ACCESS TO COVID-19 VACCINES IN LICS IN AFRICA: AN EXAMINATION OF THE HUMAN RIGHTS CONCERNS AND THE OBLIGATIONS OF INTERNATIONAL ASSISTANCE AND COOPERATION

Suliyat Omotolani Olapade[1]

1.0 Introduction

States have the obligation under international human rights law (IHRL) to guarantee the right to health of their people by '*the prevention, treatment and control of epidemic, endemic, occupational and other diseases'*[2] and access to medicine (including Covid-19 vaccines) has been argued to be an integral component of the right to health[3]. The fulfilment of this obligation was only imagined in the Covid-19 era, especially in African LICs, despite the advent of vaccines and the clarity of the provisions of the law.

The inequities in access to the vaccines were very apparent. Research showed that vaccine availability and distribution were linked to a country's income status, with HICs being prioritised over LICs.[4] While most HICs vaccinated their populations and even rolled out booster shots, the populace of LICs were not adequately vaccinated. This led to vaccine nationalism, under which rich countries prioritised their country's vaccination over global vaccination by amassing billions of Covid-19 vaccines for their populations, to the detriment of LICs' populace who have difficulty accessing vaccines.[5] LICs recorded high Covid-19 infection and death rates. In fact, the World Health Organisation (WHO) reported twice that

[1] Suliyat Omotolani Olapade is a legal practitioner in the Netherlands and can be reached on suliyatolapade0@gmail.com

[2] Article 12 (2) (c) International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICESCR).

[3] Perehudoff and Sellin, (n 1) 35.

[4] Olugbenga Olatunji, Failed or rigged? The international patent system and access to COVID-19 vaccines in high- and low-income countries, https://ilareporter.org.au/2021/12/failed-or-rigged-the-international-patent-system-and-access-to-covid-19-vaccines-in-high-and-low-income-countries-olugbenga-olatunji/ accessed 25 December 2021.

[5] Ellen 't Hoen, 'The Pandemic Treaty and Intellectual Property Sharing: Making Vaccine Knowledge a Public Good' (15 October 2021) https://blog.petrieflom.law.harvard.edu/2021/10/15/pandemic-treaty-intellectual-property/. accessed 25 December 2021.

African nations were behind with their Covid-19 vaccinations and missed two global targets for vaccination.[6]

In addition to unequal access to Covid-19 vaccines, LICs also battled with vaccine shortages and the dumping of nearly expired vaccines.[7] These actions and others are collectively classified as "Vaccine Apartheid".[8] This has been argued to undermine the right to health guaranteed under the ICESCR, whereas the ICESCR under its Article 2 requires 'international assistance and cooperation (IAC) to realise the rights protected thereunder.

The above-identified problem and the actions of the HICs during the pandemic give rise to the question of whether their actions conform to international human rights standards. Therefore, it is essential to examine the legal obligation and responsibility of HICs under IHRL to assist LICs during the global pandemic to ensure the right precedent for future equitable pandemic preparedness and other crises affecting the global south. This essay ultimately seeks to contribute to the ongoing debate on how to find a lasting solution to the access to medicine conundrum in Africa.

To achieve the above, the overarching question the essay seeks to consider is whether HICs' obligation to secure the right to health under the ICESCR, extends extraterritorially to African countries. To further establish the scope of the paper, the following specific research question is addressed: what avenues can be explored within international law to enhance access to medicines (Covid-19 vaccines) in African LICs?

2.0 Access to Covid-19 Vaccines in Africa and HICs

Covid-19 is a disease caused by a novel coronavirus called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), identified amid an outbreak of respiratory illness cases in

[6] Peter Mwai, Covid-19 vaccinations: African nations miss WHO target, (31st December 2021) https://www.bbc.com/news/56100076 accessed 2 January 2022.

[7] Brigit Toebes, Lisa Forman, and Giulio Bartolini, 'Toward Human Rights-Consistent Responses to Health Emergencies: What is the Overlap between Core Right to Health Obligations and Core International Health Regulation Capacities?'(2020) 22 Health and Human Rights Journal 99.

[8] Beauty Dhlamini, Vaccine Apartheid includes Dumping Expiring Vaccines in Africa https://science.thewire.in/external-affairs/world/vaccine-apartheid-dumping-expiring-vaccines-africa/ accessed 3 January 2022.

Wuhan City, Hubei Province, China.[9] Reported to the WHO on December 31, 2019, and declared a global pandemic on March 11, 2020, by the WHO.[10]

The devastating nature of the first variant of the SARS-CoV-2 declared and experienced in 2020 led to global solidarity that resulted in quick discovery, approval and production of overwhelmingly effective Covid-19 vaccines. By the end of 2020, the WHO and the United States Food and Drug administration (FDA) had approved the Pfizer BioNtechmRNA vaccine and AstraZeneca viral vectored vaccine for emergency use.[11] Research shows that typically, it takes 10-15 years to fully develop a vaccine, however, the development of vaccines for Covid-19 was fast. [12] Although the pharmaceutical companies' investment in the research and development (R&D) of Covid-19 vaccines was complemented by public funding, these companies charged heavily for the vaccines. This aggravated the vaccine gap between HICs and LICs since the governments of HICs could afford the high prices while governments of LICs could only secure a limited number of vaccines because of their limited resources.[13] These actions undermined global equitable access to the vaccines, especially in countries that were severely hit by the pandemic. Accelerating vaccine equity worldwide is therefore important. Essentially, the Covid-19 pandemic not only exposed the grave inequality between the HICs, (where about 70% of the population was fully vaccinated) and LICs (with only about 12% of the population vaccinated),[14] but exacerbated these inequalities.

Africa's low vaccination rate led to overwhelmed healthcare services and high death rates, with health workers and vulnerable populations being mostly affected. The problem of vaccine inequality experienced in Africa is not the first of its kind; the issue could be traced back to the

[9] Centre for Disease Control 2019 Novel Coronavirus, Wuhan, China. CDC., online: <https://www.cdc.gov/coronavirus/2019-ncov/about/index.html> accessed 25 December 2021.

[10] The New York Times. Coronavirus Live Updates: W.H.O. Declares Pandemic as Number of Infected Countries Grows. The New York Times, March 11, 2020. Online: <https://www.nytimes.com/2020/03/11/world/coronavirus-news.html#link-682e5b06> accessed 25 December 2021.

[11] Marguerite Massinga Loembe and John N. Nkengasong, 'COVID-19 vaccine access in Africa: Global distribution, vaccine platforms, and challenges ahead', (2021) Elsevier Inc. 1353.

[12] G Grey 'The Scientists' Collective 10-point proposal for equitable and timeous access to COVID-19 vaccine in South Africa' (2021) 111 South African Medical Journal, 89.

[13] Samantha Smit, 'Herd Immunity or Political Power?' (2021) 15 Pretoria Student L Rev 77, 78.

[14] see Global Dashboard for Vaccine Equity <https://data.undp.org/vaccine-equity/?> accessed 21 February 22. see also 't Hoen, (n 7).

access to medicines for HIV/AIDS in the early 2000s and vaccine hoarding for the HN1 pandemic in 2009.[15]

Other factors that affected vaccine access in LICs apart from patent protection and vaccine hoarding include but are not limited to [1] the scarcity of sustainable national investments in domestic R&D programs and industry. [2] Lack of capacity to manufacture vaccines and lack of proper access to medical technologies. This is mostly due to reasons of economic development and insufficient investment in healthcare systems.[16] In reality, despite the prevalence of infectious disease in Africa and its 1.3 billion population, Africa only produces 1% of the drugs it uses.[17] [3] Lack of adequate support and incentives available to assist local vaccine companies. [4] Over-reliance on international supplies of vaccines. [5] Poor and fragile health care system [6] Vaccine storage issues: most African countries lack the capacity to receive vaccines in large amounts, even when donated. A World Bank report revealed that most low- and middle-income countries (LMICs) were only adequately prepared to receive a small consignment of vaccines through the Covid Vaccination (COVAX) initiative.[18]

2.1 International Community's effort to bridge access to Covid-19 vaccines gap

Considering the communicable nature of the virus SAR-COV 2 and based on the realisation that no country is safe until every country is safe and the situation with vaccine access in Africa, public health experts and global leaders urged that vaccines should be fairly and equitably distributed and available across the world.[19] The international community realising its role in ending the pandemic by vaccination developed the COVAX Initiative.[20] The Initiative is meant to facilitate equitable access to Covid-19 vaccines worldwide, particularly in LMICs.[21] The

[15] John N Nkengasong, et al, 'COVID-19 vaccines: how to ensure Africa has access' (2020) Nature 586, 197–199. https://doi.org/10.1038/d41586-020-02774-8

[16] See generally Loembe and Nkengasong (n 13).

