HOW EFFECTIVE IS THE RIGHT TO HEALTH AT IMPROVING EQUITY IN THE LEVELS OF ACCESS TO CHILDHOOD IMMUNISATIONS?

by

Rebecca Carr

A thesis submitted in conformity with the requirements for the degree of Master of Laws
Graduate Department of the Faculty of Law
University of Toronto

© Copyright by Rebecca Carr 2014
How effective is the right to health at improving equity in the levels of access to childhood immunisations?

Rebecca Carr

Master of Laws
Faculty of Law
University of Toronto

2014

Abstract

This thesis explores various inequities in children’s levels of access to vaccinations and considers how the normative aims of the international human right to health are being implemented in order to address them. It is argued that the right to health is a transformative right that places obligations upon states to achieve health equity. In light of this objective, this thesis investigates ways in which the right to health, in reality, is serving to influence levels of access to childhood vaccinations – a health equity enhancing intervention - and the rights impact upon equity is assessed throughout. It concludes that applications of the right to health are effective at procuring the equitable levels of access to childhood vaccinations that, in theory; its framework has been designed to effect. Remaining inequities in levels of access to childhood vaccinations might be more effectively addressed, if further rights-oriented approaches to the issues are adopted.
Acknowledgments

I wish to thank my supervisor Professor Colleen Flood, who I admire on so many levels, for her kindness, encouragement and support with this thesis and beyond. I also thank Jacob Shelly, my SJD advisor, for his helpful comments and mentorship throughout the year.

I am also incredibly lucky to have met and wish to thank the many classmates, friends, and flatmates who were similarly interested in issues of global health, whose discussions, debate and insights have been instrumental in shaping this thesis.

I am extremely grateful for the academic and financial support that I have received from the Canadian Institute of Health Research’s Training Program in Health Law, Ethics and Policy and from the University of Toronto, Faculty of Law.

Finally, thank you always to all of my family and friends back home, whose encouragement, stories and support have kept me going in what has been both a challenging and thoroughly rewarding year!
# Table of Contents

**Introduction** ......................................................................................................................... 1

**Part A**  
**Immunisation, equity and the right to health**

**Chapter 1: Current inequities in immunisation** ................................................................. 3

1.1 The benefits of immunisation ......................................................................................... 3
1.2 The current picture ........................................................................................................... 5
1.3 Why are there such vast inequalities in access to childhood immunisations? .............. 7
   1.3.1 Supply-side factors ................................................................................................. 7
   1.3.2 Demand-side factors ............................................................................................. 11
1.4 Health equity .................................................................................................................. 17

**Chapter 2: The legal significance of health equity: a concept grounded in the international human right to health** .............................................................................. 19

2.1 Health equity and the normative content of the right to health .................................... 20
2.2 Social Justice .................................................................................................................. 22
2.3 Progressivity as a process of health equalisation ............................................................ 25
2.4 Public Health .................................................................................................................. 29

**Chapter 3: Legal obligations that stem from the right to health and its encompassing right to equity in access to childhood immunisations** ..................................................... 34

3.1 Legal obligations under the right to health ................................................................. 34
   3.1.1 The right to health’s ‘tripartite typology’ of obligations to respect, to protect and to fulfil .................................................................................................................................................................................. 34
3.2 Minimum core obligations ............................................................................................. 37
   3.2.1 State Party obligations to provide immunisation against preventable diseases ................................................................................................................. 38
   3.2.2 State Party obligations to prioritise children’s health ........................................... 39
Part B
How is the right to health being used to improve equity in the levels of access to childhood immunisations?

Chapter 4: The integration of right to health-based principles within global immunisation policy

4.1 Introduction and definition of a rights-based approach to health
4.2 Examining the application of rights-based approaches within global immunisation policy
  4.2.1 AAAQ framework as a critical lens: Availability as a common theme
4.3 Determining the equity-impact of the rights-based principles advanced within the immunisation policies surveyed
4.4 Discussion of the policies’ impact upon equity

Chapter 5: The creation of an ‘enabling environment’ for the realisation of the right

5.1 Introduction and definition of an ‘enabling environment’
5.2 Examples of measures that contribute to an enabling environment and their impact upon equity
  5.2.1 Constitutional rights to health
  5.2.2 National vaccine laws
5.3 Examples of how enabling environments can be used to achieve greater equity
  5.3.1 An enabling environment as a foundation for civil society action
  5.3.2 More collaborative public-private health action
5.4 Discussion of an enabling environment’s impact upon equity

Chapter 6: Rights based mechanisms that enhance State accountability

6.1 Introduction and definition of accountability
6.2 An examination of accountability mechanisms contributing to greater equity in access to vaccinations
  6.2.1 Right to health based litigation
  6.2.2 UN accountability mechanisms
6.3 Discussion of accountability mechanisms’ impact upon equity
Part C

How *effective* is the right to health at improving equity in the levels of access to childhood immunisations?

Chapter 7: Further analysis and conclusion..........................................................87

Bibliography.................................................................................................................92

Appendices..................................................................................................................112
List of Appendices

Appendix A: Elements of a human rights-based approach within each of the global immunisation policies surveyed

Table 1. Elements of a human rights-based approach in the Expanded Program on Immunisation (EPI) (1974)

Table 2. Elements of a human rights-based approach in the Universal Childhood Immunisation (UCI) scheme (1984)

Table 3. Elements of a human rights-based approach in the Eradication of polio by the year 2000 initiative (1988)

Table 4. Elements of a human rights-based approach in the Vaccine Independence Initiative (1991)

Table 5. Elements of a human rights-based approach in the Children’s Vaccine Initiative (1990)


Table 8. Elements of a human rights-based approach in the Global Polio Eradication Initiative (GPEI) (2010-2012)

Table 10. Elements of a human rights-based approach in the Polio Eradication and Endgame Strategic Plan (2013-2018).................................................................124

Appendix B: Timeline of Global Immunisation Policies..................................125

Appendix C: Graph 1: Diptheria-tetanus-pertussis (DTP3) immunisation (%) coverage rates Global and by WHO region, 1980-2012.................................................................126

Appendix D: Graph 2: Diptheria-Tetanus-Pertussis (DTP3) Coverage (%) by WHO Region according to household wealth quintile.........................................................127

Appendix E: Graph 3: Percentage point difference between children from the highest and lowest wealth quintiles being vaccinated with DTP3 by country...........................128

Appendix F: Results of regression analysis on the impact of the recognition of national constitutional rights to health, upon levels of equity in access to immunisations........129
Introduction

Inequity is the issue *du jour*. As our interconnections through globalisation and communication draw us closer together, the distribution of opportunities to be healthy continues to drive us apart. The international human right to health, however, presents a legal framework designed to transform the social status quo: to ensure that States health law and policy is inclusively progressive.

At its core, the right to health is a right to health equity; a right to an equality of the conditions in which people are able to live healthy lives. The conditions required to achieve such ends remain somewhat under-determined (particularly as evidence of the wider influences, upon health, are still emerging). Contained within the minimum core of the right to health, however, are a number of key determinants that, not just heuristically but now also objectively, have been proven as key to the realisation of ‘health’ and further, as key to the attainment of equity. Immunisation is one such critical, capability and equity-enhancing measure, being not only of normative relevance to the rights broad objectives, but its provision being a matter of specific legal obligation also. Vaccine-preventable disease, however, remains a key factor in child mortality and rates of access to immunisation services remain disparate as both between and within the world’s states.

A paradox thus emerges. States are required to fulfil obligations under the right to health and further, the right ostensibly has something valuable to contribute to attempts to ameliorate health inequity, and yet; the reality of inequity in access to childhood immunisations persist. Does this mean that the right, in ostensibly failing to address the problems that it has been designed to achieve is ineffective, or does it speak more plainly to the lack of uptake of the right’s strategies to begin?

Faced with these questions, this thesis sets out to do two things. Firstly: to clarify the normative objective of the right to health, and secondly: to assess the right’s ability to impact upon equity, in practice. The broader right-to-health narrative of this thesis is developed by reference to the specific and substantive issue of access to childhood immunisations, throughout.
Outline of thesis

To begin, a thorough analysis of the current inequities in access to childhood immunisations, and of their causes, is undertaken in chapter 1. The purpose of this endeavour is to illuminate the complexity of the issues of inequity and to lay the foundations for analysis in further chapters, as to how the right to health might be able to respond. In chapter 2, the legal relevance of the inequities discussed in chapter 1, is explored by an analysis of the right to health’s objectives: objectives that are argued to culminate in a right to health equity. In chapter 3, the specific legal obligations incumbent upon state parties to achieve equity in access to immunisations are set out, before concluding the first Part (A) of this thesis. In Part B, a range of quantitative and qualitative, inter-disciplinary methods are deployed to both explore and animate the ways in which the normative aims of the right to health are being implemented and applied by states in practice. Assessments of the impact of such applications, upon equity, are made throughout. Whilst, in this thesis, it is not feasible to capture all of the possible dimensions of the ways in which the right to health is being applied in matters concerning childhood immunisations, or indeed to capture its impact upon all of the possible dimensions of equity that such applications will likely engage, the areas deemed most important are surveyed. To this end, chapter 4 considers the equity-impact of applications of rights based approaches to immunisation policy; chapter 5 considers the impact of measures that contribute to a rights enabling environment upon equity in access to immunisation; and chapter 6 considers the impact of rights-based accountability mechanisms, upon equity in access to immunisations. Part C draws upon some of the themes that have been explored throughout this thesis, before bringing the analysis to a close. It is concluded that the instances of applications of the right to health that are surveyed, are effective at bringing about the health-equity enhancing aims that the right purports to be able to effect. It is therefore argued that further applications of the right could help in attempts to reduce remaining inequities in levels of access to childhood immunisations.
Part A: Immunisation, equity and the right to health

Chapter 1
Current inequities in immunisation

1.1 The benefits of immunisation

Immunisation is one of the most effective public health interventions of all time.\(^1\)
Around 2.5 million deaths are prevented\(^2\) each year with the help of routine vaccinations\(^3\) and an estimated 440 million children have been immunised against preventable diseases since 2000.\(^4\) Immunising individuals has been shown to yield significant benefits for the global community at large.\(^5\) Vaccination efforts have eradicated smallpox\(^6\) and are now well on their way towards eliminating polio:\(^7\) with the elimination of other human-human transmissible diseases such as measles, rubella and neonatal tetanus to potentially follow.\(^8\)

\[\text{References}\]


3. Standard WHO-recommended vaccines protect against eight diseases- tuberculosis, diphtheria, tetanus (including neonatal tetanus through immunisation of mothers), pertussis, polio, measles, hepatitis B, and Hib. State of the world’s vaccines supra note 2.


5. See also Angus Dawson, “The Moral Case For The Routine Vaccination Of Children In Developed and Developing Countries” (2011) 30:6 Health Affairs, 1029 (who argues that the community benefits of immunisation form a key aspect of the moral case for immunisation).


7. The Global Polio Eradication Initiative, an initiative that, as is later discussed was initiated in the 1980s is now in its final ‘end-game’ phase. The current Polio Eradication and Endgame Strategic Plan 2013-2018 outlines the steps that will need to be taken to “deliver a polio-free world by 2018.” See Global Polio Eradication Initiative, Polio Eradication and Endgame Strategic Plan (Geneva: World Health Organization, 2013).

Immunisation not only reduces the number of deaths from vaccine-preventable diseases, it also provides children with the capability to be healthy. Children benefiting from immunisation are more likely to be able to go to school, to contribute to society and to escape from the cycle of poverty.

Immunisation is also a highly cost-effective intervention and has been described as “one of the few preventive public health measures that directly saves money.” Radboud et al, for instance, have estimated that the Global Polio Eradication Initiative will generate 40-50 billion dollars in net benefits in terms of both the treatment costs that it will avert and the higher productivity gains that it will procure from its investment in human capital. The economic rationale for immunisation is further advanced by the fact that its impact upon population health tends to be rapid. Between 2000 and 2007, for instance, global mortality from measles was reduced by 74%: from 750,000 to 197,000, as a result of greater immunisation and similar rates of decrease can be viewed in relation to other vaccine-preventable diseases such as polio.

11 See Radboud J. Duintjer Tebbens et al, “Economic Analysis of the global polio eradication initiative” (2011) 29 Vaccine 334. The authors estimate that the incremental net benefits of the Global Polio Eradication Initiative between 1988 and 2035 to be approximately 40-50 billion dollars. Importantly, they estimate that low-income countries will account for approximately 85% of the total net benefits generated by the GPEI. This may be contrasted with views that suggest developing countries do not reap the most benefits of global disease-eradication programs. It has been argued, for instance; that "polio is not a priority for...developing countries...yet the programme has been justified by the proponents of the GPEI on the grounds that it would result in small savings to the Western countries which would no longer need to spend on polio vaccination once polio eradication is achieved globally.” Sujata Prasad and C Sathyamala, eds, Securing Health for All Dimensions and Challenges (New Delhi: Institute for Human Development, 2006) at 282.
13 The World Health Organization reports, for instance that polio cases have decreased by over 99% since 1988, from an estimated 350,000 cases then, to 406 reported cases in 2013. See World Health Organization, “Poliomyelitis Factsheet No 114” (2014) online: WHO <http://www.who.int/mediacentre/factsheets/fs114/en/>.
1.2 The current picture

The advances made by immunisation efforts over communicable disease are laudable. No longer are societies faced by the ‘demon’ of smallpox whose propensity to disfigure and inflict splitting pain and misery is now happily consigned to the literary pages of Victorian-era novels such as Dickens’ Bleak House. Whilst the positive effects of greater immunisation are experienced by many the protections that are afforded by this intervention, however, have yet to be equitably extended to all.

In 2010, close to 20 million children did not receive the most basic set of vaccinations and about 1.5 million children under the age of 5 died from vaccine-preventable causes. The rates of children being immunised with the third diphtheria-tetanus-pertussis vaccine DTP3 (a rate that is often used as a proxy for indicating the strength of a countries immunisation system given that individuals receiving this particular vaccine will have used the system on at least three occasions) have stagnated at an 83% global average for every year since 2009. This suggests that a more proactive approach needs to be taken to both seek and reach the remaining fifth of children who do not appear to be receiving routine vaccinations.

With newer vaccines the coverage rates between countries are particularly stark. A novel rotavirus vaccine developed in 2012 against strains of severe diarrhoeal

15 For example, “And thus poor Charley sickened and grew worse, and fell into heavy danger of death, and lay severely ill for many a long round of day and night…I was very sorrowful to think that Charley’s pretty looks would change and be disfigured, even if she recovered- she was such a child with her dimpled face- but that thought was, for the greater part, lost in her greater peril.” Charles Dickens, Bleak House (London: Bradbury & Evans, 1853) at 309.
diseases that kill more than 450,000 children each year,\textsuperscript{20} has a global coverage rate of 11\%.\textsuperscript{21} Most of the 59 countries that have introduced rotavirus vaccines into their national immunisation programmes however, are from middle-and high-income countries\textsuperscript{22} despite “nearly 95\% of rotavirus-related deaths occurring in developing countries where access to [curative] treatment is [already] limited or unavailable.”\textsuperscript{23} Indeed low and lower-middle income countries make up around 90\% of the total number of children who are currently unimmunised against vaccine preventable diseases\textsuperscript{24} and 10 countries alone account for 70\% of this total.\textsuperscript{25}

The inequalities that occur within a country are even more pronounced. Save the Children has reported that a child’s immunisation status is strongly associated with their “household wealth, mother’s education and whether they live in an urban or rural location”\textsuperscript{26} meaning that a country’s national immunisation rate will often serve to conceal some of the more illuminating patterns of inequity in immunisation. In 2013 the World Health Organization reported that only 9\% of children from Nigeria’s lowest household wealth quintile were vaccinated with DPT3 antigens, for instance, despite 77\% of children from the country’s wealthiest households receiving the same.\textsuperscript{27} Similarly, while 73\% of Ethiopian children whose mothers had received at least a secondary school level of education received DTP3 vaccinations, only 32\% of

\begin{itemize}
\item \textsuperscript{20} GAVI Alliance, “Rotavirus disease factsheet”, online: GAVI Alliance <http://www.gavialliance.org/library/publications/gavi-fact-sheets/>.
\item \textsuperscript{21} supra note 4.
\item \textsuperscript{22} See PATH, “Rotavirus Vaccine Access and Delivery: Country introductions of rotavirus vaccines Maps and Lists” online: PATH <http://sites.path.org/rotavirusvaccine/rotavirus-advocacy-and-communications-toolkit/country-introduction-maps-and-list/>.
\item \textsuperscript{23} GAVI rotavirus factsheet supra note 20.
\item \textsuperscript{24} See “Finding the final fifth” supra note 19 at vii.
\item \textsuperscript{25} UNICEF, “Immunization facts and figures” (April 2013) online: UNICEF <http://www.unicef.org/immunization/files/UNICEF_Key_facts_and_figures_on_Immunization_April_2013(1).pdf>.
\item \textsuperscript{26} See “Finding the final fifth” supra note 19 at vii.
\end{itemize}
children whose mothers had received no level of education were vaccinated with DTP3.  

1.3 Why are there such vast inequalities in access to childhood immunisations?

The causes of current disparities in access to childhood immunisations are complex and current reasoning emerges to be multifactorial. As is outlined below, inequitable states of affairs can be seen to characterise both the supply and demand side determinants of immunisation accessibility and the influence of each on the other ostensibly adds weight to the intractability of the issues at hand.

1.3.1 Supply-side factors

a. Weak health care infrastructures

The World Health Organization reports that 84% of the world’s total financial resources that are devoted to health are currently spent in OECD countries, which account for just 18% of the world’s population. The inadequate financing of national health care systems within many developing countries undoubtedly contributes to the current picture of immunisation inequality. Countries lacking the capacity to accurately monitor (and therefore effectively respond to) patterns of disease, to set up health facilities that are well-stocked for the widespread dissemination of vaccines and to train health workers that are able to administer

---

28 See WHO, World Health Statistics, supra note 27 at 147.
30 See for example, Jeanette J. Rainey et al, “Reasons related to non-vaccination and under-vaccination of children in low and middle income countries: Findings from a systematic review of the published literature, 1999-2009” (2011) 29 Vaccine 8215. (Among the 202 relevant articles the authors found, 838 reasons were abstracted that were associated with under-vaccination 45% of the reasons were related to immunisation systems). See also, Favin, M et al, “Why children are not vaccinated: a review of the grey literature” (2012) 4:4 Int. Health 229. (Which found the main reasons for under-vaccination were related to immunisation services and to parental knowledge and attitudes.).
31 Save the Children report for instance that vaccine availability may be crucial to ensuring that children are brought back for repeated, routine vaccinations and note that “Parents may have crossed
immunisations, are unlikely to be able to meet the health needs of their populations. A further infrastructural barrier to immunisation stems from the inability of many countries to establish reliable cold-chains. Vaccines, as heat-sensitive biological products become less effective and may even be destroyed when exposed to temperatures outside of their recommended 2-8°C range. This can ultimately leave children susceptible to the very disease they were vaccinated against and may result in displays of mistrust towards the practice of immunisation in communities requiring re-vaccination. Establishing ‘cold chains’ to ensure that the transport, storage and handling of vaccines is carried out in the most optimal fashion is both an imperative for the preservation of vaccine potency and for maintaining the status of immunisation’s therapeutic credibility on the ground. In low resource settings, however, where electricity supplies for the vaccine’s refrigeration may be intermittent, where roads (for their safe transportation) may not exist and where storage facilities are often limited, establishing a reliable cold chain can present as an insurmountable challenge.

b. ‘Big Pharma’ and the international political economy of global health

One might question why, if most of the world’s unimmunised children live in areas of the world where transporting refrigerated vaccines is a relatively burdensome task, have more appropriate vaccines that are in fact better adapted to meeting the long distances, arrived on a day where immunisations are offered, waited in long queues, encountered a well-trained and respectful health worker who is ready to immunise their child- only to find that the clinic does not have an adequate supply of vaccines, needles or syringes,” Save the Children, supra note 19 at 21.


See Medecins Sans Frontieres “The Right Shot: Extending the reach of affordable and adapted vaccines” (2012) online: MSF <http://www.msfaccess.org/sites/default/files/MSF_assets/Vaccines/Docs/VACC_report_RightShot_ENG_2012Update.pdf> (which discusses how the development of better adapted vaccines could reduce barriers to immunisation and could increase coverage levels of both new and traditional vaccines).


See also, “Giving immunisation efforts a booster,” supra note 4.
particular epidemiological needs of the demography’s concerned, not been more forthcoming?\textsuperscript{36} Similarly, one could also question why more vaccines haven’t yet been created that are able to prevent some of the common (and ‘so-called’ neglected) tropical diseases that procure rampant levels of infection and threaten the development of some of the most impoverished children in the world?\textsuperscript{37} The reasons derive, at least in part, from more macro-level factors that are thought to be at play. On this view, inequities in levels of access to childhood immunisations might ultimately be explained by the powerful market systems and international political economies conditioning the normative orderings of the world in which we live.\textsuperscript{38}

Oxfam and Médecins Sans Frontières have, for example, suggested that one of the biggest impediments to immunisation lies in the profiteering agendas of the five pharmaceutical companies (GSK, Merck, Novartis, Sanofi-Pasteur and Wyeth/Pfizer) that currently exert the most control over the direction of vaccine markets.\textsuperscript{39} The World Health Organization further reveals that these companies, which take in over 80\% of total immunisation revenues,\textsuperscript{40} provide only 14\% of the vaccines that are required to meet current levels of demand.\textsuperscript{41} Alternative suppliers based in developing countries produce the remainder of the current, routine vaccines at lower costs and en masse (and are more often awarded large procurement contracts from organisations such as PAHO as a result).\textsuperscript{42} Their products tend to be centered on the more

\textsuperscript{36} See also MSF, “The right shot,” supra note 33.
\textsuperscript{37} See Peter Hotez, “A handful of ‘Antipoverty Vaccines Exist For Neglected Diseases, But The World’s Poorest Billion People Need More” (2011) 30:6 Health Affairs 1080. Hotez illuminatingly points out that the “bottom billion- the 1.4 billion people who live below the poverty level defined by the World Bank- suffer from one or more neglected tropical disease that has been given little attention in the research and development agenda.”).
\textsuperscript{38} See also, Sonia Bhalotra and Thomas Pogge, “Ethical and Economic Perspectives on Global Health Interventions” (2012) IZA Policy Paper No. 38 online: <http://ftp.iza.org/pp38.pdf> (The authors consider how the current global economic order may be contributing to the perpetuation of poverty and poor health in less-developed countries).
\textsuperscript{39} Wilson P, Giving developing countries the best shot: An overview of vaccine access and R & D (Geneva: Oxfam and Médecins Sans Frontières Campaign for access to Essential Medicines, 2010) at 3.
\textsuperscript{40} Miloud Kaddar, “Global Vaccine Market Features and Trends” World Health Organization PowerPoint Slides, online: WHO <http://who.int/influenza_vaccines_plan/resources/session_10_kaddar.pdf> at 10.
\textsuperscript{41} “State of the world’s vaccines and immunization,” supra note 2 at 27.
\textsuperscript{42} Ibid at 28.
traditional vaccines whose patents and product ‘know-how’ have been available in the public domain for some time. These suppliers, however, still often lack the capacity to undertake the research and development into new and perhaps more epidemiologically appropriate vaccines.

