Country Policy Portraits: Civil Society Engagement in Vaccine Policy Across National Archetypes

Country Policy Portraits

This section presents country policy portraits illustrating how vaccine policy is made in seven countries, with particular attention to the presence or absence of community and civil society involvement. The seven countries profiled represent different archetypes of high-TB-burden countries that would be benefit from new TB vaccines: Bangladesh, Kazakhstan, Kenya, Malawi, Mongolia, South Africa, and Vietnam. The seven countries were chosen to represent a mix of settings with respect to Gavi and Global Fund eligibility, World Bank country income level, TB epidemiology, and history of state–civil society relations.

Each archetype serves as a guide for how vaccine policy making may operate in similar contexts. Understanding what is shared or different across national archetypes provides insight into how CSO engagement in vaccine decision making can be strengthened in a range of settings. No archetype optimally involves communities and civil society in all aspects of vaccine policy making. But all countries have experiences that can inspire productive arrangements if adopted in other places.

Each portrait was developed by a local TB advocate associated with one of TAG's three regional CAB partners: AFROCAB, APCASO, and ECAT. Authors worked from a common template to collect information on nine domains (see Box). TAG then worked with authors to condense each portrait into a four-page illustration. Each portrait ends with the author proposing 1) an easy win that would strengthen the role of communities and civil society in immunization work and 2) a high-impact change that would offer the greatest improvement in CSO inclusion.

Country Policy Portrait Domains

- Vaccine decision making
- Data for decision making
- Vaccine implementation
- Existing vaccines and recommendations
- Vaccine planning, preparedness, and sustainability
- Financing vaccines
- Strengthening community engagement and impact
- Vaccine information landscape
- Vaccine hesitancy and mis-/disinformation

Across the seven countries, suggestions for easy wins and high-impact changes point toward a clear common recommendation: normalize, formalize, and institutionalize civil society participation in vaccine decision making. This same recommendation was also echoed strongly in the survey findings and key informant interviews in section one of this report.

Although there is not a single process to determine vaccine policy across these countries, in most of the archetypes examined here, decision-making spaces lack formal CSO representation. For example, CSOs are almost entirely excluded from NITAGs. In one country, Bangladesh, CSOs currently make up three of 15 NITAG representatives but come from either large NGOs (ICDDR,B) or global civil society structures (the chair of the Gavi CSO constituency). In most places, CSO engagement is left to informal or ad hoc forums — stakeholder consultations, public comment periods, or external advocacy by influential groups. Even in contexts where CSOs exert some influence, they are often relegated to the margins, or prescribed roles in vaccine implementation and rollout well after concrete policies are formulated.

The easy wins and high-impact changes suggested by portrait authors include creating dedicated forums for engaging CSOs on vaccine-related issues, designating NITAG seats for CSO representatives, establishing national CABs to guide vaccine introduction, and integrating community and civil society voices into other relevant health policy-making spaces. Some authors pointed to a need to establish legal frameworks to guide public involvement in vaccine decision making, implementation, and evaluation. Such frameworks could be leveraged to establish specific roles for CSOs within the vaccine ecosystem, which in turn might help foster trust by establishing clear standards for public participation, transparency, and accountability.

Table 4

Capacity Strengthening Needs of CSOs to Engage with National Immunization Programs

Areas	Needed Capacities and Skills
Vaccine policy and immunization planning	Training on National Immunization Program structure, NITAG functions, and vaccine decision making
Funding and governance	Understanding of national budgeting processes and skills in resource mobilization
Vaccine safety	Understanding of adverse event reporting systems, and skills for community education
Equity and rights-based access to vaccines	Skills to advocate for marginalized populations (e.g., homeless, people who use drugs, migrants, persons deprived of liberty, LGBTQ+)
Risk communication and misinformation	Systems to track and respond to mis-/disinformation, and platforms for community dialogue
Community-led monitoring	Training in data collection, and systems for feedback and continual monitoring

In line with one of the key recommendations coming out of the landscape assessment in section one, CSOs need to be strengthened and equipped with the necessary knowledge and skills to engage meaningfully with national immunization programs. Investments by governments and funders in training, information-sharing, and education for CSOs and communities could serve a dual purpose of demonstrating a political commitment to strengthening civic engagement in vaccine work while ensuring that CSOs can effectively shape policy recommendations. It is insufficient to bring CSOs to decision-making tables without providing the knowledge and tools so they can participate fully as equal members. In Table 4, the author of the Mongolia policy portrait matched areas of engagement to capacitation needs; although developed for Mongolia, the listed needs speak to all the countries profiled.

The process of creating a country policy portrait is itself an exercise in building understanding of how vaccine policy and planning occur in a specific context. Advocates in other countries can use the same template used here, available on TAG's website, to learn about their NITAG, national immunization program, and other aspects of vaccine policy making.

Abbreviations Used in the Country Policy Portraits

ASEAN: Association of Southeast Asian Nations

EPI: Essential Program on Immunization (sometimes Expanded Program on Immunization)

MOH: Ministry of Health (or Ministry of Healthcare)

MOHFW: Ministry of Health and Family Welfare (Bangladesh)

NDOH: National Department of Health (South Africa)

NIP: National Immunization Program

NITAG: National Immunization Technical Advisory Group

NRA: National Regulatory Authority

NTP: National TB Program

NVIP: National Vaccines and Immunization Program (Kenya)

SRA: Stringent Regulatory Authority

WHO: World Health Organization

USAID: United States Agency for International Development

U.S. FDA: United States Food and Drug Administration

Source notes:

NITAG maturity rankings are taken from the Global NITAG Network map and based on the 6 criteria in the WHO-UNICEF Joint Reporting form: https://www.nitag-resource.org/network/map

NRA maturity rankings are taken from the WHO list of NRAs operating at maturity level 3 (ML3) and maturity level 4 (ML4): https://www.who.int/publications/m/item/list-of-nras-operating-at-ml3-and-ml4

COUNTRY POLICY PORTRAITS

Kazakhstan
Population: 20.6 million
World Bank Income: MIC
WHO Status: High MDR-TB
WHO Region: Europe

(N/A)

Kenya
Population: 56.4 million
World Bank Income: LMIC
WHO Status: High TB & TB/HIV
WHO Region: Africa

Accelerated Transition

Mongolia
Population: 3.54 million
World Bank Income: UMIC
WHO Status: High TB & MDR-TB
WHO Region: Western Pacific

(2015)

Vietnam
Population: 101.1 million
World Bank Income: LMIC
WHO Status: High TB & MDR-TB
WHO Region: SE Asia

(2020)

Malawi
Population: 21.1 million
World Bank Income: LIC
WHO Status: High TB/HIV
WHO Region: Africa

Initial Self-Financing

South Africa
Population: 64.0 million
World Bank Income: UMIC
WHO Status: High TB, TB/HIV, MDR-TB
WHO Region: Africa

(N/A)

Bangladesh
Population: 173.6 million
World Bank Income: LMIC
WHO Status: High TB & MDR-TB
WHO Region: SE Asia

Accelerated Transition

Key

Gavi Eligible (*status)*

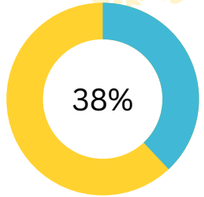
Gavi Ineligible *(year of ineligibility)*

Global Fund Eligible (TB)

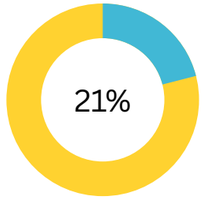
BANGLADESH

Population: 170 million
World Bank Income: LMIC
WHO Status: High TB & MDR-TB
WHO Region: SE Asia

Funding & Financing



Funding for TB Programs
In 2023, 38% of TB funding in Bangladesh came from domestic resources (blue).



Funding for Vaccine Programs
Bangladesh's immunization program is still largely donor dependent, with 21% (blue) coming from domestic resources.

Bangladesh is reliant on external funding for both the TB and immunization programs. The Global Fund is the largest donor to the TB Program, historically supplemented by USAID support for diagnostics, treatment, and health system strengthening.

Gavi is the primary supporter of Bangladesh's immunization program, supporting and guiding vaccine implementation from policy review to procurement. Currently in Gavi's accelerated transition phase, Bangladesh has increased self-financing of its immunization program. Domestic investments are primarily for co-financing vaccine purchase, infrastructure, operational costs, and staffing.

Decision Making	*Political Visibility*	*Information Environment*
NITAG Est. 2019 13 members	**TB Vaccines in National Health Strategy** No, formal strategy does not exist. Vaccines included in program strategies	**CSOs Spreading Antivaccine Information?** No
NITAG Representation Diverse expertise, mandate requires CSO members and has 3 CSO representatives	**TB Vaccines in National TB Strategy** Yes, including novel TB vaccines	**Faith Leaders Spreading Antivaccine Information?** No, not extensively
NITAG Transparency Meetings and minutes are not shared with the public	**TB Vaccines in National Immunization Strategy** Yes, BCG	**Political Leaders Spreading Antivaccine Information?** No
Primary Decision Makers The MOHFW holds the primary responsibility for deciding to introduce new vaccines. NITAG recommendation of a vaccine is required for MOHFW approval and implementation. The NITAG mandate requires inclusion of CSO representatives, but current community and civil society representatives come from larger NGOs.	**Political Will to End TB** Bangladesh recently increased domestic funding for TB and introduced the National Strategic Plan to End TB 2024–2030. The framework emphasizes TB prevention and intersectoral collaboration to reduce TB risk factors (e.g., undernutrition). The plan also recognizes the need for future TB vaccines and other new tools to accelerate progress.	**Strategy to Address Mis-/Disinformation** No single, formal strategy for combating vaccine mis-/disinformation exists. However, Bangladesh has developed a comprehensive multi-year communication strategy to promote vaccination and acceptance across multiple platforms tailored to each community.

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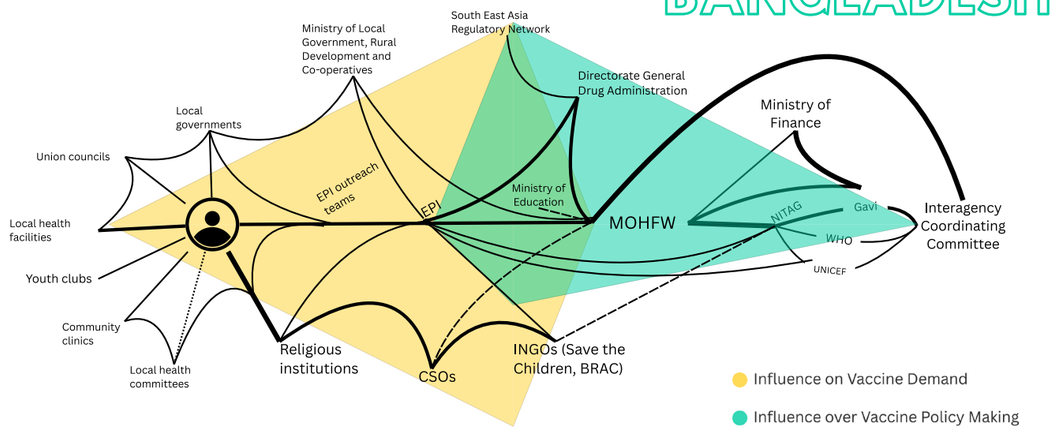
BANGLADESH



Web of Vaccine Influence

This web depicts the interlocking relationships between different stakeholders across the vaccine policy landscape and the relative strength of influence of each grouping. At the center is the recipient of vaccination. Stakeholders nearer to the person icon operate closer to individual beneficiaries of vaccination, but actors at the edge still exert a large influence.

