STUDENT ESSAY

Business as Usual? Centering Human Rights to Advance Global COVID-19 Vaccine Equity Through COVAX

KAITLIN FAJBER

Abstract

This essay examines the extent to which COVID-19 Vaccines Global Access (COVAX) has been a successful mechanism for global COVID-19 vaccine equity as a component of the human right to health. First, I provide background on COVID-19 vaccine equity and COVAX as part of the Access to COVID-19 Tools ACT-Accelerator. Second, I situate access to COVID-19 vaccines within the context of human rights to exemplify how the international community intended COVAX to advance both health equity and the human right to health. Third, I assess how those intentions have played out in practice due to challenges of vaccine nationalism, lack of transparency, funding shortfalls, unreliable donations, inadequate civil society participation, and inequitable resource allocation. Fourth, I suggest how COVAX might function differently if human rights were centered within its purpose, strategy, and operations. Ultimately, I argue that COVAX is upholding a largely market-oriented approach to making essential medicines accessible and that COVAX would be a more effective mechanism for vaccine equity and global health if it were grounded in human rights.

Kaitlin Fajber, BA, is a master of public health candidate at the Dalla Lana School of Public Health at the University of Toronto, Canada.

Please address correspondence to the author. Email: k.fajber@mail.utoronto.ca.

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Introduction

Vaccines are essential to the global COVID-19 pandemic response; however, many countries have lacked adequate access. Despite the rapid development of COVID-19 vaccines, the distribution of and access to vaccines has been fraught with inequity, perpetuating health risks, endangering lives, giving rise to new virus variants, and increasing overall health disparities between high-income countries (HICs) and low-income countries (LICs). Importantly, access to these vaccines is essential to save lives in the face of a deadly pandemic and thus implicate the international human right to health. The International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health," including the "prevention, treatment and control of epidemic, endemic, occupational and other diseases."[1] Persistent vaccine inequity has contributed to the rising global death toll from COVID-19 and impeded the realization of this right.

Given the urgent need for vaccines, a global collaboration known as the Access to COVID-19 Tools Accelerator (ACT-Accelerator) was initiated at the start of the pandemic with four main pillars: vaccines, diagnostics, therapeutics, and strengthening health systems.[2] The vaccine pillar, also known as COVID-19 Vaccines Global Access (COVAX), is led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations (CEPI). In theory, COVAX was envisioned as a global pooling mechanism to incentivize rapid vaccine development and facilitate equitable global vaccine allocation.[3] In practice, COVAX has faced significant challenges and fallen short of its aims.

This essay examines the extent to which COVAX has been a successful mechanism for global COVID-19 vaccine equity as part of the human right to health. First, I provide background on COVID-19 vaccine equity and COVAX as part of the ACT-Accelerator. Second, I situate access to COVID-19 vaccines within the context of human rights to exemplify how the international community intended for COVAX to advance both health equity and the human right to health. Third, I assess how those intentions have played out in practice due to challenges of vaccine nationalism, lack of transparency, funding shortfalls, unreliable donations, inadequate civil society participation, and inequitable resource allocation. Fourth, I suggest how COVAX might function differently if human rights were centered within its purpose, strategy, and operations. Ultimately, I argue that COVAX is upholding a largely market-oriented approach to making essential medicines accessible and that COVAX would be a more effective mechanism for vaccine equity and global health if it were grounded in human rights.

Global COVID-19 vaccine inequity and COVAX

Vaccine equity refers to distributing vaccines globally based on need, irrespective of economic status.[4] As of July 2022, COVID-19 vaccine equity was still far from being realized; approximately 33.1% of the global population remained unvaccinated, and vaccination rates varied widely.[5] There remains a stark difference between countries: 72.38% of individuals had received at least one vaccine dose in HICs, compared to 20.42% in LICs.[6] These disparities continue to be highlighted by world health and human rights leaders, such as the United Nations High Commissioner for Human Rights and the Director-General of the World Health Organization, who have called for increased global cooperation to end vaccine apartheid.[7] One of the mechanisms working to reduce vaccine inequity is COVAX.

