



INEQUALITY OF PANDEMIC PROPORTIONS

STATE AND PHARMA FAILURES NOT TO BE REPEATED

AMNESTY
INTERNATIONAL



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Cover image: A man wearing a face mask as a precaution, walks past a wall with an awareness graffiti during the Covid-19 pandemic. Nairobi, Kenya. 5 February 2020. © 2020 SOPA Images

As the Covid-19 pandemic enters its fourth year, this briefing identifies four key lessons from the failure of states and pharmaceutical companies to comply with their human rights obligations and responsibilities to ensure fair access to Covid-19 vaccines globally. It further makes concrete recommendations for structural changes to ensure the world can withstand future pandemics collectively, without leaving anyone behind.

1. METHODOLOGY

This briefing summarizes how both states and key pharmaceutical companies have fared vis-à-vis their human rights obligations on universal access to Covid-19 vaccines at the three-year mark of the World Health Organization declaring Covid-19 a pandemic. It provides an update to Amnesty International's three prior reports on the topic from 2020 to 2022: *A Fair Shot: Ensuring Universal Access to Covid-19 Diagnostics, Treatments and Vaccines*;¹ *A Double Dose of Inequality: Pharma Companies and the Covid-19 Vaccines Crisis*;² and *Money Calls the Shots: Pharma's Response to the Covid-19 Vaccine Crisis*.³

All leading vaccine manufacturers mentioned in this report - AstraZeneca plc (AstraZeneca), BioNTech SE (BioNTech), Johnson & Johnson, Moderna, Inc. (Moderna), and Pfizer, Inc. (Pfizer) - have been contacted by Amnesty International about their policies and practices regarding Covid-19 vaccines during the pandemic. The two specific reports by Amnesty focused on pharmaceutical companies' record include copies of the correspondence with the companies. Updated information on vaccine allocation was provided by Airfinity, a science information and analytics company. Please note that in this report, Amnesty International uses the World Bank income bands to aid our analysis of global vaccine equality, but recognizes that these categories have important limitations.⁴

2. INTRODUCTION: ENTERING THE FOURTH YEAR OF THE COVID-19 PANDEMIC

As the Covid-19 pandemic enters its fourth year, the World Health Organization (WHO) has reported more than 758 million cumulative Covid-19 cases that have claimed nearly 7 million lives,⁵ though the number of Covid-related deaths is estimated to be as high as 27 million, if considering excess deaths that go unrecorded as such.⁶ While many countries seemed to be emerging from the Covid-19 pandemic in 2022, the world faced a surge in cases and deaths towards the end of the year, which in turn led to a steep increase in deaths in early 2023. During the week of 12 December 2022, the WHO recorded an increase of 222% in Covid-19 cases, and a 60% increase in deaths during the week of 2 January 2023.⁷ China faced the highest spike, reporting a nearly 900% weekly increase in cases and 125% weekly increase in deaths in the same period.⁸ As of March 2023, the global number of Covid-19 cases and deaths has decreased significantly, but the virus continues to be very much present around the globe, with more than 1 million confirmed cases at any given time and more than 160,000 Covid-19 recorded deaths so far this year.⁹

In January 2023, the World Health Organization extended its declaration that the Covid-19 pandemic was an international public health emergency into its fourth year.¹⁰ The lessons of the last three years show that

¹ Amnesty International, *A Fair Shot: Ensuring Universal Access to Covid-19 Diagnostics, Treatments and Vaccines*, (Index: POL 30/3409/2020), 8 December 2020, [amnesty.org/download/Documents/ POL3034092020ENGLISH.PDF](https://www.amnesty.org/download/Documents/POL3034092020ENGLISH.PDF)

² Amnesty International, *A Double Dose of Inequality: Pharma Companies and the Covid-19 Vaccines Crisis* (Index: POL 40/4621/2021), 22 September 2021, [amnesty.org/en/documents/pol40/4621/2021/en/](https://www.amnesty.org/en/documents/pol40/4621/2021/en/)

³ Amnesty International, *Money Calls the Shots : Pharma's Response to the Covid-19 Vaccine Crisis* (Index POL 40/5140/2022), 14 February 2022, [amnesty.org/en/documents/pol40/5140/2022/en/](https://www.amnesty.org/en/documents/pol40/5140/2022/en/)

⁴ This briefing refers to country income levels as high-income, upper-middle-income, lower-middle-income, low-income, per the World Bank classifications. World Bank, World Bank Country and Lending Groups, datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

⁵ World Health Organization (WHO), WHO Coronavirus (COVID-19) Dashboard, covid19.who.int/ (accessed on 5 March 2023), "Overview".

⁶ The Economist, "The pandemic's true death toll", updated on 6 March 2023, [economist.com/graphic-detail/coronavirus-excess-deaths-estimates](https://www.economist.com/graphic-detail/coronavirus-excess-deaths-estimates)

⁷ WHO, WHO Coronavirus (COVID-19) Dashboard, covid19.who.int/ (accessed on 5 March 2023), "Overview".

⁸ WHO, WHO Coronavirus (COVID-19) Dashboard, covid19.who.int/ (accessed on 5 March 2023), "Overview: China".

⁹ WHO, WHO Coronavirus (COVID-19) Dashboard, covid19.who.int/ (accessed on 5 March 2023), "Overview".

¹⁰ WHO, "Statement on the fourteenth meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic", 30 January 2023, [who.int/news/item/30-01-2023-statement-on-the-fourteenth-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-coronavirus-disease-\(covid-19\)-pandemic](https://www.who.int/news/item/30-01-2023-statement-on-the-fourteenth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic)

international cooperation is paramount to ensure that the rights of all people are protected, no matter where they live, and that human rights must be at the centre of any response. The Covid-19 pandemic also demonstrated the heightened need for increased international assistance and cooperation, with several states lacking the financial and technical resources to effectively protect people from the impacts of the pandemic.

While this pandemic ultimately led to huge strides in scientific progress and arguably the largest global immunization effort in history, the global allocation of Covid-19 vaccines also turned out to be one of the worst examples of global inequality. Research shows that the “disproportionate impact of COVID-19 between and within countries mirrors colonial hierarchies.”¹¹ These failures in ensuring universal access to Covid-19 vaccines around the globe are the focus of this briefing, which assesses how both states and pharmaceutical companies failed vis-a-vis their human rights obligations and responsibilities, and how they should prepare for future public health emergencies. Divided into four lessons, the analysis reviews the status of several initiatives undertaken to foment fair distribution of vaccines over the last three years. The briefing also looks towards the future, detailing related emerging multilateral initiatives, such as the Pandemic Treaty, that are under discussion to ensure a more robust equitable response to any future global public health emergencies. Finally, the briefing offers several recommendations to states, businesses, and investors, advocating for deeper structural changes to ensure the world can withstand pandemic shocks collectively, without leaving anyone behind.



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2.1 THE IMPORTANCE OF UNIVERSAL ACCESS TO COVID-19 VACCINES

The Covid-19 pandemic exposed a myriad of failures, gaps and delays in the world’s ability to respond effectively and collaboratively to a global public health crisis, weakening each country’s ability to respond effectively to the pandemic. The lack of access to life-saving health products such as diagnostics, personal protective equipment (PPE) and oxygen debilitated all countries’ ability to cope with Covid-19. For example, health and essential workers in the United States and the United Kingdom were left unprotected due a global shortage in PPE,¹² while patients faced shortages of oxygen in Nepal and Brazil,¹³ and dire structural weaknesses in Somalia’s health system meant the population had little to no options for preventive, palliative, or curative care.¹⁴ While every country was affected by this unprecedented global health crisis, disparities in access to health products severely hampered countries’ ability to cope with the virus throughout the pandemic and ultimately lift themselves out of the most acute phase of the pandemic.

Among the many injustices that came about in addressing the pandemic, the lack of cooperation to ensure universal access to Covid-19 vaccines was perhaps the most impactful. As governments rolled out their vaccination programmes, immunization lowered the rate of severe cases of illness and reduced the risk of more contagious and deadly variants emerging, which can cause outbreaks even in populations with high

¹¹ UN Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance (UN Special Rapporteur on contemporary forms of racism), Report: *2030 Agenda for Sustainable Development, the Sustainable Development Goals and the Fight Against Racial Discrimination*, 13 June–8 July 2022, Fiftieth session, Agenda item 9, UN Doc. A/HRC/50/60, para. 10.

¹² Amnesty International, *Exposed, Silenced, Attacked: Failures to Protect Health and Essential Workers During the Covid-19 Pandemic* (Index: POL 40/2572/2020), [amnesty.org/en/documents/pol40/2572/2020/en/](https://www.amnesty.org/en/documents/pol40/2572/2020/en/)

¹³ Amnesty International, “*Struggling to Breathe*”: *The Second Wave of Covid-19 in Nepal* (Index: ASA 31/4229/2021) 14 June 2021, [amnesty.org/en/documents/asa31/4229/2021/en/](https://www.amnesty.org/en/documents/asa31/4229/2021/en/); Amnesty International, “Brazil: Lack of oxygen to treat patients in Manaus” (Index: AMR 19/3539/2021), 15 January 2021, [amnesty.org/en/documents/amr19/3539/2021/en/](https://www.amnesty.org/en/documents/amr19/3539/2021/en/)

¹⁴ Amnesty International, “*We Just Watched Covid-19 Patients Die*”: *Covid-19 Exposed Somalia’s Weak Healthcare System But Debt Relief Can Transform It* (Index: AFR 52/4602/2021), 18 August 2021, [amnesty.org/en/documents/afr52/4602/2021/en/](https://www.amnesty.org/en/documents/afr52/4602/2021/en/)

vaccination rates.¹⁵ This, in turn, eased the strain on already weakened health systems and reduced the number of Covid-19 related deaths. In fact, the Lancet estimated that vaccinations prevented up to 19.8 million deaths in 185 countries and territories in the first year of immunizations alone, representing a reduction of 63% of total deaths around the world.¹⁶ Broad vaccine coverage shifted the course of the pandemic, allowing countries to ease restrictions and incrementally resume economic activity throughout 2022.¹⁷



Workers finishing a mural outside Tambaram station. Chennai, India. July 2021. © Feature China/Future Publishing, Getty Images

2.2 LOW-INCOME COUNTRIES BORE THE BRUNT OF INEQUALITY

The development and roll-out of Covid-19 vaccines arguably has been the largest global immunization effort in history in the shortest amount of time. However, what could have been an extraordinary feat for humanity - countries working closely together to ensure no one is left behind in vaccination efforts - eventually became the clearest and starkest indication of global inequality. This inequality becomes particularly evident when the Lancet’s data on 19.8 million deaths averted in the first year of Covid-19 immunizations is disaggregated - the estimated number of deaths averted roughly break down as 41% in high-income countries, 21% in upper-

¹⁵ New York Times, “What data shows about vaccine supply and demand in the most vulnerable places”, 9 December 2021, [nytimes.com/interactive/2021/12/09/world/vaccine-inequity-supply.html](https://www.nytimes.com/interactive/2021/12/09/world/vaccine-inequity-supply.html) All immunization rates in this briefing refer to people who have received at least the last dose of the primary series of shots. For most Covid-19 vaccines, this refers to two doses (Johnson & Johnson is an exception as it is a single dose vaccine).

