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

Ensuring equitable, affordable, timely and universal access for all countries to vaccines in response to the coronavirus disease (COVID-19) pandemic

Report of the United Nations High Commissioner for Human Rights

Summary

The present report, prepared pursuant to Human Rights Council resolution 49/25, contains an examination of the human rights implications of and good practices and key challenges in affordable, timely, equitable and universal access to and distribution of quality, safe, efficacious and affordable coronavirus disease (COVID-19) vaccines and the impact on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Universal and equitable access to vaccines, medicines and treatments is essential to reversing the trajectory of any pandemic. Among the many lessons of the COVID-19 pandemic is the need for vaccination strategies that are human rights-based and sustainable, the need for increased investment in health systems towards expanding universal health coverage, the need for bolstered international cooperation and innovative partnerships and the need for stronger legal frameworks grounded in human rights to ensure an effective global pandemic response in the future.



I. Introduction

1. The world has paid a high price for the failure to ensure universal and equitable access to coronavirus disease (COVID-19) vaccines, with serious negative consequences for the enjoyment of human rights and deepening inequalities within and between States.
2. The beginning of the COVID-19 pandemic was marked by competition over scarce supplies of vaccines, with short-sighted vaccine nationalism, stockpiling and export bans, in disregard of international obligations. Now, the global supply of COVID-19 vaccine is abundant, with yearly manufacturing capacity at 11 billion–16 billion doses.¹ Ample volumes, therefore, are available for lower-income countries. Although 63 per cent of the world's population have received a primary vaccination series, significant disparities continue to exist between regions and population groups.² The risk of viral mutations remains elevated and uncertainties regarding the strength and duration of immunity from vaccination persist. Sustaining a coordinated global response will be key to ending the pandemic.
3. The present report contains an examination of the human rights implications of and good practices and key challenges in affordable, timely, equitable and universal access to and distribution of quality, safe, efficacious and affordable COVID-19 vaccines and the impact on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The report is submitted pursuant to Human Rights Council resolution 49/25 and should be read in conjunction with the report of the United Nations High Commissioner for Human Rights on the human rights implications of the lack of affordable, timely, equitable and universal access to and distribution of COVID-19 vaccines and the deepening inequalities between States.³
4. In its resolution 49/25, the Human Rights Council requested that the present report be prepared in consultation with States, United Nations agencies, funds and programmes, in particular the World Health Organization, the special procedures of the Council, the treaty bodies, civil society organizations and other stakeholders. In response to a request for input, 26 written contributions, including 15 from States, were received.⁴

II. Human rights implications, good practices and key challenges

5. Equitable, affordable, fair, safe, timely and universal access to vaccines is a determinant of the right to health, and is essential to reversing the trajectory of any pandemic.
6. Promises of vaccine equity were insufficient to prevent many deaths from COVID-19 in lower-income countries. Estimates show that approximately 600,000 deaths could have been prevented globally if all countries had reached 40 per cent primary series vaccination coverage by the end of 2021, a target for which there was sufficient supply if vaccines had been equitably distributed.⁵ The failure to ensure vaccine equity directly affected a range of human rights, including the rights to life, health, equality and non-discrimination. Vaccine inequity also exacerbated existing economic and social inequalities and weakened social cohesion.⁶ It also exposed serious gaps in the effectiveness of multilateral action when it was needed most.⁷

¹ See the submission of the World Health Organization (WHO), available at <https://www.ohchr.org/en/calls-for-input/2022/call-inputs-high-commissioners-report-human-rights-implications-and-good>.

² See <https://news.un.org/en/story/2022/11/1130402>.

³ [A/HRC/49/35](#).

⁴ The submissions received are available at <https://www.ohchr.org/en/calls-for-input/2022/call-inputs-high-commissioners-report-human-rights-implications-and-good>.

⁵ Oliver J. Watson and others, "Global impact of the first year of COVID-19 vaccination: a mathematical modelling study", *The Lancet Infectious Diseases*, vol. 22, No. 9 (September 2022).

⁶ [A/HRC/49/35](#), paras. 37 and 44. See also <https://news.un.org/en/story/2022/03/1114762>.

⁷ Report of the Secretary-General entitled "Our Common Agenda" ([A/75/982](#)), para. 60.

A. Human rights-based vaccine strategy

1. Upholding the principle of non-discrimination

7. Non-discrimination and equality are fundamental principles that need to underpin any strategy for pandemic preparedness and response. COVID-19 vaccines should be affordable to all and accessible without discrimination; exclusionary approaches that reinforce existing inequalities should be avoided. An intersectional human rights approach, consistent with the principle of non-discrimination, requires taking into account the vulnerabilities, risks and needs of those who, because of underlying societal, geographical or biomedical factors, are at risk of experiencing greater burdens from the COVID-19 pandemic.⁸

8. Several countries⁹ indicated that, when rolling out vaccines, special attention was paid to the populations considered most at risk and those in vulnerable or marginalized situations, such as older persons, persons with disabilities, persons from minority groups, migrants, Indigenous Peoples, persons in detention and LGBTIQ+ persons.

9. Structural inequalities and discrimination have, however, led to disturbingly uneven access to COVID-19 vaccines in many places. Persons from minority groups have largely been left behind in the design of the health responses to the pandemic and vaccination rates among minority communities are lower.¹⁰ Despite the high risk of COVID-19 infection as a result of their living conditions, in some regions, migrant workers have not been prioritized for vaccination, and some risked being excluded from national vaccination programmes on the basis of their irregular migration status.¹¹ While significant progress has been made, refugees and displaced persons hosted in developing countries continue to face barriers in accessing COVID-19 vaccines.¹² Around the world, persons with disabilities, who are at higher risk of adverse COVID-19 outcomes, have not always been prioritized for vaccination and face accessibility barriers. Women and girls also risk discrimination in vaccine distribution for many reasons, including higher rates of poverty and the impact of societal norms. Unequal access to COVID-19 vaccines and treatments has also significantly affected population groups who are marginalized on account of race. Some countries, moreover, were reportedly vaccinating persons at low risk and younger persons instead of health workers, older persons and at-risk groups.¹³

10. It has been reported that only 47 out of 157 countries included stateless persons in their national vaccination plans. Even if not intentionally excluded from immunization programmes, stateless persons and others were often excluded de facto, because they lacked identity documents or legal residency. The official character of vaccination programmes also deterred undocumented persons from applying for vaccination for fear of being arrested or detained.¹⁴

2. Human rights-based vaccine governance

11. An essential element of vaccine equity is human rights-based governance, which requires transparency in the development of national health strategies and plans, including immunization campaigns.¹⁵

⁸ WHO, "SAGE values framework for the allocation and prioritization of COVID-19 vaccination" (Geneva, 2020).

