Revista Direito e Praxis

[Unpublished articles]

Distributive Struggles in Global Health: Postcolonial Structures of Domination in Law

Lutas por Distribuição na Saúde Global: Estruturas pós-coloniais de dominação no direito

Andreas Fischer-Lescano[1]

[1] University of Kassel, Kassel, Germany. E-mail: fischer-lescano@uni-kassel.de. ORCID: https://orcid.org/0000-0002-0606-2099.

Article received on 01/19/2025 and accepted on 01/12/2025.

Abstract

Global health, like global law, the global economy or global politics, is a global functional system. The law of this communication system transcends the paradigm of the international. The UN Human Rights Council and especially the UN Committee on the Elimination of Racial Discrimination (CERD) correctly pointed out to the post-colonial legacy and the resulting unequal distribution of health care. However, its understanding of the post-colonial lines of dominance in the sense of a legal succession as juridical continuities is too narrow. The postcolonial question is about critically reflecting on iterations of coloniality. Genealogy and current manifestations of patterns of postcolonial dominance can only be adequately analysed by differentiating between the Global South and the Global North – as fields of forces heterogeneous in themselves – and taking into account the specific vulnerabilities of subalterns.

Keywords: Global Health Law; Postcolonialism; System Theory.

Resumo

Assim como o direito global, a economia global ou a política global, o sistema global de saúde é um sistema funcional global. A lei desse sistema de comunicação transcende o paradigma do internacional. O Conselho de Direitos Humanos da ONU e, especialmente, o Comitê da ONU para a Eliminação da Discriminação Racial (CERD) apontaram corretamente para o legado pós-colonial e a distribuição desigual da assistência médica. Entretanto, sua compreensão das linhas de dominação pós-coloniais como uma sucessão legal de continuidades jurídicas é muito restrita. A questão pós-colonial diz respeito à reflexão crítica sobre as interações da colonialidade. A genealogia e as manifestações atuais dos padrões de dominação pós-colonial só podem ser adequadamente analisadas por meio da diferenciação entre o Sul Global e o Norte Global como campos de forças heterogêneos em si mesmos, considerando-se as vulnerabilidades específicas dos subalternos.

Palavras-chave: Direito Global da Saúde; Pós-colonialismo; Teoria dos Sistemas.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

Today, the right to equal health for all
is caught in a mechanism
which turns it into
inequality.
(Michel Foucault
2004: 18)

Issues of distribution arise in the context of scarcity – with scarcity here not referring to the finite nature of numerous prerequisites for a healthy life, such as water, resources or land. It is true that such finiteness is typically perceived as situations of potential shortages, but in contrast to general finiteness, scarcity is only ever relevant when it comes to specific decisions over distribution in an economic sense, whether in the form of "*original*" distributions that enable political-economic access or in the form of redistributions.[1] It is only by way of such distribution decisions that the totality of basically finite quantities is divided into scarce and non-scarce goods (LUHMANN, 2020: 190).

Seen in this light, the health system lacks many things, but there is no lack of scarcity. This scarcity can be depicted graphically through dashboards, for example, by correlating the (limited) number of ICU beds with the incidence of COVID infections – an omnipresent image during the peak phases of the pandemic. But we can also experience scarcity in everyday life, for example, when seeking help in underequipped healthcare institutions. Such situations offer a first-hand experience that the notorious *invisible hand* is not always particularly successful in optimizing markets through aligning the interests of individual benefit and collective supply. "*Can the invisible hand wring our necks, so to speak?*", Niklas Luhmann asked his baffled discussion partner *Friedrich August von Hayek* at the 1982 Salzburg Pfingstsymposium,[2] thus getting right to the heart of the problem.

Staying with the image of a potentially lethal *invisible hand* and turning our attention to "*distribution issues in the world health system*" as part of our overarching topic "*colonial continuities in international law*", we may now suspect that in situations of scarce goods the lethal effects of this invisible hand do not affect everyone in the same way – but that there are certain patterns. These patterns, so the suspicion, become particularly obvious in handling the COVID-19 pandemic. "*Vaccine apartheid*" is a catchword often used in this

[1] On the contributions of law, see KENNEDY, 2021.
[2] The discussion round is documented in RIEDL; KREUZER, 1983: 239.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

respect; it has also been adopted by the WHO Director General in May 2021.[3] This accusation highlights segregation, criticizing that the right to health with its dimensions of availability, accessibility, acceptability and quality of health facilities, goods and services[4] is being put into practice in an extremely unequal manner around the globe – with the effect that universal health coverage, as stipulated in the UN's Sustainable Development Goals (target 3.8),[5] is currently far from reality. Quite the contrary: the distribution patterns of COVID-19 victims and vaccinations reveal some conspicuous clusters, particularly in terms of vaccine access, attesting to exclusion along historically evolved lines of dominance.

Indications as to what lines of dominance are involved in this exclusion can be found in statements from the UN human rights system,[6] for example, in a 2021 resolution by the UNHRC:

> Recognizing with concern that the legacies of colonialism, in all their manifestations, such as economic exploitation, inequality within and among States, systemic racism, violations of indigenous peoples' rights, contemporary forms of slavery and damage to cultural heritage, have a negative impact on the effective enjoyment of all human rights.[7]

And in a statement issued in 2022, the UN CERD also makes reference to colonialism, noting that the vast majority of COVID-19 vaccines had been administered in high- and middle-income countries. The committee explicitly states being

> … *deeply concerned* that the pattern of unequal distribution of lifesaving vaccines and COVID-19 technologies between and within countries manifests as a global system privileging those former colonial powers to the detriment of formerly colonized states and descendants of enslaved groups.[8]

[3] The term has since appeared in various statements, see e.g. ACHIUME, 2022; ALVAREZ, 2022: 57.
[4] CESCR. General Comment No. 14. "Substantive issues arising in the implementation of the International Covenant on economic, social and cultural rights". 11 August 2000. E/C.12/2000/4, para. 12.
[5] UNITED NATIONS, General Assembly Resolution 70/1 of 25 September 2015, A/RES/70/1.
[6] See, in particular MOFOKENG, 2021: para. 11.
[7] HUMAN RIGHTS COUNCIL. "Resolution: Negative Impacts of the Legacies of Colonialism on the Enjoyment of Human Rights". United Nations, Geneva. 8 October 2021, A/HRC/RES/48/7, p. 2; this resolution makes explicit reference to the Durban Declaration (World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance, 2002).
[8] CERD. "Statement on the Lack of Equitable and Non-Discriminatory Access to COVID-19 Vaccines". 106th meeting of 11–29 April 2022, meeting of 25 April 2022. Committee on the Elimination of Racial Discrimination; see also CERD. General Recommendation No. 34. "Racial Discrimination Against People of African Descent", 3 October 2011, CERD/C/GC/34, para. 17; CERD. General Recommendation No. 23. "On the Rights of Indigenous Peoples", 1997, Committee on the Elimination of Racial Discrimination, para. 3; CERD. "Concluding Observations to the State Report of the USA", September 2022, CERD/C/USA/CO/10-12, 21. Committee on the Elimination of Racial Discrimination, para. 55.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

This article asks whether this concern is justified, in other words, whether the pattern identified by the CERD applies in this form and if so, how we can respond to possible postcolonial lines of dominance in law. To do so, I will first briefly introduce the relevant systems and their respective postcolonial critique (I). Bearing the issue of postcolonialism in mind, I will then analyse distributional constellations in the global health system during the COVID-19 pandemic, focusing on distribution decisions made by the WHO, the COVAX initiative and the WTO (II). And finally, I will outline selected ways how law might respond to this inequality in distribution (III).

I. Law in the Global Health System

Let us first turn to the "Global Health System". But given the fragmentation and the obviously existing inequalities in healthcare, can we even speak of a "system"?

1. The System of Global Health

A widely-held view defines the global health system via the actors involved in the health sector. According to this definition, the relevant actors not only include state parties but also philantrocapitalists and doctors (HOFFMAN; COLE, 2018). This view is based on a rather naive understanding of "system" conceptualized as an assemblage of people.

By contrast, an understanding informed by systems theory – which I will use in this article – does not conceive of the global health system and other functional systems of society, such as global law, global politics or the global economy, as a group of people but as a specific chain of communication. Tasked with providing healthcare, the world health system is an autopoietic communication system of global society, which has created its own specific code (sick/healthy), its own guiding concept (disease) and its own formal constraints (diagnoses, medical findings) (LUHMANN, 1990). Autopoiesis means that the health system applies and governs its guiding concept according to its own criteria and through its own procedures. However, there certainly are interferences and structural couplings with other global functional systems – in particular with those of science, law and the economy but, of course, also with politics.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

The latter system is by no means limited to state or national institutions. The issues to be addressed – global transmissions of diseases in pandemic situations, global environmental depletion as a health problem etc. – regularly take dimensions that render dysfunctional any retreating to the supposed primary realm of national politics. This is why complex global health organizations and policies have evolved since the days of nineteenth-century tropical medicine – when, for instance, Robert Koch made use of the medical "experimental space" offered by the colonies.[9] Political-science publications on this subject now list a vast a number of organizations and programmes as being part of the global health complex: apart from the WHO, founded in 1948, they list the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Bank, the WTO, the Council for International Organizations of Medical Sciences (CIOMS) and the United Nations Population Fund (UNFPA), among others (PANTZERHIELM; HOLZSCHEITER; BAHR, 2020: 397).

2. Global Health Law

The large number of organizations involved already indicates that the law dealing with this global health system is equally differentiated. Even the terminology is disputed: is the appropriate concept that of *international* health law or that of *global* health law (GROSS, 2021: 754 et seqq.)? One fact speaking in favour of the latter is that the dualism of international and national law in public law – on which the concept of *international* health law is based – has long ceased to exist (GOSTIN, 2014: 59 et seqq.). To put it in more abstract terms: if we were to link the classification under public law with any kind of (modified) subject theory, only the measures and omissions by states and international organizations would come into the focus of international law. This understanding does not adequately acknowledge the hybrid structure of the global health system and hinders the development of appropriate legal responses to the challenges at hand.

[9] On the colonial "laboratories" of medicine, see TILLEY, 2011.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

a) Networks

To illustrate this by way of an example: the COVAX initiative, a public-private partnership (PPP) founded in 2020 as a purchasing pool for COVID-19 vaccines, is organized as a network. Key actors are the WHO, the GAVI Vaccine Alliance (a foundation under Swiss law) and the Coalition for Epidemic Preparedness Innovation (CEPI). The failure of the COVAX initiative in terms of equitable vaccine distribution will be discussed later; the question here is whether this initiative is grasped more adequately through the paradigmatic lens of international or of global health law. To answer this question, those favouring the internationality paradigm – that is, the proponents of international health law – offer two pointed approaches that stand in what we might call a dialectic relationship, making their respective blind spots mutually visible. The *first approach* categorically ignores the fact that COVAX is a public power as GAVI cannot be grasped in the categories of international legal subjectivity (VON BODGANDY; VILLARREAL, 2021). The *second approach* seeks to avoid regulatory gaps in international law by measuring the COVAX initiative against the standards applied in justifying public authority, categorising this form of delegating healthcare provision to private actors as a violation of the state's duty to protect (VON ACHENBACH, 2023). Both approaches, however, share a gaze narrowed on state action and thus fail to capture the complex constellations created by hybrid networks.

It would therefore be more expedient to detach the legal analysis of hybrid constellations in the transnational sphere from the narrow focus on state actors and the paradigm of *inter*-nationality. This is precisely what the systems theory of networks achieves: focusing on hybrid, network-like phenomena, it overcomes the dualism of public vs. private as well as the dichotomy of organization and contract (PEREZ, 2022). This perspective on the network's structure reveals the specific network obligations emerging from the hybrid character of the COVAX initiative – which needs to be taken into account in developing a legal framework that builds on the form of action and the associated expansive potential. Legal obligations thus do not arise from any kind of subjectivity, but the legal subjects are bundled arrangements of rights and obligations that depend on the respective form of action (TEUBNER, 2008: 842).

