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"WE ARE GOING TO DIE OF HUNGER BEFORE THIS VIRUS EVEN KILLS US": THE POLITICAL ECONOMY OF HEALTH AMIDST COVID-19 FOR MARGINALISED GROUPS IN AFRICA

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FEMINISTS
FOR A PEOPLE'S
VACCINE

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INTRODUCTION

Globally, most countries were woefully unprepared for the COVID-19 pandemic, as even those with the most robust health systems were overwhelmed. Africa in particular, with decades of pummeling from austerity measures imposed by International Financial Institutions had largely been stripped of its ability to sustain health systems that met the AAAQ framework-failing to guarantee the Availability, Accessibility, Acceptability/Appropriate, and quality of health for all. So, concerns and predictions of mass infections and deaths from COVID-19 in Africa[1] were not unfounded. The continent's weak health system, high disease burden with a combination of high HIV and tuberculosis infections contributed to its vulnerability to COVID-19. The Disease Vulnerability Index shows that 22 countries out of 25 marked as most vulnerable are from Africa.[2] By November 18, 2022, a total of 12 million cases of COVID-19 had been recorded in Africa and 257,984 were reported to have died from the pandemic.[3]

The management of the transmission of COVID-19, its treatment and later access to vaccines all proved challenging for the continent. While Africa's infection and mortality rates from COVID-19 are lower relative to other geographies, excess deaths in Africa from other unrelated health complications may have occurred simply due to disruptions in the health system, in effect, making COVID-19 as deadly on the African continent, as it was elsewhere.

Critical to this analysis is that, while COVID-19 "thrust itself in the public realm as a scourge blind to class, racial, gender, age and other distinctions,"[4] its impacts were not felt equally. Individuals and groups on the margins of society, already bearing the brunt of historic and continuing discrimination were subjected to multiple and compounding effects of socio-economic collapse, as well as the impacts of the health crisis that COVID-19 unleashed.

This paper considers the experiences of minoritized people in Africa, illustrating the ways in which their marginal status exacerbated the ways in which they experienced the pandemic and impeded their access to health. It adopts an intersectional framework to reflect how compounding marginalization increased vulnerability, and further deploys a necropolitical lens to show the role of the state in unequally distributing precariousness[5] through its pandemic response or lack thereof.

METHODOLOGY

This paper is the result of desk-based research, drawing on existing documentation of experiences of marginalized people's access to health during the COVID-19 pandemic. Therein also lies its limitations as it is bound by the breadth and depth of existing research on these groups. Only in the instance of the experiences of LGBTQI (Lesbian, Gay, Bisexual Transgender, Queer, and Intersex) persons in Uganda were Key Informant Interviews conducted to supplement the literature. That notwithstanding, this paper's unique contribution is in its collation of these disparate experiences across East and Southern Africa, and perhaps most importantly, its use of critical frames of analysis to understand these marginalisations, complementing what has largely been empirical research on the COVID-19 pandemic.

INTERSECTING OPPRESSIONS, NECROPOLITICS, AND COVID-19

The framing of this paper is underpinned by the concept of intersectionality which foregrounds the recognition of diverse and different social identities and the ways in which they interact with each other, and at the same time with different systems of power. Intersectionality posits that the location of marginalized individuals' and groups' identities within the socially determined hierarchies of race, class, gender, sexual orientation, nationality, caste, etc interact with power structures to produce oppression or privileged status.[6] Crenshaw argues that a "single axis-analysis" distorts the complexity of marginality[7] as marginality is not homogenous, even within groups that are structurally excluded. So, an intersectional frame of analysis demonstrates that marginalisations are not siloed or additive but instead co-mingle and mutually reinforce each other to produce further complex and aggravated vulnerability. So in using this lens to analyse the experiences of COVID-19, this paper demonstrates that while everyone was vulnerable to COVID-19, vulnerability was exacerbated under certain political, economic, and social conditions resulting in an "unequal distribution of precariousness."[8] Moreover, this vulnerability did not happen sequentially, waiting for one sort of marginalisation to pass before the appearance of another, but rather bore down on individuals and marginalised identities in an onslaught.

