HEALTH JUSTICE INITIATIVE

STRATEGIC PLAN

2022 - 2024

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ACKNOWLEDGEMENTS

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For more on HJI's funders see also: healthjusticeinitiative.org.za

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STRATEGIC PLAN 2022 - 2024

Health Justice Initiative's 3-year Strategic Plan was informed by an external assessment of the work that the HJI has carried out since July 2020 when it was established, together with an intensive consultative and planning process led by an independent consultant and the HJI team. It has been enriched by the commitment, knowledge, energy, drive, and input of all team members, the HJI Board, and members of the Reference Advisory Group, experts in the field, partner organisations and key stakeholders. We are grateful for their valuable contributions.

We are sharing our plans with the sector and our current and prospective donors, as it will guide the HJI in its future endeavours to work towards health justice for all.

"...about 50% of health expenditure in South Africa is spent in the public sector on health care to the poorest 82% of South Africans with the greatest burden of disease..."

BACKGROUND

The Health Justice Initiative (HJI) was formed in July 2020. It is an initiative dedicated to ensuring lifesaving diagnostics, treatment and vaccines for all by using the law to advocate for a more inclusive, equitable public health system.

Given South Africa's deep inequalities and dual health care system, the HJI endeavours to address the factors that influence inequity in health access (with a focus on medicine access) during pandemics such as COVID-19, and beyond, with a focus on race, class, and gender. We draw on the expertise of researchers in law, public policy, economics, and public health, as well as universities and scientific experts in and outside of South Africa. We also work closely in partnership with other organisations and stakeholders that focus broadly on rights protections within the health sector.

HJI is founded and headed by Fatima Hassan, a social justice activist and health and human rights lawyer. HJI operates remotely and the team is made up of a Senior Researcher (Dr Marlise Richter), Administrator (Althea Adonis) and Researcher (Yanga Nokhepheyi). From time-to-time HJI relies on the support of research consultants.

HJI has a strong and committed Board and Reference Advisory Group whose members provide guidance and support regularly. HJI's multidisciplinary advisors are highly regarded in and outside of South Africa and are long-standing experts in their respective fields. Drawing on their expertise in law, public health, economics, scientific advancement, policy development, activism, and community engagement, they guide HJI on its governance, strategic focus areas and partnership models.

HJI Board:
Noncedo Madubedube (Equal Education), Dr Shuaib Manjra (UCT School of Public Health) and Fatima Hassan (Founder/Director)

Reference Advisory Group:
Dr Francois Venter (Ezintsha, WITS), Phumi Mtetwa (JASS Southern Africa), Dr Francois Bonnici (Schwab Foundation), Phumeza Mlungwana (IBP-SA), Dr Els Torreele, Professor Tshepo Madlingozi (CALS), Justice Kate O'Regan (Bonavero Institute), Noncedo Madubedube (Equal Education) and Dr Shuaib Manjra (UCT School of Public Health)

METHODOLOGY

As a newly established organisation, the 3-year **2022 – 2024 Strategic Plan** for HJI was developed with the support of an independent consultant, and over a period of four months, during the COVID-19 pandemic. The Consultant led an intensive and participatory process.

THE PROCESS CONSISTED OF THE FOLLOWING:

1. **17 local and international experts** in the health and justice sector were interviewed.
   a) 22 individuals were invited to participate
   b) 12 people were interviewed on a one-on-one basis
   c) 5 members of the HJI team participated in joint discussions
2. The consultant carried out a brief **situational analysis** of the local and international context in which the HJI operates.
3. The HJI team participated in a two-day Strategy e-retreat that included expert input from other health sector specialists. The mission, vision, and objectives and the overall strategic focus areas were developed. These meetings consisted of a 'blended' approach of online presentations, inputs from experts and discussions that were held online. Further feedback was elicited during these engagements.
4. Two e-meetings with members of the Board and the Reference Advisory Group were held where the HJI Team presented the draft strategy. Based on feedback and further input from members, the HJI team further developed the Strategic Plan for approval by the HJI Board.

LIMITATIONS:

Due to COVID-19 and lockdown restrictions, the strategic planning process was restricted and the retreat was converted to an e-retreat and therefore could not benefit from in-person participation.