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

b) Regimes

But what is now the substance of global health law? Here, too, opinions differ, even though all sides will certainly agree that this area of law is a fragmented one. It includes regulations created in the context of the WHO, especially the 2015 International Health Regulations (IHR), and the human rights as referred to in the WHO's constitution. In addition, global health law encompasses law from numerous other contexts and areas, including United Nations law, international humanitarian law and international trade, property and investment law. But global health law also includes norms of global animal law and global environmental law; this is in line with the *One-Health* approach, which assumes the solidarity of all living beings and a holistic understanding of health (i.e. it also protects ecological and animal lives in their interactions with human life by way of affording them subjective rights of their own) (PRATA et al., 2022; PETERS, 2021: 92).

3. Postcolonial Critique

Global health law, fragmented and marked by hybrid regulatory arrangements, has developed from international health law, rooted, among others and in particular, in colonial tropical medicine. Despite its appearance as being modern, hybrid and differentiated, this global health law is permeated by historical lines of dominance still today – thus reads the bottom line of postcolonial critique. And while having "*attempted to rebrand itself away from the colonial legacies of international health and tropical medicine and weave contemporary narratives of health improvement and equity*" (ALOUDAT, 2022: 4), global health law inevitably remains entangled in this postcolonial history.

a) Postcolonial Studies

But what does this entanglement look like? The answer will depend on how we actually define the postcolonial question – and also distinguish it from decolonial, neocolonial, imperial and colonial issues.[10] *Postcolonial studies* that focus on *entangled histories* in describing constellations of postcoloniality are probably the most plausible

[10] On the basic assumptions, see DO MAR CASTRO VARELA; DHAWAN, 2015: 15.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

approach among the multitude of interpretations on offer (RANDERIA, 2002). Building on the hierarchical basic difference of civilized vs. uncivilized, colonial lines of dominance take shape and span across epochs and states and have an impact still today, albeit in partially altered ways. The prefix "post" in *postcolonial studies* indicates that these patterns have never disappeared (hence are no "*neo*-colonialism") but are effective to this day (QUIJANO, 2000), particularly when functional systems' destructive tendencies to maximize their inherent rationality in the substantive dimension meet with asymmetrical power positions in the social dimension that are permeated by postcolonialism. Postcolonialism here means that while colonialism is history, it shapes not only the past but also the present – and does so not only in the former colonies but also in the countries of the Global North.

The introduction of German patent law, for example, not only intended to unify legislation within the German Empire but also to improve the country's international economic standing in the era of colonialism (HEGGEN, 1975: 99 et seqq.). It is thus no coincidence that the first patent registered with the Imperial Patent Office in 1877 was for a process for "*the production of red ultramarine colour*" – ultramarine because the raw materials needed for this production process came from *ultra maris*, that is, from overseas. Patent law, including that of the other European metropolises, has had colonial affiliations from its very beginnings, and has so to this day.[11]

Postcolonial studies aim at uncovering the persistence of postcolonial lines of dominance to enable their overcoming. The focus is not solely on law; it is about epistemically identifying the traces of complicity with colonial power structures (SPIVAK, 1999) in philosophy as well as in other spheres of society, for example, in medicine where the "postcolonial" persists to this day – in racist theories on pain perception, in attitudes held by medical staff or in exploiting vulnerable individuals for clinical tests by pharmaceutical companies (FLEAR, 2014; WASHINGTON, 2008: 25 et seqq.; MENDE-SIEDLECKI et al., 2021; MONNAIS, 2019: 116; GREEN et al., 2013; AGORO, 2020).

The aim of this critique is to sensitize for the postcolonial, for alterity and subalternity (SPIVAK, 2004: 526) in order to mitigate the asymmetry in relationships with the subaltern, that is, the *subjected Others* (SPIVAK, 1988). In a political perspective, these approaches seek to disrupt postcolonial hierarchies; in an epistemological perspective, they

[11] On the connections between colonialism and the establishing of patent law in the 19th century, see GALVEZ-BEHAR, 2020.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

are about new forms of knowledge, also with regard to international law. The terminology and concepts of the latter have been developed in contact with the colonised Others in the context of their oppression – and thus need to be scrutinized for still persisting lines of dominance, inclusion and exclusion.

An approach of this kind calls into question the narrative of Western civilization of promoting global processes of rationalization (ALLEN, 2017: 16 et seqq.). *Postcolonial studies* hence expose the "civilizational progress" as a recurring pattern of a postcolonial exercise of power. This affects all areas and aspects of international law: the *concept of the state* – European and excluding; the *concept of law* – developed from a colonial concept of the state; the *concept of human rights* – linked to European subject philosophy and liberalism.[12] The ensembles of norms are thus shaped and pervaded by colonialism. This also applies to the global health system. Creating "health subalternity", it is "*the manifestation of this coloniality for many peoples whose opportunity for better health, and hence a possible future, is foreclosed by the very discourse that claims to provide them with health.*" (ALOUDAT, 2022: 10).

b) Iterations and Genealogies

This postcolonial critique has been a marginal voice in global health law so far (GROSS, 2021: 769). And this is why the UN CERD is now making an important start by introducing the critique of colonialism into global health law. But does the criticism really get to the point? Is the core problem really that of a "*global system privileging those former colonial powers to the detriment of formerly colonized states and descendants of enslaved groups*" (CERD, 2022a: 2)? At any rate, the wording is strikingly state-centred and reveals a peculiar juridism. Postcolonialism in law is conceptualized as a matter of legal succession by contrasting the privileged side of the former colonial powers with two disadvantaged groups: formerly colonized states and the descendants of enslaved groups. This is a fateful reductionism, which is based on a juridically narrowed concept of history that understands postcoloniality as the legal succession into privileged or underprivileged legal positions, thereby failing to acknowledge that the historical beginnings, ends and causalities of this legal succession are themselves infested with postcolonialism.

[12] See e.g. SAMSON, 2020: 161 et seqq.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

Even the categorial distinction into *former colonial powers* and *formerly colonized states*, as made by the CERD, is inappropriate in this respect. The postcolonial world is more than this dualism; it also encompasses a large number of states that participated in and benefited from colonial exploitation without ever having had colonies of their own. Switzerland, for example, is no "former colonial power" but was nonetheless historically involved in the transatlantic slave trade. Rather than using a simple cartography of former colonial powers, postcolonial studies identify fields of power in describing the matrix of postcolonial dominance (OSTERHAMMEL; JANSEN, 2021: 22). These fields of power are marked as antagonistic pairs: First/Third World or Global North/South – not to be understood in the sense of geographical positioning but as pointing to entangled power relations (PAHUJA, 2011: 261; GONÇALVES, 2021).

Turning to how the CERD defines dominated and underprivileged populations, we find an equally inadequate description. The phrase "*formerly colonized states*" merely reproduces postcolonial patterns in applying the Eurocentric concept of the state to constellations that are neither historically nor currently represented by this terminology. The *Herero and Nama*, for example, were organized and significant collective actors (and as such capable of concluding contractual agreements), but they have never been a state and thus are no "formerly colonized state" today. This is why *postcolonial studies* use collective formulas – such as "Global South" or "Third World" – to describe dominated populations rather than focusing on the status of former colony (CHIMNI, 2006: 5 et seq.).

And finally, the CERD's reference to "descendants of enslaved groups" is equally imprecise in capturing the actual constellation. This is because the term "enslaved" only addresses a very specific form of colonial violence, which, at best, only partially reflects the injustice and wrongfulness of oppression, especially with regard to the so-called "protectorates". The UN HRC's 2021 resolution quoted above is far more precise in this respect: it specifies the emanations of colonialism – economic exploitation, inequality within and among states, systemic racism, violation of indigenous peoples' rights, contemporary forms of slavery and damage to cultural heritage (HUMAN RIGHTS COUNCIL, 2021) – without linking them to any concept of descendancy.

In this sense, "colonial continuity" is a placeholder standing for *iterations*[13] of coloniality in constellations of *subjected alterity*. The lines of exclusion and subordination in

[13] On the term "iteration", see DERRIDA, 1982: 307 et seqq.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

historical colonialism are no linear continuum but subject to change as they are modified and recalibrated according to context. The *genealogy* of postcolonial dominance in global society must include a comprehensive reconstruction of the complexes of power and knowledge involved in a given constellation.[14] Only such an approach can open new avenues for understanding the multiple constellations of postcoloniality that manifest, in particular, in the difference between Global South and Global North as well as in racist and/or intersectional practices of discrimination.[15] Postcolonial lines of dominance affect subaltern individuals and groups not only in the Global South but around the globe. Forms of postcolonial subalternity can also be traced in the Global North.

II. Distribution Issues

If these vulnerabilities and fields of power shape the patterns of how postcolonial dominance impacts global society, this leads us to the next question: Is this dominance evident in specific constellations of distribution related to the COVID-19 pandemic? Here we need to differentiate between distribution outcomes and processes.

1. Distribution Outcomes

Let us begin with the outcomes. Access to healthcare is marked by extreme inequalities. The world's 20 richest countries, most of them located in the Global North, account for 90 percent of global spending on health but only for 20 percent of the global population. While annual per-capita health expenditures exceed 10,000 USD in the United States and 5,000 in Germany, only 30 USD per person are spent in many African countries.[16]

According to the Sustainable Development Goals Report 2021, the resulting extreme inequality in healthcare provision has been exacerbated by the COVID-19 pandemic to such an extent that achieving the goal of universal health coverage, as laid out in SDG 3.8, is now way out of reach.[17] A report by the World Bank and WHO states that one third of the

[14] From the large number of publications on this issue, see in particular FOUCAULT, 1977: 139.
[15] On the term "intersectionality", see CRENSHAW, 1991: 1244; CARLEY, 2022: 83.
[16] See <https://de.theglobaleconomy.com>
[17] UNITED NATIONS. "Sustainable Development Goals". Report 2021. New York: United Nations, 2021, p. 30.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

global population – more than 2.5 billion people – currently have no adequate access to basic healthcare (WORLD BANK/WHO, 2021: V). Looking at the measures taken to combat the coronavirus pandemic, we also find significant differences between the Global North and the Global South (SEKALALA et al., 2021: 5). While in Germany the rate of those who had received their first immunization stood at 77.8 percent in 2023, only 23.5 of the Namibian population had their initial shot. In Switzerland, 69.7 percent of the population had received their first vaccination, compared to 11.3 percent in Senegal. And in terms of full vaccinations, African countries, in particular, fall far from the global average rate of 66 percent (THE NEW YORK TIMES, 2023). The distribution figures also reflect intersectional forms of discrimination. In the United States, for example, the death rate among non-whites was consistently higher than among whites, especially during the peak phases of the pandemic, which is also due to the fact that non-white populations in the US are more likely to be affected by poverty and/or unemployment and thus often lack adequate health insurance (CDC, 2022; YAYA et al., 2020; WHYTE; KNOX, 2023).

The overall picture is clear: The discrepancies in terms of access to vaccines are dramatic in scale. Immunization rates in the Global South are drastically lower than in the Global North. And we find constellations of subalternity – also in the Global North – with people in vulnerable life contexts having only limited access to healthcare. For many countries in the Global South, on the other hand, the COVID-19 pandemic was just one health emergency on top of many others, which exacerbated the already existing health crises related to measles, malaria, HIV etc.

2. Distribution Processes

These distribution outcomes are the combined effect of many interacting distribution decisions in different regulatory contexts. Three of these contexts – the WHO, the COVAX initiative and the WTO – shall now be outlined as examples, including their respective postcolonial critique.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

a) The WHO

Being the key organization in global healthcare, the WHO has been involved in handling the coronavirus crisis from the very onset. Its actions met harsh criticism, especially from the United States. In May 2020, the Trump administration suspended US contributions to the WHO, justifying this decision by accusing the organization of "repeated missteps"[18] – on closer inspection, however, these allegations proved unjustified in their severity. What this challenging of the WHO is actually about can be considered a paradigmatic example of *Jürgen Habermas*' observation that right-wing populists are pursuing projects of "*falsely turning social issues into national issues*" in order to address them in a way that is inappropriate but helps mobilize their clientele (HABERMAS, 2013: 70). In fact and contrary to what critics from the US have claimed, the WHO has made use of its crisis intervention tools early on – the fact that these intervention options are limited cannot be attributed to the WHO but to its member states. The WHO simply lacks the resources to shape global health policy in an inclusive and solidarity-based manner. The three most striking problems in this respect:

Firstly, the WHO lacks the necessary economic resources.

