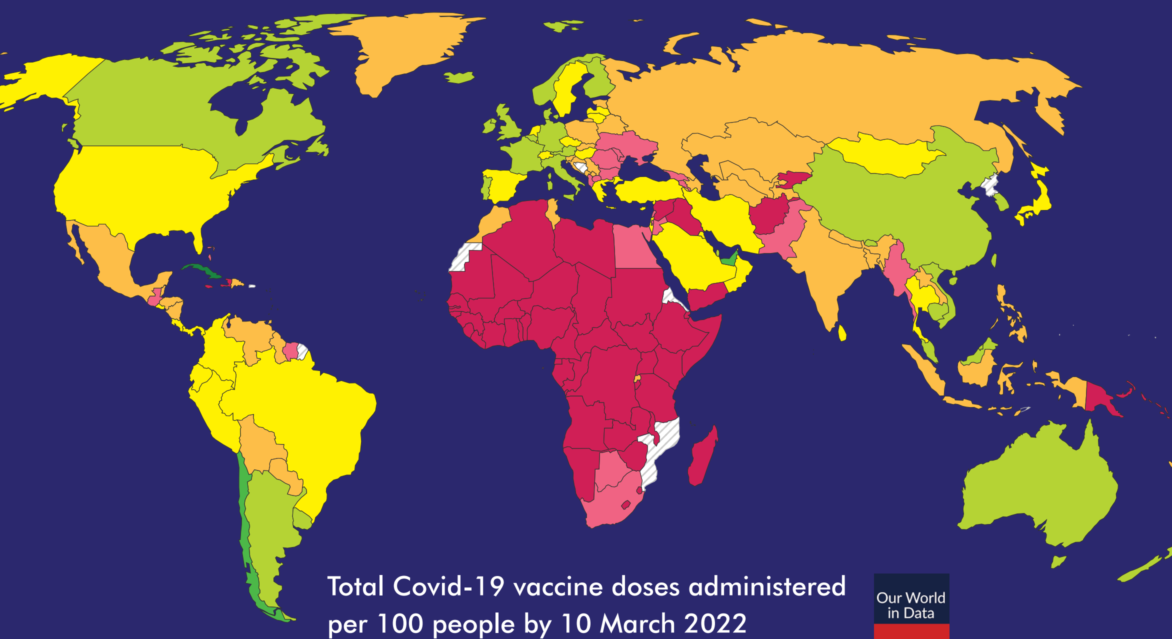
Pandemics and the illumination of “hidden things”

Lessons from South Africa on the global response to Covid-19

L. Paremoer

Negotiating Pandemic Preparedness, Response and Recovery in a hierarchical global system



HEALTH JUSTICE INITIATIVE

Suggested citation: Health Justice Initiative *Pandemics and the illumination of “hidden things” – Lessons from South Africa on the global response to Covid-19*. Edited Volume. June 2023.

Editor: Laura Lopez Gonzalez
Project Lead: Marlise Richter
Proofreader: Sigwabusuku Mafu
Lay-out & Design: Jaywalk Design
Funding: The Health Justice Initiative is grateful to all its organisational and individual donors for funding and supporting its work. We would like to acknowledge the contributions of the Rockefeller Brothers Fund, the Joffe Trust and the Claude Leon Foundation towards funding this Compendium in particular.

Credit front-page image:

Adaption of *World in Data*. Image shows Total Covid-19 vaccine doses administered per 100 people, as of 11 March 2022 (two years since the WHO declared Covid-19 a “pandemic”).

Credits for republished pieces and quotations:

Bhekisisa
Groundup
Spotlight
News24
People’s Vaccine Alliance
Arundhati Roy
World Health Organization
Our World in Data
The Lancet

Creative Commons: Attribution 4.0 International (CC BY 4.0)

This license allows reusers to distribute, remix, adapt, and build upon the material in any medium or format, so long as attribution is given to the creator. The license allows for commercial use.

Negotiating Pandemic Preparedness, Response and Recovery in a hierarchical global system

Lauren Paremoer

The Covid-19 pandemic has exposed the life-and-death consequences of the hierarchies that characterise the contemporary multilateral system, prompting what has been seen by many as a need for a new international pandemic treaty. In December 2021, the WHO's main governing body, the World Health Assembly (WHA), established an intergovernmental negotiating body to draft and negotiate a new treaty to strengthen pandemic prevention, preparedness and response. The WHO's intergovernmental negotiating body presented a preliminary conceptual draft of the treaty in December 2022 at the intergovernmental negotiating body's (INB) third meeting (INB3). Known as the Conceptual Zero Draft, the version provided the first steps towards an eventual initial draft of the treaty.