¹⁶ Oliver J Watson and others, “Global impact of the first year of COVID-19 vaccination: A mathematical modelling study”, 23 June 2023, *The Lancet Infectious Diseases*, Volume 22, Issue 9, [thelancet.com/journals/laninf/article/PIIS1473-3099\(22\)00320-6/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00320-6/fulltext), pp. 1293-1302.

¹⁷ UNDP, “Assessing the world’s progress towards the 70 percent goal”, Data Futures Platform, last updated September 2022, data.undp.org/vaccine-equity/assessment-70-percent-global-goal/

middle-income countries, 37% in lower-middle-income countries, and only 1% in low-income countries.¹⁸ Furthermore, the Lancet’s research indicates that, if each country had been able to reach 20% coverage by the end of 2021 – as per the WHO’s vaccination coverage targets for that period - an additional 45% of deaths could have been averted in low-income countries.¹⁹ In short, if international cooperation had led to a fairer distribution of doses around the world, more lives could have been saved.

FIGURE 1: OVERALL COVID-19 VACCINE GLOBAL ALLOCATION BY ALL COMPANIES²⁰

Country Classifications by Income	Estimated % of World Population	Cumulative % Vaccine Allocation	Year 1 (2020-2021)	Year 2 (2021-2022)
High-income	20.79%	24.98%	22.84%	26.57%
Low-income	7.91%	2.57%	0.89%	4.71%
Lower-middle-income	39.76%	33.69%	31.54%	38.43%
Upper-middle-income	31.53%	38.76%	44.73%	30.29%

NOTE: Covid-19 vaccinations started on 8 December 2020 and are ongoing. For consistency in data collection and presentation, “cumulative” covers 8/12/2020 to 28/-22023; Year 1 refers to 30 November 2020 to 1 December 2021; Year 2 refers to 30 November 2021 to 1 December 2022. Any “donated” doses are attributed to final recipient countries.

Although the distribution of vaccines became less unequal over time, it has been consistently skewed throughout the last three years. Lower-middle-income countries - especially low-income countries - have received disproportionately few vaccines relative to their population. This is particularly stark for low-income countries, which received just 0.89% of available doses during the first year of Covid-19 vaccinations, then 4.71% during the second year. The United Nations Development Programme (UNDP) estimated that by June 2021, more than 95% of high-income countries experienced no vaccine supply issues, while all 27 low-income countries had little to no supply.²¹ In a call to action for international cooperation, in September 2021, the WHO called on all countries to achieve 40% vaccination rates by the end of 2021 and a 70% vaccination rate by the end of June 2022 in every country.²² At that point, low-income countries had immunized less than 1% of their population, while high-income countries and upper-middle-income countries had 57% and 54% vaccination rates, respectively.²³

Although higher-income countries began sharing excess doses and ordering shipments as donations for other countries, this proved to be insufficient. By November 2021, only 60% of low-income countries had enough supplies to immunize 5% of its population and only four low-income countries (Mozambique, Rwanda, Togo and Uganda) had enough doses to vaccinate 40% of their populations, in line with WHO’s first milestone. When the WHO’s second milestone arrived in June 2022, the only low-income countries that had enough supply to vaccinate 70% of its population were Liberia, Mozambique and Rwanda.²⁴

Not surprisingly, as we enter the fourth year of the pandemic, vaccination rates remain starkly uneven. As of March 2023, more than 13.2 billion vaccine doses have been administered²⁵ and roughly 65% of the global population is considered immunized, meaning they have received at least the last dose of the primary series of

¹⁸ Oliver J Watson and others, “Global impact of the first year of COVID-19 vaccination: A mathematical modelling study” (previously cited).
¹⁹ Oliver J Watson and others, “Global impact of the first year of COVID-19 vaccination: A mathematical modelling study” (previously cited).
²⁰ Data provided by Airfinity, March 2023.
²¹ United Nations Development Programme (UNDP), “Assessing the world’s progress towards the 70 percent goal” (previously cited).
²² WHO, “UN set out steps to meet world COVID vaccination targets”, 7 October 2021, who.int/news/item/07-10-2021-who-un-set-out-steps-to-meet-world-covid-vaccination-targets
²³ Our World in Data, Coronavirus (COVID-19) Vaccinations, ourworldindata.org/covid-vaccinations (accessed on 5 March 2023).
²⁴ United Nations Development Programme (UNDP), “Assessing the world’s progress towards the 70 percent goal” (previously cited).
²⁵ WHO, WHO Coronavirus (COVID-19) Dashboard, covid19.who.int/ (accessed on 5 March 2023), “Overview”.

shots.²⁶ Although this seems to indicate wide global coverage, the disaggregated numbers tell a different story. While roughly 80% of the population in high-income and upper-middle-income countries have been immunized, vaccination rates in lower-middle-income countries hover around 60% and lower-income countries only have 24% of their populations vaccinated.²⁷ In ten countries around the world, vaccinated rates are under 15%, providing very limited protection against Covid-19 and the emergence of new variants.²⁸ Some countries have low vaccination rates even after receiving doses, and the reasons vary by country and range from the need for stronger distribution infrastructures to lack of trust in information campaigns.²⁹ That said, data shows there also are countries that have used most of its available doses and still have a low vaccination rate, indicating a supply problem.³⁰

As noted by the UN Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance (UN Special Rapporteur on contemporary forms of racism), racial discrimination operates at the level of the individuals and groups, as well as the level of countries that were subject to colonial powers. Within this context, the Special Rapporteur addresses global vaccine inequality faced by low-income countries as an ongoing a “racialized health inequity” throughout the pandemic.³¹ Indeed, the fact that “the distinction between ‘high-income’ and ‘low-income’ countries is directly related to the racist economic extraction and exploitation that occurred during the colonial era,” shows there is a direct link between Covid-19 global inequality and systemic racial injustice in the world.³² In 2022, the UNDP estimated that high-income countries would have to increase their health care spending by 0.81%, whereas low-income countries would have to increase their spending by 56.6% to reach the WHO’s target vaccination rate of 70%.³³ Coupled with a lack of adequate and timely stock, this burden ultimately created a “two-track pandemic”, where higher-income countries were emerging from the pandemic while lower-income countries “plunged into multiple interlinked emergencies – a debt crisis, a development crisis and a human rights crisis.”³⁴



A health worker carrying supplies during Covid-19 vaccination efforts in Goma, Democratic Republic of Congo. 5 May 2021. © Guerchom Ndebo/Getty Images

²⁶ Our World in Data, Coronavirus (COVID-19) Vaccinations, ourworldindata.org/covid-vaccinations (accessed 5 March 2023).

²⁷ Our World in Data, Coronavirus (COVID-19) Vaccinations, ourworldindata.org/covid-vaccinations (accessed 5 March 2023).

²⁸ New York Times, The coronavirus pandemic, nytimes.com/interactive/2021/world/covid-vaccinations-tracker.html (accessed March 2023).

²⁹ Ahmed Mushfiq Mobarak and others, “End COVID-19 in low- and middle-income countries”, 10 Mar 2022, *Science*, Volume 375, Issue 6585, pp. 1105-1110, science.org/doi/10.1126/science.abo4089; Amnesty International, *Silenced and Misinformed: Freedom of Expression in Danger During Covid-19* (Index: POL 30/4751/2021), 19 October 2021, amnesty.org/en/documents/pol30/4751/2021/en/

³⁰ New York Times, The coronavirus pandemic, nytimes.com/interactive/2021/world/covid-vaccinations-tracker.html (accessed March 2023).

³¹ UN Special Rapporteur on contemporary forms of racism, Report: *2030 Agenda for Sustainable Development, the Sustainable Development Goals and the Fight Against Racial Discrimination* (previously cited), paras 4, 10, 11, 12.

³² UN Special Rapporteur on contemporary forms of racism, Report: *Ecological Crisis, Climate Justice and Racial Justice*, 25 October 2022, UN Doc. A/77/549, para 2. See also UN Special Rapporteur on contemporary forms of racism, Report: *2030 Agenda for Sustainable Development, the Sustainable Development Goals and the Fight Against Racial Discrimination* (previously cited) and UN Special Rapporteur on contemporary forms of racism, Report: *Global Extractivism and Racial Equality*, 14 May 2019, UN Doc. A/HRC/41/54.

³³ UNDP, “Assessing the world’s progress towards the 70 percent goal”, Data Futures Platform, last updated September 2022, data.undp.org/vaccine-equity/assessment-70-percent-global-goal/

³⁴ United Nations High Commissioner for Human Rights, statement to the forty-ninth session of the Human Rights Council, Geneva, 11 March 2022. UN Special Rapporteur on contemporary forms of racism, Report: *Ecological Crisis, Climate Justice and Racial Justice*, 25 October 2022, UN Doc. A/77/549, para 2. See also UN Special Rapporteur on contemporary forms of racism, Report: *2030 Agenda for Sustainable Development, the Sustainable Development Goals and the Fight Against Racial Discrimination* (previously cited) and UN Special Rapporteur on contemporary forms of racism, Report: *Global Extractivism and Racial Equality*, 14 May 2019, UN Doc. A/HRC/41/54.

