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Inaugural Public Lecture
Fighting on the Frontlines AND Shaping the Future: African Leadership in Pandemic Preparedness and Response
Africa Centre for Inclusive Health Management, Stellenbosch University
STELLENBOSCH, SOUTH AFRICA

Thank you so much, our host, Professor Munya Saruchera, the Director of the Africa Center for Inclusive Health Management, Professor Reza Daniels, the Dean of the Economic and Management Sciences Faculty.

Professor Thulani Makhalanyane, the chair of SARChI, my sister, Professor Elizabeth Nanziri, thank you so much for the kind introduction.

I am excited and a little intimidated. Thank you for the warm welcome.

Good morning. It is a pleasure to be here at Stellenbosch University, and especially at the Africa Centre for Inclusive Health Management.

I want first to recognise the transformation journey of this university. Stellenbosch has a distinguished record of academic excellence, but also a difficult history, closely intertwined with apartheid. Its commitment to becoming a more inclusive, diverse, genuinely African university is important. Transformation is never easy. It requires confronting uncomfortable truths, changing institutions and sometimes giving up privileges. And I suspect the students here would agree that universities can be very good at teaching transformation — and rather slower at transforming themselves! But seriously, I salute this university for undertaking that journey. Transformation is not a destination that we can reach and then declare victory. It is a continuous struggle.

I also congratulate the Africa Centre for Inclusive Health Management on its evolution from HIV/AIDS management to a broader vision of inclusive health management, grounded in African knowledge, community leadership and social justice. Your use of educational theatre particularly interested me. It recognises that communities are not passive recipients of expert knowledge. They are creators of knowledge and solutions.

And that brings me to my central argument today.

Our continent, Africa, has demonstrated extraordinary leadership in fighting pandemics. But deep inequalities in the global economic and political order continue to undermine our ability to protect our people's health.

- Inequality in access to medicines and technology.
- Inequality in access to finance.
- Inequality in power over the rules of the global economy.
- And inequality in the enjoyment of human rights.

These inequalities are not inevitable. They are consequences of political choices, of economic interests, of rules that people have made — and here is what makes me an optimist: what people have made, they can unmake. So, these rules can be changed. Our challenge is to turn Africa's leadership on the frontlines into the collective power to reshape those rules.

1. Inequality drives pandemics — and pandemics deepen inequality

In 2023, I convened the Global Council on Inequality, AIDS and Pandemics. It is a multidisciplinary group bringing together economists, epidemiologists, public health experts, political leaders and human rights advocates. It is co-chaired by Nobel Prize-winning economist Professor Joseph Stiglitz, Professor Sir Michael Marmot, who is a leading authority on the social determinants of health, and Monica Geingos, former First Lady of Namibia and a formidable advocate of social justice. The Council brings these disciplines together because pandemics cannot be understood through medicine alone.

The central argument of that council is that inequality drives pandemics, and pandemics deepen inequality. It's a vicious cycle. People living in poverty, in overcrowded housing, without clean water, adequate nutrition or access to healthcare are more vulnerable to disease. That's obvious. Women and girls facing violence and unequal power are less able to protect their health. People who are criminalised or discriminated against are driven away from life-saving services. Then pandemics strike, they destroy livelihoods, they interrupt education, increasing unpaid care work and push families deeper into poverty. That is the vicious cycle. Yet conventional pandemic preparedness still concentrates heavily on laboratories, surveillance, stockpiles and emergency plans. All are necessary. None is sufficient.

Pandemic preparedness must also mean reducing the inequalities that turn outbreaks into human catastrophes. Africa's experience with AIDS, COVID-19 and Ebola demonstrates this powerfully. And I'll touch on this.

Let us return to the darkest years of AIDS. By the late 1990s, scientists had developed antiretroviral medicines that could transform HIV from a death sentence into a manageable chronic condition. But treatment cost around US$10,000 per patient per year. For most African countries, those medicines might as well not have existed. Unaffordable. The science had succeeded. The medicines existed. But millions of people were dying because they could not afford to live. At the epidemic's peak in 2004, about 1.7 million people died of AIDS-related illnesses in sub-Saharan Africa in a single year. But people were living healthy lives in the rest of the world, in the rich world. Here in South Africa, the Treatment Action Campaign refused to accept this injustice. People living with HIV, trade unions, women's organisations, scientists, lawyers

and health workers organised to demand affordable medicines and hold governments accountable. They challenged pharmaceutical monopolies, confronted stigma and fought for the right to treatment. We know that heroic story.

