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Whose rules-based order? Lessons from the health justice movement for a broken multilateralism

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Whose Rules-Based Order?

Lessons from the Health Justice Movement for a Broken Multilateralism

Thank you Chris [Prof Christopher Cramer, DLD Co-Director], thank you very much.

Good evening, friends, I'm really delighted to be here tonight. It is a deep honour to speak here at SOAS. I am humbled to be following in such remarkable footsteps and to give this lecture.

For the last six years I have led the global AIDS response for the United Nations. I come before you as a daughter of Africa, born in Uganda during the time of British colonialism. I spent some of my formative years as a refugee here in the United Kingdom, where I studied to be an engineer. I'm a daughter of Africa who left my engineering job to join a resistance army in my country and then, after the war, served as a diplomat, a parliamentarian, an activist, and internationally at the African Union, the United Nations and Oxfam.

I tell you that not to recite my résumé, but to say that I have had a very particular front row seat to the creation of the global order.

I have seen its bright side: the extraordinary advances in science, the growth of women's rights and human rights, the expansion of international cooperation, the possibility of countries to come together to solve problems that no country can solve on its own.

But I have also seen its shadow side. For many of us in the majority world, the global order often spoke the language of universality while operating through unequal power. It promised common rules, but the rules were rarely neutral. Trade rules. Finance rules. Tax rules. Debt rules. Technology rules. Intellectual property rules. These rules constrained the policy space of poorer countries while expanding the freedoms for capital and for corporations.

We are now in a moment of rupture. Many people say this, and I think they are right. But from where I sit, the rupture is not simply because one man in America does not play by the rules of the old order that his North American and European peers expect him to follow. No. We are in rupture because extreme inequality has risen and continues to rise,

global problems have multiplied, and a multilateral system shaped and overwhelmed by neoliberalism has proven incapable of addressing the world's biggest crises.

Climate breakdown. Pandemics. Conflicts. Debt. Rapid and unregulated expansion of artificial intelligence, biotechnology, and other technological change. The spread of authoritarian politics. Extreme inequality is both an outcome and a driver of these crises. Ordinary people feel left behind. Middle classes feel abandoned. Trust in institutions is eroding. Populists exploit that anger. Authoritarianism is rising. The countries that built multilateralism are now among those turning away from it.

This is not simply a geopolitical crisis. It's a crisis of a global system whose rules increasingly serve concentrated wealth rather than human wellbeing.

Tonight I want to explore that crisis through one lens: medicines and vaccines.

Because nowhere is the contradiction sharper. Humanity can invent life-saving science, yet millions still die because they cannot access it. The international institutions mandated to address inequality repeatedly collide with the economic rules that produce it. And nowhere do we see this more clearly than in the struggle between life and monopoly, between public goods and private extraction, between the promise of multilateralism and the rules that have captured it.

The Social Contract We Lost

The multilateral system was first built, as you know, in the aftermath of crisis by the victors of the Second World War. It gave rise to institutions and norms that were, on one hand, universal and humanitarian, intended to guarantee peace and security, advance development and human rights. On the other hand, they also preserved the power of the system's founders. As new powers rose, they were invited into that system, but often on terms already set by the founders.

After the Second World War there was also, implicitly, a social contract around science and health. Science, public investment, and international cooperation were meant to create public goods.

Jonas Salk captured it clearly when asked who owned the polio vaccine: "The people. Could you patent the sun?" he replied.

Switzerland, the country that gave birth to powerful pharmaceutical corporations like Roche and Novartis, did so in a legal environment that did not allow pharmaceutical monopolies. Canada limited pharmaceutical patents until as late as the 1990s. The Indian Patents Act allowed Indian companies to develop the capacity to produce affordable medicines. Indira Gandhi said it clearly at the World Health Organization's World Health Assembly of 1981. "My idea of a better ordered world is one in which medical discoveries would be free of patents and there would be no profiteering from life or death."

Let me be clear, up until the 1990s, some rich countries had moved on, but most of the world still did not allow patents on medicines. Medicine patents are not manna from heaven. They are a recent creation.

As the Cold War ended, pharmaceutical companies, entertainment companies and other industries teamed up. Through the newly created World Trade Organization and the TRIPS [Trade-Related Aspects of Intellectual Property Rights] Agreement, intellectual property was recast as a trade issue and, in a rather impressive coup, these companies convinced policy makers that global monopolies were "Free Trade".