3. HUMAN RIGHTS STANDARDS AND INTERNATIONAL COOPERATION

3.1 STATE HUMAN RIGHTS OBLIGATIONS REGARDING COVID-19 VACCINES

International human rights law and standards establish that states have a core obligation to ensure the right to health, which includes essential primary health care³⁵ and essential medicines, without delay.³⁶ These measures include prevention, treatment and control of epidemics and other diseases by making relevant technologies available and implementing and/or enhancing relevant immunization programmes and other strategies.³⁷ States also must consider extraterritorial obligations to support other states, which includes providing financial and technical support so that all countries can uphold the right to health, especially in the face of the international spread of disease.³⁸ This international cooperation may include the sharing of research, knowledge, medical equipment and supplies, as well as coordinated action to reduce the negative economic and social impacts of the crisis and promote economic recovery.³⁹

Likewise, both Article 27 of the Universal Declaration of Human Rights (UDHR) and Article 15 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establish the right to enjoy the benefits of scientific progress and its applications, or the right to scientific progress.⁴⁰ The CESCR General Comment 25 on Science and Economic, Social and Cultural Rights specifies that these benefits include medical technologies such as vaccinations.⁴¹ In April 2020, the CESCR highlighted that “pandemics are a crucial example of the need for scientific international cooperation to face transnational threats”⁴² and that scientific progress must be available, accessible, acceptable and of good quality to all people, without discrimination.⁴³

3.2 BUSINESS’ HUMAN RIGHTS RESPONSIBILITIES REGARDING COVID-19 VACCINES

As articulated by the UN Guiding Principles on Business and Human Rights, companies have the responsibility to respect human rights,⁴⁴ which requires them to avoid causing or contributing to abuses through their business activities, and to address impacts in which they are involved, including by remediating any abuses.⁴⁵ For companies developing and manufacturing vaccines in the context of a pandemic, this means that all

³⁵ UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 3: The Nature of States Parties’ Obligations (Art. 2, Para. 1, of the Covenant), 14 December 1990, UN Doc. E/1991/23, para. 10.

³⁶ UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12), 11 August 2000, UN Doc. E/C.12/2000/4, para. 43.

³⁷ CESCR, General Comment 14 (previously cited), paras 16, 44.

³⁸ WHO, *International Health Regulations (2005), Third Edition*, 1 January 2016, who.int/publications/i/item/9789241580496

³⁹ CESCR, “Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural Rights”, 17 April 2020, UN Doc. E/C.12/2020/1, para.19. The duty of international assistance and cooperation is also highlighted in Articles 2(1),11(1) of the ICESCR.

⁴⁰ UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 25 on Science and Economic, Social and Cultural Rights (Article 15(1)(b), (2), (3) and (4) of the International Covenant on Economic, Social and Cultural Rights), 30 April 2020, UN Doc. E/C.12/GC/25, para. 45.

⁴¹ CESCR, General Comment 25 (previously cited), para. 8.

⁴² CESCR, “Statement on the Coronavirus (COVID-19) Pandemic and Economic, Social and Cultural Rights” (previously cited), para. 23.

⁴³ CESCR, General Comment 25 (previously cited), para. 17.

⁴⁴ This responsibility was expressly recognized by the UN Human Rights Council on 16 June 2011, when it endorsed the UN Guiding Principles on Business and Human Rights, and on 25 May 2011, when the 42 governments that had then adhered to the Declaration on International Investment and Multinational Enterprises of the OECD unanimously endorsed a revised version of the OECD Guidelines for Multinational Enterprises. Human Rights Council, “Human Rights and Transnational Corporations and Other Business Enterprises”, Resolution 17/4, adopted on 6 July 2011, UN Doc. A/HRC/RES/17/4; OECD, *OECD Guidelines for Multinational Enterprises*, 2011 Edition, 29 September 2011, doi.org/10.1787/9789264115415-en

⁴⁵ UN Office of the High Commissioner for Human Rights (OHCHR), Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework, 2011, UN Doc. HR/PUB/11/04, ohchr.org/Documents/Publications/GuidingPrinciplesBusinessHR_EN.pdf, principles 11 and 13 including commentary.

decisions and actions related to the vaccine roll-out should have been rigorously assessed through proactive, ongoing human rights due diligence to ensure that they are not causing or contributing to any harm.⁴⁶

To do so, pharmaceutical companies should have developed and implemented policies to make Covid-19 vaccines available, accessible, and affordable. The UN Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines, further states that companies “should issue non-exclusive voluntary licences with a view to increasing access, in low-income and middle-income countries, to all medicines... They should also include any necessary transfer of technology. The terms of the licences should be disclosed.”⁴⁷ As this briefing describes, by and large, major pharmaceutical companies failed to uphold the aforementioned responsibilities during the last three years of the Covid-19 pandemic and states have failed to hold them to account for these failures.



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4. FOUR LESSONS FROM COVID-19 VACCINE INEQUALITY

4.1 ENSURE FAIR GLOBAL ACCESS TO HEALTH PRODUCTS: “VACCINE NATIONALISM” AND COVAX

One month after the WHO declared Covid-19 a pandemic, in April 2020, the WHO and other actors launched COVAX, a procurement mechanism that set out to pool global demand for Covid-19 vaccines and fairly distribute two billion doses by the end of 2021.⁴⁸ COVAX’s goal at inception was to “guarantee fair and equitable access” for every country in the world by using its collective purchasing power to negotiate pricing and distribute vaccines around the world. However, the lack of adequate and timely global supply of vaccines due to “vaccine nationalism” at all stages of the pandemic, coupled with complex internal policies, hampered its ability to deliver on this commitment.

⁴⁶ Amnesty International, *A Double Dose of Inequality: Pharma Companies and the Covid-19 Vaccines Crisis* (previously cited), pp. 17-18.

⁴⁷ UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (UN Special Rapporteur on health), Annex: *Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines* (Human Rights Guidelines for Pharmaceutical Companies), 11 August 2008, UN Doc. A/63/263, Guideline 30.

⁴⁸ Gavi, The Vaccine Alliance, “The COVAX Facility Commitment Agreements” 19 October 2020, gavi.org/sites/default/files/covid/pr/COVAX_CA_COIP_List_COVAX_PR_19-10.pdf

Even before any Covid-19 vaccines had been approved, it was evident that supply of vaccines would be problematic due to the practice of “vaccine nationalism” by many countries,⁴⁹ whereby high-income countries made massive advance purchases of most vaccine candidates under clinical trials. If all these candidates had been approved for use – they could have vaccinated their populations three times over.⁵⁰ By August 2020, Canada was at the top of the list with enough doses for five times its population. Meanwhile, the United States already had struck deals with six companies, securing enough doses to vaccinate 140% of its population. The UK did the same with seven companies, giving it access to enough doses to vaccinate 225% of its population.⁵¹ By September 2020, Oxfam had reported that governments representing 13% of the global population had already secured over half of the promised doses of Covid-19 vaccine candidates,⁵² Although not all these contracted vaccines came to fruition, these huge advance purchases undermined efforts to ensure sufficient availability and fair distribution around the world, contravening states’ human rights obligations to take into consideration the needs of other countries.⁵³



Amnesty International Thailand organized an action campaign in Bangkok city with messages demanding access to Covid-19 vaccines. 20 August 2021. © Faozee Lateh, Kan Sangtong

In addition to high-income countries buying up supply early on, COVAX implemented policies to persuade higher-income countries to join its efforts, but these turned out to compromise the goal of COVAX to ensure fair access for every country. For example, the 92 countries relying on COVAX for financing could only receive doses to cover up to 20% of their population, while higher-income countries who joined COVAX and would pay for their own doses could order doses to cover up to 50% of their population, with the option to select the and.⁵⁴ While some of these rules were adjusted in 2022, they still resulted in high-income countries that already had a plethora of secured doses through pharmaceutical companies also dipping into COVAX’s limited stock. For example, soon after COVAX delivered its very first batch of 600,000 doses in February 2021 to Ghana, COVAX allocated 1.62 million doses to Canada and 500,000 doses to the UK in February and April, raising questions about how it would prioritize deliveries amidst the scarcity of doses.⁵⁵

⁴⁹ Alexandra L Phelan and others, “Legal agreements: Barriers and enablers to global equitable COVID-19 vaccine access”, 7 September 2020, *The Lancet*, Volume 396, Issue 10254, [thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31873-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31873-0/fulltext)

⁵⁰ The People’s Vaccine, “Campaigners warn that 9 out of 10 people in poor countries are set to miss out on Covid-19 vaccine next year”, 9 December 2020, [peoplesvaccine.org/resources/media-releases/nine-out-of-ten-people-in-poor-countries-set-to-miss-covid-19-vaccine/](https://www.peoplesvaccine.org/resources/media-releases/nine-out-of-ten-people-in-poor-countries-set-to-miss-covid-19-vaccine/)

⁵¹ Ann Danaiya Usher, “A beautiful idea: How COVAX has fallen short”, 19 June 2021, *The Lancet*, Volume 397, Issue 10292, pp. 2322-2325, [thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)01367-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01367-2/fulltext)

⁵² Oxfam International, “Small group of rich nations have bought up more than half the future supply of leading COVID-19 vaccine contenders”, 17 September 2020, [oxfam.org/en/press-releases/small-group-rich-nations-have-bought-more-half-future-supply-leading-covid-19](https://www.oxfam.org/en/press-releases/small-group-rich-nations-have-bought-more-half-future-supply-leading-covid-19)

⁵³ Alexandra L Phelan and others, “Legal agreements: Barriers and enablers to global equitable COVID-19 vaccine access” (previously cited).

