

Africa: Covid-19 vaccines - the new apartheid?

Monday 29 March 2021, by [CAIRNCROSS Lydia](#), [HASSAN Fatima](#) (Date first published: 20 March 2021).

At the end of February, [ILRIG](#) held a webinar on the issue of Covid vaccines. Two of the speakers were Fatima Hassan, Director of the Health Justice Initiative, and Lydia Cairncross, a medical doctor and health activist with the People's Health Movement. Fatima spoke mainly on the general vaccine situation, which we have covered in other articles. So we are publishing what she had to say on two key issues - the control of drug companies and the question of vaccine prioritisation. Lydia spoke more on the South African situation and we have presented an edited version of a transcript of her input. The information (both science and politics) on vaccines shifts at great speed. It was accurate as far as possible at the time of the webinar.

Who is in control?

By Fatima Hassan

Despite the fact that we are in a pandemic, despite the pledges of solidarity in the beginning, despite all the warnings from the WTO and the UN, and despite the fact that many governments actually co-own the technology, what we are seeing is that drug companies are driving things. They are deciding on the licensing and the pricing. But more importantly, many countries are now hostages to these negotiations. You have to sign non-disclosure agreements. In Latin America this week, Pfizer asked national governments to put up state assets as collateral for waiver provisions or indemnity provisions. Our own government has admitted that it is going to set up a no fault compensation scheme.

So the way in which the industry is exercising power and is being allowed to exercise that power really has implications for many countries and particularly for democratic institutions or for institutions that are trying to build democratic measures.

Vaccine priority and the Afri-Forum case

There is the key public health principle that there can't be any queue jumping. We have seen the vaccine nationalism that's playing out between richer and poorer nations. We don't want a similar situation playing out in each local context. So far the global best practice has been that scientists meet, they develop consensus and through their relevant expertise they make recommendations to their government. There is a prioritisation and an allocation policy and a plan for a state or a country.

You follow the best public health practice and advice around how to prioritise. That is the reason why you start with health care workers, then people over 65 and people with co-morbidities. You don't start with the person who has the private jet, or the person who has medical scheme coverage or the person who has a lot of money. There is a public health reason for that in addition to a human rights and equity reason for that. And it's what we very simply call queue jumping or vaccine

apartheid.

We've intervened as the Health Justice Institute (HJI) in a case which Afri-Forum and Solidarity have brought. They say that in SA they want medical schemes and private groups to be able to procure the vaccine and to start administering in the private sector on their own. Any restriction on their ability to do that is a restriction of their constitutional rights.

We obviously have a very different view on that. We have applied to be a friend of the court in that matter. Globally there is consensus that you have to have a national and global immunisation strategy that prioritises the collective interest, that prioritises equity and that prioritises public health. We are in a time in which there are limited supplies. Currently, in February 2021, there is an absolute shortage of vaccine supplies because of the way in which patents operate, opposition to the waiver of intellectual property rights and the restrictions on scaling up manufacturing. So this scarcity is self-created.

South Africa: Covid, vaccines and the health system

By Lydia Cairncross

This massive pandemic has hit us very hard. After our first wave there was talk of SA having been exceptional, that we had missed the worst of things and that somehow our strategy had worked well. Then we were hit with a second wave which was much worse, with deaths much higher than in the first wave. And there are very strong indications that there will be a third wave coming through in the winter months.

Firstly, I think it's worth reminding ourselves about what we have been able to do for Covid and ourselves:

- We've had the lockdown with its massive social and economic impact; in SA it was particularly militarised and authoritarian.
- We've had attempts at individual responses – masking, washing hands, avoiding crowds and so on, which has helped to a certain degree.
- There's been a lot of community support for those affected both by the virus itself and also by the impact of the lockdown, which has really saved many lives.

But what hasn't happened in the last year is real steps to build a better health system or to improve the interface between communities and the health system.

On the treatment side, while there are lots of drugs that are being investigated and trialled, and a couple that have been registered and some repurposed, currently there is no cure for Covid.

So we're locked in this cycle of lockdown, opening up, Covid spreads, hospitals fill up and people die. And really we need to get to 60-70% population immunity (otherwise known as "herd immunity"). This could be achieved through people acquiring the virus, recovering and having antibodies. Seventy per cent of the SA population is about 40 million. Without a vaccine, and with a 2 per cent mortality rate, we would be looking at about 800 000 deaths.

So it is quite clear, particularly with the devastation of the second wave, that we can't let this burn.

Vaccination is an alternative path to population immunity. There's been massive global investment in developing vaccines, both from private industry but also, often not mentioned, from the public sector as well.

How has this vaccine been developed so fast?

