FEMINISTS FOR A PEOPLE'S VACCINE

# FEMINISTS 4 A PEOPLE'S VACCINE PODCAST EP17 Transcript

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## Lessons Learned from the Pandemic in Africa

*With Adija Adamu, Khoudia Sow and Leah Eryenyu*

Vanita Mukherjee [00:00:00] Welcome to the Feminists for a People's Vaccine podcast. A space for imaginations, discussion, and feminist analysis from the Global South. In this creative journey, we approach the tough questions brought to light by the pandemic.

Vanita Mukherjee [00:00:22] In today's episode, we delve deep into the experiences of COVID-19 pandemic in Africa. Our podcaster today is Adija Adamu who works for the International Indigenous Women's Forum and the Ayni Fund. Belonging to an Indigenous Community, she has several years of experience of working on and with Indigenous groups and women in Africa. Our speakers are Leah Eryenyu from Uganda and Khoudia Sow from Senegal. Leah leads the Gender Just Economy Learning Community at the Trust Accountability and Inclusion Collaborative. She comes with a rich experience of working on women's rights and gender justice in Africa. Leah has held key positions in feminist and other organizations in the areas of public finance, labor rights, and reproductive justice. Khoudia is a physician and a researcher at the Regional Research and Training Center in Senegal with 20 years of experience in social and health dimensions of HIV infections. Her main focus is on women and children. She has worked on the Ebola epidemic and the COVID pandemic. Khoudia was a part of the Ethics Committee and AIDS Division in the Ministry of Health in Senegal and has engaged with the World Health Organization and UNAIDS.

Adija Adamu [00:01:42] Hi, Leah! Nice to talk to you again and nice meeting you again. Discussions around the pandemic in Africa was really highlighted during the pandemic. But I'm sure you have some experiences in East Africa that you would like to share with us and especially in Uganda and

other neighboring countries around Uganda. So I'm going to give you time to really give us an insight as to the experiences.

Leah Eryenyu [00:02:11] Thank you so much for having me, Adija, and it's really nice to be back having a chat with you. And I'd like to start off by sharing the story of a woman called Vidia Dooku from Kenya. Vidia went into labor sometime in March, in the early days of the pandemic. If you remember very clearly, when things were very uncertain. Her husband immediately sought the help of a motorcycle rider to take them to the hospital but the motorcycle rider refused. And this is because a dawn to dusk curfew had been issued in Kenya which basically required everybody to stay put and not be out and about from their houses after dark. The motorcycle rider also refused because one of his colleagues had actually been beaten to death by the police a few days prior. Normally, going into labor would have been some sort of exemption to this requirement of curfew but because of that death then, that motorcycle rider was very fearful.

Leah Eryenyu [00:03:11] Vidia's husband approached a midwife in the neighborhood who then failed to help Vidia and at that point, about 3 a.m., Vidia starts bleeding. But they couldn't do anything and they had to wait until it was light and then they were able to get a motorcycle rider to take them to the hospital. Unfortunately, Vidia did not make it. She actually died as she was awaiting a blood transfusion. And unfortunately, Vidia's story is also not unique. So many stories of people who are not able to access healthcare. People who were not able to get emergency services because of the public health mandates that were put in place in 2020. COVID also crowded out other health concerns. So women who are going for ante-natal care were turned away. Some of them were no longer able to have access to HIV testing which increased the risk of mother-to-child transmission. We also saw a high number of children born

Leah Eryenyu [00:04:10] outside health facilities. You know, some women giving birth by the side of the road. And so, you know, you're having children that are being born with low birth weight, complications for babies with difficulty  breathing and so on and so forth. On the other hand, when we also look at how public health mandates made it very difficult to access healthcare, it's important to look at people living with HIV in Africa because of the very high disease burden. So there was a disruption in HIV testing mostly because of disruptions in transport. Also testing was being re-routed to COVID-19 instead of HIV. The other thing that became very difficult for people that are living with HIV is access to pre and post exposure prophylaxis and generally, just sexual health commodities like condoms. What we see then was that there was an increased risk of transmission of HIV but also critically because of inconsistent use of antiretroviral therapy, there's a possibility of developing drug resistance.

