

Global vaccine equity demands reparative justice – not charity

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INTRODUCTION

By late April, more than 80% of the world's COVID-19 vaccines had gone to people in wealthy countries, with just 0.3% to people in low-income countries.¹ This reprehensible imbalance is no accident. High-income countries have used neocolonial negotiating power, global policy leverage and capital to procure enough doses to cover 245% of their citizens while leaving few doses for poorer countries.² As a result, lower-income countries may not be able to vaccinate their populations until 2023.³

Such inequity is yet another example of how the interests of racial capitalism run roughshod over the golden rule of global solidarity—attend to the highest risk first.⁴ Currently, older and medically vulnerable individuals are dying from COVID-19 disproportionately in poor countries, while young, healthy individuals are getting vaccinated in wealthy ones.⁵ Vaccine apartheid is a not novel phenomenon. The notion that only certain corners of the world get to benefit from life-saving treatments is an everyday reality of a global health system driven by a capitalist, philanthropic model.^{6,7} But in times of crises—and as new variants threaten the vaccination plans of wealthy countries—these inequities and their solutions come to the forefront of global debate.⁸

Policy-makers in rich nations are aware of these issues. But the solutions they have proposed so far do nothing to address the underlying structural problems. They offer charitable donations and partial, temporary fixes that are designed to deflect the substantive demands for reform that global South countries are fighting for, including challenges to unethical intellectual property (IP) regimes.⁹ This approach will not work, because it is not designed to 'work.' If we want to end vaccine apartheid, we need to target the root causes of global health inequities. We need reparative justice.

THREE LIMITED 'SOLUTIONS' TO VACCINE INEQUITY

There are currently three approaches to reduce inequity in COVID-19 vaccine distribution: bilateral charity, multilateral charity and temporary waivers or suspensions of IP.

The first is the most straightforward. States that stockpile COVID-19 vaccines have committed to sharing their leftovers with low-income and middle-income countries. Norway was one of the first nations to accede to donating doses to poorer countries in parallel with its vaccine programme.¹⁰ This is the weakest form of equity as it is unclear if this will be done for free, at a lower cost, tied to diplomacy or conditionality, or crucially, when these vaccines will be made available, where they will go, or how many will be delivered. The bilateral charity approach has little to do with equity and more to do with geopolitics, wealth and aid dependency.^{11,12}

The second is multilateral charity, best exemplified by COVAX. In 2020, COVAX emerged as an international collaboration by the World Health Organisation (WHO), United Nations Children's Fund, Gavi and the Coalition for Epidemic Preparedness Innovations to ensure equitable global access to COVID-19 vaccines.¹³ Rich countries can access doses for 10%–50% of their populations, depending on how much they have paid in, and poor countries can access doses for 20% through the scheme. It is the 20% for poor countries that has come to be COVAX's unique selling point: here is a mechanism that ensures every country in the world can get the vaccine regardless of ability to pay. This is the first time such an initiative has been trialled.

The shortcomings of COVAX are numerous. If vaccines are delivered as planned, COVAX may reach 27% of the population in lower-income countries by the end of 2021—a depressing goal compared with the estimated 70% coverage needed for herd immunity and the open vaccine access currently granted to

Americans.¹⁴⁻¹⁵ Furthermore, COVAX is still significantly underfunded and there are concerns regarding supply chains.

While capital and resource transfer from wealthy countries to poorer ones is surely needed in the current pandemic response, any system that solely relies on aid will ultimately fail to achieve equity. In the setting of vaccine scarcity, in which suppliers are unable to deliver doses as scheduled and countries are banning exports to keep vaccines at home, there is a risk that COVAX aid-recipient states will fall further down the priority list, awaiting the leftover vaccines from the rich country stockpiles.¹⁶⁻¹⁸

What may be most pernicious about the COVAX scheme, however, is that rich countries and their pharmaceutical companies have repeatedly used it as a shield to deflect demands for IP waivers. This is an enduring problem with aid: it papers over and distracts our attention away from the underlying structural violence. And in so doing, it maintains and perpetuates inequalities. Over 50 years ago, Kwame Nkrumah observed how aid is a ‘revolving credit’ which returns to countries of the global North in the form of increased profits.¹⁹ To the extent that COVAX is being leveraged to protect corporate patents and profits, Nkrumah’s words continue to be germane.

The third approach is focused on pooling, temporary waivers, or suspension of IP. In May 2020, the WHO created the COVID-19 Technology Access Pool for companies to share IP and transfer technologies in a coordinated manner. But to date, not a single company has utilised the transfer process—likely because such forms of global IP sharing would quell profits, even if royalties are included.²⁰ Pharmaceutical companies and universities prefer one-off transfer deals because it enables them to set their own terms with non-disclosure agreements. Given that they are accountable to shareholders and boards—not patients—financial incentives will drive transfer decisions, not public health demand.

