

Covid-19 Vaccine Nationalism and International Human Rights Law

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ABSTRACT

The rollout of COVID-19 vaccines was referred to as the “parallel pandemic of human rights” of some sort, running neck to neck with the pandemic itself. The production, distribution, and profiteering that followed the announcement of vaccines were so unequal, between the rich countries of the global north and their poor counterparts in the global south, that the exercise was satirically termed ‘vaccine nationalism’ or ‘vaccine apartheid’. Against the backdrop of the COVID-19 pandemic, this article examines the extent to which existing International Human Rights Law (IHRL) provides for a framework of equity in vaccine distribution across the globe, particularly in the context of pushing back ‘vaccine nationalism’. Given that the questions relating to access to vaccines sit at the intersection of intellectual property (IP) protection and human rights, the article examines the delicate balance between IP protection and the broader rights of users/society to vaccine access. The article then proceeds to discuss how far human rights jurisprudence can go in engendering access to vaccines for all.

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1. INTRODUCTION

The goal of International Human Rights Law (IHRL) is to safeguard basic rights and fundamental freedoms of all humans by affirming their universal character as inherent and inalienable.^[1] One event that has, however, challenged this cardinal goal is the outbreak of COVID-19, particularly the upsurge of ‘Vaccine Nationalism’. While the Director-General of the World Health Organisation (WHO) in an obvious bid to rally the troops had declared that ‘no one is safe until everyone is safe’,^[2] the subsequent medical and pharmaceutical breakthrough in the development of COVID-19 Vaccines with substantial potency to fight the virus, has

introduced a troubling dimension to the pandemic. This is the surge of Vaccine Nationalism. The massive havoc wreaked by the pandemic and the atmosphere of apprehension it has created through reports of different variants as well as several waves has driven governments to the habit of national self-preservation and populist attitudes.

Under international law, persons have a right to the highest attainable standard of health, which obligates state parties (in the current instance) to take steps to prevent, treat, and control epidemics.^[3] Also, in a health emergency, access to healthcare must be guaranteed on a non-discriminatory basis, especially for persons falling into vulnerable

groups.^[4] In its General Comment 14, the Committee on Economic, Social and Cultural Rights reiterates that “*health is a fundamental right indispensable for the exercise of other human rights*”.^[5] This right also appears in the text of the Sustainable Development Goals (SDGs), a set of international developmental priorities adopted by the international community in 2015. Instructively, Goal 3 of the SDG borders on the need to “*ensure healthy lives and promote wellbeing for all at all ages*”.^[6] Though the above provisions are tantalising, with the corollary argument that signatories to IHRL respond to their obligation having a persuasive flavour, the quest for equitable distribution of vaccines continues to face a major obstacles under international law.

The recent battle of wits over waiver of COVID-19 Vaccines’ intellectual property rights at the World Trade Organisation (WTO) brings this into better perspective. The People’s Vaccines Alliance, in its bid to ensure vaccine equity, has been calling on pharmaceutical companies to share their intellectual property through the WHO, to facilitate the production of billions of doses of vaccines, to increase availability as much as possible.^[7] However, in a rather bare-faced resoluteness, vaccine nationalism was demonstrated when a proposal for a waiver of Trade and Intellectual Property Rules (TRIPS) for COVID-19 vaccines backed by more than 100 countries, mostly developing countries, was blocked by rich countries at the WTO talks.^[8]

This article examines the extent to which the existing IHRL framework provides for equity in vaccine distribution across the globe, especially in the context of increasing vaccine nationalism. Given that the questions relating to access to vaccines sit at the intersection of intellectual property (IP) protection, trade and human right, the article examines the delicate balance between IP protection and the broader interests of users/society by examining how far human rights jurisprudence can go in endangering access to vaccines for all.

