COVID-19 POLICIES: HUMAN RIGHTS APPROACHES TO PROTECTING VULNERABLE GROUPS IN AFRICA.

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Table of Contents

Abstract **4**
1.0 Introduction **5**
1.1 Research priorities and key questions 5
1.2 Objectives 6
1.3 Conceptual framework 6
2.0 Methods **8**
2.1 Search methods for identification of studies 8
2.2 Selection of studies 8
2.3 Study quality assessment 8
2.4 Data extraction 9
2.5 Data management, analysis, and synthesis 10
3.0 Findings **10**
3.1 Recognising and supporting vulnerable groups in policy responses 11
3.2 Addressing the underlying conditions that reproduce and exacerbate structural vulnerability 13
3.3 Implementing a human rights approach to COVID-19 policies 15
4.0 Discussion and Concluding Remarks **18**
5.0 Limitations **20**
6.0 References **21**
Appendices **26**
Appendix 1: Search strings for Scopus database 26

List of Figures

Figure 1. Conceptual framework for the literature review 7
Figure 2. PRISMA flow diagram 9
Figure 3. Analysis and synthesis procedure 10
Figure 4. Refined conceptual framework 19

Abstract

Multiple social interventions have been introduced to contain the COVID-19 pandemic across Africa. These policies have caused school and workplace closures, controlled informal work activities, led to the cancellation of many public events, restricted the size of public and private gatherings (including religious congregations, weddings and funerals), suspended public transport, limited travel, imposed curfews, and required contact tracing. In anticipation of negative economic impacts of these measures, many governments introduced cash transfers, social pensions, food aid, utility and tax waivers and related measures. However, people living precariously and/or in a structurally vulnerable position have not always had access to this support, and the measures imposed to contain and mitigate the pandemic did not take sufficient account of the effects of the human rights of these individuals.

The pandemic is too recent for much empirical research on the impacts of COVID-19, or on the effect of interventions to protect human rights. In undertaking a rapid review of these questions, we examined primary studies, editorial notes, opinion papers and literature reviews using mainly qualitative approaches, and discussions of quantitative studies where these contribute to further understanding the impacts of interventions on human rights in Africa. In this synthesis and analysis, we contribute to understanding how social interventions impact the human rights of vulnerable populations and identify proposals for a policy response to COVID-19 that better integrates the needs of these populations in Africa.

1.0 Introduction

Diverse non-pharmaceutical interventions (NPI) were introduced from early in the COVID-19 pandemic to contain the transmission of the virus, both to minimise the direct effects on people's health and to ensure the readiness of health services to care for patients. These included the temporary closure of schools and workplaces, cancellation of public events, restrictions on the size of public and private gatherings (including religious congregations, weddings and funerals), suspension of public transport, imposition of curfews, restrictions on travel, and contact tracing (1). These stringent measures were considered necessary by governments, on the advice of local scientists and specialists from multilateral organizations. However, they have had tremendous impacts on the lives of citizens, in particular those disadvantaged by precarious living conditions, exploitation and discriminatory practices (2).

To mitigate the anticipated social, health and economic impacts of these interventions, governments across Africa introduced various forms of social assistance, social insurance and labour market policies. These included supplements to social pensions, cash transfers and utility, food aid and tax waivers (3). Scholars have expressed concern, however, that neither the NPIs nor social policies accounted sufficiently for the links between health and human rights (4). In this review, we examine the effects of health, human rights and the NPIs on vulnerable populations, and provide guidance for a more integrated and holistic policy responses to COVID-19 in Africa.

1.1 Research priorities and key questions

To support Africa's response to the pandemic, the Alliance for Accelerating Excellence in Science in Africa (AESA) is working with partners to produce rapid evidence syntheses and policy briefs to inform African government responses to COVID-19. We addres two priority questions: 1) What are the short- and long-term social impacts of COVID-19 in Africa? and 2) What socioeconomic, cultural and contextual factors have an impact on the effectiveness of COVID-19 public health initiatives (NPIs)?

We discussed these priority areas with a variety of stakeholders from African countries, applying social science to understand the pandemic and its implications for policy. This formative discussion was undertaken through a tele-convening (15 June 2021) with stakeholders from policy, academic, NGO and community sectors contributing in both a plenary session and three break-out panels. The primary focus was on the effectiveness of government responses to COVID-19 in addressing social risk factors and protecting structurally vulnerable populations. The group focused on four questions:

- Who were considered vulnerable (and by whom)?
- What stakeholders were involved in designing policy responses?
- In what ways were existing vulnerabilities amplified? and
- What new inequalities emerged because of COVID-19 NPIs?

The consensus of participants was that social science research and analysis are critical to understand the non-biomedical implications of current policies related to the COVID-19 pandemic. Participants drew attention to the uneven impact and consequences of NPIs on vulnerable populations, often exacerbating their powerlessness and social and economic

insecurity. They emphasised the importance of learning from previous pandemics, the need for human rights approaches to policy making, and the imperative of social research to inform pandemic policy responses.

Our review addresses this need for research through a synthesis of the literature, expanding on the connections among underlying social conditions, vulnerability, national policies and human rights. The impact of the pandemic on vulnerable populations was not addressed in the main policy document that helped frame an integrated response of Africa to COVID-19 to prevent "severe illness and death" and minimise "social disruption and economic consequences" (5, p.3). The document did not question who was included or excluded in state responses, and focused on disruption to social and economic life rather than on protecting human rights. Our review sought to draw out the policy implications of research on pandemic containment measures and programmes to mitigate their negative impact; as we illustrate, gaps in the government response to the pandemic had unintended consequences for vulnerable populations and their human rights. We build on a conceptual framework to understand the links among health, vulnerability and human rights.

1.2 Objectives

Not surprisingly, there is little published research on the immediate social and economic impacts of the current pandemic, and even less on the impact of NPIs on the human rights of vulnerable people in this context (6,7). We apply a broad framework of human rights, structural vulnerability and health, and their interconnections, to inform policy making in relation to pandemics. Below we:

- Provide a framework of human rights, structural vulnerability, health and their interconnections to analyse public health policy responses to the COVID-19 pandemic;
- Understand the impact of COVID-19 NPIs on the health, human rights and structural vulnerability, and on the conditions of everyday life, of vulnerable populations in Africa, and
- Consider the implications of the findings for integrated and holistic interventions and policy responses to COVID-19 in Africa.