This conceptual framing however does not sufficiently explain the outsized role of states in shaping marginalisation, nor does it adequately convey the severity of decimation of life, due to state action or inaction. This paper therefore additionally adopts the concept of necropolitics, in complement, to understand the "state of exception"[9] that was triggered by the states of emergency declared, necessitating the suspension of certain civil liberties by instituting public health mandates to mitigate the spread of COVID-19. Necropolitics, as defined by Achille Mbembe, posits that the State has the sovereign power to subjugate life to death[10], and thus has "the capacity to define who matters and who does not, who is disposable and who is not."[11] The calculus of who lives and who dies is not accidental but rather the logical outcome of a confluence of systems of power designed to exclude certain groups. Suitability for death may not bring death outright, but a group's living conditions may be so debased that they confer on them the status of the "living dead"[12]. In other words necropolitics "names the long, drawn-out state of dying that many marginalised people were condemned to from birth,[13] that were then supercharged by COVID-19.

COVID-19: EXPERIENCES FROM THE MARGINS

An intersectional analysis invites a scrutiny of the socio-economic and political structures that undergirded the varied experiences of marginalized groups, with overlaps and intersections that exacerbated marginality. This paper distills these structures into two major analytical but co-constitutive categories; firstly, the legal and policy framework, considering two dimensions-- public health mandates and how they shaped the enjoyment of the right to health, and legal and social (mis)recognition and the ways in which this withheld rights for certain groups, heightening vulnerability to the impacts of COVID-19. Secondly, the paper considers the political economy of financing for health and social protection within a neoliberal economic system and how this structured the inadequate pandemic response, rendering those on the margins even more vulnerable. Within these analyses, the state, exercising its necropower, and in its role as a primary duty bearer, is implicated as a key driving force of how marginalized groups experienced the pandemic.

1. LEGAL AND POLICY FRAMEWORK

The paper analyses two components of the legal and policy framework, the public health mandates instituted to mitigate the spread of COVID-19 and how they

challenged access to health, and the legal (mis)recognition of certain groups and how that shaped marginality in relation to health before and during the pandemic.

PUBLIC HEALTH MANDATES AS A BARRIER TO HEALTH ACCESS

The immediate result of instituting public health mandates to contain the spread of COVID including lockdowns, curfews, banning of both public and private transport in some areas, etc was the curtailing of access to health. So, while certain health facilities and services remained available, they were not accessible because of restrictions in movement. COVID also crowded out and deprioritised other health concerns affecting hours of operation of health centres, information about other health needs, and prolonged waiting times.

COVID's disruption of HIV/AIDS management, raised alarms that Sub-Saharan Africa already burdened with the highest HIV infections globally, accounting for 67% of people living with HIV[14] would regress further. Moreover the propensity of HIV to depress immunity made People Living with HIV (PLHIV) vulnerable to morbidities from COVID-19.[15] Modelling has shown that due to the COVID-19 pandemic, deaths from HIV in low and middle income countries with high burdens of HIV could increase by 10% over the next 5 years compared to if there was no COVID-19.[16] Three factors can be identified for this potential increase;

- Reduction in HIV testing due to disruptions in community-based testing typically done during outreaches; testing resources being rerouted to testing COVID-19 since it presented a bigger and more immediate threat; and reduction in the number of HIV high risk groups seeking services at health centres.
- Impeded access to HIV/AIDS services and commodities such as Antiretroviral Therapy (ART), Post and Pre-Exposure Prophylaxis (PEP/PrEP), and other sexual health commodities such as condoms,[17] thereby increasing the risk of transmission. The inconsistent access to ART also raised the possibility of developing drug resistance.[18] In Kampala, Uganda, visits to an HIV clinic decreased by more than 50% during the lockdown, and the risks of patients running out of ART which was at 5% before the pandemic increased to 25%, even as the clinic remained operational.[19] In Kenya, biting deprivation impacted ART use with lack of food cited as the reason for missing ART medication as this study participant shares;

"...remember you first have to eat and take the medication. But right now, food is budgeted, and we no longer work. When you eat lunch, then it means you won't eat supper. And remember you have to take the medication twice, so you'll have to take the medication only once" [20]