To be effective, any new international agreement promoting pandemic preparedness, response, and recovery (PPRR) must institutionalise measures to overcome these hierarchies. This chapter focuses on December 2022 discussions surrounding the Conceptual Zero Draft of the new pandemic treaty undertaken at the

INB3 (WHO, 2022). Specifically, this chapter unpacks developing countries' comments that provide insights into the forms of international cooperation they consider essential for building a fair and equitable PPRR framework. These include:

1. greater reliance on legally binding mechanisms to ensure co-ordinated cooperation for PPRR;
2. guaranteeing the WHO's role as the lead co-ordinating body in international health emergencies;
3. building research and development, production and regulatory capacities for pandemic response products in low and middle-income countries;
4. increasing states' power to regulate the practices of pharmaceutical corporations during pandemics; and
5. promoting functional people and worker-centred public health systems.

Lessons from previous pandemics

The Covid-19 pandemic highlighted long-standing shortcomings of existing PPRR measures. During the early years of the HIV pandemic, for example, equal access to antiretroviral treatment was made impossible by the high prices of patented antiretrovirals and the lack of generic alternatives. This was a direct consequence of the TRIPS Agreement of 1995. As discussed before, the TRIPS Agreement grants inventors intellectual property rights over their innovations for a period of 20 years. During this period, they have exclusive control over who may manufacture their new technologies, which markets they should be sold in, and at what price. TRIPS has been justified on the grounds that it promotes innovation because it allows inventors to recover their research and development costs. However, a growing body of literature suggests that it has done little to promote innovation, technology transfer, and access to new medicines in developing countries (Thambisetty et al., 2021).

Another lesson from previous pandemics was that developed states tended to prioritise national health security at the expense

of international cooperation. The response to the 2014 West African Ebola outbreak largely in Liberia, Guinea, and Sierra Leone demonstrated that international solidarity only became a political priority to high-income countries when the outbreak directly threatened their populations through imported cases of the virus (DuBois et al., 2015). The outbreak also indicated that developed countries' governments and non-governmental organisations (NGOs) tended to dominate pandemic response decision-making processes, with national government representatives and even the WHO being marginalised within these processes.

This dynamic is repeating itself in the context of the Covid-19 pandemic. Developed countries have been guilty of vaccine nationalism, hoarding more Covid-19 vaccines for their populations than they could ever use (Dyer, 2020). The voices of developed countries' NGOs and philanthropic foundations have dominated multi-stakeholder initiatives such as COVAX, a global initiative that aimed (and ultimately failed) to provide more equitable access to Covid-19 vaccines and, in particular, guarantee the poorest countries access to enough immunisations to vaccinate the most vulnerable.

Even though developing countries' governments and the WHO are subject to oversight — and the WHO is mandated to take a leadership role in co-ordinating international health governance — they were marginalised within multi-stakeholder initiatives such as COVAX that were meant to respond to the pandemic (Gleckman, 2022). In doing so, developed countries have neglected their obligations under Article 44 of the International Health Regulations (IHR). This chapter calls on countries to collaborate on technical cooperation and logistical support during outbreaks declared by the WHO to be Public Health Emergency of International Concern (PHEIC), and to support legal proposals and regulations to address these outbreaks at home and abroad. These regulations were amended in 2005, after the 2002 outbreak of the severe acute respiratory syndrome (SARS) demonstrated the international community's failure to engage in co-ordinated international cooperation in response to the outbreak. Despite this, countries did no better on this count during the Ebola outbreak roughly a decade later.

Both the HIV and Ebola outbreaks showed the importance of

health systems strengthening as a baseline condition for launching effective PPRR interventions. Unfortunately, subsequent efforts to obtain this goal have led to reforms that introduce new distortions and sources of vulnerability into developing countries' health systems that undermined their Covid-19 responses. For example, after the 2002 SARS outbreak, the WHO proposed universal health coverage as an approach to strengthening health systems and promoting "individual health security" (WHO, 2007). For the WHO, "[f]inancial protection is at the core" of universal health coverage (WHO, no date).

In other words, the WHO's approach to universal health coverage focuses on ensuring individuals and households are protected against financial catastrophe when they have to pay for health services. The WHO is, however, agnostic about whether those services are provided by the public or private sector, as long as they are free or affordable at the point of care (Sanders et al., 2019). As a result, the shift to universal health coverage has not reversed the commercialisation and privatisation of healthcare services, which have contributed to the deterioration of the public health sector in developing states (WHO, 2007).

Finally, the HIV pandemic led to the employment of community health workers as a mechanism to strengthen developing countries' health systems, particularly their abilities to deliver routine care to marginalised populations. During the Ebola outbreak of 2014, community health workers were crucial in convincing communities to follow prevention and treatment protocols (Ballard et al., 2022).

