

COVID-19, SRHR AND HEALTH SYSTEMS

“Coronavirus makes clear what has been true all along. Your health is as safe as that of the worst-insured, worst-cared-for person in your society. It will be decided by the height of the floor, not the ceiling.” - Anand Giridharada

HEALTH IMPACT OF COVID-19 IN AFRICA

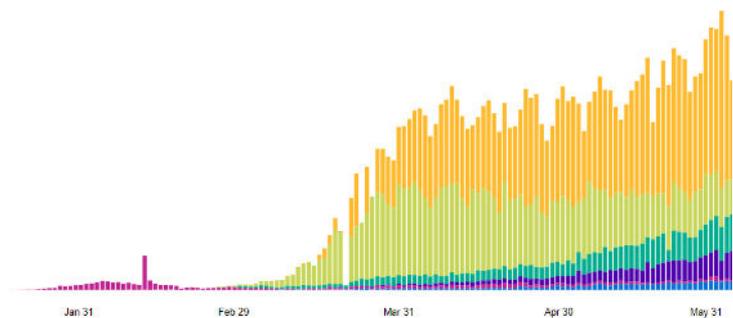
The COVID-19 pandemic has created a huge public health crisis and a subsequent economic crisis globally. It has also exposed the consequences of decades of chronic under-investment in health systems everywhere, but especially in low-income countries. Health systems in most African countries, already under severe strain before the massive outbreak of the virus, are at increased risk of collapsing.

COVID-19 has spread to all African countries, but despite a steady rise in the number of confirmed cases, the outbreak on the continent appears slower than the global curve for infections and deaths.^{1, 2, 3}

Case Comparison

WHO Regions

Americas	3,022,824 confirmed cases
Europe	2,191,614 confirmed cases
Eastern Mediterranean	552,497 confirmed cases
South-East Asia	296,620 confirmed cases
Western Pacific	186,853 confirmed cases
Africa	115,639 confirmed cases



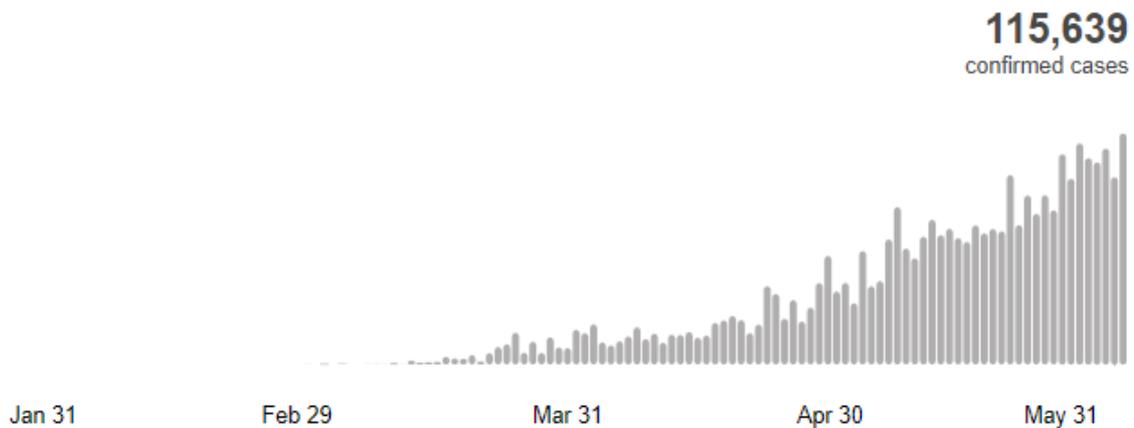
Source: <https://covid19.who.int/> (accessed on 4 June 2020)

¹ <https://www.theafricareport.com/27470/coronavirus-unpacking-the-theories-behind-africas-low-infection-rate/>

² <https://www.economist.com/middle-east-and-africa/2020/05/16/why-covid-19-seems-to-spread-more-slowly-in-africa>

³ <https://medicalxpress.com/news/2020-04-africa-coronavirus-outbreak-slower.html>

The World Health Organization predicts that the peak of the pandemic is yet to come.⁴



Source: <https://covid19.who.int/> (accessed on 4 June 2020)

There is wide recognition that beyond health, COVID-19 will have a huge impact on the socio-economic and political situation in Africa.

