Journal of Southeast Asian Human Rights, Vol. 8 Issue. 2 December 2024 pp. 314 - 346
doi: 10.19184/jseahr.v8i2.35534

Achieving Fair and Equal Access to Vaccination for Persons with Disabilities in Indonesia: A Lesson Learned from the Vaccination Programme in the COVID-19 Outbreak

Erna Dyah Kusumawati
Sebelas Maret University, Indonesia
Email : erna.d.kusumawati@staff.uns.ac.id

Sasmini
Sebelas Maret University, Indonesia
Email : sasmini_fh@staff.uns.ac.id

Adriana Grahani Firdausy
Sebelas Maret University, Indonesia
Email : adriana.grahani@staff.uns.ac.id

Abstract

The World Health Organisation has recommended that its member states conduct national vaccination programs based on fair and equal access principles. COVID-19 has had more severe impacts on persons with disabilities (PwDs). This article focuses on how the provisions of international human rights instruments obligate countries to provide vaccination for PwDs. Further, these provisions will be used to analyse the law and policy adopted by the Indonesian government related to the vaccination program designed for this group. This article used both normative/doctrinal and empirical legal research methods. Based on international human rights law, access to vaccines and medical technology are elements of the right to health under the AAAQ principles. Member states should consider groups' vulnerabilities, risks, and needs when designing the vaccination program. Some groups risk experiencing a more significant burden from the pandemic due to underlying social, geographic, or biomedical factors. PwDs are people coming from diverse backgrounds. Thus, the challenges they face will vary according to age diversity, gender, types of disability, ethnicity, sexual orientation, and migration status. The results show that Indonesia, during the first vaccine rollout, did not explicitly mention disability as a priority. PwDs have experienced barriers in accessing vaccination due to a few persistent problems. In the future, national vaccination programs should include measures to overcome such barriers and ensure that PwDs have equal access to the vaccine and other healthcare services. Such access will enable the fulfilment of the right to health of the PwDs as guaranteed both under international human rights law and domestic law. In addition, future healthcare policy should put PwDs at the centre and address the unique needs and preferences of disabled people, including their cultural and language requirements.

Keywords: *COVID-19 Vaccine, Persons with Disability, Equal Access, Indonesia*

I. INTRODUCTION

The year 2024 marks four years of the COVID-19 pandemic. World Health Organization (WHO), an organisation under the United Nations (UN) mandated to respond to the pandemic, has adopted several rules to be followed by countries around the world, including the policy to deal with the pandemic, as mentioned in the International Health Regulation (IHR).[1] As a member of the WHO, Indonesia is responsible for implementing the organisation's decisions.[2] The spread of COVID-19 is avoidable through vaccination, and WHO recommends its member countries plan national vaccination programs for all citizens.[3]

Fair and equal access should be the fundamental principle in conducting a vaccination program. However, one cannot deny that some groups might be more vulnerable to illness than others. In this case, affirmative action in the form of prioritisation on which groups could receive the vaccine in advance is crucial. To decide priorities, a country must consider individuals' or groups' needs, vulnerability, and risks regarding COVID-19.[4] These considerations should also include social, geographic, or biomedical factors that underlie the vulnerability of specific individuals toward bearing the bigger burdens of the COVID-19 pandemic.[5] WHO suggests that the national vaccination program includes measures to address the obstacles of vaccination and ensures that persons with disabilities (PwDs) who are eligible for vaccination receive equal access.[6] COVID-19 posed heavier burdens for PwDs. Its impacts on them were both direct impacts of being infected and indirect impacts due to the social restrictions policy. PwDs consist of people from various backgrounds, resulting in various risks, barriers, and impacts in multiple contexts based on age, gender, disability, ethnicity, sexual orientation, and migration status.[7]

In implementing COVID-19 vaccination in Indonesia, PwDs, as one of the vulnerable groups, have received less attention. This is evidenced by the low number of vaccine recipients from this group. The vaccination program for PwDs faces obstacles, such as false information about the vaccine and its effects on health and limited access to vaccination venues. Issues found in the field include the vast number of PwDs receiving hoax or false information about vaccine effects.[8] As a result, the number and pace of vaccination distribution in Indonesia are still low. Until August

1 WHO, *The International Health Regulations (2005)*, 3d ed (Geneva: WHO, 2016).
2 Erna Dyah Kusumawati, *States Responsibility vs Domestic Control Measures of the COVID-19 Pandemic : An Analysis of the Current International Health Regulation (IHR) Regime* (Atlantis Press, 2021).
3 World Health Organization & UNICEF, *Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines: interim guidance* (2020).
4 World Health Organization and UNICEF, "Disability considerations for COVID-19 vaccination" (2021) 1–17.
5 *Ibid.*
6 World Health Organization & UNICEF, *supra* note 3.
7 World Health Organization and UNICEF et al, "Disability considerations for COVID-19 vaccination" (2021) 8:3 Frontiers in Public Health 1–17.
8 Prisca Triferna Violetta "Vaksinasi penyandang disabilitas butuh penerapan lebih inklusif", *ANTARA* (2021).

2021, only about 55,158 PwDs have been vaccinated,[9] out of around 22 million PwDs in Indonesia.[10]

This article analyses the government's responsibility in securing access to COVID-19 vaccines for PwDs under the right to health stipulated in international human rights instruments. Moreover, it evaluates Indonesia's policy on distributing COVID-19 vaccines to PwDs based on international human rights instruments. This study was conducted in four Indonesian cities: Surakarta, Yogyakarta, Magelang, and Surabaya. Furthermore, it uses international human rights instruments to analyse the conformity of the adopted rules and policies relating to PwDs' access to COVID-19 vaccines.

As the Pandemic ended over two years ago, this analysis can still be functional as a lesson learned to provide equal access to vaccination for PwDs in non-pandemic situations, as well as if such a pandemic might happen again. The lesson learned will be beneficial in assessing the readiness of the government. For PwDs, access to general health care is still challenging, especially in low and middle-income countries.[11] As a matter of fact, the past pandemic situation has had a significant impact on both PwDs and healthcare providers.[12] Therefore, discussing such care services in the post-pandemic era is still essential. The findings provided in this article can be used as a basis for further research on strategies for how PwDs could access health services in times of emergency, including future pandemics, the effect of climate change, and perhaps humanitarian crises.

II. GOVERNMENT'S RESPONSIBILITY IN SECURING ACCESS TO COVID-19 VACCINES FOR PWDS

In the early days of the COVID-19 pandemic, the United Nations (UN) specified that the COVID-19 vaccine "must be distributed in a non-discriminatory manner."[13] They acknowledged that the "human rights-based approach is the practical way in preventing critical health risk in the society."[14] The higher rates of COVID-19 cases among the Latin community, indigenous community, and refugees are intriguing cases to determine how the vulnerability is embedded in structural injustice, affecting people's health. This vulnerability causes differences in health risks and

9 Ade Nasihudin Al Ansori, "55.158 Penyandang Disabilitas Sudah Vaksinasi per 29 Agustus 2021", *Liputan 6* (2021).

10 https://www.kemenkopmk.go.id/pemerintah-penuhi-hak-penyandang-disabilitas-di-indonesia#:~:text=Saat%20ini%2C%20jumlah%20penyandang%20disabilitas,disabilitas%20terbanyak%20pada%20usia%20lanjut. There is no uniform data regarding the number of people with disabilities in Indonesia. According to the Central Bureau of Statistics (BPS), the number of PwD in Indonesia in 2020 was 22.5 million. Meanwhile, the 2020 National Economic Survey (*Susenas*) recorded that there were 28.05 million PwD. The World Health Organization (WHO) states that the percentage of PwD in Indonesia is 10 percent of the total population or around 27.3 million people.s

11 Brian Chiluba, "Barriers to Health Care for Disabled People: A Review of the Literature from Low Income Countries" (2019) 6:2 IJDS Indonesian Journal of Disability Studies 210–214.

12 Xanthe Hunt et al, "Impacts of the COVID-19 pandemic on access to healthcare among people with disabilities: evidence from six low- and middle-income countries" (2023) 22:1 International Journal for Equity in Health 1–12.

13 OHCHR, "Statement by UN Human Rights Experts Universal access to vaccines is essential for prevention and containment of COVID-19 around the world", (2020), online: *OHCHR*.

14 *Ibid.*

disadvantages for marginalised groups. In this regard, in handling the pandemic, states are urged to address such differences in a more collective response against COVID-19, including prioritising marginalised groups in their vaccine priorities scheme. International human rights law provides a universal framework to advance global health with justice, transposing moral duty into legal rights.

Every country, including Indonesia, has signed at least one human rights treaty. Moreover, there is empirical evidence that all nations, to a certain extent, have internalised human rights norms into their regulations, policies, and government, despite poor compliance with the norms.[15] The human rights-based approach reframes commitment as duty and rights and implements accountability measures for the country. Incorporating various individual and collective rights related to access to vaccines into international human rights law is crucial to mitigate the pandemic,[16] and the principles of human rights law can potentially direct a fairer COVID-19 vaccine allocation.[17]

When the pandemic struck, the closest human right that one can think of is the right to health (RtH). The RtH is enshrined in multiple international, regional, and national human rights instruments. The international instruments recognising and guaranteeing the RtH include the International Covenant on Economic, Social and Cultural Rights (ICESCR), Universal Declaration of Human Rights, International Convention on the Elimination of All Forms of Racial Discrimination (CERD); Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); Convention on the Rights of the Child (CRC); and Convention on the Rights of Persons with Disabilities (CRPD).

The foremost instrument is Article 12 of ICESCR, which stipulates "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." The human rights monitoring body of this Covenant, the Committee on Economic, Social and Cultural Rights (CESCR), has interpreted the content of this right in its General Comment No. 14 on the Right to the Highest Attainable Standard of Health (GC 14).[18] The GC 14 is considered the most authoritative interpretation of the RtH[19] by far, and serves as a "dynamic, multifaceted and inclusive notion" interpretation of the RtH.[20]

15 S Katrina Perehudoff, Nikita V Alexandrov & Hans V Hogerzeil, "Legislating for universal access to medicines: A rights-based cross-national comparison of UHC laws in 16 countries" (2019) 34 Health Policy and Planning III48–III57.

16 Sharifah Sekalala et al, "An intersectional human rights approach to prioritising access to COVID-19 vaccines" (2021) 6 BMJ Global Health 1–8.

17 S Katrina Perehudoff, Nikita V Alexandrov & Hans V Hogerzeil, "The right to health as the basis for universal health coverage: A cross-national analysis of national medicines policies of 71 countries" (2018) 14:6 PLoS One 1–15.

18 Committee on Economic, Social, and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) (2000) (GC 14).

19 Brigit Toebes, Lisa Forman & Giulio Bartolini, "Toward Human Rights-Consistent Responses to Health Emergencies: What is the Overlap Between Core Right to Health Obligations and Core International Health Regulation Capacities?" (2020) 22:2 Health and Human Rights Journal 99–111.

20 Ingrid Nifosi-Sutton, "Realising the Right to Health during the COVID-19 Pandemic: An Antidote to the Pandemic and the Catalyst for Fulfilling a Long-Neglected Social Right?" (2022) 3:1 Yearbook of International Disaster Law Online 126–153.

