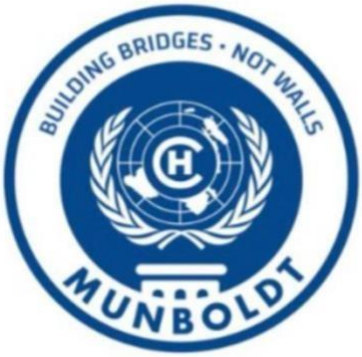
World Health Organization

(WHO)



Government Authority to Enforce Vaccinations During Public Health Emergencies

President: Katia Bouchan Guillan

Moderator: Ana Sofía Lozada Ortega

Secretary: Heidi Scheinmann Hinterholzer

INDEX

INTRODUCTION

The World Health Organization (WHO) was established on 7 April 1948, when its Constitution entered into force as part of the United Nations system. The organization was created to serve as the directing and coordinating authority on international public health and to support countries in achieving the highest possible standard of health for their populations.

Since its creation, the World Health Organization (WHO) has played a central role in combating infectious diseases, promoting vaccination programs, and strengthening national health systems. Today, the organization works with 194 Member States through its main governing bodies, including the World Health Assembly, the Executive Board, and the Secretariat.

One of the World Health Organizations (WHO) most important responsibilities is to provide technical guidance and coordinate global responses during disease outbreaks and other health emergencies. Under the International Health Regulations (2005), the World Health Organization (WHO) may declare a Public Health Emergency of International Concern (PHEIC) when an extraordinary event poses a risk to multiple countries and requires a coordinated international response. In such situations, vaccination often becomes a key strategy to prevent the spread of disease and protect vulnerable populations. Therefore, the debate regarding government authority to enforce vaccinations during public health emergencies is highly relevant to the World Health Organizations (WHO) mandate. The issue raises important questions about how states can protect public health effectively while also respecting human rights, national sovereignty, and public trust in health institutions.

In the context of public health emergencies, vaccination policies have become an increasingly important tool for governments seeking to control the spread of infectious diseases. The World Health Organization (WHO) has consistently emphasized that immunization is one of the most effective and cost-efficient public health interventions available. However, the question of whether governments should have the authority to enforce mandatory vaccination remains complex and sensitive. While some states argue that mandates are necessary to protect population health and prevent health system collapse, others stress the importance of respecting individual autonomy, informed consent, and cultural or religious considerations. For this reason, the World Health Organization (WHO) promotes a risk-based and proportionate approach, encouraging member states to adopt measures that are scientifically justified, legally sound and socially acceptable.

At the broader level, the United Nations (UN) system has also recognized the critical role of vaccination in achieving global health security, and advancing the Sustainable Development Goals, particularly SDG 3 on good health and well-being. Through international cooperation, funding mechanisms and technical guidance, United Nations (UN) bodies have supported large-scale immunization campaigns and pandemic preparedness efforts worldwide.

Nevertheless, recent global health crises, especially the COVID-19 pandemic, have revealed significant disagreements among states regarding the limits of government authority during emergencies. Differences in legal frameworks, levels of public trust, and vaccine access have created uneven responses across regions. As future outbreaks remain likely, the international community faces the urgent challenge of clarifying how governments can protect public health effectively while maintaining human rights standards and public confidence in vaccination programs.

The tension between government authority and individual rights in the context of vaccination is not a new debate. It has existed for as long as vaccines themselves have been available to the public. The first significant conflict arose in the 19th century, when several governments began introducing compulsory smallpox vaccination laws.

This is a very relevant topic because infectious diseases do not stop at national borders. In a globalized world where millions of people cross international borders every day for trade, tourism, and migration, a disease outbreak in one country can become a global threat within a matter of weeks. This was demonstrated clearly during the COVID-19 pandemic, which spread to every corner of the world in a short period of time.

HISTORY OF THE PROBLEM

Governments exist, among other reasons, to protect the welfare of their populations. When a dangerous infectious disease threatens the lives of large numbers of people, governments face an urgent responsibility to act. Vaccination is widely recognized by the scientific community as one of the most effective tools available to control the spread of infectious diseases, reduce mortality, and prevent health systems from being overwhelmed.

Some public health experts argue that insufficient vaccination coverage may hinder a government's ability to fully protect population health. Proponents of vaccination enforcement argue that in situations of genuine public health emergencies, the state is not only permitted but obligated to implement measures that ensure the protection of its citizens, even when those measures restrict certain individual freedoms.

Mandatory vaccination, particularly when enforced through penalties, legal consequences, or physical compulsion, represents a direct interference with one of the most intimate spheres of individual freedom. Critics of enforcement measures argue that no matter how serious a public health emergency may be, the state does not have unlimited authority to override the bodily integrity of its citizens.

The conflict took its first formal legal shape in England in 1853, when the British Parliament passed the Vaccination Act, making smallpox vaccination compulsory for all infants within the first three months of life. Parents who refused to comply faced financial penalties. This was the first time in modern history that a government had legislated mandatory vaccination, and the public reaction was immediate and fierce.

