POLICY BRIEF

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Health Equity in Global Governance: growing recognition in need of concrete actions

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ABSTRACT

Health equity is a foundational principle of global health governance that should ensure all individuals have fair and just opportunities to achieve optimal health, regardless of social, economic, or geographical disparities. The right to health is recognized as a fundamental human right in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). This document explores the concept of health equity drawing on United Nations General Assembly (UNGA) resolutions and key instruments from the World Health Organization (WHO). It discusses the challenges and opportunities for developing countries in pursuing equitable health outcomes, including advancing sexual and reproductive health and rights.

KEYWORDS: Health Equity, Right to Health, Sexual and Reproductive Health and Rights, United Nations General Assembly (UNGA) Resolutions, World Health Organization (WHO), International Health Regulations (IHR), Pandemic Agreement

L'équité en matière de santé est un principe fondamental de la gouvernance mondiale de la santé qui devrait garantir à tous les individus des chances équitables et justes d'atteindre un état de santé optimal, indépendamment des disparités sociales, économiques ou géographiques. Le droit à la santé est reconnu comme un droit humain fondamental dans l'article 12 du Pacte international relatif aux droits économiques, sociaux et culturels. Ce document explore le concept d'équité en matière de santé en s'appuyant sur les résolutions de l'Assemblée générale des Nations unies (AGNU) et les principaux instruments de l'Organisation mondiale de la santé (OMS). Il examine les enjeux et les opportunités pour les pays en développement dans la quête de résultats équitables en matière de santé, y compris en la promotion de droits en matière de sexualité et de procreation.

MOTS-CLÉS: *L'équité en matière de santé, Le droit à la santé, Les droits en matière de sexualité et de procreation, Les résolutions de l'Assemblée générale des Nations unies (AGNU), L'Organisation mondiale de la santé (OMS), Le Règlement sanitaire international (RSI), L' Accord sur les pandémies*

La equidad en salud es un principio fundamental de la gobernanza sanitaria mundial que debe garantizar que todas las personas tengan oportunidades justas y equitativas para alcanzar un estado de salud óptimo, independientemente de las disparidades sociales, económicas o geográficas. El derecho a la salud está reconocido como un derecho humano fundamental en el artículo 12 del Pacto Internacional de Derechos Económicos, Sociales y Culturales (PIDESC). Este documento explora el concepto de equidad en salud basándose en las resoluciones de la Asamblea General de las Naciones Unidas (AGNU) y en instrumentos clave de la Organización Mundial de la Salud (OMS). Analiza los retos y las oportunidades de los países en desarrollo a la hora de perseguir resultados equitativos en materia de salud, incluido en el avance de los derechos sexuales y reproductivos.

PALABRAS CLAVES: *La equidad en salud, El derecho a la salud, Los derechos sexuales y reproductivos, Las resoluciones de la Asamblea General de las Naciones Unidas (AGNU), La Organización Mundial de la Salud (OMS), El Reglamento Sanitario Internacional (RSI), El Acuerdo sobre pandemias*

KEY MESSAGES

- Health equity has emerged as a central tenet in global health discussions, particularly in the wake of rising disparities in health outcomes and access to healthcare services across countries. Health equity is both a moral imperative and a strategic necessity for achieving global health and sustainable development.
- An area where lack of equity has been tangible relates to the failure of enforcing sexual and reproductive health and rights (SRHR) and its impact on health of women and girls. Despite the human rights obligations to protect and respect SRHR, violations of women's sexual and reproductive health and rights are frequent and take many forms.
- While United Nations (UN) resolutions contribute to set objectives and authoritatively advocate for a human-centered perspective on health, by themselves they have no transformative power. The World Health Organization (WHO) Pandemic Agreement can be seen as a step towards embedding health equity in global health governance, but the extent to which it may be achievable will largely depend on the content and implementation of the pathogen access and benefit sharing system (PABS).

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I. Introduction

Health equity has emerged as a central tenet in global health discussions, particularly in the wake of rising disparities in health outcomes and access to healthcare services across countries. The catastrophic global management of COVID-19, in particular, showed the absence of effective mechanisms to realize health equity at the international level.[1]

Health equity refers to the absence of avoidable, unfair, or remediable differences among populations or groups defined socially, economically, or geographically. The concept is close to but differs from "health equality", which focuses on the uniform distribution of health resources without regard to varying needs and circumstances.

