



# Security Council

Seventy-seventh year

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*Provisional*

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<i>President:</i>	Lord Ahmad/Mr. Kariuki . . . . .	(United Kingdom of Great Britain and Northern Ireland)
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	Norway . . . . .	Ms. Moe
	Russian Federation . . . . .	Mr. Varganov
	United Arab Emirates . . . . .	Ms. Al Amiri
	United States of America . . . . .	Mrs. Thomas-Greenfield

## Agenda

Maintenance of international peace and security

Implementation of resolutions 2532 (2020) and 2565 (2021)

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*The meeting was called to order at 3.05 p.m.*

### **Adoption of the agenda**

*The agenda was adopted.*

### **Maintenance of international peace and security**

#### **Implementation of resolutions 2532 (2020) and 2565 (2021)**

**The President:** In accordance with rule 39 of the Council's provisional rules of procedure, I invite the following briefers to participate in this meeting: Mr. Ted Chaiban, Global Lead Coordinator for COVID-19 Vaccine Country Readiness and Delivery; Ms. Esperanza Martinez, Senior Adviser to the Office of the Director-General of the International Committee of the Red Cross; and Mr. Emmanuel Ojwang, Health and Nutrition Coordinator, CARE South Sudan.

Mr. Chaiban, Ms. Martinez and Mr. Ojwang are joining via video-teleconference.

The Security Council will now begin its consideration of the item on its agenda.

I now give the floor to Mr. Chaiban.

**Mr. Chaiban:** I wish to thank you, Mr. President, for the opportunity to address the Council today. We congratulate the United Kingdom on its presidency and appreciate convening with the United Arab Emirates and other Council members to recognize the importance of accelerating progress in coronavirus disease (COVID-19) vaccination as a key milestone towards ending the pandemic.

Slightly more than 1 million cases of COVID-19 were reported to the World Health Organization (WHO) in the past 24 hours. The pandemic is still far from over. We have safe and available vaccines that can protect against death and severe illness caused by COVID-19 and help avoid the next variant. There is an urgency, with more than 6 million lives having been lost to date, to raise COVID-19 vaccination rates in countries that did not have that opportunity in 2021.

The next six months are critical. More than 11.1 billion doses of COVID-19 vaccines have been administered globally, and 124 of the 194 WHO member States have vaccinated more than 40 per cent of their population; 51 countries have reached more than 70 per cent of their population.

However, that figure is only 11 per cent in low-income countries. A total of 83 per cent of the population in WHO's Africa region and 51 per cent in its eastern Mediterranean region, which includes Afghanistan, remain unvaccinated. In 2022 we must take the rapid action needed to accelerate vaccination. The window of opportunity is gradually closing. We risk losing the momentum and failing on vaccine equity.

The COVID-19 vaccine delivery partnership is focused, among other things, on 34 countries that were at 10 per cent or less of full vaccine coverage and face the biggest challenges to increasing such coverage. The goal is to vaccinate all adults and adolescents, starting with the elderly, health-care and other front-line workers, and those with underlying health conditions, who are at the highest risk from COVID-19.

Nineteen of the 34 countries identified for concerted support by the delivery partnership are included in the global humanitarian overview for 2022. We know that there are many competing health, humanitarian and economic priorities in those countries. We must therefore use every opportunity to bundle or integrate COVID-19 vaccination with other health and humanitarian interventions and leverage those investments for the longer-term strengthening of health-care systems.

In many countries, COVID-19 vaccination is being integrated with measles campaigns and, in complement, with maternal health and routine immunization. COVID-19 vaccination is being used to strengthen the cold chain and health-management information systems and to train and provide incentives to health workers, including the surge required.

With strong political leadership, country coordination and planning, and the implementation of mass vaccination campaigns, countries can quickly pick up their vaccination rates and coverage. Since January, the number of countries with a full population vaccination coverage rate at or below 10 per cent has dropped from 34 to 18. We have just wrapped up a mission in Ethiopia where the campaign rounds have increased vaccination coverage from 4 per cent in January to slightly more than 20 per cent now, including in some of the conflict-affected areas. We have agreed to bundle COVID-19 vaccination efforts with an upcoming measles campaign and to focus on the vaccination of internally displaced persons using the single-dose Johnson & Johnson vaccine.

In the Central African Republic, strong community engagement through focus-group discussions, television and radio spots with leaders and influencers, and young people being mobilized has led to almost 19 per cent of the population being vaccinated. I am speaking to the Council now from the Democratic Republic of the Congo, where this week we will be meeting with the Government and key partners to better address the urgent needs regarding and bottlenecks to expanding vaccination coverage across this country of nearly 100 million people.

We know that risk communications and community engagement are key components to success. We will therefore be working with in-country partners to support clear communications to increase demand and work to improve convenient access to vaccinations.

In humanitarian settings, from Afghanistan to Yemen, addressing low vaccination coverage rates requires integrating campaigns with humanitarian priorities, working with humanitarian partners and a sustained country-by-country effort to identify and overcome the primary obstacles to increasing vaccination rates among the populations affected by natural disasters, conflict and socioeconomic instability.

We recognize the significance of the humanitarian buffer, a mechanism established within the COVID-19 Vaccine Global Access (COVAX) Facility to ensure access to COVID-19 vaccines for high-risk and vulnerable populations living in humanitarian settings. As of today, two applicants — the Ministries of Health of Iran and Uganda — have successfully received vaccine doses via the humanitarian buffer, but the partners are committed to making sure it is a more user-friendly, easily accessible mechanism and that populations that are affected by humanitarian settings not included in national vaccination plans, microplanning or the implementation process can equally benefit from vaccination.

The COVID-19 vaccine delivery partnership and partners, such as UNICEF, the World Health Organization Global Alliance for Vaccines and Immunization, the World Bank and others, provide concerted support to all these countries, mobilizing political engagement, providing flexible funding — \$21 million in the past few months — strategic advice and technical assistance and lining up partners behind one country team, one plan and one budget to put countries at the centre and reduce their transaction costs.

To address the significant vaccine equity gap that continues to pose a threat to global health security, I ask members to consider the following requests.

First, we call for continued strong support and actions to implement resolutions 2532 (2020) and 2565 (2021), with a particular focus on ensuring that countries continue to prioritize COVID-19 vaccinations.

Secondly, with appreciation for the \$4.8 billion in pledges made at the COVAX Advance Market Commitment Summit, co-hosted with Germany, we must turn these commitments into tangible support for lower income countries with COVID-19 vaccination needs and a priority on a delivery system. Flexible, agile funding is vital, and these investments can last beyond the pandemic.

Thirdly, we ask that they advocate for and help guarantee full, safe and unhindered access, in line with international humanitarian law, including protecting humanitarian corridors as a means to getting vital supplies of vaccines and other essential equipment for the delivery of COVID-19 vaccination to populations in need, and ensuring the safety of health and humanitarian personnel administering vaccines in humanitarian settings.

Fourthly, we ask that they advocate across Government and work with United Nations country teams and partners to ensure strong national vaccination planning that addresses the needs of all populations living within the national territory, regardless of nationality, migration or refugee status.

Fifthly, we ask that they engage in the important conversations on the global health emergency architecture and advocate for strong governance and investment in the basics of primary health care as a key element of future pandemic preparedness.

**The President:** I thank Mr. Chaiban for his briefing, in particular as he is joining us from the Democratic Republic of the Congo.

I now give the floor to Ms. Martinez.

**Ms. Martinez:** I thank Council members for the opportunity to address them today and the United Kingdom for the spotlight it has shone on the importance of vaccination in conflict settings, through resolution 2565 (2021), as well as for continuing the Council's focus on what needs to be done.

As Mr. Chaiban just said, the coronavirus disease (COVID-19) has killed more than 6 million people globally, with the number probably much higher, as these are only the official reported statistics. The successes in the development and production of vaccines mean that many countries are starting to regain a sense of normalcy. However, to end the pandemic, vaccination needs to occur everywhere and that is not the case in conflict-affected areas.

Health systems torn apart by conflict are less able to contain the spread of diseases across front lines and international borders. Vaccination and other health activities in such contexts are incredibly difficult to carry out. Furthermore, many people in conflict settings are overlooked in public health responses, including people who have been displaced or detained or are living in areas controlled by non-State armed groups. Moreover, in areas affected by armed conflict, COVID-19 is now the most pressing issue people face, as the most basic needs, such as food, water and shelter, are often not covered. Even if the health system continues to function, its focus turns from general health care, including vaccination, to treating war-wounded patients and keeping the core of the system functioning. That can happen in any conflict setting.

The good news is that as the supply of vaccine doses grows, the potential to get jabs in arms grows too. To achieve that in conflict settings, the International Committee of the Red Cross (ICRC) presents three asks to the Council, States Members of the United Nations and conflict-affected countries.

First, they must ensure that international humanitarian law is respected. Under international humanitarian law, hospitals and other medical facilities, as well as medical personnel, including those administering vaccines, are specifically protected from attacks, and where States cannot meet the basic needs of populations, they must allow impartial humanitarian organizations to conduct health activities, including vaccination. Those obligations are reaffirmed in resolution 2565 (2021). We call on all parties to conflict to implement them in good faith, as attacks on health care have a profound effect on people's lives and futures.

Secondly, it is important to integrate COVID-19 vaccinations into a broader health strategy and, in tandem, strengthen the health system. We have seen vaccines expire on airport tarmacs in Afghanistan, Nigeria, South Sudan and several other places. Some of

those vaccines were wasted because they arrived with expiration dates that were too short. Others were wasted because the health systems of receiving countries were not ready to distribute them. Countries need a degree of capacity to deliver vaccines.

