Big Pharma and the Problem of Vaccine Apartheid

By Cassandra Azumah

The webinar on 'Vaccine Imperialism: Scientific Knowledge, Capacity and Production in Africa' which took place on 5 August 5, 2021, was organized by the Review of African Political Economy (ROAPE) in partnership with the Third World Network-Africa (TWN-Africa). It explored the connections and interplay of Africa's weak public health systems, the profit and greed of Big Pharma enabled by the governments of the industrialized Global North, and the Covid-19 pandemic from a political economy perspective. This report summarizes the main discussions held during the conference, including an overview of each of the main points discussed. The webinar was the first in a three-part series of webinars scheduled by the two organizations under the theme *Africa, Climate Change and the Pandemic: interrelated crises and radical alternatives*.

The format of the event involved keynote presentations from three speakers, a five-minute activist update on the COVID-19 situation from two African countries, and an interactive discussion with participants. Chaired by Farai Chipato, a Trebek Postdoctoral Fellow at the University of Ottawa and ROAPE editor, the session included presentations from Rob Wallace, an evolutionary epidemiologist and public health geography expert at the Agroecology and Rural Economics Research Corps; Tetteh Hormeku, Head of Programmes at Third World Network-Africa (TWN-Africa) and Marlise Richter, a senior researcher at the Health Justice Initiative in South Africa.

The current state of the pandemic – Rob Wallace

Rob Wallace began the session by providing a global perspective on the current state of the COVID-19 pandemic. He presented data showing that though the total number of vaccinations are increasing, the percentage of people fully vaccinated is concentrated in the West. We are currently experiencing a third wave of the pandemic, which is being driven by the delta variant. Though the cases in Africa are relatively lower than in other parts of the world, it is still a marked increase from the first and second waves which were less severe. This is not the trajectory that was predicted for COVID-19 on the continent in the early days of the pandemic. Marius Gilbert et al had speculated that Africa would be vulnerable to the virus due to a lower public health capacity and underlying co-morbidities that might increase the spread and damage of the virus. However, the incidence of the virus has played out in a different way, Africa's cases are not as high as that of other continents. The possible reasons that have been given for this are: demographics (a younger population), open housing (which allows greater ventilation), and an ongoing circulation of other types of coronaviruses which have induced a natural, partial immunity in the population.

Wallace also commented on herd immunity, stating that it is not a panacea for defeating the virus. He referenced a paper by Lewis Buss et al on COVID-19 herd immunity in the Brazilian Amazon which found that although 76% of the population had been infected with the virus by October 2020, they had not achieved herd immunity (which is usually estimated at 70-75%), and proliferation of the virus was ongoing. He pointed out that the key lesson from this study is that there is no magical threshold for herd immunity; it may be different for different populations or there may be no threshold at all.

Likewise, he contended that defeating COVID-19 has little to do with vaccination as a silver bullet, but much to do with governance and the wellbeing of the population being at the crux of any public health decisions a government would take. A multi-pronged approach should be taken to defeat the virus, one that includes vaccinations, wearing of masks, social distancing, and testing and tracing. He argued however, that in the neoliberal regimes of the industrialised North, dealing with COVID-19 is organized around profit.

This was not the case in the early days of the outbreak. Initially, the World Health Organisation (WHO) and the National Institutes of Health (NIH) in the US were in favour of having open medicine and making sure any pharmaceutical products produced to fight the virus were free to all. To this end, WHO developed the COVID-19 Technology Access Pool (C-TAP). However, the lobbying of Big Pharma and the likes of Bill Gates worked to centre the COVID-19 response around the model of intellectual property rights. This has had a considerable impact on the evolution of the virus, allowing it enough room to evolve such that pharmaceutical companies can make profits by selling booster shots of the vaccine. According to Wallace, this speaks to the "sociopathic nature" of the neoliberal regimes in the Global North who are willing to put the profits of Big Pharma over the lives of people. He opined that we need to act in solidarity to create a system in which disparities between the Global South and Global North are removed.

Health justice and the pandemic in South Africa – Marlise Richter

Marlise Richter's presentation shed light on the work of the Treatment Action Campaign (TAC) and the lessons that can be learnt from their struggles for access to medicines (in particular ARVs). She pointed out that the TRIPS agreement (Trade-Related Aspects of Intellectual Property Rights – TRIPS – is a legal agreement between member states of the World Trade Organisation) had a big impact on how the HIV/AIDS epidemic was addressed, resulting in a limited number of ARVs reaching the Global South.

The HIV epidemic was particularly acute in South Africa, the number of people living with the virus ballooned from 160,000 in 1992 to over 4.2 million people by 2000. At this time, ARV's had been developed but were unaffordable in Africa, costing up to US$10,000 a year in 1998.