• The lack of clear information about COVID particularly in the early days of the pandemic, in combination with states' heavy handedness in enforcing public health mandates, created fear about the unknown, forcing people to gamble with other health conditions rather than catch COVID. An administrator of an HIV/AIDS programme captures this aptly; "Among our clients we notice that the fear of COVID-19 is higher than that of HIV, so some opt to stay indoors rather than come for services."[21]

On the maternal and neonatal health front, COVID-19 created adverse outcomes, with an increase seen in pregnancy complications and fetal and infant health due to delayed care. Transport restrictions, and patients' fear of contracting COVID disrupted services for maternal and newborn health, exacerbating already concerning maternal and newborn mortality rates--Sub-Saharan Africa accounted for 70% of global maternal deaths in the world in 2020,[22] and also had the highest neonatal mortality rate in the world at 27 per 1000 live births.[23] In Uganda while only 53 cases of COVID had been recorded by April 9th 2020, a news report recorded seven women's deaths from pregnancy complications, as a result of restrictions in movement.[24] A study conducted in a rural health neonatal unit showed an increase in children born outside the medical facility, and increase in admissions due to birth asphyxia. Generally, there was excess mortality[25] of 35.7% in new-borns compared to a similar period before COVID, with children born out of the medical facility accounting for a 55% increase.[26]

Additionally, because COVID crowded out other health concerns, antenatal care (ANC) was significantly scaled back. In Zambia, there was a 10% drop in utilisation of ANC services among pregnant women compared to the time before the outbreak of COVID-19.[27] Decreased ANC and infant follow-up were identified as leading to low birth weight and increase in neonatal deaths.[28] Decreased ANC access also meant that the proportion of women receiving HIV testing during ANC visits also dropped[29], potentially frustrating the goal of achieving an HIV-free generation through curbing mother to child HIV transmission.

DISRUPTIONS TO ADOLESCENT GIRLS AND YOUNG WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH

The pandemic necessitated the closure of schools around the world. As school is considered a "social vaccine" because it increases protection of girls against early marriage, pregnancy, and STIs,[30] their closure impacted the delivery of sexual and reproductive health and rights (SRHR) and HIV programming in Africa. Evidence shows that this exposed Adolescent Girls and Young Women (AGYW) to numerous SRH related challenges including earlier sexual debut, teenage pregnancy, and undesired sexual encounters.

A study on the impact of the pandemic on a community-based HIV programme in South Africa targeting AGYW shows the target group's visits for HIV testing and PrEP decreased by 29%. Within the group analysed, HIV positivity increased from 0.54% to 1.94%; STI positivity went up from 23% to 30%; while pregnancy increased from 1.2% to 4.1% during the pandemic, from a sample total of just 546 AGYW.[31] In Western Kenya, a study conducted in 12 schools shows that adolescent girls who were out of school for six months due to school closures were twice as likely to become pregnant compared to the pre-pandemic period. The research also shows that more girls became sexually active and were less likely to report their first sexual experience as desired. In the pre-COVID research cohort, 36.0% of girls who were sexually active reported their first sex as having been desired, while only 17.8% of girls in the COVID-19 cohort reported the same. Additionally, school going adolescent girls were three times as likely to drop out of school (9.4% compared to 3.2% in the pre-covid cohort).[32]

Teenage pregnancies were another consequence of prolonged school closures. In Gauteng, South Africa's most populous province, a 60% jump in teenage pregnancies was reported between April 2020 and March 2021. More than 23,226 teenagers aged 10 to18 girls gave birth during this period compared to 14,577 girls in the same period a year earlier.[33] A study in a region in Uganda found that among girls aged 10-14 years, incidence of pregnancies had increased by a staggering 366.5% from 290 in March to 1,353 in September, 2020.[34] Uganda had the longest school closures in the world at 22 months[35] so it is likely that this picture is more dire when numbers from the entire country are considered.

While the pandemic can be singled out for these impacts, it is critical to note that these dire outcomes emerge from a context that was ill prepared to truly address AGYW's SRHR needs to begin with. While Adolescent girls and young women (AGYW) are not recognized in HIV policy as Key Populations, the disproportionate rate of HIV infections amongst the group, merits specialised attention. In sub-Saharan Africa AGYW (15-24 years) accounted for 77% of new HIV infections in 2022.[36] Globally, of the 4000 AGYW infected with HIV every week in 2022, 3100 were in sub-Saharan Africa.[37] In spite of this, demands for policies around Comprehensive Sexuality Education, provision of sexual health commodities such as contraceptives and condoms, as well as access to abortion have largely been thwarted.