As part of our ongoing sexual and reproductive health and rights (SRHR) and health systems advocacy work, Wemos has regular exchange of information with civil society in Kenya, Malawi, Mozambique, Tanzania and Uganda to understand the reality in the countries and strategise responses to global developments. From our recent collaboration, we jointly identified key areas of concern resulting from the COVID-19 outbreak in each of these countries:

- the lack of public awareness, information and communication about COVID-19;
- general shortages of health workers;
- a lack of personal protective equipment (PPE) for health workers;
- concern about availability, accessibility and affordability of medicines and vaccine;
- the added burden on vulnerable and marginalised populations (refugees, urban slum dwellers, women, adolescents, key populations, people with chronic diseases, as well as the LGBTQIA+ community);
- disruption of key essential and emergency services including for sexual and reproductive health (SRH), and HIV/AIDS, tuberculosis and malaria;
- lack of transparency and accountability about COVID-19 funds and the lack of coordination between donors;

⁴ <https://www.afro.who.int/news/new-who-estimates-190-000-people-could-die-covid-19-africa-if-not-controlled>

- restricted access to health services due to lockdowns, movement restrictions and curfews, enforced with arbitrary arrests and police brutality;
- the socio-economic impact further limiting people's ability to afford transport to health facilities;
- redirection of critical funds for SRHR programmes to COVID-19;
- disruptions in supply chains for contraceptives and other essential medications;
- increased reports of sexual and gender-based violence combined with less access to emergency services.

Given these common threats that systematically demonstrate the harmful effects in each country, it is also clear that contexts differ and evolve rapidly, and there is no blanket solution to address the most critical needs.

In **Kenya**, the [Legal and Ethical Issues Network on HIV and AIDS \(KELIN\)](#) highlights that the country's extraordinary measures such as strict lockdown and curfews taken in the name of public health, are not grounded in Kenyan law, are top-down, and do not align well with Kenya's devolved system of government.⁵ There has been an overall decrease in other health services, particularly for SRH. This comes in part from a decrease in demand, either for fear of the virus or misinformation about discontinuation of services. Additionally, there are reports of women and girls being turned away or unable to reach services because of curfew. While there is a recognition for the need to protect health workers, more could be done to secure their protection. Moreover, there are worrying reports that the quarantine centres are misused as a punishment for people violating curfew or not wearing facemasks in public, not just for quarantining new arrivals into the country.⁶ Additionally, poor enforcement of social distancing measures, inadequate sanitation and provision of food and water in some facilities contribute to the spread of the virus instead of its containment.⁷

In **Malawi**, [Malawi Health Equity Network \(MHEN\)](#) highlights the difficulties that the political environment in the country has posed.⁸ With the presidential elections results of May 2019 annulled by the Supreme Court on electoral irregularities grounds and new elections slated for early July 2020, lockdown measures have been resisted by civil society and citizens, and are seen as a political move that could potentially allow the ruling government to remain in power.



6 May 2020, Blantyre City, Malawi. Opposition party leaders Dr Lazarus Chakwera and Dr Saulos Chilima on their way to present their nomination papers for candidacy for the upcoming elections in July.

⁵ <https://www.hrw.org/news/2020/05/28/kenya-quarantine-conditions-i>

⁶ <https://www.kelinkenya.org/kenyas-growing-anti-rights-public-health-agenda-during-covid-19/>

⁷ <https://www.voanews.com/covid-19-pandemic/kenyan-capitals-water-shortage-raises-covid-19-risk>

⁸ <https://www.dailymaverick.co.za/article/2020-04-20-covid-19-and-the-future-of-malawis-2020-presidential-election-re-run/>

In addition, the country is the 3rd poorest in the world in terms of GDP per capita⁹ with a large informal economy and a government that cannot afford socio-economic protection measures. Early in April, the lack of PPE and other protection measures for the already limited health workforce sparked a nationwide shut down of all main hospitals by health workers leading to the loss of lives.¹⁰ MHEN emphasises the need for coordination between donors, greater transparency and accountability about contributions and allocation of resources.¹¹