SITUATIONAL ANALYSIS OVERVIEW

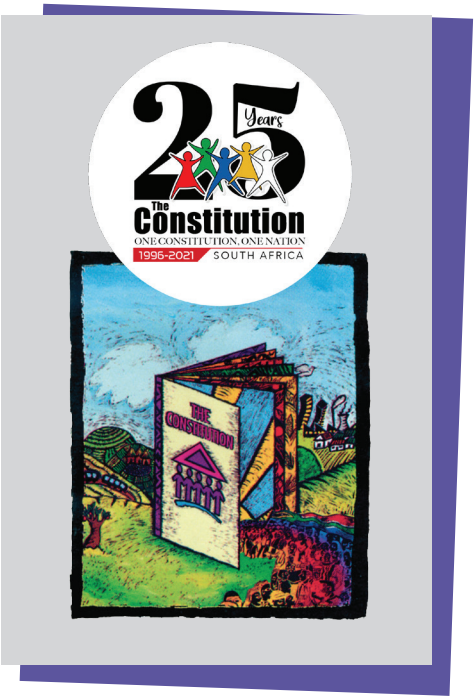
The Situational Analysis was informed by a combination of interview findings with key stakeholders and a desktop review by independent consultants. This resulted in an expanded Situational Analysis. It is summarised as follows:

1. South Africa is a deeply divided and unequal society between rich and poor, and this is most clear in the divide in access to private and public health care.
2. Challenges for those living in rural areas include issues of geographical access to health services.
3. The majority of poor rural people are underserved in respect of access to health services.
4. Take up of health services by people in South Africa tends to be higher in urban areas where access to services and capacity in terms of health workers, diagnostic technology and equipment is better resourced and more widely available.
5. Many communities face infrastructural and transport challenges when attempting to access health care.

Health and access to health care in South Africa is therefore heavily influenced by race, gender, class, nationality, and geographic location.

Health care and access to medicines, treatment and services is a *human right, and accordingly recognised as such* in South Africa.

This right is enshrined in Section 27 of the Constitution which states that: every person has the right "*to have access to health care services and reproductive health care*".



Patients at the Lurwayizo Clinic, in the Eastern Cape, who travel long distances to seek medical care, often do not have immediate access to nurses and doctors, due to staff shortages in the public health sector.

Photo: Nombulelo Damba-Hendrik/GroundUp

"Every person has the right to have access to health care services and reproductive health care."

HJI was also formed at a time when its work could become aligned with ***Sustainable Development Goal 3*** that addresses "*universal health coverage, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all*".

With COVID-19, inequalities in access to testing, treatment, vaccination, social relief, protection, and socio-economic support soon emerged. The negative impact of the application of intellectual property and especially patents in respect of equitable access to diagnostics and vaccines in particular, have also become clearer. Unequal access to vaccines between richer and poorer countries, due to knowledge monopolies has become the key international, human rights, legal and moral issue of our time. But while the COVID-19 pandemic has upended the provisioning of health services globally, it has also created an opportunity to make the connection between the social and political determinants of health rights and equity locally and globally. HJI was also launched at a time when the South African government is STILL working on introducing a National Health Insurance scheme, to improve *equity* in health care in South Africa. This work has been ongoing for more than 15 years. While there are ongoing debates about NHI governance, financing, procurement, to date there has been little practical progress in implementing the scheme, which has been further delayed by the COVID-19 pandemic.

HJI's work in addressing multiple equity, transparency, corruption, medicine and vaccine pricing and procurement challenges in the COVID-19 pandemic offers a unique entry point for its future work on National Health Insurance.

SUSTAINABLE DEVELOPMENT GOALS

Photo: MSF Southern Africa

"Universal health coverage, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

STAKEHOLDERS

The HJI works with a number of stakeholders at the local, national, regional and international level. We hope to work with many more partners over time, and to strengthen and deepen collaborative efforts and relationships.

In the Situational Analysis Network Mapping exercise, the following organisations were identified as critical stakeholders to the HJI:

HEALTH JUSTICE AND RIGHTS SECTOR LOCALLY AND REGIONALLY

TAC Treatment Action Campaign
+SECTION27 catalysts for social justice 10 YEARS OF IMPACT
FIX THE PATENT LAWS!
Health for All Now! People's Health Movement
ARASA AIDS & Rights Alliance for Southern Africa
CANCER ALLIANCE Collective Voices for Cancer in South Africa
African Alliance
C19 PEOPLE'S COALITION
PEOPLES' VACCINE CAMPAIGN VACCINES FOR ALL PVC SA
sweat Sex Workers Education & Advocacy Taskforce
LRC Legal Resources Centre
LAWYERS FOR HUMAN RIGHTS
PSAM Public Service Accountability Monitor
open secrets power & profit | truth & justice
CoRMSA Consortium for Refugees and Migrants in South Africa

INTERNATIONAL NGOs WITH A LOCAL AND REGIONAL PRESENCE

NGO

icj International Commission of Jurists
Oxfam
AMNESTY INTERNATIONAL
ITPC INTERNATIONAL TREATMENT PREPAREDNESS COALITION
CLINTON HEALTH ACCESS INITIATIVE
FRONTLINE AIDS
SOUTHERN AFRICA TRUST
EQUINET
MEDECINS SANS FRONTIERES

OTHER INTERNATIONAL NGOs WORKING ON HEALTH AND MEDICINE ACCESS

Global Justice Now

PrEP4All

HEALTH GAP
GLOBAL ACCESS PROJECT

I·MAK

Observatoire
de la transparence
dans les politiques
du médicament

PUBLICCITIZEN

KEI

HAI HEALTH ACTION INTERNATIONAL

ACADEMIC INSTITUTIONS, UNITS AND STATUTORY BODIES

Academic and research organisations concerned with health systems strengthening in South and Southern Africa are located at most universities and specifically in the Schools of Public Health.

