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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Summary of the full-day intersessional seminar on good practices, key challenges and new developments relevant to access to medicines and vaccines

Report of the United Nations High Commissioner for Human Rights*

Summary

The present report, submitted pursuant to Human Rights Council resolution 41/10 and decision 45/113, contains a summary of discussions at a full-day intersessional seminar, held on 8 December 2021. The seminar was focused on good practices, key challenges and new developments in the area of access to medicines and vaccines as one of the fundamental dimensions of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Recommendations were focused on ways to improve universal access to medicines and vaccines in the context of the coronavirus disease (COVID-19) pandemic, including the need to treat COVID-19 vaccines as a global public good, in order to ensure a global response to the pandemic and universal and equitable access to medicines and vaccines without discrimination.

* Agreement was reached to publish the present report after the standard publication date owing to circumstances beyond the submitter's control.

I. Introduction

1. Pursuant to Human Rights Council resolution 41/10 and Council decision 45/113, the United Nations High Commissioner for Human Rights convened a full-day intersessional seminar on 8 December 2021. The seminar was focused on good practices, key challenges and new developments relevant to access to medicines and vaccines as one of the fundamental elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. Opening statements were made by the United Nations High Commissioner for Human Rights, Michelle Bachelet; the Minister of Health of Brazil, Marcelo Queiroga; and the Assistant Director-General of the World Health Organization (WHO), Mariângela Batista Galvão Simão. The intersessional seminar was composed of two panel discussions. The first panel focused on human rights challenges in the context of the coronavirus disease (COVID-19) pandemic, with a special focus on developing countries, particularly their poorest and most vulnerable populations. The second panel focused on global cooperation and measures to improve the universal access to health as a fundamental human right. The seminar was concluded by the Director of Thematic Engagement, Special Procedures and Right to Development of the Office of the United Nations High Commissioner for Human Rights (OHCHR), Peggy Hicks; and the Permanent Representative of Brazil to the United Nations Office at Geneva, Tovar da Silva Nunes. Pursuant to Council resolution 41/10, the seminar was organized in coordination with WHO. More than 90 representatives from Member States, specialized United Nations agencies, the special procedures of the Human Rights Council and civil society organizations participated in the discussions. The present report contains a summary of the discussions.

II. Opening statements

3. In her opening remarks, made via video statement,[1] the United Nations High Commissioner for Human Rights recalled that the COVID-19 pandemic had killed at least five million people to date and had thrown every State and community into turmoil, with the people most affected being those who suffer systemic discrimination and pervasive inequalities – both within nations, and among them. Noting the stark inequality of access to COVID-19 vaccines globally, the High Commissioner indicated that the lack of universal and equitable access and distribution of vaccines was prolonging the pandemic and that no one was safe until all were safe. New spikes of infections were a concrete demonstration of vaccine inequity, and new variants were more likely to emerge among largely unvaccinated populations while they posed a threat to everyone.

4. As a major global crisis, the pandemic required a united, global response. The High Commissioner welcomed the swift development of vaccines and medications that effectively prevented the most severe forms of COVID-19, making it possible for WHO and other partners to draw up an effective and affordable initiative to vaccinate the world – the COVID-19 Vaccine Global Access (COVAX) Facility for pooled research, development, manufacturing and equitable distribution.[2] It seemed unlikely, however, that the vaccination target of protecting 40 per cent of the world's population by the end of 2021 would be met, and the target of 70 per cent by mid-2022 was also under threat.

5. The High Commissioner reiterated that vaccines against COVID-19 were a global public good. Urgent action, therefore, needed to be prioritized to eliminate all obstacles, including licensing processes that were unduly complex and restrictive, to ensure that vaccines reached everyone. All options needed to be explored to expand vaccine production capacity – such as voluntary licences and technology transfers, patent pooling, and flexibility on intellectual property rights. Efforts needed to be stepped up urgently to ensure a massive increase in supply to COVAX for low- and low-middle-income countries, including

[1] For the text of her statement, see www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=27924&LangID=E.

[2] See www.who.int/initiatives/act-accelerator/covax.

emergency steps to bolster the production of vaccines, tests, protective equipment, treatments and oxygen. The High Commissioner concluded her remarks by emphasizing that the pandemic was far from over and that human rights measures made everyone safer.

6. The Assistant Director-General of WHO recalled the fast pace of vaccine development and approval but noted that that record achievement had been marred by inequitable access to vaccines globally, delaying the collective emergence from the pandemic. She noted that the establishment of COVAX, the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator,[3] was inspired by experiences with other diseases, especially HIV/AIDS, and the knowledge that market forces by themselves would not lead to vaccine equity. While various challenges to the COVAX supply occurred, more than 600 million doses had been distributed to 145 countries. Low- and middle-income countries had received more than 80 per cent of those doses. There was a need to strengthen local production of medicines and vaccines and to ensure reliable and predictable supply.