COVAX is a public-private partnership (PPP) that works as a global pooling mechanism to incentivize rapid vaccine development and ensure equitable vaccine allocation.[8] Countries can join the COVAX Facility as a self-financed country or be funded through the Gavi COVAX Advanced Market Commitment (AMC).[9] The COVAX Facility monitors the vaccine landscape for promising candidates and uses collective purchasing power to secure vaccine access while doses are still being developed.[10] Self-financed countries join the COVAX Facility through committed purchase agreements, which require upfront payments of US$1.60 per

dose, or through optional purchase agreements at a steeper price of US$3 per dose in exchange for the ability to opt out of certain vaccines.[11] Simultaneously, the AMC is funded through official development assistance and donations from the private sector and philanthropists to provide vaccines for 92 eligible lower- and middle-income countries (LMICs).[12] Altogether, COVAX is built to promote both international cooperation and access to vaccines—core components of the right to health.

The right to health and COVAX

Achieving global COVID-19 vaccine equity is intimately intertwined with realizing the human right to health. One hundred and seventy-one states are party to the ICESCR, whose article 12 outlines the obligation of states to prevent and protect against infectious disease.[13] The Committee on Economic, Social and Cultural Rights has interpreted the rights enshrined in the ICESCR through a series of general comments. Specifically, General Comment 14 on the right to health lays out the obligation for international cooperation, the role of the private business sector in actualizing human rights responsibilities, and the provision of essential drugs and immunizations as core responsibilities.[14] Within the first year of the COVID-19 pandemic, the committee clearly stated that "every person has a right to have access to a vaccine for COVID-19 that is safe, effective and based on the application of the best scientific developments" and that COVAX can facilitate international cooperation for vaccine distribution and prioritization.[19]

Furthermore, the United Nations Special Rapporteur on the right to health has highlighted how a right to health approach prioritizes making medicines available, accessible, acceptable, and of good quality, in contrast to a market-oriented approach, which prioritizes profit over public health.[15] COVAX was designed to promote the availability of vaccines through pooled funding and investment, and accessibility of COVID-19 vaccines through allocation and distribution, illustrating alignment with a right to health approach. However, the global availability and accessibility of COVID-19 vaccines has been dictated by market forces as states and pharmaceutical companies operate in secrecy and compete for resources, suggesting a market-oriented approach to access to medicines. This approach is misaligned with the right to health and is contributing to ongoing vaccine inequity.

Indeed, a right to health approach for access to medicines requires explicit state action to ensure the human rights of people over the mere legal rights of businesses. General Comment 17 distinguishes the human right to moral and material protection to benefit from scientific production, which upholds human dignity, from intellectual property rights, which protect private business interests.[16] The production of COVID-19 vaccines involves companies that have profited from providing a critical health resource during a global pandemic. General Comment 17 clarifies that economic gains for businesses should not impede access to medicines and that states "have a duty to prevent unreasonably high costs for access to essential medicines."[17] Simultaneously, the human right to benefit from science must be balanced with the intellectual property rights of private corporations.[18] Specific to vaccines, "states should promote scientific research, through financial support or other incentives, to create new medical applications and make them accessible and affordable to everyone, especially the most vulnerable."[19] Advocating for vulnerable groups is further reinforced in General Comment 20 on the right to nondiscrimination, which distinguishes formal and substantive equality.[20] While formal equality refers to providing everyone with the same treatment, substantive equality acknowledges that differential treatment is sometimes required to achieve the same outcome and "requires paying sufficient attention to groups of individuals that suffer historical or persistent prejudice."[21] As a result, countries with fewer resources and more vulnerable populations should be intentionally prioritized when it comes to access to medicines. These instruments underscore that states must take deliberate action to protect human rights and prevent private interests from determining the accessibility of medicines, including COVID-19 vaccines.

