COVID-19 AND HEALTH SERVICES DELIVERY AND UTILIZATION IN UGANDA.

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Introduction

The following essay compiled after a thorough documentary review method of research presents the impact of social economic inequalities in Uganda on the delivery and utilization of health services during the COVID-19 pandemic. The entire stretch of the essay is guided by the concept of the social determinants of health.

Background

The ministry of Health observes that the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) is a new virus that had not been previously identified in humans and therefore no population-level immunity exists. This virus belongs to the coronaviridae family grouped together in 1968 due to existence of crown-like appearances on their cell membrane. The virus is highly transmissible by way of droplet infections attacking the respiratory, intestinal and brain tissues. Infection from SARS-CoV-2 results in coronavirus disease (COVID-19) which manifests along a spectrum ranging from mild to severe symptoms; in severe cases, death can occur due to complication from the disease.[1] The seafood and animal market in Wuhan, China has been alleged to be the origin for the current outbreak of COVID-19. The World Health Organization (WHO) was notified of this outbreak on 31 December 2019 and the causative agent was subsequently identified as SARS-CoV-2 on 7 January 2020 by the Chinese government. In view of the rapid spread, the WHO upgraded the status of the outbreak to a Public Health Event of International Concern (PHEIC) on 30 January 2020 and announced it as a pandemic on 11 March 2020. The early symptoms of COVID-19 have been identified as fever, myalgia, and fatigue which might be confused with malaria and other febrile infections. The ministry of health notes that this non-specific presentation can lead to challenges in early clinical diagnosis and management. These features of COVID-19 and the previous experiences of Ebola Virus Disease (EVD) outbreaks, for example, point to the need for malaria-endemic countries to consider preventive measures against not only the COVID-19 threat but also its likely impact on existing malaria control efforts.

COVID-19 which, like has been earlier on noted originated in Wuhan, China in December 2019 and has since spread in the greater parts of the world including Uganda. COVID-19 has claimed many lives globally. Uganda has as well had its own share of the disease burden having currently 28,733 cases, 10,070 recoveries and 225 deaths. The disease has had a

[1] MoH, (April, 2020) National guidelines for management of COVID-19

devastating effect on humanity as countries have put measures to curb its spread.[2] After the first COVID-19 case was officially confirmed in Uganda on the 22nd of March 2020, the government put in place some of Africa's most stringent nationwide lockdown measures. Schools and businesses were closed, public gatherings banned, road and rail travel restricted, and a night-time curfew introduced. The lockdown was slightly eased in May with the reopening of restaurants, shops and factories. The long-term impacts of the lockdown measures on people's social and economic status, education, health and general wellbeing remain to be seen. With this working paper we report study findings that shed light on the immediate and often severe effects on young people and their families of the early stages of the pandemic in Uganda (from end of March until end of June 2020); affecting their livelihoods, education, family relationships, social life, communities, mobility and at times health.[3]

The COVID-19 pandemic is an exceptional time, and international human rights law permits governments to temporarily limit the exercise of some human rights for the compelling and legitimate purpose to protect lives and public health. Lessons from the HIV response reaffirm the imperative to follow key principles when applying rights-limiting measures namely that these measures must be lawful, necessary, proportionate, non-discriminatory and limited to achieving a legitimate aim. The requirement of proportionality means the restrictions must be appropriate to achieve their function (effective), the least intrusive and least restrictive to achieve their protective function, and proportionate to the interest being protected.[4]

The conceptual basis of the essay: The social determinants of health

It is now widely recognized that health outcomes are deeply influenced by a variety of social factors outside of health care. These factors are what are referred to as the social determinants of health by the world health organization. The dramatic differences in morbidity, mortality, and risk factors that researchers have documented within and between countries are patterned after classic social determinants of health.[5] It is these factors that have played out the most during the management of the COVID-19 pandemic in Uganda. As such the essay proceeds

[2]Minority Rights Group International, (2020) Impact of COVID-19 on Batwa and Benet IPs Communities in Uganda

[3] Parkes, et al., (2020) Young People, Inequality and Violence during the COVID-19 lockdown in Uganda. CoVAC Working Paper | October 2020

[4] UNAIDS, (2020) RIGHTS IN A PANDEMIC: Lockdowns, rights and lessons from HIV in the early response to COVID-19

[5] Emily Zimmerman and Steven H. Woolf, (2014) Understanding the Relationship Between Education and Health

to consider how social economic inequalities have played out in the delivery and utilization of health services in Uganda.