[17] Toyin Abiodun et al, 'Vaccine Manufacturing in Africa: What It Takes and Why It Matters' (1 April 2021) https://institute.global/advisory/vaccine-manufacturing-africa-what-it-takes-andwhy-it-matters accessed 10 January 2022.

[18] The World Bank, 'Assessing Country Readiness for COVID-19 Vaccines.' (2021). http://documents1.worldbank.org/curated/en/467291615997445437/pdf/Assessing- Country-Readiness-for COVID-19-Vaccines-First-Insights-from-the-Assessment-Rollout.pdf. accessed 10 January 2022.

[19] Abiodun et al (n 19) 1.

[20] Bogdandy and Villarreal (n 2).

[21] Loembe and Nkengasong (n 13) 2.

aim of the initiative led by Gavi,[22] the Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI), and the WHO[23] was to vaccinate 20% of the LMICs population in 2021. COVAX intends to guide and supplement national authorities in their roles and not replace them.[24] Although Africa received 58% of its 587 million vaccine doses through the COVAX Facility in early 2022,[25] research showed that COVAX did not achieved the aim of equal access to vaccines and preventing vaccine nationalism.[26] HICs have through this initiative donated near to expired vaccines to LICs. For instance, on December 22, 2021, Nigeria destroyed more than 1 million doses of AstraZeneca's Covid-19 vaccine donated to it because they could not be used before their expiration.[27] As Faisal Shuaib, head of Nigeria's National Primary Health Care Development Agency rightly said, HICs procured these vaccines and hoarded them, and afterwards offer them for donation when they were about to expire.[28]

Although HICs pledged and have been financially committed to COVAX, HICs gave priority to 'national access over global equity'.[29] HICs hoarded vaccines to vaccinate their population despite the world's plea that excess vaccines be shared.[30] This act was detrimental to access and availability of vaccines in Africa.

3.0 International Human Rights Law and Access to Covid-19 vaccines

In discussing access to medicines (vaccines), it is imperative to discuss the right to health as a starting point. This is because access to medicines is a human rights issue and a component of the right to health.[31] The Committee on Economic, Social and Cultural Rights (CESCR), under its directive to interpret the ICESCR's obligations expressly recognised access to medicines as

[22] Global Alliance for Vaccines and Immunization.
[23] It has 186 participating states.
[24] Bogdandy and Villarreal (n 2).
[25] WHO Africa, 'Africa needs to ramp up COVID-19 vaccination six-fold' https://www.afro.who.int/news/africa-needs-ramp-covid-19-vaccination-six-fold (3 February 2022) accessed 10 February 2022.
[26] Bogdandy and Villarreal (n 2) 28.
[27] Associated Press, 'Nigeria Destroys 1 Million Nearly Expired COVID Vaccine Doses', (22 December 2021) https://www.voanews.com/a/nigeria-destroys-1-million-nearly-expired-covid-vaccine-doses/6365879.html accessed 27 December 2022
[28] ibid.
[29] Loembe and Nkengasong (n 13) 2.
[30] 't Hoen (n 7).
[31] Perehudoff and Sellin (n 1) 41.

a means of fulfilling the right to health in its General Comment (GC) 14.[32] Likewise, the UN Human Rights Council (UN HRC) in its resolution[33] affirms and recognises access to vaccines as an element of the right to health and calls for "equitable, affordable, timely and universal access by all countries of vaccines". Also, in recognition of the global inequitable vaccine distribution, the said UNHRC resolution calls on states, individually and collectively to "remove unjustified obstacles restricting exports of vaccines" to "facilitate the trade, acquisition, access and distribution of Covid-19 vaccines" globally. The Covid-19 pandemic was a disruption to the right to health, access to healthcare services was affected and millions of deaths was recorded. The pandemic threatened the world's health and stalled the functioning of societies.

3.1 International Human Rights Instruments on Right to Health

The WHO Constitution, 1946[34] through its preamble was the first international instrument to recognize health as a human right.[35] The ICESCR recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[36] The Universal Declaration of Human Rights (UDHR);[37] the Convention on the Elimination of All Forms of Discrimination Against Women;[38] the Convention on the Rights of the Child (CRC);[39] the African Charter on Human and People's Rights;[40] the Convention on the Elimination of All Forms of Racial Discrimination[41] and the Convention on the Rights of Persons with

[32] UN Committee on Economic, Social and Cultural Rights, 'General Comment No 14: The Right to the Highest Attainable Standard of Health, UN Doc E/C/12/2000/4 (11 August 2000) para 43 (d) hereinafter CESCR, 'General Comment No. 14'.

[33] UNHRC, *Resolution on promoting mutually beneficial cooperation in the field of human rights,* A/HRC/46/L.22 (22 February – 23 March 2021); UN Human Rights Council, *Resolution on Action on Resolution on Ensuring Equitable, Affordable, Timely and Universal Access for All Countries to Vaccines in Response to the Coronavirus Disease (COVID-19) Pandemic*, A/HRC/46/L.25/Rev.1 (22 February – 23 March 2021).

[34] Constitution of the World Health Organization, (signed 22 July 1946, entered into force 7 April 1948) A/RES/131.

[35] Toebes, Forman, and Bartolini (n 9) 99.

[36] Art 12(2) (c).

[37] Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III) (UDHR) Art 25 Universal Declaration of Human Rights, GA Res 217A (III), UN Doc A/810 (10 December 1948), Article 25.

[38] Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13 (CEDAW) Arts 11(1)(f), 12 and 14(2)(b).

[39] Convention on the Rights of the Child, (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC) Art 24.

[40] African Charter on Human and Peoples' Rights, ("Banjul Charter") (adopted 27 June 1981, entered into force 21 October 1986) CAB/LEG/67/3 rev 5, 21 ILM 58 (ACHPR). Article 16.

[41] International Convention on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965, entered into force 4 January 1969) 660 UNTS 195 (CERD) Art 5 (e) (iv)

Disabilities[42] recognized the right to health.[43] It nonetheless encompasses several other socio-economic factors that enhance the attainment of the highest standard of health possible.[44] Indeed, the CESCR referred to it as an all-inclusive right.[45]

As this essay focuses on ICESCR, Article 12(2) provides an unexhaustive list of actions to be taken by states to realise the right to health comprising '*the prevention, treatment and control of epidemic, endemic, occupational and other diseases'.*[46] Accordingly, the CESCR resolved that immunisation is an element of the states' obligations to protect individuals against epidemic diseases.[47] Thus, states which are parties to the ICESCR have legally binding obligations to provide (essential) medicines under the right to health.[48]

An authoritative interpretation was given to the right to health and the obligations arising therefrom by the CESCR in its GC 14. GC 14 elucidated the tripartite obligation of states, to protect (prevent others from interfering with the enjoyment of the right), fulfil (adopt appropriate measures[49] towards the full realization of the right) and respect (refrain from interfering with the enjoyment of) the right to health of its population. Although GCs lack any binding force, they are authoritative and crucial tools in the interpretation of the Covenant's obligations.[50] The GC 14 introduced also the 'AAAQ' standard for the fulfilment of the right to health. By the 'AAAQ' standard, states are obligated to ensure access to available, accessible (physically, economically and without discrimination), acceptable and good quality healthcare, health facilities, good and services. Such healthcare goods which include essential medicines must be available in sufficient quantity in the state party for the prevention and treatment of diseases.[51] The CESCR considers securing the necessary pharmaceutical products, including