The COVID-19 pandemic offers an opportunity to strengthen health systems in conflict-affected countries. We need to consider how COVID-19 vaccinations can be routinized, where possible, and integrated with other health services that are prioritized during times of conflict. That does not mean that we have to do everything, but we must invest in country preparedness and fortify the building blocks of the health system that support immunizations and which, in turn, support the response to other pre-existing health needs. Critically, this investment can help address renewed outbreaks of other highly contagious and lethal diseases that are occurring today, for example, measles in Afghanistan and polio in the Democratic Republic of the Congo.

One strategy for addressing that is to invest in developing health workers' capacities and skill sets, as well as improving the key components of service delivery, such as local supply chains and infrastructure. That is both critical and doable in contexts affected by armed conflict. For example, the ICRC supported more than 600 health facilities in Iraq in 2021, which allowed the administration of more than 14 million doses of COVID-19 vaccines.

Thirdly, we must involve the community in vaccination activities and adequately resource community engagement. Done well, effective community engagement is a force multiplier. It enhances the safety of front-line health workers and expands the reach of vaccination and other health efforts. Community involvement allows the community to identify pressing needs and to take ownership. For example, the ICRC has established a network of community health committees attached to 28 primary health-care centres in Somalia and 16 in South Sudan. Many representatives are women from the community, who play an important role in the control and prevention of the COVID-19 pandemic and other diseases.

However, lack of or ineffective community engagement can undermine public trust in vaccinations and Government-run programmes more broadly, with ramifications beyond the pandemic. We have witnessed the effects of distrust in West Africa with Ebola and now in many countries with COVID-19.

Even if communities can be reached, people will not accept being vaccinated if they do not trust those administering the vaccine and if they do not see other pressing priorities being addressed.

For the ICRC and the wider Red Cross and Red Crescent Movement, community engagement ensures that communities' insights are an integral part of the design and delivery of programmes, and that people have accurate information about vaccines and public health interventions so they can make informed choices for themselves.

Beyond vaccination, the ICRC strives to build trust with communities and parties to conflict concerning all its humanitarian activities. The ICRC — as part of the Red Cross and Red Crescent Movement — will continue to play its part. The ICRC helped to administer more than 21 million doses of COVID-19 vaccines last year in areas impacted by armed conflict, and we maintain our offer of services to support States in implementing their vaccination plans, in supporting national Red Cross and Red Crescent Societies as humanitarian auxiliaries, and in acting as a neutral intermediary to facilitate access to vaccines and vaccination activities in hard-to-reach areas.

Equitable access to COVID-19 vaccination is a humanitarian imperative. Our collective recovery depends on it, because the longer COVID-19 circulates anywhere, the longer it remains a threat everywhere.

**The President:** I thank Ms. Martinez for her briefing.

I now give the floor to Mr. Ojwang.

**Mr. Ojwang:** I thank the members of the Security Council. I am honoured to address this organ today on behalf of my organization, CARE International in South Sudan.

CARE has been operating in South Sudan for almost 30 years, providing humanitarian assistance to various parts of the country in multiple sectors, including health care, nutrition, gender and protection, and food security and livelihoods. In the health-care sector, CARE is one of the lead actors in South Sudan supporting 56 health facilities across the country. We are working in 4 of the 10 states, some of which are hosting internally displaced persons severely affected by seasonal flooding and recovering from prolonged conflict.

We are working hand in hand with the Ministry of Health, the World Health Organization (WHO), UNICEF and the Health Pooled Fund to reach communities, especially women and children, with health services in various parts of the country. Those are communities facing multiple challenges and crises, not just coronavirus disease (COVID-19). They are facing food insecurity, and there are still flare-ups of intercommunal conflict and flooding that have caused displacement in some of the states.

As has been the case elsewhere in sub-Saharan Africa, there has been misinformation in some of the locations where we work, which has contributed to vaccine hesitancy, including very persistent myths that vaccines cause infertility in women and men.

Even before COVID-19 hit, the health systems in the areas where we work were fragile and overstretched. Fifty-six percent of people had inadequate access to health services and had to walk miles and miles to reach a clinic. We faced shortages of skilled health-care workers; only 30 per cent of women delivered with skilled birth attendants, which meant we had some of the highest rates of maternal mortality in the world, related to very preventable causes. When COVID-19 hit, only 49 per cent of our children had received the standard childhood vaccines.

One can imagine the huge challenge South Sudan's health system faced when we had to suddenly roll out COVID-19 vaccines to a population of about 12 million people, many of whom live in regions that are cut off from the rest of country for several months of the year owing to seasonal flooding.

But the story I really want to share with the Council today is about how South Sudan's Ministry of Health and its partners worked together in June and July of 2021 to make a series of smart investments that dramatically increased their collective ability to roll out COVID-19 vaccines, even in conflict-affected areas. In fact, despite having had to send back 70,000 vaccine doses in May 2021, just two months later the Ministry of Health was able to administer almost all the 60,000 doses of COVID-19 vaccines they had in stock.

Key to those success stories were several innovative approaches that the Government of South Sudan and its partners implemented in June and July 2021.

First, we made strategic investments in community education and mobilization to bust the myths and

misinformation surrounding vaccines. For example, we mobilized religious leaders to provide accurate information to their congregations. Knowing that radio is the primary source of information for most people in South Sudan, we worked with local call-back radio stations so that anyone could phone in to ask questions in their local language and receive accurate information from expert health-care workers.

Secondly, we extended and strengthened the health-care workforce by bringing on additional vaccinators and service providers. This meant that we could roll out the COVID-19 vaccine without disrupting other essential health services, such as childhood immunizations.

Thirdly, we made sure that all health-care workers, including existing and new ones, were adequately trained and supervised. We made sure that they had personal protective equipment, and we rotated vaccinators between COVID-19 vaccine delivery and childhood immunizations to reduce burnout.

Fourthly, we made sure that everyone was paid the same daily salary in accordance with the Ministry of Health standards so that there were no pay gaps between vaccinators working on the COVID-19 response versus routine health-care services. We agreed that those health-care workers would stay on after the COVID-19 vaccine effort to leave behind a more resilient health system.

One key point I want to underscore is that the real cost of inclusive, last-mile COVID-19 vaccine delivery in South Sudan is significantly higher than the current global estimates. We know the exact cost of vaccine delivery will vary from context to context, but South Sudan is just one of many conflict- and post-conflict settings with a fragile health system where we know we will need additional health-care workers, training and infrastructure if we want to roll out the COVID-19 vaccine to the last mile, while also preventing the disruption of other essential health services. In fact, costs will go up as South Sudan works to reach remote and underserved communities with highly effective but very expensive approaches, such as mobile clinics and health outreach. The WHO has already noted that those approaches have been dramatically underfunded.

I also want to stress that we must centre gender at the heart of COVID-19 vaccine roll-out if we want to ensure an equitable and effective response. Seventy per cent of front-line health-care workers globally are women, many of whom are working without fair pay

and in unsafe and unsupportive working conditions. We have to invest in those women at the front lines of service delivery if we are serious about an effective vaccine roll-out.

CARE's experience and evidence from across South Sudan and other conflict and post-conflict settings indicates that women are less likely to be vaccinated than men, they are less likely to have access to health information and services, and they may also have less trust in vaccines, including persistent misconceptions that COVID-19 vaccines cause infertility.

It is critically important that we identify and address gender-related inequities and take concrete and proactive steps to make sure women and girls in all their diversity are reached with information and services.

In conclusion, I urge all Security Council members to call on the United Nations system, the international donor community and host Governments to take the following actions.

First, they should ensure safe and unhindered humanitarian access to all people in need. That is essential to create the enabling environment for equitable vaccine delivery in conflict, post-conflict and humanitarian settings across Africa and beyond.

Secondly, they should ensure that COVID-19 vaccine costing models and budgets cover all aspects of delivery and reflect the real-world costs of rolling out the vaccines to the last mile. That must include investments in front-line health-care workers, community outreach, monitoring and logistics.

Thirdly, they should ensure that non-governmental organizations (NGOs), women-led organizations and front-line health-care workers have meaningful roles in the COVID-19 vaccine roll-out, not just in delivering services to the last mile, but also in decision-making about the response. That includes consistent roles in the humanitarian cluster system. It also means investments in feedback and monitoring systems that enable NGOs to provide real-time data so we can pinpoint service bottlenecks, identify equity gaps and address them.

Fourthly, they should invest in community-driven, bottom-up approaches. That must include the meaningful and consistent participation of local NGOs, community groups and women's groups. Such groups understand the local contexts and real-world barriers to delivery. They speak the local language and have earned the trust and acceptance of communities. They

can reach remote areas and underserved communities where the United Nations and Governments may not have access.

Finally, they should make concrete investments to ensure an equitable COVID-19 vaccine roll-out that leaves no one behind. That must include consistently collecting and using sex-, age- and disability- disaggregated data. It requires robust gender analyses that help us understand the unique barriers to vaccination faced by men, women, boys, girls and historically marginalized groups. All that data must be used to tailor the response to ensure that we are reaching the most marginalized with COVID-19 information and services.

**The President:** I thank Mr. Ojwang for his briefing.

I shall now make a statement in my capacity as the representative of the United Kingdom.

