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South-South Ideas

Did South-South cooperation step up during the COVID-19 response?
National-level experiences and implications for the development cooperation architecture

United Nations Office for South-South Cooperation
United Nations Development Programme
304 East 45th Street
New York, NY 10017 USA

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Did South-South cooperation step up during the COVID-19 response? National-level experiences and implications for the development cooperation architecture

Centre for Policy Dialogue (CPD)
House 40/C, Road No 11 (new), Dhanmondi, Dhaka – 1209, Bangladesh
www.cpd.org.bd

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List of acronyms

ADB	Asian Development Bank
AfDB	African Development Bank
AIIB	Asian Infrastructure Investment Bank
ASEAN	Association of Southeast Asian Nations
AU	African Union
BAPA	Buenos Aires Plan of Action
BRI	Belt and Road Initiative
BRICS	Brazil, Russia, India, China and South Africa
CAF	Corporación Andina de Fomento (Development Bank of Latin America)
CBSL	Central Bank of Sri Lanka
CEPI	Coalition for Epidemic Preparedness Innovations
CGTN	China Global Television Network
COVAX	COVID-19 Vaccines Global Access
C-TAP	COVID-19 Technology Access Pool
DAC	Development Assistance Committee
DSSI	Debt Service Suspension Initiative
EU	European Union
EUR	Euro
EVD	Ebola Virus Disease
FDI	foreign direct investment
G20	Group of Twenty
Gavi	The Vaccine Alliance
GMCC	Global MediXchange for Combating COVID-19
GPEDC	Global Partnership for Effective Development Cooperation
HIV	human immunodeficiency virus
ICU	Intensive Care Unit
IMF	International Monetary Fund
IP	intellectual property
IsDB	Islamic Development Bank
LIBOR	London Interbank Offered Rate
MHRA	Medicines and Healthcare products Regulatory Agency
NDB	New Development Bank
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
PCR	polymerase chain reaction
PPE	personal protective equipment
PSA	pressure swing adsorption
SAARC	South Asian Association for Regional Cooperation
SADC	Southern African Development Community
SII	Serum Institute of India
SSC	South-South cooperation
TRIPS	Trade-Related Intellectual Property Rights
UN	United Nations

UNCTAD	United Nations Conference on Trade and Development
UNOSSC	United Nations Office for South-South Cooperation
US$	United States dollar
WHO	World Health Organization
WTO	World Trade Organization

Executive summary

The COVID-19 outbreak in 2019 has impacted the international development cooperation architecture, providing an impetus for South-South cooperation (SSC) to step up. With threats to lives and livelihoods, countries constrained by their social security systems and fiscal space needed emergency support more than ever. However, the traditional Northern providers of development assistance were more focused on mapping their own domestic recoveries. SSC therefore rose to the occasion, emerging as the substitutive source of bilateral, regional and multilateral support in non-finance (health and vaccine-related) and finance (grants and loans).

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Medical aid was provided by the traditional providers of the South (particularly China and India), who played significant roles in extending emergency medical support (such as test kits, surgical masks, liquid medical oxygen and ambulances) to not only their neighbours and trade partners but to anyone in need. China's emergency humanitarian campaign provided over 200 countries with essential medical supplies and equipment. Similarly, India's medical support reached over 150 countries. With all hands on deck, non-traditional providers took discrete steps to play their part, regardless of their economic status. For example, Bangladesh provided personal protective equipment (PPE) to the United States of America, hailed as a "significant milestone of international partnership" by the US Secretary of State. Other new or emerging providers also came forward (for example, Saudi Arabia and Turkey). Medical assistance was complemented by vaccine support from China, Cuba and India. While vaccine nationalism and patents threatened the success of mass immunization efforts, China and India's assistance helped improve vaccine accessibility. These two countries supplied vaccines either as donations, commercially or even as contributions to the COVID-19 Vaccines Global Access (COVAX) initiative.

China committed to providing the vaccine it had developed as a 'global public good'.

China committed to providing the vaccine it had developed as a 'global public good'. By November 2021, the country had delivered nearly 1 billion vaccine doses as gifts or sales worldwide, the bulk of which was received by the Asia-Pacific region. It also provided vaccines to 46 African countries, albeit in small quantities. The country even outsourced its vaccine production to Brazil, Indonesia, Serbia and the United Arab Emirates. Similarly, India delivered more than 50 million vaccines to 66 countries by the end of 2021. The country stayed true to its Neighbourhood First policy, with the most extensive vaccine assistance going to neighbouring countries.

Additionally, Cuba also developed vaccines, which were administered in Mexico and Nicaragua, among other countries in the Global South. As part of Cuba's commitment towards vaccine internationalism, the country pledged solidarity prices and technology transfer for the vaccines. In addition to bilateral vaccine support, China and India contributed to the COVAX initiative, but Cuba's inclusion is yet to be approved. Monetary donations to COVAX were made on top of surplus vaccines. China pledged to contribute 10 million vaccine doses and US$100 million, and India provided almost 20 million vaccines to the initiative. However, achieving equitable global access to COVID-19 vaccines will be delayed. Only 5 percent of the population in low-income countries have been vaccinated with at least one dose of the COVID-19 vaccine. Thus, the poorest countries may need to wait until 2023 to have access to the vaccines.

Regional collaborative initiatives such as the South Asian Association for Regional Cooperation (SAARC) COVID-19 Emergency Fund pledged to provide finance for medical-related assistance. Multilateral institutions such as the Asian Infrastructure Investment Bank (AIIB) and the Islamic Development Bank (IsDB) also assigned funds to

medical assistance. Additionally, the Southern countries deployed medical experts and teams (including from China and Cuba) to help the affected countries in the fight against COVID-19. Moreover, virtual symposia were held and national-level survey research was undertaken to share medical insights, experiences and best practices across borders. Knowledge-sharing online platforms were created, such as the World Health Organization's (WHO) COVID-19 Technology Access Pool (C-TAP). However, bilateral medical support has been more prominent and widespread in the Global South than regional or even multilateral initiatives have been.

Bilateral and multilateral financial support also featured prominently.

Bilateral and multilateral financial support also featured prominently. Before the outbreak, the Global South's dependency on foreign aid had been decreasing, which was reversed by the pandemic. As a result, the need for a few pre-existing financial channels of support (such as rapid credit facility or debt repayment servicing) intensified. At the same time, new financial measures (such as currency swaps) were also seen. Bilateral aid commitments from traditional donors plummeted, for example the United Kingdom cut its aid spending by 10 percent. However, there were examples of significant bilateral financial assistance in the Global South. For example, China played a pivotal role in providing bilateral financial support to the Global South. The country announced US$3 billion in international assistance to help COVID-19 recovery in developing countries such as Afghanistan, Cambodia and Sri Lanka. Additionally, China suspended nearly US$1.5 billion worth of debt service payments. The Reserve Bank of India and Bangladesh Bank extended US$400 and US$200 million in currency swaps, respectively, to Sri Lanka. A currency swap of US$150 million from India was also extended to Maldives.

On the other hand, regional entities such as the Association of Southeast Asian Nations (ASEAN), the Southern African Development Community (SADC) and SAARC created regional funds to help the pandemic response, but their allocations were slow and information regarding disbursements was not readily available. The regional development banks in the South (such as AIIB, the Development Bank of Latin America (CAF in Spanish) and IsDB) played a timely role in emergency crisis response. They dedicated a hefty amount of financial support to the countries in need, but their disbursement rate has not been fully realized. Moreover, they each had their own peculiarities. For instance, AIIB mainly approved loans to countries in the Asia-Pacific region, whereas IsDB was relatively active in providing for the African region. However, given the active involvement of the Southern aid providers, some challenges remained.

Firstly, the rise of the Global South has historically followed episodic trends. Whether its cooperation will actively continue during the post-pandemic recovery period will be interesting to observe. Secondly, the existing discourse traditionally follows a top-down flow of assistance that often lacks contextualization at the local level. Moreover, information disclosure, adequate logistical support and most importantly a universal framework of principles and accountability need to be put in place now more than ever. The cooperative exercises may prove hazardous without a universal framework in place. Lastly, debt sustainability and the digital divide may be an issue of growing concern in the post-pandemic era. Given the concerns, strengthened participation of international bodies (such as the International Monetary Fund (IMF) and United Nations) and the private sector (including civil society organizations (CSOs) and think tanks) is required.

1. Introduction

The coronavirus hit the world at a time when the international cooperation system was already afflicted with a number of challenges (Bhattacharya and Khan, 2020)[1] The outbreak caught the world unprepared. Declared a pandemic less than three months after the first reported case,[2] the worst was yet to come. As the threat to lives and livelihoods became more evident, countries initiated national lockdowns and border closures. Emergency support packages were assembled, but the developing countries with their constrained social security systems and fiscal space had to consider how to respond. In addition, the shortcomings of health care systems became apparent, including some that had previously been considered the most resilient.[3]

International cooperation was urgently required to limit the health-related and socio-economic damage caused by the pandemic.

To make matters worse, lockdowns resulted in a decline in trade (export in particular), private foreign direct investments, remittance flows and other economic activities. Thus, besides health-related interventions, the pandemic response required large fiscal injections into the economies, which were restricted by available low fiscal space underpinned by poor revenue collection, higher demand for government expenditure and growing public debt (Bhattacharya, 2020). Foreign debt servicing in many developing countries has become a major burden (United Nations Conference on Trade and Development [UNCTAD], 2020). Thus, international cooperation was urgently required to limit the health-related and socio-economic damage caused by the pandemic. This became a particular issue as the traditional providers[4] themselves were also tackling the pandemic. Against this backdrop, this study discusses how South-South cooperation (SSC)[5] rose to the occasion and bolstered pandemic-related support.

Deepening interdependence among the countries of the Global South is nothing new; for decades, the Global South's share in global trade and investment has been on a positive trajectory. Moreover, the Southern share of ODA receipts has decreased since reaching its peak in 2005 (Table 1.1). While the traditional Northern providers were more focused on mapping domestic recoveries amid the pandemic,[6] the Southern providers emerged as a substitutive source for extending emergency support, financial assistance, technical expertise, human resources and, most importantly, vaccine support. This should come as no surprise, since the countries of the Global South have weathered multiple

1 For instance, the divergence of official development assistance (ODA) from economic infrastructure development to humanitarian emergencies in addition to donor fatigue in Organisation for Economic Co-operation and Development (OECD) countries (Khan and Tashfiq, 2019). On the other hand, the Buenos Aires Plan of Action Plus 40 (BAPA+40) may have given impetus for development cooperation.

2 Several cases of pneumonia were reported by the Wuhan Municipal Health Commission in China on 31 December 2019. Eventually it was identified as a novel coronavirus (World Health Organization [WHO], 2020a).

3 China, Italy, Spain and the United States of America were critically affected, despite their higher health system performance ratings (El Bcheraoui *et al*., 2020).

4 Traditional providers of development cooperation are countries who are members of the Development Assistance Committee (DAC) and belong to the OECD. On the other hand, non-traditional providers are not members of the DAC (Luijkx *et al.*, 2016).

5 SSC encompasses the idea of partnership between providers and recipients under the aegis of ODA, foreign direct investment (FDI), remittances and trade, among other things (Bhattacharya and Rashmin, 2019).

