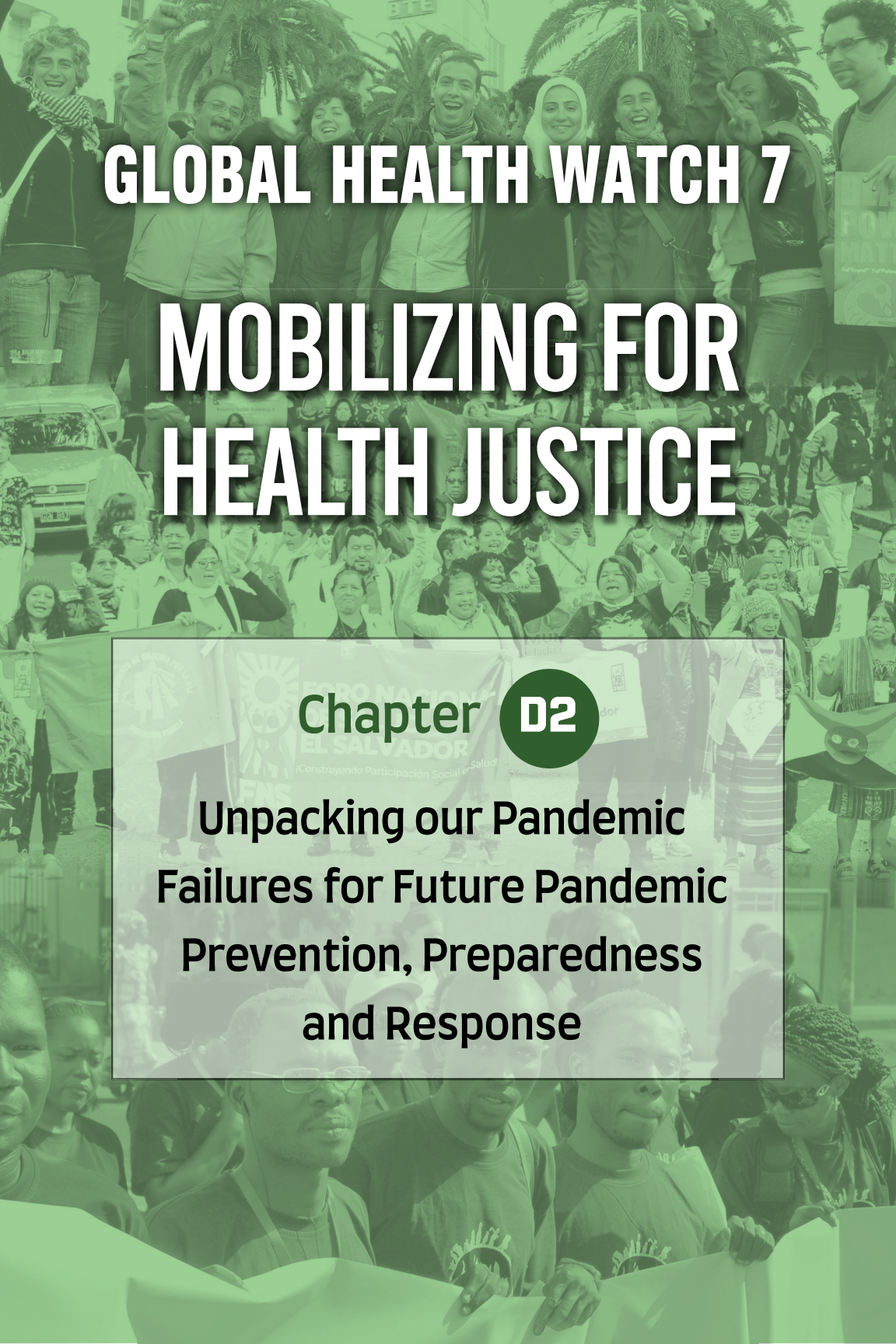

GLOBAL HEALTH WATCH 7

MOBILIZING FOR HEALTH JUSTICE

Chapter D2

Unpacking our Pandemic Failures for Future Pandemic Prevention, Preparedness and Response

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Unpacking our Pandemic Failures for Future Pandemic Prevention, Preparedness and Response

Introduction

In March 2020, the World Health Organization (WHO) declared COVID-19 a "global pandemic" – just over a month after it had officially been declared a Public Health Emergency of International Concern (PHEIC).[1] Though no official legal definition of the term "pandemic" existed in 2020, renaming the "PHEIC" a "pandemic" signaled that the world was being confronted with a public health crisis of disastrous proportions. This chapter explores the aftermath of the COVID-19 pandemic and considers whether the initiatives pursued in its wake have heeded the call to use the pandemic as an inflection point for creating a more just and equitable pandemic prevention, preparedness and response (PPR) system.