May I first thank our expert briefers Ted Chaiban, Ms. Martinez and Mr. Ojwang for their insightful and detailed briefings and, indeed, for reminding us all that we are not out of the woods. The coronavirus disease (COVID-19) pandemic is still very much a reality for all of us.

Together, we have now been battling the COVID-19 pandemic for a little over two years. It has been a time of great pain for us all and for our families and our friends, but also a true expression of how far humankind has come on this journey together. We moved from having no vaccine at all to having a steady supply of multiple vaccines.

The United Kingdom has committed £1.4 billion of United Kingdom aid to address the impacts of the COVID-19 pandemic and to help end the pandemic as quickly as possible. That includes £829 million for global development and the manufacture and delivery of COVID-19 vaccines, treatments and tests.

Another good example was the United Kingdom-India partnership on vaccines, which enabled more than 1 billion people to receive a COVID-19 vaccine, saving lives and mitigating the spread of the pandemic globally. The University of Oxford, AstraZeneca and Serum Institute of India partnership combined the United Kingdom's leadership in research and development and India's manufacturing capacity as the pharmacy of the world.

Last month, the United Kingdom hosted the Global Pandemic Preparedness Summit, which raised \$1.5 billion in funding for the Coalition for Epidemic Preparedness Innovations to develop vaccines against new health threats in 100 days and to rapidly scale up regional manufacturing for an affordable global supply.

Through the COVID-19 Vaccine Global Access (COVAX) Facility, the United Kingdom plays its part in giving access to vaccines, wherever they are needed. Indeed, we are among the largest donors to the advance market commitment, having committed £0.5 billion pounds so far. The COVAX Facility has now delivered more than 1.4 billion vaccines to 144 countries, the majority of which are low- and lower-middle-income ones.

Vaccination rates are also steadily increasing. But, as we already heard from our briefers today, they continue to lag in many low-income countries, and particular communities in conflict and a humanitarian crisis risk being left behind.

After more than a year of steady vaccine production, the challenge has moved from being one of supply to one of roll-out. The Office for the Coordination of Humanitarian Affairs report that less than 4 per cent of the populations of the Democratic Republic of the Congo, Yemen, Haiti and Burundi are vaccinated. Frankly, that is a staggering inequity, which is bad for us all.

The delivery of vaccines to marginalized and conflict-affected communities is being obstructed by underresourced and overstretched health systems and by curtailed humanitarian access. Last year, the Security Council unanimously adopted resolution 2565 (2021), calling for the provision of vaccines to areas in conflict. It gained the highest-ever number of co-sponsors of a Council resolution.

It is clear that full, safe and unhindered humanitarian access and the protection of health workers, in line with international humanitarian law, remain vitally important, but, sadly, elusive. That point was amplified by Ms. Martinez. What more can we do to ensure that the most vulnerable are not left behind?

First, we can help to ensure that COVID-19 vaccination is prioritized by Governments in countries in conflict. We can offer support through the COVAX Humanitarian Buffer, a measure of last resort to target individuals in fragile regions not included

in national vaccination plans. We can also support efforts to strengthen international cooperation. The COVAX Facility recently set up a new vaccine delivery partnership to improve coordination at the global and country levels, including with the African Union, for COVID-19 vaccine delivery and support, including in the most vulnerable countries, most of which are in Africa. Again, our expert briefers outlined that very point.

Secondly, we can spell out to all parties to conflicts their obligations under international humanitarian law to provide unhindered humanitarian access, including for vaccinations. That must happen.

Thirdly, we must work together, as the United Nations, to overcome obstacles to delivery and to advance Sustainable Development Goal 3 and our collective efforts to build stronger health systems worldwide. Mr. Ojwang also stressed the importance of leveraging all in-country networks through his own experience in South Sudan. Indeed, I welcome the important role of faith leaders, who have also been brought on board, as Mr. Ojwang highlighted.

In conclusion, resolution 2565 (2021) continues to be an important road map for our discussions on vaccines and health in conflict zones. COVID-19 has shown us that the best way to achieve success is through a collaborative effort and by working together. The resolution also represents a genuine investment in stability and global health, not of just an individual country but of the world as a whole, and, as such, must remain a top priority for us all.

I now resume my functions as President of the Council.

I give the floor to Her Excellency Ms. Al Amiri. I am so pleased that we have been able to co-organize this important briefing with the United Arab Emirates.

**Ms. Al Amiri** (United Arab Emirates): The United Arab Emirates is honoured to partner with the United Kingdom and France in preparing today's briefing, and I would like to thank you, Sir, for presiding. The United Kingdom's leadership in the Council on vaccination in conflict and fragile settings remains deeply appreciated, not least on resolution 2565 (2021). I would also like to extend our gratitude to Mr. Ted Chaiban, Ms. Esperanza Martinez and Mr. Emmanuel Ojwang for their insights.

This meeting is an important prompt to accelerate our collective commitment to global vaccination and

to realize the promise and values of resolutions 2565 (2021) and 2532 (2020). As a policymaker in science and technology, I am heartened by the unprecedented speed of innovation around coronavirus disease (COVID-19) vaccines. It is a testament to the speed that we can globally work at, leveraging existing capabilities and, in our case, building new ones.

However, the pandemic is far from over and new waves, coupled with new variants, are evidence that no one is safe until everyone is safe. Furthermore, the impact of COVID-19 on global security has a long tail that reaches beyond mobility restrictions and supply chain disruptions. It has inflicted social and economic stress — and, in some cases, devastation — on already fragile communities by undermining livelihoods and basic services like education and health. As we know, women and girls are still bearing the brunt of those effects. The pandemic's lasting security legacy will likely be the worsening of the root causes of those challenges globally, and a solution is necessary to avoid far-reaching ripple effects from the pandemic.

Last month, during the United Arab Emirates presidency, we highlighted the status of vaccination in countries on the Council's agenda. Progress in those countries against the global goal of 70 per cent ranged from a high of 49 per cent of the eligible population to a low of less than 1 per cent, with an alarming average below 10 per cent. We are therefore encouraged by the Council's continued commitment to the implementation of resolution 2565 (2021). We have come too far to give up and, as we have heard, this year represents perhaps the best opportunity in two years to improve vaccination in countries on the Council's agenda.

The United Arab Emirates has been proud to support both multilateral and bilateral vaccination efforts, including vaccine and logistical contributions to the COVID-19 Vaccine Global Access (COVAX) Facility and large-scale global personal protective equipment distribution in over 135 countries. From that experience of working with humanitarian and health agencies, we would like to highlight four areas where the Council can support a faster implementation of resolution 2565 (2021).

First, it is important that the Council continue to underscore the security benefits of vaccination. It is an important incentive for sustained contributions to global vaccination campaigns, especially through COVAX and its humanitarian buffer.



Secondly, all instances of improved humanitarian access enhance vaccination efforts, providing safety and mobility for health workers and patients alike. The Council's support for those tools — from ceasefires to days of tranquillity to humanitarian notification systems, as appropriate in specific contexts — can make a difference in the rapid delivery and distribution of vaccines.

Thirdly, the Council should encourage entities operating under its mandate to ensure coordination at the country level so that COVID-19 vaccination is part of the bundle of essential services provided by the United Nations and its partners. That is especially important in a period of food insecurity and high commodity prices. That coordination will also ensure that we are taking full advantage of opportunities provided by access to communities.

Finally, the Council must advocate for gender responsiveness in vaccination. Women receive fewer doses in many fragile countries because of physical and social barriers, prolonging the pandemic's security impacts. Women's leadership in vaccination efforts, as well as gender accountability tools for implementing agencies, are proven ways to improve equity.

While much of the heavy lifting on vaccination and resolution 2565 (2021) will be done by humanitarian and health actors, the Council has a clear stake in the results of their work and in supporting them at every turn. The fair and equitable distribution of vaccines is both a strategic investment and a moral obligation. It is also achievable. This current drive, if dealt with from a long-term perspective, will build the necessary know-how and experience to aid in future vaccine distribution, strengthening existing health-care and logistical systems.

We learned through the global drive towards developing, testing and deploying the COVID-19 vaccine that silos can be broken and that global collaboration is a possibility. As I look at my experience in other aspects of my portfolio once deemed improbable, working towards addressing the challenges while building a better vaccine delivery system will remove COVID-19 as a source of fragility.

**Mrs. Thomas-Greenfield** (United States of America): I thank you, Sir, for bringing us together today for this very important discussion. I also thank the briefers for their insights.

I think we all remember where we were when we realized that the coronavirus disease (COVID-19) was not a minor outbreak, but a highly contagious virus that would change our lives. That was a little over two years ago, but it feels like much longer than that. During the past two very long years, COVID-19 has caused immense hardships around the world. There have been 500 million confirmed cases and 6 million people have died. So many of us have personally lost loved ones to the virus.

However, while COVID-19 represents a darker chapter, there is reason for hope. After all, the scientific community was able to develop, test and start to roll out life-saving vaccines in under a year — a historic feat. Of course, having safe and effective vaccines and getting shots into arms are very different things. The United States recognized early on that we could play a crucial role in vaccinating the world. Working with the COVID-19 Vaccine Global Access (COVAX) Facility and other partners, we have provided over 518 million doses to 114 countries, with no strings attached. We are committed to donating 1.2 billion doses in total. Thanks in part to those efforts, nearly 6 in 10 people around the world have had at least two shots of the vaccine.

That is encouraging, but we know that we still have work to do and we know that too many countries lack far behind, especially countries in the midst of conflict and instability. In Yemen, for example, just 1.3 per cent of the population is fully vaccinated. In Haiti and in the Democratic Republic of the Congo, that number is less than 1 per cent. Tragically, that list goes on and on.