What happens in one part of the web is felt in other parts, even if seemingly far away. Some strands in the web are stronger than others (here, the influence of the NITAG and MOHFW). Bangladesh's web reveals the top-heavy approach to vaccine decision making, in which decision making is primarily influenced by multilaterals, the NITAG, and the MOHFW, with few formal channels for CSO input, though CSOs play a larger role in vaccine demand and acceptance.

Data for Decision Making

Bangladesh is unique in that NITAG recommendation is mandatory for vaccine introduction (and not merely advisory). The NITAG consults with external stakeholders, including government ministries, international partners (e.g., Gavi, WHO), and academic experts to review trial data and programmatic factors for introduction of the vaccine. After NITAG endorsement, a proposal is submitted to the Inter-Agency Coordinating Committee made up of the MOHFW, Gavi, WHO, UNICEF, and other partners) to review and make the final policy. The Directorate General of Drug Administration (DGDA) under the MOHFW is Bangladesh's regulatory authority responsible for vaccines and medicines. The DGDA also collaborates with the NITAG to review new vaccines before recommendations are issued. The DGDA has regulatory reliance with several organizations, including the WHO and the South-East Asia Regulatory Network platform that facilitates collaboration and reliance among NRAs in the region.

NITAG Maturity	★★★★★★
NRA Maturity	Below ML3
Local Trial Data Requirement	✓*
Local Manufacture	✗

*Required, but may be waived if WHO-PQ or stringent regulatory authorities have approved

Procurement

Bangladesh law requires that procurement of all medicines and vaccines follows a standardized process, beginning with a needs assessment to establish required volumes for purchase. This is followed by a review and funding allocation process overseen by the MOHFW in collaboration with international partners and donors like Gavi and UNICEF. For vaccines without external funding support, Bangladesh covers the entire cost of procurement. Following funding allocation, a tendering process begins with suppliers invited to submit bids, which are evaluated through a preestablished, competitive, and transparent process.

Bangladesh often collaborates with UNICEF to procure vaccines, leveraging UNICEF's procurement mechanisms to ensure the most cost-effective procurement prices.

Implementation

Bangladesh has developed a standard implementation protocol to introduce new vaccines into the country. The protocol begins by collecting locally relevant data to address any unanswered questions about vaccine safety and efficacy. During this period, the MOHFW in partnership with Gavi will assess the costs of introducing the vaccine and identify funding gaps as well as develop a public communication strategy, a surveillance plan, and training programs for service providers.

Working with the MOHFW, the Ministry of Local Government, Rural Development and Co-operatives develops a vaccine rollout plan with local government bodies (e.g., city councils, municipalities, union councils). Local health committees work with EPI and local outreach teams and local governments to develop an action plan to address vaccine access and equity at the grassroots level.

Before the final implementation plan can be initiated, the NITAG, DGDA, and MOHFW review and approve the plan before the MOHFW issues a formal endorsement of the vaccine and rollout.

Vaccine Hesitancy and Misinformation

Bangladesh has experienced some vaccine hesitancy and misinformation on a vaccine-by-vaccine basis. Often, vaccine hesitancy and misinformation have been rooted in concerns about religious acceptability (e.g., concerns about vaccines and fasting) or reproductive health. The HPV vaccine, for example, was associated with rumors about vaccine-caused infertility or promiscuity. To combat misinformation within these communities, religious leaders worked closely with EPI to reassure communities and issue religious rulings affirming vaccine safety and permissibility within the religious practice.

Consumer Cost and Transparency

Bangladesh primarily purchases vaccines through UNICEF, which promotes pricing transparency and reduces the need for civil society oversight into vaccine pricing at the local level. However, CSOs are represented in EPI committees, which provides them with a forum to raise concerns from the community level about pricing, if access barriers arise.

BANGLADESH

Civil Society as the Foundation of Community Awareness and Trust in Vaccines

Because of Bangladesh's top-down vaccine decision-making structure, CSOs are largely kept out of policy-making spaces outside of ad hoc consultations and engagement in specific EPI committees. This dynamic has given CSOs and community little room to influence policy as it is being developed. Despite their absence from decision-making spaces, civil society and community groups have claimed a integral role in vaccine implementation at the local level.

Information Sharing

Civil society plays a crucial role in information dissemination and addressing vaccine hesitancy. Groups will use miking, which involves broadcasting announcements via loudspeakers mounted on rickshaws, vans, or positioned at local gatherings. Miking can quickly and cheaply disseminate information about vaccines, vaccination schedules, and eligibility in the local dialect, making information easy to understand and to share in real time. Civil society groups also coordinate directly with media outlets and schools to promote accurate information, combat myths, and encourage vaccine buy-in. During COVID-19 vaccine rollout, civil society groups leveraged all available tactics to promote vaccine uptake.

Community Mobilization

Beyond sharing information, civil society groups also play a significant role in community engagement, mobilization, and service delivery. CSOs tap into their deep ties in the communities they serve to coordinate community events, vaccine discussions, and ultimately mobilization to vaccination. Groups also provide logistical support to ensure vaccination sites are accessible, identify high-risk groups for outreach, conduct outreach to high-risk and rural populations, and mobilize local caregivers to expand the health care workforce for vaccination campaigns.

Monitoring

Throughout implementation and rollout, CSOs will leverage the same grassroots networks they rely on to spread vaccine awareness and mobilize communities to conduct community-level monitoring on accessibility and monitoring for any emerging concerns.

While decision making regularly excludes civil society and community engagement, vaccine implementation and acceptance rely heavily on their relationships with communities across the country.

BANGLADESH

Spotlight:

Since its inception in 2000, Gavi has supported Bangladesh in funding and implementing vaccines to ensure widespread coverage. Gavi's investment has been critical for boosting vaccination rates in Bangladesh over the past quarter-century. Despite the clear benefits of this support, there have been some unanticipated impacts. Gavi's large role in financing and supporting vaccination in Bangladesh has contributed to top-down, centralized decision making for vaccine policy that vests ample power in multilaterals.

In Bangladesh, while the MOHFW is the formal decision maker, an Interagency Coordinating Committee (ICC) made up of representatives from Gavi, WHO, UNICEF, and INGOs and chaired by the MOHFW makes the final policy recommendation. The ICC's high proportion of multilateral representatives shifts decision making away from impacted communities and closer to global experts who are less attuned to the diversity of needs across Bangladesh. This top-heavy dynamic is echoed during the vaccine budgeting phase, as all budget planning must follow Gavi's structure and approval process to advance vaccine introduction.

The involvement of Gavi, WHO, and UNICEF during the review, planning, and implementation phases means they carry outsized influence over Bangladesh policy, often in the absence of representatives from Bangladesh civil society and affected communities. This has far-reaching implications as Bangladesh approaches Gavi graduation. As Gavi has long provided critical funding and technical input, government institutions have had limited opportunities to independently develop policy and technical experience. Strengthening local capacity and leadership is now a priority as Bangladesh prepares to transition from donor support. Similarly, while the ICC has some larger INGO representatives, civil society at large has not been well capacitated and integrated into the policy-making process. This leaves civil society without the adequate tools or access necessary to push back on Gavi, UNICEF, and WHO directives and tailor Bangladesh's vaccine policy to local contexts.

"CSOs should actively participate in policy discussions at earlier stages to ensure policies are more inclusive and widely accepted."

Strengthening the Role of Civil Society in Bangladesh's National Immunization Program

An **easy win** that would strengthen the role of civil society in vaccine programming:

- CSOs participate in the EPI decision-making committees.
- CSOs enhance their technical knowledge, networks, and engagement with influential leaders to improve expertise sharing and coordination. CSOs work closely with local communities to empower communities toward local stewardship of vaccine policy.

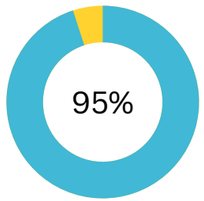
A **high-impact change** that would offer the greatest improvement in civil society inclusion:

- Forming a national-level group representing diverse segments of society and CSOs to ensure broad public participation in vaccine policy making.
- Recognizing and formalizing the role of CSOs in vaccine policy making and implementation, with a memorandum of understanding with the MOHFW and NITAG guaranteeing civil society engagement in policy making and delineating responsibility to advocate for vaccines.

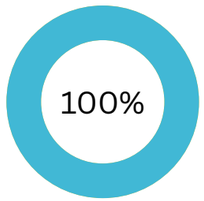
KAZAKHSTAN

Population: 20.3 million
World Bank Income: UMIC
WHO Status: High MDR-TB
WHO Region: Europe

Funding & Financing



Funding for TB Programs
In 2023, 95% of TB funding in Kazakhstan came from domestic resources (blue).



Funding for Vaccine Programs
Kazakhstan's vaccination program is self-funded.

Kazakhstan is not eligible to receive support from Gavi and funds its immunization program with domestic resources raised from republican (national) and local budgets. The republican budget funds HPV and COVID-19 vaccines, while local budgets cover other routine vaccines included in the national immunization schedule.

Domestic resources fund 100% of vaccine procurement, managed by SK-Pharmacia, a limited liability partnership that reports to the MOH.

Kazakhstan's TB program is mostly domestically funded, but the country continues to receive support from the Global Fund and other international partners.

Decision Making	*Political Visibility*	*Information Environment*
NITAG Est. 2012 17 members	**TB Vaccines in National Health Strategy** No	**CSOs Spreading Antivaccine Information?** No, not in widespread manner
NITAG Representation Diverse expertise, but no civil society	**TB Vaccines in National TB Strategy** No	**Faith Leaders Spreading Antivaccine Information?** No, not extensively
NITAG Transparency Some meetings are public, but minutes are not published	**TB Vaccines in National Immunization Strategy** No	**Political Leaders Spreading Antivaccine Information?** No
Primary Decision Makers The MOH is responsible for approving the list of vaccines included in the national immunization calendar. The NITAG plays an advisory role to the MOH, meeting twice a year. Civil society and community groups are not represented on the NITAG but may be invited as outside, nonvoting observers on occasion.	**Political Will to End TB** Civil society has prepared a draft TB Multisectoral Accountability Framework (MAF) and shared it with the government. The MAF includes access to TPT but does not discuss TB vaccines. Kazakhstan has a national roadmap for addressing TB (2023–2025); including vaccines in the next roadmap is one opportunity to increase political visibility.	**Strategy to Address Mis-/Disinformation** No standalone strategy for combating vaccine mis/disinformation though activities to increase acceptance of specific vaccines is undertaken. A 2021 UNICEF survey found that health care professionals are the main source of information on immunization.