This paper hypothesizes that despite AGYW having similar socio-structural challenges that heighten exposure to HIV like Key Populations, they are not integrated into that category for specialised HIV intervention because of a moralizing over girls and young women having sex outside marriage. But a case could also be made that there is a pathologizing of Key Populations which demands purely clinical interventions to cure them of their perceived deviance, and moreover the category is composed of "criminal" populations that would taint the perceived purity of AGYW. By refusing to acknowledge AGYW's sexuality, they are left unprotected to be ravaged by HIV and unwanted pregnancies, all of which was then exacerbated with the onset of COVID.

1.2. THE POLITICS OF LEGAL AND SOCIAL (MIS)RECOGNITION

Marginalized groups experienced the squeeze of blanket public health mandates most acutely, but even more so when those groups, such as sex workers and LGBTQI persons were criminalized. Criminalization of identity amounts to social and legal misrecognition, revoking rights that simply being human guarantees.[38] Institutions like the state, church, family, etc have the power to legitimate identities by recognizing or misrecognizing them, and by that token deciding who gets to enjoy rights and who, by the fact of their criminalisation, is visible and of interest to the state only for purposes of punishment or discipline. For example, while Global HIV policy recognizes sex workers and LGBTQI persons as Key Populations because of their increased risk of HIV infection,[39] this recognition characterised by targeted HIV programming is contradicted by the criminalisation of both groups in most African countries, opening the door for discrimination and exploitation.

To misrecognize is thus a condemnation to a social death, exposing those groups to all manner of debasement as the state's protection is withdrawn. Sex workers and LGBTQI persons who were already poor because of this ostracization became even more vulnerable during the pandemic as their poverty co-mingled with the suspension of some civil liberties triggered by the COVID-19 state of emergency. Both groups were forced deeper into extra-legal spaces where they became doubly disenfranchised--first because of their criminalised identity and secondly by existing in a space where laws had largely been suspended. These spaces where increased desperation resulted in heighted exploitation can be likened to Mbembe's death worlds-- "forms of social existence in which vast populations are subjected to conditions of life conferring upon them the status of living dead."[40] These extra-legal spaces forced poor health choices as people literally put their lives on the line, gambling with COVID in order to eat, as this 22 year old female sex worker from Uganda attests;

"Sometimes when you get a client for sex work, it's very hard to refuse even if we are aware that COVID is there, we just go because if you refuse, you die of hunger even before you remember that COVID kills" [41]

Sex workers, already breaking laws against prostitution, additionally had to violate curfew in order to earn a living, resulting in depressed negotiating power over earnings and safe sex, increasing exposure to HIV and other STI infections as well as unwanted pregnancies. And yet the lack of access to sexual health commodities to prevent HIV infection and prevent pregnancy also raised the risk of "corona babies"[42] for sex workers. An 18-year-old sex worker shared that within three months of lockdown she had already gotten pregnant because she could not afford contraception and transport to the sex worker clinic.[43] Another 23 -year-old sex worker shared the consequences of having a "corona baby", showcasing heightened desperation and precarity.

"I am suffering because I am not getting enough income to cater for my needs. I have a 4 months baby [sic] and I cannot afford essentials like diapers .... Clients are paying very poorly- ksh 50 (USD 0.5) and the highest I get is ksh 500 (USD 5). I accept it because I have many financial problems." [44]

