Title

Whose Lives Are Worth Saving? Standpoint Theory, Racial Capitalism, and the Cancer-Malaria Funding Gap

Author

Veld, Steven

Publication Date

2026-03-16

Whose Lives Are Worth Saving? Standpoint Theory, Racial Capitalism, and the Cancer-Malaria Funding Gap

Steven Veld[1]

[1]Computer Science Department, University of California, Los Angeles

*sveld03@g.ucla.edu

Abstract: This paper uses standpoint theory and the heteropatriarchal triad to problematize global health disparities, focusing on the case studies of cancer and malaria treatment. It then discusses community-led alternatives to global health initiatives.

1. INTRODUCTION

The U.S. Department of Health and Human Services (HHS) estimates the *value per statistical life* (VSL) to be $13.6 million [4]; this means U.S. federal agencies deem health and safety regulations worthwhile if they are estimated to save at least one life per $13.6 million spent. This is indicative of a something bigger: life is extremely valuable, and those with the means to save lives – governments, philanthropists, and even corporations – should be willing to spend a lot of money to do so.

In many cases, funders are more than willing to invest in life-saving interventions. In 2023, $223 billion was spent on cancer treatment worldwide [5]; at the margin, high-income countries such as the U.S. spend $1-5 million in cancer care for each additional death averted [6].

However, this generosity is not universal. Today, it costs roughly $4,000 to save a life by donating to cost-effective malaria interventions [7]. The same $1-5 million that the U.S. spends to save a life from cancer could save hundreds of lives from malaria; the same $13.6 million that is deemed worthwhile to save one life could save thousands. By this logic, funders should be pouring money into malaria treatments as they do with cancer. Yet, in 2023, only $4 billion was spent on malaria interventions globally [8]; in 2024, this dropped to $3.9 billion, $5.4 billion short of the target set by the World Health Organization (WHO) [9].

This disparity raises the question of why funders are willing to spend so much more to save a life from cancer than from malaria. The answer: cancer is most prevalent in wealthy nations [10], while malaria affects predominantly low-income countries – 95% of malaria cases occur on the African continent alone [11].

The case studies of cancer and malaria illustrate a broader trend: medical and humanitarian funding is not impartial, but rather driven by the political and economic interests of dominant groups. This analysis will investigate and problematize how the global health landscape has been shaped by hegemonic interests and narratives, and explore alternative community-led models of health and development. Rather than striving for an unattainable "view from nowhere," the analysis will adopt a view from below to attain a clearer picture of the ways in which dominant STEM paradigms marginalize those in the Global South.

This work is in partial fulfillment of the ENGR184 course using the blueprint curriculum in Ref [1,2] and captured in a collection [3].

2. METHODS

One methodological framework used in this analysis is *standpoint theory*. Standpoint theory posits that marginalized groups have an *epistemic advantage* – that is, they have exposure to both hegemonic and marginalized perspectives – and thus starting inquiry from the lives of marginalized groups produces more comprehensive and reliable knowledge, achieving *strong objectivity* [12]. Standpoint theory will be used to elucidate how decisions that are touted as "objective" are rooted in dominant assumptions shared across the entire medical funding apparatus. Additionally, the analysis will draw upon critiques of settler colonialism, racial capitalism, and the heteropatriarchal triad [13], investigating how the structural forces of property, sovereignty, and personhood have produced and maintained vast disparities in global health.

These methods will be used to answer the central question of whose interests shape health outcomes around the world and by what means, using cancer and malaria as case studies to illustrate broader health disparities between the Global North and the Global South. The analysis will include both an empirical examination of the 21st century funding landscape, along with a more holistic view of how colonial extraction created the economic conditions and set the decision-making precedents that exist today.

3. RESULTS AND INTERPRETATION

3.1. PROBLEMATIZING THE GLOBAL HEALTH LANDSCAPE

Investment in medicine and global health is not impartial, but driven by hegemonic interests and narratives. Disparities in funding are rooted in pharmaceutical market incentives, colonial extraction, and governance frameworks that concentrate decision-making power among wealthy nations. Analyzed through standpoint theory and the heteropatriarchal triad, these disparities reveal how racial capitalism shapes whose suffering counts as a research priority and whose lives are deemed "worth" saving.

The case study of cancer vs. malaria funding is indicative of a more pervasive issue, colloquially known as the 10/90 gap: less than 10% of global health R&D addresses conditions responsible for over 90% of the world's preventable mortality [14]. This gap is not new: it was first brought to light in 1990, and has likely been true for much longer.