The CESCR has emphasised that the RtH does not mean the right to good health or the right to be healthy; rather, it has to be understood as a right to access "timely and appropriate health care."[21] Appropriate health care encompasses health facilities, goods, and services[22] which are necessary for preventing, detecting and treating illnesses;[23] and providing rehabilitative and palliative care for all,[24] including children,[25] women,[26] and persons with disability.[27] Furthermore, access to health care should also extend to access to mental health care services and medicines.[28]

Under the RtH, states must respect, protect, and fulfil this right to the maximum available resources, including those obtained through international assistance and cooperation.[29] Although many states are hiding behind the wording of "progressive realisation" in complying with their international obligations related to realising economic, social, and cultural rights, several obligations to realise these rights have immediate effects and should be prioritised.[30] These are core and non-derogable obligations related to satisfying minimum essential levels of the RtH that should be fulfilled even though states are in an emergency or crisis with a dire need for access to health care.[31] Such obligations include[32] ensuring equal access for everyone (especially for disadvantaged groups) to health facilities, goods, and services, nutritious and safe food, shelter/housing, sanitation, and an adequate supply of clean drinking water. Moreover, states are under obligation to provide essential medicines, ensure reasonable distribution of health care facilities, as well as adopt and implement a national public health strategy and action plan based on epidemiological research and evidence.

The obligation to ensure equal access for everyone, especially for disadvantaged groups, to health facilities, goods and services is, to a certain extent, challenging for some states, particularly those with resource constraints. Even though this obligation is considered an immediate obligation and no state is permitted to fall behind, considerable inequities remain in healthcare access, primarily due to discrepancies in resource allocation and systemic discrimination.[33] Systemic discrimination can be found in, for example, national legislation,[34] which puts barriers for people from

21 CESCR, *supra* note 18, para 11.
22 Ibid, para 9 and 17
23 Ibid, para 17
24 Ibid, para 14
25 Committee of the Rights of the Child (CRC), 'General comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24)' (17 April 2013) CRC/C/GC/15, para. 2.
26 CRPD, 'General Comment No. 3 (2016) on Women and Girls with Disabilities' (25 November 2016) CRPD/C/GC/3, para. 28; CEDAW 'General recommendation No. 24: Article 12 of the Convention (Women and Health)' (1999), para. 1.
27 Convention on the Right of People with Disabilities (CRPD), 3 May 2008, art. 25.
28 CESCR, *supra* note 18, para 17
29 Ibid, para 38.
30 Nifosi-Sutton, *supra* note 20; see also Toebes, Forman & Bartolini, *supra* note 19
31 Ibid.
32 CESCR, *supra* note 18, para 43
33 Chiluba, *supra* note 11.
34 Katarzyna Bielińska et al, "Equal access to healthcare in national legislations: how do Croatia, Germany, Poland, and Slovenia counteract discrimination in healthcare?" (2022) 22:1 BMC Health Services Research 1–11.

certain groups, such as minority groups (on the grounds of religion and belief, sexual orientation, and gender identity), to access healthcare goods and services.

The RtH is considered both a social and an equal right. As a social right, it protects not only individuals but also the public interest, meaning that the realisation of the RtH affects the individual's health and the society's public interest. This relationship between individuals and public health was seen during the pandemic. As a social right, the RtH requires states to protect the individual from economic and social injustice related to health, to ensure that health services are accessible and thoroughly adapted to the individual cultural background, and to provide the individual with a series of rights and freedoms relating to health services.[35] Therefore, although the realisation of the right to health is restrained by the levels of development of health care and the economy, its equal and universal nature requires that health policy must embody "fair and equality of opportunity." Thus, the principle of non-discrimination is central to this right. The RtH should be realised to all inhabitants without discrimination in terms of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Further, General Comment No. 14 expands the prohibited grounds for discrimination, which includes health status, such as HIV/AIDS, disability, and sexual orientation.[36]

Moreover, the RtH contains several interrelated elements that should be considered when member states take measures to fulfil the right. These elements are availability, accessibility, acceptability, and quality, also known as AAAQ (triple AQ principles).[37] The element of accessibility includes access to health care that is non-discriminatory, physically and economically accessible, as well as access to information on health issues.[38] These elements will later be assessed to examine the accessibility of the COVID-19 vaccine for PwDs in Indonesia.

As we have witnessed, COVID-19 has severely impacted the health of the world's population, including that of PwDs. The COVID-19 pandemic can also be said to be an emergency faced by the world in the 21st century. It has impacted almost all countries around the globe, triggering devastating and severe setbacks to the economy and disrupting social life.[39] As mentioned in previous paragraphs, the states' obligation to fulfil the RtH still stands in times of emergency, which may well be the case in the COVID-19 pandemic.

---

35 Yu Shaoxiang, "Jurisprudential Analysis of the Nature of the Right to Health", online: *Institute of Law and Institute of International Law,* <http://www.iolaw.org.cn/global/en/new.aspx?id=36829>.

36 GC 14 *supra note* 18

37 For a detail definition related to the triple AQ elements, please refer to GC 14 *supra not*e 18, para 12.

38 *Ibid,* para 12 b.

39 *Impact of the Covid-19 Pandemic on Trade and Development: Lessons Learned*, by United Nations Conference on Trade and Development (Geneva, 2022). https://unctad.org/system/files/official-document/osg2022d1_en.pdf, accessed 5 June 2023; World Health Organisation, Impact of COVID-19 on People's livelihoods, their health and our food systems, https://www.who.int/news/item/13-10-2020-impact-of-COVID-19-on-people's-livelihoods-their-health-and-our-food-systems#:~:text=The%20economic%20and%20social%20disruption,the%20end%20of%20the%20year, accessed 5 June 2023.

During the pandemic, the CESCR and other UN Human Rights Bodies confirmed that all elements of the RtH were applicable. With regard to epidemics and pandemics,[40] states' obligations under the RtH include preventing, controlling, and combating epidemic diseases.[41] It also includes access to immunisation programmes against the major infectious diseases.[42] Thus, it is confirmed that the RtH encompasses the right to access COVID-19 treatment and vaccines.[43]

Such a conclusion can be drawn from statements from the UN human rights bodies such as CESCR, CEDAW Committee, CRC Committee, CRPD Committee and Migrant Workers Committee. Each of these committees has concluded a statement in relation to COVID-19 and the RtH. The CESCR stated that the provision of COVID-19 vaccines should be based on an equal and non-discriminatory policy.[44] States must take all the necessary measures, to the maximum of their available resources, to guarantee access to vaccines for COVID-19 to all persons, without any discrimination.[45] The obligation to provide immunisation against major infectious diseases and to prevent and control epidemics is considered a priority obligation under the RtH.[46] Therefore, states must give maximum priority to providing vaccines for COVID-19 to all inhabitants, including PwDs.[47] In a similar line, the CRPD Committee, in its statement, argues that response and recovery efforts to tackle the COVID-19 pandemic will not be effective unless everyone is equally valued and included.[48] Critical and urgent action is required to ensure that those most at risk, including persons with disabilities, should be explicitly included in public emergency planning, health response, and recovery efforts.[49] This line of argument shows that COVID-19 treatments and vaccines should also include PwDs. Thus, the non-discriminatory approach to COVID-19 vaccine provision (including any other vaccination programme) will be crucial to fully realising the RtH.[50]

The CESCR has firmly specified that adopting crucial provisions of medicines for COVID-19 treatments and vaccine provision is considered a 'core obligation' under the RtH.[51] The core obligations, as defined in General Comments No. 3, refer to the minimum standard that states must fulfil to provide significant enjoyment of

40 The difference between pandemic and epidemics (also endemic) is based on a disease's rate and degree of spread and not based on the severity of the disease. Generally, a pandemic cuts across international boundaries or occurs globally, affecting large numbers of people across the globe. Epidemics, on the other hand, can be large but are generally contained to or expected to spread only in certain areas. For details see https://www.publichealth.columbia.edu/news/epidemic-endemic-pandemic-what-are-differences#:~:text=The%20WHO%20defines%20pandemics%2C%20epidemics,as%20opposed%20to%20regional%20epidemics.

41 CESCR, *supra note* 18, para 44, see also Toebes, Forman & Bartolini, *supra* note 19.

42 *Ibid*, para 36

43 Nifosi-Sutton, *supra note* 20

44 CESCR, 'Statement on Universal and Equitable Access to Vaccines for the Coronavirus Disease (COVID-19)' (15 December 2020) E/C.12/2020/2, para 1

45 *Ibid*, para 3

46 *Ibid*, see also GC 14, *supra note* 18, para 44.

47 *Ibid*.

48 https://www.ohchr.org/en/news/2020/06/statement-COVID-19-and-human-rights-persons-disabilities

49 ibid

50 OHCHR, *supra* note 13.

51 CESCR, *supra note* 44

the rights under the Covenant.[52] Therefore, the provision of the COVID-19 vaccine, as a part of an effort to reduce the health and life risks posed by the COVID-19 disease, should be prioritised and fall under the state's minimum core obligation under the RtH.

The human rights framework suggested that allocation decisions relating to the pandemic should meet several minimum core obligations, including availability, accessibility, acceptability, and quality (AAAQ) elements. In a similar vein, as discussed above regarding the authoritative interpretation of the RtH, health facilities, services and goods, including health treatment for COVID-19 patients, as well as COVID-19 vaccines, must meet the AAAQ elements. Each of the elements of access to COVID-19 vaccine will be discussed in the following paragraphs.

The first element is the availability of COVID-19 vaccine. This vaccine functions to mitigate the symptoms of the virus.[53] As of now, vaccines have successfully been developed, and states have to guarantee that vaccines are available in adequate amounts. When it is inadequate, priority, at least at the initial stage of vaccine rollout, must be given to people with a higher risk of being infected by the disease and experiencing severe health disorders.[54] The criteria for prioritisation must be established through a transparent and adequate public consultation process. The criteria should also be open to public debate, and when conflicts arise, the criteria should be subject to judicial review. In that manner, prioritising certain groups with justified reason will not violate the prohibition of discrimination under international human rights law. Therefore, vaccines must be provided without discrimination, especially to those most in need and those with a greater risk of infection, such as the elderly, people with comorbidities whose health might decline, people in specific settings, such as detention centres and shelter homes, marginalised and minority groups who usually experience lack of access to health care, and health workers with a high risk of infection. Under the minimum core obligations, equal distribution is expected to incorporate obligations to reduce substantive inequality, such as social-economic differences and other disadvantages.[55]

The second element is the accessibility of the COVID-19 vaccine. The COVID-19 vaccine not only has to be available but also accessible to all elements of society. To allow such accessibility, states must remove discrimination based on any grounds (including disability) and guarantee physical accessibility to vaccination centres, especially for marginalised groups and people living in remote areas. Increasing physical accessibility can be achieved by employing both state-run and private channels and strengthening the capacity of health systems to deliver vaccines. In

52 United Nations Committee on Economic Social and Cultural Rights, *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)* (United Nations Committee on Economic, Social and Cultural Rights, 1990).

53 Angela K Shen et al, "Ensuring equitable access to COVID-19 vaccines in the us: Current system challenges and opportunities" (2021) 40:1 Health Affairs 62–69. Lawrence O Gostin, Safura Abdool Karim & Benjamin Mason Meier, "Facilitating Access to a COVID-19 Vaccine through Global Health Law" (2020) 48:3 Journal of Law, Medicine and Ethics 622–626.

54 CESCR, *supra note* 44 para 5.

55 United Nations Committee on Economic Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)* (United Nations Committee on Economic, Social and Cultural Rights, 2000); OHCHR, *supra* note 13.

addition, the accessibility element of vaccine services requires states to guarantee vaccine affordability and provide vaccines free of charge for lower-income persons and the poor. Accessibility also includes accessibility of information on the pandemic and vaccines, which can be done through a) dissemination of accurate scientific information on the safety and effectiveness of different vaccines, and b) public campaigns protecting people against rapidly spreading false, misleading or pseudoscience information concerning vaccines.