⁹ See, for example, the submissions of Azerbaijan, Bahrain, Ecuador and Mauritius.

¹⁰ See <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25916&LangID=E>.

¹¹ A/HRC/47/23, para. 33. See also the joint guidance note on the impacts of the COVID-19 pandemic on the human rights of migrants by the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families and the Special Rapporteur on the human rights of migrants (26 May 2020).

¹² See <https://www.unhcr.org/news/press/2022/3/621e499f4/unhcr-highlights-great-progress-refugee-vaccine-inclusion-inequities-hamper.html>.

¹³ See <https://news.un.org/en/story/2021/03/1087992>.

¹⁴ See the submission of Maat for Peace, Development and Human Rights Association.

¹⁵ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 43 (f).

12. Several countries¹⁶ stressed the importance of developing a national vaccination plan and strategy that identify risks and different vulnerable groups within the population, along with needs assessments to determine the allocation of vaccines, including at the local level. Monitoring and evaluation throughout the vaccination process had allowed the size of vaccination teams to be adapted to changing local needs and for the implementation of new vaccination modalities and strategic alliances with community leaders.¹⁷

13. Prioritization of vaccine delivery should be done by means of transparent protocols and procedures that respect human rights. Vaccination targets must be based on equity as much as absolute numbers. Targets and priorities should be decided through dialogue with relevant ethnic, cultural and other community groups. The meaningful participation of civil society and relevant actors at the local and national levels and the engagement of communities in the development of national vaccination plans and strategies, including vaccine distribution protocols, the administration of vaccines and the development of policies concerning the prioritization of allocations, are necessary,¹⁸ including to ensure greater effectiveness and to curb corruption in that sector.

14. Vaccinations should be provided to migrant populations and people experiencing homelessness, irrespective of whether or not they hold a regular social security number or temporary fiscal number.

15. Several countries¹⁹ reported that the vaccine roll-out had been done in phases to cover the population most at risk speedily. Initial roll-out protocols depended on the context and the priorities that had been set. Some countries started with front-line health-care workers, followed by other health-care workers, residents in long-term health-care facilities, in particular persons at high-risk of experiencing a severe course of COVID-19, such as those with pre-existing diseases or compromised immune systems, and older persons. There was also a differentiation between different age cohorts of the population of older persons. Others prioritized airport and port personnel and police officers. Once the population at risk was vaccinated, vaccination was opened to the general public, again in a staggered fashion, and then to adolescents and children aged 5 years and above.²⁰

16. Going forward, it will be important to assist countries in applying an intersectional human rights approach when determining priority groups for vaccinations within their national plans and strategies.

3. Promoting regional and national resilience

17. At the beginning of the COVID-19 pandemic, some high-income countries took measures that resulted in restricted access to COVID-19 vaccines and related commodities in low-income countries. It was reported that some countries enacted laws to prevent the export of essential medicines, curbed exports of hospital supplies and restricted exports of personal protective equipment.²¹ Some high-income countries entered into advance purchase agreements with COVID-19 vaccine manufacturers to secure doses well beyond the needs of their populations,²² even though stockpiling of COVID-19 vaccines was not consistent with States' human rights obligations to contribute to the enjoyment of all human rights, including the right to health, globally, given that universal and equitable access to vaccines globally

¹⁶ See, for example, the submissions of Colombia, Ecuador, Guatemala and Poland.

¹⁷ See the submission of Guatemala.

¹⁸ See the submission of Ecuador.

¹⁹ See, for example, the submissions of Colombia and Poland.

²⁰ See the submission of Mauritius.

²¹ Sharifah Sekalala and others, "Health and human rights are inextricably linked in the COVID-19 response", *BMJ Global Health*, vol. 5, No. 9 (September 2020); and Katrina Perekhodoff and Jennifer Sellin, "Innovation and access to medicines under international law", in *Global Health Law Disrupted: COVID-19 and the Climate Crisis* (Leiden, Royal Netherlands Society of International Law, 2021).

²² Armin von Bogdandy and Pedro Villarreal, "The role of international law in vaccinating against COVID-19: appraising the COVAX initiative", *Heidelberg Journal of International Law*, vol. 81, No. 1 (2021).

had not yet been ensured.²³ In the light of how the pandemic developed and the virus mutated, the failure to act globally or in solidarity with other States undermined the right to health everywhere, including in the stockpiling countries. The virus does not respect borders, but too many countries acted as if it did, thereby prolonging its existence and exacerbating its impact. It was also reported that low-income countries later received shipments of nearly expired COVID-19 vaccines, which then proved impossible to administer.²⁴

18. Few developing countries have the technological facilities required to make or store vaccines, the scientific personnel to develop vaccines or the capacity to produce the ingredients. Typically, the network of health facilities is insufficient to ensure territorial coverage as there is a lack of cold chains and transport infrastructure and an insufficient number of health centres and health personnel to undertake mass vaccination campaigns within short time frames. International technical and financial cooperation, transfer of technologies and equipment at affordable prices and unrestricted marketing of inputs and training are needed to build or increase vaccine-production capacity in developing countries and to allow them to carry out mass vaccination campaigns themselves.²⁵