⁵⁴ Gavi, the Vaccine Alliance, “COVAX explained”, 3 September 2020, [gavi.org/vaccineswork/covax-explained](https://www.gavi.org/vaccineswork/covax-explained)

⁵⁵ Ann Danaiya Usher, “A beautiful idea: How COVAX has fallen short” (previously cited). [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)01367-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01367-2/fulltext)

Even once vaccines were approved and being administered, a lack of sufficient and timely supply of vaccines limited deliveries to COVAX, which relied heavily on one supplier in India. For example, just one month after COVAX’s first delivery, India paused vaccine exports for months to prioritize national needs due to a major national surge of Covid-19 cases, leading to the delay of nearly 100 million doses for COVAX.⁵⁶ Three months later, the WHO described COVAX supply situation as “dire” because the facility had no AstraZeneca, Serum Institute of India and Johnson & Johnson vaccines doses in stock to distribute.⁵⁷



COVAX IN FEBRUARY 2023

Two years after its first delivery and nearly one year behind schedule, COVAX finally provided nearly 2 billion doses of Covid-19 vaccines around the world. While COVAX’s deliveries increased access to vaccines, these doses now only represent approximately 15% of the more than 13.2 billion vaccines administered.⁵⁸ Furthermore, only roughly 44% of these 2 billion doses came from procurement contracts between COVAX and vaccine manufactures, while about 56% of these deliveries came from individual countries as “donations.”⁵⁹ This raises the question whether COVAX served more effectively as a pass-through mechanism for high-income countries to donate doses, than as the global procurement mechanism intended to guarantee fair and equitable access to vaccines for all countries.⁶⁰

In terms of fair distribution, COVAX allocated these 2 billion doses across 148 countries, with nearly 75% of its stock going to lower-middle-income countries, followed by almost 16% to low-income countries, about 9% to upper-middle-income countries and less than 1% to high-income countries (namely, Canada, United Kingdom).⁶¹ These deliveries were skewed towards two countries - India and Bangladesh, which received 25.29% of COVAX’s supply. In fact, nearly 65% of COVAX’s supply went to 12 countries, of which only two were low-income countries - Ethiopia and Uganda, which received 2.74%, and 2.17% of COVAX’s supply, respectively.⁶²

FIGURE 2: COVAX VACCINE DELIVERY TYPE FROM FEBRUARY 2021 TO FEBRUARY 2023⁶³

Delivery type	Doses Delivered	Percentage of total
COVAX procurement from vaccine manufacturers	862,530,980	44%
Donations from country to country via COVAX	1,093,493,552	56%
TOTAL	1,956,024,532	100%

⁵⁶ New York Times, “India cuts back on vaccine exports as infections surge”, 22 April 2021, [nytimes.com/2021/03/25/world/asia/india-covid-vaccine-astrazeneca.html](https://www.nytimes.com/2021/03/25/world/asia/india-covid-vaccine-astrazeneca.html)
⁵⁷ Reuters, “Just give us the vaccines, WHO pleads, as poor countries go wanting”, 26 June 2021, [reuters.com/world/just-give-us-vaccines-who-pleads-poor-countries-go-wanting-2021-06-25/](https://www.reuters.com/world/just-give-us-vaccines-who-pleads-poor-countries-go-wanting-2021-06-25/)
⁵⁸ WHO, WHO Coronavirus (COVID-19) Dashboard, covid19.who.int/ (accessed on 9 March 2023).
⁵⁹ Data provided by Airfinity, March 2023.
⁶⁰ Gavi, The Vaccine Alliance, “The COVAX Facility Commitment Agreements” (previously cited).
⁶¹ Data provided by Airfinity, March 2023.
⁶² Data provided by Airfinity, March 2023.
⁶³ Data provided by Airfinity, March 2023.

FIGURE 3: COVAX DELIVERIES PER INCOME GROUPS TO DATE (FEBRUARY 2021 TO FEBRUARY 2023)⁶⁴

Country Classifications by Income	Number of Doses Delivered	% of COVAX's Deliveries
High-income	14,888,790	0.76%
Low-income	307,598,820	15.73%
Lower-middle-income	1,461,415,132	74.71%
Upper-middle-income	172,121,790	8.80%
TOTAL	1,956,024,532	100%

4.2 RESET GLOBAL TRADE RULES: HUMAN RIGHTS AND SUBSTANTIVE EQUALITY ABOVE INTELLECTUAL PROPERTY RIGHTS

While intellectual property (such as copyrights, trademarks, patents, trade secrets and test data) sets out to develop products through economic incentives, this system of exclusive rights has historically adversely impacted availability, accessibility and affordability of health products. Intellectual property enables companies to set prices and limit the entry of other suppliers, thereby preventing competition.⁶⁵ The World Trade Organization (WTO)'s Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) sets out minimum standards for many forms of intellectual property.⁶⁶ Given that intellectual property rights play a key role in access to healthcare, the TRIPS Agreement also includes “flexibilities” that allow states to take measures to address public health emergencies, such as issuing compulsory licenses that would allow a company to produce a drug without following intellectual property.⁶⁷ From the start of the pandemic, experts warned that the flexibilities were inadequate for Covid-19 vaccines as they often require onerous reporting requirements and domestic legal and policy changes. Moreover, licences on patents alone are insufficient to produce vaccines, which require technology transfer and/or local manufacturing capacity.⁶⁸

In October 2020, India and South Africa requested a temporary waiver to the WTO TRIPS Agreement, which would allow countries to neither grant nor enforce intellectual property rights for Covid-19 products.⁶⁹ Although this would not automatically increase manufacturing of products, the waiver would ensure that intellectual property did not pose a barrier to production. Most lower- and middle-income countries supported the proposal while most high-income countries – especially those with strong pharmaceutical industries such as the United States, Canada, the United Kingdom, and Switzerland - opposed it,⁷⁰ insisting that the current flexibilities were sufficient and adequate, even though some flexibilities had only been used successfully once in 20 years.⁷¹

⁶⁴ Data provided by Airfinity, March 2023.

⁶⁵ A Fair Shot: ensuring universal access to Covid-19 diagnostics, treatments and vaccines, (Index: POL 30/3409/2020), www.amnesty.org/download/Documents/POL3034092020ENGLISH.PDF

⁶⁶ A Fair Shot: ensuring universal access to Covid-19 diagnostics, treatments and vaccines, (Index: POL 30/3409/2020), www.amnesty.org/download/Documents/POL3034092020ENGLISH.PDF

⁶⁷ WTO, TRIPS and public health, wto.org/english/tratop_e/trips_e/pharmpatent_e.htm

⁶⁸ Eduardo Urias and Shyama V Ramani, “Access to medicines after TRIPS: Is compulsory licensing an effective mechanism to lower drug prices? A review of the existing evidence, 3 September 2020, US National Library of Medicine, J Int Bus Policy. 2020, 3(4), pp. 367–384, ncbi.nlm.nih.gov/pmc/articles/PMC7468182/#CR59

⁶⁹ World Trade Organization (WTO), “Waiver from certain provisions of the TRIPS Agreement for the Prevention, Containment and Treatment of COVID-19; Communication from India and South Africa, 2 October 2020, IP/C/W/669, docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/IP/C/W669.pdf&Open=True. The waiver request was co-sponsored by Kenya and Eswatini. See also briefing by Médecins Sans Frontières, *India and South Africa proposal for WTO waiver from intellectual property protections for COVID-19-related medical technologies*, 18 November 2020, https://msfaccess.org/sites/default/files/2020-11/COVID_Brief_WTO_WaiverProposal_ENG_v2_18Nov2020.pdf

⁷⁰ WTO, “Members discuss intellectual property response to the COVID-19 pandemic”, 20 October 2020, wto.org/english/news_e/news20_e/trip_20oct20_e.htm

⁷¹ Public Citizen, “Waiver of the WTO's intellectual property rules: Existing TRIPS “flexibilities” unworkable for necessary scale up of COVID-19 medicines production”, 5 April 2021, citizen.org/article/waiver-of-the-wtos-intellectual-property-rules-existing-trips-flexibilities-unworkable-for-scale-up-of-covid-19-medicines-production/

In May 2021, the WTO discussion shifted when the United States administration announced it supported the TRIPS waiver (with the reservation that it would be for vaccines only), and several other high-income countries such as Canada indicated openness towards a waiver approval.⁷² After nearly 18 months of discussions, in June 2022, the WTO member states finally decided upon a diluted version of the waiver for vaccines only,⁷³ and postponed the decision on tests and treatments until the end of 2022.⁷⁴ In December 2022, the United States then requested that the decision on tests and treatments be postponed again so that its own trade agency, the United National International Trade Commission (USITC),⁷⁵ could conduct a formal investigation into the impact of intellectual property rights on the availability of Covid-19 diagnostics and treatments around the world. In what seems to be a delay tactic, this lengthy process is expected to delay the WTO decision until the end of 2023.⁷⁶ By then, the world will be close to entering its fifth year of coping with Covid-19, setting a worrying precedent for the ability of governments around the world to adequately address future public health emergencies that require a paradigm shift to ensure that an adequate supply of much-needed, life-saving health products reach those who need it the most in a timely fashion.

CANADA'S POSITION ON INTELLECTUAL PROPERTY RIGHTS

Canada's position exposed the contradiction in states' position regarding intellectual property rights. In accordance with WTO rules, in March 2021, the Canadian pharmaceutical company Biolyse requested Canadian authorities approve a compulsory licence under the "flexibilities" regime. The goal was to produce up to 20 million biosimilar Johnson & Johnson vaccines per year, supplying Bolivia with the first 15 million doses, which could have covered the country's adult population. Despite Canada's insistence at the WTO TRIPS waiver discussions that "flexibilities" were sufficient for the pandemic, Canada ignored the requests to add Covid-19 to the list of eligible diseases for this license, which had been drafted prior to Covid-19's existence and included comparable diseases. This left Biolyse unable to move forward with production.⁷⁷ Interestingly, Canada immediately waived patents nationally to respond to the public health emergency⁷⁸ for its own domestic use at the onset of the pandemic in March 2020; yet Canada has failed to take the same approach by supporting the TRIPS waiver and the approval of a compulsory license.

⁷² Amnesty International, "Recommendations to WTO member states ahead of the 12th Ministerial Conference: On the need for a comprehensive TRIPS waiver for Covid-19 health products and technologies (Index: IOR 30/5645/2022), 23 May 2022, [amnesty.org/en/documents/ior30/5645/2022/en/](https://www.amnesty.org/en/documents/ior30/5645/2022/en/)

⁷³ Amnesty International, "Covid-19: WTO ministerial decision on TRIPS Agreement fails to set rules that could save lives", 17 June 2022, [amnesty.org/en/latest/news/2022/06/covid-19-wto-ministerial-decision-on-trips-agreement-fails-to-set-rules-that-could-save-lives/](https://www.amnesty.org/en/latest/news/2022/06/covid-19-wto-ministerial-decision-on-trips-agreement-fails-to-set-rules-that-could-save-lives/); WHO, "Draft ministerial decision by the WTO Director General Revision", 17 June 2022, [WT/MIN\(22\)/W/15/Rev.2, docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/WT/MIN22/W15R2.pdf&Open=True](https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/WT/MIN22/W15R2.pdf&Open=True)

⁷⁴ Amnesty International, "Covid-19: WTO ministerial decision on TRIPS Agreement fails to set rules that could save lives" (previously cited).