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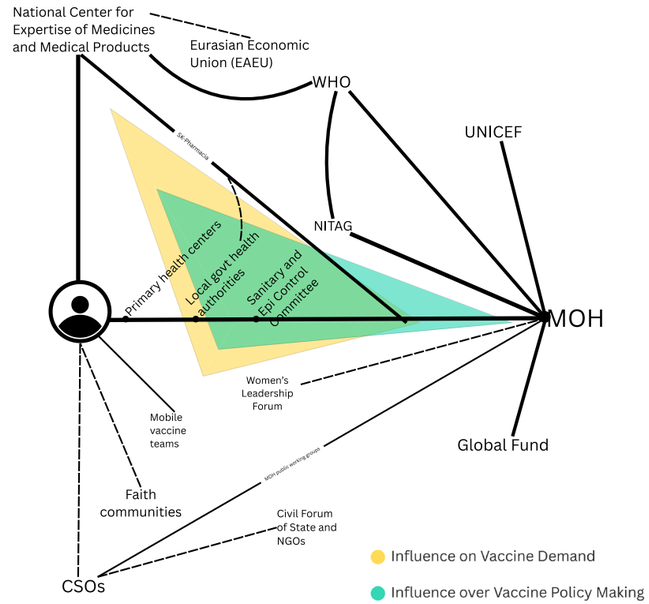
KAZAKHSTAN



Web of Vaccine Influence

This web depicts the interlocking relationships between different stakeholders across the vaccine policy landscape and the relative strength of influence of each grouping. At the center is the recipient of vaccination. Stakeholders near the center operate closer to individual beneficiaries of vaccination, but actors at the edge may still exert a large influence.

What happens in one part of the web is felt in other parts, even if seemingly far away. Some strands in the web are stronger than others (here, the influence of the MOH). Other strands may be broken or nonexistent (notice the lack of connection between the NITAG and CSOs). The web shows that CSOs currently play a limited role in immunization programs in Kazakhstan.

Data for Decision Making

The National Technical Advisory Group of Experts on Population Immunization acts as Kazakhstan's NITAG and plays an advisory role to the MOH. The National Center for Expertise of Medicines and Medical Products is Kazakhstan's regulatory body; it operates below WHO maturity level 3. Kazakhstan does not require local clinical trial data to register a vaccine for use; however, local data can facilitate the approval process and enhance regulatory confidence, especially for products not yet approved by stringent regulatory authorities in other countries (e.g., EMA, U.S. FDA). There is no mandate for domestic manufacture, but medicines produced in Kazakhstan may have a competitive advantage in public tenders.

NITAG Maturity ★★★★★★
NRA Maturity Below ML3
Local Trial Data Requirement ✗
Local Manufacture ✓*
* Not required but preference through tendering process

Procurement

SK-Pharmacia, a limited liability partnership founded in 2009 that reports to the MOH, is responsible for vaccine procurement and distribution. Article 245 of the national health code defines the role of a single distributor, establishing SK-Pharmacia as the sole legal entity with responsibility for organizing public procurement of pharmaceutical products within the package of state-guaranteed medical services. SK-Pharmacia procures vaccines through tenders or direct negotiations with suppliers. Vaccines endorsed and prequalified by the WHO are typically procured from foreign manufacturers and imported.

Kazakhstan is a member of the Eurasian Economic Union (EAEU), together with Armenia, Belarus, Kyrgyzstan, and Russia. In 2025, the EAEU approved the draft "Concept for the Development of a Common Market for Medicines." The aim is to cultivate a functional common market for medicines, including through the cooperation in registration procedures and pharmaceutical production.

Implementation

Routine vaccination is carried out by a network of primary health care providers throughout the country. Most vaccines are administered in clinics; however, mobile vaccination teams can be organized to respond to urgent situations or extend access to areas without nearby health centers.

The private sector plays a limited role in vaccine delivery. Private medical centers can import and offer any vaccine as long as it is registered with Kazakhstan's national regulatory agency.

Vaccine Hesitancy and Misinformation

Overall, Kazakhstan has not faced major public scandals or controversies related to vaccines, but misinformation is an emerging concern and was a factor during COVID-19. A UNICEF report (2022) found that half of COVID-19 vaccine misinformation in the Kazakhstani social media ecosystem was spread by no more than two dozen accounts. Misinformation circulating in Kazakhstan is influenced by antivaccine movements in Russia and the United States. Accounts spreading misinformation invoke emotionally charged, right-wing rhetoric and emphasize themes of internal/external divisions.

There is no widespread opposition to vaccines among faith-based organizations, though the Church of Scientology (not officially registered as a religious association in Kazakhstan) has been involved in spreading antivaccine sentiment. While vaccine acceptance remains high, one of the main reasons for refusal to vaccinate is parents' religious beliefs. To address this, the MOH has plans to strengthen its cooperation with religious organizations such as the Spiritual Administration of Muslims in Kazakhstan.

Consumer Cost and Transparency

All tender-related information from SK-Pharmacia is made available through government web platforms. However, SK-Pharmacia has at times published incomplete or inaccurate tender data and has been implicated in several corruption scandals, raising concerns about transparency and fairness in procurement processes. While civil society does not have an official role in monitoring vaccine pricing, some civil society groups regularly monitor the prices of other health commodities such as medicines for HIV, TB, and hepatitis C virus. Civil society also engages with SK-Pharmacia on medicines pricing and transparency.

KAZAKHSTAN

Dividing Responsibilities for Immunization Nationally and Locally

Kazakhstan's immunization program is built around an intentional division of responsibilities between national and local governments.

The MOH has overall oversight of immunization planning, product registration, vaccine procurement (via SK-Pharmacia), and financing.

Local health authorities assess the annual demand for vaccines in each region, develop vaccination plans, set targets for vaccination coverage, sign contracts with SK-Pharmacia for procurement, and manage funds for immunization provided by the national government. According to MOH Order No. 150 (2023): "Planning, organization, and carrying out of preventive vaccinations to the population are carried out by local public health authorities of regions, cities of republican significance (Almaty, Shymkent), and the capital (Astana)." There are 20 administrative units, including 17 regional governments and three cities.

Using a standardized planning form, local clinics draw up monthly, facility-level vaccine distribution plans based on the number of people registered to a particular location. Forms are submitted to district health offices and then transferred to regional health offices for consolidation into a single regional plan. Though standardized, this process preserves significant leeway for the application of professional judgement by individual planning officials ("adjusters").

Based on these plans, local governments allocate funding for vaccination from central MOH budget transfers. Regional authorities also sign direct contracts with SK-Pharmacia for procurement of vaccines. Local budgets cover costs associated with most vaccines included in the national vaccine calendar, but HPV and COVID-19 vaccines fall within the republican (national) budget.

Pharmacovigilance occurs through a centralized system managed by the National Center for Expertise of Medicines and Medical Devices. All health care professionals are required by law to report adverse events, including those related to vaccines.

Civil society does not have a visible role in vaccine planning, procurement, or implementation.

KAZAKHSTAN

Spotlight:

Civil society in Kazakhstan as a whole has played a passive role in vaccine policy development and introduction. The government has at times engaged large associations in specific vaccine campaigns (e.g., the Women Leaders Forum and HPV vaccination), and medical groups have disseminated information on vaccines among health care workers (e.g., Medsupportkz, a volunteer movement created during the COVID-19 pandemic to support health care professionals with access to information). But there is no formal process by which the government engages with civil society on vaccine decision making, planning, or implementation.

In a sign that the government is interested in deepening its engagement with civil society, the "Comprehensive Plan for Improvement of the National Immunization System of the Population of the Republic of Kazakhstan, 2023–2025" proposes the following opportunities for civil society participation:

- Educating students, teachers, and parents on the importance of vaccination.
- Assisting with vaccination efforts for migrants, refugees, and other temporary residents of Kazakhstan.
- Developing communication plans for introducing vaccines against new types of infectious disease.
- Developing and distributing informational and educational materials on the importance of vaccination.
- Encouraging parents and other stakeholders to report adverse events after immunization.
- Involving opinion leaders at the national and regional levels to popularize immunization.

Civic space in Kazakhstan is actively developing, and the capacity of civil society actors in the health space is growing. Since 2003, the government of Kazakhstan has held a regular Civil Forum, which provides a platform for dialogue between the state and NGOs on a variety of issues, including health. The government has also created an Open Regulations Portal to allow for public discussion of draft legal acts. In the health sector, the MOH and SK-Pharmacia both have public working groups to host interactions between health agencies and civil society representatives.

Strengthening the Role of Civil Society in Kazakhstan's National Immunization Program

An **easy win** that would strengthen the role of civil society in vaccine programming:

- One area where civil society can be empowered to participate in vaccine policy development is joint planning for comprehensive immunization programs, including advocacy, information, dissemination, and awareness raising to prevent misinformation.
- Addressing access gaps — affordability, availability, and equity issues — in new vaccine introduction is another area where civil society can contribute.

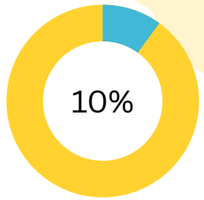
A **high-impact change** that would offer the greatest improvement in civil society inclusion:

- Identifying and publicly exposing channels for disseminating misinformation about vaccination and the motives of actors involved in spreading misinformation.

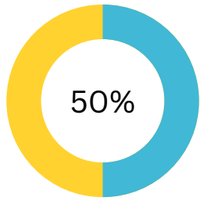
KENYA

Population: 55 million
World Bank Income: LMIC
WHO Status: High TB & TB/HIV
WHO Region: Africa

Funding & Financing



Funding for TB Programs
In 2023, 10% of TB funding in Kenya came from domestic resources (blue).



Funding for Vaccine Programs
In 2023, Kenya's vaccination program was 50% (blue) self-funded.

Kenya is reliant on external support for new vaccine introductions, participating in Gavi's tiered financing model since 2008 and increasing its share of contributions to the immunization program from 10% to 50% since 2017. The WHO and, previously, USAID have contributed to closing the remaining financing gaps in the immunization program.

The Global Fund is the largest single contributor to Kenya's TB program. Domestic funding makes up a small proportion of the NTP's budget, increasing gradually under the Global Fund's co-financing requirement and Kenya's commitments to meeting the 2023 UN HLM on TB targets. Kenya has more recently started emphasizing domestic resource mobilization to reduce reliance on external lenders and promote health system sustainability.

Decision Making	*Political Visibility*	*Information Environment*
NITAG Est. 2015 9 members	**TB Vaccines in National Health Strategy** Yes	**CSOs Spreading Antivaccine Information?** Yes
NITAG Representation Diverse expertise, but no civil society	**TB Vaccines in National TB Strategy** Yes	**Faith Leaders Spreading Antivaccine Information?** Yes
NITAG Transparency Meetings and minutes are not shared with the public	**TB Vaccines in National Immunization Strategy** Yes, BCG	**Political Leaders Spreading Antivaccine Information?** Yes, on occasion
Primary Decision Makers The National Vaccines and Immunization Programme (NVIP), under the MOH, holds the primary responsibility for reviewing and approving vaccines, with KENITAG, Kenya's NITAG, providing expert advice. There is no formal process for engaging civil society and community in any decision-making organization beyond stakeholder consultations.	**Political Will to End TB** Kenya launched the 2024 National Plan for TB, Leprosy, and Lung Health in response to the 2023 UN HLM on TB. The plan includes frameworks to coordinate all sectors around the social determinants of TB and integrates vaccine planning. Kenya has aligned with global TB targets, including increased domestic financing, and has strengthened regional and cross-border TB programming.	**Strategy to Address Mis/Disinformation** Kenya has implemented a National Communications Strategy to promote vaccines through proactive, coordinated campaigns. The communication strategy is comprehensive, multichannel, and multisectoral, and it leverages mass media, digital platforms, and community engagement for maximum impact.