It is not an issue of supply. We have enough doses. It is an issue of access. Aid organizations face steep barriers to delivering humanitarian assistance, including COVID-19 vaccines and treatments, to conflict zones. Ukraine is a prime example. Russia's unprovoked brutal invasion has meant that COVID-19 vaccine distribution and routine immunizations have come to a sudden halt. Since the start of the war, COVID-19 vaccinations have plummeted from more than 52,000 a day to less than 1,000 a day. Why? Because Russia's senseless violence has damaged the infrastructure necessary to get aid and vaccines to people. Safe passage through humanitarian corridors is sporadic, at best.

Let me be absolutely clear. Aid organizations delivering humanitarian assistance, including COVID-19 vaccines and treatments, must be given unfettered access in Ukraine, in Syria, in Burma — in every single

country, in every single conflict. The United States is already working with the international community to expand access through our global vaccination initiative. Thanks to the COVID-19 Prioritized Global Action Plan for Enhanced Engagement, we have been able to bolster supply chains, address information gaps, support health-care workers and strengthen the global health security architecture.

But the Security Council has a central role to play here as well. The Council has taken some important steps by adopting resolution 2532 (2020) and 2565 (2021), but those resolutions need to be implemented, as we have just heard from Ted Chaiban. We can and must do more, including by renewing the United Nations authorization to deliver cross-border humanitarian assistance into Syria. The cross-border mechanism is a literal lifeline and the only route through which COVAX vaccines are reaching north-western Syria, home to more than 3 million people.

Many of the crises that we face do not have an instant cure. We wish we could vaccinate the world from war, hunger and all forms of suffering. Unfortunately, it is not always that simple, but when it comes to COVID-19, if we can get vaccines into arms, it is that simple. We can save lives and end the pandemic. The challenge is ensuring that the world's most vulnerable, especially those suffering in conflicts, get the COVID-19 vaccines they need. Aid organizations are prepared to do that difficult work. Let us support them in every way we can.

**Mr. De Rivière** (France) (*spoke in French*): I thank Mr. Chaiban, Ms. Martinez and Mr. Ojwang for their briefings.

At the outset, I commend the outstanding work of the entire United Nations and of humanitarian and medical personnel in responding to the coronavirus disease (COVID-19) pandemic. Despite some progress, vaccination rates remain extremely unequal from one country to another, particularly between the countries of the North and the countries of the South, especially in Africa. We are still far from the reaching global herd immunity. In the Democratic Republic of the Congo, Yemen and Haiti, the vaccination rate remains below 4 per cent of the population. The number of COVID-19 cases is widely underestimated, owing to low testing capacity. The World Health Organization (WHO) estimates, for example, that two-thirds of the population on the African continent has been infected with COVID-19.

The obstacles preventing vaccination are numerous: restrictions to humanitarian access and the effective delivery of doses on the ground, insecurity, weak health-care systems, disinformation and mistrust vis-à-vis vaccination and many other humanitarian priorities. We therefore have a collective responsibility to achieve herd immunity. That is why we must focus our efforts on four priorities.

The first is equitable and affordable access to COVID-19 vaccines. The vaccine must be a global public good and accessible to all. We continue to fully support the COVID-19 Vaccine Global Access (COVAX) Facility, which has enabled the delivery of more than 1 billion doses to low- and middle-income countries. France has committed to donating 120 million doses by the summer of 2022, of which more than 86 million have already been delivered. More than 90 per cent of the vaccines we provide go through the COVAX facility, and more than half of them benefit African countries. Moreover, we are contributing to several multilateral and bilateral initiatives to strengthen long-term local production of health products, particularly vaccines, on the African continent.

The second concerns the cessation of hostilities and a humanitarian pause, in accordance with resolution 2532 (2020). That is a necessary condition for facilitating vaccine campaigns. International humanitarian law must be respected by all. I am referring not only to full humanitarian access, but also to the protection of humanitarian and medical personnel.

The third involves taking into account the most vulnerable people in national vaccination plans, in particular refugees and internally displaced persons. It is also important that vaccination campaigns incorporate the gender dimension, as women and girls are particularly affected by inequalities in access to vaccines. In that regard, we must ensure the participation of women in decision-making processes and the humanitarian response. It is also imperative to strengthen communication and awareness campaigns to counter misinformation and mistrust concerning vaccines.

The fourth concerns strengthening health-care systems and responding to humanitarian needs. Without resilient health-care systems that enable the improvement of effective access to quality health services and contribute to achieving universal health coverage, we will not be able to definitively end to the

pandemic. Beyond COVID-19, France will continue to fully support the Gavi Alliance, which has made possible the vaccination of nearly 900 million children since 2000, and to support the work of WHO, including through Access to the COVID-19 Tools Accelerator, to strengthen health-care systems. We will also continue to increase our financial contributions to the humanitarian response. In addition to the humanitarian response in Ukraine, we must collectively remain poised to meet humanitarian needs throughout the world.

**Mr. Costa Filho** (Brazil): The whole United Nations system has ended up involved in the multilateral response to the coronavirus disease (COVID-19) pandemic, including the Security Council through the important adoption of resolutions 2532 (2020) and 2565 (2021).

The first resolution demands a general and immediate cessation of hostilities in all situations on its agenda and calls on all parties to armed conflicts to engage immediately in a durable humanitarian pause to enable the safe, unhindered and sustained delivery of appropriate humanitarian assistance. With a large number of sponsors, the second resolution states that people in conflict zones must not be left behind, as mass vaccination campaigns were happening at a speed never seen before. It also recognizes the crucial role of extensive immunization on the path to ending the pandemic.

The Council made it clear that it is both an ethical and practical imperative to assist people in need in conflict zones, including refugees, internally displaced persons and those living in areas under the control of non-State armed groups, out of reach of basic services provided by the State.

The pandemic has shown once again the enormous challenges to overcoming the current scenario of profound inequalities among countries regarding access to vaccines, medical equipment and other medical products. The Access to COVID-19 Tools Accelerator and the COVID-19 Vaccine Global Access (COVAX) Facility still face many challenges to promote a more equitable and just distribution of safe, effective, high-quality and affordable COVID-19 vaccines, treatment and diagnostic tests. Having faced vaccine hoarding and structural access barriers, Brazil, like many developing countries, supports those important multilateral initiatives. However, they were not able to deliver on their initial promises.

We believe that COVAX might be better equipped to fulfil its role. It has a humanitarian buffer — a mechanism established to act as a measure of last resort to ensure access to COVID-19 vaccines for high-risk and vulnerable populations. Nevertheless, vaccination rates in situations of armed conflict are disturbingly low.

Let us be clear. The role of ensuring that people are fully vaccinated and that the world is better equipped to respond to future pandemics with strong and resilient national health systems rests with other international bodies, especially the World Health Organization (WHO). We must, however, ask ourselves the question whether the Council can do more to guarantee that people in conflict-affected areas have access to vaccines, and resolution 2532 (2020) already provides some clues as to what the Council can do.

First, it must try to overcome the access challenges in conflict zones by renewing its call on all parties to armed conflicts to engage in humanitarian pauses so as to facilitate the full, safe and unhindered delivery and distribution of vaccines and medical assistance in areas of armed conflict. Those services must be provided by impartial actors in accordance with the humanitarian principles of humanity, neutrality, impartiality and independence.

Secondly, the Council can make sure that civilian infrastructure, which is critical to the delivery of humanitarian aid for essential health services, including vaccinations, is always protected, in accordance with international humanitarian law.

Thirdly, the Council should adapt peacekeeping operations and special political mandates so they can, as appropriate, support host country authorities in their efforts to strengthen their health systems and carry out vaccination campaigns that include refugees and internally displaced persons. The full, equal and meaningful participation of women in those efforts should be welcomed and encouraged.

Before concluding, I would like to thank the briefers for their insightful information. We commend the International Committee of the Red Cross for its efforts to gain access across front lines through its neutral humanitarian work and for helping with the logistics of transport and cold chains to enable vaccinations. We also thank Ted Chaiban, the Global Lead Coordinator for COVID-19 Vaccine Country-Readiness and Delivery for his commitment to achieving the targets established by the WHO. We add our appreciation to

Mr. Ojwang for his clear presentation of realities and challenges on the ground.

Brazil remains committed to contributing to global efforts aimed at increasing vaccine coverage against COVID-19, especially in developing countries. We have already donated more than 5.6 million doses through bilateral cooperation and the COVAX Facility. On 8 April, the Brazilian Government announced the donation of \$86.6 million to the COVID-19 Vaccine Global Access Facility Advance Market Commitment, the greatest donation COVAX has ever received from a developing country, and we hope that, throughout 2022 it will be possible for us increase this figure.

We also stand ready to contribute by sharing our experience with mass-vaccination campaigns. Brazil has been able to achieve high vaccination coverage, including during the ongoing pandemic, thanks to the strength of its universal health system, which aims at covering all 5,570 municipalities in the country, with priority given to those in the most vulnerable situations.

**Mr. Varganov** (Russian Federation) (*spoke in Russian*): Today's briefing on the topic of vaccination in the context of armed conflicts, post-conflict situations and complex humanitarian crises is a timely one. We thank the briefers for their useful overview of the global situation in terms of ensuring universal immunization against the coronavirus disease (COVID-19) in the most challenging conditions, as well as recommendations for improvements on this track.

