FEMINISTS FOR A PEOPLE'S VACCINE

Issue Paper #1

ACCESS TO MEDICINES: WHY SHOULD FEMINISTS CARE?

#Fem4PeoplesVaccine

DAWN FEMINIST

TWN Third World Network

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Access to Medicines: Why should Feminists care?

Perhaps one of the main reasons feminists should care about access to medicines[1] (A2M) is that we have been caught short by the COVID-19 pandemic in terms of both analysis and mobilising for action and advocacy. The pandemic has become the crucible in which global and local inequalities, weak health systems, and colossal failures of governance have bubbled and risen to the surface to affect almost everyone, everywhere. For feminists, the lens of toxic and persistent gender power inequalities and injustices highlights why we need to pay particular attention. Indeed, we should have done so long ago. No issue combines such a toxic brew of global political economy, corporate power and interests, technology, law, and human rights in the way A2M does. But feminists, with a few exceptions, have been slow to enter this fray in the past for a variety of reasons.

1- We use "access to medicines" to mean access to vaccines, therapeutics, and personal protective equipment (PPEs)

Not any longer in this pandemic. Daily news headlines, data trackers, endless webinars have made us acutely aware that:

• Women are the overwhelming majority of health workers but predominantly at the lower rungs in facilities and as outreach and community workers[2], and hence more at risk, less protected, and with less voice and agency.

• Weak health services and shortages in human resources and infrastructure for health have thrown greater burdens on those responsible for home-based care, largely women, adding to the already heavy workloads imposed by intermittent lockdowns with the resulting childcare and online education support, as well as the needs and demands of others.

• Lockdowns have been particularly challenging because of the hidden pandemic of intimate partner violence and increased physical, psychological, and sexual abuse of the vulnerable within households.

• Not only have well-established programmes for antenatal and maternal care (along with others such as childhood vaccination, TB programmes, and cancer care) been hit hard by the diversion of health resources to the pandemic. The challenge is worse for newer, hard-won programmes such as those to address gender-based violence, sexuality education, the needs of sex workers or people living with disabilities, to name only some.

• The economic crisis exacerbated by the pandemic has severely affected the incomes and jobs of informal and migrant workers. Women are predominantly informal workers – poorly paid and with few worker protections or benefits – and job and income losses have been severe. An estimated 54% of job losses have been incurred by women even though they account for less than 40% of the global workforce[3]. Women[4] and women entrepreneurs[5] are also more likely to report a drop in income and/or in financial support.

2- Janoch, E., Rodriguez, M., & Turner, B. (2021, March 25). Our best Shot: WOMEN FRONTLINE health workers around the world are keeping you safe FROM COVID-19. Retrieved April 31, 2021, from https://www.care.org/news-and-stories/health/our-best-shot-women-frontline-health-workers-around-the-world-are-keeping-you-safe-from-covid-19/

3- Kenward, S. (2021, February 02). Covid-19 vaccination strategies must ensure equity for all women. Retrieved April 01, 2021, from https://swhr.org/covid-19-vaccination-strategies-must-ensure-equity-for-all-women/

4- Lewis, H. (2020, April 01). The Coronavirus Is a Disaster for Feminism. Retrieved June, 2020, from https://www.theatlantic.com/international/archive/2020/03/feminism-womens-rights-coronavirus-covid19/608302/