The new vaccines that have emerged in the last decade (e.g. the human papilloma virus (HpV), pneumococcal conjugate and rotavirus vaccines) have typically been produced by bigger, ‘Western’ pharmaceutical companies which, in turn, made the vaccines predictably costly and often unaffordable for low and middle income countries to independently provide.

Compounding the high unit costs of newly introduced vaccines is the relative absence of subsequent, competitive generic-vaccine markets. Unlike drugs, which are derived from synthetic, chemical compounds, vaccines are produced by means of a different, biological process. The vaccine production process renders it near impossible for regulators to determine whether vaccines produced by different manufacturers are sufficiently identical, (or bioequivalent), in their final composition as to ensure their safe classification as generics. The safety and effectiveness of all vaccine products must therefore be verified in independent sets of clinical trials, which render the financial advantages of trying to bring a ‘generic’ vaccine to market,

---

43 See Wilson, supra note 39 at 13 who highlights the “increasing complexity of, and regulatory stringency towards, new vaccines work together with know-how and intellectual property (IP) obstacles to delay the entrance of competitors and preserve markets for the largest companies”.

44 Although, see the developing Countries Vaccine Manufacturers Network who are a public health driven, international alliance of manufacturers that are working to improve the capacity of developing country vaccine manufacturers, online: dcvmn <http://www.dcvmn.org/about-dcvmn>.

45 For example, there are currently three pneumococcal conjugate vaccines on the market: Prevnar, Synflorix and Prevenar 13 and they are currently produced by Wyeth, GlaxoSmithKline and Pfizer respectively. The current rotavirus vaccines: Rotarix and RotaTeq are produced by GlaxoSmithKline and Merck respectively and the current Human Papilloma (HPV) Vaccines: Gardasil and Cervarix are produced by Merck and GlaxoSmithKline.

46 It can be noted that vaccine prices are traditionally set for wealthier countries, on the basis of “a vaccine’s value as it relates to savings in health care spending (such as days of hospital stays averted) rather than the cost of R & D production”. See, “The Right Shot” supra note 33. Thus while a vaccine may appear as extremely good value for money in a wealthy country (in terms of the treatment costs it will subsequently avert), in a country with few resources (where significantly less money is spent on its healthcare interventions and treatments to begin with), vaccines can still present as inordinately expensive.

47 It is acknowledged that most new health technologies will be more costly to begin with, however, many become more affordable once more health market and or generic supplier competition kicks in.

48 See Wilson, supra note 39 at 13.
less clear. The practice, therefore, is much less common. This notable absence of ‘generic’ vaccines, when coupled with the effects of the international legal order’s establishing of a global intellectual property regime; which incentivises medical innovation through the promise and vehicle of patent protections, has resulted in pharmaceutical patent-holders tending to hold monopoly positions over vaccine markets (and thereby set their prices) for extended periods of time. Consequently many countries have not been able to access simple, life-saving vaccine technologies for up to decades at a time.

1.3.2 Demand-side factors

In addition to the factors that prevent the provision of a more equitable level of access to appropriate childhood immunisations, are factors working to determine whether a child will even present for vaccination at all. The two ‘sides,’ of course, are highly

---

49 While the current intellectual property regime is often thought the best model for encouraging (vaccine and other health product) innovation, it appears incapable of aligning levels of vaccine access with the broader levels of current vaccine need. Since vaccine-preventable diseases currently affect the poorest people in the world the most severely, (people residing in countries that (and who themselves) are unable to afford expensive vaccine technologies), the incentives to create vaccines for these individuals under the current – profit maximising – regime are arguably few. Several models and mechanisms have been suggested in recent years to attempt to incentivise the realignment of levels of vaccine access and need. One idea is to build specialised patent pools that serve to facilitate the licensing of patents from patent-holding institutions to ‘patent pools’ whose administrators then sub-license any further use of the patents, in an economically efficient and ideally, access-enhancing way. While there has been high-level support for such pools, (See, for example, Global strategy and plan of action on public health, innovation and intellectual property, WHA61.21, WHA, 61st Sess, (2008) at page 35, element 4.3.; see also, Intensifying Our Efforts to Eliminate HIV and AIDS, GA Res on the Political Declaration on HIV and AIDS, A/RES/65/277 (2011) at page 12, point 71(c).), only a handful have been created and so far, it is unclear how effective, in practice, they serve to be (in either encouraging pharmaceutical companies to share their existing patents with other companies or in encouraging the creation of medical products that are better able to respond to some of today’s most critical health based needs). A further idea, proposed by the Health Impact Fund, is to incentivise “the delivery of new medicines through pay-for-performance mechanisms” which reward medical product innovators for the real impact their product has, irrespective of the market it is used in, and thus removing some of the commercial risk of creating a drug or vaccine for use in the developing world, where fair financial returns on such a product might otherwise be unattainable. See, Health Impact Fund, “Making new medicines available” online: HIF < http://healthimpactfund.org>.

50 See, for example, Richard T. Mahoney & James E. Maynard, “The introduction of new vaccines into developing countries” (1999) 17 Vaccine 646 (who argue that “from the time a vaccine is first licensed in a developing country to the time most of the poor in developing countries have access to the vaccine can be 20-30 years”). It is acknowledged that several public-private financing mechanisms and alliances have since emerged (such as the GAVI alliance and the International Finance Facility for Immunisation) to attempt to overcome this problem, however there is still a long way to go.
interrelated and many of the issues here classified as a question of ‘demand’ are simultaneously informed by underlying, ‘supply’ side considerations.

a. Poverty

Household wealth is strongly associated with rates of immunisation; children from lower socio-economic backgrounds are less likely to receive immunisation against vaccine-preventable diseases.\(^{51}\) Whilst childhood vaccinations are typically provided by governments for free,\(^ {52}\) the indirect costs of immunising a child that are faced by a family can be prohibitive. The costs incurred in travelling to a clinic (particularly if the child lives in a rural location\(^ {53}\)), of taking days off work, and of arranging childcare for the supervision of other children, present several financial barriers that are much less of an issue to those with the means to overcome them.

The “synergy between poverty and immunisation”\(^ {54}\) also works to exacerbate resultant child health and disease-based outcomes. Unvaccinated children are more likely to succumb to disease and will likely lack the resources needed to mitigate the consequences.\(^ {55}\)

As is later elaborated health, and one’s susceptibility to disease, is only partly determined by one’s access to healthcare and to the technologies that it gives rise to.

---

\(^{51}\) See “Finding the final fifth,” supra note 19 at 8 and see also “World Health Statistics 2013,” supra note 27 at 144-153.

\(^{52}\) See “Finding the final fifth,” supra note 19 at 21. However, it should be noted that in some parts of the world, there may be illicit charges for immunisations as either costs for syringes and other items or as a penalty for arriving late to start a vaccination session. Millimouno D et al, “The Social Dynamics of Infant Immunisation in Africa: Perspectives from the Republic of Guinea” (2006) Working Paper 262 Institute for Development Studies, University of Sussex, online: ids <http://www.ids.ac.uk/files/Wp262.pdf> at 20. Taken from John Snow Inc., “Epidemiology of the Unimmunized Child: Findings from the grey literature” Immunization basics Project, World Health Organization, online: WHO <http://www.who.int/immunization/sage/ImmBasics_Epid_unimm_Final_v2.pdf> at 13.

\(^{53}\) See “Finding the final fifth” supra note 19 at vii and “World Health Statistics 2013” supra note 27 at 143-152.

\(^{54}\) "Finding the final fifth,” supra note 19 at viii.

\(^{55}\) Victoria, C.G et al “Applying an equity lens to child health and mortality: more of the same is not enough” (2003) 362 Lancet 233 at 234.
Health is, to a much greater extent (and perhaps even by 80-90%\textsuperscript{56}), determined by an array of underlying determinants such as access to nutritious foods, to safe drinking water, and to sanitary living conditions. Pogge notes that for children living in poverty, “under-nutrition [for instance] lowers resistance to infectious diseases which in turn aggravates under nutrition.”\textsuperscript{57} Such factors also serve to attenuate the impact of vaccination.\textsuperscript{58}

\textbf{b. Educational barriers}

An associated factor of poverty is its tendency to inhibit access to educational opportunities.\textsuperscript{59} Education plays a key role in informing people about the necessity and benefits of immunisation, and so it perhaps comes as little surprise that children with uneducated parents (particularly mothers\textsuperscript{60}) are less likely to be immunised than


\textsuperscript{57} See, Bhalotra & Pogge, supra note 38 at 5, citing, Black, R.E et al, “Global, regional, and national causes of child mortality in 2008: a systematic analysis” (2010) 375:9730 Lancet 1969 (which provides information on the causes of child deaths and estimates that infectious diseases caused 68% of deaths in children under 5.) See also, Jones, R. et al “How many child deaths can we prevent this year?” (2003) 362:5 The Lancet 65 (which points out the leading causes of preventable deaths which include a number of diseases and the authors note the underlying cause of under nutrition in deaths among children younger than 5 years.) Under-nutrition itself is currently though to be a factor underlining 45% of all child deaths, see Black RE et al, “Maternal and child under nutrition and overweight in low-income and middle income countries” (2013) 382:9890 Lancet 427.


\textsuperscript{60} See “Finding the final fifth.” supra note 19 at 12 and “World Health Statistics 2013,” supra note 27 at 143-153.
their peers. The failure to educate (future) parents about the benefits of vaccination, contributes to a more fundamental problem concerning the social landscape that informs the availability of immunisation services around the world.

c. Lack of demand

Where there is less scientific knowledge being disseminated about the merits of vaccination and further, where the time constraints of those trapped in the monotony of abject poverty, (and thus fighting for survival), takes command, there is also likely to be less community participation and demand for the intervention to be provided. Further, where there is little or no demand for immunisation services to be prioritised, politicians may correspondingly lack the necessary incentives to invest in this fundamental cause. The result is that the better educated, more informed and ultimately better resourced populations will tend to demand immunisation (and other essential health services) as of right, and others, in these absence of these key commodities, will tend to miss out.

---


62 See “Giving immunisation efforts a booster,” supra note 4.
d. (Mis)-informational constraints

The accuracy of the informational environment surrounding the status, safety and efficacy of vaccines can also impact upon a child’s ability to access immunisations.\(^{63}\) Formal education plays a role in helping people to understand the initial, scientific benefits of immunisation however the changing risk factors and evolving epidemiology of communicable disease requires that even beyond the school years, accurate and relevant information surrounding immunisation be dispersed. It is also particularly imperative that countries create channels of communication to respond to adverse vaccine events\(^{64}\) and to the dissemination of false ‘scientific’ information (such as the now-disproved MMR vaccine-autism link\(^{65}\)). Those lacking access to the mediums that broadcast this sort of information often fail to be protected against vaccine preventable diseases when they occur.\(^{66}\) In large numbers, this can prove fatal to an overall outbreak response.

Such a threat often arises in circumstances where the disease in question has remained dormant for a long, and perhaps to some: immemorial, period of time. Vaccinations on this account, become “a victim of their own success”\(^{67}\) since the re-emergence of

\(^{63}\) See Heidi J. Larson et al, supra note 61.

\(^{64}\) This issue arose with the introduction of the pentavalent vaccine in India. A number of children are reported to have died following receipt of the vaccine and many attribute the deaths to the vaccine itself (and not, as has been intimated by some, to pre-existing conditions). The lack of clarity and swift official response, however, has resulted in many parents deciding not to have their children vaccinated with this vaccine. See Mohuya Chaudhuri, “The sad story of a good vaccine” (September 24, 2013) The Hindu, online: The Hindu <http://www.thehindu.com/opinion/op-ed/the-sad-story-of-a-good-vaccine/article5160984.ece>; See also, Ganapati Mudur, “Antivaccine lobby resists introduction of Hib vaccine in India” (2010) 340 BMJ (which explains the chronology of events leading to the opposition).


\(^{66}\) Public confidence is highlighted as being a key determinant of immunisation by Heidi J Larson et al, supra note 61. See also, Mosiur Rahman & Sarker Obaida-Nasrin, “Factors affecting acceptance of complete immunization coverage of children under five years in rural Bangladesh” (2010) 52:2 Salud Publica de Mexico (who find that mass media exposure had a strong positive relationship with immunisation status in the communities it looked at. Similarly- negative relationships between mass media and immunisation status can be found where the messages that are being broadcasted, are of a negative nature as one study in Canada demonstrated. See Morin A et al, “Maternal knowledge, attitudes and beliefs regarding gastroenteritis and rotavirus vaccine before implementing vaccination program: Which key messages in light of a new immunization program?” (2012) 30 Vaccine 5921 at 5925.

disease, for reasons perhaps linked to globalisation, may be treated less seriously than if the symptoms were more common and visible in their reach.

e. Social opposition

Current disparities in access to childhood immunisations might also be attributable to religious, cultural and political opposition to vaccines. Such social opposition derives from a “complex interplay of factors” including “a lack of trust in modern medicine, political and religious motives...[histories] of perceived betrayal by...government[s] and...conceivably - genuine- albeit misplaced and ineffective-attempt[s] by local leadership[s]” to protect their people.

68 A particular factor to underpin some of the current, religious opposition towards vaccines stems from unpalatable revelations that the US’s Central Intelligence Agency had been using vaccination programmes as a proxy for some of their counter-terrorism surveillance efforts in the wake of 9/11. (See, for example, Eleanor Hall, “UNICEF’s polio advisor confirms CIA revelations led to deaths of vaccine workers” (27, May 2014) ABC News (radio interview, transcript), online: ABC <http://www.abc.net.au/news/2014-05-27/unicefs-polio-advisor-confirms-cia-revelations-led/5481240>.) The long-term repercussions of this highly misguided policy continue to endure and bears (at least) some responsibility for the deaths of the (now hundreds of) vaccine-workers that have been shot by Taliban insurgents in Pakistan (See, for example, Jon Boone, “Pakistan polio vaccinator’s murder by militants raises health workers’ fears” (25 March 2014), online: The Guardian <http://www.theguardian.com/society/2014/mar/25/pakistan-polio-vaccinators-murder-militants-salma-farooqi>) and by members of the Boko Haram in Nigeria, (See, for example, David Smith, “Polio workers in Nigeria shot dead” (8 February 2013) The Guardian, online: The Guardian <http://www.theguardian.com/world/2013/feb/08/polio-workers-nigeria-shot-dead>). Though, the agency and culpability of these terrorist organisations are not to be diminished. Similarly, the yearlong cessation of polio immunisation efforts in the Northern Nigerian state of Kano in 2003 (as a further reaction of mistrust) served to set global polio eradication initiatives back, by (at the time) causing the importation of the virus into 29 previously polio-free African countries. Centers for Disease Control and Prevention, “Progress toward global polio eradication - Africa, 2011” (2012) 61:11 MMWR Morb Mortal Wkly Rep 190.


70 Ibid.
It is acknowledged that the likelihood of a child being vaccinated often remains a highly context-dependent matter. Nonetheless, the determining factors will likely draw from the abovementioned array of individual, community and global supply and demand side considerations. The interaction of these issues ultimately serves to procure the inequitable levels of access to childhood immunisations, and the resultant childhood mortalities attributable to vaccine-preventable (and thus inherently inequitable) diseases.

1.4 Health equity

Although the concept of health equity is analysed in Chapter 2, it is worth briefly outlining what is meant by the term from the outset. Health equity, as Braveman argues:

Is the principle or goal that motivates efforts to eliminate disparities in health between groups of people who are economically or socially worse off and their better-off counterparts - such as different racial/ethnic or socioeconomic groups or groups defined by disability status, sexual orientation, or gender identity - by making special efforts to improve the health of those who are economically or socially disadvantaged.\(^{71}\)

The reasons currently conditioning the non-immunisation of children (e.g. lack of appropriate vaccines due to international political and market economy biases against the poor, poverty, lack of parental education, social opposition, weak health-infrastructures and lack of access to health information) appear attributable to systematic and socially produced features that either national or international governments are in a position to address.\(^{72}\) Further, and to the extent that structurally preventable (and thus unfair) disparities in health continue to exist, their resultant


health inequities ought to be tackled. Health inequity, however, is not only a matter for moral and ethical contemplation, but it is also a concept that finds normative relevance in the international legal regime: specifically in the human right to health. The particular significance that health equity occupies in relation to this branch of international law is an issue to which I now turn.
Chapter 2

The legal significance of health equity: a concept grounded in the international human right to health

The right to health has been recognised as a fundamental human right in a number of international, \(^{73}\) regional \(^{74}\) and domestic \(^{75}\) human rights based treaties. Moreover, every country in the world has now ratified at least one international legal treaty that encompasses the right. \(^{76}\) The right to health, which derives from an explicit commitment to respect the inherent dignity of all people, \(^{77}\) provides the international community with a universally applicable standard to be met and aspired towards in attempts to achieve population health. A central feature of the right to health is its concern for health equity: both as a population health outcome and as an agenda for


\(^{76}\) See Lawrence O. Gostin, supra note 56 at 244.

\(^{77}\) See the Preamble to the ICESCR, supra note 73.
the operationalization of provisions seeking to enhance human health. In this chapter, the normative content of the right to health is explored in order to better illuminate its objective of health equity.

2.1 Health equity and the normative content of the right to health

Whilst the right to health can be derived from a number of legal sources, it is widely acknowledged that the most comprehensive explication of the right can be found in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). As such, further discussions of the ‘right to health’ within this thesis refer primarily to this text.

Article 12 ICESCR

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The Steps to be taken by the States parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child;
   (b) The improvement of all aspects of environmental hygiene;
   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 12.1 defines the purpose of the right to health whilst 12.2 “enumerates illustrative, non-exhaustive examples of State parties’ obligations.”

---

Of immediate note are the facts that the right to health must be universally secured (since it is a “right of everyone”), it is progressive in its nature, (advocating for the enjoyment of “the highest attainable standard”) and aspires towards the realisation of a particular human state, (“physical and mental health”) as opposed to a more narrow entitlement centreing solely around the provision of specific, healthcare goods.  

The Committee on Economic, Social and Cultural Right’s General Comment No. 14 which, although not legally binding, offers an authoritative interpretation of the right, further elaborates that “the right to health is not to be understood as a right to be healthy”, but “contains freedoms and entitlements” including “the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health.”

Already, the concept of health equity is implicated as an objective of the right to health in at least three, interrelated ways. Both appear to be concerned with issues of social (in)justice, both would see value in prioritising strategies that are designed to promote ‘public health’ and both assimilate progressivity, within processes of health equalisation. Each factor is discussed below.

---

79 For an alternative view, see for example, Norman Daniels, “Justice, Health and Health Care” Tufts University, online: HSPH http://www.hsph.harvard.edu/benchmark/ndaniels/pdf/justice_health.pdf>. (Who argues that a theory of justice for health and healthcare can help us to decide how we should distribute healthcare resources. Daniels, while acknowledging that health is more than healthcare, appears to stick with the idea that healthcare is the good to be decided and tries to mitigate against the unresolved distributive problems that this brings about for individual health, by proposing that a process of “accountability for reasonableness” be used in order to give the distributive process greater legitimacy).

80 General Comment No. 14, supra note 78 at Para 8.

81 Ibid.

82 Ibid.
2.2 Social Justice

If health is to be systematically protected, (as per General Comment No. 14 above), those attempting to secure the right to health must necessarily address the justness of a State’s socially constructed affairs. Where the status quo serves to systematically disadvantage groups (or individuals) on the basis of some socially determined characteristic; the state, in its conditioning of the organisation of such affairs, can be seen as “primarily responsible for [the] production of inequities.” The “resulting task of eliminating health inequities” thus “becomes a matter of social justice” that states themselves, with their unique power to enact policy and distribute resources, are best placed to address.

Adherence to the principle of social justice thus requires that organised efforts be made to ensure that everyone benefits from opportunities to be healthy, with particular emphasis being placed on the needs of the least advantaged. General Comment No. 14’s interpretation of the interrelated, essential elements of the right to health: namely the “AAAQ framework” (availability, accessibility, acceptability and quality), further confirms the rights socially just vision for greater equity in

---

85 Ibid.
86 See Erdman, supra note 72. It is acknowledged that the role of other actors, and their ability to influence the distribution of resources, is now - more than ever - extremely significant and there may even come a time when the government alone cannot influence the actions of such actors; particularly in an ever globalised world where demarcating positions of accountability is increasingly difficult and where companies are no longer grounded within one jurisdiction. (Indeed, we already see this happening with things like corporation tax evasion).
87 See, Madison Powers & Ruth Faden, Social Justice: The Moral Foundations of Public Health and Health Policy (New York: Oxford University Press, 2006) at 82; Alan R. Hinman, “Immunization, Equity, and Human Rights” (2004) 26:1 American Journal of Preventive Medicine 84 at 84; Fabienne Peter, “Health Equity and Social Justice” in Sudhir Anand, Fabienne Peter & Amartya Sen, eds, Public Health, Ethics and Equity (Oxford: Oxford University Press, 2004) at 103-104 who note “social inequalities in health are unjust or inequitable if they result from an unjust basic structure of society – that is, a basic structure that imposes sacrifices on the worse off only to benefit the already better-off groups.”. See UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15 at Para 11 “children in disadvantaged situations and underserved areas should be a focus of efforts to fulfil children’s right to health.” [Hereafter General Comment No. 15].
88 See General Comment No. 14, supra note 78 at Paragraphs 12(a)-(d).
population health. The AAAQ framework requires that States prioritise a distribution of health goods that advance the needs of the least advantaged. Health facilities, goods (e.g. vaccines) and services must, “be accessible to all, especially the most vulnerable or marginalized sections of the population” and, importantly, must include sufficient quantities of “the underlying determinants of health” (whose absence often impacts upon the marginalised, most adversely). Equity further “demands that poorer households…not be disproportionately burdened with health expenses as compared to richer households” and that medical services and access to the underlying determinants of health be within a safe and physical reach for all. Erdman notes how a system which fails to pay attention these aspects, and which “places already disadvantaged groups at further disadvantage with respect to their health” violates the right to health, by consequence of its discriminatory effects.

This distributary, health equity enhancing, objective of the right to health, however, arguably poses a challenge to some of the more traditional understandings of individual rights; understandings that – when applied to the present context – have been argued to undermine the principle of health equity’s fundamentally distributary aims.

---

89 Ibid at Para 12(b).
90 General Comment No. 14, supra note 78 at 12(a).
91 Ibid at 12(b).
92 Ibid.
94 It might also be argued that a State’s legal recognition of a justiciable right to health emerges as a necessary element of an effective, health equity enhancing toolkit since it provides individuals with the means to effect a more socially just state of affairs. Those subjected to the injustices of a social arrangement are, by definition, more vulnerable and in the absence of such a right, will likely lack the power or voice to effect broader change, when faced with the competing majoritarian interest. [Indeed Bambass and Casas note that “once a society embraces a political foundation of egalitarianism, whereby all citizens of a country are due equal regard under the law and have equal political voices, societies themselves become the ultimate arbitrators of equity in health or any other sphere” Bambass, A. & Casas, J.A. “Accessing equity in health: Conceptual criteria” in R. Hofrichter, ed, Health and social justice: Politics, ideology and inequity in the distribution of disease (San Francisco: Jossey-Bass, 2006) at 333].
95 See, for example, Octavio Luiz Motta Ferraz, “The right to health in the courts of Brazil: Worsening health inequities?” (2010) 11 Health & Hum Rts 33.