In **Mozambique**, [N'weti](#), reports an overall well-coordinated cooperative response between government, civil society organisations (CSOs) and development partners. The country goes into the third month of the emergency state (until end of June). Although this is not a full lockdown, the restrictive measures do deeply impact the people relying on the informal economy for their livelihoods. Prevention messages thus far have mainly been targeted at the urban population. Rural communities lack access to reliable information on the situation and prevention measures. The government has encouraged the continuation of other services at facility level but suspended various services at community level. N'weti reports that large programmes within the country's HIV response, including community HIV service delivery and other interventions in the community, have been partly suspended as part of the COVID-19 prevention measures. Services at facility level mostly continue, but people living with HIV fear going to health facilities to collect treatment due to the corona virus. Additionally, whereas some donors have provided flexibility for CSOs to adapt their work in the current times, others have been more stringent or even stopped funding because of reallocation of their fund to the COVID-19 response. This also affects N'weti's ability to assure continuation of health services, including for the most vulnerable, such as adolescent girls.

In **Uganda**, the [Centre for Health Human Rights and Development \(CEHURD\)](#) brings to attention the adverse effects of the lockdown and the deaths indirectly related to the pandemic, particularly affecting those who are the most vulnerable. Overall, the right to health has been affected in terms of accessibility, affordability, availability and quality of services, with people dying because they cannot access care or are afraid to break curfew.¹² People are afraid to seek help, face additional challenges to reach facilities, and facilities may not attend them, due to lack of staff or PPE. Furthermore, unclear governmental directives are often mis-interpreted and result in issues like pharmacies closing because they are seen as regular shops and not essential services or health workers being unable to reach health facilities because they are not exempted from transportation restrictions. Additionally, LGBTQIA+ people are now left unattended due to the service chain disruption, as NGOs, who are the main service providers for these vulnerable groups, cannot bring the services to them. CEHURD reports the challenges in monitoring, accountability and transparency regarding the

⁹ Latest data from the World Bank, retrieved on 28th May 2020 from: <https://data.worldbank.org/>

¹⁰ <https://www.aljazeera.com/news/2020/04/malawi-high-court-blocks-coronavirus-lockdown-200417184430403.html>

¹¹ <https://www.telegraph.co.uk/global-health/science-and-disease/malawis-public-hospitals-close-medics-strike-lack-funding-covid/>

¹² <https://www.reuters.com/article/us-health-coronavirus-uganda/in-uganda-mothers-in-labour-die-amidst-coronavirus-lockdown-idUSKCN21R2FA>

resources collected via wage deductions from the population and received from donors, which have been mostly concentrated in the capital, leaving the rural areas bereft.

Tanzania is an exception on the continent. Its response has been different to other countries in the region and is perceived to be deadly due to a pure lack of recognition of COVID-19 as a threat.^{13, 14, 15, 16} The political driven response constrains surveillance, monitoring, response coordination and accountability of donor resources for the response. In the case of Tanzania, most donors have opted to directly fund NGOs and CSOs for the response, instead of through the central funding or government mechanism.

NEW OPPORTUNITIES

Despite these challenges, the pandemic has opened new opportunities in the use of mobile and tele-health technologies in many contexts. There is now an increase in innovative approaches to health service delivery that use technology to shape new responses. Some examples include the re-development of a call centre that is working seven days a week, a digital communication platform that allows service providers to share and receive information, and the development of training packages for service providers and health promotion using mobile phones in Tanzania. In Mozambique, N'weti is also planning to roll out large scale messaging via community radio to counter misinformation and myths, promote uptake of other services and move from the strict biomedical focus by sharing information on holistic well-being. In Kenya, to ensure documentation and assistance for cases of human rights violations KELIN and other partners have set up a toll-free line (as well as SMS and email service) where people can report if their rights have been violated.