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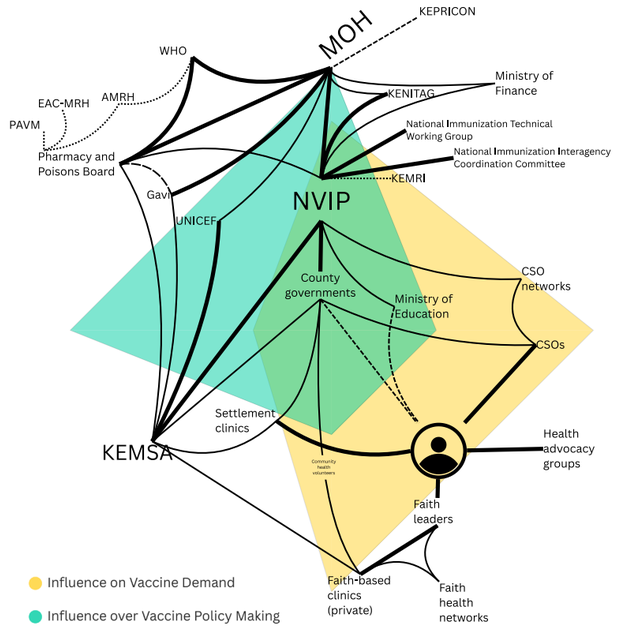
KENYA



Web of Vaccine Influence

This web depicts the interlocking relationships between different stakeholders across the vaccine policy landscape and the relative strength of influence of each grouping. At the center is the recipient of vaccination. Stakeholders near the center operate closer to individual beneficiaries of vaccination, but actors at the edge may still exert a large influence.

What happens in one part of the web is felt in other parts, even if seemingly far away. Some strands connect to disparate parts of the web (notice how KEMSA, the NVIP, and the MOH are axes around which the entire network operates). Other strands may be nonexistent (notice the lack of connection between the KENITAG and civil society, faith, or community groups). The web shows that CSOs currently play a limited role in immunization policy in Kenya, but have strong influence during implementation.

Data for Decision Making

NITAG Maturity	★★★★★★
NRA Maturity	Below ML3
Local Trial Data Requirement	✗*
Local Manufacture	✗†

*Not required except in cases of high disease burden; †Not required, but incentivized

Following a request from the MOH, KENITAG initiates review of novel vaccines or vaccine policy changes. Technical working groups are developed for each policy, drawing representatives from KENITAG and the research community with specialized expertise relevant to each review. The Pharmacy and Poisons Board (PPB) works closely with KENITAG during vaccine review and is responsible for regulating vaccines and other medicines. PPB has established regulatory reliance with several partners and is a signatory to the African Medicines Agency treaty, which aims to establish a continental regulatory authority. Kenya strongly prefers localclinical trial data, but it is not mandatory for approval unless the vaccine targets a disease with high prevalence in Kenya (e.g., malaria vaccine). Manufacturing policy encourages domestic manufacture of vaccines, with government policy pushing toward Kenya's first locally produced vaccine by 2027, but stops short of requiring it at this time. Pharmaceutical production receives tax exemptions to promote local manufacturing efforts and strategic partnerships with domestic manufacturers to boost local fill-and-finish capacity.

Procurement

The NVIP, in collaboration with the National Treasury, Gavi, and county health departments, develops a budget and procurement plan. The MOH reviews the plan for alignment with national health priorities. The Kenya Medical Supplies Authority (KEMSA) works closely with the MOH, Gavi, and UNICEF to manage the procurement process, with UNICEF acting as the procurement agent for all Gavi-funded vaccines and KEMSA initiating a tender process for all other vaccines. Following procurement, KEMSA takes over responsibility for vaccine warehousing and distribution to local facilities and county governments.

Implementation

Vaccine implementation proceeds through close collaboration with federal and county governments. The NVIP oversees the planning, coordination, training, monitoring, and timelines of vaccine delivery across the country. County health departments create micro-plans for health facility capacitation trainings, local delivery protocols, and community outreach. During the implementation phase, civil society works with county governments and communities to identify and document any challenges to vaccine access.

Vaccines are administered through a mix of public health infrastructure and targeted outreach efforts coordinated by the NVIP: public health clinics, faith-based and private clinics, mass immunization campaigns, settlement clinics, and school immunization. For remote areas, health care workers are sent to rural settlements to ensure broad vaccine coverage.

Vaccine Hesitancy and Misinformation

Religious, political, and community leaders all have shared vaccine misinformation, creating mistrust in the health system. When those amplifying misinformation are high-trust figures, vaccine hesitancy is amplified, requiring intensive counter-campaigns.

Civil society plays a large role in combating vaccine hesitancy (see: Spotlight), engaging pro-vaccine religious and cultural leaders to organize door-to-door outreach campaigns to encourage vaccination. Given the high degree of trust religious figures enjoy in Kenyan society, a pro-vaccine religious leader can be an effective counterweight to misinformation campaigns.

Consumer Cost and Transparency

Under the Division of Vaccines and Immunization Comprehensive Multi-Year Plan, routine immunizations are provided free of charge, primarily to cover vaccination for those under five. However, additional vaccines for high-risk groups (e.g., tetanus for pregnancy, HPV for young girls) have been included in the program for older individuals. Vaccines considered "voluntary" or associated with travel will often carry out-of-pocket expenses.

While KEMSA provides some mechanisms to support pricing transparency through the Public Procurement Oversight portal for routine vaccines, vaccine prices in the private sector are not regulated or systematically monitored. As a result, there is limited civil society engagement in price monitoring, and the private sector can set prices absent accountability.

KENYA

All in This Together: Collaboration to Communicate the Value of Vaccines

Kenya has developed a National Communication Strategy for promoting vaccines and other pro-health messages through government-led campaigns. Campaigns are guided by integrated health promotion plans that are embedded within the National Immunization Policy, aligning all campaigns with the overall objectives of the government's immunization policy. The communication strategy emphasizes evidence-based messaging and leverages target audience segmentation, diverse media channels, and trusted messengers to reach all of society.

In the case of the HPV vaccine:

- The president personally led the HPV vaccine introduction campaign to reinforce trust and vaccine safety.
- CSOs worked with media to promote the voices of technical experts, clergy, and policy makers to discuss positive impact of the vaccine.
- Influential faith leaders publicly endorsed the vaccine.

While Kenya has begun targeting vaccine misinformation through the communication strategy, the country has not yet developed a single consolidated national strategy for misinformation. In addition to the immunization communication campaigns, Kenya trains community health workers to address vaccine myths and educate communities during face-to-face dialogue and local radio journalists on best practices to verify vaccine information in local dialects. Collectively, these efforts have improved accuracy during radio call-in shows and reduced the amplification of rumors. To support these efforts, the MOH conducts social media monitoring to measure public sentiment online. This allows the MOH to identify antivaccine rumors as they emerge and proactively respond with messages addressing misconceptions before they spread widely.

In the case of COVID-19 vaccination:

- Kenya developed a digital campaign targeting the urban youth population on popular social media platforms, with social influencers spreading pro-vaccine messaging.
- A partnership with Meta allowed Kenya to test messaging and optimize the vaccine campaign across demographic groups.

Beyond government-led efforts, the health communication strategy also places high importance on partnerships with civil society networks to design and implement inclusive outreach and demand generation campaigns tailored to each community. The government's Health Promotion Unit works in tandem with civil society groups to engage communities through mass media and share informational resources.

KENYA

Spotlight:

Kenya's civil society network plays a supportive and corrective role in addressing vaccine-related controversies in partnership with the MOH, thereby driving vaccine acceptance. From its position between government and the communities it serves, civil society acts as a translator of pro-public health information, ensuring broad understanding of the benefits of vaccines. The importance of civil society in promoting vaccine acceptance is particularly evident during times of fear, controversy, or misinformation, when communities turn to trusted CSOs to understand conflicting reports and manage concerns. Some examples include:

Tetanus
In 2014, when religious groups raised concerns about the tetanus vaccine and advocated for independent safety testing, civil society and community advocates defended the integrity of the immunization program. When independent testing verified the safety findings of the government tests, civil society restarted the tetanus vaccination campaign with a greater focus on community engagement and transparency to combat government mistrust and support community acceptance.

OPV
Similar mistrust arose in 2015, associated with the oral polio vaccine (OPV). Civil society worked closely with the MOH and other stakeholders to dispel myths about OPV, support clear communications of OPV risks, and eventually lead community campaigns to advocate for the switch to OPV2 when it became available.

COVID-19
To preemptively combat fears about the COVID-19 vaccine, civil society organized community forums, engaged local media to share evidence-based pro-vaccine messaging, and worked closely with community leaders and influencers to combat vaccine hesitancy before it began.

Kenyan civil society efforts have been foundational to advancing vaccine uptake, especially among communities with low trust in government health systems. A future TB vaccine will similarly rely on the efforts of civil society to build trust and understanding in the communities civil society serves.

> ***"Overall, civil society in Kenya has remained a central player in vaccine acceptance, acting as a bridge between government and community — especially during times of fear, controversy, or misinformation."***

Strengthening the Role of Civil Society in Kenya's National Immunization Program

An **easy win** that would strengthen the role of civil society in vaccine programming:

- Formally include civil society representatives in KENITAG to ensure community voices and lived experiences directly inform vaccine policy decisions, promote transparency, and enhance public trust and uptake.

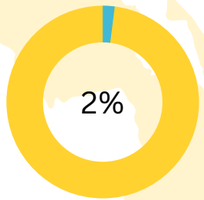
A **high-impact change** that would offer the greatest improvement in civil society inclusion:

- Institutionalize a national Civil Society Immunization Forum with a formal mandate to advise the MOH on vaccine priorities, rollout strategies, demand creation, and equity monitoring. Such a platform would enable sustained, structured engagement of communities across all stages of vaccine policy making, ensuring policies are people centered and contextually relevant.

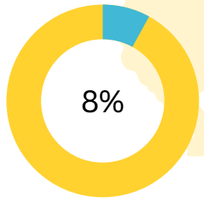
MALAWI

Population: 21.1 million
World Bank Income: LIC
WHO Status: High TB/HIV
WHO Region: Africa

Funding & Financing



Funding for TB Programs
In 2023, 98% of TB program funding in Malawi came from international sources (yellow).



Funding for Vaccine Programs
Malawi's immunization program is heavily reliant on international funding, with the bulk (92%, yellow) coming from Gavi and bilateral donors.

Malawi is heavily reliant on international sources to fund both TB and immunization services. Gavi, Health Services Joint Fund (Norway, Germany, and the United Kingdom), GSK, and UNICEF support the immunization program, while the Global Fund (and previously USAID) funds the TB program.

The Government of Malawi's immunization contributions support operational costs required to ensure continuous delivery, as well as a $0.20 per vaccine dose contribution to procurement, in line with Gavi policies.

As the destruction of USAID reshapes the global health funding landscape, Malawi is exploring sustainable and innovative financing models to bolster domestic support for both programs looking forward.

Decision Making	*Political Visibility*	*Information Environment*
NITAG Est. 2015 10 members	**TB Vaccines in National Health Strategy** Yes, BCG	**CSOs Spreading Antivaccine Information?** No, not in widespread manner
NITAG Representation Diverse expertise, but no civil society	**TB Vaccines in National TB Strategy** Yes, BCG	**Faith Leaders Spreading Antivaccine Information?** No, not extensively
NITAG Transparency MAITAG meetings and notes are not open to the public, but some are webcast	**TB Vaccines in National Immunization Strategy** Yes, BCG	**Political Leaders spreading anti-vaccine information?** No
Primary Decision Makers The MOH is responsible for reviewing, approving, and implementing vaccines. MAITAG, Malawi's NITAG, reviews evidence and issues advisory recommendations for the MOH's consideration and collaborates closely with the EPI. CSOs are not represented in MAITAG or offered opportunities to engage with MAITAG directly. CSOs do engage in MOH-led consultations.	**Political Will to End TB** TB enjoys high political visibility in Malawi. The First Lady is a strong advocate for TB awareness and stigma reduction, and the country has pledged to end TB by 2030. In addition to participating in TB vaccine trials, Malawi developed a comprehensive 5-year National Strategic Plan to guide strategy to address TB through cross-sectoral partnerships and support for investment in TB diagnostics and treatment.	**Strategy to Address Mis-/Disinformation** Malawi does not have a comprehensive national strategy for combating mis-/disinformation, but it does have initiatives to address mis-/disinformation and promote vaccine uptake, including the Health Education Service, which provides information and refutes misconceptions through education and collaboration with community leaders and influencers.

