Health Justice is Social Justice: The duty to speak up and out

Annual David Sanders Lecture in Public Health and Social Justice 2024

University of Western Cape (UWC), School of Public Health (SoPH) and Peoples Health Movement South Africa (PHM-SA)

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1. Good evening. A special thank you to Prof. Fawcus, Prof. Pretorius, and Profs George, Schneider and Akintola from the SoPH at UWC, and the PHM-SA for honouring me by inviting me to present this lecture to honour David, who I also had the privilege of knowing. This tribute recognises his unwavering commitment to social justice and health equity.
2. Of course, in the times that we live in, no lecture about health justice, pandemic preparedness, or public health would be complete if it does not consider the ongoing genocide in Gaza and other places such as Sudan and the DRC.
3. Given the unique health-related aspects of the Gazan genocide, I want to address it this evening.
4. In Gaza [as you have just seen in the short video by Health Care Workers for Palestine South Africa][ii] there is a deliberate obliteration of health services and the intentional targeting of health workers through assassinations, killings, and abductions.
5. Just days ago, Francesca Albanese, the UN Special Rapporteur on the OPT, stated: “Reading the health experts, I am starting to think with horror that if it’s not stopped, Israel’s assault could end up exterminating almost the entire population in Gaza over the next couple of years…’’
6. This lecture and tribute to David, comes at a gravely worrying time because the genocide in Gaza is worsening and what we do and say here and in the public health community in SA matters more than you can imagine.
7. David was certainly not afraid to call out public health inequality, social injustice, apartheid, or genocide. He would have been at the forefront of local solidarity efforts

including, I know, fully supporting the current efforts of training a recently arrived cohort of Gazan medical students at UCT, Pretoria, and WITS to complete their medical degrees because their universities and medical schools have been destroyed by Israeli occupation forces. This is just one of many promising local steps towards rebuilding the Gazan health system and confirms that international solidarity is indeed possible. I will return to the situation in Gaza shortly.

8. I last met David a few years ago at a National Health Insurance (NHI) civil society convening where we were catching up and laughing a lot that day. Still, we also shared many concerns about the consultation and research carried out for NHI and wondered whether a robust evidence base existed to justify several plans. We discussed options for civil society groups to intervene in a highly polarised debate and discussion, which we noted was heavily influenced by government officials and business leaders, including the big medical schemes, leaving us out in the cold, so to speak.
9. We had noted that the issue then was not just about the need for broad consultation, but it was also about how we could practically merge such an unequal system at a time of state capture and a failing health system.
10. We also noted that it was not just the state health sector that needed urgent reform and attention. For example, the Competition Commission's Health Market Inquiry[iii] on "private sector regulation found that the private healthcare market is characterised by high and rising costs of healthcare and medical scheme cover, significant overutilisation, and an absence of demonstrable associated improvements in health outcomes''.[iv]
11. All of us need to urgently engage with NHI plans since its trajectory will determine how the health system will function in the immediate and distant future.
12. But let me reflect first on *who we are* as a country:
    a. As a result of apartheid and colonialism, SA is the most unequal country in the world, with high[v] poverty rates.[vi]
    b. Wealth inequality too is alarming, despite BBBEE and other policies, still, the richest 10% of people – the majority of whom are white – own more than 90% of the country's wealth.
    c. Inequality has been worsened by the government's budget austerity.
    d. We spend wastefully and inefficiently on health, in both private and public sectors, leading to poorer health outcomes.

e. And we have a two-tier, unequal health system with a skewed[vii] proportion of each population group that is covered – 9.8% of Black Africans, 19.6% of Coloureds, 41.3% of Indians, and 71.7% of Whites belong to medical schemes. Here, remember that GEMS – the government employee medical scheme – is one of the largest closed (restricted) medical schemes and is massively subsidized by the state.

