



**Is the pandemic an opportunity to decolonise development,
or is it rather widening inequalities and fueling power
imbalances?**

Three perspectives towards sustainable solutions

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Abstract

The COVID-19 pandemic has had a tremendous yet varied impact on different societies and population groups, such as minorities, across the world. The grave inequalities in COVID-19 vaccine distribution patterns that can be observed between and within countries have underlined this. No-one is safe until everyone is safe, because delays in the international vaccine distribution and administration increase the risk of virus mutations to develop. Therefore, the topic of (un)equitable vaccine access and its implications for global health and international development requires urgent attention. This paper researches whether *the pandemic is an opportunity to decolonise development or if it is rather widening inequalities and fueling power imbalances*, studying the phenomenon through the lens of vaccine distribution during the pandemic by means of a three-country case study of Serbia, India and South Africa. To answer how the distribution of COVID-19 vaccines is impacting inequalities across the globe, semi-structured interviews were conducted with NGO professionals working in the case study countries. There are great differences between and within countries when it comes to vaccine distributions: distribution to countries outside of the global North needs to be rapidly scaled up to ensure that everyone has the option to get vaccinated. Within countries, it is important that minorities are actively included in vaccination efforts. It was found that COVID-19 vaccine distribution has a strong political dimension that is often rooted in colonial/ postcolonial relations and that power imbalances gravely affect the international patterns of distribution and the location of vaccine production supply chains. The global vaccine distribution mechanism 'COVAX' has thus far not delivered urgently needed global and equitable access to the COVID-19 vaccine, especially for many low-income countries. Moreover, it was found that distribution patterns favor countries which have a critical position within international and diplomatic networks: vaccine diplomacy privileges recipient countries that are located in geopolitically relevant junctures, such as Serbia. Lastly, the national production of COVID-19 vaccines could potentially constitute an enabler of easier access to the vaccines and of new development paths.

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GIULIA STEEN, LENA GROBUSCH, VLADIMIRO LABATE

1 Aims and objectives

The COVID-19 pandemic has had and continues to have a tremendous yet varied impact on different societies, population groups, and individuals around the world (UNDESA, 2021). As countries and regions move towards a recovery from the pandemic, it is important that lessons and insights from the crisis are gathered and carried forward in order to ‘build back better’ (UNDESA, 2020). In the framework of the Regional Academy of the United Nations 2021 theme ‘COVID-19 recovery: towards more resilient and inclusive solutions’, this paper aims to contribute to the current discourse by researching the topic of decolonising development, through the lens of vaccine distribution during the pandemic. The research question ‘Is the pandemic an opportunity to decolonise development or is it rather widening inequalities and fueling power imbalances?’ is answered through a comparative case study of three countries from different continents: Serbia, India, and South Africa. Such a comparison remains a rare approach in the literature to date and helps to amplify the voices of people (who will however stay anonymous) on the ground who are facing different COVID-19 realities. The paper is written by three postgraduate students with international foci in their studies and supervised by Arianna Briganti at the Organization for Security and Co-operation in Europe (OSCE).

2 Introduction and background

The first COVID-19 infection was reported to the World Health Organization (WHO) on December 31st, 2019 (WHO, 2020). In the following year, the virus spread across the majority of the world’s states, infecting more than 191 million people, partly with lethal progression. Measures to contain the virus have been taken and have had an impact on infection rates as well as on the national and global economy. This has been particularly evident for populations in low and middle-income countries (LMICs) (OECD, 2021d), where grave inequalities have been highlighted and populations have been disproportionately affected in terms of response, which includes vaccination distribution (Bedurke, 2020). Given the “no-one is safe until everyone is safe” approach (UNICEF, 2021), the mandate of the United Nations (UN) to “maintain international peace and security” and

to “achieve international co-operation in solving international problems” (United Nations, n.d.), is currently more important than ever.

The global impact and response to the COVID-19 pandemic are intricately correlated with power imbalances across the world (OECD, 2021a; Çakmaklı, Demiralp, Kalemlı-Özcan, Yeşiltaş, & Yıldırım, 2021). The power imbalance emerges more prominently when focusing attention on vaccination campaigns and specifically on vaccine distribution. The emphasis on this issue represents a way to consider how developing countries are politically and economically impacted by the pandemic, given that unequal patterns of vaccine distribution affect not only the economic recovery of LMICs but that of the whole world (OECD, 2021a; Çakmaklı et al., 2021). Vaccination is a two-dimensional effort: on the one hand, vaccine production remains dominated by a small group of industrialized countries, the “COVID-19 Vaccine Production Club”, where almost the entire world’s production capacity and facilities are concentrated to date (Evenett, Hoekman, Rocha, & Ruta, 2021). On the other hand, vaccine distribution constitutes an important dimension in the provision of equitable access to the COVID-19 vaccine, not only in the international arena but also in national and local contexts.

For this reason, vaccine distribution appears to be a meaningful instrument to investigate relations between COVID-19 vaccination and future development prospects for LMICs. In the international sphere, two political phenomena concern vaccine distribution: Vaccine Diplomacy and Vaccine Nationalism. The former consists of vaccine donations to developing countries by the principal vaccine producing countries, such as the US, China, Russia, and India. This would have the double aim to improve their soft power in the global sphere, by strengthening ties with countries aligned to their interests, and to ensure global vaccine distribution and access (Hotez, 2014). Vaccine delivery is channelled either bilaterally or through the multilateral initiative COVAX (Kiernan, Tohme, Shanks, & Rosenbaum, 2021; Leigh, 2021). Since the XVIII century, Vaccine Diplomacy has become a relevant tool in great powers’ foreign policies for promoting their strategic and national interests through public health measures (Hotez, 2014). The latter, namely Vaccine Nationalism, is defined as “*a scramble among countries to stockpile [vaccines] for its own citizens*” (Chatterjee, Mahmood, & Marcussen, 2021, p. 358), reflecting the priority of the vaccine producers of immunizing their own population before the rest of the world. In the national context, vaccination remains still a politicized issue: historically, vaccine programmes have contributed to shaping national identity, by delimiting the boundaries of the national community through the inclusion or exclusion of minorities (Greenough, Blume, & Holmberg, 2017). Coercion, intimidation, and resistance have been features of national and international public health policies, to the extent that they are salient tools of political oppression or political fear (Greenough, 1995).

These different behaviours pertaining to vaccine distribution make this topic extremely important in terms of equitable access to COVID-19 vaccine. Since power politics and national interests are influencing inequalities of vaccination access across the globe (Pannu & Barry, 2021), it is worthwhile to research the multifaceted patterns of distribution by investigating three case studies that present specific political and economic dynamics related to COVID-19 vaccines. This approach will focus on Serbia, South Africa, and India: these countries are located at different

stages of the COVID-19 vaccine production supply chain, but they are all taking part in vaccine distribution networks, by facing supply-side issues or because of international pressure. Moreover, at national level, they face similar challenges, for example the integration and equal treatment of all citizens. There are groups whose integration and equal treatment will be questioned in the following paper. In order to do justice to the multi-layered backgrounds and contexts, we refrain from using scientifically well-defined terms such as 'refugees' (UNHCR, 1951) or 'minorities' (OHCHR, 2010) or 'the poor' (Worldbank, 2015). These imply, each in its own way, very concrete conditions that do not apply in every country mentioned in this paper. Leaning on the OHCHR definition of minorities, we propose to use the term *minorities* in the following sense: This term includes *a group of people in a non-dominant position, whose members possess economical, ethnic, religion, nationality, political opinion, age, gender or linguistic characteristics differing from those of the rest of the population and are structurally disadvantaged because of one or more of these characteristics. A minority might in some cases include a big part of the population.* The OHCHR definition was broadened by age, gender and political opinion, furthermore the condition to have the local nationality was removed.