Research and development (R&D) success

In a very narrow technological and biomedical sense, the global response to COVID-19 achieved the spectacular "success" of rapidly producing safe and efficacious vaccines. Scientists drew on decades of publicly-funded research on mRNA technologies,[2] and in the USA especially benefited from billions in public financing for derisking research and development (R&D) efforts to create COVID-19 vaccines.[3,4,5] The first vaccines to receive emergency use authorization from the WHO were the Comirnaty (developed by Pfizer and BioNTech),[6] and Covishield (AstraZeneca and University of Oxford).[7]

While the sharing of digital sequencing information for COVID-19 and vaccine development moved at spectacular speed, reports of the initial outbreak in China were not shared rapidly enough, undermining the ability of these technological measures to contain the initial outbreak before it reached pandemic proportions.[6] This is one reason why, in later reforms for pandemic preparedness and response (PPR) discussed in this chapter, WHO and Global North countries have emphasized improving surveillance and containment through rapid and unconditional access to pathogens required for R&D in diagnostics, therapeutics and vaccines. Many Global South countries focused more on the implications of sharing such data, and its role in developing international PPR frameworks that operationalize legally binding, equity-promoting responses.

Manufacturing and intellectual property challenges

From a right to health perspective, PPR efforts were an utter failure: most populations in the Global South did not have timely access to vaccines.[9] Partly this

failure could be the approach of governments allowing the companies to assert the intellectual property rights on the publicly funded vaccines and other health products. Under the global legal framework demands, inventors of new medical products – including COVID-19 vaccines – could register their inventions as their own private intellectual property (IP), thereby being given the exclusive right to decide the terms on which these products could be produced, sold, priced and distributed. In practice what this meant was that pharmaceutical companies refused to transfer the technology to facilitate diversified production and chose to first sell their products to high-income markets in the Global North (thereby leading to vaccine hoarding in these markets), and at relatively high prices in middle income markets or not at all in low income markets (leading to under-supply in low and middle income countries). This maldistribution of vaccines, which became known as "vaccine apartheid", was irrational from a public health perspective as often vulnerable populations in need of vaccines supplies (e.g. elderly or immunosuppressed populations in the Global South) could not access vaccines until very late in the pandemic – when younger, healthier populations in the Global North had already been fully vaccinated (or even received booster doses).

The vaccine shortages experienced by low and middle income countries (LMICs) were intensified by the fact that many, with the exception of India, Brazil and China, did not have the infrastructure or know-how to produce their own vaccines.[10] In the Global North vaccine manufacturing capabilities were boosted by a massive expansion of public subsidies for (re)building domestic production of vaccines (especially in the USA).[11] The pandemic also led to the use of flexibilities of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement in Canada and the USA, and spurred the European Union to work on establishing a legal framework for Union-wide compulsory licensing flexibilities, which would allow it to more easily manufacture medical products during health emergencies without the IP owner's consent.*[12] Hypocritically, these countries were either neutral (Canada) or opposed some (USA) or all of the (EU) components in relation to the TRIPS waiver proposal tabled by India and South Africa in October 2020. The waiver requested the temporary suspension of TRIPS rules in order to facilitate expanded production capabilities and trade in COVID-19 diagnostics, therapeutics and vaccines. Though it was supported by over 100 members of the World Trade Organization (WTO), the aforementioned countries were amongst those who successfully blocked a meaningful intellectual property rights waiver from being implemented.

*See Chapter B4 in GHW6.

Global Day of Action in support of the TRIPS waiver Campaign to end the Vaccine Apartheid (Geneva, 30 November 2021)

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Containment measures: deepening socioeconomic costs and trust deficits

Globally, the lockdowns and social isolation regulations many countries implemented to contain the spread of COVID-19 left already-vulnerable populations like women, migrants, people living with disabilities, children and racialized minorities burdened with the socioeconomic and care work costs of the pandemic.[13] These burdens were acutely felt in societies where the state provided little social assistance, while at the same time imposed measures that disrupted and sometimes criminalized the solidarity practices poor and marginalized communities relied on to navigate the many "slow catastrophes" that structured their lives even before the pandemic.[14]

In many countries, public discourses centered on suspicion of being manipulated and exploited by government and big corporations. In the USA, significant portions of the population reacted to public health guidelines and government officials' advice on pandemic prevention and containment measures (e.g. masking, getting vaccinated) with mistrust and skepticism.[15] There and elsewhere, significant numbers of people believed public institutions could not be trusted to protect them, because they were beholden to powerful interests within the scientific, philanthropic and business communities that made government more prone to surveillance or economic exploitation of their populations than to advancing the right to health.[14] These groups regarded the WHO, the leading

intergovernmental organization mandated to coordinate the pandemic response, as incompetent and beholden to geopolitical competition.[17,18]

