

DISPOSABLE LIVES:
COVID-19, VACCINES, AND THE UPRISING

*Matiangai Sirleaf**

“If I can be provocative, shouldn’t this study be done in Africa, where there are no masks, no treatment, no intensive care, a bit like some studies on AIDS or among prostitutes. We try things, because we know they . . . are highly exposed and they don’t protect themselves. What do you think about that?”

— Jean-Paul Mira, Head of the Intensive Care Unit at the Cochin Hospital in Paris, April 1, 2020¹

“You’re right We’re currently thinking in parallel about a study in Africa with the same type of approach I think a call has been issued or will be issued and I think we are going to consider it.”

— Camille Loch, Research Director at the French Institute of Health and Medical Research, Inserm, April 1, 2020²

INTRODUCTION

Two French doctors appeared on television and publicly discussed potentially utilizing African subjects in experimental trials for a tuberculosis vaccine as an antidote to the novel coronavirus (COVID-19).³ Tedros Adhanom Ghebreyesus, the Director-General of the World Health Organization (WHO), denounced these kinds of racist remarks as a “hangover from ‘colonial mentality’”⁴ and maintained that “Africa can’t and won’t be

* Nathan Patz Professor of Law, University of Maryland Francis King Carey School of Law. Much gratitude to Aziza Ahmed and Timothy Lovelace for their helpful comments on an earlier draft.

1. What French Doctors and the WHO Really Said About Africa and Vaccine Testing, Euronews, <https://www.euronews.com/2020/04/07/what-french-doctors-and-the-who-really-said-about-africa-and-vaccine-testing> [<https://perma.cc/ZFQ3-6H89>] (last updated Aug. 4, 2020).

2. Id.

3. James Ojo, Watch: Outrage as French Doctors Discuss Testing COVID-19 Vaccine in Africa, Cable Lifestyle (Apr. 2, 2020), <https://lifestyle.thecable.ng/watch-outrage-as-french-doctors-discuss-testing-covid-19-vaccine-in-africa> [<https://perma.cc/2J3K-5MSE>].

4. Coronavirus: Africa Will Not Be Testing Ground for Vaccine, Says WHO, BBC News (Apr. 6, 2020), <https://www.bbc.com/news/world-africa-52192184> [<https://perma.cc/EYN8-UZEG>].

a testing ground for any vaccine.”⁵ The fallout on social media was similarly swift, with Samuel Eto’o, a Cameroonian football legend, referring to the doctors as “[d]es assassins”⁶ and several others questioning the motives behind testing a vaccine on the African continent.⁷ The dialogue between the doctors and the strong reactions to their statements reopen the wounds of Black, Indigenous, and other people of color’s lives being treated as disposable.

This Piece connects how racialized notions regarding which lives are disposable are reflected widely in the areas of health and human rights. The presumed expendability of Black lives is made manifest from systemic police violence, to the devastating racially disproportionate impact of COVID-19,⁸ to historic and ongoing medical experimentation, and to inequitable vaccine access.⁹ The twin pandemics of systemic racism and COVID-19 have heightened the visibility of the disposability with which society views the lives of people of color. The cumulative effect of this disposability furthers the devaluation of subordinated groups. Through exploring the theme of disposability, this Piece clarifies the roles of international human rights law, global public health, and international intellectual property law in either advancing racial justice efforts or contributing toward racial subordination. This period of racial reckoning and reform creates an opening to challenge the racial status quo in these areas and beyond.

I. DISPOSABLE LIVES AND THE UPRISING

The ongoing uprising challenges the assumption of disposability of Black lives in the United States and elsewhere. The seemingly unrelenting

5. Id.

6. Samuel Eto’o (@SamuelEtoo), Twitter (Apr. 2, 2020), <https://twitter.com/SamuelEtoo/status/1245655021162659841?lang=en> (on file with the *Columbia Law Review*).

7. See, e.g., Musa Okwonga, The French Doctors Who Wanted to Test Vaccines on Africans and Western Medicine’s Dark History, *Quartz Afr.* (Apr. 10, 2020), <https://qz.com/africa/1836272/french-doctors-say-test-covid-19-vaccine-on-africans-spark-fury> (on file with the *Columbia Law Review*); Rim-Sarah Alouane (@RimSarah), Twitter (Apr. 2, 2020), <https://twitter.com/RimSarah/status/1245680422614446081> (on file with the *Columbia Law Review*).

8. Jazmyn T. Moore, Jessica N. Ricaldi, Charles E. Rose, Jennifer Fuld, Monica Parise, Gloria J. Kang, Anne K. Driscoll, Tina Norris, Nana Wilson, Gabriel Rainisch, Eduardo Valverde, Vladislav Beresovsky, Christine Agnew Brune, Nadia L. Oussayef, Dale A. Rose, Laura E. Adams, Sindoos Awel, Julie Villanueva, Dana Meaney-Delman & Margaret A. Honein, Disparities in Incidence of COVID-19 Among Underrepresented Racial/Ethnic Groups in Counties Identified as Hotspots During June 5–18, 2020—22 States, February–June 2020, 69 *Morbidity & Mortality Wkly. Rep.* 1122, 1123 (2020) (“A high percentage of cases in hotspot counties are among persons of color.”).

9. Uché Blackstock & Oni Blackstock, Opinion, White Americans Are Being Vaccinated at Higher Rates than Black Americans. Such Inequity Cannot Stand., *Wash. Post* (Feb. 1, 2021), <https://www.washingtonpost.com/opinions/2021/02/01/racial-inequality-covid-vaccine/> (on file with the *Columbia Law Review*).

onslaught of police violence against Black people in the United States has resulted in many lives lost, both seen and unseen. Notoriously, Derek Chauvin, a Minneapolis police officer, kned George Floyd to death for over nine minutes.¹⁰ During this time, George Floyd told officers, “I can’t breathe” more than twenty times while the officer’s knee remained on his neck.¹¹ The officers treated him as disposable. In Louisville, several police officers shot and killed Breonna Taylor, an EMT worker who was sleeping when the police forcibly entered her home attempting to enforce a no-knock warrant.¹² Additionally, a former police officer killed Ahmaud Arbery for “jogging while Black” in Brunswick, Georgia.¹³ The banal circumstances surrounding their deaths indicate the precariousness of Black lives and the ease with which our lives can be disposed. The public health community has belatedly recognized that addressing police violence is a public health issue.¹⁴

Mr. Floyd’s death vividly illustrates the relationship between police brutality, systemic racism, and health equity. The Hennepin County Medical Examiner’s autopsy report indicates that he was positive for COVID-19 at the time of his death.¹⁵ It also observes that he was likely asymptomatic with persistent positivity from a previous infection.¹⁶ Mr. Floyd’s positive test for COVID-19 on April 3, 2020 occurred nearly eight

10. Nicholas Bogel-Burroughs, Prosecutors Say Derek Chauvin Knelt on George Floyd for 9 Minutes 29 Seconds, Longer than Initially Reported., *N.Y. Times* (Mar. 30, 2021), <https://www.nytimes.com/2021/03/30/us/derek-chauvin-george-floyd-kneel-9-minutes-29-seconds.html> (on file with the *Columbia Law Review*).

11. Maanvi Singh, George Floyd Told Officers ‘I Can’t Breathe’ More than 20 Times, Transcripts Show, *Guardian* (July 9, 2020), <https://www.theguardian.com/us-news/2020/jul/08/george-floyd-police-killing-transcript-i-cant-breathe> [https://perma.cc/HX4N-UNZJ].

12. Amina Elahi, ‘Sleeping While Black’: Louisville Police Kill Unarmed Black Woman, *NPR* (May 13, 2020), <https://www.npr.org/2020/05/13/855705278/sleeping-while-black-louisville-police-kill-unarmed-black-woman> [https://perma.cc/35EE-GNLC].

13. Zack Beauchamp, Ahmaud Arbery and the Dangers of Running While Black, *Vox* (May 8, 2020), <https://www.vox.com/policy-and-politics/2020/5/8/21250914/ahmaud-arbery-mcmichael-arrest-black-men-exercise> (on file with the *Columbia Law Review*); see also Marie Andruszewicz, Georgia Attorney General Asks for DOJ Probe into Handling of Ahmaud Arbery Case, *NPR* (May 10, 2020), <https://www.npr.org/2020/05/10/853581211/georgia-attorney-general-asks-for-doj-probe-into-handling-of-ahmaud-arbery-case> [https://perma.cc/Q7A6-JYMW].

14. See, e.g., Addressing Law Enforcement Violence as a Public Health Issue, *Am. Pub. Health Ass’n* (Nov. 13, 2018), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence> [https://perma.cc/LQ52-FWKM]; see also Sirry Alang, Donna McAlpine, Ellen McCreedy & Rachel Hardeman, Police Brutality and Black Health: Setting the Agenda for Public Health Scholars, *107 Am. J. Pub. Health* 662, 662 (2017).

15. Andrew M. Baker, Hennepin County Medical Examiner’s Office Autopsy Report 3 (June 1, 2020), <https://www.hennepin.us/-/media/hennepinus/residents/public-safety/documents/floyd-autopsy-6-3-20.pdf> [https://perma.cc/Z6RG-Z3J7].

16. *Id.*

weeks prior to when police murdered him.¹⁷ The Hennepin County autopsy report found that Mr. Floyd went into cardiopulmonary arrest while the police restrained him and that the police compressed his neck.¹⁸ An independent autopsy report commissioned by the Floyd family found that his death was due to “asphyxiation from sustained pressure” when Minneapolis police officers compressed his neck and his back.¹⁹ It is telling that structural racism manifested in such a way that over Mr. Floyd’s brief life, he was more likely to encounter things that we know jeopardize life and limb—like systemic police violence and the racialized health inequities witnessed with COVID-19.²⁰

The ongoing racial reckoning inspired in part by Mr. Floyd’s death challenges the disposable nature with which his life and those of countless others are regarded. During the uprising, people across the globe joined together demanding full equality, accountability, and an end to police brutality and systemic racial injustice.²¹ In the United States, the response to the Black Lives Matter uprising and allies protesting racial subordination included substantial militarization with armored vehicles, curfews, tear gas, pepper spray, and rubber and wooden bullets.²² The ongoing racial reckoning has illuminated how quickly and swiftly some states are willing to deploy the military and the police to quell those agitating for racial justice. This must be read against the drastically different state responses to the anti-lockdown protests occurring across the United States during the COVID-19 pandemic, which are characterized by the police showing

17. *Id.*

18. *Id.* at 1.