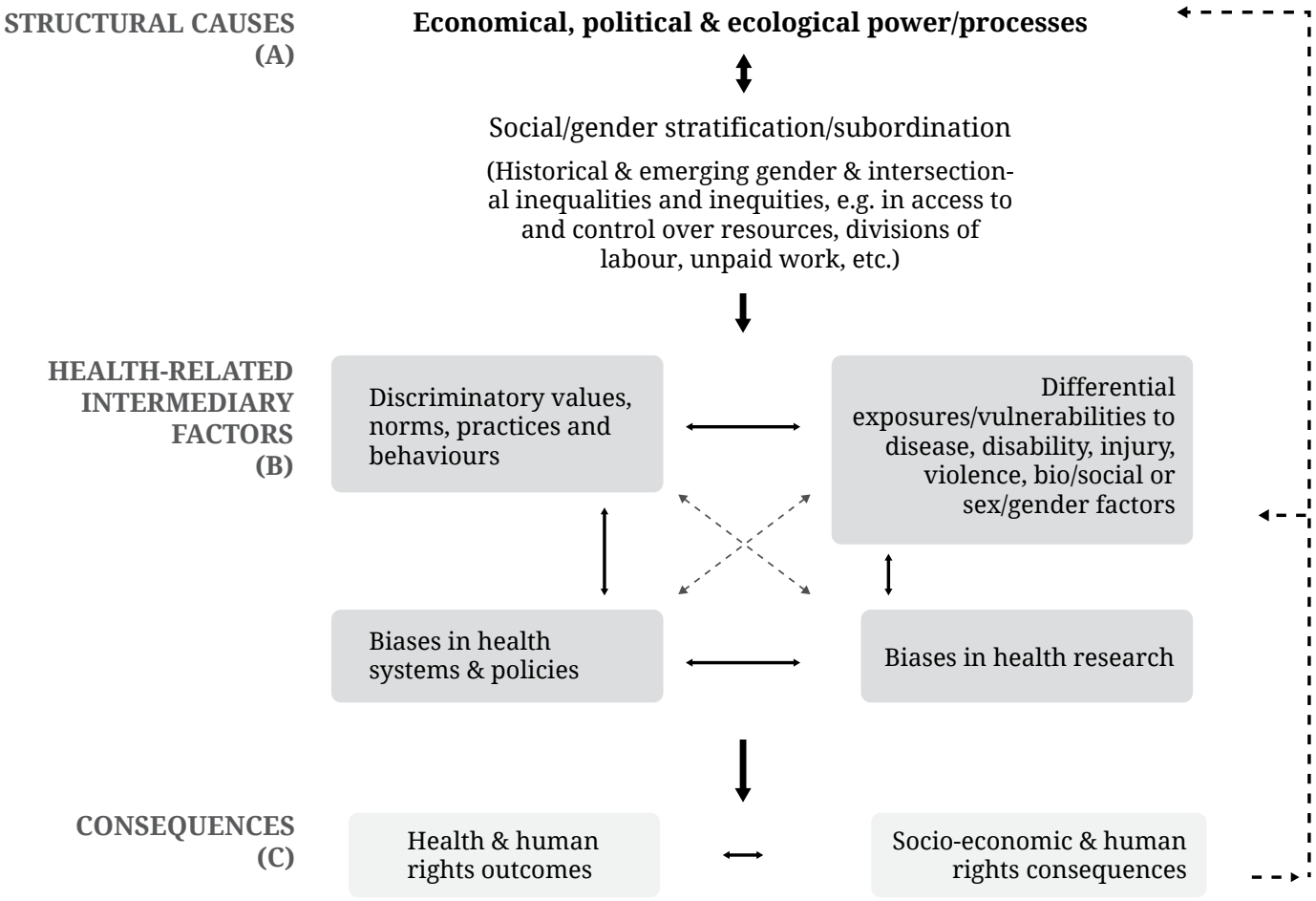
5- Kneeshaw, S. (2020, July 24). Exploring the gendered impacts of Covid-19. Retrieved July, 2020, from https://urbact.eu/exploring-gendered-impacts-covid-19

Not all of the above appear to pertain directly to vaccines and the inequities in their roll-out. But what is clear is that fairer and faster A2M for all is the crying need of the hour. Without this, avoidable pandemic deaths will not end, recurring waves and surges in infections will not taper down, economies and employment will not recover, and global and national inequalities will become even worse than the unconscionable levels they have already reached. Feminists are centrally concerned with all of the above.

Responses to earlier epidemics have typically been gender blind. However recent Ebola, Zika epidemics brought gender issues to the fore. Zika of course had sexual and reproductive health and rights (SRHR), and women's bodily autonomy and reproductive choices at the centre because of the possibility of damage to the foetus and hence the need for abortion. A UN Women – Oxfam report of the Ebola epidemic of 2013 – 15 in Liberia pointed to disproportionate effects by gender, geography, and disability, because of economic vulnerability, differential roles, and weak health systems. The HIV/AIDS epidemic draws attention to gendered paradoxes of exclusion. Women account for more than 50% of PLHIV worldwide, yet they are not a recognized key population. In sub-Saharan Africa (SSA) where over 70% of all new infections occur, girls and women (ages 10-24) are twice as likely to acquire HIV. In the worst affected countries, 80% of those newly infected among adolescents are girls. Only 25% of new infections in SSA (versus 80% in the rest of the world) are in the 5 'key populations' – gay men / men who have sex with men, sex workers, injecting drug users, trans, prisoners / incarcerated. There has been glacially slow recognition of the explosion of infection among adolescent girls and young women in SSA.

We need a framework that learns the lessons of recent epidemics. It should bring together both biological and socioeconomic factors; recognize disproportionate effects despite biological protection; and address the importance of indirect effects. To enable us to bring a number of seemingly disparate issues together, we have developed a framework that combines structural and systemic causes with health-related intermediary factors, tracing their consequences for health, human rights, and other social and economic outcomes.