2. THE COVID-19 VIRUS: A BRIEF OVERVIEW.

The early part of the year 2020 saw the human community reverberate to its very foundation following the outbreak of the novel coronavirus. The virus, a member of a large family of Coronavirinae in the family of Coronaviridae and the order Nidovirales,^[9] causes human diseases, often mild, for example common cold.^[10] Two coronaviruses that are known to have earlier manifested and were highly pathogenic were the severe acute respiratory syndrome (SARS-CoV) and Middle East Respiratory Syndrome (MERS-CoV), both of which caused outbreaks between 2002 to 2003 as well as 2012 to 2015, respectively.^[11] According to a 5-year study of SARS-CoVs in Yunnan province of China, 11 strains of SARS-CoVs were discovered in different species of horseshoe bats, with SARS-CoV-2 being the seventh human coronavirus.^[12] The SARS-COV-2 is the strain which causes the infectious disease currently referred to as coronavirus disease 2019 i.e., COVID-19.^[13]

Coronavirus disease 2019 was first spotted in Wuhan, the capital city of Hubei province of China, after a group of severe pneumonia cases with unknown etiology was reported by the Wuhan Municipal Health Commission on 31 December 2019.^[14] Many of the initial patients were reported to have visited a wet seafood market, where wildlife materials were sold ^[15] and by 1 January 2020, the market was shut down.^[16] By 7 January 2020, the etiological agent was identified as a novel coronavirus, i.e., SARS-CoV-2, with its clinical manifestation referred to as COVID-19.^[17] On 12 January 2020, China was reported to have shared the genetic sequence of the virus, which countries can use in developing their diagnosis.^[18] On 29 January 2020, the WHO, at its third briefing towards providing an update on the virus and in line with its best practices for naming infectious diseases, recommended that an interim name be given to the virus, which is ‘2019 nCoV acute respiratory disease’.^[19]

Though there were suggestions that it could be tempered by local weather conditions, the pathogen was reported as having the capacity for wide geographic spread and being one not confined to any climate.^[20] Early treatment for the virus was in the form of a combination of drugs, while patients with underlying health conditions were noted to be at greater risk. It was also reported that approximately 2.5% of patients required a ventilator to help their body while it combats the virus, with such a process often lasting between 2 – 3 weeks.^[21] Also, more knowledge about the virus revealed that persons could be carriers of the virus, yet be asymptomatic, i.e., not showing the usual symptoms such as general fever conditions, loss of sense of taste and smell, etc.^[22] This presented a major dimension to the crisis, as several persons could get infected with the virus without knowing, thereby enhancing rapid community transmission.^[23]

Much of the virus was initially trailed by a paucity of information and tardiness of response. Initially, governments in response to the spread of the virus adopted a wait-and-see approach. However, as the number of infected persons increased, tentativeness and ambivalence quickly gave way to political decisiveness and direct action. For instance, the United States (US), which at that time held the highest number of infections and fatalities, declared a national emergency on March 13, 2020, as the virus spread to 49 of its 50 states.^[24] Then US President Donald Trump announced a \$50 billion package to combat the virus, as well as waiving laws to allow for interventions such as allowing doctors to practice in states where they were not licensed.^[25] The shocking spread of the virus triggered panic across domestic jurisdictions, as efforts were made to arrest the situation. While top public health experts spoke of the uncanny and amoebic character of the virus, political leaders lamented how the pandemic had disrupted national economies and disorganised the global state of affairs. At a point, the effort to combat the pandemic was even labelled a conflict between saving lives and rescuing people's sources of livelihood.

Challengingly, at the time of its initial outbreak, the virus had no reported vaccine^[26] and governments were simply left to containment measures already mentioned above, such as isolation of suspected cases/infected persons, social distancing, national lockdowns, travel restrictions, and community containment.^[27]

After much hesitation, on 23 January 2020, the WHO through its emergency committee admonished that, *"all countries should be prepared for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention of onward spread of 2019-nCoV infection and to share full data with the WHO"*.^[28] Finally, having attained the epidemiological standard for it to be declared a pandemic, i.e., that it has infected over 100 000 persons in 100 countries, on 30 January 2020,^[29] the WHO declared COVID-19 a Public Health Emergency of International Concern (PHEIC).^[30] However, years down the line, new variants of the virus have emerged in different parts of the world, jolting the international community from its reverie.^[31] While the impact of the pandemic has been staggering, its direction at the time of the outbreak remained unclear, with its reach depending on how much human-to-human transmission could be mitigated.^[32] As noted earlier, the approach to achieve this was the introduction of long-held public health measures such as vaccination, quarantining of infected persons, contact tracing, etc.^[33] Unfortunately, South Africa later informed the WHO of its discovery of a new variant of the COVID-19 virus, which on 26 November 2021, was designated as the variant B.1.1.529, a variant of concern, named Omicron, on the advice of WHO's [Technical Advisory Group on Virus Evolution](#) (TAG-VE).^[34] In making this decision, the TAG-VE considered evidence that Omicron has several mutations that could affect how it behaves, for example, affecting how easily it spreads or the severity of illness created by the virus.^[35] The Omicron variant made it clear that the end of the pandemic was not as simple as everyone thought and that getting to the end would require concerted global effort.