1.3 Conceptual framework

NPIs are intended to minimize the spread of COVID-19. Hygiene, social isolation and strict controls of social interaction are the most effective public measures to contain a novel pandemic and its unknown effects (8), although evidence of the optimal mix of measures is not conclusive (9). In general, NPIs draw on a traditional understanding of public health and biomedical aspects of disease transmission; while they address the needs and priorities of medical and health services, they do not account for a broad and holistic perspective of their social and economic constraints and local contingencies (10,11). Health policies can impact the human rights of citizens both positively and negatively, while, conversely, human rights policies affect public health, creating an interdependent and bidirectional relationship between the two (10). Structural vulnerability both shapes and is an outcome of variations of health and human rights (2). This broader framework recognises that human rights and health are inextricably linked (4,12).

Structural vulnerability can be defined as “a positionality that imposes physical, social, emotional and economic suffering on specific population groups and individuals in patterned ways” (13, p.339). Structural vulnerability “derives from economic exploitation and discrimination,” and we use the term to draw attention to how “disparities of class, culture, gender, sex and race impact on individuals, families and communities” (14). In the context of the COVID-19 pandemic, we define structurally vulnerable populations as those “at risk for adverse health outcomes through their interface with socioeconomic, political and cultural/normative hierarchies” (15, p.17). A search of the published literature through 30 June 2021 produced a range of vulnerable populations, including women, children and youth, people living in multidimensional poverty, residents of institutions, refugees and people living with disabilities. For health outcomes, we use the conventional WHO definition of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (12). Economically, vulnerability is reflected in decreasing living standards and growing hunger among many people in African countries (7,16). However, the impact of pandemic NPIs extends well beyond this level of vulnerability.

The significance of structural vulnerability during the COVID-19 pandemic is well described by Garimella et al (17) in their analysis of the circumstances of “waste pickers” in India. This population, which survives by collecting and selling recyclables, was invisible in public health policies even before the COVID-19 outbreak. These communities were particularly disadvantaged by pandemic measures that restricted people’s income generation activities, and by policies that did not recognise them explicitly as vulnerable and maintained them in a state of “debility”. Specific measures to reduce the transmission of coronavirus magnified their difficulties, as they sought to generate an income while living in conditions of extreme poverty, in poor housing without access to hygiene and sanitation services and subject to discrimination and marginalisation.

To map this rapid review and analyse the links among health, vulnerability and human rights, we adopted a framework in which the multidirectional relationships among underlying conditions, health and human rights both produced and are affected by structural vulnerability (Figure 1).

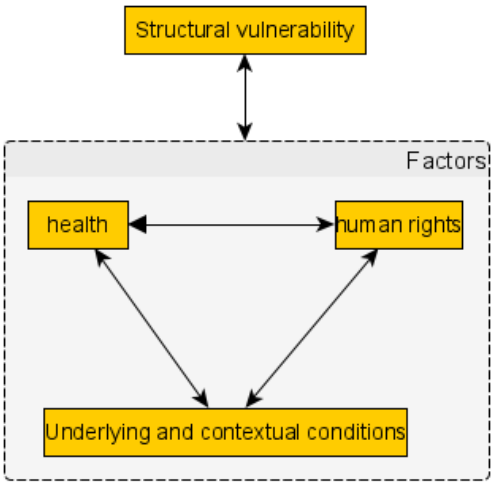

Figure 1. Conceptual framework for the literature review
Source: Based on Mann et al. (10), WHO (18) and Team and Manderson (14).

2.0 Methods

2.1 Search methods for identification of studies

Because this review was rapid, we focused on the peer-reviewed studies directly addressing Africa as their main subject of analysis, at continental, national or subnational levels. We performed three searches in the Scopus database. The first one identified literature related to structural vulnerability in Africa. The second added a series of NPIs such as lockdowns and social distancing. The third included human rights. These searches were supplemented by Epistemonikos and the Cochrane COVID-19 register database of reviews. Annex 1 provides each search string used in this review.

2.2 Selection of studies

We included primary studies that used qualitative methods for data collection and analysis and studies that use secondary data, including quantitative data analysis. After performing the searches and deduplicating the records, two review authors (DC and LM) screened titles and abstracts for studies meeting the key criteria of identifiying connections among human rights, health, NPIs and vulnerable populations in African settings at the continental, regional, national or subnational levels. Primary groups identified as vulnerable were women, children, migrants and refugees and institutionalised residents. Additional vulnerable groups and populations included adolescents and young people, sex workers, sexual minorities, inmates, persons with medical comorbidities, and homeless people. NPIs introduced to contain the pandemic included: school and workplace closures, cancellation of public events, restrictions on the numbers of people at gatherings (e.g., religious services, weddings and funerals), changes in the provision of public transport, curfews, quarantine, restrictions on private travel and contact tracing (1). In this review, we define an impact on human rights as any actual or potential effect that an NPI has on the rights of a population, with human rights understood as a domain rather than as individual aspects of human relations (10). For this reason, we did not list all human rights to select the studies, but rather we relied on the identification and justification given by authors.

We downloaded all potentially relevant papers and selected those meeting the selection criteria based on full-text screening. We crosschecked this with documents identified by the expert knowledge of the review team (authors) to ensure we had identified all relevant studies. The final sample consists of 38 papers as follows: 15 commentaries, 11 law articles, five other qualitative and quantitative articles, four letters to the editor, two editorials, one case study and one case report. The literature predominantly reported South Africa's experience, with 13 reports from this country – followed by Nigeria (2), and one each from Malawi, Lesotho, Kenya, Uganda, Central African Republic and South Sudan. Of those with a regional focus, 12 addressed Sub-Saharan Africa, two Southern and East Africa, and two Western Africa. Two documents did not address a specific region. This distribution demonstrates the uneven distribution of research on COVID-19 and human rights in Africa.

Figure 2 (page 9) shows the selection procedure. Annex 2 provides the list of articles retrieved from the searches (worksheet "merged searches").