Notably, although states are typically seen as

the duty holders for providing medicines, international cooperation also requires the participation of pharmaceutical companies to progressively realize the right to health and ensure core obligations—including access to vaccines—across the globe.[22] State parties have a duty to monitor and regulate companies to ensure that they respect the right to benefit from scientific progress and its applications.[23] The Special Rapporteur on the right to health has outlined the human rights responsibilities of pharmaceutical companies in relation to access to medicines, emphasizing that companies should be transparent with information, accountable to the public, and flexible with the pricing and licensing of pharmaceutical products for less-developed countries.[24] Specifically in the context of COVID-19, the Committee on Economic, Social and Cultural Rights has articulated that pharmaceutical companies hold human rights duties, and therefore intellectual property rights should not obstruct access to safe and effective vaccines.[25] Although COVAX was intended to unite state parties and pharmaceutical companies to vaccinate the world against COVID-19, the enduring vaccine inequity suggests that human rights have not been taken seriously enough by public or private international actors.

COVAX in practice: Challenges and shortcomings

Thus far, the benefits of rapid COVID-19 vaccine development have disproportionately benefitted HICs and left LICs behind.[26] In terms of delivery, COVAX has made notable but insufficient contributions toward global vaccination: 1.58 billion doses had been delivered as of July 2022, which is far short of the 2 billion doses COVAX had aimed to deliver by the end of 2021.[27] COVAX has also been used to support the World Health Organization's targets to vaccinate 40% of all countries' populations by the end of 2021 and 70% of all countries' populations by mid-2022.[28] However, by May 2022, only 33% of countries had reached the latter target, and vaccine inequities persisted along lines of country income: 65% of HICs had met or were on track to meet that target, versus 29% of upper middle-income countries, 15% of lower middle-income countries, and 0% of LICs.[29]

As of January 2022, COVAX had procured enough vaccines to meet the 70% global vaccination target, prompting a shift in strategy from procurement to supporting on-the-ground delivery.[30] This pivot included the initiation of COVAX's COVID-19 Vaccine Delivery Partnership, which specifically targets countries with less than 10% of the population vaccinated to overcome delivery challenges and get doses into arms.[31] There was renewed international support illustrated by the Break COVID Now Summit in April 2022, which raised US$4.8 billion in commitment funding for the COVAX AMC, a mechanism that has been responsible for facilitating 80% of vaccines delivered in LICs.[32] Despite progress, COVAX continues to be unable to meet its goals due to challenges of vaccine nationalism, hidden agreements and unknown costs, funding shortfalls, unreliable donations, imbalanced governance, and a lack of targeted support for marginalized groups.

Vaccine nationalism

When COVID-19 vaccines first entered the market, HICs rushed to make bilateral deals with pharmaceutical companies to secure vaccines, effectively buying up global supply and undermining the ability of COVAX to lead equitable resource allocation through multilateral agreements.[33] Wealthy countries have used COVAX to supplement their national vaccine supplies, forcing COVAX to compete for resources and pushing LMICs further to the back of the line to receive vaccines. Canada has been one of the worst culprits: by mid-2022, the country had procured enough supply to vaccinate the national population 5.71 times over, equivalent to 11.41 doses per inhabitant.[34] Comparatively, LICs in Africa have procured an average of 0.40 doses per inhabitant, and 84 countries participating in COVAX were still below the targeted 70% vaccine supply coverage at the start of 2022.[35]

The Committee on Economic, Social and Cultural Rights has clarified the obligation for international cooperation in public health

emergencies; however, vaccine nationalism demonstrates a departure from said duties.[36] United Nations member states have repeatedly affirmed their commitment through General Assembly and Human Rights Council resolutions that call for strengthening partnerships and using COVAX to coordinate a global pandemic response.[37] These resolutions are evidence that states recognize the importance of global solidarity to promote vaccine access; however, many states continue to hoard vaccines for national use. Though countries may operate under the guise that they are upholding the duty to provide medicines through securing and distributing vaccines nationally, global disparities between country vaccination rates do not align with the obligations of the right to health.