⁷⁵ United States International Trade Commission (USITC), About the USITC, [usitc.gov/press_room/about_usitc.htm](https://www.usitc.gov/press_room/about_usitc.htm)

⁷⁶ Office of the United States Trade Representative, Executive Office of the President, "Ambassador Tai requests USITC investigation of COVID-19 diagnostics and therapeutics, 16 December 2022, ustr.gov/about-us/policy-offices/press-office/press-releases/2022/december/ambassador-tai-requests-usitc-investigation-covid-19-diagnostics-and-therapeutics

⁷⁷ Amnesty International Canada, "Open letter: Canada must ensure fair global access to Covid-19 vaccines" (Index: TG AMR 20/2021.1865), 13 August 2021, [amnesty.ca/human-rights-news/open-letter-canada-must-ensure-fair-global-access-covid-19-vaccines/](https://www.amnesty.ca/human-rights-news/open-letter-canada-must-ensure-fair-global-access-covid-19-vaccines/)

⁷⁸ Government of Canada, Justice Laws Website, Patent Act (R.S.C., 1985, c. P-4), laws-lois.justice.gc.ca/eng/acts/p-4/



Activists from various organizations demonstrating at the Place des XXII Cantons in support of the WTO Member States approving a waiver to the TRIPs Agreement to expand global access to Covid-19 vaccines. Geneva, Switzerland. 30 November 2021. © Amnesty International Switzerland

4.3 CONDITION PUBLIC FUNDING EARLY ON: THE NEED FOR KNOWLEDGE & TECHNOLOGY TRANSFER

As it was clear that the Covid-19 vaccine developers would not meet the scale, scope and urgency of pandemic, the WHO, with other partners, created two major initiatives for knowledge and technology transfer to increase availability and affordability of Covid-19 health products, as well as to decentralize manufacturing around the world so lower-income companies would be less dependent on supply in higher-income countries in the future. While debates as to whether other pharmaceutical companies could scale up supply in a short time frame, one analysis identified 120 manufacturing sites around the world where it would be technically feasible to produce Covid-19 vaccines,⁷⁹ and another analysis of ongoing deals showed that it typically took less than six months for a manufacturer to produce doses once they had the proper knowledge and technology transfer.⁸⁰

In April 2020, Costa Rica and the WHO launched the Covid-19 Technology Access Pool (C-TAP) - a voluntary sharing platform to pool all data, know-how, biological material and intellectual property needed to produce Covid-19 health products. As a single, global, non-exclusive licensing platform, C-TAP's goal was to maximize supply and lower costs of production; by the end of 2020, fewer than 40 states had expressed support for C-TAP and some companies voiced opposition to the premise.⁸¹ Since then, Spain's National Research Council

⁷⁹ Achal Prabhala and Alain Alsalhani, "Pharmaceutical manufacturers across Asia, Africa and Latin America with the technical requirements and quality standards to manufacture mRNA vaccines", Médecins Sans Frontières, 10 December 2021, msfaccess.org/sites/default/files/2021-12/COVID19_TechBrief_Manufacturing-mRNA-Report-10DEC2021_ENG_0.pdf

⁸⁰ Luis Gil Abinader, "Manufacturers of COVID-19 vaccines typically start delivering in under six months after tech transfer", 22 February 2021, Knowledge Ecology International (KEI), keionline.org/35364

⁸¹ Amnesty International, *Money Calls the Shots: Pharma's Response to the Covid-19 Vaccine Crisis* (previously cited).

(CSIC) signed two global non-exclusive licenses under C-TAP to produce Covid-19 diagnostics.⁸² While the United States did not join C-TAP, in May 2022, the U.S. National Institutes of Health (NIH) signed non-exclusive licensing agreements with C-TAP to share early-stage technology related to Covid-19 therapeutics, vaccines and diagnostics,⁸³ which could lead to new products, if paired with data from other developers.⁸⁴ As of March 2023, no Covid-19 vaccine manufacturer has indicated willingness to collaborate with C-TAP⁸⁵ and only 43 states have shown support for C-TAP; most countries with strong pharmaceutical industries remained silent, including France, Germany, Switzerland and the UK.⁸⁶



Employees of the Afrigen biotechnology company and the mRNA Vaccine Technology Transfer Hub, working to make Africa's first homegrown messenger mRNA jab in a bid to overcome unequal global access to vaccines. Cape Town, South Africa, 5 October 2021. © AFP via Getty Images

In June 2021, the WHO also established the mRNA Vaccine Technology Transfer Hub in South Africa, which works with 15 partner facilities in low- and middle-income countries (six in Africa, five in Asia, two in South America and two in Eastern Europe) to make mRNA vaccines. Before they start functioning, these spokes must build or adjust current facilities, as well as go through the necessary legal and regulatory processes at the national level.⁸⁷ Neither Pfizer-BioNTech nor Moderna have voluntarily shared their knowledge and technology with the WHO mRNA Hub, even though both vaccines were developed with strong public funding. The Pfizer Covid-19 vaccine benefited from public funding via its partner BioNTech, which received a

⁸² Medicines Patent Pool (MPP), “WHO and MPP announce the first transparent, global, non-exclusive licence for a COVID-19 technology”, 23 November 2021, [medicinespatentpool.org/news-publications-post/who-and-mpp-announce-the-first-transparent-global-non-exclusive-licence-for-a-covid-19-technology](https://www.medicinespatentpool.org/news-publications-post/who-and-mpp-announce-the-first-transparent-global-non-exclusive-licence-for-a-covid-19-technology); Medicines Patent Pool, “New agreement under C-TAP aims to improve global access to COVID-19 testing technologies”, 16 June 2022, [medicinespatentpool.org/news-publications-post/new-agreement-under-c-tap-aims-to-improve-global-access-to-covid-19-testing-technologies](https://www.medicinespatentpool.org/news-publications-post/new-agreement-under-c-tap-aims-to-improve-global-access-to-covid-19-testing-technologies)

⁸³ WHO, *Report from the C-TAP Technical Advisory Group to the WHO C-TAP Secretariat on NIH Licenses*, 12 May 2022, [who.int/publications/m/item/tag-report-nih-licenses-publication](https://www.who.int/publications/m/item/tag-report-nih-licenses-publication)

⁸⁴ National Institutes of Health, NIH Contributions to WHO COVID-19 Technology Access Pool and Q&As, Technology Transfer, 12 May 2022, techtransfer.nih.gov/policy/ctap

⁸⁵ WEMOS, *Make Pooling Work to End Pandemics A Qualitative Analysis of the Covid-19 Technology Access Pool*, November 2022, The People’s Vaccine, peoplesvaccine.org/wp-content/uploads/2022/11/Wemos_Make-pooling-work-to-end-pandemics_November-2022.pdf

⁸⁶ WHO, *Solidarity Call to Action; Making the Response to COVID-19 a Public Common Good*, [who.int/initiatives/covid-19-technology-access-pool/solidarity-call-to-action](https://www.who.int/initiatives/covid-19-technology-access-pool/solidarity-call-to-action)

⁸⁷ Andrew Green, “South Africa's mRNA hub confronts old problems and new directions”, 10 November 2022, Devex, devex.com/news/south-africa-s-mrna-hub-confronts-old-problems-and-new-directions-104398

US\$443 (€375million) grant from the German government.⁸⁸ Likewise, the United States reported having invested approximately US\$5.75 billion of public funding in Moderna's vaccine development, clinical trials, manufacturing and purchases.⁸⁹ The US government and Moderna also are embroiled in disputes over the rights of certain aspects of the Covid-19 vaccine; in February 2023, Moderna paid US\$400 million to the NIH and two US-based universities for a chemical technique used, but disputes over other components remain unresolved.⁹⁰

Given the lack of cooperation from pharmaceutical companies that hold intellectual property rights to the technology, the WHO mRNA Hub is working with their reverse-engineered version of the Moderna Covid-19 vaccine.⁹¹ While Moderna pledged not to enforce its patents for the Covid-19 vaccine in 92 lower-income countries, the company did not formally extend this pledge to other future products and countries,⁹² which means that any other products the global spokes may eventually manufacture risk being challenged by Moderna. Moreover, Moderna filed for a patent in South Africa, where the WHO mRNA hub is based, indicating the company seeks to protect its intellectual property.⁹³ In March 2022, the company also announced its intention to establish its own mRNA manufacturing facility in Kenya.⁹⁴ Clearly, the success of knowledge and technology sharing platforms such as C-TAP and the WHO mRNA hub depend on states supporting these initiatives, as well as pushing the pharmaceutical industry within their jurisdictions to share knowledge and technology, especially when the companies have received public funding.⁹⁵ Without this support and cooperation, their success will be limited.

THE PROMISE OF MRNA TECHNOLOGY FOR THE FUTURE

The transfer of knowledge and technology related mRNA is especially important to ensure future pandemic preparedness and broad access to health products. Firstly, the mRNA technology can be adapted rapidly to target other pathogens and can be used to produce other products, such as insulin to treat diabetes or cancer medicines; the mRNA technology also could, potentially, lead to the development of vaccines for diseases such as malaria, tuberculosis and HIV.⁹⁶ Secondly, experts also report that the mRNA technology also seems to offer a particularly unique opportunity for the diversification of manufacturing capacity around the globe, as the technique's lack of cell-based biological components allows even pharmaceutical companies with no prior experience of manufacturing vaccines to use the technology.⁹⁷

⁸⁸ BioNTech, "BioNTech to receive up to €375M in funding from German Federal Ministry of Education and Research to support COVID-19 vaccine program BNT162", 15 September 2020, investors.biontech.de/news-releases/news-release-details/biontech-receive-eu375mfundinggerman-federal-ministry; On advance orders see, for example, summary in supplementary appendix to Olivier J Wouters and others, "Challenges in ensuring global access to COVID-19 vaccines: production, affordability, allocation, and deployment", 12 February 2021, *The Lancet*, Volume 397, Issue 10278, doi.org/10.1016/S0140-6736(21)00306-8, pp. 8-9.

⁸⁹ Amnesty International, *Money Calls the Shots: Pharma's response to the Covid-19 vaccine crisis* (previously cited).

⁹⁰ New York Times, "After long delay, Moderna pays N.I.H. for covid vaccine technique", 23 February 2023, [nytimes.com/2023/02/23/science/moderna-covid-vaccine-patent-nih.html](https://www.nytimes.com/2023/02/23/science/moderna-covid-vaccine-patent-nih.html)

⁹¹ Guardian, "'Like copying a Louis Vuitton handbag': big pharma hits out at Africa's replica Covid vaccine", 5 October 2022, [theguardian.com/global-development/2022/oct/05/covid-vaccine-inequity-south-africa-afri-gen-mrna](https://www.theguardian.com/global-development/2022/oct/05/covid-vaccine-inequity-south-africa-afri-gen-mrna)

⁹² Moderna, "Moderna announces its global public health strategy", 7 March 2022, investors.modernatx.com/news/news-details/2022/Moderna-Announces-Its-Global-Public-Health-Strategy/default.aspx

⁹³ Medicines Patent Pool, mRNA Technology Transfer Programme, edicinespatentpool.org/what-we-do/mrna-technology-transfer-programme

⁹⁴ Moderna, "Moderna announces Memorandum of Understanding with the government of the Republic of Kenya to establish its first mRNA Manufacturing facility in Africa", 7 March 2022, investors.modernatx.com/news/news-details/2022/Moderna-Announces-Memorandum-of-Understanding-with-the-Government-of-the-Republic-of-Kenya-to-Establish-its-First-mRNA-Manufacturing-Facility-in-Africa/default.aspx

⁹⁵ WEMOS, *Make Pooling Work to End Pandemics A Qualitative Analysis of the Covid-19 Technology Access Pool* (previously cited).