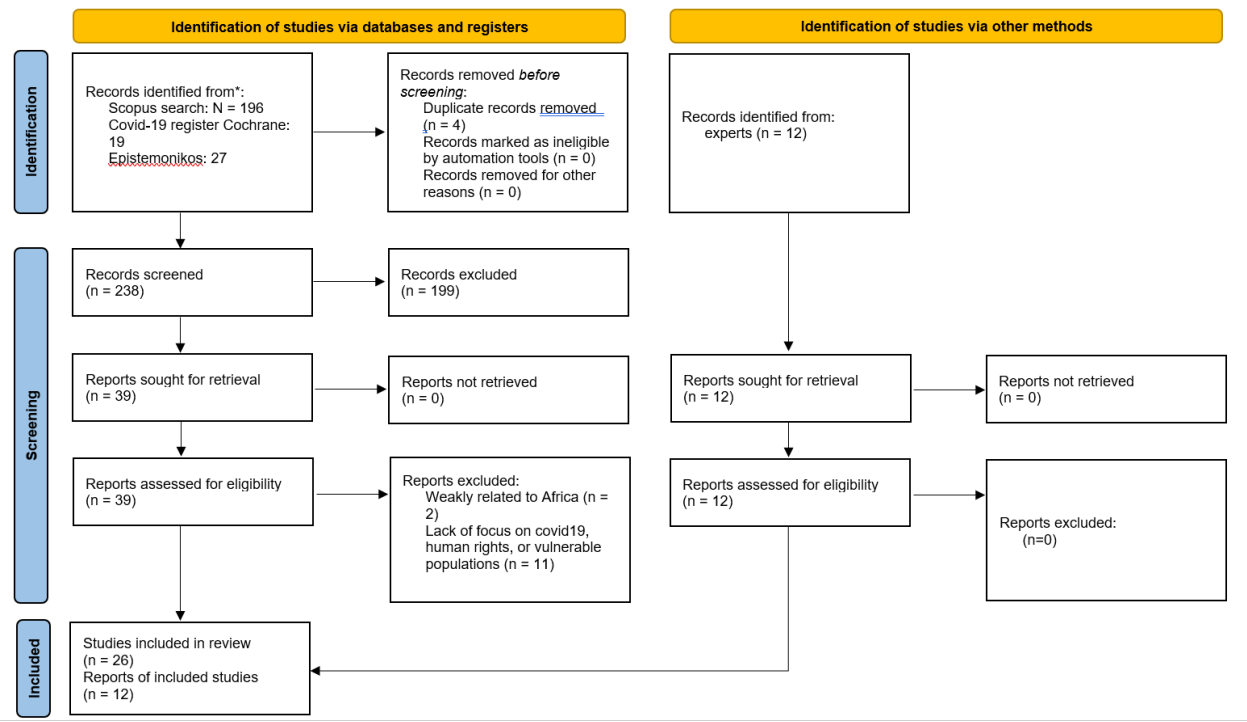

Figure 2. PRISMA flow diagram
Source: Based on Page et al. (20)

2.3 Study quality assessment

Given that most of our sample is from studies that use secondary data or conceptual discussions, we adopted a general approach to evaluate their quality, based on the Ways of Evaluating Important and Relevant Data (WEIRD) tool (19). The criteria of this tool are: *1) Is there a clearly stated aim, objective, or purpose for the source material? 2) Is there a clear description of the source of the information reported (transparency)? 3) Is there a clear description of the programme or intervention or policy or reform on which the source material focuses? 4) Is there a clear description of the context/s to which the information described in the source material relates? 5) Is the information accurate? 6) Is the evidence representative? 7) Are any limitations of the information and / or methods discussed in the source material? 8) Is evidence provided to support any findings or conclusions made? 9) Are relevant rights and ethics considerations described? 10) Are any interests declared and any potential conflicts of interest noted?* Documents were given a concern level rating of none or very minor, minor, moderate or serious. DC performed a first assessment, and LM checked a subsample. There were no major disagreements to be resolved. Of the 38 documents, 35 had no or very minor concerns, and three documents were of moderate concern. One common feature for the 35 documents with no or minor concerns is that they were based on non-representative samples, although the cases, statistical analyses, and arguments allowed us to draw broader conclusions. The reasons for the moderate concerns about the remaining three documents were: for Oladimeji et al. (34), we found weaknesses in the aim of the editorial piece, the description of the source of information used, the description of the context, and no discussion of limitations. For Dube (30), an article based on interviews through a WhatsApp group, we found lack of reporting of ethical clearance and recruitment procedure, and a lack of discussion

of limitations. For Boretti (29), a commentary, we found weaknesses in stated aims, description of the sources used, description of the program or intervention, description of the context, and discussion of limitations. Annex 2, worksheet “Screening, info, and assessment”, provides the evaluation criteria for all included studies from columns AE to AO.

2.4 Data extraction

The main elements we extracted from the papers were:

- Vulnerable population (sex workers, women, children, etc);
- Underlying conditions (social, economic, environmental, etc);
- Impact:
    - Social, economic, environmental, cultural, mental, other
    - Description of the impact, and
- Policy proposal:
    - Description of the policy proposal(s) in the paper.

We also identified methods, journal, country of authorship, and other bibliographic information. Annex 2, worksheet “Screening, info, and assessment”, shows the data extracted from each article (columns P-Z). It also provides a classification of documents according to the features they address: vulnerable groups, social risk factors, policies, impacts and vulnerability as a concept (columns F-K). Column M indicates if the document was included.

2.5 Data management, analysis, and synthesis

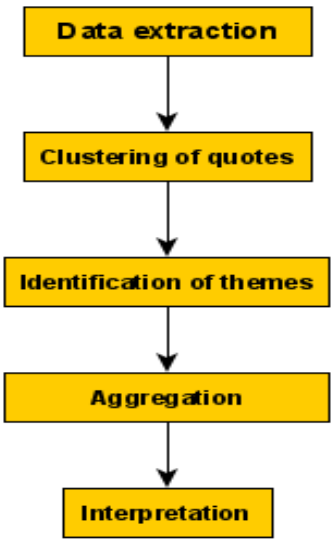

Figure 3. Analysis and synthesis procedure

The flowchart shown in Figure 3, above, illustrates the analytic stages. We undertook data extraction and analysis simultaneously. Using thematic analysis, we first classified studies into those that addressed vulnerable groups, underlying conditions, human rights, NPIs and policy proposals. Within these categories we identified specific vulnerable groups, underlying conditions co-existing with vulnerability, human rights being protected or violated, policies that were analysed, and policy proposals. These constituted our categories for analysis, allowing us to cluster documents by different themes. These themes were aggregated and interpreted in

relation to our conceptual framework, which changed with new evidence, as we explain in the discussion. We also synthesised policy proposals from the literature and developed prompts for policy making. These prompts are not definitive recommendations: they provide a guide for implementers to consider within specific policy and regulatory contexts.

3.0 Findings

In our review of the academic literature, we describe and analyse aspects of policy responses to COVID-19 infection that reproduce or exacerbate existing inequalities, and identify proposals to protect the human rights of structurally vulnerable groups. We identified policy issues that scholars consider harmful, insufficient or needing significant revision to counteract immediate or structural vulnerability. Below, we describe the key needs related to social vulnerability, underlying and contextual conditions, human rights and the interrelationships among them.