19. Scott Neuman, Medical Examiner’s Autopsy Reveals George Floyd Had Positive Test for Coronavirus, NPR (June 4, 2020), <https://www.npr.org/sections/live-updates-protests-for-racial-justice/2020/06/04/869278494/medical-examiners-autopsy-reveals-george-floyd-had-positive-test-for-coronavirus> [<https://perma.cc/6CGE-7STC>].

20. Ruqaiyah Yearby, Structural Racism: The Root Cause of the Social Determinants of Health, Petrie Flom Ctr.: Bill of Health (Sept. 22, 2020), <https://blog.petrieflom.law.harvard.edu/2020/09/22/structural-racism-social-determinant-of-health> [<https://perma.cc/EGD2-LGW7>].

21. Damien Cave, Livia Albeck-Ripka & Iliana Magra, Huge Crowds Around the Globe March in Solidarity Against Police Brutality, N.Y. Times (June 6, 2020), <https://www.nytimes.com/2020/06/06/world/george-floyd-global-protests.html> (on file with the *Columbia Law Review*) (last updated June 9, 2020).

22. Tom Nolan, Militarization Has Fostered a Policing Culture that Sets Up Protesters as ‘The Enemy’, Rice: Kinder Inst. for Urb. Rsch. (June 10, 2020), <https://kinder.rice.edu/urbanedge/2020/06/10/police-brutality-militarization-racism-protests> [<https://perma.cc/94RC-SF52>]; Liz Szabo, Jay Hancock, Kevin McCoy, Donovan Slack & Dennis Wagner, Fractured Skulls, Lost Eyes: Police Break Their Own Rules when Shooting Protesters with ‘Rubber Bullets’, USA Today (June 19, 2020), <https://www.usatoday.com/in-depth/news/nation/2020/06/19/police-break-rules-shooting-protesters-rubber-bullets-less-lethal-projectiles/3211421001> [<https://perma.cc/5WJC-GAFE>] (last updated Sept. 11, 2020).

phenomenal restraint.²³ Juxtaposing the two shows starkly how efforts to enforce the racial status quo and those that challenge racial hierarchy are regarded. The knowledge that those most detrimentally impacted by COVID-19 belong to different racial groups than the majority White²⁴ anti-lockdown protestors informed the grievance and entitlement of those seeking the premature lifting of COVID-19 restrictions. The implicit question was: Since the suffering and disposability associated with racial health inequities has historically been normalized, why should COVID-19 be treated any differently and require more mutual regard and concern for subordinated groups?

II. DISPOSABLE LIVES AND RACIAL HEALTH DISPARITIES

The failure to protect historically subordinated groups has meant that Black people in the United States are dying at approximately 1.5 times the rate of White people from COVID-19.²⁵ Additionally, Black lives lost account for nearly 20% of the deaths across the United States where race is known.²⁶ Significantly, the glaring racial health disparities observed with

23. Aymann Ismail, *The Anti-Lockdown Protests Prove Police Know How to Treat Protesters Fairly*, Slate (May 28, 2020), <https://slate.com/news-and-politics/2020/05/police-response-george-floyd-minneapolis-shutdowns.html> [<https://perma.cc/DL3C-NG6A>].

24. The author capitalizes the “W” in White in this Piece, contrary to the typical practice of the *Columbia Law Review*, to render Whiteness visible and avoid unparallel terms. The capitalization of White does not imply the existence of a single ethnic group. See Ann Thúy Nguyễn & Maya Pendleton, *Recognizing Race in Language: Why We Capitalize “Black” and “White”*, Ctr. for the Study of Soc. Pol’y (Mar. 23, 2020), <https://cssp.org/2020/03/recognizing-race-in-language-why-we-capitalize-black-and-white> [<https://perma.cc/AP5K-PDAR>] (“To not name ‘White’ as a race is, in fact, an anti-Black act which frames Whiteness as both neutral and the standard.”); see also Kwame Anthony Appiah, *The Case for Capitalizing the B in Black*, Atlantic (June 18, 2020), <https://www.theatlantic.com/ideas/archive/2020/06/time-to-capitalize-blackand-white/613159> (on file with the *Columbia Law Review*) (“Racial identities were not discovered but created . . . and we must all take responsibility for them. Don’t let them disguise themselves as common nouns and adjectives. Call them out by their names.”); Nell Irvin Painter, *Opinion, Why ‘White’ Should Be Capitalized, Too*, Wash. Post (July 22, 2020), <https://www.washingtonpost.com/opinions/2020/07/22/why-white-should-be-capitalized> (on file with the *Columbia Law Review*) (“[W]hite Americans have had the choice of being something vague, something unraced and separate from race. A capitalized ‘White’ challenges that freedom, by unmasking ‘Whiteness’ as an American racial identity as historically important as ‘Blackness’—which it certainly is.”); Eve L. Ewing, *I’m a Black Scholar Who Studies Race. Here’s Why I Capitalize ‘White.’*, Medium (July 2, 2020), <https://zora.medium.com/im-a-black-scholar-who-studies-race-here-s-why-i-capitalize-white-f94883aa2dd3> [<https://perma.cc/89EP-39J2>] (“Whiteness is . . . a specific social category that confers identifiable and measurable social benefits.”); Kanya Stewart, *NABJ Statement on Capitalizing Black and Other Racial Identifiers*, Nat’l Ass’n of Black Journalists (June 11, 2020), <https://www.nabj.org/news/news.asp?id=512370> (on file with the *Columbia Law Review*).

25. The COVID Racial Data Tracker, COVID Tracking Project at The Atlantic, <https://covidtracking.com/race> [<https://perma.cc/J43D-D4E9>] (last visited Feb. 16, 2021).

26. Jeremy A.W. Gold, Lauren M. Rossen, Farida B. Ahmad, Paul Sutton, Zeyu Li, Phillip P. Salvatore, Jayme P. Coyle, Jennifer DeCuir, Britney N. Baack, Tonji M. Durant,

COVID-19 are not the result of innate susceptibility in historically subordinated groups.²⁷ Accordingly, focusing on preexisting health conditions like hypertension, diabetes, obesity, and the higher prevalence of cardiovascular disease among Black people—which can make for greater and more severe and deadly complications with COVID-19²⁸—provides an incomplete picture. Instead, structural factors that ensure that Black people are “more likely to encounter those things that we know compromise health—like inaccessible or biased health care providers, inadequate schools and education systems, unemployment, hazardous jobs, unsafe housing, and violent, polluted communities”²⁹—provide a more robust explanation for the racial disparities witnessed with COVID-19. For instance, those with higher incomes are better able to follow social distancing guidelines, while lower-income individuals are not,³⁰ and people of color are overrepresented among “essential workers.”³¹ For example, Black workers are about one in nine workers overall in the United States, yet they make up about one in six of all front-line-industry workers.³² Essential personnel employed in transportation, sanitation, retail, and other public-facing sectors tend to face greater risks from COVID-19 because such jobs require greater contact with the public and have minimal structural protections like paid sick days and adequate

Kenneth L. Dominguez, S. Jane Henley, Francis B. Annor, Jennifer Fuld, Deborah L. Dee, Achuyt Bhattarai & Brendan R. Jackson, *Race, Ethnicity, and Age Trends in Persons Who Died from COVID-19—United States, May–August 2020*, 69 *Morbidity & Mortality Wkly Rep.* 1517, 1518 (2020).

27. Khiara M. Bridges, *The Many Ways Institutional Racism Kills Black People*, *Time* (June 11, 2020), <https://time.com/5851864/institutional-racism-america> [<https://perma.cc/2UF5-BDSN>]; see also Ladan Golestaneh, Joel Neugarten, Molly Fisher, Henny H. Billett, Morayma Reyes Gil, Tanya Johns, Milagros Yunes, Michele H. Mokrzycki, Maria Coco, Keith C. Norris, Hector R. Perez, Shani Scott, Ryung S. Kim & Eran Bellin, *The Association of Race and COVID-19 Mortality*, 25 *EClinicalMedicine* 1, 6 (2020) (“Black patients engaged in care did suffer disproportionate higher mortality in the COVID period . . .”).

28. See, e.g., Kristen M.J. Azar, Zijun Shen, Robert J. Romanelli, Stephen H. Lockhart, Kelly Smits, Sarah Robinson, Stephanie Brown & Alice R. Pressman, *Disparities in Outcomes Among COVID-19 Patients in a Large Health Care System in California*, 39 *Health Affs.* 1253, 1260–61 (2020); Manish Pareek, Mansoor N. Bangash, Nilesh Pareek, Daniel Pan, Shirley Sze, Jatinder S. Minhas, Wasim Hanif & Kamlesh Khunti, *Ethnicity and COVID-19: An Urgent Public Health Research Priority*, 395 *Lancet* 1421, 1421–22 (2020).

29. Bridges, *supra* note 27.

30. Nicholas W. Papageorge, Matthew V. Zahn, Michèle Belot, Eline van den Broek-Altenburg, Syngjoo Choi, Julian C. Jamison & Egon Tripodi, *Socio-Demographic Factors Associated with Self-Protecting Behavior During the COVID-19 Pandemic*, 34 *J. Population Econ.* 691, 693–94 (2021).

31. Dion Rabouin, *Black Workers Overrepresented in Essential Work During Coronavirus Pandemic*, *Axios* (June 3, 2020), <https://www.axios.com/black-workers-essential-coronavirus-c502fc2e-a4fc-4c4f-ae0c-722a50d74ecd.html> [<https://perma.cc/7BKA-ZPQU>].

