IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG PROVINCIAL DIVISION, PRETORIA

Case Number: 3623/21

In the application of:

HEALTH JUSTICE INITIATIVE	Applicant for admission as an *amicus curiae*

In the matter between:

SOLIDARITY	First Applicant
AFRIFORUM NPC	Second Applicant
and	
MINISTER OF HEALTH	First Respondent
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	Second Respondent
MINISTER OF CO-OPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS	Third Respondent
THE CHAIRPERSON OF THE COVID-19 SCIENTIFIC MINISTERIAL ADVISORY COMMITTEE	Fourth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, WESTERN CAPE	Fifth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, GAUTENG	Sixth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, FREE STATE	Seventh Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, EASTERN CAPE	Eighth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTHERN CAPE	Ninth Respondent
MEMBER OF THE EXECUTIVE COUNCIL	

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FOR HEALTH, LIMPOPO	Tenth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, MPUMALANGA	Eleventh Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTH WEST	Twelfth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, KWAZULU-NATAL	Thirteenth Respondent
PHARMACEUTICAL SOCIETY OF SA	Fourteenth Respondent
COUNCIL OF MEDICAL SCHEMES	Fifteenth Respondent
SOUTH AFRICAN MEDICAL ASSOCIATION	Sixteenth Respondent
PHARMACEUTICAL INDUSTRY ASSOCIATION OF SA	Seventeenth Respondent

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AFFIDAVIT: DR TLALENG MOFOKENG

I, the undersigned,

DR TLALENG PETRONELLA MOFOKENG

do hereby make oath and say that–

1. I am a South African medical doctor. I am the United Nations (UN) Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

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2. The facts contained in this affidavit are within my personal knowledge, except where I indicate otherwise. To the extent that I rely on information supplied by others, I believe that such information is true and correct.

3. I have been asked to provide expert evidence in my capacity as the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. I attach a copy of my Curriculum Vitae marked **"TPM1"**.

4. This submission is made on a voluntary basis without prejudice to, and should not be considered as a waiver, express or implied, of the privileges and immunities of the United Nations, its officials and experts on missions, pursuant to the 1946 Convention on the Privileges and Immunities of the United Nations, to which South Africa acceded on 30 August 2002. Authorisation for the positions and views expressed herein by Ms. Mofokeng, in full accordance with the independence of her position, was neither sought nor given by the United Nations, including the Human Rights Council, the Office of the High Commissioner for Human Rights, or any of the officials associated with those bodies.

MY ROLE AS UN SPECIAL RAPPORTEUR ON HEALTH

5. At its forty-fourth session in July 2020, the United Nations Human Rights Council appointed me as the United Nations (UN) Special Rapporteur on *The right of*

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everyone to the enjoyment of the highest attainable standard of physical and mental health, effective August 2020.

6. In this role, I am the mandate holder and independent expert to the UN Human Rights Council (UNHRC) on this right. The appointment is not compensated by the UN or the SA government or any other entity. It is independent of any government or organisation. I serve in this role in my individual capacity to retain my independence.

7. Special Rapporteurs are part of what is known as the *Special Procedures* of the UN Human Rights Council. Special Procedures, the largest body of independent experts in the UN Human Rights system, is the general name of the UNHRC's independent fact-finding and monitoring mechanisms that address both specific country situations and thematic issues in all parts of the world.

INTERNATIONAL OBLIGATIONS AND GUIDELINES

8. United Nations mandate holders have taken various initiatives on COVID-19.[1] These initiatives all stress the importance of adopting a human rights approach in addressing the crisis. They emphasise that the principles of non-discrimination, participation, empowerment, and accountability must be applied with special attention to people in vulnerable situations.

[1] Accessible at https://www.ohchr.org/EN/HRBodies/SP/Pages/COVID-19-and-Special-Procedures.aspx.

9. The former Special Rapporteur on the right to health, in March 2020, initiated a general call stressing that '*everyone has the right to life-saving interventions*'. It was issued by more than 60 mandate holders. A copy of the call is attached as **"TPM2".**

9.1. The call stressed that the COVID-19 crisis cannot be solved with public health and emergency measures only, all other human rights must be addressed too.

9.2. Further, that:

> '*Everyone, without exception, has the right to life-saving interventions and this responsibility lies with the government. The scarcity of resources or the use of public or private insurance schemes should never be a justification to discriminate against certain groups of patients*' and '*Everybody has the right to health… Advances in biomedical sciences are very important to realise the right to health. But equally important are all human rights. The principles of non-discrimination, participation, empowerment, and accountability need to be applied to all health-related policies.*'

10. Mandate holders have continued to identify trends and emerging issues, and to formulate advice in connection with the emergency.

10.1. As of 22 January 2021, they had issued 136 press releases, 14 guidance, and other tools.

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10.2. 15 reports have been released and/or presented to either the Human Rights Council or the General Assembly. Three reports are expected to be issued and presented in 2021.

10.3. Special Procedures have examined allegations of human rights violations or concerns through the communication procedure and have so far (as of 22 January 2021) issued 287 letters related to concerns directly connected to COVID-19 or the measures adopted in the context of the pandemic.

11. The UN General Assembly has passed Resolution 74/274 (April 2020) on International Cooperation to Ensure Global Access To Medicines. In summary, the relevant portions of the resolution (**"TPM3"**) are as follows:

11.1. It reaffirmed the '*right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health*'.

11.2. It recognised that '*the poor and the most vulnerable people are the most affected and that the impact of the pandemic…*'.

11.3. It emphasised *that 'equitable access to health products is a global priority and that the availability, accessibility, acceptability, and affordability of health products of assured quality are fundamental to tackling the pandemic'*

and that *'a global response based on unity, solidarity and multilateral cooperation'* is required.

12. The UNHRC Resolution of July 2020, guided by the Universal Declaration of Human Rights (UDHR), also addressed the central role of the State in responding to pandemics and other health emergencies, and the socio-economic consequences thereof in advancing sustainable development goals, and the realisation of all human rights. A copy of the resolution is attached (**"TPM4"**). It reaffirmed *inter alia*:

12.1. That *'each State should take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources with a view to achieving progressively the full realisation of the rights recognised in the International Covenant on Economic, Social and Cultural Rights by all appropriate means, including in particular the adoption of legislative measures'*.

12.2. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health requires States to *'take the necessary steps to prevent, treat and control epidemic, endemic, occupational and other diseases, and to create the conditions that would assure medical service and medical attention to all in the event of sickness'*.

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12.3. The Declaration on the Right to Development recognises that States have the right and the duty to formulate appropriate national development policies that are aimed at the constant improvement of the well-being of the entire population and of all individuals.

12.4. The *'role of extensive immunisation against COVID-19 as a global public good for health for preventing, containing and stopping transmission in order to bring the pandemic to an end once safe, quality, efficacious, effective, accessible and affordable vaccines are available'* (emphasis added, here and elsewhere).

13. On 9 November 2020, different mandate holders of the Special Procedures of the UNHRC, including me, issued a Statement on the Universal Access to Vaccines which is essential for the prevention and containment of COVID-19 around the world. The statement is attached (**"TPM5"**).

14. On 15 December 2020 the UN Committee on Economic, Social and Cultural Rights (CESR) issued a Statement on universal and equitable access to vaccines for the coronavirus disease (COVID-19) (**"TPM6**"). It elaborates on the binding obligations of member states in terms of Article 12 (right to health) of the Covenant on ESCR, which South Africa ratified on 12 January 2015.

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14.1. The Committee reminded State parties of their obligations '*to avoid unjustified discrimination and inequalities in access to COVID-19 vaccines*'.

14.2. Further: '*Vaccines for COVID-19 must not only be produced and made available; they must also be accessible to all persons. In order to ensure access to COVID-19 vaccines, States must, firstly, remove any discrimination based on grounds such as religion, national origin, sex, sexual orientation and gender identity, race and ethnic identity, age, disability, migration status, social origin, poverty or any other relevant status; secondly, guarantee physical accessibility to vaccines, especially for marginalised groups and people living in remote areas, using both State-run and private channels and by strengthening the capacity of health systems to deliver vaccines; thirdly, guarantee affordability or economic accessibility for all, including by providing vaccines free of charge, at least for lower-income persons and the poor; and fourthly, guarantee access to relevant information*'.

14.3. It is also stated: 'It *is impossible to guarantee that everyone will have immediate access to a vaccine for COVID-19, even if several vaccines are approved soon. The mass production and distribution of vaccines implies not only enormous financial costs but also complex administrative and health procedures. The prioritisation of access to vaccines by specific groups is unavoidable, at least in the initial stages, not only nationally but*

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also at the international level. In accordance with the general prohibition of discrimination, such prioritisation must be based on medical needs and public health grounds. According to these criteria, priority may be given, for instance, to health staff and care workers, or to persons presenting greater risks of developing a serious health condition if infected by SARS-COV-2 because of age, or pre-existing conditions, or to those most exposed and vulnerable to the virus owing to social determinants of health… In any case, criteria of prioritisation must be established through a process of adequate public consultation, be transparent and subject to public scrutiny and, in the event of a dispute, to judicial review to avoid discrimination'.

15. On 17 December 2020, the Office of the UN High Commissioner for Human Rights issued Guidelines on human rights and access to COVID-19 vaccine (**"TPM7"**). While they are not binding, they provide important guidelines to States.

15.1. It recommends that COVID-19 vaccines should be treated as global public goods – *'rather than as marketplace commodities available only to those countries and people who can afford to pay the asking price'.*

15.2. It highlighted that uneven access has severe consequences for marginalised groups, and raises a substantial risk that these populations and groups will fall behind in vaccination rates relative to others.

VACCINE EQUITY

16. Since late January 2020, when the WHO declared Covid-19 a *Public Health Emergency of International Concern* (PHIEC), all the mandate holders of the Special Procedures of the UNHRC, including me, have been acutely aware of the crisis at hand especially with reference to global shortages and the scarcity of safe and effective vaccines for everyone in the world that needs it.

17. We have been seized with the issue of how best to respond to this pandemic using the human rights framework included in international treaties, regional frameworks, and national laws. Given our focus on the need for a human rights approach to ensure equitable access for everyone, especially those in the most marginalised and vulnerable situations, and for all key interventions, and vaccines in a pandemic, we have a particular interest in this matter

18. According to the most recent information from organisations such as the WHO, as at early February 2021, more than three-quarters of vaccinations have occurred in ten of the world's biggest and richest economies, while almost 130 countries have yet to administer a single dose.

19. In the 9 November 2020 statement the UN Experts made several recommendations to member states (including the states participating at the 31st Special Session of

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the UN General Assembly in Response to the COVID-19 Pandemic), the private sector, and financial institutions, which prioritise equity, fairness and public good.

20. The statement said: 'In *order to mitigate and contain the spread of the pandemic globally and to support national and international economic and financial recovery, it is imperative that COVID-19 diagnosis and treatment goods, including any potential vaccine, are fully available, accessible and affordable to all on this planet'*.

21. It is my expert view that equity has to underpin national efforts too. It is my expert view, given my direct experience of often unequal health access globally and in South Africa, that without co-ordination there is also a risk that prices of potential vaccines will be higher in some sectors and the private sector in particular.

MEDICAL SCHEMES IN SOUTH AFRICA AND UNEQUAL ACCESS IN SOUTH AFRICA

22. In my experience as a medical practitioner in South Africa's two-tiered health care system, which I regard as unequal and unfair, I have personally observed the race and gender disparities between the systems, and also what unequal access to health care service means for the majority of our population.

23. According to information included in the South Africa Health Review (SAHR, 2020), the population of South Africa as at the end of 2020 was just under 60 million (59 797 656) people. Page 219 of the Review is attached ("**TPM8**").

24. I am acutely aware, from my own professional and work experience, that medical scheme coverage in South Africa is sometimes the difference between sickness and health, or life and death, and that Medical Schemes (medical insurance) cover less than 20% of our country's population, with the majority of people depending on the public health sector.

25. The SAHR extrapolated data for the extent of medical scheme coverage in South Africa using provincial estimates of medical scheme coverage, as reported in the General Household Survey by Statistics South Africa (SSA) from which our country's uninsured population can be calculated. The relevant portions are attached as "**TPM9**". It found that:

    25.1. The proportion of the South African population that is covered by a medical scheme varies is approximately 16% - from a low of 7.2% in Limpopo to a high of 24.6% in Gauteng.

    25.2. At a district level, that proportion is estimated to vary from 3.8% (Alfred Nzo district, Eastern Cape) to 30.6% (Tshwane metro, Gauteng).

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25.3. Due to the socio-economic impact of Covid-19 in the country and the extent of job losses, there may be a reduction in the number of South Africans who are beneficiaries of medical schemes. This needs to be quantified and confirmed by the regulatory body, the Council for Medical Schemes.