LESSONS FROM PREVIOUS DEVELOPMENT AND DISEASE-SPECIFIC RESPONSES

EVOLUTION OF THE HIV RESPONSE

Since the human immunodeficiency virus (HIV) was first identified three decades ago, the HIV pandemic is becoming endemic in Sub-Saharan Africa.¹⁷ What started as an emergency response, has now become a long-term strategy to prevent new infections and respond to the needs of people living with HIV. Much can be learned from this experience, in terms of health inequalities, developing a multi-disciplinary approach, creating an enabling

¹³ <https://mg.co.za/africa/2020-05-25-tanzania-magafuli-risk-coronavirus/>

¹⁴ <https://www.egyptindependent.com/tanzania-says-virus-defeated-through-prayer-but-fears-grow/>

¹⁵ <https://www.csis.org/analysis/implications-tanzanias-bungled-response-covid-19>

¹⁶ <https://theconversation.com/tanzanias-covid-19-response-puts-magufulis-leadership-style-in-sharp-relief-139417>

¹⁷ https://www.researchgate.net/publication/51799344_Reducing_the_AIDS_response_for_long-term_impact

environment to support behaviour change, and applying a human rights approach.^{18, 19}

Whilst COVID-19 is in an emergency response stage, the focus is on ensuring access to essential supplies, protecting health workers, vaccine development, behaviour change communication and community mobilisation. At the same time, it is also necessary to invest in preventing future outbreaks and strengthening health systems to incorporate long-term COVID-19 prevention and care.

MULTI-SECTORAL AND HEALTH SYSTEMS APPROACH

Past lessons of disease-specific responses show there is a need for multi-sectoral and health systems strengthening approaches alongside the bio-medical focus that is currently being prioritised in most contexts of the COVID-19 response.²⁰ Policy debates, development and implementation of programmes have often focused on treatment and achieving disease-specific results, without incorporating the full spectrum of essential, quality health services to achieve Universal Health Coverage (UHC), i.e. prevention, health promotion, treatment, rehabilitation and palliative care.²¹

COMMUNITY AND CIVIL SOCIETY ENGAGEMENT

Evidence further shows that engagement and involvement of communities and civil society organisations early on is key, from inception, design, implementation and monitoring and evaluation of programmes.²² Community and civil society engagement allow for greater transparency and accountability of both donor and governments investments and responses.

GENDER AND INCLUSIVITY ANALYSIS

Experience from past outbreaks has also shown the importance of incorporating a gender and inclusivity analysis within programmes, particularly into preparedness efforts. This inclusion has positive effects on improving the effectiveness of health interventions and the promotion of gender and health equity.²³

¹⁸ [https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018\(20\)30110-7/fulltext](https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30110-7/fulltext)

¹⁹ <https://www.unaids.org/en/resources/documents/2020/human-rights-and-covid-19>

²⁰ <https://stopaids.org.uk/wp-content/uploads/2020/01/HIV-Universal-Health-Coverage-and-the-future-of-the-global-health-architecture.pdf>

²¹ Discussion Paper: [Living with COVID-19: Time to get our act together on health emergencies and UHC](#). UHC2030, 27 May 2020.

²² [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(18\)30482-0/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30482-0/fulltext)

<https://www.chathamhouse.org/file/international-affairs-webinar-civil-society-and-covid-19-sub-saharan-africa>

²³ https://esther.eu/wp-content/uploads/2020/05/Gender-COVID-19-Webinar-Summary-Publication.pdf?mc_cid=f7f18c545f&mc_eid=6883b8e804

COVID-19 AND SRHR

COVID-19 has shown that successes in SRHR cannot be sustained without resilient and sustainable health systems. As with any health outcome, the attainment of SRHR requires a multisectoral effort, involving schools, communities, workspaces and many more. However, the most critical prerequisite for SRHR is a responsive, strong and well-functioning health system, that is properly staffed and financed (see also this recent Wemos [paper](#) on health systems strengthening and SRHR).

As acknowledged by Minister Kaag in a recent debate²⁴ on the Dutch COVID-19 response, it has become increasingly evident that a broader health systems focus is necessary in addition to the SRHR focus of the Dutch development assistance in this new reality.