7. She referred to a number of important developments in that regard, including:

(a) The launch by Costa Rica and WHO, with support from 41 Member States, of the solidarity call to action to realize equitable global access to COVID-19 health technologies through pooling of knowledge, intellectual property and data and the WHO COVID-19 Technology Access Pool,[4] which was aimed at increasing equitable global access to COVID-19 health technologies through the voluntary pooling of knowledge, intellectual property and data to support technology transfer and rapidly expand manufacturing globally;

(b) Current discussions among Member States for a waiver of the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement);

(c) The recent agreement at the World Health Assembly to initiate negotiations towards a pandemic preparedness treaty.[5]

8. The Minister of Health of Brazil stated that the COVID-19 pandemic had demonstrated the fragility of global supply chains and the need to ensure fair and equitable access to safe, effective and quality medicines and vaccines at the lowest possible cost. Noting that only 5.2 per cent of the population in low-income countries had received at least one vaccination dose, he underscored the importance of overcoming inequality in access to immunization and promoting the global distribution of vaccines, which has become even more crucial following the emergence of the Omicron variant. He noted that Brazil had strongly supported discussions and initiatives aimed at strengthening national and regional capacity for the production of medicines and other health technologies, with a view to increasing equitable access to those medicines and vaccines. Expanding access should be considered not only from the point of view of individuals, especially of those who were most vulnerable, such as older persons, persons with disabilities and people living in poverty, but also from the perspective of the need to promote access for all countries to new health technologies. Furthermore, it was also important to ensure adequate resources for research, development and innovation aimed at all diseases and health conditions, especially neglected tropical diseases.

9. He affirmed that ensuring access to vaccines for all Brazilians, in particular through the expansion of the national production capacity, was a priority for the Government. Brazil would continue to contribute to strengthening the global health arena, for the benefit of the right to health, the promotion of universal access, and strong and inclusive national health systems.

[3] The ACT Accelerator is a global collaboration to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines. COVAX is co-led by the Gavi Alliance, the Coalition for Epidemic Preparedness Innovations and WHO. Its aim is to accelerate the development and manufacture of COVID-19 vaccines, and to guarantee fair and equitable access for every country in the world. See www.who.int/initiatives/act-accelerator/covax.

[4] See www.who.int/initiatives/covid-19-technology-access-pool.

[5] See www.who.int/news/item/01-12-2021-world-health-assembly-agrees-to-launch-process-to-develop-historic-global-accord-on-pandemic-prevention-preparedness-and-response.

III. Human rights challenges in the context of the COVID-19 pandemic, with a special focus on developing countries, particularly their poorest and most vulnerable populations

10. The first panel discussed human rights challenges in the context of the COVID-19 pandemic, with a special focus on developing countries, particularly their poorest and most vulnerable populations. The panel was moderated by the Officer-in-Charge of the Economic, Social and Cultural Rights Section of OHCHR, Rio Hada. The panellists were: Member of the Independent Panel for Pandemic Preparedness and Response and Senior Fellow of the Global Health Center of the Graduate Institute of International and Development Studies, Michel Kazatchkine; President of the Oswaldo Cruz Foundation, Nizia Trindade; Secretary General of the International Federation on Ageing, Jane Barratt; Dean of the Faculty of Medicine of the University of Malaya, Malaysia, and Member of the WHO Science Council, Adeeba Kamarulzaman; and Director of the Health Justice Initiative, Fatima Hassan.

A. Panel presentations

11. Mr. Kazatchkine recalled that the Secretary-General and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health had recognized people who use drugs as a vulnerable group in the pandemic context due to criminalization, stigma, discrimination, underlying health issues, social and economic vulnerability and limited access to life-saving harm reduction programmes. Data indicated that more people had been using drugs during the pandemic because of the psychological toll of the pandemic and that more people were using drugs alone.

12. He noted that independent of the pandemic context, people who use drugs would face human rights abuses around the world, and that the harm caused by the implementation of punitive drug laws could not be overstated. He observed a number of innovations in the provision of services to people using drugs under COVID-19 restriction measures, such as partnerships between medical centres and non-governmental organizations for the daily provision of preventive materials, therapy for dependence, antiretroviral medicines and food supplies to clients, particularly in remote areas. Mr. Kazatchkine called for those initiatives – taken in exceptional circumstances – to be the basis for relevant policy reforms and a reconsideration of current criminalization approaches for non-violent drug offences.

