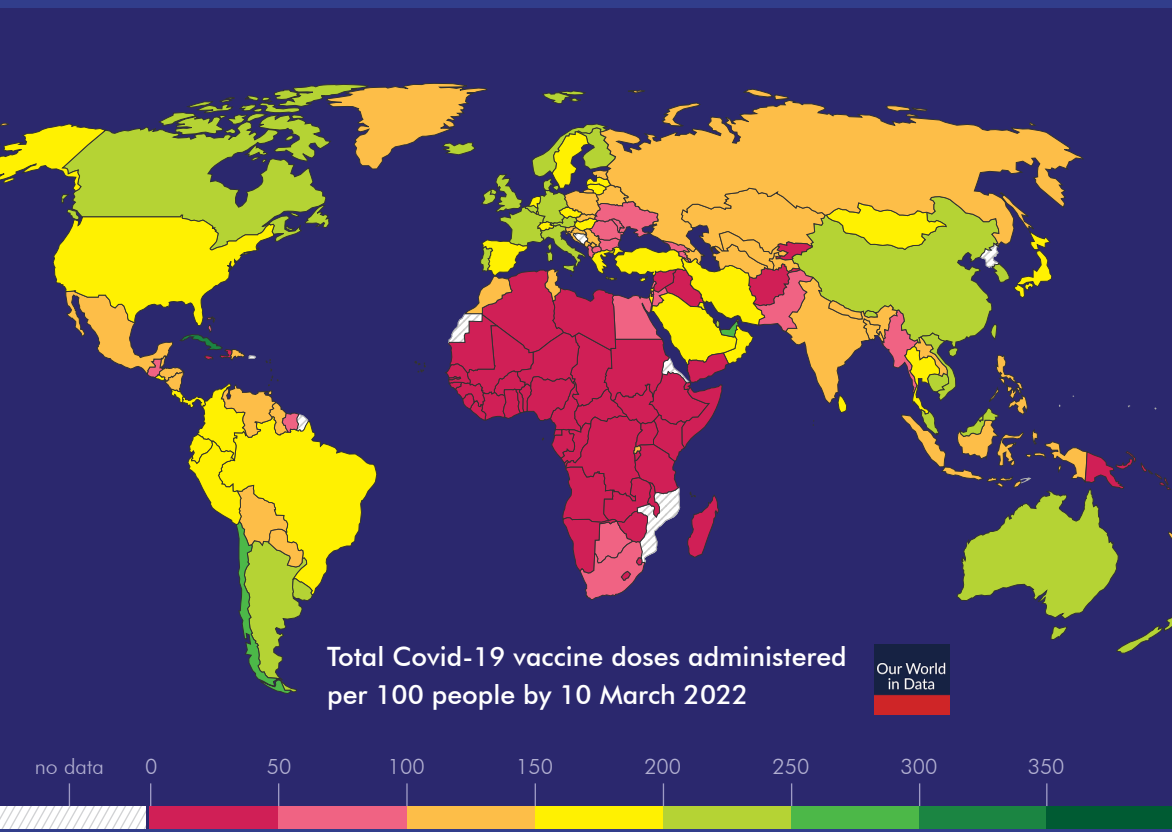
Pandemics and the illumination of "hidden things"

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

M. Pai

Afterword: Can Global Health abandon saviourism for justice?



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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").

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Afterword: Can global health abandon saviourism for justice?

Madhukar Pai

Any autopsy of how the world dealt with the Covid-19 pandemic must examine the structural inequities and power asymmetries that are deeply rooted in all of global development and global health (Abimbola, 2021). Global health and development are current versions of old, colonial systems, and hence deeply rooted in white supremacy and white saviourism (Binagwaho, 2022) (Khan, 2021) (Khan, 2023). Anti-Blackness and de-prioritisation of Black, Brown and Indigenous lives is an inescapable consequence.

As we described in a recent article by Kyobutungi and colleagues (Kyobutungi, 2023), the Covid-19 pandemic is a striking recent example of anti-Blackness and racism that is inherent in global health and development. No continent is less vaccinated and boosted than the African continent. While wealthy nations cleaned up the shelves, hoarded vaccines, and trashed millions of expired vaccines, the African region was left last in the line. Covid-19 vaccine hoarding might have cost more than a million lives in 2021 alone (Ledford, 2022).