THE 3 GS

Strong and well-functioning health systems that can ensure UHC, including SRHR, can only be achieved through sufficient, sustained and aligned investments from domestic and external resources. The alignment of global health initiatives (GHIs) to enhance impact and increase efficiency of their respective activities is much needed, particularly now for the short-term COVID-19 response, but also in the long-term, contributing to the Sustainable Development Goal (SDG) 3, good health and well-being. We acknowledge the role of other partnerships that support health systems strengthening and bilateral funding. But within this context, we consider it is important to focus on the alignment efforts of three major GHIs, that are also receiving the support of the Dutch government.

GAVI, the Vaccine Alliance (GAVI), the Global Financing Facility (GFF), and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) are examples of different GHIs with a specific focus area but are very relevant to the discussion of a pandemic response and health systems strengthening. Starting in 2019, these initiatives have increased alignment of global partners to progress towards the SDGs, culminating in the Global Action Plan for Healthy Lives and Well-being, that all three co-signed together with nine other institutions.²⁵

All three institutions (collectively known as the 3Gs) have incorporated health systems strengthening as a key strategy of their investment. All emphasise that their strategies are country-led and owned. However, their respective strategies are tailored to reaching their disease-specific goals. GAVI's investments must be in line with GAVI's vaccination goals and have to be approved by GAVI's independent review committee. Within the GF perspective, health systems strengthening equals countries meeting the standards of GF programmes, in

²⁴[https://www.youtube.com/watch?v=BSH3cQBY0wQ&t=3289s&utm_source=Deelnemers+05+07+2020+Webinar+Minister+Kaag+%26+C+orona+gezant+Sijbesma&utm_campaign=2f22e71f52-](https://www.youtube.com/watch?v=BSH3cQBY0wQ&t=3289s&utm_source=Deelnemers+05+07+2020+Webinar+Minister+Kaag+%26+C+orona+gezant+Sijbesma&utm_campaign=2f22e71f52-email_report_militarymobility_COPY_01&utm_medium=email&utm_term=0_44a272a953-2f22e71f52-80138106)

²⁵ <https://apps.who.int/iris/bitstream/handle/10665/330060/WHO-DGO-GAP-19.1-eng.pdf?sequence=1&isAllowed=y>



CEHURD
social justice in health



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terms of procurement and supply chain mechanisms, financial management systems, data systems, analytical capacity and strengthening of the health workforce. The GFF on the other hand, focuses on the broader area of reproductive, maternal, neonatal child and adolescent health and nutrition, with mobilisation of resources and efficiency gains through high-impact interventions at the heart of its mechanism. Despite the intention to be country-led, its linkages with the World Bank pose some limitation on the utilisation of funds.

If all GHIs require alignment of health system programmes with their own disease-specific goals, limited space is left for countries to invest in true general responsiveness of the health system - something that has been proven essential in the current pandemic. Besides strong rhetoric on health systems strengthening which includes primary healthcare and universal health coverage, these three initiatives could do more to support these broader goals in their respective country partnerships by partnering to leverage the joint objectives in countries.²⁶

LONG-TERM COVID-19 RESPONSE: CREATING RESILIENT AND SUSTAINABLE HEALTH SYSTEMS

We are at a cross-roads: we can either go for business-as-usual *or* choose to truly invest in the UHC agenda, including quality SRH. The only way to deal with this new challenge effectively is through a strong public health system that is designed and implemented to provide quality prevention and care services for *all*, including the poorest, the most marginalised, and the people with multiple compounded vulnerabilities.