3.1 Recognising and supporting vulnerable groups in policy responses

A number of vulnerable groups are under-represented in government responses to the pandemic. Women are considered particularly vulnerable, with a lack of policy measures to protect them and the inadequacy of measures that do exist (6,21–27). Women are affected by the expectations of their role in patriarchal society, in which they carry the burden of caring for their families, and are subject to discrimination. They appear to be more exposed than men to the virus because of the nature of their work and time spent caring for others (26). Women often work without pay, and are under-remunerated for paid work, so experience greater economic pressures than men. Gender-based violence is pervasive and increased under pandemic conditions (24–26): lockdowns and curfews limited women's capacity to seek help, and impeded women from providing for their families and accessing basic health and other services. Govender et al (23) report that various sexual and reproductive health services in South Africa were suspended because of the prioritisation of COVID-19 treatment, leaving women with unmet needs for contraceptives, health screening and related exams, and other key services. In Sudan (21), lockdowns affected women entrepreneurs, most working in the informal economy; as one farmer explained: "COVID-19 is like a death sentence to us vulnerable women who depend on farming to feed our children" (21, p.595). Sekalala (26) finds that in West Africa, the lack of education of many women who live in poverty makes it almost impossible for them to know the law and demand protection of their rights. Even when they bring claims for harm, "courts are likely to underestimate the degree of harm faced by women" (26, p.14), thus failing to fully recognise and address their suffering.

Children have been identified as especially affected by the pandemic and related NPIs; like women, they are exposed to increased violence and illness because of containment measures (21,22,27–31). Boretti warns that "the indirect impact of COVID-19 on mortality especially children through malnutrition is expected to be larger in Africa than everywhere else in the world" (29, p.1). Interruptions to vaccination schedules have placed many children at risk of vaccine-preventable diseases (28). In some countries, such as South Africa, parental visits to children in hospitals were prohibited to limit transmission, leading one author to argue that this "is a clear violation of the child's right to 'family care or parental care ... likely to undermine the child's 'emotional security'" (31). Lack of capacity at national and regional levels to support

online learning, including to provide access to the Internet, affects children's schooling, with immediate costs to education and long-term negative consequences (30).

Migrants have become increasingly vulnerable because of xenophobia, other forms of extreme stigmatisation, lack of protection by national laws, and exclusion from social assistance policies for COVID-19 (6,32–35). Migrants include documented and undocumented foreigners, internally displaced persons in conflict areas, persons who move from rural to urban settings, survivors of human trafficking, undocumented persons, asylum-seekers, and refugees (32,33,36). Immigrants are disadvantaged by lack of familiarity with their new place of residence, sometimes not speaking the local language, with financial constraints, overcrowded living spaces, and precarious employment (32,37). This population faces a "lack of consideration … in economic, poverty, and hunger alleviation schemes" (33, p.1). Because of stigma as vectors of infection (35) and fear of being deported or imprisoned, Mukumbang et al argue that "migrants are less willing than nationals to seek testing or care for COVID-19 symptoms" (33, p.3). Even documented persons have problems finding support, access to food parcels and essential healthcare where policy measures prioritise nationals or exclude people without identity papers (36).

Researchers include as vulnerable people living in institutions, including inmates of prisons (34,38–40) and people living in confined settings such as mental health institutions (39). Many suffer from the consequences of COVID-19 policy measures; they already live under conditions of extreme deprivation and may be unable to survive without the help of persons outside the institution (34,41,42). In many countries, prohibitions during the pandemic have broken the links between relatives and prison staff inside and outside prison walls necessary to guarantee basic medicines, food, clothes and emotional support (34,43). Living conditions in institutions also heighten the risk of transmission of infection. In some countries, such as South Africa, visits to people in confined institutions, as well as in hospitals, were prohibited. Like health workers in hospitals, prison staff (43) bear a risk similar to prisoners to COVID-19 contagion because they share the same buildings and are in close contact for long periods. Prison staff have low salaries, impacting their everyday conditions of living, and they are not explicitly supported by social assistance policies for COVID-19.

These vulnerable groups were most frequently addressed in the literature, and were described in greatest detail:

- Women (6,21,23–27);
- Children (21,22,27–31);
- Youth (22,23,25);
- Migrants, including refugees, asylum-seekers, documented and documented immigrants, persons who migrate from rural to urban environments, internally displaced persons, trafficked survivors (6,33–35,37);
- Inmates (34,38–40), people in closed settings (39), and prison staff (43);
- Persons with medical comorbidities, including chronic pulmonary disease, cardiovascular disease, cerebrovascular disease, diabetes and compromised immunity (23,24,28,39);
- Populations living in extreme poverty, such as in informal settlements (36,38,44,45);

- Persons living with disabilities (28,38), including learners living with severe disabilities (46,47);
- Professional (24,26,28) and non-professional (26) healthcare workers. The latter includes birth attendants, community volunteers, traditional healers, and women healthcare givers;
- Homeless populations (34,38);
- Sex workers (28,39);
- People who use drugs, especially people who inject drugs (28,39);
- Elderly people (24,38);
- Sexual minorities, including men who have sex with men and transgender populations (39), and
- Individuals in conflict regions (24).

These groups have specific needs. For instance, Adebisi et al (28) specify social and mental health support for older adults, antenatal care services and medications for pregnant women, access to sexual and reproductive care services for women, COVID-19 information in accessible formats for people living with disabilities, needle exchange and opioid substitution therapy for people who use drugs, access to HIV drugs and care services, access to condoms for sex workers and sexual minorities, access to health services in prison and other closed settings. Many of the people listed here are marginalised in their own societies, do not have access to services at any time, and in some cases are subject to police harassment and the risk of apprehension. They are rendered invisible or intentionally omitted from programmes to mitigate the effects of NPIs to contain COVID, and authors call for policy responses that attend to their specific needs.

Although studies have classified vulnerable groups into distinct categories, the authors also note their intersectionality: that is, people typically belong to more than one vulnerable group, with compounding disadvantages. For instance, Molobe et al (32) observe that women and children, both vulnerable groups, are doubly disadvantaged when they are immigrants, further still if they are undocumented and therefore anxious to avoid surveillance. Sekalala (26, p.4) illustrates the intersectionality in healthcare work, where women's "race, class, gender and other axes of oppression overlap." Odunitan (36) points out that during the pandemic, being poor, an immigrant, and having low income all hinder access to food, secure housing and personal safety, and increase vulnerability to social injustice.

Authors argue the importance of acknowledging the diverse vulnerable groups, their specific needs, and their overlaps and interactions, and to address these in policies and programs; this requires specific measures rather than general lockdowns and closing of borders.

3.2 Addressing the underlying conditions that reproduce and exacerbate structural vulnerability

Different underlying conditions reproduce or aggravate inequalities, leading to new structural vulnerabilities. Although we lack evidence for many countries in Sub-Saharan Africa, the economic, health and social conditions prevalent across the continent all heighten the risk of contagion and deepen the vulnerability of poor populations. Olufadewa et al (24) highlight that populations throughout SSA experience high rates of unemployment, limited access to social

protection schemes, and unfair employment conditions. Informal work contributes “50-80% of gross domestic product, and 60-80% of employment and 90% of new jobs" (24, p.5).