6 Global FDI fell by 42 percent in 2020 from 2019 (UNCTAD, 2021).

critical health crises in the past or are still battling deadly diseases aside from COVID-19.[7] Thus, they are more experienced in pandemic response. As the crisis hit all counties at once, the Global South had to quickly adapt and translate global recovery plans to a national level based on their local context.[8] In addition, significant drivers of development cooperation, notably from the Global South, came forward to provide aid to nations, irrespective of their economic state of development.[9]

Table 1.1. *Southern share of financial and trade flows in the global economy (as a percentage)*

	2000	2005	2010	2015	2019	2020
Southern share of global FDI inflow	10.96	28.20	35.70	24.72	34.0	43.94
Southern share of global FDI outflow	1.40	6.91	14.70	14.90	21.73	27.50
Southern share of global exports	-	27.11	32.86	34.61	34.41	35.36
Southern share of global imports	-	22.45	29.45	32.69	32.55	32.76
Southern share of remittance inflow	57.11	65.03	68.44	71.19	71.45	72.34
Southern share of remittance outflow	24.30	25.91	31.93	43.23	39.37	35.52
Southern share of ODA receipts	41.86	58.95	43.52	38.0	37.89	-

Sources: Estimated from OECD.Stat (2021), UNCTADstat (2021) and the World Bank (2021).

The Global South has performed impressively, and this paper is a consolidatory discussion of the financial and non-financial support extended by and to the Southern countries.

Thus, the Global South has performed impressively, and this paper is a consolidatory discussion of the financial and non-financial support extended by and to the Southern countries. Southern providers, particularly China and India, have been significant bilateral donors of medical aid and vaccines worldwide.[10] New financial support lines such as currency swaps have been introduced.[11] Moreover, Southern international financial institutions such as the Asian Infrastructure Investment Bank (AIIB), the Islamic Development Bank (IsDB) and the New Development Bank (NDB) have significantly augmented their development finance facilities for pandemic response in poorer countries. The actions of these emerging donors have modified the landscape of international development aid.

Amid these promising new feats, there are some challenges (such as debt trap, geopolitical issues and regional cross-border issues) to SSC from the recipient countries' perspectives, and evidence regarding SSC in the COVID-19 response is mostly scattered in grey literature and often incompletely captured. There has been a lack of means to collect, collate and interpret data on SSC from both the perspectives of provider and

[7] South and West Africa retain the highest prevalence of the human immunodeficiency virus (HIV) and the Ebola Virus Disease (EVD) respectively (Erondu and Agogo, 2020; WHO, n.d). Nigeria recorded the largest outbreak of Lassa Fever in the first quarter of 2022, which has been declared an endemic in Benin, Ghana and numerous West African countries (Erondu and Agogo, 2020; Okonkwo, 2022). Moreover, Cholera (an acute diarrhoeal disease) which started in South Asia in the 1960s, is now an endemic in several countries (WHO, 2022).

[8] While temporary export bans were being enacted by China, some countries in the European Union (EU) and the United States of America, hygiene products (such as mask and sanitisers) for the prevention of COVID-19 needed to be made more accessible and affordable at the local level (OECD, 2020).

[9] Bangladesh exported 6.5 million personal protective equipment (PPE) gowns to the United States of America in May 2020 (TBS Report, 2020a).

[10] China and India had collectively gifted nearly 26 million vaccine doses by May 2021 (United Kingdom, UK Parliament, 2021).

[11] For instance, currency swaps between Bangladesh and Sri Lanka, and between India and Sri Lanka (ENS Economic Bureau, 2020; Mavis, 2021).

recipient countries.[12] Analysis of global linkages of SSC trends is also largely missing from the discourse, yet this understudied aspect has important implications for anticipating national-level opportunities and challenges. Nevertheless, it is interesting to see how SSC experiences have shaped the overall development cooperation landscape in the context of COVID-19, such as attitudes towards the response and resilience of recipient countries.

Objectives. The general objective of this paper is to map the flow of SSC inputs in response to the COVID-19 pandemic in terms of:

(a) Channels via which the support was delivered (bilateral and multilateral)

(b) The type of support:

  (i) Health-related assistance, which includes medical aid and equipment in addition to vaccine support (gifts and procurement)

  (ii) Financial support, which includes the loans approved and debt repayment suspension

  (iii) Knowledge-sharing, especially health and vaccine-related

(c) The type of providers (traditional and non-traditional)

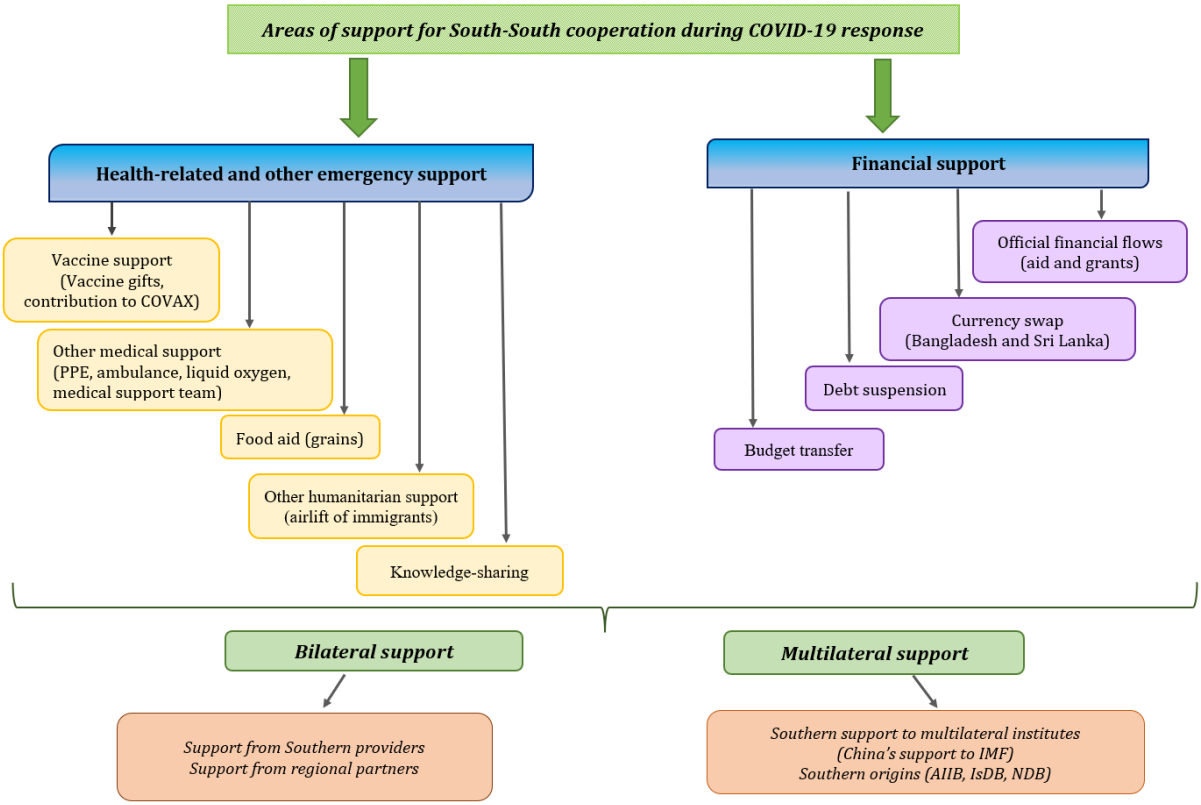
(d) The recipients

The implications of these deepened relationships under SSC during the pandemic are linked to the overall architecture and governance of international development cooperation.

Methodology. This paper provides a narrative and holistic review of SSC based on the existing literature and empirical observations. Information and data from public and official forums have been consolidated, which include peer-reviewed journals, news articles, national archives and detailed databases of the Organisation for Economic Co-operation and Development (OECD), UNCTAD, the International Monetary Fund (IMF) and so on.

[12] SSC quantification efforts are weakened by the lack of a collectively accepted definition or common concepts, procedures maintaining transparency or answerability, and consistent monitoring or recording of exchanges (Nigam, 2015).

Figure 1.1. *South-South cooperation and COVID-19 responses*



Source: Compiled by the authors.

The review of existing evidence suggests that the Southern assistance in response to the pandemic manifested in three essential ways. These are:

I. Medical and humanitarian assistance

II. Vaccine support

III. Financial assistance

The channels through which these supports were extended are presented in Figure 1.1. Knowledge-sharing among the Global South has also been an important element of the pandemic response.[13] For instance, virtual symposia facilitated via online platforms engaged policymakers, scientists, academicians, think tanks, civil society and other stakeholders to share knowledge and best practices.

Structure of the study. The three types of support and assistance mentioned above are discussed in the following order of the sections. The following section (Section 2) articulates a consolidated version of the health-related support which includes medical equipment and doctors. Section 3 discusses the vaccine support extended under SSC, whereby the support includes vaccine donations and purchases. Section 4 highlights the financial response from traditional and new Southern institutes through loan approvals and temporary debt repayment cancellations. Section 5 scrutinizes the implications of SSC for Southern providers as well as for global development cooperation and, finally, Section 6 summarizes the Global South's response to the COVID-19 pandemic and its current standpoint on cooperation, in order to pin down some policy recommendations.

[13] While knowledge-sharing could be categorized as the fourth essential form of assistance, this paper discusses it by complementing it with mainstream activities undertaken during the crisis. For instance, health-related and vaccine-related knowledge-sharing has been the most common form of knowledge exchange.

2. South-South health support in response to COVID-19

Southern countries were affected by the COVID-19 pandemic to varying degrees. Yet, with health and social protection systems faltering, the Global South put momentous effort into SSC to respond to the pandemic even during its initial stage. As the virus soared, rapid response in terms of providing bilateral medical supplies was offered. Against this backdrop, this section presents the response of major Southern countries in delivering medicine, medical equipment and food aid bilaterally. The rest of the section firstly discusses the pandemic response of the traditional providers, followed by that of the non-traditional providers. Moreover, the health-related knowledge-sharing that took place between the Southern countries is also discussed. The facts and figures for this section were essentially sourced from grey literature and publicly available sources including news articles and national databases.

2.1. Response of the traditional Southern providers

China's medical aid response. For over five years, China's Belt and Road Initiate (BRI) has sought to support international cooperation in the health sector. Since the onset of the pandemic, the country "has been promoting this aspect of the initiative ('health silk road') as essential to building a 'global community of common destiny'" (Rudolf, 2021). Initially, when coronavirus cases in Wuhan were rising disproportionately, China appealed to the international community for aid, to which 58 countries (including Australia, Bahrain, Pakistan and the United States of America) responded. Even aid as small as EUR 100 from the Comoros was extended (The Express Tribune, 2020). By February 2020, China had gradually contained the outbreak and assumed the role of providing relief worldwide.

China was at the heart of providing medical masks and kits globally.

The country was at the heart of providing medical masks and kits globally, as half of the world's masks were produced in China (Subramanian, 2020).[14] Aid supplies (including test kits, masks and respirators) were dispensed to countries with inadequate medical facilities. Moreover, teams of doctors from Beijing were sent to 43 countries (Rudolf, 2021). Almost all the countries in the world received some support from China (Rudolf, 2021). Table 2.1 gives an indication of the sort of non-financial support that China provided to the Asian countries of the Global South as the crisis unfolded.

[14] The figure may have been as high as 85 percent in April 2020 (Subramanian, 2020).