32. Elise Gould & Valerie Wilson, *Econ. Pol’y Inst., Black Workers Face Two of the Most Lethal Preexisting Conditions for Coronavirus—Racism and Economic Inequality* 4 (2020), <https://files.epi.org/pdf/193246.pdf> [<https://perma.cc/LTZ2-H2N2>].

health insurance.³³ The racialized health disparities of the COVID-19 pandemic have vividly exposed systemic racism and clarified which communities are deemed disposable.

The COVID-19 pandemic implicates several fundamental human rights, including protections against the arbitrary deprivation of life and the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”³⁴ Under the International Covenant on Economic, Social and Cultural Rights (ICESCR), affected states are to take primary responsibility to prevent, treat, and control diseases.³⁵ Additionally, a fundamental principle of economic, social, and cultural rights is that a state should “take steps . . . to the maximum of its available resources, with a view to achieving progressively” the right to health as well as other economic, social, and cultural rights.³⁶ Notably, only state parties to the Covenant on Economic, Social and Cultural Rights are accountable for compliance with it.³⁷ Moreover, under the ICESCR, state parties “undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law” in the right to public health, amongst others.³⁸

Further, the International Covenant on the Elimination of All Forms of Racial Discrimination (CERD) regime broadly defines racial discrimination to encompass any “distinction, exclusion, restriction or preference based on race, color, descent, or national or ethnic origin which has the *purpose or effect* of nullifying or impairing the recognition, enjoyment or

33. Celine McNicholas & Margaret Poydock, Who Are Essential Workers? A Comprehensive Look at Their Wages, Demographics, and Unionization Rates, *Econ. Pol’y Inst.: Working Econ. Blog.* (May 19, 2020), <https://www.epi.org/blog/who-are-essential-workers-a-comprehensive-look-at-their-wages-demographics-and-unionization-rates> [<https://perma.cc/3MSW-4A3G>].

34. See International Covenant on Civil and Political Rights art. 6(1), Dec. 16, 1996, 999 U.N.T.S. 171 (“Every human being has the inherent right to life.”); International Covenant on Economic, Social and Cultural Rights art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].

35. ICESCR, *supra* note 34, art. 12(2)(c).

36. *Id.* art. 2.

37. See, e.g., *id.* (requiring state parties to take steps to realize the rights recognized in the Covenant). Some countries have not recognized socioeconomic rights as legally binding primary obligations. See International Covenant on Economic, Social and Cultural Rights, UN Treaty Collection, <https://treaties.un.org/doc/Publication/MTDSG/Volume%20I/Chapter%20IV/IV-3.en.pdf> (on file with the *Columbia Law Review*) (last visited Sept. 28, 2019) (noting that the Covenant has 171 state parties). Notably, the United States, Palau, the Comoros, and Cuba have not ratified the treaty. *Id.*

38. International Convention on the Elimination of All Forms of Racial Discrimination art. 5, Dec. 21, 1965, 660 U.N.T.S. 195 [hereinafter CERD]; see also ICESCR, *supra* note 34, art. 2(2) (“States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”).

exercise . . . of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.”³⁹ International human rights law explicitly allows claims based on disparate impact by allowing discrimination claims based on effect.⁴⁰ Significantly, the CERD framework for combatting discrimination is more expansive than the United States’ equal protection jurisprudence, which primarily focuses on purposive discrimination. Moreover, the availability of disparate impact claims in the United States has been severely hampered due to requirements that claims reach a certain threshold level of significance and demonstrate a causal relationship, and by the business necessity defense.⁴¹ Internationally, disparate impact claims have not been hollowed out to the same extent, which is welcome news for those hoping to challenge racialized global health inequities seen with COVID-19.

CERD potentially creates an avenue for destabilizing racialized health inequities, because under the Convention, state parties are supposed to “take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists.”⁴² The CERD regime is potentially very useful for addressing racialized health inequities because its applicability goes beyond laws and policies that are invidious by design. By focusing on the impact and effects of laws, policies, and actions, the CERD regime supplies fertile ground for generating creative challenges to racialized health inequities observed with COVID-19.

While the CERD framework is laudable in significant ways, it faces several obstacles in effectively combatting racialized health inequities. For example, Article 2 of the Convention provides:

State Parties shall, when the circumstances so warrant, [to account for] the social, economic, cultural and other fields, special and concrete measures to ensure the adequate development and protection of certain racial groups or individuals belonging to them, for the purpose of guaranteeing them the full and equal enjoyment of human rights and fundamental freedoms.⁴³

CERD’s state-centric framework prioritizes “groups or individuals belonging” to states and may fundamentally curtail the ability to raise transnational or global racial justice claims.⁴⁴ Further, the Convention envisions the creation of limited state-based programs when both global and

39. CERD, *supra* note 38, art. 1 (emphasis added).

40. Comm. on the Elimination of Racial Discrimination, Rep. of the Comm. on the Elimination of Racial Discrimination, U.N. Doc. A/48/18, at 115 (Sept. 15, 1993).

41. Mary Crossley, Disparate Impact in Law and Bioethics 9 (Sept. 27, 2019) (on file with the *Columbia Law Review*).

42. CERD, *supra* note 39, art. 2(1)(c).

43. *Id.* art. 2.

44. *Id.* art. 1(4).

state interventions are necessary to remedy global health inequities witnessed with COVID-19. Additionally, the Convention cautions that any affirmative action measures “shall in no case entail as a consequence the maintenance of unequal or separate rights for different racial groups after the objectives for which they were taken have been achieved.”⁴⁵ This temporal limitation could be read narrowly in ways that inhibit the ability to address the continued effects of racial subordination in health that inform the trajectory of the COVID-19 pandemic. Alternatively, this provision could theoretically apply until state actors achieve substantive equality in health.

Overall, the CERD regime potentially creates a useful platform for legal and institutional reform. Ultimately, addressing the impact of racial inequities in global health exhibited during the COVID-19 pandemic requires significant legal and institutional restructuring to shift how people, society, and laws respond to diseases depending on which racial populations are deemed disposable.⁴⁶

III. DISPOSABLE LIVES AND EXPERIMENTAL TRIALS

The discussion between the doctors in the Introduction reveals the way that disposability and medical neocolonialism are intertwined and reflexively invoked.⁴⁷ The concept of medical neocolonialism aptly characterizes the pattern of extraction of resources from Black and other people of color for experimental clinical trials.⁴⁸ The knowledge generated from this research is subsequently utilized for the development of new treatments and drugs. However, the subjects of the research and their communities generally do not share equitably in the benefits of these innovations.⁴⁹ Medical neocolonialism draws on many of the characteristics of historical colonialism in that it is similarly driven by economic dependence, exploitation, inequality, and the treatment of communities of color as disposable.

Given the stark racial disparities witnessed with COVID-19, there is understandable skepticism that COVID-19 vaccines will be used to help subordinated groups, since we have generally not been protected in the first place. An Associated Press nationwide poll conducted between May 14–18, 2020 (approximately a week before the police killed Mr. Floyd), revealed that, while 56% of White people were willing to take a potential COVID-19 vaccine, only 37% of Latinx and 25% of Black people would do

45. *Id.*

46. For further discussion, see generally Matiangai Sirleaf, *Racial Valuation of Diseases*, 67 *UCLA L. Rev.* 1820 (2021).

47. See Jin Un Kim, Obinna Oleribe, Ramou Njie & Simon D. Taylor-Robinson, *A Time for New North-South Relationships in Global Health*, 10 *Int'l J. Gen. Med.* 401, 407 (2017).

48. See *id.* at 401–03.

49. *Id.* at 406–07.

the same.⁵⁰ The following month, the University of Oxford announced it would begin a new trial of its COVID-19 vaccine in Johannesburg, South Africa.⁵¹ In June 2020, protestors challenged the trials as exploiting African people as “guinea pigs,” informed by the ongoing disposability with which their lives are regarded.⁵²

In response, some have stressed the necessity of diversity in clinical trials in ways that problematically reify biological understandings of race.⁵³ Others have dismissed concerns about the vaccine as irrational in the face of a public health emergency.⁵⁴ Yet, the resistance of Black people from the United States to South Africa must be contextualized against both present and past experiences with systemic racism. Indeed, the sordid history of human experimentation carried out on Black and other people of color has reinforced the disposable nature with which our lives are regarded: from J. Marion Sims conducting unanesthetized fistula surgeries on enslaved Black women’s bodies based on the stereotyped belief that Black people have a high tolerance for pain;⁵⁵ to the notorious Tuskegee syphilis experiments, wherein health authorities deliberately failed to treat and misled 600 Black men about the nature of their care;⁵⁶ to the exploitation of Henrietta Lacks in research;⁵⁷ and to present day issues

50. Lauran Neergaard & Hannah Fingerhut, AP-NORC Poll: Half of Americans Would Get a COVID-19 Vaccine, AP-NORC (May 27, 2020), <https://apnorc.org/ap-norc-poll-half-of-americans-would-get-a-covid-19-vaccine> [<https://perma.cc/Z76S-2LQL>].

51. Trial of Oxford COVID-19 Vaccine in South Africa Begins, Univ. of Oxford (June 23, 2020), <https://www.ox.ac.uk/news/2020-06-23-trial-oxford-covid-19-vaccine-south-africa-begins> [<https://perma.cc/7EES-CLR2>].

52. ‘We Are Not Guinea Pigs,’ Say South African Anti-Vaccine Protesters, Reuters (July 1, 2020), <https://www.reuters.com/article/us-health-coronavirus-safrica-vaccine/we-are-not-guinea-pigs-say-south-african-anti-vaccine-protesters-idUSKBN2426RY> [<https://perma.cc/JBC2-75HM>].