In the light of the responsibilities of the Security Council and the guidance provided by its resolutions 2532 (2020) and 2565 (2021), we would like to acknowledge the efforts of the United Nations Department of Operational Support aimed at organizing a proper vaccination campaign among peacekeepers. We also welcome the establishment by the World Health Organization (WHO), UNICEF and the Gavi Alliance and their COVID-19 Vaccine Delivery Partnership, which is designed to strengthen the coordination of relevant efforts. This is especially important given that logistical issues and the ability of national health systems to ensure that received vaccine doses are administered are problems that are now coming to the fore, primarily as a result of an unprecedented number of illegal sanctions. In this regard, we trust that by improving the coordination and effectiveness of these activities, it will be possible to increase the vaccination

rates in the 25 countries most in need where vaccination coverage currently does not exceed 10 per cent.

We also hope that it will be possible to swiftly set up the work of the so-called humanitarian buffer, which is focused on the most vulnerable categories of recipients, as part of the framework of the multilateral COVAX mechanism. It would be interesting to hear the briefers' opinion on how to address problems hindering this process, particularly the legal issue of indemnities. Unfortunately, as is traditionally the case, we did not hear any analyses or assessments of how the goal of achieving universal vaccination is affected by unlawful unilateral economic coercive measures that undermine the health systems and economies of the countries affected. We regret to note that this topic continues to receive a lack of attention in the Council, which does nothing to improve the situation. Other factors that deserve attention include delays in national and international approval of anti-COVID-19 drugs, expanding access to technology and supply chains, and combating disinformation and vaccine hesitancy.

For its part, Russia also possesses experience in helping to combat COVID-19 in difficult conditions. Indeed, we have delivered millions of doses of vaccines and testing systems to foreign countries, including countries on the Council's agenda, for example, to colleagues in the Syrian Arab Republic. According to the latest data, our country is currently hosting more than 730,000 citizens of the Donetsk and Luhansk People's Republics and Ukraine. Refugees can access COVID-19 testing at accommodation centres and medical facilities, and, if they wish, they can also be vaccinated with the vaccines used in our country or receive free treatment for COVID-19 on an equal footing with Russian citizens.

We are continuing to work on improving our response to the novel coronavirus infection at the research and development level as well. Therefore, at the beginning of this month, a nasal form of the Sputnik V vaccine was registered in Russia. It is to be administered using a special spray nozzle. We would like to note that, according to resolution 2565 (2020), information on its implementation should necessarily be provided — and it should also be an option — as part of the ordinary reporting of the special representatives of the Secretary-General, where and when that is required. We would consider this mode of discussing this issue within the Council to be optimal.

In conclusion, we are forced to respond to the statement made by one delegation, which insists on continuing to use practically every meeting of the Security Council to attack our country. We have repeatedly provided clarifications with regard to the special military operation in Ukraine, and we do not intend to return to this topic now.

**Mr. Zhang Jun** (China) (*spoke in Chinese*): The Chinese delegation thanks Global Lead Coordinator Ted Chaiban and Ms. Martinez for their briefings. We listened to Mr. Emmanuel Ojwang's statement.

I would like to take this opportunity to pay a special tribute to the health workers who have been fighting on the front line against the coronavirus disease (COVID-19).

Our world is now in the third year of the COVID-19 pandemic. Armed with nearly all the effective tools needed to fight this pandemic, humankind is beginning to see the light at the end of the tunnel. That said, the pandemic is not over yet. New variants of the virus, each spreading faster than its predecessor, keep cropping up. We are nowhere near the point where we can afford to be complacent and let up. Only when each and every country has subdued this common enemy of ours can the world declare that we have prevailed.

I would like to make the following points in connection with some pending issues that warrant our special attention. First, we must work hard and work together to build immunological barriers globally. The World Health Organization target of 70 per cent vaccination coverage is far from being achieved. In particular, vaccination rates in countries in conflict are generally below the world average — indeed, less than 1 per cent in such countries as the Democratic Republic of the Congo, Yemen and Mali.

Resolution 2565 (2021) calls for increased access and affordability of vaccines in conflict areas. Right now, it is imperative to scale up vaccine assistance and supply to leave no country behind and no one forgotten.

China has provided a total of 2.2 billion doses of COVID vaccines to more than 120 countries and international organizations and is currently providing an additional 1 billion doses to African countries, 150 million doses to Association of Southeast Asian Nations countries and 50 million doses of free vaccines to Central Asian countries.

To date we have contributed \$100 million and 220 million doses of vaccine to the COVID-19 Vaccine Global (COVAX) Facility. Localizing vaccine manufacturing is important to putting developing countries in a better position to respond to the pandemic. China was the first to support intellectual property right (IPR) waivers for vaccines and the first to transfer its vaccine technology to developing countries. China is co-producing vaccines with 20 countries, with an annual capacity of 1 billion doses. We support an early decision by the World Trade Organization on an IPR waiver for vaccines in an active and positive response to the strong appeals made by broad segments of developing countries.

Secondly, public health systems in developing countries should be strengthened. Developing countries are at a serious disadvantage in the global health system, as they were already facing all manner of grave challenges. Many countries have been struggling to provide timely vaccinations to all those in need because of war, conflict, lack of transport access or poor health-care infrastructure. Even when sufficient vaccines are available, timely vaccinations are still not possible or difficult to achieve.

The root cause of the bottlenecks in the last mile of vaccine access is the long-standing problem of inadequate public health systems. In order to better prevent and respond to the next pandemic when it arrives, the international community should look far ahead and vigorously help developing countries strengthen their public health system.

In that regard, it is necessary to expand medical-services coverage and improve public infrastructure such as transport and the power supply, train more medical professionals and health workers, and better disseminate public health information to the entire population, especially youth and children.

The Council should work with other bodies and take a pragmatic approach and tangible measures to bring hope to people in countries in conflict.

Thirdly, we should inject fresh momentum into post-pandemic recovery and socioeconomic development. The pandemic is responsible for a slowdown or even a recession in many economies, and the implementation of the 2030 Agenda for Sustainable Development faces even more daunting challenges. The recent global political and security upheaval, the soaring prices of energy, food and other bulk commodities,

and a new upsurge in trade protectionism have added to the woes of many developing countries that were already struggling to cope. Today's more challenging external environment highlights the importance and urgency of development for developing countries. That is something that the international community must take very seriously, and the United Nations should act swiftly and take robust and effective measures to both address current crises and explore long-term solutions so that the world can discern fresh hope on the horizon.

China's Global Development Initiative (GDI) aims to address, as the first order of business, poverty eradication, equitable vaccine access and financing for development, among other things, which are of the greatest concern to developing countries, and help place development at the centre of the global macro policy framework, thus providing a viable path to the accelerated implementation of the 2030 Agenda and post-pandemic recovery. China will host a high-level meeting of the Group of Friends of the GDI in the near future. We hope for extensive participation and active contributions to the event.

Fourthly, true multilateralism is an imperative. During the pandemic, which lasted more than two years, more than 6 million people lost their precious lives. The lesson is profound and deserves serious reflection on our part. Nothing is more valuable in this world than human lives. A people-centred approach is the most important tenet that guides all our decisions.

At the global level, cooperation in solidarity is the most powerful weapon in defeating the pandemic and is as effective in tackling other global challenges. Under these unprecedented circumstances, we must work together to build back better with the conviction — stronger than ever — that we are in this together as a global community with a shared future.

Meanwhile, we must not lose sight of the fact that our world is still confronted with multiple challenges. A scant few countries are still holding on to their cold-war mentality for dear life, drawing lines of distinction based on ideology, provoking renewed bloc-to-bloc confrontations, imposing unilateral sanctions thick and fast and without scruples, weaponizing economic interdependence and forcing countries to choose sides. That is plunging the international community into division and pushing the world into a quicksand of grave risks and uncertainties. Those irresponsible actions are

harmful to others, as they are to themselves, and must be categorically rejected.

The need for true multilateralism is even greater in today's world. In the post-pandemic period, all countries should strengthen their solidarity under the banner of the United Nations, respect one another, build mutual trust and be trustworthy, show goodwill, cooperate for mutual benefit and work together for a better future.

**Ms. Moe** (Norway): I thank the briefers for their insightful presentations.

It is clear that vaccines are not effective until all people are vaccinated, and the disparity today is stark. While some countries are close to universal vaccination, others, including those affected by humanitarian crises, have reached only 5 per cent. In the Democratic Republic of Congo, less than 1 per cent of the population is fully vaccinated and in Ethiopia, less than 18 per cent. Equitable access between countries remains a global challenge.

The most vulnerable have been hit the hardest by the pandemic, including children affected by armed conflict. They have seen an increase in the military use of schools and in their vulnerability to recruitment and use in armed conflict, as well as their vulnerability to rape and other forms of sexual violence, including trafficking. Community-protection mechanisms and rule-of-law institutions have been weakened, and monitoring and protection mechanisms on the ground have been severely affected. All that has been caused by isolation and the critical deterioration of the socioeconomic situation resulting from the pandemic as well as some of the measures put in place to counter it.

While the coronavirus disease (COVID-19) has brought faster research and development and a larger manufacturing capacity than ever before, delivery still remains a challenge. Two years on, a fully financed Access to COVID-19 Tools Accelerator and its COVID-19 Vaccine Global (COVAX) Facility could not be more urgent in order to ensure equitable access to vaccines, diagnostics and treatments, including for those displaced or living in areas beyond the reach of national health authorities.