Economic conditions have deteriorated in African countries due to the pandemic, as illustrated by Egger et al (7). They analysed different household surveys on living standards, conducted during the pandemic in Sierra Leone, Rwanda, Kenya, Ghana, Burkina Faso and various low- and middle-income countries beyond Africa. While the surveys were not statistically representative of national populations, the authors identified effects that included drops in income and employment, reduced access to markets, delayed healthcare access, missed or reduced meals and increasing dependence on NGO or government support (7).

People reported that lockdown measures threatened their livelihood and exacerbated inequalities. Chiwona-Karltun et al (6) analysed data from 12 Sub-Saharan countries – Benin, the Democratic Republic of Congo, Ghana, Cote d’Ivoire, Kenya, Mozambique, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia – to understand the concern of people over food security during lockdowns through a gender perspective, and noted both men and women were concerned that lockdowns would impact economic and food security. Odunitan-Wayas, Alaba and Lambert likewise observed that under lockdown, “the triple burden of food insecurity, poverty and malnutrition compounded with social injustice and income inequality [was] inevitable for the urban poor African immigrants in South Africa” (36, p.151). Authors call for policy responses to directly address these interrelated underlying conditions, and argue that measures such as cash payments and financial relief are ineffective, insufficient or palliative (25,28,29).

Other studies confirm that economic conditions arising from COVID-19 policies have had direct negative affects on vulnerable groups. Foreign-born migrants, asylum-seekers and undocumented migrants (33) must find alternative means of income when free movement is restricted, often increasing their risk of infection and incarceration for breaking isolation and quarantine measures (48). The majority of elderly people in SSA do not have access to pensions, and most rely on sources of income restricted by NPIs (25). In countries where extreme poverty is widespread, such as Malawi, people face increasing prices of goods, lack of commercial activity and opportunities to work, and closure of schools that provide food for children (44). Rural learners lack access to technology, the Internet and training for online learning (30).

Vulnerable groups are particularly affected by poor health systems and limited access to health care during the pandemic. Renzaho (25, p.2) emphasises that now as decades ago, “the leading causes of death in Sub-Saharan Africa are communicable, maternal, neonatal and nutritional (CMNN) diseases”, including HIV/AIDS, lower respiratory infections, diarrheal diseases and malaria. As countries address the immediate challenges to cope with pandemic control, less attention is being paid to these conditions. Renzaho (25, p.4) too notes that still “the majority of women giving birth do not have access to maternity cash benefits,” leading to insufficient protection of life even when it is available in other social welfare and protection programmes. These conditions are especially prevalent in countries where civil unrest is endemic, with poor infrastructure and inadequate medical facilities, materials and professionals (26, p.2). People living in such settings are likely to also suffer from other conditions, both physical and mental (33).

War and conflict aggravate the situation of many vulnerable groups who already face xenophobia and racism (21). Most asylum-seekers, refugees, and undocumented immigrants come from places where communicable diseases are endemic, and these continue in their new settings. Upon migration and resettlement, structural vulnerabilities continue to compromise their health and wellbeing. The needs of people who live in temporary, contained living conditions, including refugee camps, have not yet been addressed.

Throughout SSA, women are subordinated and expected to perform certain roles that put them at high risk of contagion, discrimination and economic burden (26). Sexual minorities are excluded by dominant social values, and these are reflected in COVID-19 policies (28). Sexual minorities such as men who have sex with men, transgender people and sex workers are excluded from social protection mechanisms in some countries, and often cannot access appropriate health support (28). Prisoners and people in other closed settings also face exclusion, stigma and discrimination, and are deprived of basic healthcare and hygiene (40,49,50). The health conditions of inmates and prison staff are threatened by “old physical infrastructure, insufficient sanitation, ventilation and hygiene, [and] severe congestion” (43, p.128).

Sekalala (26) shows that health workers are embedded in a hierarchy in which well-paid workers delivering international humanitarian aid, with formal contracts and health support systems, are at the top, while national healthcare professionals have poorer employment conditions and do not enjoy access to a first-tier hospital if required. Sekalala (26) argues that non-professional caregivers are at the bottom of this hierarchy, with women the least recognised and rewarded, and struggle to get access even to basic personal protective equipment.

3.3 Implementing a human rights approach to COVID-19 policies

Certain rights have been restricted to curb the spread of COVID-19 during the pandemic. As governments across Africa are declaring states of emergency and introducing disaster laws, an important question is the extent to which these measures protect human rights. Scholars call for a reasonable and proportionate response, using the least intrusive interventions available (21,44,51).

Distinct from the personal issues we describe above, states of emergency and disaster laws threaten the right to regular elections. Ethiopia and Chad have postponed legislative and parliamentary elections respectively, and other countries are contemplating the same (25). While postponing elections may be justified by the severity of the pandemic, scholars warn that this decision may be abused by some to gain and remain in power indefinitely (25,51).

There was also concern expressed in the literature about the use of special powers by governments, particularly militarisation to contain COVID-19 spread (52). Amadasun (22, p.1) refers to "widely reported cases of violence against citizens by security forces who were deployed to enforce curfews and lockdowns" in Kenya, South Africa and Nigeria. Manderson and Levine (53) describe soldiers strong-arming homeless residents and people living in informal settings in South Africa. Mukumbang, Ambe and Adebiyi (33, p.3) report that organizations for migrants have denounced “the arrest and detention of foreign-born migrants, their placement in, and subsequent repatriation from camps and shelters.” Other vulnerable

groups, such as persons who inject drugs and sex workers, have been targeted by the police more during the pandemic than usual (39).

The deployment of armed soldiers to enforce public health laws is not the only instance of militarisation. The COVID-19 pandemic has been cast as a war against a common enemy, and this narrative is used to justify the restriction of human rights. Nkuubi (51), for instance, shows that in Uganda the rhetoric of war has been used in government media campaigns, with military staff appointed to positions of authority in most civilian institutions that deal with the pandemic, including hospitals. In South Africa, militarisation has been built on repressive structures and technologies that were used to enforce apartheid (2,53). Addressing the pandemic as a war has reinforced dominant patriarchal hierarchies, leading to the increased abuse of women (26). In addition, the criminalisation of people who have ignored curfews, lockdowns and/or face mask wearing has amplified an atmosphere of fear and anxiety in vulnerable populations (6,21).