53. Colleen Campbell, Racial Inclusivity in COVID-19 Vaccine Trials, Petrie Flom Ctr.: Bill of Health (Sept. 22, 2020), <https://blog.petrieflom.law.harvard.edu/2020/09/22/racial-inclusivity-covid19-vaccine-trials> [<https://perma.cc/U3V8-QQNA>] (“Recent calls for racial inclusivity in vaccine trials, which often rely on genetic rationales while emphasizing medical distrust among African Americans, unfortunately lack an equally robust critique of medical racism and the ongoing reasons for this distrust.”).

54. Max Boot, Opinion, No Vaccine Can End America’s Pandemic of Ignorance and Irrationality, Wash. Post (Dec. 22, 2020), <https://www.washingtonpost.com/opinions/2020/12/22/no-vaccine-can-end-americas-pandemic-ignorance-irrationality> (on file with the *Columbia Law Review*).

55. Keith Wailoo, Opinion, Historical Aspects of Race and Medicine, The Case of J. Marion Sims, 320 JAMA 1529, 1529 (2018); see also Durrenda Ojanuga, The Medical Ethics of the ‘Father of Gynaecology’, Dr J Marion Sims, 19 J. Med. Ethics 28, 29 (1993).

56. Marcella Alsan & Marianne Wanamaker, Tuskegee and the Health of Black Men, 133 Q.J. Econ. 407, 413–14 (2018).

57. Robert D. Truog, Aaron S. Kesselheim & Steven Joffe, Paying Patients for Their Tissue: The Legacy of Henrietta Lacks, 337 Science 37, 37 (2012).

with clinical trials that treat Black and other people of color as disposable.⁵⁸

This past is very much present, and unethical trials on Black and other people of color continue to take place on the African continent and elsewhere. For example, in 1996, during the worst ever meningitis outbreak on the African continent, Pfizer conducted a clinical trial in which a hundred children in Nigeria were given an experimental oral antibiotic called Trovan, while an additional hundred received Ceftriaxone.⁵⁹ Five children died on the former antibiotic and six on the latter.⁶⁰ Some children allegedly received a dose lower than recommended, “leaving many children with brain damage, paralysis, or slurred speech.”⁶¹ The parents of the children sued Pfizer for failure to obtain informed consent and Pfizer settled the suit with the drug trial victims after a protracted fifteen-year legal battle.⁶²

Moreover, early research trials conducted in Uganda for an AIDS vaccine were designed to test the safety of HIV Subtype B—a type most prevalent in Europe and the Americas.⁶³ HIV has more than ten major subtypes, which correspond with geographical range;⁶⁴ Subtype D is the dominant form in East Africa.⁶⁵ Thus, the research done in Uganda tested a vaccine designed to attack a virus subtype not prevalent in Uganda.⁶⁶ Developers wanted a vaccine for Subtype B of HIV to market to high-income countries in Europe and elsewhere in the Global North.⁶⁷

58. LaVera M. Crawley, African-American Participation in Clinical Trials: Situating Trust and Trustworthiness, 93 *J. Nat'l Med. Ass'n* 14S, 14S (2001) (“Reports on African-American attitudes and perspectives toward clinical research suggest that mistrust is a significant barrier in the accrual of minorities in clinical trials.”); Idara L. Udonya, Opinion, Black People Are Not Your Guinea Pigs, *Peak* (July 25, 2020), <https://the-peak.ca/2020/07/black-people-are-not-your-guinea-pigs> [<https://perma.cc/D6YT-NYN9>].

59. Jacqui Wise, Pfizer Accused of Testing New Drug Without Ethical Approval, 322 *BMJ* 194, 194 (2001).

60. David Smith, Pfizer Pays Out to Nigerian Families of Meningitis Drug Trial Victims, *Guardian* (Aug. 12, 2011), <https://www.theguardian.com/world/2011/aug/11/pfizer-nigeria-meningitis-drug-compensation> [<https://perma.cc/AP6A-LTB5>].

61. *Id.*

62. *Id.*

63. Johanna Tayloe Crane, Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science 57 (2013).

64. *Id.*

65. Matthew Hierholzer, R. Ross Graham, I. El Khidir, Sybil Tasker, Magdi Darwish, Gail D. Chapman, Ademola H. Fagbami, Atef Soliman, Deborah L. Birx, Francine McCutchan, & Jean K. Carr., HIV Type 1 Strains from East and West Africa Are Intermixed in Sudan, 18 *AIDS Rsch. & Hum. Retroviruses* 1163, 1164 (2002).

66. José Esparza, A Brief History of the Global Effort to Develop a Preventive HIV Vaccine, 31 *Vaccine* 3502, 3505 (2013); see also Crane, *supra* note 63, at 70–72 & n.7.

67. See Crane, *supra* note 63, at 54–80 (“The uptake of subtype B viruses as the basis for HIV laboratory research and technology development was not random, but reflects the fact that the great majority of both research funding and infrastructure are located squarely in the United States and Western Europe, where subtype B predominates.”).

Boehringer Ingelheim also supported suspect clinical trials in Uganda between 1997 and 2003 that led to thousands of serious adverse effects for women taking the anti-HIV transmission drug Nevirapine.⁶⁸ Their symptoms went unreported, but testing continued and resulted in the deaths of fourteen of these women.⁶⁹

Furthermore, during the 2014–2016 Ebola outbreak, an Italian NGO tested the heart drug Amiodarone on Ebola patients at a treatment facility in Sierra Leone.⁷⁰ The drug is not among the fifty-three drugs listed to have an antiviral effect on Ebola.⁷¹ Some British medics working at the center concluded that the side effects from the drug could be contributing to the increased morbidity within the center.⁷² Certain medical staff staged a walk-out from the facility to protest the use of the drug outside of a clinical trial concomitant with the lack of informed consent obtained from patients.⁷³ Some researchers also took thousands of blood samples from Ebola patients during the 2014–2016 epidemic and now hold these samples in secretive laboratories around the world.⁷⁴ Ebola survivors did not consent to their blood being used for research.⁷⁵ Several African scientists accused the laboratories of “biological asset stripping,” as the scientists are unable to access the samples for their own research despite African health practitioners assuming all the risk in drawing the blood.⁷⁶

68. Efe Egharevba & Jacqueline Atkinson, *The Role of Corruption and Unethical Behaviour in Precluding the Placement of Industry Sponsored Clinical Trials in Sub-Saharan Africa: Stakeholder Views*, 3 *Contemp. Clin. Trials Commc'ns* 102, 103 (2016).

69. Francis Weyzig & Irene Schipper, *SOMO Briefing Paper on Ethics in Clinical Trials* 6 (2008), <https://www.somo.nl/wp-content/uploads/2008/02/Examples-of-unethical-trials.pdf> (on file with the *Columbia Law Review*).

70. Philippe Calain, *The Ebola Clinical Trials: A Precedent for Research Ethics in Disasters*, 44 *J. Med. Ethics* 3, 5 (2016); Fabio Turone, *Doctors Trial Amiodarone for Ebola in Sierra Leone*, 349 *BMJ* 7198, 7198 (2014).

71. Jennifer Kouznetsova, Wei Sun, Carles Martínez-Romero, Gregory Tawa, Paul Shinn, Catherine Z Chen, Aaron Schimmer, Philip Sanderson, John C McKew, Wei Zheng & Adolfo García-Sastre, *Identification of 53 Compounds that Block Ebola Virus-Like Particle Entry Via a Repurposing Screen of Approved Drugs*, 3 *Emerging Microbes & Infections* 1, 4–7 (2014); see also *Study Identifies 53 Approved Drugs that May Block Ebola*, *Infection Control Today* (Dec. 17, 2014), <https://www.infectioncontroltoday.com/view/study-identifies-53-approved-drugs-may-block-ebola-infection> [<https://perma.cc/76P3-6CTY>].

72. Sarah Boseley, *Untested Ebola Drug Given to Patients in Sierra Leone Causes U.K. Walkout*, *Guardian* (Dec. 22, 2014), <https://www.theguardian.com/world/2014/dec/22/ebola-untested-drug-patients-sierra-leone-uk-staff-leave> [<https://perma.cc/Z24M-TFW9>].

73. *Id.*

74. Maryn McKenna, *Colonialists Are Coming for Blood—Literally*, *WIRED* (Mar. 3, 2019), <https://www.wired.com/story/ebola-epidemic-blood-samples> [<https://perma.cc/M7MB-45A3>].

75. *Id.*

76. Emmanuel Freudenthal, *Ebola's Lost Blood: Row over Samples Flown Out of Africa as 'Big Pharma' Set to Cash In*, *Telegraph* (Feb. 6, 2019), <https://www.telegraph.co.uk/global-health/science-and-disease/ebolas-lost-blood-row-samples-flown-africa-big-pharma-set-cash> [<https://perma.cc/VC4D-Y8ZA>].

These incidents are clear violations of established research guidelines, reflected in the World Medical Association's Declaration of Helsinki and the WHO's Handbook for Good Clinical Research Practice. Furthermore, they indicate the limitations of the guidelines' ability to protect the rights and welfare of Black and other people of color.⁷⁷ Moreover, even where legal and regulatory frameworks exist on paper for study participants, the de facto policy of treating Black, Indigenous, and other people of color as disposable requires more robust mechanisms to counteract the praxis of dehumanization. Accordingly, the unethical treatment and exploitation of subordinated groups informs the hesitancy of some to participate in clinical trials and to sign up for the COVID-19 vaccines authorized for emergency use.