19. A key aspect that has driven vaccine inequity is the insufficient number of vaccine manufacturers. Stepping up vaccine production in low-income countries, including through manufacturing that is uncoupled from donated doses or excess production capacity in high-income countries, would facilitate equitable and universal vaccine roll-out in the early stages of public health crises. Equitably distributed vaccine manufacturing capacity will yield additional benefits, such as vaccine production for other communicable diseases, increased investments in biomedical innovation and the strengthening of public health infrastructure.²⁶ Unilateral coercive measures imposed against countries, which could hinder access to and distribution of vaccines, should be eliminated.²⁷

20. Ongoing efforts at the regional and national levels to enhance global vaccine manufacturing capacity include the Partnerships for African Vaccine Manufacturing launched by the African Union. The objective is to increase the share of vaccines manufactured in Africa from 1 per cent in 2021 to 60 per cent by 2040.²⁸ The creation of the messenger RNA South African vaccine technology transfer hub, as a specific application of the concept of open-source pharma,²⁹ has the potential to contribute to a growing independence in terms of pharmaceutical production in the African region, not only for COVID-19 vaccines.³⁰ The recent establishment of the African Medicines Agency may also represent a real opportunity to improve regulatory capacity across the African continent. Another regional platform to advance the manufacturing of COVID-19 vaccines and other health technologies was created by the Pan American Health Organization.³¹

21. Strengthening the resilience of supply chains and boosting and diversifying vaccine manufacturing capacity can contribute to promoting the resilience of low- and middle-income countries. Preparedness for future health crises needs to encompass the capacity of countries to research, develop, produce and distribute all the essential tools for pandemic control,

²³ A/HRC/49/35, para. 62; and E/C.12/2020/2, para. 11.

²⁴ See https://www.lemonde.fr/en/science/article/2022/04/04/the-huge-waste-of-expired-covid-19-vaccines_5979632_10.html.

²⁵ See the submission of Cuba.

²⁶ Victor J. Dzau, Celyne A. Balatbat and Anaeze C. Offodile II, “Closing the global vaccine equity gap: equitably distributed manufacturing”, *The Lancet*, vol. 399, No. 10339 (May 2022).

²⁷ See the submission of Cuba.

²⁸ See <https://africacdc.org/download/partnerships-for-african-vaccine-manufacturing-pavm-framework-for-action/>.

²⁹ A/HRC/20/26, para. 34.

³⁰ See <https://www.who.int/initiatives/the-mrna-vaccine-technology-transfer-hub#:~:text=The%20mRNA%20vaccine%20technology%20transfer%20hub&text=Announced%20on%2021%20June%202021,the%20mRNA%20vaccine%20technology%20hub>.

³¹ See <https://www.paho.org/en/regional-platform-advance-manufacturing-covid-19-vaccines-and-other-health-technologies-americas>.

including vaccines.³² This should include capacity-building and innovations for vaccine producers in low- and middle-income countries, including regulatory authority capacity.

4. Stimulating and sustaining vaccine uptake and demand

22. Vaccine hesitancy is a complex issue. It is ranked by the World Health Organization (WHO) as one of the 10 biggest threats to global health.³³ It is a problem that varies depending on the context, country and type of vaccine concerned, making the issue particularly challenging. As part of their obligation to ensure access to vaccines, States should use a wide range of evidence-based means to tackle vaccine hesitancy. Stimulating demand for vaccines is becoming a crucial determinant of success in reducing the threat from COVID-19.

23. Explanations of low vaccine uptake that emphasize knowledge deficits and disinformation, misinformation and conspiracy theories overlook the critical role of context, including structural inequalities and political dynamics, and how they have an impact on the access of different groups to vaccines and the level of trust that different groups have in vaccines and those promoting them. They also fall short of considering the role of other actors involved in the production delivery and distribution of and communication about vaccines:³⁴ increasing vaccine uptake depends not only on the population that is to be immunized but also on other actors, including those offering the vaccination, those planning how and where to offer the vaccination, and those tasked with maximizing uptake using strategies such as persuasion and the use of trusted endorsers or so-called validators.³⁵

24. While vaccine uptake is high in many regions and countries, complex social factors drive hesitancy for some communities. For example, “a history of colonial medical and vaccine research abuse in Africa” was reported to diminish trust in current vaccines.³⁶ Scarcity and unpredictability of vaccine supply were also reported to have complicated the building of confidence in vaccines.³⁷ Alongside structural racism and economic precarity, hostile migration policies may also have contributed to vaccine inequity within countries and in urban settings in the COVID-19 context.³⁸ Indeed, vaccine hesitancy seems to be more likely in contexts of high inequality and where the enjoyment of the right of everyone to participate in decision-making is limited, as this affects the perception of people and groups about the State and its motives.³⁹

25. Behavioural science, including social psychology, can play a leading role in understanding what drives people’s decisions and behaviours and in addressing a range of psychological and social constraints to vaccine uptake.⁴⁰ While good information is critical to addressing vaccine hesitancy, it is not enough to bring about effective changes in behaviour; it needs to be partnered with active psychosocial interventions. There is no one-size-fits-all approach, and a sustainable investment in better understanding people’s concerns

³² Group of 20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response, *A Global Deal for our Pandemic Age* (2021).

³³ See <https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019>.

³⁴ Santiago Ripoll and others, “Vaccine equity in multicultural urban settings: a comparative analysis of local government and community action, contextualised political economies, and moral frameworks in Marseille and London” (London, The British Academy, 2022), p. 10.

³⁵ WHO Technical Advisory Group on Behavioural Insights and Sciences for Health, “Behavioural considerations for acceptance and uptake of COVID-19 vaccines” (Geneva, 2020), p. 2.

³⁶ Polydor Mutombo and others, “COVID-19 vaccine hesitancy in Africa: a call to action”, *The Lancet Global Health*, vol. 10, No. 3 (March 2022).

³⁷ Gavin Yamey and others, “It is not too late to achieve global covid-19 vaccine equity”, *British Medical Journal*, No. 376 (March 2022).

