**WHO’s response to the Call for Inputs: Human Rights Council Resolution 49/25:** Ensuring equitable, affordable, timely and universal access for all countries to vaccines in response to the coronavirus disease (COVID-19) pandemic

Further to the Human Rights Council *Note Verbale* regarding the above resolution and requested report, WHO is pleased to provide an update of its ongoing work to advance the right to health through affordable, timely, equitable, universal access to COVID-19 vaccines through its advocacy on Vaccine Equity and innovative collaborations with WHO partners via the Access to COVID-19 Tools Accelerator (ACT-A) and COVAX, the vaccines pillar of ACT-A. .

WHO’s leadership in advocating for global solidarity in ensuring access to COVID-19 diagnostics, treatments and vaccines, is based on its constitutional principles, which recognize the enjoyment of the highest attainable standard of health as a fundamental human right, without distinction based on race, religion, political belief, economic or social condition.[[1]](#footnote-2) WHO’s 13th General Programme of Work (GPW 13), based on Sustainable Development Goal 3 and associated targets on health and well-being, established the Triple Billion Goals in its mission to Promote Health, Keep the World Save and Serve the Vulnerable. [[2]](#footnote-3) To achieve the transformative cross-SDG commitment to Leave No One Behind, GPW 13 commits to stepping up leadership in health diplomacy, human rights, gender equality and health equity across the three levels of the organization. This also aligns with the current vision of WHO Director-General on the renewed global health architecture for health emergency preparedness, response and resilience which emphasizes the need to advance gender equity and human rights.

1. **Human Rights Impacts: The COVID-19 Pandemic and Access to Vaccines**
2. Human rights, gender and health equity as central to WHO’s response to COVID-19,[[3]](#footnote-4) including the need for multisectoral “whole of society, whole of government” and “Health in All Policies” approaches that deal comprehensively with the determinants of health and vulnerability to COVID-19.2 As affirmed in WHO’s Constitution, the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, the right to health is a fundamental human right and – as our collective experience with COVID-19 unequivocally demonstrated - inextricably linked and interdependent on other social, economic, civil and political rights, including the right to development. The right to health includes, as WHO has repeatedly stated, the right of everyone to benefit equitably from advances in scientific progress and its applications, including global public health goods such as COVID-19 vaccines.[[4]](#footnote-5) WHO remains deeply concerned regarding ongoing inequities in vaccine coverage which result from the severe supply constraints and inequitable access to vaccine doses in 2021 but also ongoing constraints in access to immunization services, perceptions of disease risk, competing health and non-health priorities, financing for delivery and political leadership. Along with the Secretary-General, WHO DG, Dr Tedros and other senior WHO leadership have warned over the past two years about the dangers of “vaccine nationalism”, including emerging variant strains and sub-strains of SARS-CoV-2 that may undermine the efficacy of currently approved vaccines.[[5]](#footnote-6) This issue has been raised by the WHO Director-General through interventions at the Human Rights Council, including UNGA, G7 and G20 meetings, underscoring including the right to health, right to development and the right to benefit equitably from scientific progress and its applications.[[6]](#footnote-7) Dr Tedros has also urged that public health and social measures ensure that human rights are respected*:* “Integrating human rights protections into the response to COVID-19 is not only a moral imperative, it is a binding legal obligation. Respect for all human rights will be fundamental to the success of the public health response”.[[7]](#footnote-8)
3. As of 14 October 2022, there were almost 621 million confirmed cases of COVID-19 and over 6.5 million deaths.[[8]](#footnote-9) As WHO Director-General (DG), Dr Tedros Ghebreyesus states in WHO’s updated ***Strategic Preparedness, Readiness and Response Plan to end the Global COVID-19 Emergency in 2022***, these numbers underestimate the actual number of COVID-19 cases and deaths.[[9]](#footnote-10) WHO released an updated estimate of excess deaths directly or indirectly related to COVID-19 (“excess mortality”) between 1 January 2020 and 31 December 2021 of approximately 14.9 million (range 13.3 million to 16.6 million).[[10]](#footnote-11) In addition to the direct impacts that inequitable vaccine access has on the right to health and the right to life, it has contributed to the severity and scope of the COVID pandemic which has had disastrous impacts on other social and economic rights, driving tens of millions into poverty, hunger, economic insecurity and undermining hard-fought gains on SDG 3 targets and many other SDGs.[[11]](#footnote-12)
