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Boehm Lecture in Public Health and Healthcare

Toronto, May 8, 2024

How Can Canadians Help Lead the Global Fight for Health Equity?[1]

Exploring the concept of solidarity and leadership in pandemic, epidemic and war responses and explain why, in an era of rampant commercialization and commodification of life-saving medicines, healthcare must be secured as a global public good.

Introduction and thanks…

- It is a privilege to be here tonight with all of you – thank you for coming.
- I am very grateful for the chance to share knowledge on the traditional land of the Huron - Wendat, the Seneca, and the Mississaugas of the Credit.
- A special thanks to Prof. Boehm for his work and for supporting this lecture series, to Prof. Steiner and his team at the *DLSPH* for the invitation, and Naheed Mustapha, Greg Kelly and Nahla Ayed at *CBC Ideas* and the team there.
- I want to dedicate this lecture to the 14 million + people who died in the COVID pandemic in the space of just two years when life-saving technologies existed that could have mitigated unimaginable loss, but were denied to us, so that human greed, nationalism and hoarding caused untold suffering and death.

A. Apartheid second-class citizens…

I grew up under apartheid, a system characterised by inequality against Black people in education, healthcare, housing and land ownership. Those who protested it were detained without trial, imprisoned or executed. I was five years old when the historical student-led uprising of 1976 called the "Soweto Riots" took place. The uprising is now commemorated as Youth Day in June.

[1] With thanks to Prof. Matthew Herder, Dr Shuaib Manjra, Christine McNab for reviewing earlier drafts of this lecture. This lecture also draws on ideas and remarks included in previous lectures, op. eds, reports and articles prepared by me, the Health Justice Initiative and our partner organisations.

The context which I come from is one of youth-led movements, mobilising in the streets, in the courts, in international fora, one with historic exclusion, and it influences all of my work:

1. At present, my country, owing to this legacy of apartheid, colonialism and racism, is regarded as one of "the most economically unequal countries in the world… this inequality has grown in the last decade."[i] Still, the richest 10% of people, the majority of whom are white, own more than 90% of the country's wealth.[ii]
2. Inequality has a profound impact on the cost of healthcare and medicines. And it should, therefore, influence our policies to make health rights a reality.
3. Many of you are familiar with this level of historical exclusion and racial division.
4. But of course, I can't be here in Toronto, Canada and not thank you for your solidarity in helping us fight apartheid.
    a. Canada was one of the first countries to respect the Boycott, Divestment and Sanctions (BDS) call and impose, rightly so, sanctions against the apartheid government in SA. Thank you![iii]
    b. The late Brian Mulroney, Canada's Prime Minister, was an ally of the anti-apartheid movement who also campaigned tirelessly for Nelson Mandela's release.
    c. His "tough stance" against apartheid SA is considered to be one of his finest legacies – also earning him my country's highest honour for foreign citizens in 2015.
    d. On his passing, a really important article to honour his legacy was published by Peter Loewen setting out key lessons from his work against apartheid:
        i. Mulroney "recognised apartheid as indefensible and contrary to Canadian values;"
        ii. he leveraged political and personal power;[iv] and
        iii. he played a long game – on Mandela's release, he waited for the *actual system* of racial separation in SA law to be dismantled before agreeing to lift sanctions.[v]
5. Mulroney is not alone: thousands of Canadians supported our struggle for freedom. These include:

    a. Ken Luckhardt and Brenda Wall who received honour awards just days ago. They were recognised for twenty years of campaigning against apartheid by mobilising protests, boycotts and sanctions. No one else from Canada except Brian Mulroney has so far been given this SA honour:

While studying at the University of Alberta, Luckhardt and Wall's first act of resistance was organising a mass occupation of a cricket pitch in Edmonton, Alberta, when an Apartheid-sponsored cricket team was paraded across Canada in 1976. They were arrested along with 59 other protestors who were eventually acquitted.

They previously said:

"The supermarkets in St. Catharines, Ontario certainly didn't expect a group of mostly white, working-class auto workers to fill up their carts with South African products like canned fruit, only to abandon them on the conveyor and state that the goods were from Apartheid South Africa."[vi]

B. Let's talk about global wealth inequality and the "billionaire" class...:

1. As I have just shared, in my country, poverty is alarmingly high. We see it everywhere and this has been the reality 30 years since our democratic transition in 1994, celebrated just days ago.
2. Inequality is not natural and it has a huge impact on our ability to access affordable healthcare.
3. Domestically, not just in SA, it thrives because of a **global** backdrop of staggering economic inequality and global trade, regulatory, and economic policies or rules that do not prioritise the economic upliftment of poor people everywhere, forcing us to rely on charity and what I call "voluntary benevolence" from donors and richer governments.
4. Oxfam's 2024 Inequality Report[vii] shows that a **handful** of billionaires and financiers in the Global North control a system of global **economic** apartheid.
5. Their big corporations and market monopolies have historically created unprecedented inequality and wealth on the backs of the poorest people and of the poorest nations.
6. To put the global wealth disparity crisis in perspective, Oxfam's Report reveals that:
    a. Since 2020 (when COVID started) almost **five billion people** have become **poorer**.
    b. Poverty at current rates will not be ended for **230 years**, but we could have our first trillionaire in just over a decade.
    c. Seven out of ten of the world's biggest corporates have either a billionaire CEO or a billionaire as their principal shareholder.
7. As campaigners for access to equitable healthcare, we know all too well what this means for us:

a. While huge pharmaceutical corporations make more profit, ordinary people across the world are often denied timely access to medicines that could save their lives.
b. In the GS, we have experienced colonial exploitation and racism. Ultimately, we also want access to the best science has to offer, and to the fruits of scientific research and knowledge that we also contribute to, but at the SAME time as all of you in the GN.
c. So, I want you to imagine a loved one, or yourself finding out they or you have Tuberculosis (TB), cancer, HIV, or cystic fibrosis, and you find out that there is a drug that can cure them or you or prevent suffering or even death. And now imagine that you cannot access it, either because it is not sold in your country or because you cannot afford it. How would you feel about this?
d. Right now, people are dying from many diseases, like they did during COVID, while pharmaceutical corporations protect their markets and extraordinary profits.
e. Nations including Canada that contribute to scientific research too are often prevented from manufacturing health products, including medicines, that could help free us from dependence, neocolonialism and arbitrary trade rules.
    i. These "rules" are globally enforced and are commonly called *intellectual property* rules.
    ii. They require that for medicines, corporations anywhere can seek protection for a medical innovation, even if publicly funded, for at least 20 years. This usually is in the form of a patent, but there are other IP rights that companies in the medicine market regularly seek, including copyright claims, trade secrets and confidentiality.
    iii. In that 20-year period (and sometimes more) they have the exclusive right to manufacture the relevant medicine or vaccine. They can choose when to share the "recipe" with and with whom; we call this a 'voluntary license'. If a state compels them to share the technology before the expiry of the 20-year patent period, it is called a compulsory license. These rules are contained in an international agreement called TRIPS, governed by the WTO. Member states of the WTO are in turn required to domesticate these rules in their own laws – with a few exceptions.
    iv. Essentially, TRIPS codifies monopoly power, giving too much power to CEOs – they decide the price, the countries they will sell to or not sell to, and the pace and volume of manufacturing – which influences global supply chains.

8. Understanding TRIPS (the rules), and the historical role big pharmaceutical corporates played in *shaping* these rules to begin with, is key to understanding the reasons why the world failed to deliver medicines with urgency to treat HIV/AIDS in Africa in the 1990s and early 2000s, and why in COVID, again, as Africans, we were last in line. The same is true for cancer, TB, and cystic fibrosis medicines. The list is endless.