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

UNIVERSITY of the WESTERN CAPE

University of Cape Town · Iyunivesithi yaseKapa · Universiteit van Kaapstad

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

MANDELA INSTITUTE

SAMRC/WITS Centre for Health Economics & Decision Science
PRICELESS SA

SAHPRA
South African Health Products Regulatory Authority

saMRC
advancinglife

HSRC
Human Sciences Research Council

REGIONAL AND GLOBAL MULTILATERAL BODIES/ INSTITUTIONS

World Health Organization

UNAIDS

Gavi
The Vaccine Alliance

Stop TB Partnership

AFRICA CDC
Centres for Disease Control and Prevention
Safeguarding Africa's Health

NOTE: SERVICE ORGANISATIONS:

Specifically in relation to HIV and TB there are about nine organisations, mainly funded by the US government (PEPFAR, USAID, CDC) that provide extensive HIV and TB services and health system strengthening support at a district health level in South Africa. Between them they employ several thousand health workers and provide services to millions of people. While they specifically do not engage in advocacy, they have very deep experience of issues relating to access and resources in some of the poorest parts of South Africa and amongst marginalised groups such as sex workers, young women, and girls and LGBTI communities.[1] Between them, these organisations also engage in extensive research relevant to treatment and health service strengthening in relation to HIV and TB in particular.

1 Anova, Aurum Institute, Broadreach, Health Systems Trust, Keth'Impilo, Maternal, Adolescent And Child Health Systems, Right to Care, TB HIV Care, WITS Reproductive Health and HIV Institute.

HJI's COMPARATIVE ADVANTAGE

There are several health and social justice non-governmental organisations and advocacy groups in South Africa that work on a broad range of issues.

The Situational Analysis conducted found that the HJI has carved out a niche by focusing on COVID-19 and pandemic related matters (for example, Intellectual Property reform and inequity in vaccine access) and is thus recognised as a leading voice, along with others, on health equity and health justice in the region. As a relatively small organisation, HJI is able to be 'agile, nimble-footed and quick to respond' to a range of issues that have long term impact or benefit for health rights. HJI employs a range of advocacy and research strategies to further our work including:

- Research
- Time-sensitive analysis and submissions
- Convening educational webinars
- Initiating innovative advocacy campaigns, and
- Pursuing legal interventions that advance health equity.

We strategically use social media for information dissemination and educational purposes and to help shape progressive narratives on health justice. The demand for information from other organisations and the public has increased significantly in the past year as HJI is both respected by its peers and the field it is in, and its work is evidence based.

There is strong administrative capacity, technical expertise and relevant legal, health systems, advocacy, research, and administration experience amongst all current team members. In addition, HJI has specific legal, and rights based public interest litigation experience that can also be used as a last resort to translate research into policy and into legal precedent. Interviewees also noted that there is a groundswell of support for HJI, its leadership and for the *impressive amount of work* it has achieved in a short space of time (1 year) with a small team and urged that HJI continue -with others- to advance health justice goals in the country and region.

HEALTH JUSTICE INITIATIVE

VISION

Health Justice Initiative's **VISION** is a health sector that is fair, just, transparent, and accountable where everyone has equitable and affordable access to healthcare and life saving technologies.

MISSION

Health Justice Initiative's **MISSION** is to address systemic health inequities and injustices.

OBJECTIVES

HJI will work towards achieving its Vision and Mission through four objectives using research, advocacy, litigation, social media engagement, education and training.

1. To contribute to positive legislative reforms that support Universal Health Coverage for all.

2. To examine and address the structural determinants of ill health and the legal and other socio-economic barriers faced by people who use and rely on the health system.

3. Advocate for law and policy reform to address barriers to affordable and fair access to life-saving medical technologies.

4. Advocate for greater transparency and accountability of the public and private health sectors including statutory, regulatory and oversight bodies.

OBJECTIVES:

1. To contribute to positive legislative reforms that advance Universal Health Coverage for all

Over the next three years HJI will examine issues related to financing, procurement, governance and the relationship between the public, private and also philanthropic sector in order to identify legislative reforms that will help achieve Universal Health Coverage including National Health Insurance.