And, during the Covid-19 pandemic, community health workers were charged with supporting Covid-19 prevention education, contract tracing, and vaccine uptake efforts in many developing states (Ballard et al., 2022). The incorporation of community health workers has strengthened developing countries' ability to deliver health services. Sadly, this has come at the expense of creating an exploited workforce — mostly consisting of women and ethnic or racial minorities — who experience low and irregular pay, poor job security, dangerous working conditions, and a lack of support and respect by more elite health workers. In the next section I discuss how some of these long-standing lessons on PPRR were revisited

during the INB3 in December 2022 through proposals by developing countries aimed at ensuring any new pandemic treaty explicitly addresses these issues and through legally binding measures.

Covid-19 and what pandemic preparedness means now

Rethinking the idea of an emergency

What does PPRR mean when conceptualised from the perspective of people forced to "maintain life and a degree of self-respect" in "the underbelly of economies that cannot, or will not, provide reasonably for the population" (Chabal, 2009: 128) PPRR discussions at the global level tend to frame the experiences of disaster, crisis and risk associated with pandemics as extraordinary events. This is understandable: outbreaks of rare or new diseases like Covid-19, SARS, and Ebola have catastrophic consequences in terms of loss of life, long-term disability, and economic hardship for households and national economies. Additionally, the early phases of these pandemics were characterised by a lack of specialised tests and treatments, thereby heightening their sense of exceptionality. However, it is also true that these emergencies occur alongside the overlapping "slow catastrophes" of "grinding poverty, food insecurity and hunger, everyday violence and climate shocks" (Robins, 2020). Similarly, pandemics occur alongside pre-existing economic inequality, social oppression and ecological destruction (Andrews, 2021). These crises are understood as "neither spectacular nor instantaneous, but rather incremental and accretive" (Nixon in Shepherd, 2019: 2). Their negative effects are most acutely felt by marginalised social groups such as impoverished people, racial minorities, migrants, and women (Paremoer et al., 2021).

These slow catastrophes have been driven by the increased privatisation and commercialisation of basic services over the past three decades, which have been associated with poorer health outcomes in developing and developed states (Viva Salud, 2019). A fuller conception of PPRR involves taking these slow catastrophes and their causal drivers seriously to ensure that dismantling them forms part of PPRR efforts. Finding ways to rebuild public institutions that protect and promote social rights, including the

right to health, should be a foundational feature of any new PPRR instrument. Without this, seemingly straightforward, common-sense advice about how to survive pandemics like Covid-19 becomes wildly impractical for impoverished individuals in both developed and developing states.

For example, common-sense advice like going to a hospital when a Covid-19 infection causes difficulty in breathing is near-impossible in countries where decades of under-investment in public hospitals leave people without free transport to medical facilities, and where facilities do not have the infrastructure and budgets to provide sufficient beds and oxygen. Where vaccines were available and provided for free, uptake is undermined by the everyday manifestations of slow catastrophes such as fear of authorities amongst marginalised communities such as racial minorities and migrants (Njoku et al., 2021), lack of required documentation to register for vaccination or to be residing in a particular country (Matlin et al., 2022), and workers' inability to take leave (Matahari Global Solutions, 2022).

How do these everyday struggles relate to the global governance measures being developed in the name of "better" PPRR for future pandemics? Interventions by WHO Member States during INB3 serve as reference points for how "health systems strengthening" might be translated into concrete policies that do the work required to address slow catastrophes.

For example, financing provisions in the Conceptual Zero Draft of the new pandemic treaty includes calls for strengthening domestic financing for PPRR as well as making funds rapidly available for countries, in part through new or established international mechanisms, for instance.

Uganda astutely observed that these provisions are incomplete without references to debt relief (Intervention by Uganda, 2022).

> We propose that measures to initiate debt relief mechanisms to developing countries with active disease outbreaks [for] purposes of epidemic response [be included]. Number two: measures to restrict payment of existing

> national debt for a time bound period for developing countries with active epidemic events. Number three: measures to ensure that commercial banks have mechanisms to relieve or restructure their debt payments for citizens in time-bound periods in the event of an epidemic or pandemic …

Uganda's intervention clearly acknowledges the strain debt servicing requirements have placed on health budgets during "normal" years, and the reality that the Covid-19 pandemic has forced developing countries to take on additional debts in order to keep their populations alive (Dentico et al., 2022). Similarly, Bangladesh highlighted that "fiscal space for developing countries would be important to increase domestic financing" for health systems (Intervention by Bangladesh, 2022). "Fiscal space" is a term used by the International Monetary Fund (IMF) to refer to the amount of money a government can spend on a specific policy priority like healthcare, without undermining the stability of the entire economy. The term is also repeated in WHO publications.

In referring to it during discussions of the pandemic treaty's Conceptual Zero Draft, Bangladesh effectively pushed back against the austerity measures, that is, budget cuts on social spending, that many developing states are being forced to adopt by the IMF in the name of speeding up their economic recovery from the pandemic.

In sections of the Draft dedicated to "health systems strengthening", it suggests measures such as improving disease surveillance, increasing access to related technology and safeguarding other essential healthcare services during outbreaks.