According to the WHO, health equity means that "everyone should have a fair opportunity to attain their full health potential, and no one should be disadvantaged from achieving this potential"[2]. One of the founding principles of the WHO is that "[u]nequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger".[3] The organization was set up "for the purpose of co-operation" among the contracting parties and "with others to promote and protect the health of all peoples".[4]

The right to health, one of the fundamental human rights as recognized in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) aims at ensuring the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health". It includes ensuring fair distribution of health products and eliminating preventable disparities among populations. The entitlements under the right to health include, inter alia, the right to "a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health" and to "equal and timely access to basic health services" while public health and health-care facilities, goods and services must be available and accessible physically "for all sections of the population".[5]

An important element underpinning the concept of health equity is that the differences in the enjoyment of health are avoidable.[6] Inequity, or the lack of equity, describes an objective situation (insufficient access to health products and services) seen from an ethical perspective based on the principles of fairness and justice in health distribution,[7] thus rooted in principles of social justice, human rights, and distributive fairness.

Health equity has often been examined in the context of structural and intermediary determinants of health[8] and of theories explaining how social and biological processes interact to produce health disparities.[9] Of particular interest is the analysis of the role of governance, policy, and power in creating and sustaining health inequity.[10] Dr. Paul Farmer has also highlighted how market-based systems and policies disproportionately harm the poor, leading to increased pathologies that could be prevented with better resource allocation.[11] Further research is needed to assess how international bodies and instruments can contribute to address existing gaps and asymmetries that lead to different manifestations of health inequity.

This document presents, first, some examples of real-life situations of health inequity Second it briefly examines how health equity has been addressed (directly or indirectly) in international instruments, notably UNGA resolutions and instruments adopted by the WHO that are intended to support health equity. Finally, the document discusses some strategies to achieve health equity and the need of more decisive action at the international level.

II. Health inequity: real-life examples

Health equity is not an abstract concept, or an ideal that is desirable or perfect but not likely to become a reality. Health equity must be seen as a cornerstone of global health to ensure that all individuals have fair opportunities to attain their highest level of health.

Health inequity may be the result of a great diversity of factors, whether long-existing conditions or unresolved gaps or deficiencies in health systems, or a result of emergencies or health crises. Box 1 presents examples of some manifestations of what may be called "structural" health inequities.[12] They also show that they may arise in both developed and developing countries while they are more common and severe in the latter given the scarcity of resources and the obstacles to achieve universal health coverage (UCH).

1 Carlos Correa, "Vaccination inequalities and the role of the multilateral system", SouthViews, No. 224 (Geneva, South Centre, July 2021). Available from https://www.southcentre.int/wp-content/uploads/2021/07/SouthViews-Correa.pdf; Efrat Shadmi, Yingyao Chen, Inês Dourado et al., "Health equity and COVID-19: global perspectives", *International Journal for Equity Health*, vol.19 (2020). Available from https://link.springer.com/article/10.1186/S12939-020-01218-Z; Remco Van De Pasa, Marc-Alain Widdowson, Raffaella Ravinetto et al., "COVID-19 vaccine equity: a health systems and policy perspective", *Expert Review of Vaccines*, vol. 21 (2022). Available from https://pmc.ncbi.nlm.nih.gov/articles/PMC8631691/.

2 Erik Blas and Anand Sivasankara Kurup, eds., *Equity, Social Determinants and Public Health Programmes* (World Health Organization, 2010). Available from https://iris.who.int/bitstream/handle/10665/44289/9789241563970_eng.pdf.

3 Constitution of the World Health Organization. Available from https://www.who.int/about/governance/constitution.

4 Ibid.

5 See Office of the United Nations High Commissioner for Human Rights , World Health Organization, "The Right to Health", available at https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf.

6 See, e.g., M. Whitehead, "The concepts and principles of equity and health", *International Journal of Health Services*, vol. 22, No.3 (1992), 429-445.

7 See, e.g., P. Braveman and S. Gruskin, "Defining equity in health", *Journal of Epidemiology & Community Health*, vol. 57, No. 4 (2003) 254–258.

8 See, e.g., O. Solar and A. Irwin, "A Conceptual Framework for Action on the Social Determinants of Health", Social Determinants of Health Discussion Paper 2 (Geneva, World Health Organization, 2010). Available from https://www.afro.who.int/sites/default/files/2017-06/SDH_conceptual_framework_for_action.pdf.

9 See, e.g., Nancy Krieger, *Epidemiology and the People's Health: Theory and Context* (Oxford University Press, 2011).

10 See Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (Bloomsbury Publishing, 2015).

11 See Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (University of California Press, 2003).

12 "*Structural inequities* are the personal, interpersonal, institutional, and systemic drivers—such as, racism, sexism, classism, able-ism, xenophobia, and homophobia—that make those identities salient to the fair distribution of health opportunities and outcomes" (A. Baciu, Y. Negussie, A. Geller et al., eds, *Communities in Action: Pathways to Health Equity* (Washington D.C., National Academies Press, 2017). Available from https://www.ncbi.nlm.nih.gov/books/NBK425845/.