ACTIONS:

a Develop a framework for transparency in selection, procurement, private sector contracting and pricing of health products that bring about health equity - with an emphasis on the role of the National Department of Health, National Treasury, and statutory bodies such as the South African Health Products Regulatory Authority (regulator) and the Competition Commission.

b Conduct research on how the *Single Exit Price* system could be amended; engage with Parliament about medicine pricing regulation, in line with international best practice. Monitor and engage Parliament on its processes and provide evidence- based submissions where applicable.

c Develop educational materials, submissions and training that deepen understanding of health equity including within any National Health Insurance scheme and specifically by:

i. Creating an accessible repository of information and timeline of key events relating to the implementation of the National Health Insurance.

ii. Preparing research submissions on the appropriate architecture for South Africa's medicine pricing system.

iii. Collaborate with existing medicine access advocacy groups to collectively advocate for a broad and evidence-based interpretation of health equity.

iv. Support others, where possible, to make submissions or prepare shadow reports to local and global bodies on the right to health and the Sustainable Development Goals.

2. To examine and address the structural determinants of ill health and the legal and other socio-economic barriers faced by people who use and rely on the health system.

ACTIONS:

- **a** Support government departments, statutory and regulatory bodies to increase access to medicines and health technologies for those most marginalised.
- **b** Identify laws and policies that create barriers to health for women, poor people, marginalised and criminalised populations, and advocate for their repeal or amendment.
- **c** Proactively support laws and policies that provide an enabling environment for health rights and defend attempts to erode these.

3. Advocate for law and policy reform to address barriers to affordable and fair access to life-saving medical technologies.

ACTIONS:

- **a** Support advocacy and research efforts to de-commodify all medical technologies locally and globally including at the World Trade Organization with a focus on global intellectual property rules and other competition or trade barriers to access.
- **b** Provide training and technical support to government, community and medicine access or advocacy groups, community media houses, and work with relevant academic units.
- **c** Use constitutional and competition law, regulation, industrial policy and other legal avenues to scale up affordable access to medicines and other technologies.
- **d** Document the lessons from the COVID-19 pandemic and advocate for non-market-based solutions to equity in access.
- **e** Track the Research & Development pipeline including financing of key health innovations (especially for diseases considered to be neglected) in order to advance equity in access.

4. Advocate for greater transparency and accountability for the public and private health sectors including statutory, regulatory and oversight bodies.

ACTIONS:

a Advocate and/or litigate for greater transparency on the part of any health product regulatory agencies, the health ministry and department, and the private sector – this includes procurement and contracting related to TB, HIV and COVID-19.

b Advocate for greater funding and independence of the health product regulator and other relevant statutory bodies, including advocating for greater transparency in line with international best practice.

1.

To contribute to positive legislative reforms that support Universal Health Coverage for all.

2.

To examine and address the structural determinants of ill health and the legal and other socio-economic barriers faced by people who use and rely on the health system.

3.

Advocate for law and policy reform to address barriers to affordable and fair access to life-saving medical technologies.

4.

Advocate for greater transparency and accountability of the public and private health sectors including statutory, regulatory and oversight bodies.

VALUES AND WAYS OF WORKING

HEALTH JUSTICE INITIATIVE VALUES

We are committed to:

- Inclusivity, diversity and intersectionality.
- Transparency, accountability, and integrity in all our work and dealings.
- Excellence and ethical practice that is non-partisan.
- Instilling a passion for, and the courage to speak out for justice.
- Contribute towards addressing the injustices of our apartheid past.
- Wellbeing of staff and maintaining a healthy work and life balance.

Ways of working:

- We will continue to work collaboratively and constructively with government, the private sector, other organisations, and movements in the sector.
- We will continue to strengthen links at an international level with other health equity and justice organisations.
- We will contribute towards building a new generation of health justice advocates, practitioners, and activists.
- We will support research that is evidence-based and verifiable.
- We will openly share our educational resources and work.
- We will continue to use social media as an advocacy tool and to counter misinformation.

HJI is strongly committed to our independence and critical thinking. We therefore do not accept funding from the South African government or pharmaceutical companies. Our fund-raising strategy will be informed by this principle and by our strategic focus areas described here.

In addition, as a new organisation, we will devote time to work on expanding our organisational understanding of three pressing and specific areas:

- *Feminist approaches to organisation-building, leadership, and activism*
- *Approaches to decolonising global health with the aim of 'repoliticising and historicising' it*
- *'Intersectionality' in health justice work*

GLOBAL AND LOCAL CONTEXT

**This section is partly drawn from the expanded inception report and other expert submissions.*

HJI's strategy development process was mindful of the well established global context and practice of health and health care activism that is embedded in a long human rights tradition. In the South African and global mobilisation around HIV/AIDS and for the right to dignity, treatment and affordable medicines, this human rights tradition gave rise to a wide spectrum of international and local organisations. These organisations increasingly link specific struggles to the call for universal health care.

Health rights and access to health care in South Africa are structured by race, gender, class, and geographic location. In choosing our key strategic objectives, we tried to locate our work appropriately within the existing constellation of organisations, and to choose areas of work that are specific, but which link clearly to the broader goal of health for all within the guiding vision of the Alma Ata Declaration, our Constitution and other documents and principles including the Sustainable Development Goals.