IV. DISPOSABLE LIVES AND ACCESS TO VACCINES

Importantly, however, the turn to "vaccine hesitancy" to account for the gross disparities in the distribution of the COVID-19 vaccines obscures structural, legal, and policy barriers to access. For example, vaccine redlining policies have located many distribution centers outside of communities of color in the United States. Indeed, officials in Dallas County had to stop a plan prioritizing COVID-19 vaccine doses for people living in the most vulnerable zip codes after the state of Texas threatened to cut off the county's vaccine supply.⁷⁸ Moreover, preliminary data from states that track vaccination data by race indicate that COVID-19 vaccines are primarily going to White people, despite the fact that the pandemic is ravaging communities of color disproportionately.⁷⁹ Commentators

77. See WMA Declaration of Helsinki—Ethical Principles for Medical Research Involving Human Subjects, World Med. Ass'n (July 9, 2018), <https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects> [<https://perma.cc/A327-PKEV>] ("Physicians must consider the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards."); WHO, Handbook for Good Clinical Research Practice (GCP): Guidance for Implementation 19 (2005), https://apps.who.int/iris/bitstream/handle/10665/43392/924159392X_eng.pdf [<https://perma.cc/U9VM-KAZ2>] ("[T]he most important considerations are those related to the rights, safety, and well-being of the research subjects.").

78. Emma Platoff & Juan Pablo Garnham, Dallas County Axes Plan to Prioritize Vaccinating Communities of Color After State Threatens to Slash Allocation, *Tex. Trib.* (Jan. 20, 2021), <https://www.texastribune.org/2021/01/20/dallas-vaccine-plan-communities-of-color> [<https://perma.cc/93UE-Y4SR>].

79. See, e.g., COVID-19 Vaccines, NYC Health, <https://www1.nyc.gov/site/doh/covid/covid-19-data-vaccines.page> [<https://perma.cc/J787-YC9D>] (last visited Feb. 27, 2021) (providing data on adults that were vaccinated with at least one dose and where race was indicated); see also Shelby Livingston, Most COVID-19 Vaccines Are Going to White People, Even Though the Pandemic Has Ravaged Communities of Color, *Bus. Insider* (Jan. 8, 2021), <https://www.businessinsider.com/covid-shots-given-to-white-people-state-vaccine-data-2021-1> [<https://perma.cc/G6U6-52JQ>]; Amy Schoenfeld Walker, Anjali Singhvi, Josh Holder, Robert Gebeloff & Yuriria Avila, Pandemic's Racial Disparities Persist in Vaccine Rollout, *N.Y. Times* (Mar. 5, 2021), <https://www.nytimes.com/interactive/2021/03/05/>

developed the concept of vaccine apartheid to capture the nature of these stark inequities.⁸⁰

Vaccine apartheid is similarly glaring when examining access to vaccines internationally. Globally, vaccine redlining has meant that people living in many countries in the Global South are not expected to have significant doses of vaccines administered until as late as 2024.⁸¹ Some of this delay is the result of limited supply, lack of production facilities, and logistical impediments, such as the need for vaccine storage at subzero temperatures requiring the development of a cold distribution chain for vaccine administration.⁸² Moreover, international solidarity has been wanting; instead, vaccine nationalism has predominated, with some countries prioritizing and competing for bilateral deals and hoarding enough supplies to vaccinate their populations several times over.⁸³ Indeed, some analyses indicate that rich countries are on track to hoard over one billion COVID-19 vaccines.⁸⁴ Further, the European Union

us/vaccine-racial-disparities.html (on file with the *Columbia Law Review*); Only One U.S. State Has Vaccinated 10% of Its Black Population: COVID-19 Tracker, Bloomberg (Feb. 24, 2021), <https://www.bloomberg.com/graphics/covid-vaccine-tracker-global-distribution/us-vaccine-demographics.html> (on file with the *Columbia Law Review*).

80. See, e.g., Winnie Byanyima, A Global Vaccine Apartheid Is Unfolding. People's Lives Must Come Before Profit, *Guardian* (Jan. 29, 2021), <https://www.theguardian.com/global-development/2021/jan/29/a-global-vaccine-apartheid-is-unfolding-peoples-lives-must-come-before-profit> [https://perma.cc/YEN9-NCW2].

81. See Francesco Guarascio, WHO Vaccine Scheme Risks Failure, Leaving Poor Countries with No COVID Shots Until 2024, *Reuters* (Dec. 16, 2020), <https://reuters.com/article/amp/idUSKBN28QILF> (on file with the *Columbia Law Review*).

82. Michaelen Doucleff, Why Poorer Countries Aren't Likely to Get the Pfizer Vaccine Any Time Soon, *NPR Ill.* (Nov. 11, 2020), <https://www.nprillinois.org/post/why-poorer-countries-arent-likely-get-pfizer-vaccine-any-time-soon#stream/0> [https://perma.cc/3TC2-XNWV].

83. Peter S. Goodman, One Vaccine Side Effect: Global Economic Inequality, *N.Y. Times* (Dec. 25, 2020), <https://www.nytimes.com/2020/12/25/business/coronavirus-vaccines-global-economy.html> (on file with the *Columbia Law Review*) (last updated Dec. 31, 2020) (“Wealthy nations in Europe and North America have secured the bulk of limited stocks of vaccines Developing countries—home to most of humanity—are left to secure their own doses.”); Rich Countries Hoarding COVID Vaccines, Says People's Vaccine Alliance, *BBC News* (Dec. 9, 2020), <https://www.bbc.co.uk/news/amp/health-55229894> [https://perma.cc/QR3L-7MNS] [hereinafter Rich Countries Hoarding COVID Vaccines] (describing a study that found that “rich countries have bought enough doses to vaccinate their entire populations three times over if all the vaccines are approved for use”); WHO Director-General's Opening Remarks at 148th Session of the Executive Board, WHO (Jan. 18, 2021), <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-148th-session-of-the-executive-board> [https://perma.cc/K9AW-3CDN] (“Even as they speak the language of equitable access, some countries and companies continue to prioritize bilateral deals, going around COVAX, driving up prices and attempting to jump to the front of the queue.”).

84. See, e.g., ONE, Rich Countries on Track to Stockpile over 1 Billion Surplus C19 Vaccines 1 (2021), https://s3.amazonaws.com/one.org/pdfs/ONE_Analysis_on_excess_doses.pdf [https://perma.cc/BB63-S9G8].

authorized its member states to put limitations on the exportation of vaccines.⁸⁵

Concomitantly, wealthy countries have failed to adequately support and fund global health schemes like COVAX,⁸⁶ which is the main initiative of the WHO to provide COVID-19 vaccinations to people in low- and middle-income countries.⁸⁷ COVAX requires financial contributions and donations from wealthy countries to work.⁸⁸ Yet, it is unseemly and unjust for wealthy countries to hoard vaccines and drive up prices on the one hand, which makes it difficult for other countries to acquire vaccines, while also promising charitable donations that are insufficient. Further, even if the COVAX initiative were fully funded, a philanthropic model that relies on the munificence of others to donate money or share vaccine surpluses is fundamentally flawed, given the need for countries to vaccinate entire populations. In late February 2021, Ghana became the first country to receive vaccine doses under this scheme.⁸⁹ Yet, the late “timing and the relatively modest supply—enough for just 1% of Ghana’s population—point to major challenges”⁹⁰ moving forward. Indeed, by April 2021, COVAX “distributed 43 million doses of vaccine to 119 countries—covering just 0.5 percent of their combined population of more than four billion.”⁹¹ Additionally, as detailed below, an artificially limited supply of vaccines is caused by Big Pharma’s monopoly on prices and profit, which exacerbates inequities and results in more restricted or delayed vaccine access for many countries in the Global South. Moreover, COVAX depends on extant power relations that are skewed in favor of the

85. Obiora Chinedu Okafor & James Thuo Gathii, *The EU’s Vaccine Export Controls Negate Its Self-Interest, International Solidarity and International Law*, *Afronomics L.* (Feb. 18, 2021), <https://www.afronomicslaw.org/category/analysis/eus-vaccine-export-controls-negate-its-self-interest-international-solidarity-and> [<https://perma.cc/5KNN-XGNB>] (discussing the EU’s binding regulations that authorize member states “to limit the export of COVID-19 vaccines produced within its borders”).

86. See, e.g., Anna Rouw, Jennifer Kates, Josh Michaud & Adam Wexler, *COVAX and the United States*, *Kaiser Fam. Found.* (Feb. 18, 2021), <https://www.kff.org/coronavirus-covid-19/issue-brief/covax-and-the-united-states> [<https://perma.cc/6ZMS-R2FA>] (discussing funding and regulatory challenges with COVAX).

87. COVAX: Working for Global Equitable Access to COVID-19 Vaccines, WHO, <https://www.who.int/initiatives/act-accelerator/covax> [<https://perma.cc/C9V7-2CBX>] (last visited Feb. 13, 2021).

88. Rouw et al., *supra* note 86 (“COVAX has an overall funding target (2020–2021) of \$11.1 billion but faces a \$7.2 billion funding gap. Given the economic crisis that has gripped much of the world due to COVID-19, it is not yet clear how this gap can be filled.”).

89. Danielle Paquette & Emily Rauhala, *First Vaccine Doses Distributed by Covax Land in West African Nation of Ghana*, *Wash. Post.* (Feb. 24, 2021), https://www.washingtonpost.com/world/africa/covax-ghana-astrazeneca-vaccine/2021/02/24/558d31bc-7617-11eb-9489-8f7dacad51e75_story.html (on file with the *Columbia Law Review*).

90. *Id.*

91. Tedros Adhanom Ghebreyesus, *Opinion, I Run the W.H.O., and I Know that Rich Countries Must Make a Choice*, *N.Y. Times* (Apr. 22, 2021), <https://www.nytimes.com/2021/04/22/opinion/who-covid-vaccines.html> (on file with the *Columbia Law Review*).

pharmaceutical industry and countries where the production of vaccine doses takes place.