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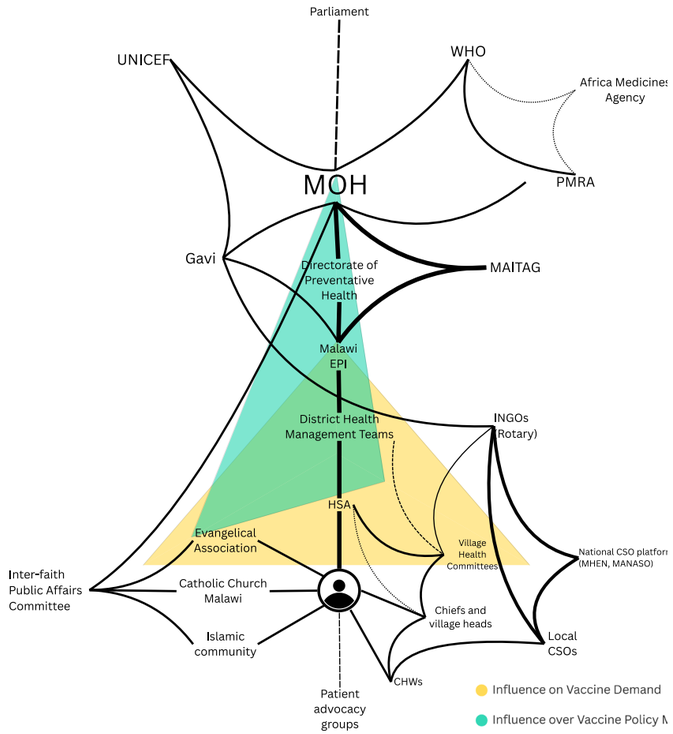
MALAWI



Web of Vaccine Influence

This web depicts the interlocking relationships between different stakeholders across the vaccine policy landscape and the relative strength of influence of each grouping. At the center is the recipient of vaccination. Stakeholders near the center operate closer to individual beneficiaries of vaccination, but actors at the edge may still exert a large influence.

In Malawi's web we see the influence of faith leadership, which directly interfaces with the MOH and UNICEF while retaining its close position and strong influence over community vaccine demand. Power over vaccine policy making is concentrated within the MOH, with coordination between national, regional, and local authorities. Community and faith leaders drive vaccine implementation and demand in close coordination.

Data for Decision Making

The MOH is the centralized coordinator of all immunization decision making. The Malawi Immunization Technical Advisory Group (MAITAG) provides the MOH advisory guidance on vaccine introduction, strategy, and implementation and the Pharmacy and Medicines Regulatory Authority (PMRA) is responsible for ensuring the quality, safety, and efficacy of vaccines.

To assess vaccine introduction and safety, Malawi requires clinical trial data from local populations. However, that requirement may be waived for vaccines approved by stringent regulatory authorities (e.g., U.S. FDA). Generally, Malawi leverages regulatory reliance partnerships to ease approval processes and is part of the African Medicines Regulatory Harmonization Initiative to harmonize regulation across the continent.

NITAG Maturity	★★★★★★
NRA Maturity	Below ML3
Local Trial Data Requirement	✓*
Local Manufacture	✗

*Required, but may be waived if stringent regulatory authorities have approved

Procurement

The MOH, in collaboration with the WHO and UNICEF, is responsible for planning for and procuring vaccines. The MOH develops a vaccine introduction plan including vaccine demand forecasting and budget estimates for vaccine procurement, distribution, storage, and delivery, as well as training, social mobilization, and monitoring and evaluation. UNICEF serves as the primary procurement agency, with Malawi national procurement procedures aligning with UNICEF policies. The government coordinates with international donors (e.g., Gavi, the Global Fund) to mobilize funding and allocates domestic funding for vaccine procurement within the national budget.

Implementation

When introducing new vaccines, Malawi first runs a pilot introduction in select areas to assess feasibility and effectiveness, followed by the gradual scale-up of vaccinations countrywide. During implementation, the MOH works closely with district management teams, civil society, community-based organizations, and village health committees to promote vaccines in their communities.

Malawi leverages both Health Surveillance Assistants, coordinated and paid by the local government, and Community Health Volunteers, volunteers from local organizations, to administer vaccines. Vaccine access varies based on each community, with vaccines administered in clinics, hospitals, mobile sites, schools, churches, palaces, or even outdoors in remote areas.

Vaccine Hesitancy and Misinformation

Malawi has experienced some controversies surrounding vaccines, leading to hesitancy. Vaccine hesitancy is driven primarily by traditional healers, community members, and some political leaders and religious groups that have shared disinformation about the components or safety of vaccines (e.g., vaccines make girls barren, are associated with Satan, etc.). Malawi leverages an "all of the above" approach to countering misinformation: partnering with education services, engaging religious organization and political leaders to convey accurate information, leveraging social media and community outreach campaigns, and training traditional healers on vaccine safety and effectiveness.

Consumer Cost and Transparency

Vaccines in Malawi are free of charge, yet many Malawians incur costs due to the need to travel to vaccination sites. CSOs advocate for affordable and accessible health care, including vaccination services, and easier access to routine health care services.

At the national level, the Malawi National Pricing Committee is made up of expert members tasked with setting and monitoring medicine and vaccine prices for affordability and accessibility. The committee uses several tools, including Malawi's Medicine Price Monitoring System, the WHO's Global Vaccine Market Report, the WHO's Vaccine Price Transparency Initiative, and PAHO's Vaccine Procurement Price Database to monitor vaccine pricing in Malawi and globally. This pricing transparency helps inform budgets for vaccination programs.

MALAWI

Malawi's National-Local Approach to Vaccine Implementation

The vaccination program in Malawi has two centers of gravity — the national government, which makes vaccine policy decisions for the country, and the community-level organizations that implement the policy on the ground. These poles work in tandem to adapt vaccine policy to each community's context, opting for a diffusion of decision making. Local leaders and stakeholders work closely with district health management teams to integrate local vaccine implementation plans within national vaccination and prevention strategies.

Local vaccine implementation follows a partnership approach between local and national government coordination. During implementation, government-coordinated Health Surveillance Agents (HSAs) and civil society–coordinated Community Health Volunteers (CHVs) worked together to administer vaccines and promote vaccination in partnership with local leaders and stakeholders. HSAs are responsible for managing community, family, and environmental health initiatives, prevention and control of communicable diseases, and case management, in addition to immunization programs. Each HSA goes through a six-week training program to provide regular health care to 1,000 people in their community. HSAs work in tandem with CHVs to leverage their relationships and trust from the community to disseminate vaccine information and ensure widespread vaccine reach in each community.

CHVs also assist community organizations to monitor vaccine coverage and equity, helping to expose gaps. CHVs and CSOs provide health counseling and vaccine follow-up. One CSO network, Malawi Health Equity Network, worked with local mothers' groups to identify and contact immunization holdouts and ensure their children were vaccinated. CHVs are also empowered to administer some vaccines. During COVID-19 vaccination campaigns, CHVs went to marketplaces and door to door to administer COVID-19, cholera, and malaria vaccines, boosting vaccine coverage.

HSAs and CHVs play a significant role in adapting government vaccination policy to the community and facility level. They build trust within the community, leveraging ongoing relationships with patients and community leaders to promote health education, address misinformation, and mobilize communities in vaccination campaigns. Malawi's relatively high vaccine support is the result of the emphasis placed on community trust, strong relationships between community members and their health care providers, and vaccine policies responsive to local contexts and social networks.

MALAWI

Spotlight:

Religious leaders and faith groups have significant influence over vaccine policy making and demand creation in Malawi. Faith groups leverage their platforms and community trust to endorse vaccines (e.g., through public statements, messaging in sermons, etc.) to influence uptake among their congregations. Faith-based organizations also develop and support community health initiatives including community clinics, hospitals, and outreach programs to support vaccine promotion. Some examples include:

- The Catholic Church in Malawi publicly endorsed HPV vaccination campaigns and encouraged congregants to get vaccinated.
- The Evangelical Association of Malawi partnered with the government to promote vaccination and to disseminate vaccine information during COVID-19.

Interfaith coalitions have formed to work together to support vaccine uptake and acceptability within the broader community, with unifying messages of vaccines as pro-life and pro-health. One of these coalitions, the Public Affairs Committee, works directly with the government to advise on political and economic issues — including vaccines. These partnerships between faith institutions and government allow for regular sharing of expertise, information, and community perspectives between key decision makers, influencing vaccine decision making, strategy, and approaches to overcoming misinformation and vaccine hesitancy.

While some faith-based communities stand in opposition to vaccines, Malawi's faith groups are largely supportive of vaccines and have been instrumental to driving demand and coordinating government and civil society action around vaccines.

"By engaging faith-based communities and religious leaders, vaccine policy makers and implementers can leverage the trust, influence, and reach of these groups to promote vaccine acceptance and uptake and overall public health."

Strengthening the Role of Civil Society in Malawi's National Immunization Program

An **easy win** that would strengthen the role of civil society in vaccine programming:

- Restructure the Malawi EPI's existing technical health committees to include a committee made up of representatives from CSOs, community groups, and faith-based organizations. This committee would serve as a formal mechanism providing feedback on vaccine policies. Further, the group could be empowered to bolster community engagement and participation in decision making and transparency and accountability in vaccine policy making and implementation.

A **high-impact change** offering the greatest improvement in civil society and community inclusion:

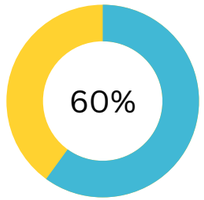
- Formalize and institutionalize community-led vaccine decision making. This can be accomplished by a) establishing Community Vaccine Advisory Boards at the local, district, and national levels; b) capacitating and resourcing the boards to ensure they have the necessary skills and knowledge; and c) enabling community-led and informed vaccine introduction and implementation decision making through these boards, positioning them as equal stakeholders in the vaccine policy-making process.

These changes would empower communities to take ownership of vaccine decision making, improve vaccine uptake by increasing trust and confidence in the program, and enhance accountability and transparency.

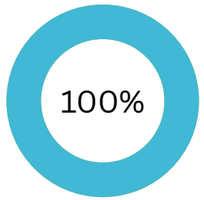
MONGOLIA

Population: 3.5 million
World Bank Income: UMIC
WHO Status: High TB & MDR-TB
WHO Region: Western Pacific

Funding & Financing



Funding for TB Programs
In 2023, 60% of TB funding in Mongolia came from domestic resources (blue).



Funding for Vaccine Programs
Mongolia's vaccination program is self-funded.

Mongolia transitioned from Gavi eligibility in 2015. The government is the main funder of the NIP, though external support (mainly via UNICEF) supports capacity building, emergency preparedness, and sustaining immunization coverage. The World Bank provided emergency financing during COVID-19.