³⁸ MedAct, Migrants Organise and New Economics Foundation, “Patients not passports: migrants’ access to healthcare during the coronavirus crisis” (London, 2020); and Ripoll and others, “Vaccine equity in multicultural urban settings”, p. 5.

³⁹ Luisa Enria and others, “Power, fairness and trust: understanding and engaging with vaccine trial participants and communities in the setting up the EBOVAC-Salone vaccine trial in Sierra Leone”, *BMC Public Health*, vol. 16 (November 2016).

⁴⁰ A/75/982, para. 123. See also United Nations, Innovation Network, *Behavioural Science Report* (2021).

and developing behaviourally informed, tailored vaccination strategies, alongside targeted communication campaigns, is required. Interventions must be multiple, layered and deployed at the local level, taking into consideration the specific context. They need to make sure that they respond to people's inherent cognitive biases, including in the light of misinformation and disinformation campaigns⁴¹ that make it difficult for people to distinguish reliable information.⁴²

26. In this regard, it is important to work with communities to understand what their concerns and barriers to take-up are, and to address their concerns through meaningful participation in decisions that affect them. The use of information campaigns, surveys, interviews and various research methodologies can help contextualize interventions. Evaluations and rapid assessments help ensure that interventions are appropriate and customized and that messaging is developed to reduce perception-based vaccine hesitancy. Two-way communication between the community and the implementing organization can empower the community in its decision-making, and effectively engage gatekeepers, as well as faith-based organizations, faith communities and leaders.⁴³

27. WHO has been working to capture accurate and up-to-date social and behavioural data on the changing knowledge, attitudes and behaviours of people. WHO regional teams have been producing tools and have provided training to support the management of the COVID-19 pandemic.⁴⁴ The WHO Regional Office for Europe, for instance, developed a behavioural insights survey tool that has been used for the regular collection of behavioural data in 25 States in the region and beyond since March 2020.⁴⁵ This tool was adapted to the African region and tested and piloted in Nigeria and Zambia, where it allowed the identification of key barriers to be addressed with behaviourally informed interventions. In the Western Pacific, behavioural and perception data are also used to inform communication strategies and support decision-making in relation to the COVID-19 response. Behavioural design is also being integrated into COVID-19 campaigns. WHO, the United Nations Children's Fund (UNICEF) and the International Federation of the Red Cross are collaborating to review behavioural and social data from publicly available sources to ensure that their communications and operational approaches are closely aligned with people's perceptions, capacities and needs.⁴⁶

28. Another aspect that affects vaccine uptake is the accessibility of services, including in terms of the scheduling of appointments and the accessibility of vaccination sites. Making it easy for people to get vaccinated by introducing simplified appointment processes, providing rewards for vaccinations and working with trusted messengers was reported to have significantly increased vaccination uptake.⁴⁷ The diversification of those allowed to administer vaccines was also reported as a means of speeding up vaccine roll-out. In addition to doctors, the administration of vaccines was also carried out by health professionals such as nurses, paramedics, final-year medical students and pharmacists.⁴⁸ Large-scale vaccination campaigns that gave people the choice of the type of vaccine through a special website for registration and appointments were also mentioned in the submissions received. Such campaigns contributed to accelerating the vaccination process for all segments of society targeted for vaccination in a short period.⁴⁹ Providing COVID-19 vaccines free of charge for all was also among the measures mentioned to ensure vaccine uptake.⁵⁰

29. Some countries⁵¹ reported on specific measures taken to ensure access to COVID-19 vaccinations, such as mobile teams to overcome geographical barriers, which included

⁴¹ See <https://www.un.org/en/un-coronavirus-communications-team/un-tackling-%E2%80%98infodemic%E2%80%99-misinformation-and-cybercrime-covid-19>.

⁴² See <https://www.undp.org/stories/using-behavioural-insights-respond-covid-19>.

⁴³ See the submission of Save the Children.

⁴⁴ See <https://www.who.int/initiatives/behavioural-sciences/covid-sbi-data-collection>.

⁴⁵ See <https://www.who.int/europe/tools-and-toolkits/who-tool-for-behavioural-insights-on-covid-19>.

⁴⁶ United Nations, Innovation Network, *Behavioural Science Report*, p. 57.

⁴⁷ See, for example, the submissions of Iraq, Poland and Saudi Arabia.

⁴⁸ See the submission of Poland.

⁴⁹ See the submission of Bahrain.

⁵⁰ See the submission of Mauritius.

⁵¹ See, for example, the submissions of Azerbaijan, Bahrain, Ecuador and Mauritius.

deploying special vaccination teams by boat to ensure an inclusive approach in allocating and administering vaccines. Vaccine centres were also established at places frequented by large numbers of people, such as public squares, shopping centres, markets and parks.⁵²

30. Examples of specific efforts focusing on areas where vaccination targets had not been reached and the need for differentiated strategies because of a high vulnerability context, such as logistical barriers, remoteness, presence of social unrest or ethnic composition, were also provided.⁵³ Such efforts included the deployment of interdisciplinary medical health teams and the application of an intercultural approach, for example with regard to Indigenous communities.⁵⁴ Ensuring free and informed consent by Indigenous communities was reported to have been achieved through awareness-raising campaigns,⁵⁵ which involved several visits to communities to provide clear and reliable information regarding COVID-19 and vaccines. It was also reported that ensuring the vaccination of some Indigenous Peoples required inter-institutional cooperation and coordination.⁵⁶

31. Developing specific interventions to increase the rate of vaccination among specific groups, such as refugees and migrants⁵⁷ and women, has been key in increasing the uptake of COVID-19 vaccines in many countries. Focus group discussions with women in South Sudan, for example, helped to identify barriers to vaccination and allowed evidence-based advocacy through female influencers, leading to a significant increase in vaccination rates.⁵⁸

5. Role of local governments

32. While national Governments play important roles in the promotion and protection of human rights, cities and local and regional governments are at the forefront of bringing human rights to all. Local governments can play a key role in vaccination campaigns among local populations and in supporting and rolling out vaccination, including by making it more accessible and acceptable to the population. They have unique local knowledge and access to people, including those who are often less visible and marginalized. Acknowledging the need for increased collaboration with subnational authorities, the Secretary-General announced the creation of the Advisory Group on Local and Regional Governments in his report entitled “Our Common Agenda” (para. 119).