Hidden agreements, unknown costs

The lack of transparency by pharmaceutical companies regarding the agreements they make—with whom, for what price, and who is prioritized to receive doses first—has complicated COVAX operations. Information on COVID-19 vaccine costs comes almost exclusively from investigative journalism and news articles that are collated by UNICEF. Based on these records, the known price is US$2–$40 per dose across all vaccines.[38] This wide range showcases the power of companies to dictate prices and suggests a lack of coordination between countries to advocate for equivalent or tiered pricing. The COVAX AMC draws on philanthropy and development assistance to provide vaccines at a lower cost for LMICs, yet there are records of HICs still paying less than COVAX for COVID-19 vaccines. For instance, COVAX AMC pays US$4 per dose for AstraZeneca, while the European Union reportedly pays US$2.19 per dose for the same vaccine.[39] Affordable pricing is critical to making vaccines accessible, and pricing that disproportionately burdens LICs reflects injustice.

Funding shortfalls

COVAX has been chronically underfunded since its inception, demonstrating a lack of buy-in from the international community. For the 2021–2022 fiscal year, the ACT-Accelerator required US$5.98 billion to fund COVAX.[40] Halfway through the fiscal year, COVAX was 18% of the way toward this goal, leaving a funding gap of US$4.93 billion.[41] Further complicating matters are reports that up to 75% of donations to COVAX have been earmarked for specific countries or regions, further limiting the ability of COVAX to operate independently and allocate vaccines equitably.[42] Scholars have highlighted that COVAX financializes global health by shifting understanding of public health risk from the people at risk of COVID-19 infection to the corporations competing to produce COVID-19 vaccines.[43] Indeed, COVAX remains reliant on the voluntary actions of states, private organizations, and philanthropists to obtain funding and must often compete with those same actors to access vaccines. Though there are suggested monetary amounts for each country to contribute to COVAX, few countries have met those targets.[44] The persistent funding gap implies that states view resourcing COVAX as optional charity rather than a human rights obligation of international cooperation during a global health crisis.

Unreliable donations

Donations made up 60% of all doses delivered through COVAX in 2021: notable yet insufficient for meeting the target of two billion doses distributed by the end of that year.[45] Although donations are often viewed as benevolent, COVID-19 vaccines have been donated largely at the convenience of the donor and the expense of the receiver. HICs have been accused of donating unwanted "leftovers"; in fact, over half of the vaccine donations to COVAX in 2021 occurred in the last six weeks of the year.[46] Challenges due to unreliable donations were so great that COVAX issued a joint statement with the African Center for Disease Control and the African Vaccine Acquisition Trust in October 2021 requesting that donors meet certain basic standards: doses should be of large quantity, predictable, and unearmarked; should have a minimum of 10 weeks of shelf-life before expiry; should include adequate notice before arrival; and should include ancillaries (e.g., syringes and diluents).[47]

These challenges demonstrate how partic-

ipation in COVAX is considered charity rather than obligation under international human rights law. Wealthy countries have procured vaccines in excess for their populations, then donated doses to poorer countries in quantities and at times that convenience them. Meanwhile, pharmaceutical companies are also complicit by making bilateral agreements to sell doses to the highest bidder, effectively prioritizing profit over people. Dose-sharing through COVAX has been framed as a win-win-win situation: COVAX claims success by getting more donations, donor countries rebrand themselves as charitable donors instead of vaccine hoarders, and the pharmaceutical industry protects commercial interests selling vaccines to countries that can afford to pay and deflecting responsibility for equitable vaccine allocation.[48] This excludes a win for countries receiving donated COVID-19 vaccines who often have fewer resources and greater need. COVAX could be better operationalized if both states and nonstate actors understood their monetary contributions and dose donations as acts of international cooperation to best allocate resources and progressively realize the right to health.