Domestic resources fund a majority of Mongolia's TB program, reaching a peak of 81% in 2019 prior to the pandemic and holding at ~60% in years since. Under the Debt2Health initiative, Mongolia redirected 29 million euros of national debt held by Germany toward Global Fund–led health system strengthening with a focus on TB and HIV.

Decision Making	*Political Visibility*	*Information Environment*
NITAG Est. 2011 24 members	**TB Vaccines in National Health Strategy** No	**CSOs Spreading Antivaccine Information?** No, not in widespread manner
NITAG Representation Diverse expertise, but no civil society	**TB Vaccines in National TB Strategy** No	**Faith Leaders Spreading Antivaccine Information?** No
NITAG Transparency Regulations stipulate meetings and minutes should be public	**TB Vaccines in National Immunization Strategy** No	**Political Leaders Spreading Antivaccine Information?** No
Primary Decision Makers The Dept. of Public Health Policy and Coordination of MOH develops immunization policy implemented by the NIP of the National Center for Communicable Diseases (NCCD). The NITAG advises the MOH. Civil society and community groups are not represented on the NITAG but may occasionally participate as nonvoting observers.	**Political Will to End TB** A TB Multisectoral Accountability Framework (MAF) was formally integrated into the national TB strategy in 2024. TB prevention is a key focus, but TB vaccines are not discussed. Mongolia finalized a new national TB strategic plan for 2025–2028 in September 2025. Civil society is organized under the Mongolian Anti-TB Coalition, and the TB Parliamentary Lobby Group was recently relaunched.	**Strategy to Address Mis-/Disinformation** No standalone strategy for combating vaccine mis-/disinformation exists, though activities to increase acceptance of specific vaccines are undertaken.

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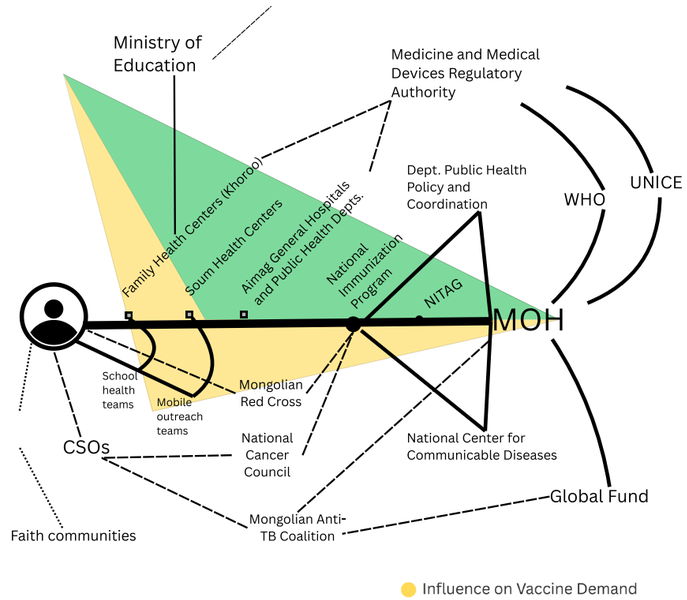
MONGOLIA



Web of Vaccine Influence

This web depicts the interlocking relationships between different stakeholders across the vaccine policy landscape and the relative strength of influence of each grouping. At the center is the recipient of vaccination. Stakeholders near the center operate closer to individual beneficiaries of vaccination, but actors at the edge may still exert a large influence.

What happens in one part of the web is felt in other parts, even if seemingly far away. Some strands in the web are stronger than others (here, the influence of the MOH). Other strands may be broken or nonexistent (notice the lack of direct influence on vaccine uptake exerted by faith communities).

Data for Decision Making

The NITAG is an independent body that advises the MOH on new vaccine introductions, schedules, quality and safety, and delivery. The Medicines and Medical Devices Regulatory Authority (MMRA), established in 2020, is Mongolia's regulatory body; it operates below WHO maturity level 3. The Law on Medicines and Medical Devices (2024) does not require local clinical trials for vaccine approval. Mongolia's regulatory framework permits reliance on international evaluations, and WHO SAGE endorsement and prequalification are usually required. Domestic manufacturing is not a requirement for procurement.

NITAG Maturity ★★★★★★
NRA Maturity < ML3
Local Trial Data Requirement ✗
Local Manufacture ✗

Procurement

The MOH is responsible for procuring vaccines via a standard procedure as follows:

- Provinces submit vaccine supply requests to the NIP/NCCD at the MOH.
- The NCCD compiles requests for review by the Vaccine and Bio-preparation Planning & Coordination Committee.
- The NCCD submits its final proposal to the MOH, which forwards a budget request to the Ministry of Finance to present for approval by Parliament.
- After parliamentary approval, the MOH assumes direct budgetary control and establishes a procurement committee to organize tenders for locally produced vaccines and submits requests to UNICEF for vaccines procured internationally.

CSOs play a limited but emerging role in the national immunization landscape. Their involvement is often informal, not institutionalized, and not reflected in policy documents such as NIP strategies or ministerial orders. […] The Multisectoral Accountability Framework for TB emphasizes the roles of communities and people affected by TB, reflecting a rights-based, whole-of-society approach to TB.

Vaccine Hesitancy and Misinformation

Overall, Mongolia has not had to confront an organized antivaccine movement. There are no formal CSO networks promoting vaccine misinformation, but informal rumor spreading via social media is a challenge. In one instance, an individual associated with the Mongolian Women's Coalition shared misinformation about the HPV vaccine.

The participation of religious leaders in vaccination is relatively limited, as over 80% of the population identifies as Buddhist. There is little evidence of faith-based organizations promoting vaccination in Mongolia; at the same time, the lack of religious opposition has contributed to the smooth implementation of vaccination programs. In a 2022 survey, 78% of respondents agreed that vaccines align with their religious views.

Public Trust and Local Data: Learning from the HPV Vaccine (Re)Introduction

In 2012, Mongolia introduced the HPV vaccine through a pilot program. The program encountered significant resistance, driven by misinformation and lack of locally available data on vaccine safety and efficacy. Widespread concerns included fears that the vaccine could cause infertility, as well as doubts about its necessity. The lack of proactive community engagement and public education contributed to hesitancy; the controversy quickly escalated when national and online media amplified opposition, polarizing public opinion. As a result, the HPV pilot was suspended in less than a year.

In response, the National Cancer Council of Mongolia undertook studies to generate local evidence on the HPV vaccine's safety and effectiveness. The findings were instrumental in rebuilding public trust. Using these data, the National Cancer Council of Mongolia, an NGO, advocated for the inclusion of the HPV vaccine in national immunization policies. In 2023, the MOH approved an updated national immunization schedule, reintroducing the HPV vaccine as a mandatory single-dose regimen for 11-year-old girls and boys.

Health care providers were trained to communicate the benefits and safety of the vaccine, but the reintroduction was not accompanied by a broad public education campaign or community demand generation activities. Consequently, HPV vaccination coverage remains low (<30%).

MONGOLIA

Delivering Vaccines to a Dispersed, Mobile Population across a Vast Geography

Mongolia has 614 designated immunization units that provide routine immunization services across a country known for its vast open spaces and for being the least densely populated country on earth.

These immunization units are part of a well-structured health system organized across *aimag* (provincial), *soum* (subprovincial), and *khoroo* (district and subdistrict) levels.

At the provincial level, aimag general hospitals and public health departments serve as regional hubs for cold-chain storage and vaccine distribution. In addition to providing vaccine services, they are responsible for supervising soum health centers and family health centers, which provide routine childhood and maternal immunization (tetanus toxoid and influenza) at the khoroo levels. Family health centers coordinate school-based vaccination for HPV and tetanus/diphtheria vaccines in collaboration with the Ministry of Education.

In rural areas, mobile immunization teams are deployed from aimag and soum centers. Mobile outreach services provide vaccines for hard-to-reach (remote) populations and nomadic communities and also deploy during extreme weather events and to carry out supplementary immunization activities such as measles vaccination campaigns.

In all settings, vaccines are typically administered by trained vaccinator nurses.

Outside of routine and mobile immunization services, individuals can obtain certain vaccines — HPV, COVID-19, influenza — for a fee at the NCCD's voluntary immunization unit.

The MMRA collects information on vaccine-related adverse events. Health care workers are required to report any suspected adverse reactions to the MMRA, which analyzes the data and forwards the information to the Human Medicines Council for further evaluation and action. The Human Medicines Council is an expert advisory body under the MOH that reviews adverse event data and provides recommendations on regulatory actions, including potential updates to vaccine safety guidelines.

MONGOLIA

Spotlight:

Mongolia does not have a national strategy for achieving vaccine equity. However, Mongolia's legal framework emphasizes nondiscrimination, universal health coverage, and inclusive immunization, thereby supporting equality even in the absence of a dedicated vaccine equity strategy.

At the most foundational level, the Constitution guarantees every citizen the right to health and access to medical care. The Law on Immunization mandates that all Mongolian citizens, as well as foreign nationals and stateless persons, be included in immunization programs. It further supports equitable access by granting individuals the right to choose between public, private, or mixed-ownership health facilities for vaccination and obliges employers to ensure employees receive necessary immunizations — promoting personal choice within a system designed to be fair and inclusive. Other health sector laws and policy documents emphasize principles of nondiscrimination, equity, and human rights.

However, these principles are not fully realized in practice. While gender equality is referenced in legal frameworks, most policies are gender neutral, recognizing men and women without addressing the specific needs and vulnerabilities of different genders.

Stigma and discrimination stemming from TB remain prevalent. The 2022–2023 National TB Stigma and Discrimination Assessment found that nearly half of people with TB reported experiencing stigma. Health facilities were the most frequently reported setting where stigma occurred. In 2024, the Mongolian Anti-TB Coalition completed a Community, Rights, and Gender Assessment that identified priority populations for TB services, including people living in poverty, people who use drugs, PLHIV, and prisoners. Focus group discussions revealed that these groups face significant barriers in accessing health care, largely due to stigma and discrimination.

CSOs have a role to play at each point in the vaccine policy-to-implementation cycle. See Table 4 for ideas from Mongolian communities on where CSOs should be engaged and related capacity-strengthening needs.

Strengthening the Role of Civil Society in Mongolia's National Immunization Program

An **easy win** that would strengthen the role of civil society in vaccine programming:

- Creating one or two observer seats for civil society representatives in Mongolia's NITAG, particularly those working with vulnerable or underserved populations, would bring community perspectives into early-stage policy discussions, improve transparency and trust in vaccine decision making, and establish a formal mechanism to ensure sustained civil society engagement. This change would only require a minor revision to the NITAG's operating procedures.

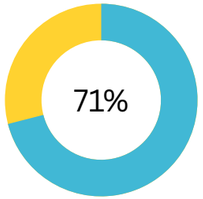
A **high-impact change** that would offer the greatest improvement in civil society inclusion:

- Establishing a Community Immunization Advisory Board (CIAB) linked to the national immunization program would help shape rights-based, equitable vaccine responses and serve as a bridge between decision makers and communities, ensuring policies reflect real lives. The CIAB would be particularly useful for demand generation during new vaccine introductions.

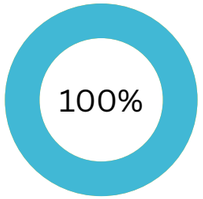
SOUTH AFRICA

Population: 64.0 million
World Bank Income: UMIC
WHO Status: High TB, MDR-TB, TB/HIV
WHO Region: Africa

Funding & Financing



Funding for TB Programs
In 2024, 71% of TB funding in South Africa came from domestic resources (blue).