India resisted. Many majority-world countries resisted the inclusion of medicines in these strict rules. But they lost.

Under TRIPS, countries were required to introduce strict intellectual-property protections, including twenty-year patents on medicines. Knowledge became tradable property. Public science became private assets. Medicines became globally protected monopolies. The space for countries to shape their own industrial and health policies narrowed dramatically.

And then, just as these rules were coming into force, effective AIDS treatment arrived.

When Science Met Monopoly

In 1996, at the International AIDS Conference in Vancouver, researchers announced they had developed an effective HIV treatment—a combination of three drugs that could stop the HIV virus. It was extraordinary. People who had been close to death came back to life. The death sentence of AIDS was transformed, for those who could access treatment.

Science had delivered.

At that point, in 1996, 6.5 million people had already died of AIDS globally. Another 22 million people were living with HIV. For them, science had brought hope.

AIDS deaths in North America, and here in the UK, in Europe, plummeted.

But around the world the same did not happen.

Treatment cost at that time was between 10,000 and 15,000 dollars per person per year. If you take a country like my country, Uganda at the time, the total annual public health spending per person was about 16 dollars.

So, while the medicines existed, what stood between them and people who needed them was price. And behind price stood law.

The new rules declared that countries had to respect patents and could not produce affordable generic versions without permission. Governments and communities appealed to companies to share their technology or reduce prices. They refused.

AIDS deaths continued to rise across Africa, Asia and Latin America. A person in London could live. A person in Kampala would die. Not because the science differed. Not because the disease differed. But because the rules differed in their consequences for rich and for poor people.

In the decade after effective treatment was known to exist, more than 16 million people died of AIDS—twice as many as those who died before treatment was found. About 12 million of these were in Africa. This was not a scientific failure. It was a failure of politics.

The tragedy was even greater. Because we now know clearly that HIV treatment not only saves lives, but it also stops HIV transmission. By putting people on treatment in the rich North, they stopped new HIV infections. They got to control this pandemic. But that did not happen in the global South.

Here I want to debunk a racist myth—that HIV is concentrated in Africa because of the "African sexual norms". Africa has the highest burden today in part because we lost over a decade of access to the medicines that could have stopped new infections.

The AIDS Movement Changed History

Now, out of this crisis emerged one of the greatest justice movements of our time.

People living with HIV organised. Gay men. Sex workers. Women's movements. Youth. Doctors and scientists. They all joined a movement. You had activists in London and New York linking with movements in Kampala, Johannesburg, São Paulo and Bangkok. They brought the moral scandal into the streets, into courts, into parliaments, into the media and into multilateral institutions.

They refused the idea that poor people should wait patiently for charity while others lived. They insisted that health was a right for all. They insisted that communities were not passive beneficiaries. They were political actors.

Indian manufacturers led by Cipla, an Indian company, began producing affordable generic medicines. When Cipla announced that it could provide a year of treatment for about a dollar a day, it shattered the claim that high prices were inevitable. Some in the pharma industry called such companies "pirates". But history proved otherwise. They were not stealing life – they were making life possible.

Governments in the majority world then used the law. They stepped in. They invoked the flexibilities that existed within WTO rules. They issued compulsory licences. They imported and produced generics.

At Doha in 2001, developing countries, supported by the HIV movement, won the Doha Declaration on TRIPS and Public Health. In this Declaration, governments affirmed that the TRIPS Agreement did not prevent member states from taking measures to protect public health.

Then financing followed. The Global Fund was created. Another organization called UNITAID was created. It brought innovative financing, including through airline levies. The United States government launched its own bilateral programme, called PEPFAR, that became the largest single disease programme ever.

With generic purchasing at scale, prices fell by more than 99 percent. Today, modern HIV treatment costs less than 50 dollars per person per year. Millions of people are alive because communities, governments, scientists and allies refused to accept that markets should decide who lives and who dies.

And this was never just about money.

The AIDS movement showed that health equity requires at least four things:

- First, organised communities with power
- Second, governments willing to intervene through law.
- Third, global solidarity.
- Fourth, recognition that health is a human right for all people.