The Africa group, Colombia and Nigeria all cautioned against conflating health systems strengthening with measures narrowly focused on PPRR like surveillance and related data dissemination systems, with Nigeria pointing out that developing countries would need external financial support to achieve health systems strengthening. Mozambique warned against adopting vertical approaches to health systems strengthening that "in the long run … induce weak coordination … hampering the capability of

health systems to respond to health challenges, and also drives to duplication of efforts and resource ineffectiveness" (Intervention by Mozambique, 2022). Member States pointed to the importance of employing enough health workers and providing them with good quality wages and conditions of employment. Addressing the maldistribution of health workers globally, Botswana requested that the 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel be explicitly captured in the pandemic treaty's Conceptual Zero Draft (Intervention by Botswana, 2022). This would represent a modest first step towards exposing the benefits that high-income country health systems reap from employing health workers trained with public funds in low and middle-income countries. This practice by high-income countries exacerbates shortages of personnel in these states, thus making them less capable of developing the PPRR capabilities.

Building medical manufacturing capabilities in low and middle-income countries

During the Covid-19 pandemic, developed countries benefited from their status as pharmaceutical manufacturing mRNA Hubs. These governments could shape the research and development, and manufacturing scale-up efforts of corporations like Pfizer and Moderna through massive public subsidies (Rizvi, 2022). This helped to ensure that these countries would be the first in line to receive vaccines for their populations. The lack of pharmaceutical manufacturing capabilities in many developing states meant this type of policy intervention was not available to them. In response to this kind of vaccine nationalism, the best some low and middle-income countries could do was offer to participate in clinical trials as one way of obtaining early access to vaccines for some of their populations. However, participation in vaccine trials did not secure developing countries access to broader benefits like preferential pricing, timely procurement deals or technology transfer. In fact, developing countries' manufacturers that had the capability to produce viral vector Covid-19 vaccines were prevented from doing so as companies who held the intellectual property rights to these vaccines refused to issue timely voluntary licences to developing

countries' producers. The Serum Institute of India was one of the very few developing countries' producers that early on received a voluntary licence to produce just one Covid-19 vaccine.

In the case of mRNA vaccines, developing countries' producers had to contend with spurious arguments that this technology was too complex for them to produce, despite research by MSF identifying more than 100 companies in Africa, Asia and Latin America whose existing facilities could have been retrofitted to manufacture mRNA vaccines within a matter of months following a "full and transparent transfer of vaccine know-how". The success of the WHO's mRNA Technology Transfer Hub in producing its own mRNA Covid-19 vaccine within seven months of its establishment suggests that a co-ordinated international effort to promote technology transfer could, by now, have contributed to expanding mRNA vaccine manufacturing capabilities in developing countries (Maxmen, 2022). In light of this, it is understandable that many developing countries are insisting that concrete and legally binding measures to support technology transfer be included in any new pandemic instrument. Many developing countries' interventions at INB3 showed support for provisions in the pandemic treaty's Conceptual Zero Draft that could alter the balance of power between pharmaceutical companies and states. These include proposals to ensure corporations assume part of the liability associated with bringing pandemic response products to the market while they are still in the research phase, sharing information about the results of publicly and government-funded research and development efforts, sharing regulatory dossiers, and compelling companies to disclose the prices and contractual terms of public procurement contracts (WHO, 2022: 16-18). These measures would significantly increase ease of access to information required by developing countries to build their local manufacturing capacities, and to assess whether corporations are charging extortionate prices for pandemic response products.

The INB3 negotiations also offer an opportunity to negotiate legally binding mechanisms that limit the TRIPS agreement's relevance during pandemics. The Conceptual Draft Zero includes four different proposed formulations of its paragraph 38 aimed

at "recognising" the ways in which TRIPS impedes technology transfer and building new manufacturing capabilities for pandemic response products.

The first three of these proposed versions all argue that intellectual property rights are "important for the development of new medical products" while recognising concerns about their negative impact on medicines prices and equitable access. They are not expressly coupled with an acknowledgement that these effects of the TRIPS regime violate the rights to health and to enjoy the benefits of scientific progress and its applications, as codified in the ICESCR (ICESCR, 1967). Most countries in the world are signatories to the covenant and have a legal obligation to protect and promote these rights. The fourth and final proposed formulation of paragraph 38 in the draft is the only one that explicitly recognises "concerns that intellectual property on life-saving medical technologies continue to pose [a] threat and barriers to the full realisation of the right to health and to scientific progress for all" (WHO, 2022). Article 7 of the Conceptual Draft Zero, which discusses, "promoting sustainable and equitably distributed production and transfer of technology and know-how" is also drafted in a manner that remains ambivalent about whether countries should institutionalise voluntary or legally binding multilateral mechanisms "that promote and provide relevant transfer of technology and know-how in a manner consistent with international legal frameworks, to potential manufacturers in developing countries/all regions to increase and strengthen regional and global manufacturing capacity".

