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ARTICLE

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When maximizing profit endangers our humanity: vaccines and the enduring legacy of colonialism during the COVID-19 pandemic

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ABSTRACT

The inequitable distribution of COVID-19 vaccines that we see today must be situated within the historical context of colonialism, global capitalism, and the othering of the Global South. The effects of these structural factors have resulted in an exclusive preoccupation with profitmaking through vaccine manufacturing at the expense of humanitarian concern. The deliberate neglect in the vaccination of those in the Global South will enable the virus to survive and mutate in marginalized parts of the world. Notably, in our globally-connected world, this neglect will provide opportunities for new variants to flourish and spread, thus contributing to the likely emergence of new pandemic threats in the future. **This paper is part of the SPE Theme on the Political Economy of COVID-19.**

KEYWORDS

COVID-19; public health security; vaccine hesitancy; vaccine imperialism; vaccine nationalism

Introduction

On Sunday morning, December 19, 2021, I (Mosoka Fallah) woke up with a burning fever and joint pain. I told myself it could not be COVID-19, as I had taken a test four days earlier in preparation for my mission trip to Tanzania through the Africa Centres for Disease Control and Prevention. Additionally, I had been consistently using masks and practiced social distancing. I concluded that it must be malaria because the manifest symptoms were unlike those typically associated with variants of COVID-19: I had no cough, nor had I lost my sense of taste or smell. I started a malarial treatment, but the fever persisted. When I tested again for COVID-19, the result came back positive—what I had feared and tried to prevent had happened.

I had been very fearful of contracting COVID-19 because I have hypertension and diabetes, comorbidities associated with increased risk of death from the SARS-COV-2 virus. Fortunately, my symptoms were not very severe. I developed persistent fatigue,

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a cold, and a cough, but I was eating normally and the fever subsided. From professional experience, I knew that I was one of the very few fortunate Africans able to blunt the full effect of COVID-19 with a full dose of the AstraZeneca vaccine, which I had received in August 2021. I was optimistic, therefore, that I would make a quick and full recovery, and eventually receive negative test results for the virus.

This experience intensified my thinking about Africans and many others from developing countries who were not as fortunate and who did not have access to life-saving vaccines against COVID-19. By November 2021, only seven percent of the 1.2 billion people in Africa had received such a vaccination.[1] Even more disturbingly, the inequity in vaccine access has created the perfect environment for the emergence of new variants of concern, like Omicron, which was first detected in Southern Africa among HIV/AIDS patients.[2] The pervasiveness of variants has resulted in the need for booster doses, with their associated costs. Today, the United States and many European countries are seeing a reversal of the gains attributable to vaccines because the Global North has refused to make vaccines available to those without economic power, choosing instead to boost further the excessive profits of big pharmaceutical companies.

How have we come to lose our humanity? Why are we deliberately prolonging the pandemic by refusing to vaccinate 70 percent of the world, regardless of whether they have the ability to pay? In this commentary, we discuss some of the structural factors that promulgate this very dangerous, yet eminently avoidable situation.

The impact of colonial discourse and practices on vaccine uptake in Africa is an important issue and, as we shall see, is also related to vaccine equity concerns more generally. Journalist and political activist Chernoh Bah notes that medical research and experimentation has been widespread across Africa for several centuries, including more recent research projects in West Africa that were being conducted directly before the Ebola virus epidemic.[3] Reflecting the influence of what we will later refer to as the Emerging Infectious Disease (EID) worldview in conjunction with the security paradigm—a system of beliefs and values based on a preoccupation with ensuring personal and national safety—much of the research conducted in West Africa involved "dogged medical research on vaccine development in response to deadly pathogens with a bio-weapons potential against civilian or military targets."[4] According to Bah, research of this type was surreptitiously carried out in specific West African nations under the guise of "investigating new infectious diseases" or "neglected tropical diseases."[5] Such research was funded by a conglomeration of leading pharmaceutical corporations, corporate organizations, and multinational entities. In this respect, American science journalist Sonia Shah notes that foreign pharmaceutical companies increasingly export their clinical research industry to Africa and India because, in these places, they may violate ethical issues and patients' rights without fear of reprisal.[6] Consequently, disease outbreaks are deliberately and instrumentally used by western medical corporations and academic institutions to test vaccines without the consent and knowledge of the subjects.