South Africa is a prime case study of vaccine apartheid, as it is one of the first countries on the African continent to procure a vaccine and is also one of the hardest hit by the pandemic.⁹² Notably, the Oxford–AstraZeneca vaccine, the trials for which were greeted with protests in Johannesburg,⁹³ has an increasingly uncertain future in South Africa and beyond.⁹⁴ The Oxford–AstraZeneca vaccine was supposed to be used widely in countries in the Global South, as the manufacturer projected that it could quickly produce billions of doses.⁹⁵ This supply is substantially greater and at a significantly lower price than any of the other vaccines shown to offer protection against COVID-19.⁹⁶

Recalling the concept of medical neocolonialism is instructive here, as South Africa obtained millions of vaccine doses at a cost of \$5.25 per dose, which is more than double the \$2.16 per dose that European Union countries paid to AstraZeneca.⁹⁷ Moreover, since South Africans initially participated in clinical trials for the development of the drug, they should have had greater post-trial access and benefit-sharing based on fundamental principles of research referenced earlier.⁹⁸ Instead, South Africa had to

92. See Keymanthri Moodley & Theresa Rossouw, *South African COVID-19 Vaccine Trials Hold Key Lessons for Future Partnerships*, *Conversation* (Feb. 9, 2021), <https://theconversation.com/south-african-covid-19-vaccine-trials-hold-key-lessons-for-future-partnerships-154676> [<https://perma.cc/42C7-YVHU>].

93. See *supra* note 52 and accompanying text. Initially, the University of Oxford promised to donate the rights to its vaccine but then reneged on this promise by selling the sole rights to the producer AstraZeneca. Jay Hancock, *They Pledged to Donate Rights to Their COVID Vaccine, Then Sold Them to Pharma*, *KHN* (Aug. 25, 2020), <https://khn.org/news/rather-than-give-away-its-covid-vaccine-oxford-makes-a-deal-with-drugmaker> [<https://perma.cc/4J8N-W6DW>].

94. See Robert Hart, *Expert Panel Calls on Norway to Ditch AstraZeneca and Johnson & Johnson COVID Vaccines over Blood Clot Risks*, *Forbes* (May 10, 2021), <https://www.forbes.com/sites/roberthart/2021/05/10/expert-panel-calls-on-norway-to-ditch-astrazeneca-and-johnson-johnson-covid-vaccines-over-blood-clot-risks> [<https://perma.cc/4BQU-2CVS>]; see also Lisa Schnirring, *More Global Reports of Blood Clots After AstraZeneca COVID Vaccination*, *CIDRAP: Ctr. for Infectious Disease Rsch. & Pol’y* (Apr. 2, 2021), <https://www.cidrap.umn.edu/news-perspective/2021/04/more-global-reports-blood-clots-after-astrazeneca-covid-vaccination> [<https://perma.cc/SXD2-KWKV>].

95. Jon Cohen, *South Africa Suspends Use of AstraZeneca’s COVID-19 Vaccine After It Fails to Clearly Stop Virus Variant*, *Science* (Feb. 8, 2021), <https://www.sciencemag.org/news/2021/02/south-africa-suspends-use-astrazenecas-covid-19-vaccine-after-it-fails-clearly-stop> [<https://perma.cc/9MC4-554A>].

96. See *Rich Countries Hoarding COVID Vaccines*, *supra* note 83.

97. Helen Sullivan, *South Africa Paying More than Double EU Price for Oxford Vaccine*, *Guardian* (Jan. 22, 2021), <https://www.theguardian.com/world/2021/jan/22/south-africa-paying-more-than-double-eu-price-for-oxford-astrazeneca-vaccine> [<https://perma.cc/8MRG-8YQ2>]; see also Moodley & Rossouw, *supra* note 92.

98. See Hae Lin Cho, Marion Danis & Christine Grady, *Post-Trial Responsibilities Beyond Post-Trial Access*, 391 *Lancet* 1478, 1478–79 (2018) (“[P]ost-trial care is necessary to prevent the exploitation of participants with insufficient access to health care . . .”); D.

pay more for a drug it ultimately will not be able to use. The trial of the vaccine revealed comparatively low efficacy rates (under 25%) against mild and moderate cases of the disease in South Africa, a threshold that does not “meet minimal international standards for emergency use.”⁹⁹ South Africa has discontinued its plans to use the AstraZeneca vaccine, given the vaccine’s ineffectualness against a newer variant of the virus that is prevalent in South Africa.¹⁰⁰ At the time of writing, its national immunization drive is in flux. This is compounded by Moderna’s (manufacturer of one of the most expensive COVID-19 vaccines¹⁰¹) earlier indication that it did not plan to distribute its vaccine in South Africa.¹⁰² Significantly, a single dose of the Moderna vaccine costs approximately \$32–\$37 and has an efficacy of approximately 95%.¹⁰³ While Moderna pledged not to enforce its patent during the COVID-19 pandemic,¹⁰⁴ it does not own all the patents in its vaccine.¹⁰⁵ Accordingly, Moderna cannot make credible commitments that bind other patentholders.

Conventional analyses would simply treat vaccine apartheid as driven by and fully accounted for by poverty. Such shallow analyses, however, tend to obscure the functioning of race and histories of subordination, which is why the concept of medical neocolonialism is so useful. The South African example vividly illustrates how “the fruits of medical and scientific advances are stockpiled for some and denied for others.”¹⁰⁶ By failing to

Schroeder, Benefit Sharing: It’s Time for a Definition, 33 *J. Med. Ethics* 205, 207 (2007) (“Benefit sharing is the action of giving a portion of advantages/profits derived from the use of human genetic resources to the resource providers in order to achieve justice in exchange with particular emphasis on the clear provision of benefits to those who may lack reasonable access to resulting products”); see also *supra* note 77.

99. Cohen, *supra* note 95.

100. *Id.*

101. Rich Countries Hoarding COVID Vaccines, *supra* note 83.

102. Geoffrey York, COVID-19 Vaccine Supplies for Africa Dwindling as Moderna Opts Out, *Globe & Mail* (Jan. 3, 2021), <https://www.theglobeandmail.com/amp/world/article-vaccine-supplies-for-africa-dwindling-as-moderna-opts-out> [<https://perma.cc/AGY3-DKAT>].

103. Sissi Cao, COVID-19 Vaccine Prices Revealed from Pfizer, Moderna, and AstraZeneca, *Observer* (Nov. 23, 2020), <https://observer.com/2020/11/covid19-vaccine-price-pfizer-moderna-astrazeneca-oxford> [<https://perma.cc/S6P7-VEEF>]; Berkeley Lovelace Jr., Moderna Is Pricing Coronavirus Vaccine at \$32 to \$37 Per Dose for Some Customers, *CNBC* (Aug. 5, 2020), <https://www.cnbc.com/2020/08/05/moderna-is-pricing-coronavirus-vaccine-at-32-to-37-per-dose-for-some-customers.html> [<https://perma.cc/VP8Y-7VQV>].

104. Statement by Moderna on Intellectual Property Matters During the COVID-19 Pandemic, *Moderna* (Oct. 8, 2020), <https://investors.modernatx.com/news-releases/news-release-details/statement-moderna-intellectual-property-matters-during-covid-19> [<https://perma.cc/MD43-J8U2>].

105. See, e.g., Arthur Allen, Government-Funded Scientists Laid the Groundwork for Billion-Dollar Vaccines, *KHN* (Nov. 18, 2020), <https://khn.org/news/vaccine-pioneers-basic-research-scientists-laid-groundwork-for-billion-dollar-pharma-products> [<https://perma.cc/GJ38-YXSF>] (discussing how the University of Pennsylvania sublicensed the RNA modification patent to Cellscript who then sublicensed it to Moderna).

106. Paul Farmer, Pathologies of Power: Rethinking Health and Human Rights, 89 *Am. J. Pub. Health* 1486, 1488 (1999).

take an intersectional approach, traditional analyses may not fully capture how multiple overlapping areas such as race, class, and geography may function to produce heightened subordination. The political economy explanation also does not consider how market failures for pharmaceuticals aimed at diseases that disproportionately impact people of color are tied to long histories of exploitation, dispossession, and devaluation of the lives of Black, Indigenous, and other people of color.

A thorough analysis of COVID-19 vaccine apartheid and disposability must also consider the role of the international intellectual property regime in severely compounding the challenges of equitable vaccine distribution. Briefly, the international intellectual property regime provides a twenty-year monopoly for pharmaceuticals.¹⁰⁷ Until the creation of this regime, many countries did not even place patent protection on pharmaceuticals. Previously, states regarded patent rights as a national prerogative rather than a minimum international substantive regime with standards for what intellectual property rights protections countries should adopt. Recognizing this, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement grants extra implementation time to developing countries and delayed implementation for the least-developed countries.¹⁰⁸

Although the DOHA Declaration, which reaffirms the TRIPS Agreement, and some TRIPS provisions were meant to create better flexibilities for public health or incentivize research and development, they have had limited effect in facilitating access to medicines,¹⁰⁹ given the

107. See Agreement on Trade-Related Aspects of Intellectual Property Rights art. 33, Apr. 15, 1994, 1869 U.N.T.S. 299 [hereinafter TRIPS Agreement] (“The term of protection available [for patents] shall not end before the expiration of a period of twenty years counted from the filing date.”).

108. *Id.* art. 66(1)–66(2).

