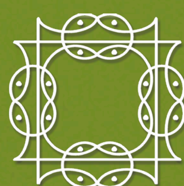
INTERSECTIONAL FEMINIST FRAMEWORK

THE UNRAVELLING PANDEMIC:

ENVISIONING OUR INTERSECTIONAL FEMINIST FUTURES



Sama

Resource Group for Women and Health

The Unravelling Pandemic: Envisioning Our Intersectional Feminist Futures

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Preface

Over the past few years, the world has faced the most catastrophic health and humanitarian crisis as a result of the pandemic caused by the novel coronavirus (henceforth Covid-19)[1], and it continues to be a lived reality for all of us. Since the pandemic began in late-2019, we have seen not only an unprecedented loss of lives, but also increased hardships, particularly for marginalized and vulnerable communities. Furthermore, it has critically exposed and exacerbated the existing structural inequities and disparities within and between countries.

Through this period, Sama Resource Group for Women and Health[2] has been engaged with feminist interrogations of the various dimensions of the pandemic through research, policy advocacy, capacity-building, and public dialogues.

Sama has developed this Intersectional Feminist Framework to help guide the analysis and response to the current pandemic as well as future pandemics or public health emergencies.[3] The framework is grounded in conversations representing different perspectives—from feminist, LGBTQI+, disability rights, health, and other rights-affirming movements. It has drawn upon the experiences of people, particularly the marginalized communities and frontline health workers during the pandemic. The framework has also gained insights from the critical inquiry by experts of the present and past pandemics and the findings of researchers and scientists working at the intersections of science, medicine, and public health.

The intersectional feminist framework is intended to be a reference document based on a collective and evolving understanding of the situation. The framework can be adapted to meet the needs of specific locations, situations, and circumstances for public health planning or policy inputs, develop global advocacy actions, and forge solidarity.

The framework begins with a discussion of the 'what' and 'why' of the feminist framework, examining the meaning, scope, and significance of an intersectional feminist analysis. It further looks into responses to the current and past pandemics and public health emergencies. It deliberates on these under four realms: decoloniality and health justice, centring care, people over profit, and science, knowledge production and practice. Given the complex character of the pandemic and ongoing contemplations over its impact, the

interconnectedness of these realms is apparent. Each of them illustrates the key emergent concerns and their analysis, which motivates the responses to current and future pandemics or public health emergencies. Critical elements of solidarity and resistance, to take forward the intersectional feminist framework, are underscored in the concluding part.

Endnotes

1. Coronavirus disease (Covid -19) is an infectious disease caused by the SARS-CoV-2. It has spread throughout the globe, infecting almost 470 million people and causing over six million deaths (official figures reported by WHO as of March 22, 2022).

2. Sama is a Delhi-based resource group working on issues related to gender and health. It was initiated in 1999 by a group of health professionals and activists who were involved in the autonomous women's movement, which views health from a broader perspective and finds linkages between women's well-being and various determinants of health. Sama considers health a fundamental human right and believes this can be achieved by strengthening the public health system, regulating the private sector, and curtailing multiple forms of discrimination based on caste, race, class, gender, religion, ethnicity, ability, work, sexuality, diverse gender identities, migration, refugee status, etc. Through its interlinked core strategies of research, advocacy, capacity building, and knowledge creation and dissemination, Sama enables the creation and strengthening of critical evidence to substantiate advocacy efforts and inform policy agendas. Sama's creation and dissemination of knowledge resources at various levels allows for the broadening of discourses and the development of effective information tools on the intersection of health rights and gender justice. For more information visit: https://samawomenshealth.in/

3. Over the last three years, Sama has followed a conscious path to address multiple issues related to the pandemic through a wide range of discussions and collective experiences, including research, advocacy, webinars, consultations, relief work, capacity building, and the development of knowledge resources, including videos and handouts. Sama has dedicated a section of its website, *Covid Canvases,* to various aspects of the Covid pandemic. For more information visit: https://samawomenshealth.in/ | https://samawomenshealth.in/category/our-work/covid-canvases/webinars-and-consultations/

I. Introduction

Why an Intersectional Feminist Framework?

Feminism is a dynamic thought and political movement that has different meanings for different people and changes over time. It is important to articulate what we understand by feminism as we present this intersectional feminist framework.

Feminism is as much an imagination of a utopia as it is the recognition of its transient character and chimeral possibility. Yet, the same imagination allows us to dream of a better tomorrow, envision a more equitable world, and build strategies to work collectively across our differences.

In the last few decades, our feminisms have transformed, as have our notions of health and well-being. Our feminist understanding of health, illness, and care is influenced by our involvement with the women's health movement. Many of us started working on reproductive health in the 1970s and 1980s and soon realized that issues of women's health are not merely confined to biology or medicine but are also closely related to the right to life and health, and these, in turn, are connected to, and dependent on, all our other rights. For example, reproductive health, while perceived as a deeply personal matter, should be understood within the larger rubric of international politics, population control policies, the overall discourse of development, the vested interests of corporations and multinational pharmaceutical companies, and the use of resources. The patriarchal and eugenic lens through which science and medicine look at our bodies and gender relations, and the multiple patriarchies that govern intimacies between people, must necessarily be examined. **A feminist approach to health sees it connected to all aspects of our lives, from the very personal ways in which we live to all the macro ways in which society is structured.**

Further, the evolving and changing understanding of gender as a construct over time has ultimately recognized that the people facing the greatest threat to their lives and health are those who do not normatively fit into the gender binary. Our understanding of gender, however, recognizes that gender is not a binary and that sex is more than merely a biological fact; it is also socially determined. The focus of feminist work has shifted from being completely about cis women and girls to recognizing the fluidity of gender

and acknowledging the intersectionality between various identities and vulnerabilities. Furthermore, we believe that gender should be self-determined by every individual and not defined by any particular notion of the body. Therefore, in order to address the inequalities embedded in the larger health system, we attempt to understand the interplay of biological and social factors.

Our feminism explores the complex intersection of gender with larger political, social, economic, and environmental structures. Our other locations of race, caste, class, gender, religion, age, ability, gender identity and expression, sexuality, geography, work, ethnicity and indigeneity, migration and refugee status, and other structural conditions have determined these experiences. **Our feminisms are necessarily intersectional and underscore the experiences of vulnerability and marginalization due to the complex, intersecting identities and social locations.**

Our feminist framework also interrogates other binaries, such as the Global North and the Global South, which are often taken as definitive and normative. Our understanding of the Global North and South as entirely distinct has seen shifts and a more nuanced articulation in the past several decades. The existence of characteristics of the South in the North and vice versa prompts a deeper analysis of such binary categorizations. The pandemic has been indiscriminate in the Global North and the Global South in the context of infections and their health consequences. However, the Global North-Global South dichotomy was perceptible in the context of the intellectual property waiver on Covid-19 technologies. **Our framework reveals how such conceptual limitations are both the cause and result of unequal power relations.**

The collapse of public health systems in many parts of the world and the rising commodification of healthcare depict the increasing crisis in health as a consequence of the current neoliberal order. The poor health outcomes in marginalized communities are rooted in the unequal and unfair distribution of resources and power throughout the world. Accompanying these trends, the governance of health is being held captive by private foundations, corporations, and pharmaceutical companies. Internationally, transnational corporations are indulging in the rampant destruction of ecosystems and biodiversity, generating enormous volumes of toxic waste, and endangering diverse knowledge and ways

of living. The complexities of the climate crisis, conflicts, migration, and refugee crisis to name a few, are presenting new challenges every day. All of this, aided by unjust global and national economic and trade policies, is promoting an unsustainable and inequitable development paradigm, resulting in a complex canvas of factors that are impeding the realization of the right to health.

Moreover, in many parts of the world, we are witnessing the growing power of authoritarian democracies and the complete erosion of democratic processes, violating the human rights of people, especially marginalized and racialized groups. While much of this we have assimilated through our collective experience over many years, the Covid-19 crisis has revealed new complexities we must learn from. The experience of the Covid-19 pandemic globally has brought into sharp focus many of these issues around the control, access, denial, and sharing of resources. **A feminist response focuses on the 'cracks' in the existing systems and structures, enabling us to recognize who gets left behind and how we can resist and transform the current social arrangements.**

During the pandemic, the nature of the virus and its spread necessitated many collaborative scientific efforts across disciplines. The understanding of science and technology and their location within social, economic, political, cultural, legal, and geopolitical contexts, was often missing. We view science and technology as sites of knowledge and social action and seek to understand their connection to other forces and structures in society. Therefore, for us, it is necessary to evaluate the role of science and technology through a feminist lens, particularly in healthcare, within and beyond the current pandemic.

We seek connections globally to understand the use and distribution of scientific and technological advances during public health emergencies, the actions of pharma companies, the condition of healthcare systems, and the effect of all these factors in shaping our lives in the past two and a half years. What has changed? What lessons did this pandemic teach us? How have fears of the recurrence of pandemics shaped our thinking about the future? Answers to these questions present new perspectives, allowing different voices to emerge. **We need more feminist analysis of 'pandemic science'.**

We are motivated to develop our intersectional feminist framework to amplify and augment our analyses of the pandemic through the tracing of multiple and intersecting axes of

discrimination and marginalization. These, to us, are integral and it is imperative to unravel the disproportionate impact of the pandemic and situate structural inequity in the spotlight.

Our intersectional feminist framework could be an approach or viewpoint, an expression of collaboration or resistance. We do not think there is a singular feminist way of understanding and responding to the pandemic. Nevertheless, a framework based on ideas, contributions, and inputs from our diverse realities will help us engage with our local, national, and global ecosystems, to address the current pandemic and other future public health crises. **Our framework seeks to challenge the status quo and interrogate all kinds of power to create urgent and systemic changes.**

Response #1

Colonial Lockdowns and Unjust Isolation: Covid-19 and beyond

The sudden and unplanned lockdowns, confinement and 'social' distancing measures during the peak phases of Covid-19 were claimed to be the essentials of a 'comprehensive and robust' approach globally to 'control' the spread of the infection. However, these measures with their 'historical and colonial legacies' were embedded in structural intersectional inequalities.[1] Coloniality was unequivocally manifest during the pandemic; measures by the Global North and richer countries were touted as 'pandemic solutions' and mimicked by a significant number of countries in the Global South, with little regard to the implications in their local contexts and environments. In countries already reeling under economic depression, the pandemic lockdowns only furthered it, contributing to the worsening of socio-economic inequities, loss of livelihoods and severe disruptions in the labour markets. According to an ILO report, the incomes of informal workers worldwide dropped by 60 per cent in the first month of the pandemic.[2] This resulted in widespread hunger, poverty, unemployment and other devastating conditions, particularly for marginalized communities and vulnerable groups. This health crisis has also aggravated stigmatization, discrimination and violence, isolating some of the most vulnerable people and communities, and pushing them further to the margins.