African governments, working with other developing countries, challenged global intellectual-property rules. The Doha Declaration of 2001 affirmed countries' rights to protect public health and use safeguards such as compulsory licensing. Generic competition helped bring treatment prices down dramatically. Millions of lives were saved. But in this room, I'm sure you - like myself - know many who did not get this opportunity. It took 10 years to get here. That was not charity. It was fought for with sweat and blood. It was organised people changing the balance of power. Challenging global rules, challenging their governments. And it taught us something profound: science alone does not defeat pandemics. We also need political courage, community leadership and human rights.

Then came COVID-19 and the injustice was repeated. African scientists once again demonstrated extraordinary capability. This is the untold story. Researchers in South Africa and Botswana identified and shared crucial information about the Omicron COVID variant. Scientists at Wits and Afrigen in Cape Town advanced mRNA technology, demonstrating Africa's capacity to develop sophisticated vaccines and to share that knowledge with other regions. But scientific leadership in Africa did not translate into equitable access of the vaccines.

Before the first COVID-19 vaccine had been developed, I together with other global activists, we formed the People's Vaccine Alliance. We knew what was coming. We had learnt from AIDS what happens when lifesaving science is left to pharmaceutical monopolies and the purchasing power of rich countries. In May 2020, we, the People's Vaccine Alliance, called for a global agreement to guarantee that COVID-19 vaccines, tests and treatments would be shared equitably. We demanded the sharing of knowledge and technology, manufacturing across all regions in the world and access should happen according to need — not wealth. We wanted governments to agree on the rules before the vaccines arrived. But they did not.

Instead, rich governments hoarded the vaccines. Pharmaceutical companies defended their monopolies and refused to share the technology needed for widespread production. Africa was pushed to the back of the queue. Your President took the lead at the African Union, brought all the countries together, formed a committee. I was on it, negotiating with the governments that hosted the producing companies. Nothing came out of that.

In November 2021, the People's Vaccine Alliance estimated that Pfizer, BioNTech and Moderna were making combined pre-tax profits of

approximately, guess what, US$1,000 every second from their COVID-19 vaccines. It is crazy, the profits they were making from hiking the price and selling only to the rich countries. One thousand dollars. Every second! While people in poorer countries were dying without access to vaccines, just like had happened with AIDS.

South Africa and India took the lead to demand for a comprehensive waiver of intellectual-property protections at the WTO (World Trade Organization). More than 100 countries supported the proposal, but a handful of rich countries resisted it. The eventual compromise was far too limited.

And there was another inequality during COVID. Rich countries borrowed cheaply, drew from their reserves, and spent trillions protecting their economies. African countries, already struggling with high debt burdens, faced much higher borrowing costs and had far less fiscal space to protect their own people. Children lost years of education. Women carried enormous burdens of unpaid care. Families fell deeper into poverty. Home, where people were locked, did not prove to be safe. Teenage pregnancies spiked. Violence against women spiked. The virus was global. But the capacity to protect people was profoundly unequal.

Ebola tells a similar story. African scientists and institutions have led vital research. In Uganda, my country, researchers, collaborating with others, launched a Sudan-virus vaccine within days of the 2025 outbreak being confirmed. Yet investment in research, manufacturing and resilient health systems remains very inadequate, while community health workers often work for very little, have little protection or even work for no pay at all.

Across these pandemics, the lesson is clear. Africa does not lack knowledge, talent or leadership. No, we have it. The challenge is to overcome the inequalities that prevent that leadership at various levels from delivering health for all.

2. Inequality in access to medicines and technology

Let us examine the rules that govern scientific innovation.