3. COVID-19: THE INTERNATIONAL RACE TOWARDS VACCINATION

The COVID-19 virus did not relent, as it continued to spread inexorably. On the human level, it had become physically exhausting as well as emotionally injurious. The raft of responses deployed in combating the virus had only succeeded in slowing down its advance, but not really combating it effectively. This made the need to develop a vaccine more urgent than ever. Finally, on November 9, 2020, there was a breakthrough in global efforts when the American Pharmaceutical giant, Pfizer, and its partner BioNTech, announced that, based on initial interim efficacy analysis, its mRNA-based vaccine candidate, BNT162b2, had shown potency against COVID-19 in participants without prior infection.^[36] In a study that enrolled 43,538 participants, with 42% having diverse backgrounds and no serious safety concerns, the vaccine proved to be over 90% effective in preventing COVID-19 in participants.^[37] With a final analysis of the phase 3 trial showing that the vaccine is over 95% effective, Pfizer/BioNTech submitted a request to the US Food and Drug Administration (FDA), for emergency use authorization of their vaccine.^[38]

A week after the Pfizer/BioNTech announcement, another US company, Massachusetts-based Moderna, announced that its COVID-19 vaccine could be up to 94.5% effective against the virus.^[39] According to the company, in an early analysis of data involving 95 participants with confirmed COVID-19 infections, its Phase 3 trial satisfied the necessary criteria with an efficacy of 94.5%.^[40] Following this, Pfizer/BioNTech and Moderna both requested authorization from the European Union (EU) for their respective vaccines.^[41] However, in what has been described as a 'landmark moment' for the coronavirus pandemic, while approval from both the FDA and the EU was being awaited, the United Kingdom (UK) became the first western nation to grant authorization for emergency use of the Pfizer/BioNTech

vaccine.^[42] Since the vaccine breakthrough, countries began to place orders to have the vaccine delivered to vaccinate their domestic population. While the US secured an initial 100 million doses of the Moderna vaccine with an option to buy 400 million later, the EU had a potential purchase agreement for between 80 – 160 million doses.^[43] The UK also secured 5 million doses of the Moderna vaccine in addition to 350 million doses secured for other potential vaccines.^[44]

By mid-2021, about 298 COVID-19 vaccines were at different stages of development, with 10 either approved or in use and another 70 in clinical trials.^[45] As of March 24, 2021, there are 99 vaccine candidates, 274 trials and 13 approved vaccines.^[46] The 13 vaccines approved by at least one country are Anhui Zhifei Longcom RBD-Dimer; Bharat Biotech-Covaxin; CanSino AD5-nCov; FBRI EpiVacCorona; Gamaleya Sputnik V; Janssen (Johnson & Johnson) AD26. CoOV2. S; Moderna mRNA-1273; Oxford/AstraZeneca AZD1222; Pfizer/BioNTech BNT162b2; Serum Institute of India Covishield; Sinopharm (Beijing) BBIBP-CorV; Sinopharm Wuhan (Inactivated (Vero Cells); Sinovac CoronaVac.^[47] By clinical trials, Pfizer/BioNTech and Moderna still appear to be the most potent of the vaccines, with both 95% and 94.1% effective rates, respectively.^[48] To achieve mass immunity, the vaccine has to be delivered to as many people as possible. Each individual requires two doses for it to be effective, and each dose has to be 21 days apart.^[49] Yet, about \$8.4 billion is required to distribute these vaccines.^[50]

The global rush for these vaccines created a situation where rich countries bought up large stocks and leaving poor countries highly vulnerable.^[51] At that time, there were only about 7% of Africans who were fully vaccinated, and only one in four health workers in Africa were fully protected.^[52] This was not just morally grotesque, but also dangerous. It created a breeding ground for new variants. In nearly two years of the pandemic, the disparity between wealthy and developing countries in

vaccination rates became stark. For instance, whereas in countries such as Portugal and the United Arab Emirates (UAE), nearly 9 out of 10 people are fully vaccinated, only about 6% are fully vaccinated in Africa.^[53] In a country such as the Democratic Republic of Congo, only approximately 0.1% of the population had received full vaccination.^[54] This brought the issue of vaccine nationalism to international consciousness, as wealthy countries were accused of buying up the available supply and leaving just a little for the rest of the world. Putting this crisis in perspective, in late October 2021, UN Secretary-General António Guterres declared that *"Vaccine nationalism and hoarding threaten us all"*.^[55]