Box 1. Health inequity-real life examples

Maternal Mortality in Sub-Saharan Africa

Sub-Saharan Africa and southern Asia accounted for around 87% (225 000) of the estimated global maternal deaths in 2023. Sub-Saharan Africa alone accounted for around 70% of maternal deaths (182 000), while southern Asia accounted for around 17% (43 000). Just over 90% of all maternal deaths occurred in low- and lower-middle-income countries in 2023. Women die as a result of complications during and following pregnancy and childbirth, most of which are preventable or treatable.[13]

Racial Disparities Among African Americans

African Americans in the United States experience significantly higher rates of chronic conditions like hypertension, diabetes, and kidney disease compared to white Americans. For instance, the prevalence of hypertension among African Americans is about 40%, one of the highest in the world.[14] African American women are more likely to give birth to low-birthweight infants, and their newborns experience higher infant death rates that are not associated with any biological differences.[15] Structural racism and disparities including with regard to preventative care and medical treatment, education quality, housing and employment contribute to this manifestation of health inequity.

Sexual and Reproductive Health and Rights (SRHR)

An area where lack of equity has been tangible relates to the failure of enforcing SRHR and its impact on health of women and girls. In accordance with the Office of the High Commissioner of Human Rights,[16] despite the obligations to protect and respect SRHR, violations of women's sexual and reproductive health and rights are frequent and take many forms, including:

- denial of access to services that only women require;
- poor quality services;
- subjecting women's access to services to third party authorization;
- forced sterilization, forced virginity examinations, and forced abortion, without women's prior consent;
- female genital mutilation (FGM); and
- early marriage.

13 World Health Organization, *Maternal mortality* (7 April 2025). Available from https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.
14 See John M. Flack, Keith C. Ferdinand, Samar A. Nasser, "Epidemiology of Hypertension and Cardiovascular Disease in African Americans", the *Journal of Clinical Hypertension*, vol. 5 (May 2007). Available from https://pmc.ncbi.nlm.nih.gov/articles/PMC8101861/; Aleksandra A. Abrahamowicz, Joseph Ebinger, Seamus P Whelton et al., "Racial and Ethnic Disparities in Hypertension: Barriers and Opportunities to Improve Blood Pressure Control", *Current Cardiology Reports*, vol. 25 (January 2023). Available from https://pmc.ncbi.nlm.nih.gov/articles/PMC9838393/.
15 A. Baciu, Y. Negussie, A. Geller et al., eds, Communities in Action: Pathways to Health Equity (Washington D.C., National Academies Press, 2017). Available from https://www.ncbi.nlm.nih.gov/books/NBK425845/.
16 See https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights.

The manifestations of health inequity in Box 1 reflect a broader pattern of social and institutional inequities that lead to unequal health outcomes. Systemic racism, stigmatization, denial of women and girls' rights, unequal access to health services, among other factors, explain the described outcomes.

One of the most persistent examples of health inequity is the dramatically higher maternal mortality rates in Sub-Saharan Africa compared to high-income countries. In accordance with one study, "[t]he risk of maternal death remains high in low-income countries, as 1 in 45 women die from pregnancy-related causes, compared with 1 in 5400 in high-income countries. Women in the [Sub-Saharan] SSA region have the highest risk of maternal death at 1 in 38".[17] As also noted by a recent WHO report, "[w]omen from disadvantaged or marginalized groups – measured by income, race and ethnicity, educational level, or place of residence – are still far more likely to die from pregnancy-related causes than their more advantaged counterparts in countries at all income levels".[18] These inequities are avoidable with improved healthcare services and broader social policies that tackle the root causes of inequity, notably poverty and lack of adequate health infrastructure.

In the case of African Americans in the USA, their living conditions, including access to education, create an environment that perpetuate health inequity. Like in the previous example, this situation would be avoidable if the appropriate public policies were put in place.