When enforcing lockdowns, governments have limited human rights or have failed to guarantee them, including in relation to constraints on the freedom of opinion and expression, as political opponents, those who contradict the official government position and protesters may be detained and prosecuted (24,39,54). The right to education is limited when schools are closed for an undetermined period and school systems are unable to support learners with disabilities or, as is common, with poor access to the Internet (46,47). The right to work has been compromised because of restrictions to movement, whether or not justified by the severity of the pandemic (32,36,44,55). Countries face increasing challenges in accessing food because of blanket policies that restrict all sectors of the economy, and have failed to implement measures to assist those who are most vulnerable (6,36,44). The right to be free of discrimination is violated by social assistance policies that do not acknowledge the needs of vulnerable populations, and some of these categories are criminalised (32–34,40,43). Further, while provision by the state of medicines and services for vulnerable populations are interrupted, private health institutions are generally not affordable (23,26,28,34,35,39,45).

The boundaries between reasonable and unreasonable responses by governments can be difficult to estabish, and national courts are central to interpreting the law and limiting the exercise of power. Nkhata and Mwenifumbo (44, p.525) report that the National Court of Malawi has reviewed different measures decreed by the government, and concluded that, in light of the severity of the pandemic at that moment, the Coronavirus Rules “exceeded the authority provided by the parent Act, namely, the Public Health Act;” The Court’s decision prevented a lockdown. Conversely, in Kenya the Court ruled that, while no data were available on the effectiveness of lockdown measures, a curfew was constitutional on the precautionary principle (56). In other countries such as Eswatini, Lesotho and South Africa, national courts have played a decisive role (9,55,57,58) while only partially endorsing government actions which violate constitutional rights (57).

Government policy measures influence the behaviour of civilians, leading to further threats to human rights. As noted earlier, Amadasun (22, p.1) documents that “gender-based violence [has] intensified in countries where promulgation of shutdown or stay-at-home orders have been implemented.” Mukumbang, Ambe and Adebiyi (33) describe an increase in violence against foreigners in South Africa associated with COVID-19 stigma. Iversen et al (39) foreshadow the exploitation of sex workers and drug users even more than usual by clients and drug dealers,

and Akech (21) reports that sexual violence against girls in South Sudan has increased during lockdowns. Research reports reveal an increase in violence indirectly related to stringent policy measures, while also revealing increasing inequalities on the continent.

This evidence leads to several recommendations to ensure that COVID-19 policy responses protect the human rights of vulnerable populations, although how these might be interpreted and implemented will vary in different countries. They include:

- *Achieving a balance between the containment of COVID-19 and protection of human rights.* Policy responses aimed at containing COVID-19 spread need to balance measures to avoid harm to vulnerable people (6,9,23,24,26,31,35,40,45,48). The authors have described laws decreed for emergency and disasters which violate international human rights conventions and national constitutions, and they call for governments to abide by internationally agreed upon standards such as the Siracusa principles to produce responses that are “legally and ethically justifiable under particular circumstances, [and offer] a fair measure of compassion, restraint and respect for human rights" (48, p.2). Recommendations include consulting with relevant institutions of the state before declaring states of emergency and disaster (21), allowing and promoting internal and international oversight of the policy process (6,40), and ensuring transparency through accountability (9).
- *Implementing population-specific versus uniform responses*. Scholars identify the need to identity various vulnerable populations not well represented in or excluded from general policies. Curfews and lockdowns, for example, disproportionately affect these groups by limiting their access to food, health services and medicines, reducing their incomes, increasing their exposure to xenophobia and exploitation, and exposing them to other forms of violence that violate their human rights (23–25,28,32,34,39,40,48,59).
- *Treating the causes instead of the symptoms.* Recognising vulnerable groups in policies implies that “social policy response must address root causes that elevate the vulnerability of people to abuses” (22, p.2). They include weak health systems, increasing privatisation of health, exclusion of people living in informal settings or working in the informal economy, income inequality, and other inequalities (6,21,24,26,34–36,40,43,45–47). To identify appropriate action and protection, we need better data on vulnerable groups and the disproportionate experiences of poverty, discrimination and stigma.
- *Planning vs reacting.* In light of a real sense of urgency during the pandemic, government actions are often reactive, enforced by police and the military, with the criminalisation of minor infringements (2,22,24,33,39,51,54,59), violence against and distress among citizens as NPIs are implemented and enforced (60), leading to clashes with national courts (9,44,58). Authors recommend enhancing social protection systems to be responsive to crises (25), updating legislation that derives from and still reflects the colonial past (40), retraining law enforcement officials and civil servants in human rights (22), designing laws to include social protection measures for people regardless of national identity or type of official registry or lack thereof (33), and enhancing capacity to

the anticipate the social, economic and environmental consequences of interventions (6,27).

- *Co-constructing vs instructing.* Scholars recommend planning exercise strategies to minimise the unintended effects of interventions by designing them in collaboration with different vulnerable groups and stakeholders such as NGOs (21,23,24,36,39). This lesson was clearly learned from experience from the Ebola and HIV crises. A similar approach could ensure that "the COVID-19 response, or 'cure', is not worse than the disease itself" (39, p.2).

4.0 Discussion and Conclusion

In reviewing the literature, we sought to provide a conceptual framework to analyse public policy responses to COVID-19, which included structural vulnerability and examined the impacts of NPIs on the health and human rights of vulnerable populations. We based the recommendations from this review on the implications of this analysis for policy making.

As explained above, structural vulnerability refers to the social structures and institutionalised conditions that position some people as more vulnerable than others. People who lack the right to health care and/or social support, for example, are structurally vulnerable because of the importance of citizenship or legal resident status, and they are obliged to organise their lives to avoid being apprehended and deported, which makes them structurally vulnerable. This vulnerability may be compounded by being female, for instance, or by holding certain occupations. As we have argued, social status, citizenship, economics and health are all interrelated and interactive, and those who were already vulnerable and disadvantaged prior to the pandemic are especially vulnerable under COVID-19 regulations.

To study structural vulnerability, we proposed an initial framework that assumes that it results from and is affected by the interrelationships among human rights, health and underlying socio-economic conditions. Based on this framework, we examined the literature to identify different vulnerable groups affected by COVID-19 regulations, their underlying conditions, and the impacts of regulations on their human rights. As described in the literature, we found that:

- A large yet incomplete list of vulnerable groups is excluded from or not adequately represented in policy responses to COVID-19;
- The precarious socio-economic conditions of these populations are not adequately addressed by dominant policy responses; and
- The human rights of these populations are threatened or violated.

Dominant policy responses to COVID-19 recognise people who fall within the state's ambit of citizenship; only partial support is offered to certain vulnerable groups. This reinforces structural vulnerability, structural violence and the increased risk of people who are situationally vulnerable, as is the case for people confined to institutions.

The effects of intersectionality on vulnerable groups are clear from evidence from various countries on the continent. Intersectionality emphasises that structural conditions, such as gender, race and class, interact with each other. COVID restrictions and vulnerability to COVID as a disease increase other vulnerabilities, compounding their effects. Take as an example a

young woman living in a patriarchal society, in which inequality and insecure work without social protection prevail under any conditions. She is more prone during COVID-19 lockdowns to violation of her human rights, including physical and sexual violence and worsened living conditions; in turn, the violation of her human rights makes her especially vulnerable to contracting the virus and to not receiving timely access to care.