[42] Convention on the Right of Persons with Disabilities, (adopted 24 January 2007, entered into force 3 May 2008) A/RES/61/106 (CRPD), Art 25.
[43] CESCR, 'General Comment No. 14' (n 34) para 8.
[44] It embodies other human rights such as the right to education, life, work, food, an adequate standard of living, water, human dignity etc.
[45] CESCR, 'General Comment No. 14' (n 34) para11.
[46] Perehudoff and Sellin (n 1) 42.
[47] CESCR, 'General Comment No. 14' (n 34) para 44.
[48] Katrina Perehudoff and Ellen 't Hoen, 'Human rights & intellectual property for universal access to new essential medicines' In Zaheer-Ud-Din Babar, (eds), Equitable Access to High-Cost Pharmaceuticals (Elsevier 2018) 68 and 69.
[49] Including but not limited to legislative measures, judicial measures and other relevant measures the States consider appropriate in any circumstance. For instance, information campaigns and educational programmes.
[50] Toebes, Forman and Bartolini (n 9) 101.
[51] CESCR, 'General Comment No. 14' (n 34) para 12(a).

vaccines, to be part of the element of 'availability'.[52] To put this in context, states are required by Article 12(2)(c) to make available Covid-19 vaccines (medicines) in sufficient quantity to realise the right to health of their population.

3.2 States Obligations and Vaccine Inequality and Nationalism

Vaccine inequality, vaccine nationalism and the gap in access to Covid-19 vaccines posed serious problems to the full realisation of the right to health in LICs during the pandemic. 'Vaccine nationalism' is a phrase devised by public health experts[53] to describe the action of the HICs entering into the different pre-purchase agreements (also known as Advance Purchase Agreements, APAs)[54] with Covid-19 manufacturers to secure doses of vaccines above what their population need at the expense of the availability of those vaccines in LICs. This action, which has been argued to include the dumping of expired Covid-19 vaccines[55] in LICs, has also been referred to as 'vaccine apartheid' in different literatures.[56] These APAs left LICs' populace behind in the supply chain of Covid-19 vaccines[57] and have forced LICs to pay more for the vaccines than the HICs. For instance, in 2021, Botswana ordered 500,000 Moderna Covid-19 vaccines at 29 dollars per dose, a price costlier than the sale price for HICs.[58] Yet, Moderna did not deliver to Botswana, because some HICs allegedly jumped ahead of the queue. This was reported to increase the spread of the Omicron Variant in Botswana.[59]

Unequitable access to Covid-19 vaccines and nationalism has been condemned by the CESCR as global discrimination in the right to access to vaccination and an undermining factor of the

[52] Bogdandy and Villarreal (n 2) 110. See also Eibe Riedel, 'The Right to Health under the ICESCR. Existing Scope, New Challenges and How to Deal with It'' in: Andreas von Arnauld, Kerstin von der Decken and Mart Susi (eds), *The Cambridge Handbook of New Human Rights. Recognition, Novelty, Rhetoric* (Cambridge: Cambridge University Press 2020), 107-123 (113).
[53] Lukasz Gruszczynski and Chien-huei Wu, 'Between the High Ideals and Reality: Managing COVID-19 Vaccine Nationalism' (2021), 12 European Journal of Risk Regulation 711, 712.
[54] Bogdandy and Villarreal (n 2) 96.
[55] Dhlamini (n 3).
[56]'t Hoen, (n 7).
[57] Bogdandy and Villarreal (n 2) 100.
[58] Rebecca Robbins**, '**Moderna, Racing for Profits, Keeps Covid Vaccine Out of Reach of Poor', (9 October 2021) https://www.nytimes.com/2021/10/09/business/moderna-covid-vaccine.html accessed 27 December 2021,
[59] Mariam Ileyemi and Medinat Kanabe, 'COVID-19 Omicron: Africa fumes as EU, U.S., others impose travel bans 'targeted' at continent' (29 November 2021) https://www.premiumtimesng.com/news/headlines/497954-covid-19-omicron-africa-fumes-as-eu-u-s-others-impose-travel-bans-targeted-at-continent.html accessed 10 January 2022.

UN Sustainable Development Goals (SDG) 3, 10 and 17 on ensuring healthy lives and well-being at all ages, reducing inequalities within and among countries and on strengthening the means of global partnership for sustainable development respectively.[60]

Vaccine nationalism is *self-defeating* as it hampers the cooperation needed to end the pandemic.[61] Given how interconnected the world is, its proliferation can result in the emergence of new variants of the virus which the present vaccine might be less effective for and its effect will be felt by all countries.[62] Thus, drawing from the lessons of the devastating effects of the delay in distribution of Anti-retroviral medications for HIV/AIDS in the 1990s and early 2000s in Africa, HICs and the world should be wary of the consequences of placing a whole continent at the end of the supply chain.[63]

Global solidarity, international cooperation and assistance of HICs have been identified as essential ways to end the pandemic.[64] What remains unsettled is the legal nature of the HICs' duty arising therefrom. Thus, the next section would give a thorough analysis of this duty.

3.3 HICs Extraterritorial Obligation under Article 2 ICESCR; the Duty of IAC and the No Harm Principle.

3.3.1 The Duty of IAC

States' obligations under the right to health have mostly been interpreted as primarily owed to their population.[65] However, Scholars have argued Article 2(1) ICESCR establishes 'health-related extraterritorial obligations (ETOs) that exist alongside (and separate to) a state's

[60] UN Committee on Economic, Social and Cultural Rights (CESCR), Statement on universal affordable vaccination against coronavirus disease (COVID-19), international cooperation and intellectual property, 23 April 2021, E/C.12/2021/1, para 1 [hereinafter CESCR, 'Statement on Covid-19, international cooperation and intellectual property,' 23 April 2021].
[61] Bogdandy and Villarreal (n 2) 99.
[62] CESCR, 'Statement on Covid-19, international cooperation and intellectual property,' 23 April 2021, (n 62) para 1.
[63] Bogdandy and Villarreal (n 2) 101.
[64] Sekalala et al (n 1) 4. See also United Nations. Shared responsibility, global solidarity: responding to the socio-economic impacts of COVID-19, 2020. Available: https://www. un. org/ sites/ un2. un. org/ files/ sg_ report_ socioeconomic_impact_ of_ covid19. pdf accessed 9 December 2021.
[65] Bogdandy and Villarreal (n 2) 110, see also Martin Buijsen, 'The Meaning of "Justice" and "Solidarity" in Health Care' in: Andre den Exter (ed.), International Health Law. Solidarity and Justice in Health Care (Apeldoorn: Maklu, 2008), 55.

domestic human rights obligations'.[66] Nevertheless, the extent of the application of this obligation remains unclear and authors have disagreed on its nature and scope.[67] The WHO Director-General, Dr Tedros Adhanom Ghebreyus[68] and the UN Secretary-General, António Guterres framed the issues in terms of morals and fairness rather than a legal obligation.[69] It is imperative to examine the legal nature and scope of this obligation under the relevant international human rights instruments.