The next element is the acceptability element which requires that "all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned."[56] This element can also apply to COVID-19 vaccine. The COVID-19 vaccine is relatively new, and its development should fit the values and norms of society. This aims to create greater acceptance of the vaccine in society. The government should think of strategic measures to increase the acceptance rate. For example, in Sub-Saharan African countries, governments have adopted people-centred strategies by identifying trust-enhancing triggers and using creative strategies to counter social media and internet-generated misinformation on vaccine efficacy.[57] They also adopt practical training in social listening and the use of role-play to empower caregivers to respond in a non-judgmental manner to misinformation about vaccines. In addition, health promotion messages were tailored to resonate with specific subpopulations and the delivery of such messages was conducted by non-traditional messengers that were proven to be more effective among young people, religious organisations, and traditional societies.[58] In addition to the acceptance element discussed above, the vaccines must be distributed in compliance with the transparency requirements and primary medical ethics, such as patient approval and confidentiality, as well as the protection of the patients.[59]

The next element of the RtH is safety and good quality. These elements require that all "health facilities, goods and services must be scientifically and medically appropriate and of good quality."[60] This requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. Good quality means that healthcare facilities, including vaccines, should be, among other things:[61] safe, effective, people-centred, timely, equitable, integrated, and efficient. Thus, vaccines should fulfil the requirement for good quality. Safe vaccines should avert physical harm or damage to people and be effective with support from evidence-based and rigorous research. When providing vaccines for Pandemics or other diseases, states must promote

56 CESCR, *supra note* 18, para 12 (c).

57 Olufunke Ajeigbe et al, "Culturally relevant COVID-19 vaccine acceptance strategies in sub-Saharan Africa" (2022) 10:8 The Lancet Global Health 1090–1091.

58 *Ibid.*

59 Noni E MacDonald et al, "Royal society of Canada COVID-19 report: Enhancing COVID-19 vaccine acceptance in Canada" (2021) 6 Facets 1184–1246.

60 CESCR, *supra note* 18, para 12 (d)

61 WHO, Human Rights, 22 December 2022, https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health, accessed 11 June 2023.

people-centred services that accommodate individual preferences, needs and values. Moreover, vaccine delivery should be done in a timely manner, meaning that people have timely access to care or services. The timely access may reduce waiting times and prevent harmful delays for the people. Another requirement of safe and good-quality vaccines is that vaccine delivery should be equitable, which means that when delivering vaccines, states are not allowed to differ in quality on the grounds of discrimination. Lastly, good quality vaccine delivery should be integrated and efficient. Integrated means that vaccines are available in the full range of health services throughout life. At the same time, efficiency means that the care is provided by maximising the benefit of available resources and avoiding waste. To guarantee the vaccine's safety, quality, and efficacy, WHO has conducted a rigorous evaluation of COVID-19 vaccines developed by several manufacturers worldwide. WHO ensures that all vaccines are safe and effective in protecting against serious illness, hospitalisation and death from COVID-19.[62]

III. PRIORITY SETTING CRITERIA IN HEALTH CARE INTERVENTION IN THE TIME OF PANDEMIC

In general, there are three principles embedded in the right to health that establish priority setting in health care access. These principles are: equal distribution or priority service is based on the needs, with priority is given to the most disadvantaged group (as specified in AAAQ above), cost-effectiveness, and fair contribution (based on the contribution and capability to pay, instead of on the needs).

In the early days of the pandemic, CESCR stated that "states must make all efforts to mobilise the required resources to mitigate COVID-19 most fairly, to avoid worse economic burden to these marginalised groups" and that "resource allocation should prioritise the unique needs of these groups."[63] These statements support the approaches under human rights in terms of vaccine allocation. This statement also aligns with the Committee's General Comments No. 3, which considers state resource limitations in meeting the minimum core obligations.[64] At this point, General Comment No. 3 suggests that if there are resource constraints, states must prioritise their health care for those most in need. This prioritisation complies with the principle of equal distribution and the AAAQ principles, which were discussed previously.

The resource limitations in most low-income and mid-income countries will intensify priority issues. Efficient allocation of the available resources obliges the state to consider monetary value, meaning that with similar efficiency, the state chooses the least expensive vaccine available in the market. Considering the various vaccines offered at different prices,[65] member states must ensure that the vaccine candidates

62 WHO, Statement for healthcare professionals: How COVID-19 vaccines are regulated for safety and effectiveness (Revised March 2022), https://www.who.int/news/item/17-05-2022-statement-for-healthcare-professionals-how-COVID-19-vaccines-are-regulated-for-safety-and-effectiveness, accessed 11 July 2023.

63 Sandra Fredman, "Substantive equality revisited" (2016) 14:3 International Journal of Constitutional Law 712–738.

64 CESCR, *supra note 5*2.

65 OHCHR, *supra* note 13.

with specific costly requirements (such as refrigeration) should not be prioritised in an environment where low-quality resources prevail. The state must also collect resources to buy less expensive vaccines to expand the benefit for more people. Thus, even though a state experiences a lack of resources, it must adopt measures to provide and further prioritise vaccines for its population, especially the most vulnerable.

Based on the discussion above, it is clear that international human rights law requires the WHO member states to provide vaccines equally to all citizens. Access to vaccines and medical technology is one element of the right to health, as stated in the International Covenant on Economic, Social, and Cultural Rights, as well as in other national and international conventions. However, many citizens do not have access to the vaccine, particularly those belonging to vulnerable groups and especially PwDs.

Even though human rights instruments tend to focus on universal access, there is a need to utilise 'intersectional human rights' to conceptualise how equal access can be achieved with limited resources.[66] Intersectionality is a crucial concept that asserts the interconnectedness of different social categories, including gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies.[67] It highlights how these categories interact with each other to shape power dynamics in society and play a vital role in understanding the experiences of marginalised individuals.[68] When it comes to the right to health, an intersectional approach prioritises groups that are vulnerable, marginalised, or experience multiple forms of discrimination—"overlapping vulnerabilities."[69] For example, in prioritising funding for AIDS, experts have promoted an approach based on intersectional vulnerabilities to prioritise resources for underrepresented groups.[70] This is crucial as underlying health factors can be considered as a form of vulnerability.

By the same token, the intersectional approach to human rights can be used to determine vaccine recipients' priority. The assessment of pandemic vulnerability is based on epidemiological vulnerability and other factors causing discrimination towards certain disadvantaged groups,[71] such as health prospects, socioeconomic status and outcomes, and social determinants of health.[72]

To assist member states in setting priorities in health care, WHO has developed the Guidance on Priority Setting in Health Care (GPS-Health). This guidance aims to provide health intervention that can achieve the goals of the health system, which are: (a) maximisation of health, (b) reduction of inequities in health, and (c) financial protection against the costs of ill health.[73] Priority setting assists governments

66 Sekalala et al, *supra* note 16.see also Kathy Davis, "Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful" (2008) 9:1 Feminist Theory 67–85.
67 Davis, *supra* note 66.
68 *Ibid.*
69 Sekalala et al, *supra* note 16.
70 *Ibid.*
71 OHCHR, *supra* note 13.
72 Sekalala et al, *supra* note 16.
73 World Health Report: Financing for Universal Coverage. Geneva: World Health Organization; 2010; see also WHO: Making fair choices on the path to universal health coverage. Final report of the WHO

worldwide to make decisions on their health care system. Their decisions may have negative or positive effects on their populations. Their decisions should align with their social values concerning health maximisation, health distribution, and financial protection.[74] Since vaccination is one of the health interventions that should be offered to inhabitants, prioritisation on who will receive the COVID-19 vaccine is necessary considering the effect of the virus on each individual.

GPS-Health differentiates three groups of criteria in prioritising health interventions: criteria of infection risk and disease severity, criteria related to social vulnerability, and criteria related to the protection against social and financial impacts due to worsening health conditions.[75] Health conditions always become a basis for providing health treatment. Interventions will be given depending on the severity of the disease. The more severe the disease or the health conditions are, the more preference will be given to provide health interventions. Numerous studies on public preferences and ethical theories have supported this proposition.[76] These criteria relate to health risk factors, comorbidity, age, and disability.[77]

Social vulnerability criteria relate to sociodemographic factors, which increase the vulnerability of individuals. These factors include socioeconomic status, living area, gender, race, ethnicity, religion, and sexual orientation. Socioeconomic factors are usually related to individuals' jobs, for example, individuals with high-risk jobs include health workers, other types of front-liners, delivery staff, and waste collectors. These jobs increase people's vulnerability to diseases; therefore, they should be considered in providing health interventions. To a certain extent, an area of living could also increase vulnerability, for example, living in crowded places or with limited access to clean water and sanitation facilities. Area of living may also include interim housing, such as detention centres, shelter homes for PwDs and homeless people, nursing homes or facilities for long-term treatment, and refugee camps. Gender criteria need to be considered in providing health intervention for women since unfair treatment against women occurs in most countries in the world. Such health interventions need gender disparity checks, particularly if related to reproductive health services and interventions against domestic violence. Moreover, health intervention should also consider factors such as race, ethnicity, religion, and sexual orientation. These factors often lead to stigma and access restrictions to healthcare. The third criterion of GPS-Health is criteria related to the protection against social and financial impacts due to worsening health conditions. These criteria include treatment responsibility, disaster health and other expenses when individuals are infected.

Consultative Group on Equity and Universal Health Coverage. Geneva: World Health Organization; 2014. online: http://www.who.int/choice/documents/making_fair_choices/en/, accessed 20 July 2023.

74 Ole F Norheim et al, "Guidance on priority setting in health care (GPS-Health): the inclusion of equity criteria not captured by cost-effectiveness analysis" (2014) 12:1 Cost Effectiveness and Resource Allocation 2014, 1–8.

75 *Ibid.*

76 See for example: E Nord et al, "Incorporating societal concerns for fairness in numerical valuations of health programmes" (1999) 8:1 Health Econ 25–39; Dan W Brock, "Priority to the Worse Off in Health Care Resource Prioritization" in Rosamond Rhodes, Margaret Battin & Anita Silvers, eds, *Medicine and Social Justice: Essays on the Distribution of Health Care*, 2d ed (Oxford: Oxford University Press, 2012) 155.

77 Norheim et al, *supra* note 74.

Based on the criteria by Northeim, PwDs are a vulnerable group that must be prioritised to receive the COVID-19 vaccine.[78] Moreover, Article 11 of the Convention on the Rights of Persons with Disabilities mandates that states should "...take...all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters." The COVID-19 pandemic is a humanitarian emergency during which the state must act to protect the rights of people with disabilities.[79] This, as explained above, is also one of the obligations of the Indonesian government, according to the international human rights law ratified by it.

Numerous media outlets in Indonesia have reported that the Indonesian government has conducted vaccinations for PwDs. However, the program has various fundamental flaws, and PwDs still face difficulties in participating in the COVID-19 vaccination program. Such hindrances include the lack of comprehension about the COVID-19 vaccination, comorbidity among PwDs, and inaccessibility of the vaccination venues. The following section will discuss the regulations and policies from the Indonesian government related to COVID-19 vaccine distribution and its implementation for PwDs.

IV. INDONESIAN LAW AND POLICY RELATED TO THE VACCINATION PROGRAMME FOR PWDS

In general, the Indonesian government has taken some initiative in respecting, protecting, and fulfilling the rights of PwDs in the country. One such measure was ratifying the Convention on the Rights of Persons with Disabilities with Law No. 19 of 2011. Based on this ratification, Indonesia has amended Law No. 4 of 1997 on Persons with Disabilities with Law No. 8 of 2016 on Persons with Disabilities, which is viewed to be more oriented toward respecting the human rights of PwDs. This law guarantees equal opportunities for persons with disabilities to develop themselves in their social life. With the implementation of Law No. 8 of 2016 on Persons with Disabilities, the Indonesian government has enacted several regulations to protect the rights of PwDs in general.[80]

78 World Health Organization and UNICEF et al, *supra* note 7.; see also International Disability Alliance, "Reach the furthest behind first : Persons with disabilities must be prioritized in accessing COVID-19 vaccinations" (2020) International Disability Alliance (IDA) 1–3.