The interactions among health, human rights, and underlying conditions can produce “recursive cascades”, a descriptor “to capture the often inevitable trajectory of increasing ill health and growing impoverishment” (61, p.479). Consider the experience of a woman leaving her country, and then finding herself excluded in the new country, perhaps on the streets, then exposed to the virus and to harassment and criminalisation. At each point of her experience, the circumstances and conditions of vulnerability interact with and amplify other vulnerabilities. To capture this, we suggest a modification to our framework (Figure 4), which reflects this complexity to better inform planning and analysis of policy responses to COVID-19.

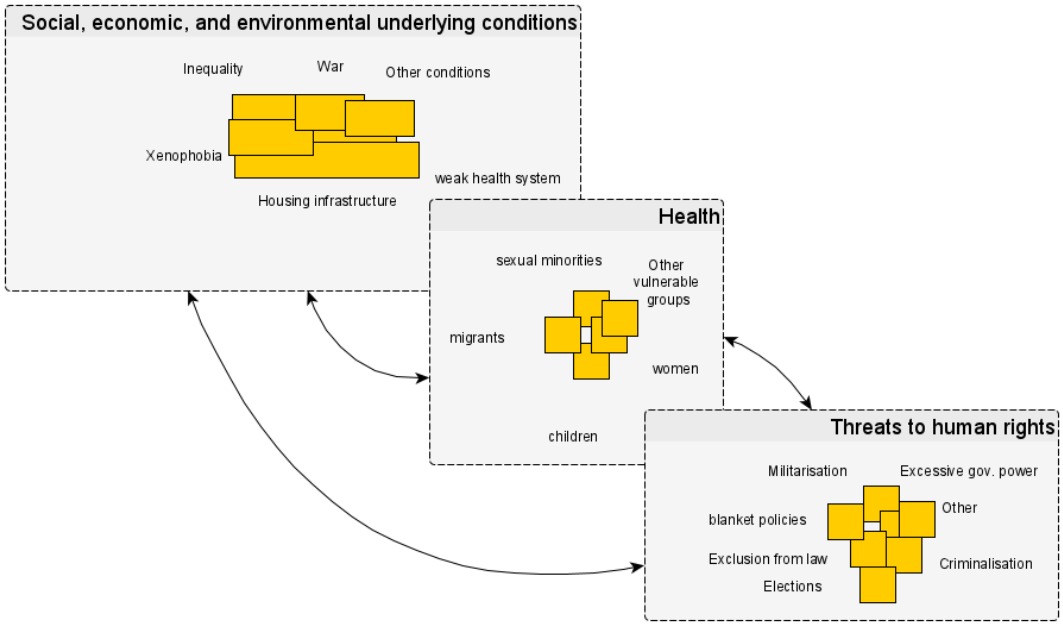

Figure 4. Refined conceptual framework

Source: Based on the concept of recursive cascades by Manderson and Warren (61).

This framework can be used to consider policy interventions in relation to their interactions and causes, and to anticipate the potential effects of these interventions. In this framework, factors can exist concurrently, with overlaps within and between categories.

In the literature, scholars call for COVID-19 policies that achieve the following. We present these recommendations as instruments to be considered when designing new policies, to incorporate a human rights perspective to current and future pandemics:

- Balance efforts to restrict COVID-19 spread and the protection of human rights;
- Implement population-specific responses to supplement uniform public health responses;
- Treat the causes instead of the symptoms;

- Plan instead of react; and
- Co-construct with, instead of instructing, people, especially vulnerable populations.

Our review also identified some characteristics of the research on human rights and its relationship with COVID-19 policies. The first is that most documents are commentaries or editorial pieces, the majority from the perspective of the law. Few documents are based on primary data, such as that derived from interviews, surveys or ethnography. This is likely due to the ongoing nature of the pandemic, limiting the availability of data on complex issues such as the relationship among policy, human rights, and COVID-19. A second characteristic of the literature is that most of it focuses on South Africa, leaving other Sub-Saharan countries with few or no studies, thus limiting a broader understanding of human rights during the pandemic. This may reflect a concentration of research in more affluent countries on the continent, a long-standing issue Africa. These two characteristics underscore the need to produce primary data on the relationship among human rights, policies and health to support research that uses this data and to expand the geographic focus of research and the research capacities on the continent.

5.0 Limitations

Our familiarity and interest in this subject influenced our literature search and conclusions. Specifically, we looked for articles addressing impacts on the human rights and health of vulnerable populations, focusing our attention on a controversial subject that goes beyond physical understandings of health. Because of our integrated understanding of health, we have constructed a conceptual framework (see above) that may not be consistent with dominant biomedical approaches to health, although it is in accordance with more common holistic understanding of health over the past decade or so (11). We are aware that identifying human rights is likely to emphasise violations rather than the protection of human rights. This may have biased our results towards the negative impacts of policies. Our aim, however, is to contribute to a body of literature that considers the importance of understanding negative impacts to inform policy to achieve human well-being. We did not intend to include all literature on the subject, but rather sought to bring a conceptual understanding of health policy in the broader framework of human rights and structural vulnerability. Our findings provide a basis to infer other potential impacts, underlying conditions, vulnerabilities and vulnerable populations, potential interventions and policy recommendations.

As mentioned above, our conclusions are also limited the the predominance of South Africa in the literature identified.

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Contributions of authors

The rapid review was led by the main author with inputs and collaboration in writing from the other four authors.

Declarations of interest

This is an objective rapid review of evidence and thus no interests to declare.