C. We have been here before... *From HIV to COVID: When Solidarity is just a word*[viii]

1. Just after our first democratic elections in the 1990s, my country tried to protect itself[ix] from these rules and pharmaceutical company interests.
    a. Mandela took on pharma power by passing a law that could enable us to access generic medicines to treat HIV and other diseases. These were more affordable but safe versions.
    b. He also wanted to make sure SA could import a cheaper version of a brand name drug to save on medicine costs.
2. Forty-nine multinational pharmaceutical companies responded by suing him in what became an epic global battle about medicine access and pricing and the ethics of power, at a time when SA could not afford the expensive drugs that could treat HIV/AIDS.[x]
3. The companies withdrew the case after global mass protests and a PR disaster. However, the laws Mandela tried to use were never fully utilised thereafter, which is why SA still has a medicine access crisis, on top of a two-tiered unequal health system.
4. Those vested interests continued in other ways and were compounded by Thabo Mbeki's refusal to accept the science of HIV/AIDS and the effectiveness of the medicines that could treat it.[xi] These conditions caused preventable deaths of hundreds of thousands of people and suffering in my country.
5. In the late 90s and early 2000s, most of the people living with AIDS in the world were in Africa and the rest of the GS, but the medicines that could treat HIV were not.
6. But the global solidarity during that time, including from researchers, academics, students, select governments and officials here in Canada and elsewhere[xii] was unprecedented, including from a dear colleague and friend Dr Stephen Lewis[xiii] a Canadian (who at the time was the UN Special Envoy on AIDS for Africa).
7. After many battles lasting almost a decade, involving protest action, litigation, civil disobedience and even importing our own drugs in defiance of SA's patent laws, we won the fight – SA now has the largest AIDS treatment programme in the world.

a. In fact, the last time I was in Toronto was for the XVI International AIDS Conference in the early 2000s.

b. The SA government's position on treating HIV/AIDS took centre stage: its infamous official display booth was "decorated with a garlic, beetroot and lemon exhibit" suggesting that as a remedy for treating HIV/AIDS. We engaged in civil disobedience, and we demolished the garlic stall and disrupted the SA Minister's speech too.

8. Stephen Lewis, as Special Envoy, in his closing speech at the conference (with our support as activists) stated that the SA government had a '*lunatic fringe'* attitude on AIDS, and that it had been '*obtuse, dilatory, and negligent about rolling out treatment'* – that one moment amplified the dysfunction of SA's response to a serious epidemic. His words will be etched in my memory forever.
    a. His speech lit up the room.
    b. It was followed by 65 of the world's leading scientists in the field of HIV/AIDS writing to the SA President calling for the SA Health Minister to be fired.[xiv]
    c. Stephen was of course temporarily barred from doing UN work in SA after that! And what struck me was his response:

    "While it may not be politically correct for a U.N. envoy to publicly condemn a member state....It is not my job to be silenced by a government when I know that what it is doing is wrong, immoral and indefensible." IOW, the duty to speak up trumps any role.
9. In 2008, the SA health minister was finally dismissed (for other reasons). That day, Stephen, Canadian health and human rights NGOs that we have worked with closely over the years, and all of us at the Treatment Action Campaign (TAC) and our allies worldwide celebrated together.
    a. Weeks later, I was asked to serve as the Special Advisor to the new Minister of Health, Barbara Hogan (a former political prisoner).
    b. You see, change does happen, even if it takes decades and when it is least expected.[xv]
10. Cleary, the SA government's denialism of the science of HIV/AIDS and big pharmaceutical companies' actions, backed by governments of rich countries, contributed to the suffering and deaths of thousands of people. They talked *solidarity* but *acted* to prevent poor countries from accessing affordable medicines that could prevent premature death.
    a. Moreover, when poor people were getting sick and dying in Africa from AIDS, we were "told" by the representatives of richer nations and pharmaceutical companies that we did not need those life-saving medicines because Africans "cannot tell time." So, the argument was we wouldn't take our medicines *on time*. Worse, if we used legal

measures to secure cheaper versions of the medicines, we would face trade or legal repercussions. As a result, millions of people in Africa died.[xvi]

b. And when we did get widespread access and generic medicines, it was because we fought for it – it was social movements that mobilised to demand access, at affordable prices.

Medicines should not be treated as luxury handbags, fancy cars or expensive perfumes

11. The death toll of HIV/AIDS then, and the global activism of the AIDS movement played a huge role to catalyse many groups and medicine access lawyers, researchers and activists to tackle undue medicine commodification and excessive profiteering ever since.
12. We advocated for the recognition of medicines and vaccines and diagnostic tests, for example, as public goods because these medicines save lives, and because publicly funded universities and state-supported institutions generate the research to develop them, and often Africans are trial or study subjects that help generate a knowledge base for researchers working on HIV, TB, cancer and more. But post-trial access and benefit sharing is not guaranteed and is a mere afterthought. That cannot be right.
13. When it mattered the most, we were not allowed to manufacture the medicines also known as the 'Lazarus drugs' for HIV (because it brought people back to life) even though we would have been able to manufacture the drugs. Instead, we were made to rely on charity, donations and empty promises. And we had to wait. [xvii]
14. Even with COVID, vaccines that had been created thanks to publicly funded research and the work of public scientists, were protected by IP and patent rules designed to make huge profits.
15. In my view, any policy decision (even if informal) to vaccinate everyone in the GN first, without prioritising timely access for the GS, is, frankly, rooted in racism – because for those people making such decisions, it suggests to us that black and brown lives in the GS matter less.

COVID's Many lessons: Inequality is profitable...

A pandemic beset by hoarding of scientific knowledge and life-saving vaccines is wrong

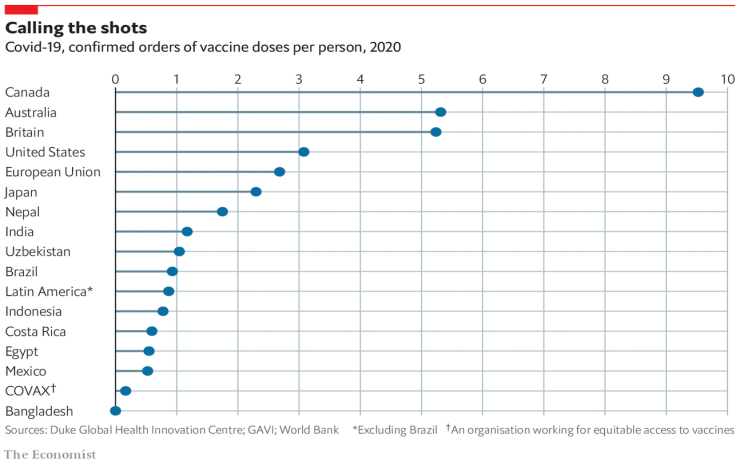
1. Let us recap what happened in the COVID pandemic with vaccine apartheid in 2020 and onwards:

a. By the end of 2021, according to the WHO, not even 10% of people in Africa were vaccinated.
b. Three of four healthcare workers in Africa were still waiting for a first dose of a vaccine.[xviii] The same workers being poached by richer nations such as Canada.
c. This is why even the DG of the WHO called the situation "morally grotesque" and a “recipe for seeding viral variants” capable of escaping vaccines.[xix]
d. And in 2022, when multiple vaccines were authorised for use in the GN and 11 billion vaccine doses had been administered, nearly seven of every ten of those doses administered benefited people living in wealthier countries. The share of people in the GS who managed to receive just a single vaccine dose was abysmally low, even among healthcare workers in Africa. Not vaccinating everyone, everywhere at the same time, in a pandemic, was one of the biggest failures of the global response to COVID, and it was a self-defeating public health strategy.
e. The Peoples Vaccine Alliance has documented the scale of profit for pharmaceutical corporations in 2021 and 2022[xx] all while vaccine nationalism[xxi]and vaccine apartheid prevented the proper management of the pandemic, causing untold suffering and death.
f. The cost? At least fourteen million people lost their lives[xxii] in two years; these are excess deaths associated with the pandemic.
g. So, "while the tools existed to mitigate the pandemic from December 2020 already, the political will to share supplies and knowledge was absent."[xxiii] This has also been described as a "moral failure" by the WHO.[xxiv]
h. These preventable deaths were caused and accelerated by the so-called "free market," IP protections, and lack of political will and genuine solidarity. The pandemic was a textbook case of how the political determinants of ill-health shape global responses to a pandemic.