1.1 Coloniality in the pandemic context

Our colonial pasts have taught us many important lessons about how pandemic outbreaks have not only caused large number of deaths but also sanctioned extreme powers to the governments. During the 1896 plague epidemic in Bombay, the British government targeted the migrant poor who were considered 'carriers' of the virus. They were restricted and subjected to medical experiments, and their homes were demolished.[3] During colonization, race-based segregation was imposed across Africa to protect 'white' officials from others, whom they considered 'carriers' of diseases such as plague, smallpox, syphilis, sleeping sickness, tuberculosis, malaria and cholera.[4] Similarly, the Asiatic Cholera and the Asiatic Plague were examples of diseases tagged with certain geographies, although the outbreak was experienced all over the world. These labels of prejudice precipitated the stigma and human rights violations of the past, into the present.[5]

Reflecting on these pre-existing interlinkages of social phenomena—including pandemics—with coloniality is one way to interpret how colonialism has controlled the social production

of wealth and also the narrative of the world by dominating the thoughts and perceptions of the colonized and their relationship to the world.[6] For instance, during the Ebola virus outbreak of 2014–2016 in West Africa, the traditional healer was imputed the status of 'super spreader'.[7] However, there was no discourse about stipulating decades of epistemic violence that dismantled health systems in these historically plundered regions.[8] The scientific community conveniently used the term 'super spreader' to target individuals as agents of the disease rather than questioning why Ebola thrived in colonized countries. This completely disregarded coloniality—the linkages with colonialism as well as the repercussions due to structural adjustment policies, illicit financial flows, extractive systems, and several other patterns of power. [9]

1.2 Social distancing and stigmatization—the process of 'othering'

The language of 'social distancing' reinforced stereotypes, prejudices, and stoked 'othering' on the basis of race, caste, class, religion, ability, occupation and gender identity. Throughout history, 'othering' has led to the genesis of imperialism, colonialism, racism, sexism, and cultural subordination.[10] Like the colonizers had contrived the process of 'othering', during the current pandemic too, measures were used by a number of countries with a similar purpose.

Governments' responses through 'social distancing', isolation, and quarantining—all seemingly 'public health' measures—had serious implications for the rights to autonomy, privacy, health and healthcare, and were, in fact, detrimental to the mitigation of the pandemic. There has been a plethora of reports about unacceptable conditions in quarantine facilities and a complete absence of rational protocols and processes to isolate and quarantine individuals. People were not provided with any information about why and where they were being quarantined or for how long. Stigma, discrimination, and ostracization of people who tested positive or those in 'quarantine' were widely reported.

Racial discrimination against people from certain regions and communities was seen globally. They were blamed to be either 'originators' or 'spreaders' of the coronavirus and were threatened with eviction from their homes and other spaces. For example, in the aftermath of the lockdown, many people from the north-eastern states residing in other parts of India were called 'corona' and were ostracized, harassed, beaten, and even

suspended from employment. They faced difficulty accessing healthcare and were evicted from their homes. They were, like the Chinese, blamed for the genesis of the pandemic.[11] In India, the outbreak of the pandemic was also linked to Muslim communities leading to fear-mongering, social and communal prejudice, as well as widespread discrimination and stigmatization of the community.[12]

The dominant narrative placed the blame for the spread of the pandemic and its consequences erroneously on individuals and communities, obfuscating structural factors. Governments were not held accountable for their failures and lapses. Instead, people, especially from the socio-economically marginalized communities, were deemed to be 'irresponsible vectors and spreaders' of the infection. In Costa Rica, migrant workers from Nicaragua and refugees who worked in the agricultural sector were accused of contributing to the spread of the coronavirus infection.[13] In Serbia, migrants were portrayed as possible carriers of the virus, which exacerbated the anti-migrant narrative.[14] In India, migrant and informal workers were viewed as 'carriers' of the virus, sprayed with chemical disinfectants,[15] and locked up in quarantine centres with minimal facilities.[16]

Further, instances of marginalization and discrimination were seen in the prevention, diagnosis and treatment of Covid-19—such as whose symptoms were taken seriously and who was able to get tested, who had access to personal protection or respiratory devices in hospitals, home care, and ultimately, who had access to vaccines. A cross-sectional study of 1,000 children tested for Covid-19 in the US found that the children from racially or ethnically marginalized and low-income families had higher Covid-19 positivity rates than non-Hispanic 'white' children and those from high-income families.[17] Similarly, another study from the US indicated that "AIAN individuals were 1.7 times more likely to be infected with Covid-19, 3.4 times more likely to be hospitalized, and 2.4 times more likely to suffer from Covid-19-associated mortality compared to non-Hispanic white individuals."[18]

1.3 Colonial policies: Control of freedoms or epidemics?

The Covid-19 pandemic witnessed countries implementing several legal and policy measures that were discriminatory towards indigenous groups (Brazil), migrant and informal workers (India), and immigrant communities (US).[19] In India, the Epidemic Diseases Act, 1897—formulated about 125 years ago during the colonial era to prevent

the spread of 'dangerous epidemic diseases ' such as the bubonic plague that broke out in Bombay and its Presidency—was invoked in many states in response to the Covid-19 pandemic.[20] The Epidemic Diseases Act merely mentions the powers to be exercised by the governments but not their duties towards prevention and control of the epidemic. The Act neither states explicitly the rights of the people nor provides substantive and procedural safeguards to prevent excesses. It does not ameliorate the impact of epidemics on people's lives—for instance, the consequences of the loss of livelihoods.[21] On the contrary, the implementation of such a law during the current pandemic has allowed arbitrariness in response, condoned excesses, and justified rights violations that disproportionately impacted the marginalized.

In Bulgaria, for example, movement in Romani neighbourhoods was more harshly restricted than in areas where Roma people did not constitute a majority.[22] According to a 2020 news report, in the Philippines, the punishment for violating Covid restrictions included imprisonment of up to two months or fines of up to USD 20,000.[23] Such punitive methods led to mass arrests, mainly of the poor. In the UK, people of Asian and African American descent were unfairly and disproportionately detained by the police.[24]

Several countries initiated legal and policy changes that favoured increasing and normalizing mass surveillance measures to monitor the movements of individuals across the world and the assumption of extraordinary emergency powers that were likely to extend beyond the pandemic itself. These measures have sparked a global debate on the use of emergency powers by the states at the cost of civil liberties and the fundamental freedoms of the people.[25] The restrictions and lockdowns, while claiming to 'prevent' the spread of the virus, were used unjustly by the law enforcement agencies and state institutions, leading to injustice and suffering.

1.4 Imposed isolation: Politics of borders and cooperation

When South African scientists identified a coronavirus 'variant of concern' (VOC) in 2021, later named Omicron, many rich countries dismissed the discovery of the variant. Once it was recognized and designated as a variant, they announced the suspension of all air travel to African countries until they clearly understood how severe the mutations of this new variant were. The USA, Brazil, Canada, Australia, Japan, Israel, Morocco, Oman, and others

banned travel from the southern African countries, including those that had not recorded any Omicron cases.[26]

Precedents for such a response include travel restrictions imposed by the United States on West African countries in 2014–15 during the Ebola outbreak.[27] These were introduced in spite of the existence of sufficient evidence that asymptomatic people with Ebola were not infectious.[28] In fact, much before Ebola, travel restrictions were imposed on people with HIV, despite the absence of any public health rationale. These restrictions led to deportations, denial of entry into countries, loss of employment, denial of asylum, and increased stigma and discrimination, disproportionately affecting people from African countries.[29] Colonial prejudices towards African countries remained unchanged even in 2021, with the richer, more dominant countries enforcing inter-country restrictions through carceral, punitive, and authoritarian measures. These persistent neo-colonialist and racial biases in their relationships with African countries stirred considerable outrage from African governments and the African people.

During the pandemic, this targeted isolation of certain countries—particularly LMIC and particular areas within countries—through travel or movement restrictions and closure of borders exacerbated the consequences of multiple crises. The travel restrictions severely affected the delivery of medical equipment, medicines, PPE, and vaccines that were vital for mitigating the fury of the pandemic.

These measures were enforced and justified as necessary to 'protect' others and secure countries from perceived (foreign) threats. However, they served to deepen pre-existing conflicts and economic inequities across and within countries, in violation of multilateral commitments and compliance with international agreements.[30]

1.5. Fallacy of the home as a 'safe' space

The flawed assumption of the home as a 'safe' space has been further exposed during the pandemic. The gender and intersectional inequities in the social and economic dynamics within homes determine the nature of living spaces, power inequities, the extent of invisible labour, and the distribution of resources. Evidence suggests that a significant number of people in both poor and rich countries live in cramped and precarious living spaces and

conditions, with insufficient access to water, sanitation, and other essential facilities that do not fulfil the ideal notion of 'home'.

The lockdown responses to the pandemic ignored the gendered impact within households. Countries failed to recognize and address these gendered realities and the risks to health and lives due to lockdowns and isolation. These caused a substantial rollback in previous efforts and outcomes for gender equality achieved over several years.

Evidence from past crises also suggests that confinement measures often lead to increased violence against women and young girls. For example, during the 2014-16 outbreak of Ebola in West Africa, women and girls experienced higher rates of sexual violence and abuse at home due to confinement.[31] Nevertheless, most governments side-lined longstanding demands, especially by diverse marginalized communities, for adequate infrastructure and quality of services, including shelter, helplines, health care, transport, support and referral networks, which are essential, especially in crisis situations. However, these were not considered essential and were therefore not available or accessible to those who needed them the most. The absence of these services is expected to have deep, long-term implications for their well-being.

Reports of intimate partner violence saw a sharp surge during the lockdown. According to a report by UN Women, in 2020, emergency calls for domestic violence cases in Argentina increased by 25 per cent.[32] Similarly, in the US, the NDVH reported an increase in calls for help via text or phone.[33] Other parts of the world observed similar trends, with more women seeking help against domestic violence during lockdowns: a 30 per cent rise in emergency calls in Cyprus, 40–50 per cent in Brazil, and 60 per cent in the EU.[34] An IRC survey in 15 countries found that 73 per cent of refugee and displaced women reported increased domestic violence, and 51 per cent reported increased sexual violence during the pandemic.[35] Philippines, Australia, India, and many countries in the MENA region also reported a rise in the online harassment of women and girls.[36]

Moreover, persons experiencing IPV also grappled with serious barriers to leaving violent, unsafe households and accessing alternative safe spaces or shelters. Those already in shelters, in other institutional care or in prisons, experienced fear and aggravated risks of infection.

The stringent lockdowns also deeply affected LGBTQI+ persons, women with disabilities, including those from underrepresented groups such as deaf women, deafblind women, women with intellectual and psychosocial disabilities,[37] and sex workers, with their pre-existing vulnerabilities worsening manifold. A rapid assessment conducted by HWDI with women with disabilities during the pandemic in Indonesia found that 80 per cent were facing abuse, with 40 per cent indicating this abuse was recurring daily. Most of the survivors did not report the crimes to the police or any other authorities.[38] For many women with disabilities, access to care and support for leaving violent situations diminished because of the lockdowns.