13. But, inequality is by design, human-made, thriving on a global backdrop of staggering economic inequality and global trade, regulatory, and economic policies or rules that ignore the economic upliftment of poor people in the Global South especially. These systems force us to rely on charity, donations, and what I call "voluntary benevolence" from philanthrocapitalists and richer governments, usually in exchange for something else.
14. To put the global wealth disparity crisis in perspective, Oxfam's Inequality Report[viii] reveals that, since 2020 almost five billion people have become poorer. Poverty at current rates will not be ended for 230 years, but we could have our first trillionaire in just over a decade.
15. This *is* the global and local system within which SA is going to implement NHI.
16. Furthermore, it is within this socio-economic environment that we all faced a devastating pandemic just a few years ago – COVID – which is a textbook case of how the political determinants of ill health shaped the world's (inadequate) response to a devastating global pandemic:
    a. We saw richer nations making it very clear to us all that their lives mattered more than those of Black and brown people in the Global South. How else does one explain the pervasive vaccine apartheid we witnessed?[ix]
    b. Here at home, we also saw first-hand, through multiple lockdowns, the scale of hunger, joblessness, homelessness, and poverty that our people face.[x]
17. In COVID, the creed of intellectual property (IP) fundamentalism preached to us by the ultra-wealthy and by pharmaceutical corporations was to tell us to monopolise and privatise the manufacture and supply of publicly created vaccines, medicines, etc., while relying on voluntary market measures – not effective regulation or compulsory measures – to ensure access. That creed has failed us.[xi]
18. This is why addressing the pharmaceutical industry's power, and by virtue of that, the global and local medicine patent (reward) system and its abuse matters.[xii] Here, the NHI will have to either overthrow or better regulate the medicine patenting and pricing

system to survive, failing which, NHI money could dry up just on health products and medicine costs alone.

19. The human cost of COVID was at least fourteen million people dead globally, in two years. Many of these deaths were preventable. In SA, COVID was the leading cause of death in 2020, outstripping deaths due to other diseases in that year.[xiii]
20. And yet, while the tools existed to mitigate the pandemic from December 2020 already, the political will to share supplies and knowledge was absent.[xiv] This has been described as a "moral failure" even by the director general of the World Health Organization (WHO).[xv]
21. In addition, in Geneva, the World Trade Organization (WTO) scuppered all attempts by Global South countries to relax the very trade and IP rules – or the system – that makes meaningful access to medicines, vaccines, and other technologies difficult and at times, impossible, even in a pandemic.
22. While the WTO was deliberating, the HJI documented that in 2021 SA had negligible and staggered[xvi] access to vaccines, waiting very long for supplies to come in. Yet scientists developed and governments authorised effective COVID vaccines less than a year after the first reported cases. Discoveries in mRNA vaccination went on to win a Nobel prize. SA participated in several vaccine research trials, contributing to the research and development of front-runner vaccines. But the gap between the speed of science and the ability to vaccinate or treat people in the Global South remained wide.
23. The same thing is playing out again: With Mpox, Africa does not have enough vaccines and is now desperate for supplies, while Northern countries stockpile, and while we wait for real technology transfer licenses. Ironically, with the current Mpox cases in the Global North, research has accelerated, more than it has in previous decades when Mpox was confined to Central and East Africa.
24. It should be clear to everyone that diseases and outbreaks know no borders. Hoarding supplies or manufacturing know-how[xvii] is a self-defeating public health strategy. Now during COVID, you will recall that for the world to move forward and so too us here in SA, we needed vaccines. The Government, acting through the Department of Health (Department) entered into agreements with private manufacturers for the supply of vaccines.[xviii] However, the contracts were secret, going against the constitutional prescript of open procurement when using public resources.

HJI goes to court – in a pandemic:

25. For this reason, in mid-2021, the HJI requested and then filed access to information requests to obtain copies of all the contracts. HJI also tried to get the contracting parties' details and complete identities, but these requests were denied on the grounds of "confidentiality''.[xix]
26. After the Department refused HJI's requests in 2022, we filed legal papers and argued that the obligation therefore rested with the Department to join any other interested party (pharmaceutical company). It did not.
27. Late last year, the Gauteng High Court ruled in HJI's favour and in a ground-breaking Judgment ordered the disclosure of all the unredacted contracts and negotiation records within ten court days of the Judgment. The Department complied. A world-first, court-mandated disclosure of contracts that were not redacted.
28. Our analysis showed a set of highly "one-sided" terms[xx] including striking conditions that required Non-Disclosure Agreements (NDAs) and secrecy[xxi] with significant advance payments but imposed no legal obligations on suppliers in terms of delivery volumes or dates. The contracts provided sweeping indemnity terms, limits on international redistribution/donations, and overly broad IP protections. Remember that public money was used to purchase these vaccines, but the CEOs of these companies had all the power.
29. While the contracts were negotiated, other efforts to produce vaccines locally in SA were blocked. Companies that received public funding and relied on previous research and existing technologies, such as Moderna, refused to share vaccine technology with the groundbreaking Global South mRNA partnership programme just down the road from us.[xxii]
30. One of the most egregious terms was in the contract for Johnson & Johnson (J&J) which effectively traded our sovereignty away. It traded "scarce supplies for extractionist terms and conditions" demanding the right to[xxiii] export vaccines finished in East London by Aspen to Europe, while we desperately waited for supplies and faced devastating waves of infection in 2021.[xxiv]
31. Even by the SA President's account, we became "beggars,''[xxv] begging for vaccine supplies on the global market.[xxvi]
32. Now, if you read the *negotiation* records, it is clear SA did not want to agree to some of the terms for these multi-million-dollar contracts, but it had little bargaining power. We urgently needed vaccines, and the government had promised to secure them.

33. Within days of the contracts and our analysis being released to the public, and after months of silence, government officials finally admitted, publicly, that it was "screwed'' in the negotiations.[xxvii]
34. This type of take-it-or-leave-it contracting signals a dangerous precedent for future pandemic readiness measures and systems and shows why this level of bullying, secrecy, and lack of transparency has no place in any democracy.
35. More importantly, for all of our work going forward now, the Judgment[xxviii] affirmed the public interest in disclosure to encourage and advance procurement transparency.[xxix]
36. We hope it will have far-reaching implications not just for the next set of pandemic procurement negotiations but also for substantial state-led procurement due to take place under NHI.
37. But, despite this legal victory, pharmaceutical companies worldwide continue insisting on NDAs – with broad confidential information clauses, to suppress the disclosure of pricing and supply terms, particularly in negotiations covering monopoly health products.
38. So unless acted upon with a clear, legally binding international agreement, we will arrive at the next pandemic with little more to enforce fair terms than platitudes and scathing press statements from the Health Minister and President and other world leaders in the Global South.
39. This is why the frustratingly slow global Pandemic Accord negotiations are a priority for our advocacy.
40. But the COVID story for SA is not just about one-sided contracts, brutal lockdowns, and socio-economic devastation. It is surprisingly also about a stunningly brave and unprecedented move by the SA Government via the DTIC, SA's Geneva-based diplomats and the Presidency to address some of the systemic barriers that I have highlighted tonight, including on IP:
    a. Before the first vaccine was approved for use in 2020, SA approached the WTO to propose a waiver of global IP rules *during* the pandemic to ensure timely and affordable access to any available technology that may still come to the market, to avoid a repeat of what happened with HIV drug access in the late 1990s, and to ensure that Africa and others in the Global South would not be last in line again. This is commonly referred to as the "*TRIPS Waiver Proposal''*.
41. The SA and Indian governments jointly requested the waiver against the following backdrop:

a. High-income countries were clearing the vaccine shelves[xxx] for their own stockpiles of multiple vaccines.
b. Lockdowns and travel bans were being imposed, alongside a global economic crippling crisis leading to even more unemployment, hunger, and homelessness.
c. Low and middle-income countries were waiting for vaccines and were bullied into secret and one-sided contracts for limited supplies – they were not the priority.
d. Low-income countries also waited for COVAX to send supplies, but that effort, premised on equity, honestly, failed; it only reached less than half of its goal of distributing two billion doses in 2021.[xxxi]
e. Thus, the waiver proposal was key, because just 1% of all vaccines worldwide went to low-income countries in the first year of vaccines coming to the market.