This movement also expanded rights. It challenged discrimination. It advanced women's rights. It strengthened democracy. It pushed back against criminalisation of people most affected by HIV. At the beginning of the AIDS pandemic most countries criminalized same-sex sexuality, but today two thirds of countries do not criminalise. Progress has not been linear. There have been setbacks, including in Africa. But the broader lesson remains: health justice and democratic rights move together.

Here is an important point to note. The AIDS movement did not defeat the system. AIDS forced an exception inside the system of trade rules. So, the HIV movement bent the rules; it did not rewrite them.

That's important, because neoliberal globalisation continued. New trade agreements expanded intellectual property protections. Pharmaceutical corporations became larger and more powerful. Corporate influence over rule-making deepened. In many countries companies were themselves shaping the laws meant to regulate them. The role of the state was narrowed. Public institutions were weakened. Markets became the organizing principle not only of economies, but increasingly of governance itself.

Yet the AIDS movement taught the opposite lesson. States matter. Communities matter. Public institutions matter. Rights matter. Collective action matters. The extraordinary success of the AIDS response was not a triumph of markets. It was a triumph of politics. Of public action. Of solidarity. Of communities organized and forcing systems to change.

But because the underlying rules stayed in place, the exception remained fragile. And when the next global crisis hit, the world failed to apply the lesson from AIDS.

COVID: When We Abandoned the Model

I'm talking about COVID.

We already had the model when COVID arrived. To publicly fund research. To share technology. To use the law to compel technology transfer when necessary. To produce vaccines, diagnostics and medicines in every available factory. And treat health technologies as global public goods.

Even when a vaccine was not yet in sight, we formed an alliance – UNAIDS and civil society– demanding that any vaccines developed be treated as global public goods.

And science delivered. Vaccines were developed in under a year. The promise of mRNA technology was not only that it could be effective, but that it could be scaled. Even a small company, with the right knowledge, could produce at very large volumes.

Governments had invested more than 50 billion dollars in research and development, and in procurement commitments. Public money reduced the risk of innovation. Public institutions supported the science. Public purchasing guaranteed the market.

Yet ownership remained private. The intellectual property, the know-how, the trade secrets remained private. And which countries' orders got filled, in what order, in what amount—it wasn't WHO deciding. It wasn't governments. It was a handful of pharma CEOs.

The WHO – at the height of the pandemic – created what was called the COVID-19 Technology Access Pool [C-TAP] and asked companies to share their patents, knowledge and technology in that pool. But participation was voluntary. The companies refused. The world waited for corporate permission in the middle of a pandemic. Imagine—asking companies to voluntarily share their technology. Of course they didn't.

Instead, with limited supply, rich countries horded supplies and the majority world stood in the back of the queue waiting and getting nothing.

This cost lives. A study in Nature showed that a more equitable distribution of vaccines could have saved over 1.3 million lives. And a full vaccine sharing scenario would have prevented 296 million infections.

That was not a failure of science. It was a failure of politics.

I was part of building the People's Vaccine Alliance, now called People's Medicines Alliance. We called for technology transfer. We demanded that publicly funded science serve the public. We pushed for a TRIPS waiver at the World Trade Organisation so that countries with the capacity to manufacture could produce COVID vaccines and technologies without fear of trade sanctions.

South Africa and India led demand for a WTO waiver. UNAIDS and civil society mobilised across continents. But a handful, and I really mean a handful – less than 10 – countries blocked meaningful action. Lobbyists for the pharmaceutical companies were influential – I can remember them hovering around the room like they were member states. The institution created to manage trade, the WTO, could not respond when trade rules themselves became the obstacle.

In the end, after several years of negotiation, what emerged was an agreement that was too little and too late. WTO could not overcome the rules it had been built to defend.

COVID exposed something profound. The world had the science. The world had the money. The world had the manufacturing capacity. What it lacked was political will to overcome monopoly control.

The Pandemic Agreement: The Same Struggle Returns

One might think that the world would have learned from COVID. In some ways it has, because governments came together to negotiate a new Pandemic Agreement under the WHO, that would help the world to be prepared for the next new pandemic. This Agreement was adopted in 2025, but it did not come into force because the negotiations got stuck – and guess on what: on the question of technology sharing.