4. **Good Practice Examples: Innovative Partnerships for universal, equitable vaccines**
5. In April 2020 WHO, together with the European Commission, France and The Bill & Melinda Gates Foundation (BMGF), launched the Access to COVID-19 Tools (ACT) Accelerator with two goals: (1) the rapid development of vaccines, diagnostics and therapeutics; (2) equitable access to those tools. This set the basis for the formation of a partnership among WHO, BMGF, the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), Unitaid, the Foundation for Innovative New Diagnostics (FIND), the Wellcome Trust, the World Bank Group, and UNICEF as implementing partners. WHO and its partners have joined forces with Member States, industry, civil society, private sector and others to speed up an end to the pandemic by supporting the development and equitable distribution of the tests, treatments and vaccines the world needs to reduce mortality and severe disease, restoring full societal and economic activity globally in the near term and facilitating high-level control of COVID-19 disease in the longer term.
6. As of 10 October 2022, the COVID-19 Vaccine Global Access (COVAX) Facility - the Vaccines Pillar of the ACT-Accelerator partnership – delivered over 1.77 billion vaccine doses to 87 low and lower-middle income countries around the world. COVAX shipments account for an estimated 75% of vaccines delivered to low-income countries, the majority in humanitarian settings. This collaboration is the fastest, largest and most complex global vaccination effort in history, and has helped raise the global proportion of people protected by a primary vaccine course to 63%.[[12]](#footnote-13)
7. WHO’s collaboration with partners, through the COVAX Advance Market Commitment (AMC) mechanism, voluntary patent pooling through the COVID-19 Technology Access Pool (C-TAP) and advocacy is facilitating the acquisition and delivery of vaccines to lower income countries, guided by the ***Fair Allocation Mechanism for COVID-19 vaccines***,[[13]](#footnote-14) the ***WHO Strategic Advisory Group on Immunization and Vaccines (SAGE***) ***Values Framework for the allocation and prioritization of COVID-19 vaccination,[[14]](#footnote-15)*** and updated ***Roadmap For Prioritizing Use Of COVID-19.***[[15]](#footnote-16) This guidance expressly incorporates human rights, gender equality and equity considerations in the acquisition and distribution of vaccines among and within countries, informed by research on vaccine hesitancy and the gendered impacts of COVID-19 on women, including the almost 70% of women working in the health and care workforce. The WHO/UNICEF collaboration on the Country Readiness and Delivery workstream of COVAX developed the [***Guidance on Developing a National Deployment and Vaccination Plan for COVID-19 Vaccines***](https://www.who.int/publications-detail-redirect/WHO-2019-nCoV-Vaccine_deployment-2020.1), supporting national vaccine delivery and planning.[[16]](#footnote-17)
8. In January 2021, WHO Director-General, Dr Tedros Ghebreyesus launched the ***Vaccine Equity*** campaign, calling on Member States, foundations, donors, vaccine manufacturers and other actors to work collectively to achieve the goal of WHO’s ***Strategy to Achieve Global Covid-19 Vaccination***, with a vaccination target of reaching 70% of the population in every country by mid-2022. The growing inequalities and inequities in access to public health goods due to COVID-19 informed WHO’s decision to dedicate a year-long campaign, launched on World Health Day 2021, with Five Key Actions to address growing health inequalities and inequities within and among countries, with an aim to build fairer, more equitable health systems.[[17]](#footnote-18)
9. In January 2022, WHO, UNICEF and GAVI launched the ***COVID-19 Vaccine Delivery Partnership***, a collective international partnership with a ‘One Country Team, One Plan, One Budget’ focus on 34 low-coverage countries to accelerate COVID-19 vaccination and secure a step-change in vaccination rates. In addition, the ACT-Accelerator Hub was established to increase distribution of vaccines to and within countries.