The TAC used multiple strategies such as skilled legal advocacy, high quality research, social mobilization, demonstrations, and public education to fight the pharmaceutical industry and their abuse of intellectual property rights protections. It joined the case brought by the Pharmaceutical Manufacturers Association (PMA) against the South African government for allowing parallel importation of drugs in order to bring down prices of medicines. Its intervention contributed to pressuring the PMA to withdraw its claims in 2001. In addition, it applied pressure at the 13th International AIDS Conference in Durban in 2000 by staging a march to highlight the danger of President Mbeki's AIDS denialism and demanded access to ARVs in Africa.

From 1999 onwards, the TAC also campaigned for a national prevention of mother-to-child transmission of HIV. This case was won at the high court and precipitated a national ARV roll-out plan in April 2004. Finally, in 2002, TAC and the AIDS Law Project filed a complaint with the Competition Commission against GlaxoSmithKline (GSK) and Boehringer Ingelheim arguing that they violated the competition law by abusing their dominance in the market and charging excessive prices for ARVs. This forced the companies to reach a settlement in 2003 leading to a drastic cut in ARV prices. By employing these tactics, the TAC and other activists were able to transform both the national and global conversation on drug pricing, eventually leading to South Africa having the largest HIV treatment program globally and pharmaceutical companies reducing the prices of ARVs.

Following the success of the campaigns to provide access to ARVs in Africa, activists in the Global South fought for the Doha Declaration. The Doha Declaration waived some of the provisions in TRIPS in order to prevent public health crises and promote access to medicines for all. However, Richter commented that not many of these flexibilities have been used. She posits that this is due to immense political pressure from the West. The US in particular has singled out governments that seek to use the TRIPS flexibilities and placed them on the US Special 301 Watch List.

Returning to the present, Richter presented data that showed that on 3 August, there have been just under 200 million confirmed cases and over 4.2 million deaths of COVID-19. 28.6% of the world's population has received at least one dose of the vaccine with 14.8% fully vaccinated. But to give a sense of the disparity in vaccine administration across the world, she indicated that 4.21 billion doses have been administered globally with 38.67 million administered daily, but in low-income countries only 1.1% of people have received at least one dose. Narrowing it down to Africa, only 1.58% of the population has been fully vaccinated. This variance in administered vaccines is also present across the continent. In July 2021, Morocco had 28.9% of its population fully vaccinated, Botswana and South Africa had 5.3% and 5% of their populations fully vaccinated, and the Democratic Republic of the Congo had 0%. These incongruities are also evident when we assess the number of vaccines promised against vaccines delivered, with South Africa receiving only 26% of the vaccines promised. Continuing at the current pace, it would take South Africa two years and three months just to vaccinate 67% of its population.

Richter quoted the WHO Director-General saying, "The world is on the brink of a catastrophic moral failure – and the price of this failure will be paid with lives and livelihoods in the world's poorest countries." Following from this, she believes that it makes ethical sense and public health sense for vaccines to be distributed equitably amongst the world's population. In a bid to fight for vaccine equity, South Africa and India co-sponsored the TRIPS waiver in October 2020. If successful, this waiver will bring about flexibilities in the TRIPS agreement which would have an immense impact on the manufactured supplies of vaccines and other medical goods. For the waiver to be passed, a consensus amongst all member states of the WTO needs to be reached. While the waiver is

supported by over 100 countries (predominantly in the Global South), it has been blocked most notably by the EU, Australia, Norway and Japan, countries which have enough vaccines to vaccinate their population many times over. Putting this into perspective, in January 2021 the EU had 3.5 vaccines per person and Canada had 9.6 vaccines per person, as compared to 0.2 vaccines per person in the African Union. By blocking this waiver, the industrialised North is further entrenching the extreme inequalities currently faced by the Global South.

Richter concluded her presentation by speaking on a recent development in South Africa, where Pfizer-BioNtech has recently signed a 'fill and finish' contract with the Biovac Institute. She claimed that while this is a first step in developing manufacturing capacity, it is not enough to achieve vaccine independence because it does not include the sharing of Pfizer-BioNtech's technology or know-how. In addition, the 'fill and finish' approach does not address issues of security of supply, nor does it allow local manufacturers the freedom to make their own pricing decisions. She believes that if we start from the premise that health is a human right, as the TAC does, we will regard health equity and especially vaccine equity as essential in the struggle against the pandemic.