The third example, concerning SRHR, introduces a human rights perspective in the consideration of health inequities, as the denial of SRHR has a direct impact on women and girls' health. This is an important perspective allowing for a right-based approach to tackle a situation of deprival of a widely recognized human right.[19]

Another major example of health inequity emerged during the COVID-19 pandemic, particularly in relation to the global distribution of vaccines. While high-income countries secured large supplies of vaccines –in some cases several times in excess of their real needs– and began immunization campaigns in December 2020– many low- and middle-income countries (LMICs) were not able to get sufficient doses in time. By the end of 2022, about 80 percent of people in high-income countries had received at least one vaccine dose compared to only 23 percent in low-income countries.[20] Notably, COVAX, the global vaccine-

17 Osaretin Christabel Okonji, Chimezie Igwegbe Nzoputam, Michael Ekholuenetale et al., "Differentials in Maternal Mortality Pattern in Sub-Saharan Africa Countries: Evidence from Demographic and Health Survey Data", *Women 2023*, vol. 3 (March 2023). Available from https://www.mdpi.com/2673-4184/3/1/14#:~:text=The%20risk%20of%20maternal%20death%20remains%20high,maternal%20death%20at%201%20in%2038%20%5B1%2C2%5D.
18 World Health Organization, *World report on social determinants of health equity* (2025). Available from https://iris.who.int/bitstream/handle/10665/381258/B09387-eng.pdf?sequence=1.
19 See, e.g., Carlos Correa and Daniel Uribe, "Sexual and Reproductive Health and Rights in the Context of International Human Rights", Policy Brief, No. 144 (Geneva, South Centre, June 2025). Available from https://www.southcentre.int/wp-content/uploads/2025/06/PB144_Sexual-and-Reproductive-Health-and-Rights-in-the-Context-of-International-Human-Rights_EN.pdf.
20 Christopher Wolf, Alex Leeds Matthews and Horus Alas, "Wealthy Countries Are Outpacing Poor Nations in COVID-19 Vaccination Rates", *U.S. News*, 7 November 2022. Available from https://www.usnews.com/news/best-countries/articles/covid-19-vaccination-rates-by-country.

-sharing initiative, failed in ensuring an equitable distribution of vaccines.[21]

The COVID-19 pandemic revealed deep vulnerabilities in healthcare systems and public health preparedness. It highlighted a deep structural imbalance in the global health system, including unequal manufacturing capacity, insufficient global financing mechanisms, and the impact of intellectual property protection under the standards mandated by the Agreement on Trade Related Aspects of Intellectual property Rights (TRIPS Agreement), which remained essentially unchanged after the late approval of a narrow "TRIPS waiver".[22] Despite various solemn statements by government leaders, vaccines and other needed products were not considered as global public goods, technology was not shared and the needed rapid expansion of manufacturing capacities never became a reality.

III. Health equity in international instruments

The UNGA and the WHO have developed frameworks and instruments that address on. This section examines how health equity has been addressed by these international bodies.

A. UNGA Resolutions relating to Health Equity

The UNGA has adopted many resolutions which directly or indirectly address issues related to health equity; recent UNGA resolutions that are relevant in this respect include:

• Resolution A/RES/74/2, "Political declaration of the high-level meeting on universal health coverage"[23] (2019), affirms the commitment of member states to achieve universal health coverage (UHC) as a key component of the 2030 Agenda for Sustainable Development. It specifically recognizes "the need to tackle health inequities and inequalities within and among countries through political commitment, policies and international cooperation, including those that address social, economic and environmental and other determinants of health" (para. 11).

• A/RES/74/274, Global solidarity to fight the coronavirus disease 2019 (COVID-19)"[24] (2020), called for "intensified international cooperation to contain, mitigate and defeat the pandemic, including by exchanging information, scientific knowledge and best practices and by applying the relevant guidelines recommended by the World Health Organization". It did not refer, however, to equitable access to needed medical products to control the pandemic.

• Resolution A/RES/74/307, "United response against global health threats: combating COVID-19"[25] (2020), stressed "the necessity of urgent short-term actions to step up the global efforts to fight global health crises and pandemics and maintain economic stability, including by ...swift delivery of medical supplies, especially diagnostic tools, treatments, medicines and vaccines...and expanding manufacturing capacity to meet the increasing needs for medical supplies and ensuring that these are made widely available, at an affordable price, on an equitable basis, where they are most needed and as quickly as possible" (emphasis added). The need for an "equitable" access appears for the first time in this resolution as a shared objective of "urgent short-term actions to step up the global efforts".

• Resolution A/RES/75/130, "Global health and foreign policy: strengthening health system resilience through affordable health care for all"[26] (2020), focuses on strengthening health system resilience through affordable healthcare for all and equitable access to vaccines and health technologies. This resolution referred to "equitable access", not as an objective to be reached by the international community but rather as an aim of "the Access to COVID-19 Tools Accelerator initiative as well as other relevant initiatives, which aim to accelerate development and production of and equitable access to COVID-19 diagnostics, therapeutics and vaccines to all countries that need them, and to strengthen health systems, without undermining incentives for innovation". As noted, COVAX failed to ensure equitable access to the vaccines needed to address the COVID-19 pandemic, particularly in Africa.