10. In July 2022, WHO updated the ***Strategy to Achieve Global Covid-19 Vaccination***. The ***Global COVID-19 Vaccination Strategy in a Changing World*** provided an update on global vaccination targets and metrics. A modelling study estimated that 20 million lives have been saved due to COVID-19 vaccine administration, which has cut deaths by 63%.[[18]](#footnote-19) A highly vaccinated population diminishes the risk of transmission, lowers the risk of severe illness and hospitalization, and reduces the chances of new variants emerging.
11. **Key Challenges in ensuring universal, equitable access to COVID-19 vaccines**
12. Thanks to the ACT-Accelerator and COVAX facility partnerships, the failures of vaccine equity commitments during 2021 have been largely overcome. Global COVID-19 vaccine supply is now abundant with yearly manufacturing capacity of 11-16 billion vaccine doses, and ample volumes available for lower income countries through contracts and donations via the COVAX Facility, regional mechanisms, and bilateral approaches.[[19]](#footnote-20)
13. Transmission reduction through vaccination has been difficult to achieve due to the inadequate response to the Vaccine Equity campaign in 2021 and the resources required to deliver on the vaccination targets outlined in the ***Strategy to Achieve Global COVID-19 Vaccination***. Estimates show that approximately 600,000 deaths could have been averted globally if all countries had reached 40% primary series vaccination coverage by the end of 2021, a target for which there was sufficient supply if COVID-19 vaccines had been equitably distributed.[[20]](#footnote-21)The development of viral mutations, such as the Delta and Omicron strains and sub-strains, underscores the ongoing need for a coordinated global response that leverages the innovative partnerships that have facilitated the significant improvements in access. Although 63% of the world’s population has received a primary vaccination series, significant disparities exist between regions and income groups.[[21]](#footnote-22)
14. The innovative partnerships outlined above have been instrumental in facilitating access to COVID-19 vaccines. To provide actionable approaches to meet the 2022 SPRP objectives, WHO produced six policy briefs, synthesizing technical guidance on testing, clinical management, vaccination targets, infection control procedures, community engagement and managing the COVID-19 Infodemic.[[22]](#footnote-23)
15. **Ongoing Work: International Pandemic Treaty/Accord/Instrument**
16. Pursuant to World Health Assembly (WHA) Resolution 73.1*: COVID-19 Response*, which called for, *inter alia*, the creation of an independent evaluation of the global COVID-19 response, in addition to ongoing assessments of the COVID-19 response pursuant to mechanisms under the International Health Regulations (IHR) and WHO Health Emergencies Programme, several reports were submitted in advance of the 74th WHA (24 – 31 May 2021) for discussion. These included the Director-General’s Report on Implementing WHA Res. 73.1,[[23]](#footnote-24) the final report of the Independent Panel on Pandemic Preparedness and Response (IPPPR),[[24]](#footnote-25) the report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response,[[25]](#footnote-26) and the report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme.[[26]](#footnote-27)
17. From 29 November – 1 December 2021, WHA Member States held a Special Session on COVID-19 and passed WHASS2/2021/REC/1, establishing, *inter alia*, a Member State Intergovernmental Negotiating Body (INB), tasked with negotiating the drafting of a new international instrument on pandemic planning, preparedness, response.[[27]](#footnote-28) Following extensive consultations with WHA Member States and technical experts, a working draft of the treaty was circulated for comment, which includes in Article 4, applicable principles for the proposed Zero Draft including the right to health, universal health coverage, respect for human rights, health equity, One Health, transparency, accountability, gender equality, non-discrimination and respect for diversity and the rights of vulnerable populations.[[28]](#footnote-29) Additional Informal Focused Consultations with subject-matter experts were conducted in September and October to develop a Zero Draft of the pandemic treaty for submission to the WHA Executive Board in January 2023.

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