I will return to this later as it is affecting the current *global* pandemic treaty negotiations and *domestic* efforts in many parts of the world to drop the high prices of medicines. And where well-funded vested interests are lobbying to remove equity and price transparency especially, from government undertakings.[xxv]

Vaccine apartheid

1. It is a myth to believe that high-income countries were *hit harder* by the COVID pandemic. Even if they were, they certainly did not "deserve" to have hoarded the lion's share of the global vaccine supply in 2021 and 2022.
2. By early 2021, because of the refusal to share the recipe to make vaccines, only a handful of manufacturers were allowed to make them, creating artificial global scarcity. I call this "hoarding" -of knowledge and of vaccine supplies.
3. Richer nations pre-purchased most of the vaccine supplies in 2020 already, affecting the availability and pace of delivery of supplies.
4. They pre-purchased enough doses to vaccinate their citizens reportedly three to five times over. The *Economist* [xxvi] reported Canada as being the lead over "order-er" - leading the pack in vaccine hoarding in 2020:



5. At the time, Canada **also drew supplies from COVAX** – a COVID vaccine funding, procurement and poling mechanism - the only G7 member to do so. COVAX was supposedly set up to address equitable access for GS and poorer countries who could not pay for vaccines themselves.[xxvii]
    a. This is one of the reasons I have always argued that COVAX was part of a bigger global health injustice because it allowed self-funding countries to jump the queue while pretending that it was focused on equity.[xxviii]
    b. Canada's decision to accept vaccines from COVAX was "the clearest evidence yet of how rich countries [were] hedging their bets"[xxix] over-ordering and clearing the shelves leaving us with nothing – and turning us into what the SA President called us: "beggars".[xxx]
6. The impact for the GS was dire – delaying vaccine access contributed to new variants, lockdowns, multiple travel bans that were often frankly racist, and self-defeating, as well as health, financial and economic devastation.

7. The *UN Committee on the Elimination of Racial Discrimination* in 2022 said that the "pattern of unequal distribution of vaccines within and between countries replicated slavery and colonial-era racial hierarchies and deepened structural inequalities affecting vulnerable groups."[xxxi] Let us unpack this:
    a. By December 2020 already, activists had warned that nine out of ten people in poor countries were set to miss out on a vaccine.[xxxii]
    b. By late April 2023, while ¾ of people in high-income countries had received at least two vaccine doses only six out of ten people in lower- and middle-income countries had received just a single vaccine dose.[xxxiii]
8. Canada was *not alone* in its gross vaccine nationalism:
    a. The French President, Macron, flew in his own special container of vaccines on his presidential jet when he visited SA in mid-2021 (part of his trip to Africa to "apologise" for France's role in the Rwanda genocide).[xxxiv] But – the vaccines Macron brought were only for *French people* living in SA, while the rest of us in SA were waiting and waiting for supplies from manufacturers including **Johnson & Johnson (**J&J), Pfizer and COVAX.[xxxv]
    b. We learnt from a *New York Times* exposé that the EU took about 30 million J&J vaccines filled and finished in SA and diverted them for *Europeans* while SA entered a devastating wave of COVID infections without supplies in 2021. In other words, when it mattered the most for us. Those exports were only paused when the story broke.[xxxvi] We were outraged by vaccines leaving our shores, for Europeans, when we had negligible access, as it triggered memories of segregation during apartheid (Europeans v Non-Europeans).
    c. The UK initially procured enough doses for four times its population – then dumped expired doses[xxxvii] and donated left-over doses,[xxxviii] claiming that its vaccination response was "a magnificent achievement."
    d. The US imposed a war-time measures ban on vaccines/materials leaving the US until it had vaccinated its population first – but reports of inequity in allocation within the US too soon emerged.[xl]
    e. In fact, *within* the US and in several other countries in the GN and the GS, there was also inequity: multiple vaccine programmes were found to have deliberately excluded Palestinians under occupation,[xli] asylum seekers, refugees, migrants, Hispanic communities, Indigenous communities, African American communities, people in rural areas, the elderly and people with comorbidities.[xlii]

f. The double standards practised, while our knowledge and trial participation were being extracted, enraged us in the GS.[xliii] You see, we took part in at least 4 COVID vaccine trials, contributing to the knowledge that enabled GN countries to start vaccination programmes much earlier than us.

D. Everything is a "secret" and "confidential" in a public health pandemic – scarce supplies for secrecy. *On the push for transparency to "let the light in..."*[xliv]

1. Secrecy fuels public health disinformation.
2. When the world did not prioritise vaccine doses for us in Africa and Latin America, our governments had to belatedly look and beg for supplies.
3. Akin to a hostage situation, supplies were then dependent on coerced acquiescence – secrecy. This fundamentally altered the expected principles of pricing transparency, competitive norms and open procurement standards.
4. The SA Government signed agreements with three manufacturers and COVAX.
    a. But the contracts were a **secret** and came at great cost to our "national sovereignty."
    b. During a two-year state of disaster, the HJI asked to see the vaccine contracts. We were told no, that it was confidential and subject to NON-DISCLOSURE AGREEMENTS (NDAs).[xlv]
    c. We argued that the public had a right to see the contracts, and to know what is in them because it cost us millions of rands of our tax money, and also our lives and livelihoods depended on them.
    d. We won. In 2023, the High Court[xlvi] in SA affirmed the public interest for disclosure and the principle of procurement transparency in a Constitutional democracy. It ordered the unredacted disclosure of all supply agreements and negotiation documents. Government complied.
5. A multistakeholder analysis of the four agreements[xlvii] detailed how the supply agreements favoured pharmaceutical companies, often to the detriment of the SA public and our national fiscus.
6. And the SA government, after fighting the case for close to two years, then finally admitted that it was "screwed" in the negotiations!
7. The agreements show how these vaccine companies "leveraged the conditions of the pandemic and their monopoly control with minimal transparency, eliminated accountability for the late, or even the complete failure, to deliver doses, and required full indemnification against all risk".

a. In Latin American countries, these companies demanded that governments there put up sovereign assets as collateral; our government refused to do so.[xlviii]
b. As Canadians, you paid for all the vaccine overordering of your government, so you may want to open up all of your contracts too....