13. Ms. Trindade reiterated that the pandemic had highlighted the pre-existing social, economic, environmental and health inequalities worldwide; that it had increased the number of people living in poverty; and that it had disproportionately impacted individuals and families. She recalled the high expectations on the richest countries to act in solidarity with the rest of the world to support an equitable approach to the pandemic. She also noted that vaccination against COVID-19 had been frustrated by a lack of support for collective global public health mechanisms, such as the COVAX initiative.

14. She welcomed the recent decision at the World Health Assembly to initiate negotiations on a new instrument on pandemic response, which represented a unique opportunity to explicitly include the responsibility of States to protect the right to health, not only during times of crisis but at all times. Affirming that health was not only dependent on individual biological factors, but that it was also the result of political, social, economic and other determinants of health, she highlighted the importance of the right to development as the only way to meet all imperative human needs and called for solidarity and multilateralism. She concluded by recognizing the important work of the special procedure mandate holders of the Human Rights Council, who identified challenges as well as potential solutions.

15. Ms. Barratt shared key human rights challenges in the context of the COVID-19 pandemic. She referred to the fact that the value of human life was being questioned in decisions on eligibility, which linked value with productivity. This was an issue for older persons who, in some countries, received lower priority for vaccination, resulting in thousands of needless deaths.

16. Another challenge she highlighted was that vaccines were being deployed through existing systems, while 40 per cent of countries had no immunization infrastructure to provide adult immunization and nearly 60 per cent of the global population lived in countries without routine immunization programmes, including many of the poorest countries. Many of those countries lacked the infrastructure for vaccine storage, handling, delivery and waste management. Operational readiness was essential, as was investment in health promotion, prevention and vaccines. Hard-to-reach areas posed another challenge.

17. Attention needed to be paid to vaccine hesitancy and to understand contexts as it often was a very local problem, particularly in rural and remote, semi-urban, slum areas, and among older and less educated populations. The issue needed to be addressed at local levels.

18. The pandemic had also highlighted systemic issues, including the limited funds invested by Governments to buy and store vaccines, vaccine shortages, expired vaccines, the limited number of trained service providers and sub-optimal cold chain systems. Ms. Barratt noted that advocates for access should be aware that, until the quantity of vaccines was sufficient, trade-offs would be made, and it was necessary to work with Member States and other stakeholders across disciplines and sectors. This was an opportunity to have a life-course approach to immunization where COVID-19 was a catalyst for positive policy change.

19. Ms. Kamarulzaman shared experiences from Malaysia, an upper middle-income country. The significant surge of the Delta variant, with tens of thousands of new cases daily during the peak, brought to the fore the challenges of having in-country inequalities that led to a higher burden of disease and mortality rates. She highlighted three vulnerable groups in Malaysia. Among the urban poor, who typically lived in multigenerational families and in crowded living conditions with poor ventilation, entire families would become infected with COVID-19, and severe cases were presenting late to hospital and leading to mortality. She noted that Malaysia had an estimated four to seven million migrant workers, many of whom were undocumented. Difficulties in accessing health care, lack of health insurance and prohibitive fees discouraged people from seeking treatment, leading to delayed presentation and deaths. Regarding access to vaccines, mixed messages from the Government deterred many foreign workers, who were already at high risk, from seeking health care, and it led to delays in vaccination. People in prisons and places of detention had also not been prioritized in vaccine rollout programmes.

20. Ms. Kamarulzaman noted that Malaysia had achieved significant vaccine rollout, while highlighting a number of key lessons, including the need to prioritize at an early stage groups of extremely vulnerable people; the importance of engaging community leaders; and the need to ensure the coordination and collaboration of government agencies with community leaders and civil society.

21. Ms. Hassan stressed that the promise of solidarity in sharing knowledge had failed to translate into vaccine equity. A serious commitment to resolving the current equity crisis in Africa was lacking, and recently, several African countries had been subjected to rash, non-scientific and, arguably, racist travel bans upon the emergence of the Omicron variant. The right to health had definitely been undermined by vaccine inequity and vaccine apartheid. Vaccination targets had been missed in Africa, including for health workers and older persons. Without timely access to even a first vaccine dose, despite other countries being at the vaccine booster stage, marginalized populations would be left even further behind.

22. She noted that inequity could not be addressed without dealing with supply barriers, which were linked to rules governing the protection of intellectual property rights, particularly through the international trade system. As widely recognized by United Nations experts in the context of advocacy for the relaxation of strict intellectual property rules, the protection of patents, in particular, has been prioritized over the protection of human rights. In Africa, although methods of measuring vary, according to one source, only one in four health-care workers had been vaccinated and only seven per cent of the continent’s population had been fully vaccinated. The majority of the 8 billion doses administered globally had been distributed to high- and middle-income countries, and more boosters had been administered in those countries than first doses in Africa over the previous four months. Achieving equity, therefore, was an urgent priority.