33. Specific examples of actions that national and local authorities may take include the mapping of inequalities and their root causes to be able to address them in the development and implementation of a vaccination strategy to reach the most marginalized. This would need to be supported by human rights-based needs assessments, including of persons with disabilities, in particular children with disabilities, women and girls, persons with high support requirements and older persons. Authorities at the local level are key, moreover, in ensuring uninterrupted accessibility to appropriate health-care and social services that are available to everyone on an equal and non-discriminatory basis.⁵⁹

34. Examples of initiatives by local governments to implement vaccination activities included deploying mobile vaccination teams to work with marginalized groups, engaging with asylum-seekers, establishing women-only vaccine clinics, addressing low vaccination uptake in men through sports-related activities, establishing outreach clinics for persons who were homeless, training local advocates and “community champions”, strategically selecting local venues, providing transport for people to reach vaccination sites and engaging with faith communities.⁶⁰ For those who were not able to register themselves, local governments and

⁵² See the submission of Guatemala.

⁵³ See the submission of Colombia.

⁵⁴ See the submission of Ecuador.

⁵⁵ See the submission of Iraq.

⁵⁶ See, for example, the submission of Ecuador.

⁵⁷ See WHO, “Strengthening COVID-19 vaccine demand and uptake in refugees and migrants: an operational guide” (Geneva, 2022).

⁵⁸ WHO and others, *Accelerating COVID-19 Vaccine Deployment: Removing Obstacles to Increase Coverage Levels and Protect Those at High Risk* (Group of 20, Washington, D.C., 2022), p. 26.

⁵⁹ Ripoll and others, “Vaccine equity in multicultural urban settings”, p. 16–20.

⁶⁰ See <https://www.local.gov.uk/our-support/coronavirus-council-information-and-support/covid-19-good-council-practice/covid-19-0>.

medical centres organized call centres and information services that helped people register and receive information about appointments and vaccination sites.⁶¹

6. Closing the data gap

35. A key function of data in the context of access to vaccines is to provide the evidence base required to identify concrete gaps, improve the formulation of targeted measures, monitor the implementation thereof and report on progress.

36. One of the failures of international cooperation during the pandemic has been the lack of timely, accurate and systematic data on infections, deaths, viral variants, health system responses and indirect health consequences. For example, fewer than half of countries worldwide reported data on COVID-19 cases and deaths that were disaggregated by sex. Consequently, the full extent of the impact of COVID-19 on women has not been accurately measured, while preliminary studies have found evidence that all women have been disproportionately affected by the pandemic.⁶² Another data gap that the pandemic has revealed relates to older persons.⁶³ Typically, older persons are represented in statistics as a single age cohort of 55 plus, 60 plus or 65 plus. This impedes targeted policy planning and responses, including in situations, such as emergency situations, in which the needs and rights of older persons are more likely to be overlooked.⁶⁴

37. Delivering national vaccination campaigns that can respond to the evolving epidemiological situation demands complete, real-time, granular and precise data, which were not available in many countries. Data disaggregation is a central element of a human rights-based approach to data, as it allows for an initial comparison and appraisal of certain groups with other population groups.⁶⁵ Although disaggregated and granular health data on social diversity are essential for effective action, some countries do not disaggregate data by ethnicity or other social dimensions. This impedes the identification of and response to health disparities; there is a need to review existing disaggregation protocols for data. However, safeguards need to be in place to avoid stigmatizing or scapegoating populations in the collection and communication of such data.⁶⁶

38. The pandemic has also shown the importance of improving data-monitoring systems for the most vulnerable groups to ensure that COVID-19 vaccine programmes are adjusted in line with evolving science and needs. Going forward, there is a need to set standards and reporting requirements for data-gathering in order to improve the existing data ecosystem and as an important impetus for statistical offices to gather more data and for data to be more granular in relation to critical sociodemographic variables.⁶⁷ The new WHO Hub for Pandemic and Epidemic Intelligence will support countries, regional and global actors with better access to data, better analytical capacities and better tools and insights for decision-making.⁶⁸

7. Responding to misinformation and disinformation

39. The COVID-19 pandemic demonstrated the importance of access to information and spaces for free and vibrant debate for an effective pandemic response. It also showed the threats and challenges that misinformation and disinformation pose to societies globally. The proliferation of misinformation and disinformation – termed an “infodemic” by WHO⁶⁹ – has contributed to undermining the global response to the pandemic and has contributed to

⁶¹ See the submission of Serbia.

⁶² See <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2901651-2>.

⁶³ United Nations, “Policy brief on the impact of COVID-19 on older persons” (2020).

⁶⁴ [A/HRC/45/14](#), para. 33.

⁶⁵ Office of the United Nations High Commissioner for Human Rights, “A human rights-based approach to data: leaving no one behind in the 2030 Agenda for Sustainable Development” (Geneva, 2018), p. 7.

⁶⁶ Ripoll and others, “Vaccine equity in multicultural urban settings”, p. 10; and Sekalala and others, “An intersectional human rights approach to prioritising access to COVID-19 vaccines”.

⁶⁷ [A/HRC/45/14](#), para. 81.

⁶⁸ Available at <https://pandemichub.who.int/>.

⁶⁹ See <https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019>.

vaccine hesitancy.⁷⁰ The amount of disinformation and misinformation about COVID-19, including about the production, effects and distribution of COVID-19 vaccines, was unprecedented.⁷¹ Anti-vaccination communities have emerged that have supporters from a diverse spectrum of the population, including some extremist groups.⁷²

40. Misinformation, disinformation and the politicization of health information impede access to vaccines; as such, they undermine the right to health.⁷³ When people lack access to credible, objective and evidence-based information, and there is no open public debate, their ability to make informed decisions about their own health, including vaccines, is limited.