25.4. Most people in this country are therefore dependent on the public health sector for health care.

26. The Council for Medical Schemes (CMS) reported in its 2019-2020 Annual Report (the relevant portions are attached as **"TPM10**") that:

26.1. There are 8.95 million people (members and beneficiaries) belonging to medical schemes in South Africa.

26.2. The CMS regulated 78 registered medical schemes in 2019, comprising of about 20 open schemes and 58 restricted schemes. Open schemes accounted for 55.38% of medical scheme membership and beneficiaries.

26.3. The biggest open medical scheme is Discovery Health. The Government Employees Medical Scheme (GEMS) is the largest restricted scheme.

26.4. Principal members covered an average of 1.20 dependents each.

26.5. The gender distribution of members was almost equal in all schemes, although the average age for women was higher with 34.1years versus 31.9 years for men, with an average age across schemes being 33 years.

26.6. Based on principal member addresses, approximately 40% of all medical schemes members are in Gauteng, followed by the Western Cape, and KwaZulu-Natal with 15% and 14% respectively.

27. In highly unequal socio-economic settings, such as South Africa, it is necessary for *state and* non-state actors to cooperate to prevent a vaccine-divide.

STATE OBLIGATIONS ON EQUITY

28. According to the Statement to which I have referred, the UN Committee on Economic, Social, and Cultural Rights clarified that States parties to the International Covenant on Economic, Social, and Cultural Rights have an obligation to take all the measures necessary, to the maximum available resources, to guarantee access to vaccines for COVID-19 to all persons, without discrimination. The duty of States to provide immunisation against major infectious diseases and to prevent and control epidemics is a priority obligation concerning the right to health. Under the

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current conditions, States are required to give maximum priority to the provision of vaccines for COVID-19 to all persons.

29. In the Statement of November 2020 by mandate holders of the Special Procedures of the Human Rights Council (the relevant portion is attached as **"TPM11"**, we also emphasised that in domestic settings:

> *'States have an obligation to ensure that any COVID-19 vaccines and treatments are safe, available, accessible, and affordable to all who need them. This is particularly relevant to people in vulnerable situations who are often neglected from health services, goods, and facilities, including those living in poverty, women, indigenous peoples, people with disabilities, older persons, minority communities, internally displaced people, persons in overcrowded settings and in residential institutions, people in detention, homeless persons, migrants and refugees, people who use drugs, LGBT and gender diverse persons. Many of them may have lived experience of poverty and find themselves in situations where they are most likely to be exposed to the risk of contagion, yet the least likely to be protected from COVID-19 or supported by adequate and timely tests and health services. It is imperative that access to COVID-19 vaccines and treatment is provided to all without discrimination and prioritized for those who are most exposed and vulnerable to the risk of COVID-19'.*

CONCLUSION

30. In light of the above, and given the well-known shortage of supply of vaccine, vaccine acquisition and allocation by the private sector without national oversight and co-ordination would be contrary to international human rights guidelines and vaccine equity. It would harm South Africans who do not have access to private medical resources.

DR TLALENG MOFOKENG

I hereby certify that the deponent stated that she knows and understands the contents of this affidavit and that it is to the best of her knowledge both true and correct. This affidavit was signed and sworn to before me at Westdene on this the 18th day of February 2021. The Regulations contained in Government Notice R.1258 of 21 July 1972, as amended, have been complied with.

COMMISSIONER OF OATHS

KELLY KROPMAN
Commissioner of Oaths
Practising Attorney
20 Baker Street,
Rosebank, Johannesburg
(011) 485 0352

RESUME

"TPM1"

Dr Tlaleng Mofokeng (MBChB)

Education

- Nelson Mandela School of Medicine, University of Kwa-Zulu Natal, Durban
  Bachelor of Surgery and Bachelor of Medicine (MBChB), 2007

Summary of Skills

- **Clinical practice executive** – delivery of health care, supervision of medical staff, medical practice management, strategic planning and outreach; Community clinics, District Hospital, Private clinics and Hospitals.
- **Policy**– analysis, briefing, advice and advocacy on gender equality, medical and health issues of importance to marginalized communities, gender and sexual minorities, migrant populations, sex workers, and people living with HIV and disabilities;
- **Facilitator** – from small classrooms to global platforms, speaking on reproductive justice, health access, sensitivity in the medical field and in society in general, inspiring young people and marginalized people to enter the medical field, and experienced practitioners to engage on social justice advocacy and health rights;

Professional Highlights

United Nations Special Rapporteur - Mandate holder and independent expert to the UN Human Rights Council on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Commissioner - Commission for Gender Equality, a constitutional entity, working on a framework for a new society, premised on the desire for a free and equal society in all fundamental and material aspects of life. Promoting, protecting and advancing gender equality.

Health education – advice on curriculum, plan topics and lectures, deliver content; facilitate community dialogues, creating safe, trusting, inclusive learning environment on sensitive subject matter ranging from sexual education, practice, social norms and behaviours, to intersectionality and justice; health policy and advocacy, advice on outreach programme design and implementation, incorporation of feedback into programme design.

Contributor and Master Trainer: Healthcare Professional Toolkit developed by Global Advisory Board for Sexual Health and Wellbeing

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Advisory role – support NGOs, advocacy organizations, and national government departments providing appropriate policy analysis, language and implications, craft intersectional policies and offer insights focusing on the impact of marginalized communities such as Black Women, communities impacted by poverty, gender-based violence and inequality.

– advise on corporate policies promoting inclusiveness and sensitivity, appropriate health coverages, human resource policies such as medical and personal leave; diversity and inclusion; privacy and protection of employees and the law. Medical evacuation and clinical care coordination.

Advocacy – Supported by Sexual Rights Initiative (SRI) to deliver the first ever statement delivered on behalf of 286 global organisation using Human Rights for Safe and Legal abortion care at the United Nation's Human Rights Council, Geneva, 2017.

Advocacy campaigns include #Fight4HER #mybodymychoice #AbortionProviderDay #YoungFeministvoices with advocacy partners over the last 5 years such as ONE campaign, UNFPA, Catholics for Choice, Amnesty International, IWHC, Gates Foundation and Inroads.

Employment / Consultancy Highlights

Period	Role	Organisation
August 2019-	Commissioner	Commission for Gender Equality
January 2016 -	Medical Director	DISA Clinic
2018 - March 2019	Regional Medical Advisor	African Development Bank
January 2017 -	Technical Advisor	Global Health Strategies
January 2018 -	Producer, Host	Sex Talk with Dr T, Mojalove TV
2008 - 2014	Medical Officer	Gauteng Department of Health

Affiliations

- Safe Abortion Action Fund: Board Member, 2018
- Aspen New Voices Fellowship: Fellow, 2018
- International Women's Health Coalition's Advocacy in Practice Alumni Board: Member
- Global Advisory Board for Sexual Health and Wellbeing: Board Member
- Soul City Institute for Social Justice: Vice-chair of Board
- Sexual and Reproductive Justice Coalition: Founding member
- Global Doctors for Choice: Country Co-lead, South Africa
- 8th National AIDS Conference: Organising Committee Member and Chairperson of Track 3

Awards and Recognitions

- Goalkeeper (Sustainable Development Goals), Bill and Melinda Gates Foundation, September 2018
- Most Influential Young South African in Personal Development, 2017
- Winner, "120under40 New Generation of leaders in Family Planning" Award, Bill & Melinda Gates Institute, 2016 in New York
- Most Influential Young South African in Science and Technology, 2016
- Mail and Guardian 200 Young South Africans, 2016
- Nominated, "South African Medical Association (SAMA) Junior Doctor" Award, November 2016

Speaker/Consultancy highlights

- Panelist: Powerful Conversations: Celebrating 25yrs of Scholarship and Science for Social Change, Johns Hopkins School of Public Health, September 2019
- Keynote Speaker, Bill and Melinda Gates Foundation, Goalkeeper's Awards, Berlin, 2018
- Keynote address, Capitol Hill days, Population Action Fund, Washington D.C, March 2018
- Delegate: United States Senate Briefing: Reality Check: The Global Gag Rule, Capitol Hill, Washington D.C, April 2018
- Delegate, Reimagining African Enlightenment Workshop, Catholics for Choice, 2018
- Panellist at the 19th International Conference on AIDS and STIs in Africa, Ivory Coast, 2017.
- Keynote Address at 20th Anniversary of Sister Song, New Orleans, October 2017
- Delegate: International Convention on Conscientious Objection, Uruguay, 2017
- Delegate: Post G20 summit Women's health summit, Germany, 2017
- Panellist: Johns Hopkins School of Public Health's webinar titled "Building Trust One Tweet at a Time: Building a strong, credible brand in the Public Health Sector, Baltimore, April 2017.
- National task team member of the 2nd and 3rd National Adolescent Sexual and Reproductive Health and Rights Framework Strategy Technical Committee meeting, Department of Social Development, August 2016-2017
- 21st International AIDS Conference, Keynote address at the launch of the Sex Rights Africa Network, Durban 2016;
- Weekend Breakfast, Radio 702, 4-part Reproductive Justice Series, October 2016
- National Dialogue on Sexual Assault & Harassment in Higher Education Institutions, supported by Foundation for Human Rights, May 2016
- The World AIDS Program Facilitator: Adolescent girls & Young Women's Conversations Boot camp, in association with PASOP GP, She Conquers and Gauteng Department of Health, December 2016
- Women's Parliament, South Africa, Delegate, August 2016
- 21st International AIDS Conference, Chairperson of the official live session for Gauteng health department, June 2016

[redacted]

No exceptions with COVID-19: "Everyone has the right to life-saving interventions" – UN experts say

GENEVA (26 March 2020) – The COVID-19 crisis cannot be solved with public health and emergency measures only; all other human rights must be addressed too, UN human rights experts* said today.

"Everyone, without exception, has the right to life-saving interventions and this responsibility lies with the government. The scarcity of resources or the use of public or private insurance schemes should never be a justification to discriminate against certain groups of patients," the experts said. "Everybody has the right to health.

"People with disabilities, older persons, minority communities, indigenous peoples, internally displaced people, people affected by extreme poverty and living in overcrowded settings, people who live in residential institutions, people in detention, homeless people, migrants and refugees, people who use drugs, LGBT and gender diverse persons – these and other groups need to receive support from governments.

"Advances in biomedical sciences are very important to realize the right to health. But equally important are all human rights. The principles of non-discrimination, participation, empowerment and accountability need to be applied to all health-related policies."

The UN experts supported the measures recommended by the WHO to defeat the pandemic. They called on States to act with determination to provide the needed resources to all sectors of public health systems – from prevention and detection to treatment and recovery.

"But addressing this crisis is more than that. States must take additional social protection measures so that their support reaches those who are at most risk of being disproportionately affected by the crisis," they stressed.

"That includes women, who are already at a disadvantaged socio-economic position, bear an even heavier care burden, and live with a heightened risk of gender-based violence."

The group of experts expressed their gratitude and admiration to health workers around the world who heroically battle the outbreak. "They face huge workloads, risk their own lives and are forced to face painful ethical dilemmas when resources are too scarce. Healthcare workers need to have all possible support from States, business, media and the public at large.

"COVID-19 is a serious global challenge," the experts said. "But it is also a wake-up call for the revitalization of universal human rights principles. These principles and trust in scientific knowledge must prevail over the spread of fake news, prejudice, discrimination, inequalities and violence.

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"We all together face this unprecedented challenge. The business sector in particular continues to have human rights responsibilities in this crisis. Only with concerted multilateral efforts, solidarity and mutual trust, will we defeat the pandemic while becoming more resilient, mature and united.

"When the vaccine for COVID-19 comes, it should be provided without discrimination. Meanwhile, as it is still to come, the human rights-based approach is already known as another effective pathway in the prevention of major public health threats," the experts concluded.

