similarly, in Thailand, an eventual private hospital vaccination drive would give precedence to those who can afford to pay, irrespective of their need.

And let's not think that there are endless vaccines up for grabs by both the public and private sector, as entire sovereign countries are fighting to assure procurements even when they can afford to pay. As more vaccines are being developed and approved, we can envision a future situation of plenty, but as of now, giving vaccines to the private sector implies a choice of not using them in the public sector, thus diverting limited stock from people who need them most.

Evidence is clear on giving vaccine priority to those at greatest risk of becoming seriously ill and dying from COVID-19, such as the elderly and vulnerable adults with comorbidities. This not only saves the maximum number of lives, but also saves the most years of life since what the vaccines do best is reduce the severity and thus the fatality of the disease. It is a question then, whether allowing the private sector, companies or hospitals – or even governments themselves rushing to resuscitate the economy and the tourism sector – to follow other priorities dictated by market considerations rather than risk and need will indeed lead to better, let alone fairer, public health.

At this critical juncture, efforts are underway to seek more transformative alternatives to ramp up production. Just a few days ago at a virtual World Trade Organization (WTO) meeting, trade ministers from India and South Africa and their cosponsors, with the support of WHO director-general Tedros Ghebreyesus and civil society movements, again advocated to waive provisions related to patents, copyright, industrial design and undisclosed information under the Trade-Related Aspects of Intellectual Property Rights for COVID-19 in order to allow generic manufacturing and increase production diagnostics, therapeutics and vaccines globally.

Civil society groups in the region, such as Third World Network in Malaysia, AIDS Access in Thailand and the Southeast Asia chapter of the People Health Movement have launched campaigns to raise public awareness on this urgent effort, also embraced by most governments in the region. As Indonesia made clear at the WTO event 'the core challenge in rapid, equitable and affordable access to health' is caused by stringent protection of intellectual properties. And as the waiver's advocates stress, vaccine research was mostly publicly funded.

Yet pharmaceutical corporations as defended by more affluent countries are opposing the removing of monopolies on COVID-19 medical tools, even if for the benefit of the whole humanity. Yet pharmaceutical corporations, as defended by more affluent countries, are

opposing the removal of monopolies on COVID-19 medical tools, even if for the benefit of all of humanity.

This all should make us reflect on health as an inalienable right, equal for everyone, and increase our commitment and action to uphold the collective right to safety for all ahead of the purchasing power of the few – whether for countries or individuals.

And for those who prefer more pragmatic considerations, let us be reminded by the CDC that the risks of infection in vaccinated people "cannot be completely eliminated as long as there is continued community transmission of the virus". And thus, for the benefit of all, vaccines cannot be for the few.

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