In economic terms, the WHO is part of an underfunded sector of society. In its first statement on the coronavirus pandemic in April 2020, the UN CESCR rightly criticized that "*healthcare systems and programmes have been weakened by decades of underinvestment in public health services and other social programmes*".[19] In 2020, investment in the global health system stood at 29 billion USD,[20] compared to global military spending exceeding 2 trillion USD for the first time in 2021 (SIPRI, 2022). And while public healthcare is dramatically underfunded, the pharmaceutical industry sees unprecedented capital growth. According to calculations by the Dutch NGO SOMO, the 27 largest pharmaceutical companies distributed

[18] Donald Trump's letter to Tedros Adhanom Ghebreyesus of 18 May 2020 is documented on <https://trumpwhitehouse.archives.gov/wp-content/uploads/2020/05/Tedros-Letter.pdf>.
[19] CESCR. Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural Rights. E/C.12/2020/1, 17 April 2020, para. 4. Available at: <https://digitallibrary.un.org/record/3856957>; see also SPARKE; WILLIAMS, 2022; QUINTANA; URIBURU, 2020.
[20] See figures on <https://donortracker.org/topics/globalhealth>.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

more than 1.5 trillion USD (profits plus sales of shares) between 2018 and 2020 alone (FERNANDEZ; KLINGE, 2020: 5).

Altogether, these imbalances significantly hamper access to healthcare in the Global South and for subaltern groups and individuals. The WHO lacks the resources that it would need to fulfil its mandate in the health sector in a robust manner and through which it could help balance the unequal capacities of national health systems. The organization is financed by mandatory contributions from member states and voluntary, programme-specific contributions from states and private actors, with the latter currently outweighing the former by factor five (5 billion USD versus ca. 1 billion USD). This means that the WHO can fund only about 16 percent of its key operations through mandatory contributions.[21] A financial reform adopted in May 2022 was intended to increase this share to 50 percent by 2023[22] – still far from being enough to liberate the WHO from its dependence on voluntary payments. The establishing of the WHO Foundation cannot offer a sufficient equivalent for a major financial reform of the WHO.[23] The situation will ultimately remain the same as described by *Nitsan Chorev* back in 2012: "*The shift from mandatory contributions, which were decided by the World Health Assembly, to voluntary contributions meant that the director-general and developing countries lost their influence over the amount of funds and over how these funds were to be spent.*" (CHOREV, 2012: 231).

Secondly, the WHO lacks the political means for change.

The WHO constitution does not include sufficiently robust procedures to compensate for the organization's financial vulnerability (BENVENISTI, 2020: 595). But without the necessary and long-term financial resources at its disposal, an organization all too easily becomes a pawn in the game of global politics and power relations – which is then more or less directly reflected in staffing and agenda setting.

There also is a postcolonial dimension to this. Critical voices from the Global South particularly complain about the WHO's staff and focus of activity being dominated by the Global North (BUYUM et al., 2020). In the same vein, the 2019 annual report by the WHO

[21] An itemised WHO budget can be found on <https://www.who.int/about/accountability/budget>.
[22] See WORLD HEALTH ASSEMBLY. WHA-endorsed report by the Working Group on Sustainable Financing. A75/9, 13 May 2022. Available at: <https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_9-en.pdf>.
[23] For a critique, see AUST; FEIHLE, 2022.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

Director-General draws attention to the fact that the Emergency Committee – under Article 12 IHR to be consulted prior to declaring a "*public health emergency of international concern (PHEIC)*" – lacked diversity as the body was dominated by members from the Global North.[24] Postcolonial critics call for more far-reaching forms of decentralization by more broadly involving local communities, NGOs and patients through more inclusive multi-stakeholder processes (CAMPOS-RUDINSKY; CANALES, 2022).

The bias in favour of the Global North is also reflected in the WHO's agenda and approaches. Here, postcolonial critics accuse the WHO of focusing too much on communicable diseases while neglecting non-communicable diseases, which "*replicates the colonial concern with disease spreading from the Global South to the Global North*" and fails to recognize the dangers posed by non-communicable diseases especially to people in the Global South (GROSS, 2021: 768).[25] One may claim that with the WHO Pandemic Agreement, adopted by the 78th Word Health Assembly at May 20th 2025, and the revised IHR, adopted by the 77th World Health Assembly,[26] the WHO is more closely aligning with the principle of equality in pandemic sitiations. Both projects, however, have met criticism for their priority on pandemic containment, attributed to a postcolonial reading of the COVID-19 pandemic and agenda-setting by the Global North.[27] Critics focus, for example, on Article 1 of the revised IHR which defines situations of "pandemic emergency" using the criterion of "*substantial social and/or economic disruption*", that this critizesed of being of narrow scope and with its economic focus "*oriented to the interests of high-income countries and exclude health emergencies such as localised epidemics of Ebola virus disease, Marburg virus disease, or mpox, or pandemics that do not overwhelm health systems but disproportionately affect vulnerable populations.*" (PHELAN, 2023).

[24] WORLD HEALTH ORGANIZATION. Annual Report on the Implementation of the International Health Regulations (2005). 4 April 2019. Document A72/, para. 26.
[25] With further references.
[26] The revised IHR (WOLRD HEALTH ASSEMBLY. "International Health Regulations (2005)". 1 June 2024. A77/A/CONF./14; available at: <https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_ACONF14-en.pdf>) were adopted by the World Health Assembly following Articles 21(a) and 22 of the Constitution of WHO which confers upon the World Health Assembly the authority to adopt regulations "designed to prevent the international spread of disease" which, after adoption by the Health Assembly, enter into force for all WHO Member States that do not affirmatively opt out of them within a specified time period. The "WHO Pandemic Agreement" was adopted at May 20th, 2025, in accordance with Article 19 of the Constitution of the World Health Organization, which provides that "[t]he Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes" (WOLRD HEALTH ASSEMBLY. „Pandemic Agreement". 20th May 2025. A78/10; available at: <https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_10-en.pdf>).
[27] In more detail see WHITE, 2023: 128 et seqq.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

In light of these developments, critics speak of a "*covidization*" of health law since the one-dimensional focus on pandemic risks neglects the fact that health policy can only be sustainable if we devote more attention to the social determinants of disease (e.g. poverty) and the growing burden of non-communicable diseases, now becoming the most common causes of death in countries of the Global South. Another factor that has not been given due attention so far are health risks resulting from climate change (PAI, 2020: 1159).

Thirdly and finally, the WHO is also underequipped in legal terms.

This relates, *on the one hand*, to the lack of enforceability of hard law, as illustrated by the example of the "Public Health Response" requirements. Article 13 IHR stipulates that until 2012 "*each State Party shall develop, strengthen and maintain […] the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern*" (the capacities to develop are then described in detail in Annex 1). By 2014, however, this legal obligation had been fulfilled by only 64 states. *On the other hand*, the WHO operates to a large extent via non-formal regulations in networks with private institutions (SEKALALA, 2018: 216). This network structure, however, is inherently problematic as the involvement of private actors creates dependencies, and the "*operation through foundations and public-private partnerships based mostly in the Global North is often viewed as replicating North-South power relationships*." (GROSS, 2021: 769).[28] The unresolved question of how private parties can be integrated into systems of responsibility under international law becomes particularly pressing in this respect.

To illustrate this by way of an example: In 1992, the WHO, World Bank and others initiated the database project *Global Burden of Disease* (GBD) to record deaths, diseases, disabilities and risk factors broken down by regions and population groups.[29] The GBD study database – to which Bill Gates refers as his "*favorite website*" (GATES, 2022: 22) – offers comparative data to inform global health governance and is thus a manifestation of a governance technique that Michel Foucault once described as a "*dispositif of security*" in his analysis of smallpox vaccination (FOUCAULT, 2009: 10):[30] healthcare institutions collect data,

[28] And see also ABIMBOLA; PAI, 2020.
[29] The results of the study can be retrieved from <https://www.healthdata.org>.
[30] Foucault describes this "dispositif" on the example of "epidemics and the medical campaigns that try to halt epidemic or endemic phenomena".

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

create distribution curves, correlate variables and ultimately compile statistical values on normalities, which then serve as normative points of reference. This is exactly how the GBD study informs and governs health policies; it now has become one of the key benchmarks for global health financing as its data guide decisions over investments. The study was initially carried out under the responsibility of the WHO and the World Bank until, in 2007, the Institute for Health Metrics and Evaluation (IHME) was founded with the help of a 105-million-dollar donation from the Bill & Melinda Gates Foundation. Collaboration between the WHO and the IHME has since been regulated through memorandums of understanding (MoU). According to the MoU of 22 May 2018, the IHME acts as the coordinating centre of the collaborative project, which has more than 3,000 contributors worldwide.[31] The project is led by a network of actors over whom public institutions have no final responsibility. Here, too, governance takes place through data collection: with the GBD project and the related financial flows, private actors (IHME) can decisively influence global health policy even inside international organizations (WHO) because the study serves as a basis for distribution decisions despite being beyond control by public institutions. This form of transnational public power is already having a massive impact on the protection of fundamental rights[32] and underlines once again that focusing solely on international forms of public power is dysfunctional – as the GBD project has been transferred to the IHME, such a focus would imply losing sight of the study precisely when the need for regulation becomes most urgent.[33]

b) The COVAX Initiative

As we have seen, the WHO does not provide sufficient economic, political and legal safeguards for distribution processes based on the principle of non-discriminatory access to healthcare. This is why the organization joined the COVAX initiative to combat the coronavirus pandemic. COVAX stands for *COVID-19 Vaccines Global Access*; the basic idea behind the initiative was that all countries in the world purchase their vaccines via a joint

[31] Most recent MoU between WHO IHME of 22 May 2018, 9, <https://www.healthdata.org>.
[32] The warning against a "securitization" of the WHO is thus justified, which is why the constitutional control and human rights limitations of the WHO must be further expanded as part of the constitutionalization of the health sector. However, criticizing the WHO's involvement in these processes e.g. in BEHRENDT; MÜLLER, 2021.
fails to recognize that containing the proliferation of current network-like regulation practices will be hardly feasible without an institutional link with public organizations such as the WHO.
[33] On the desiderata regarding the human rights obligations of non-governmental networks in this field, see LEVINE, 2015.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

fund, thereby enabling equitable access and distribution. The initiative has, however, failed to achieve this goal, just as it failed to achieve any of the intermediate goals it had set since 2020. Since the distribution mechanism was not established as an exclusive purchasing channel but as one option among others, it did not prevent countries in the Global North from concluding bilateral agreements with pharmaceutical companies.[34] Moreover, the initiative's decision-making structures, too, were shaped by the postcolonial distinction between Global North and Global South (COVAX, 2022). While the self-financing participant (SFP) countries from the Global North were represented in the COVAX Shareholders Council and thus involved in strategic decision-making (COVAX, 2022: 20) the AMC countries of the Global South were only part of the COVAX Advance Market Commitment Engagement Group (hence AMC countries), a separate consultation body dealing solely with operative issues concerning the application of distributed vaccines – a body that also included donors (COVAX, 2022: 20).