One of the most powerful forces behind the escalation of this conflict has been globalization. As international travel, trade, and migration expanded dramatically throughout the late 20th and early 21st centuries, the speed at which infectious diseases could spread across borders increased proportionally. The single most important factor in the escalation of this conflict in recent history was the COVID-19 pandemic. When the World Health Organization (WHO) declared COVID-19 a pandemic in March 2020, governments around the world were confronted with the most serious public health emergency in a century. The vaccines were developed and authorized for use in a fraction of the time normally required for vaccine approval. This achievement generated legitimate concerns among portions of the public about whether the vaccines had been adequately tested. Governments that chose to mandate vaccines authorized under emergency use conditions faced particularly intense opposition, as critics

argued that compelling citizens to receive a vaccine whose long-term effects were not yet fully understood represented an unacceptable overreach of state authority. The Republic of Austria became the first country in the world to introduce a nationwide mandatory vaccination law in February 2022, imposing fines on unvaccinated adults.

The COVID-19 pandemic represented the most acute expression of this conflict in modern history, but its formal end has not resolved the underlying tensions. Most countries that implemented mandatory vaccination policies during the pandemic have since repealed them. Despite the retreat from emergency measures, vaccination coverage in numerous countries remains below the levels required for robust protection against future outbreaks.

The most immediate human rights concern raised by mandatory vaccination is the violation of bodily autonomy, the right of every individual to make decisions about their own body free from coercion. This right is recognized under Article 3 of the Universal Declaration of Human Rights (UDHR), which guarantees the right to personal liberty and security, and is further reinforced by the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

When a government compels an individual to receive a medical intervention against their will, whether through direct physical enforcement or through penalties severe enough to eliminate meaningful choice, it interferes directly with this right. The fact that the intervention is medically beneficial does not extinguish the rights violation, as international human rights law is unambiguous that informed consent is a prerequisite for any medical procedure. The Nuremberg Code of 1947, established in direct response to the medical atrocities of the Second World War, enshrined the principle of voluntary informed consent as an absolute requirement in medical practice, a principle that remains foundational to international medical ethics.

Article 3 of the Universal Declaration of Human Rights (UDHR) and Article 6 of the International Covenant on Civil and Political Rights (ICCPR) recognize the right to life as the most fundamental of all human rights. This right imposes on governments not only a negative obligation to refrain from taking life, but a positive obligation to take reasonable measures to protect the lives of those under their jurisdiction.

When a government fails to implement sufficient vaccination measures during a public health emergency, and as a result, preventable deaths occur among its population, it can be argued that the state has failed in its most basic human rights obligation.

The international legal framework has long acknowledged the dual nature of state obligations in matters of public health. The International Health Regulations of 2005 explicitly recognize that states must balance the protection of individual rights with the collective need to prevent the international spread of disease. Article 3 of the International Health Regulations (IHR) establishes that its implementation shall be guided by the principles of the Charter of the United Nations and the Constitution of the World Health Organization (WHO), with full respect for the dignity, human rights, and fundamental freedoms of persons.

The World Health Organization (WHO) estimates that vaccines currently prevent between 3.5 and 5 million deaths annually, and that COVID-19 vaccines alone prevented approximately 20 million deaths in their first year of deployment, illustrating the direct human cost of insufficient immunization coverage.

Across numerous democracies, governments invoked emergency powers to implement vaccination mandates, passport systems, and employment restrictions through executive decree rather than ordinary legislative processes, bypassing parliamentary oversight and weakening the institutional checks and balances upon which democratic governance depends. The perceived influence of political considerations on health policy decisions produced significant erosion of public trust in democratic institutions that persisted well beyond the immediate emergency.

The historical trajectory of vaccination enforcement cannot be fully understood without acknowledging several developments that further shaped the international legal and political landscape surrounding this conflict. The landmark United States Supreme Court ruling in Jacobson v. Massachusetts (1905) established one of the earliest and most cited legal precedents in this area, affirming that state authority to enforce vaccination during a public health emergency could be compatible with constitutional protections of individual liberty, provided that enforcement measures were reasonable and proportionate. The eradication of smallpox in 1980, achieved through an extensive international vaccination campaign coordinated by the World Health Organization (WHO), demonstrated that largescale immunization efforts could achieve outcomes of global significance, while also revealing the considerable political and logistical complexity that such campaigns inevitably generate. The Declaration of Alma-Ata in 1978 represented an important moment in the internationalization of health as a human right, establishing the principle that governments bear a fundamental responsibility for the health of their populations and laying important groundwork for future debates about vaccination

obligation. The HIV/AIDS crisis of the 1980s and 1990s significantly reshaped the relationship between public health governance and human rights, as the international response to the epidemic helped establish important precedents regarding informed consent, non-discrimination, and the limits of state authority in compelling medical interventions. The subsequent integration of human rights frameworks into public health governance marked a meaningful shift in how the international community understood the relationship between state authority and individual dignity in matters of health, a shift whose consequences continue to define the terms of the current conflict.