Objectives of the essay

Specific Objectives

- To establish the weaknesses and strengths of Uganda's health system in view of the COVID-19 pandemic
- To evaluate the impact of social inequalities in the delivery and utilization of health services during the COVID-19 pandemic
- To offer recommendations for better closure of social inequalities in the delivery and utilization of health services during the COVID-19 pandemic

The problems/weaknesses of Uganda's health system

In light of the first specific objective of this essay, it is important to note that Uganda's current testing capacity for the novel Corona virus is limited. Tests only go to the labs at the Uganda Virus Research Institute; government has not yet tapped private labs. Health system is under-funded and fragmented with approximately ½ of system capacity in an uncoordinated private sector that could add capacity, facilitate proper testing and referral practices, and share essential data about potential cases and treatment. There is acute shortage of human resources for health with a ratio of 1:24,000 doctors and 1:11,000 nurses within the population. Current staffing levels in public and faith-based facilities average 77%. Uganda has a capacity of only 55 ICU beds which is equal to 1.3 ICU beds for every one million Ugandans.[6]

The above weaknesses set aside; the country boasts of some initial capacity gained through the experience of a number of epidemic outbreaks that have happened over time. World Health organization observes that Uganda's health surveillance system has been growing throughout the many different outbreaks experienced. The system is designed to promptly detect diseases, from the community level through village health teams. To substantiate this position, it can be argued that before any cases were registered in Uganda, the country used available evidence from WHO and from affected countries such as China to plan for the pandemic. Uganda developed a comprehensive Corona Virus Preparedness and Response

[6] THE UGANDA SP4PHC TEAM, (August, 2020) COVID-19 Summary Update for Uganda

plan, various guidelines and SOPs, risk communication and widely disseminated public awareness messages. The world health organization reports that these messages relied heavily on the scientific evidence on COVID-19 provided to member states by the WHO. The categorisation of countries into risk categories, meant that travelers from high-risk countries were subjected to the compulsory institutional quarantine and only released after testing negative on the last day. Those from low-risk countries were required to fill in a surveillance form and proceed to their homes for self-quarantine, while being monitored daily by surveillance rapid response teams. The evidence was used to implement infection prevention and control measures; capacity building for health workers and a re-organization of service delivery points, while also ensuring continuity of care. The government activated the EVD infrastructure at border points of entry, increased capacities and introduced screening at points of entry.[7]

The general impact of COVID-19 on Uganda's health system

In light of the second specific objective of this essay, it is important to consider the impact that the pandemic has had on the health service system in Uganda.

By far, the biggest challenge that has been identified is of overwhelming of the country's health system as an immediate direct impact on health as observed by the UNDP. The rapid transmission of the virus, has since overwhelmed the health system to unprecedented levels and as such has caused severe morbidity and mortality. Following the experience from advanced economies like Italy, it is evident that Uganda's health care, characterized by less than 100 intensive care Units that are largely concentrated in the city, staffing challenges, and limitations of medical supplies, has faced more impediments.[8] In reference to the Health Sector Performance Report 2018/19, there are only 1.87 professional health workers per 1000 people, below the national target of 2.28. One nurse is expected to serve 2,967 people, while a doctor serves 23,700 people. Additionally, Uganda currently has only 55 functional ICU beds, resulting in approximately 1.3 ICU beds per million Ugandans. The COVID-19 outbreak as noted by the state minister for Health Morricu Kaduchu has been strained the health sector. She noted this in an interview in the Mighty Breakfast early morning show at 9.33 K. FM on the 17th December, 2020.

[7] Kadowa I., (2020) Using evidence and analysis for an adaptive health system response to COVID-19 in Uganda in 2020

[8] UNDP, (2020) socio-economic impact of COVID-19 in Uganda: Short, medium and long-term impacts on poverty dynamics and SDGs using scenario analysis and system dynamics modeling

The social determinants of health: Social inequalities in health service delivery and utilization during the COVID-19 pandemic

As earlier on noted elsewhere in this essay, the arguments raised in this essay are conceptually guided by the concept of the social determinants of health. In this case, social economic inequalities will be viewed in how they have affected and been affected by the COVID-19 pandemic and the responses from government and development partners.