Imbalanced governance and participation

COVAX has a complex governance structure that caters to many stakeholder interests and is dominated by representatives from donor countries and industry, which influences how and to whom COVAX distributes vaccines.[49] Self-financing countries sign agreements to join and make up the Shareholders Council, which provides strategic advice and guidance on COVAX Facility operations.[50] Meanwhile, funded participants apply for support and become members of the AMC Engagement Group alongside AMC donors.[51] Ten civil society representatives were recruited at the start of COVAX to participate in these working groups, an important yet inadequate attempt to engage civil society in global access to COVID-19 vaccines.[52]

COVAX has been referred to as a "super PPP" in global health because it is a partnership of partnerships that is attempting to represent diverse needs of public and private, and national and international interests.[53] However, the complex nature of this super partnership has arguably weakened public accountability: COVAX has relied on sharing risk for vaccine development and sharing doses for vaccine distribution, while overlooking the sharing of knowledge and decision-making power.[54] For instance, many African countries have depended on COVAX for vaccines, but there has been a lack of consultation with African experts, indicating a disproportionate decision-making power among Western nations on issues of distribution in Africa.[55] Moreover, none of the 1.3 billion doses shipped through COVAX as of May 2022 came from African companies, which has negatively impacted the growing local manufacturing capacity and perpetuated reliance on international aid.[56] Despite being a partnership, closer interrogation of the organizational structure of COVAX reveals that companies and HICs may be better positioned to leverage their power compared to civil society and LMICs.

Inequality and marginalized groups

COVAX's vaccine allocation strategy has not gone far enough to prioritize disadvantaged groups. Through the fair allocation model, COVAX aimed to first provide 20% of vaccines for all participating countries, regardless of income level, before moving to a need-based approach that prioritizes vulnerable populations.[57] This strategy was meant to incentivize wealthier countries to join COVAX and, by doing so, provide capital to invest in vaccine development, which supports vaccine availability for all countries. From a market perspective, this model makes sense because it drives vaccine innovation and production forward, yet from a human rights perspective, vulnerable and disadvantaged populations are not adequately considered or prioritized. Fair allocation was arguably not fair at all—wealthy countries could use COVAX to augment their already exorbitant supply of vaccines, thus exacerbating vaccine inequities between countries. In fact, the growing disparities caused COVAX to change strategies in the fall of 2021 to target countries with less than 10% vaccination coverage.[58] COVAX exemplifies the implementation of formal equality, which provides the same resource to all, over substantive equality, which would ad-

dress different levels of need. This approach has prolonged injustice for the most vulnerable.

COVAX reimagined: Centering human rights

COVAX has fallen far short of its aims to make COVID-19 vaccines accessible to all because it uses a market-oriented approach to provide vaccines, effectively promoting "business as usual." The examples in the preceding sections indicate the failings of this approach, in which COVAX has operated as a business and charity instead of a mechanism for progressively realizing the right to health. The following recommendations aim to center COVAX on human rights through the principles of international cooperation, participation, accountability, transparency, and equality.

Recommendation 1: Reframe participation in COVAX as a human rights obligation for states and companies

If COVAX were rooted in the right to health, international cooperation and assistance of states and pharmaceutical companies through COVAX would be viewed as requirements under international human rights law, as opposed to charity. As is, COVAX reinforces a business model by promoting market structures and vaccine monopolies.[59] The voluntary participation, rampant vaccine hoarding by HICs, lack of enforcement ability by global institutions such as the World Health Organization, and pooling of COVID-19 resources have inhibited COVAX from working as originally intended.[60] To achieve vaccine equity, participation in COVAX needs to be seen as a path for international cooperation to achieve human rights, global solidarity, and justice, and not only charity from wealthier nations.