• Resolution 76/132, "Addressing the challenges of persons living with a rare disease and their families"[27] (2021), reiterates the right of everyone to enjoy the highest attainable standard of physical and mental health and urges States to eliminate barriers to healthcare access and reduce health disparities. This resolution specifically refers to "equity" in access to health services as a matter of national policy. It recognizes "the fundamental importance of equity, social justice and social protection mechanisms as well as the elimination of the root causes of discrimination and stigma in health-care settings to ensure universal and equitable access to quality health services without financial hardship for all people, particularly for those who are in vulnerable situations, including those living with a rare disease".

• Resolution A/RES/76/300, "The human right to a clean, healthy and sustainable environment"[28] (2022), recognizes "the right to a clean, healthy and sustainable environment as a human right" and that environmental degradation disproportionately affects vulnerable communities.

• Resolution A/RES/78/280, "Global health and foreign policy:

21 See, e.g., Carlos Correa, "Vaccination inequalities and the role of the multilateral system", SouthViews, No. 224 (Geneva, South Centre, July 2021). Available from https://www.southcentre.int/wp-content/uploads/2021/07/SouthViews-Correa.pdf.
22 See e.g., Carlos Correa, Nirmalya Syam and Daniel Uribe, "Implementation of a TRIPS Waiver for Health Technologies and Products for COVID-19: Preventing Claims Under Free Trade and Investment Agreements", Research Paper, No. 135 (Geneva, South Centre, September 2021). Available from https://www.southcentre.int/research-paper-135-september-2021/ ; Carlos Correa and Nirmalya Syam, "The WTO TRIPS Decision on COVID-19 Vaccines: What is Needed to Implement it?", Research Paper, No. 169 (Geneva, South Centre, November 2022). Available from https://www.southcentre.int/wp-content/uploads/2022/11/RP169_The-WTO-TRIPS-Decision-on-COVID-19-Vaccines_EN.pdf; Nirmalya Syam and Muhammad Zaheer Abbas, "TRIPS Waiver Decision for Equitable Access to Medical Countermeasures in the Pandemic: COVID-19 Diagnostics and Therapeutics", Research Paper, No. 191 (Geneva, South Centre, January 2024). Available from https://www.southcentre.int/research-paper-191-25-january-2024/.
23 Available from https://docs.un.org/en/A/RES/74/2.
24 Available from https://docs.un.org/en/A/RES/74/274.
25 Available from https://docs.un.org/en/A/RES/74/307.
26 Available from https://digitallibrary.un.org/record/3895879?ln=en&v=pdf.
27 Available from https://digitallibrary.un.org/record/3953765?ln=en&v=pdf.
28 Available from https://docs.un.org/en/A/RES/76/300.

addressing global health challenges in the foreign policy space"[29] (2024), covers various aspects of global health and foreign policy, including UHC, pandemic preparedness, and the impact of climate change.

These resolutions provide a framework for international cooperation and guidance for national policies and international cooperation, but they are not legally binding. They encourage countries to prioritize global health in their national agendas and to integrate health considerations into their foreign policy decisions. The implementation of many aspects of these resolutions requires international cooperation, financing and support to the developing countries that lack the resources to achieve the stated objectives. The intervention of international organizations and civil society are also required to support governments and, particularly, poor and vulnerable communities.

However, the UNGA resolutions do not contain actionable measures able to bring about the needed resources and cooperation. One telling example was provided by the UNGA's resolutions dealing with COVID-19. Resolution A/RES/74/307, as noted, referred to make medical supplies "widely available, at an affordable price, on an equitable basis…". Despite the UN Secretary-General's call to ensure that vaccines, therapeutics and diagnostics for COVID-19 be universally affordable and available as global public goods,[30] no concrete action was taken to make this a reality. As observed by Syam,

> …in order for the General Assembly resolutions to serve as an effective guiding instrument, it is important that the resolutions adequately address all aspects relating to a particular global challenge that need to be addressed, pointing to the desirable action on the part of different actors. Measured against this yardstick, the UN General Assembly resolutions on COVID-19 do not provide sufficient guidance beyond broad exhortations of good faith principles.[31]

International cooperation, moreover, has weakened in recent times as a result of geopolitical tensions and the US Administration decision to cut aid, which affects many health-related programs including access to HIV-AIDS treatment.[32]

B. WHO Instruments

The constitution (1946) of the WHO enshrines health as a fundamental right, stating that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." This foundational document provides a legal and ethical basis for the organization's commitment to health equity. For instance, the final report of the WHO Commission on Social Determinants of Health, "Closing the Gap in a Generation" (2008) emphasized the role of social determinants—including education, income, and living conditions—in shaping health outcomes. It called for action across all sectors to reduce inequities.