Skepticism and disdain towards WHO was also displayed by some Member States and pharmaceutical corporations. WHO recommendations were sometimes simply ignored by other intergovernmental organizations (e.g. its support for the TRIPS waiver was largely ignored by the WTO). In 2022, WHO's Dr. Mike Ryan stated that "We failed [to distribute vaccines equally] because of the greed of the north, we failed because of the greed of the pharmaceutical industry, we failed because of self-interest of certain member states that were not prepared to share."[19] Member States not only ignored WHO's ethical pleas to prevent the "catastrophic moral failure"[20] of inequitable vaccine distribution, but also its technical advice such as asking for greater solidarity in vaccine procurement,[21] lifting irrational travel restrictions,[22] or supporting the TRIPS waiver proposal.[23,24]

Restoring trust in WHO? Revising the International Health Regulations

In response to the difficulties the WHO experienced in coordinating an equitable and effective response to the COVID-19 pandemic, Member States undertook revisions to the International Health Regulations (IHR) of 2005. The revisions mean that equity and solidarity are now included in Article 3.1 as guiding principles for interpreting significant provisions. The IHR now also defines a "pandemic emergency" as a new category of public health emergencies of international concern (PHEIC) that "requires rapid, equitable and enhanced coordinated international action, with whole-of-government and whole-of-society approaches".

Article 13 of the IHR now provides for international assistance to facilitate equitable access to health products such as diagnostics, vaccines and therapeutics for responding to both PHEICs and pandemic emergencies. Three new paragraphs in Article 13 further specify the role of WHO during PHEICs and pandemic emergencies: Art. 13.7 mandates WHO to support IHR State parties during emergencies; Art 13.8 suggests the role of WHO in facilitating timely access to relevant health products; and Art 13.9 obligates State Parties to support the WHO in implementing Art.13 (subject to applicable law and available resources).

The definition in Article 1 of relevant health products that are needed to respond to PHEICs and pandemic emergencies now includes an illustrative list of health products but, significantly, also references "other health technologies" which may not be explicitly mentioned in the list.

Article 44 was amended to increase international collaboration and assistance including mobilization of additional financial resources. More specifically, it establishes a Coordinating Financing Mechanism to promote the "provision of timely, predictable, and sustainable financing" for implementing the IHR and notes the importance of developing, strengthening and maintaining core health system capacities described in Annex 1. The Mechanism is also mandated to "maximize the availability of financing for the implementation needs and priorities of States

Parties, in particular of developing countries", and with working to "mobilize new and additional financial resources" relative to effectively implementing the IHR.

From a governance perspective, Article 54bis establishes the State Parties Committee for Implementation of IHR – a forum to discuss in detail the challenges, strengths and weaknesses in the implementation of IHR.

These amendments are a micro step towards creating an equity-based response system during PHEIC and pandemic emergencies, which was otherwise absent in IHR.

The Pandemic Accord (PA) negotiations*: "prioritizing the need for equity"?[25]

In December 2021 a special session of the World Health Assembly established an intergovernmental negotiating body (INB) mandated to "develop a new instrument for pandemic prevention, preparedness and response with a whole-of-government and whole-of-society approach, prioritizing the need for equity".[26] Member States were called on to develop an instrument defined by the "principle of solidarity with all people and countries, that should frame practical actions to deal with both causes and consequences of pandemics and other health emergencies."[27] However, at the time of writing this chapter (early April 2025), the INB is failing to deliver on this mandate in a number of respects.

Health systems

Immediately prior to the COVID-19 pandemic, health systems in both the Global North and South were overstretched, partly due to being reconfigured by longstanding efforts to privatize and commercialize the public health sector.[28] Globally, private health care facilities catered to the minority of the population who could afford them (see Chapter B1).[29] Both the public and private health and care sectors in the Global North sought to address staffing constraints by intensifying recruitment of health workers that had migrated from poorer countries from neighboring regions in the North, but also from the Global South, leaving these systems further weakened.[30,31]

The WHO's emphasis on Universal Health Coverage (UHC) from about 2008 onwards has tried to ensure that everyone can access care when they need it and without financial hardship. However, UHC as envisioned by WHO has been agnostic about whether care should be provided by the public versus private sector. As implemented in many countries, UHC has effectively amounted to designing health financing reforms while neglecting interventions to bolster public capabilities to provide care.† Consequently, the limited UHC reforms that have been rolled out to date have often failed to strengthen public health systems.[32]

These UHC weaknesses compromised efforts to manage the COVID-19 pandemic in both the Global North and South, as pandemic response efforts were

*This chapter focuses on the 12 November 2024 version of the Pandemic Accord text, as issued by the Intergovernmental Negotiating Bureau.