The political economy of the continuing fight against intellectual property rights negatively affecting public health goods in Africa – Tetteh Hormeku

Tetteh Hormeku's presentation was centred around the challenges that African countries have confronted in the process of trying to develop their own pharmaceutical capacity. These challenges go beyond the struggles for the TRIPS waiver and include the impact of some of the choices governments have made. He focused on two interrelated points that frame the predicament of African countries in relation to the current vaccine situation:

1) The vaccine process is dominated by pharmaceutical Multinational Corporations (MNCs) based in the advanced industrial countries and supported by their governments. The controversy around the TRIPS waiver is a clear example of the extent to which advanced countries and their MNCs would like to hold on to their place in the international order.

2) On the non-existent domestic pharmaceutical capacity in African countries, Tetteh explained that he uses the phrase "domestic pharmaceutical capacity" because:

- It does not include a subsidiary of an MNC signing a production agreement with a local African company.
- The word 'domestic' combines both the local character of production and the fact that it is embedded within the nation, its challenges, people, drives and imperatives.
- It does not refer to nations alone, but also to regional and continental initiatives.
- It captures pharmaceutical capacity beyond the production of vaccines.

Tetteh provided the following case-study to show how these two points are interrelated. 24 February marked the first shipment of COVID-19 vaccines to Ghana, and there was an optimism that it would be the beginning of a steady supply of vaccines to the country – six months later, less than 2% of the population has been vaccinated. Around the time Ghana received this first shipment, it was in talks with the Cuban government for support on the transfer of technology to improve its pharmaceutical capacity.

This date in February also marked the anniversary of the overthrow of Kwame Nkrumah in 1966. Six months before the coup Nkrumah's government had established a state pharmaceutical enterprise. After the coup, the military government tried to hand it over to Abbott Laboratories, an American pharmaceutical company, under such outrageous terms that the resulting backlash from the populace led to the abandonment of this plan.

The creation of a state-owned pharmaceutical enterprise in Ghana and in other African countries in the post-independence era was a reaction to colonial policies which deliberately curtailed the production of knowledge and science across the continent. The aim of developing a pharmaceutical industry domestically was to intervene on three levels:

- Creating an industry with the technical know-how and the machinery to be able to participate in the production of pharmaceutical products.
- Creating an industry which is linked to the process of developing and building knowledge and being at the frontiers of knowledge. This involved creating linkages with universities and scholars.
- Making use of traditional sources of medical knowledge. The state pharmaceutical enterprise was in operation until the 1980s when due to the Structural Adjustment Programs (SAPs) it was privatized and unable to compete in the free market.

Tetteh pointed out that two lessons can be taken from this anecdote:

- The government strongly intervened to ensure pharmaceutical production was linked to public procurement and public policy. The market for the product was guaranteed (army, public hospitals etc.).
- The government intervened to ensure that certain medical products could not be imported into the country. These interventions were crucial in creating the legal and scientific conditions within which the state-owned enterprise thrived until the SAP period.

A key success of the state pharmaceutical enterprise was that it was able to bargain with Big Pharma on its own terms. At the time, Big Pharma needed to negotiate with the state pharmaceutical enterprise to produce their products locally since they had no access to the Ghanaian market. Although Ghana's intellectual property rights regime replicated and mimicked some of the standards in the Global North, it was an indication of the amount of space countries in the Global South had to develop their own legislation with respect to intellectual property for public health. However, this option is no longer available to these countries. According to Tetteh, TRIPS inaugurated the monopoly that Big Pharma has over technical know-how for medical products. It has also enabled bio-piracy which allows Big Pharma to appropriate African traditional knowledge and patent it for themselves. In the 1990s, the Organisation of African Unity (OAU) tried to create an African model law to enable a fight against bio-piracy but was unsuccessful.

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Tetteh noted that the current situation highlights the importance of getting the TRIPS waiver, as it is a starting point for building domestic pharmaceutical capacity. The waiver goes beyond just patents and encompasses a host of other intellectual property rights such as copyrights, and industrial design. It covers all the important bases for making medicines in a modern context. Looking back to the Doha Declaration, very few countries were able to make real changes to their laws in order to make use of the flexibilities. This was due in part to the entrenchment of TRIPS in other agreements such as AGOA (the African Growth and Opportunity Act) and the EPAs (Economic Partnership Agreements). However, importantly, there was no real commitment by African leaders to making these changes.

Tetteh argued that African leaders are not making the strategic choices that would eventually lead them to developing independent pharmaceutical industries. Suggesting that South-South cooperation is an avenue to address the current issues the continent faces, he argued that instead of using all their funds to buy vaccines, African countries could have allocated some funds to support phase three of Cuba's vaccine trials. By doing this, they would have been able to negotiate for a consistent relationship in terms of knowledge exchange and the transfer of technology.