ENDS

(*) The experts: ***Dainius Pūras**, Special Rapporteur on the right to physical and mental health; **Dubravka Šimonović**, Special Rapporteur on violence against women; **Ahmed Shaheed**, Special Rapporteur on freedom of religion or belief; **Victor Madrigal-Borloz**, Independent Expert on sexual orientation and gender identity; **Javaid Rehman**, Special Rapporteur on the situation of human rights in the Islamic Republic of Iran; **Rosa Kornfeld-Matte**, Independent Expert on the enjoyment of all human rights by older persons; **Léo Heller**, Special Rapporteur on the human rights to water and sanitation; **Fabian Salvioli**, Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence; **Alioune Tine**, Independent Expert on the situation of Human Rights in Mali; **Fernand de Varennes**, Special Rapporteur on minority issues; **Obiora Okafor**, Independent Expert on human rights and international solidarity; **Aristide Nononsi,**Independent Expert on the situation of Human Rights in Sudan; **David R. Boyd**Special Rapporteur on human rights and the environment; **Urmila Bhoola**, Special Rapporteur on contemporary forms of slavery; **Ahmed Reid (Chair), Dominique Day, Michal Balcerzak, Ricardo A. Sunga III, and Sabelo Gumedze**, Working Group of experts on people of African descent; **Saad Alfarargi,** Special Rapporteur on the right to development; **Victoria Tauli Corpuz**, Special Rapporteur on the rights of indigenous peoples; **Livingstone Sewanyanan**, Independent Expert on the promotion of a democratic and equitable international order; **Catalina Devandas Aguilar**, Special Rapporteur on the rights of persons with disabilities; **Yanghee Lee**, Special Rapporteur on the situation of human rights in Myanmar; **Elizabeth Broderick (Vice Chair), Alda Facio, Ms. Ivana Radačić, Meskerem Geset Techane (Chair), Melissa Upreti**, Working Group on discrimination against women and girls; **Yao Agbetse**, Independent Expert on the situation of Human Rights in the Central African Republic; **S. Michael Lynkthe**, Special Rapporteur on the situation of human rights in the Palestinian Territory occupied since 1967; **Alice Cruz**, Special Rapporteur on the elimination of discrimination against persons affected by leprosy and their family members, **Nils Melzer**, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; **David R. Boyd,**Special Rapporteur on human rights and the environment; **Rhona Smith**, Special Rapporteur on the situation of human rights in Cambodia; **Ikponwosa Ero**Independent Expert on the enjoyment of human rights by persons with albinism; **Daniela Kravetz**, Special Rapporteur*

on the situation of human rights in Eritrea; ***David Kaye****, Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression;* ***Anais Marin,*** *Special Rapporteur on the situation of human rights in Belarus****; Githu Muigai (Chair), Anita Ramasastry (Vice-chair), Dante Pesce, Elzbieta Karska, and Surya Deva****, Working Group on the issue of human rights and transnational corporations and other business enterprises;* ***Clément Voule****, Special Rapporteur on the right to freedom of peaceful assembly and association;* ***Fionnuala D. Ní Aoláin****, Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism;* ***Michel Forst****, Special Rapporteur on the situation of human rights defenders;* ***Cecilia Jimenez-Damary****, Special rapporteur on the human rights of internally displaced persons;* ***José Antonio Guevara Bermúdez (Chair), Leigh Toomey (Vice-Chair on Communications), Elina Steinerte (Vice-Chair on Follow-up), Seong-Phil Hong and Sètondji Adjovi****, Working Group on Arbitrary Detention;* ***Diego García-Sayán,*** *Special Rapporteur on the Independence of Judges and Lawyers;* ***Luciano A. Hazan (Chair), Tae-Ung Baik (Vice-chair), Houria Es-Slami, Henrikas Mickevičius, Bernard Duhaime,*** *Working Group on Enforced or Involuntary Disappearances;* ***E. Tendayi Achiume,*** *Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance;* ***Karima Bennoune,*** *Special Rapporteur in the field of cultural rights;* ***Bahame Nyanduga,*** *Independent Expert on the situation of human rights in Somalia;* and ***Maud de Boer-Buquicchio*** *Special Rapporteur on the sale and sexual exploitation of children.*

The Special Rapporteurs, Independent Experts and Working Groups are part of what is known as the Special Procedures of the Human Rights Council. Special Procedures, the largest body of independent experts in the UN Human Rights system, is the general name of the Council's independent fact-finding and monitoring mechanisms that address either specific country situations or thematic issues in all parts of the world. Special Procedures' experts work on a voluntary basis; they are not UN staff and do not receive a salary for their work. They are independent from any government or organisation and serve in their individual capacity.

For more information and ***media requests*** *please contact Lucía de la Sierra (+ 41 22 917 9741 / ldelasierra@ohchr.org) or write to srhealth@ohchr.org*

For media inquiries related to other UN independent experts please contact Xabier Celaya (+ 41 22 917 9445 / xcelaya@ohchr.org)

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General Assembly

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Agenda item 123
Strengthening of the United Nations system

Resolution adopted by the General Assembly on 20 April 2020

[*without reference to a Main Committee (A/74/L.56 and A/74/L.56/Add.1)*]

74/274. International cooperation to ensure global access to medicines, vaccines and medical equipment to face COVID-19

The General Assembly,

Recalling its resolutions 74/270 of 2 April 2020 and 74/2 of 10 October 2019,

Noting with concern the threat to human health, safety and well-being caused by the coronavirus disease 2019 (COVID-19) pandemic, which has spread all around the globe, as well as the unprecedented and multifaceted effects of the pandemic, including the severe disruption to societies, economies, global trade and travel and the devastating impact on the livelihoods of people,

Recognizing the competence, generosity and personal sacrifice of health-care professionals and services in the exercise of their duties to contain the spread of the pandemic,

Reaffirming the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health,

Recognizing that the poor and the most vulnerable people are the most affected and that the impact of the pandemic will have repercussions on development gains, hampering progress in the achievement of the Sustainable Development Goals, including target 3.8,[1]

Underscoring that equitable access to health products is a global priority and that the availability, accessibility, acceptability and affordability of health products of assured quality are fundamental to tackling the pandemic,

Recognizing the importance of international cooperation and effective multilateralism in helping to ensure that all States have in place effective national protective measures, access to and flow of vital medical supplies, medicines and

[1] See resolution 70/1.

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vaccines, in order to minimize negative effects in all affected States and to avoid relapses of the pandemic,

Recognizing also that the COVID-19 global pandemic requires a global response based on unity, solidarity and multilateral cooperation,

1. *Reaffirms* the fundamental role of the United Nations system in coordinating the global response to control and contain the spread of the coronavirus disease (COVID-19) and in supporting Member States, and in this regard acknowledges the crucial leading role played by the World Health Organization;

2. *Requests* the Secretary-General, in close collaboration with the World Health Organization and other relevant agencies of the United Nations system, including the international financial institutions, to identify and recommend options, including approaches to rapidly scaling manufacturing and strengthening supply chains that promote and ensure fair, transparent, equitable, efficient and timely access to and distribution of preventive tools, laboratory testing, reagents and supporting materials, essential medical supplies, new diagnostics, drugs and future COVID-19 vaccines, with a view to making them available to all those in need, in particular in developing countries;

3. *Encourages* Member States to work in partnership with all relevant stakeholders to increase research and development funding for vaccines and medicines, leverage digital technologies, and strengthen scientific international cooperation necessary to combat COVID-19 and to bolster coordination, including with the private sector, towards rapid development, manufacturing and distribution of diagnostics, antiviral medicines, personal protective equipment and vaccines, adhering to the objectives of efficacy, safety, equity, accessibility, and affordability;

4. *Calls upon* Member States and other relevant stakeholders to immediately take steps to prevent, within their respective legal frameworks, speculation and undue stockpiling that may hinder access to safe, effective and affordable essential medicines, vaccines, personal protective equipment and medical equipment as may be required to effectively address COVID-19;

5. *Requests* the Secretary-General, in close collaboration with the World Health Organization, to take the necessary steps to effectively coordinate and follow up on the efforts of the United Nations system to promote and ensure global access to medicines, vaccines and medical equipment needed to face COVID-19, and, in this regard, to consider establishing, within existing resources, an inter-agency task force, and to brief the General Assembly on such efforts, as appropriate.

20 April 2020

United Nations

"TPM4"

A/HRC/44/L.23/Rev.1

General Assembly

Distr.: Limited
15 July 2020

Original: English

Human Rights Council
Forty-fourth session
30 June–17 July 2020
Agenda item 2
Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General

Argentina, Azerbaijan,* China,* Eswatini,* Namibia, Pakistan, Russian Federation,* Somalia, South Africa,* Turkey* and Zimbabwe*: draft resolution

44/... The central role of the State in responding to pandemics and other health emergencies, and the socioeconomic consequences thereof in advancing sustainable development and the realization of all human rights

The Human Rights Council,

Guided by the purposes and principles of the Charter of the United Nations,

Recalling that one of the purposes of the United Nations is to achieve international cooperation in solving international problems of an economic, social, cultural or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all, without distinction of any kind,

Guided by the Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations,

Recalling all relevant international human rights treaties, including the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights,

Recalling also General Assembly resolution 74/270 of 2 April 2020, on global solidarity to fight the coronavirus disease 2019 (COVID-19), and 74/274 of 20 April 2020, on international cooperation to ensure global access to medicines, vaccines and medical equipment to face COVID-19, and President's statement PRST 43/1 of 29 May 2020 on the human rights implications of the COVID-19 pandemic,

Expressing its solidarity to all countries affected by the pandemic, as well as its condolences and sympathy to all families of the victims of COVID-19,

Reaffirming that each State should take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources with a view to achieving progressively the full realization of the rights recognized in the International Covenant on Economic, Social and Cultural Rights by all appropriate means, including in particular the adoption of legislative measures,

* State not a member of the Human Rights Council.

Recalling the Vienna Declaration and Programme of Action, which affirms that all human rights are universal, indivisible, interdependent and interrelated, and that the international community must treat human rights globally in a fair and equal manner, on the same footing and with the same emphasis, and that, while the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms,

Reaffirming the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, which requires States to take the necessary steps to prevent, treat and control epidemic, endemic, occupational and other diseases, and to create the conditions that would assure medical service and medical attention to all in the event of sickness,

Recalling that States emphasized in the Vienna Declaration and Programme of Action and the 2005 World Summit Outcome that they bear the responsibility, in conformity with the Charter, to develop and encourage respect for human rights and fundamental freedoms for all, without distinction of any kind such as race, colour, sex, language, disability, religion, political or other opinion, national or social origin, property, birth or other status,

Reaffirming that the 2030 Agenda for Sustainable Development is guided by the purposes and principles of the Charter, including full respect for international law, and is grounded in the Universal Declaration of Human Rights, international human rights treaties, the United Nations Millennium Declaration and the 2005 World Summit Outcome, and is informed by other instruments, such as the Declaration on the Right to Development,

Deeply concerned at the morbidity and mortality caused by the COVID-19 pandemic, the negative impact on the enjoyment of all human rights, including physical and mental health and social well-being, the negative impact on the economy and society and the consequent exacerbation of inequalities within and between countries,

Recognizing that the poor and the most vulnerable people are the most affected, and that the impact of the pandemic will have repercussions on development gains, hampering progress in the achievement of the Sustainable Development Goals,

Recalling the Declaration on the Right to Development, which recognizes that States have the right and the duty to formulate appropriate national development policies that are aimed at the constant improvement of the well-being of the entire population and of all individuals on the basis of their active, free and meaningful participation in development and in the fair distribution of the benefits resulting therefrom,

Reaffirming the fundamental role of the United Nations system in coordinating the global response to control and contain the spread of COVID-19 and in supporting Member States, and in this regard acknowledging the crucial leading role played by the World Health Organization,

Emphasizing the importance of human rights in shaping the response to the pandemic, both for the public health emergency and the broader impact on people's lives and livelihoods,

Expressing deep concern at the stigmatization, xenophobia, racism and discrimination, including racial discrimination, surfacing in the COVID-19 pandemic in many parts of the world, and stressing the need to combat it,

Recognizing the importance of international cooperation and effective multilateralism in helping to ensure that all States, in particular developing States, have in place effective national protective measures, access to and flow of vital medical supplies, medicines and vaccines, in order to minimize negative effects in all affected States and to avoid relapses of the pandemic,

Welcoming the activities carried out by the Office of the United Nations High Commissioner for Human Rights on the promotion of economic, social and cultural rights, mainly through technical cooperation, the work of its field offices, its relevant reports to United Nations bodies, the development of in-house expertise, including on human rights indicators, and its publications, studies, training and information activities on related issues, including through new information and communications technology,

Recognizing that the 2030 Agenda has been accepted by all States and is applicable to all, taking into account different national realities, capacities and levels of development and respecting national policies and priorities, and that the Sustainable Development Goals and their targets are universal and involve the entire world, developed and developing States alike,

1. *Underscores* the central role of the State in responding to pandemics and other health emergencies, and the socioeconomic consequences thereof in advancing sustainable development and the realization of all human rights;

2. *Reaffirms* the importance of international cooperation, in particular during times of health emergencies and pandemics, on the basis of mutual respect, in full compliance with the principles and purposes of the Charter of the United Nations, with full respect for the sovereignty of States while taking into account national priorities;

3. *Also reaffirms* that emergency measures taken by States in response to the COVID-19 pandemic must be in accordance with States' obligations under applicable international human rights law;

4. *Stresses* the need for States to collaborate with all relevant stakeholders, to take collective action in response to pandemics and health emergencies, and the socioeconomic consequences thereof, in advancing sustainable development and the realization of all human rights;

5. *Calls for* universal, timely and equitable access to and fair distribution of all quality, safe, efficacious and affordable essential health technologies and products, including their components and precursors required in the response to the COVID-19 pandemic as a global priority, and the urgent removal of unjustified obstacles thereto, in accordance with the provisions of relevant international treaties, including the provisions of the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and its flexibilities, as confirmed by the Doha Declaration on the TRIPS Agreement and Public Health;

6. *Emphasizes* the importance of timely, equitable and unhindered access to safe, affordable, effective and quality medicines, vaccines, diagnostics and therapeutics, and other health products and technologies necessary to ensure an adequate and effective response to the pandemic, including for the most vulnerable people affected by armed conflict, extreme poverty, natural disasters or climate change, and of the urgent removal of unjustified obstacles thereto;

7. *Recognizes* the role of extensive immunization against COVID-19 as a global public good for health for preventing, containing and stopping transmission in order to bring the pandemic to an end, once safe, quality, efficacious, effective, accessible and affordable vaccines are available;

8. *Reiterates* the critical importance of the means of implementation of the 2030 Agenda for Sustainable Development, while being mindful of the impact of high debt levels on States' ability to withstand the impact of the pandemic and other health emergencies, and the socioeconomic consequences thereof, in advancing sustainable development and the realization of all human rights;

9. *Requests* the United Nations High Commissioner for Human Rights, working within existing efforts across the United Nations system, and in consultation with States, to conduct a needs assessment, in particular for developing countries, to support their efforts to promote and protect human rights and fundamental freedoms in responding to pandemics and other health emergencies, and the socioeconomic consequences thereof, in advancing sustainable development and the realization of all human rights, and to submit a report thereon to the Human Rights Council at its forty-seventh session during an interactive dialogue, and to provide an oral update to the Council at its fiftieth session, also during an interactive dialogue;

10. *Decides* to remain seized of the matter.