†See Chapter B1 in GHW6.

weakest in countries where health systems were fragmented and understaffed.[33] While the November 2024 text of the PA encourages governments to "develop, strengthen and maintain a resilient health system, particularly primary health care"[34] and to be mindful of equity while doing so, this is framed entirely as a national responsibility. The text imposes no binding obligations with regards to international cooperation for health systems strengthening. Previous versions of the PA text had included references to global measures that could unlock financing for health systems strengthening – e.g. debt relief – but these were absent from later version so of the negotiating text.[35]

Research suggests that countries with higher levels of human resources for pandemic preparedness reported lower COVID-19 cases and deaths in the initial eight weeks of their pandemics.[36] The PA text of 12 November 2024 acknowledges the importance of national governments taking "appropriate measures with the aim to develop, strengthen, protect, safeguard, retain and invest in a multi-disciplinary, skilled, adequate, trained, domestic health and care workforce" for PPR. "[T]aking into account its national circumstances, and in accordance with its international obligations" it also recognizes the need to "take appropriate measures to ensure decent work, protect the continued safety, mental health, wellbeing, and strengthen capacity of its health and care workforce".[37] The protections offered to workers, including migrant workers, in this Article are welcome.

However, shortcomings remain. Despite an injunction to support "individual and collective empowerment" of the health and care workforce, the text imposes no obligation on governments regarding social dialogue or consultation in relation to PPR measures. It is therefore unclear what rights workers have to participate in deciding on the terms of their involvement in PPR efforts. The text also does not acknowledge the overwhelmingly feminized nature of this labor force, nor the gender-specific pressures this imposes on women workers during PHEICs and pandemics. Women worldwide disproportionately take on the burdens of reproductive and care work in their households. During the COVID-19 pandemic female health workers had to work extended hours and in high-risk situations, and struggled with accessing childcare and isolation facilities that would limit household members' exposure to infection.[38,39] The text makes no mention of obligations to provide childcare and elderly care services or isolation facilities for health workers working extended working hours or at risk of infection. Nor is mention made of giving household members priority access to pandemic-related products.

Box D2.1: Geopolitics and the Pandemic Accord negotiations

The Pandemic Accord (PA) negotiations are coordinated by the Bureau of the Intergovernmental Negotiating Body (INB). The INB was established in December 2021 and started its work the following year under the leadership of its founding co-chairs, Ambassadors Roland Driece (Netherlands) and Dr. Precious Matsotso (South Africa). The INB Bureau hosted talks about the PA in parallel with the proceedings to revise the IHR (2005).

Between first INB meeting (February 2022) and the 8th (February / March 2024), no text-based negotiations took place. This modality was only introduced during the 9th INB meeting, which took place in two sessions (March 2024, and then April / May 2024). Prior to this, and throughout the subsequent process, Member States engaged in informal discussions organized around particular Articles of the PA document and until the 13th round negotiations, there were only five days of text-based negotiations. All discussions, except for the opening and closing proceedings of the INB meetings, are closed to the public. Throughout the proceedings, the media and non-state actors have relied on briefings hosted by the INB Bureau, formal consultation sessions with select non-state actors, and personal exchanges with insiders, to gauge the state of the negotiation process.

Reporting on the INB negotiations, as covered in Geneva Health Files and Third World Network, have raised the concerns of Global South delegates who have indicated that they feel their interventions are not always reflected in the texts developed by the INB Bureau. Throughout the process these delegates, particularly members of the Africa Group and the Group for Equity, have proposed binding measures to operationalize equity in the PA.

Reporting on the PA negotiations suggest the process has been plagued by opposed interests between the Global North and South, but also within the Global South. One notable example of alleged "intense pressure"[40] by the US and EU includes reports that Namibia was asked to replace its chief negotiator, a strategic and emphatic voice for equity in the PA, in order to curtail his influence over the process. In some ways this attests to the influence even smaller delegations can have in multilateral processes. Whether true or not, smaller countries like Namibia and Bangladesh have made significant contributions in articulating and defending equity provisions for inclusion in the PA – and have perhaps shaped the PA conversations to a greater extent than other countries in their regions with bigger economies, populations and a bigger national pool of technical experts.

Numerous reports on tensions within the South have surfaced, and of attempts by Global North countries to break unity within regional blocs that are making pro-equity demands. For example, in March 2024 Politico[41] reported that Africa CDC was being lobbied by US and EU representatives to encourage African Health Ministers

Continues on next page

Box D2.1 continued

to soften their demands on the Pathogen Access and Benefit-Sharing (PABS) system. In May 2024 Geneva Health Files reported[42] that the US and EU had a closed-door meeting with four African countries aimed at "bridging" their positions on Article 12 (PABS).

In November 2024, Donald Trump was re-elected as the US President. Within hours of entering office Trump signed an Executive Order announcing the US's withdrawal from the WHO. This has intensified the uncertainty about the prospects for concluding an Accord that contains robust equity demands but also raises concerns about implementing an Accord not endorsed by a major superpower.