For LGBTQI+ persons, the inability to leave abusive, discriminatory living spaces aggravated isolation, caused mental distress, and inhibited access to peer support and care.

1.6 Digital inequity and isolation

Pandemic lockdowns and restrictions forged the digitalization of healthcare and the growth of internet-based platforms and apps. Technology contributed to navigating the pandemic restrictions through online schooling, work, shopping, entertainment, medical consultations, and pandemic-related information, including vaccination. However, technology-driven solutions rarely acknowledge the digital divide, especially in poorer countries. Where people from marginalized communities, particularly women, young people, and people with disabilities, do not have easy access to mobile phones, laptops or internet connectivity, neither do they have the wherewithal or language skills to manoeuvre complex web tools.

Indeed, digital technology magnified the effects of isolation for many given the growing emphasis on access and connectivity for economic survival or to social and support networks. Even though the use of technology (specifically the internet) has grown at an exponential pace, it is accessible to only around 63.1 per cent of the people globally.[39] According to a report on the gender digital divide, ‘men are 12 per cent more likely to be online than women’, and the gender parity score for Asian and African nations remains abysmal.[40]

Furthermore, the digital divide during the pandemic was exacerbated as many countries imposed internet lockdowns even during the peak of the pandemic. Evidence indicates that internet lockdowns for prolonged periods, particularly in conflict areas, affected

people's daily lives, their access to education, their health (including mental health), their livelihoods, and social interaction. Furthermore, in many countries including India, this information was not accessible to persons with disabilities. Government, media or medical experts did not provide information in forms and formats that were easy to access and read, such as sign language.[41] Many persons with disabilities do not have access to independent phones, digital devices, or internet connection.[42] Given that access to digital technology, infrastructure, and knowledge production is deeply gendered, ableist and inequitable, the consequences of physical and digital isolation need to be interrogated and nuanced.

The pandemic also saw a scramble for a whole host of digital health technologies that opened the doors to large-scale tracking, tracing, and surveillance measures that were widely used, ostensibly to keep people safe. The health emergency was utilized as a ground to test new platforms and applications, supposedly to facilitate response to the pandemic. Such experiments included using Bluetooth to detect the real-time location of persons affected by Covid-19, online registration for vaccination, and verification of vaccination status. In the absence of comprehensive data protection laws in several countries, the digitalization of health records and Covid-19 services raised serious concerns about privacy, data security of people seeking healthcare, as well as wide-ranging surveillance and data misuse.[43]

We call out large, privatized and profit-driven data systems for reinforcing inequities and minimizing the obligations of the state to provide and enable access to health facilities and medical infrastructure. This is especially urgent in these times when data surveillance, data privacy and data extraction are matters of profound concern because they allow government and non-government actors to exploit the crisis to further their own interests.

The intersectional feminist framework ...

... attempts to examine how systems of dominance—patriarchy, colonialism, and capitalism—reinforce each other to maintain power over the dispossessed and marginalized.

... questions and condemns the lockdowns, racialized measures of containment through forced isolation and the indiscriminate restrictions, imposed on people.

The intersectional feminist framework ...

… recognizes that isolation, restrictions on movement and freedoms are deeply embedded in power structures and arrangements at the global, national, and local levels.

… reiterates that any public health response, whether or not in a health emergency or pandemic context, must refrain from imposing these structures of power and from stigmatizing, discriminating, and alienating people, communities, and countries.

... acknowledges the exacerbated gender and other inequities due to the "public health" responses of lockdowns and isolation, causing those on the margins especially to bear the brunt.

… reiterates that any public health response must be inherently caring, inclusive, non-discriminatory, non-authoritarian, and democratic, with an emphasis on upholding and respecting dignity and human rights.

… underscores health justice, necessitating a decolonial response that interrogates patterns of power and advances equity and inclusion in decision-making and access to the determinants of health, including health care.

… calls for the strengthening of public health systems at all levels so that care, and not coercion, becomes the foundation of future pandemic responses or health imperatives.

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Response #2

Centring Care: Towards transformation and accountability

The absence of care emerged as a serious concern during the pandemic. The high death toll as a result of Covid-19 attests to the grievous neglect by uncaring states and the collapse of overburdened public health systems globally. These fatalities added to the already large number of preventable deaths in several countries.

We also witnessed aggravated inequities that determined who could access healthcare—hospital beds, oxygen, diagnostics, or medicines—and who could not. The increase in gender-based violence, structural marginalization of sexual and reproductive health and rights, and precarious environments within health systems for women and other frontline workers were starkly visible during this pandemic, which magnified the gendered fault lines in our societies and systems. The disproportionate focus on Covid-19 care while relegating all other health needs to the margins has been debilitating. The huge dependence on private healthcare, the reduction in health and other social sector budgets as well as human resources, and the exorbitant OOPE have led to a public health catastrophe in several countries, including India.

2.1 No death is just a statistic

The WHO's preliminary estimates suggest that the total number of global deaths due to Covid-19 in 2020 was at least three million, which is 1.2 million more than the officially reported numbers.[1] Many reports suggested an undercounting of deaths, of which many were not officially registered as Covid-19 deaths. There were also attempts to downplay these numbers.[2] Many died either due to a lack of treatment or because the public health care system, without adequate facilities, was stretched beyond its capacity during the surge in cases. All of the deaths can be attributed in some way to the pandemic, and many of those who lost their lives could have been saved. Many deaths in LMICs were also a consequence of inadequate oxygen supply, ventilators, ICUs, lifesaving medicines, and hospital beds. Unfortunately, discussions on non-functioning public health systems in countries only surface when they are faced with a challenge.

The pandemic has revealed the vast disparity in access to health facilities both between and within countries. When faced with massive demand, health systems in several countries

collapsed on all counts—prevention, diagnostics, treatment, and intensive care. Many private and corporate facilities were charging enormous amounts for testing and prescribing expensive medicines, which posed barriers to health care access for some of the most vulnerable, resulting in serious health consequences and even death. Within countries, there was a lack of regulation on how much private health facilities could charge for testing, medicines, hospital beds, PPE, or treatments.

In Nepal, for example, a PCR test cost USD 16.87 in private labs and USD 8.43 in government facilities, which were later reduced to USD 12.65 and USD 6.75, respectively.[3] However, most private and public hospitals in the country did not comply with this price ceiling. In India, the cost of an RT-PCR was USD 60.38 in 2020.[4] Following advocacy by civil society organizations and on the recommendations of the ICMR, the price was reduced to USD 21.47 in August 2020, and then to USD 12.23 by October 2020.[5] South African civil society demanded that its private-sector diagnostic facilities and laboratories be nationalized so that they would adhere to a single testing protocol, provide free access to tests in order to address the backlog of tests in the public sector, and give equitable access to diagnostics.[6]

Further, irrational drug prescriptions took a heavy toll on Covid-19 patients. When many health professionals in India were prescribing steroids, the Union Health Ministry intervened and cautioned against their use in Covid-19 treatment, citing an increase in cases of Mucormycosis, or black fungus.[7]

Several drugs that were already on the market were repurposed for the treatment of Covid-19. Remdesivir and Tocilizumab were such drugs. Remdesivir was developed in 2009 to treat Hepatitis C. It was later repurposed to treat Ebola. The drug was already on the Indian market with prices ranging from USD 12 to 47.[8] When it was recommended in India for the treatment of Covid-19 in 2021, its price skyrocketed due to the overwhelming demand and scarcity of supply. It was even sold on the black market for USD 406 per vial.[9] Tocilizumab, the other drug recommended for Covid-19 treatment in India is a known immunosuppressant used to treat rheumatoid arthritis. The licensee for Tocilizumab in India was importing the drug. Pegged as a 'rich person's drug' because of its market price of USD 541-USD 676, the medicine could only be sold by the patent holder or its licensee—a situation that did not alter despite its critical need during the Covid-19 period.[10]

The absence of a steady supply of oxygen for critical care also emerged as a potential barrier to care in many countries. The experience of acute shortages in oxygen supply in Delhi, the comparatively well-resourced capital city of India, highlighted the need not only for improved manufacturing and logistics but also for expanded in-hospital oxygen plants and the widespread introduction of oxygen concentrators. Similarly, Indonesia faced an acute shortage of oxygen across the country in 2021 when it was hit by a massive surge in Covid-19 cases. When the hospitals ran out of oxygen, patients were denied admission. In Jakarta, the number of funerals conducted according to Covid-19 protocols every day jumped tenfold from early May 2021.[11] In Thailand, the severe shortage of beds for Covid-19 patients at major hospitals in Bangkok necessitated the rapid building of makeshift hospitals.[12]

The pandemic also visibilized the neglect of the prison system and posed specific challenges to women, children, and trans* persons in prisons. Lack of access to health services, including the availability of regular testing for Covid-19, masks, and later vaccination—apart from the lack of sanitary products, proper nutrition, etc.—was apparent in many countries. Shortages and poor-quality PPE negatively impacted the delivery of health services and placed the lives of health care workers at risk.

2.2 Deprioritized non-Covid care: irrational and unethical

In many countries, particularly in LMICs, the public health infrastructure struggled to meet healthcare requirements, seriously impacting access to care for patients with other severe ailments. One in five surveyed countries (20 per cent) reported disruptions or suspension of their healthcare services due to shortage of medicines, diagnostics, and other technologies.[13] For example, during the initial lockdown in 2020, many government hospitals in Delhi closed their OPDs to non-Covid patients.

Covid-19 side-lined the treatment of all other ailments or surgical interventions. Access to treatments for tuberculosis, cardiac conditions, cancer, and renal disorders were substantially reduced. As per a WHO survey in 2020, around 53 per cent of the countries had partially or completely disrupted services for hypertension treatment; 49 per cent for treatment for diabetes and diabetes-related complications; 42 per cent for cancer treatment; and 31 per cent for cardiovascular emergencies.[14] According to this survey, people living with NCDs are at higher risk of severe Covid-19-related illness and death. For almost 60 per cent of

Indian patients with kidney or renal disorders, the nearest dialysis centres were at least 50 kilometres away. Since most Indian patients depend on haemodialyses, which require frequent sessions, their plight and physical discomfort during the lockdown were extreme.[15]

Other effects included disruptions to screening, radiotherapy, testing and treatment for uterine and breast cancer. Cancer treatments were temporarily discontinued during the lockdown period in many countries, including India. Similarly, in many countries, people living with HIV who were on ART drugs did not receive their dosage of medicines due to lockdowns. Hormone therapy for many trans* people and gender reassignment surgeries came to a standstill. The uncertainty of access to therapy further exacerbated their distress as a result of the hormonal imbalance they were experiencing.[16]

Further, the pre-existing biases in the health system in responding to LGBTQI+ persons, persons with disabilities, and sex workers were aggravated during the pandemic. This posed further barriers to seeking timely healthcare. According to a study conducted by the IIPH in Hyderabad with a sample of 403 respondents from 14 states, people with disabilities were adversely affected during the pandemic; 42.5 per cent of them reported that the lockdown made routine medical care difficult to access.[17]

2.3. Echoes of neglect: SRH care during the pandemic

Sexual and Reproductive Health (SRH) care has always been consigned to the peripheries of public health systems. During the pandemic, when the entire focus of care was given to Covid-19 needs, access to SRH care was further compromised. Pandemic lockdowns and restrictions exacerbated shortfalls within SRH care as several public and private hospitals diverted resources to Covid-only care and limited emergency medical care. The non-recognition of SRH care as an essential and crucial component of emergency health response had grave implications. Poor access to abortion services, menstrual hygiene products, contraceptives, antenatal and post-natal care, or other pregnancy and childbirth-related care had devastating consequences for the health and lives of some of the most vulnerable people and communities.