Consider this, I call it a magic drug, it's called lenacapavir. It's an extraordinary HIV prevention medicine that requires only two injections a year. With that, you have like 99% protection from HIV infection. It could transform HIV prevention at a time when we have approximately 1.2 million people newly infected every year. That was the data for 2025. Yet the company that developed it, Gilead, controls the patents and the terms on which generic manufacturers may produce it. It gave out voluntary licences, 6 of them, yet these excluded several middle-

income countries who are seeing a rise in new infections, including a country like Brazil, which participated in the research. Our countries did – Uganda did, South Africa did – but when it comes to sharing the knowledge, then we are excluded. In the United States, this same drug, lenacapavir, is offered at US$28,000 per person per year. That's the price in that market. But meanwhile, the generic version is now being offered at US$40 per person per year. Think about that difference! Selling at US$10,000, but it can cost US$40.

That difference tells you just what the power of monopoly companies can do. Put life-saving medicines out of reach of people. This is why African countries, together with partners across the Global South, must challenge the rules that allow pharmaceutical monopolies to determine who gets lifesaving medicines and when. Who lives and who dies. Of course, innovation has to be rewarded. That's not what we are arguing. But why should the reward be the power to exclude people from medicines they need to live?

Why should public resources help finance research while private companies control the benefits? Do you remember the Moderna covid vaccine? That vaccine had been completely publicly financed. The innovation was done by a public health institution, NIH, of the United States. And there was only one investor, one private investor, who put in one million dollars. That was Dolly Parton. That was all the private money that went into this innovation. But once Moderna got it, then it became a private asset, sold at a very high price, but actually it was publicly funded. NIH tried to sue them but found that the laws were so heavily tilted in favour of the private company, they couldn't win. That is the injustice.

Why should African countries contribute scientific expertise, research participants – our own bodies as in the case of lenacapavir, women and girls in this country, in Uganda, in other countries – yet have so little influence over access and production? This is not simply a market failure as some would call it. It is a failure of justice.

There are better ways to finance and reward innovation, including public investment, transparent licensing, technology transfer and conditions ensuring that publicly supported discoveries are affordable. And during pandemics, intellectual-property monopolies must not stand between people and lifesaving technologies. This is why the ongoing negotiations on the Pathogen Access and Benefit-Sharing under the WHO Pandemic Agreement are so important. They are going on in Geneva just now, but I must tell you that they are in their fourth year of negotiation, and governments are stuck on that part: pathogen access, benefit sharing. With African countries saying it's time we have a binding agreement that when we work together scientifically and then when there is a breakthrough, we should share it.

So, the principle is clear: no pathogen sharing without fair benefit-sharing. Not donations of leftover vaccines as we got here during COVID. Some would arrive expired from the stores where they had been hoarded in the north. Not charity after wealthy countries have secured their own supplies. Binding arrangements for equitable access, technology transfer and regional manufacturing. Sharing risks must mean sharing benefits.

3. Inequality in access to finance and economic power

But having talked about the injustice in access to medicines, it is only part of the problem. How can African governments prepare for the next pandemic when they lack the financial resources to protect their people today?

African governments want to employ more nurses, strengthen laboratories, invest in research, provide social protection and build resilient health systems. Yet many are today spending more servicing their debt, making their debt repayments, than investing in their own people. UNCTAD, a part of the United Nations, has reported that 3.4 billion people globally live in countries that spend more on interest payments than on health or education. So it's a big problem. It's not just an African one. Imagine what that means. A nurse not employed. A clinic without medicines. A school without teachers. A laboratory that cannot function. But debt has to be repaid.

And these are not simply domestic budgetary problems. Don't look at it like that. The international financial system systematically through its rules disadvantages developing countries. After COVID-19 and the economic shocks that followed the war in Ukraine, borrowing costs rose sharply. African governments, who were already finding it hard to cope with interest rates because they borrow at a higher rate than richer countries, now found that their debt was multiplying three, four times because of the rising interest rates.

When countries became unable to repay their debts, restructuring mechanisms proved painfully slow. During COVID the G20 countries came together and created a new framework called the Common Framework for restructuring the debt. In other words, a country that is paying so much towards its debt could go there to renegotiate for the debt to be pushed a bit forward, so it has breathing space and can have money to pay for the vaccines they needed. So, the countries went there. One year. Two years. COVID ended. That is when four countries managed to get some debt relief. After COVID and it was too little too late, people had died. This is how low the commitment was to help countries find the money they need in a crisis.