Non-State actors: multistakeholderism, public private partnerships, NGOs and global health initiatives

Since the 1970s, structural adjustment and austerity policies in the Global South, together with debt repayment obligations and an embrace of neoliberal policies, have contributed to public health facilities being poorly maintained, governed and staffed – even though most of the population depend on these facilities. From the 1990s onwards many of these countries have depended on a patchwork of global health initiatives to provide basic health care services. These interventions often take a siloed approach to health care, contributing to health systems fragmentation. Overseas development assistance programs (e.g. PEPFAR), global health initiatives (e.g. Gavi), private sector initiatives (e.g. hospitals and clinics established by religious groups), and humanitarian non-governmental organizations (e.g. MSF field hospitals) have effectively been given the authority to determine health system resource allocation and programmatic priorities at the national level.*

The Pandemic Accord discussions risk further institutionalizing Public Private Partnerships (PPPs) and multistakeholderism by referencing them as integral components of pandemic preparedness and response. For example, Article 10(d) encourages states to "promote and/or... incentivize public and private sector investments, purchasing arrangements, and partnerships, including public-private partnerships, aimed at creating or expanding manufacturing facilities or capacities for pandemic-related health products".[43] Article 9(5) uses highly qualified and non-binding language to encourage states to include provisions on publicly funded research conducted by private entities or PPPs that promote equitable access to "pandemic-related health products", "particularly for developing countries" during PHEICs and "pandemic emergencies". Striking in these two passages is the relatively unqualified call for engaging in PPPs, and the highly qualified call to impose equity provisions on publicly funded research.

*The rise and significance of PPPs and multitstakeholderism has also been discussed in previous issues of GHWs. See for example Chapters B3 and D5 in GHW6; Chapters B5 and D4 in GHW5; and Chapter D6 in GHW3.

While PPPs are envisioned as essential to R&D and geographically diversified production, multistakeholderism is framed as a viable modality for governing pandemics more equitably, despite the critiques that multistakeholder initiatives like COVAX lacked transparency and accountability.[44] In some instances stakeholders are given a seat at the decision-making table as "partners" in designing key PPR infrastructures. For example, Article 13 proposes that a global supply chain and logistical network "shall be developed, coordinated and convened by WHO in full consultation with the Parties, WHO Member States that are not Parties, and in partnership with relevant stakeholders"[45] and gives them a role in periodically reviewing its functions and operations.[46] This potentially opens space for for-profit companies (especially pharmaceutical corporations) to be involved in processes they stand to benefit from financially."

Pathogen access and benefit sharing

A focus on technological fixes, and a less robust engagement with structural impediments to the right to health, has also been part of the negotiating posture of many Global North countries during the Pandemic Accord process. Negotiations have made little progress in developing a mechanism for Pathogen Access and Benefit Sharing (PABS). During negotiations Global North countries have frequently insisted that pathogen sharing should happen rapidly, so that technical "fixes" to pandemics – e.g. vaccines – can be developed with urgency. They have argued that pathogen sharing should be delinked from obligations to provide equitable access to the medical products developed thanks to pathogen sharing.

This line of argument has been justified on the basis that such conditions will impede scientific research into diagnostics, therapeutics and vaccines, and thus ultimately result in avoidable deaths. However, this ignores the avoidable deaths that resulted from, and continue to result from, inequitable access to pandemic response products that, once developed and achieving regulatory approval, remain beyond the reach of the world's poor and marginalized because of high costs or limited manufacturing capabilities in regions where outbreaks, PHEICs and pandemics occur.

R&D and medical manufacturing

The Pandemic Accord text contains three Articles (9, 10, and 11) aimed at correcting the structural constraints to building R&D and medical manufacturing capabilities in the Global South, to promote more equitable access to medicines. There is an implicit acknowledgement in these Articles that vaccine equity was undermined by their lack of control over the infrastructure and know-how required for manufacturing these products, and states' reluctance to impose conditionalities on the use of publicly funded R&D and / or its commercialization. Global North governments tended to avoid such regulations as their economic interests are to some extent aligned with those of the hugely profitable pharmaceutical corporations registered in their territories. Global South countries tended

to avoid imposing such regulations for fear of political blowback and / or lack of technical and financial resources to do so. Despite this, the Pandemic Accord text does not introduce language that obliges WHO Member States to facilitate technology transfer or imposing conditions on publicly funded R&D to enable more equitable access to pandemic-related products through diversified production. These articles are couched in best endeavor language which does not translate into concrete obligations to facilitate sustainable and predicable access to health products during pandemics.