Funding for Vaccine Programs
South Africa self-funds its vaccination program.

South Africa is not eligible to receive Gavi support. The government provides the primary financial and operational backbones of the National Expanded Programme on Immunization (SA-EPI). UNICEF and the Solidarity Fund supported COVID-19 vaccination efforts.

Domestic resources fund a majority of South Africa's TB program. The Global Fund is the largest external donor, making up around 21% of program funding in 2024. South Africa historically received significant TB support from USAID and PEPFAR, though these funding channels have shrunk or disappeared in the wake of U.S. funding cuts.

Decision Making	*Political Visibility*	*Information Environment*
NITAG Est. 1994 14 members	**TB Vaccines in National Health Strategy** Yes	**CSOs Spreading Antivaccine Information?** No, not in widespread manner
NITAG Representation Diverse expertise, but no civil society	**TB Vaccines in National TB Strategy** Yes	**Faith Leaders Spreading Antivaccine Information?** Some, but not in organized manner
NITAG Transparency Meetings and minutes are not open or posted publicly	**TB Vaccines in National Immunization Strategy** Yes, BCG	**Political Leaders Spreading Antivaccine Information?** Some politicians, appointees, and parties have shared misinformation
Primary Decision Makers The NDOH leads vaccine policy with advice and guidance provided by the NITAG: National Advisory Group on Immunization (NAGI). The NAGI includes space for "community health representative" among its members, but community health is not defined, and CSOs are not currently represented.	**Political Will to End TB** South Africa has demonstrated substantial political will to end TB, with a national strategic plan and multisectoral accountability framework, each of which address new TB vaccines. South Africa leads the world in TB vaccine research and clinical trials. South Africa sits on the WHO TB Vaccine Accelerator Council and co-chairs the Council's working group on financing and access.	**Strategy to Address Mis-/Disinformation** Vaccine misinformation management has revolved around COVID-19. The government developed a training toolkit, fact checking platform, and hotline for reporting misinformation. The strategy was led by the Government Communications and Information System (GCIS) and involved both online and traditional media.

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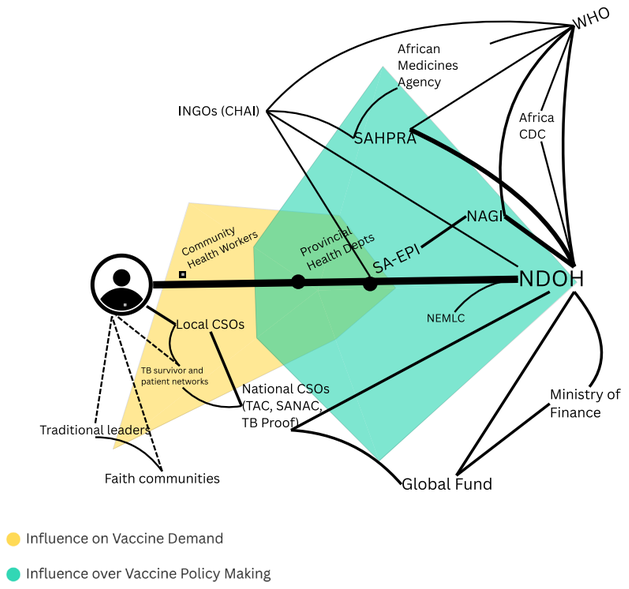
SOUTH AFRICA



Web of Vaccine Influence

This web depicts the interlocking relationships between different stakeholders across the vaccine policy landscape and the relative strength of influence of each grouping. At the center is the recipient of vaccination. Stakeholders near the center operate closer to individual beneficiaries of vaccination, but actors at the edge may still exert a large influence.

What happens in one part of the web is felt in other parts, even if seemingly far away. Some strands in the web are stronger than others (here, the influence of the NDOH). Other strands may be broken or nonexistent (notice the lack of connection between NAGI and CSOs). The web also shows the important constellation of regional and global relationships between South African institutions and organizations like the WHO and African Medicines Agency.

Data for Decision Making

NAGI makes recommendations to the NDOH regarding the inclusion of new vaccines in the SA-EPI. NAGI's advice is necessary but not binding; the NDOH may not fully implement NAGI recommendations when facing resource limitations or policy disagreements. The South African Health Product Regulatory Authority (SAHPRA) is responsible for approving and regulating vaccines and operates at WHO maturity level 3 (vaccines). SAHPRA participates in a number of regulatory reliance schemes, including with other SRAs and regionally through ZAZIBONA (a collaborative medicines registration initiative in Southern Africa).

NITAG Maturity ★★★★★★
NRA Maturity ML3
Local Trial Data Requirement ✗*
Local Manufacture ✗†
*Local data is preferred, but not required for approval †Not required, but incentivized

Procurement

Vaccine procurement occurs through a competitive tender process managed by the NDOH. Local manufacturing is not a requirement for answering a tender, though South Africa's procurement and industrial policies support preferential treatment of locally manufactured vaccines, and a partnership with local producers like BioVac or Aspen can increase the likelihood of success. To compete in the tendering process, a company must work with a local supplier or designate a local agent. The government is placing increasing emphasis on domestic vaccine manufacturing, though most vaccines bought by the NDOH continue to be sourced from external suppliers (see next page).

"Civil society should own the role of building community trust in vaccines by highlighting prevention gaps, setting targets for key groups, representing community values in program planning, monitoring implementation, and refining best practices. This will help the NDOH understand the causes of certain challenges, like why some people are not getting vaccinated. There is a gap between what the department knows and what civil society knows."

Introduction and Implementation

New vaccine introduction in South Africa follows a multistep process involving the interplay of numerous government bodies operating across different levels of administration.

- **Step 1: Initial assessment and recommendation from NAGI.** NAGI's mandate is to advise and guide the NDOH on the decision to introduce new vaccines. NAGI considers disease burden, cost-effectiveness, implementation feasibility, and other evidence when forming recommendations.
- **Step 2: NDOH deliberation and provincial involvement.** Senior NDOH officials deliberate on NAGI's recommendation and consult provincial health departments.
- **Step 3: Funding and implementation.** Once a NAGI recommendation is accepted, the NDOH makes a funding request to the Ministry of Finance. When funding is secured, new vaccines are implemented by the NDOH with support from provincial governments through the SA-EPI.

Other government departments play important roles. SAHPRA reviews and approves vaccines. The National Essential Medicines List Committee reviews data on cost and cost-effectiveness and makes recommendations to the Pricing Evaluation Committee, which makes final decisions on tender outcomes. Within the NDOH, the National Institute for Communicable Diseases and its Center for Vaccines and Immunology conducts public health surveillance and provides laboratory and epidemiological support to the NDOH.

Vaccines are usually offered at primary health care facilities but may be offered in other settings in the context of specific campaigns through mobile vaccination clinics, school programs, or immunization drives. In rural areas, community health care workers play a big role in bridging access to services or points of care.

COVID-19 as a Civil Society Entry Point

The COVID-19 pandemic placed a large demand on government capacity, resulting in the government relying more on CSOs than in previous vaccine drives. CSOs emerged as a reliable partner in identifying and reaching hard-to-reach areas and in connecting key and vulnerable populations (such as PLHIV or people living with other chronic conditions) to vaccines, since there were hesitancy issues among some of these groups. CSOs engaged in door-to-door campaigns, organized community dialogues, worked with media, and monitored problems in vaccine distribution.

SOUTH AFRICA

Investing in Local Manufacturing for Vaccine Sovereignty

Grave inequities in vaccine access during the COVID-19 pandemic laid bare the stark reality that Africa currently produces less than 1% of the vaccines it consumes. To reduce reliance on external suppliers, governments across the continent have prioritized local manufacturing as a central health and development priority and key pillar of pandemic preparedness and response.

In South Africa, this has meant nurturing a nascent but capable vaccine manufacturing sector led by players like BioVac and Aspen Pharmacare.

Established in 2003 as a public-private partnership with the South African government, BioVac engages in different types of partnership activities with external suppliers, including packaging and labeling, fill and finish, and local formulation (e.g., PCV13 vaccine via technology transfer from Pfizer). BioVac has also embarked on research and development of its own vaccines, including for group B streptococcus and oral cholera. BioVac is also part of the mRNA Technology Transfer Hub, a consortium established together with Afrigen, the Medicines Patent Pool, and the WHO to democratize mRNA vaccine capacity across low- and-middle income countries.

Although a clear policy priority, the development of a local vaccine manufacturing industry in South Africa faces a number of serious hurdles. These were illustrated in 2023 when BioVac lost a tender to supply pneumococcal conjugate vaccine to the NDOH that was awarded instead to an external supplier (Serum Institute of India). The incident brought to light the challenge of building competitive, sustainable domestic vaccine manufacturing — a lesson that holds relevance as governments prepare to procure and introduce new TB vaccines.

SOUTH AFRICA

Spotlight:

South Africa has a rich tradition of civil society leadership in health, exemplified by activism targeting the country's response to HIV, which paved the way for global access to affordable antiretroviral treatment, and TB, where the country catalyzed the research and policy enabling access to shorter, safer treatments for drug-resistant TB. In the realm of vaccines, South African civil society played a prominent role in holding the government and pharmaceutical companies accountable for ensuring equitable access to vaccines during the COVID-19 pandemic.

Although civil society voice is prominent in health policy, there are numerous ways to better integrate CSOs into South Africa's national immunization program. Under the status quo, vaccination campaigns are planned by the NDOH and other relevant government departments. CSOs are then expected to help implement campaigns without being part of the planning — a dynamic that should change through purposeful, early involvement of community representatives along the following lines:

- Civil society should collaborate with the NDOH and the Government Communication and Information System to plan vaccine communication campaigns, including by co-designing key messages in local languages and disseminating these through local media.
- The NDOH and provincial departments of health should establish vaccine stakeholder forums to monitor vaccine uptake and any emergent community concerns about vaccine safety.
- Provincial health departments should include TB community leaders and champions in clinic committees to help monitor vaccine implementation, represent community values in outreach strategies, and document best practices.
- The government should fully resource community structures that provide a platform for facilitating vaccine implementation, including local health committees, ward committees, and community health worker initiatives.

"TB stigma is a big issue. Communities do not want to see celebrities tell them to get vaccinated. They want to see real-life experiences shared by people that they encounter in their own communities and neighborhoods."

Strengthening the Role of Civil Society in South Africa's National Immunization Program

An **easy win** that would strengthen the role of civil society in vaccine programming:

- Representation of CSOs at all levels of decision making, including during initial policy development through community representation in NAGI. A community representative should always be involved in the development of new policies — for example, a TB survivor or member of the South African National AIDS Council (SANAC).
- When South Africa decides to introduce a new TB vaccine, the NDOH should appoint a TB survivor as a spokesperson for the vaccine alongside the government on national television and media.

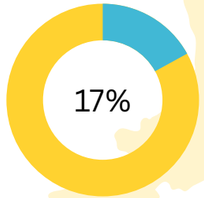
A **high-impact change** that would offer the greatest improvement in civil society inclusion:

- As a long-term vision, the Government of South Africa and CSOs should put together a comprehensive plan for building community leadership and capacity on vaccine introduction. CSOs need to be trained on key data sources of vaccine decision making and the logistics of vaccine implementation to help bridge the gap between what the NDOH knows and what the community knows.