79 G Gulati et al, "People with intellectual disabilities and the COVID-19 pandemic" (2021) 38 Irish Journal of Psychological Medicine 158–159.

80 These regulations are: a) Government Regulation No. 52 of 2019 on the Social Welfare Management for Persons with Disabilities; b) Government Regulation No. 70 of 2019 on the Management and Evaluation Planning on the Respect, Protection, and Fulfillment of Rights for Persons with Disabilities; c) Government Regulation No. 13 of 2020 on Proper Accommodation for Students with Disabilities; d) Government Regulation No. 39 of 2020 on Proper Accommodation for Persons with Disabilities in Judicial Process; e) Government Regulation No. 42 of 2020 on the Accessibility to Post-Disaster Public Housing for Persons with Disabilities; f) Government Regulation No. 60 of 2020 on the Service Unit of Employment for Persons with Disabilities; g) Presidential Regulation No. 67 of 2020 on the Requirements and Procedures of Granting an Award to the Respect, Protection, and Fulfillment of Rights for Persons with Disabilities; h) Presidential Regulation No. 68 of 2020 on the National Commission of Persons with Disabilities and other regulations; i) Presidential Regulation No. 1 of 2020 on the Ratification of Marrakesh Treaty to Facilitate Access to Published Works for Persons Who Are Blind, Visually Impaired or Otherwise Print Disabled.

PwDs have a higher risk in the COVID-19 pandemic due to various factors, such as obstacles in accessing information concerning their rights in general,[81] and especially those related to their health and the pandemic. PwDs also have a high dependency on physical contact with the environment or caregivers, which makes them vulnerable. Moreover, some types of disability have a higher vulnerability to being infected by the disease. Such vulnerability may increase during treatment when they are infected with the disease.[82] The number of PwDs in Indonesia in 2020 was 22.5 million, or about five per cent of the country's population.[83] Therefore, the Indonesian government must establish the appropriate regulations, policies, and measures, including within the vaccination program, to handle the pandemic's effects on PwDs.

In its effort to combat the pandemic, the Indonesian government, amid a few alternatives suggested by some authors,[84] preferred to use existing legislation to manage emergency public health or national disasters. These existing legislations are Law No. 5 of 2018 on Health Quarantine and Law No. 24 of 2007 on Disaster Management. Employing the two pieces of legislation above as a legal basis for dealing with the Pandemic, the Indonesian government has adopted several regulations for handling COVID-19,[85] including those relevant to vaccinations, from the onset of the COVID-19 pandemic in April 2020 until December 2022.[86] In addition, the

For further information please see: Agus Sahbani, "Mengintip 9 Aturan Turunan UU Penyandang Disabilitas, Mengintip 9 Aturan Turunan UU Penyandang Disabilitas", (2020), online: Hukum Online <https://www.hukumonline.com/berita/a/mengintip-9-aturan-turunan-uu-penyandang-disabilitas-lt5fc7817a40ecb/>, accessed 20 June 2023.

81 Eilionóir Flynn, *Disabled Justice? Access to Justice and the UN Convention on the Rights of Persons with Disabilities* (London and New York: Routledge, 2016).

82 Ministry of Woman Empowerment and Child Protection of the Republic of Indonesia, "Tanggap COVID-19 Inklusif Disabilitas: Berdasarkan Rekomendasi International Disability Alliance (ADS)", (2020), online: *Satuan Tugas Penanganan Covid-19*.

83 Ministry of Social Affairs of the Republic of Indonesia, "Kemensos Dorong Aksesibilitas Informasi Ramah Penyandang Disabilitas", (2020), online: *Ministry of Social Affairs of the Republic of Indonesia*.

84 Few authors suggested that in handling COVID-19 Pandemic, states could choose three options, in particular relating to adopting legislation/measures. These options are: (a) declaring a of state of emergency under the constitution; (b) using existing emergency legislation to deal with public health or national disasters; or (c) passing new emergency legislation. See for example Mila Versteeg & Tom Ginsburg, "States of Emergencies: Part I", (2020), online: *Harvard Law Reviews: Blog Essays* <https://harvardlawreview.org/blog/2020/04/states-of-emergencies-part-i/>; Mila Versteeg & Tom Ginsburg, "States of Emergencies: Part II", (2020), online: *Harvard Law Review: Blog Essays* <https://harvardlawreview.org/blog/2020/04/states-of-emergencies-part-ii/>.

85 Evyta Rosiyanti Ramadhani & Savira Anggraeni, "The Uncertainty of the Right to Health in Indonesia during Covid-19 Pandemic" (2022) 6:1 Journal of Southeast Asian Human Rights 55–71.

86 During the pandemic, 336 regulations on COVID-19 have been adopted. Some of the regulations are as follows: a) Government Regulation Number 21 of 2020 on Large-Scale Social Restrictions dated 31 March 2020; b) Presidential Decree Number 9 of 2020 on the Amendment to Presidential Decree Number 7 of 2020 on the COVID-19 Response Acceleration Task Force dated 20 March 2020; c) Presidential Decree No. 11 of 2020 on the Establishment of Public Health Emergency Status of COVID-19; d) Presidential Decree No. 12 of 2020 on the Determination of the Non-Natural Disaster of the Spread of Corona Virus Disease as a Non-Natural Disaster; e) Regulation of the Minister of Health Number 9 of 2020 on Guidelines for Large-Scale Social Restrictions to Accelerate COVID-19 Response dated 3 April 2020; f) Regulation of the Minister of Health Number 84 of 2020 on the Implementation of COVID-19 Vaccinations in the Management of the COVID-19 Pandemic dated 24 December 2020; g) Decree of the Director-General of Disease Prevention and Control Number HK.02.02/4/1/2021 on Technical Guidance for COVID-19 Vaccinations in the Management of the COVID-19 Pandemic dated 3 January 2021; and h) Decree of the Minister of Health Number HK.01.07/MENKES/4638/2021 on Technical Guidance for COVID-19 Vaccinations in the Management of the COVID-19 Pandemic dated 20 September 2021.

government has enacted several policies in the form of standard operating procedures, guidelines, guidance, and protocols. Overall, to prevent and manage COVID-19, the Indonesian government has formulated 113 policies.[87]

However, with all adopted regulations and policies, the Indonesian government has yet to formulate any specific regulation on vaccinations for people with disabilities. In general, vaccinations during the Pandemic have been stipulated under the provisions of two regulations and two policies, *i.e.:*

1. Decree of the Minister of Health Number HK.01.07/Menkes/4638/2021 on Technical Guidelines for COVID-19 Vaccinations in the Management of COVID-19 Pandemic dated 7 May 2021;
2. Decree of the Minister of Health Number HK.01.07/Menkes/6424/2021 on Technical Guidelines for COVID-19 Vaccinations in the Management of the COVID-19 Pandemic dated 21 September 2021;
3. Circular Letter Number HK.02.01/Menkes/598/2021 on the Acceleration of COVID-19 Vaccinations for the Elderly, People with Disabilities, Educators, and Education Personnel; and
4. Circular Letter Number HK.02.02/III/15242/2021 on COVID-19 Vaccinations for Vulnerable Groups and Persons without Identity Number.

These regulations and policies address the general public and are not specifically designed for PwDs' vaccination. Based on the four legal bases, people with disabilities are among the primary targets under the priority list for vaccinations across Indonesian regions. In addition, they are included in the sub-category of disability under the main category of a vulnerable group. Minister of Health Circular Letter No. HK.02.01/Menkes/598/2021 aims to accelerate COVID-19 vaccinations for the community, including people with disabilities. This acceleration will be achieved with the support from and collaboration with healthcare facilities and local governments. The letter mandates regional heads, heads of health offices, and heads of healthcare facilities providing COVID-19 vaccinations to prioritise, facilitate, and provide access to PwDs. People with disabilities could access vaccination in all healthcare facilities or vaccination centres regardless of the domicile indicated on their ID cards. Regional heads, heads of health offices, and heads of healthcare facilities were given a chance to collaborate with communities, local organisations, and the private sector to

87 Satuan Tugas Penanganan Covid-19, "Protocol", (2022), online: *Satuan Tugas Penanganan Covid-19*. Some of the policies are as follows: a) On 31 March 2020, the government issued the COVID-19 Health Protocols for examining and taking health measures for anyone having a travel history or close contact with those who tested positive for COVID-19; b) On 3 April 2020, the government issued the COVID-19 self-quarantine protocols for the community to curb the spread of COVID-19 to their family members or other people in their immediate vicinity through self-isolation; c) On 31 July 2020, the government issued the 5th Revision of the National Guidelines on COVID-19 Prevention and Control; and d) On 3 February 2020, 5 professional organisations, i.e., the Indonesian Association of Pulmonologists (PDPI), Indonesian Cardiovascular Specialists Association (PERKI), Indonesian Society of Internal Medicine Specialists (PAPDI), Indonesian Association of Anaesthesiologists and Intensive Therapy Specialists (PERDATIN), and Indonesian Paediatric Association (IDAI) issued the 4th Edition of the COVID-19 Management Guidelines for COVID-19 patients treatment in Indonesia.

mobilise people with disabilities, register them, and arrange their transportation to and from healthcare facilities or vaccination centres.

Furthermore, the government has also adopted Circular Letter Number Hk.02.02/III/15242/2021 on COVID-19 Vaccinations for Vulnerable Groups and Persons without Identity Cards. This circular letter mandates health offices in all provinces and regencies/cities to coordinate with government agencies and government apparatuses at the provincial and district/city levels to vaccinate vulnerable groups, including people with disabilities who do not have identity cards. The organiser of the vaccination programme should consult with the Office of Population and Civil Registration if the targeted groups do not have a National Identity Number (NIK). In this case, the people who do not yet have identity cards would receive a double benefit from the programme. First, their data will be recorded, and they will receive their identity number; second, they will receive their shots. Before this circular letter, people without identity cards could not be vaccinated.

In addition, the Central Government issued guidance and a protocol for people with disabilities, i.e. guidance on the Special and Improved Protection of Women with Disabilities during the COVID-19 pandemic (7 May 2020)[88] and Protocol for the Protection of Children with Disabilities during the COVID-19 Pandemic dated 1 June 2020.[89] These guidelines aim at supporting and taking care of asymptomatic children with disabilities, patients under monitoring, patients under surveillance, and those with a confirmed case of COVID-19. The guidance's purpose is to create a social environment in which the rights of children with disabilities are fulfilled and protected, considering their diverse backgrounds and particular needs.

As mentioned previously, PwDs are particularly vulnerable to COVID-19 infection. Additionally, the number of people with disabilities in Indonesia is relatively high, around 22,5 million (5 per cent of the Indonesian population);[90] however, nationally aggregated data is not available.[91] Regardless of this high number, in practice, the policies on COVID-19 prevention have yet to be implemented for all people with disabilities. For example, some people with disabilities cannot implement social or physical distancing as they need caregivers to interact with others to fulfil their daily needs and assist them in carrying out daily activities. The protocol and guidance did not directly regulate vaccination for people with disabilities. Although

88 Ministry of Woman Empowerment and Child Protection of the Republic of Indonesia, "Panduan Perlindungan Khusus dan Lebih Bagi Perempuan Penyandang Disabilitas Dalam Situasi Pandemic Covid-19", (2020), online: *Satuan Tugas Penanganan Covid-19*.