23
Rights are traditionally shaped by the “classic liberal conception of the nature of the human person;” as persons that are free, autonomous and intrinsically possessing of rights. As part of the notional transition to the modern, juridical state, expounded by a number of liberal, political philosophers, where civilised societies as opposed to anarchical tyrannies serve to reign, individuals (as political persons) are expected to surrender a number of their intrinsic, civil and political rights, for the benefit of securing other citizens’ basic freedoms. The state, as the guardian of the resulting ‘social contract,’ is entrusted with protecting individual’s rights and moreover, individuals are entitled to enforce their rights, as against the state, if they have been breached or inadequately protected.

The reason the right to health, as a socio-economic right, poses a challenge to this state of affairs, is that its ostensibly positive, resource requiring nature appears to contradict this liberal understanding of rights, “which presumes that social living requires the surrender, not the creation,” of individual rights. Further, the right to health – as a right to a system of health protections – is often understood as being a collective right, and thus attempts to interpret it from the classical (and necessarily individualised) standpoint, could prompt negative distributary effects; particularly when the budgetary effects of its enforcement are considered in their entirety.

Nevertheless the traditional, theoretical “superiority” of civil and political rights has been rendered at least somewhat obsolete by the explicit recognition now afforded to

---

98 For Kant, this must be done in accordance with the ‘universal Law:’ “Right in general, may be defined as the limitation of the Freedom of any individual to the extent of its agreement with the freedom of all other individuals, in so far as this is possible by a universal Law.” Ibid.
99 Jeanne M. Woods, supra note 96 at 765.
100 Colleen M. Flood & Aeyal Gross, eds, The Right to Health at the Public/Private Divide: A Global Comparative Study (New York: Cambridge University Press, 2014) at 453 who state “the classical structure of rights, notably its individualized focus, may undermine the distributional potential making the rise of social rights – and as we shall see, specifically health care rights – a Pyrrhic victory.”
the indivisibility of socio-economic, and civil and political rights in international human rights law\textsuperscript{101} in practical realisation of these rights’ indivisible fact:

To offer political rights, or safeguards against intervention by the State, to men who are half-naked, illiterate, underfed and diseased is to mock their condition; they need medical help or education before they can understand, or make use of, an increase in their freedom… Without adequate conditions for the use of freedom, what is the value of freedom?\textsuperscript{102}

Further, while conceptualisations of the right to health, as an individual right, raises important, collective implications, as this thesis explores, its proper and health equity oriented interpretation enables the prioritisation of individual needs in a manner that is arguably consistent with the underlying, broader societal interest.

2.3 Progressivity as a process of health equalisation

The formulation of the right to health as a progressive right “to the highest attainable standard of health” is often criticised for its operational imprecision and foundation upon seemingly utopian ideals. To some extent, such criticisms can be justified as the right’s broad aspirations appear to render the “rigorous monitoring and enforcement,”\textsuperscript{103} of states’ fulfilment of obligations particularly difficult. Given, however, that “human rights law is the only universally applicable international regime designed to safeguard public health,”\textsuperscript{104} over-emphasising the right’s limitations could serve to undermine the already limited calls to realise its highly progressive and equitable aims. Of more help, is to work on framing interpretations of

---

\textsuperscript{101} See, for example, the Preamble to the International Covenant on Economic, Social and Cultural Rights, \textit{supra} note 73 which states “Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights.”


\textsuperscript{103} See Lawrence O. Gostin, \textit{supra} note 56 at 20.

\textsuperscript{104} \textit{Ibid}, at xv.
the right to health in a less ambiguous fashion, and to work on identifying the specific elements of the rights minimum core (See 3.2).^{105}

It is suggested that interpretations of ‘progressivity’, can in fact be affixed to a somewhat practical and thus perhaps more actionable concept centring on equity. In particular: realisation of the right to health requires that states engage in processes of health equalisation.

**a. What kind of ‘equalisation’ does the right to health envisage?**

It is acknowledged that equality is an ambiguous and empirically natured term that on its own lacks the normative force to indicate the kind of equality that is being sought.^{106} In the sphere of health, Temkin notes how a “host” of “equality candidates” have “been championed, including, among others, income, resources, primary goods, wealth, power, welfare, opportunity, needs satisfaction, capabilities, functioning’s, rights and liberties.”^{107} There is one philosophically grounded conception of equality, however, that emerges as particularly relevant to General Comment 14’s interpretation of Article 12.

**b. A capability oriented approach towards processes of health equalisation.**

As mentioned, General Comment 14 states that individual entitlements under the right to health include “a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health.”^{108} Furthermore, and after acknowledging “a number of aspects which cannot be addressed solely within the relationship between States and individuals,”^{109} the

---


^{108} See General Comment No. 14, *supra* note 78 at Para 8.

comment stipulates, “the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation”\textsuperscript{110} of the right. In suggesting that the right to health is a right to an enjoyment of the conditions in which people can be healthy, the right to health accords with prominent capability theories of health. Capability theories make “individual capability to achieve valuable functionings the focal variable for social evaluation.”\textsuperscript{111} Further, by introducing an “inter-personal metric”\textsuperscript{112} of comparison that is based upon opportunity as opposed to outcome, the capability approach “incorporates both well-being and the freedom to pursue well-being”\textsuperscript{113} as central aims.

From a health-equity stand point the capability approach offers an ideal metric for monitoring health equalisation since it respects the inherent value of individual choice (which to some, may be considered more valuable than health) and is simultaneously attentive to the diversity of people’s ‘internal’ and background characteristics that would make the equalisation of healthcare resources alone, an inappropriate objective for progressivity.\textsuperscript{114} The capability approach is fundamentally interested in the relationships that arise between people, resources and the availability (or equality) of opportunities to convert such resources into good health.\textsuperscript{115}

Evidence that a capability-oriented approach towards the process of progressive realisation (or equalisation) is an objective of the right to health is apparent in the ICESCR.

\textsuperscript{110} Ibid.
\textsuperscript{111} See Jennifer Prah Ruger, supra note 9 at 293.
\textsuperscript{113} See Jennifer Prah Ruger, supra note 9 at 294.
\textsuperscript{114} Yukiko Asada, Health Inequality, Morality and Measurement (Toronto: University of Toronto Press, 2007) at 47.
\textsuperscript{115} See, Amartya Sen, Inequality re-examined (Cambridge, MA: Harvard University Press, 1992) at 27. In many ways, capability theories accord very closely with ‘prioritarian’ theories of justice, which argue that, “What is morally problematic in inequality is not that someone fares worse than others but that the worst off have not achieved the level they could have achieved.” See Yukiko Asada, supra note 114 at 29; Yukiko Asada, “A summary measure of health inequalities incorporating group and individual inequalities in” in Nir Eyal et al, eds, Inequalities in Health: Concepts Measures and Ethics (Oxford: Oxford University Press, 2013) at 66.
As “an initial step towards the realisation of rights”\(^{116}\) within the Covenant for example, “states are required to identify the disadvantaged sectors of the population”\(^{117}\) (i.e. those who lack capabilities to achieve good health) through, for instance, “data collection on a disaggregated basis.”\(^{118}\) As a matter of legal obligation, States are further required to “adopt and implement a national public health strategy and plan of action on the basis of [such] epidemiological evidence, addressing the health concerns of the whole population… [whilst] giv[ing] particular attention to all vulnerable or marginalized groups.”\(^{119}\)

In addition, the specific steps that Article 12.2 enumerates as necessary for States to achieve realisation of the right, further confirms its agenda for ‘equalisation’. The issues of child mortality (12.2a), unsanitary living conditions (12.2b), infectious disease (12.2c) and lack of access to acute healthcare services (12.2d), are all factors tending to disproportionately affect socially disadvantaged members of society and ultimately inhibits their individual opportunities to achieve the highest attainable standard of health. Through explicitly requiring states to “take steps” to address these very basic, health needs and further, their underlying determinants; the right to health, as Erdman points out, prioritises health equity as a specific policy objective.\(^{120}\)

General Comment No. 14 further makes clear that it is a substantive (vs. a formal) conception of ‘equality of opportunity’ that is aspired.\(^{121}\) The Comment emphasizes that Article 2.2 (which details the nature of State Party obligations under the ICESCR) proscribes all forms of “discrimination in access to health care and [the] underlying determinants of health, as well as to [the] means and entitlements for their

---


\(^{117}\) Ibid. The author states that this is stated as being one of the specific aims of the reporting process, citing General Comment No. 1, UN Doc. E/1989/22, Annex III, at 87, UN ESCOR, Supp. (No. 4) (1989).

\(^{118}\) General Comment No. 14, *supra* note 78 at Para 16.

\(^{119}\) Ibid at Para 43(f).

\(^{120}\) See also, Erdman, *supra* note 72.

\(^{121}\) In other words, the right to health doesn’t only require equality of treatment before the law, but requires that there be an active assurance of equality of treatment (in relation to access to health goods facilities services and its underlying determinants) by the law. See also, Maite San Giorgi, *The Human Right to Equal Access to Health Care* (Cambridge: Intersentia Publishing Ltd, 2012) at 65-66.
procurement which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.”

2.4 Public Health

Health equity is further implicated as an objective of the right to health by virtue of the right’s inherently public health oriented agenda. If evidence from the epidemiological literature that health is determined (primarily) by social conditions is to be believed, then logically, States seeking to effectively secure the right to ‘health,’ must take action on these more upstream determinants of wellbeing. Indeed, current articulations of the right to health in Article 12 of the ICESCR, and beyond, derive from formulations that have placed an explicit emphasis on tackling the broader determinants of health, in pursuit of the achievement of ‘health’. Article 25.1 of the Universal Declaration of Human Rights (1948), for example, subsumes the right to health within its, “right to a standard of living” deemed “adequate for the health of himself and his family.” Furthermore, the preamble to the Constitution of the World Health Organization (1946), in similarly conceptualising health as “a state of complete physical, mental and social wellbeing,” strengthens the assumption that the social conditions of health must be viewed at least as importantly as the (highly ethnocentric) paradigms of health that focus solely on an absence of disease.

122 General Comment No. 14, supra note 78 at Para 18. Also note that discrimination (discrimination of any sort- on the proscribed grounds), necessarily violates the equality of opportunity principle and thus, through the rights prohibition on discrimination, a clear avenue for the justiciability of the right is provided.
123 UDHR, supra note 73.
a. But what is ‘public health’?

The World Health Organization defines public health as referring to

All organised measures….to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.\textsuperscript{125}

Public health theoretically encompasses any preventive intervention aiming to promote population-level health. As increased evidence of the social determinants of health and of the impact of social inequality upon the life course are more forthcoming,\textsuperscript{126} the commensurate policy jurisdictions that committed public health practitioners will have to cross will likely expand.

From a political standpoint public health can thus present as an extremely contentious concept. Holding unduly myopic views as to the role of state in this domain however, can be counter-intuitive and as Tobin observes, “the history of public health [has] demonstrated that in the absence of collective action to deliver health services and protect health, the humanitarian, economic and political consequences [can be] profoundly negative for both states and individuals.”\textsuperscript{127} The failure to invest in public health is detrimental to all, and as the preventable deaths of monarchs and aristocrats in pre-public health conscious times reminds us, money and power alone are insufficient guarantors of good health.

Public health, which can be characterised as a non-rivalrous and non-excludable, public good, thus emerges to have an inherently equalising force. It raises the minimum standards of the health of a population, and indiscriminately benefits all

within its reach.  

Of course, policies that are designed to give effect to public health alone, cannot resolve all of the “distributive problems [that] arise within efforts to reduce health inequalities.” Erdman notes how it is often the better off that derive the initial and maximal benefits of the health technologies that are provided as public goods and thus a purely utilitarian-driven approach towards public health, can only take quests for greater equity in health, so far.

The right to health, as has been argued, does however offer some solutions. It places its health-enhancing strategies within a binding legal framework that a) tends to the least advantaged by focusing upon the structural causes and barriers to individual’s physical and mental health, and b) requires that the steps that are being taken towards the right’s realisation contribute to processes of ‘health equalisation.’ Public health, as a strategy that is now scientifically thought to bring about the greatest benefits to individual physical and mental health, is thus the operational strategy that must logically be adopted in order for states to achieve universal fulfilment of the right. In many ways, this is plain. Public health provides the foundation from which all, social and economic action can take place and within industrialised countries, its “widespread or sustained disruption” is typically “treated as a [national] crisis.”

General Comment No.14 indicates that this is, in fact, the policy approach the Covenant’s framers have sought to proffer, stating:

The Committee interprets the right to health…as an inclusive right extending…not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and

---

128 See also Hinman, supra note 87 who states, “If asked about the basic underpinning of public health, public health workers are likely to say it is the quest for social justice or equity.”
130 See Erdman, supra note 72. According to the inverse equity hypothesis, Erdman states “advantaged social groups with the most resources will derive the initial and maximum benefit of any new public health intervention, increasing social health disparities.” See also, Cesar G Victora et al, “Explaining trends in inequities: evidence from Brazilian child health studies” (2000) 356 The Lancet 1093, whom Erdman cites, and which provides evidence of the “inverse equity hypothesis” in action in Brazil.
131 See Lawrence O. Gostin, supra note 56 at 415.
132 Ibid.
housing, healthy occupational and environmental conditions, and access to health related education and information…

And further:

Investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

The reality characterizing how the right to health is being interpreted (assuming indeed, that it is at all) appears, however, somewhat different. Many countries fail to prioritize their public health needs over expensive healthcare resource allocations and similarly most of the current global health initiatives, institutions and aid spending objectives designed to arguably give effect to the right to health, disappointingly reflect the same.

133 General Comment No. 14, supra note 78 at Para 11.
134 Ibid at Para 19. Public health is a highly cost-effective intervention and this becomes extremely apparent when one considers how many health benefits it brings about in spite of the relatively little money that is directed towards public health efforts in developed countries (typically 3-5% of total health budgets.) See for example, “Public health and the U.S. economy” (2012) Harvard School of Public Health, online: HSPH < http://www.hsph.harvard.edu/news/magazine/public-health-economy-election/>.
135 The UK Department for International Development, for instance, currently has as its health assistance priorities, to “help immunise more than 55 million children against preventable diseases; save the lives of at least 50,000 women in pregnancy and childbirth and 250,000 newborn babies; help at least 10 million more women to use modern methods of family planning by 2015; help halve malaria deaths in 10 of the worst affected countries.” All are extremely important measures, and on the face of these priorities alone, it is unclear what the specific measures and policies will be to achieve them. Nevertheless, one immediately notes the highly disease and medically natured focus of all of these priorities, and ones sees the lack of commitment to the underlying issues of under-nutrition and sanitation for instance, within the international health agenda itself. See, UK Department for International Development webpage, online: Gov.uk https://www.gov.uk/government/organisations/department-for-international-development/about#priorities>. Similarly, whilst extremely important causes in themselves, (arguably) the biggest global health initiatives in the world: the Global Alliance for Vaccines and Immunisation and the Global Fund to Fight AIDS, Tuberculosis and Malaria, are both heavily disease focused; perhaps diverting resources from some of the underlying causes that would militate against the spread of such diseases in the first place.
As this chapter has sought to demonstrate, the normative content of the right to health is instilled with a clear aspiration for health equity. In the next Chapter, this objective is related to the specific health issue of this thesis; namely the inequitable levels of access to childhood immunisations. The particular legal obligations that are incumbent upon State Parties to achieve such equity in access to childhood immunisations are outlined and attention is drawn to some of the ways in which State Party obligations have been designed to overcome barriers of the sort that were explored in Chapter 1.
Chapter 3
Legal obligations that stem from the right to health and its encompassing right to equity in access to childhood immunisations

In Chapter 2, it was argued that the normative content of the right to health forms a right to health equity. The right to health, after all, manifests as a right to be both protected from, and empowered within, the inequitable social structures that have an impact upon individual health (the social justice element); it is described as a right to a system of public health protections that (amongst other things) have regard for the broader determinants of health (the public health promoting element); and is further expressed as a right to an equality of the conditions in which individuals are able to achieve the highest attainable standard of health (the health equalisation aspect).

Given this equity-enhancing interpretation of what the normative content of the right to health appears to be, this chapter surveys the legal obligations that are incumbent upon States Parties to achieve it. In particular, it considers the legal obligations that are incumbent upon State Parties to achieve equity in the levels of access to the health good under discussion: namely the good of childhood immunisations.

3.1 Legal obligations under the right to health

3.1.1 The right to health’s ‘tripartite typology’ of obligations to respect, to protect and to fulfil.

The right to health, like all other human rights under the ICESCR, “imposes three types or levels of obligation [upon] States parties:”136 Namely obligations to respect, to protect and to fulfil.137 Obligations to respect require that states refrain from

---

136 General Comment No. 14, supra note 78 at Para 33.
137 This respect, protect and fulfil terminology, first developed by the Special Rapporteur for Food in the early 1980s, is widely deployed in human rights advocacy; perhaps offering a more workable (and
violating the right to health by “inter alia, denying or limiting [its] equal access for all persons.”138 This requires states to “abstain from enforcing discriminatory practices”139 and to also take affirmative, corrective actions where required.

Obligations to protect “include, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties.”140 State party obligations to protect are considered extremely significant in this discussion given the expansive role that third party actors now play in delivering healthcare goods. Most states depend upon third party actors to research, develop, manufacture, market and price childhood-vaccines and thus a State’s regulation of, and influence over, these actors’ actions are thought to be critical in attempts to attenuate the inequitable disparities often procured by the ‘corporate agenda’.

Indeed the Committee on the Rights of the Child in its General Comment No. 15 (also on the right to health) markedly highlights the “profound impact of the pharmaceutical sector on the issue of the health of children”141 and thus notes additional duties upon state parties to promote awareness of non-state actors’ responsibilities to recognise, respect and fulfil children’s attempts to achieve their rights to health.142 The Committee on the Rights of the Child appears to further expand the CESCR’s interpretation of state duties of protection, by not only outlining States’ obligations to protect against third parties, but by also articulating a need for them to protect against “social and environmental threats”143 to individual health too.

---


138 Koch, supra note 137.
139 General Comment No. 14, supra note 78 at Para 34.
140 Ibid at Para 35.
141 See General Comment No. 15, supra note 87 at Para 82.
142 Ibid at Para 76.
143 See General Comment No. 15, supra note 87 at Para 71.
The purpose and effect of State Party ‘obligations to protect’ is such that it brings the needs of its correlative, individual right-holders “to the fore”\textsuperscript{144} by requiring states to look upon ‘health’ through a human rights lens; a lens that offers “a counterbalance to other perspectives”\textsuperscript{145} that tend to only see health through the “prism of the globalized economy.”\textsuperscript{146}

The obligation to fulfil “requires state parties, \textit{inter alia}, to give sufficient recognition to the right to health in…national, political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health.”\textsuperscript{147} The obligation to fulfil essentially requires that states take positive measures to \textit{ensure} the availability, accessibility acceptability and quality of health goods, facilities and services (and health’s underlying determinants).\textsuperscript{148} By requiring that formal policy, legal and other measures be implemented to give recognition to the right, the ‘obligation to fulfil’ also contributes to a climate, perhaps more amenable to rights based monitoring and thus to greater accountability from the State.

This respect, protect and fulfil typology of obligations under the right to health is ultimately subject to the principle of ‘progressive realisation.’\textsuperscript{149} Whilst the principle of progressive realisation (a principle earlier defined as an obligation to engage in processes of ‘health equalisation’) is to be realised as “expeditiously and effectively as possible,”\textsuperscript{150} the differing socio-economic realities that face individual States, and

\begin{footnotesize}
\begin{enumerate}
\item Christine Chinkin, “Health and Human Rights” (2006) 120 Public Health 52 at 59.
\item \textit{Ibid.}
\item \textit{Ibid.} Indeed, the need to approach child health issues from this perspective is explicitly emphasised by the Committee on the Rights of the Child, “The present general comment is based on the importance of approaching children’s health from a child-rights perspective.” See General Comment No. 15, \textit{supra} note 87 at Para 1.
\item The obligation to fulfil has also been interpreted as including subsidiary duties to “facilitate, provide and promote.” See General Comment No. 14, \textit{supra} note 78 at Para 37. Of particular note is the obligation to provide: which requires that states actively “provide” a specific right within the covenant “when individuals or a group are unable for reasons beyond their control to realize that right themselves by the means at their disposal.” This has clear salience in the case of children who are invariably dependent upon the means of others.
\item See Ida Elisabeth Koch, \textit{supra} note 137 at 91.
\item Article 2.1 ICESCR, \textit{supra} note 73.
\item See General Comment No. 3: The Nature of States Parties’ Obligations (Art. 2, Para 1 of the Covenant), 14 December 1990, E/1991/23 at Para 9. [Hereafter General Comment No. 3].
\end{enumerate}
\end{footnotesize}
which condition the resources available to them to ensure the rights implementation, must be recognised.\textsuperscript{151}

The CESCR, in its General Comment No. 3, nevertheless confirms that “States parties [still] have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care.”\textsuperscript{152} Further, the Comment notes the explicit undertaking of States parties to the ICESCR to both “take steps, individually \textit{and} through international assistance and cooperation, especially economic and technical…”\textsuperscript{153} if, and where, required.

\subsection*{3.2 Minimum core obligations}

General Comment No. 14 thus outlines the specific core of obligations that states (either alone or in concert) must ensure to achieve individuals’ realisation of the right to health. Two major themes to run through the right’s core are State Parties’ obligations to provide access to immunisation services and State parties obligations to prioritize children’s health. A number of reasons might be canvassed as to why these particular measures have been prioritized as specific policy objectives of the right to health (and indeed some of the reasons have already been outlined above). A, and perhaps the most, significant consideration however, is a practical one; namely the continued non-prioritisation of preventive and child health within both global and national-level health policy, arguably poses the greatest obstacles to the achievement of the right’s objective of health equity.

\begin{flushleft}
\textsuperscript{151} Article 2.1 ICESCR, \textit{supra} note 73. “Each State Party to the present Convention undertakes to take steps, individually and through international assistance…\textit{to the maximum of its available resources}.”
\end{flushleft}

\begin{flushleft}
\textsuperscript{152} See also General Comment No. 14, \textit{supra} note 78 at Para 9.
\end{flushleft}

\begin{flushleft}
\textsuperscript{153} General Comment No. 3, \textit{supra} note 150 at Para 10.
\end{flushleft}

\begin{flushleft}
\textsuperscript{153} \textit{Ibid} at Para 13.
\end{flushleft}
3.2.1 State Party obligations to provide immunisation against preventable diseases

Minimum core obligations incumbent upon state parties require that equitable levels of access to immunisations be provided to all (“especially for vulnerable or marginalised groups” such as children) particularly where vaccine preventable diseases serve to threaten the health of a population. The essence of the obligation arises from General Comment No. 14’s requirement that states provide access to all drugs as listed under the WHO Action Programme on Essential Drugs: a list that currently includes 21 recommended vaccines for children.