Table 2.1. *China's non-financial aid to Asia-Pacific countries of the Global South (from 2020 to 2022)*

Recipient country	Amount	Sources*
Afghanistan	20,000 protective suits, 40,000 test kits, 2 fully automated nucleic acid extractors, 2 PCR (polymerase chain reaction) machines, masks and gloves	Xinhua
Bangladesh	1,600,000 surgical masks, 65,000 N95 masks, 1,000 infra-red thermometers, 60,000 testing reagents, 50,000 personal protective equipment (PPE) suits, 50,000 goggles and other medical logistic supplies	People's Republic of Bangladesh, Embassy of People's Republic of China
Brunei Darussalam	100,000 KN95 masks, 1,000 isolation gowns, goggles, protective clothing, isolation suits	ISEAS – Yusof Ishak Institute
Cambodia	Detection reagent, hazmat suits, surgical masks, medical team, test kits, KN95 masks, isolation gowns and PPE, 1 million face masks	Xinhua
Indonesia	More than 66 tonnes of medical supplies, including 800,000 test kits, 50,000 gloves, KN95 and other masks, PPE, ventilators and other medical instruments	Xinhua
Kiribati	Medical supplies (unspecified)	Xinhua
Laos	Test kits, automatic nucleic acid extractors, medical oxygen generators and ventilators	Xinhua
Malaysia	10,000 face shields, 691,000 surgical masks (in different consignments), 100,000 KN95 face masks, 100,000 test kits, 50,000 PPE suits and 200 ventilators	New Straits Times
Maldives	Medical protective masks, surgical masks, gloves, stethoscopes, goggles and protective suits	Xinhua
Myanmar	152,016 test kits, 275,000 surgical masks, 13,500 KN95 masks, 28,500 PPE suits	ISEAS – Yusof Ishak Institute
Nepal	1 million disposable surgical masks, 162,880 N95 masks, 10,000 pieces of medical protective clothing, 500 ear thermometers, 50 non-contact infra-red thermometers, 430,000 oxygen cylinders, 150 liquid oxygen cylinders and 10 ventilators, 7,510 oxygen concentrators, 20,000 oxygen nasal cannulas and 20,000 oxygen face masks, 200 Intensive Care Unit (ICU) beds, 5 ventilators, 15,000 antigen kits and 2,000 coveralls	Nepal, Ministry of Foreign Affairs
Philippines	1.3 million surgical masks, over 252,000 test kits, 70,000 KN95 masks, 33,000 PPE suits, 70,000 medical protective goggles, 5,000 face shields and 100 ventilators	Xinhua and ISEAS – Yusof Ishak Institute
Singapore	Assignment work constructing 96 isolation units, more than 500,000 surgical masks and 100,000 KN95 masks	ISEAS – Yusof Ishak Institute

Recipient country	Amount	Sources*
Sri Lanka	50,000 medical masks, 1,008 nucleic acid diagnostic kits, 20,000 test kits, 10,000 PPE suits, 110,000 facial masks, 30,000 PCR testing kits, 30,000 disposable coveralls, 30,000 medical protective face masks, 600,000 surgical masks, 30,000 medical goggles and US$90 million in grants	Xinhua
Solomon Islands	20,000 rapid antigen test kits, 21,000 disposal syringes, 120 tents, 320,000 testing reagents, 20 oxygen concentrators, 20 pulse oximeters, 180,000 pairs of gloves, 20,000 protective eye goggles, 10,000 protective suits, 100 folding beds	China Global Television Network (CGTN)
Thailand	Medical assistance came in seven different consignments: 115,000 surgical masks, 10,500 pairs of goggles, 7,000 PPE suits, 6,000 test kits, 120 boxes of gloves, 6 ventilators, 10 electrocardiograms, 30 infusion pumps and 100 infra-red thermometers	ISEAS – Yusof Ishak Institute
Timor-Leste	US$14 million worth of medical supplies including 42,000 masks, 40,000 KN95 masks, 4,400 protective suits, 4,440 visors, 4,400 shoe covers, 5,000 medical gloves, 80 thermometers and 90 portable ventilators and construction of a new hospital and a school	Government of Timor-Leste
Viet Nam	Medical supplies worth nearly US$10 million which included KN95 masks, surgical masks, protective suits, gloves, goggles, consignment of more surgical masks	Vietnam Plus

**Sources:* Babulal (2020); Nepal, Ministry of Foreign Affairs (2021); CGTN (2022); People's Republic of Bangladesh, Embassy of People's Republic of China (2020a and 2020b); Fook (2020) (ISEAS – Yusof Ishak Institute); Nanjing (2020); Government of Timor-Leste (2020); CGTN (2022); Vietnam Plus (2021) and Xinhua (2020a–2020f).
Note: This list of non-financial aid is not exhaustive.

The Jack Ma Foundation[15] and Alibaba Foundation committed to providing medical supplies to 54 African countries to withstand the health-related fallouts. Within two weeks of the announcement, 46 countries were provided with 20,000 test kits, 100,000 masks and 1,000 medical use face shields and protective suits (Shaban, 2020). A second batch of aid included 9,500 medical gloves, 3,800 face shields, 3,800 items of medical disposable protective clothing, 18,900 swabs and viral transport media, 18,912 extraction kits, 5 ventilators and 36 thermometer guns (People's Republic of China, Ministry of Foreign Affairs, 2020). A further 4.6 million masks, 200,000 face shields, 200,000 sets of protective clothing, 500,000 pairs of gloves, 500,000 test kits, 300 ventilators, 2,000 temperature guns and 100 body temperature scanners followed the first two consignments of aid from the Jack Ma Foundation (Africa Centres for Disease Control and Prevention, 2020). Apart from the African countries, prior assistance recipients included Italy, Japan, Spain, Republic of Korea and the United States of America (Xinhua, 2020g). The foundation also announced medical donation to 24 Latin American countries (such as Argentina, Brazil, Ecuador, Mexico and Peru) which included 2 million masks, 400,000 testing kits and 104 ventilators (Koop *et al.*, 2020).

[15] A charitable organization founded by Mr. Jack Ma (also the founder of the Alibaba Foundation) (Mostofa, 2022).

Arab countries, including Egypt, Iran, Lebanon and Jordan, received masks. In South Asian countries such as Cambodia and Myanmar, medical aid supplies were delivered by the People's Liberation Army of China (Rudolf, 2021). China's presence in Latin America reached new heights with increased bilateral partnerships (Telias and Urdinez, 2021) (Table 2.2). Some Latin American states that did not have any diplomatic relations with China, such as Belize, were offered aid supplies (Rudolf, 2021). Thus, for most states, China's support was significantly beneficial while traditional aid donors were less serviceable.

Table 2.2. *China's non-financial aid to Latin American countries (June 2020)*

Recipient countries	Amount
Argentina	Two tonnes of equipment, 200,000 masks, 10,000 biosafety suits, 50,000 test kits, 20,000 disposable gloves, thermal imaging cameras, 550 digital thermometers, 10 respirators and more
Brazil	Two tonnes of equipment, including 50,000 surgical masks, 5,000 protective garments along with goggles, gloves, shoe covers, thermometers and 264 hospital beds
Chile	1.6 million masks, 1,000 ventilators, test kits, thermometers and more than 230,000 other medical supplies
Colombia	US$1.5 million worth of medical supplies which included 680,000 masks, 30,000 nucleic acid tests, respirators, infra-red thermometers, protective suits and gloves
Ecuador	5,400 KN95 masks, 1,000 surgical suits and 1,000 protective suits
Mexico	200 tonnes of medical supplies including 16.4 million face masks, 1.5 million KN95 masks, 1.2 million pair of gloves, 411,000 pair of goggles, 466 ventilators and 300,000 test kits, among others
Panama	20,000 face masks and 200 hazmat suits
Venezuela	22 tonnes of medical equipment including 500,000 test kits, 70,000 infra-red thermometers, masks, gloves and ventilators

Sources: Aguilar (2020); Gamba (2020); Koop *et al.* (2020); Myers and Barrios (2020); Xinhua (2020h).
Note: This list of non-financial aid is not exhaustive.

India's medical aid response. In March 2020, India took the initiative of bringing together all the South Asian countries that are members of the South Asian Association for Regional Cooperation (SAARC) to set up a COVID-19 Emergency Response Fund to meet the emergency costs required in combating the pandemic. India's voluntary contribution of US$10 million to the fund was followed by the other member countries (SAARC Disaster Management Centre, 2020). India's set contribution to the fund was immediately operationalized to respond to the needs of the countries in the region. By February 2021, India had provided approximately US$4.05 million worth of essential supply of drugs, medical consumables, test kits, protective gear and other equipment. From Table 2.3 it is evident that Nepal received the lion's share of the Indian fund for medical assistance, and Pakistan did not receive any aid from India due to political contention. A breakdown of the medical supplies from India to the SAARC members is provided in Table 2.3.

Table 2.3. *Medical assistance provided by India under the COVID-19 Emergency Response Fund (April 2020)*

Country	Amount in US$ (million)
Afghanistan	0.35
Bangladesh	0.55
Bhutan	0.30
Maldives	0.52
Nepal	2.12
Sri Lanka	0.21
Total	4.05

Source: SAARC Disaster Management Centre (2020).

Table 2.4. *India's non-financial aid to South Asian countries of the Global South (in 2020 and 2021)*

Recipient country	Amount
Afghanistan	Surgical masks, gloves and sodium hydrochloride solution (disinfectant) and 75,000 tonnes of wheat in 10 instalments
Bangladesh	30,000 surgical masks, 15,000 headcovers, 50,000 sterile surgical latex gloves, 100,000 hydroxychloroquine tablets (anti-malarial), 30,000 COVID-19 test kits, 200 metric tonnes of liquid oxygen, 2 mobile medical oxygen plans and 100 ambulances
Bhutan	Medical supply including surgical masks, shoe covers, hand sanitizers, digital thermometers, forehead sensors, disposable gloves, disposable surgical caps, surgical hoods, gowns, fumigation system, glycerine (450 ml), glutaraldehyde solution (5l), coveralls, safety goggles and medicines
Maldives	11.7 tonnes of essential medicines and 580 tonnes of food aid
Nepal	320,000 paracetamol, 250,000 hydroxychloroquine and 2,000 vials of remdesivir injection
Sri Lanka	26 tonnes of essential medical supplies gifted, 100 tonnes of liquid medical oxygen, 150 tonnes of oxygen and 100,000 rapid antigen test kits

Sources: Chaudhury (2020a); India, High Commission of India Male, Maldives (2020); Sibal (2020); The Hindu (2020); The Times of India (2021); The Times of India (2020); Colombo Page (2022).

India extended medical support to not only its neighbouring countries, but also to almost 150 countries around the world, which were beneficiaries of its medical or other assistance (Sarkar, 2020). At the beginning of 2020, China received about US$0.28 million worth of COVID-19 medical aid from India, which included five tonnes of medical assistance comprising approximately 100,000 surgical masks, 4,000 N95 masks, 500,000 gloves, 75 infusion pumps, 30 enteral feeding pumps and 21 defibrillators (Joy, 2020). As the United Arab Emirates and Saudi Arabia are India's third- and fourth-largest trade partners, strengthening bilateral engagements with these countries was a top priority for India (Ningthoujam, 2020). India permitted 800 health professionals to travel to the United Arab Emirates to support the country's fight against the virus, which was reciprocated with the seven tonnes of medical supplies to India that followed (Laskar, 2020b).

India-Africa cooperation during this time was also crucial. Early in 2020, India extended medical and food assistance to the Comoros, Madagascar, Mauritius and Seychelles. This was followed by more food aid of about 270 metric tonnes (including 55 metric tonnes of wheat flour, 65 metric tonnes of rice and 50 metric tonnes of sugar) to central African countries (including Djibouti, Eritrea, Sudan and South Sudan) (Sibal and Tiwari, 2020). Consignments of the anti-malaria drug hydroxychloroquine, paracetamol and other drugs

were sent to more than 25 countries in Africa (including Burkina Faso, Chad, Congo, Eswatini and Zambia) by mid-2020, at a total cost of US$7.9 million (Basu and Chanda, 2020; Marandi and Kumar Sharma, 2020).

India's extensive cooperation in terms of providing medical assistance around the world was appreciated globally. When the second wave of COVID-19 hit the country in March 2021, 52 countries from all over the world came forward to reciprocate the support they had been shown. The country received 27,116 oxygen cylinders, 19,375 ventilators, 29,327 oxygen concentrators and 48 oxygen pressure swing adsorption (PSA) plants. Moreover, the country also received 33,30,187 favipiravir, 11,06,940 vials of remdesivir, 5,10,245 tocilizumab and a total of 19,88,985 rapid diagnostic kits (Business Standard, 2021).