B. Summary of the discussion

23. In the ensuing discussion, contributions were made by representatives of Armenia, China, Cuba, Egypt, Indonesia, Iran (Islamic Republic of), Malaysia, Maldives, Mauritius, Morocco, Portugal and Venezuela (Bolivarian Republic of), and of the European Union, as well as of non-governmental organizations.

24. Key themes emerging from the discussion included:

(a) *Impact on developing countries*. Many of the participants noted the disproportionate impact of the pandemic on developing countries, across a wide range of human rights, including the rights to health and food. Several interventions highlighted the specific compounding impact of the pandemic on human rights in conflict areas and in those States subject to sanctions imposed by other countries.

(b) *Wide divergence in vaccine coverage*. Various participants acknowledged the wide divergence in vaccine coverage, noting that only approximately six per cent of COVID-19 vaccinations had been administered in Africa, the lowest rate in the world, in contrast to rich nations in the global North, and that only 1.2 per cent of doses had been administered in least developed countries, despite constituting 14 per cent of the world's population. A number of reasons were asserted, including vaccine hoarding, export controls, a lack of transparency and – as reiterated by a number of participants – the pursuit of profit regardless of the impact on human beings. Several participants denounced nationalistic approaches as vaccine apartheid, and noted that such approaches were prolonging the pandemic and leading to increased numbers of deaths.

25. Participants shared experiences in support of the rollout of vaccinations, diagnostics and treatment globally. Examples included the domestic production of vaccines and support to production efforts in other countries; the distribution of large numbers of vaccine doses to other countries; the sharing of health workforces across borders; and the amplification of the role of civil society in reaching communities.

26. Participants also referred to experiences in identifying and supporting communities in vulnerable or marginalized situations, either as a result of the pandemic or of pre-existing inequalities and discrimination. Several participants detailed the adoption of whole-of-government and whole-of-society national strategies, which operated across government departments, sectors and disciplines, and which incorporated financial stimulus packages for those facing health-related and socioeconomic impacts of the pandemic or response measures. A number of Member States have paid particular attention to protective measures for children, older persons, women, persons with disabilities, refugees, migrant workers and others at risk of marginalization and discrimination.

27. Responding to the discussion, Mr. Kazatchkine affirmed the existence of a crisis of delivery of global public goods and urged immediate global action. Ms. Barratt reiterated that significant systemic, societal and individual barriers affected access to vaccines for people regardless of age or other grounds of discrimination. Ms. Kamarulzaman reiterated that vaccine inequities were a gross injustice and expressed hope that Malaysia had shown it was possible to reach out to the most vulnerable populations. Ms. Hassan highlighted that promises lacked enforceability and that donations were unsustainable. She emphasized the need to address systemic barriers to scale up vaccine production and the availability of diagnostics and COVID-19 treatment. Life-saving technology, particularly in emergencies, should not be subject to intellectual property monopolies and the transfer of technology should be expedited.

28. There was a strong consensus among participants that no one was safe until everyone was safe and that a global response to the pandemic must include vaccine equity, recognizing that closing the gap between developing and developed countries was the only way to end the pandemic and that vaccines, diagnostics and treatment were global public goods. Key recommendations and commitments centred around the following, with explicit recognition that all action must be informed by, and based on, human rights obligations:

(a) *Waiver of the TRIPS Agreement*. A number of participants noted the role played by their Governments in proposing or supporting swift decision-making and action

regarding intellectual property rights in connection with COVID-19, noting that life-saving technology should not be subject to intellectual property restrictions;

(b) *COVAX*. While noting a number of implementation challenges, participants expressed appreciation for the operations of the COVAX Facility, with more than 600 million doses having been distributed worldwide and the most recent 100 million doses having been delivered in just over two weeks. As the COVAX Facility constituted the only means for some countries to gain access to vaccines, there were calls for continued support for the facility and for the vaccination targets set by WHO;

(c) *Increased diversification*. Several participants recommended increased diversification in terms of local and regional production of vaccines;

(d) *Strengthening of global pandemic responses*. Participants welcomed the agreement of the World Health Assembly to initiate a global process to draft and negotiate a convention, agreement or other international instrument under the WHO Constitution to strengthen pandemic prevention, preparedness and response. Among other things, participants highlighted that the process reaffirmed commitments to global solidarity and cooperation, and must be aligned with human rights.