In 2016, the WHO Framework on Integrated People-Centred Health Services was adopted. It advocates for health systems that are responsive to the needs and preferences of individuals, families, and communities. Equity is a guiding principle, with the aim of ensuring that marginalized groups are not left behind.

The WHO developed a software-based tool –the Health Equity Assessment Toolkit (HEAT)– to facilitate the monitoring and assessment of health inequities. It allows policymakers to visualize and understand disparities with the aim of aiding evidence-based decision-making.

As a result of the catastrophic management of the COVID-19 pandemic in terms of global, equitable access to vaccines, equity became a key issue in the context of the WHO.[33] The COVID-19 pandemic exposed, as noted, the disparities in health systems' capacities and in access to medical resources, and the absence of effective mechanisms for international cooperation despite solemn declarations.[34] In response, the WHO Member States undertook a revision of the International Health Regulations (IHR) and launched negotiations on a "pandemic treaty" which was adopted in May 2025. For developing countries, one of the main objectives of these processes was to put in place international instruments that will bring about global equity in addressing health emergencies such as pandemics.

The International Health Regulations (IHR)

The IHR, first adopted in 1969 and revised in 2005, have served as a legally binding framework for WHO members to prevent and respond to public health risks that have the potential to cross borders. The 2005 revisions expanded the scope of the IHR to include all public health threats, not just specific diseases. However, the COVID-19 pandemic highlighted gaps in the IHR ability to ensure equitable access to health resources, prompting further amendments in 2024. These amendments introduced several provisions that are relevant to health equity.

A new category of health events, "pandemic emergency", was established as a trigger for enhanced international collaboration, emphasizing the need for rapid, **equitable**, and coordi-

29 Available from https://docs.un.org/en/A/RES/78/280.
30 See "Guterres: Vaccines should be considered 'global public goods'", *UN News*, 11 June 2021. Available from https://news.un.org/en/story/2021/06/1093912. In contrast, UNGA Resolution A/RES/75/130 recognized 'extensive immunization' as a 'global public good' ("the role of extensive immunization against COVID-19 as a global public good for health in preventing, containing and stopping transmission in order to bring the pandemic to an end once safe, quality, efficacious, effective, accessible and affordable vaccines are available").
31 Nirmalya Syam, "The UN General Assembly Resolutions on COVID-19: Solemn Assurances for Access to Health Technologies without an Action Plan", Policy Brief, No. 81 (Geneva, South Centre, July 2020). Available from https://www.southcentre.int/wp-content/uploads/2020/07/PB-81.pdf, p. 6.
32 Camelia Abdelgelil, "How could US foreign aid cuts affect global public health?", *Economics Observatory*, 8 May 2025. Available from https://www.economicsobservatory.com/how-could-cuts-to-united-states-foreign-aid-affect-global-public-health.

33 See, e.g., Viviana Muñoz Tellez, "Can Negotiations at the World Health Organization Lead to a Just Framework for the Prevention, Preparedness and Response to Pandemics as Global Public Goods?", Research Paper, No. 147 (Geneva, South Centre, February 2022). Available from https://www.southcentre.int/wp-content/uploads/2022/02/RP147_Can-Negotiations-at-WHO-Lead-to-a-Just-Framework-for-the-Prevention-Preparedness-and-Response-to-Pandemics-as-Global-Public-Goods_Pandemic-Treaty_EN.pdf.
34 See Syam, op. cit.

nated action across governments and societies.[35] Reaching an agreement on the added responsibilities of WHO members to achieve equity, notably with regard to access to health products, faced resistance from some developed countries,[36] which was finally reflected in the lack of effective commitments by Members.

The revised IHR now explicitly require that their implementation promotes **equity** and solidarity. This includes equitable access to health products and the mobilization of financial resources for developing countries.[37] A new Coordinating Financial Mechanism was established to support the identification and access to financing required to address the needs and priorities of developing countries, particularly in developing, strengthening, and maintaining core capacities. The mechanism aims to provide predictable and sustainable financing, enabling developing countries to build and maintain essential public health capacities.[38] The amendments also call for the creation of National IHR Authorities to ensure that interventions are tailored to local needs and contexts and improve coordination within countries and a States Parties Committee to facilitate effective implementation of the amended regulations.

While the explicit reference to equity and solidarity reinforces the principle that health threats are a shared global concern, necessitating collective action and support, the amendments fall short of imposing concrete obligations on developed countries to facilitate timely access to health products and financial support for developing nations. In addition, while the WHO is tasked with facilitating access to necessary health products, its authority to enforce compliance among Member States is limited.[39]

The Pandemic Agreement

The negotiation of a Pandemic Agreement, finally adopted by 124 WHO Member States on May 20, 2025, also aimed to address the inequities exposed by the COVID-19 pandemic. Ensuring a fair distribution of medical resources during future pandemics was one of the key objectives of developing countries participating in the negotiation.