As an entry into this part of the essay, the work of Akumu titled "Health Equality Dilemma in Uganda" is worth referring to here which will as well inform most of the arguments raised in this part of the essay. Akumu notes that Uganda's development response over the years, has seen impressively high economic growth rates that have not translated into a better life for the poorest and most vulnerable such as women, and this has spilled into its COVID-19 response.[9] This kind of development response has widened social inequalities in the country and no serious efforts have been made to close the gaps. It is these gaps that have become even more glaring in the wake of the COVID-19 pandemic and the delivery and utilization of health services amidst the same disparities.

Social inequalities marked by poverty have had poor people run the risk of contraction of COVID-19 because of their living conditions that do not allow spontaneous following of the standard operation g procedures and guidelines. Akumu notes that research has long shown that among poor people, bad health is accepted as a reality they must live with. These poor people do not always appreciate the ways in which their circumstances contribute to their ill health. Even when they do, they do not have power or money to do something about it. They accept poor health as an inevitable reality. For example, poor people are more likely to not have proper sanitary facilities, live in a poorly ventilated house or have no access to nutritious food that boosts their immunity in the face of a pandemic such as COVID-19. In Uganda, the poorest have jocularly accepted their position with the euphemism, omwavuwakuffa- the poor person is meant to die. This statement is an actualization of systems that have for decades taught that poverty and inequality are inevitable. The masses are internalizing inequality- with dire consequences.[10]

The question of poverty had made the access and utilization of health services hard for the poor communities, a phenomenon that has been heightened during the COVID-19 pandemic.

[9] Akumu P., (2020) Health Equality Dilemma in Uganda
[10] Akumu P., (2020) Health Equality Dilemma in Uganda

It is generally agreed that to be poor is to live below the poverty line as set by the World Bank. But poverty, like inequality, comes with a lot of layers. In Uganda, one is likely to be poor if they are from the northern or eastern region, are a small holder farmer, live in a rural area or you are a woman. Poverty and inequality affects people differently, mingling with other status such as disability, homelessness, statelessness, gender identity, sexual orientation among others. Like the charmed circle of equality theory posits, the more outside what society considers dominant and normal, the less likely you are to be rewarded by economies designed for the powerful. The more likely to fall in that ominous group called poor, your face getting lost alongside other forlorn faces- looking for healthcare solutions in a system that has not tried to understand your needs.[11] This way, number of poor people have not been able to access routine health services during the COVID-19 pandemic from the public health facilities in the country whose concentration has been on COVID-19 leaving almost the other illnesses to the private facilities that cannot be afforded by the poor. In the month of October, a story ran on NTV on their health focus segment in the NTV weekend Edition (9.00pm News bulletin) about a poor woman from Entebbe that had lost her child after she had been turned away from the Entebbe Grade B hospital. The hospital insisted it was handling basically COVID-19 cases and as such had left her with the option of private facilities that she could not afford and as a result she lost her child. Her story of agony on how she wrapped the body of her child for burial could be felt in the endless flow of tears down her pale cheeks. This story shows how the social determinants of health have played out in the delivery and utilization of health services during the COVID-19 pandemic.

The issue of socio-economic inequalities in Uganda has been accentuated by the poor budget allocation to the health sector which has in a way impacted the delivery and utilization of health services before and during the COVID-19 pandemic. As Akumu recounts, the health budget for financial year 2019/2020 was 8.9 percent, a drop from 2018/2019 financial year when it stood at 9.2 percent. This however is still far less than the 15 percent commitment under the Abuja declaration. Further back in 2017/2018, health commanded a paltry 5.7 percent of the national budget after having suffered a big slash in 2016/2017 when it stood at 8.7 percent. The percentage of the budget allocated to health is ever fluctuating and decidedly non-committal which is indicative of the way government has handled health issues over the last years. Health- the mental, physical and emotional wellbeing of people- is not only an important development indicator but also an issue that often determines the political destiny

[11] ibid

of governments. The Uganda government has managed to keep Ugandans just above the floating line, when it comes to health- investing just enough to keep flailing government hospitals and health centers from completely closing. Enough for there to be one success story of a disease successfully treated while masking the stories of the hundreds turned away because there are no drugs. It is this that played out during the height of the COVID-19. Most people particularly the poor were often turned away from health facilities because of the lack of the necessary medicines.