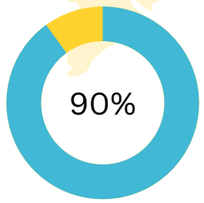
VIETNAM

Population: 101.1 million
World Bank Income: LMIC
WHO Status: High TB & MDR-TB
WHO Region: SE Asia

Funding & Financing



Funding for TB Programs
Vietnam is reliant (83%, yellow) on international funding.



Funding for Vaccine Programs
Vietnam's vaccination program is 90% (blue) self-funded

Since transitioning from Gavi support in 2022, Vietnam has depended on domestic resources for vaccine funding. For new or more expensive vaccines (e.g., rotavirus and polio), Vietnam still receives international support. In recent years, Vietnam has rapidly scaled up its domestic vaccine manufacturing and regulatory capacity, allowing domestic manufacture of key required vaccines (e.g., BCG), reducing costs to the vaccine program.

Vietnam's TB program remains reliant on external funders, including Stop TB Partnership and the Global Fund.

Decision Making	*Political Visibility*	*Information Environment*
NITAG Est. 2017 16 members	**TB Vaccines in National Health Strategy** Yes, BCG	**CSOs Spreading Antivaccine Information?** No, not in organized manner
NITAG Representation Diverse expertise but no CSOs	**TB Vaccines in National TB Strategy** Yes, BCG	**Faith Leaders Spreading Antivaccine Information?** No
NITAG Transparency Membership and minutes not public	**TB Vaccines in National Immunization Strategy** Yes, BCG	**Political Leaders Spreading Antivaccine Information?** No
Primary Decision Makers The MOH is responsible for all vaccine decisions, informed by subgroups including NITAG, Drug Administration of Vietnam and General Department of Preventive Medicine. *CSOs are largely excluded from vaccine decision making, with informal forums available to provide input.*	**Political Will to End TB** Following the 2023 UN HLM on TB, the Prime Minister issued a series of declarations aimed at ending TB and strengthening TB prevention and control — including the intent to develop new TB vaccines. The orders directed ministries to review the National TB Strategy and effectively develop and implement a modernized TB strategy with whole-society participation. The fruits of those efforts are currently developing.	**Strategy to Address Mis-/Disinformation** Vietnam has formal strategies for vaccine acceptability and combating misinformation. The MOH is responsible for developing a core immunization acceptability plan, with communications flowing through media, health care workers, social media, mass organizations, and commune health centers. Commune health centers share information via village loudspeaker and direct outreach.

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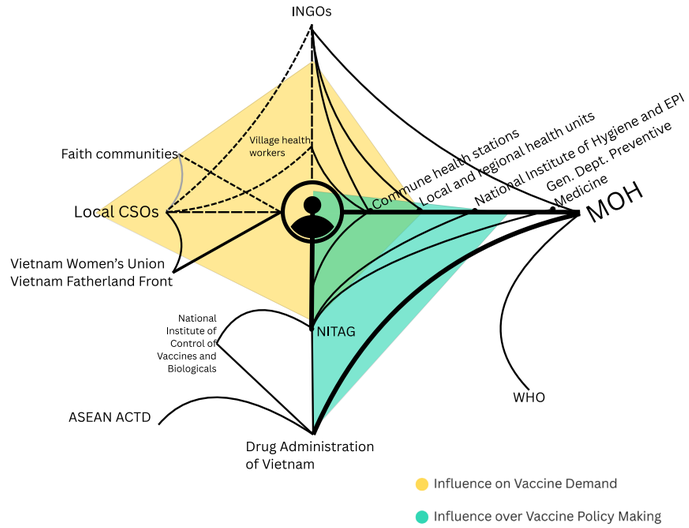
VIETNAM



Web of Vaccine Influence

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What happens in one part of the web is felt in other parts, even if seemingly far away. Some strands in the web are stronger than others (here, the influence of the MOH). Other strands may be broken or nonexistent (notice how the MOH does not work directly with local CSOs, who exert modest influence on vaccine information and community acceptance).

Data for Decision Making

Data on Asian racial factors are considered necessary by the NITAG to ensure safety in the population, and failure to include clinical data on Asian participants severely limits NITAG recommendation. Data for Vietnam–specific populations are required only for vaccines that are not entirely produced on the production lines under the jurisdiction of stringent regulatory authorities (e.g., U.S. FDA, EMA). Vietnam's NRA maturity is the result of continuous investment and commitment to quality and safety in close cooperation with WHO and regulatory partnerships with ASEAN & WHO-PQ.

NITAG Maturity ★★★★★★
NRA Maturity ML3
Local Trial Data Requirement ✓
Local Manufacture ✓ *
*Preference through tendering process

Procurement

The MOH is the central authority tasked with procuring vaccines. Procurement involves two MOH departments — the Department of Financial Planning, which manages budget development and approval, and the General Department of Preventative Medicine, which oversees vaccine forecast assessments in partnerships with local and regional health departments. Purchase of vaccines largely flows through a national bidding process, with direct procurement or UNICEF contracts used for specific vaccines. Domestically produced vaccines are prioritized in bidding through preferential policies, administrative procedures, and financial support.

"The Ministry of Health is the lead agency making the final decision, but this decision is based on close coordination and a system workflow among specialized departments, technical control units, and advisory and ethics committees. This interaction ensures that vaccines are comprehensively evaluated from research and clinical trials stages through to licensing and introduction into use, as well as being closely monitored thereafter."

Implementation

The General Department of Preventative Medicine (GDPM) carries primary responsibility for directing the implementation of vaccine activities. Working closely with the National Institute of Hygiene and Epidemiology, local clinics, and commune health centers, the GDPM develops specialized vaccine rollout plans built off a standard vaccination framework. Implementation begins with the identification of target groups for vaccination, which informs procurement estimates. Following vaccination, the GDPM coordinates centralized reporting of adverse events and coordinates with the WHO and government agencies tasked with safety monitoring — including the National Institute for Control of Vaccines and Biologicals.

Vaccination Campaigns

Vaccination campaigns are primarily run through commune health stations. Beyond administering vaccines, commune health stations also share vaccine campaign information via local loudspeakers and keep registries of individuals not yet vaccinated — following up with them directly to ensure coverage. Routine vaccination programs mainly target children and pregnant persons, with nonpregnant adults vaccinated on an ad hoc basis via mobile vaccine units, hospitals, temporary sites (e.g., schools), within their neighborhoods, or in their workplace. For hard-to-reach communities (i.e., remote villages), Vietnam deploys mobile vaccination units directly to villages.

Consumer Cost and Transparency

Vietnam's health system ensures that all recommended vaccines are provided free of charge to all persons who qualify. This includes all vaccines included on the EPI list. However, for any vaccines outside of this list, the entire cost is borne by the patient out of pocket. Newer vaccines or vaccines that fall outside of broad public campaigns are those most likely to carry fees to patients. The pricing of these vaccines is centrally managed by the MOH; however, detailed pricing information is not made available to the public and enforcement of out-of-pocket pricing is lacking, with minimal opportunity for individuals to compare costs across facilities. Within this dynamic, CSOs have a limited role in price monitoring in both the public and private sectors, leaving little pricing accountability or transparency for vaccines procured outside of the national vaccine program.

VIETNAM

Vietnamese CSO Engagement in Vaccination: A Case Study of the Rotavirus Vaccine (2023)

During the last vaccine introduction in Vietnam, CSOs and INGOs were engaged to varying degrees across the decision and implementation process.

Decision Making:
Local CSOs were largely excluded from the vaccine decision-making process due to lack of formal venues for community engagement. INGOs, however, supported clinical trials and surveillance in partnership with the Government of Vietnam.

Policy Creation:
Larger INGOs (i.e., PATH) collaborated directly with the MOH as part of expert working groups to review current vaccination policies.

Advocacy:
Community-driven socio-political mass organizations played a large role in advocacy in support of rotavirus vaccine introduction. State-aligned mass organizations like the Vietnam Women's Union and Vietnam Fatherland Front were critical to messaging around preventative measures that undergirded support in vaccines as a tool for prevention. Their efforts underscore the untapped potential for mass organization engagement in vaccine rollout and acceptance.

Information Sharing and Media Engagement:
Mass organizations, alongside village health workers, led grassroots communications programs in support of vaccine uptake — supporting official MOH and UNICEF messaging and promoting dissemination throughout Vietnam.

Vaccine Rollout:
Health workers of local ethnic communities were critical to overcoming language barriers, building trust among communities, and navigating cultural nuances to generate community buy-in and acceptance in even the most remote communities.

Budgeting:
CSOs were not engaged in the budget or forecasting process for rotavirus vaccines. However, the Vietnam Fatherland Front had previously established a COVID-19 Vaccine Fund that called for financial contributions from community members to support vaccine procurement and participatory budgeting processes — again highlighting the interest and potential of CSOs and community groups to engage.

Overall, INGOs and state-aligned mass organizations have a defined role in vaccine policy making and rollout in Vietnam. However, grassroots groups and smaller, more independent CSOs have not yet been able to claim a role in the process, creating a dynamic in which groups with substantial resources or state approval have the strongest influence over decision making.

Spotlight:

Vietnam is one of the most recent Gavi graduates, moving to fully self-sufficient financing as of 2022. The most recent data show the success of the graduation, with Vietnam funding 90% of its vaccination program with the remaining 10% coming from external funding to support newer vaccines (i.e., Gavi support for rotavirus vaccines), which are currently priced quite high, or as support from existing multilateral programs targeting childhood vaccination (i.e., UNICEF funding injectable polio vaccines).

The success of Vietnam's transition — in which the country went from 60% self-funded in 2020 to 90% in 2023 — is the result of long-term planning between Gavi, Vietnam's NIP, and the MOH paired with longer-term Gavi investments in underlying health system strengthening and infrastructure. These investments allowed Vietnam to expand its domestic manufacturing of vaccines included in the Essential Program on Immunization, keeping costs down following the accelerated transition phase. Since Vietnam transitioned, Gavi has continued to provide ongoing technical assistance, especially for newly introduced vaccines, as well as targeted support for high-cost vaccines to ensure access as Vietnam continues to bolster its domestic investments.

"Strong planning enabled Vietnam to sustain its immunization program after Gavi support ended."

Vaccine Scandals and Hesitancy

Recent vaccine scandals in Vietnam have focused on corrupt behavior of government officials accepting bribes for enhanced access to COVID-19 tools or services. The Vietnamese government swiftly prosecuted the offenders, resulting in minimal disruption to COVID-19 vaccines. This dynamic reflects the relative absence of vaccine hesitancy across Vietnam, with very little organized effort to promote antivaccine mis-/disinformation. Vietnam enjoys cultural factors, such as high social respect for health care workers and trust in the medical community at large, that undercut the impact of vaccine misinformation and generate broad vaccine acceptance.

Strengthening the Role of Civil Society in Vietnam's National Immunization Program

An **easy win** that would strengthen the role of civil society in vaccine programming:

- Civil society is largely excluded from vaccine decision making, with no government-level requirement for open or regular engagement with CSOs in vaccine-related decisions. The development and implementation of regulations that ensure representation of CSOs and communities in committees, advisory boards, and other decision-making forums across clinical trials, licensing, and vaccine deployment would create opportunities for CSOs to shape vaccine policy.

A **high-impact change** that would offer the greatest improvement in civil society inclusion:

- Expansion and formalization of community-led monitoring. CSOs need an official mechanism and resources to independently monitor the implementation of vaccine programs, evaluating their effectiveness and identifying areas for improvement.

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