By assigning countries of the Global South the status of AMC states with structurally inadequate participation opportunities, the COVAX network has been stabilizing postcolonial structures rather than redressing economic negotiation imbalances in the global race for vaccines (PAPAMICHAIL, 2023: 1685). Yet, "*human rights require equality in access to vaccines rather than the limited and ineffective charity currently made available in a glacial manner through initiatives like COVAX*." (SEKALALA et al., 2021: 7).

c) The WTO

One way of meeting this human rights requirement would have been to organize not only the distribution of the available quantities of vaccines in a more equitable manner but to reorganize their production – that is, to reconsider those legal and economic policy decisions that govern the scarcity of goods like vaccines and knowledge (PINHEIRO ASTONE, 2023). This is where the WTO comes into play: a key obstacle to increasing vaccine production are property rights (i.e. patents on vaccines) granting exclusive usage rights, with the effect of creating systemic scarcity in the production of goods. These rights are allocated on the basis of distribution decisions that are not about optimizing the distribution of already existing vaccine doses but about their production: global patent law, which builds on the

[34] For more detail, see BÄUMLER; SARNO, 2022: 186.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

WTO's TRIPS agreement, protects patents on pharmaceuticals (including vaccines). After the Doha compromise of 2001, the agreement has been expanded in certain areas, particularly with regard to compulsory licensing as regulated in Article 31 TRIPS – however, the entire system still is too expensive, time-consuming and legally risky, especially in export settings.[35] In all the years since the introduction of the new regulations in Article 31*bis* TRIPS, there has only been one case of an export-related compulsory licence, and it took a full three years to be issued.[36]

The other instruments to provide for restrictions under the TRIPS Agreement have also not been utilized to this date. Some twenty years ago, Brazil and other countries of the Global South launched an initiative aimed at enabling the production and export of generic drugs in emergency situations via an exemption in Article 30 TRIPS.[37] This reading of Article 30 was, however, vehemently opposed by the United States at the time[38], with countries of the Global North in general not sharing the view taken by the Global South (FEICHTNER, 2009: 626). Article 73 TRIPS, too, has not been activated so far due to legal uncertainties with regard to the *lex specialis* (ABBOTT, 2020).

This is the background as to why, in October 2020, India and South Africa proposed a waiver to temporarily suspend the protection of COVID-19-related intellectual property and thus enable countries in the Global South to develop solidarity-based forms of cross-border drug distribution by facilitating the export of medical products under compulsory licensing (MERCURIO, 2022). But countries of the Global North, including Germany, showed little willingness to accept a weakening of patent protection. When numerous human rights committees (including the CERD in its statement of April 2022 (CERD, 2022a)) demanded that the waiver be concluded, the danger of a paralyzing collision of regimes was imminent. Statements and recommendations by human rights bodies and the demands raised by the WHO seemed incompatible with decisions at the WTO.[39] Against this backdrop, the 12th WTO Ministerial Conference (MC12) in June 2022 adopted a declaration based on Article IX

[35] On the procedures and counter-strategies with regard to TRIPS flexibilities, see KAPCZYNSKI, 2009: 1636.
[36] This was about an HIV drug by the company Apex; for more detail, see SEKALALA, 2010. During the COVID-19 pandemic, Bolivia initiated proceedings for compulsory licensing, but ultimately without success (see AOUN et al., 2023: 35 et seq.). See also MEDICINES LAW & POLICY, n.d.
[37] WORLD TRADE ORGANIZATION. BRAZIL. Statement of 21 June 2002. IP/C/W/355, 24 June 2002. Available at: <https://www.wto.org>.
[38] UNITED STATES. Statement during the Minutes of the Meeting of the TRIPS Council, 5–7 March 2002. IP/C/M/35, 22 March 2002, para 84.
[39] On the still pressing issue of regime collisions, see AGON, 2022.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

para. 3 of the WTO agreement.[40] Compared to the 2020 proposal by India and South Africa, this declaration has a rather limited scope: it only refers to vaccines and does not include diagnostic or therapeutic measures. What remains unclear, in particular, is to what extent this decision clarifies the legal situation *de lege lata* and what precisely falls under the term "waiver" – the declaration does not provide any differentiation but speaks of a decision on "*clarifications and waiver*".[41]

The declaration, however, distinguishes between developed and developing countries – here we have the postcolonial difference again – demanding that those developing countries with existing capacity to manufacture COVID-19 vaccines "*are encouraged to make a binding commitment not to avail themselves of this decision*".[42] This has raised the not unjustified question as to where in the Global South generic drugs should actually be produced if precisely those countries with manufacturing capacities are to be exempt.

With its decision, the Ministerial Conference avoided an open conflict of regimes – which, however, cannot conceal the underlying substantial regime collision. In essence, this collision arises from the fact that the human rights perspective requires and also calls for a strengthening of the duty to protect,[43] hence leaving little manoeuvring room for a WTO waiver in the given situation. But as no clear words were spoken in this regard,[44] with the UN High Commissioner's report, for example, only vaguely mentioning that "*states should consider the introduction of a temporary waiver*"[45] under the TRIPS Agreement, there was ample room for formula compromise. The winners were "*the pharmaceutical companies and their host governments, predominantly in the Global North*." (SEKALALA et al., 2021: 3). This is why this would-be waiver – which ultimately turned out futile – has been criticized as "*too little, too late*" (RANJAN; GOUR, 2022; JUNG, 2022).

[40] WORLD TRADE ORGANIZATION. Ministerial Decision on the Agreement on Trade-related Aspects of Intellectual Property Rights. WT/MIN(22)/30, 17 June 2022. Available at: <https://www.wto.org>.
[41] For more detail, see SUCKER; KUGLER, 2022; HAMBISETTY et al., 2022.
[42] WORLD TRADE ORGANIZATION. Ministerial Decision on the Agreement on Trade-related Aspects of Intellectual Property Rights. WT/MIN(22)/30, 17 June 2022, para. 1, footnote 1. Available at: https://www.wto.org.
[43] See e.g. Sri Lanka, WORLD TRADE ORGANIZATION. TRIPS Council Statement, 10 October 2020. IP/C/M/96/Add.1, para. 1215; SAMTANI, 2022: 70 et seq.
[44] For a critique, see FISH HODGSON; DE FALCO, 2021.
[45] REPORT OF THE UN HIGH COMMISSIONER FOR HUMAN RIGHTS. Human rights implications of the lack of affordable, timely, equitable and universal access and distribution of coronavirus disease (COVID-19) vaccines and the deepening inequalities between States, 1 February 2022, A/HRC/49/35, para 63.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

3. Postcolonial Patterns of Distribution

We can thus certainly agree with the UN CERD in its identification of postcolonial patterns of unequal distribution in the global health system (CERD, 2022a: Statement 2). The situation is marked by drastic inequalities in both distribution outcomes and procedures; these inequalities give rise to *triage* constellations within global institutions – constellations for which there is neither legal nor procedural control. Their lethal effect is the result of a complex interplay involving a multitude of separate decisions.

a) Necroliberalism

Achille Mbembe ascribes a "hydraulic" effect to global institutions in the sense that they significantly increase the danger posed by the postcolonial lines of dominance in global society (MBEMBE, 2019: 59). According to him, this dominance manifests in a demonstration of power that he calls "necropolitics" in his discussion of apartheid policies but also with regard to global drone missions. This form of politics produces "*people for whom living means continually standing up to death […] This life is a superfluous one, therefore […] Nobody even bears the slightest feelings of responsibility or justice towards this sort of life, or rather, death.*" (MBEMBE, 2019: 37 et seq.). Drawing on this analysis, other authors have described the situation created by the coronavirus pandemic as a necropolitical constellation (SANDSET, 2021; OTIENO SUMBA, 2021; ALOUDAT, 2022: 8), while *Mbembe* himself has remained rather cautious in this respect. His analysis of necropolitics addresses decisions and measures of intentional and targeted state repression that generate "*superfluous life*" – a figure similar to Judith Butler's "*deplorable lives*" (BUTLER, 2009) – characterized by being completely subjected to political sovereignty.

In the COVID-19 pandemic, however, this being subjected assumes a different shape. Here it is not the political sovereign taking direct decisions over life and death, but the latter occurs as a consequence of polycontextural processes. When asked in an interview if the coronavirus pandemic could be seen as a necropolitical constellation, *Mbembe* thus avoided speaking of necropolitics but rather used the term "*necroliberalism*" to bring the economy into focus (MBEMBE; BERCITO, 2020).[46]

[46] See also WHITE, 2023: 242 [„necrofinance"]; BANERJEE, 2008 [„necrocapitalism"].

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

b) Nosopolitical Matrices

According to *Mbembe*, the economy as the "*system working with a calculating machine*" (MBEMBE; BERCITO, 2020) has a destructive impact as the pandemic turns the economy's neoliberalism into necroliberalism – a system with lethal effects.[47] He thus differentiates between (state/political) necropolitics and (economic) necroliberalism. While this differentiation is an important step, it would still be wrong to attribute the postcolonial lines of dominance in global society to the economy alone. The situation is actually far more complex. The economy is a major factor, but global society is a formation without top and centre. And the world economy is not the one big global system that determines everything and from which all further differentiations are derived. The global economic system uses its calculating machine in the context of other large-scale systems: global health, global politics, global law, global science; they are all entangled in the postcolonial question in their own ways.

This entanglement is particularly well documented with regard to health science. Its starting point was the scientific use of the colonies as "laboratories", where German medical science, too, "*left the terrain of what had already been established as ethical consensus at home to make common cause with the colonial metropole's exploitative interests.*" (ECKART, 1997: 550). And it still persists to date despite the Nuremberg Code, created at the Nuremberg Doctors' Trial,[48] which stipulates "*prior informed consent*" to medical examinations; this legal figure of consent is in itself a Eurocentric category that is based on the notion of a rational subject[49] and does not include adequate protection in the case of asymmetric bargaining power. As a consequence, the prerequisite of consent is circumvented regularly and in many respects (FLEAR, 2017: 75; CONSTANTIN; ANDORNO, 2020).

[47] For more detail, see GRIMALDI, 2022: 16.
[48] See the documentation in MITSCHERLICH et al., 2008.
[49] On the Global South's underrepresentation in debates over bioethics, see PRATT; DE VRIES, 2023.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

The healthcare system contributes its own share to the postcolonial lines of dominance in global society. *Firstly*, because scientific findings, even if gained in the Global South, are not sufficiently disseminated and made available for application in healthcare. Therefore, the principle of benefit sharing after prior inclusion in clinical trials, as set out in the Helsinki Declaration and the CIOMS and WHO guidelines (in particular, Guideline 11)[50], "*has not been followed in most cases*." (SCHUMAN, 2012: 149 et seq.). And *secondly*, the healthcare system has postcolonial dynamics of its own. The pandemic has increased the significance of the healthcare system – which, in turn, has increased the impact of postcolonial asymmetries inscribed into this system. This becomes evident in combating the COVID-19 pandemic where we can see a systemic tendency towards expansion as the fight against the virus requires a systemic shift from reactive disease control to future-oriented prevention: it is no longer just about the diseased but about the potentially diseased. With this shift transforming the application criteria of the medical code from present to future, the healthcare system gains more relevance in society (ANICKER, 2020: 181) as it implements not only its own postcolonial preconceptions (of a healthy body, of hygiene etc.)[51] but also acts as an agent of the postcoloniality of other functional systems linked to healthcare, such as science, politics, economy and law. The consequences of this medicalization of society, indeed, of the polycentric nosopolitics in the form of a "somatocracy" (of which Michel Foucault warned us so impressively (FOUCAULT, 2004: 7)) do not affect everybody in the same manner – their impact on people in the Global South is amplified by the hydraulic lever of institutions.[52]

What makes the situation so confusing is the fact that the postcolonial lines of dominance are transverse to the lines of functional differentiation in global society. Their manifestation in the healthcare system differs from that in the systems of global economy or global politics – even though these systems are coupled via organizations and linked to law via regime constitutions. While the resulting "*distribution of distribution*" may result in the formation of clusters (as Niklas Luhmann exemplified for a different context (LUHMANN,

[50] WORLD MEDICAL ASSOCIATION. "Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects". Amended by the 64th WMA General Assembly in Fortaleza, Brazil in October 2013. Available at: <https://www.wma.net/wp-content/uploads/2024/10/DoH-Oct2013.pdf>. See also CIOMS/WHO. "International ethical guidelines for health-related research involving humans". 2016. Available at: <https://cioms.ch/publications/product/international-ethical-guidelines-for-health-related-research-involving-humans/>.

[51] See FLEAR, 2014: 75; WASHINGTON, 2008: 25 et seqq.; MENDE-SIEDLECKI et al., 2021; MONNAIS, 2019: 116; GREEN et al., 2013; AGORO, 2020.