⁹⁶ WHO, "WHO announces first technology recipients of mRNA vaccine hub with strong support from African and European partners", 18 February 2022, [who.int/news/item/18-02-2022-who-announces-first-technology-recipients-of-mrna-vaccine-hub-with-strong-support-from-african-and-european-partners](https://www.who.int/news/item/18-02-2022-who-announces-first-technology-recipients-of-mrna-vaccine-hub-with-strong-support-from-african-and-european-partners)

⁹⁷ Achal Prabhala and Alain Alsahani, "Pharmaceutical manufacturers across Asia, Africa and Latin America with the technical requirements and quality standards to manufacture mRNA vaccines" (previously cited).

4.4 PUT PEOPLE OVER PROFITS: PHARMA’S EVER-INCREASING PRICES AND REVENUES

Vaccine developers’ human rights responsibilities require that in their pricing decisions, they do not consider only their economic interests and economic viability, but also address the potential adverse impact of profit. Pricing plays a key role in determining access to Covid-19 vaccines because purchasing price directly impacts a state's ability to make Covid-19 vaccines available – to its own population as well as at a global level. Further, investments in high-priced vaccines reduce a state’s capacity to finance other crucial avenues to fight the pandemic such as investing in hospitals and providing much needed social services in a time of emergency. Profit margins must remain reasonable in order not to amount to obstacles to vaccine access.⁹⁸

As of September 2021, nine months into the Covid-19 vaccine roll-out, pharmaceutical companies had delivered 71% of their stock to upper-middle or high-income countries.⁹⁹ While this distribution became less unequal over time, those who had to wait to receive doses faced the hardships of Covid-19 for longer. When disaggregating global allocation data by company, Moderna and Pfizer/BioNTech vaccines stand out as the two vaccines that have been mostly allocated to high-income countries that can pay more for vaccines. Whereas 75.61% of Moderna’s and 60.69% of Pfizer’s vaccines have gone to high-income countries, only 10.06% of AstraZeneca’s and 16.72% of Johnson & Johnson’s vaccines have gone to these countries,¹⁰⁰ even though all four companies diversified their sales to other income bands.



Amnesty International Germany’s projection at the International mRNA Health Conference, calling on pharmaceutical companies to make vaccine knowledge and technology available to lower- income countries. This conference brought together industry and academics to explore the rapidly advancing science and business of mRNA vaccines and medicines. Berlin, Germany, 9 November 2021. ©Amnesty International Germany

⁹⁸ Amnesty International, *Money Calls the Shots: Pharma's response to the Covid-19 vaccine crisis* (previously cited).

⁹⁹ Amnesty International, “A double dose of inequality”, p. 25.

¹⁰⁰ Data provided by Airfinity, March 2023. These number represent the cumulative allocation from approval of each vaccine until 28 February 2023.

FIGURE 4: CUMULATIVE COVID-19 VACCINE ALLOCATION¹⁰¹**(ASTRAZENECA, J&J, MODERNA AND PFIZER/BIONTECH)**

Country Classifications by Income	AstraZeneca	J&J	Moderna	Pfizer/BioNTech
High-income	10.06%	16.72%	75.61%	60.69%
Low-income	1.60%	33.80%	1.07%	1.78%
Lower-middle-income	73.92%	37.05%	16.21%	19.16%
Upper-middle-income	14.42%	12.42%	7.11%	18.36%

NOTE: Cumulative covers the date of approval of each vaccine until 28 February 2023. Any “donated” doses are attributed to final recipient countries.

FIGURE 5: YEAR 1 (2020-2021) COVID-19 VACCINE ALLOCATION¹⁰²**(ASTRAZENECA, J&J, MODERNA AND PFIZER/BIONTECH)**

Country Classifications by Income	AstraZeneca	J&J	Moderna	Pfizer/BioNTech
High-income	12.76%	42.32%	79.66%	68.22%
Low-income	1.29%	11.00%	0.85%	0.65%
Lower-middle-income	70.01%	26.21%	13.97%	9.54%
Upper-middle-income	15.94%	20.47%	5.52%	21.59%

NOTE: Covid-19 vaccinations started on 8 December 2020 and are ongoing. For consistency in data collection and presentation, this chart covers a 12-month period: Year 1 refers to 30 November 2020 to 1 December 2021. Any “donated” doses are attributed to final recipient countries.

FIGURE 6: YEAR 2 (2021-2022) COVID-19 VACCINE ALLOCATION¹⁰³**(ASTRAZENECA, J&J, MODERNA AND PFIZER/BIONTECH)**

Country Classifications by Income	AstraZeneca	J&J	Moderna	Pfizer/BioNTech
High-income	2.40%	10.48%	71.01%	52.64%
Low-income	2.43%	37.04%	1.37%	2.79%
Lower-middle-income	84.36%	41.03%	19.90%	29.01%
Upper-middle-income	10.82%	11.44%	7.71%	15.56%

NOTE: Covid-19 vaccinations started on 8 December 2020 and are ongoing. For consistency in data collection and presentation, this chart covers a 12-month period: Year 2 refers to 30 November 2021 to 1 December 2022. Any “donated” doses are attributed to final recipient countries.

¹⁰¹ Data provided by Airfinity, March 2023. These number represent the cumulative allocation from approval of each vaccine until 28 February 2023.

¹⁰² Data provided by Airfinity, March 2023.

¹⁰³ Data provided by Airfinity, March 2023.

Unsurprisingly, the Covid-19 vaccine manufacturers that sold most of their stock to high-income countries are also the ones who generated the most revenues. In 2021 and 2022, Pfizer earned US\$74.587 billion and Moderna earned US\$36.110 billion in revenues, from the sales of their Covid-19 vaccines.¹⁰⁴ In contrast, AstraZeneca has collected US\$5.715 billion, and Johnson & Johnson has made US\$4.564 billion in revenue from their Covid-19 vaccines.¹⁰⁵ In February 2023, Moderna announced that it already had at least US\$5 billion worth of vaccines contracted for delivery and was "expecting additional sales from key markets."¹⁰⁶ Similarly, Pfizer's had a record-breaking year in 2022 with an all-time high revenue of more than US\$100 billion for the first time in its 174-year history. This represents a 30% overall growth for the company compared to 2021.¹⁰⁷

Despite these record-breaking revenues, some pharmaceutical companies have announced plans to increase their prices for the Covid-19 vaccines. Both Pfizer and Moderna announced they were considering quadrupling the price of each Covid-19 vaccine to between US\$110 and US\$130 in high-income countries.¹⁰⁸ For example, the US government purchased the original Moderna vaccine at US\$15 per dose and US\$26 for each booster dose, and this proposed price hike represents a minimum increase of 733% for the original vaccine and a 423% increase for the booster.¹⁰⁹ This increase is being implemented, even though the United States reported having invested approximately US\$5.75 billion of public funding in Moderna's vaccine development, clinical trials, manufacturing and purchases.¹¹⁰ In 2021 and 2022, these two companies, made more than US\$110 billion in Covid-19 vaccine revenue.

FIGURE 7: COVID-19 VACCINE REVENUE REPORTED BY RESPECTIVE COMPANIES IN US DOLLARS¹¹¹

Period	AstraZeneca	J&J	Moderna	Pfizer/BioNTech
Total 2021	3.917 billion	2.385 billion	17.675 billion	36.781 billion
Total 2022	1.798 billion	2.179 billion	18.435 billion	37.806 billion
TOTAL	5.715 billion	4.564 billion	36.110 billion	74.587 billion

NOTE: The years above refer to each company's fiscal year, which matches calendar years.

¹⁰⁴ Data provided by Airfinity, March 2023.
¹⁰⁵ Data provided by Airfinity, March 2023.
¹⁰⁶ Moderna, "Moderna reports fourth quarter and fiscal year 2022 financial results and provides business updates, 23 February 2023, investors.modernatx.com/news/news-details/2023/Moderna-Reports-Fourth-Quarter-and-Fiscal-Year-2022-Financial-Results-and-Provides-Business-Updates/default.aspx
¹⁰⁷ Pfizer, "A record-breaking year and strong fourth quarter for Pfizer", 31 January 2023, insights.pfizer.com/fourth-quarter-fy-earnings/
¹⁰⁸ Wall Street Journal, "Moderna considers price of \$110-\$130 for Covid-19 vaccine, 9 January 2023, [wsj.com/articles/moderna-considers-price-of-110-130-for-covid-19-vaccine-11673289609](https://www.wsj.com/articles/moderna-considers-price-of-110-130-for-covid-19-vaccine-11673289609) In February, Moderna announced in that in the United States it would offer the shot for free for those who do not have health insurance. Moderna, "Moderna's commitment to patient access in the United States", 15 February 2023, investors.modernatx.com/Statements--Perspectives/Statements--Perspectives-Details/2023/Modernas-Commitment-to-Patient-Access-in-the-United-States/default.aspx
¹⁰⁹ Amnesty International, *Money Calls the Shots: Pharma's response to the Covid-19 vaccine crisis* (previously cited).
¹¹⁰ Amnesty International, *Money Calls the Shots: Pharma's response to the Covid-19 vaccine crisis* (previously cited).
¹¹¹ Data provided by Airfinity, March 2023.