42. It was supported by one hundred countries; it had sixty-five co-sponsors (member states of the WTO), Nobel laureates, the director general of the WHO, the head of UNAIDS, faith leaders, trade unions, health groups, the African Union, researchers, scientists, economists, activists, as well as politicians in several countries. For almost two years, advocacy and patient groups around the world supported the Waiver Proposal.[xxxii]
43. Here, we should not underestimate the resentment and opposition expressed by certain Global North governments because SA went to the WTO then. It was actively blocked by richer countries, notably the US, Canada, UK, Australia, Switzerland, Japan, and EU – especially Germany. They "delayed and prevented textual negotiations and took it upon themselves to decide what low-income countries needed''.[xxxiii] The list of countries opposed to the proposal is similar to that of countries that are not happy with SA approaching the International Court of Justice (ICJ) in 2023 on the genocide charge against Israel.
44. Finally, in mid-2022, about two years later, there was a belated WTO deal – it was such a weak deal, just on vaccines, that we described it as "a slap in the face of poor countries''.[xxxiv]

National Health Insurance in SA:

45. Turning to NHI, knowing what we know from COVID, what lessons can help us to ensure “equity’’ for all? A few key lessons or themes come to mind: Market power, secrecy, transparency, accountability, timely access, and affordability.
46. NHI will be dependent on the market whether we like it or not – “top-up’’ products and insurance offerings will presumably fill the gap if the State is unable to offer a health product or service according to the NHI Act. Yet, we just spent 30 years to move away from risk rating and insurance principles for providing healthcare.
47. The NHI, we are also told, will be based on the principles of “universality and social solidarity’’ and will “unify’’ our health system.
48. But tonight, if we just focus on one aspect included in the Act – the medicine access system. It is drafted in a way that creates at least four medicine access systems, operating in parallel.[xxxv] This is far from the promised system of unification.
49. Some of the areas on the narrow issue of medicine access under NHI that remain uncertain require probing by researchers too and include:
    a. Whether we can be guaranteed transparency and information, including about the deliberations of the various NHI ministerial advisory, benefit and selection committees, and procurement structures under the NHI – or will we have to litigate every access to information request?
    b. How will the NHI Fund (Office of Health Products Procurement) negotiate with the global pharmaceutical industry without the bullying we witnessed in COVID, for example?
        i. And specifically for medicines and health products: Will manufacturers be permitted to sell to health providers other than the State? If so, how will this be done, and what will be the maximum price?
        ii. Which medicines and health products will be covered under NHI benefits as part of the NHI Formulary and how will the price of those not covered (“top-ups”) be regulated?
        iii. What role will External Reference Pricing (ERP) play in the NHI and beyond? How and when will the Single Exit Price (SEP) system be amended?

    In other words, why is a competitive and different single medicine pricing system for SA not being urgently designed and considered? Should we shadow-design one? I think yes.

50. So, as our country lunges forward with NHI and noting *who we are* as a country, let me unequivocally call out some of our immediate concerns that we believe will affect implementation:
    a. We live in a country with worsening health outcomes, a high burden of HIV and TB, and alarmingly high levels of gender-based violence.
    b. Politically, we have had multiple ministers in the space of just five years – even during a pandemic – due in part to corruption allegations and now, a new GNU.
    c. NHI has become a lightning rod of disagreement in the GNU, including for business, creating a hostile climate for civic engagement. Sadly, the political gamesmanship over NHI is coming across as unaccountable, arrogant, and non-engaging. This will not build our health system. Surprisingly, in a recent Bhekisisa interview, the Minister conceded that restricting NHI basic health services (so non-emergency care) to SA ID holders may be self-defeating for public health. He said that that is a "mistake" that needs to be "rectified" in the Act.[xxxvi]
    d. We have an unaccountable rotating door system for appointing ministers, deputy ministers and health Portfolio Committee members, seriously blurring the Legislature's oversight function. This is not good governance.
    e. We have outstanding laws and regulations that could address some of the "now'' issues but which are not being prioritised. For example, we are still subject to an apartheid-era Patent Law.[xxxvii] Vested interests, we believe, are blocking key amendments.
    f. We do not have a robust local, properly state-subsidised health manufacturing industry in SA, often making us reliant on external manufacturers.
    g. We have xenophobia seeping into our health system, where patients have been attacked in state hospitals because of their nationality.
    h. And on top of all of that, we have growing reports not just of provincial health product stockouts,[xxxviii] but also reports of widespread health sector tender corruption, and targeted assassinations of whistleblowers.[xxxix]
    i. Finally, our medicine costs are astronomical, needlessly.
51. Of course, we all support the vision of a unified, equitable health system. But aspirations aside, I am afraid that the NHI Act does not deal with the systemic issues that cause high prices and inequity in access. Instead of investing effort into systems

that control prices better at the outset, it is investing in systems to deal with the consequences of unaffordable drugs (the various NHI Committees).