[52] What *Mbembe* calls the "hydraulic" lever was the "racket" in critical theory (e.g. HORKHEIMER, 1988: 138).

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

2022)), the latter will, however, fit into a complex world order that is not governed in its entirety by one single discourse (BROWN, 2015: 115).

The structure criticized as "neoliberal" is not about the effects of one single system but about multipolar discriminatory matrices that produce their specific forms of subalternity as well as system-specific formations of "the neoliberal" in the context of functionally embedded postcolonial dominance.[53] This is why, strictly speaking, the lethal consequences are not inflicted by one *invisible hand* in the singular but by the combined effect of many different *invisible hands* interacting in different system and regime contexts. *Martti Koskenniemi* thus rightly points out that there is not *the* one system or regime whose postcolonial arsenal of violence we need to dismantle in order to create a more just world – as there will always be some other regime "*that is ready to take over*." (KOSKENNIEMI, 2017: 347).

The postcolonial concepts of the Global North/South and of subalternity are thus to be seen as ciphers for functionally interwoven patterns of dominance that are in themselves heterogeneous and produce a variety of exclusionary constellations of subalternity. These constellations can range from systemic chains of dominance to constellations of total exclusion; they differ from region to region. This explains why postcolonial critics have shaped differentiated notions of subalternity. Concepts developed, for example, in India in response to colonial domination and its interaction with religious distinctions (WAKANKAR, 2010) differ significantly from debates in the US, which often focus on the nexus between classist and racist lines of dominance (ISSAR, 2020; ROBINSON, 1983).

III. Constitutionalization

The quest for a legal containment of the lethal consequences of the current "*distribution of distributions*" requires finding solutions adequate to the complexity of the situation – solutions that go beyond the social containment of the dangers posed by the neoliberal world economy and take into account what *Ayten Gündoğdu* refers to as an obvious "*rightlessness in an age of rights*" (GÜNDOĞDU, 2014: 203). After all, there is certainly no lack of relevant norms and eligibility systems: equity requirements embedded in law also apply to the

[53] On neoliberalism as a technique and tool of polycentric institutions, see BROWN, 2015: 115.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

provision of healthcare. The human rights recognized in the UN covenants and the UDHR prohibit discriminatory access to healthcare and the associated violations of integrity. According to the WHO constitution, *"[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*" These rights correlate with certain state duties and obligations (COCO; DIAS, 2020). The UN Human Rights Committee derives from this the particular duty to provide adequate protection against life-threatening diseases.[54] As per Article 12 para. 2c) of the International Covenant on Economic, Social and Cultural Rights, it is the member states' duty to prevent, treat and control "*epidemic, endemic, occupational and other diseases.*" (CESR, 2000: para. 16 and 43). These obligations, however, not only include the right to health but also involve other rights, such as the right to life, the freedom of science and the right to equality – and this not only with regard to individuals but also to states.[55] A formal principle of equality thus also applies, for instance, to distribution processes in the system of global politics.

But despite all these norms, some crucial aspects of this "*right to equal health*" – emphatically emphasized by *Foucault* as early as 1974 (FOUCAULT, 2004: 7) – still require clarification: the WHO's understanding of equitable health is deficient and full of contradictions (AMIRI et al., 2021); the SDG 3.8 target of universal health coverage still remains to be linked to human rights guarantees (NYGREN-KRUG, 2019); and the contours of extraterritorial state obligations, the human rights obligations of and within international organizations and the legal framework for hybrid forms of action are highly contested (MEIER et al., 2022).

And yet, it is precisely this contradiction between factual inequality and the promises of equality and solidarity embedded in law[56] that ultimately provides us with a leverage point to address unjust patterns of distribution, criticize them from a legal perspective and transform them (MEIER et al, 2022: 33). However, we cannot simply direct such calls for equality and solidarity at just one of the systems involved but rather need to address the issue of inequality in a normative manner and with rules specifically adjusted to

[54] CCPR. General Comment No. 36. 3 September 2019. CCPR /C/CG/36.
[55] Unilaterally linking the global health system to the right to health, as in GOSTIN, 2014: 251 et seqq., fails to recognize the polycontextural constellations of inequality in healthcare.
[56] On the solidarity principle's roots in international law, see UNHRC. Report of the Independent Expert on Human Rights and International Solidarity, Rudi Muhammad Rizki, 5 July 2010, A/HRC/15/32.; for more detail, see GOROBETS, 2022.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

the context in question. Doing so also requires keeping an eye on interactions going on between the regimes. This can ultimately only be achieved through polycentric processes of constitutionalization that also incorporate national patterns of order.[57] In other words, establishing an organizational constitution in the form of the WHO Constitution is far from enough – especially since the latter hardly deserves the label "constitution" due to its insufficient checks and balances. What we need instead is a comprehensive health constitution that involves sector-specific constitutional law, with an organizational part guaranteeing equal participation and a human rights part guaranteeing equal access to rights, including access to healthcare.[58]

I will now briefly outline this need for constitutionalization by using the example of two different questions that arise from WHO efforts to reform the International Health Regulations (IHR) and the WHO Pandemic Agreement:[59] (a) what can the procedural organization of polycentric forms of solidarity look like, and (b) can health equity be achieved through global commons?

1. Polycentric Forms of Solidarity

In procedural terms, the postcolonial lines of dominance can only be broken and dismantled if we develop adequately complex decision-making and responsibility structures, which take into account the high level of differentiation within global healthcare, hybrid forms of action and the lines of dominance that are relevant to this field. But for the time being, we lack such appropriate procedural designs. Legislative efforts within the framework of the WHO, too, are insufficient in this respect.

This becomes particularly evident in the Pandemic Agreement. Article 3 para. 5 of the Agreement emphasizes solidarity, declaring it a point of reference for pandemic-related measures. At least, the final version of the agreement demands "solidarity with all people and countries". This is an improvement, as all versions of the agreement that have been presented until 2024 failed to mention the key dimension of transnational solidarity, that is,

[57] On the manoeuvring room in the constitutional interpretation of national patent laws, see KAPCZYNSKI, 2019: 93 et seq.
[58] On the concept of polycentric constitutionalization, which differentiates between organizational and human rights aspects, see TEUBNER, 2012.
[59] Both text were adopted by the World Health Assembly in June 2024 (IHR) and May 2025 (Pandemic Agreement), see footnote 26.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

of a solidarity transcending the categories of nation and state. But the new wording is still limited, gender, language, race, ethnicity etc. as lines of potential discrimination are not mentioned and obviously not on the radar of global health governance. It comes in addition that also the final version of the Pandemic Agreement remains silent about organizing the relevant transnational forms of participation as well as about integrating the hybrid forms of action of public-private partnerships and non-state actors into the solidarity structures.[60]

Transnational solidarity requires adequate procedural safeguarding to be developed. The Pandemic Agreement lacks the necessary determination, especially with regard to the intersectional relationship with the WTO. Although Article 11 para. 4 of the Pandemic Agreement, for instance, reaffirms that WTO member states have the right to make full use of the TRIPS Agreement and the Doha Declaration, this is nothing more than a self-evident statement that does not change the substance of the matter: when it comes to the issue of postcolonialism in healthcare, WHO and WTO law are not sufficiently linked but all too politely regulated past each other in the manner of regime appeasement. Adequately linking the regimes regarding the relationship between WTO/TRIPS and WHO would first require a reorganization of the waiver procedure: despite its general potential to enable a political reconciliation of conflicting interests,[61] the waiver procedure still generates procedural requirements for medical products that work to the structural disadvantage of the Global South.

This is particularly due to the *consensus culture* prevailing in the WTO: even though Article IX of the WTO Agreement permits majority decisions, waivers have always been passed unanimously so far. The challenge here is to disrupt the hegemonial consensus within the WTO and the associated "*bulldozing*" through queering and by establishing a culture of dissent (O'HARA: 2022: 35). Abandoning the consensus strategy in the waiver procedure and returning to votes would already be a good start to counteract formula compromises, which ultimately reflect the interests of the Global North. A more far-reaching step would, of course, be to reorganize the waiver procedure for drug patents and *include the WHO in decision-making*. If temporary patent exemptions for drugs were to be decided by the WHO bodies rather than at WTO level, the WTO system would be linked more closely to health law requirements. This would also help counteract the unilateral abuse of patent exemptions

[60] On the necessity of a solidarity that transcends the structures of the state, see GARLAND MAHLER, 2018: 126 et seqq.
[61] For more detail see FEICHTNER, 2012: 327.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

that is regularly cited by opponents of such exemptions, particularly pointing at China.[62] The Pandemic Agreement could establish an obligation for the WHO member states in the WTO to implement such a coupling with the WTO system – ideally by way of a specific "*WHO waiver*" on essential drugs.[63] This would enable a clear focus on healthcare issues, provided that the WHO procedures are designed accordingly. In essence, this coupling of regimes would be about developing responsivity norms for the relationship between economy and health sector.

2. Health Equity through Global Commons

In addition, global health law needs a stronger focus on human rights than there has been so far. The amendments to the International Health Regulations (IHR) as well as the Pandemic Agreement laks convincing legal responses to the dangers posed by multipolar systems of dominance towards a really substantive health equity. Doing so would require including the goal of universal health coverage as formulated in SDG 3.8 and linking this Agenda-2030 target with human rights and the WHO Constitution in a way that enables modelling legal mechanisms to safeguard basic healthcare. This, of course, also requires robust procedures. *Four* regulatory issues are key in this respect:

Firstly, a more effective right to health requires specific procedural enforcement structures.

The Implementation Committee established under Article 54 IHR is a first step, but is confronted with severe sovereignty imperatives. The participation of the Global South in staffing this body, the diversification of access and complaint rights and the incorporation of hybrid forms of action into obligation and complaint structures[64] lacks till today appropriate regulation.

Secondly, equal access to healthcare requires a transfer of relevant technology and knowledge.

[62] See e.g. SCHAEFER; GROVES, 2023: 4.
[63] In the event that not all WHO member states are prepared to go down this route, one might also conceive of an optional protocol to this effect.
[64] In this respect, see HOLZSCHEITER, 2023: 4.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

The debate over adequate healthcare cannot stop at discussing patent issues but must also include the access to approval data and the transfer of technology and knowledge.[65] Both the IHR amendments and the Pandemic Agreement indicate some steps taken in this direction; these, however, have so far met massive resistance within the bodies in charge. The group of African countries, for example, had suggested introducing a new IHR Article 13A to regulate access to technologies and expertise. But for unspecified reasons, the Review Committee has been of the opinion that such regulation at WHO level would exceed the organization's constitutional mandate[66], even though Article 21 of the WHO Constitution stipulates that "*[t]he Health Assembly shall have authority to adopt regulations concerning […] procedures to prevent the international spread of disease*" – this should also include facilitating access to the relevant technologies and expertise.

The transfer of technology and knowledge is now vaguely mentioned in the Pandemic Agreement (Art. 9 para. 5 and Art. 11). But these regulations are inadequate and insufficient – particularly in view of the fact that despite the enormous amount of money invested in vaccine development,[67] a setting of conditions has largely been avoided. The issue of legal obligations of contractual networks in the field of healthcare cannot be left to the arbitrariness of *good* and *bad practices* (BERMAN, 2022). What we need instead is to develop a constitutional obligation structure that firmly links the contractual system of healthcare guarantees to the principle of equality.

Thirdly, global commons are needed with regard to research, development and distribution of medicines.

Patents on pharmaceuticals are typically justified by pointing out that adequate healthcare requires innovation and that actors driven by economic rationality take patents as an

[65] In 1980, the WHO referred to the insufficient transfer of technology and knowledge as "technological neocolonialism" (WORLD HEALTH ORGANIZATION. Background Document for a reference and use at the technical discussions on the contribution of health to the new international economic order, 25 February 1980, A33/Technical Discussions/1. para. 53); see also CHOREV, 2012: 92.
[66] WORLD HEALTH ORGANIZATION. Report of the Review Committee regarding amandments to the International Health Regulations (2005), Report by the Director-General, 6 February 2023, A/WGIHR/2/5, p. 55.
[67] By July 2021, more than USD 5 billion had been invested in the development of COVID-19 vaccines alone; if we include the advance purchase agreements, the total amount stands at USD 50 billion (KNOWLEDGE PORTAL on innovation and access to medicines, 2021).