4. VACCINE NATIONALISM – THE COVID-19 DIMENSION

Generally, vaccines perform the dual function of protecting the vaccinated individual against infections as well as protecting those not vaccinated by reducing the potential for transmission.^[56] It also reduces the transmission of diseases, by indirectly protecting the community and individuals too young to get vaccinated or immunocompromised.^[57] A well-coordinated mass vaccination programme helps to achieve to achieve what is referred to as 'herd immunity' during a public health crisis. However, to achieve herd immunity, equity in the distribution of vaccines is key.^[58] However, the expected goal of herd immunity appeared to have come against a major counterforce following the surge of a corollary epidemic, i.e., vaccine nationalism. Vaccine nationalism happens when governments enter into agreements with corporations to secure vaccines for their people, even before such becomes globally available.^[59] It involves the completion of contractual agreements, often between national governments and one or more pharmaceutical companies, who are often in the late-stage of vaccine development and production.^[60] These contracts are also referred to as *"advanced market commitments or*

pre-production agreements".^[61] Capturing what this act indeed means in ordinary plain language, Miami University Professor of Public Health, Phillip Smith, says, *"vaccine nationalism means putting your own nations' vaccine needs ahead of others, to the detriment of others"*.^[62] In capturing vaccine nationalism with some sort of satirical undertone, it has been stated that the arms race has metamorphosed into a vaccine race, particularly one *"characterised by a fierce hunt for priority rights"*.^[63]

As the world contended with the COVID-19 pandemic, many of the world's richest countries were undermining collective global efforts with their nationalist policies.^[64] The manifestation of vaccine nationalism has bred all kinds of behaviour amongst wealthy nations. For instance, the race has seen rich countries unveiling nationalistic policies, pushing mouth-watering deals to fund research, and in exchange for access to life-saving medical products.^[65] These nations have also secured billions of doses of vaccines, while developing countries are left to scramble for the rest.^[66] The emergence of vaccine nationalism has seen high-income countries grabbing available vaccines to cover their people.^[67] Not only are nations working to get their hands on enough doses to meet their immediate domestic needs, but they are equally unrelenting in ensuring a stockpile as some form of backup.^[68] According to the WHO DG, *"at present, rich countries with just 16% of the world population have bought up 60% of the world's vaccine supply"*.^[69] Countries such as the US and Canada, as well as the European Union (EU), were alleged to have pre-purchased vaccine doses for up to six times of their population.^[70] Highlighting this point, the UN Secretary-General noted that, *"we have been appealing to developed countries to share some of the vaccines that they have bought. And in many situations, they have bought more than they need"*.^[71] The appeal of the UN boss came just about the time the EU was tightening restrictions on the export of COVID-19 vaccines.^[72] This action demonstrated how much the practice continued without any sign of abating. With vaccine nationalism, these

countries are not too excited or forthcoming about sharing their stock with others, not until they see all of their people inoculated.^[73] In addition, it was also alleged that because of national agreements with some pharmaceutical companies, some of these countries were buying these vaccines for far less prices, such as, the allegation that while on the one hand the EU paid \$2.15 for the AstraZeneca vaccine, on the other hand South Africa was made to pay \$5.25 for the same commodity.^[74]

Mostly hit by vaccine nationalism were countries on the African continent. Before the outbreak of the pandemic, governments on the continent relied mainly on the Global Alliance for Vaccines and Immunisation (GAVI).^[75] To expand access to vaccines, GAVI had decided to partner with the WHO as well as the Coalition for Epidemic Preparedness (CEPI), resulting in the COVAX Initiative, which was finally able to secure a deal for 300 million doses of the vaccine with AstraZeneca, the company producing the Oxford vaccine.^[76] While a total of 78 high-income countries and 92 lower-income countries expressed interest in working with the COVAX Initiative, the US, through a White House Spokesperson, declared on 1 September 2020 that it would not join the Initiative because, in its view, the effort was being influenced by the WHO and China.^[77] As of February 2021, out of the 50 countries that had commenced one form of vaccination programme or the other, all are high-income countries, with the lower-income countries simply biding their time to when the limited tranches from COVAX would come.^[78] Amid the vaccine nationalism storm, the COVAX Initiative remained the breather for most African countries.