52. Frankly, we are in a health crisis and I hope that people can see the signs. The recent findings of a panel appointed by the Academy of Science of SA (ASSA) found that despite numerous pockets of excellence across the country, our healthcare system still "suffers from widespread problems in its governance. …These include the large number of managers in acting positions, frequent changes in senior leadership, worse health outcomes than similarly resourced countries, and deterioration of morale and trust in the public health system.''[xl]

GAZA, Occupied Palestine: Why solidarity matters

Now let me return to Gaza:

53. Like apartheid SA, Palestine has been subjected to a brutal apartheid regime, since 1948, through ongoing colonial settler occupation.
54. Hundreds of health, aid, and UN workers have been killed in Israel's bombardment, many in targeted assassinations, and others kidnapped, tortured, and then killed.[xli]
55. On 26 January 2024, the world's highest court, the ICJ,[xlii] ruled by an overwhelming majority that Israel is plausibly committing genocide in Gaza. The deliberate targeting of the health service and health workers in Gaza was set out in detail in the case (paragraphs 76–87).
56. The ICJ also ruled in July[xliv] that Israel has imposed a regime of apartheid in the occupied territories "*as part of an institutionalised regime of systematic oppression and domination*" of the Palestinians.[xlv]
57. Health workers in Palestine and health activists worldwide have stressed that the purposive and systematic destruction of the health system relied upon by 2.2 million people in Gaza is a depraved crime.
58. Shuaib Manjra, Leslie London, and I have argued in the British Medical Journal (BMJ) that "once the 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''.[xlvi]
59. The UN Special Rapporteur on the Right to Health, Dr Tlaleng Mofokeng, also warned months ago that Gaza's health care system "is under attack".[xlvii]
60. And the situation is worsening, violating international humanitarian law and norms too:
    a. Food, medicines, and other basic supplies cannot freely enter Gaza.

b. 85% of school buildings have been directly hit or damaged.[xlviii]
c. All 12 of Gaza's universities have been bombed, leaving 88,000 university students unable to continue their studies.[xlix]
d. For nearly 11 months now, international media have been banned from entering and reporting in Gaza.
e. Predictably, there is now a polio outbreak – with makeshift polio vaccination centres being bombed.

61. The Lancet recently published[l] an estimate of deaths in Gaza: About 186,000 total deaths by June and an estimated additional 149,500 deaths by the end of the year, should there be no ceasefire. This is why we, as a strong and well-resourced public health community in SA, need to not just speak out but actively work to build solidarity. How can we do that?
    a. We can support the local chapter of HCW4Pal and endorse its demands including an immediate ceasefire and the rebuilding of the entire Gazan health system.
    b. We can support the current cohort of Gazan medical students who are completing their medical degrees at three SA universities.
    c. We could create scholarships to enable Palestinian doctors to continue their training here and elsewhere.
    d. We can join global calls and endorse several circulating Open Letters demanding that the World Medical Association (WMA), World Organisation of Family Doctors (WONCA) and other such professional bodies condemn Israel's obliteration of the Gazan health system and rescind the membership of, at the very least, the Israeli Medical Association (IMA), just as the world isolated apartheid SA.
    e. We can actively challenge the organisers of convenings and conferences that platform either genocide-supporting representatives and academics from Israeli medical, research, and academic institutions and those that seek to host global health meetings in genocide-supporting countries (as the IAS did by hosting the 25th AIDS Conference in Germany this year).
    f. We can mobilise for more universities and institutions to adopt BDS resolutions: One excellent example is the University of the Western Cape (UWC) which adopted a motion to disengage from Israeli academic institutions in support of Palestine.

i. UWC has undertaken to fully disengage from Israeli academic institutions, in line with the PACBI[li] guidelines and University management will disclose all investments and commit to divestment. UWC has also undertaken to advocate, at a national level, for all universities in SA to adopt full academic disengagement from Israel.

ii. At UCT, resolutions were adopted by the Council and Senate earlier this year.[lii] However, these resolutions have been taken on review to the Cape High Court by a single applicant (a professor). UCT faculty members and the administration there have also been subject to all kinds of pressure tactics, and right now, they and UCT need our support.