8. Why? Well in SA, we found that in "all four agreements, the pernicious nature of pharmaceutical bullying was evident":
    a. We overpaid for vaccines compared to other countries even in the GN.
    b. We had very little leverage against late or no delivery of supplies.
    c. The most egregious term in the agreements was one where J&J demanded the right to[xlix] export any number of vaccine doses finished and filled in SA for European benefit *first*, contractually barring the SA government from imposing ANY export restrictions in ANY contract involving J&J - thus benefiting J&J and its ''VIP or preferred'' customer- the EU. This is how vaccines made in East London in SA, left my country for Europe.
9. Our forthcoming analysis of the *second part of the disclosed* documents (negotiation documents) shows that in that phase, there was an absurd level of arm twisting and contractual bullying, even by companies that SA did not sign final supply agreements with, like Moderna (for the better part of the pandemic, it reserved its supplies for richer nations and not a single African country). I mention Moderna because Canadians now have an interest in how this company operates; I will return to what that interest is shortly.
10. The legal case brought by HJI was significant because it affirmed that in a constitutional democracy, *emergency public sector procurement* cannot be secretive, and commercial confidentiality clearly does not translate to blanket secrecy that overrides the public interest.
11. However, despite this legal victory, even more pharmaceutical companies are insisting on NDAs in every part of the world – not just in SA – with broad confidentiality clauses, to suppress the disclosure of pricing and supply terms, particularly in negotiations covering medicines and tests for HIV, TB, and cancer.
12. *Let me just add here as an aside, that one of the most ridiculous aspects of litigating this case was when the pharmaceutical companies and government stated that even the legal name and legal service address of the companies that we bought vaccines from were ''confidential'' – they refused to confirm those details – so we sued the health department and told them it was their duty to deliver the legal papers on whomever it contracted with!*

E. Why does price transparency matter?

1. In a pandemic or emergency, with supply scarcity, price gouging is a common concern. To prevent or remedy that, transparency is critical.
2. In addition, in light of corporate profiteering, the public must know the basis of the pricing of these medicines since public money is used to buy these products and even fund research and development.
3. Price determination and scrutiny thereof also have a direct bearing on vulnerable populations and countries that wish to manage a public health emergency.
4. Over-paying for medicines comes at the cost of properly managing other diseases too.
    a. In SA, we recently took on J&J's pricing and secondary patent for a TB drug, called bedaquiline. Our anti-trust regulators announced an investigation into its conduct in September 2023, and **within days,** J&J announced a price reduction.
    b. A few weeks later, it announced a patent non-enforcement pledge for LMICs.
    c. I am aware that Canada like SA, is facing a TB crisis, particularly amongst Inuit populations. TB is preventable and treatable. There is massive underinvestment in new drugs and tests to diagnose TV, but there are drugs that are available that offer simpler adherence options.
    d. Bedaquiline, for example, is simpler to use for TB patients. I believe that it is still not available for general use in Canada. That is alarming.
5. So why did it take CSOs in India, Brazil and SA to force this massive price reduction and patent pledge? Why are states suddenly powerless to act against predatory pricing?
6. Because vested interests are lobbying to influence our regulators and our governments, everywhere. And at times, they bully us with governments doing nothing to stop it. This is happening in Canada too:
    a. Canada is reckoning with the fallout from the resignation of a leading medicine access scholar and others from the Canadian Patented Medicine Prices Review Board (PMPRB). The Board has the mandate to investigate medicine pricing in Canada.
    b. In his resignation letter Prof Matthew Herder stated:

> *Prior to the creation of the PMPRB, Canadians enjoyed access to relatively affordable medicines through a robust system of compulsory licensing and generic drug manufacturing. In 1987, Canada reformed its patent laws in an effort to satisfy its major trading partners while also encouraging the brand name pharmaceutical industry to finance more drug research and development (R&D) in the country…for the*

*past several years the prices of patented medicines in Canada have been the **third highest in the world, behind only the United States and Switzerland.***

c. And he said:

*In the "recent round of consultations, it was evident that **industry** would not accept the Board scrutinizing any price below the highest international price of the new basket of comparator countries. That position is fundamentally at odds with [inter alia]'the Board's core mandate of "policing excessive prices"...It is difficult enough for a sector-specific regulator to do its job in the face of a hostile industry**. But when government adds its voice to that of industry, all that lies before the regulator is an endless tunnel with no light.***

d. He concluded his resignation letter by saying:

***Canadian healthcare is in crisis**.*[l]

7. Make no mistake, this is a powerful and very profitable industry. And Matthew is not the only one in Canada to point out the risks of undue influence when you have a lucrative US$32 billion Canadian drug market on offer.[li]
8. What is the i**mpact on patients when commercialisation, commodification, non-regulation and inequity collide: There will be no equity locally.**
9. **With Canada's pharmacare here, I want to** suggest that you urgently think about reforming the practice of setting the prices of medicines in Canada.[lii]
    a. Pharmacare will over time include more pharmaceuticals.[liii] You therefore have a *golden opportunity* to advance equity and ensure that the right laws are passed to protect patients, not patents or corporations, and to make sure that you are not forced to pay obscene and excessive prices for essential medicines.
    b. Your fight will have ramifications elsewhere, be it via policy reform, price transparency norms, or even anti-trust investigations.[liv]

Now let me return to COVID:

F. The global trade and health System – Stacked to favour richer nations:

IP as "sacrosanct" – The TRIPS waiver proposal

1. Amid the worst pandemic in 100 years, with devastation globally, instead of a freely available public good, COVID technologies remained a commodity owned by companies, first sold to rich countries.
2. My colleagues and I have written in the British Medical Journal (BMJ) that this "moral scandal, enabled by corporate and political permission of mass death, is tantamount to a crime against humanity."[lv]
3. And despite socialising the risk of vaccine development through significant public funding and government-funded subsidies and initiatives [such as the USG's Operation Warp Speed] access was "privatised."[lvi] Yet, blockbuster profits resulted: In 2021 Oxfam reported that drug companies made "$1,000/ second" during the pandemic creating at least nine new COVID pandemic *vaccine billionaires*.[lvii]

G. The TRIPS waiver saga – we said what we needed; we were told we did not need that!

1. Against this backdrop, from 2020 to 2023, a surprisingly bold joint proposal from SA and India called the "TRIPS waiver" was tabled at the WTO in Geneva.
    a. Because of the lessons of the AIDS crisis, SA and India wanted to ensure that during COVID, IP barriers would not block access to life-saving vaccines and treatments, and other technologies for people in the GS.
    b. They wanted permission from member states to suspend the rules of the TRIPS agreement for the duration of the pandemic for COVID technologies including vaccines, COVID tests, and treatments.
2. My view is that the proposal was an "existential threat"[lviii] to the private pharmaceutical industry and to the continuing practice of treating medicines as a commodity (with implications for future climate change adaptation technologies too).
3. Of course, for all the reasons I have discussed already in my talk, the proposal was actively blocked by richer nations. Almost all countries that over-ordered vaccines, that "cleared the shelves"[lix] blocked the proposal, and mainly it was the US, EU, UK, Australia, Switzerland, Canada and Japan.
    a. Essentially, "high-income countries delayed and prevented textual negotiations and took it upon themselves to decide what low-income countries needed."[lx]
    b. Canada too started out opposing the proposal, but it then had a strange about-turn and said it would remain "neutral". It never really remained neutral.[lxi]

4. The proposal was, however, supported by one hundred countries, sixty-five co-sponsors (member states of the WTO), Nobel laureates, the DG of the WHO, The Independent Panel for Pandemic Preparedness and Response, the head of UNAIDS, faith leaders, trade unions, health groups, the African Union, researchers, scientists, economists, activists as well as many politicians.
5. But the WTO and its richer, more powerful member states scuppered all attempts to pass the waiver.[lxii] This is widely documented.
    a. The US initially opposed the proposal in its entirety but then announced limited support for a vaccine-only deal in May 2021, after some domestic public pressure.
    b. Eventually, by mid-2022, more than two years into the most urgent health crisis of the century, despite the death, infections, illness, economic and other forms of disruption, we were bullied into such a weak deal on vaccines that we regard it as a "a slap in the face of poor countries" . It did virtually nothing to expand COVID-19 vaccine access. [lxiii]
6. The irony is the mixed messaging and self-interest:
    a. Canada has for some time, insisted, like the US, despite its own use of compulsory measures in the past (Canada for anthrax, the US for COVID and more), that countries should not push for the relaxation of IP rules and use voluntary measures- i.e. ask for the cooperation of pharmaceutical companies (and we all know how that turns out...).Germany and Canada also passed laws about overriding patents during and for COVID.
    b. The EU on the other hand, 'gaslighted'' us. It said that IP rules do not need to be temporarily paused in a pandemic because all countries can in theory use what are called ''compulsory state measures''. The said this despite knowing the inherent technical and trade (and political) difficulties in making use of these infrequently employed measures in the GS. It is hardly ever employed by GS countries, without inviting the wrath of the US based pharma industry and its lobbyists, and US Congressmen.
    c. The EU is also passing a law right now to make it easier **for the EU** to make use of these compulsory measures in a health emergency or in the next pandemic. This IS what Mandela tried, and he was sued.