Despite the failure of voluntary measures during the Covid-19 pandemic and previous pandemics (Paremoer, 2022), many high-income countries have used the INB3 to emphasise their support for voluntary international co-ordination and cooperation during health emergencies. The US for example "reiterate[d] that any references to technology transfer in the document must be clear that such transfer should always be voluntary and occur on mutually agreed terms consistent with past WHO agreed language" (Intervention by the United States, 2022). The EU echoed the US's position, saying:

> [I]ssues related to technology diffusion and transfer as well as manufacturing capacities will be important to improve PPR... At the same time, we think that technology transfer should be conducted on a voluntary basis. We also believe the World Trade Organization and World Intellectual Property Organization are the most appropriate for a for international rule making on intellectual property rights. In the framework of the INB we remain open to discuss how the cooperation between WHO, World Trade Organization and World Intellectual Property Organization can be strengthened when it comes to health-related matters.
>
> (Intervention by the EU, 2022).

Framing the relationship between the WHO, WTO and World Intellectual Property Organization (WIPO) as one amenable to cooperation — as this intervention does — obscures the fact that WHO's mandate to promote the realisation of the highest attainable standard of health for all is diametrically opposed with WTO's and WIPO's mandates to protect property rights and for-profit markets. As Bangladesh highlighted during INB3, in the "case of cross cutting issues involving the WTO, WIPO or other institutions" any new pandemic instrument "needs to clarify whose institutions and provisions would be triggered during [a Public Health Emergency of International Concern] and pandemic, otherwise we shall see people dying while we are at negotiations" (Intervention by Bangladesh, 2022).

That said, the Covid-19 pandemic suggests that unless the WHO is explicitly mandated to take a leading role in co-ordinating access to pandemic response products — including by offering support for the production of generic versions of patented products — other institutions will step into this space. If the WTO does so, it is likely to prioritise the defending conservative interpretations of the

TRIPS Agreement rather than suspending these rules to promote equitable access to life-saving medical technologies, as the WTO did in response to the failed TRIPS waiver request that would have temporarily waived some intellectual property protections on Covid-19 tools that countries needed to implement pandemic response programmes.

Fair and equitable benefit sharing

Developing countries have strongly resisted the idea that any new pandemic instrument should legitimate PPRR efforts organised around nebulous notions of voluntary cooperation or "sharing" information in the interest of securing rapid access to pandemic response products. The controversy generated by the Conceptual Zero Draft's demand for "early, safe, transparent and rapid sharing of samples and genetic sequence data of pathogens, as well as the fair and equitable sharing of benefits arising therefrom" (WHO, 2022) provides a good example of this. This debate revolves around whether countries that share samples of pathogens or their genetic sequences should be entitled to demand that they be given fair and equitable access to any benefits (for example, vaccines or treatments) that recipients derive from this. An international treaty known as the 2010 Nagoya Protocol of the Convention on Biodiversity sets out a legally binding framework to govern access and benefits sharing and many developing states are calling for these principles to be applied to pathogens and their genomic sequencing data.

For example, during the INB3's discussion of the draft in December 2022, Namibia called for "guard[ing] against final outcomes… where access to pathogens and genetic sequencing data is prioritised without a clear and comprehensive benefit sharing mechanism" (Intervention by Namibia, 2022). The country went further, arguing that it did not want the relevant article in the draft "to be interpreted as an aspiration on access and benefit sharing to be achieved in the distant future".

Following this, Namibia supported Indonesia's call for an annex on access and benefit sharing to be added to the instrument.

Several countries, including Egypt and Botswana explicitly called for access and benefit sharing to be treated in a manner consistent with the Nagoya Protocol of the Convention on Biodiversity. For instance, Botswana proposed that "access and benefit sharing should be a legally binding multilateral mechanism negotiated as part of the instrument". Kenya joined the chorus, saying: "We take this opportunity to underscore that sovereign rights, prior informed consent and benefit sharing are established principles that cannot be undermined in the text" (Intervention by Kenya, 2022).

Bangladesh argued that benefit sharing should not be reduced to accessing final products, for example, but should be conceived of in more robust terms (Intervention by Bangladesh, 2022). Bangladesh stated that "under [the] aegis of access and benefit sharing mechanisms it would be important to create a space for WHO to receive technology and know-how with a right to use them in designated manufacturing facilities during a [Public Health Emergency of International Concern] and pandemics". The South Asian country similarly argued for greater benefit sharing around genetic sequencing information:

> In the whole process of sharing research and use of [genetic sequencing information] we would ask for the source entities the right to access information, research and its commercial use. It would be important to facilitate participation of the professionals of the source countries in research and manufacturing processes as a part of training and capacity building.