Taken together, these historical developments illustrate that the debate over vaccination enforcement has consistently revolved around the need to balance effective public health protection with respect for individual autonomy and human rights. While large-scale immunization campaigns have demonstrated their capacity to control and even eliminate life-threatening diseases, they have also highlighted the legal, ethical, and political sensitivities associated with state intervention in personal medical decisions. As global mobility and the risk of future pandemics continue to increase, the challenge of defining the appropriate scope of government authority in vaccination policy remains unresolved and highly relevant for the international community.

CURRENT HAPPENINGS

The most significant development currently unfolding is the negotiation of the World Health Organization Pandemic Agreement, which, as of 2024, remains under active discussion among member states. The agreement seeks to establish binding international commitments governing the response to future pandemics, including provisions on vaccine development, equitable distribution, and the responsibilities of member states during declared health emergencies.

Simultaneously, the mpox outbreak, declared a Public Health Emergency of International Concern by the World Health Organization (WHO) in August 2024, has renewed urgent discussions about the capacity of the international community to coordinate vaccination responses to emerging infectious diseases. The outbreak, which has disproportionately affected the Democratic Republic of the Congo and several neighboring states in Central and Eastern Africa, has once again exposed the deep inequalities in global vaccine access, as affected nations faced significant delays in receiving adequate vaccine supplies while wealthier countries secured doses with considerably greater ease.

Several European states are reviewing their legal frameworks for health emergency powers following the controversies generated by COVID-19 enforcement measures, seeking to establish clearer legislative boundaries for future government action. In the United States of America, ongoing legal and political disputes about the constitutional limits of federal and state vaccination authority remain unresolved, reflecting the broader polarization that the COVID-19 pandemic entrenched in that country's political landscape.

The World Health Organization (WHO) and the United Nations (UN) Children's Fund reported in 2023 that approximately 66 million children missed routine vaccinations between 2019 and 2021 as a consequence of pandemic disruptions, representing the largest sustained decline in childhood immunization coverage in approximately thirty years.

The most immediate and measurable impact of this conflict on the global population is expressed in preventable deaths and illnesses resulting from insufficient vaccination coverage. The World Health Organization (WHO) estimates that vaccine-preventable diseases currently kill between 3.5 and 5 million people annually, a figure that reflects the cumulative consequence of coverage gaps, access barriers, and enforcement failures across the international system. During the COVID-19 pandemic, the uneven global distribution of

vaccines and the political controversies surrounding enforcement measures contributed directly to prolonged transmission and elevated mortality in numerous countries.

The economic impact of insufficient vaccination coverage during the COVID-19 pandemic fell most heavily on the populations least equipped to absorb it. The World Bank estimated that the pandemic pushed between 88 and 115 million people into extreme poverty in 2020 alone, reversing years of progress in global poverty reduction.

The most fundamental humanitarian violation currently being generated by this conflict is the preventable loss of human life on a massive scale. When governments fail to achieve adequate vaccination coverage, whether through insufficient enforcement, inadequate access mechanisms, or the absence of a coherent vaccination policy, the direct consequence is preventable mortality among populations that existing vaccines could protect.

The erosion of public trust in health institutions generated by this conflict is currently producing humanitarian consequences that extend beyond the specific question of vaccination. Populations that have lost confidence in government health authorities are less likely to seek medical care, less likely to participate in disease surveillance programs, and less likely to comply with public health guidance during future emergencies. This breakdown in the relationship between populations and health institutions represents a form of humanitarian harm whose full consequences will only become apparent when the next major public health emergency tests the capacity of the international community to respond effectively, and finds that the social foundation necessary for that response has been significantly weakened by the unresolved conflicts of the present moment.

The implementation of vaccine mandates and enforcement mechanisms has also generated significant economic impacts. In several countries, the dismissal or suspension of workers who refused vaccination created short-term labor shortages in critical sectors, including healthcare, education, and public services. In the United States of America, the dismissal of hundreds of military personnel and healthcare workers for refusing vaccination generated considerable economic disruption, as the costs of replacing experienced workers in highly specialized roles significantly exceeded the costs that would have been incurred by retaining them.

Among the most widely implemented enforcement mechanisms have been employment-based sanctions, under which individuals who refused vaccination faced suspension, termination, or exclusion from certain professional sectors. In the French Republic, the Italian Republic, and

the Federal Republic of Germany, healthcare workers who declined vaccination against COVID-19 were suspended from their positions without pay or dismissed entirely.

Several nations imposed particularly stringent vaccination requirements on their military and security personnel, with non-compliance resulting in discharge or disciplinary proceedings.

While the World Health Organization (WHO) does not possess the authority to impose legally binding sanctions on member states, its formal recommendations during declared Public Health Emergencies of International Concern carry significant practical consequences for non-compliant nations. Countries that fail to implement World Health Organization (WHO) recommended vaccination measures may face travel advisories, restrictions on international trade, and reputational consequences that affect their relationships with other member states and international financial institutions. During the COVID-19 pandemic, the World Health Organization's (WHO) recommendations regarding vaccination formed the basis upon which numerous countries imposed travel restrictions on nations with low vaccination coverage, effectively creating an informal system of international consequences for insufficient immunization programs.