Leah Eryenyu [00:05:11] That difficulty in accessing anti-retroviral therapy was a combination of both just difficulty in accessing public transport, but also for people who are economically deprived, it is required that you swallow your ARVS with some food. Because of the food insecurity, because of disruptions in livelihoods, there were some people who simply could not continue their consistent use of ART because they did not have food. So in short, I think marginalized groups experienced the pandemic very very acutely and they bore the brunt of the pandemic in ways that other people did not.

Adija Adamu [00:05:53] Thank you for that insight. It was a really horrible experience for humanity, especially in that region. I will now call on Khoudia. I know Khoudia is a medical doctor from Senegal, I think she was at forefront of the pandemic. Khoudia, can you share with us your experience during the pandemic in Senegal, that is West Africa?

Khoudia Sow [00:06:11] In West Africa and Senegal, COVID created panic for all marginalized people like people living with HIV, LGBT communities, and people suffering from chronic disease.

Khoudia Sow [00:06:25] Health systems were unable to take care of all people affected by COVID or common illness because of restrictive measures and fear of being infected by COVID. Many of them don't receive consultations, follow up check up, biological tests, care, medication they need. Response against epidemic remains dominated by repressive measures and medical solutions. But civil society, like people living with HIV associations supported their members, even special distribution of food kits, payment of electricity bills, cash transfers have been organized during the epidemic.

Adija Adamu [00:07:17] Thank you, Khoudia, for the experience that you shared by you and Leah. I will now move to the second question. I would like to know from you, how did the State's different responses highlight the inequalities in different regions in Africa or specifically in your own different countries? Can you highlight the inequalities that were at the forefront during the pandemic? Leah, can you start and we move to Khoudia.

Leah Eryenyu [00:08:16] Yeah. I'm going to start by linking back to the issue of the public health mandates that I mentioned earlier. So depending on where you are in the African continent, you probably saw people being beaten up for not masking, for selling food by the side of the road, or killed for breaking the curfew just like I shared earlier. It is important, however, to remember that those who bore the brunt of this very coercive public health mandates were marginalized groups. So the poor, you know, sex workers, LGBTI persons. Essentially people who are economically deprived and had no choice but to continue working. So when we think about the people who are beaten up for not masking, for example, they were not masking because they were making a political statement in the same way that libertarians in the Global North were making political statements about individual freedoms and the right to not mask. They were not masking because they simply could not afford masks. So they were forced to either share masks or you know, wear very poor quality ones or just put a piece of cloth around their noses just so that they could escape the wrath of the State. When we think about sex workers whose work mostly happens at night and requires physical contact, breaking of public health mandates was inevitable and they paid a high price for this. Sex workers were getting arrested because they were seen as these reservoirs or these transmitters of COVID because

Leah Eryenyu [00:09:17] of the nature of their work. And then when we think about when we look at LGBTI persons, the public health mandates were used as a pretext to raid shelters where there was seeking refuge for those that were homeless. So these shelters were ostensibly raided to enforce social distancing requirements. The police were saying that they were overcrowded and here I'm talking about Uganda specifically, but if this were the reason, the police then should have raided a number of Ugandan households that were also overcrowded. Basically, what we

are seeing is that the State was using public health mandates to further subjugate and control populations they deemed undesirable. And then the other point that I would like to make about State responses, was actually State non-response or State incapacity to properly respond to the COVID-19 pandemic. So I can ask the question: in what state did COVID-19 find African health systems? We find a situation before COVID-19