This is a well-known reality to many in Africa because of several high-profile cases, such as Pfizer's use of an uncertified antibiotic, Trovan, during a meningitis outbreak in northern Nigeria in the 1990s.[7] This incident and other scandals have resulted in a

deep-rooted distrust of Western medicine—a viewpoint that was further reinforced during the COVID-19 pandemic when two medical researchers from the Global North (specifically France) proposed in April 2020 that COVID-19 vaccine trials be conducted in Africa.[8] Many in Africa are aware of the glaring hypocrisy of the international community when it comes to vaccines: its promise of global vaccine coverage to end the COVID-19 pandemic and the simultaneous unwillingness to expedite vaccine deployment to the African continent.

It is in this sociopolitical context that vaccine hesitancy within Africa must be understood. In the end, it is the legacy of an othering discourse so central to a colonial mentality that diminishes trust in current vaccines. Just as vaccine hesitancy is related to the effects of colonization, so vaccine nationalism is also the result of a (post) colonizing project. An understanding of the myriad issues arising from the exercise of vaccine imperialism that we see today during the COVID-19 pandemic requires consideration of how the legacy of colonialism endures and manifests in various ways in our current "post-colonial" condition. We argue that vaccine imperialism today continues to represent non-Western regions of the world in ways that benefit the North/West at the expense of such non-Western regions. The benefits that accrue to the Global North are economic, and, as the vaccine response to the pandemic reveals, also extend to health and well-being.

Historically, the colonial perspective of health was essentializing, so that differences, such as health disparities, were attributed to purported biological differences between people. Based on this understanding, it was argued that diseases that disproportionately affected certain populations were the result of intrinsic differences.[9] According to this perspective, biological, physiological, genetic, and cultural factors made certain groups of people more (or less) susceptible to particular illnesses. Notably, this kind of essentialism was often expressed in geographical terms, with certain diseases being associated with certain parts of the world. Moreover, such essentialist ideology served as the rationale for various exploitative and racist colonial policies, ranging from the "white man's burden" of the British and the "ethical policy" of the Dutch, to "La mission civilisatrice" of the French. This colonial-essentialist perspective has had profound implications for health policies of the past as much as the present—evident today in the vaccine policies of metropolitan countries. Essentialism was useful to colonizing powers because the explanation of phenomena on the basis of "natural" characteristics justified the failure to address the problems and needs of the colonized. According to this false logic, if the colonized populations suffered from higher rates of disease because of their essential physical differences, then colonial public policies would be deemed powerless to address these seemingly "natural" health disparities, allowing the colonizing to be absolved of responsibility.

An essentializing perspective serves as the basis for "othering" the colonized by the colonizer. While the discourses associated with an othering process assumed different forms at different times, essentialist and othering themes are especially prominent today as the pandemic unfolds in the Global South. In its earliest form, otherness was expressed through the discourse of "tropicality," whereby Europeans from the seventeenth to the twentieth century distinguished themselves from the areas they colonized by emphasizing the differing flora, fauna, climate, topography, culture, and,

most importantly for the purposes of our argument, the apparently distinctive nature of the diseases found in colonized lands. Indeed, it was in response to the latter that the London School of Hygiene and Tropical Medicine was established in 1899 to serve as medical advisors to the Colonial Office. As historian Nicholas B. King notes, this European "episteme of separation" led to Western medical theories that scapegoated specific places or populations as sources of infection, whereby the "unhealthy" non-Western places or populations posed a risk to the "healthy" Westerners.[10]

The tropicality discourse tacitly implies that tropical lands are threatening to Westerners. By the postcolonial period, roughly after the Second World War, the essentializing influence of otherness assumed different forms—notably, in ways that supported neocolonial policies. Thus, we see the emergence of the development discourse in which the non-Western world was still seen as dangerous, but the threat was no longer defined in terms of disease. Rather, the threat was defined in terms of increasing global poverty that would eventually come to threaten Western prosperity. During this period, the ideology of developmentalism arose, based on the paternalistic idea that formerly colonized nations would need the help of the colonizer to alleviate social and economic problems. Such a discourse inspired structural adjustment polices in the 1980s, leading to the further economic dependence of the Global South on the Global North.