35 See World Health Organization, "World Health Assembly agreement reached on wide-ranging, decisive package of amendments to improve the International Health Regulations", 3 June 2024. Available from https://www.developmentaid.org/news-stream/post/180190/who-assembly-international-health-regulations?utm_source=chatgpt.com.

36 See, e.g., Third World Network, "WHO: Switzerland rejects proposals for equity in International Health Regulations", 16 May 2024. Available from https://twn.my/title2/health.info/2024/hi240510.htm#:~:text=WHO%3A%20Switzerland%20rejects%20proposals%20for%20equity%20in%20International%20Health%20Regulations&text=Geneva%2C%2016%20May%20(TWN),the%20International%20Health%20Regulations%202005.

37 See Nirmalya Syam, "Equity and Pandemic Preparedness: Navigating the 2024 Amendments to the International Health Regulations", Research Paper, No. 206 (Geneva, South Centre, August 2024). Available from https://www.southcentre.int/wp-content/uploads/2024/08/RP206_Equity-and-Pandemic-Preparedness-Navigating-the-2024-Amendments-to-the-IHR_EN.pdf.

38 See World Health Organization, "World Health Assembly agreement reached on wide-ranging, decisive package of amendments to improve the International Health Regulations", 1 June 2024. Available from https://www.who.int/news/item/01-06-2024-world-health-assembly-agreement-reached-on-wide-ranging--decisive-package-of-amendments-to-improve-the-international-health-regulations--and-sets-date-for-finalizing-negotiations-on-a-proposed-pandemic-agreement?utm_source=chatgpt.com.

39 See, Syam, op. cit.

The adopted Agreement encourages, *inter alia*, the strengthening of health systems in low-resource settings to enhance resilience against future pandemics. However, it does not contain binding rules –despite the adoption of the Agreement under article 19 of the WHO Constitution– to provide the required resources. The Agreement incorporates several provisions directly or indirectly relevant to promote health equity and, in particular, will establish mechanisms which, if effectively operationalized, could contribute to that end. Such mechanisms include:

- The **Global Supply Chain and Logistics Network (GSCL)** should facilitate the removal of barriers and ensure timely, safe, and affordable access to pandemic-related health products for countries in need.

- The **Coordinating Financial Mechanism** was designed to support the identification and access to financing required to address the needs and priorities of developing countries, particularly in developing, strengthening, and maintaining core capacities.

In addition, the Agreement creates the **Pathogen Access and Benefit-Sharing System (PABS)** which should constitute a central mechanism to address inequities in the management of pandemics. Given the differences between developed and developing countries on all the elements that should be part of this system (including key definitions) at the time of the Agreement's adoption, they are still to be elaborated in an Annex to the Agreement, taking into account certain elements agreed upon and incorporated into article 12 of the Agreement. Thus, inter alia, the system should ensure that pharmaceutical manufacturers allocate 20 percent of their real-time production of vaccines, therapeutics, and diagnostics to the WHO for equitable distribution—10 percent as donations and 10 percent at affordable prices.

Since many aspects were left for definitions by the Conference of the Parties after the Agreement enters into force and the adoption of the PABS Annex is pending, it is difficult to assess the possible impact of the Agreement on health equity. The reality now is that the Agreement, as it stands, lacks enforceable obligations, relying rather on the goodwill of the WHO members for implementation. No concrete obligations, for instance, exist regarding financial support for developing countries, much less on the transfer of technology, which remains fully voluntary.

While the WHO Pandemic Agreement can be seen as a step towards embedding health equity in global health governance, the extent to which it may be achievable remains an open question. When the agreement enters into force, this will largely depend on the willingness of the Member States to implement its provisions effectively and, critically, on the content and implementation of the PABS. The negotiation of the Pandemic Agreement has shown how health equity is closely linked to equitable participation in global health policy processes, which is often subject in the case of developing countries to serious limitations with regards to funding, capacity, location, etc., that limit their capa-

city to influence the negotiation outcomes.

Strategies for Achieving Health Equity

Developing countries face many challenges in the process of achieving health equity, including limited financial and human resources that constrain the ability to deliver equitable healthcare services. At the international level, the rise of nationalistic paradigms –like the "vaccine nationalism" that emerged during the COVID-19 crisis[40] – and the lack of instruments to overcome access barriers, such as those created by intellectual property rights, make health equity an elusive objective.