Firstly, Serbia constitutes an example of a recipient country, having received vaccine supplies by all major vaccine producer countries, and having tried to gain an advantage in terms of vaccine access by its standing in power relations in the Western Balkans. Secondly, South Africa has been developing its own vaccine production capabilities, with potential consequences over its future development and its economic upgrading in vaccine global value chains. This production transformation would enable it to become an important vaccine distributor for the African continent. Finally, India has assumed the role of vaccine producer and distributor for LMICs because of its manufacturing facilities. However, the evolution of the pandemic and the Delta variant within its borders has drawn out the tension between its commitment to vaccine diplomacy and the need to accelerate the immunisation of its local population.

This research paper does not exclusively focus on global power imbalances but analyses them and examines their consequences at the national level. The resulting work is shown in figure 1, where the triangle on the left, illustrates the three interconnected dimensions: Decolonizing Development, Vaccine distribution, and Inequalities. These dimensions are manifested on a global level e.g., through vaccine diplomacy and vaccine nationalism. The same dimensions are to be

found on a national level but are manifested differently. Vaccine distribution for example is reflected within the national immunisation plans.

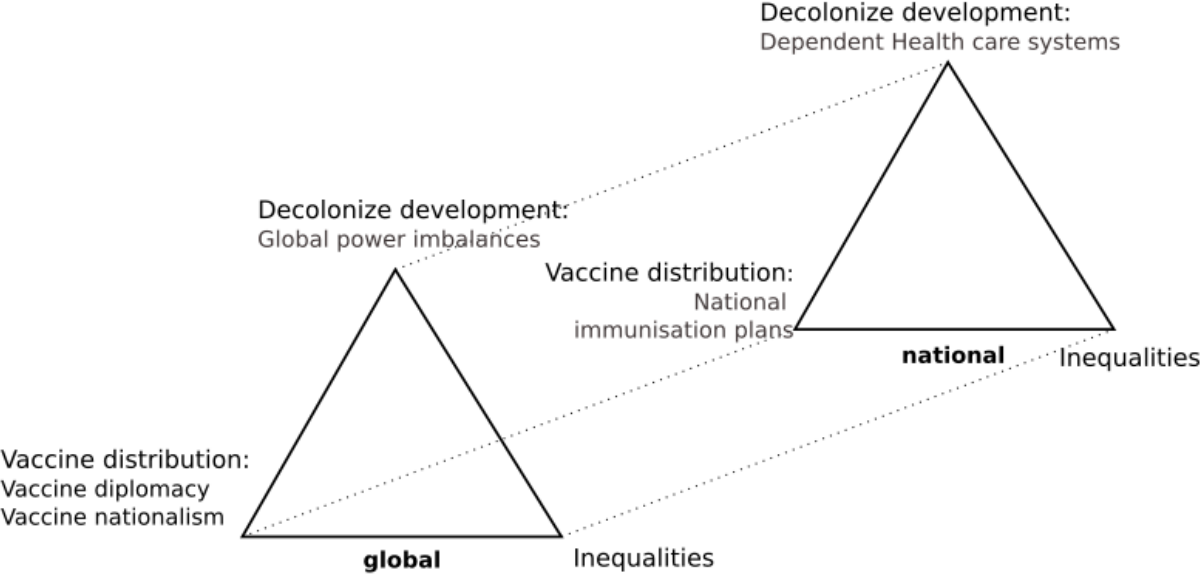


Figure 1: The three interconnected dimensions addressed in this paper are Decolonizing Development, Vaccine Distribution and Inequalities. This is applicable on a global, as well as on a national scale.

3 Theory

To contribute to engendering global solutions and sharing best practices, the following research question will be investigated: How is the distribution of COVID-19 vaccines impacting inequalities across the globe? This research question is assessed on the global level with a focus on vaccine distribution, and on the national level, using case studies from India, Serbia, and South Africa. The assessment on a national level will pay attention to minorities, gender, and race relations as cross-sectional topics.

Possible solutions that are being proposed and discussed should be sustainable. In 1987, the United Nations Brundtland Commission defined sustainable as “meeting the needs of the present without compromising the ability of future generations to meet their own needs.” (UN, 2021). Following this definition, the Sustainable Development Goals were defined and a comprehensive academic discourse developed. In the scope of this paper, sustainability is defined as a positive long-term development within three dimensions: economical, ecological and social.

Decolonising Development for many authors in academia means questioning and challenging how colonial and hegemonic structures of power continue to produce and strengthen inequalities, and reflecting on how the resulting unequal structures can be addressed. (Escobar, 1992; Kothari, 2005). Within the framework of this paper, the focus is narrowed down to decolonising the used

research methods, recognising colonised health structures and amplifying voices from people that are impacted by these very structures.

The research question further unfolds into three interconnected dimensions (cf. figure 1): Exploring the root causes of unequal COVID-19 vaccine distribution; analyzing its negative consequences for LMICs; contributing to decolonizing development in practice. These dimensions define in particular the perspective of LMICs on the COVID-19 pandemic, because legacies of colonialism have resulted in unequal power dynamics and stark differences in development, which are now perpetuating inequalities even further (Binagwaho and Mathews, 2021). A change in these global power dynamics naturally entails a change in inequalities (Alaran et al., 2021).

Several health care systems in LMICs are rooted in the colonial era and included colonial elements until the 20th century (Phua, 1989). Speaking on a more global scale, during the colonial era and for many years after, public health was a state activity strictly related to the control of national borders, in order to protect citizens from infectious diseases coming from foreign or colonial territories. In this context, public health was connected with the ideologies of national security and international commerce and translated into the ideology of international health, where the needs of colonial powers governed the choice of public health (King, 2002). New international institutions and organizations were devoted to public health, implying the cooperation of sovereign nations in tackling health issues. The health of indigenous populations was considered through the lenses of the “civilizing mission” and the “colonial healing”, as well as a way to ensure a productive pool of labour (King, 2002).

As globalization began and new emerging diseases started to spread around the globe through its growing flows, the new ideology of “global health” emerged. During the 90s, the “emerging diseases worldview”, as it is called by King (2002, p. 767), took root within the American medical community as a new way to perceive the potential threat of epidemic diseases to the national security and interest of the United States, which had to take account of novel health issues in its external projection. This postcolonial worldview aimed to integrate the local communities and territories into the global circulation of health information and pharmaceutical commodities, in order to assure the American interests of control of epidemic outbreaks and economic integration and openness (King, 2002).