The obligation of IAC is enshrined in other international legal orders like the UN Charter[70] and the WHO's International Health Regulations,[71] the focus here is the ICESCR. Also, although outside the scope of this research, there are indications that this obligation may exist under customary international law. In essence, while Article 38(1) of the Statute of the International Court of Justice provides authoritative sources of international law to be: international conventions, international custom and general principles of law (amongst other sources), the analysis below are on the ICESCR, an international convention. Furthermore, the different views on the correct interpretation of the obligation of IAC contained in Article 2(1) ICESCR raises the question of what rules should be applied to interpret this provision. The starting point for the answer is that the ICESCR is a treaty and there is the CESCR saddled with its interpretation; consequently, it is to be interpreted using the rules of treaty interpretation and the CESCR's authoritative interpretations. These rules of treaty interpretation have been codified in the Vienna Convention on the Law of Treaties (VCLT), Article 31 sets out the general rule of treaty interpretation.[72] Thus, the arguments below are drawn from the CESCR's

[66] See ibid and see also Alicia Ely Yamin, 'Our Place in the World: Conceptualising Obligations Beyond Borders in Human Rights-Based Approaches to Health', 12(1) *Health and Human Rights Journal* (2010) pp. 3-14; Judith Bueno de Mesquita, Paul Hunt and Rajat Khosla, 'The Human Rights Responsibility of International Assistance and Cooperation in Health', in Mark Gibney and Sigrun Skogly (eds.), *Universal Human Rights and Extraterritorial Obligations*, University of Pennsylvania Press 2010, pp.104-129

[67] Perehudoff and Sellin (n 1) 52; John Tobin, 'The Right to Health in International Law', Oxford University Press 2011, at p. 326, 340.

[68] WHO Director-General's opening remarks at the 148th session of the Executive Board available at https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-148th session-of-the-executive-board> accessed 20 December 2021.

[69] UN Secretary-General Statements and Messages, https://www.un.org/press/en/2022/sgsm21137.doc.htm accessed 13 February 2022.

[70] Articles 55 and 56;

[71] Article 44. See also the UDHR Article 22.

[72] These rules are generally considered the customary rules of interpretation of international law international, including by the International Court of Justice (ICJ). See, e.g., Jadhav (India v. Pak.), Judgment, 2019 I.C.J. Rep.

interpretations, a general principle of international law – the 'No Harm Principle' (relying on Art 31 (c) VCLT), and authors' opinions.

For ease of reference, Article 2(1) ICESCR provides:

> "Each State Party to the present Covenant undertakes to take steps, individually *and* ***through international assistance and co-operation, especially economic and technical,***[73] to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means…"

The CESCR has interpreted the obligation of IAC to emphasise the necessity for states to assist developing countries in realising the right to health.[74] According to Tobin, it embodies the tripartite legal obligation to: refrain from measures that undermine the right of access to medicines for individuals in other jurisdictions; take reasonable measures to protect against measures by non-state actors that undermine the right; and take measures, subject to available resources, individually and collectively to assist in fulfilling the right of access to medicines for individuals in other jurisdictions, especially developing states.[75] Accordingly, the CESCR has interpreted the international obligations of states to include facilitating access to medicines in other countries, (depending on the available resources) and respecting the enjoyment of the right to health in other countries'.[76] This can be interpreted to mean that States should not take action which impedes the enjoyment of that right in other countries (e.g. through embargoes on the importation of medicines).[77] In essence, the CESCR has stressed in its several GCs, the obligation of LICs to seek assistance and equally, the obligation of HICs to assist and cooperate with LICs in the full realisation of the rights under ICESCR, particularly the right to health.[78]

418, ¶ 71 (July 17); Avena and Other Mexican Nationals (Mex. v. U.S.), Judgment, 2004 I.C.J. Rep. 12, ¶ 83 (Mar. 31). See also Perehudoff and Sellin (n 1) 64.

[73] Emphasis added.

[74] Bogdandy and Villarreal (n 2) 144. See also CESCR, 'General Comment No. 14' (n 34), para. 38.

[75] Tobin (n 69) 351-352.

[76] CESCR, 'General Comment No. 14' (n 34), para. 39.

[77] CESCR, 'General Comment No. 14' (n 34), para. 41.

[78] CESCR, General Comment No. 3. 'The Nature of States Parties Obligations', (1990) UN Doc.E/1991/23, para. 13-14; CESCR, 'General Comment No. 14' (n 34), para. 38; General Comment No. 17. 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 (2006) UN Doc. E/C.12/GC/17, para. 36; CESCR, 'General Comment

Moreover, the CESCR has reiterated this legal obligation in several guidance and statements concerning universal access to Covid-19 vaccines.[79] Worth noting that while these CESCR statements and GCs are authoritative interpretations of the ICESCR, they are non-binding.[80]

To understand the scope of ETOs of HICs, a relevant instrument is the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights 2011[81] (the Maastricht Principles on ETOs).[82] This document, though not binding, has been argued to be very useful for interpretations of the obligation because the principles build on the CESCR's interpretation and are usually used and referred to by international human rights bodies like the UN HRC.[83]

According to the Maastricht Principles, the HICs ETOs under ICESCR cover:

1. 'Obligations of a global character […] to take action, separately, and jointly through international cooperation, to realise human rights universally'.[84] Thus, by this ETO, states that can do so must provide international assistance to LICs in the fulfilment of their ESCRs.[85] This assistance, which is not limited to economic and technical assistance,[86] would include facilitating access to vaccines[87] especially during a pandemic by sharing technology, and expertise amongst other things. The CESCR also buttressed this by stating that states have the

No. 22' (May 2016) UN Doc. E/C.12/GC/22, para. 50; CESCR, General Comment No. 25. Science and Economic, Social and Cultural Rights (2020) UN Doc. E/C.12/GC/25, at para. 77.

[79] CESCR, 'Statement on Covid-19, international cooperation and intellectual property,' 23 April 2021, (n 62) para 2; Statements of the Committee on Economic, Social and Cultural Rights of 6 April 2020 on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights (E/C.12/2020/1) and of 27 November 2020 on universal and equitable access to vaccines for the coronavirus disease (COVID-19) (E/C.12/2020/2). Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, (n 25) paras 19-20.

[80] Toebes, Forman and Bartolini (n 9) 101.

[81] Perehudoff and Sellin (n 1) 52. See also David Patterson, 'On the brink of a catastrophic moral failure' – not the time to abandon international law' (Human Rights Here, 15 April 2021) https://www.humanrightshere.com/author/David-Patterson accessed 20 February 2022; Bogdandy and Villarreal (n 46) 114.

[82] Developed by Maastricht University and the International Commission of Jurists on 28 September 2011, available at https://www.etoconsortium.org/en/main-navigation/our-work/what-are-etos/ accessed 21 February 2022.

[83] Perehudoff and Sellin (n 1) 52.

[84] Principle 8(b).

[85] Principle 33.

[86] Olivier De Schutter et al, 'Commentary to the Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights', (Human Rights Quarterly 2012) 51.

[87] Patterson (n 83).

duty to ensure universal and equitable access to Covid-19 vaccines by voting to support the work of different international institutions and organisations to which they belong and refraining 'from taking measures that obstruct this goal'.[88]

2. 'Obligations relating to the acts and omissions of a state […] that have effects on the enjoyment of human rights outside that state's territory'.[89] States should not hinder the exercise of the right to health in other territories.[90] Thus, actions of the HICs affecting the realisation of the right to health of the population of LICs during the pandemic is a breach of ETOs. To exemplify this: at the beginning of the pandemic, HICs enacted many isolationist laws that ignored the plights of the LICs. For instance, 'the UK enacted laws to prevent exporting essential medicines, the European Union curbed exports of hospital supplies and the USA restricted PPE exports for healthcare staff'.[91] Another example is vaccine nationalism discussed earlier. The CESCR authoritatively stated that 'Vaccine nationalism infringes extraterritorial obligations of States to avoid taking decisions that limit the opportunity of other States to make vaccines available and thus to implement their human rights obligations related to the right to health, as it results in the shortage of vaccines for those who are most in need in the least developed countries'.[92]

Meanwhile, authors have rightly noted that this obligation is closely linked to the states' obligations under the right to enjoy the benefits of scientific progress and its applications (right to benefit from scientific progress) contained in Art 15 (1)(b) ICESCR.[93] Unarguably, the process and end product of the Covid-19 vaccines can safely be said to be one of the benefits of scientific progress.[94] The CESCR noted that access to Covid-19 vaccines is an essential