This is the biggest question we come up against, and this is a summary of the answer:

1. We had the scientific basis already through development of other vaccines. Both Sars and Mers were corona viruses and vaccines were developed against those. So we had that scientific platform. Also, the Ebola vaccine uses very similar technology to some of the Covid-19 vaccines.
2. There was massive investment, both public and private.
3. The three phases of vaccine development were overlapped instead of happening one after the other.
4. There was a lot of collaborative work.
5. The pandemic conditions meant that many people volunteered to test the vaccines out of a sense of social responsibility. And because the pandemic was raging, the high number of cases speeded up the trials.

So instead of 15 years it's been done in one year. From 290 vaccine candidates, there are about 40 or so that are in clinical trials. Four of them have been registered with the FDA and seven are currently in widespread use. And the three that are relevant to SA are Pfizer, Astra Zeneca and J&J.

Vaccine rollout to date

Almost immediately the Astra Zeneca vaccine arrived in SA, the preliminary results came out that the vaccine was not working against the SA variant (501.V2).

And then the J&J vaccine came into the equation. It had also been trialled in SA, in Latin America and the US. The SA component was about 15% of the trial, so a reasonable number of participants came from South Africa. And importantly 95% of people who got Covid-19 in the SA part of the trial had the new variant. So it was possible to check if this vaccine was working against this new variant. You've all seen the results: 57 per cent protection against mild and moderate disease, but very good results (85%) in preventing severe disease, and 100 per cent reduction in deaths.

In the last week or so we have vaccinated 41,000 health workers. But during that time global vaccination figures have increased from 131 million to 218 million. So the pace of vaccination is very fast in the high income countries.

We know there is a global scarcity of vaccine, so part of the national plan is to prioritise. Health care workers were prioritised as the first group; that's to stabilise the health system to help to treat others and also because health care workers are exposed daily in their work.

The second phase would be essential workers, those in settings where many people live together, and those over 60 and with co-morbidities. Phase 3 would be the rest of the adult population.

There were no real time frames put against these phases, but this is the overarching plan.

Divided healthcare system

SA is implementing this vaccine rollout in a system which is deeply divided. It's divided into two health systems - a public and a private system. And it is divided on urban and rural lines as well as on provincial lines. So there are massive inequalities between the different provinces.

There are a few key things we need to remember about the public and the private sector:

- The public sector is serving 86% of the population. To serve that 86%, the public sector has only one third of the doctors in the country, 30% of the specialists and 40% of the nurses.
- In the private sector, three big hospital groups dominate: Mediclinic, Life Healthcare and Netcare. They have about 80% of the private hospital beds in the country.
- We don't often hear the problems of the private sector but they are significant and they apply here on the issue of vaccine rollout. The system is based on fee for service, there are no outcome measurements, there is very little follow up, consistency and auditing of outcomes. It's an individual and individualistic health care system which is not promotive or preventive. And it's extremely expensive. So it's not very efficient and it's not very effective.

I just also wanted to mention some strengths in SA because I think they are also important:

- We have a good health infrastructure in most of the provinces, particularly the big academic hospitals and the urban centres.
- We've got a very large skilled workforce.
- We've got thousands of Community Health Workers, although they're underpaid and exploited.
- We've got an active citizenry.

The vaccine rollout process

To roll out the vaccine to 40m people, we first need to buy it and then we have to distribute it.

Buying: there is central purchasing. We've got 20m on order from Pfizer, 9m from J&J and then the Covax numbers are unclear: some report 4.3m and others 12m. We also don't know what's coming through the African Union.

Distribution: This is going to be through the different sectors, not only the public sector. Right now 30% has been put aside for vaccination of private health care workers working in the private sector. But they are coming through to state facilities or to the research site in order to get the vaccine.

What must we demand?

We can see that we need central procurement. We need to hold our state accountable, but that requires a shift in political power. The kind of vaccine rollout that we'd like to see would be transparent, accountable, no corruption, people before profit, through a strong public health system and not nationalistic – in other words no xenophobia and covering everybody. The question is how we get there and what are some of the demands that we should make.

Firstly, we really need to change the way decisions are made. There are Ministerial Advisory Committees (MACs) on vaccines, on Covid and on social behavioural change. These are not democratic structures. They gag the individuals that get on to them. We need to have organisations represented there – community, labour and health sector representatives there. And they need to be accountable to their members.

This pandemic has really shown the disconnect between the health system and the communities. We can't be ready for future health crises unless we shift and change that. So health promoters, community health workers and health communities need to be focused on and strengthened during this time. That's one of the lessons.

The COVID-19 vaccine rollout is probably the biggest single public health programme we will see in our lifetime. We could go through this programme entrenching the old inequalities and injustices in our health system. Or we could use it as a catalyst to build a different kind of health system built on equity and social solidarity.

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