109. See, e.g., *id.*, art. 31 (authorizing compulsory licensing). The Doha Declaration looked to clarify that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health, and that it should be interpreted as compatible in a manner that promotes access to medicines. World Trade Organization, Ministerial Declaration on the TRIPS Agreement and Public Health of 14 November 2001 ¶ 4, WTO Doc. WT/MIN(01)/DEC/2, 41 ILM 755 (2002) [hereinafter Doha Declaration]. The TRIPS Agreement also seeks to bind developed countries to provide incentives to “enterprises and institutions in their territories” for technology transfer to developing countries to “enable them to create a sound and viable technological base.” TRIPS Agreement, *supra* note 107, art. 66(2). Additionally, the Doha Declaration tries to reaffirm the commitment of countries in the Global North to provide incentives to corporations and other institutions to promote and encourage technology transfer to countries in the Global South. See Doha Declaration, *supra*, ¶ 7. For further discussion, see Report of the United Nations Secretary-General’s High-Level Panel on Access to Medicines: Promoting Innovation and Access to Health Technologies 23–27 (2016), <http://www.unsgaccessmeds.org/s/UNSG-HLP-Report-FINAL-12-Sept-2016.pdf> [<https://perma.cc/QQ9C-6SFR>] [hereinafter U.N. High-Level Panel on Access to Medicines] (discussing the mixed results of the compulsory licensing provisions and limited utility of other TRIPS flexibilities).

larger incentive structure toward profit maximization.¹¹⁰ Indeed, the creation of the international intellectual property regime and the ratification of this regime in the Doha Declaration has functioned to expand and increase U.S.-style pharmaceutical patent protection globally.¹¹¹ Further, the United States often threatens to close off its market to countries that run afoul of its interpretation of what the TRIPS regime requires for protecting pharmaceuticals.¹¹² The United States and others also advance their structural power against states in the Global South through a mix of TRIPS-plus provisions placed in bilateral and regional free-trade agreements that have imposed much more stringent requirements on countries than required by TRIPS.¹¹³

110. For example, EpiPen's original marketing approval occurred on December 22, 1987. See Drugs@FDA: FDA Approved Drug Products, New Drug Application (NDA): 019430, FDA, <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=019430> [<https://perma.cc/54YP-W2GT>] (last visited Feb. 14, 2021). Mylan, a global pharmaceutical company, acquired the rights to make and sell EpiPen, which sold in 2007 for approximately \$100 for a two-pen set. Tara Parker-Pope & Rachel Rabkin Peachman, EpiPen Price Rise Sparks Concern for Allergy Sufferers, N.Y. Times: Well (Aug. 22, 2016), <https://well.blogs.nytimes.com/2016/08/22/epipen-price-rise-sparks-concern-for-allergy-sufferers> (on file with the *Columbia Law Review*). Mylan used its market power to raise the price of the two-pen set to exceed \$600, raising their sales from over \$200 million annually to over \$1 billion. Andrew Pollack, Mylan Raised EpiPen's Price Before the Expected Arrival of a Generic, N.Y. Times (Aug. 24, 2016), <https://www.nytimes.com/2016/08/25/business/mylan-raised-epipens-price-before-the-expected-arrival-of-a-generic.html> (on file with the *Columbia Law Review*). Given that EpiPens expire after a year, the price hike put a huge strain on patients' ability to afford this life-saving medicine. Parker-Pope & Peachman, *supra*.

111. See James Thuo Gathii, Construing Intellectual Property Rights and Competition Policy Consistently with Facilitating Access to Affordable Aids Drugs to Low-End Consumers, 53 Fla. L. Rev. 727, 754–59 (2001) (discussing the shift in U.S. trade policy in the 1980s to focus on the production and transformation of conceptual notions into intangible flows of idea and money). This led to a concerted policy toward enhancing the protection of U.S. intellectual property rights globally and culminated in the TRIPS Agreement. *Id.* Notably, the Doha Declaration continues to affirm the importance of patent protection. Doha Declaration, *supra* note 109, ¶ 5, ¶ 7.

112. Section 301 authorizes the use of unilateral trade sanctions as a retaliatory measure by the United States. U.S. Trade Act of 1974, Pub. L. No. 93-618, § 301, 88 Stat. 1978, 2041 (codified at 19 U.S.C. § 2411 (2018)). The United States removed South Africa from its watch list following advocacy by HIV/AIDS organizations. See, e.g., Press Release, Off. of the U.S. Trade Rep., U.S.–South Africa Understanding on Intellectual Property (Sept. 17, 1999), <https://web.archive.org/web/20001030065239/https://ustr.gov/releases/1999/09/99-76.html> (on file with the *Columbia Law Review*). For further discussion, see Rosalyn S. Park, Note, The International Drug Industry: What the Future Holds for South Africa's HIV/AIDS Patients, 11 Minn. J. Global Trade 125, 136–39 (2002); see also Exec. Order No. 13,155, 65 Fed. Reg. 30,521, 30,522 (May 12, 2000) (noting that the United States would not seek the revocation or revision of any intellectual property law in sub-Saharan African nations, so long as they promote access to HIV/AIDS treatment, and requiring sub-Saharan African countries to provide intellectual property protection as a precondition for increasing access to HIV/AIDS drugs).

113. U.N. High-Level Panel on Access to Medicines, *supra* note 109, at 25–26 (table with sample TRIPS-plus provisions).

Conventional wisdom holds that pharmaceutical companies depend on charging monopoly prices to recover their investments in experimental drugs and technologies.¹¹⁴ Yet, there are well-established arguments that a market-based monopoly incentive for pharmaceuticals is ill-suited for addressing health needs.¹¹⁵ Commentators have artfully pointed out the severe limitations of a research and innovation system based on monopoly rights.¹¹⁶ Such a system tends to focus research and development efforts toward “lucrative” medical conditions that pose minimal risks and toward ailments that already have existing effective therapies.¹¹⁷ This incentive system allows many pharmaceutical corporations to benefit substantially from publicly funded research and still charge monopoly prices. Overall, the intellectual property regime shelters corporations from competition, enables them to increase prices, underproduces certain drugs, cuts back on product quality, and declines to produce some pharmaceuticals.¹¹⁸

Vaccines in particular have been deprioritized by the pharmaceutical industry as insufficiently profitable. This was the case with the Ebola virus,

114. See Ingo Venzke, *International Law and the Spectre of Inequality* 8 (2019), http://cf.bc.uva.nl/download/oraties/oraties_2019/Venzke_Ingo.pdf [<https://perma.cc/826J-HWBB>].

115. See Yaniv Heled, Liza Vertinsky & Cass Brewer, *Why Healthcare Companies Should Be (come) Benefit Corporations*, 60 *B.C. L. Rev.* 73, 107 (2019) (discussing how the failure of price to serve as a good indicator of public health value, the public sharing of costs but not benefits, and the regulation and market structure that limit competition often produce poor public health outcomes); see also Debora J. Halbert, *Resisting Intellectual Property* 4 (2005) (“In addition to the negative consequences of patenting the inventions derived from the human body, pharmaceutical companies have placed profits before lives as they aggressively litigate to halt the unauthorized production of drugs used to fight HIV and AIDS.”); Kaushik Sunder Rajan, *Pharmocracy: Value, Politics, and Knowledge in Global Biomedicine* 37 (2017) (“[L]ogics of capital grounded in the generation of surplus lead to a structure of crisis in global pharmaceutical industries, leading to trials for the industry itself, for patients and consumers who constitute its markets, and for populations who are excluded from these markets.”); Madhavi Sunder, *From Goods to a Good Life: Intellectual Property and Global Justice* 175–77 (2012) (“[T]he exclusive patent right allows a monopoly on the production of the drug, which generally leads to higher prices for the cure.”); Margaret Chon, *Intellectual Property and the Development Divide*, 27 *Cardozo L. Rev.* 2821, 2891 (2006) (“The inequitable nature of technical knowledge production and capacity-building relevant to developing countries is starkly illustrated by health care research and development.”); Venzke, *supra* note 114, at 8 (discussing how there “is now a growing consensus across disciplines that such protection has gone too far, stifling rather than sparking innovation, and transferring rather than creating value”).

116. See Keith Aoki, *Space Invaders: Critical Geography, The “Third World” in International Law and Critical Race Theory*, 45 *Vill. L. Rev.* 913, 930 (2000) (discussing the problems of transplanting U.S. and European intellectual property regimes to countries in the developing world and expecting comparable results); Anjali Vats & Deidre A. Keller, *Critical Race IP*, 36 *Cardozo Arts & Ent. L.J.* 735, 738 (2018) (discussing the interdisciplinary movement of scholars connected by their focus on the racial and colonial non-neutrality of intellectual property laws).

117. Heled et al., *supra* note 115, at 84.

118. See, e.g., *id.* at 118 n.198 (discussing studies that show the impact of price concentration).

which first appeared in 1976.¹¹⁹ Until the West African Ebola outbreak in 2014, no approved vaccine existed,¹²⁰ resulting in fatal and devastating consequences for many.¹²¹ The swift development of the COVID-19 vaccines was the result of work done in academic labs with public funding and benefitted from the significant financial investment by wealthy governments that negotiated massive buyout contracts relying on money from taxpayers.¹²² As discussed above, wealthier countries rushed to outbid each other to secure vaccines from a limited supply. Yet, there is an insufficient supply of vaccines in part because pharmaceutical companies exercise their monopoly power to prevent others from accessing the publicly funded technologies needed to create the vaccines. For example, in 2020, the WHO created a technology access pool to encourage pharmaceutical companies to share their knowledge with manufacturers in other countries that need to develop vaccines, but not one company has done so at the time of writing.¹²³

Against this background, in October 2020, India and South Africa requested that the Council for TRIPS recommend a waiver from the implementation, application, and enforcement of certain provisions of the TRIPS Agreement.¹²⁴ They argued that a waiver was needed to prevent, contain, and treat COVID-19, given the acute health shortages faced by

119. Ebola Virus Disease, WHO (Feb. 23, 2021), <http://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease> [<https://perma.cc/T9FF-WZY9>].

120. See, e.g., Janice E. Graham, Ebola Vaccine Innovation: A Case Study of Pseudoscapes in Global Health, 29 *Critical Pub. Health* 401, 401, 408 (2019) (discussing how an international platform was created to accelerate testing of existing experimental Ebola vaccines due to the WHO's declaration of a public health emergency).

121. *Id.* at 401, 405.

122. See Matthew D. Shin, Sourabh Shukla, Young Hun Chung, Veronique Beiss, Soo Khim Chan, Oscar A. Ortega-Rivera, David M. Wirth, Angela Chen, Markus Sack, Jonathan K. Pokorski & Nicole F. Steinmetz, COVID-19 Vaccine Development and a Potential Nanomaterial Path Forward, 15 *Nature Nanotechnology* 646, 651–52 (2020); Ognian Kassabov, Opinion, What the Vaccine Debacle Tells Us About Predatory Capitalism, *Al Jazeera* (Feb. 21, 2021), <https://www.aljazeera.com/opinions/2021/2/21/the-vaccine-debacle-shows-the-predatory-nature-of-capitalism> [<https://perma.cc/AFZ5-P3NU>].