Leah Eryenyu [00:10:17] where 22 countries out of the 25 that are deemed the most vulnerable on the Disease Vulnerability Index, 22 of them were from the African continent. And this can be attributed to poorly resourced health systems, which in turn can be linked to global political economy issues of debt and austerity that have characterized the neoliberal era and that have truly truly pummeled the African continent. When we think about the impact of structural adjustment programs of the 80s and 90s that saw the mass privatization of State-led enterprises, you know, cuts in public sector wages, all of that is visible today and COVID brought them to a head within the health sector. The point I'm trying to make is that the State capacity to respond to COVID was severely diminished, which basically created a vacuum that allowed for private health care players to come in and commercialize the health sector and

Leah Eryenyu [00:11:17] gauge prices such that it was very difficult for people to afford the cost of managing COVID should someone fall sick. I would like to make an additional point. In thinking about this commercialization of health, in effect, what we are saying is that people who could not afford critical care had, in essence, received a death sentence. And then when we put this side by side with the fact that the State additionally could not even fund social protection in the form of food relief or cash transfers to be a buffer for the lost livelihoods, then we can see that the State basically did not have the capacity to respond to all the emerging critical issues out of the pandemic. So Christopher J Lee argues that this inability of African States to respond to the pandemic is emblematic of necropolitics. When we talk about necropolitics, it is this

Leah Eryenyu [00:12:17] idea that the State has a sovereign power to decide who lives and who dies. And the State does this by marking certain lives and mostly the lives of marginalized groups as expendable. So this diminished response from the State is evidence that African States did not have capacity to guarantee life. They therefore resorted to the only thing that was familiar to them which was violence, which was control. And so that is why we had that very punitive and that very coercive public health mandate which, in turn, ended up further reproducing and exacerbating inequalities that marginalized groups were already experiencing before the pandemic.

Adija Adamu [00:13:17] Leah, that was really really a sad reality. And we can see that Africans States's decision-making did not consider the realities, the context in which people in their various States are working with. But I would like to hear from Khoudia. Was that a similar situation in West Africa? Can you shed a light on the State responses?

Khoudia Sow [00:14:17] Most West African States used force, authoritarian or repressive measures. Policeman often used violence to enforce confinement. People were beaten, arbitrarily arrested and in sometimes skilled. In Senegal, for example, ban of collective prayers in mosques led to police arrests. Many cases of physical and psychological violence, emotional abuse, humiliation, and sometimes even marital rape have been reported, specially in marginalized groups and many

victims were unable to get help. Also, COVID-19 pandemic exacerbated domestic violence in West Africa, especially for young women and girls forced to stay at home in confined spaces. In most West African countries, poverty increased for people with informal jobs. And in some countries like Mali, Niger, Nigeria and Burkina Faso, armed group have stepped attacks leading to kidnapping and massive population displacement aggravating security and humanitarian situation and improving humanitarian crisis.

Adija Adamu [00:14:39] I am going to move to the next question. And I see that the State response, was in a way, kind of copy paste from North to South without taking into consideration what were the realities in our continent. So I'm going to want to know how did the State respond to marginalized groups, that is groups that were not considered as part of the planning during the pandemic? I may shed light on the groups that may be we can talk about such as HIV and teen pregnancy. And also we can also discuss on the aspect of Indigenous people and the LGBTI community. So I'm going to start with Leah again. Leah, I can you share with us?

Leah Eryenyu [00:15:40] Adija, you make a really good point about a pandemic response that was copy and pasted from the Global North to the Global South. This demographic that I'm going to talk about definitely experienced the pandemic quite acutely because of that copy and paste methodology. And here, I'm going to talk about adolescent girls and young women. We could say that obviously States had no choice but to close schools as part of their strategy of mitigating the spread of the coronavirus. When you look at the Global North, they closed schools, but school continued online because you know, that infrastructure was there, there was some kind of continuation. That was not necessarily the case in the African context and particularly for poor families who make up the majority of you know, people on the continent. School closures had such a significant effect on adolescent girls and young women and specifically on their sexual reproductive health and rights that we are probably going to feel the reverberation of these decisions for generations to come. So school is such an important community and some have called it some sort of social vaccine. And it's called a social vaccine because of the modicum of protection that it provides.