The consequences of legal misrecognition and criminalization also spilled over to access to vaccines, specifically for LGBTQI persons in Uganda. In the early days of the COVID vaccine campaign, the Ministry of Health in Uganda required national IDs as

a conditionality for accessing vaccines.[45] In a context where vaccine misinformation was already creating hesitancy, the national ID requirement immediately created another barrier to vaccine rollout and access. For LGBTQI persons who live in the shadows in Uganda, this was another obstacle to their right to health. The process of getting national IDs is a bureaucratic nightmare requiring signatures from parents and letters of support from local government officials. For queer people, some of whom have been disowned by family members, the process of getting a national ID is a degrading one inviting scrutiny and the violence of government bureaucracy onto oneself. So national IDs were not within reach and by extension, neither were COVID-19 vaccines. For a group with a disproportionate number of HIV infections which was considered a comorbidity for COVID, reduced access to vaccines was consequential. The policy was reversed about a week after it was announced, on the heels of the government of Uganda being sued by Civil Society Organizations citing the policy as constituting a violation of the right to health.[46] However the policy that some of form of ID was still required was maintained which still excluded those without any documentation.

A MILITARISED AND BRUTAL PUBLIC HEALTH RESPONSE AND LEGAL (MIS)RECOGNITION

Violence including mass arrests,[47] brutal enforcement of mask wearing, and extra-judicial killings characterized the enforcement of COVID-19 mitigation measures across Africa. By mid-April 2020, while Kenya had recorded only 12 confirmed COVID-19 deaths, police had killed 18 people while enforcing lockdown measures.[48] Others died or suffered severe health complications as they tried to avoid altercations with the police--a woman who went into labour in the middle of the night died after she failed to access care on time because motorcycle riders were afraid of police violence.[49] Some PLHIV expressed that walking to far-flung health centres for ART refills carried the risk of similar violence should they fail to return to their homes before curfew.[50]

The illogical enforcement of public health mandates through brute force or arresting and stuffing people in overcrowded jails ostensibly to mitigate the spread of a killer virus is the ultimate show of the state's power to subjugate life to death as Mbembe has argued.[51] However while this brutality may have been aimed at all errant persons, the fact that it was mostly marginalized groups that were ensnared shows how disenfranchisement produces a criminality identity— stay at home

measures, which in many places were not complemented with food or cash relief, automatically criminalised a large swathe of society as people had no choice but to break those rules in order to live. This automatically criminalised a large swathe of society as people had no choice but to break those rules in order to live. That the people who bore the brunt of the wrath of the state tended to be poor is evidence of this. That the poor tend to be those who are socially and legally misrecognised such as women, girls, LGBTQI folks, sex workers, etc cements this argument.

Sex workers, already historically pathologised as "reservoirs of infection"[52], were a target for further control by the state through public health mandates--117 sex workers in Uganda were arrested in an operation by the Ministry of Health for COVID related violations.[53] The physical nature of their work as well as its location in COVID hotspots like border towns marked them as high-risk carriers of the coronavirus. In Uganda, cross border truck drivers were "warned against prostitutes" and told in no uncertain terms that should they get infected with COVID, it was no longer the responsibility of the state but a consequence of their poor choices.[54]

LGBTQI persons also experienced heightened discrimination with social distancing laws used to target shelters where queer people were seeking refuge ostensibly because they were overcrowded and therefore likely to spread COVID.[55] However the confiscation of materials such as condoms, HIV self-testing kits and HIV medication and the lack of enforcement of similar measures against other equally crowded households in Uganda shows that the Public Health Act was used as a ruse to criminalise LGTBQI persons.

In summary, in misrecognising and criminalising certain identities, the state can be seen as a steward of discrimination, excluding certain populations from enjoying their citizenship rights, condemning them to a life of economic precarity that made COVID-19 even more life threatening.

2. HEALTH AND SOCIAL PROTECTION SYSTEMS AND THE NEOLIBERAL ASSAULT OF AUSTERITY

In addition to the legal and policy framework, the role of the state in mediating the right to health is best evaluated in its capacity to resource health directly, and its investments in complementary social structures that ensure wellbeing. In

undertaking this line of evaluation, it can be asked to what extent states can be held culpable for the degree of suffering and the loss of life of its citizens during the pandemic. If, as Mbembe argues, the necropolitical state has the sovereign power to determine who lives and who dies, this paper argues therefore that the state can be held responsible for its actions and inactions during the pandemic, in respect to the social contract between state and citizen.

