# Vaccine Apartheid: How South Africa can Set a Precedent for Future Crisis Response

***HARVEY GRAHAM** analyses the issues faced by Pakistan's sira community and their barriers to equal treatment as citizens.*

Since the introduction of the first COVID-19 vaccines in late 2020, there has been an enormous discrepancy in their distribution around the globe. To date, more than 10.9 billion doses have been produced (Bloomberg 2022), yet only a fraction of this output has made its way to the less wealthy countries in Africa, South Asia, and Latin America. As soon as the pandemic hit, wealthy nations were quick to forego commitments of international unilateralism and philanthropy, instead opting for an 'every man for himself' or a 'pirating' approach (McCann 2020, 162). However, it has 'not simply [been] "me first", but "me first, second, third and fourth"' in terms of vaccine hoarding by wealthy nations (Dearden 2021). This bifurcation has been worsened by pharmaceutical companies refusing to waive intellectual property (IP) laws for these vaccines and implementing prices that ensure a substantial profit margin (Economist 2021). This hoarding has created an opportunity for countries in Africa and the Global South, headed by South Africa, to collaborate and create their own vaccine production facilities. Setting a precedent of multilateral, independent crisis response, this has the potential to be a defining moment not just for COVID-19 recovery, but also for the norms of international cooperation in and around Africa for the next decade (Adhanom 2020).

The first doses of the COVID-19 vaccine began rolling out in the United Kingdom (UK) at the end of 2020. There have been 210 vaccines administered per 100 people globally, which has been hailed as a great achievement (Bloomberg 2022). Unfortunately, this achievement has been overshadowed by the low number of vaccines administered in poorer countries. African countries have administered in the range of zero to 55 vaccines per 100 people, with the Democratic Republic of the Congo giving only one dose per 100 people (Bloomberg 2022). Furthermore, nineteen countries in Africa have been unable to fully vaccinate more than five percent of their population so far (WHO Africa 2022). This begs the question: why, after one and a half years, does such a disparity exist? With companies such as Moderna and Pfizer producing the vaccines as a business endeavour to generate large revenues and increase stock prices, while the free market is responsible for the rapid development of COVID-19 vaccines, the system should be more dynamic and equitable in the case of global health emergencies. The 'marketisation' of the pandemic is a zero-sum game, with profit coming at the expense of human life (Bajaj et al. 2022). Médicins Sans Frontières (MSF) describes how '[t]he current monopoly-based pharmaceutical research and development system fails to develop, produce and distribute life-saving tools in the interests of public health… Medical tools are often allocated not based on public health needs, but on the ability to pay high prices' (MSF 2020).

There are protocols in place to waive IP laws in the case of international health emergencies, though to the bemusement of Tedros Adhanon—head of the World Health Organisation (WHO)— they have not been invoked for COVID-19 (Cohen 2021). This is due to governments' reluctance to lose the


US delivering more than 5,660 million Pfizer COVID-19 vaccine doses to South Africa in July, 2021

*Image: US Deparment of State | WikiCommons*

revenues that domestic pharmaceutical companies are receiving from vaccine sales, with the UK and many European Union members having all blocked motions to waive IP laws in the case of COVID-19 vaccines (Bajaj et al. 2022). The power of pharmaceutical lobbying is also worth considering, as their influence is deep within the legislatures of many higher income countries (Torbati and O'Connell 2021). A stark reminder of the unequal distribution of vaccines is the reality that healthy, low risk citizens of wealthy nations have received their third COVID-19 vaccine before high-risk health workers in poorer countries have had theirs. There have been efforts to bridge the gap, as the WHO set up COVAX (COVID-19 Vaccines Global Access) in collaboration with Gavi to distribute the vaccine equitably with an ambitious target of giving two billion doses by the end of the year (Gupta 2022). The Biden administration has pledged an additional 500 million doses, taking the United States' (US) donations to one-point-one billion (Dearden 2021). Other wealthy nations have also set donation targets and have been partially fulfilling them. While these donations are important and will save lives, they are not tackling the root causes of why poorer countries, particularly those in Africa, have been unable to procure vaccines independently.

**The Problems of Philanthropy**

Donations of COVID-19 vaccines from wealthy countries are useful and reduce the fatality rates of those most in need. However, the practice of vaccine donations follows a long tradition of limited efforts in Africa that promote a reliance on Western aid and proliferate the isolation and ineffectual crisis response capabilities of the aid recipients. The WHO's aim to vaccinate 70 percent of the population will not be reached by wealthy countries donating vaccines (Bajaj et al. 2022). This is especially likely considering that 'the majority of vaccine donations have not included syringes, diluent, or freight costs' (Gupta 2022). There is also a cynical aspect to vaccine donations as a form of 'health diplomacy initiatives' from leading powers to secure preferential treatment or privileges in the recipient countries (Esteves and Van Staden 2020). This trend is not a new phenomenon: issues