In all epidemic responses, and during pandemics, we have shown repeatedly why benevolence and charity serve the PR agenda for some companies and Presidents, not the people – it does not result in equitable access for us in the GS[lxiv]

H. When global institutions are not fit for purpose – the WTO:

1. This is why many of us in the global health justice community have argued for some time that the **WTO** is "not fit for purpose" and that its rules do not serve people in the GS or poor patients.[lxv] Even Nobel Laureate Joseph Stiglitz has called the TRIPS agreement "ethically indefensible".[lxvi]
2. The way the WTO responded to the COVID crisis (and AIDS before) illustrates this point.
3. In my view, the WTO represents everything that is wrong with monopoly capitalism and its commodification of life-saving technologies, because:
    a. It treats medicines like luxury jewellery[lxvii] or a designer handbag. And that wasn't always the case.
    b. It compels member states, poor and developing countries, to subscribe to a set of norms, which if resisted, attracts trade and diplomatic pressure or frankly, bullying. It is a colonial relic.
    c. The WTO and its rules affect everything we try and do to promote *open* science and equity in the GS.
    d. As People Health Movement Brazil perfectly explained recently: IP is not a neutral institution, on the contrary it is built on eurocentrism, on the affirmation of the knowledge and humanity of some, and denial of others…". [lxviii]

The vaccine programme in SA that seeks to ensure Global South self-reliance and involves significant Canadian public funding:

I. A "silver lining" for technology sharing in the global south – The mRNA hub/programme - of which Canada is the second largest funder

1. During COVID, GS countries decided to take radical action by challenging certain racist assumptions, including the myth about the GS's inability to generate research, knowledge and new technologies to foster self-reliance in vaccine development and manufacturing.
2. When the WHO announced an invitation for GS countries to bid to host a vaccine technology transfer programme using an mRNA platform, SA was chosen to be the host. And herein lies our joint path with Canada: you are now the second largest funder of this programme[lxix] which is based in Cape Town, where I live.
3. Prof. Brook Baker and I wrote last year that the programme is:

"...*one of the most important and innovative approaches to reduce dependency on Global North countries that have fuelled gross inequity in global pandemic responses. Crucially, it has to succeed for the people of Africa, Latin America and the broader Global South to realise the advantages of open science research, and the fruits of scientific progress and its applications.*

Not surprisingly, companies such as Moderna have not explicitly committed to cooperating with the mRNA Hub. Instead, Moderna's CEO, Stéphane Bancel, in an interview with the Financial Times in 2021 likened the [programme's] work to a "fake Luis Vuitton handbag". [lxx]

4. Why is this important for GS self-reliance for future pandemics and the epidemics of TB, HIV and cancer? Well, the programme has agreed to "share back all such relevant innovations with each other, creating a virtuous circle of reciprocal and wide sharing of the benefits of scientific progress and its applications."[lxxi]
5. As many of us have argued before, this programme cannot rely on the goodwill and misleading promises of Moderna to moderate its mRNA IP empire. This does not create the freedom to operate with respect to vaccines for diseases such as HIV, cancer and TB and it makes the work of the programme more time consuming.[lxxii] In the next pandemic, and there will be one, we will all need vaccines and treatments, so imagine if we could make this programme a success sooner, how many lives will be saved.
6. However, the programme's big funders are dead set against taking any compulsory measures – yes, Canada too, and ironically #TeamEU too (Belgium, Norway, Netherlands).[lxxiii] It makes no sense for the programme to be at the mercy of Moderna and Pfizer's lawyers. While funding the programme is important, the freedom to operate without the fear of patent infringement or governance interference is critical.

J. Current pandemic treaty negotiations: there will be no equity

"A pandemic instrument that does not deliver on equity is a failure..."[lxxiv]

1. I have spoken a lot about what happened during the COVID pandemic and the dire impact of a lack of global solidarity and knowledge sharing.
2. The irony is that right now, in Geneva, there are negotiations taking place amongst WHO member states to prepare for the next pandemic.

3. Previously, we had a 114-page draft document (and 5000 brackets representing member states' concerns]. This week we have a 30-page document. Treaty negotiations have been close to 2.5 years.
4. Despite the obvious GN and GS differences and contestation, the WHO DG called this moment "a once-in-a-generation opportunity" – but again, we are witnessing a resistance to enforce solidarity throughout the entire ecosystem of pandemic management and preparedness.
5. As with the 2020 proposal on IP rules that I have discussed already, that was shot down, the same richer nations are, once again, insisting on language that only benefit corporations, not people. Regrettably, this includes the Canadian government too.
    a. There was a time when Canada had a proud history of promoting and advancing global health equity.
    b. Take Canada's important role in *sharing* manufacturing technology for the production of penicillin in the post-WWII era - a remarkable story recently shared by colleagues at MSF Canada.[lxxv]
    c. In contrast, now, the *Globe and Mail* has reported that *Canada like the US and others is* pushing for "weak language and vague aspirations" in the text of the pandemic treaty.
6. This is really a concern because the Treaty should provide a roadmap for critical aspects of pandemic preparedness and management: the mechanisms for technology transfer and equitable sharing of life-saving technologies. Canada should support that, not block it.
7. Just this last week, several civil society groups issued a statement[lxxvi] urging member states to reconsider their positions. We also called on GS countries to not adopt a treaty that does not centre equity in all aspects. To be honest, we do not want a one-sided treaty that makes concessions to companies, that does not benefit patients.
8. Basically, if it does not deliver on equity, it will be a spectacular failure.

M. Solidarity in a time of war: When healthcare is under attack in a genocide, global health starts at home…

1. At the beginning of my lecture, I mentioned SA's 30 years of freedom. I also mentioned the remarkable leadership of people such as Brian Mulroney, Stephen Lewis and others, in the anti-apartheid and AIDS movements.
2. Now, in this final section, I want to talk about another Canadian, a former lieutenant general by the name of Romeo Dallaire – who as you all know led a UN peacekeeping force in Rwanda in 1994. As Canadians, you know his contribution better than me.