Let me end by saying that we all have a duty to speak out and speak up. If we remain silent, the inequities which we are supposed to challenge in our work will be exacerbated, and the impunity of tyrannical regimes will continue. And that will only make our field complicit – both today and every day. This is why health justice is intrinsically linked to social justice.

Long live the memory of David Sanders, long live.

Ends

ENDNOTES

[i] Director, HJI, UCT SPHFM Honorary Research Associate, 2023 Echoing Green Fellow. This paper also draws from previous lectures, speeches and op eds available at: https://healthjusticeinitiative.org.za/news/. The author is grateful to Dr S Manjra and Prof. L London for their feedback on an earlier draft.

[ii] HCW4Pal SA–Obliteration of Health Services in Gaza, September 2024: Available at https://youtu.be/AwUkHTvKXHQ?feature=shared

[iii] Competition Commission, South Africa. *Health Market Inquiry Final Findings and Recommendations Report*. September 2019. https://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf
See: https://www.compcom.co.za/healthcare-inquiry/

[iv] See: The Conversation. *South Africa's healthcare system: eight steps that would get it on the right track*. L Dudley et al. 5 July 2024. https://theconversation.com/south-africas-healthcare-system-eight-steps-that-would-get-it-on-the-right-track-233893

[v] Institute for Economic Justice, Section 27. 2019.
https://www.iej.org.za/wp-content/uploads/2020/02/IEJ_Fact_Sheet_July_2019_HLPF-1.pdf

[vi] In 2019 already, it was reported that Black African children in South Africa, who constituted about 85% of the "child'' population, accounted for about 94% of all poor children then.
Cited in *Yoliswa Dwane Public Lecture 2024: The Local and Global: Connecting Struggles for Justice and Equality*, Fatima Hassan. https://healthjusticeinitiative.org.za/2024/03/01/yoliswa-dwane-public-lecture-2024-the-local-and-global-connecting-struggles-for-justice-and-equality/

[vii] See: https://www.statssa.gov.za/publications/P0318/P03182023.pdf

[viii] *Inequality Inc: How Corporate Power Divides Our World And The Need For A New Era Of Public Action*. OXFAM. January 2024. https://oi-files-d8-prod.s3.eu-west-2.amazonaws.com/s3fs-public/2024-01/Davos%202024%20Report-%20English.pdf
https://www.oxfam.org/en/research/inequality-inc

[ix] See: Daily Maverick. *OPINION: The great Covid-19 Vaccine Heist (Part Two): Moderna – when solidarity is only a word*. F Hassan. January 2021. https://www.dailymaverick.co.za/opinionista/2021-01-24-the-great-covid-19-vaccine-heist-part-two-moderna-when-solidarity-is-only-a-word/ And see: Podcast Interview: Geneva Health Files. https://genevahealthfiles.substack.com/p/fatimahassan-covax-contract-vaccine-covid-africa

[x] See: H. Abrahams-Fayker *Safety nets during the height of the Covid-19 pandemic: SA's Social Relief of Distress Grant – A perspective from the Black Sash* and *Activist Q&A with Tinashe Njanji: "Information in the time of outbreaks" – both* 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*

[xi] *Profiteering from vaccine inequity: a crime against humanity?*
Hassan, Yamey, Abbasi. BMJ 2021; 374 doi: https://doi.org/10.1136/bmj.n2027 16 August 2021.