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"TPM5"

Statement by UN Human Rights Experts Universal access to vaccines is essential for prevention and containment of COVID-19 around the world*

9 November 2020

To date, there have been more than 49 million confirmed cases of COVID-19 and over 1.2 million deaths reported to WHO.[1] This disease continues to prove more deadly than anticipated while the world carries on facing the cumulative and interconnected health, economic, social and human rights crises it has unleashed.

In October 2020, the World Bank estimated that the pandemic will push an additional of between 88 to 115 million people into extreme poverty this year, with the total rising to as many as 150 million by 2021. The World Food Programme projected that 265 million people will face crisis levels of hunger unless direct action is taken, doubling their estimations of hungry people pre-COVID-19.

These and many other figures offer only a glimpse of the exorbitant human costs of the pandemic. At the national and international levels, COVID-19 has brought to the fore systemic inequalities, aggravated pre-existing institutional weaknesses including in health, food and procurement systems, and highlighted a lack of access to quality, accessible and affordable health care for all. Socio-economic inequality has deepened even further.

At a global level, inequalities are also increasing between countries with enough economic means to face the crises and those without. Responses to the pandemic have sometimes been used as a pretext by Governments and business enterprises to undermine or lessen international human rights commitments.

In our capacity as UN human rights experts, we emphasise that a global pandemic of this scale and human cost, with no clear end in sight, requires a concerted, principled and courageous response. All efforts to prevent, treat and contain COVID-19 must be based on the bedrock human-rights based principles of international solidarity, cooperation and assistance. There is no room for nationalism or profitability in decision-making about access to vaccines, essential tests and treatments, and all other medical goods, services and supplies that are at the heart of the right to the highest attainable standard of health for all.

Since millions of people's hope is that vaccines are developed safely and swiftly, that they are made universally available, that they are affordable, easily accessible, this statement aims at raising some of the critical human rights aspects that are intertwined with regard to the rights to life, to health and to international cooperation and assistance and to provide some recommendations for States, including the States participating at the 31st

special session of the General Assembly in Response to the COVID-19 Pandemic, the private sector, financial institutions.

Tackling the pandemic individually: a path to further deaths

As the Committee on Economic, Social and Cultural Rights has underlined[2] about the right of everyone to enjoy the benefits of scientific progress, "pandemics are a crucial example of the need for scientific international cooperation to face transnational threats. Viruses and other pathogens do not respect borders [...] Combating pandemics effectively requires stronger commitment from States to scientific international cooperation, as national solutions are insufficient. [...] If a pandemic develops, sharing the best scientific knowledge and its applications, especially in the medical field, becomes crucial to mitigate the impact of the disease and to expedite the discovery of effective treatments and vaccines."

In a similar vein, the UN Office of the High Commissioner for Human Rights, the UN Educational, Scientific and Cultural Organization (UNESCO) and the World Health Organization (WHO), with the participation of the European Organization for Nuclear Research (CERN), recently launched a call for Open Science. This initiative recognizes that scientific knowledge can play a role in reducing inequalities, help respond to the immediate challenges of COVID-19 and accelerate progress towards the implementation of the 2030 Agenda.

Unfortunately, it appears that some Governments have undertaken to secure vaccines for their citizens only. Isolationist health policies and procurement are in contradiction with international human rights standards.

In addition, epidemiologists and others fear that, because of the limited capacity of production of the vaccine, countries that are striking deals to secure vaccines for their own population – instead of engaging in a coordinated global effort to share them across borders– will not achieve their intended purpose. The pandemic will continue and will come back to impact those countries sooner or later, including through further economic disruption. A message, often repeated in 2020, remains essential: No one is secure until all of us are secure.

Some States have already expressed their concerns that countries with more financial means are rushing to sign deals to gain preferential access to vaccines which will in turn leave other countries behind. WHO and others have warned about the dangers of "supply and vaccine nationalism."[3] As stated by South Africa: "World leaders from the North and South have referred to vaccines as a global public good, which should be fairly and equitably available globally, leaving no one behind. Now is the time to put it into action."[4]

According to Oxfam, in a note of 17 September 2020, "51 percent of the doses to be produced based on current capacity have already been reserved for countries with just 13 percent of the global population. If the rest of the world depends on the same manufacturing facilities, they will have to wait for them

to deliver on their pre orders and hope that more doses can be produced before too many more die or become seriously ill."[5]

International cooperation and multilateralism are vital for facilitating countries' navigation of the present crisis and for laying the groundwork for a robust, sustained and inclusive socio-economic recovery around the world. To address the pandemic and its consequences and realize universal human rights, States should take action, both individually and jointly through international cooperation and assistance.

Availability, access and affordability at international level

In order to mitigate and contain the spread of the pandemic globally and to support national and international economic and financial recovery, it is imperative that COVID-19 diagnosis and treatment goods, including any potential vaccine, are fully available, accessible and affordable to all on this planet.

In this spirit, on 18 August 2020, WHO Director-General urged member States to join the COVAX Global Vaccines Facility, a mechanism aimed at guaranteeing fair access for all countries, rich or poor, to effective immunization. If States do not coordinate globally, there is a high risk that global competition will increase the prices of medical supplies and of a potential vaccine which, in turn, will affect all countries. This will be of particular detrimental effect to the various developing countries already facing high debt and financial crises.

Intellectual property rights should not override States' obligations to protect and fulfil the right to health, which entails providing for immunization and treatment against major infectious diseases to all without discrimination. The existing TRIPS regime, however, may have an adverse impact on prices and availability of medicines since, as noted by a former Special Rapporteur on the right to health, it makes it difficult for countries (especially developing and least developed countries) to promote access to medicines.[6]

Against this background, the petition to WTO by India and South Africa, dated 2 October 2020, to waive certain provisions of the TRIPS agreement for the prevention, containment and treatment of COVID-19 is welcome. Both countries argue that "an effective response to the COVID-19 pandemic requires rapid access to affordable medical products, including diagnostic kits, medical masks, other personal protective equipment and ventilators as well as vaccines and medicines for the prevention and treatment of patients in dire need."[7]

International cooperation and assistance between developed and developing countries are crucial in ensuring that all relevant health technologies, intellectual property data and know-how on COVID-19 vaccines and treatment are widely shared as a global public good. In addition, economic soundness dictates that all countries will benefit from global action that could provide

vaccines for everyone at affordable prices and cost that is hugely less than that of the COVID-19 pandemic on global and national economies.[8]

In this regard, the World Bank has approved $12 billion grants and highly concessional loans to developing countries, in order to finance their purchase and distribution of COVID-19 vaccines, tests, and treatments. Such a financing package should be provided in furtherance of a globally coordinated approach to ensure wide and fair access to COVID-19 vaccines, rather than of a profit-driven market model whereby developing countries pay high prices for vaccines with their grants and loans.

Developing countries have entered the pandemic with unprecedentedly high debt levels. While low-income countries are in a position to reduce their debt burden when the global economic environment is favourable and commodity prices are stable, the global economy is in a deep recession and faces risks of a further downward slide. As a result, there is fear of a widespread debt crisis in the world, with more sovereign and private defaults to come in the near future.

The so-called "supply and vaccine nationalism" will only worsen the situation. Low and middle income countries will have to devote more resources for obtaining the various products, leading to more debt and further reducing fiscal space for measures and policies for acute needs on health, food and social security, all crucial elements to address the situation of their population. With the credit crunch and worsening fiscal positions for developing countries, it would be even more difficult for them to obtain vaccine for their nations if the prices are high or the supply has been monopolized, or if shortages of essential medical goods and protective gear continue to increase, placing additional stress on the health care systems.

Availability, access and affordability at national level

States have an obligation to ensure that any COVID-19 vaccines and treatments are safe, available, accessible and affordable to all who need them. This is particularly relevant to people in vulnerable situations who are often neglected from health services, goods and facilities, including those living in poverty, women, indigenous peoples, people with disabilities, older persons, minority communities, internally displaced people, persons in overcrowded settings and in residential institutions, people in detention, homeless persons, migrants and refugees, people who use drugs, LGBT and gender diverse persons. Many of them may have lived experience of poverty and find themselves in situations where they are most likely to be exposed to the risk of contagion, yet the least likely to be protected from COVID-19 or supported by adequate and timely tests and health services.[9] It is imperative that access to COVID-19 vaccines and treatment is provided to all without discrimination and prioritized for those who are most exposed and vulnerable to the risk of COVID-19.

To cope with limited fiscal space, there is a high risk that Governments in developing countries, instead of adopting human rights compliant policies, will

resort once again to austerity measures, including cuts in social protection, food assistance or health supplies. This would further deepen poverty, discrimination and the inequality gap within countries. Deeper social impacts will also delay the economic recovery process.

The austerity measures implemented in the aftermath of the 2008 financial crisis have left public health care and social protection systems severely underfunded, increased precarious employment, and widened inequality between the rich and the poor. While a plethora of social protection measures has been adopted to deal with the socioeconomic consequences of the pandemic, they have largely proved to be ad hoc and inadequate, revealing a critical need to build comprehensive and sustainable social protection systems.[10]

Saving lives and the economy: a social function of businesses

Industry and private benefit cannot be prioritized over the rights to life and health of billions with so far reaching consequences. That does not mean that companies should not be adequately compensated for their work in case of success developing a safe and effective vaccine. It means that they should not remain solely in control of selling and distributing to the highest bidder, not the least. Pharmaceutical and other companies involved in this endeavour should join the collective and global efforts to effectively contain COVID-19.

In some cases, public funding has greatly contributed to the development of vaccines, directly and indirectly, as well as to researching and developing various products.[11] While support from States to assist companies in developing vaccines and other supplies needed to fight the pandemic is important, it seems fair that in return, companies accept that they have a responsibility to support the right to health. Furthermore, States should ensure that businesses benefiting from State assistance respect human rights and are committed to transparency and accountability. The Working Group on Business and Human Rights has urged States to consider respect for human rights as an essential requirement when offering businesses pandemic-driven support.[12] Similarly, it has reminded businesses of the need for the private sector to respect human rights and prevent adverse human rights impacts in their provision of goods and services during the COVID-19 pandemic, in line with the UN Guiding Principles on Business and Human Rights.[13]

The emerging intellectual property disputes over patents as well as the possibility of having oligopolistic manufacturers could also hinder the development and production of COVID-19 vaccines as well as the availability, accessibility and affordability of the vaccine at national and international levels. Pharmaceutical companies have responsibilities regarding the realization of the right to health, in particular in relation to access to medicines, including vaccines. In order to protect the right to health, States should use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) regarding flexibilities to protect public health and provide access to medicines for all. This through, inter alia, granting

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compulsory licences as recognized in the Doha Declaration on the TRIPS Agreement and Public Health and following the a commitment made in the Sustainable Development Goals (SDG3)[14]. Human rights mechanisms have provided extensive guidance on this issue for private businesses and States.[15]

Recommendations to States, business and other stakeholders

The race for a COVID-19 vaccine must be, above all, a race to prevent more deaths and to protect the human kind, without discrimination on any ground and without consideration for national origin. This race, which serves as a light of hope in dark social and economic times, should be anchored in the essentiality of international cooperation and assistance and in the conviction that sharing the benefits of scientific progress is a human right as central as the rights to health and to life. Access and availability of a vaccine cannot be left in the hands of traditional market forces, to be defined by rules of supply and demand. Market solutions alone will not efficiently contain this pandemic nor prioritize the protection of millions of people in situations of vulnerability.