---

154 General Comment No. 14, supra note 78 at Para 43(e) States have a core obligation, “To ensure equitable distribution of all health facilities, goods and services.”
155 Ibid at Para 43(a) States have a core obligation, “To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.”
156 Ibid at Para 43(f) States have a duty to adopt and implement a national public health strategy and plan of action “...addressing the health concerns of the whole population.”
157 Ibid at Para 43(d), States have a core obligation “To provide all essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs.” Also, see Para 73 (b) of General Comment No. 15, supra note 87 which requires that states ensure the universal coverage of quality primary health services, including prevention, health promotion, care and treatment service, and essential drugs.
159 Some uncertainty has, however, been generated by General Comment No. 14s ostensible decision to draw a distinction between its interpretation of “core obligations” and additional “obligations of comparable priority” listed under the ‘core obligations’ subsection of the comment. (See General comment No. 14, supra note 78 at Para’s 43-44.) Forman et al, supra note 105 also discuss some of this uncertainty. Contained within the ‘obligations of comparable priority’, are the requirements that states “provide immunization against the major infectious diseases occurring in the community.” (General comment No. 14, supra note 78 at Para 44 (b)) and that states “take measures to prevent, treat and control epidemic and endemic diseases” (General comment No. 14, supra note 78 at Para 44 (c)) which overlaps with the obligations that have already been assumed by states in the more definite ‘core’ requiring State Party provision of essential drugs. Whilst there is a potential for the obligations of comparable priority to be considered less critical than obligations that have been more explicitly defined as ‘core’, it is argued that a purposive interpretation of the elements within the core obligations subsection should be taken, so that both aspects of states’ obligations are deemed equally significant. Given the obligations of comparable priorities’ substantive focus on mitigating the spread of infectious disease, such interpretation would not reach beyond the levels of obligation that states already appear to assume within this domain since historically, states have tended to adopt a heightened level of responsibility for the maintenance of public health, against the spread of infectious disease. (For more, see for example Lawrence O Gostin, Public Health Law Power Duty, Restraint, 2d ed (Berkeley, CA, USA: University of California Press, 2008) Also, see Tobin, supra note 127.
3.2.2 State Party obligations to prioritise children’s health

The minimum core provisions of the right to health also require that enhanced levels of protection be afforded to the particular needs of children. General Comment No. 14 says states must “ensure…child health care” as a matter of priority\textsuperscript{160} and the Committee on the Right’s of the Child’s General Comment No. 15 similarly discusses the right’s imposition of a “strong duty of action…to ensure that health and other relevant services are available and accessible to all children;”\textsuperscript{161} and recommends, \textit{inter alia}, that states “prioritise children’s health in budgetary allocations.”\textsuperscript{162} There are clear legal, moral and ethical reasons for prioritising children’s health within State’s national policy agendas, however (and in a world where the bottom-line counts) there is an increasingly clear economic rationale for adopting such an approach too. Deaton notes that since “disadvantages at birth from a wide range of conditions (income, housing, nutrition, health care) widen with age”\textsuperscript{163} there is a fiscal imperative to invest in child health, and its wider determinants, as early as possible if states are to effectively militate against the otherwise cumulative cost of poor health.\textsuperscript{164} Indeed, so important are these underlying determinants of health to the realisation of ‘health,’ that both the Committee on the rights of the child and the CESC\textsuperscript{R} include them within the minimum core of the right to health. (Included for example are obligations to provide access to nutritious food, basic shelter, housing, sanitation, potable water and education).\textsuperscript{165}

\begin{flushright}
\textsuperscript{160} General Comment No. 14, supra note 78 at Para 44(a).
\textsuperscript{161} General Comment No. 15, supra note 87 at Para 28.
\textsuperscript{162} Ibid at Para 106(b).
\textsuperscript{164} Ibid at 267.
\textsuperscript{165} See General Comment No. 14, supra note 78 at Para’s 43(b) and (c) and General Comment No. 15 supra note 87 at Para 73(c).
\end{flushright}
A further reason to underline the right to health’s emphasis on child health, stems from State Parties’ obligations to respect the right to life.\textsuperscript{166} The rights to health and life are highly interrelated and the Committee on the Rights of the Child’s General Comment No. 15 similarly stipulates how the “many risks and protective factors that underlie the life, survival, growth and development of the child need to be systematically identified in order to design and implement evidence-informed interventions that address a wide range of determinants during the life course.”\textsuperscript{167}

One of the biggest threats to both the health and the life of children are preventable diseases. Pneumonia, diarrhoea and malaria were the biggest preventable killers amongst children aged under-5 in 2012, needlessly taking the lives of around 4,600 children each day.\textsuperscript{168} All, however, are preventable with basic vaccine technologies, (with the exception of malaria, for which other low cost interventions exist), and General Comment No. 15 sees this fact as important; “states have an obligation to reduce child mortality…[and] should put particular emphasis on scaling up simple, safe and inexpensive interventions that have proven to be effective.”\textsuperscript{169}

The right to health, as a right to equity in the goods, services, facilities and underlying determinants that condition individual health is, in accordance with the ICESCR, to be realised through State Parties’ fulfilment of legal obligations. This chapter has sought to provide an overview of the nature and structure of the obligations that are incumbent upon state parties to achieve the right to health and has emphasised some

\textsuperscript{166} General Comment No. 6 on the right to life for example, states that the right to life in Article 6 of the International Covenant on Civil and Political Rights “should not be interpreted narrowly” and to that extent proclaims, “Protection of the right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.” See, UN Human Rights Committee (HRC), CCPR General Comment No. 6: Article 6 (Right to Life), 30 April 1982 at Para 5.

\textsuperscript{167} General Comment No. 15, supra note 87 at Para 16.


\textsuperscript{169} General Comment No. 15, supra note 87 at Para 35.
of the provisions deemed critical to realising the right’s minimum core. As a matter of health equity and of legal obligation, States have a duty to ensure that equitable levels of access to childhood immunisations are being achieved. Furthermore, given that all states have ratified at least one international legal treaty that recognises the right to health, it is incumbent upon all states to (at the very least, work together\textsuperscript{170} to) achieve this.

Thus, from a legal perspective, evidence of persisting health inequities in children’s levels of access to immunisation is highly problematic. Whilst it is appreciated that human rights cannot resolve every equity and access-enhancing health issue that exists, the fact that there are such vast inequities in children’s levels of access to immunisation, “testif[ies] to the still unmet potential of international human rights law.”\textsuperscript{171} The legal obligations to be satisfied under the right to health, after all, give rise to a variety of approaches, mechanisms and strategic frameworks that, if fully utilised, appear well equipped to respond to inequities of the sort that were discussed in Chapter 1.

Whilst the normative potential of the human right to health has been explored in this Part (A), an informed response to this thesis question now requires that a more practical analysis, of how applications of the right are impacting upon equity, (in practice), is taken. Part (B) therefore explores some of the ways in which the right to health appears, in reality, to be supporting the equitable improvements in levels of access to childhood immunisations that, in theory, the right purports to be able to effect. This endeavour is of a practical relevance. For politicians, policy makers and those with the powers to effect social change, theoretical discussions of what the right to health is and of what it aspires towards carries little weight if the right, and the principles and strategies that it encompasses are insufficiently operationalized or, worse, are discarded if thought to be failing to meet the objectives they are designed

\textsuperscript{170} See Article 2(1) ICESCR, supra note 73 “State Parties to the present Covenant undertakes to take steps, individually \textit{and through international assistance and cooperation…}”.

\textsuperscript{171} See Lawrence O. Gostin, \textit{supra} note 56 at 244.
to achieve. By drawing attention to some of the ways in which the right to health, when implemented and advanced in practice, is impacting upon health equity, (specifically equity in access to immunisations), it is hoped that this thesis will contribute to an evidence base that further encourages policy-makers to address public health, from a human rights-based vantage.

172 See also, Ryan Goodman & Derek Jinks, “Measuring the Effects of Human Rights Treaties” (2003) 14:1 EJIL 171. (Who argue, “The effectiveness of any regulatory strategy turns on whether its rules and institutions actually mitigate the problems they are designed to address”).
Part B
How is the right to health being used to improve equity in the levels of access to childhood immunisations?

The right to health, being a highly multi-dimensional right, serves a dynamic array of functions. State Parties’ obligations to progressively realize the right to health, not only requires that “accessible, transparent and effective mechanisms of accountability”,173 be established for individuals to be able to enforce the right; it also requires that State Parties take active programmatic measures to advance the right’s essential elements of availability accessibility, acceptability and quality (AAAQ) (See 4.2).174 In order to comment upon the contributions of the right to health, to health equity, one must first identify how the right is even being applied. To this end, Part (B) of this thesis is divided into three chapters that, whilst not all-encompassing, aim to broadly address the ways in which the right to health is being utilised in practice. The analysis focuses on the advancement of rights to health based standards within global immunisation policy (Chapter 4); on the creation of conditions that enable the realisation of the right (Chapter 5); and on mechanisms that enhance State Party accountability (Chapter 6). Each chapter, whilst drawing upon different (and in some cases, inter-disciplinary) methodologies, follows a similar structure that captures some of the ways in which the right to health is being applied to improve equity in access to childhood vaccinations.

Chapter 4

The integration of right to health-based principles within global immunisation policy

4.1 Introduction and definition of a rights-based approach to health

This chapter traces how the right to health, via the application of rights-based principles within global immunisation policy, is impacting upon children’s immunisation coverage rates. It focuses upon global (as opposed to national) immunisation polices as many of the countries currently experiencing low, or highly unequal, rates of immunisation coverage, are guided by polices that have been set at the global level; and further, are often dependent upon the strategic input and financing of the international collaborations that set them. After outlining what it is that a rights based approach consists of, it provides a detailed overview of the application and advancement of one of the key elements of a rights based approach: the principle of availability, to illustrate how applications of the principles appear to manifest in practice. The methodology for assessing the equity-impact of applications of the rights based principles within global immunisation policy is then considered, before concluding with discussion of the results.

175 Since eradication of the smallpox virus in the late 1970s, where the international communities’ concerted, political response managed to conquer one of the most debilitating diseases in existence, immunisation policy has continued to take shape from a largely global standpoint. In addition to the reason mentioned, further reasons serve to explicate why immunisation policy; polices that are designed to protect people who are often already healthy, are consistently prioritised and orchestrated at the global level. Most obviously, the diseases to which these policies are designed to militate against, being highly communicable and thus posing risks to all populations around the world, necessitates the need for coordinated, international action. On a more humanitarian note however, in recognising that the burden of infectious diseases (many of which are now preventable with relatively inexpensive vaccine technologies), disproportionately effects the populations of less developed countries, there is an ethical imperative to ensure that more equitable levels of access to childhood immunisations are achieved, as a matter of global justice. Whilst State Parties bear ultimate responsibility for implementing any inter-governmentally devised strategies, significant portions of the planning, goal-setting and procurement processes required for the operationalization of national immunisation schemes, currently takes place at these higher supra-national levels which have the technical capacity and access to funding mechanisms to often assist the countries that do not.
a. Rights based approaches

Rights based approaches recognise that “every human being, by virtue of his or her inherent human dignity, is a holder of rights and it is an obligation on the part of the government to respect, protect and fulfil these rights.” Rights based approaches work to build the capacity of States so that they are able to fulfil their human rights obligations and further, work to empower individual rights holders so that they are enabled to achieve them. A variety of rights based principles have been proffered as fundamental to the advancement of the approach including: availability, equality, non-discrimination, participation, indivisibility, universality and accountability amongst others. General Comment No. 14 also sets out a number of its own evaluative rights based criteria that can be used to assess a state’s realisation of its obligations under the right to health. In the Committee on Economic, Social and Cultural Rights’ view, the right to health “in all its forms and at all levels contains the following interrelated and essential elements:” availability, accessibility (non-discrimination, physical economic and informational accessibility) acceptability and quality. These “AAAQ” principles are therefore the criteria that this chapter adopts in further analysis.


179 General Comment No. 14, supra note 78 at Para 12(a)-(d).
4.2 Examining the application of rights-based approaches within global immunisation policy

The tables in Appendix A, below, use the AAAQ framework as a critical lens to detail the specific right-to-health based elements that have appeared in each of the major global immunisation policies to date. An exploration of all of the issues that they contain (for reasons of space) is beyond the scope of this paper. Given the prevalence of the availability-enhancing aspects of the immunisation strategies surveyed, however, (9 out of the 10 policies contain measures that are consonant with the principle), the principle of availability, and the kinds of issues that availability-enhancing strategies have given rise to is further explored; in order to provide the reader with a sense of how elements of the right to health are being applied in practice.

4.2.1 AAAQ framework as a critical lens: Availability as a common theme

a. Defining availability

General Comment No. 14 stipulates that availability requires “functioning public health and health-care facilities, goods and services, as well as programmes...[to be] available in sufficient quantit[ies] within the State Party.” Availability is an element of the right to health essentially designed to ensure the physical availability of health facilities and, by implication, the necessary processes that lead to such facilities’ existence. In line with the state capacity enhancing role of a human rights-based approach to health (capacity to fulfil its obligations), the principle of availability also requires that attention be given towards some of the more systemic

---

180 Nine of the ten policies surveyed were classified as having strategies and objectives that advanced the right to health principle of ‘availability,’ five polices advanced the principle of ‘accessibility,’ six advanced the principle of ‘acceptability’ and six advanced the principle of ‘quality’. The specific aspects of the policies giving rise to these categorisations can be found in the tables below in Appendix A.
181 General Comment No. 14, supra note 78 at Para 12(a).
182 Meaning “health goods, facilities and services” per General Comment 14, supra note 78.
elements of obligations under the right. States must, for instance, take measures that are aimed towards the strengthening of its primary health infrastructures in the context of making health facilities ‘available,’ and must further ensure that the underlying determinants of health are provided for.

There are three central themes that characterize the measures that have been designed to improve child-vaccine ‘availability’:

i) The strengthening of immunisation and health system infrastructures
ii) The canvassing of large amounts of funding to increase immunisation efforts’ reach and
iii) Improvements in access to new vaccines

As will become clear from the discussion and tables (see Appendix A) below, a diverse array of objectives and strategies have been adopted within the global immunisation policy arena. At times, this has procured contradictory (and arguably negative equity-related) effects. 183 In the following examination of how the principle of ‘availability’ is being applied, attention, therefore is also drawn to elements of the strategies that serve to undermine the right to health’s equity-enhancing aims.

(i) Strengthening of infrastructure

a. Routine immunisation

The World Health Organization’s move to establish routine immunisation as its guiding strategy for childhood vaccination in the Expanded Program on Immunisation (EPI) re-affirmed the need for state’s to strengthen their primary health systems so as to enable a more effective implementation of the EPI. 184 Okwo-Bele and Cherian note

183 See also, Hardon, A & Blume, S, “Shifts in global immunisation goals (1984-2004): unfinished agendas and mixed results (2005) 60:2 Soc Sci Med 345 (who argue that shifts in global immunisation goals over the period of immunisation polices that they survey lead to fragmentation in the implementation of vaccine programmes at the local level in developing countries.).
that the design of the EPI, which reaffirmed “the importance of systematic immunization programs in all countries,”\(^{185}\) draws from the experiences “accumulated during implementation of the intensified campaign for smallpox eradication.”\(^{186}\) in which limitations to existing health care networks’ abilities to reach those in need had been emphasised.\(^{187}\) The benefits of a more strategic and integrated approach towards immunisation initially appeared to pay off and by 1990, following the Universal Childhood Immunization (UCI) Policy’s expansion of the EPI,\(^{188}\) UNICEF declared that 80% of children under 13 months of age had been vaccinated with antigens from the EPI’s basic immunisation schedule.\(^{189}\)

b. Polio eradication: a more ‘vertical’ trajectory

In spite of the EPI’s initial emphasis on the strengthening of health infrastructures as an aspect of routine immunisation, a number of subsequent vaccination policies followed an alternative trajectory: choosing to advance a much less integrated agenda for vaccination. Hardon and Blume attribute the emergence of specific disease eradication strategies to health policy-makers’ need to re-awaken a then wavering international donor community who, following announcement of the UCI’s 80% coverage target having been reached, retreated, (allegedly suffering from a wave of ‘donor fatigue’).\(^{190}\) The authors also attribute the success of eradication initiatives to their political attractiveness; whose ‘blockbuster’ goals worked to rally action around clear focal points that the international community were more willing to respond.

Indicatively, the Global Polio Eradication Initiatives (GPEI) of 1988 and 2010 managed to mobilize extensive resources\(^ {191}\) during times when other significant

---

\(^{185}\) See World Health Assembly resolution, WHO expanded programme on immunization (1974) WHA27.57.


\(^{187}\) Ibid.

\(^{188}\) Hardon & Blume, supra note 183 at 346.

\(^{189}\) The announcement that the target had been reached was made at the 1990 World Summit for Children. See, Anita Hardon, “Immunisation for All?” (2001) 6:1 HAI Europe.

\(^{190}\) See, Hardon & Blume, supra note 183 at 347.

\(^{191}\) The Global Polio Eradication Initiative reports, for instance, that over US$ 11 billion has been invested in the Global Polio Eradication Initiative since its launch in 1988. Global Polio Eradication
global health schemes had been faced with their financial demise.\textsuperscript{192} Whilst the objectives of such initiatives were fundamental, their vertical-based strategies could, however, be considered problematic.\textsuperscript{193} Eradication strategies, being highly specific and disease focused, risk compounding the pre-existing inequalities in levels of access to other basic EPI antigens still requiring delivery through insufficiently resourced health systems.\textsuperscript{194}

Subsequent and more comprehensive global immunisation polices have communicated their intention to prioritise health system strengthening as a way to enhance access to immunisation services and improve disease surveillance, however, (in practice), less resources appear to have been diverted to the approach than required.

The GAVI Alliance, established in 2000 and supporting operations in over 70 low and lower-middle income countries since its inception,\textsuperscript{195} for instance, has directed only

---

\textsuperscript{192} Despite the said period of “donor fatigue,” extensive resources were mobilised for the 1988 GPEI and during the period when the Global Fund for AIDS, Malaria and TB faced severe financial difficulties (as a result of the financial crisis and to the extent that it had to cancel its 11\textsuperscript{th} round of funding for new grants in 2011) the 2010 GPEI was still able to attract significant levels of funding. For more on the Global Fund, see Sammie Truong, “Saving the Global Fund” (2013) The Journal of Global Health online: JGH <http://www.ghjournal.org/jgh-online/saving-the-global-fund/>.

\textsuperscript{193} See, for example, Lynn P Freedman et al, “Transforming health systems to improve the lives of women and children” (2005) 365 Lancet 997 at 998 (who observe, “By proposing and pursuing disease-specific, seemingly cost-effective programmes that may or may not accord with national priorities, donors have sometimes distorted and deformed—or simply ignored—health systems. Their unhealthy fixation on what are usually short-term and short-lived successes has at times, sidetracked human rights considerations.”); Kenneth S. Warren, “The Evolution of Selective Primary Health Care” (1988) 26:9 Soc. Sci. Med. 891. (Who trace the evolution of selective primary health care— with immunisation being one of the measures with the vertical based approaches that they survey).

\textsuperscript{194} See Hardon & Blume, supra note 183 at 348 (who observe that the polio eradication programme appears to have shifted equity in access to the six basic EPI antigens; while donor funds for polio eradication increased, those for EPI decreased); UNICEF, \textit{Evaluation research: Sustainability of achievements: Lessons learned from universal child immunization: Report of a steering committee} (New York: UNICEF, 1996).

10.5% of its total donor resources towards national health system strengthening. This is in spite of its repeated acknowledgement that infrastructural constraints continue to serve as one of the major challenges to an improved level of immunisation access. Furthermore, from the limited funding that GAVI has allocated towards countries’ health systems strengthening (HSS) over the years, its commitment to the monitoring and technical improvement of HSS grant recipients’ health service infrastructures has been called into account for its inadequacy. This is problematic not least for the fact that GAVI has become a - if not, the - major body for bi-lateral funders to donate resources aimed at improving immunisation coverage rates towards; and so, in some respects, GAVI has a responsibility to ensure that it- as the face of international immunisation efforts- is using the funds to improve access to immunisations for all (which necessarily requires a greater level of investment in countries’ national health systems).

In recognising the potential for immunisation to contribute to the achievement of a number of the Millennium Development Goal’s aims, in 2006 the WHO and UNICEF presented a new strategic framework: the Global Immunization Vision and

---

196 See, GAVI Alliance, “GAVI’s impact” (GAVI Alliance data as at 31 August 2013), online: GAVI <http://midtermreview.gavialliance.org/healthsystems/>.

197 In the first official Evaluation for GAVI’s Phase 1 activities (2000-2005) for example, it was noted that GAVI had not been effective at supporting underperforming countries and should focus more attention on these countries. Evaluation of the GAVI Alliance Phase 1 (2000-2005) Executive Summary (2008), online: GAVI < http://www.gavialliance.org/results/evaluations/gavi-first-evaluation-report/> See also, GAVI Alliance, “GAVI Health Systems Strengthening Support Evaluation 2009” (2009), online: GAVI: <http://www.gavialliance.org/results/evaluations/hss-review/> (The report, whilst aiming to help identify the ways in which country health systems can be improved notes that at present the "process for technical support to countries for programme design, start up and implementation, and performance review is too 'stand back and then review' and not enough 'engage and help'”); GAVI Secretariat management response to the GAVI Health Systems Strengthening Support Evaluation 2009. (10 November 2009), online: GAVI <http://www.gavialliance.org/results/evaluations/hss-review/> (Which similarly stresses that insufficient technical support is being provided to health system strengthening grants; assessments of country funding proposals are insufficiently identifying potential problems; and weak annual review and reporting mechanisms are hindering the ambitions of the GAVI model.).

198 See for example, World Bank, “World Bank Response to the GAVI HSS Evaluation” (10 November 2009), online: GAVI <http://www.gavialliance.org/results/evaluations/hss-review/>. Insufficient attention to country health systems is problematic from another angle: Hardon & Blume, supra note 183 at 352 further note that GAVI’s reliance upon immunisation coverage rates as performance indicators (for certain types of eligibility for their new vaccines) “overlooks the absence of reliable health information systems in most countries applying for support.”

199 See, WHO, “WHO/UNICEF Global Immunization Vision and Strategy” (April 2005), online: WHO <http://www.who.int/immunization/givs/Q_and_A_EN.pdf> at 2, for example, which lists one of the key human and economic returns of WHO and UNICEFs investment in GIVS as its contribution to fulfilling the fourth Millennium Development Goal on child mortality.
Strategy (GIVS), to guide national immunisation efforts from 2006-2015.\textsuperscript{200} On its face, GIVS appears heavily informed by the right to health’s principle of ‘availability’ with its explicit desire to strengthen national health systems in the context of national schemes for immunisation.\textsuperscript{201} In acknowledging that “immunization services often have the greatest community penetration of any public health intervention, the GIVS encourages linking immunisations to other interventions rather than providing them in isolation.”\textsuperscript{202} Kamara et al report that in 29 out of the 50 countries whose GIVS implementation strategies they surveyed, additional interventions including the provision of malarial bed nets, anti-helminthics and vitamin A supplementations were delivered within the context of routine vaccination.\textsuperscript{203} The GIVS aim “to link immunization with other potentially life-saving interventions in order to accelerate reduction in child mortality”\textsuperscript{204} had the potential to encourage a more sustainable and considered approach. A problem with GIVS, however, was that its integration of immunisation activities within national health infrastructures represented only part of a very wide GIVS framework which, with three other strategic areas to incorporate through the 15 operational goals that it sets out, appeared to divert attention from infrastructural concerns with the more innovative vaccines it promoted. In an analysis of 50 of the comprehensive Multi-Year Plans (cMYP) for immunisation that the GIVS had encouraged states to develop, Kamara et al note how all countries had planned to introduce new, (typically GAVI sponsored), vaccines into their national programs despite having “inadequately prepared in terms of cold-chain requirements to deal with the expected increases in storage that [would] be required for [the] vaccines, and in making provisions to establish a corresponding surveillance system for planned new vaccine introductions.”\textsuperscript{205}

\textsuperscript{204} GIVS, supra note 201 at 13.
\textsuperscript{205} Lidija Kamara et al, supra note 203.
The systems-strengthening capabilities of GIVS can be challenged from another angle in that a mid-term progress report on its impact upon routine immunisation coverage levels, an apparent indicator of the strength of national health system infrastructures, revealed 45 countries (“encompassing nearly two thirds of surviving infants unvaccinated with DTP3” in 2010) to have made “insufficient or no progress towards the GIVS coverage goal for DTP3.”