The role of the state

These dynamics have contributed to re-opening a longstanding debate about governments' and intergovernmental organizations' obligations to prioritize provision of public goods, rather than focusing on privatizing the "health commons" or fixing market failures. The WHO's Council on the Economics of Health for All (2020-22), though emphasizing a rights-based approach to health, framed health spending as an "investment" rather than a cost. This echoes the market-based language of the World Bank (which typically emphasizes health as an investment in human capital) or as being instrumental "for economic development".[47]

The Council positions the state as a coordinator of public and private investments in health and its manifesto mentions valuing and measuring health from a "human security" and risk reduction perspective. This idea of improving health outcomes and reducing risks through "better investment" is echoed in a number of other post-pandemic initiatives, all of which emphasize the commercial viability of such investments as an important component of "channeling" financing for PPR. This includes the European Union's Global Gateway strategy of using PPP to invest in vaccine manufacturing in Africa and Latin America, and Gavi's African Vaccine Manufacturing Accelerator financing instrument to support commercial viability of African vaccine manufacturers.[48]

Other initiatives, like the WHO mRNA Hub, support technology transfer and Global South researchers' capacities to harness the voluntary licensing mechanisms recognized by the TRIPS framework, within the parameters of commercial viability.[49] However, they do not explicitly acknowledge that TRIPS flexibilities are rarely used by Global South countries due to political pressure by Global North countries.[50] In this regard, it is significant that Colombia has also sought a comprehensive review of the TRIPS agreement at the WTO to better document who has benefited from the agreement since its adoption in 1994.[51]

Civil society initiatives have focused less on the state's role in allocating capital and more on its role as a potential owner of health infrastructure (e.g. the Public Pharma for Europe Coalition;[52] PHM's public pharma research project), the public's contributions to R&D (e.g. the MSF Access Campaign's efforts to map public contributions to Ebola vaccine trials),[53] and the state's potential to promote greater accountability of "powerful and wealthy nations, organizations and individuals" in global health (e.g. a United Nations University Research Project on

Power and Accountability).[54] These projects proceed from the assumption that power inequalities are likely to influence how governments coordinate public resources, and the conditionalities they are able to impose on beneficiaries of such funding. This was starkly exposed during the pandemic when the US government was unable to compel Moderna to recognize it as a co-owner of the company's vaccine, which had benefited from public subsidies for R&D and commercialization.[55]

Conclusion: Working towards a public goods/commons approach to PPR?

The reforms to the international legal architecture that are taking place in response to the COVID-19 pandemic suggest that most countries recognize that the impact of the pandemic and its aftermath was / is deeply inequitable and unjust. Failing health systems, an intellectual property rights regime that impeded the expansion of much-needed health products, and the prioritization of national health security over global solidarity have been acknowledged by politicians and researchers as drivers of inequality in access to COVID-19 vaccines and life-saving health services within and between countries. There has also been a recognition that women in many ways functioned as the shock absorbers of the pandemic, through the paid and unpaid social reproductive work they were forced to do in the absence of social safety nets and functional health systems.

However, this recognition has not translated into "lessons learned": though the IHR amendments have institutionalized some measures that promote more equity in responding to outbreaks and PHEICs, the Pandemic Accord negotiations seem unlikely to institutionalize mechanisms that will address the fundamental drivers of inequality. The negotiations also seem unlikely to develop an international legal framework for governing the production and distribution of medical products and health technologies as global public goods, even during extreme events such as pandemics.

At the current moment, the increased volatility and declining trust in the multilateral system, the normalization of xenophobia in many countries, and the economic difficulties of the post-pandemic period make possibilities for international cooperation during pandemics seem highly unlikely. This risks creating a dynamic where national health security is once again prioritized in future pandemics – and with it the cruel logic of "letting die" that was embodied by COVID-19 vaccine apartheid.

Reference List

1 World Health Organization. Coronavirus disease (COVID-19) pandemic. World Health Organization; n.d. (Emergencies). Available from: https://bit.ly/4cGMSKf

2 Dolgin E. The tangled history of mRNA vaccines. Nature. 2021 Sep 14. Available from: https://bit.ly/44B6yNs

3 Cross S, Rho Y, Reddy H, Pepperrell T, Rodgers F, Osborne R, et al. Who funded the research behind the Oxford–AstraZeneca COVID-19 vaccine? BMJ Glob Health. 2021 Dec;6(12):e007321. Available from: https://bit.ly/42CL0xl

4 Rizvi Z. Sharing the NIH-Moderna Vaccine Recipe. Public Citizen; 2021 Aug. Available from: https://bit.ly/42FjSxU

5 DiNapoli J. Novavax bosses cash out for $46 million with COVID-19 vaccine trials still under way. Reuters. 2021 Jan 11. Available from: https://bit.ly/42ob9RN

6 World Health Organization. WHO issues its first emergency use validation for a COVID-19 vaccine and emphasizes need for equitable global access. World Health Organization. 2020 Dec 31. Available from: https://bit.ly/3EydjFh

7 AstraZeneca. AstraZeneca COVID-19 vaccine authorised for emergency use by the World Health Organization. AstraZeneca webpage. 2021 Feb 15. Available from: https://bit.ly/42HoMdN

8 The Independent Panel for Pandemic Preparedness & Response. COVID-19: Make it the Last Pandemic. 2021 May. Available from: https://bit.ly/4ishf8yf