We join our voices on the call by States, the United Nations, civil society organizations and academics, to prioritize access to vaccines and treatments for the people and to ensure scientific progress benefits all in line with international human rights principles and in consideration of their centrality as global public goods.[16]

We also support the call of the World Health Assembly to recognize "the role of extensive immunization against COVID-19 as a global public good for health in preventing, containing and stopping transmission in order to bring the pandemic to an end, once safe, quality, efficacious, effective, accessible and affordable vaccines are available"[17] States should:

- Comply with their international obligations of ensuring access to medicines, including COVID-19 vaccines and treatment to all and of international assistance and cooperation. This by combatting the COVID-19 pandemic in a globally coordinated manner, including by joining the COVAX Global Vaccines Facility and putting aside misplaced individual initiatives to monopolize vaccine or supplies.
- Ensure that important technologies, intellectual property data and know-how on COVID-19 vaccines are widely shared and developing countries are supported in scaling up development, manufacturing and distribution capacities to ensure equal access to such vaccines. Pledges and voluntary licenses - including through initiatives like COVID-19 technology access pool – are not enough in view of the current situation. "Binding commitments to facilitate the open sharing and right to use technologies, know-how, data and global non-exclusive rights to use and produce COVID-19 medical products"[18] should be put in place immediately.
- Pay particular attention on the objectives (article 7) and principles (article 8) of the TRIPS Agreement in light of the COVID-19 pandemic. In particular, States should refrain from the use of "national security" or

any argument allowing for trade secrets related to the vaccine, treatment, testing and any other information needed to combat the disease.[19]

- Fully exercise the right to grant compulsory licences pursuant to the TRIPS Agreement and the Doha Declaration on the TRIPS Agreement and Public Health to ensure that patents and other intellectual property rights do not create obstacles to providing for access to vaccines to all – particularly those in vulnerable situations and living in poverty.[20]
- Give particular attention to ensuring that vaccines are accessible to frontline health-care workers and to join WHO global initiatives.

Pharmaceutical companies should:

- Discharge their responsibilities, including by exercising human rights due diligence to identify and address adverse impacts on the rights to life and health as set out in the Guiding Principles on Business and Human Rights,. In particular, they should refrain from causing or contributing to adverse impacts on the rights to life and health by invoking their intellectual property rights and prioritizing economic gains.

International financial institutions (IFIs), consistent with their human rights duties under international law, should:

- Ensure that any grants and loans that they provide to developing countries contribute to expanding their capacity to procure, manufacture and distribute safe, effective and affordable COVID-19 vaccines. To this end, IFIs' country programs on COVID-19 vaccines should be aligned with a globally coordinated approach, such as the COVAX Global Vaccines Facility.

We finally recommend that:

- States participating at the 31st Special Session of the General Assembly in Response to the COVID-19 Pandemic take into consideration the present Statement and guiding elements to ensure universal access to COVID-19 vaccine for all in all countries through international cooperation and assistance.

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* *Tlaleng Mofokeng, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Olivier De Schutter, Special Rapporteur on extreme poverty and human rights; Anita Ramasastry (Chair), Dante Pesce (Vice-Chair), Surya Deva, Elżbieta Karska, and Githu Muigai, Working Group on the issue of human rights and transnational corporations and other business enterprises; Obiora C. Okafor, Independent Expert on human rights and international solidarity, and Saad Alfarargi, Special Rapporteur on the right to development*

Notes:

1. WHO Coronavirus Disease (COVID-19) Dashboard, https://covid19.who.int/ (accessed on 9 November 2020)

2. CESCR, general comment no. 25, on article 15.1.b), April 2020, para.82.

3. https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---18-august-2020; WHO chief warns against COVID-19 'vaccine nationalism', urges support for fair access, 18 August 2020, https://news.un.org/en/story/2020/08/1070422; "Vaccine nationalism" threatens global plan to distribute COVID-19 shots fairly, 28 July 2020, https://www.sciencemag.org/news/2020/07/vaccine-nationalism-threatens-global-plan-distribute-covid-19-shots-fairly; Oxfam, Small group of rich nations have bought up more than half the future supply of leading COVID-19 vaccine contenders, 17 September 2020, https://www.oxfam.org/en/press-releases/small-group-rich-nations-have-bought-more-half-future-supply-leading-covid-19

4. South Africa's statement at the WTO TRIPS Council of 30 July 2020, https://www.keionline.org/33593

5. https://www.oxfam.org/en/press-releases/small-group-rich-nations-have-bought-more-half-future-supply-leading-covid-19

6. A/HRC/11/12 (2009), see in particular para. 24.

7. WTO, IP/C/W/669, 2 October 2020.

8. The Economic Case for a People's Vaccine, 15 September 2020, https://bostonreview.net/science-nature/sanjay-g-reddy-arnab-acharya-economic-case-peoples-vaccine. McKinsey On pins and needles: Will COVID-19 vaccines 'save the world'?, 29 July 2020, https://www.mckinsey.com/industries/pharmaceuticals-and-medical-products/our-insights/on-pins-and-needles-will-covid-19-vaccines-save-the-world# ; Oxfam, Small group of rich nations have bought up more than half the future supply of leading COVID-19 vaccine contenders, 17 September 2020, https://www.oxfam.org/en/press-releases/small-group-rich-nations-have-bought-more-half-future-supply-leading-covid-19

9. Report of the Special Rapporteur on extreme poverty and human rights: The parlous state of poverty eradication, A/HRC/44/40 (2020).

10. Report of the Special Rapporteur on extreme poverty and human rights, Olivier De Schutter, Looking back to look ahead: A rights-based approach to social protection in the post-COVID-19 economic recovery, https://www.ohchr.org/Documents/Issues/Poverty/covid19.pdf

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11. Oxfam, 17 September 2020, https://www.oxfam.org/en/press-releases/small-group-rich-nations-have-bought-more-half-future-supply-leading-covid-19

12. www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25837&LangID=E.

13. https://www.ohchr.org/documents/publications/guidingprinciplesbusinesshr_en.pdf

14. Sustainable Development Goal No. 3 "Ensure healthy lives and promote wellbeing for all at all ages", Target 3.b. See also A/63/263 (2008).

15. For instance, the mandate of the Special Rapporteur on the right to health has extensively worked on the issue of access to medicines, intellectual property rights, including in reports A/63/263 (Human Rights Guidelines for Pharmaceutical Companies), A/HRC/11/12 (2009), A/HRC/17/43 (2011) and A/HRC/23/42 (2013).

16. Uniting behind a people's vaccine against COVID-19, 14 May 2020, https://www.unaids.org/en/resources/presscentre/featurestories/2020/may/20200514_covid19-vaccine-open-letter; Amnesty International, COVID-19 response measures: recommendations to G20 health and finance ministers on the protection of health workers, access to diagnostics, therapeutics or vaccines and to support debt cancellation and financial assistance, September 2020, https://www.amnesty.org/download/Documents/IOR3030002020ENGLISH.pdf

17. 73rd World Health Assembly, COVID-19 response, 19 May 2020, WHA73.1, paragraph 6, https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf and OP13of the Omnibus Resolution, Comprehensive and Coordinated Response to the COVID-19 Pandemic adopted at the 75th session with 169 votes in favour and 2 against.

18. South Africa's statement at the WTO TRIPS Council of 30 July 2020, https://www.keionline.org/33593

19. COVID-19 trade secrets and information access: an overview, 10 July 2020, http://infojustice.org/archives/42493

20. Africa's Response to COVID-19: What roles for trade, manufacturing and intellectual property?, 23 June 2020, http://www.oecd.org/coronavirus/policy-responses/africa-s-response-to-covid-19-what-roles-for-trade-manufacturing-and-intellectual-property-73d0dfaf/

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Committee on Economic, Social and Cultural Rights

Statement on universal and equitable access to vaccines for the coronavirus disease (COVID-19)

Statement by the Committee on Economic, Social and Cultural Rights*

1. A safe and effective vaccine is expected to reduce the health and life risks posed by the coronavirus disease (COVID-19), while allowing the progressive lifting of some restrictive measures that have been necessary to combat the spread of the virus. It will also help to recover from the serious negative impact that these measures have had on the enjoyment of economic, social and cultural rights, especially by the most disadvantaged and marginalized populations. For that reason, it is important and encouraging news for the world that several vaccines for COVID-19 might be approved soon by health authorities, after following the relevant World Health Organization (WHO) technical guidance documents for COVID-19 vaccines and other biologicals in order to guarantee their safety and effectiveness.[1] In that context, the Committee considers it necessary to remind State parties of their obligation under the Covenant in this area, in order to avoid unjustified discrimination and inequalities in access to COVID-19 vaccines.[2]

2. Every person has a right to the enjoyment of the highest attainable standard of physical and mental health,[3] which includes access to immunization programmes against the major infectious diseases.[4] Every person also has a right to enjoy the benefits of scientific progress,[5] which includes access to all the best available applications of scientific progress necessary to enjoy the highest attainable standard of heath.[6] Both rights imply 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.

3. States have an obligation to take all the measures necessary, to the maximum available resources, to guarantee access to vaccines for COVID-19 to all persons, without discrimination.[7] The duty of States to provide immunization against the major infectious diseases and to prevent and control epidemics is a priority obligation concerning the right to

* Adopted by the Committee intersessionally on 27 November 2020.

[1] See WHO, "Relevant WHO technical documents for COVID-19 vaccines and other biologicals", 25 September 2020, 25 September 2020.

[2] For a general view of the obligations of State sparties under the Covenant in relation to the pandemic, see the statement of the Committee of 6 April 2020 on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights (E/C.12/2020/1).

[3] International Covenant on Economic, Social and Cultural Rights, art. 12; Universal Declaration of Human Rights, art. 25.

[4] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 36.

[5] International Covenant on Economic, Social and Cultural Rights, art. 15; Universal Declaration of Human Rights, art. 27.

[6] Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), para. 70.

[7] See International Covenant on Economic, Social and Cultural Rights, arts. 2, 12 and 15.

health.[8] Under the current conditions, States are required to give maximum priority to the provision of vaccines for COVID-19 to all persons.

4. The right to health requires States to make health facilities, services and goods, including vaccines, available, accessible, acceptable and of good quality.[9] Vaccines for COVID-19 must not only be produced and made available; they must also be accessible to all persons. In order to ensure access to COVID-19 vaccines, States must, firstly, remove any discrimination based on grounds such as religion, national origin, sex, sexual orientation and gender identity, race and ethnic identity, age, disability, migration status, social origin, poverty or any other relevant status; secondly, guarantee physical accessibility to vaccines, especially for marginalized groups and people living in remote areas, using both State-run and private channels and by strengthening the capacity of health systems to deliver vaccines; thirdly, guarantee affordability or economic accessibility for all, including by providing vaccines free of charge, at least for lower income persons and the poor; and fourthly, guarantee access to relevant information, especially through the dissemination of accurate scientific information on the safety and effectiveness of different vaccines, and public campaigns protecting people against false, misleading or pseudoscience information concerning vaccines, which is rapidly spreading on the Internet and social media.[10]

5. It is impossible to guarantee that everyone will have immediate access to a vaccine for COVID-19, even if several vaccines are approved soon. The mass production and distribution of vaccines implies not only enormous financial costs but also complex administrative and health procedures. The prioritization of access to vaccines by specific groups is unavoidable, at least in the initial stages, not only nationally but also at the international level. In accordance with the general prohibition of discrimination,[11] such prioritization must be based on medical needs and public health grounds. According to these criteria, priority may be given, for instance, to health staff and care workers, or to persons presenting greater risks of developing a serious health condition if infected by SARS-COV-2 because of age, or preexisting conditions, or to those most exposed and vulnerable to the virus owing to social determinants of health, such as people living in informal settlements or other forms of dense or instable housing, people living in poverty, indigenous peoples, racialized minorities, migrants, refugees, displaced persons, incarcerated people and other marginalized and disadvantaged populations. In any case, criteria of prioritization must be established through a process of adequate public consultation, be transparent and subject to public scrutiny and, in the event of dispute, to judicial review to avoid discrimination.