Crowds of people wearing face masks during morning rush hour. Bangkok, Thailand, 16 March 2020. © Getty Images

5. LOOKING AHEAD: NEW INITIATIVES FOR PANDEMIC PREPAREDNESS

5.1 THE PANDEMIC TREATY ON PREVENTION, PREPAREDNESS AND RESPONSE

The Covid-19 pandemic exposed how human rights protections are indispensable for just and effective pandemic prevention, preparedness and response. A process to negotiate a new international instrument (the “Pandemic Treaty”) is underway to reform preparedness and response frameworks to ensure greater cohesion and cooperation in the face of future emergencies. In February 2023, the WHO’s Intergovernmental Negotiating Body (INB) issued a Zero Draft for discussion, and a finalized instrument is expected to be ready by May 2024.¹¹² While this Zero Draft addresses several issues related to pandemics, the text in this briefing focuses on the draft’s treatment of access to life-saving health products such as vaccines. (For a full human rights analysis, please see “The Pandemic Treaty Zero Draft Misses the Mark on Human Rights.”¹¹³)

Although the Zero Draft states that it is guided by human rights and the right to health, it fails to acknowledge the right to enjoy the benefits of scientific progress and its applications, also known as the “right to scientific progress.” Established in both Article 27 of the Universal Declaration of Human Rights (UDHR) and Article 15 of the ICESCR, this right reiterates the need to ensure universal access to medical technologies and health products such as diagnostics, treatments and vaccines. The CESCR’s General Comment 25 on science and economic, social and cultural rights¹¹⁴ further details that scientific progress must be available, accessible, acceptable and of good quality to all individuals and communities.¹¹⁵ Drawing upon these rights, the Zero Draft should clearly establish that all people must have fair access to the health applications of scientific progress, without discrimination. As this is particularly relevant for disadvantaged and marginalized groups that may have

¹¹² Elliot Hannon and others, “Why we still need a pandemic treaty”, 13 July 2022, *The Lancet Global Health*, Volume 10, Issue 9, E1232-E1233, doi.org/10.1016/S2214-109X(22)00278-9

¹¹³ Amnesty International and others, “Joint Statement: Pandemic treaty zero draft misses the mark on human rights” (Index: IOR 40/6478/2023) 24 February 2023, [amnesty.org/en/documents/ior40/6478/2023/en/](https://www.amnesty.org/en/documents/ior40/6478/2023/en/)

¹¹⁴ CESCR, General Comment 25 (previously cited).

¹¹⁵ CESCR, General Comment 25 (previously cited), paras 16-19.

limited or no access to these tools and may face heightened risks,¹¹⁶ the Zero Draft also should specify that states must ensure fair allocation of these products among and within countries.

While the Zero Draft acknowledges the role of knowledge and technology transfer in ensuring fair and timely access to health products, the text falls short of defining the human rights obligations in this realm. For example, the preamble reiterates the right of states to implement waivers and other limitations of intellectual property rights, but the text fails to identify the instances in which states must do so, according to their human rights obligations.¹¹⁷ Similarly, Article 7 addresses the importance of knowledge and technology transfer but fails to establish obligations to discharge these functions in line with human rights law and standards. Furthermore, vague language such as “promote”, “incentivize”, “encourage”, “facilitate”, or “support” mean that the draft fails to communicate states’ legal obligation to ensure that intellectual property is not a barrier.

This current diluted language in the Zero Draft is also a concern in terms of states’ obligation to hold private actors such as pharmaceutical companies to account for their human rights responsibilities. For example, while Article 9 makes it “compulsory” for manufacturers that receive public funding to disclose prices and contractual terms for pandemic-related products, this provision is subject to “the extent of the public funding received.” Furthermore, the same article only goes as far as “encouraging” manufacturers to disclose prices when they receive “other funds”. These provisions limit accountability and transparency of pharmaceutical manufacturers.

Likewise, the Zero Draft should frame international assistance and cooperation in the language of obligations. For example, Article 11(2) only “encourages” States to support others, instead of reflecting their human rights obligation to provide financial and technical support to uphold the right to health, especially in the face of the international spread of disease. This may include the sharing of research, knowledge, medical equipment and supplies.¹¹⁸ Similarly, Article 19(1)(d) should ensure that any recommended or required percentage of GDP for international assistance and cooperation recognizes that States with access to more resources (for example, health products) should provide more assistance where possible.¹¹⁸ Finally, given the failure of states and pharmaceutical companies to fulfil their human rights obligations and responsibilities during the Covid-19 pandemic, the Zero Draft should include a robust mechanism to hold states accountable for their international obligations and ensure its effectiveness.

5.2 NEW MECHANISMS TO ENSURE GLOBAL ACCESS TO HEALTH PRODUCTS IN PANDEMICS

In February 2023, following a review of COVAX in 2022,¹¹⁹ the WHO announced that it is convening a design and consultation process on a new end-to-end platform to coordinate the “rapid development of and equitable access to medical countermeasures for pandemics and major epidemics.”¹²⁰ Measures include tools, interventions and treatments used to prevent or mitigate the effects of a public health emergency of international concern such as diagnostics, therapeutics, vaccines, personal protective equipment, oxygen, among other health products. The goal is to “bring coherence to a fragmented landscape of initiatives and ensure that equity and the needs of underserved populations are at its center”.¹²¹

¹¹⁶ General Comment 25 (2020) on science and economic, social and cultural rights (article 15(1)(b), (2), (3) and (4) of the International Covenant on Economic, Social and Cultural Rights), 30 April 2020, E/C.12/GC/25.

¹¹⁷ International Commission of Jurists, *Expert Legal Opinion: Human Rights Obligations of States to Not Impede the Proposed COVID-19 TRIPS Waiver*, November 2021, [icj.org/wp-content/uploads/2021/11/Human-Rights-Obligations-States-Proposed-COVID-19-TRIPS-Waiver.pdf](https://www.icj.org/wp-content/uploads/2021/11/Human-Rights-Obligations-States-Proposed-COVID-19-TRIPS-Waiver.pdf)

¹¹⁸ CESCR, General Comment 14 (previously cited), para. 40.

¹¹⁹ WHO, *ACT-Accelerator Strategic Review An independent report prepared by Dalberg*, 8 October 2021, [who.int/publications/m/item/act-accelerator-strategic-review](https://www.who.int/publications/m/item/act-accelerator-strategic-review)

¹²⁰ WHO, “Developing a new platform for equitable access to medical countermeasures in pandemics design & consultation process”, 2 February 2023, cdn.who.int/media/docs/default-source/documents/emergencies/countermeasures-platform_who-consultative-process---concept.pdf, p. 1.

¹²¹ WHO, “WHO design and consultation process on a new medical countermeasures platform for pandemics”, 3 February 2023, [who.int/news-room/articles-detail/who-design-and-consultation-process-on-a-new-medical-countermeasures-platform-for-pandemics](https://www.who.int/news-room/articles-detail/who-design-and-consultation-process-on-a-new-medical-countermeasures-platform-for-pandemics)

To create such a platform, the WHO has called upon a range of global, regional, and national stakeholders and build on experiences and learnings from the Access to Covid-19 Tools Accelerator (ACT-A), Pandemic Influenza Preparedness Framework (PIP), and other relevant inter-agency initiatives. A “rapid initial prototype phase” is to be completed by April 2023, followed by consultations by a High-Level Consultative Group that will launch the new “full working’ platform” by September 2023. The WHO expects this platform will then be further adjusted once the Intergovernmental Negotiation Body (INB) responsible for creating an international pandemic accord, also known as the Pandemic Treaty, has concluded its work.

While this platform is still in the initial phase of planning, it is important to note that the WHO’s initial concept note focuses on the importance of “equitable access” but fails to acknowledge structural issues that limited the supply of Covid-19 vaccines, especially in the initial phase of distribution. For example, the concept note does not address how it will approach intellectual property rights and the challenge of persuading companies to share knowledge and technology to scale up production and reduce the dependency of low- and middle-income countries on high-income countries. Without these specific measures, a platform will still likely face a supply problem, as pharmaceutical companies will presumably continue to determine access by controlling supply, pricing, and allocation to individual countries based on commercial interests.

While the Zero Draft of the Pandemic Treaty acknowledges the role of knowledge and technology transfer in ensuring fair and timely access to health products, it does not lay out the clear obligations of states in this regard and it would be beneficial for both the Treaty and a new procurement mechanism to be in lockstep on this key issue that is likely to be a determining factor for access to health supplies in public health emergencies.



Healthcare workers hug in solidarity together at ICU. © eICasanelles/Getty Images

5.3 A GLOBAL PUSH TO PRIORITIZE UNIVERSAL HEALTH COVERAGE (UHC)

The first days of the Covid-19 pandemic quickly exposed the impact of significant under-investment in and under-prioritization of health systems and surge capacity across the world as entire communities ran out of hospital beds for those who fell sick and critically ill patients were often left without treatment options. In some countries, this under-investment was a result of specific governmental policies, such as austerity measures, while elsewhere health systems had been consistently underfunded for a range of reasons, including due to a lack of political will and resources, as well as an increasing trend towards private health care systems.¹²²

More notably, states' inability or unwillingness to invest in their health and social systems had a disproportionate impact on historically marginalized groups - those who face discrimination, exclusion and conditions of systemic inequality because of their race, ethnicity, disability status, sexual orientation and gender identity, among other grounds. The Covid-19 pandemic more heavily impacted certain groups such as essential workers, who are disproportionately concentrated in lower-income communities;¹²³ women, who face job insecurity often exacerbated by additional caregiving responsibilities due to distancing measures; people living with conditions considered to carry higher medical risk and people living in congregate settings, such as prisons or care homes;¹²⁴ Indigenous peoples;¹²⁵ migrants, refugees, and displaced populations; people without access to quality and affordable health care, such as sex workers,¹²⁶ transgender persons,¹²⁷ ethnic minorities,¹²⁸ among other populations.¹²⁹

Goal 3 of the Sustainable Development Goals (SDGs) addresses universal health coverage, including financial risk protection, access to quality essential health-care services and "access to safe, effective, quality and affordable essential medicines and vaccines for all."¹³⁰ However, the Covid-19 pandemic had a significant adverse impact on achievements towards this goal,¹³¹ leading to setbacks in public health gains made in the last decades.¹³² For instance, UNICEF reported that 23 million children missed basic routine vaccinations in 2020 alone, and 17 million of these children did not receive a single vaccine.¹³³ Likewise, the WHO also reported that in 2021, 90% of 129 countries still faced ongoing disruptions to health systems, nearly two years into the pandemic.¹³⁴

¹²² Amnesty International, Exposed, Silenced, Attacked: Failures to Protect Health and Essential Workers During the COVID-19 Pandemic (previously cited).

¹²³ Amnesty International, Exposed, Silenced, Attacked: Failures to Protect Health and Essential Workers During the COVID-19 Pandemic (previously cited).