A major component of the shift from the concept of “international health” to that of “global health”, which “implies consideration of the health needs of people of the whole planet above the concerns of particular nations” (Brown, Cueto, & Fee, 2006, p. 62), was the active role of the WHO. During the 90s, as a new awareness of emerging health threats was growing, the organization was an agent of change, taking advantage of a favourable international context and promoting the use of new ideas and concepts; this organizational strategy gave it a new coordinating and leadership role (Brown et al., 2006). New “global health” actors, involved directly in the global immunisation efforts, emerged, such as the GAVI Alliance, which, at its founding in 2000, seemed to represent a new model for public-private cooperation in public health. However, it failed to balance its top-down approach and its health priorities, related to vaccination and eradication programmes, and the recipient countries and local communities’ health needs (Muraskin, 2004). Notwithstanding at first the Alliance focused on between-countries inequities in

utilisation of immunisation services and it did not prioritise reaching marginalised communities, GAVI has more recently emphasised the importance of addressing within-countries inequities in immunisation programmes and in vaccine access (Gandhi, 2015).

The approach to the global Covid-19 vaccine distribution has the potential to address these inequalities by giving space to develop a unique structure from within and transform colonized health systems for the better (Byatnal, 2020). Given the postcolonial mindset at the foundation of the “global health” actors, it is of particular interest whether this potential is taken into account by actors of the international community, e.g. WHO, because international policies with a focus on health are one possible lever for improving the situation (Irfan, 2021).

The COVID-19 vaccine distribution in 2020 and 2021 shows trends of vaccine nationalism and vaccine diplomacy (OECD, 2021a/b/c) that will be discussed further in this paper. While the research of Non-Governmental Organisations (NGOs) and UN agencies explored the underlying power dynamics of these trends (OECD, 2021a/b/c; Woodcraft, 2021), it remains an open question to what extent vaccine nationalism has played a role in exacerbating infection rates. Indeed, this means wondering how vaccine distribution affected the population of vaccine producing and vaccine receiving countries.

The inequalities discussed during the COVID-19 pandemic span from global to national level, therefore this paper investigates these different albeit interrelated contexts. Global inequality becomes particularly visible through comparison: as of April 2021, only 0.2 percent of all COVID-19 shots were administered in low-income countries (UN NEWS, 2021). It is essential to understand how the international initiative COVAX, co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi and WHO, influenced this development until now and which solutions are further being proposed. Inequalities on a national level are especially visible when looking at minorities, because national immunisation plans tend to disadvantage them, e.g. by prioritising not only by medical factors like age, but also considering factors like ethnicity or nationality. (OSCE, 2020a/b). The OSCE ODIHR research already focused on consequences of containment measures and criticized negative effects on the fundamental rights of affected groups (OSCE, 2020a/b).

4 Methodology and data collection

The methodology that will be employed to answer our research question is to conduct three different case studies at state-level. These case studies will focus on Serbia, South Africa, and India. The methodology is twofold. First, a literature review will be conducted to collect information and relevant data. Given that the COVID-19 crisis is relatively recent, academic literature will be complemented with news pieces where required. While our research has a qualitative focus, we strive to go beyond qualitative data to also include quantitative statistics on distribution and vaccination rates where these are available.

Secondly, to collect qualitative data, semi-structured interviews will be conducted with interviewees from each case study country. The interviews will be an invaluable tool to collect insights from individuals on the ground. To have a common denominator in our data collection process, if possible, these interviewees should be from similar backgrounds in all countries, e.g. at least one person working for an NGO. Interviewees will be recruited primarily through personal networks and connections of our supervisor Arianna Briganti and the three group members. Written consent will be collected prior to the interviews, which will be conducted via zoom. As for data analysis, the interviews will be transcribed using the freely available software ‘Trint’. Subsequently, qualitative coding will be undertaken to analyze the interview results.

4.1 Decolonising research methods

Minorities have been disproportionately affected by the COVID-19 crisis and have also disproportionately felt the side effects of vaccine distribution (Nazareth, Shawoo, & Lager, 2021; Rose et al., 2020; Carmody, McCann, Colleran, & O’Halloran, 2020; Bamba, Riordan, Ford, & Matthews, 2020). Including viewpoints from people from minorities would therefore be critical to gain a nuanced insight into the impact of COVID-19 vaccine distribution on inequalities. However, it is recognized that this is difficult and therefore, talking to NGO representatives working with minorities may be one step to gaining insights on the impact of COVID-19 on minorities. Moreover, as Thambinatan and Kinsella (2021) write in their paper on decolonizing methodologies in qualitative research, it is also important to always practice reflexivity, for example when analyzing research results. We are also aware of unconscious biases and by being self-reflective, we may see some of those biases.

By making the interviews semi-structured, there will be flexibility for the interviews to go off-script and for the interviewees to voice their opinions freely. In the context of decolonizing qualitative research methods, Thambinatan and Kinsella write of a refugee researcher’s field notes that state that “reflexivity (was) a productive tool in realizing that her interview questions were a direct product of her colonized and Western-centric environment” (2021, p.4). In light of our commitment to contribute to decolonizing development, the semi-structured interviews were thus consciously chosen because we recognize that each of us three interviewers have their own views, unconscious biases and Western background, which affect our individual perspective of the world. It would also be helpful to ask participants to share their personal definitions of key terms at the beginning of each interview. This could for example include asking what a ‘minorities’ constitutes to the interviewee, to minimize unconscious biases from the researcher’s side as far as possible and to ensure mutual understanding of key terms.

To be conscious about the time of the interviewees, interviews shall not last longer than agreed on (Chambers, 2014). In order to manage expectations of what the research is about, a thorough explanation will be included on the interview consent form that clarifies that the primary aim of this research is to contribute to the discourse by amplifying voices and highlighting different case studies. Practitioners, e.g. people working for and with NGOs on the ground, have a thorough knowledge about how their work could be supported, but often miss the time to advocate and

spread their findings. By collecting and discussing the practitioners findings in three different countries, we hope to amplify the most important findings in the right forums. It is important to mention that we by no means expect our research to change the situation on the ground. Rather is meant to contribute to an ongoing discussion that might lead to change in the future. Lastly, interaction on an equal basis is a give and take. Therefore, when planning interviews, interviewees will receive a copy of the paper and policy brief by email.

5 Results and discussion

Before presenting the results, it must be acknowledged that our findings would have likely been different if a) different people were interviewed and b) more people were interviewed. An important finding and learning experience that emerged during the research process was that many potential interviewees whom we reached out to kindly declined the participation. Two common reasons for declining interviews that potential interviewees referenced were firstly their high workload due to COVID-19 and secondly their personal affectedness by the COVID-19 situation.

5.1 Serbia

General overview

The Serbian immunisation campaign has been marked by a strong start, since its vaccination rate was one of the highest in Europe during the first months of the year (Stanisljevic, 2021). According to the Reuters Coronavirus Tracker, as of 1 December 2021, Serbia has administered 7,852,268 doses of Covid-19 vaccines so far, which means that about 56,5% of the Serbian population is fully vaccinated (Reuters, 2021).