The most recent global vaccination strategy, the Global Vaccine Action Plan (GVAP), which details the objectives of and strategies for delivery of national immunisation services over the next decade (2011-2020) appears to offer the most comprehensive and integrated approach towards immunisation. Its framework, explicitly underpinned by an objective to uphold immunisation as a human right, seeks to achieve greater equity in the use of vaccines. One of the main ways that it hopes to do this lies in re-establishing immunisation as a core component of primary health care; using immunisation services as a “platform for other priority public health interventions”. Furthermore, whilst the plan incorporates a number of disease eradication goals (for polio, neonatal tetanus, measles and rubella) it does so with an explicit directive that states ensure their disease strategies “do not operate in silos” and acknowledges that, “synergies and efficiencies as a result of integration and coordination will be particularly beneficial in countries with fragile health systems.”

---

208 GVAP, supra note 207 at 44.
209 Ibid at 51 (Strategic Objective 4 GVAP).
210 Ibid at 53.
211 Ibid at 52.
ii) The canvassing of large amounts of funding to increase immunisation efforts’ reach

The second major way that global vaccination policies appear to have advanced the right to health’s essential element of availability lies in their efforts to secure greater financial resources to enable increased levels of immunisation access.

Typically, international donor commitments to the realization of immunisation policy goals appears to have been strong where well-defined benchmarks, that encompass ongoing monitoring and evaluation requirements, have been set. The requirement for such assessments reflects a desire to ensure that donor funds are spent wisely, and in the most cost-efficient way. In some instances, however, the conditioning of donor assistance upon a state’s attainment of specific target-based goals has led to health workers over-reporting: to the detriment of those children who are subsequently, and unknowingly unreached. Lim et al emphasize the “urgent need for independent and contestable monitoring of health indicators in an era of global initiatives that are target-oriented and disburse funds based on performance”212 after discovering “substantial differences between officially reported and survey-based coverage” levels of immunisation both during and after the UCI.213

a. Sustainability

There is a further issue to consider when assessing the extent to which immunisation policies’ ability to generate funding serves to advance ‘availability;’ namely, the issue of how sustainable such funding strategies are. The issue came to the fore following UNICEF’s announcement that the UCI’s coverage targets had been reached and donors, with no clear framework or purpose for their continued financial commitment,

213 Ibid. (The authors also report that in countries receiving GAVI ISS funding (which is a performance based payment that is paid to the government for each additional child immunised above a certain baseline) improvements on survey-based coverage were about half of the officially reported estimates and three quarters of WHO and UNICEF estimates. This shows the discrepancies that can occur between coverage rates when performance incentives are introduced into poorly organised systems).
resultantly started to retreat. Hardon and Blume note how this necessitated a new genre of vaccine policy, culminating in the Vaccine Independence Initiative (VII). VII aimed to support developing countries to better finance their own immunisation programs by means of a “gradual assumption of financial responsibility for the meeting of their vaccine needs” and appeared to encourage greater self-reliance amongst a number of middle-income countries at the time. When the GAVI alliance was formed in 1999 it, in many ways, sought to establish itself as a champion for sustainable immunisation funding mechanisms and has since invested in a number of initiatives that aim to improve the long-term predictability of immunisation policy funds. It’s International Finance Facility for Immunisation (IFFIm), which “uses long-term pledges from donor governments to sell ‘vaccine bonds’ in the capital markets, making large volumes of funds immediately available for GAVI programmes,” has so far helped to generate over US$ 4.55 billion since its inception in 2003. Furthermore, GAVI’s advanced market commitment (AMC) mechanism has secured a sustainable pricing commitment from a number of manufacturers producing the relatively new, pneumococcal conjugate vaccine which is now available in 24 developing countries: countries likely to have otherwise had to wait around 10 years for the vaccines introduction. One of the major funding sustainability challenges, yet to be adequately addressed by GAVI is how it will ensure that its ‘graduating countries,’ that is: those countries that are set to soon exceed the GNI per capita thresholds that determine a country’s eligibility for GAVI

---

214 See also, London School of Hygiene & Tropical Medicine, “Health Policy and Planning Debated: Sustainably graduating – so they don’t come home to live with us” (February 18 2014), online: London School of Hygiene & Tropical Medicine <http://blogs.lshtm.ac.uk/hppdebated/2014/02/18/sustainably-graduating-so-they-dont-come-home-to-live-with-us/>.
215 Hardon, A & Blume, S, supra note 183 at 349.
216 Ibid.
218 See IFFIm: “Overview,” online: IFFIm <http://www.iffim.org/About/Overview/>.
219 See IFFIm: “Results,” online IFFIm <http://www.iffim.org/funding-gavi/results/>.
assistance, will be able to maintain the immunisation coverage levels that GAVI support has enabled them to achieve. Since its second phase of immunisation activities GAVI has required that all countries co-finance a portion of the vaccinations that it supplies, and increases the levels that countries are expected to contribute as they proceed towards graduation. Whilst GAVI should be commended for this strategic foresight, which actively militates against countries’ over-dependence upon GAVI funding, several key issues remain inadequately addressed. The countries in receipt of GAVI support currently benefit from the highly subsidized vaccination unit costs that GAVIs unique position and ability to access previously untapped developing world markets has helped it leverage. It remains unclear whether GAVI’s graduating countries will have the technical capacity, or be able to rely upon manufacturers’ goodwill, to still be able to procure the vaccines at such reduced prices. Even assuming that countries will be able to obtain GAVI prices after GAVI support ends and that countries will be able to “continue to finance non-vaccine immunisation costs, such as health workers, transport, demand creation and community mobilization activities, and the supply chain for vaccines,” Saxenian et al estimate that the financial resources required from the governments of the next 14 countries who are set to graduate will need to increase from about US$8 million in 2012 to US$ 90 million in 2018. Such projections clearly illuminate the need for GAVI and subsequent immunisation polices (such as the GVAP) to accelerate any

221 Currently, the eligibility requirement is that countries must have a Gross National Income per capita below or equal to US$1,570 as per World Bank data. See, GAVI, “Country eligibility policy,” online: GAVI <http://www.gavi.org/about/governance/programme-policies/country-eligibility/> It’s aim, in its GAVI Alliance Country Eligibility Policy (found at the same link) is to support the poorest countries, (however, this does not necessarily ensure that it is supporting the poorest people).


223 There is some evidence to suggest that graduating countries may not be able to procure the vaccines at the same, lower costs. In 2009, for instance, the suppliers of new pneumococcal conjugate and HPV vaccines insisted that PAHO pay more than GAVI for the vaccines, despite PAHO previously being able to purchase its vaccines (through its Revolving Fund) at similar prices to UNICEF (who buys on GAVIs behalf). This shows that even with the collective bargaining power of an organisation such as PAHO, manufacturers may not be willing to continue to provide vaccines at low costs when countries are deemed to be wealthy enough to pay the higher prices. See, Wilson P, supra note 39 at 10.


225 Ibid.
strategies that could help to ensure that countries are better prepared for their transitioning between eligibility statuses, in a sufficiently sustainable way.\textsuperscript{226}

(iii) Improving the availability of new vaccines

In recent times, global immunisation policies have also been particularly successful in bringing about the introduction of newly available vaccines into countries’ national immunisation schedules. GAVI, the main supplier of such vaccines, has devoted 79.1\% of its total resources towards states’ introduction of new and underused vaccines, averting around 6 million child deaths as a result.\textsuperscript{227} Both the GIVS framework and GVAP place emphasis upon the introduction of newer vaccines, with the latter proposing that all low and middle income countries introduce at least one new vaccine by 2020\textsuperscript{228} and that at least one low or middle income country introduce vaccine(s) against one or more major currently non-vaccine preventable disease by the same deadline.\textsuperscript{229}

4.3 Determining the equity-impact of the rights-based principles advanced within the immunisation policies surveyed

All ten of the global immunisation policies that have been surveyed are, to differing degrees, informed by human rights based principles. It is possible, therefore, to consider whether the policies that appear to be more rights-oriented, are more effective at reducing the preventable disparities (inequities) that occur in rates of immunisation coverage over time, than the policies that contain less rights-oriented principles. Whilst many dimensions of ‘equity’ are likely affected, the dimension that will be considered within this chapter is children’s socio-economic backgrounds:

\textsuperscript{226} GVAP does in fact set out to try and improve the levels of country ownership of immunisation programmes and suggests, for instance, the creation of National Immunisation Technical Advisory Groups. See, GVAP, supra note 207.
\textsuperscript{227} See, GAVI Alliance, “GAVI’s impact” (GAVI Alliance data as at 31 August 2013), online GAVI: <http://midtermreview.gavialliance.org/healthsystems/> (For graphic illustrating the way GAVI funds have been spent) and see GAVI Alliance, “GAVI facts and figures,” online: GAVI <http://www.gavialliance.org/advocacy-statistics/> (for deaths averted).
\textsuperscript{228} See, GVAP supra note 207 at 135.
\textsuperscript{229} Ibid.
specifically the coverage rates of children being vaccinated with DTP3, according to their background household wealth quintiles.

a. Methodology

To try and illuminate the nature of the relationship that exists between the integration of human rights based principles within global immunisation policies, and the rates of children being immunised according to their socio-economic backgrounds, three charts are included below. The first is a timeline of the immunisation polices surveyed and have each been colour-weighted according to how many rights-based AAAQ principles the policies advance (see Appendix B). Whilst a somewhat blunt presentation of the qualitative discussion included throughout this chapter (and below, in Appendix A) this timeline can, nevertheless, be more visibly correlated with the information presented in Graphs 1 and 2 (Appendix C and D). Graph 1 is a graph, produced by the World Health Organization, which shows the average immunisation coverage rates of children being vaccinated with DTP3 vaccines both globally and regionally, and it provides a basis for the following graph (2) to be compared with.230 Graph 2 shows the immunisation coverage rates of children that are vaccinated according to household wealth quintile and it focuses upon three WHO regions in particular.231 The information itself, in graph 2, was compiled using data from the US AID’s Demographic and Health Surveys (DHS): surveys that are available

231 From the WHO African Region, data from the following countries was included: Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Cote d’Ivoire, Democratic Republic of Congo, Ethiopia, Eritrea, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe (37/47 of the WHO Region’s countries). From the WHO American region, data from the following countries was included: Bolivia, Brazil, Colombia, Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay and Peru (11/35 of the WHO Region’s countries). From the WHO South-East Asia Region, data from the following countries was included: Bangladesh, India, Indonesia, Maldives, Nepal and Timor-Leste (6/11 of the WHO Regions countries). After reviewing data from the remaining WHO Regions: the European, Eastern Mediterranean and Western Pacific Regions, it was it was decided not to pursue these regions further within the analysis as the number of countries within each of the regions that data could be found for was limited, and thus would not have provided an accurate reflection of the trend within that region. Data, for instance, could only be found for 3/37 Western Pacific Region countries, 10/52 European Region Countries and 5/21 Eastern Mediterranean region countries.
All available country data since 1990 on the background (household wealth quintile) characteristics of children being immunised with DTP3 (in percentage terms) was exported and grouped according to the countries’ WHO regions. The average DTP3 coverage rates for children being immunised from the lowest and highest wealth quintiles for each year, for each region\textsuperscript{233} was then calculated. Given that for some of the years, very few countries were represented in a particular survey-census round, the average yearly rates that had been calculated were further averaged into five year periods, in order to produce a graph more reflective of the trends. The information is plotted in Graph 2.

Whilst all of the relevant, readily available data has been included, a number of countries within each of the regions surveyed had not yet been the subject of a DHS survey and further, for the countries that had, they were not always surveyed during every DHS census-round. There remain, therefore, inherent limitations to the information presented.

4.4 Discussion of the policies’ impact upon equity

a. Impact of rights-based global immunisation policies upon global and regional average rates of immunisation

Graph 1, in line with the analysis in (4.2) confirms the sharp and rapid increases in the rates of children being vaccinated following implementation of the UCI in the early 1980s. Immunisation coverage rates appear to have stagnated throughout the 1990s, with some regions experiencing a decrease in levels of children being immunised during this timeframe; perhaps as a manifestation of the ‘donor fatigue’ that characterised the period following the UCIs coverage target having been reached, but also likely to be a reflection of the lack of rights oriented polices governing immunisation strategies during this period, as the timeline indicates. The period


\textsuperscript{233} Some of the data spanned two years e.g. 1994-1995; in these cases for the sake of consistency the data was included within the first year (e.g. 1994).
following the creation of GAVI, and the heavily rights-oriented GIVS strategy, (the early 2000s) corresponds with some improvements in the overall rates of immunisation coverage, until around 2009: where coverage levels in all of the regions appear to have either levelled off or have slightly declined.

b. Impact of rights-based global immunisation policies upon regional rates of immunisation, according to household wealth quintile

Whilst Graph 1 provides a basis to consider the impact of rights-based strategies upon average global and regional immunisation coverage rates, graph 2 better illuminates the impact of such polices upon equity. In the African region, between 1990 and 2000, the period when immunisation policies appears to have been less rights-oriented, rates of immunisation between children from the lowest and highest wealth quintiles widened greatly. Since 2000, some convergence between the two groups has occurred that appears to correspond with the emergence of the increasing rights-based strategies in this timeframe. Since the late 2000’s, however, the African region has seen a levelling off in the rates children from each of the quintiles that are being vaccinated, confirming the need for a more proactive approach to now be taken. In the South East Asian region, immunisation rates for children from both the poorest and richest quintiles has steadily improved, with the biggest decrease in disparities occurring in the early-mid 2000s in accordance with the introduction of the more rights-oriented policies. In spite of this, disparities between the two groups continue to persist and appear to have now stagnated. The American region experienced an extremely rapid reduction in its disparities between the number of children being vaccinated from the highest and lowest wealth quintiles of the region throughout the 90s, contrary to experiences within the other regions that have been displayed. The American region has also continued to reduce its inequities, up until the present. One reason that might account for the American regions particular successes in procuring more equitable levels of access to childhood immunisations could stem from many of the Latin American countries’ implementation of vaccine laws. As is discussed in Chapter 5, vaccine laws appear to contribute to an environment that enables the greater realisation of the right to health and its equity-enhancing objectives.
c. How to interpret these results, what is their evidential significance?

Research drawn from the social sciences is often thought difficult to base conclusions upon as social scientists are generally unable to optimise the conditions (and thereby minimise the variance) in which their hypotheses take place. Potential confounding factors could, for instance, arise from the fact that the countries surveyed will have likely been experiencing higher rates of growth over this period (and thus will have had more money to finance their immunisation services); or, been receiving increased levels of international assistance. It is not denied that these (and other) factors serve to contribute to the amelioration of health inequity; however, evidence of the right’s particular impact should not be dismissed. It is submitted that the research referred to in this chapter tends to show some correlation between the rights-based intensity of the global immunisation schemes surveyed, and how equitable the resultant immunisation coverage rates prove to be. Therefore, there can be a reasonable expectation that applying a human rights-based approach towards immunisation policy planning can contribute to a more equitable level of immunisation access. Corroborating evidence from the remaining chapters attempts to supplement these findings and illuminate the right’s unmet potential in addressing issues of the sort explored in Chapter 1.
Chapter 5
The creation of an ‘enabling environment’ for the realisation of the right

5.1 Introduction and definition of an ‘enabling environment’

A human rights based approach towards immunisation policy is supported and strengthened by what Bustreo et al describe as an ‘enabling environment’. An enabling environment empowers the individual agency of rights-holders, such that they are better able to realise their human rights, and builds upon the capacity of states to facilitate fulfilment of human rights obligations. Measures “that governments can take towards such a positive, [enabling] environment include ratifying key international rights treaties, endorsing global commitments, recognising the right to health in the constitution, establishing non-judicial human rights oversight bodies, and ensuring policy coherence and effective coordination among multiple stakeholders.” This chapter begins by examining two measures that ostensibly give effect to an enabling environment: constitutional rights to health, and national vaccine laws. Attempts are then made to assess both mechanisms’ impact upon equity. Next, through an examination of two qualitative case studies centring on civil society action and on the creation of public-private health partnerships, this chapter illuminates ways in which rights enabling environments are being utilised in order to achieve greater access to immunisations. It concludes with a brief discussion of the impact of an enabling environment, upon equity in access to immunisations.

234 Bustreo, F. et al, supra note 178 at 14.
235 Ibid at 14-15.
5.2 Examples of measures that contribute to an enabling environment and their impact upon equity

5.2.1 Constitutional rights to health

One of the ways in which states are encouraged to ‘fulfil’ obligations under the right to health, is to adopt legislative measures that implement and give effect to their international legal undertakings to progressively realise the right. Legislative recognition of the right to health, at the national (constitutional) level, not only provides a legal mechanism for individuals to pursue rights based litigation, (see chapter 6), but it also provides a framework for policy analysis that states can refer to when enacting measures with an impact upon health. Mulumba et al deem the constitutional recognition of a right to health as “central to the recognition of health rights,” since “national constitutions are the supreme laws of the country and any law that is inconsistent with the provisions of the constitution is, to the extent of the inconsistency, of no force or effect.”

a. Determining the rights impact upon equity

If national recognition of a constitutional right to health is constitutive of a measure designed to fulfill the right’s realization; how might we assess its impact? In particular, how might we assess the measure’s impact upon the sorts of outcomes that the right has been designed to effect: namely, equity in health? There are perhaps two ways to think about the issue. The first, (as is attempted in section (b)) is to investigate the issue empirically: to establish the possible correlations and causal effects that exist between the right and its equity-outcome. The second is to think of the role of a constitutional right to health in a less instrumental fashion: to consider the rights recognition as

---

236 General Comment No. 14, supra note 78 at Para 36.
239 Ibid.
valuable in itself. It may, for instance, represent the first step (particularly in countries with newer constitutions) in a broader developmental process towards equity and the rule of law.\textsuperscript{240} This second aspect, which also transcends some of the limitations that emerge when conducting empirical analyses of legal rights, is considered briefly in section (c).

b. The right’s impact upon equity: an empirical analysis

To determine whether a country’s recognition of a constitutional right to health bears any impact upon the socio-economic characteristics of the children that are being vaccinated within a country, (which, as suggested in chapter 4, is a helpful gage of its equity-impact), the following steps were taken. Firstly, the available country data collected by the US AID’s Demographic and Health Surveys on the percentage rates of children being immunised with DTP3, according to household wealth quintile was reviewed to remove all but the most recent DHS survey results for each of the available countries and, in any event, any country whose most recent survey had occurred prior to the year 2000 (to give a more relevant result).\textsuperscript{241} Next, the percentage point difference between children from the highest and lowest wealth quintiles that were being vaccinated within each of the countries was calculated. It can be taken that the greater the difference between these two groups, the more unequal the levels of access to childhood immunisations in that country are. This information was then corresponded with research detailing the existence/non-existence of constitutional rights to health

\textsuperscript{240} An interesting, parallel argument is made by Trubek in relation to the role of law in development. Rather than seeing law as a means to some social or economic end (often broadly conceived as ‘development’) law has, in recent decade’s thought, been characterised as a part of development itself since “‘the Rule of Law’ is a necessary part of the process of empowerment and capability-enhancement that constitutes ‘development’.” See, David M. Trubek, “Law and Development: 40 Years after Scholars in Self Estrangement” (2014) Legal Studies Research Paper Series No. 1255 University of Wisconsin Law School at 19.

\textsuperscript{241} In total, 63 countries were included in the results: Albania, Azerbaijan, Bangladesh, Benin, Bolivia, Burkina Faso, Burundi, Cambodia, Cameroon, Chad, Colombia, Comoros, Congo (Brazzaville), Congo Democratic Republic, Cote d’Ivoire, Dominican Republic, Ecuador, Egypt, EL Salvador, Eritrea, Ethiopia, Gabon, Guatemala, Guinea, Guyana, Haiti, Honduras, India, Indonesia, Jordan, Kenya, Kyrgyz Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Moldova, Morocco, Mozambique, Namibia, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Paraguay, Peru, Philippines, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Tajikistan, Tanzania, Timor-Leste, Turkmenistan, Uganda, Vietnam, Zambia and Zimbabwe.
within each of the country’s that data was available for, using Gunilla Backman et al’s 2008 study of 194 Health systems.\textsuperscript{242}

Graph 3, below (Appendix E), illustrates this information by providing a visual representation of the ‘equity impact’ of a constitutional right to health upon immunisation accessibility. The countries that recognise a constitutional right to health appear, in general, to have slightly more equal levels of access to immunisation (as represented by the generally shorter bars in the graph) than those that do not. To determine the nature and extent of the correlation that appeared to exist between a country’s recognition of a constitutional right to health and how equitable the levels of access to children’s immunisations within that country are, a regression analysis was then performed using Microsoft Excel.

The data on the percentage point differences between the children being vaccinated with DTP3 from the highest and lowest wealth quintile of each country was used as the dependent variable in the analysis. A ‘dummy’ variable was used to provide an independent variable value, and was defined as 1 if a constitutional right to health was recognised in a country and was set to 0 if not. Provided in Appendix F, below, are the results of the regression analysis. The results confirm that there is in fact a negative correlation that exists between the two variables. The results indicate that, on average, if a country has a constitutional right to health, then the difference between the highest and lowest wealth quintiles of children in that country being vaccinated with DTP3 will decrease (by 10.58 units). Furthermore, the R-squared value (0.089) indicates that on average, this difference between the percentage of children being vaccinated from the highest and lowest wealth quintiles in a country can be explained, by 8.9% of the time, by a country’s recognition of a constitutional right to health. Finally, the results are statistically significant (with a p-Value of 0.0175). This means that (with 98.25%

\textsuperscript{242} Gunilla Backman et al, “Health systems and the right to health: an assessment of 194 countries” (2008) 372 Lancet 2047. (Note that Backman et al’s definition of a constitutional right to health is slightly wider than some might consider a strict constitutional right to health. The results they have respond to the question of “Does the state’s constitution, bill of rights, or other statute recognize the right to health” at 2057. This means that more countries may have been included in my study than is strictly accurate. Nevertheless, for consistency, the results within Backman’s study have not been altered for the purposes of my own research).
accuracy) the supposed statistical process will produce similar findings.\textsuperscript{243} It is highly probable, therefore, that countries recognising a constitutional right to health will have less disparities (and therefore more equity) between the percentage of children that are vaccinated from the poorest and wealthiest households within that country.\textsuperscript{244}

c. Limitations

Whilst statistical modelling can be useful; in the realm of law, however, and in the assessment of rights, its predictive value is much less certain. The results in (b), for instance, reveal nothing of the variation in the nature of the constitutional provisions that have been assessed, or of the levels of protection they must afford, to be able to bring about their desired effects.\textsuperscript{245} In some countries, for instance, constitutional rights may be “merely figurative; in other countries they constitute enforceable entitlements that may act as a basis for litigation.”\textsuperscript{246} Also, given that law is a highly socio-relational construct that is dependent upon people and institutions to give it effect, the results in (b) suffer from a further limitation in that they fail to provide us with any real insight as to the particular institutional conditions that are required for the right’s recognition to be effective.\textsuperscript{247} Matsura, for instance, has argued that high levels of democratic governance should be present to ensure the success of the right’s recognition.\textsuperscript{248}

Whilst the results produced are statistically significant, and although more comprehensive analyses could have been undertaken; in general, statistical models

\textsuperscript{243} Another way of expressing the significance of this value would be to say that at the 5% level of significance, the data supports the supposed hypothesis (that the existence of a constitutional right to health has a negative impact upon (reduces) the disparities between children from the highest and lowest wealth quintiles that are vaccinated with DTP3 in that country).