This was an essentializing discourse because, as Arturo Escobar notes, poverty was conceived in ways that reduced the non-West to a "homogenized, culturally undifferentiated mass of humanity associated with powerlessness, passivity, ignorance, hunger, illiteracy, neediness, oppression and inertia."[11] Later in the twentieth century, this othering discourse shifted to suggest the Global South was disproportionately vulnerable to natural hazards and disasters, which led to the mobilization of "relief" efforts on the part of the West. After the terrorist attacks in New York City on September 11, 2001 (that is, 9/11), the othering discourse changed once again, redefining the threat of "the other" in terms of security. At that moment, the Islamic non-West came to be defined as a "terrorist spawning" region.[12]

Although security discourse became prominent after 9/11, approaching infectious disease as a security threat had already been set in motion nearly a decade earlier. King notes how certain events converged to produce what is referred to as the EID worldview.[13] These included the convening of a US National Institute of Health conference in 1989, chaired by noted virologist Stephen S. Morse and attended by 200 prominent scientists on the topic of "emerging diseases"; the publication of the 1992 report of the National Academy of Science Institute of Medicine (IOM, 1992), *Emerging Infections: Microbial Threats to Health in the United States*; and the release of two best-selling books in 1994, *The Hot Zone* by Richard Preston (1994) and *The Coming Plague* by Laurie Garrett (1994). The EID worldview, which emerged against the backdrop of neoliberalism and austerity, was adopted and supported by both traditional health institutions and the US Department of Defense to obtain funding at a time when such funding was difficult to secure. Funding was used to support various initiatives that the US government identified as urgent: increasing the capacity for the epidemiological surveillance of infectious diseases; training and basic research in molecular biology and virology; the strengthening of and coordination between local, national, and international public health institutions; and increased attention to the

public and private development of vaccines. As King notes, the widespread interest and appeal of the EID worldview was largely predicated on the perceived need to bolster the US economy and security interests during a time of recession.[14]

At this juncture, as we deal with the COVID-19 pandemic, we can differentiate between various elements of the discourses at play—tropicality, developmentalism, natural disasters, and security—which all inform vaccine policy today, particularly in relation to vaccine distribution. To some extent, the "episteme of separation" that undergirds the tropicality discourse manifests itself differently during the COVID-19 pandemic. It is true that the usual expression of the "episteme of separation" is seen today in the scapegoating of non-Western peoples and places. This is most evident in the dramatic increase in anti-Asian racism during the current pandemic.[15] But more than that, today that separation, and the sentiment of otherness embodied in that separation, takes the form of vaccine nationalism.

Vaccine nationalism is manifested in government agreements with vaccine manufacturers that enable them to provide vaccines to their own populations ahead of other countries.[16] Ognian Kassabov remarks that "vaccine nationalism" is fundamentally vaccine capitalism based on conventional neoliberal supply and demand principles.[17] This is seen in how rich countries seek to corner the market on an inadequate supply of vaccines—a supply issue that arises because pharmaceutical companies refuse to share their discoveries with the world on account of their alleged intellectual property (IP) rights, which, of course, protects their profits at the cost of human lives. Vaccine capitalism manifesting as nationalism is particularly disturbing when one considers the fact that countries like India and South Africa have the technology for mass production and distribution of COVID-19 vaccines but are blocked from doing so because of IP rights.[18] And the doses manufactured in these regions are shipped to the West rather than being made available locally[19]—a typical postcolonial practice of predatory capitalism in which exports are meant to service national debt in line with structural adjustment policies, rather than producing food and goods for urgent local needs.