THE 17 SUSTAINABLE DEVELOPMENT GOALS

The SDGs with 169 targets were adopted by the United Nations in 2015, for achievement by 2030.

Sustainable Development Goal 3 aspires to ensure health and well-being for all, including a commitment to end the epidemics of AIDS, tuberculosis, malaria, and other communicable diseases by 2030. It also aims to achieve universal health coverage and provide access to safe and effective medicines and vaccines for all. Supporting research and development for vaccines is an essential part of this process as well as expanding access to affordable medicines.

Goal 3: Ensure healthy lives and promote well-being for all at all ages

Goal 3 Targets include:

Achieving universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

THE ALMA ATA DECLARATION

The idea that access to health care is the right of all citizens gained ground in the post WWII social democracies and in certain socialist countries. However, the formulation of the idea of health itself as a human right was launched into global consciousness with the World Health Organization's Alma Ata Declaration on Primary Health Care in 1978, which stated that "health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal".

The Alma Ata Declaration went on to note that:

"(E)conomic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries … Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures."

SOUTH AFRICA'S HEALTH SYSTEM

South Africa's current health system was established to replace the divisive, fragmented, and discriminatory health system inherited from apartheid, with the purpose of promoting health within a comprehensive, coordinated, and unified health system based on a range of principles, one of which is the recognition of the importance of ***equity for health (Preamble to the National Health Act). South Africa had a population of just under 60 million people at the end of 2020.***

General: Rights and Laws

Section 27 of the South African **Constitution** provides that "Everyone has the right to have access to— (a) health care services, including reproductive health care" and no person "may be refused emergency treatment".

- In relation to health care services, government must:

  Respect the right of access to health care services by not unfairly or unreasonably getting in the way of people accessing existing health care services, whether in the public or private sector;

  Protect the right by developing and implementing a comprehensive legal framework to stop people who get in the way of the existing access of others;

  Promote the right by creating a legal framework so that individuals are able to realise their rights on their own; and

  Fulfil the right by creating the necessary conditions for people to access health care, by providing positive assistance, benefits and actual health care services.

- Government must also "take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation" of the right. This is the basis for advocating for universal access to quality and comprehensive health care.

Under the **International Covenant on Economic, Social and Cultural Rights**, which South Africa ratified in 2015, the State has an obligation to "ensure the prevention, treatment and control of epidemic … diseases" so as to enable people in the country to realise their right "to the enjoyment of the highest attainable standard of physical and mental health".

Inequality

In South Africa, there is a huge divide between the public and private health care sectors, which characterises the current divided health system.

Inequity arises because the private sector will service those who pay, be they members of a medical scheme or wealthier individuals but will not reach people in need who cannot afford private health care – the majority of people living in South Africa.

As a result, South Africa has severe inequalities in health status by race, rurality, class, and gender. This inequality is associated with poor health outcomes for the amount of money we spend on health. It reflects inequalities in the distribution of both the determinants of health and in access to health care.

Using spending as a proxy for access: *"Aggregate expenditure on health is estimated at R462 billion in 2019, representing 9.0% of gross domestic product in that year. Of this total, 48.7% was spent in the public sector and 51.3% in the private sector. …40.2% of aggregate expenditure was financed by medical aid benefit expenditure. There are some nuances, but in effect about 50% of health expenditure in South Africa is spent in the public sector on health care to the poorest 82% of South Africans with the greatest burden of disease."* This injustice is exacerbated by provincial and district inequalities in public spending too.

For more than 15 years the Government has been working on a *National Health Insurance* proposal to bring the public and private sectors closer together through a "National Health Fund". It would provide health care for everyone whether from the public or the private sector.

Medical Schemes – Health 'Insurance' coverage in South Africa

Medical scheme members are more likely to be wealthier than non-insured persons and more likely to be employed. This is also why the South African health system is in need of reform.

The Council for Medical Schemes reported in its 2019-2020 Annual Report that:

- There are 8.95 million people (members and beneficiaries) belonging to medical schemes in South Africa.
- The Council for Medical Schemes regulated 78 registered medical schemes in 2019, comprising of about 20 open schemes and 58 restricted schemes. Open schemes accounted for 55.38% of medical scheme membership and beneficiaries.
- The biggest open medical scheme is Discovery Health. The Government Employees Medical Scheme is the largest restricted scheme. Principal members covered an average of 1.20 dependents each.
- The gender distribution of members is almost equal in all schemes, although the average age for women is higher with 34.1 years versus 31.9 years for men, with an average age across schemes being 33 years.

- Based on principal member addresses, approximately **40% of all medical scheme members are in Gauteng, followed by the Western Cape, and KwaZulu-Natal with 15% and 14% respectively.**

The South African Health Review has extrapolated data for the extent of medical scheme coverage in South Africa using provincial estimates of medical scheme coverage, as reported in the General Household Survey by Statistics South Africa from which our country's *medically uninsured* population can be calculated.