The conflict surrounding vaccination enforcement during public health emergencies has increasingly been recognized as a genuine threat to international security and peace. In fragile states, the collapse of health systems under the pressure of uncontrolled disease transmission has historically produced state fragility, mass displacement, and the erosion of governmental authority with destabilizing consequences that extend across borders. Simultaneously, the weaponization of vaccines as instruments of geopolitical rivalry between major powers, most notably the United States of America, the People's Republic of China, and the Russian Federation, introduced strategic competition into what should have been a purely humanitarian effort, fracturing international cooperation and deepening the inequities that prolonged the pandemic.

The most fundamental obstacle to resolution is the tension between national sovereignty and the demands of effective global health governance. Under the current international legal order, each state retains the sovereign right to determine its own domestic health policies, including decisions about vaccination enforcement. While the International Health Regulations and other international instruments create certain obligations for member states, they lack effective enforcement mechanisms capable of compelling compliance from governments unwilling to implement recommended measures.

Closely related to the sovereignty barrier is the absence of a binding international legal framework specifically governing vaccination enforcement during public health emergencies. The existing body of international health law, centered on the International Health Regulations, provides general guidance but lacks the specificity, enforceability, and comprehensiveness necessary to govern the full range of legal, ethical, and practical questions that arise during a major vaccination campaign. In the absence of such a framework, governments are left to make enforcement decisions based on their own domestic legal systems, political calculations, and interpretations of international obligations, producing the fragmented and inconsistent global response that has characterized successive health emergencies.

At the deepest level, the conflict resists resolution because it reflects a genuine ethical impasse between principles that are each fundamental to the international human rights framework. The right to bodily autonomy and the right to health are both recognized under international law, and they point in opposing directions on the question of vaccination enforcement. Neither principle can be simply dismissed or subordinated to the other without violating the integrity of the human rights framework as a whole.

The most fundamental requirement for resolution is the development of a comprehensive and binding international legal framework specifically governing vaccination policy during public health emergencies.

Such a framework must accomplish several objectives simultaneously. It must establish clear and universally accepted criteria for determining when a public health emergency justifies the implementation of enhanced vaccination measures. It must define the boundaries within which governments may exercise enforcement authority in a manner compatible with international human rights obligations. It must create effective accountability mechanisms capable of ensuring that member states fulfill their commitments. And it must establish durable mechanisms for ensuring equitable access to vaccines as a prerequisite for any enforcement obligation, so that the framework is perceived as genuinely universal rather than as an imposition of obligations on lower-income nations by wealthier ones.

INTERNATIONAL ACTIONS

United Nations

- General Assembly: The United Nations General Assembly has spoken out on the failures of equitable vaccine distribution and the human rights implications of vaccination enforcement. It has proposed resolutions, including Resolution 74/274 in 2020 and Resolution 76/176 in 2021, debated the structural barriers preventing lowerincome nations from accessing vaccines, and called on member states to support COVAX, promote technology transfer, and ensure that intellectual property protections do not impede equitable access to life-saving vaccines.

- Security Council: The United Nations Security Council adopted Resolution 2532 in July 2020, acknowledging the intersection between armed conflict and public health emergency response.

- United Nations High Commissioner for Human Rights: The Office of the United Nations High Commissioner for Human Rights issued formal guidance establishing the human rights framework within which vaccination policies must operate, condemning enforcement measures that failed to meet standards of legality, necessity, and proportionality, and formally characterizing the failure to ensure equitable vaccine distribution as a violation of the international human rights obligations of wealthy nations.

- World Trade Organization: The World Trade Organization (WTO) served as the arena in which the intellectual property dimensions of this conflict were negotiated, ultimately producing a ministerial decision in June 2022 providing a limited waiver of patent protections on COVID-19 vaccines for developing country members, representing the first concrete multilateral action to address the structural barriers to vaccine equity.

- World Bank: The World Bank committed approximately $157 billion through its COVID-19 Crisis Response Approach between 2020 and 2022, financing

vaccination programs in lower-income countries, while the International Monetary Fund (IMF) provided emergency financing to over 90 countries and published influential analysis demonstrating that a $50 billion investment in global vaccination could generate approximately $9 trillion in economic returns, strengthening the financial case for equitable vaccine access.

- **IGO's**
    - European Union: The European Union, through its European Medicines Agency, coordinated the authorization and procurement of COVID-19 vaccines on behalf of its member states, negotiating advance purchase agreements with multiple manufacturers and developing the EU Digital COVID Certificate as a standardized framework linking freedom of movement to vaccination status. The EU also contributed significantly to COVAX through financial commitments exceeding €3 billion, making it one of the initiative's largest donors.

    - African Union: The African Union established the Africa Vaccine Acquisition Trust in 2021, a concrete institutional mechanism designed to enable African member states to collectively negotiate and procure COVID-19 vaccines independently of the COVAX framework. The initiative secured approximately 400 million vaccine doses for distribution across the continent and represented the most significant assertion of African institutional autonomy in the context of global vaccine procurement, directly responding to the inequities in distribution that had characterized the early phases of the international vaccination effort.