[88] CESCR, 'Statement on Covid-19, international cooperation and intellectual property', 23 April 2021, (n 62) para 3.
[89] Principle 8(a) Maastricht Principles on ETOs.
[90] Bogdandy and Villarreal (n 1) 99. See also Tobin (n 69) 331-332.
[91] Sekala et al (n 1) 4; Perehudoff and Sellin (n 1) 52; Bogdandy and Villarreal (n 2) 96.
[92] CESCR, 'Statement on Covid-19, international cooperation and intellectual property,' 23 April 2021, (n 62) para 4.
[93] International Commission of Jurists (ICJ), 'Human Rights Obligations of States to not impede the Proposed COVID-19 TRIPS Waiver - Expert Legal Opinion' (2021) available https://www.icj.org/wp-content/uploads/2021/11/Human-Rights-Obligations-States-Proposed-COVID-19-TRIPS-Waiver.pdf accessed 1 March 2022, 5. See also Perehudoff and Sellin (n 1) 42.
[94] ibid

component of the right to benefit from scientific progress.[95] Accordingly, this right is important to the realisation of other human rights particularly the right to health[96]and access to Covid-19 vaccines. This right has been argued to acknowledge science as a global good and the international disparities in science and technology that exist among states.[97] Wealthy states have more resources to develop and utilise science and technology for innovations than LICs. Owing to this disparity, the right, therefore, encompasses the obligation of HICs to contribute to the development of science and technology and the sharing of the benefits and applications of scientific progress with LICs.[98] However, this right has been argued to be under threat by the commercialisation and privatisation of science, especially in the biomedical and pharmaceutical fields.[99] Hence, with the privatisation and dominance of private companies in the pharmaceutical sector, states' compliance with this obligation has been complicated and severely affected.[100]

Further refining the discussion on the nature of HICs ETOs, some authors have argued that the HICs' duty to assist LICs is an 'obligation' and that HICs have through the ICESCR bound themselves to assist LICs in the progressive realisation of the ICESCR rights including the right to health.[101] According to Sekalala et al, this principle has been acknowledged by states since the adoption of the UDHR.[102] Despite the evidence from the Maastricht Principles on ETOs, the GC 14 and other statements from CESCR,[103] some commentators have argued that states' ETOs does not involve the duty to realise the ESC rights of persons everywhere.[104] Tobin, while admitting the legally binding nature of this obligation, argued that this obligation neither compels the HICs to provide any specific form of assistance to LICs, 'nor does it

[95] UN Committee on Economic, Social and Cultural Rights (CESCR), Statement on universal affordable vaccination against coronavirus disease (COVID-19), international cooperation and intellectual property, 23 April 2021, E/C.12/2021/1, para 1 [hereinafter CESCR, 'Statement on Covid-19, international cooperation and intellectual property,' 23 April 2021]. See also CESCR, 'General Comment No. 25' (n 80), para. 7.
[96] Perehudoff and Sellin (n 1) 48.
[97] Perehudoff and Sellin (n 1) 52.
[98] CESCR, 'General Comment No. 25' (n 80), paras. 79-80.
[99] Perehudoff and Sellin (n 1) 52
[100] ibid.
[101] Sekala et al (n 1) 4. See also CESCR, 'Statement on Covid-19, international cooperation and intellectual property,' 23 April 2021, (n 62) where the Committee noted that states 'have a duty of international cooperation and assistance to ensure access to vaccines against COVID-19 wherever needed...'.
[102] Sekala et al (n 1) 4.
[103] ibid.
[104] Bogdandy and Villarreal (n 2) 114.

provide a mandate to the treaty bodies to demand of any state the adoption of specific measures to secure the health of individuals in other states'.[105] He argued further that the obligation only requires states to consider their capacity to offer assistance subject to their available resources.[106] Concluding that Article 2(1) ICESCR represents 'a weak and imprecise' basis for IAC because states can justify their failure to assist as being reasonable on the ground of their available resources. As such, this will make it difficult to find any state guilty of violating such an obligation.[107] To buttress this, other authors argued that while Articles 2(1) and 12 ICESCR impose broader obligations that are vaguely worded and subject to competing interpretations, international human rights treaties 'provide a weak basis for construing any enforceable right to equitable access by all peoples of all States to vaccines'.[108]Conversely, other authors have argued that 'the human rights responsibility of international assistance and cooperation is a legally binding obligation on states parties to the ICESCR, as well as other relevant human rights treaties'.[109] Another commentator noted that 'this duty of assistance is the extraterritorial form of the requirement on states to *fulfil* the right to health domestically. It lies on states even where others, who are similarly capable, fail to help'.[110]

Now, it is imperative to state that contrary to Tobin's argument, Article 2(1) remains a binding obligation contained in a binding legal order for ICESCR's 171 member states. As such, LICs can request assistance and HICs are obligated to provide some except of course, where non-assistance can be justified on limited available resources. Thus, whether weak or not, there exists a compulsory legal basis to request and provide IAC. A contrary argument would mean all IAC primarily rests upon charity. Thus, states may enjoy significant discretion concerning the measures they adopt to satisfy their international obligation to secure the right to health but are obligated to justify whatever measures they adopt as being reasonable in the circumstances. Indeed, from the *travaux préparatoires* of the ICESCR, states have recognised that LICs require international assistance for the realisation of the rights under the Covenant[111] especially

[105] Tobin (n 69) 369.
[106] Tobin (n 69) 341, 342, 343.
[107] ibid.
[108] Gruszczynski and Wu (n 55) 715.
[109] Bueno de Mesquita, Hunt and Khosla (n 68) 128.
[110] See M E Salomon 'Is there a Legal Duty to Address World Poverty' (2012 European University Institute, Robert Schumann Centre for Advanced Studies) 3.
[111] See generally Philip Alston and Gerard Quinn, 'The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights' (1987 Hum Rts Q) 156. See also Ben Saul, 'The

the right to health.[112] Moreover, the recognition and acceptance of this obligation were part of the reasons for the creation of initiatives like COVAX and the Access to COVID-19 Tools (ACT) Accelerator.[113]

3.3.2 The No Harm Principle

The ETOs of HICs can further be classified under the 'No Harm Principle' of international law, which means that states have the general international obligation not to engage in activities that could cause harm in another territory.[114] This principle has been argued to create not only the above negative obligation but also a positive obligation for states to take actual steps to prevent causing harm to another state.[115] To Bogdandy and Villarie, this principle is a 'transnational element of the right to health' as there are rich literatures acknowledging that an obligation of states not to harm the health of individuals in other countries exists under Article 12 ICESCR.[116] A report of the UN Special Rapporteur on the right to health confirms this duty and adds that it extends to preventing private actors under their jurisdiction from doing so.[117] Some commentators added that this duty is 'an extraterritorial form of the requirement on states to *respect* and *protect* the right to health'.[118]

Thus, Covid-19 vaccines nationalism and vaccines hoarding being practised by HICs at the expense of the availability of these vaccines in LICs are a breach of the negative obligation under Article 12 ICESCR and the no-harm principle.[119] Especially as the WHO had directed

International Covenant on Economic, Social and Cultural Rights, Travaux Préparatoires 1948-1966, (Vol 1, OUP 2016).

[112] Article 24(4) CRC (n 10).

[113] Gruszczynski and Wu (n 55) 716. See also Sekalala et al (n 1) 4-5, where the authors noted that the recognition of this obligation has prompted some HICs to directly support LICs and some nations have also rendered their support through UN programs.

[114] Bogdandy and Villarreal (n 2) 111.

[115] Jutta Brunnee, 'Procedure and Substance in International Environmental Law?' (2020 RdC), 87, 158.

[116] Bogdandy and Villarreal (n 2) 111.