The Russian Federation pointed out the importance of defining and contextualising terms such as "benefits" or "research ecosystems", and to whom they were addressed, for instance (Intervention by the Russian Federation, 2022). However, unlike the aforementioned interventions, the Russian Federation insisted that "the requirements under a centralised system should be voluntary and not legally binding".

Developed countries with large pharmaceutical sectors shared this aversion to legal provisions that would make access to pathogens and their genetic sequencing information dependent on benefit sharing. Their interventions echo the position of the industry association, the International Federation of Pharmaceutical Manufacturers and Associations (Cueni, 2021) that legally mandated benefit sharing would amount to a form of "pathogen protectionism" that would impede access to medical countermeasures for PPRR. Switzerland, for example, argued that the "sharing of pathogens has to be a priority; this allows us to develop very quickly medical products that helps during outbreaks… we should find [access and benefit sharing] solutions that are not tied to each other, otherwise we would slow down access" (Intervention by Switzerland, 2022). However, as the Covid-19 pandemic has shown, the speedy and efficient development of pandemic response measures means little when those products are unavailable due to limited supplies or are unaffordable because of excessive pricing.

Rethinking the social organisation of care

The "social organisation of care" refers to how "care needs are met by the interaction between households, the state, the market and community organisations" (Rodríguez Enríquez and Farga, 2021). The INB process to develop a pandemic treaty must reflect on how to institutionalise PPRR interventions that depend less on the people — largely women and girls — who provide free care work within their households during health emergencies, effectively subsidising the state. This free labour is an important source of the "resilience" that health systems exhibited during the Covid-19 pandemic. The persistent silence about the unequal and gendered organisation of social care work in PPRR discussions suggests that this extractivist orientation to women's care labour is seen as unproblematic. This has the unfortunate effect of normalising the gendered division of care work, including during pandemics that expose caregivers to heightened risks of infection and death. Unless this is addressed, women offering both professionalised medical care and invisible, unpaid care within households will be forced to act as the "shock absorbers" (Fakier and Cock, 2009) of

health emergencies, particularly in developing states, and at great cost to their economic security and health.

During the Covid-19 pandemic, governments across the world experimented with temporary measures aimed at increasing households' access to publicly provided or subsidised care services. These included public facilities where people with Covid-19 could isolate, food distribution schemes, temporary cash transfers to vulnerable groups, universal basic income measures, and anti-eviction measures (Rodríguez Enríquez and Farga, 2021). A "whole of government and whole of society" approach to PPRR includes converting these temporary measures into permanent institutions in order to "break the cycle of 'panic and neglect'" associated with health emergencies (WHO, 2022,). However, without ensuring that the "communities" referred to in the Conceptual Zero Draft have the basic resources they need to live well, the principles of "gender equality" and "full engagement by communities" endorsed by the Conceptual Zero Draft are likely to be symbolic at best.

For example, the Conceptual Zero Draft's call to mobilise "social capital in communities for mutual support, especially to persons in vulnerable situations" (Art.15(2)(c)) may seem innocuous. In practice this is a tough ask: In the absence of public welfare measures, impoverished communities have long been forced to rely on mutual aid practices to manage the slow catastrophes of daily life outlined above. This is a coping mechanism, aimed at "deriv[ing] maximal outcomes from a minimal set of elements" (Simone, 2004). Asking communities to double down on such coping mechanisms by mobilising whatever "spare" social capital they have during health emergencies runs the risk of developing a framework that prioritises what governments and transnational corporations need to survive pandemics over the needs of communities.

As Rodríguez Enríquez and Farga point out:

> [o]ne of the lessons from this period is that, contrary to the dominant narrative, governments can actively implement public policies and allocate budgetary resources. In other words, the recovery of the essential role of the State in attending to the care

> needs of the population and exercising a leadership role in the social organisation of care seems to be possible when there is political will (Rodríguez Enríquez and Farga, 2021).

Additionally, without concerted efforts to build the resource base and political power of communities as part of pandemic preparedness, communities will not be able to effectively participate in national decision-making processes or co-ordinating mechanisms that involve vastly more powerful actors from government and the private sector (WHO, 2022). The same will be true at the global level. The Conceptual Zero Draft includes a proposal that the governing body of a new pandemic treaty could include non-state actors, including the private sector, in decision-making processes. This risks giving representatives of commercial interests the power to influence how future PPRR efforts are governed, despite the lack of solidarity these entities have shown during the Covid-19 pandemic.