- The proportion of the South African population that is covered by a medical scheme varies and is on average approximately 16% - from a low of 7.2% in Limpopo to a high of 24.6% in Gauteng. At a district level, that proportion is estimated to vary from 3.8% (Alfred Nzo district, Eastern Cape) to 30.6% (Tshwane Metro, Gauteng).
- Most people in South Africa are therefore dependent on the public health sector for health care.

Generally, as countries develop economically, the prevalence of infectious diseases declines, and non-communicable diseases such as diabetes, cardiovascular disease and cancer become the primary sources of morbidity and mortality.

In Africa as a whole, and in South Africa in particular, this has not happened, and infectious diseases, particularly HIV and TB (and malaria in many parts of the continent) continue to exact a high toll even as the non-communicable diseases mentioned above become more prevalent.

The most recent available figures from Statistics South Africa reflect this changing pattern*:*

> *"The top ten leading underlying natural causes of death in 2018 were: tuberculosis; diabetes mellitus; cerebrovascular diseases; other forms of heart disease; human immunodeficiency virus (HIV) disease; hypertensive diseases; influenza and pneumonia; ischemic heart diseases; chronic lower respiratory diseases; and malignant neoplasms of digestive organs.*
>
> *Tuberculosis (TB) remained the main leading cause of death in the three-year period (2016–2018), although the proportion of deaths due to TB declined in the three-year period from 6,5% in 2016 to 6,0% in 2018.*
>
> *Diabetes mellitus remained the second leading underlying cause of death in the three-year period, although the proportions of death due to diabetes mellitus increased consistently over the three years."*

Statistics South Africa: Mortality and causes of death in South Africa: Findings from death notification, 2018. June 2021

In almost every instance (with the possible exception of diabetes) these diseases are more prevalent amongst the "rich" than the "poor", generally substantially more so. COVID-19 has also exacerbated health challenges in South Africa - with increasing death, hospitalisation, and illness. In addition to the new burden of disease and death, due to lockdowns and other restrictions in movement, there has been a serious disruption of preventive and treatment services including for HIV, TB, diabetes, and childhood immunisation.

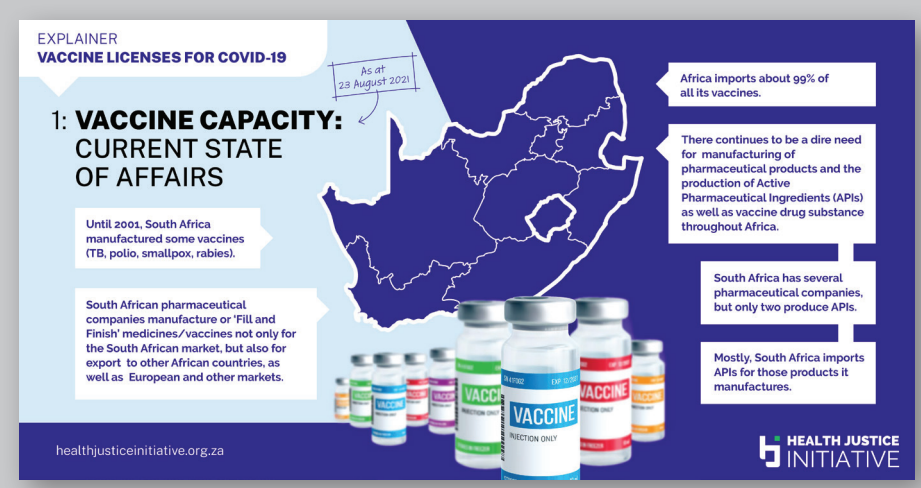
Data on Mortality and COVID-19

Statistics South Africa reported in December 2020 that almost 60% of all deaths due to COVID-19 in hospitals occurred in adults over the age of 60 and less than 12% occurred in adults under the age of 45.

An analysis of data from the National Income Dynamics Study in 2017 and the first wave of the NIDS-Coronavirus Rapid Mobile Survey 2021 suggested that income-related health inequality in the COVID-19 era increased six-fold compared with what was obtained in 2017. For example, cumulative mortality due to COVID-19 was noted in January 2021 as approximately twice as high in poorer township areas of Cape Town compared with the rest of the city. This is partly explained by differences in access to care between the public and private sectors.

As of September 2021, South Africa researchers have recorded a quarter of a million excess natural deaths (250 000) since May 2020. The number of officially reported COVID-19 deaths is approximately 84 000. The researchers note that not all of the excess deaths are due to COVID-19 as some are the result of the 'overburdening of the South African healthcare system during the surges and waves'. These researchers estimate, based on the pattern and timing of the deaths, and the results from testing, that 85-95% of excess deaths are attributable to COVID-19.