This initial success has been strictly due to the large quantity of Covid-19 vaccines Serbia has been provided, that ensued from the country's position in the Balkan region and its political and diplomatic ties with main vaccine producer countries (Tzifakis, & Prelec, 2021). Indeed, the country has received vaccine doses from 4 different suppliers: Pfizer-BioNTech (USA-Germany), the Chinese Sinopharm, the Russian Sputnik V, and the British Oxford-AstraZeneca. In order to ensure a highly diversified portfolio of vaccines, Serbia has exploited its global relations and diplomatic ties, becoming "the epicenter of vaccine geopolitics in Southeastern Europe" (Juncos, 2021, para. 16). Serbia has played the role of a 'recipient' country, taking advantage of the vaccine diplomacy effort of its international partners in the Balkan region and balancing its position between the West and the East. On the one hand, Serbia remains committed to the area of influence of the European Union, but the pandemic has shown what was perceived as a lack of solidarity by the EU and its member states towards the Balkans and Serbia, in particular concerning the access of Covid-19 vaccines through COVAX. On the other hand, Russia and China have been trying to fill this vacuum in order to strengthen their role in the region. This effort has materialised in the arrival of Chinese and Russian vaccines to supply the Serbian vaccination campaign. By way of example, on 16th January 2021, 1 million doses of Sinopharm vaccine arrived in Belgrade, while, as of March 2021, Russia supplied 400.000 Sputnik V doses to Serbia (Vladislavljev, 2021).

Simultaneously, Serbia has increased its effort to have national vaccine production. In doing so, it has signed two Memoranda to produce the Chinese Sinopharm vaccine and the Russian Sputnik V within its territory (Dragojlo, 2021; Xinhuanet 2021). This strategy would strengthen its role in the region, by the fact that it would enhance Serbia's vaccine diplomacy towards the Balkan countries, with some donations having already been delivered to North Macedonia, Bosnia and Herzegovina and the entity of Republika Srpska, and Montenegro (Stanisljevic, 2021).

At the national level, in the last months the vaccine rollout has slowed down. The primary reasons are because of the low trust in political institutions and the spread of conspiracy anti-vaccine theories, which have reinforced vaccine hesitancy especially among the young population (Tuvic, 2021; Juncos, 2021). President Vučić has decided to provide financial incentives to get the majority of the population to be vaccinated, even if the target established for the end of May 2021 has not been reached (Holt, 2021).

Results

In order to answer our research question, we met a researcher (interviewee 1) of a Serbian NGO/think tank, which has a critical stance towards President Vučić and his government, and a doctoral student (interviewee 2) of the University of Novi Grad. We interviewed them about the Serbian strategy to secure vaccine supply for its own population and the general conditions of access to Covid-19. In order to critically assess it as fluently as possible, their opinions will be included in our discussion and quoted according to formal rules. As a programmatic choice, this applies to each case study presented in this paper.

One key feature of Serbia's management of the pandemic is that Covid-19 has been handled as a political issue in all its dimensions: *“in my country COVID is more related to politics, not towards health”* (conversation with interviewee 2, 2021). As to the vaccine supply, the Serbian effort to obtain enough Covid-19 vaccines doses has relied on the foreign policy strategy which is referred to as the *“four pillars”* (Conversation with interviewee 1, 2021), which are the US, the EU, Russia and China. Serbia is *“trying to kind of coordinate closeness with each of these actors”*, in order to exploit its *“privileged position [...] where they can also, for example, get the vaccines from the West and from the East. And Serbia has [...] very, very successfully used its position, especially in the very beginning with the vaccine shortage to the COVAX programme in the West”* (Conversation with interviewee 1, 2021). As, in the early months of 2021, the COVAX programme failed to deliver Pfizer and AstraZeneca vaccines, this was perceived as *“a big crisis of the EU”* (Conversation with interviewee 1, 2021). Indeed, the EU was not seen in a good light: *“we as people who are not part of the EU notice that the EU is not any more strong as before. The EU has lots of their own problems who can't handle them [...] and also, we noticed that the EU didn't manage to find solutions to this pandemic as expected”* (Conversation with interviewee 2, 2021). Thereby, *“Serbia turned to Russia and especially China. And so even though the first 20.000 vaccines came from the COVAX Programme and it was Pfizer, then next million, the first million of vaccines came from China [...] and Serbia was the first one in the region to get this number of vaccines”* (Conversation with interviewee 1, 2021). The presence of multiple sources of vaccine supply is strictly related to the variable geometry of the Serbian foreign policy: *“Serbia is now considered to be the closest European ally of China. And there are many ways in which this is true politically, economically, especially also in the military nowadays at some low level. [...] Russia was always politically very present in Serbia for historical reasons and also because of the Kosovo*

issue. [...] And of course, EU and US are also present because especially [...] Serbia is a candidate country, and at least nominally, this is the priority of foreign policy of Serbia to become an EU member. And of course, the economic relations with the EU are very close” (Conversation with interviewee 1, 2021). But the major consequence of the pandemic is that “this crisis, especially with the vaccines, was used to shift public perception in a big way to see China, especially as the closest friend of Serbia and the West in many ways as the failed project. We can see this in the narrative that was promoted by the government officials with [...] the medical aid and the vaccines kept coming from China” (Conversation with interviewee 1, 2021). A reason why the government acted this way is that it “knows that if you play on the China card, [...] the West will pay attention more and maybe be ready to close their eyes to some autocratic shifts and say, OK, we don't want to really lose influence there” (Conversation with interviewee 1, 2021).

When considering the deals to produce vaccines within the country, we can see the same pattern of approach to China and Russia: indeed, Serbia is “producing Sputnik based on the pattern of Sputnik as is Russia. [...] And so this is being produced and packed in Serbia now and distributed to other countries based on some [...] non-transparent deals with the Russians”. Similarly, “there's like the process of the production of Sinopharm ongoing in Serbia. [...] We don't have a clue how, what's the future of these, for this production? Probably they're going to be here for the exports” (Conversation with interviewee 1, 2021). The participation of Serbia in the vaccine production is correlated with its use of Vaccine Diplomacy in the Balkans and in former Non-Aligned-Movement countries. Not only the national production is going to be delivered abroad, but also the doses Serbia received at the first stages of its vaccination campaign were partly devoted to fuel the country external projection: “in that case, Serbia at the time didn't have any production of vaccines and it was [...] just like taking vaccines from China, from Russia or whatever, even from the EU [...] and then, saying, OK, we don't need this much vaccines at this moment, we're going to give some percentage [...] to the countries in the region. [...] With the vaccines coming to Serbia first and then to the region much later, Serbia used this for the public diplomacy strategy. [...] It showed not only Serbia in a better light [...] definitely for some people, but also this kind of regime as the more efficient one because it was demonstrated” (Conversation with interviewee 1, 2021).

The abundant availability of vaccines in the early months of 2021 was also a means to promote internally and externally the image of an efficient government in tackling the pandemic and supplying the vaccines for the whole Serbian population: “the number of people who got vaccinated in [...] the first two months was really, really high, the highest in Europe, which brought Serbia a big media attention from the world as well” (Conversation with interviewee 1, 2021). Moreover, “we were helping other countries, especially in our surroundings such as Bosnia Herzegovina, North Macedonia, Montenegro [...] In Belgrade were coming people from all over the world” (conversation with interviewee 2, 2021). This success “was used to kind of, at least in a small portion, change the public perception or it was public diplomacy to the international public” (Conversation with interviewee 1, 2021). Despite this strong start, the vaccination campaign has slowed down especially due to the presence of a large anti-vax movement: “there's a high level of people who are concerned about vaccines, etcetera, etcetera, around the anti-vaxxers. So there's like a limitation to the number of people who accepted to take vaccines and then the number of cases, of course, arise again” (Conversation with interviewee 1, 2021). Nevertheless, “it's not connected to the ethnical or what are your nationality [...] It just connected with the state of mind” (Conversation with interviewee 2, 2021).