IV. Global cooperation and measures to improve universal access to health as a fundamental human right

29. The Coordinator of the Partnership and Outreach for Social Justice of the Office of the High Commissioner for Human Rights, Chitralekha Massey, moderated the second panel discussion, which was on global cooperation and measures to improve universal access to health as a fundamental human right. The panellists were former Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover; Judge of the High Court of Malawi, Zione Ntaba; Director of the Intellectual Property Division of WTO, Anthony Taubman; Director of Health Products Policy and Standards Department of WHO, Clive Ondari; COVID-19 Project Manager of the Medicines Patent Pool, Magdalena Babinska; Adjunct Research Professor of Law of Carleton University, Canada, Obijiofor Aginam; and Chair of the Committee on Economic, Social and Cultural Rights, Mohamed Abdel-Moneim.

A. Panel presentations

30. Mr. Grover outlined that the right to health needed to be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for its realization, including vaccines. While referring to the general principle of progressive realization of economic, social and cultural rights, he stressed that the minimum core obligations of States included access to health facilities, goods and services on a non-discriminatory basis. Those obligations also included the provision of essential medicines, vaccines and diagnostics, including their availability, accessibility and acceptability.

31. Considering the obligation of international cooperation, Mr. Grover pointed to article 1 of the Charter of the United Nations and encouraged respect for the human rights and fundamental freedoms of all without discrimination, in conjunction with article 55 of the Charter. He regretted that intellectual property rights had become an impediment to the realization of those obligations to provide access to medicines and vaccines. He pointed to the possibility of a waiver under article 31 of the TRIPS Agreement, which provides for the use of a patent without the authorization of the right holder, noting that no agreement had thus far been possible because of a collusion of interests between developed countries and pharmaceutical companies.

32. He noted that pharmaceutical companies had realized significant profits on COVID-19 vaccines at the detriment of universal access, resulting in the loss of lives and in vaccination rates of only 5 per cent of the population in Africa. COVAX, the ACT-Accelerator vaccines pillar, had relied on the goodwill of pharmaceutical companies and had not been able to ensure equitable access to vaccines. The COVAX failure, in his view, should

give rise to a rethinking of public-private partnerships. Against that background, Mr. Grover raised the issue of national and international accountability, including of pharmaceutical companies. Beyond the Guiding Principles on Business and Human Rights, he called for an internationally binding framework to hold businesses to account.

33. Ms. Ntaba emphasized the universality and indivisibility of human rights, which extended to access to medicines and vaccines. It was essential to consider the critical situation in developing countries, where the levels of vaccination remained insufficient and people would continue to die from COVID-19 unless equitable access to vaccines was ensured. The TRIPS agreement was central to the discussion on access to vaccines and medicines. Most members States of WTO were also parties to the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. She urged States to consider whether arguments, which resulted in the know-how and health technologies required to manufacture vaccines being available in only some parts of the world, were sound in the light of the emergence of new variants of the virus and the continued deaths in connection with COVID-19. As COVID-19 was affecting a wide array of human rights, it remained critical to protect the fundamental right to life by ensuring the promotion and protection of the right to health. Global cooperation was essential in that regard and had to be put to task in line with States' legal obligations, in the framework of WTO and the United Nations.

34. Mr. Taubman noted that member States of WTO continued the critical debate about access to vaccines and other medicines in response to the pandemic. The recent decision of the World Health Assembly to work towards negotiating an international instrument on pandemic response reflected the common desire to work together and to learn from, and act on, the hard lessons resulting from the global response to the pandemic. He recalled the human rights imperative for universal access to COVID-19 vaccines, the morally appalling and socially devastating effect of extreme vaccine inequities, the regressive effect of the economic impact of the pandemic, and the inevitable consequence of such inequities of access in the form of new variants of the virus, which in turn created further disruption and hardship.

35. Mr. Taubman pointed out that the intersecting areas of trade and public health were understood as instruments to broader social goals and were not considered ends in themselves, which was a critical point in dealing with the intellectual property dimension in addressing the relationship between the TRIPS Agreement and human rights. He referred to the past inequities of access to HIV/AIDS medicines, when the then High Commissioner for Human Rights had issued a timely analysis, outlining the fundamental difference between human rights and intellectual property rights. In addition to being inalienable and universal, human rights were absolute values in themselves, whereas intellectual property rights were contingent, subject to public interest considerations, and justified not in themselves, but only as means to broader policy ends, and were territorially bound, transferable, and generally time-limited.

36. The practical consequences for cooperation are that intellectual property rights may be subordinated to the public interest, including during times of public emergency, as is implicit in and integral to the TRIPS Agreement and which was more expressly laid out in the Doha Declaration on the TRIPS Agreement and Public Health. The question, therefore, was not whether States had the scope to take action to curb the exclusive effect of intellectual property rights in the public interest, but whether the current international principles framing such interventions were too restrictive and should be suspended during the pandemic. He also spoke about the trade dimension as part of the broader response, since no country could achieve autonomy in vaccine production and distribution. Excessive restrictions, trade costs and delays required attention alongside the intellectual property dimension.