3. Critically, he is on record as having warned the UN that a genocide was imminent in Rwanda in 1994, a warning that was unheeded, leading to the slaughter of least 800 000 people. He had the courage, moral clarity and bravery to speak up then, and since. In one haunting interview he said, "We could have actually saved hundreds of thousands…[but] nobody was interested."[lxxvii]
4. We need more Canadian voices such as Mulroney, Lewis and Dallaire and the powerful activism of people who advocate for social justice - people such as the renowned Cindy Blackstock[lxxviii] who has worked tirelessly for the rights of First Nations children. I want to quote from one of her powerful interviews:

   ***"When you see unfairness, it's** your job to learn how and why things became unfair and then do your best to fix it."*[lxxix]
5. You see Dallaire spoke about "picking up dead bodies and carrying them" in a genocide. His accounts of what happened in Rwanda remind me of the reports right now, in 2024, from doctors in Gaza, and from surgeons, the WHO, UN and other humanitarian teams who have also worked in Gaza in the last few months on medical, humanitarian and other critical missions.
6. As a South African child of apartheid and a health justice activist, I would be remiss in not concluding tonight's lecture with a few words on the unfolding genocide in Gaza.
7. In December 2023, the SA government filed a case at the International Court of Justice (ICJ) [lxxx] setting out a charge of four specific genocidal acts. South Africa stated that the *fourth genocidal act* committed by Israel in occupied Gaza included the ''assault'' on Gaza's ''health system – making life, including reproductive life, unsustainable''. On 26 January 2024, the ICJ found that South African charge of genocide is plausible, and as such, issued provisional measures including also a duty on all signatories to the *Genocide Convention*[lxxxi] to take measures within their power to *prevent genocide*, failing which, they will be regarded as **complicit** in war crimes.[lxxxii]
8. Rwanda, East Timor, Namibia, Germany, Bosnia, and more were all meant to offer us lessons, but now the world is in proximity to a genocide[lxxxiii] unfolding right now on our screens that in my view several world leaders are complicit in. [lxxxiv] So, I really want to ask all of you here today, how do we offer solidarity in a time of war, in a time of genocide?
9. Relevant to this question is the deliberate targeting and systematic destruction of the entire health sector in Gaza that 2.2 million people rely on – the targeted assassination of health workers, specialists, medical professors, and patients, the destruction of hospitals and medical universities, including fertility and cancer clinics and even ICUs.
   a. All of Gaza's health universities and medical facilities have been bombed, with over 500 healthcare workers having been killed and at least 300 health workers detained. Also

horrifying has been the recent uncovering of mass graves at two hospitals in Gaza, at Nasser Medical Complex and Al Shifa Hospital.

10. The WHO has described the state of healthcare in Gaza as being "beyond words" and regards the health system as "obliterated" while hospitals are meant to be protected from attack and destruction under international law.
    a. The UN, its agencies and many global bodies and individuals have issued countless warnings and reports of civilian and health worker attacks and deaths, but these have been largely ignored -by those with power. They have issued multiple reports n the dire situation of medicine and food shortages, of hunger, famine and ultimately, an unprecedented humanitarian disaster.
    b. As global health advocates, we know too well that "once a health system is destroyed, injuries cannot be treated, primary care cannot be delivered, and famine cannot be managed – in other words, life cannot be sustained."[lxxxv]
    c. Recently, research published by the Johns Hopkins Bloomberg School of Public Health and the London School of Hygiene and Tropical Medicine suggests that an escalation of the conflict could lead to nearly 86,000 excess deaths over the next six months once the effects of war-induced disease, epidemics and malnutrition are accounted for. The report estimates that even if there is no escalation, and conditions remain as they are today, there will still be **66,720** excess deaths in Gaza over the next six months.
11. My colleagues and I have just written in the British Medical Journal[lxxxvi] that due to the scale of the devastation and humanitarian crisis in Gaza, more of us from the global health community must speak out. After all, "global health is about recognising how global inequalities in power result in inequity in health. It involves grappling with the brutal consequences of power imbalances and colonisation."
12. All of us have a duty to speak up, even with a worrying climate of free speech censorship and penalty: this is why recently an urgent call was put to the global health and human rights community by NGOs in the health justice field via an Open Letter that called on global health bodies, and health institutions to take immediate action on Gaza, on Palestine - because healthcare in times of war, genocide and medical apartheid are issues of health justice, too.

In concluding:

I want to urge you to use your voice, it matters. It matters because domestic reforms have global impact.

Right now, you can tell the world that your governments trade and IP positions in Geneva, especially in the soon to be wrapped up pandemic treaty negotiations, do not represent your views. An indefensible position cannot be ''in your name''.

You can also urge elected officials to continue funding the mRNA "HUB" programme in SA that will directly benefit LMICs but please insist it does so without conditions and quid pro quos that result in abusive patent protections that could hobble the work of the programme - even with and after Canada's significant funding contribution.

Mainly, you can have a frank conversation with federal government officials to demand to see the procurement contracts for all medicines, and work to support the principle of pricing transparency and the better regulation of vested pharma interests going forward, even under pharmacare. This would include urging your different provincial governments to work together to push for transparency too. If this does not happen, you will likely pay more for medicines, under pharmacare, affecting health care access for the people and patients in Canada who may need it the most, and without ever knowing why.

I thank you for your time.

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March 3, 2024. Via: https://theconversation.com/brian-mulroneys-tough-stand-against-apartheid-is-one-of-his-most-important-legacies-224915 - "Mulroney was a master of the multilateral system. By the late 1980s, accelerating and amplifying pressure on apartheid South Africa required ever stronger and tighter sanctions. This required as many nations as possible to agree to as strong a sanction regime as possible... "*People who say that nations only have interests, no friendships, is nonsense. ... Everybody has interests but also friendships. And you can't deal at the international level with any hostility. You gotta try and bring people (together). Canada is a middle power. We're not a superpower. So, we have to leverage our assets as best we can.*"

[v] Ibid. https://theconversation.com/brian-mulroneys-tough-stand-against-apartheid-is-one-of-his-most-important-legacies-224915 - Peter Loewen: ''Mulroney's opposition to apartheid was not driven by simple domestic politics and certainly not by diasporic concerns. Opposition to apartheid was widely held in Canada in the late 1980s and it was a live issue. But it was not one that obviously favoured Mulroney politically. So, why did he oppose it?''. First, the issue was to him one of simple justice and morality. Like his early political mentor, John Diefenbaker, he thought the system was indefensible and immoral. It could not be redeemed by instrumental appeals to anti-Communism or whatever other realpolitik defences U.S. President Ronald Reagan or U.K. Prime Minister Margaret Thatcher advanced.''

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And see: https://www.theguardian.com/business/2001/apr/16/aids "Thirty-nine drug companies have taken the government to court over the issue. Mr Mandela is first defendant in the case, which resumes this week. "I think the pharmaceuticals are exploiting the situation that exists in countries like South Africa - in the developing world - because they charge exorbitant prices which are beyond the capacity of the ordinary HIV/Aids person. That is completely wrong and must be condemned," said Mr Mandela. "The government is perfectly entitled, in facing that situation, to resort to generic drugs and it is a gross error for the companies, for the pharmaceuticals, to take the government to court" [the case was later withdrawn, after a global campaign led by the TAC).