Leah Eryenyu [00:16:39] You know in our context here, we can see it as increasing the age of sexual debut, reducing incidences of early marriage, reducing incidences of teenage pregnancy and so on and so forth. So with that buffer gone, it meant that all these adolescent girls and young women were basically exposed to all the things that they were being protected from in the first place. So within the school context also is where quite a bit of HIV programming and SRHR programming happens. Sometimes there's HIV testing there's sharing of information, there is also distribution of sexual health commodities. This doesn't happen everywhere, depends on how liberal or conservative but anyway, all these structures were taken away. And I'm going to share with you what the impact of that has been. So what has been observed immediately is that there's been an increase in HIV infections amongst this demographic of adolescent girls and young women. And here I'm talking about

Leah Eryenyu [00:17:39] girls and women aged 15 to 24. I also must stress that actually this is one of the most vulnerable groups when it comes to HIV infections. Within this particular demographic, they counted for the highest rate of new infections in Africa in 2022. So for all HIV infections for people 15 to 24, 77% of them were adolescent girls and young women and then

when we look at it globally, of the 4,000 adolescent girls and young women who are infected per week with HIV in 2020,  3000 of them were in Africa. So I just needed to stress just how vulnerable this group is to HIV infection. So when you have a context like that and then you have no schools and then you've removed HIV programming, you've removed SRHR programming, it goes without saying that then the increase incidences of HIV infection. And it wasn't just HIV. Teenage pregnancy girls reporting earlier sexual.

Leah Eryenyu [00:18:40] sexual debut with a significant number of those saying that those experiences were unwanted. So you have high incidences of sexual violence as well. When you look at teenage pregnancy, we have crisis levels of teenage pregnancies because of school closures during the pandemic. So when you look at Uganda that had the longest school closures in the world at 22 months and then you project just this small numbers that I have given, you that should give you kind of an idea of what the impact of just the stopping of sexual reproductive health and rights outreaches and HIV programming. What the impact of that was because of the pandemic.

Adija Adamu [00:19:40] Wow, those were the effects of the pandemic that we really need to take into the future. So, I think we need to also highlight that Indigenous people when left out in the state planning and they also suffer the consequences of what Leah mentioned. I will now move to Khoudia. Khoudia, I know that in West Africa you work in hospitals and you must have experience with HIV and teen pregnancies. Can you maybe pan out what were the experiences in Senegal?

Khoudia Sow [00:20:40] COVID epidemic posed a serious threat to prevention and care service for people vulnerable to HIV. Many pregnant women couldn't come to the hospital. So they were unable to be tested and protect their children if they were HIV positive. Distribution of tools to prevent HIV transmission could not be deployed. For example, sex workers couldn't work and their vulnerability to physical violence from their partner including  unprotected sex, stigmatization, and sexual abuse increased. All vulnerable groups reported experiencing violence during confinement and financial difficulties that accentuated their stigmatization. Khoudia, that was great. And I think it's similar experiences. So I'm going to move to the next question and the next question, Leah, will be: What is the equitable public health response during the pandemic and what were the roles of activists, advocates and the stigmatized marginalized groups. Can you shed light on that? And then we will move to Khoudia.

Leah Eryenyu [00:21:47] Rwanda has been highlighted as a great example of the pandemic response. Mostly because of the low infection rate, the low number of deaths, and also a very impressive vaccine rollout process. So Rwanda has a relatively well resourced health system, but what makes it work, what makes it tick is that the health system is really decentralized. So when you go to the different administrative units, their health centers, which meant that even when they were pandemic disruptions, people still had access as close to the last mile as possible. So they did not have to go to major hospitals in order to access health services. COVID-19 disruptions were also minimized by using schools as isolation centers instead of hospitals, which left a number of health facilities to continue their regular activities. And then when it comes to vaccines, there was a really well-coordinated and organized plan that enabled a very smooth vaccine rollout including putting in place an infrastructure that enabled them to access vaccines that certain African States couldn't because of the refrigeration requirements, the transport requirements and things like that. And

so because of that, they were actually able to vaccinate people at a higher rate than most of their neighbors and lastly, they also adopted door to door vaccination for those who are most at risk and hard to reach. So for example people that were over 60 years old and people with disabilities.