37. Mr. Ondari noted that the right to health created a legal obligation for States to ensure access to timely, acceptable and affordable health care of appropriate quality and to provide for the underlying determinants of health, including safe and potable water, sanitation, food, housing, health-related information and education, and gender equality. A rights-based approach to health required that health policy and programmes prioritized the needs of those furthest behind first with a view to achieving greater equity, a principle that had been echoed in the 2030 Agenda for Sustainable Development and the political declaration of the high-

level meeting on universal health coverage.[6] Moreover, the right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status, which required States to take steps to redress any discriminatory law, practice or policy. Meaningful participation, as another feature of a rights-based approach, required national stakeholders to be involved in all phases of programming.

38. The COVID-19 pandemic had shown that access to health products needed renewed attention. Unaffordable prices for medicines and health products had become a most pressing concern that required corrective action by Governments. The production capacity of health products was concentrated in a few countries or regions and needed diversification. States also needed to strengthen competition authorities, manage contractual arrangements in the public interest, ensure transparency of negotiated access conditions and disclose public contributions for research and development.

39. Ensuring affordable access to safe and effective pharmaceutical products required an array of regulatory and policy tools, including pharmaceutical pricing policies, application and management of intellectual property, patent pooling and voluntary licences, the use of flexibility clauses contained in the TRIPS Agreement, competition policies and laws, and the potential use of a waiver to the TRIPS Agreement. In conclusion, Mr. Ondari referred to the unique opportunity the pandemic offered to rethink the interactions between health and other policy domains and to work collaboratively across all sectors to reinforce and strengthen synergies that advanced scientific progress, innovation and access to medical technologies.

40. Ms. Babinska noted that the issue of access was complex and multi-dimensional. Increasing access to affordable and life-saving medicines in low- and middle-income countries was the core mandate of the Medicines Patent Pool, which had developed an innovative model based on a voluntary licensing mechanism. When the COVID-19 pandemic started, the Medicines Patent Pool very quickly got involved in facilitating pandemic preparedness and response. It had thus far signed two licence agreements for the production and distribution of oral antiviral treatments for COVID-19, and a worldwide licence for COVID-19 serological antibody diagnostic tests. It also worked with WHO to establish the very first messenger ribonucleic acid (mRNA) technology transfer hub in South Africa. She noted that the terms and conditions of licences under the Medicines Patent Pool were unique in view of their public-health orientation, and the requirement for quality-assurance; non-exclusivity, which contributed to creating sufficient competition among generic manufacturers; and transparency, which allowed for civil society scrutiny.

41. Ms. Babinska referred to the considerable impact of the work of the Medicines Patent Pool, while noting remaining challenges, such as the need for patent holders to understand the complementarity of the Medicines Patent Pool with their work in so-called “commercial” countries. In addition, the terms of negotiated licence agreements needed to be attractive enough, especially in regard to the market size, to enable sustainable generic competition and substantial price reductions. Uptake also needed to occur promptly and smoothly, and health systems needed to continue to be strengthened to be able to absorb those medicines and ensure the appropriate enabling environment. It was crucial for generic companies to release their products into the markets of low- and middle-income countries at the same time as originator companies were preparing to enter their commercial markets. Recent advances could pave the way for that type of parallel planning for access.

42. Mr. Aginam outlined that since the establishment of WTO, the debate on trade-health policy coherence had gained traction in multiple arenas. He referred in that context to the waiver to the TRIPS Agreement requested in relation to COVID-19 drugs, vaccines, diagnostics and other technologies for the duration of the pandemic, which was supported by over 100, mostly developing, countries. Negotiations had been stalled at WTO, however, as it did not enjoy the support of the pharmaceutical industry and of most high-income countries. Mr. Aginam pointed to the failure to learn lessons from a similar stalemate during the debate on patents and access to antiretroviral drugs for HIV/AIDS, which had led to the Doha Declaration on the TRIPS Agreement and Public Health. Compulsory licences were

[6] General Assembly resolution 74/2.

extremely complex and time-consuming and not suitable for public emergencies, as the experience with HIV/AIDS also demonstrated.

43. Vaccine protectionism or vaccine nationalism would not protect anyone, owing to the mutual vulnerability that exists in an interdependent world. It led to vaccine apartheid, that is, the conscious or unintentional separation of the vaccinated populations, mostly in rich and industrialized countries, from the unvaccinated populations in low- and middle-income countries. This was fuelled by vaccine stockpiling by rich countries. The codification of the right to health in the WHO Constitution and international and regional human rights treaties provided a powerful impetus to pursue policy coherence between human rights, including the right to health, and trade obligations.