Regrettably, the COVAX humanitarian buffer has not been a success so far. We call on manufacturers to waive their indemnity and liability requirements for

buffer doses. We must address all obstacles that prevent it from being used by organizations and countries.

A sufficient supply of vaccine doses on its own is not enough to increase vaccination rates. Allow me to highlight three points in that regard.

First, community engagement is key. Close dialogue is vital to enhancing acceptance and confidence in COVID-19 vaccines, especially in conflict settings, where trust in national authorities may be low and the level of misinformation high. High-risk groups must be a priority in delivery everywhere.

Secondly, the capacity to deliver of local health systems must be addressed. We have examples of vaccines expiring on the tarmac in South Sudan, Afghanistan and elsewhere. COVID-19 vaccinations need to be integrated into our broader health strategies and should complement routine vaccinations, not occur at their expense.

Thirdly, we need to ensure access. As more vaccines arrive in countries at war, full, safe and unhindered humanitarian access remains imperative. This must include the protection of humanitarian and medical workers and their assets. Since the start of 2022, there have already been 52 reported incidents of violence or threats against health care in Myanmar, resulting in seven casualties among health-care workers and eight damaged health facilities. In the Sudan, 10 health workers were reportedly injured by violence. In Ukraine, there have been a total of 91 reported incidents, including 21 attacks on health-care workers and 77 attacks on health-care facilities, although we know that actual figures are likely much higher. Attacks on health-care, medical and humanitarian personnel are unacceptable and show parties' disregard for their obligations under international humanitarian law.

In resolution 2565 (2021), we recognize that those affected by conflict and insecurity are particularly vulnerable and at risk of being left behind. We must continue to work to ensure equitable access to COVID-19 vaccinations. The Council has a key role to play, including following up on its resolution.

**Mr. Agyeman** (Ghana): I thank the delegation of the United Kingdom for picking up this agenda item during its presidency.

I also thank Mr. Ted Chaiban, Ms. Esperanza Martinez and Mr. Emmanuel Ojwang for their unique perspectives about the vaccine delivery situation,

especially as it relates to vaccination programmes in conflict settings.

Resolutions 2532 (2020) and 2565 (2021) demonstrate the Council's concern about the impact of the coronavirus disease (COVID-19) pandemic on the maintenance of international peace and security in mandated peacekeeping missions, as well as in other conflict settings and humanitarian crises. The resolutions call for urgent and coordinated actions to ameliorate the impact of the pandemic on key peace and security objectives. Notwithstanding the absence of compliance with the appeal for a global ceasefire, made by the Secretary-General, and a durable humanitarian pause for 90 consecutive days, advocated by the Council, we believe that, overall and given the circumstances, the Organization's response to the pandemic in field missions was satisfactory in maintaining the safety of personnel. We also welcome the evolving health advisories to troop- and police-contributing countries on the management of the COVID-19 pandemic, based on available science.

The Ukrainian crisis has overshadowed COVID-19 in the media space, but we all know that the pandemic continues to linger, with devastating impacts not only on health systems, but also on the economies of nations and the development aspirations of many peoples. The pandemic has exposed underlying structural inequalities that drive conflict and instability and exacerbated the public health and socioeconomic challenges of several countries, including their capacity to distribute vital public services, such as vaccines, and respond to the needs of marginalized and vulnerable groups.

In countries already in conflict, the situation is even worse. Indeed, statistics made available by the United Nations estimate that approximately only 13 per cent of people in low-income countries have been vaccinated, compared with almost 70 per cent in high-income countries. As bad as that situation is, it pales in comparison to the plight of millions of people in countries in armed conflict situations, post-conflict situations and humanitarian emergencies, who are simply being overlooked by vaccination efforts. That is unacceptable and reflects the failure of the international community to administer vaccines in a fair and equitable manner.

The fulfilment of the mandate of resolution 2565 (2021), particularly the provisions relating to a humanitarian buffer, continues to be relevant in ensuring

equitable access to vaccines in order to bring an end to the pandemic and help those countries prepare for the next pandemic. My delegation therefore calls on major stakeholders to address issues surrounding vaccine indemnity and liability requirements, to streamline the vaccine roll-out in high-risk and vulnerable populations and to provide funding for delivery operations. We also wish to urge countries to commit a portion of their vaccine supply to the humanitarian buffer that will be used to vaccinate people in countries experiencing humanitarian crises.

In addition to the implementation of the humanitarian buffer, I wish to share a few thoughts that I believe should form the basis for global cooperation to address the issue of vaccine equity in countries in armed conflict situations, post-conflict situations and humanitarian emergencies.

First, we need to strengthen the funding of existing global health organizations. This must include a greater, more predictable base of multilateral funding for the World Health Organization and regional centres for disease control, which play a central role in global health security. It will require dedicating an additional 1 per cent of gross domestic product to funding global health. This is an investment in a global public good, not aid.

Secondly, COVID-19 vaccinations cannot be a stand-alone goal. The international community needs to take a common but differentiated approach and work to strengthen public health systems to ensure that vaccination is only one element of a broader health strategy that responds to the reality of people's health needs and priorities.

Thirdly, there is an urgent need for the deconcentration of manufacturing capacities for vaccines, including in Africa, where a significant number of conflict situations prevail and distribution challenges persist. It is for that reason that countries, such as Ghana, Rwanda and Senegal, in partnership with the German biotechnology company BioNTech SE, are venturing into vaccine development and manufacturing so as to become hubs in sub-Saharan Africa. Ghana has committed \$25 million to develop its domestic vaccine production capability and facilitate the capacity of domestic pharmaceutical companies to fill, finish and package messenger RNA COVID-19, malaria, tuberculosis and other vaccines, as the first step towards vaccine production.

Fourthly, we must strengthen and support existing mechanisms, such as the COVID-19 Vaccine Global Access (COVAX) Facility and the African Union and African Vaccine Acquisition Trust initiatives, which have played a vital role in the distribution of vaccines to vulnerable countries, as well as countries in special situations, including those in armed conflict situations, post-conflict situations and humanitarian emergencies. In that regard, we are heartened to learn that, so far, the COVAX mechanism has distributed more than 1 billion vaccines to low- and middle-income countries.

The pandemic has taught us that national solutions to international problems simply do not work. Ghana therefore affirms its commitment to supporting resolutions 2532 (2020) and 2565 (2021) and believes that, through their successful implementation, vaccination can be successfully implemented in all settings, especially in conflict settings.

**Mr. Hoxha** (Albania): We thank the United Kingdom for bringing to the Council the issue of equitable access to coronavirus disease (COVID-19) vaccines in conflict settings and humanitarian crises. I congratulate the briefers on their insightful interventions and useful recommendations.

The pandemic is far from over, despite a much changed and improved global situation due to vaccination. Our increased capacity to learn to live with COVID-19 and a push to return to normal life should not make us imprudent. We know only one way to win over the virus — that is through protection measures and vaccines.

Albania is a sponsor of resolution 2565 (2021), demanding humanitarian pauses to allow access to and the delivery of vaccines to all areas in armed conflict. In June 2020, we signed a cross-regional joint statement, together with 170 Member States, to voice our support for the Secretary-General's appeal for a global ceasefire in all conflict-affected areas to combat the COVID-19 pandemic, which is addressed subsequently in the landmark resolution 2532 (2020). Earlier this year, we joined the call of the President of the General Assembly for vaccine equity as well.

Although a strong humanitarian response is in place, challenges are on the rise. We still see the intensification of existing and new conflicts in many parts of the world. We all know the heavy toll of the COVID-19 pandemic. It has profoundly affected livelihoods around the globe, disrupting global education, throwing millions back



into extreme poverty, increasing humanitarian needs and fuelling conflicts. It marked the worst economic downturn since the great depression.

In this fragile context, I would like to highlight a few points.

First, we need a more robust response to facilitate equitable and affordable access to vaccines to fight the virus in the world's most vulnerable infrastructure, guided by humanitarian principles, as well as by inclusivity, gender, community engagement principles and, of course, by equity.

The poorest and most conflict-affected humanitarian response plan countries received the fewest doses. Reports from the Office for the Coordination of Humanitarian Affairs show that, while we count 28 humanitarian response plan countries today, more than one-third of them — including Yemen, the Democratic Republic of the Congo, Haiti, South Sudan, Cameroon, Burundi and Mali — have hardly vaccinated 3 to 10 per cent of their population. Let us not forget, as the briefers rightly recalled, there is not only a question of availability and access, but also of misinformation and vaccine hesitancy.

Secondly, we believe that the Access to COVID-19 Tools Accelerator (ACT-A) is a powerful and truly multilateral tool to deliver vaccines equally through the COVID-19 Vaccine Global Access (COVAX) Facility. Fully funding the ACT-A is of vital importance, and we welcome the efforts of all countries that have donated so far to the COVAX Facility. We urge every vaccine donor to increase supplies for developing countries and congratulate Germany on co-hosting the 2022 Gavi Alliance COVAX Advance Market Commitment Summit and for pledging additional funding for COVID-19 vaccination in lower-income countries.

Thirdly, the role of United Nations country teams, peacekeeping and special political missions in trying to support the vaccination process has proven to be of crucial importance, not only in contributing to the maintenance of international peace and security, but also in assisting local authorities and health facilities in addressing the pandemic and its consequences.

Lastly, the Security Council should spare no efforts in calling upon all parties to armed conflicts to stop their hostilities and engage immediately in a durable humanitarian solution.

The implementation of resolutions 2532 (2020) and 2565 (2021) should have our attention in each country situation file and humanitarian crisis considerations, as they are important resolutions that enjoy consensus and constitute a good solid basis to further build upon.