Leah Eryenyu [00:22:46] So within two years Rwanda had surpassed its target with 82% of the population having received at least one dose and that is really really impressive. However, I would like to stress that Rwanda did not magically start doing well during the pandemic. They were able to manage the pandemic a lot more adequately because they had put in place systems. They had a relatively robust health system even before the pandemic and this enabled them to handle the crisis relatively well. So in order to make health care accessible to all, it's important that we resource it equitably. But African States also have to understand that the right to health is intimately bound up with other structural socioeconomic issues. So the pandemic response has to always recognize that there is an intersection with other marginalizations. And as we're thinking about this, there is also important that they need to expand their understanding of what marginalization entails otherwise certain people will constantly be left out.

Leah Eryenyu [00:23:47] So for example, you've talked about the Indigenous people. So even as people try to be inclusive, there are certain groups that are still being left out and this is because these groups, some of them are not legally recognized in legal and policy frameworks. So that is a very important step. And then lastly you can't plan for what you don't know. So data, how many Indigenous people do we have? How many poor people do we have? And therefore how much food relief are we going to make available? How much of cash transfers are we going to make? So all of that is important for planning for a more equitable and inclusive pandemic response. And then you ask a very important question about what the role of activists and civil society organizations did they have did they play during the pandemic and what lessons can we adopt going forward? I think civil society institutions and movements did a very important job of holding States accountable and holding their feet to the fire. In the Ugandan context, the government had mandated that you needed to have a

Leah Eryenyu [00:24:47] national ID in order to get a vaccine. The State was immediately sued because the argument was that you're basically saying that only people who are registered should have access to vaccines. So you can see great examples of movements and civil society organizations holding States accountable. But I think also what activists and NGOs and civil society organizations did really well was modeling what an equitable pandemic response could be like. What they did was they identified marginalized groups and then they ensured that there was last mile delivery not only of medicines but also of sustenance like food. So we had people mobilizing to ensure that people that lived in hard to reach areas who could not access transportation had access to enter anti-retro viral therapy, for example, or that people with disabilities still had access to them medication. So what States could do would

Leah Eryenyu [00:25:46] Be to adopt all these good practices that were modeled by civil society organizations and then scale them up and then resource them. You know, things like telehealth, things like delivering medicines with drones. These are some of the things that were being done by civil society organizations. So I think these are some of the things that we can look at as a blueprint for responding to the pandemic in a more equitable and inclusive manner in the future.

Adija Adamu [00:25:46] Great. Earlier, I think what I picked up is it is State and stakeholder engagement is very vital in planning for pandemics and also modernizing our health systems in Africa. And now, I would like to ask Khoudia to share her reflections.

Khoudia Sow [00:26:46] COVID epidemic reinforced gaps of availability, economic access, acceptability and quality of service and structural inequalities of young girls, sex workers, people living with HIV, men who have sex with men who are already vulnerable. Responses to COVID were restrictive, uniform, one size fits all. and failed to face realities. The increased violence and suffering sometimes reinforced structural social, cultural and health inequalities. Lessons learn from preparedness and response to the new epidemic about COVID response--I think that new responses have to respect EDI: equality, diversity and inclusion, ethics, and human rights. Response have to take care of specificities and needs of invisible or discriminated groups. This is the only way to improve our response of new epidemic. Thank you.

Vanita Mukherjee [00:27:46] The Feminists for a People's Vaccine podcast is produced by DAWN -- Development Alternatives with Women for a New Era and TWN, the Third World Network. Today's episode was edited by Alice and engineered by Ernesto Cena. Thank you for joining us today. I'm Vanita Nayak Mukherjee. See you on the next episode.