While the traditional Southern providers took the lead during the pandemic, non-traditional providers also emerged. The consequent subsections introduce these countries.

2.2. Response of the non-traditional Southern providers

While the traditional Southern providers helped the Global South with much of their medical aid needs during the pandemic, support from non-traditional Southern providers was also essential. The developing countries played proactive roles as non-traditional providers in meeting the traditional providers' development goals. For instance, Bangladesh, Saudi Arabia and Turkey took steps towards solidarity by discretely doing their bit.

Bangladesh, Saudi Arabia and Turkey took steps towards solidarity by discretely doing their bit.

Bangladesh and Saudi Arabia's medical aid response. Bangladesh was overwhelmingly unprepared for the crisis. Yet, despite its lack of medical supplies, the country intervened to help as many countries as it could. Under its pledged contribution of US$1.5 million to the SAARC COVID-19 Emergency Fund, the country provided medical aid and medical equipment to Bhutan (1 million Multi-Vitamin Bextram Gold and 500,000 Vitamin C Ceevit), India (including consignments of remdesivir, injection vials, hand sanitizers), Maldives (100 tonnes of food, medicine and medical equipment) and Nepal (remdesivir injections, PPE, hand sanitizer) (Bhuiyan, 2020; The Daily Star, 2020). Similarly, Saudi Arabia provided assistance to Bangladesh (23 ventilators and 1,200 medical gloves), India (140 tonnes of liquid medical oxygen) and Malaysia (4.5 million units of medical supplies) (Daniele, 2021; Saudi Press Agency, 2021; The Express Tribune, 2021). Other new providers such as the United Arab Emirates sent seven metric tonnes of medical supplies to South Africa (Isilow, 2020b; Relief Web, 2020) and five metric tonnes of medical supplies to Peru (Brown, 2021).

Turkey's medical aid response. The country remained one of the major humanitarian aid donors, accounting for more than one quarter of global humanitarian aid in 2020 (Ergocun, 2021).[16] Turkey also became the third-largest supplier of medical aid since the outbreak of the coronavirus pandemic (Yuzbasioglu, 2020). It provided medical aid to 131 countries, starting with China (93,000 masks, 500 protective glasses and 10,000 non-sterilized pieces of equipment) (Güngör, 2021). At least one country in every continent received medical aid from Turkey, while Asia and Africa received the most aid (Güngör, 2021). Table 2.5 lists a few of the countries from the Global South that received medical aid from Turkey.

[16] Turkey's humanitarian aid expenditure was 0.98 percent of its gross domestic product (GDP), ranking the country as a top donor in terms of national income (Ergocun, 2021).

Table 2.5. *Turkey's non-financial aid to Southern countries*

Recipient country	Amount
Bangladesh	11,000 N95 masks, 5,000 surgical masks, 10,000 medical gowns, 10,000 coverall sets, 2,000 face shields and 5,000 protective goggles, 1,000 PPE suits, two ventilators, 20 ventilators monitor units, 20 ventilators stand units, 20 ventilator accessory sets, 10,000 food packages and 5,000 personal care packages
Cameroon	10,000 surgical masks, 500 N95 masks, 50 infra-red thermometers, gloves, goggles and disinfectants
Chad	Medical supplies and an ambulance
Cyprus	30,000 diagnostics kits, 30,000 viral nucleic acid isolation kits
Eswatini	Sewing machines to produce face masks
Georgia	5,000 N95 masks, 5,000 gloves, 1,000 coveralls, 1,000 face shields, 1,000 glasses, 20 ventilators, 50,000 diagnostic kits, 2,000 boxes of hydroxychloroquine tablets and more than 6,000 boxes of medicines for coronavirus treatment
India	630 oxygen tubes, five oxygen generators, 50 ventilators, 50,000 boxes of tablet medicines
Lesotho	Sanitizers, gloves and masks
Namibia	30,000 N95 masks, 60,000 three-layered masks and 20,000 protective coveralls
Rwanda	90,000 face masks
Somalia	A shipment of medical equipment including ventilators
South Africa	10,000 N95 masks, personal protection gear, surgical masks, face shields, safety goggles, hand sanitizers and disinfectant tunnel
Sudan	1,236 packages including masks, protective suits and ventilators
Syria	Multiple batches of medical aid
Tunisia	500,000 masks, 100,000 testing kits, 50,000 sterilized gloves, 100,000 disposable gloves, 30 ventilators and an oxygen generator
Uganda	100 bicycles for transportation of health care workers

Sources: Abu-bashal (2020); Aydoğan Ağlarcı (2020); Thabeti (2021); Erdoğan and Boztepe (2021); Daily Sabah (2021); Isilow (2020a); Kamruzzam (2020); FE Online Report (2020); Turkish Cooperation and Cooperation Agency, (2020).
Note: This list of non-financial aid is not exhaustive.

The leading Southern countries provided a timely medical response. Besides China and India (the traditional providers), Bangladesh, Turkey and Saudi Arabia (the non-traditional providers) participated ardently. In addition to providing medical aid in terms of equipment and medicine, the Southern countries also engaged in health-related knowledge-sharing.

2.3. Health-related knowledge-sharing

Knowledge-sharing is not a new concept in the development cooperation scenario. However, the rapidly shifting global environment has made knowledge-sharing platforms more functional. Development partners, Governments, businesses and other institutional stakeholders seek to establish knowledge exchanges to enable them to face dynamic opportunities and challenges. While knowledge-sharing has historically been offered by industrialized countries to developing countries, it was clear that an effective pandemic response would require a change in the directionality of such exchanges. A few resource-poor countries, such as Viet Nam, provided strengthened national expertise in managing COVID-19 outbreaks without compromising the capacity of their health systems (Ekpenyong and Pacheco, 2020). Thus, the pandemic presented an ideal opportunity for countries in the Global South to incorporate their best practices into the global response strategy (Ebikeme, 2020).

The most common platforms for knowledge-sharing across borders during the pandemic were online platforms or hubs. These platforms were used for virtual conferences and symposia and to undertake surveys and research to inform about medical insights, first-hand national expertise and experiences, and the best practices to combat COVID-19. Medical experts around the world jointly tapped into online knowledge-sharing platforms such as Global MediXchange for Combating COVID-19 (GMCC)[17] and the COVID-19 Technology Access Pool (C-TAP).[18] C-TAP was endorsed by 40 Member States to facilitate the timely exchange of data, knowledge and intellectual property on COVID-19 and equitable access to medicines, vaccines and other health care products (WHO, 2020b). Unintentionally, almost all of the countries supporting this initiative are from the Global South. However, the initiative has so far failed to take off, despite the window of opportunity.

A number of countries from the Global South, such as China and Cuba, also deployed medical experts to support the fight against coronavirus.

A number of countries from the Global South, such as China and Cuba, also deployed medical experts to support the fight against coronavirus. For example, China sent medical teams of doctors to Bangladesh (mostly respiratory physicians), Laos, Malaysia and Myanmar (People's Republic of Bangladesh, Embassy of People's Republic of China, 2020a and 2020b; Fook, 2020; The Straits Times, 2020). Venezuela was sent a medical mission of eight Chinese specialists and Zimbabwe also received 12 medical experts from China (Myers and Barrios, 2020; CGTN, 2020a). Moreover, nearly 150 medical workers were sent from China to 11 African countries where 46 of China's medical teams were already stationed (Xinhua, 2020i). Cuba sent doctors to at least 40 countries, including Italy and Andorra (Reuters, 2020a).[19] India also sent medical teams to Kuwait, Maldives, Saudi Arabia and the United Arab Emirates (Chaudhury, 2020b). These expert medical teams shared their expertise and experience to help fight COVID-19.

While knowledge-sharing was actively under way, health-related capacity-building between the Southern countries was missing (Bowsher *et al.*, 2019). More could have been done in terms of telemedicine and medical training among the Southern nations, and there is a need for greater commitment and investment towards emergency preparedness.

2.4. Wrap-up observations

At the outset of the pandemic, medicines were supplied through development partnerships and international cooperation. Indeed, the Global South responded at speed to emergency medical needs. Bilateral support dominated in terms of medicine- and medical-equipment-sharing. Major economies such as China and India actively promoted bilateral collaborative initiatives in health. China's response was more extensive, with its medical supplies reaching over 100 countries globally (CGTN, 2020a). Moreover, non-traditional providers such as Bangladesh and emerging providers such as Saudi Arabia and Turkey did all they could to contribute during the pandemic. Knowledge-sharing hubs played their part in disseminating national-level experiences to fight the pandemic, but more needs to be done. The medical assistance was further complemented by vaccine support, which is discussed in the following section.

[17] Established by the Jack Ma Foundation and the Alibaba Foundation in March 2020 as an online knowledge-sharing platform to fight coronavirus (Li, 2020).

[18] This technology platform was launched by WHO in partnership with Costa Rica in May 2020.

[19] Cuba has practised medical internationalism for decades (Beutel, 2020). Italy was the first country to receive doctors (52 in total) from Cuba to fight the pandemic (Pérez, 2020).

3. COVID-19 vaccine support under South-South cooperation

The emergency medical response helped Southern countries' health sectors to temporarily withstand the pandemic. With horrific global health and economic fallouts, vaccines were developed in record time to try to slow down the spread of the virus.[20] China, India, Russia and the United States of America threw themselves into a race to be the first to ensure the protection of their citizens. The multinational pharmaceutical industry and national government collaborations invested tens of billions of dollars in the global vaccine development drive. Finally, in December 2020, the Pfizer-BioNTech vaccine was approved by the United Kingdom's Medicines and Healthcare products Regulatory Agency (MHRA). Other countries followed suit and by the beginning of 2021, China, India, Russia and the United States of America were mass-vaccinating their citizens and providing vaccines to other countries. However, vaccine inequality loomed over the success of mass immunization.

In Africa, only one in approximately every 10 people were vaccinated in the first quarter of 2021.

Vaccine patents registered by the Western pharmaceutical corporations meant the lower-income developing countries of the South had limited access to vaccines (Dearden, 2021). For example, in Africa, only one in approximately every 10 people were vaccinated in the first quarter of 2021 (Bhutto, 2021).[21] In fact, by the end of the year, the state of vaccination was far from the World Health Organization's (WHO) target in almost 50 out of the 54 countries in Africa (Dhaliwal and Patterson, 2022).

Table 3.1 indicates how vaccine nationalism resulted in inequality in access to vaccines. Compared to the United States of America and the EU which had the capacity to vaccinate their entire population at least twice, the African Union (AU) would have only been able to vaccinate less than a fifth of its population with the doses it acquired (Table 3.1). The OECD highlighted the global economic loss of US$9.2 trillion due to developing economies being left behind by vaccine roll-out (Lock, 2021). This strengthened China and India's advocacy for vaccine diplomacy, with these two countries yet again proving to be the Asian drivers of development cooperation through vaccine-sharing.

Nationalism resulted in inequality in access to vaccines.

Table 3.1. *Vaccine procurement data of selected countries*

	Bangladesh	Pakistan	AU	India	Sri Lanka	United States of America	EU
COVID cases per million	5,084	4,279	3,805	21,522	10,773	101,203	73,173
Total vaccination doses acquired (million)	33	32.2	270	1,130.5	38.6	1,210	2,885

[20] Prior to COVID-19 vaccines, the fastest-ever vaccine had taken four years to develop (McKeever and National Geographic, 2021).

[21] By mid-March 2021, only 300 million doses had been administered to the 1.3 billion people in the whole of Africa (Bhutto, 2021).

	Bangladesh	Pakistan	AU	India	Sri Lanka	United States of America	EU
% of population that can be vaccinated	10.1	12.4	18.0	41.4	86.1	200	344.7
Additional doses under negotiation	44	21	480	540	5	1,300	1,500
Additional % of population that can be vaccinated	13.5	4.9	24.3	19.8	11.5	216.9	167.6

Source: SDGs Today (as at 10 September 2021), see https://sdgstoday.org/dataset/covid-19-vaccine-procurement.