    - Organisation of American States: The Organisation of American States issued formal resolutions calling on member states to ensure non-discriminatory access to vaccines and to refrain from implementing enforcement measures incompatible with the human rights obligations established under the American Convention on Human Rights.

    - Gulf Cooperation Council: The Gulf Cooperation Council coordinated vaccination policy responses among its member states during the COVID-19

pandemic, with several member states, including the United Arab Emirates and the Kingdom of Saudi Arabia, implementing some of the world's most extensive vaccination campaigns and serving as regional distribution hubs for vaccines supplied to neighboring lowerincome nations.

- **NGOs**
    - Doctors Without Borders: Doctors Without Borders was among the most vocal and active non-governmental actors in this conflict. The organization formally demanded that pharmaceutical companies waive intellectual property rights on COVID-19 vaccines, conducted direct vaccination campaigns in conflict zones and underserved regions, and published extensive documentation of the human cost of vaccine inequity in lower-income countries.

    - Oxfam International: Oxfam International conducted sustained advocacy and formal condemnation of vaccine nationalism and pharmaceutical profiteering throughout the COVID-19 pandemic, publishing detailed analyses demonstrating the gap between the public funding that supported vaccine development and the private profits generated by vaccine sales.

    - Amnesty International: Amnesty International documented and formally condemned specific instances of human rights violations related to vaccination enforcement across multiple countries, focusing particularly on discriminatory enforcement practices, the absence of adequate exemption mechanisms, and the disproportionate impact of mandatory vaccination measures on marginalized communities.

    - Human Rights Watch: Human Rights Watch published comprehensive country-bycountry reports documenting human rights concerns related to vaccination enforcement and vaccine access, formally condemning discriminatory practices, coercive enforcement mechanisms, and the failure of the international community to ensure equitable distribution of vaccines to lower-income nations.

- Gavi, the Vaccine Alliance: Gavi, the Vaccine Alliance, while operating in a hybrid capacity between intergovernmental and non-governmental frameworks, contributed directly to the vaccination of over one billion children since its establishment in 2000 through sustained partnerships with national governments, international organizations, and the private sector, representing the most extensive non-governmental contribution to global immunization coverage in history.

POSSIBLE SOLUTIONS

To address the ongoing debate regarding government authority to enforce vaccinations during public health emergencies, the international community may consider adopting a series of coordinated, evidence-based, and human-rights-oriented policy measures.

1. **Conclusion of the WHO Pandemic Agreement:**

   Finalizing the World Health Organization Pandemic Agreement remains one of the most urgent priorities for member states. The instrument should incorporate binding provisions that clarify the circumstances under which vaccination mandates may be considered legally justified, establish the human rights safeguards that must govern any enforcement action, and introduce credible accountability mechanisms to monitor state compliance. At the same time, the agreement must ensure that equitable access to vaccines is treated as a fundamental precondition for any discussion of enforcement obligations.

2. **Creation of a Permanent Vaccine Equity Mechanism:**

   Member states may consider establishing a standing, adequately financed international mechanism dedicated to vaccine procurement and distribution. Building upon the experience of the COVAX initiative, this body should address previous operational shortcomings while remaining insulated from geopolitical pressures. Its governance should be guided primarily by public health needs and supported by sufficient legal authority and predictable funding streams to guarantee timely and equitable vaccine delivery during future emergencies.

3. **Reform of Intellectual Property Rules in Health Emergencies:**

   Within the framework of the World Trade Organization (WTO), governments could negotiate a permanent arrangement governing intellectual property during global health crises. Such a framework might include automatic and time-limited waivers of relevant patent protections once a Public Health Emergency of International Concern is declared. This approach would aim to remove structural barriers that previously hindered equitable access to vaccines and other medical countermeasures during the COVID-19 pandemic.

4. **Strengthening Domestic Legal Frameworks:**

States are encouraged to review and, where necessary, update their national legislation concerning vaccination policy. Clear legal parameters should define when mandatory measures may be introduced, what procedural protections must accompany them, and which exemption pathways are available for individuals with legitimate medical, religious, or philosophical grounds. Robust parliamentary oversight and access to judicial review remain essential to ensure that emergency health powers are applied in a temporary, proportionate, and democratically accountable manner.

5. **Investment in Public Trust and Health System Capacity:**

Rebuilding confidence in public health institutions should be treated as a strategic priority. Governments and international partners may wish to expand investments in transparent risk communication, community engagement, and science-based public information campaigns. In parallel, increased financial and technical support for health system strengthening and regional vaccine manufacturing, particularly in lower-income countries, would help reduce structural dependence on external suppliers and contribute to a more resilient and equitable global health security architecture.