In many countries, the lockdown period in 2020 led to major gaps in the continuum of care and in the mitigation of risks associated with pregnancy. In addition to decreased prenatal

care visits and severe strain on the healthcare infrastructure, there were many instances of pregnant women being denied institutional delivery. Moreover, barriers to maternal health care access in the private sector due to a lack of regulation and high costs of care were reported. The devastating condition of maternal and perinatal health, as well as mental health issues, such as anxiety and depression, were also reported.[18]

For almost four million women in India, whatever insufficient maternal health services reached them, were cut off due to the March 2020 lockdown. Prior struggles of women and pregnant persons—particularly from vulnerable socio-economic backgrounds—were further exacerbated during the lockdown as they faced repeated denials and inordinate delays in accessing overall care for their reproductive and maternal health. Even women with high-risk pregnancies were severely impacted by such an indiscriminate approach that threatened their lives. A petition filed in the Delhi High Court by an NGO, Sama, reiterated the demands for the protection of pregnant women's right to life and health, who were being denied safe and dignified childbirth as well as other maternal health services.[19]

The absence of access to safe abortion care during the pandemic resulted in unwanted pregnancies and deleterious effects on women's physical health and mental well-being. A study estimated that the lockdown would have led to over 800,000 unsafe abortions along with 1,750 maternal deaths among 2.3 million unintended pregnancies.[20] Another estimated that 1.85 million women's access to safe abortion services was curtailed during the Covid-19 lockdown in India.[21] As per a study in Nepal, the number of women accessing safe abortion services at a tertiary health care centre dropped by 25 per cent during the first three months of the lockdown because of mobility issues and financial constraints.[22] Later, in September 2020, the Nepalese government approved home-based medical abortion through an outreach model as well as telemedicine, which was a critical step in addressing some of the barriers to safe abortion access.

According to a review study that included 29 countries, their singular focus on pandemic medical care and response created a significant gap in contraceptive access and sexual and reproductive health care facilities.[23] Similarly, a survey of 30 countries revealed that restricted access to menstrual products due to shortages or disrupted supply chains was a major issue during the lockdown.[24] The lack of preparedness of health systems for

maternal health and other SRH care can only be addressed through a systemized approach that includes a spectrum of actions to enable the continuum of care and services.

2.4 Gender Based Violence: Not under lockdown

Rapid assessments conducted by women's organizations and other international organizations confirmed the severity of gender based violence during the pandemic.

The evidence pointed to an aggravation of violence within homes as well as in public spaces, and the serious consequences for the health and lives of survivors, particularly those from the most marginalized communities. In India, a significant number of adolescent girls had to drop out of school and were forcibly married off. The perception of families of girls as burdens and the perceived need to control their decisions and lives were exacerbated during the pandemic and lockdown. The closure of schools also led to the trafficking of girls in many states, especially for sexual and domestic labor, which emerged as a concern. These consequences continue to persist because of the economic and social devastation caused by the lockdown and the loss of livelihoods.

Despite this stark evidence, in most countries, services for those experiencing gender based violence were largely unavailable, especially during lockdowns. They were not deemed essential, and despite its severe physical and mental health consequences, GBV was not adequately recognized as a serious public health issue.

Pandemic lockdowns and restrictions have aggravated the risks of GBV. Lockdowns forced even the minimal support and care that was otherwise available to those experiencing violence to remain out of reach. Moreover, data on GBV remained a critical gap given the persistent stigma, normalization of GBV and the silence surrounding it; evidence on care and support for GBV survivors was even more scarce. A few assessments and documented experiences of non-profit organizations asserted the absence of care and support due to their inability to access transport, the closure of essential services, a focus only on Covid-19 diagnosis and treatment, and delays or denials of health care by health facilities.

Since the onset of the Covid-19 pandemic, there has been a global rise in the online and ICT-facilitated harassment of women and girls. As it became necessary to work, study,

transact, and communicate online, women and girls were subject to online violence in the form of physical threats, sexual harassment, stalking, zoombombing,[25] or sex trolling while participating in online social events. Many women's rights organizations have been demanding online safety for women and girls and have called for an end to online and ICT-facilitated violence. [26]

2.5 Disrupted mental health and care; 'privatized' grief

The pandemic has caused a wave of losses: economic, social, physical, and emotional. Moreover, lockdowns, restrictions, and 'social distancing' have posed significant risks to physical and mental health, compelling people to 'privatize' grief and care. The grief and bereavement of families were prolonged by lockdown measures, social distancing norms, and the need to dispose bodies of the deceased quickly. People were deeply affected as they were not allowed to visit their near and dear ones, be with them in their last moments, or had to grieve alone on their passing. Many had to physically isolate infected family members at home and provide care, knowing that they were also at risk of contracting the infection.[27]

Following the surges in infection, large numbers of people were isolated without any institutional or community-based support system to deal with the immediate losses, sufferings, and emotional distress that they continued to experience. India witnessed a 35 per cent increase in mental health problems. In 2020, nearly 400 lives were lost to suicide each day, marking a 10 per cent increase in deaths by suicide.[28] Another multi-state study amongst European nations highlighted that 28.1 per cent reported deteriorating mental health since the beginning of the pandemic, ranging from 16.1 per cent in Slovakia to 54.8 per cent in Portugal.[29] This was linked to multiple factors, including increased risk of deterioration, social isolation and lack of physical contact, experiencing unmet health care needs, loss of livelihoods and financial hardship. There was a severe disruption of services related to mental, neurological, and substance use conditions, including services for suicide prevention that affected both pre-existing patients as well as those who were grappling with newly developed mental health issues. During lockdowns, trans* people in many countries experienced stress and severe depression. They experienced high rates of mental distress, which was exacerbated by family rejection, discrimination, lack of access to healthcare, disruptions in gender reassignment surgery, as well as loss of livelihoods.[30]

The pandemic also exacerbated mental distress among the frontline health workers due to their heavy workloads, lack of social support, social security, and the violence they experienced. For instance, in New South Wales, Australia, 40 per cent of frontline health workers reported increased requests for help in dealing with violence that escalated in intensity and complexity within the premises of medical facilities and workspaces.[31] This led to burnout, increased stress, depression, trauma, insomnia, or disturbed sleep. A multi-country cross-sectional study conducted in the EMR noted that 57.5 per cent of all health care workers had depression, 42 per cent had stress, and 59.1 per cent had anxiety.[32]

Mental health issues amongst children too were witnessed during the pandemic. These emerged from the impact of being restricted within their homes, experiencing the stress of their families, and the implications of physical distancing in an age group that thrives and learns through interaction with peers.

2.6 Increasing gendered precarity of care work

The increase in care work and domestic work during the pandemic imposed a hefty burden, particularly on women and young girls, adversely affecting their physical and mental health. Women's care work, domestic and reproductive labour remain invisible, unpaid, and undervalued. That the drudgery of women's labour and the absence of its recognition provide huge benefits to a patriarchal system was reinforced during the pandemic.

In March 2020, more than 15,000 women and their families from Maharashtra, a state in western India, experienced abject poverty and indebtedness following the loss of their male partners—the sole or primary earners—to Covid-19.[33] The regressive term 'Covid widows' was popularised in India to refer to them. This gave rise to a vicious cycle of financial and other crises. Their children struggled to access education due to the monetary crisis at home. The local authorities collected information from 800 women to assess the impact of the loss of their spouses on their lives, their expenditure on health care, etc. While such a process may have been required, it is necessary to interrogate the rationale for it being restricted to households whose male members died, while similar losses in women's lives were ignored.

This undoubtedly reflects how the patriarchal state systematically undermines women's labour in both the private and public spheres. Women lost their autonomy and economic

independence and were being pushed to the frontlines, unprotected, to be sacrificed. The gendered nature of care work was evident from the fact that 70 per cent of health workers and first responders worldwide were women, yet they were not treated equally with their male counterparts.[34] In many countries, the work of frontline health workers is informal and precarious. During the pandemic, they were pushed into perilous situations with the denial of timely access to wages, safety equipment, social security provisions, maternity entitlements, health care services, and additional compensation.

In India, Bangladesh, and Nepal, frontline health workers faced enormous risks due to an acute shortage of supplies in the early days of the pandemic. In an international cross-sectional study, the majority of the respondents from countries in Africa (79.2 per cent), Asia (54.0 per cent), Europe (54.0 per cent), and South America (66.7 per cent) stated that the PPE supplied by hospitals to frontline healthcare workers was inadequate.[35] Many frontline health workers across the world encountered discrimination, violence, and public anger in the wake of the sudden collapse of the health system.

In India, CHWs (referred to as ASHA)[36] assisted various state governments in contact tracing, spreading awareness about precautionary measures against Covid-19 and conducting regular follow up visits during the pandemic and lockdowns. Despite this, the state has failed to acknowledge their contribution in the face of such an unprecedented crisis. ASHAs in many states were neither paid their dues on time nor received the promised incentive for their Covid-19-related work. Moreover, the state significantly downplayed the risks associated with their work. Even though there were multiple reports of PPE not being available to them, their situation was not considered to be as risky as that of those working in hospitals.[37] ASHAs have been consistently demanding fair remuneration, safe and enabling working conditions, as well as social security protections. Unfortunately, state apathy continues to ignore their rightful claims while forcing them to work in conditions that put them at great risk.

2.7 Against all odds: civil society solidarity and resistance

What is inspiring, though, are several feminist progressive practices that offer valuable lessons for achieving or undertaking transformative policy, advocacy, and action. The pandemic motivated many women's groups, health networks, human and civil rights

groups, trade unions, NGOs, donor organizations, young volunteers, and other concerned individuals to unite in order to provide support. With the breakdown of the state support system and the adoption of aggressive and intrusive state policies during the pandemic, civil society and grassroots organizations offered a lifeline to the most vulnerable and poorest sections by delivering essentials such as food and medicines as well as offering monetary relief. Although these efforts cannot bridge the vast gap left by an uncaring and apathetic state, they have nevertheless led to greater awareness of democratic, constitutional, and human rights, and paved the way to new forms of solidarity, association, and organization, cutting across the divides of race, class, caste, community, and politics.

The intersectional feminist framework ...

… demands that in any health emergency, epidemic or pandemic, other healthcare and services must not be compromised due to the focus on that particular health crisis. Governments must provide sustained care for all people suffering from tuberculosis, HIV/AIDS, dengue, malaria, and other communicable diseases; mental health disorders and other NCDs; and sexual, reproductive, maternal and child health, hormonal treatment, and other gender affirming therapies.