The COVID-19 has made often ignored issues come to the fore and offer shame to the government whose funding to sector has been selective due to inequalities of particularly gender. Issues like the lack of the much-needed intensive care beds has come to the fore. Akumu decries how even after NGOs have moaned on for years about it being unacceptable that 15 women, an entire taxi, lose life in child birth every day without being heard; now it suddenly becomes important how many ventilators and ICU beds are in the country. Companies are laying off workers quietly while audaciously giving generous donations and pickup cars to government. Private clinics cannot handle COVID-19, and suddenly we care whether government hospitals function. The poor have been forced to rely on these government hospitals we have ignored for so long for years.[12]

In the face of COVID-19, the important work of health workers and the need for governments to invest more in their health sector has been laid bare, and is indeed not negotiable. Perhaps it is in this vein that government stampeded to return to the businesses that enjoyed tax holidays and a much-prized favorable investment environment and asked them to donate to the COVID-19 cause what they should have paid in taxes anyway. To further support the COVID budget, parliament passed a 284 billion supplementary budget to fight COVID-19. Civil Society Budget Advocacy Group notes that security is once again taking a lion's share of the health budget, presumably to enforce the COVID-19 presidential directives meant to keep people at home and stop the disease from spreading. Health is getting 27.1 of this budget and security 26.8. CSBAG argues that security budgets should be more inclusive, focusing more on issues such as domestic violence that affect marginalized people rather than reinforcing state machinery.[13]

[12] Akumu P., (2020) Health Equality Dilemma in Uganda: A Review of COVID-19 and the Health Equality Dilemma in Uganda

[13] Chimp Reports. 2020. Parliament passes 304 billion COVID-19 supplementary budget without debate. https://chimpreports.com/parliament-passes-shs-304bn-covid-19-supplementary-budget-without-debate/ cited in

The big chunk going to security in the fight against COVID-19 is a continuation of the old order, where government is more concerned about reinforcing itself than investing in pro-poor sectors like the health sector. Yet, the fact that security is getting a slightly bigger chunk than health is a grudging acceptance that government priorities have to inevitably change. The question of social welfare of Ugandans became especially important in the face of COVID-19, with the National Social Security Fund rejecting national outcry for them to release some of the money to workers- many of whom have been laid off indefinitely, pending the resolution of the COVID-19 question.[14]

In view of helping the poor deal with the devastating effects of COVID-19 including health, government responded by promising to distribute food to 1.5 million Ugandans in Wakiso and Kampala. The food distribution exercise was, however, marred with corruption, an important factor in maintaining and reinforcing inequality that compromises the health of particularly the poor. Some people in the Office of the Prime Minister were arrested. The Office of the Prime Minister, entrusted to handle disasters such as COVOD-19, is not new to corruption scandals. Akumu recollects that for example, in 2012 an accountant in the Prime Minister's office was arrested and later convicted, following the disappearance of 5 billion shillings meant for peace recovery and development plans in Northern Uganda- one of the poorest regions in the country. OPM has also been accused of mismanaging Uganda's refugee response and misallocating money meant for refugees.[15] Even with the challenges around food distribution, government has kept a stalwart face. President Museveni, the face of the fight against corona virus has captured social media with hilarious quotes. Allegations of a questionable quarantine system was promptly and publicly addressed, and human rights limitations explained as necessary to save Ugandans. The beds at Mulago hospital were displayed, where the coronavirus center is said to have 900 beds. Akumu with a tone of sarcasm notes that this is what happens when rich Ugandans become the general public. There is a show of solving problems of commitment, even though for decades we did not put our money where our mouth is.