[117] UN General Assembly, Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Note by the Secretary-General, Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 13th August 2012, A/67/302. See also CESCR, 'General Comment No. 14' (n 34), para. 39.

[118] John Harrington and Sharifah Sekalala, 'COV0102 - The Government's response to Covid-19: human rights implication' (Written evidence in UK Parliament Human Rights (Joint Committee), 11 May 2020) https://committees.parliament.uk/publications/writtenevidence/?SearchTerm=john+harrington&DateFrom=&DateTo=&SessionId= accessed 10 March 2022.

[119] ibid. See also Bogdandy and Villarreal (n 2) 111.

prioritising vaccination of the most vulnerable 20% of every state's population.[120] However, identifying the exact extent of vaccine hoarding is difficult as the instrument of 'vaccine nationalism' APAs are usually confidential contractual documents protected under trade secret rules. Some commentators have noted that this information is usually revealed through *secondary* or *indirect* sources.[121] Nevertheless, it has been suggested that these figures should be officially released to identify states that violate Article 12.3(c) ICESCR by engaging in vaccine nationalism.[122]

From the foregoing, it is concluded that, apart from the CESCR's authoritative interpretations, Article 31 (a & c) VCLT are adopted to interpret Article 2(1) ICESCR in good faith to mean binding ETOs of HICs to assist LICs in facilitating access to Covid-19 vaccines. The pandemic has revealed that LICs will not be able to fully realise the right to health except with IAC.

4.0 Practical ways to ensure equitable access to medicines (Covid-19 vaccines) in LICs and right precedent for future equitable pandemic preparedness

4.1 Waiver of IPR

The waiver of Intellectual Property Rights (IPRs) on Covid-19 vaccines, therapeutics and diagnostics, if allowed by the WTO is another useful tool that may be explored by LICs to facilitate access to the vaccines. A waiver would suspend all IP obligations (like patents, copyrights, trademarks and trade secrets) on all products and technologies needed at the time of emergency. The system will enable countries to locally manufacture Covid-19 vaccines and all treatment tools to expedite global vaccination efforts and facilitate global recovery from the virus. This system finds a legal basis in Article IX (3) of the 1994 Marrakesh Agreement which allows the Ministerial Conference to waive an obligation imposed on a member in exceptional circumstances.

In October 2020, India and South Africa submitted a request to the WTO for approval of a temporary waiver of IPRs for Covid-19 vaccines and treatments to scale up global

[120] Bogdandy and Villarreal (n 2) 107 and 108.
[121] ibid.
[122] ibid.

production.[123] The waiver aimed to enable countries to locally manufacture Covid-19 diagnostics, treatments, and vaccines. Following the concerns raised at the Council for Trade-Related Aspects of Intellectual Property Rights (TRIPS) on the initial waiver proposal as being too broad, a revised proposal was submitted by the co-sponsors of the waiver. The revised proposal, although supported by more than 100 nations and over 240 civil society organisations, was strongly opposed by some HICs (including the UK, EU, Australia and Canada, among others) on the ground that TRIPS contain enough flexibilities including voluntary licensing which should be explored.[124] However, following the US Biden administration's support for the waiver proposal,[125] the European Commission supported the waiver, and the European Parliament also issued a statement formally backing the waiver on June 10, 2021.[126] Thus, a compromise agreement was reached between the EU, South Africa, India and the US in March 2022, proposing a waiver on vaccines only for a period of three to five years. This agreement was largely criticised for not including Covid-19 tests and treatments.[127] Similar to this Agreement, the larger WTO members adopted its final decision through its Ministerial Decision of 17 June, 2022 that the waiver proposal should cover the temporary suspension of patents on Covid-19 vaccines alone for LMICs while its decision on Covid-19 diagnostics and therapeutics was initially postponed by six months.[128] This decision has been criticized for being narrower than what the proposal envisaged; it only allowed a five-year waiver of patents and not other IPRs like trade secrets, copyrights, and industrial designs.[129] The decision was also said to be a response with fewer benefits, especially in the

[123] WTO, 'Members discuss intellectual property response to the COVID-19 pandemic', (20 October 2020) available at https://www.wto.org/english/news_e/news20_e/trip_20oct20_e.htm accessed 10 April 2022.
[124] Harris (n 257). See also Philip Loft, 'Waiving intellectual property rights for Covid-19 vaccines', (House of Common Library, 8 April 2022) https://researchbriefings.files.parliament.uk/documents/CBP-9417/CBP-9417.pdf page 2 accessed 15 April 2022; Behrang Kianzad & Jakob Wested, 'No-One Is Safe until Everyone Is Safe' – Patent Waiver, Compulsory Licensing and COVID-19' (2021) 5 EPLR 71, 82.
[125] See, White House Fact Sheet https://www.whitehouse.gov/briefing-room/statements-releases/2021/05/17/fact-sheet-biden-harris-administration-is-providing-at-least-80-million-covid-19-vaccines-for-global-use commits-to-eading-a-multiatera-effort-toward-ending-the-pandemic/ accessed 2 April 2022.
[126] Kianzad and Wested (n 126) 86.
[127] ibid.
[128] WTO, 'Draft Ministerial Decision on the TRIPS Agreement Waiver', (17 June 2022) WT/MIN(22)/W/15/Rev.2 https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/WT/MIN22/W15R2.pdf&Open=True
[129] Andrew Green, 'WTO finally agrees on a TRIPS deal. But not everyone is happy', (Devex, 17 June 2022) https://www.devex.com/news/wto-finally-agrees-on-a-trips-deal-but-not-everyone-is-happy-103476 accessed 18 June 2022.

middle of a global health emergency.[130] A commentator observed that the decision offers 'little that is different from exemptions already available to WTO members under existing rules, aside from a few distinctions, including simplifying some of the notification requirements'.[131] To date, the WTO has not made a decision on the extension of the waiver to COVID-19 diagnostics and therapeutics as envisaged by its sponsors. The deadline for this decision has been extended several times despite numerous calls for a more comprehensive waiver.[132]

4.2 States' obligation to reject TRIPS-plus demands in international agreements

HICs like the US and the EU discourage LICs from using TRIPS flexibilities available under the TRIPS Agreement to facilitate access to medicines. They do this by linking IP and trade rules (IP trade linkage)[133] by entering bilateral, regional and plurilateral agreements mostly referred to as Preferential Trade Agreements (PTAs)[134] or Free Trade Agreements (FTAs) with LICs to increase the protection of IPR above the standard contained in the TRIPS Agreement. The TRIPS Agreement permits (but does not obligate) members to adopt a broader IPR protection than the minimum obligated protection.[135] This has affected LICs ability to balance their obligations under IHRL and IP law. Considering the effect of these FTAs/PTAs on access to medicines in LICs, the CESCR has stipulated states' duty to ensure that any international agreement they execute does not negatively affect the right to health. For example, the CESCR has found France in violation of this obligation.[136] It has thus been suggested that to comply with this duty, states must carefully review the FTAs/PTAs and refrain from the ones that conflict with their right to health obligations. They must also ensure the trade agreements incorporate flexibilities that may be used to secure access to medicines. Hence, states must

[130] Ibid.
[131] Ibid.
[132] WTO, 'Decision text on extension of the 17 June 2022 Ministerial Decision to Covid-19 Therapeutics And Diagnostics, (6 December 2022) IP/C/W/694 https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/IP/C/W694.pdf&Open=True
See also: WTO, 'Members continue discussion on TRIPS Decision extension to therapeutics and diagnostics', (17 March 2023) https://www.wto.org/english/news_e/news23_e/heal_17mar23_e.htm accessed 20 March 2023.
[133]Green (n 131).
[134] Frederick M. Abbott, 'Health and Intellectual Property Rights' in Gian Luca Burci and Brigit Toebes, Research Handbook on Global Health Law, Edward Elgar Publishing (2018) 139.
[135]Article 1(1) of the Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299, 33 I.L.M. 1197 (1994) [hereinafter TRIPS Agreement].
[136] Perehudoff and Sellin (n 1) 75.