Despite the efforts of activists — including many of the authors of this Compendium — rich countries, heavily lobbied by Big Pharma, delayed and blocked the TRIPS waiver that could have significantly expanded vaccine manufacturing in the Global South. More than

two years after vaccination began in wealthy nations, barely one in four people in the African region are vaccinated with two doses of any Covid-19 vaccine (Pandem-ic, 2023a). The African region has also had the lowest Covid-19 testing rate, and access to antiviral medications such as Paxlovid is practically non-existent. It is almost as if an entire continent simply did not matter.

As AIDS activists have repeatedly pointed out, this pattern of discrimination is not new. More than 30 years ago, when ARVs became available, they were too expensive to roll out in the African region. As late as 2001, some experts maintained that ARV treatment in Sub-Saharan Africa was impossible. It took incredible activism, legal action, and community effort before they started becoming available, by which time millions of Africans had died.

When the Ebola outbreak hit West Africa during 2014 — 2016, it killed more than 11,000 people. While an overwhelming majority of the mostly white American and European healthcare workers who contracted Ebola survived because of good supportive clinical care, the infection killed two-thirds of West Africans with Ebola. Even intravenous hydration was seen as being too challenging in Africa. Investments in research and development dramatically increased only after white people fell sick with Ebola; in fact, investment for new product development increased more than 900-fold after that (Fitchett, 2016).

Africa is the only continent where mpox has been endemic for decades. And yet, when the global outbreak occurred, the West was prioritised for vaccine rollouts. A giant share of the mpox vaccines is still held by some of the richest nations in the world, while the African region has been once again left behind (Kozlov, 2022).

When the same patterns echo across diseases and across decades, racism and anti-Blackness are the real explanations. From HIV to Covid-19, the de-prioritisation of Black and Brown lives by the rest of the world continues to have devastating consequences.

With Covid-19, data clearly show that low and middle-income countries have borne the brunt of the Covid-19 pandemic, with the highest excess deaths. In fact, developing countries' excess death rates are much higher than the relatively younger demographic profiles of these countries would suggest (Pandem-ic, 2023b). Early

in the pandemic, a myth emerged that rich nations had suffered the most Covid-19 deaths and morbidity. This myth was then used to make the argument that low and middle-income countries did not need equal access to vaccines and tools. Three years later, we now know that the truth was just the opposite.

Global health is all about power and privilege

Historically, and even today, every aspect of global health is dominated by rich nations in the Global North. Decisions about the health of people in low and middle-income countries are made in countries far away. Unsurprisingly, initiatives such as COVAX were found to have "insufficient inclusion and meaningful engagement" of low and middle-income countries (Yamey, 2022). In her article in this Compendium, Fifa Rahman states "ACT-A's failure to integrate Global South expertise in shaping its agenda and approaches ultimately cost it time and money that the world — and in particular its South — could not afford."

Data show that two-thirds of global health agencies are headquartered in just three countries: Switzerland, the UK and the US (Global Health 50/50, 2020). More than 80% of CEOs and board chairs of global health organisations are nationals of high-income countries. Leadership across the global health sector is mainly in the hands of older men from high-income countries. A typical CEO of a global health agency is three-times more likely to be a male, four-times more likely to be from a high-income country, and 13-times more likely to have been educated in a high-income country. A survey of more than 2,000 board seats of global health organisations shows that less than 3% of these seats are held by nationals of low-income countries (Global Health 50/50, 2022).

Vast amounts of global health funding are granted to the same Global North organisations, even when the research or programmatic work is meant to be done in low and middle-income countries (Erondu, 2021). African researchers are often neither first nor senior authors on publications, even when the research is entirely done in Africa (Hedt-Gauthier et al., 2019). A survey of 615 journal editorial boards showed that none of the editors-in-chief and

only 27 editors in total were women based in low-income countries (Dada, 2022). When it comes to participation in international conferences and meetings, African delegates often struggle with unjust visa barriers (Pai, 2022).