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Appendices

Appendix 1: Search strings for Scopus database

Scopus, search string focused on vulnerability:

(TITLE-ABS-KEY({pandemic} or {epidemic} or {sars-cov-2} or {COVID-19} or {COVID19} or {coronavirus} or {ebola} or {sars} or {swine flu}) AND TITLE-ABS-KEY({Africa}) AND (LIMIT-TO (SUBJAREA,"SOCI") OR LIMIT-TO (SUBJAREA,"MULT") OR LIMIT-TO (SUBJAREA,"ARTS") OR LIMIT-TO (SUBJAREA,"ECON") OR LIMIT-TO (SUBJAREA,"BUSI") OR LIMIT-TO (SUBJAREA,"DECI"))) AND TITLE-ABS-KEY ({Structural violence} OR {structural vulnerability} OR {necropolitics} OR {social inequality} OR {deprivation} OR {marginalisation} OR {mobile population} OR inequal* OR marginal* OR vulnerab* OR {poverty} OR {malnourishment} OR {homeless} OR {race} OR {racism} OR {violence} OR {social isolation} OR {stigma} OR {impairment} OR {abuse} OR {crime} OR {disability} OR {exploitation} OR {slavery} OR {migrant} OR {discrimination} OR {gender} OR {sexual} OR {unworthiness} OR {housing} OR {unemployment} OR {low income} OR {insecurity} OR {stratification} OR {hierarchy} OR {power} OR {segregation} OR {asylum seeker} OR {feminism} OR {empowerment}) AND TITLE-ABS-KEY ({Africa} OR Angola OR Burundi OR Benin OR "Burkina Faso" OR Botswana OR "Central African Republic" OR Cameroon OR Congo OR Comoros OR "Cabo Verde" OR Djibouti OR Algeria OR Egypt OR Eritrea OR Ethiopia OR Gabon OR Ghana OR Guinea OR Gambia OR Guinea-Bissau OR Kenya OR Liberia OR Libya OR Lesotho OR Morocco OR Madagascar OR Mali OR Mozambique OR Mauritania OR Mauritius OR Malawi OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sudan" OR Senegal OR "Sierra Leone" OR Somalia OR Sudan OR "Sao Tome" OR Eswatini OR Seychelles OR Chad OR Togo OR Tunisia OR Tanzania OR Uganda OR "South Africa" OR Zambia OR Zimbabwe OR "Ivory Coast"))

Scopus, search string focused on NPIs:

((TITLE-ABS-KEY ({pandemic} OR {epidemic} OR {sars-cov-2} OR {COVID-19} OR {COVID19} OR {coronavirus} OR {ebola} OR {sars} OR {swine flu}) AND TITLE-ABS-KEY ({Africa} OR Angola OR Burundi OR Benin OR "Burkina Faso" OR Botswana OR "Central African Republic" OR Cameroon OR Congo OR Comoros OR "Cabo Verde" OR Djibouti OR Algeria OR Egypt OR Eritrea OR Ethiopia OR Gabon OR Ghana OR Guinea OR Gambia OR Guinea-Bissau OR Kenya OR Liberia OR Libya OR Lesotho OR Morocco OR Madagascar OR Mali OR Mozambique OR Mauritania OR Mauritius OR Malawi OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sudan" OR Senegal OR "Sierra Leone" OR Somalia OR Sudan OR "Sao Tome" OR Eswatini OR Seychelles OR Chad OR Togo OR Tunisia OR Tanzania OR Uganda OR "South Africa" OR Zambia OR Zimbabwe OR "Ivory Coast")) AND TITLE-ABS-KEY ({Structural violence} OR {structural vulnerability} OR {necropolitics} OR {social inequality} OR {deprivation} OR {marginalisation} OR {mobile population} OR inequal* OR marginal* OR "mobile phone access" OR "media access" OR vulnerab* OR {poverty} OR {malnourishment} OR {homeless} OR {race} OR {racism} OR {violence} OR {social isolation} OR {stigma} OR {impairment} OR {abuse} OR {crime} OR {disability} OR {exploitation} OR {slavery} OR {migrant} OR {discrimination} OR {gender} OR {sexual} OR {unworthiness} OR {housing}

OR {unemployment} OR {unpaid} OR {corruption} OR {low income} OR {insecurity} OR {stratification} OR {hierarchy} OR {power} OR {injustice} OR {indifference} OR {segregation} OR {asylum seeker} OR {midwife} OR {xenophobia} OR {conservatism} OR {frontline} OR {feminism} OR {empowerment})) AND TITLE-ABS-KEY ({response} OR {lockdown} OR {distancing} OR {tracing} OR {tracking} OR {vaccine} OR {strategy} OR {policy} OR {intervention}) AND TITLE-ABS-KEY ({effectiveness} OR {efficiency} OR {impact} OR {effect}) AND TITLE-ABS-KEY ({Africa} OR angola OR burundi OR benin) AND (LIMIT-TO (SUBJAREA , "SOCI") OR LIMIT-TO (SUBJAREA , "MULT") OR LIMIT-TO (SUBJAREA , "ARTS") OR LIMIT-TO (SUBJAREA , "ECON") OR LIMIT-TO (SUBJAREA , "BUSI") OR LIMIT-TO (SUBJAREA , "DECI"))

Scopus, search string focused on human rights

TITLE-ABS-KEY ("human rights") AND TITLE-ABS-KEY ({Africa} OR Angola OR Burundi OR Benin OR "Burkina Faso" OR Botswana OR "Central African Republic" OR Cameroon OR Congo OR Comoros OR "Cabo Verde" OR Djibouti OR Algeria OR Egypt OR Eritrea OR Ethiopia OR Gabon OR Ghana OR Guinea OR Gambia OR Guinea-Bissau OR Kenya OR Liberia OR Libya OR Lesotho OR Morocco OR Madagascar OR Mali OR Mozambique OR Mauritania OR Mauritius OR Malawi OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sudan" OR Senegal OR "Sierra Leone" OR Somalia OR Sudan OR "Sao Tome" OR Eswatini OR Seychelles OR Chad OR Togo OR Tunisia OR Tanzania OR Uganda OR "South Africa" OR Zambia OR Zimbabwe OR "Ivory Coast")) AND TITLE-ABS-KEY ({pandemic} OR {epidemic} OR {sars-cov-2} OR {COVID-19} OR {COVID19} OR {coronavirus}) AND (LIMIT-TO (PUBYEAR , 2021) OR LIMIT-TO (PUBYEAR , 2020)) AND (LIMIT-TO (SUBJAREA , "SOCI") OR LIMIT-TO (SUBJAREA , "ARTS"))

Epistemonikos – COVID 19, accessed through https://app.iloveevidence.com:

#1: human rights

#2: Africa OR Angola OR Burundi OR Benin OR "Burkina Faso" OR Botswana OR "Central African Republic" OR Cameroon OR Congo OR Comoros OR "Cabo Verde" OR Djibouti OR Algeria OR Egypt OR Eritrea OR Ethiopia OR Gabon OR Ghana OR guinea OR Gambia OR Guinea-Bissau OR Kenya OR Liberia OR Libya OR Lesotho OR Morocco OR Madagascar OR Mali OR Mozambique OR Mauritania OR Mauritius OR Malawi OR Namibia OR Niger OR Nigeria OR Rwanda OR Sudan OR Senegal OR "Sierra Leone" OR Somalia OR "Sao Tome" OR Eswatini OR Seychelles OR Chad OR Togo OR Tunisia OR Tanzania OR Uganda OR "South Africa" OR Zambia OR Zimbabwe OR "Ivory coast"

Final search: #1 AND #2

COVID-19 register:

Applied the filters: Africa, human rights.