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

incentive to engage in innovation. This, however, is no more than a myth[68] – at least with regard to drug patents.[69] Economic incentive structures tie in with the inherent rationality of the economic system, but they do not automatically fit with the systems of healthcare or science. As for patents on drugs, the fact that the economy, science and healthcare are governed by non-identical systemic rationalities leads to dysfunctional and warped incentives, especially in the development of medicines for diseases that do not promise high profit[70] or if the risk-benefit ratio is difficult to control.[71] And then there is the so-called "10/90 gap": only ten percent of global funding for health research is being spent on the diseases that make up for 90 percent of the global health burden (LUCHETTI, 2014) – an imbalance that heavily affects people in the Global South who suffer from neglected and poverty-related diseases.

An effective means to overcome these dysfunctionalities are pooling solutions. A relatively successful example is UNITAID, an international purchase facility for drugs against HIV/AIDS, malaria and tuberculosis. In 2010, UNITAID created the Medicines Patent Pool (MPP) to negotiate voluntary licensing and patent-pooling. The MPP now holds the relevant licence rights and can thus ensure a cost-effective supply of medicines worldwide. Building on this experience, the WHO attempted to set up a COVID-19 Technology Access Pool (C-TAP) in May 2020, but this initiative was as unsuccessful as the project for hub-based technology transfer. The initiative lacked cooperation partners and financial resources, while pharmaceutical companies – including BioNTech – effectively lobbied against the hub (DAVIES, 2020).

Establishing effective mechanisms requires appropriate funding and compensation. The Pandemic Agreement takes the first steps in this direction: The Pathogen Access and Benefit-Sharing System ("PABS-System") in Article 12 para 6 lit. a), for example, demands real-time access by the WHO to 20 percent of the production of pandemic-related products, including vaccines, to ensure equitable distribution, especially to developing countries. If this

[68] Daniel Pinheiro Astone refers to the scarcity of goods caused by patent rights as an "arbitrary legal-economic construct inflicting harms against human beings" (PINHEIRO ASTONE, 2023: 162); on the criticism of patents on drugs, see DOSI et al., 2023; GOLD et al., 2010; BOLDRIN; LEVINE, 2013: 13 and CORIAT; ORSENIGO, 2014: 235: "The IPR system governing pharmaceuticals has become increasingly dysfunctional."

[69] On the history of patent exemptions in the medical sector, see CASSIER, 2014.

[70] These include, in particular, the so-called neglected tropical diseases (NTD), such as dengue fever, rabies, scabies etc., all of which "mostly affect impoverished communities and disproportionately affect women and children" (see WHO, Neglected tropical diseases, <https://www.who.int/health-topics/neglected-tropical-diseases>).

[71] For more detail, see FELDMAN et al., 2021.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

proposal that takes the call for equity seriously does not fail in the course of the negotiation of annex III to the Pandemic Agreement (on this annex see Art. 12 para. 2) due to resistance from the Global North (SCHAEFER; GROVES, 2023: 5), it could provide a starting point for new ways of pooling patent licences and transferring knowledge, thus evading the problematic dichotomy of private markets versus statist overregulation – a dilemma that manifests, for example, in concepts like that of the tragedy of the commons or the Common Heritage of Mankind as well as in the debate over vaccines as public goods (which then compete with other public goods).[72] Instead of becoming entangled in discussing the illusory alternative between open market competition and technocratic central administration, it would then be about creating bundles of rights in the form of pools, which acknowledge the complexity of the issue at hand and through which licences and the transfer of technology in the field of healthcare can be managed in ways that support achieving the goal of non-discriminatory access to the health system. For medicines, the category of ownership would then be transformed from exclusive private property to a form of global commons.[73] This, too, is not an end in itself; again it will be crucial to determine the procedural and material norms that structure these commons in order to dismantle the postcolonial lines of dominance.[74]

Fourthly, we need a systemic change in global health policy, leading to a fund fed by compulsory transfer contributions.

Overall, the underfunding of the WHO and the dramatic inequalities in global healthcare indicate that social justice in the global health system cannot be achieved without a political economy based on solidarity (KWETE et al., 2022: 4),[75] in which redistribution also builds on more effective cooperation in collecting funds.[76] This must also take into account that health depends on the minimum subsistence level being guaranteed – as is not only

[72] For more detail on the criticism, see RANGANATHAN, 2016; FEICHTNER, 2019.
[73] Elinor Ostrom's concept of the commons, which has long dominated the debates (OSTROM, 1990) has itself lead to colonizing effects in the Global South due to a conceptual weakness of the development approach but also while being implemented by international organizations, as local populations are "forced into subaltern positions". What is needed instead is the establishing of democratic forms of self-organization (SAUVÊTRE, 2018: 87).
[74] This is why the Lancet Commission on COVID-19 suggests that its proposed funds "should have representation and leadership from LMICs" (THE LANCET COMMISSION, 2022: 1267).
[75] See also BECKER LORCA, 2023.
[76] It is thus a promising start that the Group of African Countries succeeded in taking the debate over international cooperation in tax matters from the OECD to the UN level, see UNITED NATIONS, General Assembly, Resolution 77/244 of 9 January 2023, A/RES/77/244.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

expressed in the WHO's 1978 Alma-Ata Declaration but also in the 2030 Sustainable Development Goals.[77]

Without significant transfer payments, no progress will be made in this respect. More than ten years ago, the then UN Special Rapporteur on the Right to Health, *Anand Grover*, had already suggested a system change in global health policy in his interim report of August 2012.[78]

In the drafting process of the Pandemic Agreement various intents have been made to realize transfers in global health issues. They failed. Also the proposal to introduce the principle of "*common but differentiated responsibility*" into the pandemic agreement as a *legal transplant* from international environmental law (SIRLEAF, 2018), did not make it into the adopted text. All relevant proposals for a sustainable change of the structures of distribution in global heath were watered down in the drafting process and the wording of Art. 18 of the Pandemic Agreement, that demands "sustainable funding" is nothing but a euphemism which is intended to conceal the fact that the financing structures in global health continue to be absuletly insufficient. Following the final report of the *COVID-19 Lancet Commission* a "sustainable finance" in global health would require annual transfer amount to 60 billion USD, corresponding to 0.1% of the gross domestic product of high-income countries (THE LANCET COMMISSION, 2022: 1267). The compromiss of the Pandemic Agreement does not make any step towards a solid finance of this secor. Its technocratic language cannot conceal the fact that the agreement only provides declarations of intent instead of concrete figures. Once again, an example of a regulation whose linguistic disfigurement is intended to conceal the fact that nothing of relevance has been regulated. As a consequence the "Coordinating Financial Mechanism" established by Art. 18 Pandemic Agreement will suffer underfunding, as states are only vaguely called for contributions "to the extent feasible" (Art. 18 para. 1 Pandemic Agreement).

IV. Conclusion

[77] WHO, Declaration of Alma-Ata 1978; on the connections between the objective of primary healthcare, as first formulated in the Declaration of Alma-Ata, and the SDGs, see SHERRY; BISHAI, 2020.
[78] SPECIAL RAPPORTEUR on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Interim Report of 13 August 2012, A/67/302, para 33.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

We will only succeed in legally containing the multipolar lines of dominance in the global health system if we develop an understanding of the "*distribution of distribution*" within this system that is appropriate to its complexity. Only in this way can legal regulation finally overcome the postcolonial binary of Global South and Global North and charity be replaced by a truly global health law and robust norms of polycentric solidarity (DAFFÈ et al., 2021: 558) – a solidarity that, as has been called for in One-Health approaches, will have to include human as well as non-human lives, that is, animals and eco-complexes[79] just because "*human solidarity*" is part of "*the solidarity of life in general*" (HORKHEIMER, 1993: 35): a solidaric conviviality.

To this end, we need to critically examine global health law, which, in turn, requires an interdisciplinary contextualization and critical reflection of law itself. Such critical reflection can only take place in the form of an immanent critique – a perspective that, according to *Rahel Jaeggi*, differs from both a purely internal (dogmatic-positivist) and a purely external mode of criticism (where law becomes a pawn) in that it initiates change from within law in order to pinpoint the contradiction between the legal order and the requirements of social justice, thereby mitigating the violence of law (JAEGGI, 2018: 31). It must be emphasised once again that this (postcolonial) critique of law is not directed against law but rather fights for a law that does less violence to its postcolonial other.

Efforts to reflect on postcolonial iterations in global politics and law will hopefully continue and not share the fate of the WTO quasi waiver of 2022, having us once again say "*too little, too late!*"

References

ABBOTT, Frederick. The TRIPS Agreement Article 73 Security Exceptions and the COVID-19 Pandemic. Geneva: South Centre Research Paper 116, 2020.

ABIMBOLA, Seye; PAI, Madhukhar. "Will Global Health Survive Its Decolonization?". Lancet, v. 396, 2020, pp. 1627–1628.

ACHIUME, E. Tendayi. UN Expert Urges States to End 'Vaccine Apartheid', in: Press release OHCHR of 14 June 2022, <https://www.ohchr.org>.

[79] In this respect, see also Article 1 para (b) and Art. 5 Pandemic Agreement, which refers to the One-Health Approach.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

AGON, Sivan Shlomo. “Farewell to the F-Word? Fragmentation of International Law in Times of the COVID-19 Pandemic”. University of Toronto Law Journal, v. 72, 2022, pp. 1-43.

AGORO, Rafiou. “In the COVID-19 Era: Let’s Keep an Eye on Clinical Trials in Africa”. Journal of Global Health, v. 10, 2020, pp. 1–3.

ALLEN, Amy. The End of Progress: Decolonizing the Normative Foundations of Critical Theory. New York: Columbia University Press, 2017.

ALOUDAT, Tammam. “Can the Sick Speak? Global Health Governance and Health Subalternity”. Social Science, v. 11, 2022, pp. 1–15.

ALVAREZ, José E. “The Case for Reparations for the Color of COVID”. UC Irvine Journal of International, Transnational, and Comparative Law, v. 7, 2022, pp. 7–59.

AMIRI, Michelle M. et al. "Scoping review of the World Health Organization’s underlying equity discourses: apparent ambiguities, inadequacy, and contradictions". International Journal for Equity in Health, v. 20, 2021, pp. 1-16.

ANICKER, Fabian. "Die Medizinisierung der Gesellschaft". Zeitschrift für theoretische Soziologie, v. 9, 2020, pp. 173-183.

AOUN, Alejandra; CORREA, Juan; CORTESE, Martín A.; LOWENSTEIN, Vanesa; NEGRO, Sandra C.; VIDAURRETA, Guillermo E. El Debate sobre la Exención de los Derechos de Propiedad Intelectual en Tiempos de Pandemia. Geneva: South Centre, 2023.

AUST, Helmut Philipp; FEIHLE, Prisca. “The WHO Foundation and the Law of International Organizations”. International Organizations Law Review, v. 19, 2022, pp. 332–364.

BANERJEE, Subhabrata Bobby. "Necrocapitalism". Organization Studies, v. 29, 2008, pp. 1541–1563.

BÄUMLER, Jelena; SARNO, Julieta. “The Immunization against COVID-19 as a Global Public Good”. Zeitschrift für ausländisches öffentliches Recht und Völkerrecht, v. 82, 2022, pp. 159–194.

BECKER LORCA, Arnulf. "Contesting global justice from the South: redistribution in the international order“. International Affairs, v. 99, 2023, pp. 41-60.

BEHRENDT, Silvia; MÜLLER, Amrei. “Do We Need to Protect the Entire World Population from Health Threats Through One Global Biomedical Surveillance and Response System?”. German Yearbook of International Law, v. 64, 2021, pp. 41–94.

BENVENISTI, Eyal. “The WHO – Destined to Fail?: Political Cooperation and the COVID-19 Pandemic”. American Journal of International Law, v. 114, 2020, pp. 588–597.