Without intention and effort, everything in global health defaults to the same, predictable settings, as shown in Figure 6.

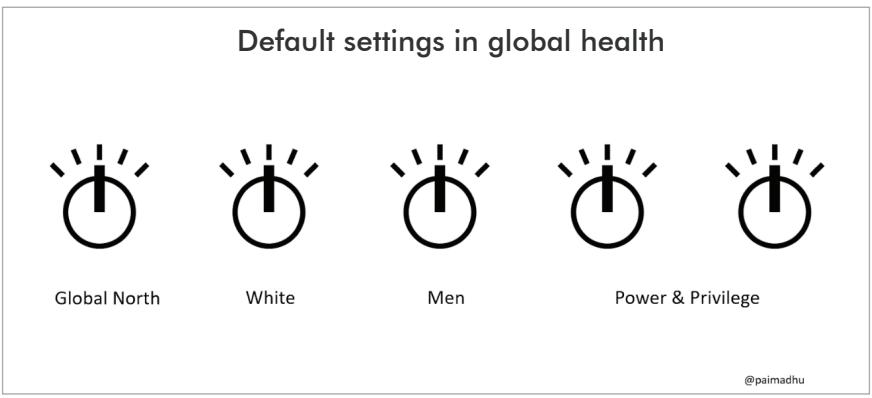

Figure 6: Research shows that the "default settings" for many positions of power within global health agency boards and journals continue to be white, male, and drawn from the Global North, reflecting broader dynamics of power and privilege within global health.

Global health is firmly centred on those with power and privilege, and focused on their generosity and saviourism (for example,. "vaccine donations"). Teju Cole called it the "White Savior Industrial Complex" (Cole, 2012). "White saviorism is simultaneously a state of mind and a concrete unequal power structure between the Global North and the Global South," wrote Themrise Khan and colleagues in their recent book, *White Saviorism in Global Development* (Khan et al., 2023).

> "White saviorism not only strips the agency of racialised people but also falsely implies that white agents need to save them from their positions as victims. While it ends up alleviating poverty on the margins, it undermines the struggles of Global South

> people to emancipate themselves from economic, social, and political oppression, and often reinforces the capitalist-heteropatriarchal system,"
> Khan and colleagues

This saviourism or charity model is archaic, unfair, and unfit for purpose, as we have witnessed during the past three years. In a global crisis, we saw that rich nations chose to hoard millions of vaccines and let them expire, rather than donate in a timely manner and save lives. We also saw rich nations actively block the TRIPS waiver proposal and delay decision-making for almost two years.

Relying on the generosity of rich countries or Big Pharma is a futile, even dangerous option.

What is the way forward?

It is clear that any future pandemic or crisis will result in the same inequities and outcomes as what we have seen with HIV, Ebola, mpox, and Covid-19. If anything, the growing momentum towards far-right, populist and autocratic leaders makes it even more likely that nationalism will trump global solidarity (Kavanagh & Singh, 2023).

The very architecture of global health and development is designed to favour those who benefit from the default settings. The entire global health security and pandemic preparedness agenda is tightly controlled by high-income nations and organisations based in the Global North. Keeping rich nations "safe" is more important than justice or equity for low and middle-income countries. As Lauren Paremoer states in her article, "developed states prioritise national health security at the expense of international cooperation."

For any meaningful change to happen, we need to challenge the dominant ways of centering global health on people and countries with the most power and privilege. It is time for people in low and middle-income countries, especially Africans, to claim the seat they have historically been denied at the global health decision-making

table (Gitahi, 2022). It is time to abandon the charity, saviourism model of global health, and demand a model rooted in justice, equity, human rights, and self-determination, as highlighted in Figure 7.