BLOCK ANALYSIS

United States of America:

The United States of America has been one of the central arenas in the international debate regarding vaccination enforcement during public health emergencies. The federal political system, which distributes authority between the national government and fifty state governments, produced highly uneven vaccination policies during the COVID-19 pandemic. In September 2021, President Joseph R. Biden introduced vaccination requirements for federal employees and certain categories of private sector workers. Several of these measures were challenged in court, and the Supreme Court of the United States limited aspects of their implementation. At the state level, responses varied significantly, with states such as the State of Florida and the State of Texas adopting legislation restricting vaccination mandates. Financially, the United States of America committed the largest national investment in vaccine development and distribution during the pandemic, allocating approximately twenty-two billion United States dollars through Operation Warp Speed and an additional ten billion United States dollars through the American Rescue Plan Act of 2021. The government also contributed four billion United States dollars to international vaccine equity efforts. Internationally, the United States of America donated more than one billion vaccine doses to lowerincome countries and announced support for the temporary waiver of intellectual property protections on coronavirus disease vaccines at the World Trade Organization in May 2021. In January 2021, the United States of America restored its participation in the World Health Organization and resumed its role as the organization's largest financial contributor, while maintaining cooperation with the
Coalition for Epidemic Preparedness Innovations, Gavi the Vaccine Alliance, and the World Bank.

People's Republic of China:

The People's Republic of China occupied a complex and frequently controversial position in the global debate surrounding vaccination enforcement. As the country in which coronavirus disease was first identified, the People's Republic of China implemented extensive public health control measures, including large-scale vaccination campaigns supported by

administrative enforcement mechanisms. The national vaccination campaign administered more than three billion doses to the domestic population, making it one of the largest vaccination efforts in history. Authorities implemented employment-based requirements and restrictions on access to certain public services for individuals who had not received vaccination. At the international level, the People's Republic of China distributed more than two billion vaccine doses to over one hundred countries through sales and donations. Government officials presented these initiatives as an expression of solidarity with developing countries and a contribution to global public health. At the same time, cooperation with the World Health Organization was affected by disputes regarding transparency in the early stages of the outbreak in the city of Wuhan. International debate also emerged concerning the geopolitical implications of vaccine distribution agreements concluded by the People's Republic of China with numerous partner states.

Republic of India:

The Republic of India played a dual role in the international vaccination effort during the COVID-19 pandemic. The country is home to the Serum Institute of India, the largest vaccine manufacturer in the world by production volume, which produced the Oxford–AstraZeneca vaccine under license. This production capacity positioned the Republic of India as a key supplier to the COVAX initiative during the early stages of the global vaccination campaign. However, the severe second wave of coronavirus disease in April and May 2021 forced the government to temporarily suspend vaccine exports in order to prioritize domestic immunization. The interruption revealed the vulnerability of global vaccine distribution systems that rely heavily on the manufacturing capacity of a limited number of states. The government invested approximately two billion United States dollars in the Nationwide Coronavirus

Disease Vaccination Programme, which administered more than two billion doses. Internationally, the Republic of India launched the Vaccine Maitri initiative to provide vaccines at reduced cost or through donations to developing countries. The Republic of India also became one of the most prominent advocates for intellectual property reform during the pandemic through the joint proposal with the Republic of South Africa at the World Trade Organization in October 2020 requesting a temporary waiver of patent protections on coronavirus disease vaccines.

Federal Republic of Germany:

The Federal Republic of Germany became an influential actor in the international vaccination response both through scientific innovation and through domestic political debate. The biotechnology company BioNTech, headquartered in the Federal Republic of Germany, partnered with the United States pharmaceutical company Pfizer to develop one of the first messenger ribonucleic acid coronavirus disease vaccines authorized for use. The German government provided approximately two billion nine hundred million euros in funding to support the research and development of this vaccine. The Federal Republic of Germany also contributed more than five billion euros to international vaccination initiatives and donated over one hundred million vaccine doses to lowerincome countries. Domestically, the question of mandatory vaccination generated significant political debate. In early 2022, the German Bundestag held a parliamentary debate on whether to introduce a general vaccination mandate for adults. The proposal was ultimately rejected in April 2022 following a free vote among members of parliament. While the Federal Republic of Germany publicly supported global vaccine equity, the government initially opposed the intellectual property waiver proposal discussed at the World Trade Organization, a position that attracted criticism from several developing countries and civil society organizations.

Federative Republic of Brazil:

The Federative Republic of Brazil experienced one of the most severe coronavirus disease crises globally, recording more than seven hundred thousand deaths. Public health experts frequently associated the scale of the crisis with political disputes surrounding vaccination and preventive measures during the administration of President Jair Bolsonaro. The federal government initially expressed skepticism regarding vaccines and resisted the introduction of mandatory vaccination measures. This position generated institutional conflict with the Supreme Federal Tribunal, which ruled in December 2020 that the federal government had a constitutional responsibility to implement a national vaccination strategy and that state and municipal governments possessed authority to adopt their own measures when necessary. The Federative Republic of Brazil invested approximately twenty billion Brazilian reais in the National Immunization Program, one of the oldest public vaccination systems in the world.

Domestic vaccine production was supported through the Oswaldo Cruz Foundation, which produced the Oxford–AstraZeneca vaccine under license. Following the election of President Luiz Inácio Lula da Silva in October 2022, the federal government renewed its commitment to vaccination campaigns and strengthened cooperation with the World Health Organization and the Pan American Health Organization.