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PLOS: https://speakingofmedicine.plos.org/2022/05/23/vaccine-apartheid-is-racist-and-wrong/

a. *First, life-saving medicines should not be commodified.*
b. *Excessive profit extraction: Second, excessive profiteering in a pandemic is pandemic gouging, enabled by IP monopoly protection.*
c. *Trial Participation without benefit sharing: Third, participation in clinical trials is being 'extracted' as there is no genuine post-trial affordable or equitable access as they become highly privatised too. Africans are used as trial subjects, with no guarantee of benefit sharing.*
d. *Undoing democratic gains – extracting contractual concessions: Fourth, we were being bullied into signing contracts that do not follow key constitutional principles. I will discuss our court case shortly, that opened up secret vaccine procurement contracts showing how they extracted concessions on indemnification, price secrecy and unlimited exports.*

[xliv] *THE GENEVA HEALTH FILES INTERVIEW: There is really no moral, legal, justifiable ground for this level of secrecy, you need to bring the light in'*. Geneva Health Files. Newsletter Edition #49. 25 October 2023. Available at: https://genevahealthfiles.substack.com/p/fatima-transparency-contracts-south-africa-covid?utm_source=%2Fsearch%2Fhassan&utm_medium=reader2 And see: *Dissecting South Africa's COVID-19 Vaccine Procurement Contracts & their Global Implications*. Geneva Health Files. Newsletter Edition #198. 29 September 2023. Available at: https://genevahealthfiles.substack.com/p/contract-south-africa-covid-19-gavi-covax-hji

[xlv] All legal papers and the Department of Health's Answering Affidavit is available at: https://healthjusticeinitiative.org.za/pandemic-transparency/#contracts

[xlvi] Health Justice Initiative v Minister of Health and Information Officer NDoH, (10009/22) [2023] ZAGPPHC 689 (17 August 2023). Gauteng High Court, Millar J. https://www.saflii.org/za/cases/ZAGPPHC/2023/689.html

[xlvii] Immediately following the release of South Africa's COVID-19 vaccine procurement contracts, the HJI worked with a group of local and global health advocacy and research groups.[xlvii]] to conduct a review and which was released in September 2023 along with all the contracts. Health Justice Initiative and Multistakeholder Group, "ONE-SIDED": VACCINES SAVE LIVES—TRANSPARENCY MATTERS (HEREAFTER "ONE-SIDED 2023 MULTISTAKEHOLDER REPORT") (Sept. 5, 2023). See: https://healthjusticeinitiative.org.za/wp-content/uploads/2023/10/HJI_One-Sided-FINAL-10-10.pdf - available at: https://healthjusticeinitiative.org.za/pandemic-transparency/#contracts

[xlviii] Pfizer's Power; October 2021. Public Citizen. https://www.citizen.org/article/pfizers-power/

[xlix] *THE BIG PHARMA BULLIES: ONE-SIDED: MULTI-STAKEHOLDER ANALYSIS: SOUTH AFRICAN COVID-19 VACCINE PROCUREMENT CONTRACTS.* HJI and MULTI-STAKEHOLDER GROUP, 5 September 2023. Available at: https://healthjusticeinitiative.org.za/wp-content/uploads/2023/10/HJI_One-Sided-FINAL-10-10.pdf

[l] February 2023, Resignation Letter: Matthew Herder, JSM LLM Director, Health Law Institute, Schulich School of Law Associate Professor, Department of Pharmacology, Faculty of Medicine Dalhousie University. Available at: https://cdn.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/nte-Herder%20-%20Letter%20of%20Resignation%20-%20final.pdf
''That the federal government is unwilling to support real change in a domain where its jurisdiction over patented medicines cannot be questioned, and those same medicines are the fastest growing contributor to the rising costs of healthcare, is deeply disappointing.''
He has since gone on record to say: *''As a former member of the board, I saw first-hand how that process was influenced and controlled by the pharmaceutical industry and its many surrogate organizations, including industry-funded patient groups —to the detriment of making medicines more affordable. Ultimately, under industry pressure, the federal minister of health made the* **unprecedented move** *of calling on the arm's-length body to suspend its consultation process.''*

[li] ''A major presence on the Hill already, the pharmaceutical industry increased its lobbying of Health Canada by almost four times relative to the pre-pandemic period'' – in: https://canadians.org/media/pharmaceutical-lobbying-press-release/
Here, reports indicate that even compared with average drug costs across the world's wealthiest 25 nations, Canada's medicine prices are 25% higher…''.

[lii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7138369/ and https://www.cmaj.ca/content/192/45/E1414
'Access to health care based on need rather than ability to pay was the founding principle of the Canadian health-care system'.

[liv] When will Canada have national pharmacare? *BMJ* 2024; 385 doi: https://doi.org/10.1136/bmj.q887
22 April 2024. '2 million Canadians older than 65 years cannot afford the drugs their doctors prescribe because of gaps in public drug plans and the high cost of private drug plans". Elderly people and other vulnerable social groups thus face unaffordable drug bills."

[lv] https:/www.bmj.com/content/bmj/374/bmj.n2027.full.pdf
In 2022 already, it was estimated that the USG contributions were approx. 1.7 bill US $ for Moderna and 1 bill US $ for JandJ - with USG advanced guaranteed purchases for Pfizer- for both vaccines and therapeutics.

[lvi] See: https://www.medicalcountermeasures.gov/app/barda/coronavirus/COVID19.aspx?filter=vaccine and https://www.citizen.org/

[lvii] https://www.oxfam.org/en/press-releases/covid-vaccines-create-9-new-billionaires-combined-wealth-greater-cost-vaccinating

[lviii] https://foreignpolicy.com/2021/02/23/dont-let-drug-companies-create-a-system-of-vaccine-apartheid/

[lix] Human Rights Watch: October 29, 2020 "Whoever Finds the Vaccine Must Share It". Strengthening Human Rights and Transparency Around Covid-19 Vaccines. At: https://www.hrw.org/report/2020/10/29/whoever-finds-vaccine-must-share-it/strengthening-human-rights-and-transparency#:~:text=Whoever%20finds%20the%20vaccine%20must%20share%20it.,be%20shared%20far%20and%20wide

[lx] A New and Weak WTO Deal on TRIPS is Not Fit for Purpose. An ineffective multilateralism. Think Global Health. Fatima Hassan. 1 July 2022. https://www.thinkglobalhealth.org/article/new-and-weak-wto-deal-trips-not-fit-purpose

[lxi] A New and Weak WTO Deal on TRIPS is Not Fit for Purpose. An ineffective multilateralism. Think Global Health. Fatima Hassan. 1 July 2022. https://www.thinkglobalhealth.org/article/new-and-weak-wto-deal-trips-not-fit-purpose

[lxii]https://www.theguardian.com/global-development/2024/feb/14/wto-fails-to-reach-agreement-on-providing-global-access-to-covid-treatments

[lxiii] Baker B and Hassan F. Covid-19's silver lining? The WHO mRNA Technology Transfer Programme for the Global South Overcoming IP Barriers is central to the South-South Innovation and Access Goals of the WHO mRNA Technology Transfer Programme, in Health Justice Initiative Pandemics and the illumination of "hidden things" – Lessons from South Africa on the global response to Covid-19. Edited Volume. June 2023.

Available at: https://healthjusticeinitiative.org.za/wp-content/uploads/2023/09/13.-Pandemic-Compendium_B.-K.-Baker-F.-Hassan.pdf

[lxiv] https://www.wto.org/english/tratop_e/trips_e/public_health_faq_e.htm

[lxv] https://genevahealthfiles.substack.com/p/-wto-intellectual-property-trips-extension-covid

[lxvi] https://rio2023.org.za/reports/

[lxvii] See here: https://www.msfaccess.org/ and 'Medicines should not be regarded as a luxury': https://www.msf.org/medicines-shouldnt-be-luxury

[lxviii] https://pehblog.phmovement.org/intellectual-property-tool-of-colonialism/

[lxx] Baker B and Hassan F. Covid-19's silver lining? The WHO mRNA Technology Transfer Programme for the Global South Overcoming IP Barriers is central to the South-South Innovation and Access Goals of the WHO mRNA Technology Transfer Programme, in Health Justice Initiative Pandemics and the illumination of "hidden things" – Lessons from South Africa on the global response to Covid-19. Edited Volume. June 2023. Available at: https://healthjusticeinitiative.org.za/wp-content/uploads/2023/09/13.-Pandemic-Compendium_B.-K.-Baker-F.-Hassan.pdf

[lxxi] Ibid. "The sharing will not only include patentable inventions but also information and data, and complex, commercial-scale manufacturing know-how. On the innovation front, the mRNA Hub and its Spokes have contractually committed to pursuing improved mRNA vaccines and therapeutics, optimising manufacturing, and adapting mRNA to address unmet health needs, particularly with respect to infectious and other diseases that disproportionately affect their countries, including HIV, TB, malaria, and neglected diseases" and "in terms of enhancing equitable access, [it] will not only serve their domestic populations with earlier, expanded and more certain sources of supply, but that they will also supply regional and global markets on fair and equitable terms".