The interviewee n.1 warned that the government's management of the vaccination campaign had some political implications on the state of Serbian democracy, since it strengthened the government's trajectory towards semi-authoritarianism: *"the government was kind of promoting it, of course, but fortunately, it was more oriented towards [...] public display of how efficient this government is and how close these relations are with different allies around the world"* (Conversation with interviewee 1, 2021). This trend is more visible in relation to the enforcement of restrictive measures after the outbreak of Covid-19 in Serbia: *"the way that these measures were introduced was completely unconstitutional. [...] These special measures were used to further deconstruct the institutional framework of the Serbian state. And this will probably have deep institutional effects going forward, regardless of the pandemic. [...] This is definitely just one piece of the puzzle that senses this trend of state capturing of redefining the democratic practises into semi autocratic and probably all the way to the autocratic practices in the future will continue. [...] COVID 19 was just [...] one step in this trend that is here to stay unfortunate for the long term"* (Conversation with interviewee 1, 2021). However, it should be recalled that this situation has not be resulted from the pandemic, since *"we would have this situation even if it's not like a pandemic because [...] we are now a country where we have like one party who supports a lot of people and we actually don't have opposite parties at all. [...] We would have the same situation, even if you don't have the pandemic."* (Conversation with interviewee 2, 2021). Covid-19 could have exacerbated an already existing trend within Serbian democracy: the elections to renew the national assembly, held in June 2020, represented decisively a further shift towards a one-party system (Fruscione, 2021).

Research answers

Serbia shows the potentials and the limits of the politicization of global vaccination efforts in ensuring equal global access to vaccines. On the one hand, the relevant international standing of Serbia within the global power structure and its role as a regional player have enabled the government to guarantee wide access to Covid-19 vaccines to its whole population. The Serbian government has cleverly leveraged its privileged relations with the major powers to take an advantage in the global struggle for vaccines, swaying around the different poles according to its own interests. On the other hand, the Serbian example stresses the flaws of the international vaccine-distribution mechanism, since it fails to ensure that all countries have access to vaccines, regardless of their ties with great powers and their position in the international sphere. As a matter of fact, not every country has the same political relevance to major powers as Serbia and cannot benefit from the same rent of position. For this reason, the correlation between great powers' interest in one country and that country's access to vaccines becomes a source of inequality in the global sphere. In fact, if "bilateral charity" (Harman et al., 2021, para. 5) is more about power dynamics than equity, "any system that solely relies on aid will ultimately fail to achieve equity" (Harman et al., 2021, para. 8).

On a national level, the case of Serbia demonstrates that the implementation of pandemic response measures and the outcome of the vaccination campaign have the potential to consolidate the autocratization dynamics which the government in office carries on (Fruscione, 2021). This happens along two different axes: first, the state-capturing trend of the ruling elite has been reinforced by the restrictive measures enforcement during the first stages of the pandemic, which

has resulted in the circumvention of constitutional rules and the redefining of transparent democratic practices (Fruscione, 2021; Pajvančić, Petrušić, Nikolin, Vladislavljević, Baćanović, 2020); second, the success in securing vaccine supplies has enhanced the legitimacy of the regime, which has exploited the political relevance of the country and its ties with the major powers to consolidate its control over the country (Tzifakis, & Prelec, 2021). This was achieved also through a propaganda machine which still exerts a powerful influence on the Serbian media market (Reporters Without Borders, 2021; Fruscione, 2021).

5.2 India

General overview

India was chosen as a case study country for this paper, because the three main dimensions illustrated in Figure 1 are addressed both on a global level (e.g., the vaccine distribution to Covax and their proposal to WTO) and on a national level (e.g., the national distribution of vaccines and the national measures to mitigate the impact of the pandemic). The Indian government provided around 65.5 million doses of Covid-19 vaccines to 95 countries between 20 January 2021 and late March 2021 (Government of India, 2021). With the Serum Institute of India (SII) being the largest single supplier to the Covax scheme (WHO, 2021), India is a main vaccine producer for low- and middle income countries. Despite this high production capacity, only 9.3 percent of India's population are fully vaccinated as of 17th of August 2021 (COVID19, 2021). These numbers illustrate the tension India's policy makers are facing: on the one hand by prioritising equal vaccine distribution across the globe, India's population may face rising numbers of infections and an overwhelmed health care system. On the other, by prioritising the vaccination of India's population, the COVAX scheme is not able to deliver the agreed upon number of doses to low and middle income countries.

As one instrument to reduce the described tension, India and South Africa proposed to the World Trade Organization a waiver on Intellectual Property Rights (IPRs), seeking to increase access to Covid-19 vaccine-related technologies in order to allow national production of vaccines in developing countries. It has not reached the requested consensus yet and is mainly blocked by the EU Commission (Abbott & Reichman, 2020).

On a national level, the first 21-day lockdown to prevent the spread of coronavirus forced millions of workers to travel from urban to rural areas, because most workplaces were shut down as well (Azeez, 2021). With losing their wages, living in the urban areas of India was not affordable for many people, who preferred to travel to family members, mostly living in rural areas (Choudhari, 2020). The shutting down of all transport meant that most of them were forced to travel on foot, partly up to 700 km long routes (Azeez, 2021). The national vaccination roll-out is managed by the national immunisation plan (Nayak, 2020).

Results

In order to answer our research question, we met the CEO of the Indian branch of an international NGO, two directors of a local NGO with strong international funding, as well as the director of a local NGO with diverse funding (national and international). We interviewed them about India's COVID-19 strategy to reduce infections and provide vaccines to the COVAX scheme, as well as securing vaccine supply for its own population and the general conditions of access to Covid-19. The topic of global political implications was mainly avoided during our interviews. One possible reason might be the shrinking space, that affects the work of NGOs in India, as well as in many other countries (Vijapur, 2021). However, this has not been studied in detail within the scope of this work.

India was not prepared for a health crisis on the scale that COVID was and it *“was evident by the sudden lockdown that was clamped on the country and people were running helter skelter, particularly the migrants, to be able to return home. There was no transportation, unemployment was coming in.”*(Conversation with interviewee No. 3) This is one example of how minorities are more affected by COVID-19 and its counter measures than others. In this example, the people are affected because they are living from a day to day wage that was, from one day to the next, not available anymore. Additionally, the social security net was believed to be stronger in the villages they returned to, than in the, partly informal, settlements they were living in in urban areas (Choudhari, 2020).

The access to vaccines was controlled by the government, the national health system was widely used to administer vaccines. There are private and governmental hospitals that offer vaccination. The vaccination in governmental hospitals has always been free of charge, *“but in private hospitals, yes, they are charging. They were charging with great height.”*(Conversation with interviewee No. 3). Especially in the beginning, when there was a considerable shortage of vaccine doses, private hospitals charged up to 47€ per shot (The Hindu, 2021). This difference between the hospitals resulted in the beginning of the vaccination campaign in an unequal access to vaccines, depending on the economical status of a person (The Hindu, 2021).