41. For universal vaccination roll-out to be successful, trust is key. Trust relies on both credible, objective, timely and accessible information, including on benefits and risks, and public debates based on scientific facts and evidence. In addition, it is essential to ensure the application of a human rights-based approach that considers social inclusion, gender, interculturality and generational, intergenerational and intersectionality aspects.⁷⁴

42. UNICEF, for example, has been working on reducing the spread of misinformation related to COVID-19. In India and Indonesia, UNICEF has applied the behavioural science-informed concept of “inoculation” or “pre-bunking” to mitigate the spread of misinformation on digital channels. This exposes participants to tactics used by purveyors of misinformation to reduce the likelihood that they will believe it. In Kyrgyzstan, two ongoing behavioural science studies also focused on COVID-19, testing the introduction of “cognitive speedbumps” to encourage people to reflect on information accuracy, which would reduce the probability of sharing inaccurate information on social media.⁷⁵

43. Large-scale media campaigns, including on social media, radio and television and in several languages, were reported to have played a major role in raising awareness of the importance of vaccines in ensuring protection against moderate to severe infections and deaths and contributed to the success of COVID-19 vaccine programmes.⁷⁶

B. Widening universal health coverage

44. In a pandemic context in particular, access to safe, effective, equality and affordable essential medicines and vaccines for all is a central element of universal health coverage.⁷⁷ The COVID-19 pandemic highlighted that respecting the right to health extends beyond purchasing vaccines. What is needed are realistic, feasible and increased investments to strengthen national health systems and the widening of universal health coverage, grounded in human rights norms and principles. Preparedness for future pandemics requires a more coordinated, comprehensive and resilient global health system.⁷⁸

45. It has been shown that the COVID-19 response was most effective in countries with adequate public health infrastructures and health-care systems that were adequately funded and well equipped in terms of tools, facilities and personnel. Gaps in capacity slowed preparation for and response to COVID-19, disproportionately affecting low and middle-income countries.⁷⁹

⁷⁰ See <https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation>.

⁷¹ A/77/287, paras. 47–61; and A/HRC/51/13, paras. 47, 60–61 and 67 (c).

⁷² Counter-Terrorism Committee Executive Directorate, “Update on the impact of the COVID-19 pandemic on terrorism, counter-terrorism and countering violent extremism” (2021).

⁷³ Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 44.

⁷⁴ See the submission of Ecuador.

⁷⁵ United Nations, Innovation Network, *Behavioural Science Report*, p. 34.

⁷⁶ See the submission of Bahrain.

⁷⁷ E/2019/52, para. 7.

⁷⁸ Stimson Center, *UN 2.0: Ten Innovations for Global Governance: 75 Years Beyond San Francisco* (Washington, D.C., 2020), p. 53.

⁷⁹ See https://www.unaids.org/en/resources/presscentre/featurestories/2021/october/20211021_dose-of-reality.

46. The existence of growing inequalities and inequities in access to health care and services in some of the wealthiest countries, contrasted with the success of other countries in extending coverage despite their resource-poor settings, strongly suggests that policies affecting health coverage are frequently political choices. Such choices may disregard the right to health by failing to consider the resources actually or potentially available for health.⁸⁰

47. The COVID-19 pandemic has exposed inconsistencies in the implementation of universal health coverage. Universal health coverage – where all individuals and communities receive the health services they need, without undue financial hardship – means committing the maximum available resources towards meeting the minimum core obligations under the right to health, including access to vaccines and essential medicines, goods and services. To lay the foundations for the future, States need to step up their investments in core health system functions, namely those “common goods for health” that are fundamental to protecting and promoting the right to health.⁸¹ A functioning health system needs core essential functions to deliver vaccines at scale: a trained, remunerated and effective workforce, a robust supply chain, capacity to engage with and mobilize communities and address questions about vaccination through dialogue, and a mix of appropriate vaccine delivery sites and data and monitoring systems.⁸²

C. Bolstering international cooperation and innovative partnerships

48. The lack of effective international cooperation and a multilateral and coordinated approach and responses by some Governments that were not in line with their human rights obligations, including in terms of applying the intellectual property rights regime in a human rights-compliant manner with regard to technology transfer, international financing, the allocation of vaccines and support for vaccine production in low- and middle-income countries, have led to inequitable access to vaccines.

49. The pandemic has shown the need to deepen international cooperation, in line with applicable human rights standards, to enable all people to share the benefits of scientific and technological progress, including access to vaccines as a global public good. International assistance and cooperation between developed and developing countries are crucial to ensure that all relevant health technologies, intellectual property data and know-how on vaccines and treatment in the context of a pandemic response are seen as a global public good.

50. In accordance with the human right to science, scientific knowledge, information and advances must be shared and made accessible to all, without discrimination.⁸³ Article 15 of the International Covenant on Economic, Social and Cultural Rights not only enshrines the right to enjoy the benefits of scientific progress and its applications, but also affirms the benefits to be derived from international scientific cooperation. States should, therefore, direct their own resources and coordinate the actions of others to ensure scientific progress and that the applications and benefits thereof are distributed and are available, in particular to groups in vulnerable and marginalized situations.⁸⁴ There were some significant examples of sharing scientific knowledge in the context of COVID-19, but production was mainly market-driven, despite the significant public monies invested. Decision makers rarely considered their obligations to protect the right to health of their populations as commensurate with their obligations in terms of international cooperation.

51. A key constraint to achieving universal access to COVID-19 vaccines has been the allocation of doses, with developing countries finding themselves at the back of the vaccine delivery queue. Licensing processes to expand vaccine production capacity were unduly complex and restrictive. Vaccines against COVID-19 should be treated as global public goods and all options, including voluntary licences and technology transfers, patent pooling

⁸⁰ E/2019/52, para. 40.

⁸¹ United Nations, Policy Brief, “COVID-19 and universal health coverage” (2020), p. 15.

⁸² WHO and others, *Accelerating COVID-19 Vaccine Deployment*, p. 27.

⁸³ Article 27 of the Universal Declaration of Human Rights refers to the right of everyone to share in scientific advancement and its benefits. See also Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020).