123. See COVID-19 Technology Access Pool, WHO, <https://www.who.int/initiatives/covid-19-technology-access-pool> [<https://perma.cc/6R3X-V3PU>] (last visited May 18, 2021) (inviting “[h]olders of COVID-19 health technology related knowledge, intellectual property and/or data . . . to join the Solidarity Call to Action NOW!”). Yet, no pharmaceutical companies are listed under endorsements of the call to action. See Endorsements of the Solidarity Call to Action, WHO, <https://www.who.int/initiatives/covid-19-technology-access-pool/endorsements-of-the-solidarity-call-to-action> [<https://perma.cc/Q4PA-63ND>] (last visited May 18, 2021); see also Selam Gebrekidan & Matt Apuzzo, Rich Countries Signed Away a Chance to Vaccinate the World, *N.Y. Times* (Mar. 21, 2021), <https://www.nytimes.com/2021/03/21/world/vaccine-patents-us-eu.html> (on file with the *Columbia Law Review*) (last updated May 7, 2021).

124. Thiru Balasubramaniam, WTO TRIPS Council: India and South Africa Submit Draft Decision Text on a Waiver from Certain Provisions of the TRIPS Agreement for the Prevention, Containment and Treatment of COVID-19, *Knowledge Ecology Int'l* (Oct. 2, 2020), <https://www.keionline.org/34061> [<https://perma.cc/28VN-9AD3>].

many countries. India and South Africa requested that the “waiver should continue in effect until widespread vaccination is in place globally, and the majority of the world’s population has developed immunity.”¹²⁵ Changing the incentive structures for the research and development of drugs, including suspending the application of trade-related intellectual property rights to essential drugs for lower-income countries, has been proposed before.¹²⁶ Notably, the UN’s High-Level Panel on Access to Medicines has not gone as far, but its recommendations recognize the need to alter the legal environment such that international treaties improve, rather than hinder, access to innovation.¹²⁷

India and South Africa’s joint submission seeks to substantially reshape the TRIPS regime by allowing for deep technology transfer for effective COVID-19 vaccines, therapeutics, and diagnostic tests. The joint submission is wide-ranging and covers not only patents, but also copyright, industrial designs, and undisclosed information including know-how and trade secrets.¹²⁸ The purpose of the temporary ban would be to allow multiple actors to start production, instead of limiting manufacturing to the small number of current patent-holders, which limits access and renders significant numbers of people disposable. The proposal has found support from the African group of countries and other developing countries at the World Trade Organization.¹²⁹ In May 2021, the Biden Administration indicated that “[t]he US supports the waiver of IP protections on COVID-19 vaccines to help end the pandemic and we’ll actively participate in . . .

125. Thiru Balasubramaniam, WTO TRIPS Council (October 2020): South Africa Issues Clarion Call Urging Support for TRIPS Waiver Proposal, Knowledge Ecology Int’l (Oct. 16, 2020), <https://www.keionline.org/34235> [<https://perma.cc/6NSX-ZLYE>].

126. For further discussion, see, e.g., Lisa Forman, The Inadequate Global Policy Response to Trade-Related Intellectual Property Rights: Impact on Access to Medicines in Low- and Middle-Income Countries, 31 *Md. J. Int’l L.* 8, 19 (2017) (“As a case in point, the 2012 U.N. Commission on HIV and the Law recommended that WTO members urgently suspend TRIPS for essential drugs for low- and middle-income countries, and that the U.N. Secretary General convene a new body to recommend a new intellectual property regime for drugs.”).

127. U.N. High-Level Panel on Access to Medicines, *supra* note 109, at 26–27 (noting that recommendations include that governments should only award patents where “genuine innovation has occurred,” not undermine TRIPS through threats, better protect countries that use international agreements to promote access to health technologies, and take punitive measures against countries that use political or commercial pressure to undermine international agreements). The Panel also proposes to close the health innovation gap through non-market-driven financing mechanisms like public–private partnerships, product development partnerships, grants, and prizes. *Id.* at 31–32.

128. Council for Trade-Related Aspects of Intellectual Property Rights, Waiver from Certain Provisions of the TRIPS Agreement for the Prevention, Containment and Treatment of COVID-19, WTO Doc. IP/C/W/669 (Oct. 2, 2020), <https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/IP/C/W669.pdf&Open=True> [<https://perma.cc/ZL5S-N74Z>].

129. See Thiru Balasubramaniam, 23 February 2021: South Africa’s Interventions at the WTO TRIPS Council, Knowledge Ecology Int’l (Mar. 1, 2021), <https://www.keionline.org/35453> [<https://perma.cc/3N27-QTZ4>].

negotiations [at the WTO] to make that happen.”¹³⁰ The pharmaceutical industry and wealthy countries like the United Kingdom, those in the European Union, and others oppose the proposal to waive intellectual property rights.¹³¹ Significantly, the South African intervention before the TRIPS Council notes that the countries opposing the waiver proposal account for 60% of the globally administered COVID-19 vaccines.¹³² In their view, intellectual property rights are not a barrier to access, as the current system is required to incentivize new inventions. The opposing countries maintain that equitable access can be achieved through voluntary licensing and technology transfer arrangements, among other means.¹³³ Yet, this Piece has already illustrated the severe constraints of voluntary transfer arrangements,¹³⁴ and as South Africa’s first intervention before the TRIPS Council aptly put it, “the problem with philanthropy is that it cannot buy equality.”¹³⁵ Given the diametrically opposed positions on the proposal, reaching a consensus (which is the way most decisions are made) in the TRIPS Council is unlikely in the immediate future.¹³⁶

Accordingly, the goal of delivering “triple billion” COVID-19 vaccine doses to the world’s most vulnerable populations appears elusive given the current impasse.¹³⁷ In January 2021, the Director-General of the WHO warned that the world is on the “brink of a catastrophic moral failure—

130. Statement from Ambassador Katherine Tai on the COVID-19 Trips Waiver, Off. of the U.S. Trade Representative (May 5, 2021), <https://ustr.gov/about-us/policy-offices/press-office/press-releases/2021/may/statement-ambassador-katherine-tai-covid-19-trips-waiver> [<https://perma.cc/4MWK-HJCJ>].

131. UK Mission to the WTO, UN and Other International Organizations, UK Statement to the TRIPS Council: Item 15 Waiver Proposal for COVID-19 (Oct. 16, 2020), <https://www.gov.uk/government/news/uk-statement-to-the-trips-council-item-15> (on file with the *Columbia Law Review*).

132. Carien du Plessis, S.A. Accuses States Opposed to Vaccine Patent Waiver of Being Pressurised by Big Pharma, *Fin24* (Feb. 24, 2021), <https://www.news24.com/fin24/economy/sa-accuses-states-opposed-to-vaccine-patent-waiver-of-being-of-being-pressurised-by-big-pharma-20210224> [<https://perma.cc/Q5BJ-C88W>].

133. See Ana Danaiya Usher, South Africa and India Push for COVID-19 Patents Ban, 396 *Lancet* 1790, 1790–791 (2020).

134. See *supra* notes 109–110 and accompanying text.

135. Aruna Kashyap & Margaret Wurth, Opinion, Rich Countries Must Stop ‘Vaccine Apartheid’, *Euronews*, <https://www.euronews.com/2021/03/11/rich-countries-must-stop-vaccine-apartheid-view> [<https://perma.cc/4WG4-5VZJ>] (last updated Mar. 11, 2021).

136. At the time of writing, states failed to reach agreement via consensus at the March 10–11, 2021 meeting on the intellectual property waiver request by South Africa and India. It is supposed to be discussed prior to the next TRIPS Council meeting scheduled in June 2021. See Members Discuss TRIPS Waiver Request, Exchange Views on IP Role Amid a Pandemic, *WTO News* (Feb. 23, 2021), https://www.wto.org/english/news_e/news21_e/trip_23feb21_e.htm [<https://perma.cc/Q9VD-9L3H>]; see also Andrew Green, TRIPS Waiver Tripped Up in WTO by ‘Third Way’, *Devex* (Mar. 5, 2021), <https://www.devex.com/news/trips-waiver-tripped-up-in-wto-by-third-way-99329> [<https://perma.cc/PP2B-PMYA>]; Jonathan Josephs, New WTO Boss Warns Against Vaccine Nationalism, *BBC* (Feb. 16, 2021), <https://www.bbc.com/news/business-56079088> [<https://perma.cc/G98K-C26U>].

137. Rich Countries Hoarding COVID Vaccines, *supra* note 83.

and the price of this failure will be paid with lives and livelihoods in the world's poorest countries.¹³⁸ If the current course is not corrected, vaccine apartheid will only deepen, and the resulting maldistribution will render historically subordinated groups even more disposable. That exacerbating racial subjugation was not the intention of law and policymakers in the intellectual property regime when structuring legal incentives for research and pharmaceutical innovation is immaterial. Indeed, this does not render the impact of further entrenching racial subordination any less acute. Nor does it alleviate the obligation of actors to remedy the inequitable racialized disparities with vaccine access that have resulted with COVID-19.

CONCLUSION

The twin pandemics of COVID-19 and systemic racism and the responses to halt their spread have fundamentally challenged the status quo. The uprising and its insistence on the value of Black lives creates an opening to rethink, reshape, and create new possibilities for antistatist efforts. Yet, as this Piece shows, the presumption of the disposability of people of color implicitly persists in disparate areas of law and policy. This Piece highlights several areas for reformation and restructuring. Further research should aim to reconcile the inconsistencies between the rights to health and equality provided by international human rights law on the one hand and trade-related intellectual property rights on the other. Additionally, addressing systemic police violence, racialized global health inequities, and medical experimentation and exploitation, as well as vaccine apartheid and redlining, will require a significant level of legal reform and restructuring to counteract years of entrenched racial subordination. This Piece makes clear that changing the baseline of disposability is required to begin to shift how people, society, and laws respond to Black lives now and in the future.

138. *Id.*