And countries seeking emergency assistance usually are also put under pressure to restrain public expenditure, because the same countries

that were trying to find resources to save lives, were borrowing from the international financial institutions, who would also condition them that if you are going to get this money, you must also not spend a lot, because you are poor. I am putting it in a simple way, but really the conditions for borrowing militate against saving lives.

How can the international community demand stronger pandemic preparedness while supporting economic policies that restrict investment in public health? That's the contradiction.

African countries need urgent, comprehensive debt restructuring, involving both from private and public creditors. They need debt-payment suspension during pandemics and major disasters. They need affordable development finance and a financing mechanism that can be activated rapidly during health emergencies. And they need a fairer voice in the IMF and World Bank, where decision-making power remains heavily concentrated among wealthy countries.

Consider now taxation. The Tax Justice Network estimated that governments worldwide lost approximately US$492 billion in a single year to cross-border tax abuse by multinational corporations and wealthy individuals. Almost half a trillion dollars! Money that could finance hospitals, schools, laboratories, research and social protection. How does this happen? Many ways. Multinational companies generate profits from African markets, from our labour, from our natural resources, but the global tax rules allow them to shift profits to jurisdictions where they pay little or no tax. You, the ordinary, person, the woman in a market in Uganda pays their taxes. They can't dodge. You can't dodge because even when you buy a tomato in the market, you pay a tax, VAT. Small businesses, they try, but they can't dodge, they pay their taxes. They follow them, they close them down. But powerful companies can move profits across borders smoothly, easily, quickly. That's because they write it in the rules, in the global rules.

When I was the head of Oxfam International, we did a report about the new oil wealth in Uganda, and we went to President Museveni and we said to him, "You know, you have a problem. The French company Total, which you have signed an agreement with to dig the oil from the ground, is trading here in Uganda as a Dutch company." They just went to Amsterdam and opened a post office box and said, "Now we are a Dutch company working in Uganda". Why? Because a long time ago, 10 years before, Uganda had signed a tax agreement with the Netherlands, allowing the Netherlands companies to pay a very low tax for the business they do in Uganda. An old agreement that the government wanted to change but hadn't changed yet. So, Total said we can appear as a Dutch company and benefit. That's called "treaty shopping" in the language of taxation. These are some of the means they use to deny our governments the money that they need for our hospitals, for our schools, for our children.

So, it is a question of who has power, political power, and sets the rules. That is why African leadership in negotiations towards a UN Framework Convention on International Tax Cooperation going on in New York is so important. That negotiation is about closing tax loopholes such like “treaty shopping”, because if we don’t close those loopholes, then powerful companies will continue taking our resources. But that negotiation is also stuck at the moment, because a handful of countries, both European and American, are blocking. They don’t want an agreement because their companies are making super profits.

African countries must have an equal opportunity to shape the rules governing international taxation. Even for that negotiation to be at the UN was a struggle. Many of us in civil society fought hard to take the negotiation out of the OECD, which is a club of rich governments. They were the ones discussing how to close tax loopholes to benefit themselves, but not to benefit our countries. We pushed it out of there and got it at the UN, but it is still stuck there.

And let me be clear, even though I am pointing to global rules that deny us the resources we need, that deny us life-saving medicines, and African countries must have an equal opportunity, I want to be clear about the responsibilities of our own governments. African governments must tax progressively. These regressive taxes on tomatoes in the market, on a little Coca-Cola for a child when they are in the hot sun, these taxes are regressive. The real taxes should be on big business, the big profits. That’s progressive taxation. Governments must fight corruption and wasteful expenditure, and prioritise health and education. They must be transparent and accountable to their citizens. Global injustice cannot be an excuse for domestic failure. But neither can domestic responsibility substitute for the reforms we need at a global level. Health sovereignty requires both - reform of global rules and reforms at the national level.