[lxxii] Ibid.

[lxxiii] Ibid:

> *"Emphasising the importance it places on its patent rights, Moderna recently sued Pfizer and BioNTech (Moderna, 2022) in the US for patent infringement, showing Moderna's willingness to defend its patents and seek royalties/ financial compensation. Pfizer has responded by countersuing (Brittain, 2022). In addition, to the best of our knowledge, these cases are alongside at least seven other legal cases involving intellectual property claims on the mRNA technology and Moderna, the US government and other US based biopharmaceutical companies. Throughout the pandemic, Moderna has steadfastly refused to share underlying, trade-secret protected know-how that is essential to commercially scale production of the vaccine. It does so despite multiple requests from the mRNA Hub, medicine access activists and even the US government (Meyer, 2022) (Malpani & Maitland, 2021) (Baumgartner, 2021), which had financed most of Moderna's research and development expenses, via the US National Institutes of Health. This funding included the costs of clinical trials and investments in expanded manufacturing capacity. Moderna and the biopharmaceutical industry, more broadly, have 12justified their refusal to share technology developed with public support and with public scientists on spurious grounds, claiming alternately — and inconsistently — that technology transfer was "too hard". The pharmaceutical industry made these claims even as it transferred technology to favoured contract manufacturing partners. Similarly, it argued that it was "too busy" to conduct technology transfers and that there were "no qualified alternative producers" although researchers identified 120 potential manufacturers (MSF, 2021). It also claimed without any basis that other producers could not manufacture "quality vaccines" and would "waste and disrupt component supplies and supply chains". In addition, despite initial decisions to supply only high-income countries almost exclusively, (Robbins, 2021) Moderna, Pfizer and industry trade groups began to vociferously claim that global supplies were "sufficient" and that there was "no need for additional capacity", despite very delayed and sporadic access to mRNA vaccines in low and middle-income countries (Johnson et al., 2021). Moderna also revealed its true intentions in calls with investors — basically arguing that the mRNA technology platform was the foundation of its plan to maintain "monopoly control" over future applications of mRNA technology to develop vaccines and treatments for other conditions, including "gold-mine" cancer medicines. Although this discussion has focused on Moderna, this is equally applicable with respect to Pfizer and BioNTech."*

[lxxiv] https://www.twn.my/announcement/CSO%20Statement_A%20Pandemic%20Instrument%20that%20Does%20Not%20Deliver%20on%20Equity%20is%20a%20Failure_Final.pdf

[lxxv] https://monitormag.ca/articles/penicillin-the-right-prescription-for-canada-in-pandemic-agreement-negotiations/

Instead of undermining technology transfer provisions, Canada once played a key role in disseminating breakthrough medical technology

"Tech transfer was not always a matter of such contention amongst WHO member states. At the Second World Health Assembly in 1949, member states resolved that "any withholding of scientific or technical information on essential therapeutic and prophylactic drugs, in selling or otherwise supplying nations with the means for their production, or withholding the free exchange of medical scientists, is not compatible with the ideals of the World Health Organization and is against the interests of humanity. Canada was at the forefront of disseminating technology for the breakthrough medical innovation that underpinned this resolution—penicillin. While a fair number of people might correctly identify Alexander Fleming as the discoverer of penicillin, fewer are aware he shared his Nobel Prize for its discovery with Howard Florey and Ernst Chain, whose subsequent discoveries were vital for its production on a large scale.

[lxxvi] https://haiweb.org/wp-content/uploads/2024/04/CSO-Statement_A-Pandemic-Instrument-that-Does-Not-Deliver-on-Equity-is-a-Failure.pdf

[lxxvii] https://edition.cnn.com/2008/WORLD/africa/11/13/sbm.dallaire.profile/
https://www.thecanadianencyclopedia.ca/en/article/canadian-peacekeepers-in-rwanda

[lxxviii] Cindy Blackstock helped establish "Jordan's Principle" that states that First Nations children should have access to the same level of social services as all children. Her work led to a landmark 23.9 billion agreement to compensate about 163 000 First Nations people. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3448536/

[lxxix] https://worldschildrensprize.org/cindy-blackstock-story

[lxxx] https://www.icj-cij.org/sites/default/files/case-related/192/192-20231228-app-01-00-en.pdf

[lxxxi] Lemkin Institute for Genocide Prevention: https://www.lemkininstitute.com/

[lxxxii] APPLICATION OF THE CONVENTION ON THE PREVENTION AND PUNISHMENT OF THE CRIME OF GENOCIDE IN THE GAZA STRIP (SOUTH AFRICA *v.* ISRAEL) PROVISIONAL MEASURES

https://www.icj-cij.org/sites/default/files/case-related/192/192-20240126-ord-01-00-en.pdf
On 26 January the ICJ Ordered that: (See para's 78 – 85):
''...Israel must, in accordance with its obligations under the Genocide Convention, in relation to Palestinians in Gaza, take all measures within its power to prevent the commission of all acts within the scope of Article II of this Convention, in particular:
(a) killing members of the group;
(b) causing serious bodily or mental harm to members of the group;
(c) deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; and
(d) imposing measures intended to prevent births within the group.
80. The Court further considers that Israel must take immediate and effective measures to enable the provision of urgently needed basic services and humanitarian assistance to address the adverse conditions of life faced by Palestinians in the Gaza Strip.
85. The Court deems it necessary to emphasize that all parties to the conflict in the Gaza Strip are bound by international humanitarian law...''.

[lxxxiii] Genocide is the deliberate and systematic destruction, in whole or in part, of an ethnic, racial, religious, or national group. The term was coined in 1944 by Raphael Lemkin. It is defined in Article 2 of the Convention on the Prevention and Punishment of the Crime of Genocide (CPPCG) of 1948 as "any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial, or religious group, as such: killing members of the group; causing serious bodily or mental harm to members of the group; deliberately inflicting on the group's conditions of life, calculated to bring about its physical destruction in whole or in part; imposing measures intended to prevent births within the group; [and] forcibly transferring children of the group to another group." The preamble to the CPPCG states that "genocide is a crime under international law, contrary to the spirit and aims of the United Nations and condemned by the civilized world", and it also states that "at all periods of history genocide has inflicted great losses on humanity." – WIKIPEDIA.

[lxxxiv] In late December 2023, the South African government filed a case at the International Court of Justice (ICJ) alleging that Israel had committed multiple "genocidal acts" against Palestinians in Gaza, including an "assault on Gaza's healthcare system, which renders life unsustainable". On 26 January 2024, the ICJ found the South African charge of genocide plausible and issued provisional measures.
In: Israel's unrelenting war on Gaza healthcare requires urgent action. F Hassan, L London, S Manjra – available at: https://www.aljazeera.com/opinions/2024/2/14/israels-unrelenting-war-on-gaza-healthcare-requires-urgent-action

[lxxxv] Ibid.

[lxxxvi] https://www.bmj.com/content/bmj/385/bmj.q782.full.pdf