Poor investments in health produced weak systems that were easily overrun by the pandemic, resulting in far reaching consequences that have been documented in the foregoing analysis. African countries, with the exception of two in 2021, have not met the threshold of the Abuja Declaration which recommends that at least 15% of government spending is allocated to health.[56] For critical care which was indispensable for critically ill patients with COVID-19, Africa had worse health outcomes than elsewhere because of insufficient care arising from a small workforce, low number of intensive care facilities, and scarcity of critical care resources.[57] In a study conducted in 64 hospitals across 10 countries, data show that despite having low COVID-19 mortality rates, Africa had the highest global mortality rate in patients with COVID-19 who were critically ill.[58] Factors associated with increased mortality included delay in admission due to a shortage of resources as well as comorbidities from other diseases. These resource shortages in turn forced the redirection of funding away from other equally urgent health issues towards COVID in some places. In Uganda for example, a USD 15.2 million grant from the World Bank was re-directed from the Reproductive, Maternal and Child Health Services project towards the COVID-19 response,[59] while in Kenya polio vaccination was suspended to prioritize COVID-19.[60] In relation to managing the spread of COVID, recommended testing was not feasible in most African countries because of associated costs, supply chain issues for reagents and equipment needed for tests, as well as lack of trained personnel.[61] The low COVID-19 detection in rate in Africa could thus be attributable to lack of testing capacity, meaning that the true size of the pandemic may remain unknown.

It is critical to note that resource challenges in Africa are also an outgrowth of a global political economy that has cannibalised state-led public services in favour of private sector-led investments, essentially commodifying life sustaining services like health and social protection. Austerity measures as well as indebtedness have burdened African economies for the past four decades, eroding the capacity of states to respond in times of crisis. With a diminished state, commercialisation of health

allowed for price gouging during the pandemic. Private hospitals in Uganda for example charged anywhere between US$920 to US$ 2660 per day to treat COVID-19 patients, with some requiring a deposit of at least US$1300 before admission into the high dependency unit or ICU.[62] In a context where 50% of people in paid employment earn about US$53 or less per month,[63] such costs were simply impossible to meet, and in effect, a death sentence for those who needed critical care.

Marina Grzinic argues that global capitalism manages and organises society through the logic of death and that neoliberal austerity cuts in health are a manifestation of this.[64] Christopher J. Lee posits in turn that the incapacity of African states is tantamount to outsourcing life sustenance to private players who charge a fee, making the ability to live available only for those who can afford it.[65] Because states are thus incapacitated, they becomes arbiters of only death and therefore cannot "guarantee or even administer life, except through the crudest forms of non-medical state control and cold violence against non-citizens"[66] as was exhibited by police brutality in trying to enforce public health mandates.

Neoliberal economic policy also meant that states could not provide social protection, further undermining the right to health. That some populations, due to economic deprivation could not adhere even to the most basic and relatively cheap requirements for mitigating the spread of COVID—social distancing, washing hands, and masking— is evidence of the state's failure to meet its role of social provisioning. Uganda's president, for example, when asked about the vulnerable poor in rural areas who needed food relief responded;

"If you were poor before the lockdown, you'll be poor after the lockdown. Eat what you were eating before...we shall deal with your poverty later." [67]

Since the logic of necropolitics is that some people must die in order that others may live, those whose identities locate them furthest away from the axes of privilege have the least power and are therefore most expendable as is shown here—the state cuts off any means of subsistence while not providing any food relief, condemning them to a slow death. An argument could be made, as indeed Núñez-Parra does using the experiences of People With Disabilities who are largely economically disenfrachised, that the neoliberal state does not see the poor as economically productive members of society and therefore as deserving of citizenship entitlements because their bodies serve no purpose in capital accumulation.[68] A mother of three in Uganda who was

forced to stretch out her rations of food during the lockdown stated aptly what the consequence of this lack of response from the state would be; “We are going to die of hunger before this virus even kills us.”[69]

LESSONS TO CONSIDER FOR FUTURE PANDEMICS

Four years removed from the height of the pandemic, we can see a return to normal without much transformative change to health systems or the socio-economic context. Clare Herrick’s fear that “even as the viral threat ebbs and our daily lives slowly re-merge; the underlying health, economic and social drivers of this pandemic will remain just as they ever were”[70] becomes more real. It is what some consider a “denial, rather than acceptance, of history” at the social policy level[71] —a seeming commitment to refuse to learn from the past. In documenting the experiences of marginalised groups with access to health during the pandemic, this paper sought to avoid exactly this pitfall. And thus proffers the following lessons for reflection