balance their obligations under IHRL and other international (trade and investment) agreements.[137]

It is recommended that LICs comply with this duty and ensure that they refrain from FTAs and TRIPS-plus agreements that will affect access to medicines.[138] Although, arguably, the concessions from these trade agreements are necessary for LICs' economic growth, they must ensure that the effects of these obligations on access to vaccines are mitigated by effectively utilising other available flexibilities. In line with this suggestion, the Special Rapporteur on the right to health, the UN High-Level Panel on Access to Medicines, and the UNDP and UNAIDS have respectively recommended that HICs refrain from pressuring LICs to accept TRIPS-plus obligations and LICs should equally desist from these agreements.[139]

4.3 Pandemic Treaty

It has been argued earlier that Covid-19 vaccines should be treated as global public goods. It has also been noted that the production of Covid-19 vaccines in LICs has been affected by the refusal of pharmaceutical companies to share their intellectual property and know-how. While the R&D of Covid-19 vaccines benefited hugely from public funding, there was no legal mechanism in place to ensure that the resulting manufacturing technologies would be globally accessible. In essence, the financing was not conditioned on the sharing of intellectual property and know-how.[140] This problem has been exacerbated by the lack of international regulation for sharing IP and technology required for a prompt and equitable response to the pandemic crisis. The situation led to a wide call for the creation of a global legal framework that would, (among other things) provide for the sharing of such technology and manufacturing know-how

[137] ibid.

[138] Mohammed El Said, 'The Impact of 'TRIPS-Plus' Rules on the Use of TRIPS Flexibilities: Dealing with the Implementation Challenges', in Carlos M. Correa and Reto M. Hilty (eds), Access to Medicines and Vaccines Implementing Flexibilities Under Intellectual Property Law (Springer 2021) 307.

[139] Perehudoff and Sellin (n 1) 76. See also CESCR, Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant, Concluding Observations, Switzerland (2010) UN Doc. E/C.12/CHE/CO/2-3, at para. 24; United Nations Secretary General's (UNSG's) High-Level Panel on Access to Medicines, Report of the UNSG's High-Level Panel on Access to Medicines. Promoting Innovation and
Access to Health Technologies (2016), at p. 27, available at <http://www.unsgaccessmeds.org/final-report>. Accessed 11 April 2022; UNDP, UNAIDS Issue Brief, 'The Potential Impact of Free Trade Agreements on Public Health' (2012), available at https://www.unaids.org/sites/default/files/media_asset/JC2349_Issue_Brief_Free-Trade-Agreements_en_0.pdf accessed 15 April 2022.

[140] 't Hoen (n 7).

for pandemic prevention, preparedness and response — a pandemic treaty.[141] Accordingly, the World Health Assembly (WHA)[142] in 2021 began the discussion on the creation of the pandemic treaty.[143] The WHA reviewed and deliberated on a report of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies' (WGPR) regarding the reasons and the implications of a pandemic treaty.[144] Based on the WGPR's recommendation in the report, an Inter-governmental Negotiation Body (INB) was established to draft and negotiate a WHO convention, agreement or other international instruments on pandemic prevention, preparedness and response.[145] The INB will report the outcome of its efforts at the World Health Assembly in 2024. Commentators have suggested that, apart from establishing the norm that the IP and knowledge needed to develop and produce essential pandemic health technologies become global public goods, the pandemic treaty should address countries' need to shift from high dependency on private players towards overall investments in strengthening the public health system.[146]

I opine that the coming into force of a global legal framework (the pandemic treaty) that will guarantee the sharing of pandemic health technologies and associated IPRs will prevent inequitable access to the lifesaving technologies required for a prompt and equitable response to the pandemic crisis. While the all-inclusive deliberations at the WHA in the pandemic treaty process involve a range of actors and agencies beyond the WHO, including pharmaceutical companies, the final decision should be protected from the undue influence of these companies and their powerful lobbyists.

[141] ibid. In March 2021, the EU, the WHO and 25 heads of state and governments signed a call to the international community to begin the negotiation process to sign a treaty on pandemics.
[142] An organ of the WHO.
[143] By Article 19 of the WHO Constitution, the WHA can adopt conventions or agreements concerning any matter within the competence of the Organization.
[144] Nicoletta Dentico, Remco van de Pas and Priti Patnaik, 'G2H2 report, The politics of a WHO pandemic treaty in a disenchanted world' (Geneva Global Health Hub, December 2021) https://g2h2.org/posts/whypandemictreaty/ accessed 20 April 2022.
[145] ibid 20.
[146] Alida Tiekoetter, 'The Continuing Quest for a New Instrument Addressing Pandemics – Where We Are at and What Is Needed', (ISGlobal, April 13 2022) available https://www.isglobal.org/healthisglobal/-/custom-blog-portlet/the-continuing-quest-for-a-new-instrument-addressing-pandemics-where-we-are-at-and-what-is-needed/5083982/14001 accessed 23 April 2022 See also Dentico, van de Pas and Patnaik (n 146) 27.

Although I argue that a pandemic treaty is a viable solution to the problem of access to vaccines and by extension, a means to better govern future outbreaks and reduce pandemic risks, its adoption is not necessarily predictive of future ratifications since governments, as well as circumstances, may change. At the same time, opting into a treaty requires states' political will, action and commitment. While the EU is one of the most vocal advocates of a pandemic treaty, the question that readily comes to mind here is: considering the actions of the HICs with the use of TRIPS flexibilities, their insistence on vaccine nationalism, and their continued reluctance to adopt waiver; will these countries be committed to such a treaty that mandates the sharing of pandemic health technologies and associated IPRs? Will LICs be able to steer the crucial conversations in a way that secures their interests and concerns? Especially considering their limited capacity (including negotiating capacity). These concerns have led some commentators' to conclude that the push for a pandemic treaty is not only politically motivated but also a distraction from the failure of global governance in managing Covid-19 and a political distraction from the TRIPS waiver dialogue.[147] Time will reveal the actual intention behind the push for the pandemic treaty by HICs (particularly, but not exclusively the EU). One lesson is clear from the long-stretched Covid-19 pandemic: the world was not prepared for and is still not effectively able to prevent the pandemic. Thus, something different from our current approach must change. In my opinion, the new approach is a pandemic treaty, as the treaty proposal aspires to bring countries together to fight against future pandemics and dispel the temptations of isolationism and nationalism.[148]

4.4 Change of innovation systems and development of new R&D Model

The current global innovation system uses the profit-motive to incentivise innovation. The patent-based incentive model for R&D has led to many public health problems, including high medicine prices, empowering pharmaceutical companies, and shifting global health governance to their whims and caprices. As demonstrated above, the present system explains the pharmaceutical companies' refusal to share know-how; thereby frustrating the WHO's effort to intensify local production of vaccines in LICs through the C-TAP. Thus, there is an urgent need to change the pharmaceutical R&D system. This is so even though the recommendations

[147] Dentico, van de Pas and Patnaik (n 146) 41 and 45.
[148] ibid 44.

for change in the pharmaceutical R&D system are often met with stern warnings from HICs of the negative effects it may have on innovation. To counter this, t'Hoen argued rightly that the incentive that has led to an increase in drug prices has not met with a similar increase in new drug development.[149] The need for this change is particularly urgent because its effect on access to medicines is mostly felt by LMICs that house over 80% of the 7.3 billion people in the world.[150]

The monopoly-based high drug pricing is always justified as compensation for the cost of R&D of new drugs and inventions by the industry and its supporters; it has been rightly argued that the price of medicines bears little relation to the cost of medicine development. Rather, pricing is based solely on the discretion of the patent holder company.[151] Even if the claims of the industry were true, there is no clear yardstick to judge the fairness of the price because pharmaceutical companies guard the cost of their R&D as trade secrets. This practice has undoubtedly put enormous power in the hands of the pharmaceutical industry and affected the affordability and accessibility of vaccines, especially in LICs where populations pay out of their own pockets for medicines. Therefore, R&D models are needed that share the results and know-how of research and ensure transparency in the costs of R&D. The current innovation system needs transformation to become less costly and more responsive to global health needs. [152] It is believed that transparency would positively affect the costs of and access to medicines.