BERMAN, Ayelet. "Equitable Access Contracts: Building Blocks of a Future Global Vaccine Strategy". EJIL:Talk!, 21 December 2022. Available at: <https://www.ejiltalk.org/equitable-access-contracts-building-blocks-of-a-future-global-vaccine-strategy/>.

BOLDRIN, Michele; LEVINE, David. "The Case Against Patents". Journal of Economic Perspectives, v. 27, 2013, pp. 3-22.

BROWN, Wendy. Undoing the Demos: Neoliberalism’s Stealth Revolution. Zone Books, 2015.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

BUTLER, Judith. Frames of War. When is Life Grievable? London/New York: Verso, 2009.

BUYUM, Ali Murad; CRANE, Johanna; FATIMAH, Tammam; et al. “Decolonizing Global Health, If Not Now, When?”. BMJ Global Health, v. 5, 2020, pp. 1–4.

CAMPOS-RUDINSKY, Thana; CANALES, Mariana. “Global Health Governance and the Principle of Subsidiarity”. I.CON, v. 20, 2022, pp. 177–203.

CARLEY, Robert F. “Intersecting Oppressions; Intersecting Struggles: Race, Class, and Subalternity”. Journal of Class & Culture, v. 1, 2022, pp. 79–95.

CASSIER, Maurice. "Patents and Health". The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society, 2014, pp. 1-8.

CENTER FOR DISEASE CONTROL AND PREVENTION (CDC). COVID Data Tracker: COVID-19 Weekly Cases and Deaths per 100,000 Population by Age, Race/Ethnicity, and Sex. 31 December 2022. Available at: <https://covid.cdc.gov/covid-data-tracker/#demographicsovertime>.

CHIMNI, Bhupinder. “Third World Approaches to International Law: A Manifesto”. International Community Law Review, v. 8, 2006, pp. 3–27.

CHOREV, Nitsan. "The World Health Organization between North and South". Ithaca/New York: Cornell University Press, 2012.

COCO, Antonio; DIAS, Talita. "Prevent, Respond, Cooperate: States’ Due Diligence Duties vis-à-vis the COVID-19 Pandemic". Journal of International Humanitarian Legal Studies, v. 11, 2020, pp. 218-236.

CONSTANTIN, Andrés; ANDORNO, Roberto. "Human Subjects in Globalized Health Research". In: GOSTIN, Lawrence et al. Foundations of Global Health & Human Rights. New York: Oxford Academic, 2020, pp. 395-416.

CORIAT, Benjamin; ORSENIGO, LUIGI. "IPRs, Public Health and the Pharmaceutical Industry: Issues in the Post-2005 TRIPS Agenda". In: CIMOLI, Mario et al. Intellectual Property Rights: Legal and Economic Challenges for Development. Oxford, 2014, pp. 221-240.

COVAX. The Vaccines Pillar of the Access to COVID-19 Tools (ACT) Accelerator, Structures and Principles. November 2022. Available at: <https://cepi.net/wp-content/uploads/2020/11/COVAX-Structure-and-Principles_FINAL_Nov-2022.pdf>.

CRENSHAW, Kimberlé. “Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color”. Stanford Law Review, v. 43, 1991, pp. 1241–1299.

DAFFÈ, Niamè Zeinabou; GUILLAUME, Yodeline; IVERS, Louise. "Anti-Racism and Anti-Colonialism Praxis in Global Health-Reflection and Action for Practitioners in US Academic Medical Centers". Am J Trop Med Hyg, v. 105, 2021, pp. 557-560.

DAVIES, Madlen. „COVID-19: WHO efforts to bring vaccine manufacturing to Africa are undermined by the drug industry, documents show“. BMJ, 2020, pp. 376-382.

DERRIDA, Jacques. “Signature, Event, Context”. In: id. Margins of Philosophy. Chicago: University of Chicago Press, 1982, pp. 307–330.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

DO MAR CASTRO VARELA, María; DHAWAN, Nikita. Postkoloniale Theorie. Bielefeld: Transcript, 2015.

DOSI, Giovanni. et al. "Do patents really foster innovation in the pharmaceutical sector? Results from an evolutionary, agent-based model". Journal of Economic Behavior & Organization, v. 212, 2023, pp. 564-589.

ECKART, Wolfgang. Medizin und Kolonialimperialismus Deutschland 1884-1945. Brill Schöningh, 1997.

FEICHTNER, Isabel. "Sharing the Riches of the Sea: The Redistributive and Fiscal Dimension of Deep Seabed Exploitation". European Journal of International Law, v. 30, 2019, pp. 601-633.

FEICHTNER, Isabel. “The Waiver Power of the WTO”. European Journal of International Law (EJIL), v. 20, 2009, pp. 615–645.

FEICHTNER, Isabel. The Law and Politics of WTO Waivers. Stability and Flexibility in Public International Law. Cambridge: Cambridge University Press, 2011.

FELDMAN, Robin C. et al. "Negative innovation: when patents are bad for patients". Nature Biotechnology, v. 39, 2021, pp. 914-916.

FERNANDEZ, Rodrigo; KLINGE, Tobias. The Financialization of Big Pharma. Amsterdam: SOMO, 2020.

FISH HODGSON, Tim; DE FALCO, Rossella. "Human Rights and Universal Access to COVID-19 Vaccines: Does the Human Rights Council Resolution go far enough?". OpinioJuris, 23 March 2021. Available at: <https://opiniojuris.org/2021/03/23/human-rights-and-universal-access-to-covid-19-vaccines-does-the-human-rights-council-resolution-go-far-enough/>.

FLEAR, Mark. “Clinical Trials Abroad: The Marketable Ethics, Weak Protections and Vulnerable Subjects of EU Law”. Cambridge Yearbook of European Legal Studies, v. 16, 2014, pp. 75–108.

FOUCAULT, Michel. “The Crisis of Medicine or the Crisis of Antimedicine”. Foucault Studies, v. 1, 2004.

FOUCAULT, Michel. “Nietzsche, Genealogy, History”. In: id. Language, Counter-Memory, Practice. Selected Essays and Interviews. Ithaca: Cornell University Press, 1977, pp. 139–164.

FOUCAULT, Michel. Security, Territory, Population. Lectures at the Collège de France 1977–1978. Edited by Michel Senellart. Translated by Graham Burchell. New York: Picador, 2009.

GALVEZ-BEHAR, Gabriel. “The 1883 Paris Convention and the Impossible Unification of Industrial Property”. In: GOODAY, Graeme; WILF, Steven (eds.). Patent Cultures. Cambridge: Cambridge University Press, 2020, pp. 38–68.

GARLAND MAHLER, Anne. From the Tricontinental to the Global South Race, Radicalism, and Transnational Solidarity. Durham: Duke University Press, 2018.

GATES, Bill. How to Prevent the Next Pandemic. London: Penguin Random House, 2022.

GOLD, Richard. et al. "Are Patents Impeding Medical Care and Innovation? ". PLoS Medicine, v. 7, 2010, pp. 1-2.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

GONÇALVES, Bruna A. “Readings of the Coloniality of Power in the COVID-19 Global Dynamics”. Social Sciences & Humanities Open, v. 4, 2021, pp. 1–6.

GOROBETS, Kostiantyn. "Solidarity as a Practical Reason: Grounding the Authority of International Law". Netherlands International Law Review, v. 69, 2022, pp. 3-27.

GOSTIN, Lawrence O. Global Health Law. Cambridge: Harvard University Press, 2014.

GREEN, Jeremy; FARMER, Paul; BASSETT, Mary-Jo DelVecchio. “Colonial Medicine and Its Legacies”. In: FARMER, Paul; KLEINMAN, Arthur; KIM, Jim Yong; BASSETT, Mary-Jo DelVecchio (eds.). Reimagining Global Health: An Introduction. Berkeley: University of California Press, 2013, pp. 33–73.

GRIMALDI, Nicole. "Bare & Myriadic Death. Necro-Subjection and the Pandemic Era". Coils of the Serpent, v. 10, 2022, pp. 1-33.

GROSS, Aeyal. “The Past, Present, and Future of Global Health Law beyond Crises”. American Journal of International Law, v. 115, 2021, pp. 754–771.

GÜNDOĞDU, Ayten. Rightlessness in an Age of Rights. Oxford: Oxford University Press, 2014.

HABERMAS, Jürgen. “Demokratie oder Kapitalismus?”. Blätter für deutsche und internationale Politik, v. 5, 2013, pp. 59–70.

HEGGEN, Alfred. Erfindungsschutz und Industrialisierung in Preußen 1793–1877. Göttingen: Vandenhoeck & Ruprecht, 1975.

HOFFMAN, Steven; COLE, Clarke. “Defining the Global Health System and Systematically Mapping its Network of Actors”. Globalization and Health v. 14, 2018, pp. 1–19.

HOLZSCHEITER, Anna. "A panacea for fixing global health governance? The promises and pitfalls of negotiating a new pandemic treaty". Global Governance Spotlight, v. 3, 2022, pp. 1-4.

HORKHEIMER, Max. Gesammelte Schriften. Band 14: Nachgelassene Schriften 1949-1972. Frankfurt am Main: Fischer, 1988.

HORKHEIMER, Max, "Materialism and Morality". In: Horkheimer, Max. Between Philosophy and Social Science: Selected Early Writings. Cambridge: MIT Press, 1993.

ISSAR, Siddhant. " Listening to Black Lives Matter: Racial Capitalism and the Critique of Neoliberalism". Contemporary Political Theory, v. 20, 2020, pp. 48-71.

JAEGGI, Rahel. Critique of Forms of Life. Cambridge: Harvard University Press, 2018.

JUNG, Anne. "Too Little, Too Late". 22 March 2022. Available at: <https://www.medico.de/en/too-little-too-late-18564>.

KAPCZYNSKI, Amy. "The Right to Medicines in an Age of Neoliberalism". Humanity Journal, v. 19, 2019, pp. 79-107.

KAPCZYNSKI, Amy. “Harmonization and its Discontents: A Case Study of TRIPS Implementation in India’s Pharmaceutical Sector”. California Law Review, v. 97, 2009, pp. 1571–1649.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

KENNEDY, Duncan. “Law Distributes I: Ricardo Marx CLS”. Working Paper 2021, <https://ssm.com/abstract=3813439>.

KNOWLEDGE PORTAL on innovation and access to medicines. "COVID-19 VACCINE R&D INVESTMENTS". 8 July 2021. Available at: <https://www.knowledgeportalia.org/covid-19-vaccine-r-d-funding>.

KOSKENNIEMI, Martti. "It’s not the Cases, It’s the System". Journal of World Investment & Trade, v. 18, 2017, pp. 343-353.

KWETE, Xiaoxiao. et al. "Decolonizing global health: what should be the target of this movement and where does it lead us?". Global Health Research and Policy 7, 2022, pp. 1-6.

LEVINE, Ruth. “Power in Global Health Agenda-Setting: The Role of Private Funding”. International Journal of Health Policy and Management (Int J Health Policy Mang), v. 4, 2015, pp. 315–317.

LUCHETTI, Marco. "Global Health and the 10/90 Gap". British Journal of Medical Practitioners, v. 7, 2014, pp. 731-732.

LUHMANN, Niklas. "On the Concept of Social Class". In: MORGNER, Christian. The Making of Meaning. From the Individual to Social Order. Oxford: Oxford University Press, 2022, pp. 165-216.

LUHMANN, Niklas. “Der medizinische Code”. Soziologische Aufklärung, v. 5, 1990, pp. 183–195.

LUHMANN, Niklas. The Differentiation of Society, 2020.

MBEMBE, Achille. Necropolitics. Durham: Duke University Press, 2019.

MBEMBE, Achille; BERCITO, DIOGO. "Pandemia Democratizou Poder de Matar, diz Autor da Teoria da Necropolítica". Gauchazh of 31 March 2020. Available at: <https://gauchazh.clicrbs.com.br/politica/noticia/2020/03/pandemia-democratizou-poder-de-matar-diz-autor-da-teoria-da-necropolitica-ck8fpqew2000e01ob8utoadx0.html>.