The implications of vaccine nationalism are far-reaching and dire. To start with, the race to combat the pandemic itself was complicated, being a race against a dynamic virus, given that new variants were not just escalating potential transmissions, but also demanding continued reworking of vaccines to ensure effectiveness.^[79] Echoing this point, Director of the Centre for Policy

Impact in Global Health at Duke University, Dr. Gavin Yamey, noted that hoarding vaccines could result in the development of new variants in places where vaccines are scarce.^[80] He also added that vaccinating the general population in wealthy countries while leaving health workers and vulnerable persons in lower-income countries will prolong the pandemic.^[81] Also, as vaccine nationalism stifles global coordination efforts, in the course of the scramble, countries may bid against each other, thereby causing prices to go up.^[82] Moreover, it was been noted that vaccine nationalism could slow down global economic growth, costing developed nations close to \$119 billion annually.^[83] Indeed, Economist Intelligence Unit raised the alarm that there was a likelihood that widespread vaccination coverage would not be achieved in 84 poor countries till 2023.^[84] Additionally, a study by the Eurasia group found that leaving lower-income countries out of the vaccine distribution could damage their economies as well as those of advanced countries.^[85] Lending his voice to the debate, the Director-General of the WHO, Dr. Tedros Adhanom Ghebreyesus, who had earlier described vaccine nationalism as a 'me-first-approach', further took a swipe at the practice, referring to it as a "*catastrophic moral failure*".^[86] He also notes that 44 bilateral deals were signed in 2020, with about 12 already concluded in 2021.^[87] In the same manner, the UN Secretary General condemned the behaviour of States, noting that such hoarding habit undermined global vaccine access.^[88]

5. IHRL VERSUS TRIPS – DEALING WITH THE CLASH BETWEEN HEALTH AND PROPERTY RIGHTS PROTECTION

Questions relating to access to vaccines and other pharmaceuticals sit at the intersection of public health, human rights, and intellectual property rights (IPRs). Although human rights and intellectual property are distinct fields that have largely evolved separately, the COVID-19 pandemic

has shone a spotlight on the cracks in global preparedness to address public health emergencies and the delicate balance between IPR and the right to health.^[89] While IPR protection encourages investment, innovation, and health science advancement, the limited-term monopoly rights granted to IPR holders often result in artificially high prices and become a barrier to access to medicines for the poor and vulnerable.^[90] Therefore, reconciling the costs and benefits of IPR protection remains at the heart of the IPR/human rights paradox.

The right to health is well captured in the Universal Declaration of Human Rights (UDHR), while the two core international charters of rights i.e., the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) make copious reference to this right. For emphasis, Article 25 of the UDHR states that:

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Importantly, Article 12 (1) of the ICESCR alludes to the “right of everyone to the highest attainable standard of physical and mental health”. Under this obligation, states are to “promote the improvement of the environment, industrial hygiene, prevention, treatment and control of diseases, and the creation of conditions that would enable their nationals to have access to

medical services and medical attention in the event of sickness”.^[91] While the ICCPR’s obligations are expected to be implemented without delay, the ICESCR has been criticized as lacking teeth. Despite having been ratified by 164 states, countries are only enjoined to progressively comply with the obligations subject to their available resources. Article 2 (1) of the ICESCR provides that:

Each State Party to the present Covenant undertakes to 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 present Covenant by all appropriate means, including particularly the adoption of legislative measures.

The above provision leaves a wide gap, which makes the right to health largely unjustifiable and a soft international law. As a result, policymakers and legislators do not often factor human rights considerations into decision-making on IP regimes and public health.^[92] They rely primarily on economic considerations. Furthermore, a handful of other international human rights treaties and regional instruments recognise the right to health. They include the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) 1965;^[93] the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) 1979;^[94] the Convention on the Rights of the Child (CRC) 1989; ^[95] the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CPRMWF) 1990; ^[96] the Convention on the Rights of Persons with Disabilities (CRPD) 2006;^[97] the European Social Charter (ESC) 1961; the African Charter on Human and Peoples’ Rights (ACHPR) 1981; and the Additional Protocol to the American

Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) 1988.