Most African countries have integrated UHC as a goal in their national health strategies. However, progress in translating these commitments into expanded domestic resources for health, effective development assistance, equitable and quality health services, and increased financial protection, has been slow.²⁷

Most low- and middle-income countries have fallen short of the Abuja target to invest 15% of their general government expenditure on health. And even less to meet the per capita investment targets for UHC²⁸, either in absolute terms (USD 112 per capita) or as a percentage of GDP (5%). Sub-Saharan Africa has by far the highest maternal mortality ratio at 546 maternal deaths per 100,000 live births²⁹, a far-cry from the SDG target of 70 per 100,000 by 2030. Africa has a share of 24% of the global burden of disease, yet, has only 3% of the global health workforce. And many countries are far below the SDG threshold of 4.45 health workers

²⁶ Note: Wemos in collaboration with Cordaid is currently preparing a paper on alignment of the 3Gs which will be published in the coming months

²⁷ https://www.who.int/health_financing/documents/uhc-in-africa-a-framework-for-action.pdf?ua=1

²⁸ McIntyre, Meheus and Rottingen (2017)

²⁹ <https://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>

per 1,000 recommended by WHO: for example, in Kenya 1.32, in Malawi 0.48, in Mozambique 0.77, in Tanzania 0.60 and in Uganda 1.41 health workers per 1,000 population.³⁰

Of the donors that prioritise health, most refer to the importance of strong health systems. However, many consider health systems strengthening as too broad, too all-encompassing an approach, or too long-term for donor funding. The common donor position is that recurrent costs, such as salaries and running costs of facilities, should be funded from domestic resources. Donors avoid taking on the long-term burden of these costs, citing risk of donor-dependence and undermining government ownership and governance. Instead, many donors have prioritised investments in interventions with the most measurable impact whilst addressing a high disease burden, for example, reducing malaria, HIV and tuberculosis, preventing maternal and child deaths, improving water and sanitation, and increasing access to contraceptives. While these interventions have led to considerable improvements in health systems and outcomes in these contexts, we have yet to achieve UHC in many countries.

There are no shortcuts to creating resilient and sustainable health systems that provide UHC and can incorporate responses to new health challenges such as COVID-19. For over a decade there has been a consensus on the health building blocks³¹ first conceptualised by the World Health Organization in 2007. However, despite good intentions and many global commitments, this has not resulted in adequate financial investments in health systems. COVID-19 has highlighted once more the need for removal of financial barriers to access health services, more and better supported health workers and sufficient funding for common goods for health, including treatment, prevention and health promotion.³²

RECOMMENDATIONS

A key structural mid- to long-term COVID-19 response is to invest in health systems strengthening, in a joint undertaking between governments in low- and middle-income countries and donor governments. Based on the information from country partners and lessons learned from our other areas of expertise, we recommend the following:

- ***Ensure and prioritise investments in practical bottom-up solutions that are locally owned and connected to bottom-up accountability mechanisms***

It is key to ensure the engagement and participation of the affected communities and CSOs to inform responses from programme inception, design, implementation and

³⁰ Data retrieved from the WHO's Global Health Observatory (<https://www.who.int/data/gho>). Health workers include medical doctors, nursing and midwifery personnel. Latest available data from 2018 (Kenya total, Malawi total, Mozambique total, Uganda nursing and midwifery personnel), 2017 (Uganda medical doctors, Tanzania nursing and midwifery personnel), 2016 (Tanzania medical doctors).

³¹ *Everybody's Business: Strengthening health systems to improve health outcomes—WHO's Framework for Action*. Geneva: World Health Organization, 2007.

³² Discussion Paper: [Living with COVID-19: Time to get our act together on health emergencies and UHC](#). UHC2030, 27 May 2020.

monitoring and evaluation, while at the same time holding donors and governments to account. For example, Community-Led Monitoring^{33, 34} is an evidence-informed advocacy and participation initiative for the all-too-often missing voice of communities in assessing and addressing the performance of health systems. It refers to the monitoring of services by communities and includes a range of qualitative and quantitative methods of gathering evidence, including - but not limited to - community scorecards, budget tracking and community treatment observatories. Communities define the indicators used for routinely monitoring the quality, access, availability and affordability of services and policies where applicable and identify challenges and bottlenecks. Funding these initiatives is critical.