Updates on COVID-19 in Senegal and Kenya

Cheikh Tidiane Dieye provided an update on the COVID-19 situation in Senegal. The country recorded its first case of the virus in March 2020. Since then, the government has put in place measures such as curfews, travel restrictions and the banning of public gatherings to contain the spread of the disease. The Senegalese government did not enforce a lockdown because the country has a large informal sector which would have been negatively impacted by a lockdown.

Senegal is currently experiencing its third wave – driven by the delta variant. The total number of cases has increased significantly over the last year, moving from 9,805 cases and 195 deaths in July 2020 to 63,560 cases with 1,365 deaths as of July 2021. This increase in cases has taken a toll on the country as it does not have the healthcare infrastructure to deal with the virus caseload. The vaccination campaign was launched in February this year, with about 1.2 million doses received, 1.8% of the population fully vaccinated and 3% receiving their first dose.

He stated that Senegal is currently facing two issues:

1. Lack of access to the vaccines. This is because the country does not have the means to purchase enough vaccines for its population and is currently relying on donations from COVAX. This has resulted in protracted waiting times for the vaccine. These waiting times can cause complications for vaccine administration, since there are people who have received the first dose but must wait for longer than the recommended time of eight weeks to receive their second dose.
2. A significant part of the population is reluctant to receive vaccines and sensitization campaigns are proving ineffective.

He remarked on one key development in Senegal – the creation of a vaccine manufacturing plant funded by the World Bank, the US, and a few European countries. The plant is expected to produce 300 million doses a year, first of COVID-19 vaccines and then other types of vaccines against endemic diseases. This project will be implemented by the Institut Pasteur de Dakar which already produces yellow fever vaccines.

ROAPE's Njuki Githethwa provided an update on the COVID-19 situation in Kenya. He mentioned that the delta variant has caused a surge in cases and deaths. There have been currently over 200,000 cases since the pandemic began with the total number of deaths at 4,000 at the end of July. He pointed out that this third wave is affecting the lower classes which were spared in the initial stages of the pandemic. Kenya has received 1.8 million doses of the vaccine, with about 1.7% of Kenyans vaccinated. He noted that if vaccinations continue at this pace, it will take over two years for Kenyans to be fully vaccinated.

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According to Njuki, the disbursement of vaccines from the West is being portrayed as a symbol of charity, solidarity, and sympathy. This portrayal is underlain by the West positioning themselves as saints while vilifying other countries like India and China. He also mentioned that there is a class dynamic at play in Kenya regarding the distribution of vaccines. People in affluent areas have ease of access whereas the less privileged wait in long queues to get vaccinated. As a result, most of the population, including frontline workers, are yet to be vaccinated. Schools in the country reopened at the end of July, and only about 60% of teachers have been vaccinated. Njuki touched on the fact that there is an optimism that more vaccines are coming, however the government is not doing enough to sensitise the population. There is still a lot of misinformation and superstition surrounding the vaccines.

Moving beyond the state?

The discussion was further enriched by contributions from the participants. Gyekye Tanoh, for example, noted that in the past the presence of state pharmaceutical enterprises around the continent constituted an active and embodied interest. This influenced the way transnational pharmaceutical companies were able to negotiate, severely limiting their power. However, such a thing is not present today on the continent. In fact, a study from the McKinsey Institute pointed to the fact that the pharmaceutical industry has the highest markups in Africa, meaning that while the continent is not the biggest market, it is the most profitable region in the world. Currently, the interests of Big Pharma dominate, he asked, how do we begin to shift this? Is it time to look beyond the state as a leading agent for change? What can progressives do in this situation?

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In response to Gyekye's question, Tetteh argued that he does not believe that it is time to look beyond the government. In the case of the pharmaceutical industry, the market is created by production and government procurement of pharmaceutical products. Real change cannot be realised without the involvement of the government and well thought out policies. But there is still a role for progressives. Activists need to mobilise and organize around broad paradigmatic changes and clear concrete policy choices that can be implemented in the immediate, medium, and long term.

Wallace added that the objectives of activists in the Global North should be to support the efforts of those in the Global South. This is especially important because COVID-19 is not the only virus that can cause real damage. We need to make structural changes that ensure the Global South is not at the mercy of the Global North whose economic model has contributed to the current situation.

Farai Chipato ended the session by thanking the speakers and participants for their contributions to the fruitful and important discussion. Chipato urged participants to join ROAPE and TWN-Africa for their two upcoming webinars: 'Popular public health in Africa: lessons from history and Cuba' and 'Alternative strategies and politics for the Global South: climate-change and industrialisation.'

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This article was originally published in the Review of African Political Economy (ROAPE) Journal.

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