¹²⁴ Amnesty International, *As If Expendable: The UK Government's Failure to Protect Older People in Care Homes During the Covid-19 Pandemic* (Index: EUR 45/3152/2020), 4 October 2020, [amnesty.org/en/documents/eur45/3152/2020/en/](https://www.amnesty.org/en/documents/eur45/3152/2020/en/); Amnesty International, *Forgotten Behind Bars: Covid-19 and Prisons* (Index: POL 40/3818/2021), 18 March 2021, [amnesty.org/en/documents/pol40/3818/2021/en/](https://www.amnesty.org/en/documents/pol40/3818/2021/en/); Amnesty International, *Prisoners of the Pandemic: The right to Health and Covid-19 in Pakistan's Detention Facilities* (Index: ASA 33/3422/2020), 13 December 2020, [amnesty.org/en/documents/asa33/3422/2020/en/](https://www.amnesty.org/en/documents/asa33/3422/2020/en/)

¹²⁵ Amnesty International, "Ecuador: Covid-19 threatens Indigenous people's lives" (Index: AMR 28/2643/2020), 3 July 2020, [amnesty.org/en/documents/amr28/2643/2020/en/](https://www.amnesty.org/en/documents/amr28/2643/2020/en/)

¹²⁶ Amnesty International, "Include sex workers in the COVID-19 response" (Index POL 30/2788/2020), 28 July 2020, [amnesty.org/en/wp-content/uploads/2021/05/POL3027882020ENGLISH.pdf](https://www.amnesty.org/en/wp-content/uploads/2021/05/POL3027882020ENGLISH.pdf)

¹²⁷ Amnesty International, "Asia and the Pacific Islands: Pandemic's disproportionate impact on transgender people should be 'wake-up call' to governments", 14 November 2022, [amnesty.org/en/latest/news/2022/11/asia-pacific-pandemics-transgender-rights/](https://www.amnesty.org/en/latest/news/2022/11/asia-pacific-pandemics-transgender-rights/)

¹²⁸ Amnesty International, "Slovakia: Roma must not be further stigmatized during Covid-19" (Index: EUR 72/2110/2020), 8 April 2020, [amnesty.org/en/documents/eur72/2110/2020/en/](https://www.amnesty.org/en/documents/eur72/2110/2020/en/)

¹²⁹ Amnesty International, "Covid-19 hits those shackled by oppression hardest thanks to decades of inequalities, neglect and abuse", 7 April 2021, [amnesty.org/en/latest/press-release/2021/04/annual-report-covid19-decades-of-oppression-inequality-abuse/](https://www.amnesty.org/en/latest/press-release/2021/04/annual-report-covid19-decades-of-oppression-inequality-abuse/)

¹³⁰ UN Sustainable Development Goals, Goal 3: Ensure healthy lives and promote well-being for all at all ages, [un.org/sustainabledevelopment/health/](https://www.un.org/sustainabledevelopment/health/), "Goal 3 targets".

¹³¹ UN Sustainable Development Goals, Goal 3: Ensure healthy lives and promote well-being for all at all ages, [un.org/sustainabledevelopment/health/](https://www.un.org/sustainabledevelopment/health/), "Good health and well-being".

¹³² WHO, "WHO's 7 policy recommendations on building resilient health systems", 19 October 2021, [who.int/news/item/19-10-2021-who-s-7-policy-recommendations-on-building-resilient-health-systems](https://www.who.int/news/item/19-10-2021-who-s-7-policy-recommendations-on-building-resilient-health-systems)

¹³³ WHO, "COVID-19 pandemic leads to major backsliding on childhood vaccinations, new WHO, UNICEF data shows", 15 July 2021, [who.int/news/item/15-07-2021-covid-19-pandemic-leads-to-major-backsliding-on-childhood-vaccinations-new-who-unicef-data-shows](https://www.who.int/news/item/15-07-2021-covid-19-pandemic-leads-to-major-backsliding-on-childhood-vaccinations-new-who-unicef-data-shows)

¹³⁴ WHO, "Essential health services face continued disruption during COVID-19 pandemic", 7 February 2022, [who.int/news/item/07-02-2022-essential-health-services-face-continued-disruption-during-covid-19-pandemic](https://www.who.int/news/item/07-02-2022-essential-health-services-face-continued-disruption-during-covid-19-pandemic)



A nurse measuring blood pressure on a patient. Nairobi, Kenya. 30 October 2021. © 2021 SOPA Images

Moving closer to universal health coverage globally will require significant additional investments in the form of international cooperation. Although there is no systematic tracking of financing for universal health coverage,¹³⁵ throughout 2023, states will have multiple political opportunities to invest in strong health systems globally. In September, the UN High-Level Meeting on UHC 2023¹³⁶ will be a space focused solely on this topic and the SDG Summit 2023 will carry out a comprehensive review of the implementation of the SDGs to date, including health.¹³⁷ Finally, the World Health Summit – a forum for discussions on global health with stakeholders from politics, science, the private sector, and civil society spearheaded by the heads of the German and French governments, the European Union, and the WHO – will be held in October 2023 and has highlighted “Accelerating Progress Towards Universal Health Coverage” as one of its central topics this year.¹³⁸

¹³⁵ Kara Hanson and others, *The Lancet Global Health Commission on Financing Primary Health Care: Putting People at the Centre*, 4 April 2022, *The Lancet Global Health Commissions*, Volume 10, Issue 5, E715-E772, doi.org/10.1016/S2214-109X(22)00005-5 [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(22\)00005-5/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00005-5/fulltext)

¹³⁶ UHC2030, “Universal health coverage (UHC) message sheet for 2023”, uhc2030.org/fileadmin/uploads/uhc2030/UHC_MESSAGE_SHEET_FOR_2023.pdf

¹³⁷ United Nations SDG Summit 2023, “The 2023 SDG Summit – the High-level Political Forum on Sustainable Development under the auspices of the General Assembly”, un.org/en/conferences/SDGSummit2023

¹³⁸ World Health Summit 2023, worldhealthsummit.org/summit.html

6. KEY RECOMMENDATIONS FOR FUTURE PANDEMICS

The Covid-19 pandemic has caused a global public health and socio-economic crisis. The development and distribution of vaccines has played a key role in moving the world out of the most acute phase of the pandemic, but the unfair global distribution of these vaccines exposed significant human rights problems, and systemic inequalities for people subjected to different oppressions, including racism. As the world evaluates its pandemic preparedness, it is crucial for states and businesses to develop and implement, in line with human rights standards, policies to ensure availability, accessibility, affordability, acceptability and quality of health products for all people to ensure the world leaves no one behind as it responds to a global emergency.

States must:

- Fulfil its human rights obligation to international cooperation and assistance and remove any existing or potential barriers to ensure that health products are developed in a timely manner, manufactured in sufficient quantities at affordable prices, and distributed fairly across and within countries to achieve broad, non-discriminatory global access. This obligation includes providing technical and financial assistance to other states, as well as refraining from behaviours, including bilateral deals, that could compromise the ability of other states to access the health products.
- Guarantee that the right to scientific progress — in addition to the right to health — is acknowledged as a key component of ensuring access to health products and pandemic preparedness, alongside the right to health; to this end, ensure that the benefits of scientific progress is available, accessible, acceptable and of good quality to all people, without discrimination.¹³⁹
- Acknowledge that intellectual property rights can be a barrier to access to health products, especially in public health emergencies, and therefore affect human rights and must be discussed in trade discussions as threats to human rights with a view to finding human-rights compliant solutions, as well as in other forums that go beyond trade discussions.
- Create laws and policies that provide for knowledge and technology transfer to scale up production of health products globally and reduce the dependency of low- and middle-income countries on high-income countries and the pharmaceutical industry.
- Ensure that any policy, instrument or mechanism related to access to health products frames the issue as a human right, describes the corresponding human rights obligations, calls for international cooperation, and includes concrete measures to address intellectual property rights and/or knowledge and technology transfer; these discussions must include effective and meaningful participation civil society, taking into account power imbalances.
- Create substantive change in global trade rules to ensure that intellectual property rights, as well as knowledge and technology transfer, are not a barrier to access to medicines, in policy and in practice, especially at the WTO and other relevant fora.
- Review national laws and policies related to intellectual property rights for health products and make public funding to companies conditional on them joining global knowledge and technology mechanisms - such as C-TAP, the Medicine Patent Pool (MPP), and the mRNA Hub – and on the companies’ publicly disclosing disaggregated costs of research, development, production, marketing distribution and all other relevant data in a timely and accessible fashion. If companies have not received public funding, states should consider incentives for them to share intellectual property, knowledge and technology.

¹³⁹ CESCR, General Comment 25 (previously cited), para. 17.

Businesses/Investors should:

- Develop and implement policies concerning access to health products, including on pricing, transparency and intellectual property, that respect the right to health and aim to make these products available, accessible and affordable to all while considering that public health emergencies generally have a disproportionate impact on historically marginalized countries and populations.
- Pursue allocation strategies that take into consideration public health and human rights concerns such as the need in the country, access to other health products, and non-discrimination, among other considerations, especially when under constrained supply.
- Conduct proactive, ongoing human rights due diligence to ensure that they are not causing or contributing to any human rights harm; both companies and investors should conduct due diligence on any investments and financial services related to companies engaged in access to health products by monitoring the human rights impacts of pharmaceutical companies, taking immediate action to prevent any adverse impacts, mitigate any risks, and remedy any identified harm.
- Disclose to the public disaggregated costs of research, development, production, marketing distribution and all other relevant data in a timely and accessible fashion; price health products so that profit does not constitute an obstacle to access; at a minimum, supply these at cost to low- and lower-middle-income countries for at least a duration of the global health emergency.
- Ensure sales with one state or entity are not of a scale or scope that compromises fair global access to health products and/or unduly impacts other states' ability to ensure availability, accessibility and affordability of health products for their populations; build in contractual flexibility regarding delivery terms to ensure that those most at risk globally get access health products in a timely manner, especially in case of outbreaks that require urgent responses.
- Ensure that intellectual property rights are not a barrier to the right to health and the right to scientific progress; issue non-exclusive licensing and share their knowledge, technology and data with sharing platforms - such as C-TAP, the Medicine Patent Pool (MPP), and the mRNA hub and/or other manufacturers, especially if receiving public funding, which should trigger robust conditionalities at the research and development phase and procurement phase.
- Assign oversight and responsibility for complying with the company's human rights responsibility to extend fair access to health products to all relevant senior management and assign board level responsibilities, including through linking it to executive pay.

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info@amnesty.org



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amnesty.org



Amnesty International
Peter Benenson House
1 Easton Street
London WC1X 0DW, UK

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Index: **POL 30/6518/2023**

Publication: **March 2023**

Original language: **English**

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