⁸⁴ Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), para. 16.

and flexibility on intellectual property rights, should therefore be explored.⁸⁵ With an ample global supply of vaccines now available, focus is shifting to supply chain logistics and national vaccine distribution plans.⁸⁶

52. A significant aspect of the COVID-19 response has been the success of public-private partnerships for the rapid development of vaccines. This illustrates the crucial role of government funding for public goods such as vaccines and essential medicines. At the same time, publicly funded intellectual property ended up entirely in non-governmental hands, which allowed for the exercise of monopoly rights and the charging of prices for vaccine doses that were much higher than the actual costs of manufacturing. Incentives are needed to delink research and development from the price of products and encourage companies to join the Medicines Patent Pool, which encourages non-exclusive voluntary licensing.⁸⁷

53. Equitable and efficient distribution of investment in research and vaccines requires more public oversight, integrating a rights perspective over research spending, production and distribution.⁸⁸ Fiduciary duty to shareholders should not be prioritized, as it was in the case of COVID-19, over respect for human rights. It has been shown that treating human rights as optional can exacerbate crises. Fully respecting the right to health includes refraining from invoking intellectual property rights in a manner that is inconsistent with the right of every person to have access to a safe and effective vaccine for COVID-19.⁸⁹ It also requires, in taking decisions regarding pricing and distribution, that the adverse impacts that such decisions might have with regard to discriminatory access to vaccines, in particular for those in situations of vulnerability and marginalization, are considered.⁹⁰

54. Despite inequities in distribution, innovative partnerships have been instrumental in facilitating access to COVID-19 vaccines. WHO and many partners⁹¹ have joined forces with Member States, civil society, the private sector, including industry, and others in supporting the development and equitable distribution of tests, treatments and vaccines.⁹²

55. The Access to COVID-19 Tools (ACT) Accelerator was launched in April 2020 to ensure the rapid development of vaccines, diagnostics and therapeutics and equitable access to those tools.⁹³ Its vaccines pillar, the COVID-19 Vaccine Global Access (COVAX) Facility, had delivered over 1.77 billion vaccine doses to 87 low- and lower-middle-income countries around the world as at 10 October 2022. COVAX shipments account for an estimated 82 per cent of vaccines delivered to low-income countries and the majority of COVID-19 vaccines administered in humanitarian settings. This collaboration was the fastest, largest and most complex global vaccination effort in history.⁹⁴ It was hampered, however, by export bans, the prioritization of bilateral deals between manufacturers and countries, ongoing challenges in scaling up vaccine production and delays in filing for regulatory approval.⁹⁵

56. Another partnership that was enacted in 2021, as supply constraints eased, although the pace of vaccination continued to vary across countries, was the COVID-19 Vaccine

⁸⁵ [A/HRC/49/35](#), paras. 4, 53 and 63.

⁸⁶ See the submission of WHO.

⁸⁷ [A/HRC/20/26](#), para. 74 (l).

⁸⁸ WHO, *Global Vaccine Market Report 2022: A Shared Understanding for Equitable Access to Vaccines* (Geneva, 2022).

⁸⁹ [E/C.12/2021/1](#), para. 6 ff.

⁹⁰ See https://www.ohchr.org/Documents/Events/COVID-19_AccessVaccines_Guidance.pdf.

⁹¹ The Bill and Melinda Gates Foundation, the Coalition for Epidemic Preparedness Innovations, the Gavi Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Unitaids, the Foundation for Innovative New Diagnostics, the Wellcome Trust, the World Bank Group and UNICEF.

⁹² See the submission of WHO.

⁹³ Ibid.

⁹⁴ See <https://www.who.int/news/item/20-05-2022-covax-calls-for-urgent-action-to-close-vaccine-equity-gap#:~:text=COVAX%20has%20access%20to%20enough,income%20countries%20remaining%20furthest%20behind>.

⁹⁵ See <https://news.un.org/en/story/2021/09/1099422>. On 8 December 2022, the Board of the Gavi Alliance decided, in principle, to integrate future COVID-19 vaccinations into its core programming (see <https://reliefweb.int/report/world/gavi-board-decisions-outline-year-renewal-vaccine-alliance>).

Delivery Partnership. This inter-agency initiative is aimed at accelerating vaccination coverage in countries that face the biggest challenges in reaching their vaccination targets. The partnership approach of “one country team, one plan, one budget” is key to aligning the actions of bilateral and multilateral partners for fast and equitable vaccine delivery. In addition, the ACT-Accelerator Hub was established to increase the distribution of vaccines to and within countries. In July 2022, WHO updated the Global COVID-19 Vaccination Strategy in a Changing World.⁹⁶

57. The pandemic revealed the need to critically examine whether the global health ecosystem is equipped to confront structural inequalities and to strengthen coordination between health and finance institutions. Progress has been made in achieving the new financial tool led by the Group of 20, the Financial Intermediary Fund, which is a multilateral mechanism dedicated to pandemic preparedness and response financing to address the current gaps, including through closer and durable cooperation between finance and health decision makers. The new fund was officially launched on 13 November 2022 and is expected to bring additional, long-term, dedicated resources, incentivize countries to increase investments in pandemic preparedness and response and enhance coordination among partners.⁹⁷

58. Building resilience against future pandemics requires mobilizing greater and sustained investments in human rights, including in relation to access to medical care and treatment. The world is interconnected, but investment in global public goods is not yet seen as part of the mutual interest of countries, flowing from their duty to their own people. There should be a greater recognition of the need for international cooperation for the realization of economic, social and cultural rights in relation to vaccine equity in order to uphold the right to health and the right to enjoy the benefits of scientific progress.

D. Stronger legal frameworks anchored in human rights

59. One of the lessons from the COVID-19 pandemic is the need for pandemic-related, collaborative global guidelines, norms and stronger legal frameworks grounded in human rights.⁹⁸ Some of the challenges in ensuring universal access to COVID-19 vaccines have resulted from the failure of high-income countries to act in accordance with their obligations under international human rights law. It is therefore essential to affirm the legal nature of the obligations as opposed to emphasizing their moral imperative, clearly differentiating them from a welfare approach,⁹⁹ and for these obligations to be properly reflected in related policies.