89 Gugus Tugas Percepatan Penanganan Covid-19, "Protokol Perlindungan Terhadap Anak Penyandang Disabilitas Dalam Situasi Pandemi Covid-19", (2020), online: *Satuan Tugas Penanganan Covid-19*.

90 Andrean Rifaldo, "Aksesibilitas 28 Juta Penyandang Disabilitas", *Kompas.com* (27 November 2023). The number of PwDs recorded in the cited article was based on a secondary publication from a mass media which mentioned the number of 28 million is based on the Central Bureau of Statistics data in 2020; nevertheless, the authors are not able to trace such result from the official website of the BPS. Therefore, the data that the authors used in this article is based on the Central Bureau of Statistics (BPS) and the news available on the website of the Ministry of Social Affairs of the Republic of Indonesia which both mention that the number of PwDs in Indonesia in 2020 was 22.5 million people.

91 The disaggregated data on the PwD occurs not only in Indonesia, but also in a developed country such as the United States. See, for example Sabrina Epstein, Kara Ayers & Bonnielin K Swenor, "COVID-19 vaccine prioritisation for people with disabilities" (2021) 6;June The Lancet Public Health e361.

the circular letter on the acceleration of the COVID-19 vaccination has been distributed, local health authorities still face hindrances in implementing the vaccination programme for PwDs.

Several local governments have also adopted local regulations for local implementation of vaccination programmes. Surakarta city has adopted Municipal Regulation No 9 of 2020 on the Protection and Fulfilment of the Rights of the People with Disabilities. This Regulation recognises the right to health and other human rights of the PwDs in Solo. The vaccination program for PwDs in Solo started in May 2021 at Dr Oen Hospital. In this initial phase, only 132 PwDs were vaccinated. The Surakarta government collaborated with an organisation of persons with disabilities (OPD), namely *Tim Advokasi Disabilitas* (Disability Advocacy Team),[92] which comprises several NGOs working on disability issues, government officers, police, and social organisations (Red Cross, and Family Welfare Program–PKK). Based on the data provided by the Local Health Office, 1,238 PwDs have been vaccinated.[93] There are approximately 2,401 PwDs in Surakarta, including those suffering from a stroke. Most vaccination programmes were designed for the general public and not specifically for PwDs. That being said, it is still unclear whether all people with disabilities have been vaccinated. The problem that was raised was that the data on the PwDs who have been vaccinated was not recorded properly.[94] In addition to data issues, the location of vaccination centres or health facilities also has substantial challenges. Due to mobility limitations, not all people with disabilities can travel to healthcare facilities or vaccination centres. Moreover, information on the COVID-19 vaccination was also not distributed equally and adequately to all PwDs.[95] Adequate distribution means that the vaccine information should be provided with consideration for PwDs' particular needs and characteristics. Adequate information provided by disseminating accurate scientific information on the safety and effectiveness of different vaccines will protect people against false, misleading or pseudoscience information concerning vaccines, which is rapidly spreading on the Internet and social media.

Another example is the vaccination campaign for the PwDs in Yogyakarta and Magelang. PwDs in Yogyakarta City receive legal protection from Municipal Regulation No. 4 of 2019 on the Promotion, Protection, and Fulfilment of the Rights of People with Disabilities. The Yogyakarta City Mayor also issued Mayor Regulation No. 16 of 2017 on the Committee of the Protection and Fulfilment of Disability Rights. Further, the committee membership is emphasised Under the Decree of the Head of the Office of Social Affairs, Manpower, and Transmigration No. 913 of 2022. The committee members consist of both state apparatuses and civil societies. The membership includes Yogyakarta City regional apparatuses, the Center for Disability Services of UIN Sunan Kalijaga, the Wahana Cerebral Palsy Family (WKCP), the Rehabilitation Center of the Christian Foundation for Public Health

92 The legal basis of the team establishment is the Decree of the Surakarta Mayor No 461.05/79 of 2021 on the Disability Advocacy Team of Surakarta City 2021–2024, which mandates the team to promote the rights of the PwD by facilitating, providing access and receiving services as well as fulfilling the rights of PwDs.

93 Interview with Surakarta Health officers, 10 October 2022.

94 Ibid.

95 Ibid.

(YAKKUM), the Indonesian Deaf Well-Being Movement (GERKATIN) of Yogyakarta, and community organisations working on disability issues.

Communities or non-governmental organisations, including OHANA Indonesia, initiated most Yogyakarta City vaccination programmes.[96] Initially, the problems faced during the vaccination were related to data unavailability. The Social Affairs Office and the Health Office of Yogyakarta City had no exact data on the number of PwDs.[97] OHANA collaborated with OPD to collect data on people with disabilities. During the first vaccine rollout in Yogyakarta, many PwDs could not be vaccinated as they had no National Identification Number *(NIK)*. To address the situation, OHANA and the local Office of Population and Civil Registration implemented on-site data collection simultaneously with vaccination shots for people with disabilities.[98] Accessibility was also an issue faced by PwDs. Several vaccination sites were inaccessible. Thus, OHANA and the disability communities provided transportation to and from the vaccination centres, ramps, wheelchairs, and sign language interpreters. These services enable and increase the accessibility of the vaccine to the PwDs. Moreover, the Centre for Disability Services of UIN Yogyakarta actively provided vaccination programmes for PwDs, particularly students with disabilities at UIN.[99] The service also included providing caregivers, transportation to and from the premises, and sign language interpreters for the vaccinated students.

As for Magelang city, the legal basis for the vaccination programme is District Regulation No. 1 of 2021 on Respect, Protection, and Fulfilment of the Rights of People with Disabilities. Data shows that there are 9,009 people with disabilities in Magelang District.[100] PwDs were vaccinated on 30 August 2021 at the open-air pavilion of Drh. Soepardi hospital, Mungkid Sub-District and at 12 community health centres (*Puskesmas*). The Office of Social and Welfare Affairs collaborated with PKK teams and cadres in villages, sub-districts, and social welfare workers to mobilise PwDs for vaccination.[101] The Indonesian Community Care for Schizophrenia (KPSI) of Magelang District facilitated the vaccination for people with mental health illnesses (ODGJ). KPSI prioritised 2,000 ODGJ as they face unique barriers, such as understanding the importance of the vaccine. In addition, several researchers have showed that severe ODGJs have more difficulties in following and applying the confusing and constantly changing rules and obligations that are established concerning the fight against COVID-19.[102] These ODGJ often believe that COVID-19 vaccines contain microchips and believe in other conspiracy theories.[103] Fueled by social media, the increasing rumour-mongering, fake news, and conspiracy theories

96 Interview with a representative of OHANA Indonesia, 10 October 2022.
97 Ibid.
98 Ibid.
99 Interview with the head of the Centre for Disability Services of UIN Yogyakarta, 15 October 2022.
100 Eko Saputra, "Tak Perlu Malu, Penyandang Tunarungu Hanya Tidak Bisa Mendengar", online: *The Regency Government of Magelang*.
101 Asef Amani, "Dinkes Kabupaten Magelang Mulai Vaksinasi Ibu Hamil dan Disabilitas", *Suara Merdeka* (August 2021).
102 Marc De Hert et al, "Prioritizing COVID-19 vaccination for people with severe mental illness" (2021) 20:1 World Psychiatry 54–55.
103 This misinformation also occurred in other parts of the world. See for example the works of Debanjan Banerjee et al, "COVID-19 Vaccination: crucial roles and opportunities for the mental health professionals" (2021) 8:e25 Global Mental Health 1–6.

about the pandemic's origin, spread, necessary precautions, and management were worrying.[104] Mental health professionals and NGOs faced challenges in providing these groups with understanding and education about the pandemic and vaccines.[105] Moreover, there was a problem related to the availability of vaccine stocks for ODGJ. MAFINDO (Masyarakat Anti Fitnah Indonesia), an NGO branch in Magelang, facilitated vaccinations for people with hearing loss and visually impaired people. The MAFINDO team members received special training to be able to communicate with ODGJ. In achieving the targets of the vaccination programme, MAFINDO also collaborated with the local POLRES, Health Office, and Social and Welfare Affairs Office.

The next example is Surabaya. Compared to those in Surakarta City, Yogyakarta City, and Magelang District, the conditions in Surabaya were quite different. There were no specific legal bases for people with disabilities. The local legislation applicable for PwDs' protection is Municipal Regulation No. 2 of 2012 on Social Welfare. In 2018, there were 8,671 people with disabilities in Surabaya City. The number rose to 8,696 and 9,852 in 2019 and 2020.[106] PwDs were vaccinated alongside the general public in their neighbourhood. It was only until the third phase of the COVID-19 National Vaccination Programme, that persons with disabilities, including ODGJs were prioritised. The programme aimed to vaccinate 5,394 PwDs and 3,671 ODGJs. On 2 June 2021, the first vaccination for people with disabilities was conducted at the health facilities (*Puskesmas*) near their domiciles. Vaccines were given to 916 people, 481 people with disabilities and 435 ODGJs.[107] The Surabaya City Government held the mass vaccination program at the Keputih Community Home *(Liponsos)* on 6th August 2021. The vaccines were only given to ODGJs, people with disabilities, and children with disabilities. The ODGJ were vaccinated with the first dose of Sinovac, while people and children with disabilities were vaccinated with the first dose of Sinopharm.[108] The local government collaborated with the Surabaya PKK implementing team (TP PKK) to give the first dose of COVID-19 vaccines to people with disabilities over 18 at the Learning Center of TP PKK, Jalan Tambaksari Nomor 11 Surabaya, on 1st–3rd September 2021. The program was aimed at vaccinating 900 PwDs.[109]

From all the examples of local vaccination programmes, it can be identified that there were fundamental problems faced by PwDs and local governments in providing inclusive vaccination for PwDs. Those problems include accessibility of the vaccination centre, lack of data on PwDs, lack of vaccine stock, false information on vaccines, the need for interpreters and caregiver service, and lack of PwD

104 Debanjan Banerjee & K S Meena, "COVID-19 as an 'Infodemic' in Public Health: Critical Role of the Social Media" (2021) 9:March Frontiers in Public Health 1–8.

105 *Ibid.*

106 Ferry Ardi Setiawan, "Legislator PDI-P Surabaya Minta Pemkot Terus Perbaiki Fasum untuk Difabel", *Memorandum.co.id* (2021).

107 Anton Kusnanto, "Hari Pertama Vaksinasi Tahap Ketiga, 900 Lebih Penyandang Disabilitas dan ODGJ di Surabaya Sudah Divaksin", *Suarasurabaya.net* (June 2021).

108 Dinas Sosial Kota Surabaya, "Kejar Target Vaksinasi, Pemkot Surabaya Sasar ODGJ, Disabilitas, dan Difabel", (2021), online: *Dinas Sosial Kota Surabaya.*

109 Dinas Kominfo Provinsi Jawa Timur, "Pemkot dan TP PKK Kota Surabaya Akan Gelar Gebyar Vaksinasi bagi Penyandang Disabilitas", (2021), online: *Dinas Kominfo Provinsi Jawa Timur.*

participation in the vaccination programmes. The challenges will be analysed in light of Indonesia's compliance with its obligation to protect the rights to health with regard to access to vaccines for PwDs.