\textsuperscript{244} For specific discussion on how to classify the strength of evidence in public health see, for instance, JP Habicht et al, “Evaluation designs for adequacy, plausibility and probability of Public health programme performance and impact” (1999) 28 International Journal of Epidemiology 10; See also, Bustreo, F. et al, supra note 178 at 88-89.


\textsuperscript{248} Ibid.
typically remain too simplistic “to capture the complexity of real legal systems and the normative choices they encode.” Limitations aside, the results are, nonetheless, supportive of this overall thesis argument, and might be considered as one of a number of possible ways to illuminate the likely impact of the recognition of a constitutional right to health, upon immunisation equity. It should also be remembered that arguably the recognition of a constitutional right to health is, in any case, of an inherent worth (irrespective of its abilities to effect certain outcomes). Its national recognition often serves as an important first step in attempts to translate international legal commitments from the realm legal theory into practice.

5.2.2 National vaccine laws

A second measure that contributes to an enabling environment is the recognition of national vaccine laws. Vaccine laws differ from constitutional health rights in their specificity and more technical orientation; and they typically contain a mixture of operational, declaratory and financially related provisions. Vaccine laws have been particularly popular in Latin American countries, where 27 Latin American governments have now either enacted or have proposed to enact vaccine legislation covering 92.3 per cent of the region’s population. Silas Trumbo et al trace the rise of Latin America’s vaccine laws to the region’s inception of its Expanded Program of Immunization, alongside which the Pan American Health Organization and its Revolving Fund for pooled vaccine procurement “promoted country ownership of national immunisation programs” from the start:

> Throughout the 1980s, as governments assumed greater responsibility for vaccine purchasing and program financing, regional and national actors in the

---

249 See, David M. Trubek, *supra* note 240 at 23. See also, Alan O. Sykes, “The Inaugural Coase Lecture: An Introduction to Regression Analysis” (1993) Chicago Working Paper in Law & Economics, online: <http://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1050&context=law_and_economics> (Who similarly points out that “statistics itself does not say how much weight a regression study ought to be given or whether it is reasonable to use a particular parameter estimate for some legal purpose or other. These assessments are inevitably entrusted to triers of fact, whose judgments on the matter if well informed are likely as good as those of anyone else” at 33).


251 *Ibid* at 84.

252 *Ibid* at 83.
legislative sphere developed legal frameworks to protect immunisation program budgets amid competing priorities. During this time, PAHO began collaborating with the Latin American Parliament (Parlamento Latino) to draft a model law that was shared with the legislative bodies throughout the Region.\footnote{Ibid.}

In many ways vaccine laws emerged as a response to the then practical problems facing the region, namely: to the lack of organisation displayed within many Latin American countries health care systems and to the threat that this posed towards realisation of the regions immunisation goals. To overcome this, Trumbo et al report, for instance, that 44% of the Latin American countries with such laws prescribed national budget lines for vaccine purchases and 63% declared immunisation to be a public good to be provided for free by the state.\footnote{Ibid at 89.} Other provisions prescribed specific vaccines to be provided in the country’s immunisation schedule (78%); many mandated vaccination amongst children (96%); others provided for the regulatory oversight of vaccines (30%) and a handful provide detail on vaccine procurement mechanisms (26%).\footnote{Ibid.} The high levels of success, efficiency and equity (see graph 2) now displayed in the outcomes of many of Latin America’s immunisation programs, can be contrasted with the current state of their broader health system landscapes, that are often characterised by their inaccessible nature and propensity to perpetuate inequality. McKinsey & Company, for instance, have reported on the high levels of out-of-pocket spending that patients within countries such as Brazil and Mexico endure and on the mismanagement and incompleteness of the drug schedules provided within their public systems.\footnote{McKinsey & Company, “Perspectives on healthcare in Latin America” (2011), online: <http://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CBwQFjAA&url=http%3A%2F%2Fwww.mckinsey.com%2F~%2Fmedia%2FMcKinsey%2FDocuments%2FClient_Service%2FPublic%2520Sector%2520Perspectives_on_Healthcare_in_Latin_America.ashx&ei=ZwyuU46zDqjH8AGbvYBY&usg=AFQjCNHCXgMBrl_DQk5SAuAhoef5JGstXA&sig2=HxQ-GaUry19Blq6_I-BU&A&bvm=bv.69837884,d.b2U>.

In specifically “linking the agendas of…key national institutions” (Ministries of Health, Finance and the Parliament)\footnote{Michael McQuestion et al, “Creating Sustainable Financing and Support for Immunization Programs in Fifteen Developing Countries” (2011) 30:6 Health Affairs 1134 at 1135.} within a country, to create binding legal commitments on vaccine resource-allocations, Latin America’s vaccine laws have demarcated a space for
immunisation to be prioritised and maintained at the highest levels. This element of certainty has produced greater levels of sustainability and institutionalisation of the programs, and has contributed to the now highly equitable levels of vaccination that are experienced by that region, as displayed in graph 2. In other regions of the world, where inequity in immunisation continues to persist, infrastructural constraints (see chapter 1) and health ministries’ inability to earmark the necessary long-term funding for national vaccination schemes to operate, has resulted in their over dependency upon external funding and their inability to strengthen national health system services. In response, and in light of the potential displayed by vaccine laws, the most recent global immunisation policy (The Global Vaccine Action Plan) has called upon all WHO Member Countries to develop and implement, national vaccine-related laws.258

5.3 Examples of how enabling environments can be used to achieve greater equity

Whilst the recognition of national constitutional rights to health and of national vaccine laws are two specific measures contributing to an enabling environment; in this thesis’ attempts to illuminate how the right to health is being used to improve immunisation equity in practice, it is also helpful to consider, more broadly, what it is that such an environment has the ability to enable. In this section, therefore, two case studies centring on civil society action and on the creation of public-private health partnerships are presented and which illustrate what can be achieved when social environments are poised to facilitate individuals’ realisation of the right health.

258 See, GVAP, supra note 207 at 37. Note also that the SABIN Vaccine Institute is currently working with 18 countries to help them strengthen their immunisation financing systems and to make them become more sustainable. One of the ways in which it is doing this, is through encouraging them to introduce vaccine laws and is currently piloting a range of techniques with these countries to implement such laws. See, SABIN Vaccine Institute “Legislation,” online: Sabin <http://www.sabin.org/programs/sif/legislation>.
5.3.1 An enabling environment as a foundation for civil society action

Civil Society: the “community groups, non-governmental organizations (NGOs), labour unions, indigenous groups, charitable organizations, faith-based organizations, professional associations and foundations”\textsuperscript{259} that “associate to advance common interests”\textsuperscript{260} play a critical role in helping states to ensure that children are able to access basic vaccinations and General Comment No. 14 emphasises the need to be attentive to their role:

\begin{quote}
Coordinated efforts for the realisation of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society.\textsuperscript{261}
\end{quote}

Civil society organisations have been particularly helpful in procuring greater levels of access and equity in immunisation, as they often help to create demands for vaccination, and further, their geographical spread enables them to reach out to the more vulnerable populations.\textsuperscript{262} In addition, as not-for-profit seeking entities, civil society organisations typically aspire towards realising the same equity-enhancing goals as the state, and thus their work tends to help states become more effective and efficient in their immunisation programming.

a. Case study 1: Polio eradication in India

(i) The problem

India, as one of the most densely populated, geographically diverse and fastest growing countries in the world, would perhaps always present something of a challenge in the global attempts to eradicate polio. In addition to the general logistical, cold-chain and

\begin{footnotes}
\item[260] Ibid.
\item[261] See General Comment No. 14, \textit{supra} note 78 at Para 64.
\item[262] It has been reported that in Pakistan, for example, civil society organisations held 4153 health sessions for marginalized, neglected and hard to reach communities in 2010. Thacker et al, \textit{supra} note 259 at B99.
\end{footnotes}
health-worker capacity problems that it experienced, India’s polio eradication strategy faced further challenges of trying to reach migratory populations, of social opposition, and of the re-emergence of differing poliovirus strains. Whilst as recently as 2009 the country was accounting for over half of all reported polio cases in the world,263 the government’s support for, and collaboration with, civil society organisations, ensured that many of its challenges were overcome.

(ii) The response

a. Greater attention to the “Quality” of the vaccine-response

In response to evidence of growing numbers of children contracting type 3 wild poliovirus (WPV3) as opposed to type 1264 (the latter being the type that between 2005-2009 the vaccines administered in India were solely affording protection against), new bivalent oral polio vaccines (bOPV) containing attenuated forms of both WPV1 and WPV3 were introduced. In addition to the technical input of the WHO and of UNICEF, the Indian Academy of Pediatrics, with its 20,000 strong membership, were also reported to have played a role in advising the Indian government on vaccine selections and on promoting disease surveillance techniques.265

264 See, for example, CDC, “Progress Toward Interruption of Wild Poliovirus Transmission --- Worldwide, January 2007 – April 2008” (2008) 57:18 MMWR 489. (Which documents the rising WPV3 cases in India as compared to decreasing WPV1 incidences in its weekly report). Polio eradication strategies had focused primarily on interrupting WPV1 transmission “based on the epidemiological argument that WPV1 cases cause higher rates of paralysis than other wild poliovirus types,” however, there was little evidentiary support for this and even if true, children were still at risk of contracting WPV3 and the consequences were no less severe. “According to the Indian Academy of Paediatrics, the surge in polio cases caused by WPV3 in 2008 and 2009 was the iatrogenic result of having replaced tOPV with mOPV1” in many of the country’s immunisation efforts. See, Narendra K Arora et al, “Global lessons from India’s poliomyelitis elimination campaign” (2009) Bulletin of the World Health Organization, online: WHO <http://www.who.int/bulletin/volumes/88/3/09-072058/en/>.
265 Thacker et al, supra note 259 at B99-B100.
b. Co-ordination in the administration of vaccines, and attention to their “physical accessibility”

To be able to reach and administer bOPVs to all children in the country, National “Pulse Polio” immunisation days were held to vaccinate over 170 million children under the age of 5, on each of the national immunisation days held. To do this, tens of thousands of vaccine workers were trained and deployed by organisations such as Rotary International and local “transit teams” positioned on trains, at bus stations, and in market places sought to vaccinate the children of no fixed abode.

c. Responding to social opposition and creating demand for the service

Due to a number of underlying misconceptions, manifesting in high levels of fear and mistrust towards the practice of vaccination, immunisation coverage rates in the Indian States of Uttar Pradesh and Bihar had been particularly low. In response, UNICEF set up The Social Mobilisation Network, which recruited more than 4800 community mobilisers, to work with communities and religious leaders, to educate them about


268 See, Narendra K Arora et al, “Bulletin of the World Health Organization: Global lessons from India’s poliomyelitis elimination campaign” (2009), online: WHO <http://www.who.int/bulletin/volumes/88/3/09-072058/en/> (Which notes that in 2009, for instance, about 80% of polio cases were reported in the state of Uttar Pradesh and 17% in the state of Bihar).

269 See, Social Mobilisation Network- Uttar Pradesh online: Social Mobilisation Network <http://www.socialmobilisation.net/>; note also that Rotary International (amongst others) carried out work with Islamic communities to try to overcome cultural and religious opposition to the vaccines. See, for example, Ashok Mahajan, “Lessons From India: How to Promote the Polio Vaccine in Pakistan” (January 11, 2013) The New York Times, online: The New York Times <http://india.blogs.nytimes.com/2013/01/11/lessons-from-india-how-to-promote-the-polio-vaccine-in-pakistan/?_php=true&_type=blogs&_r=0> (Note in particular Rotary’s creation of a state level committee
the importance of vaccination and to involve them in the design of India’s immunisation strategy so that they were more acceptable to the groups that had resisted.\textsuperscript{270} Furthermore, during the national immunisation days and campaigns themselves, over 3000 independent monitors were deployed to provide real-time feedback to campaign coordinators to ensure that the programs were meeting local needs.\textsuperscript{271} In addition to the civil society organisations’ wide geographical reach and abilities to provide physical capacity on the ground, were their abilities to engage vulnerable groups. Whilst perhaps trivial from the outset, national immunisation days, (to the children at least), became popular for the free whistles, masks and toys distributed following vaccination by groups such as Rotary International. This helped to create a demand from children, to be taken to and given access to the service and to spread the campaigns message even further.\textsuperscript{272}

(iii) The result

On 11\textsuperscript{th} February 2014, India was officially declared polio free after reporting no new cases of the disease since 2011.\textsuperscript{273} Its surveillance and infrastructure, if properly utilised, now offers a framework for the delivery of other vaccines and essential health interventions.
5.3.2 More collaborative public-private health action

Many of the problems that face today’s world: problems of rising inequality, of climate change, and of insecurity, are problems of a globalised nature. The problems surrounding health inequality are no different, and what might ultimately be required to address them, are solutions with a similarly ‘global’ force. Over the last few decades, not-for-profit development partnerships of a fundamentally transnational nature have emerged in response to a number of disease-based problems. They appear to offer new solutions to what were seemingly intractable situations.

a. Case Study 2: The Meningitis Vaccine Project

The Meningitis Vaccine Project, for instance, an innovative new arrangement that has responded to specific needs of African peoples is a case in point.

i) The problem

Every year, in a region known as the “meningitis belt,” (stretching from Senegal to Ethiopia), periodic meningitis outbreaks occur. The disease inflicts a huge human toll, typically killing more than 10% of patients that contract the disease within the region and procuring long-term disabilities in up to 25% of its survivors. The meningococcal A+C vaccine available to prevent the particular strains of the disease occurring was costly and (being heat instable) impracticable to deliver routinely.

---

274 This sentiment was echoed by Christine Lagarde, Managing Director of the International Monetary Fund in a public lecture delivered at the London School of Economics. She argued for a new “sense of common purpose and common citizenship…a reinvigorated sense of multilateralism.” Christine Lagarde, The Amartya Sen Lecture 2014 (6 June 2014) LSE Public Lectures (Podcast), online: <http://www.lse.ac.uk/newsAndMedia/videoAndAudio/channels/publicLecturesAndEvents/player.aspx?id=2505>.


Furthermore, as a polysaccharide vaccine, the vaccine could only offer short-term protections and was largely ineffective amongst young children.\textsuperscript{277} As a result, many African countries adopted a highly reactive approach to the disease, which, when it struck, placed a huge burden upon many already fragile health systems and diverted resources from other basic health causes.\textsuperscript{278} In 1996-97, the greatest meningitis epidemic in African history occurred, sweeping across sub-Saharan Africa to kill over 25,000 people.\textsuperscript{279}

In response, African ministers turned to the World Health Organization for a solution.\textsuperscript{280} In what followed over the proceeding decade was a serious of unprecedented events that drew upon the foundations of a rights-enabling environment, to ultimately produce a heat-stable Meningitis A vaccine (the MenAfriVac), able to respond to the particular epidemiological needs of at-risk children within the Sahel region.

\textbf{ii) The response}

\textbf{a. Importance of demand from “below”}

Unlike other vaccines developed for the industrialised North, and which may fortuitously trickle ‘down’ to the populations of the global South, the MenAfriVac was specifically designed with the needs of sub-Sahara Africa in mind. The vaccine’s design, development and delivery were considered together and in consultation with African health ministers from the outset and “disease control, -not simply product licensing-,”\textsuperscript{281} was the project’s goal. Affordability conditioned the entire vaccine development

\begin{footnotes}
\footnote{277 Dr Mahamadou Compaore, “MenAfrivac, a long-awaited vaccine for Burkina Faso” (2010) 14th ICDRA, Singapore, online: WHO <http://www.who.int/medicines/areas/quality_safety/regulation_legislation/icdra/WD-1_vaccine_BurkinaFaso.pdf> at 6.}
\footnote{278 Ibid at 5-6.}
\footnote{279 PATH, “Deadly epidemic gives rise to groundbreaking partnership,” online: PATH <http://www.path.org/ieniafrivac/about-mvp.php>.}
\footnote{280 Ibid.}
\end{footnotes}
process, with African countries stipulating their price ceiling as USD$0.50 per vaccine unit and all actors working to ensure that this was respected.

b. Collaboration at all levels

Consonant with the right to health’s positioning of its legal obligations to fulfil the right within a globally interdependent scheme, the design, development and production of the vaccine marked a truly global collaboration. The project was financed with a seed grant from the Gates Foundation in collaboration with PATH and the WHO. The Serum Institute of India Ltd, a developing country vaccine manufacturer, produced the vaccine in line with its production cost. SynCo Bio Partners, a bio-pharmaceutical manufacturing organisation in the Netherlands, supplied raw materials for the vaccines at a discount cost and the US Food and Drug Administration’s Centre for Biologics Evaluation and Research (FDA) provided scientists at the Serum Institute with the critical “know-how” to replicate the novel conjugation technology that was required for the vaccine’s creation. Finally, the US National Institutes of Health facilitated the licensure of the intellectual property, developed by the FDA, to the Meningitis Vaccine Project (MVP). PATH, (a partner in the MVP), noted how at every level, “everyone

---

282 PATH, supra note 279.
283 States are required, for instance, to “take steps, individually and through international assistance and co-operation…with a view to achieving progressively the full realization of the rights recognized in the present Covenant…” ICESCR, supra note 73 Article 2(1).
284 Note, from 1980 until 2014, PATH stood for Program for Appropriate Technology in Health, now, they are just known as PATH. See, PATH “Frequently asked questions,” online: PATH <http://www.path.org/about/faq.php#Acronym>.
enafrivac-paradigm-vaccine-development/>.
286 PATH, “An innovative product development plan: Passion for stopping meningitis inspired collaboration around the globe,” online: PATH <http://www.path.org/menafrivac/product-development.php>. The Serum Institute, being a developing country manufacturer was an unlikely candidate for the project, however, it was able to supply the vaccines at a much lower cost than any of its competitors. Although the profit margins were very low, the Serum Institute stood to gain from the conjugation technology transfer that it would receive to produce the vaccine, which could later be applied to other vaccines. Wilson has commented that the MVP model would be suited to the development of other adapted versions of vaccines based on already-established technologies (such as the conjugation technologies) and could be applied to make rotavirus, pneumococcal and HPV vaccines cheaper, for instance. Wilson P, supra note 39.
288 PATH, supra note 286.
289 Ibid.
[had] believed in the mission,” seeing ways to both contribute to, and benefit from the process. 290

c. Declaratory support at the highest levels

Despite its questionable record on the promotion of public health, (when faced with competing economic demands), the US has signalled that its support for the MVP emanated from a respect for, and observance of, the principles of the Doha Declaration on TRIPS and Public Health. 291 A further, important declaration, key to the success of the MVP, was the Yaounde Declaration: signed by African ministers in the meningitis belt. 292 In line with pledges made within the Declaration, a number of African countries expedited their national regulatory processes required to implement use of the vaccines on the ground.293

ii) The result

Over 151 million children have received the MenAfriVac since 2010294 and further introductions have been planned across the region.295

290 *Ibid.* Quoting Dr. Marc LaForce MVP Director, PATH.
293 See, PATH, “Beyond vaccine development: Developing and introducing a new vaccine for sub-Saharan Africa was no simple matter” online: PATH <http://www.path.org/menafrivac/trials.php>.
295 For detail on the planned introductions of the vaccines into other countries within that region see, Meningitis Vaccine Project, “Subsequent campaigns: Subsequent introductions will be country-driven and coordinated under WHO leadership,” online: MVP <http://www.meningvax.org/next-campaigns.php>.

(Around 315 million people are targeted for vaccination across the meningitis belt “with the entire population – an estimated 450 million – protected through the broader community protection resulting from reduced transmission of the disease”).
5.4 Discussion of an enabling environment’s impact upon equity

Fulfilment of the right to health (on chapter 2’s earlier interpretation of the right to health), necessarily contributes to a greater level of equity in health and thus an enabling environment, (which makes the realisation of the right more likely), serves to better advance the right’s fundamental aims. Less instrumentally, the creation of an enabling environment might also be viewed as an equity-enhancing measure in itself. An enabling environment provides the legal apparatus and social mechanisms to advance the rights of the individual: ultimately catalyzing a more democratic relationship between individuals and the State who, under such circumstances, is perhaps more likely to respond to such demands for social change. In large part this is what the right to health, as an indivisible, transformative and equity enhancing right aspires towards: a more balanced and participatory approach by States towards the social decision-making processes that impact upon individual health; since it is typically the lack of voice and power exerted by certain groups within the arenas that make such decisions, that lies at the root of health inequity. This chapter has sought to provide examples of the ways in which rights enabling environments can be both created and utilised, in order to achieve greater equity in access to immunisations.
Chapter 6
Rights based mechanisms that enhance State accountability

6.1 Introduction and definition of accountability

Accountability is often described as being the cornerstone of a human rights-based approach towards health. By affirming the binding nature of human rights, accountability mechanisms serve to transform State’s understandings of peoples’ basic needs from moral claims: normative claims lacking “objectively prescriptive properties,” into legally enforceable, fundamental human rights. Accountability requirements infiltrate every aspect of the respect-protect-fulfil typology of obligations under the right to health and effective human rights strategies embed accountability mechanisms at their core.

Crucially, accountability is a natural ally of equity. Effective processes of accountability not only improve institutional transparency and levels of civic participation: factors the amelioration of social health disparities necessarily require but (and in accordance with the progressive nature of the right to health), effective accountability processes tend to also procure substantive outcomes that reflect the realization of more equitable, social transformations.

In this chapter, two rights-based accountability mechanisms are surveyed that have, (at least in these instances), contributed to a greater level of equity in children’s rates of immunisation access.

---

6.2 An examination of accountability mechanisms contributing to greater equity in access to vaccinations

6.2.1 Right to health based litigation

Rights litigation is a key mechanism in attempts to achieve rights-based accountability. States’ incorporation of international human rights standards, in national law, has enabled individuals to call state’s (in)actions into account and, on occasion, to secure remedies where a violation of rights has been determined. As a rights-based accountability mechanism, however, rights litigation has yet to prove itself as a reliable catalyst for transformative, social change. Courts, whilst occasionally known for their bouts of judicial activism, are typically charged with fulfilling a less dynamic array of functions. The matters over which courts tend to preside either restore some form of a social equilibrium (e.g., private-law type claims such as those in tort which aim to put claimants back into the position that they would have been, had the tortious act not occurred), or, give effect to pre-ordained rules to be followed (e.g., public law type cases such as those in criminal law which regulate defendants’ social conduct.) Social rights, when adjudicated at the national level however, do not appear to fit within either of these (admittedly generalized) moulds. If realization of the right to health requires, as is argued, realization of the principle of health equity, then realization of the right to health through the courts, requires that courts be willing to assume a more dynamic role.

