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Pandemics, Wars, and Peace Global Health in Crisis?

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The Bill & Melinda Gates Foundation Main Office in Seattle, Washington, USA.

The 1918 influenza pandemic can undoubtedly be considered one of the most devastating events in history. Conservative estimates even say that, in barely two years, it killed no fewer than fifty million people worldwide. Despite being extensively censored, its terrible march through the twentieth century is well known today.

Perhaps less known, however, is the process that gave rise to it. The erroneously named "Spanish flu" did not emerge first in Spain, but in the United States. Historical and viral genealogical research have shown that the initial outbreak of the H1N1 influenza virus, the cause of the pandemic, took place in Fort Riley, Kansas. It was not by chance that it originated on a military base: the mobilization of troops for World War I brought together thousands of young conscripts from different corners of the country, confining them in cold, dimly lit, badly ventilated rooms.

Despite the fact that the virus must surely have managed to move from fowl to humans a few weeks or months before the outbreak, it was the war that created the conditions for its initial epidemic spread. From the barracks and mobilization of soldiers that spread the virus violently through the U.S. population that winter, the pandemic crossed the Atlantic in spring 1919. Once established in the European theater, it propagated ferociously and spread to the rest of the world for the following two years, sparking a humanitarian crisis of global proportions.

Linking the "Great War" to the origins of the "great pandemic" therefore obliges us to direct our attention to military conflicts as vehicles of the first magnitude for causing epidemics —and even pandemics, as we can see— and transmitting infectious diseases. This demands that we at least consider the idea that wartime conditions create environments that are extremely favorable for pathogens not only to infect human populations, but also to propagate very swiftly. In other words, wars are epidemiologically dangerous given that they radically increase the interaction and mobility of human groups.

Despite this crucial causal connection between wars and epidemics, it is important to note that the relationship does not only go one way. That is, not only have wars facilitated these disasters, but epidemics have also contributed to causing or prolonging military conflicts. The social, economic, and political wreckage that invariably come with huge pandemics often create ideal conditions for exacerbating and even causing wars or armed conflicts. Taking into consideration the role of pandemics in the creation of conflicts is, then, a matter of huge importance, especially when failures in dealing with them, as seen in the devastation caused by Covid-19, can create profoundly unstable conditions not only locally or nationally, but globally.

So, thinking about the role that pandemics can have in destabilizing relatively peaceful, prosperous conditions, it is worth critically assessing the architecture set up to protect us from them. I will allow myself, then, to mention some of the key problems involved.

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As has become clear after the first waves of global infection by the SARS-CoV-2 virus up until now, a structural inequality exists among countries in terms of their available tools and resources to deal with pandemic outbreaks. While rich industrialized countries of the global North had the capability to detect and isolate cases, as well as produce medical inputs and vaccines in record time, entire regions of the world lacked even basic public health infrastructure or supplies.

Although it is true that even supposedly better prepared countries made grave errors in their responses and their vaccination processes were especially slow, politicized, and shot through with inconsistencies, it is also the case that even today, a large number of poor or developing nations still do not have the minimum conditions of infrastructure, finances, or technology to deal with the disease.

This profound inequality is not only ethically reprehensible; it is also counterproductive: when poor or developing countries cannot implement minimum policies for identifying and containing pandemic outbreaks, the risk is that the pathogens will continue to circulate. That is, the chains of contagion remain active globally even when protection increases in specific places in the world through vaccination or other methods of control. In this sense, the immunity of privileged populations is quite precarious, since the risk of highly infections pathogens continuing to evolve to become more virulent or transmissible does not necessarily diminish, particularly in the case of the viruses of the recent emergency or those capable of mutating rapidly, such as the influenza or corona viruses. That is, it is not realistic to talk about a reduction in pandemic risk as long as the capabilities of minimum protection on a global level do not increase.

On the other hand, this inequality in preparation for and response to pandemics is not new; it is the result of a long historic process intimately linked to colonialism.

Linking the "Great War" to the origins of the "great pandemic" obliges us to recognize military conflicts as vehicles for causing epidemics, even pandemics, and transmitting infectious diseases.

We should note, therefore, that the field of "global health," responsible today for designing policies for responding to a global pandemic, has evolved from what was called "tropical medicine." This was created in the nineteenth century to govern colonized populations and facilitate their political and economic exploitation by the European and North American powers. As long as global health continues to include colonial budgets and practices, it will be part of a techno-political project that maintains a clearly asymmetrical power structure instead of subverting it. The clearly extractivist attitudes, policies, and practices that are part of global health perpetuate a structure that concentrates resources, experience, data, funding, and technology in a handful of universities or institutions of the global North, while countries of low and medium incomes continue to be dependent.

In this sense, we can identify certain institutional actors with a preponderant role in the reproduction of colonialist budgets in the design of the architecture of today's global health. Among them, I would like to emphasize four private philanthropic institutions that today have contributed to the concentration of resources and that dominate decision-making, maintaining the gap between countries of the global North and South in terms of the preparation for pandemics: the Global Alliance for Vaccines and Immunization (GAVI), the Bill & Melinda Gates Foundation (BMGF), the Wellcome Trust, and, more recently, the Coalition for Epidemic Preparedness Innovations. Particularly since the SARS, H1N1 flu, and Ebola epidemics of the first two decades of the twenty-first century, these institutions have managed to fill an international leadership vacuum in the design of pandemic control policies.