- **Responses to pandemics must foreground how structural political, social, and economic factors, in interaction with social identities, mediate experiences of health crises**. Marginalised groups were not disproportionately impacted by COVID-19 as a matter of course but because their marginalisation put them in the direct path of its onslaught. To respond to COVID with an intersectional lens, we must therefore start our analysis from the margins, and “[peel] away some of the layers of obfuscation that have made COVID-19 a disaster by scrutinizing contributing factors that lie far beyond the virus itself.”[72] An expansiveness in understanding marginalisation, and the complexity of its intersections is thus paramount. Therefore, for policy that is intentional, intersectional, and inclusive, recognition of marginality and attendant challenges is critical, and must go beyond visible and longstanding identities already recognised in international and national law. The state therefore has the obligation to reform legal and policy frameworks to recognise and dignify marginalised groups, which guarantees their right to have and enjoy rights. As has been illustrated, health interventions cannot succeed in the shadow of discrimination and criminalisation which aggravate poor socio-economic outcomes.

- **Public financing needs to be mobilised to build strong and inclusive health systems that can withstand crises.** Specifically, investment in

universal health coverage, critical care and emergency response would mitigate some of the challenges that the pandemic exposed. Again, as the experiences of marginalised groups have shown, this resourcing cannot be limited to health alone as socio-economic context shapes health outcomes. Investment in social protection systems to absorb shocks from crises would complement robust health systems. On the other hand, the stranglehold of private health which has commodified health needs to be loosened so that health is accessible no matter one's socio-economic status. This would require a challenging of narratives of state-led interventions as inefficient and a recasting of health as a public good to which all have a right. Additionally, public investment in innovative telehealth and home-based service delivery is an area of consideration. The experiences of some groups showed that telehealth was critical for narrowing the gap in access to medicines and other health services during the pandemic. However, the cost of such services still made them largely inaccessible as they are still largely private-led. A publicly funded telehealth system would benefit everyone, not only those who need special accommodations.

• **In line with building strong health systems, decentralisation is also vital for last mile reach.** Rwanda's decentralised health system consisting of health workers at the community level made it easier to weather the effects of the pandemic and further created a well-coordinated structure for vaccine rollout. Door-to-door vaccination was adopted for people above 60 and those living with disabilities.[73] Within two years, Rwanda had surpassed its target with 82% of the population having received at least one dose, far surpassing her neighbours.[74]

• **To reduce disruptions and deaths, managing other existing diseases alongside a pandemic will be an important lesson to bear in mind in preparation for future pandemics.** Zambia for example managed to continue providing HIV care and treatment amidst COVID. Guidelines extending ART refill duration to 6 multi-month dispensations and task-shifting communication and mobilization of those in HIV care to collect their next ART refill early were implemented.[75] Zimbabwe also had mobile clinics which brought ART medication and HIV testing to those who needed it.[76] For maternal and neonatal health, Rwanda provides

good practice for consideration. There were seemingly no changes in both antenatal care and other standard services related to sexual and reproductive health in Rwanda.[77] Some of this is attributed to the fact that instead of hospitals, different schools were designated as isolation centres for COVID-19 cases and health facilities were left to continue their regular activities.[78]

• **The pandemic showed the importance of a vibrant civil society.** Social justice organisations and movements sounded the alarm about marginalised groups falling through the cracks and held the state accountable through petitions and strategic litigation cases as happened in Uganda and in Zimbabwe where a consortium of Civil Society Organisations sued state broadcasters and Government Ministries for failure to provide timely critical information about the COVID-19 pandemic in accessible formats to People With Disabilities.[79] But CSOs also provided services where the state was absent. For example procuring vaccines for LBT persons in Uganda which were then administered through the Ministry of Health. In a context where States have been weakened as has happened in Africa, CSOs then play in a pivotal role in shaping government responses to crises, particularly on issues that state actors may not be adequately informed about. The resourcing of CSO and social movements' work is thus vital.

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BIOGRAPHY

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