9 Health Justice Initiative. Pandemics and the illumination of "hidden things" – Lessons from South Africa on the global response to Covid-19. Health Justice Initiative; 2023 Jun. Available from: https://bit.ly/4irqLIW

10 OECD. Securing Medical Supply Chains in a Post-Pandemic World. OECD; 2024. (OECD Health Policy Studies). Available from: https://bit.ly/4lLGhT0

11 Bown CP. How COVID -19 Medical Supply Shortages Led to Extraordinary Trade and Industrial Policy. Asian Economic Policy Review. 2022 Jan;17(1):114–35. Available from: https://bit.ly/42E7uxT

12 Love J. Summary of KEI's September 28, 2023 comments to the TRIPS Council On Paragraph 8 Of The Ministerial Decision On The TRIPS Agreement. Knowledge Ecology International. 2023 Oct 12. Available from: https://bit.ly/44lYqk3

13 Paremoer L, Nandi S, Serag H, Baum F. Covid-19 pandemic and the social determinants of health. BMJ. 2021 Jan 28;n129. Conway T. Globally, the pandemic hits women. Alternative Information & Development Centre. 2020 Sep. Available from: https://bit.ly/3GvDxsp

14 Cairncross L. COVID-19: We need both physical distancing and social solidarity. Spotlight. 2020 Mar 20. Available from: https://bit.ly/3Rr9pAQ

15 Guzman-Cottrill JA, Malani AN, Weber DJ, Babcock H, Haessler SD, Hayden MK, Henderson DK, Murthy R, Rock C, Van Schooneveld T, Wright SB. Local, state and federal face mask mandates during the COVID-19 pandemic. Infect Control Hosp Epidemiol. 2021 Apr;42(4):455-6.

16 Hotez PJ. COVID19 meets the antivaccine movement. Microbes and infection. 2020 May;22(4):162-4.

17 Yang H. Contesting legitimacy of global governance institutions: The case of the World Health Organization during the coronavirus pandemic. International Studies Review. 2021 Dec;23(4):1813-34.

18 Lee K, Piper J. The WHO and the Covid-19 pandemic: less reform, more innovation. Global Governance: A Review of Multilateralism and International Organizations. 2020 Nov 23;26(4):523-33.

19 Merelli A. The WHO is done playing nice about vaccine equity. Quartz. 2022 Oct 19. Available from: https://bit.ly/4lGPaNw

20 BBC. Covid vaccine: WHO warns of "catastrophic moral failure." BBC. 2021 Jan 18. Available from: https://bit.ly/4jgyWsH

21 Ravelo JL. Tedros calls out "me-first" approach to COVID-19 vaccines: "This is wrong." Devex. 2021 Jan 18. Available from: https://bit.ly/4lzOrgV

22 Nebehay S. WHO's Tedros warns against over-reaction to Omicron. Reuters. 2021 Nov 30. Available from: https://bit.ly/3GveG88

23 Cullinan K. WHO Director General Calls On WTO To Take 'Practical' Action On IP Waiver For COVID Vaccines & Medicines. Health Policy Watch. 2021 Feb 26. Available from: https://bit.ly/3GdS7Vp

24 The Bureau of Investigative Journalism. Who Killed the Vaccine Waiver? The Bureau of Investigative Journalism. 2022 Nov 10. Available from: https://bit.ly/4jHfkhi/

25 World Health Organization. The World Together: Establishment of an intergovernmental negotiating body to strengthen pandemic prevention, preparedness and response. World Health Organization; 2021 Dec. Report No.: SSA2(5). Available from: https://bit.ly/44z9k5P

26 ibid.

27 ibid.

28 De Ceukelaire W, Bodini C. We Need Strong Public Health Care to Contain the Global Corona Pandemic. Int J Health Serv. 2020 Jul;50(3):276-277. Available from: https://bit.ly/4jgRRn7

29 Williams, OD. COVID-19 and Private Health: Market and Governance Failure. Development. 2020 Dec;63(2–4):181–90. Available from: https://bit.ly/4jBb7eY

30 Eaton J, Baingana F, Abdulaziz M, Obindo T, Skuse D, Jenkins R. The negative impact of global health worker migration, and how it can be addressed. Public Health. 2023 Dec;225:254–7. Available from: https://bit.ly/3GiXUt3

31 Pillinger J, Yeates N. Building Resilience Across Borders: A Policy Brief on Health Worker Migration. Public Services International; 2020 Dec. Available from: https://bit.ly/3Y7xmAZ

32 Mattos L, Giovanella L, Sundararaman T, Paremoer L, Freire JM, Stolkiner A, et al. Universal Health Systems: A better pathway to achieving universal and equitable acess to comprehensive healthcare. G20 Brasil; 2024. Available from: https://bit.ly/42RO8Xs

33 The Independent Panel for Pandemic Preparedness & Response. COVID-19: Make it the Last Pandemic. 2021 May; p.33. Available from: https://bit.ly/4cCmcKo