The case of Kampala's disadvantaged groups. The world health organization notes that like many African cities, the vast majority of residents in Kampala make their living through

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Akumu P., (2020) Health Equality Dilemma in Uganda: A Review of COVID-19 and the Health Equality Dilemma in Uganda

[14] Akumu P., (2020) Health Equality Dilemma in Uganda: A Review of COVID-19 and the Health Equality Dilemma in Uganda

[15] ibid

informal employment. In Greater Kampala, 87.2% of total employment is informal. Informality often means lack of social protection, rights at work and decent work conditions, and a reliance on daily trade to feed themselves and their families. During the pandemic, informal workers have experienced a high risk of loss of income and livelihood, as well as COVID-19 infection due to trading with close person-to-person contact. Moreover, 50% of residents in the Greater Kampala Metropolitan Area live in slums, comprising 16% of total land, presenting additional challenges to health protection measures such as physical distancing and stay-at-home orders.[16]

Women bear the burden of Health Inequality during the COVID-19 pandemic

The cracks in the Uganda COVID-19 response as Akumu strongly asserts; are beginning to show. It is getting clearer that quick fixes, however well meaning, will not fix the underlying inequalities that people face every day. Taking a gender perspective, Akumu notes that in the face of disaster, women are often worse hit and COVID-19 has not been an exception. During the time of complete lockdown, at least seven women died of child birth related complications that could not be addressed on time due to the fact that they could not easily access public transport to take them to the health center.[17] People complained that RDCs, who were supposed to give permission to sick people to travel, were not answering their phones, and motor cycle taxis carrying pregnant women risk were being seized by security personnel. In essence, COVID-19 worsened the already appalling situation of women dying when giving birth.

The question of rural women and reproductive health during the COVID-19 pandemic. Women in rural areas, which also have higher levels of poverty than urban areas, are disproportionately affected by the COVID-19 pandemic. These women are, even without COVID-19, more likely to use traditional birth attendants or unskilled relatives during their pregnancy. For these women, the opportunity cost of accessing a health center is often too high. How will the bills get paid? Who will look after the children left at home? Who will look after their spouse? A COVID-19 response that pays no attention to the realities of women, and the ways at which patriarchy inherently leaves them vulnerable is flawed. It can

[16] WHO, (June, 2020) Data for equitable COVID-19 action: Kampala, Uganda

[17] Reuters. 2020. In Uganda, mothers in labour die amidst corona virus lockdown.https://www.reuters.com/article/us-health-coronavirus-uganda/in-uganda-mothers-in-labour-die-amidst-coronavirus-lockdown-idUSKCN21R2FA cited in Akumu P., (2020) Health Equality Dilemma in Uganda: A Review of COVID-19 and the Health Equality Dilemma in Uganda

be safely argued that, even as IMF predicts that Uganda's economy will emerge as one of the most resilient in the face of COVID-19, women will no doubt be left battered.[18]

The question of domestic violence and the COVID-19 lockdown and its impact on health service utilization by particularly the women. In addition to maternity deaths in the face of COVID-19, women are reporting more cases of domestic violence as abusive spouses and other men stay at home expecting to be catered to. At least 51 percent of women in Uganda have experienced domestic violence. Violence against women is linked to expectations about their roles. For instance, cooking food or taking care of children. It is also linked to how they are expected to behave towards the men in their lives; that is be meek and listen. The UN reports that reports of domestic violence have doubled during the COVID-19 pandemic. UN has recommended that domestic violence plans be made part and parcel of the coronavirus response. Further, in closed up domestic situations such as that of COVID-19, the already unfair domestic workload on women grows even heavier. They have to look after children who are out of school, older people and those who are ailing from corona virus or other diseases. Women whose behavior does not conform or who do not perform their role to expectation are beaten back into line within the confines of a lockdown. Security organs for whom domestic violence has never been a priority feel overwhelmed and are not likely to pay domestic violence victims attention- a fact the president has himself admitted.[19]

Related to the above are the by-products of the violence and abusive situation which are more unwanted pregnancies for both adults and teenagers. These jeopardize sexual reproductive health for the victims affected. Uganda already has an unmet need for family planning of 24 percent. Less women are likely to access family planning during lockdowns and quarantines. Teenagers from poor families are especially at risk. They may live in closer quarters with relatives, and they and their parents might lack appropriate knowledge to address sexual abuse. Besides, reporting sexual abuse in a lockdown situation is likely to cause family acrimony. The easier thing is therefore to stay silent- a continuation of the culture of silence on violence against women that existed even before COVID-19. Teenage pregnancy will in turn mean that girls drop out of school. This will be compounded by economic situation families will be in post COVID-19. Already, in the absence of resources, families prefer to educate boys rather than girls.