United Kingdom of Great Britain and Northern Ireland:

The United Kingdom of Great Britain and Northern Ireland held a prominent position in the global vaccination response as the first country to authorize a coronavirus disease vaccine for emergency use in December 2020. The national vaccination program rapidly achieved high coverage rates, reaching approximately eighty percent of the adult population within the first year. The government invested roughly twenty-two billion pounds sterling in domestic vaccination efforts and provided substantial financial support to international initiatives, including more than two billion pounds sterling to the
COVAX facility and over five hundred million pounds sterling to the Coalition for Epidemic Preparedness Innovations. Vaccination policy in the United Kingdom of Great Britain and Northern Ireland relied largely on voluntary participation, although temporary employment requirements were introduced for workers in the National Health Service and residential care facilities. These measures were later repealed in March 2022 following political and professional opposition. During its presidency of the Group of Seven in 2021, the United Kingdom of Great Britain and Northern Ireland supported international commitments to donate one billion vaccine doses to developing countries.

French Republic:

The French Republic became one of the most politically contested democratic cases during the vaccination debate. The government introduced the pass sanitaire system in 2021, requiring proof of vaccination or recent testing to access restaurants, transportation services, and cultural venues. In January 2022 the policy was expanded into the pass vaccinal system, which removed the testing alternative and effectively required vaccination for participation in many aspects of

public life. These measures generated large public demonstrations across the country during 2021 and produced extensive parliamentary debate regarding the constitutional limits of public health enforcement. The French Republic administered more than one hundred fifty million vaccine doses and invested approximately nine billion euros in its national vaccination program. The government also contributed more than one billion euros to international vaccine distribution efforts and donated doses to several African partner countries.

Russian Federation:

The Russian Federation became one of the earliest countries to announce the development of a coronavirus disease vaccine when the Sputnik V vaccine was registered in August 2020. The announcement occurred before the completion of large-scale clinical trials and generated significant criticism from the international scientific community. Although the vaccine was distributed to numerous countries through bilateral agreements, neither the World Health Organization nor the European Medicines Agency granted emergency authorization during the main phase of the pandemic. Domestically, several regional governments introduced vaccination requirements for workers in sectors such as healthcare, retail, and public services. Despite these measures, vaccination rates remained relatively low compared with other major states, reflecting widespread public skepticism. International distribution of the Sputnik V vaccine was coordinated largely through the Russian Direct Investment Fund, which negotiated supply agreements with dozens of countries.

Republic of South Africa:

The Republic of South Africa played a significant role in international discussions on vaccine equity. The country experienced the highest number of coronavirus disease cases and deaths on the African continent and also became globally significant for identifying new virus variants, including the Beta variant and the Omicron variant. The government allocated more than ten billion South African rand to its national vaccination program. The Republic of South Africa also invested in expanding vaccine manufacturing capacity through the establishment of a messenger ribonucleic acid technology transfer hub supported by the World Health

Organization at the Afrigen Biologics facility in Cape Town. Internationally, the Republic of South Africa became a leading advocate for reform of intellectual property rules governing vaccines. Together with the Republic of India, the government submitted a proposal to the World Trade Organization in October 2020 requesting a temporary waiver of intellectual property protections for coronavirus disease vaccines.

Commonwealth of Australia:

The Commonwealth of Australia implemented some of the most restrictive public health measures among democratic states during the COVID-19 pandemic. Early containment strategies relied on strict border controls and internal lockdowns, followed by vaccination campaigns used as benchmarks for easing restrictions. Both federal authorities and state governments introduced employment-related vaccination requirements in sectors including healthcare, education, and construction. These policies generated public demonstrations, particularly in the city of Melbourne in 2021. The government invested approximately six billion Australian dollars in the domestic vaccination campaign and committed additional funding to international initiatives supporting vaccine distribution in the Pacific region and Southeast Asia. The Commonwealth of Australia also cooperated closely with the World Health Organization, the United Nations Children's Fund, the Coalition for Epidemic Preparedness Innovations, and Gavi the Vaccine Alliance to support vaccination campaigns in neighboring island states with limited health system capacity.

KEY POINTS

Public Health Emergency

A serious health situation that threatens a large number of people and requires urgent government action to prevent harm.

Public Health Emergency of International Concern (PHEIC)

A formal declaration by the WHO that an extraordinary health event poses a risk to multiple countries and needs a coordinated global response.

Mandatory Vaccination

A policy that requires individuals to receive certain vaccines, sometimes with penalties for noncompliance.

Bodily Autonomy

The right of individuals to make decisions about their own bodies without coercion or external pressure.

Informed Consent

The principle that a person must voluntarily agree to a medical intervention after receiving full information about risks and benefits.

Herd Immunity

A form of indirect protection that occurs when a high percentage of the population is immune to a disease, reducing its spread.

Proportionality Principle

The legal idea is that government measures must not be excessive and must be appropriate to the level of the threat.

National Sovereignty

The right of a state to govern its internal affairs without external interference.

International Health Regulations (2005)

A legally binding framework that guides how countries should prevent and respond to international disease threats.

Vaccine Equity

The fair and equal access to vaccines for all countries and populations, regardless of income level.

Emergency Use Authorization (EUA)

A mechanism that allows the use of medical products during emergencies before full approval is completed.