At the heart of Pathogen Access and Benefit-Sharing system — PABS — lies an old question in a new form. If countries share pathogens and scientific information with companies, who benefits from the vaccines, diagnostics and treatments which the companies develop?

Majority-world countries have argued for a fair system. If samples and data flow from all humanity, benefits must return to all humanity. If a country shares a dangerous pathogen quickly, the resulting vaccines, tests and medicines must not then be locked away by price, monopoly or geography.

Yet once again the inequalities have appeared. Public need has collided with monopoly control. Equity was treated as something to negotiate after innovation, rather than something built into the rules from the beginning.

COVID had taught us that equity is what is needed, not charity. It must be designed into systems, but a second round of the negotiations of the pandemic treaty have failed to get us to an agreement.

Today there is a new long-acting HIV prevention injection offering extraordinary promise. If administered twice a year, it can dramatically reduce the risk of HIV infection. Just two injections will keep someone free from HIV infection. It is the closest thing we have to a vaccine. Yet access is already unequal. It's on the market in New York. I understand that it's not yet here. It's not in New Delhi. It's not in Kampala. It's not in the developing world. Some amounts are being rolled out there – 2 million, the company's saying we'll roll out about 2 million – but our estimate is you need 20 million people on long-acting prevention in order to turn the curve on new infections, so it's a drop in the ocean.

Cancer medicines show the same pattern. Monoclonal antibodies and other new therapies have transformed outcomes in wealthy countries, while remaining unaffordable for many countries where the majority of humanity lives. Climate technologies risk following the same path. If we accept monopoly control over lifesaving health technologies, why would we not see the same logic applied to battery technologies, green technologies, carbon capture, or artificial intelligence?

We cannot solve every crisis through another exception. Exceptions will not save us. The rules themselves must change.

What Comes Next

And so I return to where I began. We are living through a rupture. It is dangerous. But it's also an opening.

We need more than reform at the margins. We need to restore democratic control over the market. We need to reduce monopoly power, and we need to affirm the role of the state.

If taxpayers finance innovation, the public should have ownership. We need new models.

New coalitions are emerging. I'm ever an optimist, looking for signs of change. Brazil is leading work on local and regional production of medicines. African countries are investing in pharma manufacturing.

Industrial policy is back, once dismissed under neoliberal orthodoxy, but now countries are asserting and shaping industrial policies. Countries are rediscovering that the state is not merely a referee for markets. It's a maker of markets, a builder of capacity, and a guarantor of rights.

But we need deeper reform. We need trade rules that place health above monopoly. We need public manufacturing capacity. We need technology sharing. We need regional cooperation across the majority world. We need financing that supports production rather than dependency.

And the struggle then is larger than medicines.

It's about financing. It's about debt. It's about tax justice. It's about climate finance. It's about AI governance. It's about labour rights. It's about democratic accountability. Corporate capture is not only economic. It is political. When companies shape the rules that govern them, democracy itself is weakened.

Governments will not deliver by themselves. The AIDS movement taught us something really profound: communities are not beneficiaries. They are political actors. People living with HIV changed history. Feminists joined them to change history. Human rights activists, workers, all these changed history – in the 20th century, especially.

The alliances that built the AIDS response must become broader. We need to bring together health, women's, labour movements, human rights and democracy movements. young people, and communities excluded in the majority world. All those left behind also, in the richer world.

I believe the majority world has a particular responsibility here. Not because it is morally superior, but because it has lived longest with the consequences of unequal rules. It knows what exclusion looks like. It knows what dependency feels like. It knows that charity cannot substitute for justice.

Increasingly, it also has the institutions, the confidence and the numbers to lead. Through regional bodies. Through South-South cooperation. Through new coalitions still being formed. Through alliances with progressive forces in the richer countries whose people are also being failed by this world order.

The majority world must not wait to be invited into reform. It must lead. Not to replace one hierarchy with another, but to create rules worthy of an interdependent world.

The AIDS movement showed that history bends when people organise across borders.

Now the challenge is larger.

We are not fighting only for medicines.

We are fighting for rules that place life above monopoly.

Solidarity above extraction.

Human dignity above profit.

Perhaps this rupture is not simply the end of an old order.

Perhaps it is the beginning of a more democratic one.

Perhaps this is the historic moment of the majority world.

Not simply to join a new multilateralism.

But to create a new one.

Thank you for listening to me.