Case SU-225/1998 is a decision delivered by the Constitutional Court of Colombia, which exemplifies the assumption of such a role. The case affirmed a first instance judgment that had considered the state to have a duty to protect the fundamental rights of children and that a minimum core of the fundamental socio-economic rights of children could be directly enforced by tutela. These duties, it said, had been violated by

---


300 Case SU-225/1998, Colombia Constitutional Court. Translation provided by the Lawyers Collective (New Delhi, India) and partners for the Global Health and Human Rights Database, online: Global Health and Human Rights <http://www.globalhealthrights.org>.
the State’s failure to provide meningitis vaccines to poor children in Bogota; children of a group who, for a number of reasons, were at risk of contracting the disease. The court commented:

The State’s inaction ends lives and frustrates welfare and plenitude expectations that are constitutionally granted. In those conditions, and if the abuse of the competence of the responsible organs is verified— as it is in this case—, then the constitutional judge must order the end of the state’s abstention that traces the limit of what is intolerable in a Social Legal State.\textsuperscript{301}

The courts, in recognizing their role as social legal actors, helped to procure a greater level of equity in children’s levels of access to vaccinations in that particular community; citing the fact that the 418 children concerned were poor, and thus part of a more vulnerable, “marginalized and discriminated group,”\textsuperscript{302} as a contributing factor to its decision. The majority of courts, however, appear to be failing to see their role as encompassing this more dynamic social role and as such, cases of this sort appear difficult to come by.\textsuperscript{303} Whilst perhaps not surprising (for reasons that will be further explained), it is not a position, however, that should be readily accepted. As aforementioned, the courts, and its judicial actors, tend to operate within set (and typically non-political) paradigms. Generally, these paradigms do not lend themselves well to transformative social change. As an example, the Courts appear to be doing little to reduce the racial disparities in the levels of people being sentenced to jail where, in the UK for instance, the proportion of black people that are incarcerated is almost seven times their share of the population.\textsuperscript{304} The failure of the courts to tackle the social and broader determinants of the matters that present before them, however, is generally not deemed to be problematic. This is generally not the court’s function and is generally not the purpose of the laws that they are required to give effect to. Human rights and in particular social rights, however, are different. Social rights require that courts, in their role as social legal actors, be willing to take on a more proactive, transformative role.

---

\textsuperscript{301} Ibid at Para 34.

\textsuperscript{302} Ibid at 30.

\textsuperscript{303} Although, as a frequently cited instance of such a case see, Minister of Health v. Treatment Action Campaign CCT8/02. (Constitutional Court of South Africa).

Perhaps a further reason as to why we don’t currently see courts assuming this role in relation to the right to health, is because even if they were to accept their responsibility and role as key actors in this domain, they’ve yet to fully embrace any coherent legal standard that would allow them to attribute evidence of preventable social disparities in health, to state inaction constitutive of a rights violation. At what point, for example, can a court decide to attribute the denial of a basic human need that may, at some point down the line, result in a health inequity, to state (in)action? Common law courts have found innovative ways to deal with indeterminism and legal concepts such as material risk and loss of chance evince this.305 Fundamental human rights including the right to health are, however, arguably not concerned with the indeterminacy of issues of cause and effect. International human rights law does not speak in the language of probability or of causation; rather, it speaks of fulfillment of legal obligations. These obligations, whilst subject to the principle of progressive realization, remain grounded by an inviolable, legally enforceable minimum core:

The part of the fundamental social right that cannot be subjected to political discussion is, precisely, the one that tends to the most elemental satisfaction of the basic necessities of the right holder.306

Within this minimum core, (at least on the interpretation of the CESCR), are necessities that the attainment of greater equity in global health, currently most requires. If the right to health is construed in its health-oriented as opposed to health-care oriented fashion, the minimum core of obligations (which contain, inter alia, obligations to provide access to nutritious food, basic shelter, housing and sanitation, an adequate supply of safe and potable water and essential drugs307) provides for a number of the more upstream determinants of health that, if more rigorously enforced by the judiciary, has a real potential to address current health divides.

Whilst the courts transformative role in procuring greater equity in children’s levels of access to immunisations (that is, its role in contributing to the reduction of preventable social disparities in children’s levels of access to vaccinations) is yet to be fully realized, the courts are contributing towards equity in an alternative way. Namely, and as Flood

---

307 General Comment No. 14, supra note 78 at Para 43.
and Gross astutely assert, they play a critical role in “protecting existing standards of equity” in health services.

### a. Courts as guardians of existing standards of equity

In the field of immunisation, the standard that courts have sought to protect when relying upon the right to health, appears largely associated with issues of vaccine ‘quality’.

In a Georgian Supreme Court decision (Case # bs-434-25 (3k-05)) for instance, the Court, in recognizing that the country’s Ministry of Health and Social Affairs was legally required (According to the Law on Health Protection) to give effect to Article 37 of the Georgian Constitution’s obligation “to ensure life in a healthy and safe environment,” found the State body (amongst others) responsible for the severe injuries sustained by a child that had received an improperly regulated Hepatitis B vaccine. The equity dimension of the case lies in the fact that the court, in recognizing that children (and others receiving the vaccination) did not have the means to access information on the safety of state-administered vaccines that States, (as protectors of the consumer interest), should have made available, their failure to meet this obligation put the vaccine recipients at a grave disadvantage and thus the states (in)actions were deemed to be unlawful. Similarly, in Sahil Society v. Union of India and Anr, the Allahabad High Court, in recognizing that the right to health was a part of the right to life guaranteed by Article 21 of the Indian Constitution, directed the Union of India to “strictly follow its own guidelines and those of the WHO when manufacturing and procuring OPV [oral polio virus]…[and] to abide by internationally accepted standards for polio eradication” in order to protect children against the risks of iatrogenic harm.

---

308 Colleen M. Flood & Aeyal Gross, supra note 100 at 16.
310 Sahil Society v. Union of India and Anr. AIR 1999 All 87 (In the High Court of India). A further, interesting - protection of existing standards type - case, from an accountability perspective, is that of Viceconte, Mariela Cecilia c/. Argentine Ministry of Health: an Argentinian Federal Administrative Court of Appeal decision. (Causa no 31. 77796) Translation provided by Lawyers Collective and partners for the Global Health and Human Rights Database, online: Global Health and Human Rights <http://www.globalhealthrights.org>. (The court ordered the National Ministry of Health and Social Welfare to produce a WHO-certified vaccine for the Argentine Hemorrhagic Fever, in line with a previous (but unfulfilled) commitment to do so. The court, whilst referring to its obligations under the right to
In addition to the courts, which provide a mechanism for accountability at the national level, the right to health, as an international legal right, gives rise to a number of its own accountability mechanisms too.

6.2.2 UN accountability mechanisms

The ICESCR requires that states report on the progress that they are making towards the realization of the rights contained within the covenant to the Economic and Social Council which, through the Committee on Economic, Social and Cultural Rights, correspondingly reports back to and makes recommendations to states. Although weak in terms of its powers of enforcement, as an iterative monitoring and planning process between states and UN oversight bodies, the procedure is of some accountability-related worth. A simple search using the United Nations Human Rights Office of the High Commissioner’s online Universal Human Rights Index search-tool currently discloses 189 sets of recommendations delivered by the CESCR and the Committee on the Rights of the Child that had commented upon States right-to-health based responsibilities on immunisation since 2000. Whilst the equity-impact of the recommendations are difficult to discern, the fact that this added layer of attention is being devoted to State’s immunisation (and other health-related) actions, helps to maintain the pressure upon states to address the right-to-health issues of most fundamental concern.

Furthermore, whilst judicial analyses of States Parties fulfillment of human rights obligations have often rescinded to assessments of the legitimacy of state decision-health in international law, acknowledged that its decision was consistent with the social justice and collective welfare based aims of the country’s constitution and “recognized the liability of Judges to ensure the appliance of the rights into…society [and that] its role is not only a matter of laws”).

311 See, Lawrence O. Gostin, supra note 56 at 253.
312 See, UN Human Rights Office of the High Commissioner, “Universal Human Rights Index,” online: OHCHR <http://uhri.ohchr.org/en> (The terms “vaccine,” “vaccination,” “immunisation” and “immunization” were entered into the search box and were filtered by results mentioning the “right to health”).
making processes and of cost-benefit analyses, international accountability mechanisms have maintained a focus on some of the rights more deontological-oriented concerns.\textsuperscript{313}

The Special Rapporteur on the right to the highest attainable standard of physical and mental health, appointed as an independent expert by the Human Rights Council in 2002 to report on country situations and specific human rights themes, for instance, has drawn attention to (and has advocated for changes on) the structural barriers to the rights realization (including, in particular, issues of communicable diseases.\textsuperscript{314})

Following a country visit to Uganda, for instance, recommendations made by the then Special Rapporteur Paul Hunt, to increase research on ways to operationalize and implement strategies for neglected and tropical diseases, appears to have resulted in collaborations with schemes like the SURE project, which works to improve access to the country’s essential medical supplies.\textsuperscript{315} Furthermore, Hunt’s recommendation\textsuperscript{316} to develop a right to health unit within the Ugandan Human Rights Commission to “monitor and ensure accountability, in furtherance of the right of everyone to the


\textsuperscript{314} See, for example. Commission on Human Rights, The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt, submitted in accordance with Commission resolution 2002/31, E/CN.4/2003/58, 59th Session, (2003) at 18 (In which Hunt details that he will aim to address issues of neglected diseases in his mandate as Special Rapporteur); Commission on Human Rights, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt: Addendum Mission to Uganda E/CN.4/2006/48/Add.2 62nd session (2006) [Hereafter, Report of the Special Rapporteur: Mission to Uganda] (Which identifies the main features of a right to health approach to many of the neglected diseases within Uganda (many of which being highly communicable)); Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover: Addendum Mission to Australia, A/HRC/14/20/Add.4 14th session, (2010) at 12 (where it is noted that “Indigenous Australians are hospitalized for potentially preventable conditions at five times the rate of other Australians as a result of lack of access to preventive health measures such as vaccination, health promotion, early screening and diagnosis.”); Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover: Addendum Mission to Tajikistan, A/HRC/23/41/Add.2, 23rd session (2013) at 4 (Which draws attention to the fact that the Government in Tajikistan is only funding 30% of the country’s national immunisation program and calls upon it to make improvements in its scheme in order to realise the right to health for the people of Tajikistan); Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover: Addendum Mission to Azerbaijan, A/HRC/23/41/Add.1, 23rd session, (2013) at 10 (Which notes and calls for the state to take action upon the high rates of TB within marginalised groups within that country).

\textsuperscript{315} Report of the Special Rapporteur: Mission to Uganda, supra note 314 at 18. The Uganda National Health Research Organization, (mentioned within the report) subsequently appears to have established the Securing Ugandan’s Right to Essential Medicines (SURE) project, online: Ministry of Health, Uganda <http://health.go.ug/mohweb/?page_id=117>.

\textsuperscript{316} Report of the Special Rapporteur: Mission to Uganda, supra note 314 at 22.
enjoyment of the highest attainable standard of physical and mental health, with special attention to neglected diseases, has also been implemented, and its work is being used to better hold the Ugandan government to account.

Of particular salience, has been the Special Rapporteur’s work with the pharmaceutical sector. The role of the pharmaceutical sector in conditioning people’s access to vaccinations, as has been discussed, is instrumental. Despite the power that these organizations wield over individual’s lives these corporations are not strictly required to fulfill human rights obligations. From an equity perspective this is problematic. Organizations principally driven by market imperatives often lack the incentives to address basic needs. In seeking to respond to the issue, in a special report following a mission to GlaxoSmithKline, the special rapporteur offered a new and particularly expansive interpretation of the responsibilities incumbent upon pharmaceutical companies, to ensure that individuals are better able to realize their fundamental rights to health. The report carried a particularly egalitarian ethos, outlining pharmaceutical companies’ “crucial right to health responsibility…to take all reasonable steps to make…medicine [including vaccines] as accessible as possible, as soon as possible, to all those in need, within a viable business model.” Whilst many have subsequently expressed their skepticism over the Special Rapporteur’s apparent belief in pharmaceutical companies’ abilities to self-impose a more inclusive capitalist agenda, the attention that was shone on the particular company within the report, appears to have led to several subsequent health-equity enhancing commitments.

317 Ally Pregulman, “Health as a Basic Human Right: Efficacy of Quality Assurance for Healthcare in Uganda” (2008), online:
319 Ibid at 12.
321 Just as the report was being released, for instance, GlaxoSmithKline announced that it would make a number of improvements in its access to medicines strategy including price reductions in least developed countries, commitments to invest in their health systems and patent pooling. See Report of the Special Rapporteur: Mission to GlaxoSmithKline, supra note 318 at 13 and see GSK, “Corporate Responsibility
6.3 Discussion of accountability mechanisms’ impact upon equity

Cultivating accountability in practice “requires a dynamic process of clarifying legal standards for actors at various levels.”322 The two accountability mechanisms that have been reviewed in this chapter: right to health based litigation and UN related accountability mechanisms, are contributing to review and remedial-type processes that are serving to procure greater levels of health equity. Whilst each has its own limitations and both could be more rigorously enforced, the impact of each is still noted, not least for their contribution towards a greater rights-enabling environment. It must also be remembered that effective accountability requires action along a continuum.323 To ensure that the right to health’s more upstream vision for health is secured, innovative and pre-emptory mechanisms of accountability; such as mechanisms that are embedded into the planning and design of health impacting polices, must be implemented from the outset.324 This chapter, however, has sought to demonstrate how the right to health, via two of the more downstream accountability mechanisms that it gives rise to, is contributing to a greater level of equity in children’s access to immunisations.

323 Hunt, for instance, has argued that accountability is made up of three parts: monitoring, review and remedy. Each aspect of the process is necessary to ensure that rights are upheld. See, Maria-Luisa Escobar, “Accountability in Health Systems” (April 22, 2014), online: The World Bank <http://wbi.worldbank.org/wbi/stories/accountability-health-systems>.
324 See, for instance, Yamin, supra note 322 (Who argues that there should be a “circle of accountability” at the national level including “development and implementation of a national plan of action; budgetary analysis; monitoring and evaluation of programs based on appropriate indicators and mechanisms for redress” at 96).
Chapter 7

Analysis and Conclusion

This thesis has explored both normative aims and practical applications of the right to health in international human rights law in order to reveal evidence of its effectiveness. After conceptualizing the right to health as a right to health equity, it considers as to how the objectives of the right are being met and achieved in practice in the field of child immunisation. The process of (a) determining what it is that ‘effectiveness’ looks like; of (b) what it is that applications of the right to health even constitute and of (c) which dimensions of disparity are a true indication of the inequities that the right aims to overcome, proved a complex task; and one still ripe for further investigations.

(a) Assessing 'effectiveness,' for instance, suggests there is an objective end-point to the analysis that can be assessed; which, as has been shown, is not always the case. National recognition of a constitutional right to health, for instance, can serve a more fundamental purpose than its ability to bring about certain aims, and UN reporting mechanisms that help to keep the pressure upon states to take measures to fulfill their human rights obligations, have a more elementary role than, again, their sole ability to bring about certain aims.

(b) Assessing how applications of the right to health manifest at times required assumptions to be made as to how the content of the right to health might be applied. Whilst the global immunisation policies that were surveyed, for instance, were all deemed to have displayed elements of the right to health, (in the way that they all advanced aspects of the right’s AAAQ principles), only the final phase (3) of GAVIs immunisation strategy, and the recent GVAP policy had explicitly acknowledged the role and influence of the right to health in their strategic agendas.325 This, whilst difficult for those trying to trace its application, is not, however, problematic in itself. In fact, as rights-enabling cultures becomes more ingrained and policy-makers’ desires to

325 See, for instance, GAVI Alliance, “Health Equity,” online: GAVI <http://www.gavialliance.org/about/value/health-equity/>; GVAP, supra note 207 at 38 and 85.
give effect to the right’s deontological aims become more instinctive, we will arguably see even less explicit references to the right being made when decisions-makers are vindicating their policy approaches.\footnote{Although – admittedly- this is still a long way off.}

(c) Finally, determining which dimensions of disparity are structurally determined and which therefore have a potential to be corrected or altered by the state, (and thus become engaged by the content of right to health based obligations), presents a further challenge. At what point does a state cease to be responsible for the actions that it could alter but, for reasons of resources, liberty or autonomy chooses not to engage? From the factors suggested to be constitutive of ‘inequity’ in chapter 1, it is clear that a broad view as to the role of the state in mitigating social and other disparities has been taken. In the current climate, however, where inequality has become one of the greatest threats to development, to growth and to the satisfaction of human dignity, it is not a stance that appears inappropriate. Inequality, more than anything, inhibits opportunity and opportunities are the hallmark of a fair society. Immunisation, as a public health measure that provides children with one of the most basic, and yet cost effective protections, affords millions of children the opportunity to live a healthy life.

The right to health, as a right to health equity, is concerned with immunisation not only in its normative capabilities to improve equity, but also as a matter of strict legal obligation. The effectiveness of the right to health in achieving its aims of health equity; and in particular, equity in access to childhood immunisations, has been analyzed and shown to be effective in the instances of the rights’ application that have been surveyed.

Why though, are applications of the right to health so seemingly able and suited to improving equity? The question requires critical reflection as to the attributes of the approaches surveyed; that have helped to procure the right’s equity-advancing effects. It is argued that there are at least three attributes, to emanate from Part B, that applications of the right to health have brought to bear. Further action upon, (and removal of the limitations to the full realization of), these particular attributes, might assist those attempting to further ameliorate remaining inequities in access to children’s immunisations.
i. Increased awareness of the vulnerable

The demographic that applications of the right to health have generally sought to protect, has been the vulnerable. Even at the most superficial levels, the right to health draws attention to those in need; requiring states to form national health frameworks, for instance, that are able to identify what each of their marginalized populations require for the rights realisation. Similarly, at the higher levels, declarations made by intergovernmental bodies and reports delivered by individuals such as the UN Special Rapporteur on the right to health, have illuminated the plight of the most vulnerable. Translating the attention that is focused upon these groups, into meaningful health-enhancing action, however, has not always been an end result. Strategies to go on and reach vulnerable and marginalized groups, requires political will, social action and increasingly, the alignment of commercial agendas. Whilst this thesis has explored examples where this has been the case, it is also clear that without the environments that either mandate (c.f. vaccine laws) or enable such action, the right to health risks becoming a rhetorical tool lacking abilities to effect meaningful, transformative change.

ii. Individual needs define the sphere of actors required to fulfil the rights goals

A second feature of rights-oriented strategies is their elevation of the individual need. We live in a world of now complex power relations not only limited to the rapport between individuals and states. Effective human rights strategies recognize this and accordingly alter the sphere of actors required to fulfill human rights responsibilities: to give effect to individuals’ basic needs. The UN Special Rapporteur, for instance, has extensively engaged with the pharmaceutical sector to raise attention to their human rights responsibilities. Some of the more innovate public-private health partnerships, such as the Meningitis Vaccine Project and the GAVI Alliance have similarly, in recognizing the import of private actors’ actions upon individual rights, sought to harness the contributions of this sector in a more productive and engaging way. Clearly, however, much work on this front has yet to be done. Pharmaceutical companies, as non-state actors, are not strictly subject to the fulfillment of legal obligations under the
right to health and thus the misuse of their powers can go unchecked. Subsequently, in recent years, several leading scholars\textsuperscript{327} have called for an increased level of global health governance and for the creation of regulatory frameworks that are able to strengthen the accountability of this sector.\textsuperscript{328} Irrespective of whether these particular calls are heeded, the private sector, given its influence, must form a part of states rights-based solutions.

\textbf{iii. Collaborative action at multiple levels}

Finally, effective right to health-based strategies are acutely aware of the intricate social and institutional interconnections that arise and determine individual health; and accordingly, adopt multifaceted strategies that are able to respond to such complex landscapes. This may, for instance, require that states facilitate the creation of a strong civil society; that it facilitate, (through legal aid, where necessary), access to the courts; and that it commits to high-level agreements that better regulate third party actions within society. As a social right, ultimately informed by the values of the social environments in which it exists, the right to health in the absence of such multi-pronged integration, risks becoming “professionalised;”\textsuperscript{329} which detracts from its potential to effect meaningful, transformative change.

\begin{footnotesize}
\begin{enumerate}
\item It is perhaps telling that the calls for such measures are invariably advanced from human rights-based arguments: revealing the import of human rights movements as both catalysts for social change and as protectors of individual rights.
\item Leslie London, \textit{supra} note 176 at 6.
\end{enumerate}
\end{footnotesize}
This thesis has sought to address the question of whether the right to health is effective at improving equity in the levels of access to children’s immunisations. From the normative discussion and empirical evidence that has been both compiled and surveyed, it suggests that the right to health is effective at procuring the equitable levels of access to immunisations that its framework has been designed to address.

Such strategies, however, can only work if they exist. With economic concerns tending to displace all others, rights based strategies are often pushed aside. It is therefore incumbent upon those with the insight on how the right to health can effectively promote the agenda of rights based solutions to health problems, to continue to encourage their further adoption in practice.
Bibliography

Jurisprudence

Case # bs-434-25 (3k-05) (26 July, 2005, Tbilisi) (Supreme Court of Georgia Chamber of Administrative and Cases of Other Categories).

Minister of Health v. Treatment Action Campaign CCT8/02. (Constitutional Court of South Africa).

Sahil Society v. Union of India and Anr. AIR 1999 All 87 (In the High Court of India).


International Materials


Council of Europe, European Social Charter, 18 October 1961, ETS 35.


UN Committee on the Rights of the Child (CRC), *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, 17 April 2013, CRC/C/GC/15.


UN Human Rights Committee (HRC), CCPR General Comment No. 6: Article 6 (Right to Life), 30 April 1982.


**Secondary Materials**

**Texts**


Asada, Yukiko. *Health Inequality, Morality and Measurement* (Toronto: University of Toronto Press, 2007).


**Articles**


McQuestion, Michael. et al, “Creating Sustainable Financing and Support for Immunization Programs in Fifteen Developing Countries” (2011) 30:6 Health Affairs 1134.


Development, Regional Network for Equity in Health in East and Southern Africa (EQUINET): Harare.


Victoria, C.G et al “Applying an equity lens to child health and mortality: more of the same is not enough” (2003) 362 Lancet 233 at 234.


Online Materials


London School of Hygiene & Tropical Medicine, “Health Policy and Planning Debated: Sustainably graduating – so they don’t come home to live with us” (February 18 2014), online: London School of Hygiene & Tropical Medicine <http://blogs.lshtm.ac.uk/hppdebated/2014/02/18/sustainably-graduating-so-they-dont-come-home-to-live-with-us/>.


Meningitis Vaccine Project News Digest (2013) 38:4, online: MVP

PATH, “Deadly epidemic gives rise to groundbreaking partnership,” online: PATH

———. “An innovative product development plan: Passion for stopping meningitis inspired collaboration around the globe,” online: PATH

———. “Beyond vaccine development: Developing and introducing a new vaccine for sub-Saharan Africa was no simple matter”, online: PATH

———. “Rotavirus Vaccine Access and Delivery: Country introductions of rotavirus vaccines Maps and Lists,” online: PATH

Public health and the U.S. economy (2012) Harvard School of Public Health, online: HSPH

Preston, Richard. “The demon in the freezer” (July 12, 1999), online: The New Yorker

Preziosi, Dr Marie-Pierre. “History, implementation and impact of MenA conjugate on disease burden in Africa: First Regional Meningococcal Symposium, 19-20 March 2012 Buenos Aires, Argentina” Meningitis Vaccine Project, online: SABIN


Social Mobilisation Network- Uttar Pradesh, online: Social Mobilisation Network <http://www.socialmobilisation.net>.