6. Many of the vaccines that could be approved have been developed by private companies and may be subject to the intellectual property regime. These companies expect to obtain a profit, and it is fair that they receive reasonable compensation for their investments and research. The Committee reminds States parties, however, that intellectual property is not a human right but a social product with a social function.[12] States parties consequently have a duty to prevent intellectual property and patent legal regimes from undermining the enjoyment of economic, social and cultural rights by, for example, making critical public goods, such as vaccines or medicines, inaccessible to developing countries or impoverished communities because of unreasonable cost structures.[13] Thus, as stated in the Doha Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health, the intellectual property regime should be interpreted and implemented in a manner supportive of the duty of States "to protect public health".[14] States parties should use, when necessary, all the flexibilities of the TRIPS Agreement, such as compulsory licenses, to ensure access to a COVID-19 vaccine for all. These flexibilities will in all likelihood, however, be insufficient to face adequately the pandemic, especially in developing countries. Some States have therefore proposed, as an additional measure, that

[8] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), para. 44.
[9] Ibid., para. 12.
[10] See Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), para. 52.
[11] See International Covenant on Economic, Social and Cultural Rights, art. 2. See also Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009).
[12] Committee on Economic, Social and Cultural Rights, general comment No. 17 (2006), paras. 1–2.
[13] Ibid., para. 35.
[14] See Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), para. 69.

the World Trade Organization (WTO) to waive some of the provisions of the TRIPS Agreement in the context of the global health crisis. The proposal, supported by a number of special procedures of the Human Rights Council,[15] should be considered and implemented in order to facilitate the prevention, containment and treatment of COVID-19 through the global affordability of vaccines.

7. Business entities, including pharmaceutical companies, have, in accordance with international standards, the obligation, as a minimum, to respect the rights outlined in the International Covenant on Economic, Social and Cultural Rights.[16] Such entities should therefore refrain from invoking intellectual property rights in a manner that is inconsistent with the right of every person to have access to a safe and effective vaccine for COVID-19 and with the obligation of States to guarantee, as expeditiously as possible, universal equitable access to such a vaccine.

8. Under the Covenant, States parties may be held directly responsible for the action or inaction of business entities under certain circumstances.[17] In addition, they have an extraterritorial obligation to take the measures necessary to protect economic, social and cultural rights to ensure that corporations domiciled in their territory and/or under its jurisdiction do not violate these rights abroad.[18] States should therefore take all measures necessary to ensure that such business entities do not invoke intellectual property law, either in their own territory or abroad, in a manner that is inconsistent with the right of every person to have access to a safe and effective vaccine for COVID-19.

9. Under the Covenant, States have a duty of international cooperation and assistance to ensure universal equitable access to vaccines wherever needed.[19] The fact that the current crisis is a pandemic reinforces this obligation of States.[20] States must therefore strengthen their international cooperation to guarantee, as soon as possible, universal and equitable access to vaccines for COVID-19 globally, including for populations of least developed countries, which might not have the financial resources to guarantee access to vaccines for their people.

10. It is understandable that States give a certain priority to ensuring access to vaccines for their own citizens first. This concern should not, however, lead to a form of health isolationism or to a race for COVID-19 vaccines among States, in which some States, especially developed States, compete with others to strike costly and non-transparent deals with private companies to secure vaccines to all or most of their own citizens first. This competition among States may lead to an increase in the price of vaccines and might even create a temporary monopoly of access to the first vaccines produced for some developed States, undermining, at least temporarily, the possibility of other countries, especially developing States, to ensure access to vaccine for their population. This competition among States for vaccines is counterproductive in terms of a global health approach, as it makes the pandemic much more difficult and lengthy to control. As long as significant parts of the world population have no access to measures that control, prevent and treat COVID-19, and to its vaccines, the risk of upsurges in the pandemic remain. Furthermore, such competition for a vaccine runs counter to the extraterritorial obligations of States to avoid taking decisions that limit the opportunity of other States to realize their right to health. It also obstructs access to vaccines by those who need it most in least developed countries.[21] The secret nature of certain deals is also contrary to the duty of States to establish transparent mechanisms that allow accountability, public scrutiny of and citizen participation in decisions concerning the

[15] Office of the United Nations High Commissioner for Human Rights (OHCHR), "Statement by UN Human Rights Experts: Universal access to vaccines is essential for prevention and containment of COVID-19 around the world", press statement, 9 November 2020.

[16] Committee on Economic, Social and Cultural Rights, general comment No. 24 (2017), para. 5. See Guiding Principles on Business and Human Rights, principle 11.

[17] Committee on Economic, Social and Cultural Rights, general comment No. 24 (2017), para. 11.

[18] Ibid., paras. 26 and 28.

[19] See International Covenant on Economic, Social and Cultural Rights, art. 2 (1).

[20] See Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), para. 82.

[21] See ibid., general comment No. 24 (2017).

allocation of resources and the application of technologies for the realization of the right to health.[22]

11. Instead of pursuing health isolationism and a race for a vaccine, States should honour their obligations to contribute to the enjoyment of all human rights, including the right to health, globally.[23] The distribution of vaccines and the prioritization of access to them should be organized and supported by international cooperation and assistance, which includes the sharing of benefits of scientific progress and its applications.[24] States parties should therefore develop strategies and mechanisms for a fair distribution of the financial costs associated with research into and the production and distribution of vaccines for COVID-19, including through a reduction in the debt burden for countries that need it. They should also adopt transparent and participatory mechanisms that ensure that prioritization in the global distribution of vaccines is based – as should be the case also at the national level – on medical needs and public health considerations. Such support can be organized by using the WHO-supported COVAX Global Vaccines Facility.

12. Lastly, while the present statement focuses essentially on equitable and universal access to vaccines for COVID-19, the Committee considers that its main considerations are relevant, mutatis mutandis, to the obligations of States to also ensure universal and equitable access to treatment for COVID-19. Furthermore, the Committee reminds States parties that any measures taken to limit economic, social and cultural rights because of the pandemic must comply with the conditions set out in article 4 of the Covenant. In this regard, the Committee recalls its statement of 6 April 2020 on the pandemic and economic, social and cultural rights (E/C.12/2020/1).

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[22] See Committee on Economic, Social and Cultural Rights, general comments No. 25 (2020), para. 55, and No. 14 (2000), para. 55.

[23] See Charter of the United Nations, Arts. 55–56. See also Committee on Economic, Social and Cultural Rights, general comment No. 24 (2017).

[24] See International Covenant on Economic, Social and Cultural Rights, art. 2. See also the commitments made in Sustainable Development Goal 3.

HUMAN RIGHTS AND ACCESS TO COVID-19 VACCINES

OVERVIEW

As of the time of writing, over 73 million people have been infected with SARS-Cov-2, the virus which causes COVID-19, and more than 1.6 million people have died.[1] With some 42 vaccines in human clinical trials and more than 151 in the preclinical stage, the COVID-19 pandemic has driven an extraordinary effort to develop a vaccine.[2] Vaccines are already being distributed in Canada, China, Russia, the United Kingdom and the United States. While these developments represent a real opportunity to change the trajectory of the pandemic, the distribution process still faces significant hurdles, including complex logistical challenges.

Without a global, coordinated effort to ensure access to a vaccine for everyone who needs it, we risk priority access being granted on the basis of ability to pay and other grounds including nationality and country of residence, rather than on an evidence-based assessment of need. Affordable, non-discriminatory access to the vaccine is a human right. Ensuring access to the vaccine is not only the right thing to do, it is in the interest of us all, for unless everyone is safe, no one is safe. Fair distribution of vaccines that respects the human rights of all is also essential to build trust. While recent advances underscore the urgency of respecting human rights in relation to the development and distribution of a COVID-19 vaccine, the norms outlined in these messages apply universally to access to medicines, other vaccines, health therapies and health technologies and should guide States and other stakeholders in policy development and implementation.

KEY MESSAGES

1. COVID-19 vaccines should be treated as global public goods

Health is a right and COVID-19 vaccines should be treated as global public goods, rather than as marketplace commodities available only to those countries and people who can afford to pay the asking price. The availability of vaccines, medicines, health technologies and health therapies is an essential dimension of the right to health, the right to development and the right to enjoy the benefits of scientific progress and its applications. Everyone is entitled, on an equal footing with others, to enjoy access to all the best available applications of scientific progress necessary to enjoy the highest attainable standard of health.[3]

[1] https://covid19.who.int/.
[2] https://www.who.int/docs/default-source/coronaviruse/risk-comms-updates/update37-vaccine-development.pdf?sfvrsn=2581e994_6.
[3] Committee on Economic Social and Cultural Rights (CESCR), General Comment No. 25 (2020) on science and economic, social and cultural rights (article 15 (1) (b), (2), (3) and (4) of the Covenant), para. 70.

2. The COVID-19 pandemic is a global health emergency which demands a global response

Viruses do not respect borders. A well-coordinated global approach to the development and distribution of COVID-19 vaccines based on the solidarity of all nations and peoples is the most effective, sustainable and moral response to the crisis the world is facing. Technology transfer and the sharing of information and data, especially, will be of great importance to ensuring a successful and inclusive global vaccination campaign. This approach should also be the hallmark of all efforts to secure access to treatments and therapies beyond vaccines. In May 2020, OHCHR joined a Solidarity Call to Action, an initiative launched by Costa Rica and the World Health Organization, to realize equitable global access to COVID-19 medicines, vaccines, therapies and health technologies through the pooling of knowledge, intellectual property and data. OHCHR encourages States and other stakeholders to consider participating in this and similar initiatives.

3. Unfair distribution of vaccines across countries, or hoarding of vaccines, disregards international legal norms and undermines the achievement of the Sustainable Development Goals

Some wealthy countries have reportedly purchased enough doses to vaccinate their entire populations multiple times over by the end of 2021 if all the candidate vaccines in clinical trials are given regulatory approval.[4] At the same time, there are estimates that 90% of the population in 67 countries will not be able receive a COVID-19 vaccine in 2021, despite the fact that five of those countries have reported nearly 1.5 million cases between them.[5]

The International Covenant on Economic, Social and Cultural Rights (ICESCR) requires States to achieve the progressive realisation of the rights protected by the Covenant, including the right to health, both individually and through international assistance and co-operation.[6] States which are able to do so should provide assistance, especially economic, scientific and technical, to developing countries for immunisation against major infectious diseases and for the prevention, treatment and control of epidemic and endemic diseases.[7]

The International Health Regulations (2005) were established to facilitate cooperation in mounting an effective public health response to the international spread of disease. This objective was reaffirmed in the Declaration of Astana (2018) where States reiterated commitments to effective development cooperation and to sharing knowledge and good practices (while fully respecting human rights) in order to prevent, detect and respond to infectious diseases and outbreaks.[8]

The 2030 Agenda for Sustainable Development pledges a revitalisation of the global partnership for sustainable

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[4] This data was produced by the People's Vaccine Alliance. For more information, see: https://www.amnesty.org/en/latest/news/2020/12/campaigners-warn-that-9-out-of-10-people-in-poor-countries-are-set-to-miss-out-on-covid-19-vaccine-next-year/ See also: https://www.oxfam.org/en/press-releases/small-group-rich-nations-have-bought-more-half-future-supply-leading-covid-19.

[5] Kenya, Myanmar, Nigeria, Pakistan and Ukraine (https://www.amnesty.org/en/latest/news/2020/12/campaigners-warn-that-9-out-of-10-people-in-poor-countries-are-set-to-miss-out-on-covid-19-vaccine-next-year/).

[6] ICESCR article 2.1. See also CESCR General Comment No. 3 (1990) on the nature of States parties' obligations (art. 2, para. 1, of the Covenant).

[7] CESCR, General Comment No. 14 (2000) on the right to the highest attainable standard of physical and mental health (art.14 of the Covenant), paras. 43-45. See also UN Human Rights Experts: Universal access to vaccines is essential for prevention and containment of COVID-19 around the world (9 November 2020), available at https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26484&LangID=E.

[8] See Declaration of Alma-Ata, September 1978.

development, including through enhanced North-South, South-South and triangular regional and international cooperation on and access to science, technology and innovation.[9] The 2030 Agenda also commits to reducing inequality within and among countries,[10] making solidarity, cooperation and partnership among States and all stakeholders vital to achieving the Sustainable Development Goals. Achieving Sustainable Development Goal 17, particularly, requires the implementation of the principles of the UN Declaration on the Right to Development, with their mandate for States to cooperate towards an enabling environment for human rights and development.

4. COVID-19 vaccines should be affordable to all and accessible without discrimination

Access to vaccines and medicines is disturbingly uneven in many places, with poorer health outcomes for women and girls, national, ethnic, religious, racial and linguistic minorities, indigenous populations, persons living in poverty, LGBTI people, persons with disabilities, migrants, particularly undocumented migrants, stateless persons, and others experiencing marginalisation. COVID-19 infection rates and outcomes for minorities and people in vulnerable groups have mirrored these patterns, in part due to structural inequalities and discrimination. These facts raise a substantial risk that these populations and groups will fall behind in vaccination rates relative to others. Women and girls risk discrimination in vaccine distribution for many reasons, including higher rates of poverty and the impact of societal norms.[11]

Focused efforts are essential to remove barriers, pre-empt potential discrimination, and monitor distribution to ensure equality and avoid discrimination. These efforts are not only essential to protect human rights, but to ensure the effectiveness of the vaccination campaign. Vaccination distribution plans need to ensure full accessibility for persons with disabilities. Similarly, emerging issues including testing access and protocols, data collection and retention, "immunity passports", surveillance and tracking tools, and the discriminatory treatment of persons who have recovered from COVID-19 all require intensive attention in this context.[12]

5. Prioritisation of vaccine delivery should be done through transparent protocols and procedures that respect human rights

A critical issue today involves the protocols according to which vaccines will be distributed, including prioritisation of groups for access to the vaccine. Those complex criteria have been elaborated in detail through the WHO SAGE values framework for the allocation and prioritisation of COVID-19 vaccination.[13] As those recommendations reflect, the decision as to who should receive priority consideration for the vaccine should be based on appropriate criteria that are in line with human rights standards and norms.