Notably, United Nations Sustainable Development Goals (SDGs), a set of international developmental priorities adopted by the international community in 2015,^[98] impliedly allude to the threat posed by the WTO Agreement on Trade Related Aspects of Intellectual Property (TRIPS agreement) to the attainment of the Universal Health Coverage. Target 3 (b) of SDG Goal 3 states the need to:

Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

Since the adoption of the TRIPS agreement, this agreement has continued to inhibit the availability and affordability of essential medicines, particularly in less-developed countries.^[99] During the negotiations leading to the adoption of the TRIPS agreement, the less-developed countries were reluctant to approve a regime of IPRs that required them to embed in their national IP laws minimum standards below which they must not go.^[100] This reservation is borne out of two factors. First, as less developed countries lacked the technological infrastructures needed for ground-breaking inventions, they saw no reason to offer

protection to innovations that they did not have. Second, offering such minimum protection would preclude them from enjoying the myriad of opportunities which come with a laissez-faire IPR regime, such as technology transfer and local technological development.

For African countries, there was an additional reason not to commit to an extra-mile obligation to protect IPRs. To them, protection of IPRs was a misplaced priority.^[101] Their major problems include poverty, diseases, access to technology, etc.^[102] However, as soon as the African Group realised that the inbuilt flexibilities would be sufficient to address their fears, including affordability of essential drugs, they supported the adoption of the Agreement. The general expectation was, therefore, that the region would employ TRIPS flexibilities to bridge its developmental gaps, including in public health. Nearly three decades after the TRIPS Agreement was adopted, law and policymakers are still faced with the dilemma of balancing the needs and interests of multiple (and often competing) stakeholders. Most notable among these are how to engender access to medicines for the most vulnerable population without falling foul of IPR obligations under the TRIPS agreement. The COVID-19 TRIPS waiver debate at the WTO reflects the unresolved issues revolving around IPR, access to medicines, and human rights.

6. THE HUMAN COST OF PROTECTION

To establish patents' economic significance and value, it is necessary to weigh their social costs against their social benefits. Hall et al^[103] Explains as follows:

In principle, a patent will function to increase fixed (and most likely sunk) costs of entry into a market where the invention protected by the patent is practiced. This will reduce entry and therefore competition. From

a welfare perspective, this is the price society pays in order to encourage invention and innovation by the initial entrant. What results is a trade-off between the interests of the incumbent holding the patent and the potential entrant excluded by it. In the case of patents, policy makers need to come to a view of how much protection to afford the patentee in order to create incentives for R&D.

Given the trade-off between innovation and access, IP and public health policies should ordinarily be designed to balance the social benefit of innovation and the social cost of monopolistic distortion. It is this delicate balance that we argue in this article as lopsided. The TRIPS agreement has been heavily criticized for widening the developmental gap between developed and less-developed countries, particularly in the public health space.^[104] The Director-General of the WHO, in a 2018 report titled *Addressing the global shortage of, and access to, medicines and vaccine*, decried the global challenge of access to drugs, vaccines, and medical technologies in less-developed countries and pinpointed the TRIPS agreement as having far-reaching implications on the access problem.^[105] Although the TRIPS agreement was negotiated with the aspiration to attain mutual economic benefits and advance economic development, these aspirations have not materialized.^[106] Research in neglected tropical diseases is still deficient.^[107] Technology transfer has been held captive by corporate control.^[108] Low-income countries are the most hit by the social cost of global IP protection.^[109] While it might be argued that the TRIPS agreement encompasses certain flexibilities aimed at enhancing the effect of IPR protection, the existing literature and policy documents decry the low usage of TRIPS flexibilities.^[110] Compulsory licensing, for instance, is practically of no use to less-developed countries with little or no

pharmaceutical manufacturing capacity. The few countries that have used or attempted to use compulsory licensing have faced economic sanctions and pressure from the developed countries, particularly the US.^[111] Other flexibilities, such as parallel importation and bolar exceptions, remain mostly unused. The TRIPS agreement leaves little room for domestic governments to manoeuvre their domestic IPR laws. The minimum standards imposed by TRIPS are sacrosanct and cannot be lowered.^[113] According to Wade, the Agreement is “*vague at points where vagueness benefits the developed countries, and precise at points where precision works against developing countries*”.^[114]