V. ASSESSING THE COMPLIANCE OF THE INDONESIAN VACCINATION PROGRAM FOR PWDS WITH THE RIGHT TO HEALTH OBLIGATIONS

Based on the description above, it is evident that the Indonesian government has tried to administer vaccines to people with disabilities by formulating legislation and policies. Indonesia has been actively carrying out its COVID-19 vaccination program by taking early initiatives to secure vaccines dated in 2020.[110] The vaccination plan is based on Presidential Decree No. 99 of 2020, providing a legal basis for COVID-19 procurement and vaccination implementation. Further, the Minister of Health Regulations No. 84/2020 on December 14, 2020, defines the implementation plans, including vaccine types and targets. The country has negotiated and signed agreements with various vaccine manufacturers to procure doses and meet its vaccination needs.[111] The government was using different COVID-19 vaccines, including Sinovac, AstraZeneca, and Moderna.[112]

Based on the framework of the right to health, particularly on equal access to health care or treatment, the measures and efforts of the Indonesian government in providing equal vaccination can be analysed from a few aspects: a) the AAAQ principles on the right to health, b) resources limitation, c) the Guidance on Priority Setting in Health Care (GPS-Health). Each of these aspects will be discussed in detail in the following paragraphs.

1. The AAAQ principles

As discussed in Section II, the human rights framework suggested that allocation decisions relating to the pandemic (including access to vaccines) should meet several minimum core obligations: availability, accessibility, acceptability, and quality.

a. Availability

The availability assessment of the Indonesian policies will focus on the availability of data on the number of PwDs, the availability of adequate information and communication, and the availability of vaccines.

110 Bondi Arifin & Titik Anas, "Lessons learned from COVID-19 vaccination in Indonesia: experiences, challenges, and opportunities" (2021) 17:11 Human Vaccines and Immunotherapeutics 3898–3906.

111 Anthony D So & Joshua Woo, "Reserving coronavirus disease 2019 vaccines for global access: Cross sectional analysis" (2020) 371 The BMJ m4750.

112 Arifin & Anas, *supra* note 110; So & Woo, *supra* note 111.

In Indonesia, at the national level, data on persons with disabilities are incomplete and segregated.[113] The same is also true of data at the regional level. Health offices and offices of social and welfare affairs often have different data. Additionally, the data are often combined with the data of the poor. Due to this situation, it is difficult to determine the exact number of people with disabilities who have not yet received vaccines. This problem could be observed in the four cities where this research was conducted.

People with disabilities still face adversity in obtaining information about the COVID-19 pandemic and even health in general.[114] The central government did not provide sufficient information on COVID-19 vaccines for people with disabilities.[115] The lack of information exacerbated their vulnerability as they were exposed to hoaxes, conspiracy theories, etc. Information should be given through specialised methods and formats, such as leaflets in Braille, electronic formats, sign language, or easy-to-read sentences.[116] Such formats can facilitate understanding and accommodate the specific needs of PwDs. The information should also be widely disseminated in remote and rural areas. Continuous promotion also needs to be conducted for people with mental disabilities,[117] particularly those with mental disorders, to ensure they have a better understanding and are more willing to receive the vaccination.

Information about vaccines before the vaccination delivery should be accessible, including accessible communication.[118] This type of communication is required throughout the vaccination process. At the vaccination centre, communication with health officers must also be accessible. Such access can be provided through interpreters, communications cards, and whiteboards/pens. This method will ensure that everyone's questions and concerns are answered so that PwDs can deliver informed consent, which is crucial for such treatment. These careful considerations will benefit everyone attending a vaccination site, not just people with disabilities.[119]

One of the challenges with the vaccine rollout in Indonesia was vaccine availability, both in terms of vaccine shortage and lack of choice for PwDs. Due to the shortage issue, vaccination was often given late, especially for the second dose. There was also an issue of vaccine expiration. Vaccines like Sinovac and Moderna were often out of stock or expired. As a consequence, the second dose could not be given as scheduled. Since PwDs are generally more vulnerable than non-PwDs, they prefer to get vaccines that have lesser effects on their health. Generally, PwDs opted for Sinovac and Moderna; however, these vaccines were often out of stock. The

113 Ratih Probosiwi & Kurnia Nur Fitriana, "The Social Protection for Persons with Disabilities during the COVID-19 Pandemic" (2022) 9:01 IJDS Indonesian Journal of Disability Studies 17–35.

114 Ika Ningtyas, "Indonesia's information gap affecting the disabled", (2022), online: *Development and Cooperation*.

115 Pande Putu Januraga & Ngakan Putu Anom Harjana, "Improving Public Access to COVID-19 Pandemic Data in Indonesia for Better Public Health Response" (2020) 8:November Frontiers in Public Health 8–11.

116 Flynn, *supra* note 81.*Ibid.*

117 De Hert et al, *supra* note 102.

118 Sara Rotenberg, Matthew B Downer & Jane Cooper, "Making COVID-19 vaccinations accessible for people with disabilities Sara" (2021) 39 Vaccine 5727–5728.

119 Ibid

government offered another brand, AstraZeneca, as an alternative. Nevertheless, many rejected this alternative due to the reported strong effects of the vaccination, such as fever, severe pain, headache, fatigue, and severe allergies. These effects will influence the health condition of PwDs, and they were worried that these effects might affect their disabilities.

b. Accessibility

In analysing the accessibility element of vaccination rollout for PwDs, this subsection will focus on the accessibility of the vaccination sites and accessibility of information provided by interpreters and caregivers.

Vaccination site accessibility was the main issue faced by people with disabilities. Therefore, selecting vaccination locations is central to implementing the vaccination program for PwDs.[120] The vaccination location/centre should have accessible entrances. The location's accessibility may include a wide doorway, low-force or automatic doors, no steps, ramp, etc. These facilities should also be accompanied by clear signs indicating accessibility and signs requesting accessible accommodations, such as wheelchairs, tactile guidance, etc.[121] Unfortunately, most vaccination centres do not consider such accessibility elements. In some vaccination locations, civil society organisations, such as OHANA and MAFINDO, provided transportation to and from the sites, i.e., ambulances and mobility aids (wheelchairs), as well as caregivers for PwDs.

In addition, the availability of interpreters and caregivers constitutes an essential element to consider when it comes to vaccination for people with disabilities. People with disabilities need caregivers to help them access the vaccination site and understand the information regarding the effects of the vaccines. Caregivers will help ensure seamless vaccination. Additionally, people with hearing loss and speech impairment need sign language interpreters to help them communicate with their fellows and health workers. Sign language interpreters are important since not many health workers are fluent in sign language. Caregivers and sign language interpreters play a vital role in the vaccination for people with disabilities.

c. Acceptability

The COVID-19 vaccine is relatively new, and its development should fit the values and norms of society in order to encourage societal acceptance. The government should develop strategic measures to increase the acceptance rate. Such strategies may include mass education and the empowerment of vaccine receivers. In light of PwDs' vaccination in Indonesia, as discussed in Section IV, one of the persistent problems is the lack of participation of PwDs in the vaccination program. Genuine participation of PwDs in the decisions that affect their lives is essential to ensuring a programme's successful implementation.[122] The best practice of inclusive and

120 Rotenberg, Downer & Cooper, *supra* note 118.

121 *Ibid.*

122 Tanasoca and Dryzek emphasise the genuine participation of local Indigenous communities in the United States and Australia to achieve vaccine justice. See further in Ana Tanasoca & John S Dryzek, "Determining

accessible vaccinations can be realised by involving people with disabilities in, for example, developing technical guidelines for vaccine administration. The PwDs' involvement will improve the acceptance rate of vaccination within their network, and in the end, it will foster the success of the vaccination programs.

Furthermore, the Indonesian government at both national and regional levels needs support from PwDs in solving issues regarding vaccination for people with disabilities. Such support will be instrumental when there is still a lack of accessible information and data. The government needs to address these issues immediately. In the future, governments should design a more participatory vaccination program by involving people with disabilities and community organisations focusing on disability rights advocacy.

2. Safe and Good Quality

Indonesia considers several factors when ordering vaccines for its population to ensure the effectiveness, safety, and accessibility of the vaccination program. It prioritises vaccines proven to be safe and effective in preventing COVID-19. The government evaluates data on vaccine efficacy, side effects, and overall safety profiles before making procurement decisions.[123] Vaccines procured for the Indonesian population must undergo regulatory approval from the Indonesian Food and Drug Authority (BPOM). This approval process entails a comprehensive assessment of clinical trial data, quality control protocols, and adherence to regulatory guidelines. In addition, the government has also considered its resource limitation in vaccine procurement to order the least expensive vaccines available in the market. Yet, it can still be effective in preventing the spread and reducing the effect of the disease on individuals. The discussion on resource limitation is provided in paragraph b below.

Based on the analysis above, it can be seen that the Indonesian vaccination program has followed the AAAQ principles to some extent. However, some areas still need improvement, such as accessibility and availability of the vaccine, as well as information on the effect of the vaccine on individual conditions of PwDs. Although there are some weaknesses, administering second doses of the vaccine has shown progress, as more groups have become eligible based on risk factors and public health considerations. Booster doses were also introduced in January 2023 to protect against COVID-19 and strengthen community immunity.[124] Furthermore, non-state actors such as private companies, NGOs, and other partners have collaborated to provide COVID-19 vaccinations to the population, which has helped expand access to vaccines across the country and supported the national vaccination campaign.[125]

Vaccine Justice in the Time of COVID- 19: A Democratic Perspective" (2022) 36:2 Ethics & International Affairs 333–351. See also Toebes, Forman & Bartolini, *supra* note 19.

123 *COVID-19 Vaccine Post-Introduction Evaluation Indonesia Country Report*, by UAD; WHO Indonesia; Indonesia Ministry of Health; Clinton Health Access Initiative; Unicef (2022).

124 Andi Anugrah Pawi & Heru Susetyo, "Upaya Mewujudkan Kebijakan Ramah Disabilitas Dalam Pelaksanaan Program Vaksinasi Covid-19" (2022) 6:4 JISIP (Jurnal Ilmu Sosial dan ... 2079–2086.

125 UAD; WHO Indonesia; Indonesia Ministry of Health; Clinton Health Access Initiative; Unicef, *supra* note 123.

a. Resource Limitation

Although Indonesia is categorised as a developing country, its concerns for the health of its people cannot be underestimated. Indonesia is one of two developing countries that secured COVID-19 vaccines in the first phase of vaccine development.[126] The Indonesian government committed to providing the COVID-19 vaccine to the community for free, with vaccine procurement and implementation funded through the State Budget (APBN) and regional budget (APBD).[127] Additionally, the government has secured vaccine doses through various mechanisms, including engagement with vaccine manufacturers, participation in multilateral initiatives like the COVAX Facility, and bilateral agreements with pharmaceutical companies and other countries.[128]

Moreover, Indonesia seems to follow the CESCR General Comment No. 3 to prioritise its health care for those in need (through a prioritisation programme). The resource limitation also encourages Indonesia to consider the monetary value of its resources and to procure the least expensive vaccine candidates available on the market which nonetheless have similar efficiency. In the first phase, Indonesia negotiated with Sinovac to provide vaccines for its population. Indonesia used Sinovac in large quantities, although it has 50 per cent efficacy which is the lowest efficacy compared to other vaccines.[129] Additionally, the prices are lower than those of the other brands. Moreover, the Sinovac vaccine is easier to transport and does not need a specific treatment for storage.[130] It can be stored in ordinary refrigerators, unlike the Pfizer-BioNTech and Moderna vaccines, which must be kept at subfreezing temperatures.[131] This storage requirement will cost extra money and is almost impossible to transport to the vast area of tropical Indonesia, especially in remote areas. With this strategy, Indonesia vaccinated more people with significantly fewer resources. Thus, it can be concluded that the Indonesian government has considered its resource limitation to intensify its priority over the population's health. Indonesia has procured vaccines from other companies in the second and third phases of the vaccination wave. Further, this analysis on resource limitation consideration follows the guidelines of prioritisation (the GPS health) published by the WHO.