Accessing vaccines in governmental hospitals to receive a free vaccination is possible when obtaining one of 11 different administrative documents. The Ministry of Health and Family Welfare (MoHFW), government of India, published the national immunization plan, as well as criteria for eligible people on its website (MoHFW, 2021). According to the published forms it is only possible to register for a vaccination if one out of seven possible ID cards is shown. When asked about this, more than one interviewee confirmed it was not possible to receive a vaccination without an identification: *“Having an ID card is good, [...] I understand the argument that the government is making, but to make it mandatory. It's not working and it wont work. I mean, think about children living on the street in Delhi. I mean, I don't think they have any identification, so they're invisible. These women [in rural areas] are invisible, especially when the men die. They don't even know where these certificates are.”*(Conversation with interviewee No. 5). This is a structural disadvantage for minorities without identification documents and it was not possible within the scope of this paper to clarify the number of people affected.

Research answers

India shows the potentials and the limits of vaccine diplomacy by being the single largest supplier to the COVAX scheme and at the same time restricting access to vaccines within its own borders. On the one hand, the international role of India, especially in relation to its neighbouring countries, is strengthened. But as the devastating second wave of COVID-19 swept across India, it suspended its vaccine exports in support of its international interests in mid-April after having delivered 66 million doses to various developing countries (Zeeshan, 2021). The location of vaccine production supply chains in a country comes with the enormous power of shaping the global vaccines distribution structure; this is influencing the global flows of key medical ingredients and products (i.e. the Covid-19 vaccines). India's changing role as a supplier was one of the main examples during the COVID-19 pandemic (Evenett et al. 2021). Their supply capacity and distribution strategy was partly subordinated to the national health interest of prioritising the immunisation of their own population.

On a national level, the case of India demonstrates that the implementation of pandemic response measures and the outcome of the vaccination campaign have the potential to have immens social and economic impacts because of strict measures against COVID-19, hitting minorities the hardest (Sharma, Yount, 2020). Also, the prioritisations in national immunisation plans, as well as imbalances within the health system, were widening existing inequalities (Choudhari, 2020).

5.3 South Africa

General overview

South Africa was chosen as a case study country for this paper, because it is intricately connected to the three dimensions of 1) decolonizing development, 2) vaccine distribution, and 3) inequalities, at both the global and national level (Heleta, 2018). Given its colonial past, South Africa has been subjected to a web of power imbalances that includes actors at a global scale. With many international development efforts occurring in the country and given the history of apartheid and recent events in post-apartheid South Africa, questions of decolonizing development are also very important at national level. Additionally, “more than a quarter century after the end of apartheid, South Africa is the globes most unequal nation, according to the World Bank” (Sguazzin & Wilson, 2021).

In terms of vaccine distribution, South Africa (SA) makes for a multifaceted case study. At the end of March 2020, the South African government imposed one of the strictest lockdowns on the continent, which was lifted again at the end of April in light of surging poverty and unemployment (Müller-Mahn and Kioko, 2021). Subsequently, infection rates rose again and South Africa had the highest number of cases on the continent (Müller-Mahn and Kioko, 2021). By the end of February 2020, when the global vaccination campaign exceeded 200 million doses, only 6,500 had reached South Africa (Müller-Mahn and Kioko, 2021).

In July 2021, it was announced that Pfizer and BioNTech reached an agreement with the Cape Town based vaccine manufacturer Biovac to produce over 100 million doses of the mRNA vaccine

annually (Fletcher, 2021; Robbins, 2021). The production is set to start in 2022, with the vaccines being destined for distribution across the African Union (Fletcher, 2021). Across the African continent there is currently a shortage of vaccines, with only an estimated 1.5% of the population being fully immunized as of July 21st 2021 (Robbins, 2021; Fletcher, 2021). The hope is for this deal to contribute to alleviating vaccine shortages by distributing more to South Africa and other African countries (Robbins, 2021; Fletcher, 2021).

However, there are some caveats to the agreement (Robbins, 2021). As Robbins reports, “crucially, the South African producer, Biovac, will only be handling distribution and ‘fill-finish’ - the final phase of the manufacturing process, during which the vaccine is placed in vials and packaged for shipping. It will rely on Pfizer facilities in Europe to make the vaccine substance and ship it to its Cape Town facility” (New York Times, 2021, n.p.). This implies that while the final distribution of the vaccine will take place from Cape Town, the many steps leading up to it are still located outside of SA, off the continent in Europe. In the same article, Matthew Kavanagh, the director of Global Health Policy and Politics Initiative at Georgetown University stresses that keeping “the full production capacity to high-income-country producers (...) just perpetuate(s) the inequalities in distribution” (New York Times, 2021, n.p.).

Results

An interview was conducted with a South-Africa based social entrepreneur, researcher and founder of an NGO that works on building communities and fostering resilient cities both in South Africa and across the continent. The interviewee is hereinafter referred to as interviewee No. 6 for reasons of anonymity. The communities that they were working with, many of which are located in informal settlements or ‘townships’, were negatively affected by COVID-19, losing homes and losing livelihoods especially during the strict lockdown (Conversation with interviewee No. 6, 2021). In terms of the local picture, “*the poor communities definitely struggled the most with the COVID*” (Conversation with interviewee No. 6, 2021). Being a highly unequal country, “*the marginalised communities of the township spaces are about 70 percent of South Africa*” (Conversation with interviewee No. 6, 2021).

The interviewee explained that there was a steep learning curve between setting up COVID-19 test centres and rolling out vaccines. In the initial phase of the pandemic, the government set up COVID-19 test centres in stadiums for space and practicality reasons (Conversation with interviewee No. 6, 2021). However, the execution could have gone better: because of the history of Apartheid and the Apartheid urban planning regime which created large buffer spaces between people, poor communities live far from stadiums and had little access to testing facilities (Conversation with interviewee No. 6, 2021). This was one way in which local inequalities became visible: “*if this infrastructure was within the township, then, people would be accessing it easier*” (Conversation with interviewee No. 6, 2021). The interviewee also explained the dilemma that many people faced: inbetween having to make a livelihood and travel far for testing, many chose the livelihood (Conversation with interviewee No. 6, 2021).

In contrast to the testing however, “the vaccination process [has been] much more successful in penetrating poor communities” (Conversation with interviewee No. 6, 2021). There was a much stronger effort to ensure that the minorities living in the townships were reached, for example by placing mobile clinics near transport nodes such as bus stations so that people are able to get vaccinated on their daily commute route, rather than having to travel somewhere extra which could mean losing a day’s wage (Conversation with interviewee No. 6, 2021). Information was circulated in local gazettes and on social media, in order to make it widely available (Conversation with interviewee No. 6, 2021). Vaccination is also free and anonymous (Conversation with interviewee No. 6, 2021). In terms of inequalities widening, the interviewee describes the inequality gap as initially being like a crater before the pandemic began (Conversation with interviewee No. 6, 2021). As the virus commenced, the gap “*exploded and [...] the vaccination process has started narrowing that gap*” (Conversation with interviewee No. 6, 2021).

In terms of the global picture, the interviewee stressed that a main challenge of the North-South relationship is that the funder is the North (Conversation with interviewee No. 6, 2021). This implicates that the North has control over how money is spent (Conversation with interviewee No. 6, 2021). During the pandemic, in South Africa, this has resulted in budgets being tightened and being diverted to projects focusing on COVID-19 purposes (Conversation with interviewee No. 6, 2021). The interviewee mentioned that livelihoods need to feature more prominently in those projects that receive funding if marginalised and poor communities are to be considered. The interviewee also mentioned that the situation in South Africa is also difficult to generalize to other countries on the African continent: because South Africa has the infrastructure to produce vaccines, it had some say in how the vaccine rollout was coordinated; and South Africa also had access to different types of vaccines (Conversation with interviewee No. 6, 2021).