[xii] See for example i-MAK: https://www.i-mak.org/burden-of-patent-thickets/

[xiii] See StatsSA: https://www.statssa.gov.za/publications/P03093/P030932020.pdf

[xiv] Health Justice Initiative. *The Big Pharma Bullies*: *One-Sided: Multi-Stakeholder Analysis: South African Covid-19 Vaccine Procurement Contracts.* HJI And Multi-Stakeholder Group, 5 September 2023. https://healthjusticeinitiative.org.za/wp-content/uploads/2023/10/HJI_One-Sided-FINAL-10-10.pdf

[xv]See: *WHO chief warns against 'catastrophic moral failure' in COVID-19 vaccine access.* 18 Jan 2021. https://news.un.org/en/story/2021/01/1082362

[xvi] HJI, Vaccine Summary Sheets. https://healthjusticeinitiative.org.za/2022/02/22/hji-summary-sheets-vaccine-supplies/

[xvii] *Vaccine apartheid is racist and wrong.* Calgary Peace Prize 2022 Acceptance Speech, F Hassan. Available at: https://speakingofmedicine.plos.org/2022/05/23/vaccine-apartheid-is-racist-and-wrong/

[xviii] Health Justice Initiative. *The Big Pharma Bullies*: *One-Sided: Multi-Stakeholder Analysis: South African Covid-19 Vaccine Procurement Contracts.* HJI And Multi-Stakeholder Group, 5 September 2023. https://healthjusticeinitiative.org.za/wp-content/uploads/2023/10/HJI_One-Sided-FINAL-10-10.pdf

[xviii]See:https://news.un.org/en/story/2021/01/1082362#:~:text=%E2%80%9CI%20need%20to%20be%20blunt,from%20WHO%20headquarters%20in%20Geneva Cited in: *Law and Power in COVID-19 Vaccines Negotiations: South Africa's Pandemic Contracts with Multinational Pharmaceutical Companies* (forthcoming) F Hassan, L G Abinader, M Kavanagh.

[xix] See Judgment in *Health Justice Initiative v Minister of Health and Another* (10009/22) [2023] ZAGPPHC 689 (17 August 2023).
https://www.saflii.org/za/cases/ZAGPPHC/2023/689.html#:~:text=Summary%3A,grant%20access%20to%20records%20requested

[xx] Health Justice Initiative. *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

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

[xxii] B. K. Baker & F Hassan *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.* And see: L Paremoer, A Pollock *A passion to change the landscape and drive a renaissance: The mRNA Hub at Afrigen as decolonial aspiration.* Frontiers in Public Health. 2022 Nov 28;10:1065993.

[xxiii] *Health Justice Initiative. The Big Pharma Bullies: One-Sided: Multi-Stakeholder Analysis: South African Covid-19 Vaccine Procurement Contracts. HJI And Multi-Stakeholder Group,* 5 September 2023. *Https://Healthjusticeinitiative.Org.Za/Wp-Content/Uploads/2023/10/Hji_One-Sided-Final-10-10.Pdf*

[xxiv] https://www.nytimes.com/2021/08/16/business/johnson-johnson-vaccine-africa-exported-europe.html#:~:text=At%20the%20same%20time%2C%20Johnson,records%20reviewed%20by%20The%20New

[xxv] Https://www.News24.Com/News24/Politics/Government/We-Are-Not-Beggars-Treat-Us-As-Equals-Ramaphosa-Tells-World-Leaders-20230624

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[xli]It is estimated that at least 800 HCWs have already been killed in Gaza, and about 310 HCWs have been abducted, while HCWs have also died in Israeli detention. See: https://www.middleeastmonitor.com/20240916-palestinian-paramedic-killed-while-in-israel-custody/

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

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[xlv] "South Africa will be filing its memorial to the International Court of Justice (ICJ) next month (October 2024). South Africa intends to provide facts and evidence to prove that Israel is committing the crime of genocide in Palestine. This case will continue until the court makes a finding. While the case is in progress, we hope that Israel will abide by the court's provisional orders issued to date. The case represents a growing global effort towards ensuring peace in the Middle East. Several countries, namely, Nicaragua, Palestine, Turkey, Spain, Mexico, Libya and Colombia have all joined the South African case against Israel.'' See*: South Africa to file its memorial to the ICJ.* Media Statement. 10 September 2024. https://dirco.gov.za/south-africa-to-file-its-memorial-to-the-icj/

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[xlviii] That is 477 out of 564 buildings. Source: United Nations Office for the Coordination of Humanitarian Affairs | UN OCHA, September 3, 2024 https://www.unocha.org/

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And see: https://www.news24.com/news24/opinions/columnists/guestcolumn/opinion-why-we-must-support-ucts-israel-boycott-in-the-face-of-external-threats-20240917