34 World Health Organization. Intergovernmental Negotiating Body to draft and negotiate a WHOP convention, agreement or other internaitonal instrument on pandemic prevention, preparedness and response – Proposal for the WHO Pandemic Agreement; 2024 Nov; Article 6(1). Available at: https://bit.ly/3EyqNkn

35 Patnaik P. Financing: don't let it be an afterthought in the pandemic agreement. Wemos. 2024. Available from: https://bit.ly/3YEj4YE

36 Duong DB, King AJ, Grépin KA, Hsu LY, Lim JF, Phillips C, et al. Strengthening national capacities for pandemic preparedness: a cross-country analysis of COVID-19 cases and deaths. Health Policy and Planning. 2022 Jan 13;37(1):55–64. Available from: https://bit.ly/442xQfr

37 World Health Organization. Intergovernmental Negotiating Body to draft and negotiate a WHOP convention, agreement or other internaitonal instrument on pandemic prevention, preparedness and response – Proposal for the WHO Pandemic Agreement; 2024 Nov; Article 7(1)-(2). Available from: https://bit.ly/3EyqNkn

38 Amandla. Women are the Frontline. Amandla. 2020 Oct;(71/2). Available from: https://www.amandla.org.za/past-editions/

39 Llop-Gironés A, Vra??ar A, Eder B, Joshi D, Dasgupta J, Paremoer L, et al. A Political Economy Analysis of the Impact of Covid-19 Pandemic on Health Workers. Yale Law School; 2021 Jul. Available from: https://bit.ly/42xUdbH

40 Patnaik P. Did Some Developed Countries Oust Africa Group's Key Negotiator, a Forceful Voice on Equity Provisions in INB-IHR Negotiations? Geneva Health Files. 2023. Available from: https://bit.ly/4cGZsZZ

41 O'Neill R. EU, US court Africa with pandemic side deals amid crunch WHO talks. Pro Politico. 2024 Mar 18. Available from: https://bit.ly/3RrVXN5

42 Patnaik P. A Turning Point? The EU & the U.S. Draw Out Four African Countries to Bridge Positions on Pathogen Access & Benefit Sharing. Geneva Health Files. 2024. Available from: https://bit.ly/42G0nFe

43 World Health Organization. Intergovernmental Negotiating Body to draft and negotiate a WHOP convention, agreement or other internaitonal instrument on pandemic prevention, preparedness and response – Proposal for the WHO Pandemic Agreement; 2024 Nov; Article 10(d). Available from: https://bit.ly/3EyqNkn

44 Storeng KT, de Bengy Puyvallée A, Stein F. COVAX and the rise of the 'super public private partnership' for global health. Global Public Health. 2023 Jan 2;18(1):1987502. Available from: https://bit.ly/3EzWZDT

45 World Health Organization. Intergovernmental Negotiating Body to draft and negotiate a WHOP convention, agreement or other internaitonal instrument on pandemic prevention, preparedness and response – Proposal for the WHO Pandemic Agreement; 2024 Nov; Article 13(1). Available from: https://bit.ly/3EyqNkn

46 ibid.

47 Sachs J, Weltgesundheitsorganisation, editors. Macroeconomics and health: investing in health for economic development; report of the Commission on Macroeconomics and Health. Geneva: World Health Organization; 2001. 200 p. Available from: https://bit.ly/3GkGMD3

48 Gavi. African Vaccine Manufacturing Accelerator (AVMA). n.d. Available from: https://bit.ly/3Ewb1GM

49 Herder M, Benavides X. 'Our project, your problem?' A case study of the WHO's mRNA technology transfer programme in South Africa. PLOS Global Public Health. 2024 Sep 23;4(9):e0003173. Available from: https://doi.org/10.1371/journal.pgph.0003173

50 Gopakumar K, Namboodiri S. WIPO: Africa Group & Brazil raise concerns on political pressure against use of TRIPS flexibilities. Third World Network. 2024 Nov 25. Available from: https://bit.ly/4inaeFJ

51 Rizvi Z. Sharing the NIH-Moderna Vaccine Recipe. Public Citizen; 2021 Aug. Available from: https://bit.ly/42VnJbi

52 Public Pharma for Europe Coalition. Public Pharma for Europe Coalition. n.d. Available from: https://bit.ly/4jAFm5I

53 Médecins Sans Frontières/Doctors Without Borders. Ensuring Access to New Treatments for Ebola Virus Disease. Médecins Sans Frontières / Doctors Without Borders; 2023 May. Available from: https://bit.ly/3RYyFyB

54 UNU IIGH. Power and Accountability. United Nations University webpage. n.d. Available from: https://bit.ly/4cKU5Ja

55 Rizvi Z. Sharing the NIH-Moderna Vaccine Recipe. Public Citizen; 2021 Aug. Available from: https://bit.ly/42VnJbi