Public Trust in Health Institutions

The level of confidence that the population has in government and health authorities.

Human Rights-Based Approach

A policy framework that ensures public health measures respect fundamental human rights.

Vaccine Hesitancy

Delay in acceptance or refusal of vaccines despite availability.

Enforcement Mechanisms

Legal or administrative tools used by governments to ensure compliance with vaccination policies.

Equitable Distribution

The fair allocation of vaccines among countries and populations.

State Police Powers (Public Health Context)

The authority of governments to restrict certain freedoms in order to protect public health and safety.

Risk-Based Approach

A strategy where measures are applied depending on the severity and scientific assessment of the threat.

Medical Ethics

Principles that guide medical practice, including autonomy, beneficence, non-maleficence, and justice.

Global Health Security

The collective international effort to prevent, detect, and respond to health threats.

KEY QUESTIONS:

1) Under what conditions should governments be allowed to enforce mandatory vaccination?
2) How can states balance public health protection with respect for bodily autonomy?
3) What limits should international law place on vaccination enforcement?

4) Should mandatory vaccination be allowed when vaccines are authorized under emergency use?

5) How can governments maintain public trust while implementing strong health measures?

6) What role should the WHO play in guiding national vaccination policies?

7) Should there be a binding international framework specifically regulating vaccination mandates?

8) How can vaccine equity be guaranteed before enforcement measures are applied?

9) What safeguards are necessary to prevent abuse of emergency powers?

10) How should exemptions (medical, religious, or philosophical) be handled in mandatory vaccination policies?

11) To what extent can employment-based sanctions be considered coercive?

12) How can countries address vaccine hesitancy without undermining human rights?

13) Should failure to ensure adequate vaccination coverage be considered a violation of the right to life?

14) What mechanisms can improve global cooperation during future pandemics?

15) How can developing countries be supported to implement vaccination programs fairly?

16) Should international travel restrictions be linked to vaccination status in future emergencies?

17) What lessons from the COVID-19 pandemic should guide future vaccination policies?

18) How can the international community rebuild public trust in vaccines and health institutions?

19) What accountability mechanisms should exist for states that misuse vaccination enforcement?

20) How can governments ensure that emergency health powers remain temporary and proportionate?

SOURCES:

1. Amnesty International. (2021). COVID-19 vaccines: Ensuring equitable access and protecting human rights. https://www.amnesty.org
2. Australian Government Department of Health. (2023). Emergency powers under the Biosecurity Act

3. 2015. https://www.health.gov.au
4. Centers for Disease Control and Prevention. (2022). Global COVID-19 vaccination overview.
5. https://www.cdc.gov
6. European Commission. (2021). EU Digital COVID Certificate: Technical documentation. https://ec.europa.eu
7. European Medicines Agency. (2021). COVID-19 vaccines: Authorisation procedures in the EU. https://www.ema.europa.eu
8. Gavi, the Vaccine Alliance. (2023). Gavi's impact and results. https://www.gavi.org
9. Gostin, L. O., & Wiley, L. F. (2016). Public health law: Power, duty, restraint (3rd ed.). University of California Press.
10. Human Rights Watch. (2022). COVID-19 vaccine access and human rights. https://www.hrw.org International Monetary Fund. (2021). A proposal to end the COVID-19 pandemic. https://www.imf.org Jacobson v. Massachusetts, 197 U.S. 11 (1905).
11. Ministry of Health and Family Welfare, Government of India. (2021). National COVID-19 vaccination strategy. https://www.mohfw.gov.in
12. National Health Commission of the People's Republic of China. (2019). Law on the Prevention and
13. Treatment of Infectious Diseases. http://www.nhc.gov.cn
14. Oxfam International. (2021). The great vaccine divide. https://www.oxfam.org
15. Republic of South Africa, Department of Health. (2022). COVID-19 vaccination rollout report. https://www.health.gov.za
16. Robert Koch Institute. (2021). Infection Protection Act (Infektionsschutzgesetz). https://www.rki.de
17. United Nations. (1948). Universal Declaration of Human Rights. https://www.un.org
18. United Nations General Assembly. (2020). Resolution 74/274: International cooperation to ensure global access to medicines, vaccines, and medical equipment to face COVID-19. https://undocs.org
19. United Nations General Assembly. (2021). Resolution 76/176. https://undocs.org
20. United Nations Office of the High Commissioner for Human Rights. (2021). Human rights and COVID-
21. 19 vaccination. https://www.ohchr.org

22. UK Government. (1984). Public Health (Control of Disease) Act 1984. https://www.legislation.gov.uk
23. World Bank. (2021). Updated estimates of the impact of COVID-19 on global poverty.
24. https://www.worldbank.org
25. World Health Organization. (2005). International Health Regulations (2005) (3rd ed.). https://www.who.int
26. World Health Organization. (2022). COVID-19 vaccine effectiveness and impact. https://www.who.int
27. World Health Organization. (2023). Immunization coverage fact sheet. https://www.who.int
28. World Trade Organization. (2022). Ministerial decision on the TRIPS Agreement. https://www.wto.org