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[9] Sustainable Development Goal No. 17 "Strengthen the means of implementation and revitalize the global partnership for sustainable development," Target 17.6. See also Addis Ababa Action Agenda of the Third International Conference on Financing for Development, paras. 120-121, available at: https://sustainabledevelopment.un.org/content/documents/2051AAAA_Outcome.pdf.

[10] Sustainable Development Goal No. 10, "reduce inequality within and among countries".

[11] See OHCHR Guidance Note on CEDAW and COVID-19, available at: https://www.ohchr.org/Documents/HRBodies/TB/COVID19/Guidance_Note.docx and COVID-19 and Women's Human Rights (OHCHR), available at: https://www.ohchr.org/Documents/Issues/Women/COVID-19_and_Womens_Human_Rights.pdf.

[12] See: Racial Discrimination in the COVID-19 Context (OHCHR), available at https://www.ohchr.org/Documents/Issues/Racism/COVID-19_and_Racial_Discrimination.pdf.

[13] Available at: https://www.who.int/publications/i/item/who-sage-values-framework-for-the-allocation-and-prioritization-of-covid-19-vaccination.

The determination of early vaccine recipients should not, for instance, exclude anyone explicitly or implicitly on the basis of older age, disability, race, gender, migration status or other discriminatory criteria, and should be conducted through a fair, transparent, inclusive and accountable process.[14] Civil society and communities should be able to participate meaningfully in the development of vaccine distribution protocols and in policies concerning prioritisation of allocations. Particular care should be taken to ensure that those who are often invisible in many ways, including people in institutional settings such as care homes, psychiatric institutions, homes for persons with disabilities, homeless shelters, immigration detention centres and prisons, are included without discrimination in vaccine distribution policies and plans.

6. Private profit should not be prioritised over public health

Intellectual property rights should not be applied in a manner which undermines the rights to health, food, science and other human rights.[15] Obligations under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), for example, should be interpreted consistently with the protection of public health, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health.

States have a duty to prevent unreasonably high costs for access to essential medicines and vaccines.[16] To that end, they should take steps to protect the primacy of public health over private profit in line with their commitments to support research and development of vaccines and medicines, as well as preventative measures and treatments for communicable diseases, especially those that disproportionately impact developing countries.[17]

7. Non-discriminatory access to accurate health information is essential

Now more than ever, the free flow of information should be facilitated in a safe environment and without threat or sanction.[18] Limiting stakeholder involvement and critical feedback, including debates involving experts, medical professionals, journalists and other influencers, undermines an effective response to COVID-19.

Access to health information and education for health professionals, decision-makers and the public is crucial for facilitating optimal participation in the health response, the uptake of health measures and well informed decision-making. Relevant information on the COVID-19 pandemic and response should reach all people, without exception. This requires making information available in readily understandable formats and languages, including indigenous languages and those of national or ethnic, religious and linguistic minorities. It also requires adapting information for people with specific needs, including the visually- and hearing-impaired, and reaching those with limited or no ability to read or with no internet access. States should also work to ensure the broadest possible access to internet service by taking steps to bridge digital divides, including the gender digital divide.

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[14] See also CESCR, General Comment No. 25 (2019), para. 16 - "States parties should direct their own resources and coordinate actions of others to ensure that scientific progress happens and that its applications and benefits are distributed and are available, especially to vulnerable and marginalized groups."

[15] See the report of the Special Rapporteur in the field of cultural rights, A/70/279, para. 90.

[16] CESCR, General Comment No. 17 (2005) on the right of everyone to benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he or she is the author (article 15, paragraph 1 (c), of the Covenant), paras. 35 and 39(e).

[17] Addis Ababa Action Agenda, para. 121, https://sustainabledevelopment.un.org/content/documents/2051AAAA_Outcome.pdf

[18] See Civic Space and COVID-19 (OHCHR): https://www.ohchr.org/Documents/Issues/CivicSpace/CivicSpaceandCovid.pdf . See also Report of the Special Rapporteur on Freedom of Expression, https://undocs.org/A/HRC/44/49.

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8. Pharmaceutical companies, like all companies, have a responsibility to respect human rights

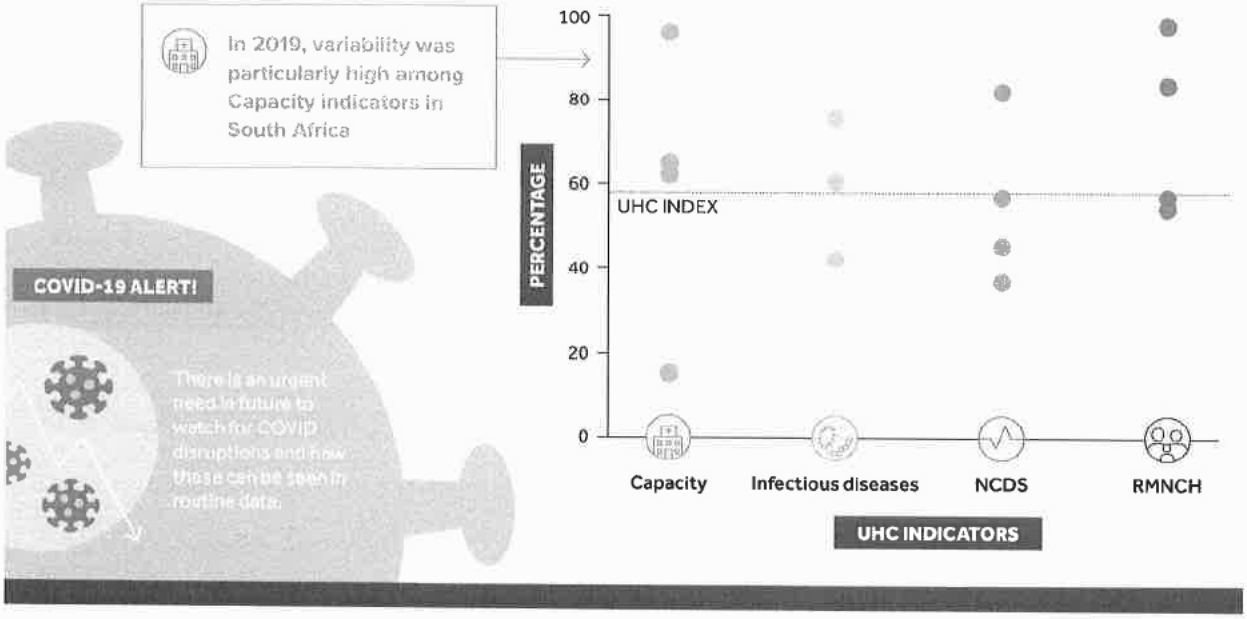
All businesses have a responsibility to respect human rights, including pharmaceutical companies and others involved in the response to COVID-19. The UN Guiding Principles on Business and Human Rights require businesses to know and show that they have taken all reasonable measures to prevent and mitigate any human rights impacts from their COVID-19 responses.[19]

This means that companies should undertake human rights due diligence. In this context, due diligence would require that pharmaceutical companies make realistic assessments of harmful side effects of any drug and mitigate these effects to the greatest extent possible before distributing the drug to the public. Similarly, companies' decisions regarding pricing and distribution must consider the adverse impacts such decisions will have as regards discriminatory access to vaccines, particularly for those in situations of vulnerability and marginalisation. To the extent that such decisions might adversely impact the right to health, companies should take appropriate action to prevent and mitigate any harms, including through exerting leverage to influence the actions of other potentially responsible parties.

[19] See: Business and Human Rights in Times of COVID-19 (OHCHR), available at: https://www.ohchr.org/Documents/Issues/Business/BusinessAndHR-COVID19.pdf.

Universal Health Coverage indicators are variable in South Africa

SOME OF THIS IS DUE TO THE LIMITATIONS OF THE INDICATOR CONSTRUCTION, THRESHOLDS OR DATA AVAILABILITY



Demographic indicators

The mid-year population estimate is a key denominator relied upon for the calculation of a number of indicators. For the 2020/21 financial year, the total South African population used from the DHIS-NDoH 2000-2030 time series was just under 60 million (59 797 656).[29] Gauteng is the most populous province (15 635 579), followed by KwaZulu-Natal (11 441 785). Where public sector-only data are described, a more appropriate denominator is the estimate of the uninsured population, as shown in Table 10. Provincial estimates of medical schemes coverage are reported in the General Household Survey by Statistics South Africa, from which the uninsured population can be calculated. Modelled estimates per province and per district have been produced by Insight Actuaries, and are also shown in the table. Expressed another way, the proportion of the population that is covered by a medical scheme varies from a low of 7.2% in Limpopo to a high of 24.6% in Gauteng. At a district level, that proportion is estimated to vary from 3.8% (Alfred Nzo district, Eastern Cape) to 30.6% (Tshwane metro, Gauteng). Not taking this wide variation into account could skew the interpretation of data gathered in the public sector. Human resources and bed density data are examples in this regard. In the short term, loss of employment resulting from economic contraction linked to the COVID-19 pandemic may be accompanied by a reduction in the number of South Africans who are beneficiaries of medical schemes, with a concomitant increase in those dependent on the public sector. More fundamentally, the separation between the public and private sectors is expected to be altered by the introduction of National Health Insurance. Accounting for the population registered with the National Health Insurance Fund, and for all service providers contracted by the Fund, across sectors, will be necessary.

049
"TPM9"

For the **benefit** of the **member**

Annual Report 2019/20

CMS
Council
for Medical Schemes

Auditor's Report: Predetermined Objectives

The Auditor-General South Africa (AGSA)/auditor currently performs the necessary audit procedures on the performance information to provide a limited assurance conclusion. The audit conclusion on the performance against predetermined objectives is included in the report to management, with material findings being reported under the Predetermined Objectives heading in the Report on other legal and regulatory requirements section of the auditor's report.

Refer to page 90 of the Report of the Auditors Report, published as Part E: Financial Information.

Situational Analysis

Service Delivery Environment

The medical schemes industry regulated by the CMS consists of various key stakeholders with diverse interests and agendas. As at 31 March 2020 the CMS regulated 76 medical schemes, 19 administrators, 41 managed care organisations, 1 078 broker organisations and 6 053 individual brokers. The role of the CMS is to regulate these entities utilising the MSA and Regulations to ensure that the 8.9 million scheme beneficiaries' interests are protected. This means that the CMS should ensure that all the regulated entities are at all times compliant with the MSA and its provisions.

The CMS regulates the medical schemes industry through beneficiary training and education; registering of medical schemes and options; accrediting administrators, brokers and managed care organisations; resolving complaints; conducting inspections; and defending legal challenges. Other important regulatory functions include the collection of key industry data, the review of the beneficiary entitlements in the form of Prescribed Minimum Benefits (PMBs) and the provision of training and support for the regulated entities. The private health industry organically responds to the demand for healthcare, but does not address healthcare needs. For this reason, public policy intervention is necessary to enhance what the private system does well and to minimise those areas where the private system fails. If interventions are well designed and successfully implemented, the private health system is capable of fully supporting the country's broader social goals. Where a coherent strategy for the private health system is absent, however, coverage will invariably diminish in both extent and quality, with knockon effects on the public health system and the quality of life possible in South Africa.

Over the past 100 years, health insurance in various forms has evolved in South Africa along with changes in regulatory instruments. It was, however, not until 1998 that a framework was implemented to modernise and update the system with a view to maximising fair access to medical scheme cover along the lines of developments in Europe and South America. The central aim of these reforms, provided for in the MSA, was to enhance the risk pooling potential of medical schemes and other important regulatory and oversight mechanisms by introducing.

A preferred health insurance vehicle, which required that any person doing the business of a medical scheme must operate in terms of a single legislative framework that incorporates:

- **Open enrolment**, which removed the discriminatory practice of medical schemes to select only good risk beneficiaries for membership (risk selection)
- **Mandatory minimum benefit**, which removed the ability of schemes to discriminate against older and sicker members through the selective non-provision of key benefits
- **Waiting periods and late joiner penalties**, to eliminate any significant application of penalties for member movement between medical schemes and options, while substantially removing opportunities for anti-selection where a member joins only when sick and then leaves, or only joins for the first time later in life
- **Improved governance**, which removed the historical conflicts of interest embedded in the oversight of medical schemes
- **Regulation of intermediaries**, which implemented accreditation and more stringent regulatory oversight of medical scheme, brokers, administrators, and managed care organisations
- **Improved oversight**, through the implementation of a substantially enhanced special-purpose regulator to oversee the Act
- **Member protection**, which includes the complaints resolution mechanisms at scheme level and provides members access to the complaints resolution mechanisms at the Registrar's office and through appeals processes

[1] Note that the term "mandatory minimum benefits" is generic in nature, in our context this refers to the prescribed minimum benefits (PMBs).