Research answers

In South Africa, at the local level, COVID-19 has (re-)emphasized and exacerbated the stark inequalities that exist within the country (De Groot and Lemanski, 2020). Answering the research question, the pandemic is therefore primarily widening inequalities within the country. However, the government is taking various steps (such as the placing of mobile vaccination units) to ensure that communities of the townships are also able to access vaccines. Referring back to the definition of minorities that was used in this paper, the South African case demonstrates that in some cases, a minority can include a big part of the population. In terms of power imbalances, the interview yielded the insight that within the North-South relationship within which South Africa receives funding for projects, the pandemic has shown that the North has power in deciding how money is spent in times of budget cuts and a strong ‘pandemic focus’ in spending.

The literature review has also highlighted that South Africa will in the future be packaging imported vaccine substances of the Johnson & Johnson and Pfizer-BioNTech vaccines, with the aim of distributing to other countries on the continent (New York Times, 2021; Usman and Ovadia, 2021). However, both in South Africa and on the African continent as a whole, vaccine shortages

remain a problem. As of November 2021, 25% of the South African population is fully vaccinated against COVID-19 (Our World in Data, 2021) and only 7% of the African population is vaccinated (Cheng and Hinnant, 2021). As the recent Omicron outbreak demonstrates, no one is safe until everyone is safe: until everyone is vaccinated, the virus has a higher chance to mutate (Cheng and Hinnant, 2021; UNICEF, 2021).

6 Conclusion

6.1 Findings

From a general review of the literature on politics of vaccination and of the press coverage on our three case studies, we can draw some general preliminary findings on the potential impact of Covid-19 vaccines supply and distribution on the global effort to decolonise development approaches.

First, Covid-19 vaccine distribution has a strong political dimension, rooted in colonial/postcolonial relations between the ‘centre’ (Europe/US) and the ‘margin’ (‘Global South’) (Greenough et al. 2017, Pannu et al., 2021, Think Global Health 2021, Bruegel 2021). Power imbalances have a crucial role in affecting the international patterns of distribution, especially in favour of those countries, which are defined as the “COVID-19 Vaccine Production Club” (Evenett et al. 2021), where pharmaceutical R&D and manufacturing capacity are mostly located. The location of vaccine production supply chains in a concentrated pool of countries gives them the enormous power of shaping the global vaccines distribution structure, by influencing the global flows of key medical ingredients and products (i.e. the Covid-19 vaccines)(Evenett et al. 2021). This also applies to countries, such as India, which is a vaccine producer and distributor for Low- and Middle-income countries (LMICs), to the extent that their supply capacity and distribution strategy can be easily subordinated to the national health interest of prioritising the immunisation of their own population.

Second, the global vaccine distribution mechanism, COVAX, implemented by “global health” international organizations, has not been successful in overcoming pre-existing power structures: as far as the three countries are concerned, COVAX has not resolved the vaccine availability issue and its supply has been insufficient to guarantee the overall access to Covid-19 vaccines. As of September 19 2021, only 281 million of the total amount of vaccine doses manufactured worldwide have been distributed through this facility (UNICEF). Moreover, the World Health Organization-backed programme estimates to deliver 1,4 billion Covid-19 doses to LMICs by the end of 2021, missing its delivery target of 2 billion doses (Stanisljevic 2021, Financial Times 2021). COVAX has been facing an underfunding problem, which is closely related to a lack of political engagement to establish a more equitable global vaccine distribution structure on behalf of donor countries. As stated before, the race of Western countries to secure the vaccine supply for their national populations has limited the impact of the multilateral initiative COVAX because of the shortages

that vaccine production has been facing in light of unprecedented global demand (Singh and Chattu, 2021).

Third, distribution patterns favour countries which have a critical position within international and diplomatic networks, in the broader framework of power competition. Vaccine diplomacy, implemented to strengthen the soft power of main vaccine producer countries, privileges recipient countries crucially located in geopolitically relevant junctures at the intersection of competing spheres of influence, as the case of Serbia clearly demonstrates (Juncos 2021).

Fourth, national production of Covid-19 vaccines could potentially constitute an enabler of easier access to the vaccines and of new development paths. The economic processes by which national production can foster development include the improvement of pharmaceutical infrastructure, the training of human capital and the upgrading of the economic positioning on the vaccines' global value chains. Production deals with producer countries, and the World Trade Organization (WTO) debate on the vaccine-patents waiver, could spread the economic potential of the vaccine manufacturing and technologies in LMICs, while enhancing the availability of Covid-19 vaccines to populations so far completely excluded from global vaccine distribution. However, an important nuance to be considered is that simply locating vaccine production facilities in a country is not necessarily enough to achieve all of the positive outcomes mentioned above that vaccine production can bring with it - as seen in the case of South Africa. There, the production plant is predicted to merely constitute a 'fill-finish' exercise, only placing the vaccine in vials and distributing it but still depending fully on the vaccine to be shipped from Europe. This simply perpetuates dependencies on high-income-country producers and hence inequalities in distribution (Robbins, 2021).

6.2 Policy implications

Our findings from case studies in Serbia, India and South Africa indicate that the current state of vaccine distribution still leaves much room for improvement, especially outside of Europe and the US. The first policy implication, most directly related to the distribution of vaccines, is thus that the distribution to countries outside of the global North needs to be rapidly scaled up. A common denominator in most research on the pandemic is the recognition that no-one is safe until everyone is safe (UNICEF, 2021), and it is important that policy makers transform this recognition into practice. Policy makers should thus actively draw attention to the current problem of vaccine shortages, and push for more distribution to those countries that still have received very little vaccinations to date. A secondary policy implication relating to this point is that policy makers should realize that vaccine inequalities do not only exist between countries but also within countries. Policy makers should thus also make arrangements so that vaccines reach everyone in the population - not only the well-off but also disadvantaged and vulnerable groups. Who these groups are, the specific challenges that they face and how they can be reached varies according to countries and country regions, and policy makers should consider these aspects when developing vaccine distribution plans.

The second policy implication relates to how vaccines are distributed. Scaling up the distribution to other countries is easier if local vaccine production facilities are established. However, as the case of South Africa shows, establishing production facilities alone is not sufficient - ideally, vaccines will be fully manufactured where they are needed (and not only filled into vials there) (Robbins, 2021). Policy makers need to recognize that countries can best take care of their own vaccine distribution when they can manufacture them themselves in a self-sufficient and independent manner. At minimum, countries need to have a say in how vaccines are distributed- and currently this is not the case, with many countries not having a place at the international negotiating table. Policy makers are thus encouraged to support the construction of manufacturing plants in those countries where the vaccines are needed the most. Where it is not possible to manufacture the vaccine, or until vaccine manufacturing facilities can be established, it is important that policies are established that secure a steady supply of vaccines.