Gender and Intersectional Inequality in Health Systems and Policies: A Framework



The framework is adapted from the report of the Women & Gender Equity Knowledge Network of WHO's Commission on Social Determinants of Health[6]. Arrows in the diagram show directions of influence. The dashed lines represent feedback effects. The framework recognizes that there may be complex causation and bi- and multi-directional influences among the different factors.

6- G Sen and P Ostlin (2010) Gender Equity in Health: The Shifting Frontiers of Evidence and Action, NY Routledge p 4.

Structural causes (A):

There appear to be five major structural causes:

i. Ecological destruction → zoonotic diseases

ii. Neoliberal economic paradigm →

- unending rise of corporate power and private intellectual property rights (IPRs) through multiple mechanisms including the WTO and regional /bilateral trade agreements, and Investor – State – Dispute Settlement (ISDS)
- weakened capacity for policy responses due to reduced fiscal and policy space for govts and constrained UN, WHO and country finances
- feeble public health and privatised health systems
- drumbeat of multi-stakeholder participation and TINA to PPPs, leading to even more power for private corporations.

iii. The rise of authoritarian populist democracies → rise of anti-gender ideologies as well as discrimination against groups as detailed in the previous bullet

iv. Digital technology revolution → biopower including increased surveillance during the pandemic.

v. Pervasive and exploding multilevel economic inequalities intersecting long-standing inequalities of gender, race, caste, ethnicity, disability, SOGIE, geography and more → increased economic and social vulnerabilities; subsistence and survival crises.

Health-related intermediary factors (B):

The above structural causes affect 4 interlinked sets of health-related intermediary factors.

i. *Discriminatory values, norms, practices and behaviours*

- Sharp reduction in a range of health services, including in programmes for antenatal care, safe delivery, neonatal and infant care, services to address gender-based violence.
- Existing stigma has the potential to be worsened, e.g., stigma around abortion, adolescent / unmarried sexuality, sex work, contraception, SOGIE, African-American teenage pregnancies

• Non-recognition of the health needs of key groups (often stigmatised by race, caste, ethnicity, migrant)
• Frontline health and sanitation workers and unpaid home-based workers, many of whom are women
• People with disabilities
• Migrants and poor groups living in overcrowded habitats with poor services
• Informal workers, many of whom are women
• Right-wing led (funded, organised, fake news'ed) and interlocking anti-LGBTQI, anti-vaxxer, nativist campaigns

ii. *Differential exposures and vulnerabilities*

• Biology is supposed to make older men with co-morbidities more susceptible to SARS COV2 infection due to ACE2 receptors.

BUT

• Differential incidence of stress and comorbidities – high death rates of young African-American men
• Rationing biases within households of access to health services
• Hidden pandemic of VAWG in homes during lockdowns
• Violence against sex workers
• Insufficient access to WASH / housing and possibility of social distancing among poorer communities
• High exposure with poor protections among frontline (predominantly women) health workers and home-based carers

iii. *Biases in health systems and policies*

• Health system weaknesses already highlighted during last Ebola epidemic.
• All 6 building blocks of the health system (financing, services, human resources, medicines/technology, data/information, governance) have been weakened by decades of neoliberal economic policies.
• Health financing, Investor-State-Dispute-Settlement (ISDS) clauses and regional /bilateral trade agreements have subverted

the Doha Declaration on the TRIPS Agreement and Public Health; opposition to the India – South Africa TRIPS waiver proposal.
• Pandemic being used to advance digital surveillance agendas by authoritarian populist democracies.

iv. *Biases in health research*
• Pandemic research has been predominantly biomedical (not entirely to be blamed)
• Little research on bio / social aspects
• Very little research on biases and biopower

Consequences for health, human rights, and socioeconomic outcomes (C)

i. Highly differentiated health, human rights, and other impacts of the pandemic – North vs South divide (but with serious fractures caused by political leaders of the day – Brazil, Mexico)
ii. Crisis in access and cost of vaccines, drugs, other therapeutics, diagnostics
iii. Serious concerns around ethics and transparency, especially regarding clinical trials data, cost information, and pharma contracts with countries
iv. Decline, even collapse, of routine SRH services e.g., ANC and child services
v. Increased burdens on frontline health workers and home-based carers
vi. Rising violence against women, sex workers, migrants, and others
vii. Crises of incomes, food, education, survival.

While this framework may evolve and develop further, it provides a way to locate and bring together disparate economic, social and health aspects. All of these are of concern to feminists. Together they help us grasp the nature of the challenges we face and key elements of the responses to which we must commit ourselves.

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