44. Mr. Abdel-Moneim recalled the relevance of the human rights framework in tackling the COVID-19 pandemic, emerging variants and any future pandemics, in particular article 12 of the International Covenant on Economic, Social and Cultural Rights on the right to health, stating that it provided one of the most comprehensive frameworks on health applicable to the COVID-19 pandemic. He also highlighted article 2 (1) of the Covenant, pursuant to which international cooperation was mandatory in the context of the implementation of economic, social and cultural rights, including the right to health. He also drew attention to the guidance offered by the Committee on Economic, Social and Cultural Rights regarding this framework, including in its general comment No. 14 (2000), setting out the normative content of the right to health, and its general comment No. 25 (2020), on science and economic, social and cultural rights. The Committee had also issued several statements, including on the COVID-19 pandemic and economic, social and cultural rights; on universal and equitable access to vaccines for COVID-19; and on universal affordable vaccination against COVID-19, international cooperation and intellectual property.

B. Summary of the discussion

45. In the subsequent discussion, contributions were made by representatives of Azerbaijan, Barbados, Bolivia (Plurinational State of), Chile, China, Cuba, India, Iran (Islamic Republic of), Malaysia, Mexico, Peru and the Russian Federation. Written submissions were received from Associazione Comunità Papa Giovanni XXIII and Human Rights Watch, which have been made available on the website.[7]

46. Key themes emerging from the discussion included the importance of cooperation efforts and regional coordination and concerns of vaccine nationalism. Participants emphasized that universal access to affordable, accessible and equitable vaccines was critical. They shared experiences both at the national level and regarding cooperation at the national and international levels in the area of COVID-19 response and vaccination. Examples included sharing of information about the pandemic, providing protective equipment and vaccines to developing countries, dispatching medical expert teams abroad, and fostering partnerships aimed at technology transfer and sharing of knowledge.

47. Speakers shared concerns about the disproportionate impact of the COVID-19 pandemic on developing countries. Some reiterated that vaccines were a global public good and that there was a need for a global response and vaccine multilateralism. It was noted in that regard that the COVAX Facility had set a precedent of multilateral cooperation and solidarity. At the same time, concerns were raised about the lack of transparency regarding its functioning and the distribution of vaccines. Persisting obstacles to vaccine equity, including complex licensing processes, vaccine hoarding and export controls, were also mentioned. Some also referred to the waiver to the TRIPS Agreement and the recent decision by WHO to start negotiating a convention or agreement on prevention, preparation, and response to public health emergencies.

48. In response to the discussion, Mr. Grover reiterated that flexibility on intellectual property rights was a core issue if progress was to be made, and he acknowledged efforts made by some countries to deliver vaccines to developing countries. Ms. Ntaba focused on the human rights obligations of businesses. She emphasized that COVID-19 was not an issue

[7] See www.ohchr.org/EN/Issues/ESCR/Pages/Access-to-medicines-and-vaccines.aspx.

between rich and poor countries as the virus itself did not discriminate. Mr. Taubman said he was struck by the convergence of views and the strong political will and common sense of purpose expressed by participants. He welcomed the sharing of accounts of very practical initiatives, both bilaterally and multilaterally, and the important lessons that could be learned from them. Highlighting the need for coordinated responses, he stressed the importance of involving multilateral institutions, including human rights institutions. Mr. Ondari underscored the importance of dialogue, regional cooperation and collaboration, and of seeking and adopting effective technology that could address the particular needs of small and medium-sized countries. Ms. Babinska reiterated that decentralizing production capacity was essential, as were voluntary licensing, patent pooling and technology transfer. Mr. Aginam called for greater policy coherence and for the breaking down of the silos between trade and health.

V. Conclusion and recommendations

49. **Concluding remarks were made by the Director of the Thematic Engagement, Special Procedures and Right to Development Division of OHCHR and the Permanent Representative of Brazil to the United Nations Office at Geneva.**

50. **The Director commended participants for the very productive and useful exchanges held during the seminar. She echoed the key messages of the day, emphasizing that as long as vaccines were not available for all, people around the world would continue to suffer a wide range of human rights impacts and adverse socioeconomic effects. Closing the gap between advanced economies and developing countries required international solidarity and cooperation. As the Secretary-General had stated, the entire United Nations system was backing the COVID-19 vaccination strategy set out by WHO, with the aim of getting 40 per cent of people in all countries vaccinated by the end of 2021, and 70 per cent by the middle of 2022.**

51. **She noted that her Office was helping countries to review national vaccine plans to ensure that no one was left behind, and to provide human rights guidance on a range of issues, including vaccine mandates. In line with the Secretary-General's call to action for human rights and the report of the Secretary-General entitled "Our Common Agenda", the Office had stepped up its work in the area of economic, social and cultural rights, inequalities and leaving no one behind, under the High Commissioner's leadership. With its surge initiative, which includes a team of macroeconomic specialists, the Office was providing country- and context-specific analyses of policy options that countries might pursue to build back better after the COVID-19 pandemic, including by moving towards universal health and social protection systems**.