- ***Ensure inclusiveness, gender and intersectionality in the COVID-19 response***
Intersectionality³⁵ and inclusiveness are key to reaching the objective to “leave no one behind”. We cannot reach UHC if the most vulnerable are left behind. Due to its complexity, inclusion of intersectionality within health systems requires joint effort, dedicated funding, and a clear definition of who it is that needs to be reached. As it has been made clear, health emergencies exacerbate problems that already exist, and the burden of consequences are carried by those who are most vulnerable.
- ***Support governments to increase and ensure equitable distribution of their health workforce***
Financial support packages from bilateral and multilateral donors and agencies do not specifically prioritise the urgent need to recruit additional health personnel in resource-limited contexts and improve remuneration, working conditions, and retention packages particularly in rural and hard-to-reach areas. Given the unprecedented pressure on advanced health systems, we have grave concerns for those countries with severe shortages of health personnel which have been insufficiently addressed since before the COVID-19 pandemic. The current crisis offers funders in global health the opportunity to commit and contribute to pooled and adequate funding, based on robust analysis of the health labour markets and the ethical international recruitment of health personnel, resulting in significant long-term investments in the health workforce.
- ***Increase the fiscal space for health with sustainability and accountability***
Health taxes, efficiency improvements and public financial reforms as currently advised will only mobilise limited resources. They will not be enough to support countries to cope with their health needs amid the pandemic, nor for a sustainable health system development in the long-term. International financial institutions, donor institutions and initiatives and donor governments should also support and fund accountability work to

³³ http://itpcglobal.org/wp-content/uploads/2020/02/Community-Led-Monitoring-Brief_full.pdf

³⁴ https://www.academia.edu/29190075/NWETIS_COMMUNITY_SCORECARD_EXPERIENCE_IN_NAMPULA

³⁵ Intersectionality refers to the recognition of the multiple identities that are associated with interrelated and overlapping mechanisms of exclusion and marginalisation (e.g. age, religion, gender, race, ethnicity, disability, and socio-economic status).

prevent the loss of huge amounts of money due to illicit financial flows, amounting to approximately USD 500 billion annually worldwide.³⁶ In addition, donor governments themselves can cancel bilateral and multilateral debt payment obligations. Notably, 46 countries in the world were spending more resources on public debt service than on their health systems in 2018.³⁷ Addressing this, will allow African countries to recover from high losses of their government budgets and get the opportunity to increase their [fiscal space](#) and invest in sustainable social sector systems, including health. International financial institutions can also refrain from policies and conditionality that contain countries' ability to spend on public health. This should be the new narrative that informs countries' abilities to increase their domestic resources for health and should be supported.

- ***Support a global patent pool***

On May 29th 2020 the WHO launched a global [COVID-19 Technology Access Pool](#), as proposed by Costa Rica and supported by 37 countries, including the Netherlands. A COVID-19 pool will enable decentralised and accelerated production of the required COVID-19 technologies. The main idea behind a COVID-19 pool is that it would enable 'non-exclusive' licensing of the rights of a product or technique to others, such as researchers and producers. It would meet the global need for affordable products - a relevant issue since COVID-19 is affecting more and more countries with limited financial resources and often weak health systems.

Now that the COVID-19 Technology Access Pool is set up, it is important for national governments to engage with the relevant stakeholders, in particular with (medical) universities, pharmaceutical industry and civil society. All these actors would be able to make contributions. It will now be very important for the Netherlands to make sure that publicly funded knowledge and intellectual property is conditioned and will be shared with the pool. Any patent that is the result of publicly funded research should automatically go into the pool. Furthermore, legal clauses should be included on the availability and affordability of future treatments that make use of these patents.

This paper has been developed as part of our ongoing work on health systems and SRHR and is co-funded by the Ministry of Foreign Affairs (as part of the Health Systems Advocacy Partnership), Open Societies Foundations and other donors. Wemos drafted the document in collaboration with the Legal and Ethical Issues Network on HIV and AIDS (KELIN), Malawi Health Equity Network (MHEN), N'weti, and the Centre for Health, Human Rights and Development (CEHURD). Given the sensitive political situation in Tanzania, the collaborating partner in Tanzania prefers not to be named.

³⁶ <https://www.wider.unu.edu/sites/default/files/wp2017-55.pdf>

³⁷ [COVID-19 and debt in the global south: Protecting the most vulnerable in times of crisis](#). Eurodad, 2020.