Kassabov astutely observes that vaccine nationalism shatters influential myths about the positive attributes of capitalism.[20] The idea that the private sector is the best innovator, for instance, does not hold up. Prior to the pandemic, companies such as BioNTech, which partnered with Pfizer to develop a COVID-19 vaccine, focused on the application of mRNA technology to drugs rather than vaccines. It was only when the pandemic started and governments (that is, public institutions) stepped in to support private pharmaceutical companies financially that the swift development of COVID-19 vaccines became possible. For example, Moderna alone received US $2.5 billion to develop vaccines. The attempts to monopolize vaccine doses and vital medical equipment, including personal protective equipment and ventilators, by Global North countries reveal the shortcomings of a second myth—namely, the notion that the invisible hand of the marketplace is taking care of us. And another myth—the perception that capitalist globalization is just as benevolent—is also revealed to be fallacious. How can anyone claim fairness when one is faced with the stark reality of the unequal global distribution of vaccines?

It is important to note that the unequal distribution of vaccines has dire consequences for us all if we consider its implications from a disease ecology

perspective. In a globally interconnected economy, predicated on the movement of people and complex supply chains,[21] the lack of vaccine coverage for significant parts of the world (that is, the Global South) means that the virus is given plenty of opportunity to mutate, evade newly created immunity, and traverse the world more quickly than ever before. Indeed, the COVID-19 virus has already done so, as we witness the emergence of different strains that have quickly infected populations worldwide in record time.

One ambitious response to vaccine nationalism is an international collaboration, the aim of which is to procure and distribute COVID-19 vaccines in a more equitable manner. Known as the COVID-19 Global Access or COVAX initiative formed by a coalition of international agencies including the Gavi vaccine alliance, the Coalition for Epidemic Preparedness Innovations (CEPI), and the World Health Organization (WHO), the framework is considered one way to address inequities in vaccine distribution. Many developing nations, weighed down by postcolonial structural adjustment debts, are not in a position to buy enough vaccines at current market prices—to do so would put more than half the world into deeper poverty than they have already experienced because of pandemic lockdowns and border closures.[22] Yet we know that COVAX has been hamstrung by vaccine nationalism, vaccine diplomacy, and protectionism of the pharmaceutical industries.

Nations of the Global North are preprocuring vaccines before they leave the production line. As a result, the rate of booster doses in these rich, developed countries exceeds the number of people who have even received their first dose in Africa with its 1.2 billion people. Many countries are using the inequity of vaccine distribution strategically for geopolitical reasons. For instance, the universal intent of COVAX is undermined by the increasing use of bilateral donations by China and the United States to increase their influence. Many developed nations have refused to pressure pharmaceutical companies to share their intellectual property and technology, despite the fact that these companies benefitted from public funds[23] to conduct the research and development necessary for vaccine production. While the US government has made commitments to share vaccine patents, the aforementioned factors are undermining all global efforts to vaccinate our world. This leaves us with the appalling reality that we are all going to be infected again very soon.

Thirty of us who were frontline workers during the 2014/2015 Ebola outbreak in West Africa saw this threat and decided to mobilize the world in May 2021. We reached out to 81 global health experts, public health professionals, bioethicists, physicians, and professors from some of the top universities, to request their assistance in mobilizing the world and taking some practical steps to forestall the impending gloom and doom with which we would have had to contend. On this basis, we drafted a letter to the WHO. Therein, we stated that we needed to provide robust support for COVAX to increase its pace of vaccine procurement and distribution, to urge pharmaceutical companies to waive their patent protection in countries that could manufacture COVID vaccines, and to support technology transfers. In the conclusion of our (unpublished) statement, we wrote:

> By committing to COVAX and waiving vaccine intellectual property for poor countries, we will have a real chance at stopping COVID-19 globally. The United States has shown

> global responsibility and leadership by agreeing to waive patent protection for COVID-19 vaccines. But this is not a battle that can be won by only the United States and a few select others. It must be the unanimous voice of all countries of the world, and global leaders must take the lead now. There is a great need for political leaders and scientists to advocate for these steps. We need citizens to call their political representatives to support global vaccination strategies. While many of the greatest heroes of Ebola are no longer with us, those like me who have survived know one thing to be true of all pandemics: "no one is safe until everyone is safe."