… reiterates that the health and well-being of the people be determined by a caring state; care that is not privatized, nor left to the family or the community, but is instead a public health imperative and the responsibility of the state.

… reiterates as we take cognizance of preventable deaths and disastrous health outcomes, that no death can be accounted for as mere statistics, and demand that the state acknowledges our losses and shows that it truly cares.

… believes that the underpinnings of health inequity reinforced and exposed by Covid-19 must be addressed, not merely to enhance preparedness for future pandemics but to transform access to health and health care for all people at all times.

… urges states to ensure that all workers have access to protective measures and equipment without discrimination in order to guarantee occupational health and safety and adopt flexible work arrangements.

The intersectional feminist framework ...

… demands equity in access to quality health care for persons from vulnerable communities—including girls and women, trans*persons, women with disabilities, sex workers, whether or not related to Covid-19—without discrimination or stigma.

… demands structural shifts that uphold women's rights, including the right to fairly remunerated work and the right to economic justice.

… supports substantive changes in policy, law, and the economy towards recognizing domestic and care work, including healthcare work by frontline workers, who are mostly women.

… demands the accountability of the health system to address GBV as a public health issue and support survivors during a pandemic and beyond.

… underscores that any policy or other intervention for mental health must recognize and address the deep inter-relationship between gender intersectionality, pre-existing inequities, stigma and discrimination, and the social determinants of mental health.

… promotes future preparedness, current recovery, and the design and delivery of gender equitable public entitlements and essential service systems.

… recognizes health justice, necessitating a decolonial response that interrogates patterns of power, advances equity and inclusion in decision making and access to the determinants of health, including healthcare for all, at all times.

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Response #3

People over Profits: Overcoming systemic inequalities

Recent decades have witnessed a significant shift in the global governance of health, which is currently characterized and shaped by multiple international agencies and private interest groups. The controlling interests of corporate capitalism are "systematically eroding the sovereignty of countries, thereby conceding people's rights and privileges to the interests of profit."[1] This, aided by unjust global and national economic and trade policies, is promoting an unsustainable and inequitable development paradigm, creating a complex canvas of social and commercial determinants that are serious impediments to the realization of health for all. Furthermore, the growing influence of philanthropic foundations over global health policies without any accountability to local contexts and needs is exacerbating systemic inequalities.

3.1 Incentivizing innovation or monopolizing health?

The international regime on IP is governed by the Agreement on TRIPS. It requires all member states of the WTO to adopt and provide a minimum standard of IP protection for a time period as prescribed in the Agreement. This means an IP holder enjoys a market monopoly for this prescribed period, during which third parties are not permitted to manufacture, import, or sell the said products. This skews the market by granting a single player the authority to unilaterally decide its pricing without regard for the impact of such prices on life-saving diagnostics, vaccines, or therapeutics.

Such private rights exacerbate the vulnerabilities of women, children and other marginalized groups who are already facing the brunt of skewed access to affordable health services. This has been far too evident in cases where patent barriers and their unregulated prices have restricted people's access to drugs, including those for breast cancer such as Trastuzumab, HIV drugs like Valganciclovir, or orphan drugs such as Zolgensma for spinal muscular atrophy.[2]

Further, IP is not only about medicine but also extends to other essential medical equipment like masks, ventilators, and diagnostics; and the IP regime has created a situation in which access to these essential and life-saving items is dreadfully inequitable. The onset of

Covid-19 in 2020 demonstrated that addressing the issue of patents on medicines alone was not enough; it also needed to extend to vaccines, diagnostics, masks, and ventilators so that trade knowledge was not monopolized.

Response to Covid-19 required maximum utilization of existing resources. It included the repurposing of existing therapeutics and making the best use of the available diagnostic tools. Sadly, even during this period of utter desperation and chaos, profit motives took priority over people's lives. In Italy, hospitals urgently needed special valves for their respirators to provide oxygen to Covid-19 patients in intensive care. Some engineers had devised an immediate solution by which the valves could be easily reproduced using 3D printing technology. However, when volunteers approached the original manufacturer for the details necessary for 3D printing, they were denied the information. Instead, they were informed about a potential patent infringement action against them.[3] The valves had to be replaced for each patient. At approximately USD 2–3 per valve, 3D printing could have been a fast and affordable method to respond to the need.[4]

Similarly, some companies hoarded patents on diagnostics. When the pandemic demanded that these diagnostics be rolled out on a larger scale, the patent holder did not produce them. When third parties started making these diagnostics, they were sued for patent infringement.[5]

Various therapeutics already used to treat other diseases were being tested for their efficacy against Covid-19. The WHO initially recommended drugs such as Casirivimab and Imdevimab for Covid-19 treatment. Despite being in the market for other treatments, the prices of these drugs in 2021 were pegged at a whopping USD 820 in India, USD 2,000 in Germany, and USD 2,100 in the US.[6] Pharma conglomerates also started seeking IP rights over the other drugs being tested and used for Covid-19 treatment.

To mitigate the imminent health emergency brought about by Covid-19, India and South Africa, along with several other countries, submitted a proposal to the TRIPS Council at the WTO in October 2020. This was to temporarily suspend provisions of the TRIPS Agreement relating to the enforcement of IP over Covid-19 vaccines, diagnostics, and therapeutics for at least three years. The proposal, if agreed to in its original form, would have been able to suspend IP related to Covid-19 technologies and tools, enabling manufacturers across the

world to produce the urgently needed vaccines, diagnostics and therapeutics, without fear of sanctions for infringing IP rights.

Instead of prompt action on the TRIPS waiver proposal, we saw a delayed response from the rich countries. In addition, the big pharma conglomerates holding the IP over several Covid-19 health tools opposed the proposal.[7] For the past two and a half years, over 100 countries that support this proposal have been in constant debate with the powerful countries that oppose it. Early negotiations on the proposal saw resistance from the US, the EU, Britain, Norway, Switzerland, Japan, and Canada. Eventually, the US indicated support for a restricted version of the proposal, agreeing to a waiver on patents for Covid-19 vaccines.

However, vaccines alone are not the solution to curb the pandemic. In addition to vaccines, we need access to quality and affordable diagnostics and therapeutics. Pre-existing patents and data protection for coronavirus-related technologies prevent companies other than the patent holders from manufacturing newer health tools. This system allows innovators to avoid sharing knowledge, thereby limiting access to vaccines, essential therapeutics and diagnostic products for those who need them the most. Even if third parties are capable of manufacturing such products, they are at the mercy of the patent holders for manufacturing licenses. Such licenses may not necessarily result in cheaper health technologies since the patent holders are most likely to impose hefty royalties on these.

3.3 Illusory multilateralism: Implications for health

In May 2022, apparently after ‘informal’ discussions among some of the member states of the WTO, a draft text of a watered-down version of the TRIPS waiver proposal was leaked. This leaked text—wrongly called “compromised text”—raised several concerns among civil society and LMICs. During its negotiation, many of the LMICs were excluded altogether from the discussions.[8] It was to be seen whether the WTO MC would agree to such a proposal. Finally, during the WTO MC in June 2022, a limited version of India and South Africa’s waiver proposal was agreed upon.[9] Interestingly, this agreed text did not waive IP rights over Covid-19 vaccines, treatments and diagnostics, nor did it appreciate the non-patent barriers such as trade secrets, design rights, and copyright on Covid-19 health tools.

It was a mere clarification of the existing public health flexibilities available under the TRIPS Agreement, with some clarifications on the procedure for issuing compulsory licenses to allow the export of Covid-19 vaccines for a limited period of five years. This five-year period should be questioned as to whether it is sufficient for scaling up vaccine production and the supply chain in LMICs.

The text also delayed the decision on the waiver of IP on diagnostics and therapeutics by another six months. It further limited the sharing of vaccines by redistribution, thereby impacting solidarities among states that might need the vaccines in times of heightened crises.[10] Though multilateral spaces have been framed within and against the geopolitical landscape, the spirit in which they function remains unipolar and hegemonic, because the decision-making power remains in the hands of the rich countries. This was clearly witnessed during the more recent post-MC12 negotiations.

By refusing timely support to the proposal on TRIPS waiver, the objecting countries not only furthered private IP rights but also failed in their duties as states to protect the rights of women, children, persons living with disabilities, indigenous people, the LGBTQI+ persons, and other marginalized groups, as mandated under various international treaties. The concentration of IP holders and manufacturing capacities in a handful of countries has severely restricted the supply of essential health tools.

Without acknowledging the efforts and contributions from the Global South, owning IP has become a race to own the knowledge and exercise privilege and financial power through it. To top it all, several patents are not even being used industrially, yet they hinder the dissemination of new tools that come under the purview of such patents.

The control of power and refusal to share technologies continue in our struggle against the pandemic. Early calls for the sharing of vaccine-related technology to improve access in the Global South were received with cynicism. For instance, the efforts undertaken by several African countries to produce the mRNA vaccine locally could have taken off much earlier with timely international support and solidarities.

Civil society has been playing a critical role in highlighting the incoherence between statements of several countries regarding IP—both at the international level and in domestic

laws and policies—as well as in challenging legal barriers to health technology access. Many CSOs urged all negotiating governments to not accept a text that prioritises corporate and political interests over saving lives. During the recent MC 12 negotiations as well, CSOs called on “all trade ministers to negotiate an effective and meaningful TRIPS waiver that covers all major IPR on all Covid-19 medical products for all people.”[11]

3.3 No charity: Reassertion of the role of the welfare state

One of the necessary responses to the pandemic is equitable access to vaccines for all countries. To this end, the C-TAP was set up in 2020 as a platform to facilitate the distribution of diagnostics, therapeutics, and vaccines to countries that needed them the most. However, instead of removing barriers to access, C-TAP has continued to support IP control of the market, thus serving the interests of big pharma.

Another initiative instituted in 2020 was COVAX, a multi-stakeholder partnership that included UN bodies, private philanthropies, and public-private partnerships.[12] It was created to accelerate development and manufacturing as well as ensure equitable and fair access to Covid-19 vaccines in participating countries.[13] COVAX relies heavily on vaccine donations from pharma companies and countries that are willing to contribute to the mechanism.[14] However, COVAX has revealed significant weaknesses and drawbacks in fulfilling its mandate of supplying vaccines to LMICs.

COVAX, as a multistakeholder body, was designed to work as a ‘market solution’ rather than a global solidarity- and human rights-based solution. It did not work towards overcoming patent monopolies and was put up as a counter to the WHO’s proposal of C-TAP, which would have challenged IP on Covid-19 technologies. Also, COVAX is not a multilateral platform but a public-private partnership with little accountability and considerable conflicts of interest with pharmaceutical companies. It does not deliver ‘value for money’ as it pays the pharmaceutical companies monopoly prices despite the latter receiving record sums of public taxpayer money for vaccine development.[15] According to a report, ‘COVAX, and other multistakeholder distributors of Covid-related products have a fundamental operating assumption that even in a pandemic, medical care must be purchased by those in need’.[16] Since the rise of multistakeholderism, decision-making has turned more and more away from democratic processes that would put people’s needs at the centre.