126 So & Woo, *supra* note 111.

127 UAD; WHO Indonesia; Indonesia Ministry of Health; Clinton Health Access Initiative; Unicef, *supra* note 123.

128 *Ibid.*

129 Niall McCarthy, "Covid-19 Outbreak: How Effective are the Covid-19 Vaccines?", (2021), online: *Statistica* <https://www.statista.com/chart/23510/estimated-effectiveness-of-covid-19-vaccine-candidates/>.

130 Yen Nee Lee, "Brazil researchers now say China's Sinovac vaccine is 50% effective — lower than announced earlier", (2021), online: *CNBC* <https://www.cnbc.com/2021/01/13/chinas-sinovac-vaccine-reportedly-50point4percent-effective-in-brazilian-trial.html>.

131 *Ibid.*

b. The GPS-Health

The GPS-Health emphasises the need for prioritisation based on resource limitations and specific conditions. The GPS-Health differentiates three groups of criteria in the prioritisation of health interventions: (1) criteria of infection risk and disease severity, which are related to individual health risk factors, comorbidity, age, and disability; (2) criteria related to social vulnerability; 3) criteria related to the protection against social and financial impacts due to worsening health conditions. Based on these criteria, disability is one of the considerations for prioritisation.

The COVID-19 vaccination program in Indonesia officially began in January 2021.[132] The government initiated the vaccination campaign to address the ongoing pandemic and protect the population from spreading the virus. Indonesia has established a priority list for COVID-19 vaccination to ensure that those most at risk are vaccinated first. The program started with the vaccination of priority groups, including frontline healthcare workers, older adults, public service workers, and individuals with underlying health conditions.[133] The intention is to protect those most vulnerable to severe illness or complications from COVID-19 and minimise the impact on healthcare systems. The prioritisation of specific groups for COVID-19 vaccination is guided by legal and regulatory frameworks to ensure an organised and equitable distribution of vaccines. The legal basis for the prioritisation of vaccination groups includes[134] Government Regulations, Decrees and Circular Letters, specific instructions provided by the Ministry of Health or other relevant authorities on the order of vaccination groups, eligibility criteria, and timelines for different stages of the vaccination program.

Based on the abovementioned priority, PwDs were not explicitly mentioned as a separate category in prioritised COVID-19 vaccination groups. However, one of the categories is vulnerable communities, which may encompass individuals with disabilities who are considered at higher risk of severe illness from COVID-19. The vaccination programme for this group was given quite late, as discussed in Section IV. The government has taken steps to speed up the COVID-19 vaccination process for people with disabilities. This was later, after issuing two circular letters from the Minister of Health. The first one is numbered HK.02.01/MENKES/598/2021 and concerns the acceleration of COVID-19 vaccination for the elderly, people with disabilities, educators, and education personnel. The second one is numbered HK.02.02/III/15242/2021 and pertains to implementing COVID-19 vaccination for vulnerable communities and other communities that do not have a population identification number. The vaccination program for people with disabilities was first carried out in June 2021 in collaboration with the Ministry of Health with 98 disabled

132 UAD; WHO Indonesia; Indonesia Ministry of Health; Clinton Health Access Initiative; Unicef, *supra* note 123.

133 Arifin & Anas, *supra* note 110.

134 UAD; WHO Indonesia; Indonesia Ministry of Health; Clinton Health Access Initiative; Unicef, *supra* note 123., pp 8, 15.

communities and is prioritised on the islands of Java and Bali, which have the highest rate of infection.[135]

However, implementing the vaccination program for PwDs in Indonesia did not go as smoothly as planned. As discussed in Section IV, the governments faced a few challenges concerning the implementation, which will potentially influence the fulfilment of the right to health of the PwDs. Given the emphasis on equitable access to vaccination and the inclusion of vulnerable populations in the vaccination program, it is important to consider individuals with disabilities as part of the broader efforts to protect those most at risk during the pandemic. Thus, this group should explicitly be mentioned as a vulnerable category and targeted as the first group who can receive the COVID-19 vaccine. Vaccination strategies should aim to address the specific needs and challenges faced by people with disabilities to ensure their access to vaccination services and support their overall health and well-being.

VI. MOVING FORWARD: IMPROVING PWDs' ACCESS TO VACCINATION AND OTHER HEALTH SERVICES IN THE POST-COVID SITUATION

Even though the pandemic is over, challenges to provide fair and equal access to vaccination and health care still exist. An inclusive healthcare system is needed to accommodate the specific needs of PwDs in accessing healthcare services. As discussed in the previous sections, the public health responses to the pandemic have been inadequate. This happened in Indonesia and many other countries, such as the United Kingdom,[136] New Zealand,[137] Ghana,[138] etc, as the preparedness for the pandemic was lacking. The inadequacy of the health system in tackling the pandemic has negatively impacted PwDs, as one of the most vulnerable groups in society, to a greater degree than their able-bodied peers. One of the problems experienced by PwDs is difficulty in accessing healthcare services during the pandemic, as well as information relating to a pandemic and healthcare services in general.

The discussion section above proves that the NGOs working on disability have played a significant role in assisting access to vaccines for PwDs. In the future, health policy should consider the capacity to leverage existing networks within the disabled community, which have proven effective in providing support during the pandemic. To address current shortcomings, healthcare and disability support systems must recognise these networks' significance and role in helping disabled individuals obtain the required information and assistance.

In addition, to improve access to healthcare for disabled individuals in the future both during pandemics and everyday situations, gathering, understanding, and

135 Pawi & Susetyo, *supra* note 124.

136 Charlotte Pearson et al, "Covid-19 and the Crisis in Social Care: Exploring the Experiences of Disabled People in the Pandemic" (2023) 22:3 Social Policy and Society 515–530.

137 Solmaz Nazari Orakani et al, "Systems Are Overstretched from the COVID-19 Pandemic: An Interpretive Description of Disabled People's Access to Healthcare and Disability Support in New Zealand" (2024) 12 Healthcare 387.

138 Chris Mike Agbelie, "Health system access challenges of people with disabilities increased during Covid-19 pandemic" (2023) 16 Disability and Health Journal 101446.

incorporating PwD's' experiences and perspectives into preparedness efforts is essential. Disabled individuals and their representative organisations should be central to this planning process, contributing to guidelines, service delivery strategies, and continuity plans. Moreover, a specific plan should address the unique needs and preferences of disabled people, including their cultural and language requirements.

IV. CONCLUSION

The discussion above concludes that persons with disabilities are part of the vulnerable groups. The COVID-19 pandemic further increases their vulnerability in both health and financial aspects. Therefore, persons with disabilities should be prioritised in the pandemic transmission prevention program, particularly regarding the COVID-19 vaccine rollout. Access to vaccines is also acknowledged in the international human rights instruments, to which the Indonesian government is bound, as part of the fulfilment of access to health for everyone, including persons with disabilities. The vulnerability analysis indicates that concerning the COVID-19 vaccine rollout, persons with disabilities should receive more attention and priority than other groups. Vaccines have the potential to reduce mortality and the effect of the COVID-19 virus on people with disabilities, yet only if there is sufficient equitable access to vaccines for this group.

However, the analysis of government practices proves that persons with disabilities were initially not prioritised, and vaccines were primarily given to the public in general, in particular non-disabled persons. No specific implementation regulations and policies have been dedicated to this vulnerable group. Later in 2021, the government enacted the regulation for PwDs' vaccinations. With that being said, in mid-2021, persons with disability started to be vaccinated due to collaborative work between NGOs and the government. In various vaccination programmes for PwDs, the government still requires support from non-governmental organisations, particularly for data collection and special services for persons with disabilities. PwDs also encounter various hindrances when accessing vaccines. Such obstacles include the inaccessibility of vaccination venues, the lack of sign-language interpreters, a few bureaucratic issues due to the non-existence of ID Cards, misinformation, and others.

Moreover, with apparent fundamental challenges in data and vaccine supplies, improvements are necessary for future policies in prioritising services relating to health for PwDs, especially as it relates to pandemics or other emergencies. Moreover, the government should improve the availability of data relating to PwDs. With a comprehensive database on PwDs, it will be easier to administer vaccine rollouts and provide other services to this vulnerable group. Furthermore, enabling the direct participation of PwDs in designing vaccination programmes is the best way to improve vaccine coverage for this group.

By addressing all the above-mentioned challenges, Indonesia may improve the programme's coverage for vulnerable groups in Indonesia, including for PwDs. Such improvement requires targeted strategies and interventions to address barriers to access, increase acceptance, and ensure equitable vaccine distribution. If all the challenges can be addressed, it is possible to achieve equal access to life-saving

vaccines regardless of disability. Enabling such access is necessary to ensure that the Indonesian government fulfils its obligations under international human rights law and guarantees the right to health of PwDs.

Furthermore, when adopting development policy, the government should consider the inclusive nature of health policy development, which puts PwDs at the centre of the policy. Therefore, when the health system is disrupted due to a crisis, the PwDs will have the necessary access to healthcare and support.

BIBLIOGRAPHY

Agbelie, Chris Mike, "Health system access challenges of people with disabilities increased during Covid-19 pandemic" (2023) 16 Disability and Health Journal 101446.

Ajeigbe, Olufunke et al, "Culturally relevant COVID-19 vaccine acceptance strategies in sub-Saharan Africa" (2022) 10:8 The Lancet Global Health 1090–1091.

Amani, Asef, "Dinkes Kabupaten Magelang Mulai Vaksinasi Ibu Hamil dan Disabilitas", Suara Merdeka (August 2021).

Ansori, Ade Nasihudin Al, "55.158 Penyandang Disabilitas Sudah Vaksinasi per 29 Agustus 2021", Liputan 6 (2021).

Antara News, "Vaksinasi penyandang disabilitas butuh penerapan lebih inklusif", ANTARA (2021).

Arifin, Bondi & Titik Anas, "Lessons learned from COVID-19 vaccination in Indonesia: experiences, challenges, and opportunities" (2021) 17:11 Human Vaccines and Immunotherapeutics 3898–3906.

Banerjee, Debanjan & K S Meena, "COVID-19 as an 'Infodemic' in Public Health: Critical Role of the Social Media" (2021) 9:March Frontiers in Public Health 1–8.

Banerjee, Debanjan et al, "COVID-19 Vaccination: crucial roles and opportunities for the mental health professionals" (2021) 8:e25 Global Mental Health 1–6.

Bielińska, Katarzyna et al, "Equal access to healthcare in national legislations: how do Croatia, Germany, Poland, and Slovenia counteract discrimination in healthcare?" (2022) 22:1 BMC Health Services Research 1–11.

Brock, Dan W, "Priority to the Worse Off in Health Care Resource Prioritization" in Rosamond Rhodes, Margaret Battin & Anita Silvers, eds, Medicine and Social Justice: Essays on the Distribution of Health Care, 2d ed (Oxford: Oxford University Press, 2012) 155.

Chiluba, Brian, "Barriers to Health Care for Disabled People: A Review of the Literature from Low Income Countries" (2019) 6:2 IJDS Indonesian Journal of Disability Studies 210–214.

Davis, Kathy, "Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful" (2008) 9:1 Feminist Theory 67–85.

Dinas Kominfo Provinsi Jawa Timur, "Pemkot dan TP PKK Kota Surabaya Akan Gelar Gebyar Vaksinasi bagi Penyandang Disabilitas", (2021), online: Dinas Kominfo Provinsi Jawa Timur.

Dinas Sosial Kota Surabaya, "Kejar Target Vaksinasi, Pemkot Surabaya Sasar ODGJ, Disabilitas, dan Difabel", (2021), online: Dinas Sosial Kota Surabaya.

Epstein, Sabrina, Kara Ayers & Bonnielin K Swenor, "COVID-19 vaccine prioritisation for people with disabilities" (2021) 6:June The Lancet Public Health e361.