EXAMPLES OF HJI MATERIALS



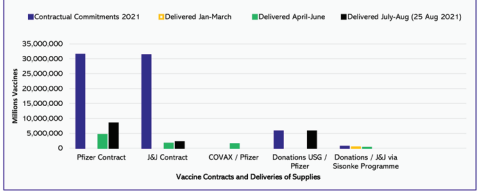
COVID-19 Vaccine Supplies //

TRACKING VACCINES COMMITTED AND VACCINES DELIVERED

SOUTH AFRICA: HJI Vaccine Supplies - Summary Sheet 2

Last Updated // 25 August 2021 //

HJI Summary Sheet 2 // Vaccine Supplies - Gap



	Committed	Delivered Jan-March	Delivered April-June	Delivered July-August*
Pfizer Contract	31 393 430	0%	14% (4 468 370)	27 % (8 345 420)
J&J Contract	31 253 600	0%	5% (1 553 600)	7 % (2 073 600)
COVAX / Pfizer	Unknown	-	1 392 300	-
Donations (USG / Pfizer)	5 660 460	-	-	100% (5 660 460)
Donations (J&J via Sisonke Programme)	500 000	60% (300 000)	40% (200 000)	-

Total vaccines committed: 68 747 050

Total vaccines delivered: 24 011 350 (25 Aug 2021) 35%

Pfizer:	12 831 390
J&J:	3 627 200
COVAX / Pfizer:	1 392 300
USG / Pfizer:	5 660 460
J&J Sisonke:	500 000

A. *Delivery dashboards and Vaccine Manufacturers Contracts are not publicly available.*
B. *The Fill and Finish License Agreements for Aspen (J&J) and Biovac (Pfizer) are not publicly available.*
C. *The mooted full manufacturing License for Aspen (J&J) is not publicly available.*
D. *All information is based on sources that are publicly available and the Health Justice Initiative (HJI) is not responsible for the results obtained from your use or reliance on this information. The information is at times imperfect due to the lack of proper information sharing by relevant stakeholders.*

Please notify us if we have inaccurately reflected any data.

1. Details on the cumulative and daily number of vaccines administered in SA, across public and non-public sites, is available at: https://sacoronavirus.co.za/
2. The President's Remarks and Press Statements from the Health Ministry are available at: https://sacoronavirus.co.za/ and http://www.thepresidency.gov.za/press-statements/president-cyril-ramaphosa
3. Bhekisisa and Media Hack 'Vaccine Dashboard' is available at: https://mediahack.co.za/datastories/coronavirus/dashboard/
4. The population of South Africa is approximately 58 million. About 40 million people are over 18 years of age. **South Africa is aiming to vaccinate about 67% of the population.**
5. **Vaccine Sites:** https://sacoronavirus.co.za/active-vaccination-sites/

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Profiteering from vaccine inequity: a crime against humanity?

Companies and rich nations are creating a deadly covid-19 vaccine "protection racket"

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Early in the pandemic, Pfizer announced an intention to profit from its covid-19 vaccine.[1] In the first three months of 2021, Pfizer's vaccine brought in $3.5bn (£2.5bn; €3bn) in revenue and hundreds of millions in profit.[2] Other companies are also making exceptional profits from covid-19. Moderna, which received public funding to develop its covid-19 vaccine, will earn several billion dollars from vaccine sales.[3] Even Astra Zeneca, with its acclaimed "non-profit" model, will receive billions in revenue and is free to raise the price once itconsiders the pandemic to be over.[4 5]

But the rich world is refusing to share vaccines with poorer countries speedily or equitably. Whereas 60% of the population in the UK is fully vaccinated, in Uganda it is only 1%.[6] The 50 least wealthy nations, home to 20% of the world's population, have received just 2% of all vaccine doses.[7] The rich world should be ashamed.

The World Health Organization wants rich nations to halt booster vaccination and instead send doses to less wealthy nations[7]—yet Pfizer is expecting rich nations to ignore WHO and recommend boosters, helping to increase its expected revenues to $33.5bn.[8]

Pandemic profiteering is, in our view, a human rights violation that demands investigation and scrutiny. The Universal Declaration of Human Rights states that everyone has the right "to share in scientific advancement and its benefits."[9] Such advancement led to accelerated development of effective covid-19 vaccines, with public funding, that lower the chances of severe illness and death.[10]

Vaccine preventable deaths and illness are occurring across Africa, Asia, and Latin America at an unprecedented speed and scale. These continents are being outmanoeuvred by rich nations flexing their market power. Let us be clear what is causing these deaths: a free market, profit driven enterprise based on patent and intellectual property protection, combined with a lack of political will. Contrary to claims, it is possible to make enough vaccines for the world.[11]