60. At the same time, the pandemic has also revealed the need for stronger legal frameworks for vaccine distribution to enhance government oversight of vaccine research, production and distribution and to better align national interests with global public health objectives. There is a need to create a more favourable intellectual property landscape, proactive technology transfers and the building and retention of local technical and regulatory capacity.¹⁰⁰ The interpretation of the Agreement on Trade-Related Aspects of Intellectual Property Rights in line with the existing flexibilities in trade regulations for emergencies to protect public health and, in particular, to promote access to medicines for all, should be adopted as a good practice, in particular, but not only, during pandemics and other health emergencies.¹⁰¹ Human rights in this context should not be seen as optional but as useful policy guardrails.

61. The working draft of a prospective international instrument on pandemic planning, preparedness and response includes applicable principles, such as respect for human rights, including the right to health, universal health coverage, health equity, One Health,

⁹⁶ See the submission of WHO.

⁹⁷ See <https://www.who.int/news/item/09-09-2022-new-fund-for-pandemic-prevention--preparedness-and-response-formally-established>.

⁹⁸ Stimson Center, *UN 2.0: Ten Innovations for Global Governance*, p. 53; and [A/75/982](#), para. 99.

⁹⁹ See the submission of the Groningen Centre for Health Law.

¹⁰⁰ WHO, *Global Vaccine Market Report 2022*, p. 6.

¹⁰¹ [A/HRC/49/35](#), paras. 10, 17 ff. and 63.

transparency, accountability, gender equality, non-discrimination and respect for diversity and the rights of vulnerable populations.¹⁰² It is hoped that these essential principles will continue to form the foundation of the prospective international instrument.

62. It is essential, in this regard, to ensure the meaningful, inclusive and safe participation of all stakeholders from all regions, including civil society organizations, communities and community health workers, in the process of the development of the above-mentioned instrument. Continuous engagement in human rights requires formal opportunities for non-State actors, including civil society, beyond those that have an official relationship with WHO, to provide input throughout the drafting process. Participatory mechanisms, structures and processes should reflect the diversity of society and ensure the representation of all populations and groups, in particular those at risk of being excluded or marginalized. The right to meaningfully participate should also be incorporated substantively into the prospective instrument.

63. Any prospective instrument on pandemic planning, preparedness and response should provide for a well-coordinated global approach to the development and distribution of vaccines, medicines and treatments. States should ensure that these products are available, affordable and accessible to everyone on the basis of non-discrimination. Vaccine delivery and distribution should be done on the basis of transparent and inclusive human rights-compliant protocols and procedures.

III. Conclusions and recommendations

64. Universal and equitable access to vaccines, medicines and treatments is a determinant of the right to health and is essential to reversing the trajectory of any pandemic. In a population with a high rate of vaccination, the risk of transmission diminishes, the risk of severe illness and hospitalization decreases and the chances of new variants emerging are reduced. Vaccine equity is a fundamental dimension of levelling up and supporting more equitable recoveries from the COVID-19 pandemic. Sustaining a coordinated global response is key to ending the pandemic.

65. Decisions made today against the background of the COVID-19 pandemic will influence the course of future pandemics. Lessons learned show that the international community must act together with unity and renewed multilateralism to create an enabling global environment free of structural obstacles, in which human rights can be protected in times of crisis. As called for in the report of the Secretary-General entitled “Our Common Agenda” and in the Secretary-General’s Call to Action for Human Rights, international cooperation should be inclusive, networked and human rights-centred.

66. Ensuring universal and equitable access to vaccines requires the sustained and collaborative engagement of public and private sector entities and actors at all levels, from the grassroots to the international levels.

67. On the basis of the lessons learned from the COVID-19 pandemic so far, the United Nations High Commissioner for Human Rights recommends that States and all relevant actors ensure:

(a) Enhanced government oversight of vaccine research, production and distribution to translate the call for COVID-19 vaccines to be treated as a global public good into action;

(b) Better alignment of national interests with global public health objectives through stronger legal frameworks for vaccine distribution anchored in human rights, and through more networked, inclusive and effective multilateralism;

(c) The implementation of vaccination strategies that are human rights-based, sustainable, flexible and adaptable, with the objective of protecting populations nationally and globally;

¹⁰² See <https://apps.who.int/gb/inb/>.

- (d) That efforts are stepped up towards universal health coverage, including through strengthened collective investments in countries' health systems;
- (e) The building of trust to counter disinformation and misinformation by providing credible, objective, timely and accessible information on COVID-19 vaccination, including the benefits and risks of the different vaccines, and by carrying out public debates on the basis of scientific facts and evidence;
- (f) Greater national and regional resilience by stepping up countries' capacity to research, develop and produce vaccines and distribute all the essential tools for pandemic control;
- (g) That vaccine hesitancy is addressed through multiple and layered interventions, including at the local level, taking into consideration the context and using social and behavioural data alongside biomedical data to ensure a response that is tailored and adapted to the needs of the population;
- (h) The stimulation of vaccine demand through the use of a variety of country-specific approaches to facilitate access to vaccinations, including mass vaccination sites in dense urban areas and flexible local capacity and mobile clinics;
- (i) The closure of the data gap by improving data collection, data disaggregation and monitoring systems to ensure that vaccine programme plans can be adjusted in accordance with evolving science and needs;
- (j) That international cooperation and innovative partnerships are encouraged, in line with human rights obligations, policy coherence, coordination and integrated approaches at all levels to respond effectively to future pandemics;
- (k) That all relevant stakeholders, including businesses, assume their shared but differentiated human rights responsibilities and obligations and commit to responsible innovation and to harnessing technology fairly;
- (l) The meaningful and formal participation of relevant actors in the elaboration of the prospective international instrument on pandemic planning, preparedness and response to ensure ongoing engagement on and grounding in human rights.
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