4. Inequality in the enjoyment of human rights

Let me now turn to another inequality that African societies must confront — the unequal enjoyment of human rights. Africans have fought long and hard for the recognition of fundamental rights. I can’t lecture to you. You fought hardest, the people of South Africa, for fundamental human rights to be enjoyed by all people. But what does the right to health mean for a young woman who cannot negotiate safe sex? For someone living with HIV who fears stigma? For an LGBTQI+ person who risks arrest or violence when seeking healthcare, like in my country, where there is a harsh criminal law? You know they made a law such that if you are a landlord and you rent your room to a gay man, and they find out, you the landlord are also guilty under the law. You should have reported him. What a stupid law. So for a sex worker or person who uses drugs and is afraid of going to a clinic, that means their fundamental human rights are denied, and they can’t get the service

they need.

Across Africa, there is an organised backlash against the rights of women and girls, LGBTQI+ people and against civil society having any space to advocate for themselves. This pushback is political. There are powerful political and religious movements supported by financing from outside our continent, but they invoke our culture, they invoke so-called 'family values' to justify exclusion and discrimination. We African women have fought for our rights as women. Does it take a foreign organization and religion to tell us what our rights should be and should not be?

Our continent is a battleground for geopolitical interests — it's really now a battleground for critical minerals, energy and geopolitical influence. And they are using our bodies, our lives, our rights, to fight these geopolitical wars, resource wars. We should understand this. Africans must not allow our people's rights, our women's bodies, to become another battleground for competing foreign agendas.

And let us reject the idea that human rights and gender equality are foreign imports. They are not. We fought them for ourselves. African women have led struggles for dignity and equality for generations. I'm the proud product of my mother who fought for girls' rights to education. African communities have long organised for freedom and justice. You know it best.

Our societies cannot achieve health for all when we criminalise and exclude some of the people who need the right to health most. The AIDS response demonstrated that communities must be free to organise, advocate, deliver services and hold governments accountable. Human rights are not optional to public health. They are not just a nice to have. They are core to achieving public health. They are its very foundation.

5. African health sovereignty and a new global solidarity

So, what must change? I believe the answer lies in building African health sovereignty, supported by a new global solidarity based on economic justice. I think this word health sovereignty is now becoming a buzzword. We talk about it. Africans are moving together around it. But I want to be clear what I mean by health sovereignty.

I mean the power of African peoples and countries to determine our health priorities, mobilise resources, develop technologies and build institutions capable of meeting our people's needs. But it is not in isolation. It does not mean every country must produce every medicine. It means having the capacity to make our own choices and cooperate with others on equal terms. That's what it means. It means adequate

investment in science, research and in our universities, pharmaceutical manufacturing and regulatory institutions. We need them.

South Africa, your country, has demonstrated remarkable scientific capability. I remember as a young girl hearing about the first heart transplant that happened at Groote Schuur in the University in Cape Town. As far back as then, Africa had capacity and continues to have capacity. World-leading HIV research happens in this country, genomics and mRNA technology. Senegal's Institut Pasteur in Dakar has decades of vaccine manufacturing experience. Afrigen, I visited them during COVID, I was so impressed, it offers a model of cooperation across Africa and other regions of the Global South , a hub and spoke system where southern countries are learning together how to develop health technologies. Our countries must build on these achievements.

We have what is called the African Medicines Agency, the African Continental Free Trade Area. We have pooled procurement happening here in SADC. We have more coordination of industrial policies, especially in your region. These are the things that will help us to build regional markets large enough to sustain pharmaceutical production. But again, health sovereignty is not only about factories. It means strong public health systems, properly paid health workers, community leadership that is not exploited but rewarded for its leadership and its work, and democratic accountability. And it means challenging the global rules that undermine our ability to finance and deliver health.

This brings me to global solidarity. What do we mean? Global solidarity has until now been synonymous literally with aid. When you hear policymakers saying we need global solidarity, they mean we need aid. But we are really now in a post-aid world. It has reduced dramatically and it’s not going to come back. In 2025, donor government funding, their aid for HIV, fell by approximately US$2.1 billion —25% in one year. Programmes were disrupted. Health workers lost jobs. Communities lost the services they were delivering. Meanwhile, while the money was dropping, that money was increasingly being redirected towards the donors' own domestic priorities. Much of the donor funding they were reinterpreting and keeping it in their countries to support migrants and security. They give countries money to control their people so that they don't migrate, and they call that also development assistance. So, we have to mobilise more domestic resources in our countries and use it well. We can’t continue hoping for that aid money, but when we face these unsustainable debts, raising domestic resources becomes difficult, and spending well on health becomes impossible.