One primary perpetrator of this disparity is the structure of modern capitalism itself. The assumption of capitalism is deeply baked into the hegemonic view of medical progress, driven largely by the pharmaceutical industry. The pharmaceutical industry's R&D priorities are driven by anticipated return on investment. There is little opportunity to get an adequate return on investment for diseases such as malaria and tuberculosis, which mainly affect people living in low-income countries [15]; as such, there is little incentive for pharmaceutical companies to invest. This is evident in the rate at which new drugs are released: the FDA approved over 60 oncology drug indications in 2024 [16], while only 37 new treatments for the full collection of neglected diseases were brought to market in the entire period from 2000 to 2011 [17].

A critical insight from racial capitalism is that there is, in fact, no other existing form of capitalism [18]. Modern capitalism emerged from colonial ventures and slavery; the extractive nature of European and American resource acquisition created the hierarchy that gives the modern pharmaceutical industry its power in the first place. Here, we see the first element of the heteropatriarchal triad – *property* – as a key factor in the creation of this systemic inequality. Property has also been essential in the maintenance of inequality, in the form of patents. Patents enable pharmaceutical companies to charge prices above marginal costs in order to make profits [19]; as a result, those most in need of vaccines and other medicine are often unable to afford them. For example, the RTS,S/AS01 malaria vaccine was initially priced at

approximately $10 per dose [20], while in Nigeria the median willingness to pay was just $0.38 per dose [21].

Importantly, corporations are not the only entities complicit in this phenomenon: governments, philanthropists, and non-government organizations have also played a role in entrenching colonial power and subsequently benefiting from it. Historically, colonial governments dispensed the antimalarial treatment quinine for Europeans but not for Indigenous populations, and housing plans mandated that European dwellings be located at high altitudes, half a mile away from any Indigenous dwelling [22]. At the expense of Indigenous health, these practices advanced European interests both economically (via selectively allocating resources to colonizers who were deemed economically essential) and via direct effects on relative population sizes of colonists and Indigenous peoples.

In the present day, the WHO is one such organization that advances the interests of wealthy donors and hegemonic Western world views. While in principle the WHO follows a one-country-one-vote system in the World Health Assembly [23], in practice they rely on roughly 80% voluntary contributions [24], giving wealthy donors outsized influence on how funding is allocated among programs. In the International Monetary Fund (IMF), the U.S. holds 16.52% of voting power, giving them effective veto power over major decisions requiring 85% approval [25]; meanwhile, 21 African countries collectively hold 3.26% voting power [26]. This evidence points to the role of *sovereignty* in shaping global health outcomes: when the United States government and wealthy donors have effective sovereignty over whether and how funds are allocated to address health problems in African nations, the outcomes will be reflective of the interests and knowledge of the American elite rather than that of the people whose lived experience is directly relevant to the issue at hand.

Thus far, this essay has primarily discussed the inputs (funding) and outputs (vaccines and other pharmaceuticals) of the research process. However, the process itself is also fraught with hegemonic assumptions, biases, and incentives. These distorting factors are often not uncovered by traditional standards of weak objectivity, however, which merely requires research to be internally consistent. Weak objectivity leaves the "context of discovery" up to the individual researcher, thus neglecting to consider the social values and interests that shape which problems researchers deem worthy of scientific examination [12]. In a culture deeply influenced by its racist and colonial roots, it is no surprise that researchers elect to invest their time and money into diseases that affect those more closely resembling themselves. For example, over 80,000 cancer-related clinical trials have been initiated to date [27], relative to merely hundreds of malaria vaccine trials [28].

The interests that are embedded in the context of discovery ripple throughout the research process. In particular, the process of clinical trials illustrates how assessments of *personhood* further serve to undermine the interests of marginalized groups. The current model of clinical trials often replicates colonial dynamics, where samples and data are appropriated from the Global South by teams in the Global North, with little benefit shared with the participants [29]. Decolonizing this process requires a fundamental shift in power, moving from "power over" to "power with" [30].

3.2. COMMUNITY-LED ALTERNATIVES

A real-world application of the strong objectivity framework can be seen in the citizen science program (CSP) for malaria control in Rwanda. This initiative challenges the dominant technocratic model by placing citizens at the center of disease surveillance [31].