[18] IMF. 2020. Policy responses to COVID-19. https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19

[19] Akumu P., (2020) Health Equality Dilemma in Uganda: A Review of COVID-19 and the Health Equality Dilemma in Uganda

Women's poor health as a question of systematic inequality. The above realities of women in the face of COVID-19 are not just sad facts. They are but an intricate part of a system designed to undermine the health and wellbeing of women while benefiting from their labor. And, without the right interventions, COVID-19 will leave Ugandans worse off. And women will be at the bottom of the pyramid. Already, women make up the majority poor and vulnerable. They work in the lowest paying sectors of the economy such as domestic work, mining and quarrying.[20]These low paying casual jobs are the first to be axed in the face of a pandemic compounded by a financial crisis and a history of inequality. The president said the poor will remain poor after COVID-19. The truth is that, for the already vulnerable, they will be even poorer.[21]

Way forward on closing the inequalities in health beyond the COVID-19 pandemic

Amidst the above challenges and realities, there is need to light a flicker of hope for better health service delivery and utilization during the COVID-19 pandemic and other crises that may come later. This section still finds great intellectual comfort in those suggested by Akumu in her paper "Health equality Dilemma in Uganda." This essay offers a modification of the same

The challenges and exclusion that we have seen during COVID-19 should set us on a path of reforming our health sector as a country. We need to increase our investment in health, and work towards reducing the amount of money people, especially the poor, spend on health. COVID-19 should cause us to rethink our priorities and redistribute money that goes to sectors such as security to health. Government should work towards meeting the Abuja declaration commitment of having 15 percent of the budget dedicated to health within the next two years. Health sector reforms should also involve revising salaries and benefits of health workers so that they are better motivated. This should be complemented by a decisive anti-corruption campaign in the health sector, led by government. COVID-19 reminds us that money should not be the decisive factor when it comes to who lives; and everyone deserves to enjoy their right to good health no matter the depth of their pocket, their sex or gender identity.

Given the gravity of COVID-19, it is difficult to think of other equities now. The popular stand is to support government completely without question. But going forward blindly only

[20] Oxfam. 2017. Who is Growing: A study of key drivers of inequality in Uganda. https://oi-files-d8-prod.s3.eu-west-2.amazonaws.com/s3fs-public/file_attachments/oxfam_in_uganda_inequality_report_compressed.pdf
[21] Akumu op.cit

means that we risk the lives of our vulnerable. Government should therefore immediately follow UN recommendations and map the needs of women and other vulnerable groups and draw up a plan on how COVID-19 response will address their specific especially in terms of maternal health, protection from violence, teenage pregnancies and ensuring all girls return to school after COVID-19. This plan must be well funded and implemented. Failure to do this will mean that we regress on the few gains that we had made in terms of empowering women and other vulnerable groups.

COVID-19 has reminded us that social norms that keep women poor and excluded flourish even in the face of a pandemic. Addressing the root causes of women's exclusion, including in access and enjoyment of better health, is still quite contentious. Culture and religion are still used as excuses to relegate the needs of women while benefiting from their hard labor. Article 52 of the Constitution of Uganda places on the Human Rights Commission the duty to educate people and enhance environment for enjoying rights. Such education should include a confrontation of social norms that exclude women and compound inequalities. COVID-19 has also showed us that government bodies have power to influence behavior change, and all they need is commitment. Under leadership of the Uganda Human Rights Commission, government should put the same effort in fighting social norms that exclude and have led to the death of women for decades, as it has put in fighting COVID-19 pandemic.

Conclusion

As a conclusion to this essay, there is no better way of ending it than how Akumu uses figures of speech and imagery to show the irrelevancy of maintaining inequalities that compromise health of some people. Akumu observes that in the face of COVID-19, the walls are crumbling around the richest who, alongside the powerful, have to, for the first time, face the reality of having nowhere to run. Uganda's richest feel as if their fences have broken down and the sewage from the ploughed garden-like roads is flowing dangerously close to their emerald compounds. COVID-19 is threatening to mash, merge and consume everyone. This essay just like Akumu notes in hers has shown that Uganda's response to COVID-19 is no different to its general approach to development which has always been blind to the situation of the poor and most vulnerable, especially women. It has shown the ways in which COVID-19 has highlighted inequality in our health system, and how the poor and women have been denied their full right to health by the rich and powerful who, before COVID-19,

had the option of flying out. It makes a case for investing more in an inclusive COVID-19 response that is alive to existing inequalities and resolves rather than compounds them.

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