Following the blockages at the WHO around IP, attention shifted towards the World Trade Organisation (WTO). In October 2020, India and South Africa proposed a temporary waiver of IP rights to COVID-19 technologies for the duration of the pandemic, so that all manufacturers with sufficient capacity and shared know-how could start production.²¹ Although backed by over 100 countries within the WTO and a global campaign for the ‘People’s Vaccine,’ the proposal has been repeatedly blocked at every committee meeting since then by select wealthy countries with large pharmaceutical industries, including the UK, Japan and EU states.²²⁻²³

Those who oppose the IP waiver argue that it will not do anything to solve the problem: even if you were to liberate the recipe for the vaccines, low-income and middle-income countries do not have the capacity to produce it.²⁴ But this argument is specious. For one, several middle-income countries—including India, Brazil, Senegal and South Africa—do have the ability

to ramp up production by repurposing existing manufacturing capacity.²⁵ In addition, an IP waiver can and should be supplemented with technology transfers, logistical support and financial investment to facilitate this repurposing process. And the most important point is that such a waiver could drastically reduce costs across the board, making vaccine imports more affordable for poor countries.

Opponents of the waiver also claim that IP-related obstacles can be addressed through existing arrangements for ‘compulsory licensing’ under the WTO’s Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).²⁶ But the past evidence suggests that this process is slow, cumbersome and subject to various shaming practices by the international community.²⁷⁻²⁸ Some point instead to the possibility of voluntary licensing. But voluntary licenses are often executed secretly and are limited to companies or governments that can afford them. The University of Pennsylvania, which owns IP rights relating to the mRNA vaccines, is helping Chulalongkorn University in Bangkok develop a vaccine production facility. This partnership was possible because Thailand—unlike other middle-income countries—was able to put up the money.²⁹ Poorer countries are left out. Sharing of IP and technology transfers can and will accelerate global vaccine production. The question is on whose terms. Organisations such as the WHO and African Union are currently mobilising support and resources to accelerate production in low-income and middle-income countries.³⁰⁻³¹ But these efforts will be to waste unless IP for COVID-19 technologies is shared broadly and quickly.

VACCINE COLONIALITY

Donor-based approaches to vaccine equity are grounded in old, even colonial ideas of aid and dependency, which have failed to serve the health needs of the Majority World or deliver on health equity. This failed model has not promoted health equity in the past and is clearly inadequate in the present, on account of dependency on donor whims (the bilateral ‘leftovers’ approach), persistent funding gaps and shortfalls (COVAX), and time-consuming diplomacy and filibustering over what is or is not within current trade rules (WTO).

Once again in the political economy of global health, the charitable model of COVAX becomes the smoke-screen for inequitable systems. When states are asked about their stockpiling, they point to COVAX. When pharmaceutical companies are asked about IP, they point to COVAX or their low-cost commitment. The focus on a donor-based model of aid in achieving vaccine equity has distracted leaders from the ideologies, economic systems and trade regulations that leave access to medicine to the forces of the marketplace rather than global health priorities.³² Achieving global vaccine justice requires a rapid shift in trade regulations and contract transparency that streamlines IP sharing and technology transfers.

The resultant collaborations across economies will not only accelerate vaccine production but will also increase competition and push vaccine prices down.

Finally, old models of vaccine equity have not kept pace with changes in discourse and thinking around global health governance, equity and justice. 2021 is not the early 2000s, where new public–private partnerships or funding models were *de rigueur*. Donor countries are increasingly wary of aid dependency as they pay the cost of continuing high profile health programmes with diminishing strategic returns. Aid-recipient countries are similarly exasperated by funding gaps that lead to delays and materiel shortfalls, the NGO-industrial complex and attendant consultants that rationalise them, and fundamentally, by the notion that their populations only seem to matter when another state can capitalise on them.

CONCLUSION

Vaccine apartheid is only one symptom of broader global health inequalities that have their roots in colonialism and persist today because of neocolonial forms of power. As Grosfoguel writes, ‘The heterogeneous and multiple global structures put in place over a period of 450 years did not evaporate with the juridical–political decolonisation of the periphery over the past 50 years. We continue to live under the same ‘colonial power matrix.’ With juridical–political decolonisation we moved from a period of ‘global colonialism’ to the current period of ‘global coloniality.’³³

Vaccine justice starts with moving beyond aid models of vaccine donation, in which poorer countries are gifted vaccine leftovers. It demands rapidly achieving global consensus for the IP waiver, democratising vaccine IP and know-how and supporting low-income and middle-income countries to build manufacturing capacity for this pandemic *and the next*. These steps can mark the start of a reparative justice movement in global health that demands we confront and overturn colonial legacies that continue to devastate the health of low- and middle-income countries.³⁴ A commitment to funding vaccine justice in the face of the COVID-19 pandemic can be a first step in this direction.

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