Donations, charity, and philanthropic initiatives are encouraged so as to secure and legitimize the persistence of profit-making and to stave off any real or perceived threat to it. Promoters of such a stance encourage the profiteering of private vaccine producers and their collaborating institutions and corporates, while simultaneously maintaining a façade of engaging in charity and philanthropy. Such ideals of charity would be unquestioning of the abdication of responsibility by governments while exulting over acts of voluntarism and aid. The act of 'donating' vaccines to LMICs or the socio-economically marginalized communities in LMICs is one example of this double standard. Such acts of donation also redirect conversations from the need to bolster local production and sharing of know-how.

Feminist investigation of charity questions the unjust dependency of the recipient on philanthropist agendas and the allocation of resources. The exploitative power dynamics of philanthropy involve the hierarchical ordering of society, with the power-holders dominating by means of control of resources.

3.4 Pandemic profiteering or a public health goal?

The rise of 'pandemic billionaires' and the ever-widening income disparity attest to how pandemic management is shaped to advance the agenda of profits over people. A report by Oxfam found that 17 of the top 25 most profitable US corporations made extraordinary profits during the pandemic. While these profits could have been invested in protecting workers and generating innovations, the report found that in 2020, these corporations were set to distribute 99 per cent of their net profits to shareholders who are overwhelmingly privileged. However, the impact of Covid-19 was used to justify wage cuts, shifting from full-time to contract employment, and massive layoffs, despite the fact that the profits of large companies and multinational corporations recovered much faster than the wage losses during the pandemic.[17]

As per reports from May 2022, the pharma companies behind two of the Covid-19 vaccines —Pfizer-BioNTech and Moderna—were making 'combined profits of USD 65,000 every minute'.[18] Pfizer made nearly USD 37 billion in sales from its Covid-19 vaccine in 2020—making it one of the most lucrative products in history—and has a forecast of a big boost coming from its Covid-19 pill Paxlovid in 2022. In association with the German company

BioNTech, Pfizer developed the Covid-19 vaccine, Comirnaty, which brought in total revenue of USD 36.8 billion in 2021.[19] The US drugmaker's overall revenues in 2021 doubled to USD 81.3 billion, and it expects to make record revenues of USD 98 billion to USD 102 billion in 2022.[20] With its annual revenue of USD 81 billion, which is more than the GDP of most countries, Pfizer is being said to be 'ripping off public health systems'.[21]

These companies have sold the majority of doses to rich countries, leaving low-income countries out in the cold. By November 2021, Pfizer and BioNTech had delivered less than one per cent of their total vaccine supplies to low-income countries, while Moderna had delivered just 0.2 per cent. Meanwhile, 98 per cent of people in low-income countries have not been fully vaccinated.[22]

The intent of profiteering was also exploited in the negotiations of the private pharma companies with states. The bilateral agreements between the countries and the pharma corporations on healthcare technology not only lacked transparency but were also aimed solely at profit maximization. It is ironic that the LMICs are paying much more than the rich countries for Covid-19 vaccines. For instance, in February 2021, Uganda paid USD eight per dose of the Covid-19 vaccine, compared to USD three to four paid by the USA and UK.[23]

Furthermore, many pharma companies received 100 per cent support from governments for developing vaccines. For example, Moderna and Janssen received over USD 900 million, while Pfizer-BioNTech received 800 million US dollars in public funding.[24] In India, Covaxin, an indigenous vaccine by Bharat Biotech, was developed in collaboration with the ICMR, a public research institute. To increase the production capacity for this vaccine, the government of India provided a grant of approximately USD 87,92,100 to Bharat Biotech in 2021.[25] Despite such public investments and subsidies, the companies continued to control the IP rights over the final tools and technologies. Even though these pharma companies make billions in profits, they often refuse to take responsibility for adverse events and other serious issues emerging from the use of vaccines or therapeutics by demanding indemnity. Such demands were withdrawn following severe criticism from stakeholders and civil society. Further, vaccines, diagnostics, and therapeutics are not perceived as global public good that should be available to all free of charge.

3.5 Inequitable access to Covid-19 vaccines in an unequal world

There also remains an egregious imbalance in vaccine distribution since the rich nations secured the rights to large volumes of vaccines even before they were manufactured or given regulatory approval. Several wealthier countries have entered into pre-purchase agreements with Covid-19 vaccine manufacturers. Because of this imbalance, poorer countries have remained deprived of the vaccine, leading to further inequalities within and among countries. A report has indicated that by the end of the first quarter of 2022, the EU and G7 countries combined would have 1.39 billion surplus vaccines, even in a scenario where 80 per cent of adults have already been administered all vaccines and boosters.[26] If the pace of donations of vaccine doses by these countries were the same as in early 2021, even if these countries donated 500 million doses, there would still be 890 million doses to spare.[27]

The share of people vaccinated against Covid-19 also shows glaring disparities where people in rich countries have already been vaccinated while millions in poorer countries are still waiting, leading to vaccine apartheid. While many rich nations were preparing for when and how a third booster vaccine could be rolled out to their populations, barely 1.3 per cent of people in low-income countries had received their first dose.[28] Reportedly, as of April 2021, the vaccination rate in rich countries was ten times faster than that in lowest income countries. On the other hand, 52 of the least wealthy places, comprising 20.5 per cent of the world's population, received 5.8 per cent of the total vaccinations across the globe.[29]

During the 2009 influenza epidemic too, we witnessed the unsavoury spectacle of almost the entire stock of vaccines against the H1N1 virus being bought up in advance by a few rich countries. In 2015, when all countries were at risk of the Zika virus spreading, global power relations at that time ensured that remedies were available first to the rich and powerful. Precisely the same happened during Covid-19 as well.[30]

The pandemic pushed us to reassess the neoliberal approach to profit generation at the expense of social justice and collective well-being. This is a clear illustration of 'disaster capitalism'[31] where private interests descend on marginalized and vulnerable communities in the wake of major destabilising events, and single-mindedly exploit the situation to reap

profits. Like in the global arena, within national boundaries, too, corporates and powers that have little to do with equity and cooperation are increasingly taking control over knowledge, resources, and decision-making. The pre-pandemic patterns, where specific populations bore all the risks while those with greater access to and control over global resources made all the decisions, continued unabated through this pandemic as well.

The intersectional feminist framework …

… prioritizes a transformational dialogue on urgent social, economic, and political issues, the fulfilment of which is the duty of all states, transnational corporations, and other global institutions.

… condemns the inequitable global economic and trade systems that have a serious impact on access to knowledge, food, medicines, and vaccines, which is mirrored in the current pandemic response that continues to put profits before people and health, the privileged before the vulnerable.

… emphasises the urgency of putting people over profits. We believe that the human rights to life and health for the vast majority of people will be fulfilled only when the concentration of power and wealth is permanently dismantled to reimagine a new global political and economic architecture.

… demands that access to vaccines around the world, particularly for the poor and marginalized, should be equal and equitable, ensuring not only their right to health but all other human rights.

… not only denounces the monopoly over the production and trade architectures of vaccines, diagnostics, and therapeutics but also demands transparency in data collection and analysis, the study of biological materials, and the sharing of know-how and technology.

… strongly believes that states have an obligation to regulate and monitor the conduct of multinational companies. It is the duty of governments to prevent the costs of essential medicines and services from escalating to unreasonable limits and undermining the rights of large segments of the population to health.

The intersectional feminist framework ...

… prioritises human rights and transformational social justice as a duty of the state and global community rather than fragmented support being offered as ‘kind’ acts of paternal protectionism. We decry the privileging of the ‘virtue of charity’ and call for the reconceptualization of aid, charity, and philanthropy.

… demands that governments make every effort, both in national regulations and international agreements on IP, to guarantee the social dimensions of IP in accordance with international human rights obligations.

… demands for access to knowledge, not just clarification of existing flexibilities in the TRIPS Agreement. To respond adequately to the current pandemic and future health crises, an unconditional waiver of the TRIPS obligations on vaccines, diagnostics, and therapeutics is indispensable towards operationalizing and scaling up production by countries.

… seeks support for countries to be able to exercise flexibilities under the TRIPS Agreement without any fear of trade sanctions. Further mechanisms for technology sharing must be developed.

… demands that all future processes of international negotiations are transparent and inclusive, and address the interests of all member states.

… recognizes that the absence of adequate spaces and equitable representation of diverse voices at decision-making tables has resulted in a hegemonic response to the pandemic and reiterates the longstanding demand for the inclusion of voices from the margins in public decision-making and policy conceptions.

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Response #4

Knowledge Gaps in Vaccine Research and Access

During the pandemic, when science, medicine, and public health, all came together, our understanding of science went through a shift. On the one hand, there was research to examine how the virus sustains itself and spreads; on the other hand, there was the 'race' to develop vaccines and therapeutics, design and conduct clinical trials, and market and/or procure them. We witnessed the tenacity of the scientists and practitioners, their exchanges, and their working across geographies, national boundaries and restraints. At the same time, we saw the control of money, national borders, and a reduction in expenditure on scientific R&D by countries across the globe. We need to understand this in the light of our feminist critiques of science and scientific research—its development and its practice.

The pandemic revealed a lack of transparency and accountability on the part of leading actors and multi-stakeholders—from governments, international agencies, and global institutions to large pharmaceutical companies. The control of pharmaceutical companies over medical research and their influence on governments over policy matters have led to widespread scepticism about knowledge production and dissemination. This became particularly evident during the pandemic. While ignoring valid concerns about vaccines and other treatments and pushing mutually beneficial solutions, the least attention has been paid to the accessibility, affordability, and availability of these vaccines for people in general, but more significantly for the socio-economically marginalized communities in LMICs.

4.1 Inclusive research and knowledge production

Biomedical research involves a wide range of complex ethical issues, including transparency, consent, information on probable adverse events, and compensation for clinical trial-related injuries. There is still an alarming lack of transparency in the planning, design, and implementation of clinical trials, which is a critical element in the process of medicine and vaccine development. Feminists and health rights activists have always stressed transparency as the key to people's autonomy over their health, protected the rights of clinical trial participants, and have tirelessly demanded the ethical conduct of clinical trials by critically monitoring them and urging regulatory agencies and pharma companies to redesign clinical trials when a need has emerged.

As several Covid-19 vaccines were being rolled out at an unprecedented pace and scale and several vaccine candidates were in clinical trials, it was imperative for gender and intersectionality to become central tenets throughout the continuum of vaccine development and deployment. It is important in such situations not to exclude vulnerable groups without reasonable scientific and ethical justification, as such exclusion can diminish trial validity because of selection bias.[1] Ethical considerations must be made according to specific situations to protect vulnerable participants from exploitation and later abandonment.[2]

Pregnant women have been historically excluded from vaccine trials. Except for the 2009 H1N1 influenza vaccines, the pertussis vaccines, and more recently, vaccines expressly developed for maternal immunization, pregnant women are hardly ever considered for the trials. The Ebola vaccine trials also excluded pregnant women in 2014–2016, despite clear data indicating the particularly devastating impact of Ebola on pregnant women.[3] We still have limited data on the safety, efficacy, and effectiveness of vaccines to understand their long-term effects on pregnant women and children. Furthermore, their exclusion from research and evidence generation automatically leads to their exclusion from vaccine delivery programmes.