Unlike previous top-down approaches to malaria prevention, the CSP was codesigned with community members through participatory workshops; citizens weren't just recipients of interventions but active participants in defining research questions, collecting data (mosquito species, nuisance levels, malaria cases), and interpreting results. Volunteers reported gaining knowledge about mosquito species and malaria control, expanded their social networks, and initiated collective action like home visits to non-volunteers and village-level meetings about malaria prevention. Even non-volunteers showed significant improvements in malaria-related perceptions and behavior.

This is standpoint theory in action: while foreign interventionists lack relevant on-the-ground knowledge such as how malaria interventions will interact with the day-to-day lives of Rwandan citizens, Rwandans have clearly demonstrated that they are able to effectively generate and share knowledge on their own terms. Most importantly, the program is likely to yield much larger long-term benefits because it is sustainable: when affected communities participate in the production of knowledge rather than just the consumption of interventions, it reduces the reliance on foreign aid that colonialists have propagated for centuries. Not only is the hierarchy of dependence inherently problematic, but it is further exacerbated by the various misaligned incentives discussed in the previous section; with community-led programs such as the CSP, the incentives of the program fundamentally reflect the goals of the community.

The lessons from Rwanda's CSP suggest a replicable model that could be adapted across malaria-endemic regions and beyond. Major funders like the Global Fund and the Bill & Melinda Gates Foundation could require that a minimum percentage of program funding support participatory research design, in which community members co-define research priorities and data collection methods. This would institutionalize the epistemic shift that strong objectivity demands: rather than treating Western cost-effectiveness analyses as the sole basis for resource allocation, funders would incorporate the questions and priorities emerging from the standpoint of those most affected.

Organizations like WHO have ongoing consultations on community engagement; one concrete action that a policy-savvy individual could take would be to submit to the WHO a policy brief grounded in the empirical evidence from the CSP and advocating for WHO to take the lead on enabling community-led programs worldwide. Such a proposal could also be developed into an article for a publication like *The Lancet Global Health*, both contributing to the academic literature and serving to raise awareness about the promise and importance of citizen science.

CONCLUSIONS

The orders-of-magnitude gap in funding between cancer and malaria is not a neutral outcome of resource constraints, but the product of a global health architecture built on colonial foundations and sustained by racial capitalism. Through the frameworks of standpoint theory and the heteropatriarchal triad, this analysis has shown how sovereignty, property, and personhood operate to determine whose suffering warrants investment under hegemonic world views, and whose does not. Rwanda's citizen science program demonstrates that when affected communities participate in knowledge production rather than merely receiving interventions, health outcomes improve measurably. This paper discusses ways in which lessons from this program might be integrated into other efforts worldwide. Future work might apply this framework to other neglected tropical diseases, examine whether increasing African Union involvement in global health governance moves toward strong objectivity, or investigate how emerging technologies like AI-driven drug discovery could either reproduce or disrupt these structural inequities depending on who controls the research agenda.