Recommendation 2: Increase inclusive representation and participation by civil society in COVAX governance

Centering human rights would involve actively redistributing decision-making power to governments and civil society in LMICs. Ten representatives from civil society organizations within COVAX governance is insufficient, and true commitment to public engagement entails sharing power to best balance "various scientific, economic, societal and global consequences of policy choices relating to global public goods and COVID-19 vaccines."[61] Currently, of the 464 individuals publicly listed as part of COVAX governance, nongovernmental organizations and civil society are represented by 16 (3.4%), and these individuals were included only after 175 civil society organizations advocated for increased representation.[62] Increased civil society participation could alter decision-making and strengthen interests currently reflected in the People's Vaccine movement, whose demands clearly prioritize public health over industry interest.[63]

Recommendation 3: Establish mechanisms to make COVAX accountable to the public

Accountability is essential to monitor duty bearers and ensure that they meet their human rights obligations; hence, COVAX needs to establish accountability mechanisms.[64] In relation to COVID-19 vaccines, the Committee on Economic, Social and Cultural Rights has articulated that states have a duty to "establish transparent mechanisms that allow accountability, scrutiny of and citizen participation in decisions concerning the allocation of resources … for the realization of the right to health."[65] Importantly, media and civil society have a crucial role to play in holding public, private, national, and international actors accountable for the right to health.[66] The principle of "common but different responsibilities" has been used to organize state responsibilities in environmental law, particularly in regard to taking action against climate change, and COVAX is an ideal opportunity for application of this principle in a public health context.[67] The principle goes beyond the rhetoric of global solidarity to set clear expectations at the international level for how wealthier countries can and should provide different financial and material resources compared to less wealthy countries.[68] Centering human rights also clarifies who COVAX is accountable to; the right of all humans to benefit from scientific progress, such as the development of COVID-19 vaccines, trumps the right of com-

panies to benefit from the creation of intellectual property.[69]

Recommendation 4: Normalize transparency in all operations and agreements

Transparency regarding resources and decisions is key to fostering equity, and though COVAX has made many of its operations (e.g., funding information, and decisions regarding the allocation of vaccines) publicly available, it still operates in a vaccine market shrouded in secrecy. Normalizing and promoting transparency of vaccine costs, numbers, and deliveries is necessary for all COVAX partners, including states and pharmaceutical companies.

Recommendation 5: Prioritize marginalized populations to reach substantive equality

The strategy of COVAX should explicitly prioritize marginalized populations, meaning that HICs would receive fewer vaccines from COVAX and pay more per dose compared to LMICs. A needs-based approach would be applied from the start, instead of providing vaccines to cover 20% of each participating country's population as an incentive to participate. Furthermore, COVAX could strive for substantive equality in its procurement efforts by buying from African manufacturers to encourage the development of local vaccine production, which is also important for future health needs beyond COVID-19.[70]

Conclusion

This essay has argued that COVAX has used a market-oriented approach to promote access to COVID-19 vaccines by prioritizing the intellectual property rights of businesses over the health and human rights of all people. If a right to health approach were prioritized instead, COVAX would require international engagement and reflect core values of participation, international cooperation, accountability, transparency, and equality to promote COVID-19 vaccine equity. By doing so, COVAX would have the potential to strengthen and articulate human rights at a time when health and rights are in crisis and at the forefront of public consciousness. COVAX may not reach perfect vaccine equity on its own, but it can be used as a tool to operationalize human rights on the ground and advance health equity and global justice. It is time to mobilize human rights to challenge the status quo and put people before profit.

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62. Bengy Puyvallée and Storeng (see note 48).

63. The People's Vaccine, https://peoplesvaccine.org/.

64. United Nations General Assembly (2008, see note 22).

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66. United Nations General Assembly (2008, see note 22).

67. M. Hamrouni and E. C. F. Alter, "Equity, International Cooperation, and Global Public Health: Use of the Common but Differentiated Responsibilities Principle in the Fight against COVID-19," *Journal of International Women's Studies* 23/3 (2022).

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69. Committee on Economic, Social and Cultural Rights (2020, see note 18).

70. Ryder and Omosigho (see note 56).