**Mr. Gómez Robledo Verduzco** (Mexico) (*spoke in Spanish*): Mexico thanks Mr. Ted Chaiban, Ms. Esperanza Martinez and Mr. Emmanuel Ojwang for their briefings. We also welcome to the Security Council Minister Al Amiri of the United Arab Emirates.

Mexico believes that the Security Council's monitoring of the implementation of resolutions 2532 (2020) and 2565 (2021, on the impact of the coronavirus disease (COVID-19) pandemic on the maintenance of international peace and security, and the initiative of the United Kingdom to that end, are particularly commendable and timely.

The devastating and multidimensional consequences of the pandemic and the unacceptable inequality that has prevailed in access to vaccines, exacerbated in countries in conflict and post-conflict and that are facing humanitarian crises, must be clearly denounced. The emergence of new variants and the onset of other armed conflicts have also stood in the way of the global efforts to address this health crises in a united and systemic manner.

Regrettably, the call for a general and immediate cessation of hostilities in the context of the pandemic has clearly been ignored. The armed conflict in Ukraine is not the only instance where peace has broken down. Hostilities continue in the Democratic Republic of the Congo, Syria, Mali and Ethiopia, to name but a few examples.

Fortunately, progress in science has made it possible to develop effective vaccines against the virus in record time, and it must be recognized there has been some progress in their availability. However, the situation in many of the countries whose situations we periodically review in the Council is discouraging. Although there are sufficient supplies to vaccinate the entire adult population of our planet, Haiti has received only enough doses to cover 3 per cent of its population and even less than that percentage has been distributed; the Democratic Republic of the Congo and Yemen have received only 4 per cent; and Mali and South Sudan only 8 per cent. Those figures are a testament to the unacceptable inequality that prevails.

To achieve a more equitable distribution of vaccines, Mexico considers two criteria to be essential.

First, intellectual property rights should be temporarily suspended in situations such as that of this pandemic, as provided for in the regulations of the World Trade Organization. Secondly, there must be universal recognition of all those vaccines that have already been approved by the World Health Organization, as we have continued to say in the Group of 20, among other forums. Politically motivated stigmatization of vaccines is simply abhorrent. The commitment and unity of Council members on those issues are critical to strengthening genuinely effective action by the United Nations and to mitigating the devastation brought on by the pandemic in conflict situations.

With better coordinated work, the country teams on the ground and the COVAX humanitarian buffer, health workers in countries that are lagging behind can be trained and the population's trust in the effectiveness of the vaccines can be enhanced. All the identified challenges in the distribution and administration of the vaccines can be overcome. Mexico therefore believes that the resolutions we are considering today have been a step in the right direction, as was General Assembly resolution 74/274, which Mexico promoted in the General Assembly in April 2020. However, we must make the provisions a reality so that people affected by conflicts benefit from what is and should be a truly global public good. That is what vaccines should be, especially in a pandemic.

Mexico has contributed to the global effort through the COVAX platform and has donated 1.1 million vaccines to six countries in Latin America and the Caribbean: Paraguay, Belize, Bolivia, Jamaica, Guatemala, El Salvador and Honduras. In an effort of solidarity and cooperation, which is even more necessary today if we have retained any universal conscience.

**Mr. Biang** (Gabon) (*spoke in French*): I thank Mr. Ted Chaiban, Ms. Martinez and Mr. Ojwang for their briefings.

Since its emergence in 2019, the coronavirus disease (COVID-19) has proven to be a formidable enemy that has challenged many of our certainties, our resilience to many challenges and our ability to predict and combat them effectively.

At the height of the crisis, recognizing the extent of the threat, two years ago the Secretary-General launched a global call for an immediate ceasefire around the world in order to focus together on the real fight: defeating COVID-19.

Resolutions 2532 (2020) and 2565 (2021) give concrete expression to and amplify that appeal. They call for an immediate cessation of hostilities by parties to conflict and for the strengthening of national and multilateral efforts and cooperation to ensure equitable access to vaccines in situations of armed conflict, post-conflict situations and complex humanitarian emergencies. Two years after the emergence of COVID-19, it is important to take stock of the implementation of those resolutions and to assess how to improve their effectiveness.

In terms of health, the results remains mixed. The moral principle of vaccines as a global common, underpinning the multilateral drive for equitable access for all, is struggling to stand up to the test of reality, nationalism and the good practices of multinationals.

As for the security situation, it is hardly more encouraging. The humanitarian ceasefire called for by the Security Council has not been observed. In several areas of conflict, the weapons have not been silenced. The situation has even deteriorated due to new hostilities, in addition to chronic conflicts, particularly in Africa and the Middle East. All that is compounded by ongoing terrorist acts.

On the humanitarian front, the needs remain as great as the obstacles to humanitarian aid. Famine and disease, exacerbated by the COVID-19 pandemic and internal and cross-border population displacements, resulting in increasing numbers of displaced persons and refugees, increase and, at the same time, complicate humanitarian needs and the conditions and means of response of humanitarian personnel.

Despite the joint efforts of the mechanisms set up for equitable access to vaccines, in particular the COVID-19 Vaccine Global Access (COVAX) Facility, the evidence is overwhelming. A small percentage of people in developing countries have been vaccinated, and even fewer in areas of armed conflict, as compared to a little over 70 per cent in developed countries. It is clear that the implementation of the envisioned mechanisms is particularly complex in conflict situations, especially where there is no humanitarian ceasefire. In order to fulfil their mandate, humanitarian

personnel must be able to depend on the guarantees provided for in the Geneva Conventions of 1949 and their Additional Protocols. Similarly, the safety of civilians must be ensured.

Let me turn to two concerns regarding the response to challenges posed by the pandemic.

First, multilateral mechanisms must be deployed in areas of armed conflict in a cooperative approach that builds on regional and subregional mechanisms. In the case of Africa, for example, the African Vaccine Acquisition Task Team of the African Union (AU), the AU Special Envoys for COVID-19 and the African Centres for Disease Control and Prevention must be engaged in effective partnerships.

Secondly, in terms of deployment on the ground, it is essential to consider and prioritize a community-based approach in order to overcome certain constraints, particularly social ones. We know that the low coverage in countries of the South is due to various factors, including reluctance and vaccine scepticism. In order to reach populations in remote rural areas or those afraid of the unknown, it may be helpful to draw on community networks to build the necessary trust in such situations.

The issue of vaccine equity cannot be resolved in a sustainable way without recourse to local production, making it possible to deal with logistical constraints, avoid stock-outs and prevent distribution problems.

In that regard, we welcome the recent announcement by the Director-General of the World Health Organization regarding the establishment of a vaccine production programme on the African continent. The implementation of such a programme should clearly be supported by robust international measures, such as a moratorium on Trade-Related Aspects of Intellectual Property Rights within the World Trade Organization. Such a moratorium would send a strong message regarding our ability to meet the challenges posed by the COVID-19 pandemic and mitigate threats to international security.

In conclusion, I would like to once again call for increased international cooperation and a greater commitment by the international community to overcoming this terrible pandemic and its impact on our collective security.

**Mr, Ragutthalli** (India): Let me begin by thanking Mr. Ted Chaiban, Ms. Esperanza Martinez

and Mr. Emmanuel Ojwang for their detailed briefings. I would also like to compliment the United Kingdom presidency on taking the initiative on this important theme.

In the past two years, we have seen a global effort to overcome the challenges caused by the pandemic. Several countries have immunized large parts of their populations against the coronavirus disease (COVID-19) and have moved on to the next round of booster dosage. However, much of the developing world is yet to be vaccinated. The vaccination levels of populations in countries facing conflict situations are even lower. The irony is that, while we made significant progress in developing newer vaccines against COVID-19, as well as in their production, the issues of vaccine equity, access, distribution and administration remain to be addressed.

The lack of coordination in vaccine distribution, as well as a lack of sufficient capacity to administer vaccines, has adversely affected vaccination initiatives in countries facing armed conflict and post-conflict situations. It has impacted underdeveloped countries the hardest. We must scale up our efforts to expedite the delivery of safe and affordable COVID-19 vaccines to such population centres.

The COVID-19 crisis has demonstrated the need to improve public health infrastructure for last-mile delivery, especially in regions where the health infrastructure is weak. We need to find ways to ensure vaccine delivery in such areas affected by conflict and post-conflict situations, which are not adequately served by a health infrastructure. We also need to work on tackling vaccine hesitancy by evolving contextualized, curated and empathetic strategies to relay scientific and accurate information to the people. With the resurgence in COVID-19 cases and an increase in the number of variants of concern, it is of paramount importance that international collaboration on genomic surveillance be encouraged to track virus mutations and exchange information on a regular basis and in a timely manner.

It is a matter of concern that the acceleration of vaccination drives against COVID-19 has seen a reduction in the vaccination of children against other diseases. We need to ensure that any slackening of other vaccinations is reversed to ensure a sustainable health recovery from the pandemic.

In line with our One Earth, One Health vision, India has been instrumental in saving innumerable lives by

providing timely and necessary medicines and vaccines to many countries. India's own vaccination efforts have strengthened the global fight against COVID-19.

Following the emergence of the COVID-19 pandemic, India played its due part by supplying made-in-India vaccines, essential life-saving medicines and medical equipment to the entire global South. India has supported more than 150 countries through the supply of essential medicines and medical accessories since the outbreak of the COVID-19 pandemic, and we continue to support countries in need.