REFERENCES

1. Lee, E., et al. (2023). Education for a future in crisis: Developing a humanities-informed STEM curriculum. arXiv preprint, arXiv:2311.06674. https://arxiv.org/abs/2311.06674
2. Carbajo, S. (2025). Nurturing deeper ways of knowing in science. Issues in Science & Technology, 41(2), 71. https://doi.org/10.58875/jkrw4525
3. Carbajo, S. (2026). Queered Science & Technology Center: Volume 4. Queered Science & Technology Center, 4. https://escholarship.org/uc/item/0zb930m0
4. Kearsley, A. (2025). HHS standard values for regulatory analysis, 2025 (Data Point). U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/documents/639756a60fbe7e51786bcec176ad52f1/Standard-RIA-Values-2025.pdf
5. IQVIA Institute. (2024). Global oncology trends 2024: Outlook to 2028. https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/global-oncology-trends-2024
6. Chow, R.D., Bradley, E. H., & Gross, C.P. (2022). Comparison of cancer-related spending and mortality rates in the US vs 21 high-income countries. JAMA Health Forum, 3(5). https://doi.org/10.1001/jamahealthforum.2022.1229
7. GiveWell. (2025). Our top charities. https://www.givewell.org/charities/top-charities
8. World Health Organization. (2024). World malaria report 2024. https://worldmalariareport2024.org/current-state
9. United Nations News. (2025, December). Malaria: Drug resistance and underfunding threaten progress towards eliminating killer disease. https://news.un.org/en/story/2025/12/1166508
10. World Population Review. (n.d.). Cancer rates by country. https://worldpopulationreview.com/country-rankings/cancer-rates-by-country
11. World Health Organization. (n.d.). Malaria [Fact sheet]. https://www.who.int/news-room/fact-sheets/detail/malaria
12. Harding, S. (2015). Objectivity and diversity: Another logic of scientific research. University of Chicago Press. https://doi.org/10.7208/9780226241531
13. Perry, I. (2018). Vexy thing: On gender and liberation. Duke University Press. https://www.jstor.org/stable/j.ctv11cw534
14. Viergever, R. F. (2013). The mismatch between the health research and development (R&D) that is needed and the R&D that is undertaken: An overview of the problem, the causes, and solutions. Global Health Action, 6, 22450. https://doi.org/10.3402/gha.v6i0.22450
15. Herrling, P. (2007). Patent sense. Nature, 449, 174–175. https://doi.org/10.1038/449174a
16. American Association for Cancer Research. (2025, January 3). FDA approvals in oncology: October–December 2024. AACR Blog. https://www.aacr.org/blog/2025/01/03/fda-approvals-in-oncology-october-december-2024/
17. Yamey, G., Batson, A., Kilmarx, P. H., & Yotebieng, M. (2018). Funding innovation in neglected diseases. BMJ, 360, k1182. https://doi.org/10.1136/bmj.k1182
18. Wispelwey, B., Osuagwu, C., Mills, D., Goronga, T., & Morse, M. (2023). Towards a bidirectional decoloniality in academic global health: Insights from settler colonialism and racial capitalism. The Lancet Global Health, 11(9), e1469–e1474. https://doi.org/10.1016/S2214-109X(23)00307-8
19. Correa, C. M. (2005). The TRIPS Agreement and access to drugs in developing countries. Sur – International Journal on Human Rights, 2(3). https://sur.conectas.org/en/trips-agreement-access-drugs-developing-countries/
20. Okeibunor, J. C., et al. (2024). Policy uptake and implementation of the RTS,S/AS01 malaria vaccine in sub-Saharan African countries: Status 2 years following the WHO recommendation. BMJ Global Health, 9(4), e014727. https://doi.org/10.1136/bmjgh-2023-014719
21. Dim, O.F., et al. (2025). Awareness, acceptability, and willingness to pay for the R21/Matrix-M malaria vaccine: A cross-sectional study among pregnant women and nursing mothers in Enugu State, Nigeria. BMC Public Health, 25, 878. https://pmc.ncbi.nlm.nih.gov/articles/PMC12625000/

22. Bump, J.B. & Aneibo, I. (2023). Colonialism, malaria, and the decolonization of global health. PNAS Nexus, 2(3), pgad072. https://pmc.ncbi.nlm.nih.gov/articles/PMC10021769/
23. Forster, T., Honig, D., & Kentikelenis, A. (2025). Formal governance matters: When, how, and why states act on the IMF Executive Board. Review of International Political Economy, 32(3), 818–846. https://doi.org/10.1080/09692290.2024.2441136
24. Kaiser Family Foundation. (n.d.). The U.S. government and the World Health Organization. https://www.kff.org/global-health-policy/the-u-s-government-and-the-world-health-organization/
25. Bretton Woods Project. (2020, April). IMF and World Bank decision-making and governance. https://www.brettonwoodsproject.org/2020/04/imf-and-world-bank-decision-making-and-governance-2/
26. Ngaire Woods. (n.d.). Unelected government: Making the IMF and the World Bank more accountable. Brookings. https://www.brookings.edu/articles/unelected-government-making-the-imf-and-the-world-bank-more-accountable/
27. Joshi, G., et al. (2025). The Current Landscape of Clinical Trials. https://pmc.ncbi.nlm.nih.gov/articles/PMC11989625/
28. World Health Organization. (2022). WHO review of malaria vaccine clinical development, November 2022. Global Observatory on Health Research and Development. https://www.who.int/observatories/global-observatory-on-health-research-and-development/monitoring/who-review-of-malaria-vaccine-clinical-development-nov-2022
29. Bedecker, A., et al. (2022). A framework for the promotion of ethical benefit sharing in health research. BMJ Global Health, 7(2), e008096. https://doi.org/10.1136/bmjgh-2021-008096
30. Keikelame, M. J., & Swartz, L. (2019). Decolonising research methodologies: lessons from a qualitative research project, Cape Town, South Africa. Global health action, 12(1), 1561175. https://doi.org/10.1080/16549716.2018.1561175
31. Asingizwe, D., et al. (2020). What do people benefit from a citizen science programme? Evidence from a Rwandan citizen science programme on malaria control. Malaria journal, 19(1), 283. https://doi.org/10.1186/s12936-020-03349-8