3.1. Bilateral vaccine supply

In a context in which vaccine nationalism had delayed low-income countries' procurement of doses and access to immunization, China and India were able to lessen the predicament of vaccine accessibility. China had pledged to provide its vaccine as a 'global public good' (Blablová, 2021). The country outsourced its vaccine production to augment its production capacity, with Brazil and Indonesia manufacturing Sinovac, and Serbia and the United Arab Emirates manufacturing Sinopharm (Blablová, 2021).[22] Similarly, as the largest vaccine-producing country globally, India had provided 66.4 million doses to almost 95 countries before it was hit by the second wave of coronavirus cases in March 2021 (India, Ministry of External Affairs, 2021). After this setback, the Serum Institute of India ramped up its production of the Oxford-AstraZeneca vaccine to 300 million doses per month (Pasricha, 2021).

China and India were the dominant providers of vaccine support in the Global South and the vaccines were supplied either as gifts or through sales.

China and India were the dominant providers of vaccine support in the Global South and the vaccines were supplied either as gifts or through sales. China focused on four geographical regions: Asia-Pacific, Latin America, Africa and Europe.[23] The Asia-Pacific region (793 million) was the number one purchaser of the vaccine produced by China, followed by Latin America (388 million) (Bridge, 2021). In terms of gifts, the Asia-Pacific region took the lead once again with 73 million vaccines received, compared to 19 million in the African region (Bridge, 2021). China's COVID-19 vaccines reached 46 African countries, albeit in small quantities. On the other hand, Asia received 50 million vaccines in the form of gifts (Bridge, 2021).

Table 3.2. *Top 10 countries that purchased vaccines from China or received vaccines as gifts from China (as at November 2021)*

Country	Vaccines sold (millions)	Country	Vaccines gifted (millions)
Indonesia	215	Cambodia	9
Pakistan	106	Nepal	8
Turkey	100	Myanmar	6
Brazil	100	Viet Nam	6
Iran	98	Bangladesh	5
Bangladesh	75	Lao People's Democratic Republic	5
Mexico	67	Sri Lanka	5
Chile	61	Philippines	5

[22] Bahrain and the United Arab Emirates were the first countries to approve China's vaccine for administration to its citizens (Blablová, 2021).

[23] By November 2021, China had delivered 1 billion vaccine doses (in sales and gifts) worldwide (697 million to Asia-Pacific, 251 million to Latin America and 89 million to Africa) (Bridge, 2021). The country highlighted that it had distributed almost 2 billion vaccine doses globally (World Trade Organization, WTO, 2022).

Country	Vaccines sold (millions)	Country	Vaccines gifted (millions)
Peru	48	Pakistan	3
Philippines	48	Afghanistan	3
Total	**918**	**Total**	**55**

Source: Bridge (2021), see https://bridgebeijing.com/our-publications/our-publications-1/china-covid-19-vaccines-tracker/#Methodology.

India's vaccine aid also merits attention. Staying true to its Neighbourhood First Policy, the country's largest vaccine assistance in the form of gifts went to Bangladesh (3.3 million), Myanmar (1.7 million), Nepal (1.1 million), Bhutan (0.55 million), Afghanistan (0.5 million) and Sri Lanka (0.5 million) (Ghosh, 2021; India, Ministry of External Affairs, 2021). Vaccines were provided to Latin America and the Middle East, but the African continent remained the main focus for India. African countries received about 1.25 million vaccine doses from India out of the planned 10 million doses (India, Ministry of External Affairs, 2021; Tiwari, 2021). By the end of May 2021, India had in total gifted 10.7 million vaccines and commercially sold 35.8 million vaccines (India, Ministry of External Affairs, 2021).

The COVID-19 Vaccines Global Access (COVAX) initiative was launched to take vaccine distribution to the next level.

In addition to bilateral vaccine aid, the COVID-19 Vaccines Global Access (COVAX) initiative was launched to take vaccine distribution to the next level. As the pandemic will not be over until the transmission rate falls for all the countries in the world, this initiative is working towards equitable global access to COVID-19 vaccines. The Southern countries' contribution to this initiative is discussed in the following subsection.

3.2. Contribution to the COVID-19 Vaccines Global Access initiative (COVAX)

COVAX is co-led by the World Health Organization (WHO), the Coalition for Epidemic Preparedness Innovations (CEPI) and Gavi, the Vaccine Alliance. Its delivery partner is the United Nations Children's Fund (UNICEF). Paving the way for sustainable recovery from the pandemic, the alliance is working with manufacturers and national Governments to provide large-scale rapid vaccine access to all of the world's economies. The initial goal was to provide 2 billion vaccine doses in 2021 worldwide and by 2022 to disburse 1.8 billion doses to 92 low- and lower-middle-income countries. Ghana received the first COVAX vaccines in February 2021, and since then, COVAX has shipped more than 300 million doses to 142 countries, including Bangladesh, Brazil and Fiji (BBC, 2021a). Wealthier countries such as Canada have also received vaccine doses from COVAX.

Countries came forward with monetary donations to COVAX as well as surplus vaccine doses from their national vaccine supplies.[24] Among the countries of the Global South, China and India largely contributed to COVAX. China pledged to contribute 10 million vaccine doses and US$100 million to the initiative (Reuters, 2021). Following through on this vaccine commitment, by November 2021 China had internationally delivered 67 percent of the doses promised (Hutt, 2021) and by May 2021, India had provided nearly 20 million vaccine doses to COVAX. After being hit by the second wave of COVID-19 in April 2021, the process slowed down, but the country resumed providing vaccines to COVAX within a few months.

Despite some delays, the COVAX facility has reached six continents with vaccine doses supplied by the manufacturers of AstraZeneca, Pfizer-BioNTech and the Serum Institute of India (SII) (WHO, 2021b). However, it may fall short of its plan to vaccinate at least 70 percent of the population of all countries (WHO, 2021c). The global picture of COVID-19 vaccine access is in a sorry state. While in high- and upper-middle-income countries, 80 percent of the population had received at least one vaccine dose by September 2021, the figure was only 20 percent for the remaining countries (UN News, 2021).

[24] Germany, Russia and the United States of America have contributed doses to COVAX. However, shortfalls are anticipated due to disruption to supply chains and international freight (BBC, 2021).

Box 3.1. *Indo-Bangla vaccine cooperation*

The Serum Institute of India (SII) started exporting Oxford-AstraZeneca's Vaxzevria vaccine (named locally as Covishield) just weeks after the country began its mass vaccination campaign. While this was an act of generosity, it also ensured that the vaccines in stock did not exceed their six months lifespan, after which they expire (Som, 2021).

Bangladesh was on the priority list of countries that would receive vaccines from India. Beximco Pharmaceuticals Ltd of Bangladesh signed a deal in November 2020 to buy 30 million doses from SII (Pharmaceutical Technology, 2020). The agreement was between the Government of Bangladesh, Beximco Pharmaceuticals Ltd and SII. Under the deal, SII was supposed to supply 5 million doses per month until June 2021 at a price of US$4–5 per dose (Pharmaceutical Technology, 2020). SII bore the transportation cost of the vaccines (Al Jazeera, 2021). Beximco paid for 15 million doses in advance, which was initially made as an investment to ensure the country was among the first few to receive the vaccine developed by SII (Paul, 2020; Tayeb, 2021).

However, when cases began to rise due to the second wave of COVID-19, India struggled to vaccinate domestically. The country therefore temporarily halted vaccine export to Bangladesh in April 2021 (BBC News, 2021). The second consignment of 5 million doses was not fulfilled; instead only 2 million doses were received (Tayeb, 2021). Bangladesh was faced with a vaccine shortage, putting a second dose of the AstraZeneca vaccine in doubt for a huge number of people. The country was compelled to source vaccines from Russia and China (Tayeb, 2021). Luckily the shortage of doses was met through the COVAX programme (The Daily Star, 2021). After an interval of more than six months, India resumed its export of vaccines, with one of the first recipients being Bangladesh (TBS Report, 2021).

Box table 3.1. *India's supply of vaccines to Bangladesh*

	Doses (in millions)	Date of dispatch
Gift	3.3	2 million in January 2021
		1.2 million in March 2021
		0.1 million in April 2021
Sale	15	5 million in January 2021
		2 million in February 2021
		1 million in October 2021
		4.5 million in December 2021
		2.5 million in December 2021
COVAX	4.3	0.2 million in December 2021
		3.3 million in December 2021
		0.8 million in December 2021
Total	**22.6 million**	

Source: India, Ministry of External Affairs (as at January 2022).

However, a few issues emerged from this tripartite agreement:

Breach of contract: India banned the export of its vaccine in March 2021, straight after SII had delivered 7 million doses to Bangladesh. Despite resuming export in October 2021, SII is yet to deliver the 30 million doses agreed. By December 2021, Bangladesh had received only 15 million doses (India, Ministry of External Affairs, 2021).

Price: The first 100 million doses of vaccine produced by SII were sold to the Government of India at approximately US$2.7 per dose (Sharma, 2021). From May 2021 onwards, the Government was charged US$5.4 and private hospitals had to pay US$8 for per dose (Koshy, 2021). Though Bangladesh had agreed a lower price, the price of Covishield was still higher than the EU's average price, which ranged from US$2.14 to US$3.5 per dose (Raghavan and Sasi, 2021).

On the other hand, SII planned to halve its production in December 2021 due to having received no new orders (BBC News, 2021). Given that the tripartite agreement has not been fulfilled and COVID-19 cases were rising prior to the third wave, future developments cannot be commented on as yet.

Box 3.2. *Cuba's vaccine advances: Global South's beacon of hope*

Cuba was the only Latin American country to have developed COVID-19 vaccines, through its Finlay Vaccine Institute and other state-run biotechnology centres (Reardon, 2021). The country developed five vaccines, including Abdala, Soberana 2 and Soberana Plus (the most promising ones). This effort was much needed in Cuba, especially considering the United States of America embargo. The vaccines were approved by the Cuban regulators and were rolled out domestically, starting May 2021 (Meredith, 2022). By November 2021, almost 90 percent of the country's population had received at least one dose of Abdala or Soberna 2, with more than 80 percent deemed fully vaccinated (Reardon, 2021). Cuba was also the first country to vaccinate toddlers from the age of two against COVID-19 (The Week, 2021). This remarkable feat came as a ray of hope for the Global South.

Despite not having been approved by WHO, Venezuela administered Abdala vaccines that it received as a gift in June 2021. In Iran, emergency administration of the Soberana 2 vaccine was approved in July, following phase III clinical trials run at the beginning of 2021 (Taylor, 2021). The country even secured a deal for industrial-scale production (Iran International, 2021). Nicaragua had also given emergency approval to the Abdala and Soberana 2 vaccines, whereas Mexico approved only the three-dose Abdala vaccine (Zamora, 2021; The Associated Press, 2021). Moreover, Viet Nam signed a deal to purchase 10 million doses of Cuban COVID-19 vaccines (Strangio, 2021). Several other countries, including Argentina and Jamaica, registered interest in buying vaccines from Cuba.

Cuba—which has a prestigious biotechnology sector catering to most of its domestic demand for medicines and vaccines—claims that its homegrown vaccines are more than 90 percent effective (Meredith, 2022). Unlike other countries and giant pharmaceutical companies, Cuba offered to transfer its vaccine-related technology and production expertise to low-income nations (Meredith, 2022). Moreover, its vaccine production process is said to be more straightforward and cheaper and as the country's vaccines do not require sub-zero temperatures, the transportation process is simpler (Meredith, 2022).