7. COVID-19 PANDEMIC, IPRS AND HUMAN RIGHTS: ARE WE IN OR OUT OF BALANCE?

When Jonas Salk - the man who invented polio vaccines in the 1950s - was asked if he was going to patent his new invention, he said: “*There is no patent. Could you patent the sun?*”^[115] Before Salk discovered the polio vaccine, polio had paralysed millions of children. To an average citizen of the world at that time, Salk’s invention made him become more of a ‘messiah’ than a virologist.^[116] His comment on whether or not polio vaccines should be patented remains at the heart of the argument for those who campaign against pharmaceutical companies’ profiteering through patent monopoly.^[117] As the world continues to battle the COVID-19 pandemic, innovation and technology have found a new battleground. We argue that the patents’ mix of costs and benefits is misaligned with what is needed as an effective policy response during pandemics. While that basic patent bargain is to block the diffusion of knowledge, the bargain is bad and should be rejected entirely in the context of a pandemic. The focus during a pandemic should be to *accelerate* the diffusion of vaccines and other treatments and not to slow it down through IP protection.

Beyond COVID-19, IP protection has already exacerbated the lack of access to

medicines globally. More effective medications for the treatment of diseases such as hepatitis C, leukaemia (dasatinib and nilotinib), HIV/AIDS, and tuberculosis are broadly patented in key generic supplier countries like India and China and largely unavailable in low-income countries.^[118] Recent research shows that about 9.3 million people who could potentially benefit from novel oral anticoagulants in developing countries lack access due to the drug's patent status.^[119] More effective patented drugs for the management of Type 2 diabetes, breast cancer (e.g., pertuzumab and trastuzumab emtansine), lung cancer, prostate cancer (e.g., abiraterone and enzalutamide), and multiple myeloma (e.g., lenalidomide and bortezomib) have no generic versions anywhere in the world.^[120] These essential patented drugs offer survival benefits to millions of patients in low- and middle-income countries.

When compared with the rest of the world, Africa bears the greatest burden of diseases. The continent relies mainly on the importation of pharmaceutical products to meet the health needs of its population. It has been reported that 90% of citizens of developing countries, particularly in Africa, lack access to affordable medicines, thereby making drugs "*the largest family expenditure after food*".^[121] Reports from the WHO Africa show that there are 20.7% chances of persons aged between 30 and 70 years dying of non-communicable diseases.^[122] The continued reliance of most African countries on China and India for drug importation has been threatened by the obligation imposed on these countries by the TRIPS Agreement to enforce protectionist intellectual property frameworks.^[123] This development impedes the continued access of African countries to the procurement of generic versions of on-patent medicines. Furthermore, the threat of antimicrobial resistance has given rise to the production of newer, effective drugs, which are protected by patent laws and therefore largely inaccessible.

An enduring question is why investment in research and development in medicines for neglected tropical diseases

(NTDs) and Non-Communicable Diseases (NCDs) is still meager in poor countries. According to the WHO, these infections are 'diminishing Africans' quality of life as individuals and thwarting the entire continent's ability to develop vibrant and productive communities.^[124] Africa's public health challenge has received low attention from big pharmaceutical companies due to concerns of low return on investment. There was no treatment or vaccine available for the Ebola Virus until recently, though the virus emerged four decades ago in the Democratic Republic of Congo.^[125] Although Malaria kills more than 400,000 people globally every year, with Africa accounting for 93% of such deaths, the disease has received little attention.^[126]

The motivation for the grant of patent rights has tilted more towards financial returns and economic benefits than the moral drive to save lives and the pursuit of human rights goals. Although Article 8 of the TRIPS agreement states explicitly that IPRs should facilitate technological innovation and dissemination while promoting the broader public interest agenda, the realities on the ground seem to suggest otherwise, as the COVID-19 pandemic has revealed the cracks and the imbalance in the IP/Human rights dynamics. The need to reconsider the exclusion of public health crisis-related inventions from patentable subject matter has therefore become necessary. The repeated waves of COVID-19 clearly show that the fates of countries are intertwined. Only a concerted global effort can overcome pandemics of this nature. With the highly contagious nature of viruses such as COVID-19, all humans are bound together under one hope, i.e., that vaccines are made accessible to all, for the sake of all. The TRIPS Agreement may be termed the Treaty of the Rich, because it seeks to protect properties that mainly belong to rich countries. It stiffens access to essential drugs in low-income countries by making the prices of these drugs out of their reach. However, the available flexibilities contained in the TRIPS Agreement for cushioning expected negative impacts are yet

to be fully utilised. The current approach, with the central focus on donor agencies and humanitarian efforts for vaccine and pharmaceutical access, is not sustainable. Hence, there is a need to strike a balance between human rights and IP market-based incentives.