A third policy implication of our research is that analyses related to vaccine distribution need to be nuanced and case study specific. Only this way, the myriad of complexities that are related to the country specific impacts of COVID-19 in different localities can be captured. The policy implications stemming from this observation include that policy making related to the corona crisis and to the distribution of COVID-19 vaccines needs to consider the global context (as our analyses show, the case study countries are all situated in complex relations with other global players that include power dynamics, colonial histories, and geopolitical and economic considerations) while also being highly aware of the situation in individual countries (Alaran et al., 2021; Phua, 1989; Pannu et al., 2021; OECD, 2021; Çakmaklı et al., 2021).

Another policy implication is that policy makers rely on research and information from different countries to base their decision making on. An important reflection point includes that while more and more sources about COVID-19 are being published online day by day, the scientific research done is conducted mostly in countries in the global North and there is also a lack of peer reviewed research (Drugs for Neglected Diseases Initiative, 2021). Policy makers should thus call for and support research being done on the impact of the crisis and on vaccine distribution in the case study countries, and other countries in the global South.

A last finding, and arguably the most important one, is that a wide variety of complexities needs to be understood if the research question ‘decolonising development: how is the distribution of COVID-19 vaccines impacting inequalities across the globe’ is to be answered. In particular, this myriad of complexities includes the different power dynamics, different colonial histories, development in practice, and different (geo)political and economic considerations (Alaran et al., 2021; Phua, 1989; Pannu et al., 2021; OECD, 2021; Çakmaklı et al., 2021). The policy implications include that policy makers need to act on their awareness of the strong influence that power relations and power asymmetries, as well as colonial histories and also geopolitical and economic considerations have on the current vaccine distribution patterns that we are seeing. Policy makers are increasingly casting light on the inequalities in vaccine distribution, but the next important step will be to understand these inequalities better, as this is the first step to comprehending how they can be addressed and ultimately overcome.

7 Bibliography

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Policy brief: No one is safe until everyone is safe

Summary

The following policy brief is based on the research paper *Is the pandemic an opportunity to decolonise development, or is it rather widening inequalities and fueling power imbalances? Three perspectives towards sustainable solutions*. The Covid-19 Pandemic demonstrates forcefully that “no-one is safe until everyone is safe” (UNICEF, 2021), because delays in the international vaccine distribution and administration increase the risk of virus mutations to develop. The mandate of the United Nations (UN) to “maintain international peace and security” and to “achieve international co-operation in solving international problems” (UN Charter), is currently more important than ever.

Recommendations

Political strings and diplomacy may not be attached to humanitarian and medical aid.

Today’s distribution patterns favour countries which have a critical position within international and diplomatic networks, in the broader framework of power competition. Vaccine diplomacy, implemented to strengthen the soft power of main vaccine producer countries, privileges recipient countries crucially located in geopolitically relevant junctures at the intersection of competing spheres of influence, as the case of Serbia clearly demonstrates. Not every country has the same political relevance to major powers as Serbia and cannot benefit from the same rent of position. For this reason, the correlation between great powers’ interest in one country and that country’s access to vaccines becomes a source of inequality in the global sphere. In fact, if “bilateral charity” (Harman et al., 2021, para. 5) is more about power dynamics than equity, “any system that solely relies on aid will ultimately fail to achieve equity” (Harman et al., 2021, para. 8).

Administrative barriers must be reduced, especially for minorities.

On a national level, the three case studies in South Africa, Serbia and India demonstrated that the implementation of pandemic response measures and the outcome of the vaccination campaign have the potential to have immens social and economical impacts because of strict measures against COVID-19, hitting minorities the hardest (Sharma, Yount, 2020). Also, the prioritisations in national immunisation plans, as well as imbalances within the health system, were widening existing inequalities (Choudhari, 2020), also due to administrative hurdles like a restricted access to vaccination centers. In order to reach a high vaccination rate in a short period of time, it is necessary to reduce these barriers.

Policy implications

Our findings from case studies in Serbia, India and South Africa indicate that the current state of vaccine distribution still leaves much room for improvement, especially outside of Europe and the US. The first policy implication, most directly related to the distribution of vaccines, is thus that the distribution to countries outside of the global North needs to be rapidly scaled up. A common denominator in most research on the pandemic is the recognition that no-one is safe until everyone is safe (UNICEF, 2021), and it is important that policy makers transform this recognition into practice. Policy makers should thus actively draw attention to the current problem of vaccine shortages, and push for more distribution to those countries that still have received very little vaccinations to date. A secondary policy implication relating to this point is that policy makers should realize that vaccine inequalities do not only exist between countries but also within countries. Policy makers should thus also make arrangements so that vaccines reach everyone in the population - not only the well-off but also disadvantaged and vulnerable groups. Who these groups are, the specific challenges that they face and how they can be reached varies according to countries and country regions, and policy makers should consider these aspects when developing vaccine distribution plans.

The second policy implication relates to how vaccines are distributed. Scaling up the distribution to other countries is easier if local vaccine production facilities are established. However, as the case of South Africa shows, establishing production facilities alone is not sufficient - ideally, vaccines will be fully manufactured where they are needed (and not only filled into vials there) (Robbins, 2021). Policy makers need to recognize that countries can best take care of their own vaccine distribution when they can manufacture them themselves in a self-sufficient and independent manner. At minimum, countries need to have a say in how vaccines are distributed- and currently this is not the case,

with many countries not having a place at the international negotiating table. Policy makers are thus encouraged to support the construction of manufacturing plants in those countries where the vaccines are needed the most. Where it is not possible to manufacture the vaccine, or until vaccine manufacturing facilities can be established, it is important that policies are established that secure a steady supply of vaccines.

A third policy implication of our research is that analyses related to vaccine distribution need to be nuanced and case study specific. Only this way, the myriad of complexities that are related to the country specific impacts of COVID-19 in different localities can be captured. The policy implications stemming from this observation include that policy making related to the corona crisis and to the distribution of COVID-19 vaccines needs to consider the global context (as our analyses show, the case study countries are all situated in complex relations with other global players that include power dynamics, colonial histories, and geopolitical and economic considerations) while also being highly aware of the situation in individual countries (Alaran et al., 2021; Phua, 1989; Pannu et al., 2021; OECD, 2021; Çakmaklı et al., 2021).

Another policy implication is that policy makers rely on research and information from different countries to base their decision making on. An important reflection point includes that while more and more sources about COVID-19 are being published online day by day, the scientific research done is conducted mostly in countries in the global North and there is also a lack of peer reviewed research (Drugs for Neglected Diseases Initiative, 2021). Policy makers should thus call for and support research being done on the impact of the crisis and on vaccine distribution in the case study countries, and other countries in the global South.

A last finding, and arguably the most important one, is that a wide variety of complexities needs to be understood if the research question ‘decolonising development: how is the distribution of COVID-19 vaccines impacting inequalities across the globe’ is to be answered. In particular, this myriad of complexities includes the different power dynamics, different colonial histories, development in practice, and different (geo)political and economic considerations (Alaran et al., 2021; Phua, 1989; Pannu et al., 2021; OECD, 2021; Çakmaklı et al., 2021).

Conclusion

The policy implications include that policy makers need to act on their awareness of the strong influence that power relations and power asymmetries, as well as colonial histories and also geopolitical and economic considerations, have on the current vaccine distribution patterns that we are seeing. Policy makers are increasingly casting light on the inequalities in vaccine distribution, but the next important step will be to understand these inequalities better, as this is the first step to comprehending how they can be addressed and ultimately overcome.