Flynn, Eilionóir, Disabled Justice? Access to Justice and the UN Convention on the Rights of Persons With Disabilities (London and New York: Routledge, 2016).

Fredman, Sandra, "Substantive equality revisited" (2016) 14:3 International Journal of Constitutional Law 712–738.

Gostin, Lawrence O, Safura Abdool Karim & Benjamin Mason Meier, "Facilitating Access to a COVID-19 Vaccine through Global Health Law" (2020) 48:3 Journal of Law, Medicine and Ethics 622–626.

Gugus Tugas Percepatan Penanganan Covid-19, "Protokol Perlindungan Terhadap Anak Penyandang Disabilitas Dalam Situasi Pandemi Covid-19", (2020), online: Satuan Tugas Penanganan Covid-19.

Gulati, G et al, "People with intellectual disabilities and the COVID-19 pandemic" (2021) 38 Irish Journal of Psychological Medicine 158–159.

Hert, Marc De et al, "Prioritizing COVID-19 vaccination for people with severe mental illness" (2021) 20:1 World Psychiatry 54–55.

Hunt, Xanthe et al, "Impacts of the COVID-19 pandemic on access to healthcare among people with disabilities: evidence from six low- and middle-income countries" (2023) 22:1 International Journal for Equity in Health 1–12.

International Disability Alliance, "Reach the furthest behind first : Persons with disabilities must be prioritized in accessing COVID-19 vaccinations" (2020) International Disability Alliance (IDA) 1–3.

Januraga, Pande Putu & Ngakan Putu Anom Harjana, "Improving Public Access to COVID-19 Pandemic Data in Indonesia for Better Public Health Response" (2020) 8:November Frontiers in Public Health 8–11.

Kusnanto, Anton, "Hari Pertama Vaksinasi Tahap Ketiga, 900 Lebih Penyandang Disabilitas dan ODGJ di Surabaya Sudah Divaksin", Suarasurabaya.net (June 2021).

Kusumawati, Erna Dyah, States Responsibility vs Domestic Control Measures of the COVID-19 Pandemic : An Analysis of the Current International Health Regulation (IHR) Regime, Rosewitha Irawaty, Metha Ramadita & Fitriyani, eds (Atlantis Press, 2021).

Lee, Yen Nee, "Brazil researchers now say China's Sinovac vaccine is 50% effective — lower than announced earlier", (2021), online: CNBC <https://www.cnbc.com/2021/01/13/chinas-sinovac-vaccine-reportedly-50point4percent-effective-in-brazilian-trial.html>.

MacDonald, Noni E et al, "Royal society of Canada COVID-19 report: Enhancing COVID-19 vaccine acceptance in Canada" (2021) 6 Facets 1184–1246.

McCarthy, Niall, "Covid-19 Outbreak: How Effective are the Covid-19 Vaccines?", (2021), online: Statistica <https://www.statista.com/chart/23510/estimated-effectiveness-of-covid-19-vaccine-candidates/>.

Ministry of Social Affairs of the Republic of Indonesia, "Kemensos Dorong Aksesibilitas Informasi Ramah Penyandang Disabilitas", (2020), online: Ministry of Social Affairs of the Republic of Indonesia.

Ministry of Woman Empowerment and Child Protection of the Republic of Indonesia, "Panduan Perlindungan Khusus dan Lebih Bagi Perempuan Penyandang Disabilitas Dalam Situasi Pandemic Covid-19", (2020), online: Satuan Tugas Penanganan Covid-19.

Ministry of Woman Empowerment and Child Protection of the Republic of Indonesia ——, "Tanggap COVID-19 Inklusif Disabilitas: Berdasarkan Rekomendasi International Disability Alliance (ADS)", (2020), online: Satuan Tugas Penanganan Covid-19.

Nazari Orakani, Solmaz et al, "Systems Are Overstretched from the COVID-19 Pandemic: An Interpretive Description of Disabled People's Access to Healthcare and Disability Support in New Zealand" (2024) 12 Healthcare 387.

Nifosi-Sutton, Ingrid, "Realising the Right to Health during the COVID-19 Pandemic: An Antidote to the Pandemic and the Catalyst for Fulfilling a Long-Neglected Social Right?" (2022) 3:1 Yearbook of International Disaster Law Online 126–153.

Ningtyas, Ika, "Indonesia's information gap affecting the disabled", (2022), online: Development and Cooperation.

Nord, E et al, "Incorporating societal concerns for fairness in numerical valuations of health programmes" (1999) 8:1 Health Econ 25–39.

Norheim, Ole F et al, "Guidance on priority setting in health care (GPS-Health): the inclusion of equity criteria not captured by cost-effectiveness analysis" (2014) 12:1 Cost Effectiveness and Resource Allocation 2014, 1–8.

OHCHR, "Statement by UN Human Rights Experts Universal access to vaccines is essential for prevention and containment of COVID-19 around the world", (2020), online: OHCHR.

Pawi, Andi Anugrah & Heru Susetyo, "Upaya Mewujudkan Kebijakan Ramah Disabilitas Dalam Pelaksanaan Program Vaksinasi Covid-19" (2022) 6:4 JISIP (Jurnal Ilmu Sosial dan ... 2079–2086.

Pearson, Charlotte et al, "Covid-19 and the Crisis in Social Care: Exploring the Experiences of Disabled People in the Pandemic" (2023) 22:3 Social Policy and Society 515–530.

Perehudoff, S Katrina, Nikita V Alexandrov & Hans V Hogerzeil, "Legislating for universal access to medicines: A rights-based cross-national comparison of UHC laws in 16 countries" (2019) 34 Health Policy and Planning III48–III57.

Probosiwi, Ratih & Kurnia Nur Fitriana, "The Social Protection for Persons with Disabilities during the COVID-19 Pandemic" (2022) 9:01 IJDS Indonesian Journal of Disability Studies 17–35.

Ramadhani, Evyta Rosiyanti & Savira Anggraeni, "The Uncertainty of the Right to Health in Indonesia during Covid-19 Pandemic" (2022) 6:1 Journal of Southeast Asian Human Rights 55–71.

Rifaldo, Andrean, "Aksesibilitas 28 Juta Penyandang Disabilitas", Kompas.com (27 November 2023).

Rotenberg, Sara, Matthew B Downer & Jane Cooper, "Making COVID-19 vaccinations accessible for people with disabilities Sara" (2021) 39 Vaccine 5727–5728.

Saputra, Eko, "Tak Perlu Malu, Penyandang Tunarungu Hanya Tidak Bisa Mendengar", online: The Regency Government of Magelang.

Satuan Tugas Penanganan Covid-19, "Protocol", (2022), online: Satuan Tugas Penanganan Covid-19.

Sekalala, Sharifah et al, "An intersectional human rights approach to prioritising access to COVID-19 vaccines" (2021) 6 BMJ Global Health 1–8.

Setiawan, Ferry Ardi, "Legislator PDI-P Surabaya Minta Pemkot Terus Perbaiki Fasum untuk Difabel", Memorandum.co.id (2021).

Shaoxiang, Yu, "Jurisprudential Analysis of the Nature of the Right to Health", online: Institute of Law and Institute of International Law, <http://www.iolaw.org.cn/global/en/new.aspx?id=36829>.

Shen, Angela K et al, "Ensuring equitable access to COVID-19 vaccines in the us: Current system challenges and opportunities" (2021) 40:1 Health Affairs 62–69.

So, Anthony D & Joshua Woo, "Reserving coronavirus disease 2019 vaccines for global access: Cross sectional analysis" (2020) 371 The BMJ m4750.

Tanasoca, Ana & John S Dryzek, "Determining Vaccine Justice in the Time of COVID- 19: A Democratic Perspective" (2022) 36:2 Ethics & International Affairs 333–351.

Toebes, Brigit, Lisa Forman & Giulio Bartolini, "Toward Human Rights-Consistent Responses to Health Emergencies: What is the Overlap Between Core Right to Health Obligations and Core International Health Regulation Capacities?" (2020) 22:2 Health and Human Rights Journal 99–111.

UAD; WHO Indonesia; Indonesia Ministry of Health; Clinton Health Access Initiative; Unicef, COVID-19 Vaccine Post-Introduction Evaluation Indonesia Country Report, by UAD; WHO Indonesia; Indonesia Ministry of Health; Clinton Health Access Initiative; Unicef (2022).

United Nations Committee on Economic Social and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant) (United Nations Committee on Economic, Social and Cultural Rights, 1990).

United Nations Committee on Economic Social and Cultural Rights,——, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) (United Nations Committee on Economic, Social and Cultural Rights, 2000).

United Nations Conference on Trade and Development, Impact of the Covid-19 Pandemic on Trade and Development: Lessons Learned, by United Nations Conference on Trade and Development (Geneva, 2022).

Versteeg, Mila & Tom Ginsburg ——, "States of Emergencies: Part II", (2020), online: Harvard Law Review: Blog Essays <https://harvardlawreview.org/blog/2020/04/states-of-emergencies-part-ii/>.

Versteeg, Mila & Tom Ginsburg, "States of Emergencies: Part I", (2020), online: Harvard Law Reviews: Blog Essays <https://harvardlawreview.org/blog/2020/04/states-of-emergencies-part-i/>.

WHO, The International Health Regulations (2005), 3d ed (Geneva: WHO, 2016).

World Health Organization & UNICEF, Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines: interim guidance (2020).

World Health Organization and UNICEF ——, "Disability considerations for COVID-19 vaccination" (2021) 8:3 Frontiers in Public Health 1–17.

World Health Organization and UNICEF, "Disability considerations for COVID-19 vaccination" (2021) 1–17.

Acknowledgments

This research paper was supported and funded by Universitas Sebelas Maret under grant agreement no. 228/UN27.22/PT.01.03/2023, with research ID number: 00300377023452022.

Erna Dyah Kusumawati is an Associate Professor in International Human Rights Law at the Faculty of Law, Universitas Sebelas Maret Indonesia. Since 2004, Erna has been a staff member of this Faculty, particularly at the International Law Department. She received her PhD in 2020 from the University of Groningen in the Netherlands. Her dissertation titled Realising the Human Right to Adequate Housing in Indonesia through Accountability as a Process was successfully defended on 13 January 2020. The dissertation focuses on implementing the right to housing, particularly at the local level in Jakarta, Yogyakarta, Surakarta and Surabaya. Her PhD was funded by the Indonesian Endowment Fund for Education (LPDP) as provided by the Ministry of Finance of the Republic of Indonesia. Her research focuses on Human Rights, especially Economic, Social and Cultural Rights, as well as International Public Law, such as International Treaty Law, Environmental Law, Humanitarian Law and Refugee Law.

Sasmini is a senior lecturer at the International Law (HI) Section, Faculty of Law, Sebelas Maret University (UNS) Surakarta. Her bachelor's (S1) degree in 2004 was obtained from the Faculty of Law, Sebelas Maret University, Surakarta, her Master of Law (S2) was obtained from the Faculty of Law, Gadjah Mada University in 2009 and her PhD (S3) degree was obtained from the Doctoral Program in Law (PDIH) at the Faculty of Law, Gadjah Mada University in 2019. The field of law she is engaged in is public international law, especially in the field of human rights law, international crimes and international humanitarian law.

Adriana Grahani Firdausy is a senior lecturer at the Department of Constitutional Law, Faculty of Law, Sebelas Maret University (UNS) Surakarta. She has been teaching constitutional law with 20 years of experience. Adriana received her PhD from the Faculty of Law, Universitas Sebelas Maret, in 2020. She also actively provides legal consultation services for both local executive and legislative bodies in adopting local regulations. Moreover, she is actively involved in the anti-hoax organisation at the national level. Her research interests mainly focus on constitutional law, local government, local legislation, and human rights.