8. TOWARDS THE GOAL OF VACCINE EQUITY: THE NEED FOR MORE INTERNATIONAL COLLABORATION

Gostin, et al, have noted that, not until there is fair and effective governance of healthcare across the globe, particularly as it relates to the organisation of national and global norms, as well as institutions and systems that determine the direction of health delivery, existing global health inequalities are likely to remain.^[127] This mirrors the current debates surrounding the global COVID-19 vaccination. There is therefore an urgent need for all to act fast. In order to vaccinate at least 60% of its population, Africa will need about 1.5 billion doses of vaccine.^[128] Interestingly, this is a far cry from what is on the ground. According to the UN Office of the High Commissioner for Human Rights (OHCHR), *“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”*.^[129] Echoing the same sentiment, the OHCHR in a statement has reiterated the fact that to mitigate and arrest the spread of the virus, and facilitate global social and economic recovery, it is key that everyone is guaranteed availability, accessibility and affordability to any potential vaccine.^[130] In the same vein, UN Human rights experts have stated that *“everyone, without exception, has a 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”*.^[131]

According to Katrina Perehudoff, when it comes to COVID-19 vaccines, *“fair*

global distribution should be based on the shared values that 171 governments have already committed to in international human rights treaties. These are common values such as an agreement to collaborate and to prioritise care for the most vulnerable regardless of where they live”.^[132] Also, in line with the objectives of the ICESCR as well as the CESCR General Comment No. 14, state parties, in compliance with their extraterritorial human rights obligations, have a duty to collaborate with each other, to combat the threat of the COVID-19 pandemic and strengthen each other's health systems.^[133]

Achieving global vaccination of individuals will require a collaborative effort between nations, companies, and NGOs.^[134] As time is already running low in the target to achieve the much-desired herd immunity, global collaboration directed at global access to data on vaccines, as well as global teamwork on the production and distribution of vaccines to ensure access, must be seen as a public good and core obligation.^[135] In order to achieve these objectives, the WHO Director-General wrote to member states urging them to join the COVAX Initiative.^[136] He accordingly notes that *“while there is a wish amongst leaders to protect their own people first, the response to this pandemic has been collective”*. Also, the DG WTO, Ngozi Okonjo-Iweala, has lent her voice to the debate, stating that *“a phenomenon where rich countries are vaccinating their population and poor countries have to wait”* has to give way.^[137]

Given the lack of a global enforcement mechanism, achieving the goal of equitable distribution of COVID-19 vaccines will rest on the willingness of wealthy nations to undertake health interventions in poor and developing countries.^[138] Notwithstanding this call, a number of countries are likely to still continue down the road of vaccine nationalism, especially due to political permutations, as for example when a domestic election is in the offing.^[139] Nonetheless, as long as the effort at global collaboration is massive enough, such cases can easily be managed. Ensuring an equitable distribution of COVID-19 vaccines

is significant, as it will help prevent future pandemics.^[140]

9. CONCLUSION

The COVID-19 pandemic depicts a world that is more interconnected, but which is also more hierarchical and divided, featuring disproportionate systemic societal inequalities. As a result of inequities in vaccine distribution, global responses to the pandemic are hindered. The core argument in this Article anchors on the importance of human rights in global health justice, as well as the importance of affordable, accessible, and standard vaccination and treatment to all, especially in light of vaccine nationalism. The WTO has promoted Western-style IP norms around the world in the past 3 decades. These IP-related endeavours can be seen as part of a global 'neoliberal' move in the direction of

less-developed states and more private entrepreneurship. This Article posits that these Western IP norms are ill-suited to the needs of developing countries, especially in the public health sector. In light of positive duties that create conditions for human health rights to be available to everyone, the Article aligns with the position that no rich country will be safe until every human is safe. As a result, moral duties should create responsibilities for collaboration and obligations at the international and domestic levels to better align with the values of global health governance. Countries must prioritise the issue of justice and human rights for all, rather than the short-term, vested, and profit-driven objectives of a few. A commitment to providing safe, effective, and affordable diagnostics, medicine, treatment, and vaccines to all, regardless of citizenship or nationality, is therefore sacrosanct.

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