But a transition away from aid, our efforts to get out of aid dependency cannot become an excuse for ending global cooperation. Because we are talking of global health, we’re talking of pandemics. They hit everybody. It might start in China, but it then hits the whole world. Might start in America. We’ll get it here. So solidarity must mean more

than aid. It must mean – and this is for me my new understanding that I keep sharing about what is global solidarity – fairer trade rules, intellectual property rights rules that get in our way must change, it must mean equitable access to technology, it must mean global tax justice, it must mean debt sustainability and restructuring that's quick and comprehensive, affordable finance going to market at fair prices to borrow. It must mean greater African power in global governance, having a voice at the table and not being overpowered in global negotiations.

It must mean climate justice and finance for countries that are already suffering consequences of a crisis that they didn't create. I keep seeing your country here and this whole region, year in year out, going from a drought to a flood, from a flood to a drought. These are the consequences of global warming where we have contributed almost nothing to. So financing to adapt, to protect ourselves, should come. It's a matter of justice, not charity.

Global solidarity must mean reforming international institutions so that the voices of poorer countries count. There is something called The Accra Reset, led by President Mahama. It's one of those new movements on our continent showing growing African determination to move away from dependency towards greater control over our development priorities. South Africa led the way when it was chairing the G20 in 2025. It demonstrated how African countries have the courage and the intellectual leadership to put new ideas on the global agenda, when President Ramaphosa proposed an International Panel on Inequality at the G20.

This is the leadership Africa needs. Not simply asking to be included in institutions whose rules others have written by other people. The IPI is about changing those rules by helping write new rules and build institutions fit for a more equal world. Africa demonstrates global leadership. And let us remember: health sovereignty and global solidarity are not opposites. Our health security is interconnected. No country can protect itself indefinitely while others remain exposed. Africa seeks interdependence — but interdependence on fair and equal terms.

6. A challenge to the next generation

So here is challenge especially to you students in this room: You are the generation that will inherit both the extraordinary achievements and the unfinished struggles of those who came before you. Some of you will become scientists. Others will manage hospitals, lead public health programmes, develop medicines, advise governments, teach or enter politics. I hope you will excel in all these fields. But I want to challenge you to do more.

Do not be satisfied with becoming excellent managers of an unjust system. Become leaders who can transform it. Learn your science. Master your profession. But also learn how power works. When a medicine is unaffordable, do not stop at asking how to buy it more cheaply. No. Ask who owns the patent, who financed the research and who determines the price. Ask those questions. When a hospital lacks nurses, ask why the government lacks the resources to employ them. Why? When an African country cannot invest in health, ask about its debt, its tax system, its spending priorities and the international rules that constrain its choices. Ask all of that. When people are excluded from healthcare, ask whose rights are being denied — and why.

Connect the dots! Connect science to economics. Connect public health to human rights. Connect African knowledge to African power. Connect national responsibility to international solidarity. And above all, organise! Because history teaches us that progress does not come simply because the evidence is convincing or the arguments are morally right.

Progress comes when people organise, build alliances, challenge power and refuse to accept injustice as inevitable.

The AIDS movement taught us that. The struggle for affordable medicines taught us that. Africa's movements for democracy, women's rights and human rights taught us that. Do not simply learn to manage inequality. Learn to dismantle it.

Africa has the knowledge, the talent, the resources and the ingenuity. What is needed is the political courage, collective determination to turn these assets into real power. To build health systems rooted in justice. To ensure scientific breakthroughs benefit everyone. To create economies that serve people, not the other way around. And to shape a global order in which every country and every person can enjoy the right to health.

The struggle for African health sovereignty is a struggle against inequality. And that struggle is not only about Africa. A world that is more equal will be a world that is safer from pandemics — for everyone. Africa must not simply prepare to survive the next pandemic. It must help build a world in which pandemics no longer become catastrophes of inequality.

Fighting on the frontlines.

AND shaping the future.

Thank you.



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