When we approached the World Health Assembly (WHA) with our concerns, they asked us to identify countries that would sponsor our letter. Of the countries in the Global North to which we reached out, one responded that they were reluctant to do so because we had included the issue of the patent waiver. Ultimately, without sponsorship from enough countries, we were unable to get our letter onto the WHA 2021 agenda. Nevertheless, we continue to fight and lobby. The West African Health Organization (WAHO) of the Economic Community of West African States (ECOWAS), for example, has responded favourably. It has shared our letter during the last ECOWAS Ministers of Health's meeting in Abuja, Nigeria, and has agreed to partner with us to sponsor this letter at the next WHA session. Our efforts, ultimately, reveal the almost insurmountable challenges faced by those advocating for equity in accessing COVID-19 vaccines in the midst of vaccine nationalism, geopolitical polarization, and the consuming drive to maximize profits at the expense of all other considerations. So far, the failure to vaccinate 70 percent of the world has proven a recipe for disaster for all humanity.

Notes

1. Fallah, "Remember Ebola: Stop Mass COVID Deaths in Africa," 627.
2. World Health Organization (WHO), "Classification of Omicron (B.1.1.529): SARS-CoV-2 Variant of Concern."
3. Bah, *The Ebola Outbreak in West Africa*, 29.
4. Bah, *The Ebola Outbreak in West Africa*, 29.
5. Bah, *The Ebola Outbreak in West Africa*.
6. Shah, *The Body Hunters*.
7. Bah, *The Ebola Outbreak in West Africa*, 41.
8. Mutombo et al., "COVID-19 Vaccine Hesitancy in Africa: A Call to Action."
9. Bankoff, "Regions of Risk."
10. King, "Security, Disease, Commerce: Ideologies of Postcolonial Global Health," 772.
11. Escobar, *Encountering Development*, 3.
12. Bankoff, "Regions of Risk."
13. King, "Security, Disease, Commerce: Ideologies of Postcolonial Global Health."
14. King, "Security, Disease, Commerce: Ideologies of Postcolonial Global Health."
15. Wu et al., "As Asian Canadian scholars, We Must #StopAsianHate."
16. Khan, "What is 'Vaccine Nationalism' and Why is it so Harmful?"
17. Kassabov, "What the Vaccine Debacle Tells Us about Predatory Capitalism."
18. Fallah, "The Paradox of Geography and Vaccine."
19. Bowdish and Chakraborty, "COVID-19 Vaccine Inequity Allowed Omicron to Emerge."
20. Kassabov, "What the Vaccine Debacle Tells us about Predatory Capitalism."
21. Ali and Keil, *Networked Disease*.
22. Fallah, "No Country Is an Island."

23. See Ghosh, Jayati, "The Unnecessary Constraints to Vaccinating the Whole World," *Studies in Political Economy* 103, no, 1 (2022): 103–109.

Disclosure statement

No potential conflict of interest was reported by the author(s).

About the authors

Mosoka P. Fallah is the Team Lead for Country Engagement and Technical Assistance of the Saving Lives and Livelihood (SLL) Program of Africa Centres for Disease Control and Master Card Foundation—a $1.5 billion donation to procure 65 million doses of vaccines for Africa and help vaccinate 70 percent of Africa. Prior to joining Africa CDC of the African Union, he served as a Consultant for the World Bank on Pandemic Diagnostics in West Africa.

S. Harris Ali is a Professor of Sociology at York University in Toronto, Ontario, Canada. His research focuses on the intersection of health, disasters, and the environment. He has published extensively on disease outbreaks, including SARS in 2003, the global spread of Avian flu, and Ebola. His co-edited volume with Professor Roger Keil, *Networked Disease: Emerging Infections in the Global City,* has been recently recognized by *The Globe and Mail* as one of the "top ten books that offer lessons from past pandemics."

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