The perpetuation of colonial policies by these philanthropical institutions involves not only their mainly utilitarian, quantitative, biomedical, and vertical approach to dealing with pandemics; they also involve their enormous financial capabilities, which allows them to conceive of and lead interventions in the name of "global" welfare, which, however, lack international scope and public scrutiny. These financial capabilities do not stem exclusively from the capital of individual magnates; these foundations also consistently build lobbying networks and use political connections to access copious amounts of public resources.

During the Covid-19 pandemic, for example, these four organizations spent significant sums just on lobbying. In the last two years, GAVI and CEPI spent at least

US$1.3 million to get funding from the United States and Europe for their own initiatives. They mainly pressured highly placed officials in the U.S. government and the European Parliament to give them resources to manage to help low-income countries to fight the pandemic. In 2020 alone, GAVI and CEPI spent more than US$435,000 for lobbying the U.S. Congress and the United States Agency for International Development (USAID), the White House, and the U.S. Department of Health and Human Services (HHS) to give them federal monies, making them the almost exclusive mediators for the global response to the pandemic. The CEPI pressured for using specific language in financial legislation to globally fight Covid-19, which authorized the U.S. government to give them US$200 million a year. Additionally, Wellcome Trust also spent at least US$1.1 million to get support from the European Parliament for its programs.

After acquiring enormous amounts of funding, Wellcome Trust, BMGF, and GAVI collectively donated US$1.4 billion to the World Health Organization (WHO) and about US$170 million specifically to Covid-related programs to win influence in that institution. In this regard, since the end of January 2020, Wellcome Trust and BMGF representatives have regularly attended WHO meetings and those with high-ranking U.S. officials dealing with issues like the international spread of the virus, the exchange of Covid samples, and clinical trials of vaccinations and medications. They even helped organize and finance the first truly international WHO meeting for establishing the basis for the "global" response to the virus.

These lobbying efforts were not carried out, however, to change the unjust, unequal, and dangerous architecture of global health. Of the US$23 billion that these institutions received in contributions during the first two years to fight the pandemic, for example, only US$2.2 billion (9.5 percent) were earmarked for strengthening basic health infrastructure in low-income countries, according to data from the WHO funds tracker. In addition, using the Covax mediation mechanism, the BMGF and the CEPI initially set the goal of giving out two billion doses of vaccines by the end of 2021. However, when the date came around, they had only distributed 319 million doses (15.9 percent). Similarly, their goal had been to supply five hundred million tests to low- and medium-income countries by mid-2022; however, they only actually supplied eighty-four million, or 16 percent of their goal.

> Protagonists in the reproduction of colonialist budgets, like some private philanthropic institutions, have maintained the gap between the global North and South in terms of the preparation for pandemics.

Finally, restrictions supported by the BMGF ensured that companies like Pfizer and Moderna could actively oppose suspending their patents to protect future profits. This was despite the fact that countries with vaccine manufacturing capabilities like South Africa and India accepted using those patents without making a profit exclusively during the health emergency.

The lack of investment in basic public health needs where it is most needed, failure to supply medical inputs equitably, and the refusal to share technological developments caused, among other things, some nations in Sub-Saharan Africa to have practically non-existent vaccination campaigns. What is more, despite big promises, by August 2022, only about 20 percent of the populations in Africa and Southeast Asia were vaccinated, an ominously insufficient number. The concentration of resources, technology, knowledge, and funding in global health has prevented the strengthening of local health systems, particularly in low-income countries. It has also hindered the possibility of their generating their own response and protection capabilities, guaranteeing adequate supply and equitable distribution of medical protection and diagnostic gear, and having medication and vaccines for emergency cases. This has perpetuated global vulnerability and left many countries and persons defenseless.

The continued existence of colonialism in the field of health has a truly dangerous cost. If firm, energetic steps are not taken to decolonize global health and improve protection levels worldwide, we run the risk of exacerbating conflicts in places that are already in chaos. The reforms will not only need to identify specific deficiencies but also to include concrete, long-term actions to radically change the dominant colonial systems and structures. The objective is to transition to much more diverse global health conceptions and practices that would be inclusive and fair and would truly eradicate our vulnerability in the face of future pandemics. VM

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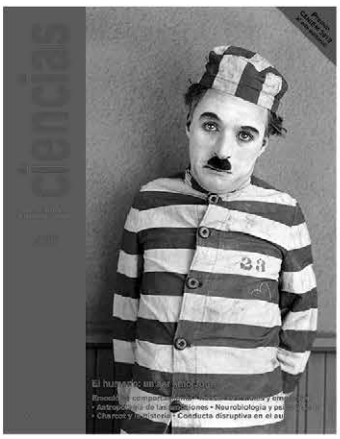

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