Achieving health equity requires actions at the national, regional and international level. One key component of a strategy to that end is to address the social determinants of health with a multisectoral approach, including poverty eradication and equitable access to health services, education, housing, employment and food security. Poverty eradication is fundamental. There are many examples of national programs that have addressed one or more of those determinants to improve health among the poor and more vulnerable. For instance, Brazil's "Bolsa Família" program, based on conditional cash transfers, is reported to have improved health outcomes.[41] Poverty eradication in China has also had tangible impacts on health outcomes.[42]

Another dimension of health-equity-oriented strategies include reforms of health systems, for instance, strengthening primary health care, removing user fees, decentralizing services, producing disaggregated data and monitoring by income, gender, ethnicity, and geography.[43] Implementing Universal Health Care (UHC) can be a major game changer in terms of increased health equity. India, for instance, launched in 2018 Ayushman Bharat, a transformative healthcare initiative with the aim to provide UHC and meet the targets set by the Sustainable Development Goals.[44]

A human rights approach also needs to be part of a health equity strategy. Enforcing the human right to health can be an important element in this regard, as shown, for instance, by the jurisprudence of the Interamerican Court of Human Rights. Such an approach is of particular importance to address situations of neglect or discrimination such as in relation to SRHR.

Health inequity, thus, can and must be addressed at the national/regional level and many developing countries are making efforts in this direction. How can the multilateral system contribute to those efforts? As noted above, many resolutions of the highest multilateral body, the UNGA, have addressed (directly or indirectly) health equity and called for international cooperation to achieve it, among other objectives. Those resolutions do not create specific mechanisms nor generate financial obligations for supporting actions at the national/regional level. However, they carry significant weight as expressions of international consensus with moral authority. They can, hence, help to promote and frame the required policies. The instruments developed in the context of WHO may have a more direct impact to the extent that they establish multilateral mechanisms and/or generate opportunities for technical assistance, capacity building and financing.

IV. Conclusion

The vision of health equity can be advanced by addressing structural determinants, reforming health systems, empowering communities and adopting a human rights-based approach, including in particularly sensitive areas, such as SRHR. Developing countries however require technical and financial support to implement equity-focused policies. International mechanisms should facilitate technology transfer and health financing. Intellectual property regimes should be framed in a manner that contributes to the accessibility and affordability of health-related products, including medicines, vaccines, diagnostics and medical equipment.

While health equity has strongly emerged in the multilateral space as a priority issue particularly after COVID-19, concrete multilateral mechanisms still need to be put in place, supported with the necessary technological, financial and human resources.

Health equity is both a moral imperative and a strategic necessity for achieving global health and sustainable development. UNGA resolutions provide guidance for realizing this goal. The non-binding nature of these instruments means, however, that no UN member is bound to implement them. While they contribute to set objectives and authoritatively advocate for a human-centered perspective on health, by themselves they have no transformative power. Achieving health-equity requires sustained political commitment, inclusive governance and effective international cooperation. While some progress has been made in developing tools for the WHO to act in this direction, there is still much to be done to make health equity a tangible reality.

40 See, e.g., Muhammad Zaheer Abbas, "Practical Implications of 'Vaccine Nationalism': A Short-Sighted and Risky Approach in Response to COVID-19", Research Paper, No. 124 (Geneva, South Centre, November 2020). Available from https://www.southcentre.int/wp-content/uploads/2020/11/RP-124.pdf.

41 See, e.g., Amie Shei, Federico Costa, Mitermayer G Reis et al., "The impact of Brazil's Bolsa Família conditional cash transfer program on children's health care utilization and health outcomes", *BMC International Health and Human Rights*, vol. 14 (2014). Available from https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-14-10#:~:text=Results,2.6;%20p%20=%200.007; World Bank, "Bolsa Família: Changing the Lives of Millions". Available from https://www.worldbank.org/en/news/feature/2010/05/27/br-bolsa-familia.

42 See, e.g., Xiaoyun Liu, Mingyue Li, He Zhu et al., "Poverty alleviation and health services for the poor in China: evidence from national health service surveys in 2013 and 2018", *International Journal for Equity in Health*, vol. 22 (2023). Available from https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-023-02000-7.

43 Tools like WHO's HEAT and the Global Health Observatory should support these processes.

44 See e.g., Minu Bajpai and Abhijat Sheth, "Ayushman Bharat: The Pradhan Mantri Jan Arogya Yojana (PM-JAY)", *Journal of Medical Sciences*, vol. 3 (April 2025). Available from https://natboard.edu.in/ejournal/article/publish/1025040119.pdf?1577026582#:~:text=The%20PM-JAY%2C%20a%20key,for%20rural%20and%20urban%20households.

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