52. **In closing the intersessional seminar, the Permanent Representative thanked all panellists and participants, OHCHR, interpreters and technical support personnel. He reiterated that the right to health was a precondition to the enjoyment of every other human right and that access to diagnostics, vaccines and medicines represented the only way out of the pandemic. Confirming that access to health products for all was not only enshrined in human rights instruments but was also part of the 2030 Agenda, he deemed it unacceptable that the safeguarding of commercial and economic interests of the few would jeopardize the right to health for all. He stressed that that approach would erode efforts to achieve the Sustainable Development Goals, and he called upon Member States to cooperate in a strong spirit of solidarity towards universal and equitable vaccine access and to remain united in that cause.**

53. **The following recommendations reflect the outcomes of the intersessional seminar, and should be read in conjunction with the report of the High Commissioner on the human rights implications of the lack of affordable, timely, equitable and universal access and distribution of COVID-19 vaccines and the deepening inequalities between States,[8] which was submitted to the Human Rights Council at its forty-ninth session, pursuant to Council resolution 46/14.**

[8] A/HRC/49/35.

54. **The COVID-19 pandemic is a global health emergency that demands a global response. Saving lives and livelihoods depends on universal and equitable access to COVID-19 vaccines. COVID-19 vaccines, therefore, should be treated as a global public good.**

55. **States have an obligation to ensure that COVID-19 vaccines are available, affordable and accessible to all without discrimination. Prioritization of vaccine delivery should be based on transparent protocols and procedures that respect human rights.**

56. **States should step up their support for initiatives to ensure universal and equitable distribution of vaccines, such as the COVAX Facility. Manufacturers and States should prioritize supply to COVAX, and excess doses should be shared with the facility.**

57. **States should take urgent steps to bolster the production of vaccines, tests, protective equipment, treatments and oxygen, including through stepped up North-South and South-South cooperation. In order to address vaccine injustice, the highest possible production intensity in producing countries should be maintained to ensure there are sufficient supplies to meet the global demand.**

58. **States should refrain from hoarding vaccines, as this disregards international legal obligations, prolongs the pandemic and undermines the achievement of the Sustainable Development Goals.**

59. **Business enterprises, including pharmaceutical companies, have a responsibility to respect human rights. That includes the responsibility to enable the realization of the right to health, including in relation to access to medicines and vaccines. Companies should be guided in their action by the Guiding Principles on Business and Human Rights. In order to ensure that economic gains do not trump public health considerations, States must, among other measures, strengthen competition authorities, manage contractual arrangements in the public interest, ensure transparency of negotiated access conditions and disclose public contributions to research and development.**

60. **All stakeholders must recognize that human rights are immutable, inalienable and universal, while intellectual property rights are contingent and justified as means to broader policy ends, and are territorially bound, transferable and generally time-limited.**

61. **Stakeholders must address all obstacles to ensuring that vaccines and treatments reach everyone and, to the extent possible, eliminate those barriers, including licensing processes, that are unduly complex and restrictive and the export bans preventing the necessary flow of vaccines and vaccine-related products. Steps towards a waiver to the TRIPS Agreement are welcome, and States should pursue discussions on that initiative at WTO.**

62. **States must also address the broader trade dimension of vaccine production and distribution, including by addressing issues such as excessive restrictions, trade costs and delays. Such steps are separate but complementary to measures on the waiver to the TRIPS Agreement.**

63. **States should address vaccine hesitancy to ensure uptake of vaccines as they become available. Non-discriminatory access to accurate and evidence-based health information is essential, including on the benefits and risks of COVID-19 vaccination. States should recognize the important role of civil society in that regard and ensure meaningful and active participation of relevant stakeholders.**

64. **States and relevant stakeholders should be working towards integrating a human rights-based approach in the prospective WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response.**

65. **Unequal access to vaccines is driving the growing prospect of vastly divergent recoveries. In order to close the gap between advanced economies and developing countries and put the world back on track to achieve the 2030 Agenda for Sustainable Development, all stakeholders must take decisive and urgent action, underpinned by international solidarity and cooperation.**