Journal of Critical Public Health, **Volume 1 (2024), No. 2, pp. 74-76**

Response

Coloniality and imperialism cannot be ignored in analysing the negotiations around the proposed pandemic agreement

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In his editorial on the negotiations for a pandemic agreement, Petersen (2024) notes that while some provisions have been endorsed by the International Negotiating Body (INB), others remain contested. He questions, with good reason, whether the negotiations will yield more equitable and effective arrangements for pandemic prevention and response. In this response we argue that the continuing expression of colonial arrogance in global health governance (de Campos-Rudinsky et al. 2024) provides important contextual framing regarding vaccine hoarding and of the conflicts over the proposed pandemic agreement and that exploration of this would have added to the usefulness of the editorial.

Coloniality refers to the legacies of the colonial relationship in both the colonising and colonised countries (Mignolo 2021). Post-decolonisation, those legacies have been subsumed into the relations of imperialism, deploying hegemonic power to impose a regime of unequal exchange, although without direct rule (Legge 2018). Vaccine hoarding, and the privileging of intellectual property protection over vaccine access, reflect the arrogance of the colonial mindset: the entitlement to exploit 'the other' through relationships of unequal power.

Dr Petersen cites, as the main issue in contention in the negotiations, the incorporation of an elimination strategy in the draft agreement. Possibly more significant has been the conflict between rich and poor countries over pathogen access and mandatory benefit sharing (Watal & Gostin 2023). The high-income countries are resisting calls to facilitate the transfer of technology in pandemic circumstances, including through the lifting of TRIPS Agreement restrictions on access to intellectual property. Likewise, they are resisting binding commitments for financial transfers to support Low and Middle Income Countries' (L&MICs') pandemic responses.

One of the key lessons from the struggle for decolonisation (national liberation) was the need to actively resist the colonisers. In the context of the INB negotiations, this resistance continues. Many L&MICs (TWN 2024) are seeking to gain leverage in the negotiations by making 'pathogen access' (the sharing of biological data and genetic sequences) conditional upon binding commitments to the sharing of benefits arising from the sharing of pathogen data (including access to medical products).

In referring to the paper on mpox by Atuk and Cannon (2024), Dr Petersen attributes the 'disregard of the situation of those in poorer countries' to a 'narrowing of attention' in Western media coverage of both the COVID-19 pandemic and the 2022 outbreak of mpox. This assessment ignores Atuk & Cannon's passionate denunciation of coloniality as a cause for such disregard. To explain vaccine hoarding and the refusal of technology transfer in terms of this 'narrowing of attention' overlooks the

systemic inequalities embedded in global economic governance including constraints on the development, production and delivery of healthcare products in L&MICs. Pharmaceutical research and development are largely controlled by transnational pharma and overwhelmingly directed to the healthcare markets of the rich world, rather than addressing the needs of the Global South (Edward-Ekpu 2021).

Dr Petersen is critical of the failings of global health governance, citing the findings of the Independent Panel (2021). He describes WHO as 'constrained by the requirement to consider the views, needs and aspirations of its Member States'. In fact, it is the member states that comprise the organisation; the Secretariat serves the member states. To attribute shortfalls in the performance of the WHO Secretariat to the governance role of member states suggests that national voice in the development of global policy is a problem, rather than a legitimate design criterion. Shortfalls in the performance of the Secretariat can be more plausibly attributed to the power relations of geopolitics, manifest particularly in restrictions on the funding of WHO. Since the 1980s, the USA and its allies have frozen obligatory contributions from member states while supplementing the budget with tightly earmarked contributions to programs of which they approve, seriously distorting institutional accountability and program delivery. A relevant example of donor control was the long-standing opposition of the USA to the creation within WHO Secretariat of an emergency response capacity, preferring that WHO be restricted to its 'normative functions' (developing technical resources). It was only after the 2014 West Africa Ebola crisis that the USA agreed to the establishment of such a capability.

In the context of the COVID response, the USA and its allies sought to bypass WHO's governing bodies through the creation of the Access to COVID Tools Accelerator (ACT-A), outside the WHO. They also refused to support Dr Tedros in his calls for a COVID Technology Access Pool (C-TAP) and for Solidarity Trials (head-to-head trials of vaccine candidates) (Legge & Kim 2021).

The discourse of 'global health security', within which much of the pandemic policy debate has been conducted, provides cover for concerns to protect the rich world from the contagion of the poor (the colonisers from the colonised). This motif has wound its way through global health governance since at least 1851. More recently it has been expressed in recurring criticisms of poorer countries regarding delays in implementing the core capacities required by the International Health Regulations (IHRs). It is ironic that the most dramatic failure of the COVID-19 pandemic was a failure of solidarity, rather than the insufficient laboratory capacity or lax border controls that are key standards required by the IHRs.

Despite several references to Big Pharma in the editorial, there are no references to intellectual property (IP), the TRIPS Agreement, or the opposition of the USA and its allies to the India/South Africa proposal in 2020 to suspend TRIPS disciplines to allow dispersed production of vaccines (Human Rights Watch 2020, Edward-Ekpu 2021). The extreme intellectual property protections provided for in the TRIPS Agreement are critical to the business model of Big Pharma. The purchase of influence by Pharma through donations to politicians is a major driver of US defence of Big Pharma, as well as the rent extracted from the rest of the world through the high prices enabled by IP monopolies.

In the present era, the arrogance of coloniality is manifest through the political economy of imperialism. The essence of imperialism is unequal exchange imposed through unequal power. Imperialism and the arrogance of coloniality lie at the heart of the failures of solidarity under Covid and the stalled debates around the proposed pandemic agreement.

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