Taking into cognizance the need and demand for such data on pregnant and breastfeeding women, vaccine manufacturers have made some attempts to initiate clinical trials on pregnant women. Right before the vaccine rollouts started in 2021, an advisory issued by the MoHFW in India suggested that pregnant and lactating women should not be vaccinated because this group had not been part of any Covid-19 vaccine clinical trials. There was no clinical trial data available at that time regarding the safety of vaccine use in pregnancy. Later, though, the government recommended vaccination for all pregnant women based on a risk versus benefit assessment.[4]

Feminists have asserted time and again, that any clinical research on pregnant and breastfeeding women must be initiated only after careful consideration of the available data from pre-clinical research in pregnant animal models, research on non-pregnant women, retrospective observational studies, and pregnancy registries. Further, clinical trial participants must be provided with complete information about the possible risks to their health, pregnancy, and future fertility, along with the risks to the foetus.[5]

4.2 Warped ecology of vaccine research and approvals

Covid-19 vaccines were developed at 'warp speed' within an extremely short timeframe. Protocols were changed, quick emergency authorizations were given, and speedy approvals were sought. However, this raises several questions—is vaccine development supplier-manufacturer induced, science induced, or both? How do we balance incentives to manufacturers, innovators, and regulatory architecture? What is the implication of such a development for regulatory independence? Answers to the above questions require data transparency at every stage and in all aspects of the clinical trials: among vaccine developers, manufacturers, regulatory authorities, as well as participating research institutions. The protocols and outcomes of scientific practices and vaccine studies must be made public so that we may gain a better understanding of how these processes originate and evolve—who influences and determines them, and who funds or sponsors them? The burden of transparency ought not to be on consumers and civil society as much as on manufacturers and the government. All information, including the rationale for clinical trial design, SAEs, agreements between governments and vaccine manufacturers, reasons for waivers of trial stages, and bridging studies of vaccines imported from abroad, must be in the public domain.[6]

During the pandemic, emergency use approvals for vaccines were granted based on limited data from largely non-transparent processes, despite calls from experts and civil society for their disclosure in the public interest.

In fact, the lessons learned from the process of Covid-19 vaccine development are relevant for the R&D of other vaccines in the future as well. The prevailing approach to information provision and knowledge production is unilateral and top-down, where the public is told about the final results but not the process by which those results were arrived at. We need to devise new ways in which members of the public are able to engage meaningfully in the practice of science to foster mutual learning, the sharing of perspectives, priorities, and concerns, and, in the process, develop mutual respect and trust.

Looking ahead, transparency is a crosscutting issue, especially in the context of information sharing, conducting of clinical trials, vaccine development procedures and protocols, along with their approvals and distribution.

4.3 Unpacking vaccine hesitancy

To counter their failure to provide equitable access to Covid-19 tools, states blamed the people for their hesitancy. However, hesitancy, whether in healthcare or vaccination, is deeply embedded in the breakdown, or absence of trust in the information or services provided by the health system. Past experiences of non-transparency in the health system have also played a significant role. In the case of Covid-19 vaccines, a lack of transparency existed at various levels—in the information on vaccine development; clinical trials, fast-track approvals, emergency authorization approvals, frequent flip-flops about prevention and treatment, uncertainty about possible adverse effects, the lack of a robust mechanism to address adverse events following immunization, as well as the shortage of vaccines.

Thailand saw a rise in vaccine hesitancy among its youth due to a lack of trust in their government and its handling of the Covid-19 pandemic. A mid-2021 YouGov poll showed that the number of Thai people willing to get vaccinated dropped from 83 per cent in January 2021 to 72 per cent in July 2021.[7] The youth had concerns about the government's slow and disorganized vaccination program. People in Thailand were calling for Pfizer and Moderna vaccines to be administered by the government, as they believed mRNA vaccines were more effective. However, before receiving their second dose, it became evident that they would receive a different vaccine due to sudden changes in government policy. Also, as some hospitals ran out of stock, many were forced to delay their second dose or take different vaccines from what they had received as their first dose.[8] In the case of Singapore, although vaccine uptake was satisfactory, there were pockets where vaccine hesitancy among adults was high, driven mainly by 'concerns about side effects, safety, and the hasty development of the vaccines'.[9]

People who were on TB treatment, HIV/ART medications, or on hormonal therapy were not sure whether they could take the vaccination or not. No such information was shared with them. Many pregnant women were hesitant due to concerns about the overall effect of the vaccine on pregnancy and on breastfeeding later on.[10]

Vaccine hesitancy among women of the reproductive age group also originated from the negligence of the scientific community in designing gender-sensitive clinical trials and health policies.

Along with the lack of information, misinformation played a significant role in fuelling hesitancy. Throughout the Covid-19 vaccination rollout, plenty of rumours and false information had been circulating on social media about the side effects of the Covid-19 vaccines,[11] including disruptions in the menstrual cycle in young girls, early menopause, infertility and impotence in men, and deaths in cases of people with co-morbidities.

Frequent changes in the dosage interval of vaccines also generated scepticism about their efficacy. In India, for instance, the intervals between the first and second Covishield doses was increased from 4–8 weeks initially, to 12–16 weeks in 2021.[12] A few months later, this timeline was relaxed for those requiring foreign travel for education, employment, or participation in international events like the Olympics.[13]

Instead of addressing the root causes of vaccine hesitancy, governments and non-state actors have responded by shifting the burden of accountability to the people. In the name of the public good, countries used coercive measures, offered incentives and disincentives, and created a false sense of choice. In India, there were reports about local administrations threatening people with denial of food rations or restricting them from reopening their shops or business premises if they were not vaccinated. Finally, citing a violation of the right to livelihood, courts set aside such orders by local governments that made vaccination mandatory for shopkeepers, vendors, and local taxi drivers to resume business activities.[14] According to a news report, a local government in the Philippines offered those who agreed to get inoculated with the Covid-19 vaccine a chance to win a house, cows, motorcycles, or free groceries.[15]

4.4 The carrot or the stick? Ethics of incentives and disincentives

The debates on incentives and disincentives have been decried in the past too. States have repeatedly used such strategies to push global and national agendas to further the use of contraception and population control measures. Activists in the women's movement have raised their voices for decades against incentivized, target-driven sterilization.[16] They asserted that disincentives, by their very character, are coercive. [17] Incentives and disincentives are, in fact, a slippery slope that creates conditionalities for access and aggravates exclusion. They never address the real needs and concerns of the people.

From social justice and rights perspectives, it is questionable to link social security and food security incentives to people's decisions to accept or reject vaccines. Compulsory Covid-19 vaccination will not help. Coercion will only increase hesitancy, not reduce it. According to a survey in Germany among 1,349 participants, people were unwilling to receive Covid-19 vaccines even when offered an incentive of up to USD 204.55.[18] A recent study in the US identified incentive-based interventions as among the least successful measures for increasing vaccine uptake.[19]

Rumours, myths, and perceptions increase hesitancy in the absence of credible and accessible information. The need for a reliable source of information and public health messaging is crucial, especially for the marginalized, to make informed decisions about vaccination. In the absence of such a source, vaccine uptake is inevitably impacted. Not only has there been an absence of complete and reliable information, but there also has been a lack of initiative or willingness to provide information in a comprehensible and accessible language. Covid-19 is an evolving situation, with guidelines and protocols being updated frequently by the WHO and health ministries of different countries. However, for a variety of reasons, including the inability to read, a lack of access to the internet, a dearth of reliable information in local languages/dialects, sign language or braille, such critical information frequently fails to reach those who need it the most, particularly vulnerable and marginalized communities, and, within these, women with disabilities.

4.5 Covid-19 vaccination access: gendered contours

The knowledge-power dynamic plays a critical role in the process of marginalization. Limited accessibility to strategic and critical information on health and the production and dissemination of information in overly technical terms exclude the marginalized from health-seeking opportunities.

The prevailing gender norms and power structures in the family inevitably affect access to healthcare for women in general and were exacerbated during the Covid 19 pandemic. There has been a visible gender divide in the accessibility of medical treatments, including vaccines, as well as unequal dissemination of information related to the disease and treatment.[20] In the Asia-Pacific region, more women than men have failed to receive both

initial vaccination doses against the coronavirus.[21] In India, there was a wide vaccination gap, with more men getting vaccinated than women, and an even larger gap for trans* persons.[22] In July 2021, only 867 women were vaccinated for every 1000 men.[23] Out of the 309 million Covid-19 vaccines delivered since January 2021, only 143 million were given to women, as compared to 167 million given to men.[24] In Somalia, vaccinated men far outnumber vaccinated women. By November 2021, 70 per cent of men had been vaccinated, compared to only 30 per cent of women.[25]

A report published in October 2021 showed that in Iraq, 55 per cent of women and 42 per cent of men had to travel for more than 30 minutes to get a vaccine. In Haiti, 26 per cent of women (compared to 34 per cent of men) were willing to travel a long distance to get a vaccine, which also revealed the infrastructural gaps and lack of efficient distribution of vaccines among the vulnerable groups. In South Sudan, women represented 70 per cent of the population that tested positive but comprised only 26 per cent of the vaccinated population.[26]

This gender gap in vaccination is attributed to several underlying factors. These include women's limited mobility and ability to reach vaccination and testing sites; their restricted decision-making power to determine their health-seeking behaviour; and their limited control over resources, including finances, digital technology, and information required to make informed health decisions.

The digital divide impacts vaccination chances, particularly among women and young girls from marginalized communities. According to reports, South Asia and sub-Saharan Africa have the highest gender gaps in phone access. During the early phase of vaccination rollout in India, it was mandatory for vaccine recipients to register themselves on the Co-WIN portal, even to book vaccination slots. Registration on the Co-WIN platform or mobile app requires the user to provide a mobile number. This requirement made it extremely difficult for poor women and young girls to access vaccination, as they simply did not own smartphones or have access to either phones or the internet. On average, less than three out of ten women in rural India and four out of ten women in urban India have ever used the internet. Further, the intra-household disparity in phone access implies that women

have to depend on male members of their families for phone access. There is also the issue of internet lag in rural areas. These impediments were further compounded by the lack of literacy or their inability to navigate digital portals and apps like Co-WIN during the initial phase of the rollout. Finally, the Supreme Court of India took cognizance of this huge divide and directed the Centre to take measures to address this grave problem that was thwarting the vaccination drive. Thereafter, walk-in vaccination drives were promoted.