Conclusion

In this chapter I have spotlighted the contributions made by developing WHO Member States during December 2022 INB3 discussions over the Conceptual Zero Draft of a proposed pandemic treaty that are aimed at creating a fairer and more equitable PPRR regime. These nations' contributions are informed by their own domestic experiences with managing PPRR. For developing states, these experiences have clearly been defined by their treatment as second-class citizens of the global community. It is for this reason that the term "vaccine apartheid" has been so apt to characterise the racialised inequalities that have defined unequal access to Covid-19 technologies. In contrast, developed countries' interventions at INB3 convey the confidence of countries expecting to retain their position of dominance in controlling the terms on which access to information, financial resources, and medical infrastructures is governed between and during pandemics.

As health activists, we are often critical of the lack of leadership

our governments in the Global South display in global governance processes. They have been criticised for paying lip service to the Alma Ata agenda of "health for all" but ultimately failing to propose bold alternatives that advance this agenda in practical terms. Additionally, their participation in WHO processes has been described as largely symbolic, given WHO's declining authority and fiscal autonomy *vis-à-vis* donors, super public-private partnerships and powerful countries within the international system (Storeng et al., 2021). This has contributed to reducing WHO's authority as the lead agency in global governance for health. The Covid-19 pandemic unfortunately revealed the lethal consequences of these hierarchies in the global political economy.

Nevertheless, I would like to end on a hopeful note by arguing that the interventions by low and middle-income countries at INB3 offer a ray of hope that the ongoing discussions about PPRR will serve as an entry point for institutionalising systemic reforms that could destabilise these trends. The discussion above shows that the Covid-19 pandemic did not necessarily present the world with new lessons about how the hierarchies that characterise the global system hamper international cooperation during times of crisis. What is new, perhaps, is the opportunity the pandemic has offered to move from a model of voluntary cooperation to one specifying concrete and legally binding measures that prevent more powerful states from ignoring the principle of common but differentiated responsibilities and commit them to reforms that expand and deepen developing states' capabilities to promote the health of their populations.

Dr Lauren Paremoer is a member of People's Health Movement SA and the representative of the Democratising Global Health Governance Programme on the Global Steering Council of People's Health Movement. She is a member of the University of Cape Town Political Studies Department.

References

Andrews D. (2021). Towards building feminist economies of life. *Feminist Africa* 2(1):126-133

Ballard M, Johnson A, Mwanza I, Ngwira H, Schechter J, Odera M, Mbewe DN, Moenga R, Muyingo P, Jalloh R and Wabwire J (2022). Community health workers in pandemics: Evidence and investment implications. Global Health: Science and Practice 10(2).

Chabal P (2009). *Africa: the politics of suffering and smiling*. Bloomsbury Publishing.

Cueni T (2022). It's time to put an end to pathogen protectionism. SwissInfo. Available at https://www.ifpma.org/global-health-matters/its-time-to-put-an-end-to-pathogen-protectionism/(accessed 5 January 2023).

Dentico N, Aye B, and Meurs M (2022). Financial justice for pandemic prevention, preparedness and response: G2H2 Report. Available at https://g2h2.org/wp-content/uploads/2022/11/G2H2-Report-2022.pdf (accessed 5 January 2023).

Doctors Without Borders / Médecins Sans Frontières (2021). Pharmaceutical manufacturers across Asia, Africa and Latin America with the technical requirements and quality standards to manufacture mRNA vaccines. Available at https://msfaccess.org/pharmaceutical-firms-across-asia-africa-and-latin-america-potential-manufacture-mrna-vaccines.(accessed 5 January 2023).

DuBois M, Wake C, Sturridge S, and Bennett C (2015). *The Ebola response in West Africa: Exposing the politics and culture of international aid.* Overseas Development Institute Humanitarian Poverty Group Working Paper. *Available at* https://cdn.odi.org/media/documents/9903.pdf (accessed 5 January 2023)

Dyer O (2020). Covid-19: Many poor countries will see almost no vaccine next year, aid groups warn. *BMJ* 371.

Fakier K and Cock J (2009). A gendered analysis of the crisis of social reproduction in contemporary South Africa. *International Feminist Journal of Politics* 11(3):353-371

Gleckman H (2022). *The three Covid crises and multistakeholderism: Impacts on multistakeholderism.* Amsterdam: Friends of the Earth and Transnational Institute. Available at https://www.tni.org/files/publication-downloads/three-covid-crises-7-18-2022-web.pdf (accessed 5 January 2023)

Intervention by the Africa Group, INB3, Day 2, Session 1 (2022). Livestream recording time stamp 1:29:08.Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023).

Intervention by Bangladesh, INB3, Day 2 Session 2 (2022). Livestream recording time stamp 14:05:00. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023).