However, very limited reports of the trials were made available to the public, giving rise to concerns about the efficacy and safety of the vaccines. The Pan American Health Organization (PAHO) urged the Cuban Government to make the vaccine particulars public in scientific journals (Taylor, 2021). Cuba submitted its vaccines (Soberana 1, Soberana 2, Soberana Plus and Abdala) to WHO for regulatory approval, which is a requisite for inclusion in the COVAX initiative (Taylor, 2021). The status of the vaccines was still listed as "awaiting information on strategy and timelines for submission" on WHO's official website in December 2021 (WHO, 2021d). In terms of the Cuban Government's commitment towards vaccine internationalism, it declared that a "lifesaving package'' of 200 million doses would be distributed among the low-income countries in the Global South (Sweeney, 2022). The Government pledged solidarity prices, technology transfer, and the extension of medical bridges for training and building medical capacity for vaccine distribution (Progressive International, 2022).

This is not only good news for the Global South but also signifies a new international health order that is moving away from the profit-making pharmaceutical monopolies (Achmat, 2022).

3.3. Vaccine-related knowledge-sharing

Vaccine-related knowledge-sharing has been a sore topic. It goes without saying that vaccine inequity resulted not only from rich nations hoarding doses but also from the constant rebuttal of the biopharmaceutical companies to share their vaccine recipes. Countries came forward to help ease this predicament. For example, India and South Africa jointly called for a Trade-Related Intellectual Property Rights (TRIPS) waiver in October 2020 (All European Academies, 2021). However, the leading producers of the Moderna[25] and Pfizer COVID-19 vaccines seem to be reluctant to share any knowledge (All European Academies, 2021).

Pharmaceutical companies such as Bio-Manguinhos in Brazil, the Biovac Institute in South Africa, Bio Farma in Indonesia, Aspen Pharmacare in South Africa, and many others are only delegated to bottle vaccines, despite most of them having WHO prequalification and the capacity to produce the Messenger RNA (mRNA) vaccines (Nolen, 2021). Removing these bottlenecks is therefore necessary for mass production of vaccines, without which the war against this pandemic cannot be won.

3.4. Wrap-up observations

The global solidarity displayed during the COVID-19 pandemic through the medical response gave hope to developing countries with gaps in their health and economic systems. In particular, China and India played an extraordinary role in prompt bilateral response. Additionally, the comradery seen among other countries of the Global South motivated others to come together. The bilateral vaccine drive was highly beneficial for countries, especially in Africa, since they remain highly dependent on foreign aid. However, the poorest countries may need to wait until 2023 to receive adequate access to the vaccines (Padma, 2021).

The vaccine patent waiver proposal put forth by India and South Africa to the World Trade Organization (WTO) may not be the silver bullet that ends the vaccine predicament.

In order to ensure vaccine equity, leading manufacturers of the COVID-19 vaccines need to facilitate partnerships with potential producers in collaboration with international bodies such as WHO (by sharing vaccine formulae, for example). However, the vaccine patent waiver proposal put forth by India and South Africa to the World Trade Organization (WTO) may not be the silver bullet that ends the vaccine predicament. This is because the entire value chain itself may continue to face scarcity of raw materials, restricted infrastructural arrangement and limited technical know-how required for vaccine production.

[25] Previously, Moderna confidentially transferred technology to a Swiss-based company named Lonza when it needed added capacity for manufacturing vaccines (Kavanagh, Gostin and Sunder, 2021).

4. Financial support from the Global South during the COVID-19 pandemic

Prior to the pandemic, the Southern countries' dependency on foreign aid had been decreasing.[26] Domestic resources, foreign direct investment (FDI), trade, commercial loans and remittances were emerging as more reliable sources of development finance. However, the pandemic increased the need for foreign assistance in developing countries. A few pre-existing trends intensified, such as a focus on debt relief, humanitarian assistance and financing global public goods, while new financial support measures were also put in place.

In this regard, this section discusses the South–South flow of finance during the pandemic, exploring the financial support of bilateral (Southern and regional providers) and multilateral providers (financial institutions such as AIIB). Regional cooperation entities have also taken steps to collectively contribute via specific COVID-19 programmes. Conventional financial support instruments such as rapid credit facilities as well as new instruments such as currency swaps have been disarmed. Some of the new support lines existed before COVID-19 (for example, currency swaps between the Reserve Bank of India and SAARC countries), while some were initiated by the non-traditional Southern providers during COVID-19 (for example, currency swap agreement between Bangladesh and Sri Lanka).

4.1. Bilateral financial support

Bilateral aid commitments from traditional donors fell by 40 percent in 2020 compared to the previous year and ODA commitments alone fell by 26 percent (Development Initiatives, 2020). The United Kingdom even pre-announced that it would cut its aid spending by 10 percent (Brown, 2021). Thus, the bilateral response of Southern countries in terms of financing COVID-19 fallouts will be analysed next to see how it motivated recovery and strengthened cooperation. Amid falling aid from the Development Assistance Committee (DAC) countries, it is interesting to see how conventional forms (grants, loans and debt servicing) and unconventional lines of financial aid were extended and utilized by Southern bilateral donors (such as China).

China played the leading role as a bilateral provider in the Global South.

In Africa alone, US$280 million in aid and support were extended by China.

China's role. China played the leading role as a bilateral provider in the Global South. In addition to its prominent role in supplying medical aid and vaccines worldwide, the country announced US$3 billion in international assistance to help support the global COVID-19 response in developing countries (ul Khaliq, 2021). In Africa alone, US$280 million in aid and support were extended by China (Alcázar *et al.*, 2021). Afghanistan received a total amount of US$31 million as emergency aid (including food aid and vaccines) from China (BBC, 2021b), while Sri Lanka received US$90 million in grants and China pledged an additional US$270 million in aid for Cambodia (The Economic Times, 2020; Thul, 2021). Pakistan was among the other Southern countries that were provided with grant assistance (US$4 million) from China to counter the COVID-19 crisis (The International News, 2020). Moreover, under the Group of Twenty's (G20's) Debt Service Suspension Initiative (DSSI)

for the poorest countries, China suspended over US$1.35 billion worth of debt service payments (CGTN, 2020b). Accounting for 20 percent of external debt, it is now the largest bilateral creditor on the continent (Deutsche Welle, 2020).

Due to strains on their foreign reserves caused by the pandemic, many countries opted for currency swaps.

Currency swap. Due to strains on their foreign reserves caused by the pandemic, many countries opted for currency swaps. For instance, Sri Lanka was heavily involved in currency swap deals during the COVID-19 pandemic,[26] as the country's exports, worker remittances and tourism industry were badly affected. It entered into a US$400 million currency swap with the Reserve Bank of India (Chaudhury, 2020c) and a US$250 million currency swap with Bangladesh Bank (Byron and Jahid, 2021). India also extended a US$150 million currency swap to Maldives in an attempt to help mitigate the COVID-19 impact (Press Trust of India, 2020).

It should be noted that the bilateral initiatives taken towards non-financial assistance were more visible than the financial response, and regional initiatives had to step up even more.

Box 4.1. *Maldives and Sri Lanka seek loan from Bangladesh*

Sri Lanka's depleting foreign reserves had been threatening the country's ability to service debt or even import goods (Ondaatjie, 2021), as the country's import cover was below the desired minimum and the maturing debt of 2022 was beyond its ability to service debt. The pandemic caused a sharp drop in the earnings from tourism and export. Amid the deteriorating economic position of Sri Lanka, Bangladesh Bank and the Central Bank of Sri Lanka (CBSL) signed a currency swap agreement in August 2021 which had been set in motion in March 2021 when the Prime Minister of Sri Lanka visited Bangladesh (Islam, 2021).

Initially, the agreed amount for the swap was US$200 million, which at a later date increased to US$250 million (Byron and Jahid, 2021). This was the first ever loan provided by Bangladesh to any country (Byron and Jahid, 2021). The currency swap is believed to have strengthened economic and financial cooperation between these two SAARC members (CBSL, 2021) and will be cheaper for Sri Lanka than borrowing from the market (Journals of India, 2021).

Box table 4.1. *Bangladesh–Sri Lanka currency swap agreement at a glance*

1st tranche: US$50 million (19 August 2021)
2nd tranche: US$100 million (30 August 2021)
3rd tranche: US$50 million (21 September 2021)
Repayment period: 3–9 months
London Interbank Offered Rate (LIBOR) interest rate + 2 percent
(if tenure crosses six months, LIBOR interest rate + 2.5 percent will be charged)

Source: Byron and Jahid (2021).

Once the first three-month tenure had expired, Bangladesh Bank extended it by another three months (New Age, 2021). It is expected that Sri Lanka will need at least nine months to repay the loan. Since 1983, no default events had been recorded by Sri Lanka until the COVID-19 pandemic hit its economy (New Age, 2021). Sri Lanka has been regularly servicing its interest to Bangladesh against the loan taken, despite the crisis worsening (Alo, 2021). As the tenure is approaching its deadline, only time will tell if the agreement will generate the intended benefits.

Bangladesh's emergence as a helper nation continued when Bangladesh and Maldives' bilateral relations took a new turn when Bangladesh decided to extend a US$200 million loan to the country in December 2021. A huge number of Bangladeshi nationals reside in Maldives, giving the countries a strong incentive for cooperation (Mostafa, 2022). At the end of 2021, an official proposal was yet to be made and the modality of the loan was yet to be decided. However, Bangladesh Bank was said to be positive about going through with the deal (Alo, 2021).

[26] Over US$3.7 billion of foreign debt will mature in 2021, whereas Sri Lanka's reserve stood at only US$4 billion (Byron and Jahid, 2021).

4.2. Regional initiatives

Regional entities that were established years before the COVID-19 pandemic funded multiple projects in response to the crisis.

Regional financial support expanded. Regional entities that were established years before the COVID-19 pandemic funded multiple projects in response to the crisis. For instance, SAARC (which was established in the 1980s) took initiatives to fund financial aid among its member countries. This included the COVID-19 Emergency Response Fund created by SAARC members, who pledged to collectively provide a total of US$22 million (SAARC Disaster Management Centre, 2021). After a strong start, the fund allocations have slowed down and information on disbursements is not widely available. The African Union COVID-19 Response Fund was created to fundraise US$300 million to undertake pandemic response (African Union, 2020).

Similarly, COVID-19 response funds (such as the COVID-19 ASEAN Response Fund) were created by regional associations to help mitigate and curb the pandemic. Moreover, the BRICS'[27] NDB agreed to allocate US$15 billion among its member countries for pandemic recovery (Laskar, 2020a). Meanwhile, regional economic communities such as the Southern African Development Community (SADC) established funds for their member states to support essential resource mobilization during the pandemic (SADC, 2021).[28]

Financial support to the Southern countries came through multilateral channels as well. The Southern financial institutions that contributed to the pandemic response are discussed next.

4.3. Flow from Southern financial institutions

The Southern financial institutions are the regional development banks that are committed to providing financial assistance to low- and middle-income countries in their regions. Before the pandemic, the regional banks' investments were directed towards sectors such as infrastructure, energy and transport, but their post-pandemic investments shifted to the social sector. Institutions such as AIIB, African Development Bank (AfDB), the Development Bank of Latin America (CAF in Spanish), IsDB and NDB[29] undertook recovery efforts that helped countries safeguard vulnerable citizens by rapidly pumping liquidity into these economies.

Asian Infrastructure Investment Bank (AIIB). In April 2020, AIIB created a COVID-19 Crisis Recovery Facility for its members and clients. The facility would extend US$13 billion (between April 2020 and April 2022) to both private and public sector entities impacted by the pandemic and in urgent need of liquidity (AIIB, n.d.a).[30] The facility largely approved loans to countries in the Asia-Pacific region in 2020 and 2021. Sovereign-backed loans were provided to central banks, which were occasionally co-financed with the Asian Development Bank (ADB) or the World Bank. The non-sovereign-backed projects were also financed during this time.