with crucial drug supply were abundant during the HIV/AIDS pandemic and H1N1 virus (Swine Flu) outbreak, and those who were in the greatest need were unable to secure available drugs for as long as ten years after they were discovered (Cohen 2021). Underpinning these failures is a negative feedback loop in which African nations do not have the capabilities to deal with crises due to a legacy of exploitation and corruption that leaves them reliant on external aid. This does not just apply to diseases, as the same can be said for conflicts, famine, and extreme weather. For many in wealthy countries, the way to deal with such life-threatening scenarios is through donations to relief organisations that can prevent large scale loss of life. While this is highly commendable, such responses detract from more substantial changes that could be made to the systems that allow for life-threatening crises to emerge. Philanthropic aid can also fail to hold those responsible to account, whether that be through corruption and negligence at the local level, or the failings of the capitalist system on a global scale. Another issue is that philanthropy usually requires qualifications. The crisis must be judged severe enough and the recipients worthy enough of aid in order for it to be sent (Gomberg 2002, 36). This system of aid therefore fails on many levels: the aid itself is often inadequate, the motivation can be dubious, and the problems persist—or are potentially worsened—as key response infrastructure is not developed.

**Why Agency is the Key to Eradicating 'Vaccine Apartheid'**

Now there is an opportunity to establish a model of agency that can immediately limit the effects of COVID-19 in Africa and provide a precedent for responses to future crises. South Africa has put itself forward as the nation to lead Sub-Saharan Africa, and to an extent the global South, in this endeavour. Having led the immediate responses to the pandemic, South Africa is demonstrating its ability and desire to implement systems that will enable increased self-sufficiency on the continent. Systems that will be key for the case of COVID-19 include the successful implementation of the WHO's mRNA hub in South Africa and the nation's recent pioneering of awareness for fast action and cooperation by using its position as chair of the African Union (AU) to lead the COVID-19 response on the continent. At the beginning of the pandemic, the AU set up the Taskforce for Novel Coronavirus (AFTCOR) well before any multilateral responses in other regions or even the first case in Africa (Gruzd et al. 2020, 2). The Ebola crisis in West Africa showed the precarious state of African healthcare systems, the need to support local structures, the need to cooperate within the region, and the benefits of acting quickly and decisively. South Africa has taken a leading role in attempting to limit the devastation caused by COVID-19 and avoid repeating the mistakes of previous outbreaks. It has called for the freezing of debt repayments, implemented special COVID-19 envoys from G20 nations, created new departments to monitor the economic impacts of the pandemic, and set up funds to assist those most in need (Gruzd et al. 2020, 8).

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However, establishing systems of prevention and self-sufficiency for the future remains vital. The mRNA hub will provide the ability to produce mRNA vaccines based on the Pfizer and Moderna shots, for distribution around the continent with six partnering countries (WHO 2022)—as currently, only one percent of the vaccines used in Africa are produced there (Beaumont 2022). The mRNA hub will ensure the continent has the production capacity that is essential for equitable vaccine rollout, therefore limiting both the threat to life and the

economic devastation of the pandemic (WHO 2022). Through this, African countries can set a precedent of using production techniques to build the tools to solve problems, rather than relying on Western aid. This provides an opportunity for the aid model to be changed in a meaningful way, as wealthy nations need to give expertise and resources, rather than the donation of vaccines, to promote self-sufficiency. This change could be accelerated by the passage of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) waiver which would allow a greater flow of information from large pharmaceutical companies to projects such as the mRNA hub, saving time, money, and resources (Bajaj et al. 2022). Yet, despite US support for the TRIPS waiver, there has been opposition from many wealthy nations, and it is unlikely that it will be able to surmount these objections for some time. This clearly reinforces the message that wealthy nations are only willing to help if it is in their best interests. Therefore, it is even more important for African nations to develop independence and agency in their crisis responses.

The South African president Cyril Ramaphosa has stressed the need for African collaboration in the economic sector too, pushing for the implementation of the African Free Trade Area (Ramaphosa 2021). This will only serve to strengthen the capabilities and bargaining power that member states have. Wealthier nations have failed to view the pandemic in Africa both as a risk to their own public health (through the emergence of variants) and as an enormous economic liability. It has been speculated that this is one of the greatest investment opportunities of the century, with an effective COVID-19 response in Africa saving trillions of dollars globally (Ramaphosa 2021).

What has been made clear by the pandemic is the fragility of many systems in African nations to cope with extraordinary challenges. The response from the rest of the world, most notably Western nations, has been a stark reminder that cooperation and international aid are subject to the convenience of the current status quo. With the climate crisis set to wreak havoc in many areas within Africa, and future pandemics becoming increasingly likely, this reminder must be acknowledged and acted upon. The implications of not doing so and continuing the international crisis response model would be disastrous and could lead to enormous loss of life or even the complete failure of already fragile states. For South Africa to lead a self-sufficient vaccine rollout, therefore, has tremendous potential and is an objective that the international system ought to put its whole weight behind.

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*This article has been edited by Devrath Jhunjhunwala (South and Central Asia Editor) and Olivia Billard (Chief Regional Editor), copy edited by Sukanya Choudhury, Evie Patel, Nicola Crowe, and Ariane Branigan (Chief Copy Editor), peer reviewed by Kshitij Betjewargi and Julia Rolim (Chief Peer Reviewer), checked and approved by the following executives: Veronica Greer (Editor-in-Chief), Sofia Farouk (Deputy Editor-in-Chief), and Lia Weinseiss (Secretary/Treasurer), and produced by Anastassia Kolchanov (Chief of Production).*

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