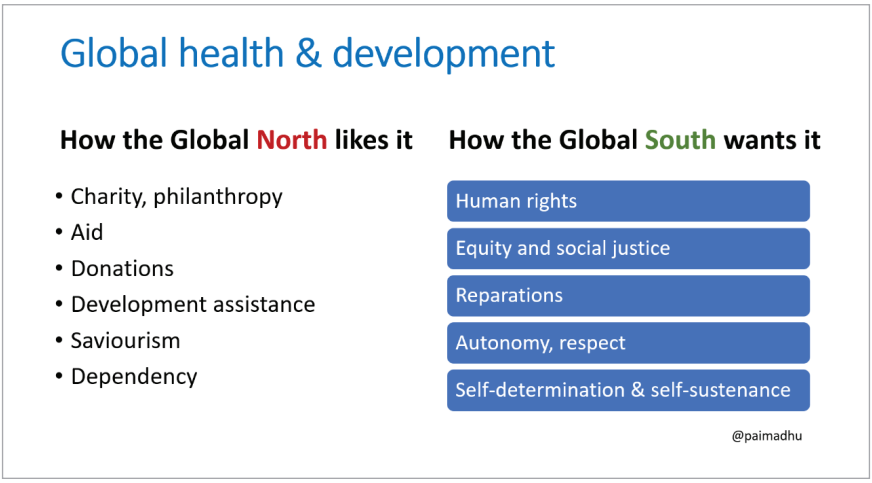

Figure 7: Global health and development

Like the fight for climate justice, this will require a people's movement, and genuine South-South solidarity among low and middle-income country actors. In her interview in this Compendium, Leena Menghaney spoke about a silver lining — that the Covid-19 pandemic made access to medicines a mainstream issue. She believes many younger activists are now engaged in this struggle and that this bodes well for the future. Tinashe Njani, in his interview, spoke about how the People's Health Movement mobilised communities in SA to support the cause of TRIPS intellectual property waiver.

African and Global South nations must work together in solidarity to realise the agenda of self-determination and self-reliance. As John Nkengasong, former head of the Africa Centres for Disease Control and Prevention, said, "Never ever should we have had to keep counting on externalities to take care of our own security needs. A key pathway for collective global security is an Africa that is self-sufficient" (Akinwotu, 2022). Nkengasong is the current Global AIDS Coordinator for the US President's Emergency Plan for AIDS Relief.

Many others have echoed these sentiments.

In their chapter in this Compendium, Petro Terblanche and Morena Makhoana write, "Covid-19's most important lesson is that countries and regions that cannot locally produce significant volumes of vaccines and other health products have no guarantee of timely access to the tools they need to respond epidemics nor pandemics."

Indeed, Africa's vision for the future, as embodied by the Call to Action: Africa's New Public Health Order, was recently endorsed by African heads of state. The document actively tackles health challenges and plans for the future, shaped by local leadership and regional solutions (Africa Centres for Disease Control and Prevention, 2022). To create a new public health order, Africa will need to strengthen public health institutions and its health workforce; expand local manufacturing of products; increase domestic resources for health; and build respectful, action-oriented, and sustainable partnerships that promote country ownership and African health priorities.

This is why the mRNA Hub in SA is an important test case. As Brook Baker and Fatima Hassan point out in their chapter, the establishment of the WHO mRNA Vaccine Technology Transfer Hub with at least 15 country mRNA Hubs / Spokes is one of the biggest silver linings of the pandemic, and its success is critical.

But it is not in the interests of Big Pharma or rich nations for low and middle-income countries to become self-reliant. Instead, they would prefer to maintain the charity model of global health, as it helps them retain and wield immense power. To fight back, we need to better understand the role the pharmaceutical industry played in creating and sustaining vaccine apartheid and the intellectual property system. Nick Dearden's chapter in this Compendium is all about that.

Nobel Laureate Professor Joseph Stiglitz recently wrote:

> Given the selfishness of rich nations that's been exposed, the only way we can be assured that low and middle-income countries will be protected, the only way that we can make the world safe, given the selfishness, is to have the

> research and production capacity for making vaccines and other pharmaceutical products distributed throughout the world. Having this production and research capacity distributed throughout the world will enable a quicker and better response to the next pandemic (Stiglitz, 2022).

In conclusion, this Compendium has brought together a diverse set of voices, primarily from the Global South, to not only document the failures of the Covid-19 pandemic but also offer invaluable lessons that we need to take away and put to good use. To me, the biggest lesson is that global health is doomed to repeatedly fail on equity unless it shifts from ***charity to justice.***

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