## Appendix A

**Elements of a human rights-based approach within each of the global immunisation policies surveyed**

<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To reduce morbidity and mortality due to vaccine-preventable diseases(^3)(^3)</td>
<td>- Shift towards immunisation services as part of routine health services(^3)(^3)</td>
<td>- Emphasis on increasing and measuring immunisation coverage of infants(^3)(^3)</td>
<td>- The WHO established a standardized vaccination schedule originally for six antigens Bacillus Calmette-Guérin (BCG), diphtheria-tetanus-pertussis, (DTP), oral polio, and measles. Yellow fever was added to the schedule in 1988, hepatitis B in 1992 and the Haemophilus influenza type b (Hib) conjugate vaccine in 1998.</td>
<td></td>
</tr>
<tr>
<td>- To develop and maintain immunisation and surveillance programs(^3)(^3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policy Details**

Following the success of the global smallpox eradication program in the 1960s and 1970s, and as a response to the large numbers of deaths occurring due to vaccine-preventable diseases,\(^3\)\(^3\) the World Health Assembly requested that the World Health Organization establish an EPI to provide universal access to immunisation.\(^3\)\(^7\)

---

\(^3\)\(^3\) The format of these tables are based upon the tables presented in Bustreo, F. et al, *supra* note 178. Whilst there is an element of subjectivity in the contents of these tables, there was a certain logic to the way they were compiled. The main global immunisation policy documents (with particular attention to the founding strategic document of most of the policies concerned) were surveyed; WHA resolutions (where relevant) and literature on each of the policies were also surveyed before the most important right-to-health based features of each of the policies were noted.

\(^3\)\(^1\) See Jean-Marie, Okwo-Bele & Thomas Cherian, *supra* note 186.

\(^3\)\(^2\) See World Health Assembly resolution, WHO expanded programme on immunization (1974) WHA27.57.

\(^3\)\(^3\) See Jean-Marie, Okwo-Bele & Thomas Cherian, *supra* note 186.

\(^3\)\(^4\) *Ibid.*

\(^3\)\(^5\) The Yellow Fever Vaccine is only used in countries endemic for the disease.

\(^3\)\(^6\) Note also that before the introduction of the EPI only 5% of children in developing countries were immunised with the six initial antigens against diphtheria, tetanus, pertussis, measles, poliomyelitis and tuberculosis. There was a real need to expand the benefits of immunisation further, in order to reduce child mortality. See R. Kim-Farley, *supra* note 184 at 223.

\(^3\)\(^7\) See Jean-Marie, Okwo-Bele & Thomas Cherian, *supra* note 186.
Table 2. Elements of a human rights-based approach in the Universal Childhood Immunisation (UCI) scheme (1984)

<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To achieve 80% coverage levels in immunisation in children aged under one by 1990(^{338})</td>
<td>- Increased funding to provide more vaccines: UNICEF was the leading donor to most developing countries under the scheme and its investment in the UCI increased from 57 million US$ in 1986 to 135 million US$ in 1990.(^{339})</td>
<td>(\quad)</td>
<td>(\quad)</td>
<td>(\quad)</td>
</tr>
</tbody>
</table>

Policy Details

The UCI goal emanated from a conference held in Bellagio Italy in 1984 that brought a range of key stakeholders together to consider how to better protect the health of children.\(^{340}\)

The UCI goal hoped to accelerate the EPI, through mobilizing resources, expanding the reach of immunisation and promoting other effective primary health care means.\(^{341}\)

---


\(^{341}\) *Ibid.*
<table>
<thead>
<tr>
<th>Policy Objective</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eradication of polio by 2000</td>
<td>National immunisation days to improve the physical reach of vaccines to children</td>
<td>Emphasis on strengthening surveillance efforts by introducing reporting requirements within all countries.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ceasefires negotiated for ‘days of tranquility’ in conflict zones to enable NIDs to take place.</td>
<td>Laboratory capabilities for isolating and characterising polioviruses strengthened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A standard case definition for polio reporting’s was developed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identified need for quality control for vaccines (including an effective cold chain to ensure the delivery of potent vaccines).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policy Details**
Adopted at the 41st WHA meeting in 1988 “in the desire to provide a new focus for donor commitment” particularly given the clear policy objective and political attractiveness that the status of ‘eradication’ had acquired.

The global eradication strategy included routine immunisation services, national immunisation days in all polio endemic countries, intensive surveillance for acute flaccid paralysis using global networks of certified virology laboratories, outbreak response immunisation and mopping-up immunisation strategies in the final areas of world poliovirus transmission.

---

345 CDC MMWR Weekly, *supra* note 338.
349 See also, Hardon, A & Blume, S, *supra* note 183.
350 *Ibid.* Also note that a further reason for the emergence of the polio eradication initiative was the influence and experience of Latin America, who had began its drive for polio eradication in 1985 (See R. H. Henderson, “The World Health Organization’s Plan of Action for Global Eradication of Poliomyelitis by the Year 2000” (1989) 569 Annals New York Academy of Sciences 69.) and its strategies were proving highly effective. (See, for example, Ciro A. de Quadros, “A template for the world” (1995) 48:1 World Health 8).
<table>
<thead>
<tr>
<th>Table 4. Elements of a human rights-based approach in the Vaccine Independence Initiative (1991)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy Objectives</strong></td>
</tr>
<tr>
<td>- To promote vaccine security by helping countries become financially self-reliant in vaccine procurement.</td>
</tr>
</tbody>
</table>

**Policy Details**

In 1990, it was announced that the UCI target had been reached, which resulted in a subsequent period of “donor fatigue.” The VII was thus created to support developing countries finance their own vaccination programs so as to reduce dependency on donor funds.\(^{353}\)

A sort of revolving fund was established to help lower middle-income countries (mainly)\(^{354}\) to become self-reliant in vaccine procurement. Government’s had to reserve budgets for vaccinations as a condition to their participation in UNICEF’s pooled procurement mechanism, which had been set up to help countries benefit from cheaper vaccines, to make payment after delivery and to enable payment in local currencies.\(^{355}\) Currently, UNICEF assists 13 Pacific countries with their vaccine purchases through the VII.\(^{356}\)

---


353 See also, Hardon, A & Blume, S, supra note 183 at 349.

354 The World Bank and GAVI alliance have commented that the range and diversity among developing countries has necessitated a variety of country vaccine finance strategies. “At one end of the spectrum are the least-developed countries that cannot finance their own vaccines and require donor support. At the other end, are more independent, industrialized countries that can procure, produce and finance their vaccine needs independently. Countries between these two poles were originally targeted by the VII, though today only a small number of countries in the category participate.” See Immunization Financing Toolkit The World Bank and GAVI Alliance, “Brief 13: UNICEF- Vaccine Independence Initiative VII” (2010), online: WHO <http://www.who.int/immunization/programmes_systems/financing/analyses/Brief_13_Vaccine_Independence_Initiative.pdf>.

355 Ibid.

Table 5. Elements of a human rights-based approach in the Children’s Vaccine Initiative (1990)

<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To create a children’s vaccine appropriate for the developing world.</td>
<td>- Aims to increase the availability of suitable vaccines. The original idea was to create a single dose-orally administered, combination vaccine that would provide immunisation against all the major infectious disease killers of children. As this objective became less realistic, the initiative sought instead to develop vaccines that were more stable and less reactogenic than those that were currently available.</td>
<td>-Aimed to be more epidemiologically and practically appropriate and thus better advance the health of the people it was designed to reach.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Policy Details

The initiative was an international undertaking established following the World Summit for Children in September 1990. The initiative sought to respond to a growing need for the introduction of new and improved vaccines, with simpler and less expensive delivery processes. It aimed to bring together a range of public and private actors in the formulation of the vaccines in order to achieve more rapid and effective results.

---

359 Ibid where the initiative is described a “utopian fantasy”.
360 Burke also points out that the initiative digressed from its original aim partly also in response to “increasing donor demands for immediate and tangible success,” to become more of a “quality-control agency for vaccine production facilities in developing countries.” See Burke, supra note 358. See also, Hardon, A & Blume, S, supra note 183 at 351.
362 See for example, WHO, Children’s Vaccine Initiative, Global Investment in Children’s Vaccine Research and Development: Results of a Survey (1993) CVI/93.1, online: <http://whqlibdoc.who.int/hq/1993/CVI_93.1.pdf> (Which provides insight on the range of actors and research being undertaken and shared to try and advance the goal of the strategy).

<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
</table>
| **Phase I objectives (2000-06)**<sup>363</sup> | - Improved availability of new and underused vaccines including:  
  - HepB  
  - Hib  
  - Yellow fever | - ISS performance based funding aims to improve equity in access to immunisation (phase 3). | - Has channelled around 0.3% of its budget (US$ 27 million) towards civil society organisations that help to engage people on the ground.<sup>366</sup> | - Injection Safety support scheme has improved the safety of immunisation services through the use of auto-disposable syringes.<sup>367</sup> |
| - To improve the supply of new and underused vaccines:  
  - HepB  
  - Hib  
  - Yellow fever | | | | |
| - To strengthen vaccine delivery systems with injection safety support initiatives. | | | | |
| - Greater supply of auto-disable syringes. | | | | |
| - Performance based funding. | | | | |
| **Phase II objectives (2007-10)**<sup>364</sup> | - Improved the availability of funding through its various funding mechanisms:  
  - IFFIm  
  - AMC  
  - GAVI Matching Fund | | | |
| - The strengthening of health systems to deliver immunisation in a more sustainable manner. | | | | |
| - To accelerate the uptake of underused and new vaccines and to improve vaccine supply security. | | | | |
| - To increase the predictability and sustainability of long-term financing for national immunisation programs. | | | | |
| - To increase and assess the added value of GAVI as a public-private global health partnership through improved | | | | |

<sup>363</sup> See GAVI Alliance “Phase I (2000-06),” online: GAVI Alliance <http://www.gavialliance.org/about/strategy/phase-i-(2000-06)/> (Where further details and reports can be found on GAVIs phase one activities.

<sup>364</sup> See GAVI Alliance, “Phase II (2007-10),” online: GAVI Alliance <http://www.gavialliance.org/about/strategy/phase-ii-(2007-10)/> (Which contains further information on GAVIs Phase two activities and work plan updates).
efficiency, increased advocacy and continued innovation.

**Phase III objectives (2011-2015)**

- To accelerate the uptake and use of underused and new vaccines.
- To strengthen the capacity of integrated health systems to deliver immunisation.
- To increase the predictability of global financing and to improve the sustainability of national financing for immunisation.
- To shape vaccine markets with regard to pricing and supply security.

**Policy Details**

At the turn of the millennium GAVI moved in and built upon the CVI; which, despite gathering support for the development of new and improved vaccines from public-private collaborations, had not managed to mobilize the resources or come up with the products that it had envisioned. GAVI is an alliance of public and private partners including WHO, UNICEF, the World Bank, the Bill and Melinda Gates Foundation, donor governments, developing countries, international development and finance organizations and the pharmaceutical industry that brings together “a single minded focus to the urgent task of closing the gap between children for whom immunisation is a given and the millions of children worldwide with no access to basic vaccines.” It has published three agendas since its inception in 2000 and its focus has evolved over time.

---

366 See, GAVI Alliance, “GAVI’s impact” (GAVI Alliance data as at 31 August 2013), online GAVI: <http://midtermreview.gavialliance.org/healthsystems/> (Which contains an illustrated chart of the money GAVI has spent on the various activities it supports). For further information on GAVIs engagement with and attempts to strengthen civil society, see: GAVI Alliance, “Civil Society,” online: GAVI Alliance <http://www.gavialliance.org/about/partners/cso/>.


<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>By 2010&lt;sup&gt;370&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Increase national immunisation coverage levels to 90% and to at least 80% in every district.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reduce measles mortality by 90% as compared to the 2000 levels.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>By 2015&lt;sup&gt;371&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- To have sustained the vaccination coverage goals reached in 2010.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reduce morbidity and mortality due to vaccine preventable diseases by at least two thirds as compared to 2000 levels.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Ensure access to vaccines of an assured quality.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Introduce new vaccines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Ensure capacities for surveillance and monitoring within all countries.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Strengthen immunisation systems.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Assure sustainability of national immunisation plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Aims to immunise more people against more diseases.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Aims to integrate immunisation with other health interventions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Emphasises the role of immunisation in strengthening health systems.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Aims to improve disease surveillance and program monitoring in order to improve the health system as a whole and ensure that immunisation is included in emergency preparedness plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Aims for greater sustainability in national immunisation systems and encourages use of comprehensive multi-year planning (cMYP).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Aims to prioritize underserved populations and areas by using a reaching every district approach.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Aims to increase community demand for immunisation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Aims to improve vaccine, immunisation and injection safety</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<sup>371</sup> Ibid. For the origin of the content of this tables’ AAAQ elements, see also, GIVS, supra note 201.
<table>
<thead>
<tr>
<th>Policy Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The GIVS strategy arose from a need to construct a more long-term strategic framework for immunisation in response to the challenges of a “rapidly changing and increasingly interdependent world”. In light of the multiplicity of immunisation strategies, and the contribution that increased levels of immunisation might have in achieving the Millennium Development Goals, GIVS was endorsed by the Member States of WHO and by the Executive Board of UNICEF as the strategy that would be used to guide the next decade of immunisation policy. The GIVS aimed to sustain existing levels of vaccine coverage, to extend immunisation services to those who had not yet been reached (and to age groups beyond infancy), to introduce new vaccines and technologies, and to link immunisation with the delivery of other health interventions and the overall development of the health sector.</td>
</tr>
</tbody>
</table>

---

374 See GIVS, supra note 201 at 6.
Table 8. Elements of a human rights-based approach in the Global Polio Eradication Initiative (GPEI) (2010-2012)

<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Interrupt wild poliovirus transmission in Asia.</td>
<td>- Enhanced technical assistance</td>
<td>- Strengthened oversight of supplementary immunisation activity operations by national and subnational leaders.</td>
<td>- Safe supply of oral poliovirus vaccines</td>
<td></td>
</tr>
<tr>
<td>- Interrupt wild poliovirus transmission in Africa.</td>
<td>- Secure supply of OPV vaccines</td>
<td>- Enhanced communications and community engagement.</td>
<td>- Vaccine quality is assured by UNICEF’s strategy to only use WHO-pre-qualified OPV products.</td>
<td></td>
</tr>
<tr>
<td>- Enhance global poliovirus surveillance and outbreak response.</td>
<td>-</td>
<td></td>
<td>- An intensified research agenda.</td>
<td></td>
</tr>
<tr>
<td>- Strengthen immunisation systems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Despite the rapid gains made towards eradicating polio since the introduction of the oral polio vaccine in countries’ national immunisation schedules (following the EPI and the 1988 polio eradication initiative’s efforts), the transmission of indigenous wild poliovirus persisted in four endemic countries, threatening the progresses that had been made towards global eradication.377</td>
</tr>
<tr>
<td></td>
<td>In 2008, the World Health Assembly consequently called for a new strategy to intensify polio eradication efforts in all remaining countries and it is from here that the renewed GPEI was launched. The initiative proposes a number of strategies, or ‘enabling factors’378 that aimed to address the challenges posed to global polio eradication.</td>
</tr>
</tbody>
</table>

375 WHO, Global Polio Eradication Initiative, Strategic Plan 2010-2012 (Geneva, Switzerland, World Health Organization, 2010) at chapter 3 [Hereafter GPEI 2010-2012].
376 Ibid, for Source for the contents of the AAAQ elements within this table, at chapter 4.
377 See Bruce Aylward & Rudolf Tangermann, “The global polio eradication initiative: Lessons learned and prospects for success” (2011) 29S Vaccine D80 at D81. (The authors note that wild polioviruses transmitted from these areas resulted in multiple outbreaks in previously polio-free countries across Asia and Africa).
378 See GPEI 2010-2012, supra note 375 at chapter 4.

<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>To achieve a world free of poliomyelitis:</td>
<td>- Calls for strengthened health systems measurable by a sustained 90% DTP3 coverage rate for three years by 2020.</td>
<td>- Calls for revitalised efforts on 90/80 (90% immunisation coverage and 80% in every district or administrative unit with DTP3).</td>
<td>- Calls for investments in research to support the development of innovations that maximise the benefits of immunisations. Such innovations include the licensing or re-licensing of vaccines for use in a controlled-temperature chain above the traditional range of 2-8% C and new vaccine technologies.</td>
<td>- Emphasis on data quality improvements to enable better programme decisions to be made.</td>
</tr>
<tr>
<td>o By interrupting wild poliovirus transmission globally by 2014.</td>
<td>- Ensure legislation or legal framework in all countries including provisions for a budget line for immunisation, and for monitoring and reporting</td>
<td>- In addition to monitoring geographic equity through coverage at district or similar administrative levels, the GVAP also aims to increase the proportion of MS with a difference of less than 20% in coverage between wealth quintiles to 60% by 2015 and 75% in 2020.</td>
<td>- Calls for states to build community grass-roots support and to develop indicators to monitor vaccine hesitancy.</td>
<td>- Calls for the strengthening of surveillance systems.</td>
</tr>
<tr>
<td>o With certification of poliomyelitis eradication by 2018.</td>
<td>- Develop comprehensive national immunisation plans that are part of overall national health plans.</td>
<td>- Create or strengthen existing independent</td>
<td>- Engage individuals and communities on the benefits of immunisation, and hear their concerns.</td>
<td>- Requires access to vaccines of an assured quality.</td>
</tr>
<tr>
<td>To meet global and regional elimination targets:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Measles and rubella eliminated in at least five WHO regions by 2020.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet vaccination coverage targets in every region, country and community:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 90% national coverage and 80% in every district or equivalent administrative unit with three doses of diphtheria-tetanus-pertussis containing vaccines by 2015.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Reach 90% national coverage and 80% in every district or equivalent administrative unit with all vaccines in national programmes, unless otherwise recommended by 2020.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop and introduce new and improved vaccines and technologies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o At least 90 low-income and middle-income countries should have</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

379 Note, GVAPs ‘goals’ as opposed to ‘objectives’ are listed in this aspect of the table, as the goals are much more specific than the objectives (but nevertheless still derive from them and are detailed further along). See GVAP, supra note 207 at 28 and 90.

380 All the AAAQ elements mentioned within the table are taken from the GVAP, supra note 207.
The GVAP was developed by the Decade of Vaccines Collaboration to stimulate the discovery, development and delivery of life saving vaccines.\textsuperscript{381} The Plan seeks to reach beyond the scope and successes of the of the GIVS strategy through taking a more holistic approach towards immunisation and providing recommendations on global levels of access, research and development and public and political support.\textsuperscript{382}

The GVAP is shaped by an explicit human rights agenda that envisions universal access to immunisation. The GVAP is underpinned by six strategic objectives\textsuperscript{383} namely that:

- All countries commit to immunisation as a priority (and calls for high-quality data collection which will help to provide the “cornerstone for accountability”) also essential that countries invest in strengthening their surveillance systems to be able to document that the programme is having its desired impact in controlling the targeted diseases.

- Individuals and Communities understand the value of vaccines and demand immunisation as their right and responsibility.

- The benefits of immunisation are equitably extended to all people.

- Strong immunisation systems are an internal part of a well functioning health system.

- Immunisation programmes have sustainable access to predictable funding, quality supply and innovative technologies.

- Country, regional and global research and development innovations maximize the benefit of immunisation.

---

\textsuperscript{381} See Decade of Vaccines Collaboration “About us,” online: Decade of Vaccines Collaboration <http://www.dovcollaboration.org/about-us/>.


\textsuperscript{383} GVAP, supra note 207.
Table 10. Elements of a human rights-based approach in the Polio Eradication and Endgame Strategic Plan (2013-2018)

<table>
<thead>
<tr>
<th>Policy Objectives</th>
<th>Availability</th>
<th>Accessibility</th>
<th>Acceptability</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Detect and Interrupt all wild polio transmission by the end of 2014.</td>
<td>- Programme must be institutionalised within the broader health agenda.</td>
<td>- Calls for operational adjustments to polio campaigns to be made (so they are shorter where necessary in order to reduce threats to vaccine workers) and calls for enhanced coordination between civilian and security services to improve the physical safety of immunisation services.</td>
<td>- Improve local demand to increase access to vaccination and basic health services.</td>
<td>- Improve local demand to increase access to vaccination and basic health services.</td>
</tr>
<tr>
<td>- Strengthen immunisation systems and withdraw OPV.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Containment and Certification of polio eradication.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Plan polios legacy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Policy Details
As the world moves towards polio eradication, the Endgame Strategy provides a comprehensive long-term strategic plan that addresses what will be needed to deliver and maintain a polio-free world by 2018.\textsuperscript{386}

The plan provides a comprehensive strategy for eradicating polio and has a different strategic focus to previous GPEI plans in that it places greater emphasis on system strengthening and explicitly accounts for the anticipated challenges and obstacles that lie ahead. The plan also details strategies that will ensure that the legacy of polio eradication can be learnt from.


\textsuperscript{385} \textit{Ibid}. The AAAQ elements of the policies are taken from information in the policy’s strategic plan.

\textsuperscript{386} \textit{Ibid}. 

124
Appendix B
Timeline of Global Immunisation policies

Key
Policy strategy and/or goals advance at least (n) AAAQ criteria:

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three</td>
<td>Four</td>
</tr>
</tbody>
</table>

- Expanded Program on Immunisation (1974)
- Universal Childhood Immunisation (1984)
- Vaccine Independence Initiative (1991)
- Eradication of Polio by the year 2000
- Children’s Vaccine Initiative (1990)
- Global Polio Eradication Initiative (2010-2012)
- Polio Eradication and Endgame Strategic Plan (2013-2018)
Appendix C

Graph 1: Diptheria-tetanus-pertussis (DTP3) immunisation coverage (%) Global and by WHO region, 1980-2012

Graph 2: Diphtheria-Tetanus-Pertussis (DTP3) Coverage (%) by WHO Region according to household wealth quintile.
Graph 3: Percentage point difference between children from the highest and lowest wealth quintiles being vaccinated with DTP3 by country

Key
- Country recognises a Constitutional Right to Health
- Country does not recognise a Constitutional Right to Health
Appendix F

Results of regression analysis on the impact of the recognition of national constitutional rights to health, upon levels of equity* in access to immunisations.

<table>
<thead>
<tr>
<th>Regression Statistics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple R</td>
<td>0.298529036</td>
</tr>
<tr>
<td>R Square</td>
<td>0.089119586</td>
</tr>
<tr>
<td>Adjusted R Square</td>
<td>0.07418712</td>
</tr>
<tr>
<td>Standard Error</td>
<td>16.92824018</td>
</tr>
<tr>
<td>Observations</td>
<td>63</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coefficients</th>
<th>Standard Error</th>
<th>t Stat</th>
<th>P-value</th>
<th>Lower 95%</th>
<th>Upper 95%</th>
<th>Lower 95.0%</th>
<th>Upper 95.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional (dummy=1)</td>
<td>-10.58316008</td>
<td>4.332060875</td>
<td>-2.44298508 0.017476816</td>
<td>-19.24565118</td>
<td>-1.920668986</td>
<td>-19.24565118</td>
<td>-1.920668986</td>
</tr>
</tbody>
</table>

* For detail on what ‘equity’ for the purposes of this regression analysis refers to, see Chapter 5.