Overall, women and girls, especially those from marginalized communities in LMICs, are likely to be far more disadvantaged in terms of access to personal technological tools. Women's mobile phones are generally considered a non-essential expense and are the first to be cut from household budgets. Thus, a technology-driven vaccine rollout is bound to leave women behind.[27]

Furthermore, the intersection of patriarchy and ableism has a deleterious impact on the access of women and girls with disabilities to vaccines. According to a report, the independence and mobility of women and young girls, particularly those with disabilities, had been restricted by families.[28] Families were either overprotecting them or neglecting to get them vaccinated because it was considered a liability to take them to vaccine centres.[29]

In India, only 4,018 persons with disabilities[30] had received both doses of the Covid-19 vaccine by November 28, 2021.[31] Persons with disabilities across the world, particularly in LMICs, have been demanding for vaccines to be administered at their homes, especially if they were residing in inaccessible locations or for whom travelling was difficult or impossible. In many countries, there have not been any concentrated efforts to ensure that this process is facilitated. There is also a gaping absence of disaggregated data on the impact of Covid-19 on LGBTQI+ persons.

Understanding vaccine hesitancy and the gender gap in vaccination would facilitate the design of focused and intersectional information campaigns that can help reduce the gaps in vaccination. The exclusion of affected communities from Covid-19 planning and decision-making leaves states ill-equipped to respond effectively to the gendered social and economic fallout of the pandemic.

The intersectional feminist framework ...

... demands that states ensure that everyone has equal access to the applications of science, which is relevant for the enjoyment of economic, social, and cultural rights.

... recognizes the imperative to address global inequities in sharing research outcomes and production capacity in the larger political, economic, institutional, and legal systems within which health technologies are developed, produced, distributed, and utilized.

... analyzes the fractures in health systems, the gaps in state policies, the irrational and discriminatory measures, and the hegemonic knowledge, science and technology.

... asserts that knowledge around the development and distribution of healthcare technologies and innovations must be founded on the principles of fairness, equity, transparency, accountability, and ethics.

... reinforces that access to healthcare technologies, including vaccines, is not only related to health system preparedness or global supply chains but is also deeply embedded in structural injustices.

... recognizes that the implications of 'warp speed' in the development of vaccines on regulatory independence need deeper analysis. The accountability of regulators to ensure safety and efficacy must not be jeopardized by corporate and political pressures.

... calls for thorough scientific, non-partisan, and transparent investigations to document the number of lives lost due to both Covid-19 and non-Covid-19 causes. This data should be made available in the public domain, in the interest of accountability and transparency.

... demands for gathering gender-segregated data on the loss of lives and livelihoods during the pandemic to chart out gender-inclusive policy measures.

The intersectional feminist framework ...

... calls for the collection of more disaggregated data on Covid cases, deaths, hospitalization, testing, and vaccination to understand the pandemic's impact on different vulnerable groups.

… demands for inclusion of diverse communities at every step of the planning process and vaccination programmes in order to help reduce the gaps in vaccination, enable the shift from 'hesitancy' to 'trust', and from individual behaviour to state accountability.

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Conclusion

Resistance, Solidarity, and the Way Forward

Covid-19 has been harsh but transient; the reality of systemic discrimination, on the contrary, remains deeply entrenched. We need to continue to dismantle these systems of discrimination and neglect.

The responses to the Coronavirus pandemic have held up a mirror to the inequities deeply embedded in the global governance systems. Pandemic policies the world over have clearly revealed the hegemonic capture of most multilateral decision-making spaces. The perennial impact of unjust global economic and trade systems on access to knowledge, food, medicines, vaccines, etc., intensified during the current pandemic. These systems were unflinching in their prioritization of profits over people and health, of the privileged over the vulnerable. Furthermore, the current fragmentation of multilateralism in several domains, most notably in climate change, is incompatible with the interdependencies that link global environmental problems.

The intersectional feminist framework raises important questions about the knowledge of health and the relationships of power that govern it: what and whose knowledge is visible and who is excluded from the processes of health knowledge creation? This is intricately linked to the construction and prioritization of the discourse on health policy, programmes, and research. As is also evident from the current pandemic, the emergent knowledge to address newer challenges to global health that have wide-ranging implications for public health should not be sequestered and utilized for the benefit of the private interests of a few corporates and countries. States, corporates, and other stakeholders must comply with their international obligations to facilitate access to healthcare technology, knowledge transfers, and ensure that LMICs are supported in scaling up development, local manufacturing, and distribution capacities.

While we prepare to advocate for action and accountability towards prevention and mitigation of the consequences of health and humanitarian crises in the future, we need to simultaneously challenge the inequities and the violation of human rights perpetrated by authoritarian policies and interventions spawned by the pandemic. We must challenge the justification and defence of authoritarian policies and interventions in the name of protecting and caring for the people. We must find the most effective ways of organizing global resistance in the face of powerful authoritarian regimes, on the one hand, and

the largely ineffectual international and multilateral, multistakeholder platforms that predominantly reflect capitalist interests and corporate control, on the other.

The causes and consequences of the pandemic are embedded in the obfuscation, denial, and neglect of an intersectional feminist vision of health, living, identities, relationships, and of politics. Yet, despite this, a feminist view and perspective guide our actions and response. The intersectional feminist framework is a step towards rethinking the pandemic within the realm of marginalization and social exclusion through multiple dimensions of power structures.

The history of pandemics indicates that as soon as they ebb, the narrative of "usual" returns and overshadows all else until we are faced with another crisis. These experiences have been disquieting, as countries invariably return to the status quo, ignoring the evidence of devastation as well as their accountability to addressing these systemic injustices to foster equity, prevent discrimination and enable access to health care services, and protect lives. They continue to overlook the asymmetries rooted in coloniality that violate the human rights of millions of people. The intersectional feminist framework recognizes the imperative of challenging the very foundations of economic, political, and social inequities across countries as well as within them. It underscores that a just and equitable future requires a transformational shift rather than a return to an unjust "normal."

Furthermore, pandemic responses and future preparedness must interrogate the multiple patterns of power and marginalization that are exacerbated along the lines of gender and sexuality as greater social and political control over our lives becomes the norm, leading to gendered consequences. Pre-existing biases and prejudices within health systems when responding to LGBTQI+ persons must be recognized, as these continue to be a barrier to seeking timely access to healthcare. As the framework takes stock of our learnings—which are vital to our feminist work and thought across all our varied locations—and makes us more aware of our future trajectory, we will be able to hear and include diverse voices and forge novel collaborations, be they local, national, regional, or global. The need for sustained dialogues to widen and deepen the contours of this framework, cannot be emphasized enough.

Through the intersectional framework, we seek to share and build on our work and activism, so that we can offer a meaningful and collective response at this critical juncture. Our

critiques are also directed at our own feminist praxis. Our demands for the creation of a just, equal, and equitable future for all peoples also include our commitment to remain reflexive, inclusive, and ever-vigilant about our words and actions. We reaffirm that global feminist solidarity is the starting point towards building a just and equitable future. This solidarity is also renewing resistance against growing social, economic, and political inequities.

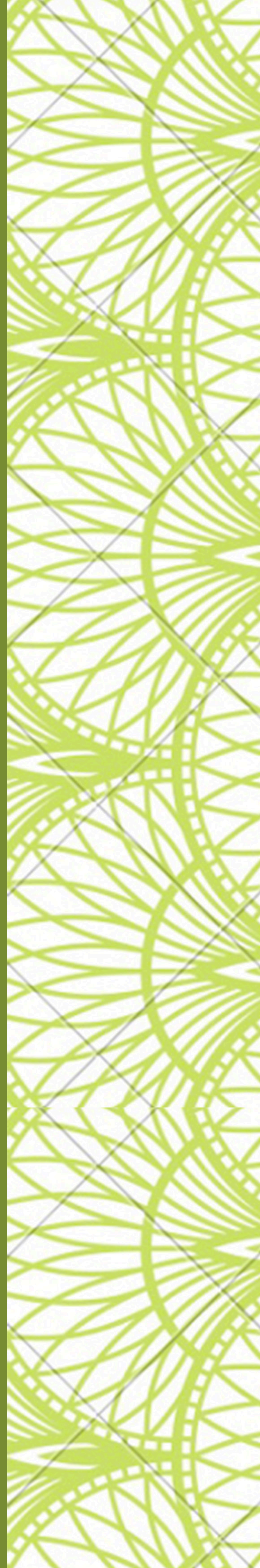
While in this framework we draw attention to a few fundamental issues that feminists have been foregrounding for a very long time, we believe that specific advocacy actions to address these issues must be contextual, inclusive, and intersectional, and should be navigated through transparent, democratic processes.

The intersectional feminist framework is an evolving understanding, flexible and open to shifts and changes in the larger political, social, economic, and environmental contexts, geographies, structures, and institutions that dominate our world. This is why the framework indicates our learnings, and analyses and presents what we regard as a potentially effective feminist response to pandemics and beyond. Finally, the intersectional feminist framework represents a commitment and contribution to our solidarities and feminist futures.

Abbreviations

AI	Artificial Intelligence
AIAN	American Indian and Alaska Native
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASHA	Accredited Social Health Activist
CEPI	Coalition for Epidemic Preparedness Innovations
CHW	Community Health Workers
COVAX	Covid-19 Vaccines Global Access Initiative
COVID-19	Coronavirus Disease 2019
Co-WIN	Covid Vaccine Intelligence Network
CSO	Civil Society Organization
C-TAP	Covid-19 Technology Access Pool
EMR	Eastern Mediterranean Region
EU	European Union
G7	Group of 7
GBV	Gender-based Violence
H1N1	Hemagglutinin Type 1 and Neuraminidase Type 1
HIV	Human Immunodeficiency Virus
HWDI	Himpunan Wanita Disabilities Indonesia
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
LMIC	Low- and Middle- Income Countries
ICMR	Indian Council for Medical Research
ICT	Information and Communications Technology
ICUs	Intensive Care Unit
IIPH	Indian Institute of Public Health
ILO	International Labour Organization
IP	Intellectual Property
IPR	Intellectual Property Rights
IPV	Intimate Partner Violence
IRC	International Rescue Committee
ITU	International Telecommunication Union
LMIC	Low and Middle Income Countries
MC	Ministerial Conference
MENA	Middle East and North Africa

MOHFW	Ministry of Health and Family Welfare
mRNA	Messenger Ribonucleic Acid
NCD	Non-communicable Diseases
NCRB	National Crime Record Bureau
NDVH	National Domestic Violence Hotline
NGO	Non Governmental Organization
OPD	Outpatient Departments
OOPE	Out-of-pocket Expenditure
PCR	Polymerase Chain Reaction
PPE	Personal Protective Equipment
R&D	Research and Development
RT-PCR	Reverse Transcription-Polymerase Chain Reaction
SAE	Serious Adverse Events
SRH	Sexual and Reproductive Health
TB	Tuberculosis
TNC	Transnational Corporations
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UK	United Kingdom
UN	United Nations
US	United States of America
USD	United States Dollar
WHO	World Health Organization
WTO	World Trade Organization



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