Human rights and fair access to COVID-19 vaccines: the International AIDS Society–*Lancet* Commission on Health and Human Rights

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The rapid development of safe and effective COVID-19 vaccines has been an unprecedented scientific achievement and offers a promise for a healthy post-pandemic future. However, inequitable vaccine access has jeopardised that vision, and our global governance institutions have failed to anticipate, prevent, or redress this inequality. As of March 21, 2021, 78% of 447 million deployed doses of COVID-19 vaccines were in only ten countries.[1,2] Nearly a quarter of the world's population might not have access to these vaccines before 2022.[3]

As members of the newly established International AIDS Society–*Lancet* Commission on Health and Human Rights, we are dismayed at how little attention has been given to human rights in discussions of access to COVID-19 vaccines. This must change. Unless we hold to the principle that everyone has equal rights to dignity, to health, and to benefit from scientific progress, our success against COVID-19 is at risk.

Unlike research efforts to develop COVID-19 vaccines, plans for distributing vaccines in low-income and middle-income countries (LMICs) have been underwhelming.[4] The consequences are serious. SARS-CoV-2, like any virus, mutates.[5] Incomplete vaccine coverage, alongside ongoing community transmission, facilitates emergence of SARS-CoV-2 variants, which may lower vaccine efficacy, something already seen in South Africa.[6] Yet the internationally supported COVAX funding mechanism provides only 20% coverage of immunisation for LMICs.[7] This coverage is insufficient to reach all who need it or to control viral spread. What citizen, health-care provider, or public health official of a wealthy nation would find 20% vaccine coverage acceptable?

Inequitable access to COVID-19 vaccines and therapeutics mirrors wider health and health-care inequities and is grounded in broader structural inequalities, putting some populations at greater risk than others. In many countries, COVID-19 cases and deaths are highest among Indigenous populations and racial minorities, the working poor, as well as prisoners and detainees.[8,9] In some regions, such as southeast Asia, migrant workers are not prioritised for vaccination despite high risks for COVID-19 infection due to poor living conditions.[10,11] Many millions of displaced people are barely considered in COVID-19 vaccine distribution schemes.[12,13] Some, including the Rohingya refugees from Myanmar, have been actively excluded.[14]

A human rights approach offers an alternative. The right to the highest attainable standard of health was first articulated in 1946 in the Constitution of WHO, and nearly every country in the world has ratified at least one international agreement that imposes specific obligations on governments regarding the right to health, including obligations related to "The prevention, treatment and control of epidemic, endemic, occupational and other diseases".[15] The International Covenant on Economic, Social and Cultural Rights lays out extraterritorial obligations for international assistance and cooperation that are widely understood to include equitable global vaccine distribution.[15]

The notion that it is acceptable for the global wealthy to be protected from a life-threatening virus while the global poor suffer unprotected was challenged decades ago. After the development of effective antiviral therapy for HIV/AIDS, about 95% of the world's people living with HIV had no access. But by 2000, the obligation to respond was uncontested, leading to the establishment of The Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan for AIDS Relief (PEPFAR), increased financing from development partners, and a restructuring of global trade and financing structures for HIV treatments, driven by grassroots activism, which enabled access to affordable therapy worldwide.[16]

Similarly, the global community understood with smallpox eradication in the 1970s that smallpox anywhere was smallpox everywhere. A successful smallpox vaccine effort was achieved, despite the tensions of the Cold War, amid multiple wars of decolonisation and liberation.[17] It was understood, on scientific and social justice grounds, that all of humanity would need to be protected to eradicate the disease.

As science achieves such remarkable advances as the COVID-19 vaccines, it is compellingly clear that we cannot

Panel: **Framing questions the Commission will interrogate**

1 What is the future of the health and human rights framework?
2 How can the health and human rights framework be revitalised and reinvigorated to achieve healthy communities?
3 What domains of the health and human rights framework are most relevant for ensuring robust health systems and universal access to prevention and care?

exclude our fellow human beings from benefiting from this advance. Allowing that kind of injustice is not only legally, politically, and morally unacceptable, but it also undermines all of our humanity. Inequitable access to COVID-19 vaccines is also reckless public health practice.

There have been demands for a people's COVID-19 vaccine with expedited vaccine production and equitable distribution.[18] The governments of South Africa and India have asked the World Trade Organization to waive some intellectual property rights for medical products until widespread vaccination is in place worldwide.[19] UN human rights experts have called on pharmaceutical companies to "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".[20] On scientific, humanitarian, and human rights grounds, we need a major effort to create a comprehensive system for COVID-19 vaccine production, funding, allocation, distribution, and deployment, based on true global solidarity.[21] The potential introduction of COVID-19 vaccine passports reinforces the importance of equitable vaccine distribution to avoid unfair distribution within resource-constrained settings and further undermining the development of emerging economies.[22] We should insist that a substantial proportion of vaccines manufactured for the high-income countries be made available to LMICs, concentrating on those vaccines with the best data on effectiveness for all; this was the approach taken with the smallpox vaccine programme and could serve as a precedent for use of COVID-19 vaccines, which must be seen as global public goods.

The Commission had its first meeting in early 2021 and expects to produce its first full report in 2022. The key questions that will inform our work are shown in the panel. We are charged with examining how to ensure that human rights are at the core of global health efforts, enabling them to fulfil the lofty goals outlined in the WHO Constitution, in international human rights treaties, and in many national constitutions and legal frameworks: that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction and that the health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest cooperation of individuals and states.[23] The Commission's work will seek to strengthen and expand health and human rights efforts to include emerging areas that impact the right to health, including misinformation, disinformation, social media, and the politicisation of health information; the climate crisis and the right to a sustainable environment; and the social determinants of health arising from inequity, social injustice, and conflict and displacement.

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