Vaccine apartheid

Vaccine manufacturers and their chief executives, accountable only to their boards, have worked with a group of powerful leaders to amass doses.[12] By September 2020, around 30 rich nations—those able to pay high vaccine prices—had cleared the world's shelves of doses through advanced purchase orders,[13] leading to vaccine apartheid.[14] Canada purchased enough doses to vaccinate its citizens five times over.[15] The UK procured enough doses for four times its population. By the end of 2021, rich nations will be sitting on one billion unused doses,[16] even though some poorer countries have not yet received the vaccines that they have paid for. WHO's director general, Tedros Adhanom Ghebreyesus, called global vaccine inequity "grotesque," a recipe for seeding viral variants capable of escaping vaccines, and a "moral outrage."[17]

But perhaps calling it a moral outrage isn't enough? Where is the redress for decisions that deny intellectual property waivers and withhold manufacturing knowledge—decisions that lead to hundreds of thousands of premature deaths in disadvantaged countries?

Some vaccine-rich countries are now destroying excess, unused doses.[18] And some have imposed export bans and restrictions to protect their stockpiles. Ironically, vaccine companies prevent poorer countries from insisting on similar measures.[19]

To try to prevent such hoarding, a global vaccine sharing mechanism called Covax was launched last year. Designed as a "global powerhouse," Covax aimed to buy enough doses to vaccinate at least 20% of people in 92 poorer countries by the end of 2021.[20] It is way off target.[21] Rich nations pushed Covax to the back of the queue of buyers, and it has struggled with procurement, delivering just 163 million doses, far short of the billions of doses needed.[22] Disappointingly, the G7 agreed to donate less than 8% of the required doses to Covax.[23]

The governments of India and South Africa are leading a proposal to temporarily waive intellectual property protection on covid-19 technologies, backed by over 100 countries.[24] But vaccine manufacturers and many rich countries are working tirelessly to block waiver discussions at the World Trade Organization, which itself is acting sluggishly.[25] Oxfam has accused the G20 rich nations of putting relations with pharmaceutical companies ahead of ending the pandemic.[15]

Knowledge must be shared

In May 2020, WHO launched the Covid-19 Technology Access Pool (C-TAP), calling on vaccine developers to share vaccine know-how through pooling and voluntary licensing agreements in a pandemic. In June 2021, WHO announced that it was working with a consortium of South African vaccine companies, universities, and the Africa Centres for Disease Control and Prevention to establish its first covid mRNA vaccine hub. But no major company with a WHO approved vaccine has shared technology with C-TAP or the WHO hub. Most governments are reluctant to make it compulsory to share such knowledge.[26] There was some hope that Oxford University's vaccine, developed through public funding, would be made open source, but the rights

Solidarity & Afriforum v Minister of Health and 16 Others

Vaccine procurement case

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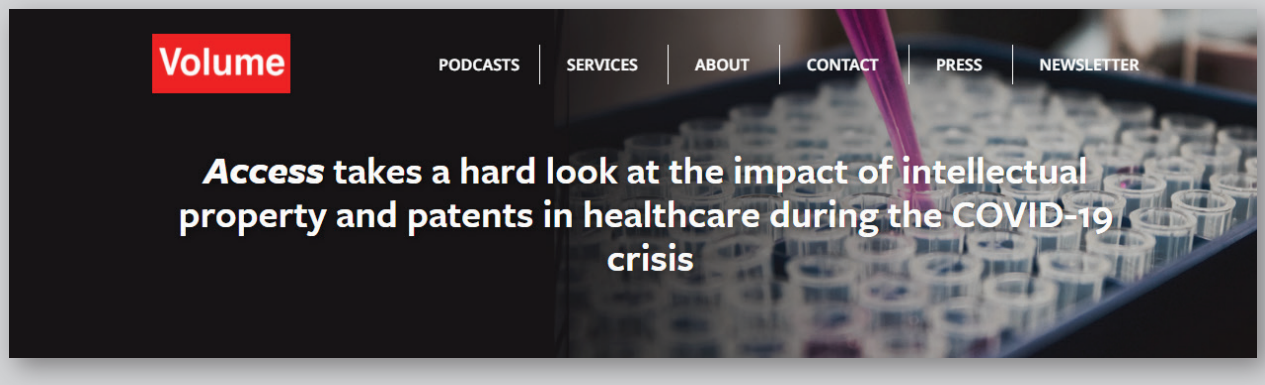

MAVERICK CITIZEN

MAVERICK CITIZEN OP-ED

Private-public politics: State control crucial for vaccine equity and to stop queue-jumping by the rich

By Fatima Hassan and Marlise Richter • 11 May 2021

Pfizer vaccines arrive at OR Tambo International Airport on 3 May 2021. (Photo: Flickr / GCIS)

If the private sector had been given the go-ahead to procure and distribute vaccines, it would have had dire ramifications for health equity in this and future pandemics. It would have allowed people with money and medical insurance to access scarce vaccine supplies (in theory) and lead to no consideration of public health equity or

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