[27] The five emerging economies cooperating are Brazil, Russia, India, China and South Africa.
[28] The disbursement figures for regional economic communities could not be readily located.
[29] Other Southern banks (such as the Central American Bank for Economic Integration (CABEI), the Caribbean Development Bank (CDB) and the Trade and Development Bank (TDB) in Africa) also showed their commitment to providing relief during the crucial times.
[30] The facility was increased from an initial US$5–10 million. The duration of the facility staying in operation was also extended from October 2021 to April 2022 (AIIB, n.d.a).

Table 4.1. *AIIB's financial response since the outbreak of COVID-19*

Year	Country	Sector	Amount (US$ million)
2021	Philippines	Vaccine	300
	China	Vaccine	10
	Bangladesh	General	150
	Azerbaijan	General	100
	Indonesia	Health	500
	Rwanda	General	100
	Mongolia	Health	21
	Turkey	General	250
	Sri Lanka	General	180
Total			**1,611**
2020	Cambodia	General	60
	Cook Islands	General	20
	Ecuador	General	50
	Russian	General	300
	Turkey	Health	82.6
	Bangladesh	Health	100
	Uzbekistan	Health	100
	Kyrgyzstan	General	50
	Fiji	General	50
	Pakistan	General	250
	Georgia	General	50
	Viet Nam	General	100
	Kazakhstan	General	750
	Turkey	General	500
	Maldives	Health	7.3[31]
	Indonesia	General	1,000[32]
	Mongolia	General	100
	Pakistan	General	500
	India	General	750
	Philippines	General	750
	Georgia	General	100
	China	Health	355
	China	Health	1[33]
Total			**6,025.9**

Sources: AIIB (n.d.b) and AIIB (n.d.c).

African Development Bank (AfDB). The bank's emergency response to assist African countries during the pandemic started in March 2020, when it raised US$3 billion in the Fight COVID-19 Social bond (AfDB, 2020a). Next, it provided emergency assistance amounting to US$2 million to WHO for its member countries. Moreover, a COVID-19 Response Facility was announced in April 2020 to provide US$10 billion in targeted support to sovereign and non-sovereign (private sector) operations. This included US$5.5 billion for sovereign operation in AfDB countries, US$3.1 billion for sovereign and regional operations in countries under the African Development Fund and US$1.5

[31] Co-financed with the World Bank.
[32] Co-financed with the ADB and the World Bank: US$750 and US$250 million respectively.
[33] Donated.

billion for non-sovereign activities in all African countries (AfDB, 2020b). By June 2020, COVID-19 emergency packages had been delivered to five regions of the continent (Table 4.2) (AfDB, 2020a).

Table 4.2. *AfDB COVID-19 emergency fund for five African regions*

Region	Country	Amount (US$ million)
Central Africa	Central African Republic, Chad and Congo	13.5
East Africa	Kenya	217.7
North Africa	Egypt	0.5
	Morocco	305.7
	Tunisia	208.5
Southern Africa	Mauritius	217.7
	Zimbabwe	13.7
West Africa	Cabo Verde	34.7
	Côte d'Ivoire	86.9
	Gambia, Mali and Niger	22
	Nigeria	288.5
	Senegal	102
Total		1,511.4

Source: Congo Basin Forest Partnership (2020).

Corporación Andina de Fomento (CAF). The Development Bank of Latin America approved more than US$14 billion in loans to countries to address health care and the economic emergency resulting from the pandemic (CAF, 2021). The bank also opened a regional US$2.5 billion line of credit to support member countries' economic measures taken towards fighting COVID-19 (Reuters, 2020b). The bank signed two loans with Trinidad and Tobago amounting to US$15 million, which were preceded by US$0.4 million in aid (CAF, 2020). Argentina borrowed US$75 million from CAF for COVID-19 vaccine procurement and development (Latin Finance, 2021).

Islamic Development Bank (IsDB). Adopting a 3-R approach,[34] the IsDB Group Strategic Preparedness and Response Programme for the COVID-19 Pandemic approved US$2.3 billion[35] for its 54 members (United Nations, 2020). The bank was at the forefront of the response in 2020, providing finance for economic resilience and public health mainly in the African region. The institution was, however, relatively inactive in 2021 (Table 4.3).

Table 4.3. *IsDB's loan approvals in 2020*

Country	Sector	Amount (US$ million)
Yemen	Health	36.6
Benin	General	131
Cameroon	Health	30.5
Morocco	General	462.2
Bangladesh	General	235.5
Djibouti	General	5
Egypt	General	126
Tajikistan	Health	9.13
Burkina Faso	General	11
Jordan	General	10.5

[34] The 3 Rs are Respond, Restore and Restart.
[35] Initially, US$730 million was approved (Segal, 2020).

Country	Sector	Amount (US$ million)
Libya	General	62.5
Mozambique	General	28.3
Palestine	General	35.7
Benin	Health	20
Chad	General	20
Côte d'Ivoire	Health	46.2
Guinea-Bissau	Health	15
Maldives	General	25.6
Mali	General	22.5
Sierra Leone	Health	25
Turkey	General	250
Uganda	General	20.2
Mauritania	General	33
Sudan	Health	35
Tunisia	General	279
Uzbekistan	General	143
Guinea	Health	20
Senegal	General	162

Source: Segal (2020).

New Development Bank (NDB): This BRICS-established bank was the first multilateral institution to initiate a COVID-19 loan facility. It committed US$10 billion as a COVID-19 Emergency Assistance Loan and a COVID-19 Economic Recovery Loan. The first loan of US$1 billion was provided to China in March 2020 and by the end of the year, emergency loans totalling US$7 billion had been approved to NDB member countries (Brazil, China, India and South Africa) (New Development Bank, 2020).[36] As at 2021, US$9 billion in loans have been approved (Table 4.4) (New Development Bank, 2020).

Table 4.4. *NDB's COVID-19 Emergency Program Loan to member countries*

Month, year	Country	Amount (US$ billion)	Sector
March 2020	China	1	Emergency assistance
April 2020	India	1	Emergency assistance
June 2020	South Africa	1	Emergency assistance
June 2020	South Africa	1	Economic recovery
July 2020	Brazil	1	Emergency assistance
December 2020	Brazil	1	Economic recovery
December 2020	India	1	Economic recovery
February 2021	China	1	Emergency assistance
March 2021	Russia	1	For front-line health workers

Source: NDB (n.d.).

[36] Brazil (US$2 billon), China (US$1 billion), India (US$1 billion) and South Africa (US$1 billion) (NDB, 2020).

4.4. Wrap-up observations

When COVID-19 struck the world, the Southern multilateral banks rose to the occasion by playing a timely role in immediate crisis response. The regional development banks of the Global South committed to providing hefty amounts of financial support in the region. Each had its own peculiarities (for instance, NDB provided loans to only its members, ADB's financial support was concentrated only regionally and IsDB's engagement was only for the year 2020). Emergency response and recovery funds were created to facilitate loans and investments in order to address economic sectors impacted by the pandemic. In terms of bilateral support, both conventional and unconventional lines of financial aid were utilized when emerging providers (such as Bangladesh) got involved. However, the Southern countries were comparatively less active regionally than bilaterally.

5. Implications of South-South cooperation during the pandemic

COVID-19 brought to the fore, once again, the benefits of global development cooperation and SSC in particular. The urgency of the situation demanded that support measures be fast-tracked. These measures involved bilateral, triangular and multilateral processes. This section tries to tease out the experiences gathered during the pandemic and reflect on their implications for the multilateral development system, for the Global Partnership for Effective Development Cooperation (GPEDC) and for the Global South. It also attempts to identify lessons for the Southern recipient countries to learn in this regard.

5.1. Implications for the global multilateral system

New financial institutions have changed the centrality of the traditional system.

The growing presence of new financial institutions from the Global South (such as AIIB and NDB) will be difficult for the traditional multilateral institutions (which include the IMF and the World Bank) to ignore in the post-pandemic context. These new financial institutions have changed the centrality of the traditional system, while sizeable foreign reserve accumulation in the Global South has reduced the region's dependency on multilateral institutions.[37] While SSC stepped up to finance many of the region's needs, the multilateral system experienced competitive pressure. However, the emerging countries will require support from the international financial institutions in the near future to overcome their challenges of structural and institutional fragmentation. Areas requiring reform include the retention of financial resources in the countries.

One of the consequences of new financial institutions from the Global South is the redistribution of quota in the favour of Southern countries. The IMF made reforms to protect its poorest members by realigning their quota and voting shares, but countries such as India are still lobbying to increase their voting shares (IMF, 2021a; Roy, 2021). Collectively, the Global South has a 59 percent share of the total distribution of quota among the 190 member countries of the IMF (IMF, 2021b). Moreover, the IMF member countries of the South account for 60 percent of the total share of voting power (IMF, 2021b). The COVID-19 response of the Southern providers may further strengthen their case for increased voting shares in the IMF and similar organizations.

A greater presence of the Southern countries may bring new instruments into play, which may divert dependency away from traditional providers, nurture healthy competition and foster more informed modalities and policies of problem-solving.

The emerging regional banks (such as the BRICS-established NDB) may decentralize development financing and deepen the architecture of international finance by both integrating and competing with the traditional international financial institutions. This would likely result in more diversified channels of aid being utilized. A greater presence of the Southern countries may bring new instruments into play, which may divert dependency away from traditional providers, nurture healthy competition and foster more informed modalities and policies of problem-solving.

Further to the multilateral system, SSC would have implications on the development effectiveness agenda, which is discussed next.

[37] China and India were among the top five countries with the largest foreign reserve in August 2020 (TBS Report, 2020b).

5.2. Implications for the Global Partnership for Effective Development Cooperation

GPEDC uses a common framework to explore the synergies between traditional and new aid cooperation.

GPEDC was formed in 2012 by multiple stakeholders (Governments, civil society, parliament representatives, the private sector, bilateral and multilateral institutions and others) in an attempt to improve development cooperation practices by facilitating engagement, monitoring effectiveness, mainstreaming implementation and sharing knowledge among participants (OECD, 2021). The development experiences of the Global South, including China and other emerging economies in the region, led to the realization that the North-South paradigm needed to shift to include the new players. Against this backdrop, GPEDC uses a common framework to explore the synergies between traditional and new aid cooperation.

The pandemic has given GPEDC an additional reason to review and learn from the COVID-19 experiences of SSC. It is essential that recipient countries' perspectives are strengthened by recognizing their complementarities and diversities. In fact, a safe platform (i.e. one that avoids negotiation and competitive pressure) for exchanging COVID-related experiences is needed to ensure these learning experiences are adopted within the international development cooperation system. The messages that these COVID-19 experiences give to GPEDC's guiding principles of country ownership, result-oriented focus, inclusive partnership and transparency and mutual accountability need to be considered as well, taking into account the sources of finance beyond ODA (GPEDC, n.d.). All these principles were observed in SSC to a certain level during the pandemic, but they were all top-down. Given the urgency of the situation, SSC was undertaken mostly at the national level and did not include multiple stakeholders.[38] The Southern countries displayed inclusive partnership on numerous instances, from providing medical assistance to supplying vaccines even when there were shortages. China outsourced the production of its vaccines to Serbia and the United Arab Emirates (Blablová, 2021). However, the Southern countries may have lagged in meeting the transparency principle, which can be overcome.[39]

With numerous SSC providers' (such as Colombia, Turkey, South Africa) progressive engagement towards an aid effectiveness agenda, movement from aid to development has become the new norm.

With numerous SSC providers' (such as Colombia, Turkey, South Africa) progressive engagement towards an aid effectiveness agenda, movement from aid to development has become the new norm (Besharati, 2019; United Nations Development Programme, 2020). Therefore, the effectiveness principles of GPEDC need to take on board the SSC experiences of the pandemic in order to facilitate synergies in the post-COVID-19 world.