Intervention by Botswana, INB3, Day 2, Session 1 (2022). Livestream recording time stamp 2:06:11. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023).
Intervention by the European Union, INB 3, Day 2, Session 1 (2022). Livestream recording time stamp 2:38:50. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023)
Intervention by Kenya, INB 3, Day 2 Session 1 (2022). Livestream recording time stamp 2:11:12. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023).
Intervention by Mozambique, INB3, Day 2, Session 2 (2022) Livestream recording time stamp 4:25:00. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023).
Intervention by Switzerland, INB3, Day 2, Session 2 (2022). Livestream recording time stamp 11.00:00. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023).
Intervention by the Russian Federation, INB3, Day 2, Session 1 (2022). Livestream recording time stamp 2:23:29. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023).
Intervention by Uganda, INB3, Day 2, Session 2 (2022). Livestream recording time stamp 1:28:47. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023)
Intervention by the United States of America, INB3 Day 2, Session 1 (2022). Livestream recording time stamp 2:04: 11. Available at https://apps.who.int/gb/inb/e/e_inb-3.html (accessed 1 January 2023)
Matahari Global Solutions (2022). Mapping access gaps in COVID-19: Results from 14 countries and territories. Available at https://itpcglobal.org/wp-content/uploads/2022/08/Mapping-Access-Gaps-in-COVID-19.pdf (accessed 5 January 2023).
Matlin S A, Smith AC, Merone J, LeVoy M, Shah J, Vanbiervliet F, Vandentorren S, Vearey J and Saso L (2022). The challenge of reaching undocumented migrants with Covid-19 vaccination. I*nternational Journal of Environmental Research and Public Health* 19(16):9973.
Maxmen A (2022). South African scientists copy Moderna's Covid vaccine. *Nature*. Available at https://www.nature.com/articles/d41586-022-00293-2 *(*accessed 5 January 2023*)*
Njoku A, Joseph M and Felix R (2021). Changing the narrative: structural barriers and racial and ethnic inequities in Covid-19 vaccination. *International Journal of Environmental Research and Public Health* 18(18):9904.
Paremoer L, Nandi S, Serag H and Baum F (2021). Covid-19 pandemic and the social determinants of health. *BMJ*, 372.

Paremoer L (2022). Berlin Declaration: Key claims and critiques. People's vaccine. Available: https://peoplesvaccine.org/wp-content/uploads/2022/11/Berlin-Declaration_2022.pdf (accessed 5 January 2023)

Rizvi Z (2022). Sharing the NIH-Moderna Vaccine Recipe. *Public Citizen*. Available at https://www.citizen.org/wp-content/uploads/Sharing-the-Vaccine-Recipe-Aug-10.pdf (accessed 5 January 2023)

Robins S (2020). Beyond the emergency: "Slow catastrophes" after Covid-19. *Daily Maverick*. Available at https://www.dailymaverick.co.za/article/2020-04-20-beyond-the-emergency-slow-catastrophes-after-covid-19/ (accessed 30 December 2023)

Rodríguez Enríquez C and Farga C (2022). The social organisation of care: a global snapshot of the main challenges and potential alternatives for a feminist trade union agenda. Available at https://pop-umbrella.s3.amazonaws.com/uploads/18ad4bcb-c002-4f85-b93c-4dbe751bae11_EN_SOOC_2021_Page.pdf (accessed 5 January 2023)

Sanders D, Nandi S, Labonté R, Vance C and Van Damme W (2019). From primary health care to universal health coverage—one step forward and two steps back. *The Lancet* 394(10199):619-621.

Shepherd N (2019). Making sense of "day zero": slow catastrophes, Anthropocene futures, and the story of Cape Town's water crisis. *Water* 11(9):1744.

Simone A (2004). People as infrastructure: Intersecting fragments in Johannesburg. *Public Culture* 16(3):407-429.

Storeng KT, de Bengy Puyvallée A and Stein F (2021). COVAX and the rise of the "super public private partnership" for global health. *Global Public Health*1-17.

Thambisetty S, McMahon A, McDonagh L, Kang HY and Dutfield G (2021). The TRIPS Intellectual Property Waiver Proposal: creating the right incentives in patent law and politics to end the Covid-19 pandemic. LSE Legal Studies Working Papers. Available at https://eprints.lse.ac.uk/112227/ (accessed 5 January 2023)

United Nations (1967). International covenant on economic, social and cultural rights. Available at https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights (accessed 5 January 2023)

World Health Organization (no date). SDG 3.8.2 Catastrophic health spending (and related indicators). Available at https://www.who.int/data/gho/data/themes/topics/financial-protection (accessed 5 January 2023)

World Health Organization (2007). The World Health Report 2007: A safer future — global public health security in the 21st century. Geneva: World Health Organization. Available at https://www.who.int/publications/i/item/9789241563444 (accessed 5 January 2023)

World Health Organisation (2022). Conceptual zero draft for the consideration of the Intergovernmental Negotiating Body at its third meeting (A/INB/3/3), 25 November 2022. Available at https://apps.who.int/gb/inb/pdf_files/inb3/A_INB3_3-en.pdf (accessed 5 January 2023)

If you found this Compendium useful, please consider making a donation towards our work. See https://healthjusticeinitiative.org.za/donate/