Finally, to reduce the prices of medicines and resolve the innovation and access problems, t'Hoen has suggested the adoption of the 'delinkage model'.[153] A model that posits that R&D should be rewarded through other means than the price of the product. The international community should develop new ways to share the burden of innovation costs.[154] It is recalled that there was a proposal for a medical R&D treaty to incorporate 'delinkage' and achieve the objectives of financing innovation and access to those innovations at the WHO. The treaty was

[149] Ellen 't Hoen, 'Private Patents and Public Health: Changing Intellectual Property Rules for Access to Medicines' AMB Press: Diemen, 2016, 4.
[150] t' Hoen (n 151) 127.
[151] t' Hoen (n 151) 129.
[152] ibid.
[153] t' Hoen (n 151) 130. See also Abbott (n 136) 157 and 158.
[154] t' Hoen (n 7) 130.

recommended by a vast number of independent scholars and proposed in a WHO resolution (WHA61.21).[155] Despite the resolution's wide consensus, it was rejected by HICs on the ground that the negotiations would be outside WHO's mandate.[156] Notwithstanding this rejection, HICs should allow the negotiations and creation of an R&D treaty to facilitate global access to medicines.

4.5 Increasing health capacity and debt cancellations

The pandemic has shown that all countries, especially the global South, need to organize and transform their health systems, particularly against future health risks. Huge investment is required in health systems because the outbreak of the pandemic and its effects have indicated that health systems were overall not prepared for a health emergency. Lack of financial resources associated with debt service payment (amongst other factors) accounts for LICs' low investment in the health system. Research showed how 64 LICs spend more on external debt payments than on public healthcare.[157] Debt has become a burden in Africa; recent reported IMF figures explain that the debt rate has grown from 35% to 65% in the last decade,[158] and is bound to increase by another 10%. With these figures, it appears that half of Africa is on the verge of bankruptcy.[159] To enable these LICs investments in the health system to facilitate pandemic preparedness and response, cancellation of these debts is suggested. Indeed, as rightly reported, 'cancelling all external debt payments due in 2020 alone by the 76 lowest income countries would liberate USD $40 billion, USD $300 billion if cancellation included 2021'.[160] Releasing such an enormous amount could positively affect global health and access to medicines.

[155] Dentico, van de Pas and Patnaik (n 146) 28.
[156] Dentico, van de Pas and Patnaik (n 146) 28-29.
[157] Dentico, van de Pas and Patnaik (n 146) 48.
[158] Ibid.
[159] ibid.
[160] ibid.

Conclusion

The world is presently battling the effects of Covid-19 on the global economy and public health. The inequities of Covid-19 apart from being a further entrenchment of the global health inequity existing in the world, were primarily caused by the actions of the HICs. Particularly the insistence on vaccine nationalism and the imposition of TRIPS-plus obligations in FTAs to discourage the use of TRIPS flexibilities. The protection of IPRs should never prevent access to vaccines, especially during a global pandemic.

While there have been various efforts at the WHO level to assist LICs in their fight against the pandemic by facilitating access to vaccines through initiatives like COVAX, we reckon that this action is insufficient. HICs are obligated to make deliberate efforts to support this course and refrain from any action that may undermine the right to health in LICs. As previously stated, though the WHO DG continued to frame this duty as a moral one, the research has argued and proved that the obligation to assist LICs in the realisation of the right to health through access to Covid-19 vaccines is a binding ETO contained in Art 2 ICESCR. It is thus argued that the actions of the HICs are a breach of ETOs. While the extent and scope of this obligation remain a subject of debate, the legal analysis of the relevant sources of international law, the ICESCR and 'the no harm principle' – a general principle of international law illustrated its bindingness. Moreover, multiple General Comments and statements of the CESCR have buttressed the position that wealthy nations are obligated to assist LICs in realising the right to health under the obligation of international assistance and cooperation contained in Article 2(1) ICESCR. Although the non-binding effects of these general comments are acknowledged, they are authoritative interpretations of the provisions of the ICESCR. Despite the contribution of the treaty body, there are still arguments on the precise nature and concrete measures required for the effective implementation of the obligation of international assistance. It is recommended that the Committee give more precise guidance on the HICs ETOs in Article 2 (1) specifically with regards to access to medicines under the right to health. The CESCR should borrow a leaf from the ground-breaking finding of the UN Committee on the Rights of the Child in Sacchi v. Argentina, where the Committee found that the CRC gives

rise to states' ETOs to address climate change.[161] The Committee elucidated the standard it used when accessing if and when ETOs are owed by states.[162] To give more credence to the bindingness of HICs ETOs under Article 2(1) ICESCR, I suggest that a LIC member state file a complaint against a HIC before the CESCR for non-compliance with the obligations of IAC particularly in the context of vaccine nationalism. The outcome of this decision, which is legally binding, will further clarify the debates surrounding the obligation.

Thus, the above analysis and the arguments presented in the body of this essay answer in the affirmative the main research question: *Does States' obligation to secure the right to health under international human rights law (ICESCR), extend extraterritorially to African countries in light of Covid-19 vaccine distribution?*

To answer the other preliminary question raised, several avenues to be explored to enhance access to Covid-19 vaccines in LICs have been suggested. Particularly the passage of a comprehensive IPR waiver by the WTO.

Similarly, recalling the effects of the proliferation of TRIPS-plus obligations by HICs on the usage of TRIPS flexibilities, in this author's view, LICs should comply with their human rights obligations to reject such obligations that will negatively affect access to medicines. This may be done after a comprehensive assessment of the health impact of the FTAs and TRIPS-Plus obligations. Also, HICs should refrain from introducing such obligations, which are eroding the policy space left for states by TRIPS. Nevertheless, since some LICs are already committed to these FTAs, it is recommended that they undertake a thorough review to identify areas where TRIPS flexibilities can still be utilised to facilitate access to Covid-19 vaccines. While it is unlikely that the proliferation of TRIPS-plus agreements will diminish in the short term because of the IP-trade linkage, their effects must be suppressed to prevent total erosion of the policy space created by TRIPS for LICs in the implementation of their obligations.

[161] UN, 'UN Child Rights Committee rules that countries bear cross-border responsibility for harmful impact of climate change', (11 October 2021) https://www.ohchr.org/en/press-releases/2021/10/un-child-rights-committee-rules-countries-bear-cross-border-responsibility?LangID=E&NewsID=27644 accessed 20 April 2022.

[162] Aoife Nolan, 'Children's Rights and Climate Change at the UN Committee on the Rights of the Child: Pragmatism and Principle in Sacchi v Argentina', (EJIL, October 20, 2021) https://www.ejiltalk.org/childrens-rights-and-climate-change-at-the-un-committee-on-the-rights-of-the-child-pragmatism-and-principle-in-sacchi-v-argentina/ accessed 20 April 2022.

To sum up, I argue that HICs owe ETOs to LICs to respect, protect and fulfil the right to health of their populations. The identified actions of the HICs are breaching this obligation, thus undermining the realisation of the right to health in LICs. Several measures have been suggested to curb this enigma and particularly to facilitate access to Covid-19 vaccines.

To conclude, from a global health perspective, health should be a shared responsibility. Consequently, no country should be left behind in the fight against the global pandemic, as evidently no one is safe until everyone is safe. As immunization remains science's best prevention tool and an important element of the right to the highest attainable standard of health, HICs are implored to comply with their obligation of IAC to facilitate access to vaccines in LICs and to ensure the right precedent for future equitable pandemic preparedness and other crises affecting the global South. The same global solidarity that led to the breakthrough in treatment for HIV and other diseases is also required for future pandemic preparedness.