MEDICINES LAW & POLICY. NGO Medicines Law & Policy Database on TRIPS Flexibilities. Available at: <http://tripsflexibilities.medicineslawandpolicy.org>.

MEIER, Benjamin M. et al. "Global Obligations to Ensure the Right to Health: Strengthening Global Health Governance to Realise Human Rights in Global Health". Yearbook of International Disaster Law, v. 3, 2022, pp. 3-34.

MENDE-SIEDLECKI, Peter; TODOROV, Alexander; HAGGARD, Patrick. “Seeing No Pain: Distinguishing Sensory and Affective Components of Pain Perception in the Human Brain”. Emotion, v. 21, 2021, pp. 932–950.

MERCURIO, Bryan. “From Necessity to Flexibility: A Reflection on the Negotiations for a TRIPS Waiver for COVID-19 Vaccines and Treatments”. World Trade Review, v. 21, 2022, pp. 633–649.

MITSCHERLICH, Alexander et al. Doctors of Infamy. The Story of the Medical Crimes. Kessinger Publishing, 2008.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

MOFOKENG, Tlaleng. “Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health”. Report of 7 April 2021, A/HRC/47/28.

MONNAIS, Laurence. The Colonial Life of Pharmaceuticals: Medicines and Modernity in Vietnam. Cambridge: Cambridge University Press, 2019.

NYGREN-KRUG, Helena. "The Right(s) Road to Universal Health Coverage". Health Hum Rights, v. 21, 2019, pp. 215-228.

O’HARA, Claerwen. "Consensus and Diversity in the World Trade Organization: A Queer Perspective". American Journal of International Law, v. 116, 2022, pp. 32-37.

OSTERHAMMEL, Jürgen; JANSEN, Jan C. Kolonialismus. Geschichte, Formen, Folgen. Munich: C.H. Beck, 2021.

OSTROM, Elinor. "Governing the Commons. The Evolution of Institutions for Collective Action". Cambridge: Cambridge University Press, 1990.

OTIENO SUMBA, Eric. "Necropolitics at large: pandemic politics and the coloniality of the global access gap". Critical Studies on Security, v. 9, 2021, pp. 48-52.

PAHUJA, Sundhya. Decolonising International Law: Development, Economic Growth and the Politics of Universality. Cambridge: Cambridge University Press, 2011.

PAI, Madhukar. “Covidization of Research: What Are the Risks?”. Nature Medicine, v. 26, 2020, p. 1159.

PANTZERHIELM, Laura; HOLZSCHEITER, Anna; BAHR, Thurid. “Power in Relations of International Organisations”. Review of International Studies, v. 46, 2020, pp. 395–414.

PAPAMICHAIL, Andreas. “COVID-19, Racial Capitalism and the Liberal International Order”. International Affairs, v. 99, 2023, pp. 1673–1691.

PEREZ, Oren. “Transnational Networked Authority”. Leiden Journal of International Law, v. 35, 2022, pp. 265–293.

PETERS, Anne. “COVID-19 as a Catalyst for the (Re-)Constitutionalisation of International Law: One Health – One Welfare”. In: MBENGUE, Makane Moïse; D’ASPREMONT, Jean (eds.). Crisis Narratives in International Law. Leiden/Boston: Brill Nijhoff, 2021, pp. 85–99.

PHELAN, Alexandra. “The World Health Organization’s Pandemic Treaty”. BMJ, v. 380, 2023, pp. 1–2.

PINHEIRO ASTONE, Daniel. "Scarcity, Property Rights, Irresponsibility: How Intellectual Property Deals with Neglected Tropical Diseases". Law and Critique, v. 34, pp. 145-164.

PRATA, Joana C.; RIBEIRO, Ana Isabel; ROCHA-SANTOS, Teresa. “An Introduction to the Concept of One Health”. In: id. (eds.). One Health. Integrated Approach to 21st Century Challenges to Health. Academic Press, 2022, pp. 1–31.

PRATT, Bridget; DE VRIES, Jantina. "Where is knowledge from the global South? An account of epistemic justice for a global bioethics". Journal of Medical Ethics, v. 49, 2023, pp. 325-334.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

QUIJANO, Aníbal. “Colonialidad del Poder, Eurocentrismo y América Latina”. In: LANDER, Edgardo (ed.). La Colonialidad del Saber: Eurocentrismo y Ciencias Sociales. Perspectivas Latinoamericanas. Buenos Aires: CLACSO, 2000, pp. 201–246.

QUINTANA, Francisco-José; URIBURU, Justina. “Modest International Law: COVID-19, International Legal Responses, and Depoliticization”. American Journal of International Law (AJIL), v. 114, 2020, pp. 687–697.

RANDERIA, Shalini. “Entangled Histories of Uneven Modernities: Civil Society, Caste Solidarities and Legal Pluralism in Post-Colonial India”. In: ELKANA, Yehuda et al. (eds.). Unraveling Ties. Frankfurt am Main: Campus Verlag, 2002, pp. 284–311.

RANGANATHAN, Surabhi. "Clobal Commons". European Journal of International Law, v. 27, 2016, pp. 693-717.

RANJAN, Prabhash; GOUR, Praharsh. "The TRIPS Waiver Decision at the World Trade Organization: Too Little Too Late! ". Asian Journal of International Law, v. 13, 2022, pp. 10-21.

RIEDL, Rupert; KREUZER, Franz (eds). “Evolution und Menschenbild“. 1983, pp. 225–241.

ROBINSON, CEDRIC J. Black Marxism. Chapel Hill: University of North Carolina Press, 1983.

SAMSON, Colin. The Colonialism of Human Rights: Ongoing Hypocrisies of Western Liberalism. Cambridge: Polity Press, 2020.

SAMTANI, Sanya. “Human Rights, Harmonious Interpretation and the Hegemonic International Trade Regime”. South African Intellectual Property Law Journal, v. 10, 2022, pp. 66–104.

SANDSET, Tony. "The necropolitics of COVID-19: Race, class and slow death in an ongoing pandemic". Glob Public Health, v. 16, 2021, pp. 1411-1423.

SAUVÊTRE, Pierre. "Forget Ostrom: From the Development Commons to the Common as Social Sovereignty". In: COGOLATI, Samuel; WOUTERS, Jan. The Commons and a New Global Governance, Edward Elgar Publishing, 2018, pp. 78-101.

SCHAEFER, Brett; GROVES, Steven. "Why the U.S. Should Oppose the New Draft WHO Pandemic Treaty". Issue Brief No. 5306. The Heritage Foundation of 27 February 2023.

SCHUMAN, Jacob. "Beyond Nuremberg: A Critique of 'Informed Consent' in Third World Human Subject Research". Journal of Law and Health, v. 25, 2012, pp. 123-153.

SEKALALA, Sharifah. “Third World Access to Essential Medicines and the WTO General Council Decision 2003”. King’s Law Journal, v. 21, 2010, pp. 172–192.

SEKALALA, Sharifah. Soft Law and Global Health Problems. Cambridge: Cambridge University Press, 2018.

SEKALALA, Sharifah; FORD, Liz; LALANDE, Emilie. “Decolonising Human Rights: How Intellectual Property Laws Result in Unequal Access to the COVID-19 Vaccine”. BMJ Global Health, v. 6, 2021, p. 1.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

SHERRY, Melissa; BISHAI, David. "Continuity between Comprehensive Primary Health Care and Sustainable Development Goals". In: SCHLEIFF, Meike; BISHAI, David. Achieving Health for All: Primary Health Care in Action. Baltimore: John Hopkins University Press, 2020, pp. 102-126.

SIPRI. World Military Expenditure Passes $2 Trillion for First Time. 25 April 2022. Available at: <https://www.sipri.org/media/press-release/2022/world-military-expenditure-passes-2-trillion-first-time>.

SIRLEAF, Matiangai. "Responsibility for Epidemics". Austin: Texas Law Review, v. 97, 2018, pp. 285-354.

SPARKE, Matthew; WILLIAMS, Owain David. “Neoliberal Disease: COVID-19, Co-Pathogenesis and Global Health Insecurities”. Environment and Planning A: Economy and Space, v. 54, 2022, pp. 15–32.

SPIVAK, Gayatri Chakravorty. “Can the Subaltern Speak?”. In: NELSON, Cary; GROSSBERG, Lawrence (eds.). Marxism and the Interpretation of Culture. Urbana: University of Illinois Press, 1988, pp. 271–313.

SPIVAK, Gayatri Chakravorty. “Righting Wrongs”. The South Atlantic Quarterly, v. 103, 2004, pp. 523–581.

SPIVAK, Gayatri Chakravorty. A Critique of Postcolonial Reason: Toward a History of the Vanishing Present. Cambridge: Harvard University Press, 1999.

SUCKER, Franziska; KUGLER, Kholofelo. “The Proposed TRIPS COVID-19 Waiver”. Manchester Journal of International Economic Law, v. 19, 2022, pp. 37–64.

TEUBNER, Gunther. “State Policies in Private Law?”. The American Journal of Comparative Law, v. 56, 2008, pp. 835–844.

TEUBNER, Gunther. Constitutional Fragments. Societal Constitutionalism and Globalization. Oxford: Oxford University Press, 2012.

THAMBISETTY, Sivaramjani; et al. “Addressing Vaccine Inequity during the COVID-19 Pandemic”. Cambridge Law Journal, v. 81, 2022, pp. 384–416.

THE LANCET COMMISSION, "The Lancet Commission on lessons for the future from the COVID-19 pandemic". The Lancet, v. 400, 2022, pp. 1224-1280.

THE NEW YORK TIMES. Tracking Coronavirus Vaccinations Around the World. 13 March 2023. Available at: < https://www.nytimes.com/interactive/2021/world/covid-vaccinations-tracker.html>.

TILLEY, Helen. Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870–1950. Chicago: University of Chicago Press, 2011.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250

VON BOGDANDY, Armin; VILLARREAL, Pedro. “The Role of International Law in Vaccinating Against COVID-19: Appraising the COVAX Initiative”. Zeitschrift für ausländisches öffentliches Recht und Völkerrecht, v. 81, 2021, pp. 89–116.

VON SCHENBACH, Jelena. “The Global Distribution of COVID-19 Vaccines by the Public-Private Partnership COVAX from a Public-Law Perspective”. Leiden Journal of International Law, v. 36, 2023, pp. 971–995.

WAKANKAR, Milinid. Subalternity and Religion. The Prehistory of Dalit Empowerment in South Asia. London: Routledge, 2010.

WASHINGTON, Harriet A. Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present. New York: Anchor Books, 2008.

WHITE, Alexandre I. R. Epidemic Orientalism. Race, Capital, and the Governance of Infectious Disease. Stanford: Stanford University Press, 2023.

WHYTE, David; KNOX, Robert. “Vaccinating Capitalism: Racialized Value in the COVID-19 Economy”. Mortality, v. 2, 2023, pp. 329–345.

WORLD BANK; WORLD HEALTH ORGANIZATION. “Tracking Universal Health Coverage”. Global Monitoring Report, 2021.

WORLD HEALTH ORGANIZATION. "Neglected tropical diseases". Available at: <https://www.who.int/health-topics/neglected-tropical-diseases>.

YAYA, Sanni; YI, Yunfeng; ZAIDI, Zubair. “Ethnic and Racial Disparities in COVID-19-related Deaths: Counting the Trees, Hiding the Forest”. BMJ Global Health, v. 5, 2020, pp. 1–5.

About the author
Andreas Fischer-Lescano, University of Kassel, Kassel, Germany.. E-mail: fischer-lescano@uni-kassel.de. ORCID: https://orcid.org/0000-0002-0606-2099.

Authorship credits
The author is solely responsible for writing the article.

Conflict of interest statement
There are no possible conflicts of interest in carrying out and communicating the research.

Funding information
This research was not funded.

Data Availability Statement
Data sharing is not applicable to this article as no data / new data were created or analyzed in this study.

Editors Responsible for the Evaluation Process and Editing
Carolina Alves Vestena and Bruna Bataglia.

https://doi.org/10.1590/2179-8966/2025/89250 | ISSN: 2179-8966 | e89250