The Medical Schemes Industry Overview in 2019

Figure 17 depicts the dependant ratio in medical schemes from 2008 to 2019, measuring the average number of dependants per principal member. The ratio declined from 1.32 in 2008 to 1.20 in 2019. It remained unchanged for restricted schemes between 2018 and 2019 at 1:1.38 while in open schemes the ratio declined by 0.02.

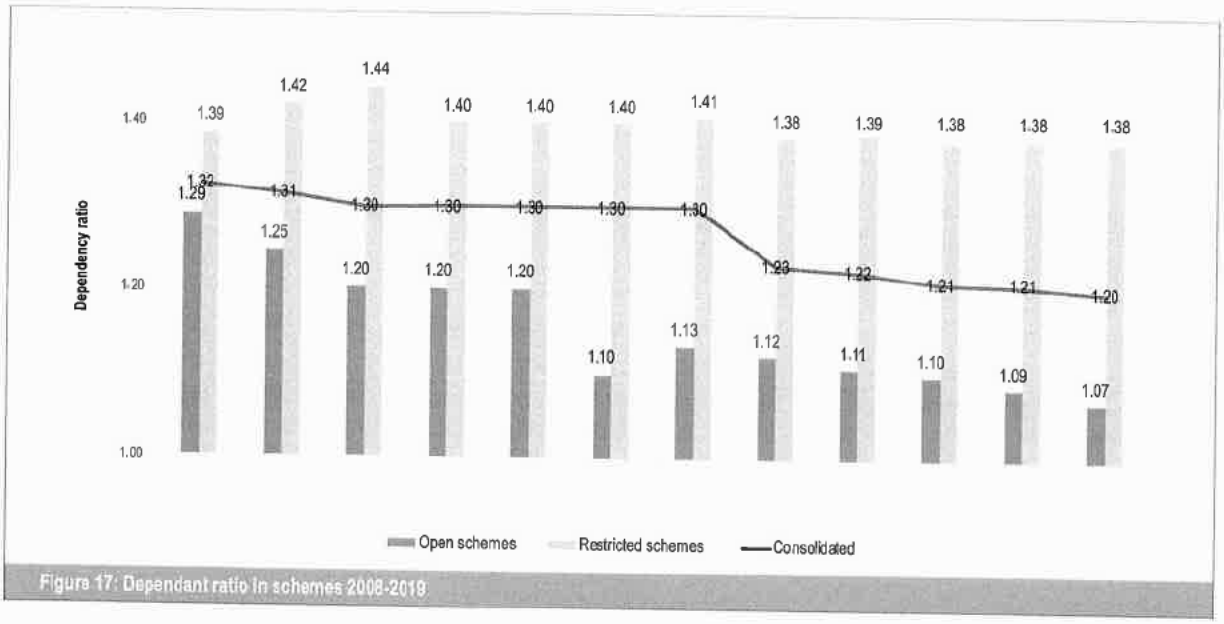


Figure 17: Dependant ratio in schemes 2008-2019

The Medical Schemes Industry Overview in 2019

Table 41 illustrates the average age of beneficiaries and the proportion of pensioners by scheme type and gender from 2016 to 2019. The industry average age of beneficiaries increased slightly by 0.2 for two consecutive periods (2017/18 and 2018/19). The average age of female beneficiaries was greater than that of male beneficiaries from 2015 to 2018. In 2019, the proportion of pensioners (beneficiaries aged 65 and older) declined to 8.6% from 9.0% in 2018. The average age and pensioner ratio of male beneficiaries were lower than that of female beneficiaries. The average age of 34.9 years in open schemes was higher than the industry average of 33.0 years in 2019, while in restricted schemes it was lower at 31.1 years.

Table 41: Average age, pensioner ratio, and distribution

	Gender	Average age (years) and pensioner ratio (%)	2016	2017	2018	2019
Open schemes	Female	Average age	34.7	34.9	35.2	35.6
		Pensioner ratio	10.1	10.9	11.6	11.3
	Male	Average age	33.2	33.3	33.5	33.8
		Pensioner ratio	8.2	8.9	9.6	9.2
	Total	Average age	34.0	34.1	34.4	34.9
		Pensioner ratio	9.2	10.0	10.7	10.3
Restricted schemes	Female	Average age	31.9	31.8	32.1	32.2
		Pensioner ratio	7.1	7.4	7.9	7.4
	Male	Average age	29.1	28.9	29.3	29.3
		Pensioner ratio	5.2	5.4	5.8	5.3
	Total	Average age	30.6	30.5	30.8	31.1
		Pensioner ratio	6.3	6.5	6.9	6.5
All schemes	Female	Average age	33.4	33.5	33.8	34.1
		Pensioner ratio	8.8	9.3	9.9	9.5
	Male	Average age	31.5	31.4	31.7	31.9
		Pensioner ratio	7.0	7.4	7.9	7.6
	Total	Average age	32.5	32.6	32.8	33.0
		Pensioner ratio	7.9	8.4	9.0	8.6

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Figure 19 depicts the geographic distribution of beneficiaries per province in 2019, with the data primarily based on the principal member's address. Approximately 40% of medical scheme beneficiaries were in Gauteng, followed by Western Cape and KwaZulu-Natal with 15% and 14%, respectively. The lowest number of beneficiaries were in Northern Cape, which had 2% of the total.

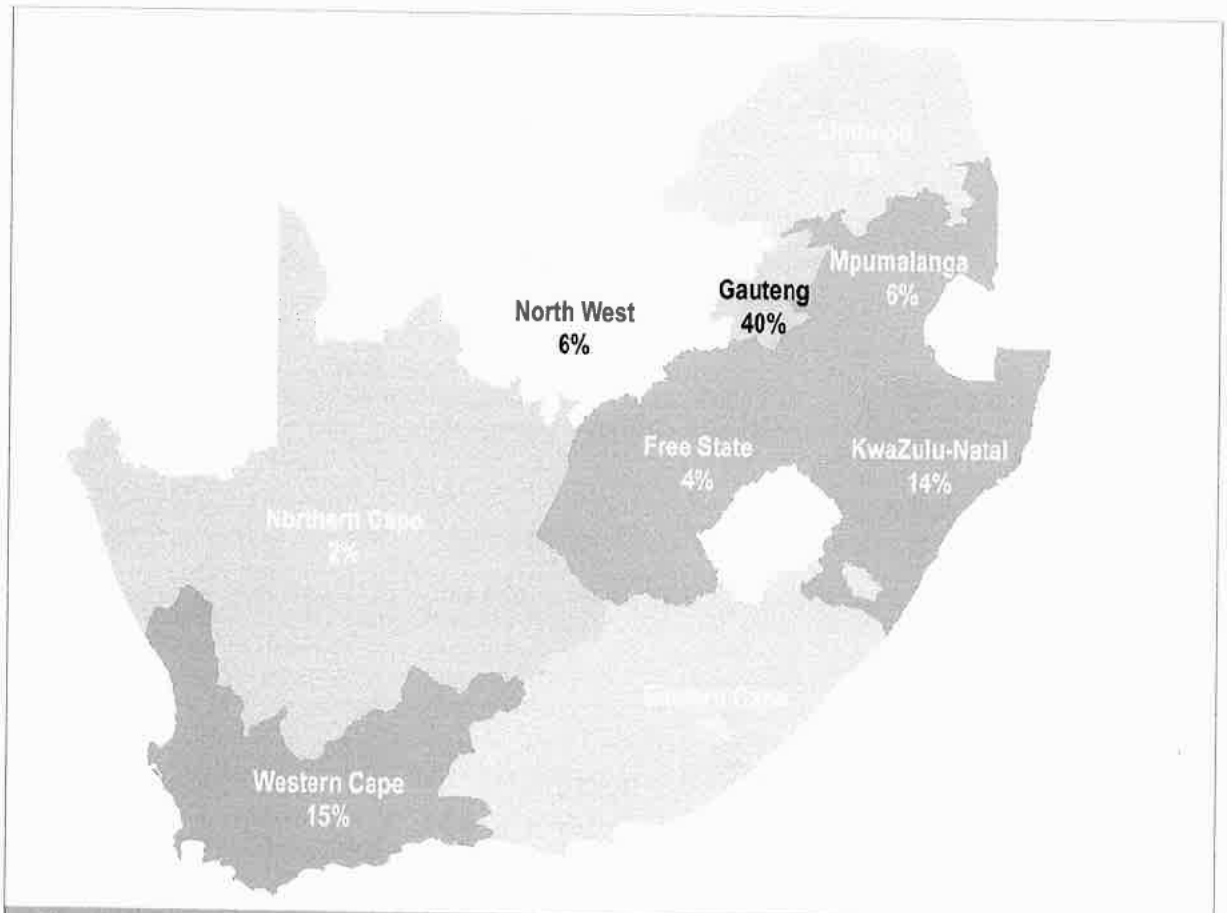

Figure 19: Distribution of beneficiaries by province

The Medical Schemes Industry in 2019

A total of 15.94% of beneficiaries in open schemes (2018: 7.36%) was covered by the three open schemes (2018: four) which failed to meet the prescribed solvency level in 2019. The remaining beneficiaries belonged to the other 15 open schemes (2018: 17) which had attained the prescribed solvency level of 25.00%.

In the period since 2000, a high proportion of beneficiaries in the open industry have been covered by schemes with reserves below 25.00%. This was mainly due to DHMS, the biggest scheme in South Africa, failing to attain the minimum prescribed solvency ratio. When DHMS reached the solvency ratio of 25.00% in 2008, 2009, 2014 to 2019 – the number of beneficiaries in schemes with reserves below the prescribed level fell significantly. In 2015 this figure was a mere 3.61% compared with 59.02 % in 2013. In 2016 and 2019, Bonitas Medical Fund fell below 25.00%, increasing the percentages again to 16.42% and 15.94% respectively.

Of the 58 restricted schemes at the end of 2019, only one had a solvency ratio below 25.00%. This scheme accounted for only 0.86% of all beneficiaries in restricted schemes.

Table 107 provides a summary of performance of schemes that were below the required statutory minimum solvency of 25.00% as at 31 December 2019.

Table 107: Summary of performance of schemes below 25% solvency – 2019

Ref. no.	Name of scheme	Average beneficiaries	Average age pb	Pensioner ratio	Net claims ratio		Net healthcare result		Solvency ratio	
		2019	2019 years	2019 %	2019 %	2018 %	2019 R'000	2018 R'000	2019 %	2018 %
1592	Thebemed	30 230	27.46	0.49	83.64	86.43	5 190	(6 091)	9.41	9.34
1582	Transmed Medical Fund	36 498	55.22	45.58	100.20	97.19	(67 663)	(49 430)	11.38	17.81
1141	Health Squared Medical Scheme	37 604	46.78	25.93	92.61	101.50	(58 442)	(82 517)	15.42	21.23
1512	Bonitas Medical Fund	718 919	33.77	9.00	92.26	91.12	(249 493)	(71 662)	24.85	25.16

pb = per beneficiary

The CMS closely monitors schemes below the 25.00% solvency ratio by having regular meetings with them to assess their performance against their business plans.

The CMS is cognisant of the structural challenges facing the medical schemes environment and the progress that schemes have made thus far in moving towards the prescribed solvency levels, but much remains to be done to ensure that all medical schemes comply with this requirement of the Medical Schemes Act.

Statement by UN Human Rights Experts Universal access to vaccines is essential for prevention and containment of COVID-19 around the world*

[EXCERPT]

Availability, access and affordability at national level

States have an obligation to ensure that any COVID-19 vaccines and treatments are safe, available, accessible and affordable to all who need them. This is particularly relevant to people in vulnerable situations who are often neglected from health services, goods and facilities, including those living in poverty, women, indigenous peoples, people with disabilities, older persons, minority communities, internally displaced people, persons in overcrowded settings and in residential institutions, people in detention, homeless persons, migrants and refugees, people who use drugs, LGBT and gender diverse persons. Many of them may have lived experience of poverty and find themselves in situations where they are most likely to be exposed to the risk of contagion, yet the least likely to be protected from COVID-19 or supported by adequate and timely tests and health services.[9] It is imperative that access to COVID-19 vaccines and treatment is provided to all without discrimination and prioritized for those who are most exposed and vulnerable to the risk of COVID-19.