5.3. Implication for the Global South

The impressive partnership of the Southern countries during the pandemic will have substantive implications in shaping relationships in the future. Since the start of the pandemic, the development cooperation of the Southern countries focused on human security (such as global health infrastructure and food security), moving away from its traditional focus on trade and investment. However, the pre-existing challenges of SSC remained and are essential issues for discussion. The gaps in SSC practice—such as the absence of accountable reporting mechanisms, a lack of coordination in national policy, and uneven mutual benefit within the developing countries—must now be addressed, guided by the recent developments (Nigam, 2015). Moreover, the countries involved in SSC are in some cases both providers and receivers of development cooperation, making it necessary to consider their dual role in development cooperation.

[38] The pandemic response was dominated by epidemiologists, politicians and virologists. Decision-making bodies rarely consulted other health and non-health stakeholders such as civil society organizations and community groups (Rajan *et al.*, 2020).

[39] The opacity of informed COVID-19 policy responses and action plans repeatedly came under scrutiny from the onset of the crisis (Tribune Desk, 2020).

The rise of the Global South has previously shown episodic trends: regional development cooperation tends to be active during a crisis, but becomes dormant afterwards (Peruffo and Prates, 2016).[40] Whether SSC will continue to assist the Southern countries during post-pandemic recovery remains debatable. Indeed, it needs to step up if it is to continue its growth trajectory. For example, SSC lacks an institutional framework and a coordinated delivery system, without which the accountability and effectiveness of the process remains difficult to assess (Nigam, 2015). Meanwhile, the lack of a central mechanism makes it difficult to predict flow of assistance (Besharati, 2019). Consequently, there is a lack of data. Therefore, a standardized template is necessary to assess the impact of the development cooperation activities (with a module on COVID-19) under the modalities of SSC. Full disclosure of activities needs to be integrated into the national and global data systems. This is necessary to assess the effectiveness of SSC and will help in forecasting needs and the gap towards the target of recovery.

The increased financial flows and favourable financing conditions during the pandemic may raise questions about the quality of the loans granted.

The increased financial flows and favourable financing conditions during the pandemic may raise questions about the quality of the loans granted. Moreover, debt sustainability issues in the post-pandemic period may take a toll on the global financial system. China, for instance, signed barter deals with a few countries whereby the loans are denominated in barrels of oil (Tan, 2020). If required production levels are not met by the respective borrowers, the build-up of debt could pose risks at the global level (Tan, 2020). Asset quality deterioration, reduced corporate lending, fall in financial yield and negative deposit rates are among the many risks that may persist in the longer term. Thus, the implications of SSC for the Southern countries need to be assessed thoroughly at the earliest opportunity.

The implications of the pandemic-related cooperation in the Global South will be crucial for the socio-economic recovery of the recipient nations, in the long term if not instantly. This is discussed next.

5.4. Implications for socio-economic recovery of the recipient countries

The pre-existing structural vulnerabilities of the Southern developing countries limit their recovery from economic fallouts. The magnitude of the COVID-19 socio-economic impact necessitated the responses discussed earlier. These experiences of cooperation during the crisis created opportunities for inclusive post-pandemic recovery.

Protracted support needs to continue. During the COVID-19 pandemic, there was a greater focus on the already distressed health sectors of developing countries. The timely provision of essential medical and health supplies included equipment for COVID-19 testing and vaccine doses, and access inequality of vaccines for recipient countries was minimized due to China and India's vaccine diplomacy. However, since vaccines hold the key to containing the pandemic, recovery will be constrained if industrialized countries continue to resist sharing their vaccine formulae.

Moreover, provision of fiscal resources via concessional finance and debt relief gave the Southern nations immediate back-up. It stabilized their financial systems, albeit temporarily (Rhyne and Duflos, 2020). However, better articulation of national requirements would be needed in the long term.

In order to improve the early warning system for transmissible diseases, a greater focus on health infrastructure is vital.

Nevertheless, there is a long road ahead. In order to improve the early warning system for transmissible diseases, a greater focus on health infrastructure is vital. This would require social protection response and health coverage on a global level. On the economic front, setting up of recovery funds, greater financial aids, and multidimensional capacity-building has not been far-reaching.

[40] However, the same is not true for the Latin American nations that regularly engage in bilateral and regional cooperation within their SSC frameworks (Ramírez, 2019).

5.5. Wrap-up observations

The support measures extended under SSC involved bilateral, regional and multilateral processes. However, logistical issues, information deficit and health-related uncertainty, among other things, made these cooperative exercises hazardous (United Nations Office for South-South Cooperation, 2021). However, in the process, the recipient countries enhanced their capacity. The responsiveness of SSC during critical times gave partnerships momentum and needs to be explored further. Thus, the implications of SSC during the COVID-19 pandemic will leave their mark. The SSC experiences during the pandemic helped in the socio-economic recovery of the recipient countries. The involvement of SSC is anticipated on a greater scale on the global platforms in the near future. A universal framework will benefit the global development cooperation front.

6. Conclusion and policy outlook

The pandemic has once again brought to the fore the strengths and challenges of the international development cooperation architecture, and SSC is no exception in this regard. As the impact of the pandemic was felt most acutely in the Global South, these countries tried to deploy all the possible instruments available to SSC to mitigate the negative fallouts. The countries of the Global South extended timely support to those in need, which included both medical and financial aid. While medical aid consisted of consignments of medicines and medical equipment in addition to vaccines, financial support was extended through grants, loans, debt servicing relaxation and currency swaps. In addition, sharing of knowledge and best practices via online platforms further strengthened the cooperation. The emergency pandemic response set the tone for strengthened SSC in the future.

Pandemic response

China, Cuba and India displayed great dynamism in providing vaccines to developing countries.

The analysis presented in the foregoing sections shows that the pandemic response in terms of medical aid was extended bilaterally by the established powers of the South, namely China and India. Emerging donors (such as Turkey) and newcomers (such as Bangladesh) actively participated as well. While industrialized countries were stockpiling the vaccines being rolled out, China, Cuba and India displayed great dynamism in providing vaccines to developing countries. Moreover, large contributions made to COVAX by China and India reflected their commitment towards Southern vaccine diplomacy. China and Cuba also offered to share their vaccine technology with the Southern countries.

Financial assistance from the Southern providers remained buoyant.

Along with support for the faltering health care systems in developing countries, financial assistance from the Southern providers remained buoyant. For example, bilateral financial assistance from China and regional associations such as SAARC aided pandemic-related resource mobilization. The Southern financial institutions such as AIIB also facilitated liquidity flows into developing economies, mostly via loan provisions and debt servicing deferment. Additionally, unconventional lines of cooperation such as currency swaps (between Bangladesh and Sri Lanka, for example) were witnessed. Such laudable partnerships among Southern countries helped cushion the pandemic-induced financial shocks.

While medical and vaccine support dominated bilateral cooperation, technology-sharing and patent waivers received less attention.

While medical and vaccine support dominated bilateral cooperation, technology-sharing and patent waivers received less attention. Moreover, emergency financial assistance was essentially sourced bilaterally from Southern institutions, but the regional pandemic response funds were less functional.

Emergency lending and suspension of temporary debt servicing by both the North and South helped low- and low-middle-income countries spend more on pandemic control and economic recovery. However, there are concerns that these recipient countries may experience an unstable debt burden. The temporary debt servicing is timebound and can downgrade the credit ratings of the recipient countries. This could trigger a formidable financial crisis in the concerned countries in the post-pandemic era. Moreover, loan disbursements and the extent to which these countries could utilize these grants are yet to be fully analysed. Therefore, the medium-term implications of the financial instruments remain unclear.

Traditionally, there has been a lack of global coordination and reporting mechanisms concerning the Southern providers. Indeed, data reporting was not prompt and transparent during the pandemic. Consequently, given the novelty and scale of the experiences, the recipient countries were not adequately poised to share data on a global scale. This was, however, not exclusive to the Southern providers; global coordination regarding pandemic-related support was also disorganized among the Northern providers.

Notwithstanding the aforementioned support extended globally and bolstered by the Southern providers during the pandemic, medical aid and vaccines remain one of the most notable achievements of international development cooperation to date. The prospect of these promising trends in development cooperation will depend on the post-pandemic global outlook. In light of the COVID-19-occasioned Southern experiences, the following policy approach may be considered for strengthening the cooperation and recovery of the developing countries.

Way forward

Having considered the SSC activities and experiences during the pandemic, this paper concludes with a number of policy recommendations pertaining to the predictability of institutional reforms; data generation and data disclosure; intellectual engagements with private policy actors (such as think tanks); and the role of international engagements (such as multilateral organizations).

The proposal submitted to the WTO by India and South Africa to waive intellectual property rights requires urgent consideration.

Firstly, the developing countries' scarcity of medical commodities and inequitable access to vaccines inflamed the debate around intellectual property rights protection under the WTO's TRIPS Agreement. Access to vaccines and domestic capacity-building for vaccine production will determine the world's recovery from the pandemic. Thereby, the proposal submitted to the WTO by India and South Africa to waive intellectual property rights requires urgent consideration. Otherwise, the promises made towards global solidarity and equity will remain unfulfilled.

Public access to information on development cooperation needs to include more detailed information on the activities undertaken, their terms and conditions, financing issues, development results, and so forth.

Secondly, the lack of data limited cooperative activities in the South. The low propensity for data disclosure related to development cooperation led to weak transparency and hampered the efficiency and accountability of these activities. Therefore, public access to information on development cooperation needs to include more detailed information on the activities undertaken, their terms and conditions, financing issues, development results, and so forth. Moreover, agencies involved in the country or countries would need to improve coordination, particularly by digitalizing the information support. This is particularly important in terms of monitoring the implementation of the contracted projects.

Intellectual engagements with private sectors with both corporate bodies and civil entities would need to be enforced.

Thirdly, intellectual engagements with private sectors with both corporate bodies and civil entities would need to be enforced. The private sector needs to scale up policies and institutional reforms in relation to financial transactions. Think tanks could provide insights into the exchange of experiences and transfer of technology and human capital during the pandemic, since consolidated information on these components is largely missing. They could also guide the future course of recovery, given their expertise.

Similarly, international bodies (such as the United Nations) will need to continue to focus on the weakest links within the Global South. Given that the pandemic crossed all borders worldwide, the focus may be fragmented otherwise. Moreover, given its existing advantages, the United Nations could bolster its role in facilitating SSC by documenting the experiences and sharing them among relevant stakeholders. This may contribute to scaling up and strengthening the role of South-South and triangular cooperation (SSTrC). Likewise, multilateral development institutions (such as the IMF) could collaborate with

SSC bodies as well. The outcomes from the Buenos Aires Plan of Action Plus 40 (BAPA+40), especially innovative institutional arrangements through technical cooperation, need to be implemented as the world enters its post-pandemic recovery phase.

Finally, although the Southern countries took *ad hoc* measures to offer immediate assistance and reduce the severity of the pandemic fallouts, it would be useful to consolidate these measures in the medium-term. This would allow the recipient countries to better prepare for, and utilize, the support. Conversely, cooperation will only be effective if it is responsive to countries' demands. At the same time, the recipient nations will need to undertake necessary institutional and policy reforms to facilitate structural transformation.

Through the rapid response and development effectiveness demonstrated by the South during the pandemic, SSC has demonstrated its potential to reach new heights.

The Global South has indeed displayed exemplary commitment in dealing with the pandemic, thus highlighting its increasing relevance for international deelopment cooperation. Bilateral engagements were the highlight of SSC, paving the way for increased regional involvement. Through the rapid response and development effectiveness demonstrated by the South during the pandemic in terms of medical and financial assistance as well as knowledge-sharing, SSC has demonstrated its potential to reach new heights.

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