India is also ready to explore expanding its domestic vaccine production capacity for a dedicated supply to partner countries in the future as part of our vision for vaccines for tomorrow. Further, in order to convert vaccines into vaccinations, countries need robust capabilities in critical sectors, including information technology tools, such as our CoWIN application, cold chain expansion and training and capacity-building for health-care workers in vaccine administration. India would be happy to partner with other countries to assist in those important areas as well.

Our scientific community, along with the support of a robust pharmaceutical industry, has been successful in developing and producing safe, effective and affordable vaccines, including the world's first DNA-based vaccine. More than 170 million doses of made-in-India vaccines have reached 96 countries and United Nations entities, including 41 million doses to 48 countries through the COVID-19 Vaccine Global Access Facility and 14 million doses to 48 countries and United Nations peacekeepers as bilateral donations. We have also assisted several countries in building their capacities to administer the vaccines through customized training programmes. We also upgraded two peacekeeping hospitals in Goma, in the Democratic Republic of the Congo, and Juba, in South Sudan, respectively, right at the onset of the pandemic.

It is a matter of deep concern that, even while the Security Council has called for a humanitarian pause in hostilities, terrorists and other non-State actors have only taken advantage of the pandemic by increasing their nefarious activities. Terrorists have made attempts to exploit the financial and emotional distress caused by pandemic-related lockdowns to weaken the cohesiveness of societies. The increased use of digital platforms during the pandemic has, unfortunately,

made people more vulnerable to radicalization and recruitment by terrorist groups.

As the current data on COVID-19 cases demonstrate, we are still far from a post-pandemic world. That means that we must continue to work together to find innovative, affordable and safe solutions to counter the virus. To ensure continued supplies of vaccines, we need to ramp up our manufacturing capacities, both qualitatively and quantitatively, and keep the global supply chain for raw materials open and uninterrupted. India has been strongly advocating for the principle of equity in the World Health Organization and has also proposed, along with South Africa, a waiver on the Agreement on Trade-Related Aspects of Intellectual Property Rights at the World Trade Organization for COVID-19 vaccines, diagnostics and medicines.

In conclusion, India stands ready to work with the global community to build adequately funded robust health systems, strengthen preparedness and ensure equitable access to vaccines.

**Mr. Kiboino** (Kenya): I would like to commend the United Kingdom for convening this meeting and acknowledge its leading role in the adoption of the landmark resolutions 2532 (2020) and 2565 (2021). I thank Mr. Ted Chaiban, Ms. Esperanza Martinez and Mr. Emmanuel Ojwang for their informative briefings and reflections.

In its capacity as the informal coordinator between the Council and the Peacebuilding Commission (PBC), Kenya would like to draw the Council's attention to the written advisory reflecting the pertinent work of the PBC in advocating for vaccine equity, availability and access in countries affected by conflicts to ensure an inclusive and sustainable recovery.

The dire effects of the coronavirus disease (COVID-19) globally and in conflict-riddled countries in particular are staggering. It has strained humanitarian aid flows; it has exposed vulnerable groups, particularly women and children, to further risks; it has undermined peace processes and peacebuilding efforts; and it has eroded critical development gains made by countries in transition or undergoing post-conflict reconstruction.

But if the multilateral machinery had been activated swiftly and effectively, we believe that the colossal impact of the pandemic could have been avoided. Instead, the pandemic exposed the fickle commitment to multilateralism and a false sense of

autonomy, resulting in a series of knee-jerk reactions that allowed the pandemic space and time to surge, including through new, rapidly spreading variants.

The yawning gap in vaccination rates between the North and the Global South is a clear manifestation of the failure of multilateralism. That is a cause for concern in relation not only to the pandemic, but also other global threats. Even as the pandemic shows signs of easing, we must not relent in our joint efforts to fight it. We must learn from the painful lesson it has taught us that no one is safe until everyone is safe.

COVID-19 is potentially a harbinger of future and possibly more potent pandemics that would further threaten international peace and security. We must continue to deal with the lack of equitable access to vaccines, poor distribution infrastructure and vaccine hesitancy through multipronged approaches. I will highlight four points in that regard.

First, to combat the pandemic, in particular in developing and conflict-afflicted countries, it is critical that we build long-term resilience in data, vaccine and testing infrastructure and provide greater institutional strength to withstand future COVID-19 waves and other pandemics.

Secondly, with a paltry 1 per cent or less of all vaccines used in Africa being produced locally, we must move from discretionary bilateral aid to strategic investment in local vaccine production. In that regard, Kenya recently signed a memorandum of understanding with Moderna for the establishment of a vaccine and related drug-manufacturing facility in the country.

Thirdly, the Security Council can, in collaboration with other United Nations agencies, encourage peacekeeping missions to enhance mediation between parties to armed conflicts to facilitate the COVID-19 response, including vaccination in situations of armed conflict. In their ordinary reporting to the Council, those missions can identify barriers to accessibility and those disrupting or blocking vaccine supply and distribution infrastructure.

Fourthly, in view of the challenging circumstances in armed conflict situations, the Security Council should reiterate its demands that all parties to armed conflicts engage immediately in a durable, extensive and sustained humanitarian pause to facilitate, inter alia, the equitable, safe and unhindered delivery

and distribution of COVID-19 vaccines in areas of armed conflict.

In conclusion, we reiterate our call for collaborative, human-sensitive action and solidarity. In that regard, we applaud the concerted continental and regional actions taken by the African Union, including through the African Medicines Agency, which is tasked with enhancing regulatory oversight across the continent and availing access to quality, safe and efficacious medicines.

**Mr. Flynn** (Ireland): I thank the briefers for providing us with updated analyses and insights on the scale of the challenge remaining on the implementation of measures related to the coronavirus disease (COVID-19) in fragile and conflict-affected contexts.

We remain firmly of the opinion that no one is safe from COVID-19 until all of us are safe. Commendable progress has been made towards the World Health Organization (WHO) target of a global vaccination rate of 70 per cent by mid-2022, but significant and persistent gaps in coverage remain. That is a risk we cannot afford to ignore. Addressing very low vaccination rates in conflict or post-conflict contexts must be prioritized and flexible, creative solutions must be applied.

The creation of the COVID-19 Vaccine Global Access (COVAX) Facility humanitarian buffer was a positive move, and COVAX has indeed been responsible for the delivery of significant volumes of vaccine doses to countries such as the Democratic Republic of the Congo, Afghanistan, Yemen and Ethiopia. COVAX is to be commended for its continued ability to adapt and respond to evolving needs, and I welcome the current strategy's emphasis on delivery, including but not limited to humanitarian and fragile contexts. Access needs to be prioritized for humanitarian actors, including the WHO, UNICEF and the International Committee of the Red Cross, and various civil society actors with the relevant expertise to ensure that the doses available can make it into the arms of those who need them.

In recent months and in general, the international community has responded well to the call for dose sharing. However, the challenge we face in 2022 goes far beyond tackling supply issues. We need to restore, rebuild and supplement health-care systems. In particular, we will need to concentrate on capacities for logistics, transport and health service delivery.

Those need to be enhanced rapidly and at scale in fragile settings.

International humanitarian law requires that parties to armed conflict protect medical personnel so that they can administer vaccinations and provide medical care without discrimination to the wounded, the needy and the sick. As of 8 April, WHO had reported 160 attacks on health-care facilities, workers and transport globally in 2022, including more than 100 attacks in Ukraine.

We must condemn in the strongest possible terms any and all incidents in which health-care workers or health-care facilities are targeted by any party to a conflict. The Council must continue to ensure the implementation of resolution 2565 (2021), and we welcome this opportunity to take stock of the progress made to date and the many challenges that remain on the ground.

It is in all of our interests to ensure that as many people as possible are safely vaccinated against this all-too-easily transmissible disease, which continues to pose a grave threat to lives, health and well-being worldwide. We supported the Secretary-General's call for a global ceasefire at the onset of the pandemic, and we reiterate that support now.

Ireland has always promoted the importance and necessity of equitable access to vaccines, and I reaffirm our commitment to that today. Alongside strengthening the capacities of health-care systems to deliver vaccinations and other essential health services, we must tackle the wealth of misinformation that has been allowed to build up around vaccines, which, as we have heard here today, is hampering the efforts of

health-care and humanitarian workers to prevent and treat COVID-19 cases.

It is imperative that we refocus our efforts on meeting the WHO target of 70 per cent global vaccination this year, lest we find ourselves once again debating the best countermeasures to be taken against a more aggressive variant of COVID-19. In order to do that, we must strengthen health systems and accelerate our work in conflict, post-conflict and humanitarian settings.

**The President:** The representative of the Russian Federation asked earlier how indemnity challenges hindered the operationalization of the humanitarian buffer. I give the floor to Mr. Chaiban to respond to that question.

**Mr. Chaiban:** In terms of the humanitarian buffer, the issue of liability and indemnity is key. We need now to recognize that there is a different situation than when we started the whole vaccination effort with billions of doses having been administered. We therefore have much more of a track record when it comes to adverse effects. That then requires an evolution in the discussion around indemnity and liability and a look, first, at steps that can be taken for the full approval of vaccines and, secondly, different insurance instruments that can be used to cover any remaining concerns about indemnity and liability. The discussion concerning the buffer is looking into those different options.

**The President:** I would like to conclude by acknowledging the advice on coronavirus disease vaccination provided to the Security Council by the Peacebuilding Commission and to thank its members for their interest in doing so.

*The meeting rose at 5.05 p.m.*