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# Mitigating the impact of COVID-19 in developing countries: policies and trade-offs in the pandemic fog

**IHF DISCUSSION PAPER**

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## “Mitigating the impact of COVID-19 in developing countries: policies and trade-offs in the pandemic fog.”

### Abstract

The COVID-19 pandemic (WHO, 2020) challenges the world at all levels, and classic methods for disease outbreak control (WHO, 2019) remain valid if applied early. It presents exceptionally complex challenges for policymakers whose responsibilities include curbing the pandemic, stewarding economies for growth, and fostering social cohesion. This IHF Discussion paper offers a perspective on the policy options and trade-offs facing those policymakers in low- and middle-income countries (LMICs) (World Bank, 2020), especially those with weak health systems and modest scores on the Global Health Security Index (GHS Index Project Team, 2019).

### Policy levers in principle

Policymakers in LMICs have three levers to curb COVID-19 and mitigate its economic damage:

- Interrupting the transmission of SARS-CoV-2, the virus that causes COVID-19 disease, remains the first lever, and includes measures like: personal hygiene and protection; testing and using test results for isolation, contact tracing, and clinical management where needed; physical distancing, including optional or mandatory lockdowns; differential risk reduction for more vulnerable groups, including allowing younger workers to resume their duties while isolating vulnerable groups like the elderly and those with pre-existing morbidities; expectations of herd immunity as an emergent by-product of COVID-19 progression in the society; and deliberate planning for herd immunity as a tool of public policy (these last two require mass serological testing).
- The second lever would be aimed at minimizing economic disruption, including a phased re-engagement in economic activities after the acute phase of the epidemic. Serologically positive individuals and low-risk individuals who are not immune but have completed a strict 14-day isolation period to ensure they are not infected could restart person-to-person interactions, gradually ending mandatory lockdowns of business activities.
- The third lever is to ensure safety nets for households and individuals, using methods such as: guaranteed wage payment by government, provided private employers undertake not to sack workers during a specified period; cash payments to households and individuals; direct supplies of food and household consumables, especially where large parts of the economy are informal (Quartz Africa, 2020); government-guaranteed low- or no-interest lines of credit to small



businesses; suspension of residential rent payments and mortgage payments during a specified period; and expansion of health insurance coverage that could include government-subsidized plans to reduce risks of catastrophic out-of-pocket payments for health care.

### **Trade-offs in practice**

Some key elements of these policy options are unlikely to be feasible in practice and policy makers in LMICs cannot achieve full success on all fronts.

Massive efforts to “flatten the curve” of COVID-19 through mandatory physical distancing and shutdown of person-to-person business activities come at high economic costs. Paradoxically, an exclusive focus on the immediate public health imperative could unwittingly harm the poor (Krishnan, 2020) and preclude robust discussions of the tradeoff between lives lost to the pandemic and the consequences of severe economic disruptions. While full lockdowns of societies could cost more lives than COVID-19, nobody knows precisely how to calibrate lockdowns without risking unintended consequences of COVID-19 resurgence. Complete and long-lasting lockdowns could be doubly costly, as good health depends not only on disease control, but on broader social and economic determinants. For example, sudden economic shocks across post-Soviet countries were associated with increased mortality, and after the financial market crash of 2008, the United States experienced an historical decline in life expectancy due to an epidemic of ‘deaths of despair.’

Success in having healthy young workers continue normal activities while the vulnerable are isolated depends on assumptions that households are willing to comply, that they have the physical space to ensure appropriate distances among family members, and that LMIC governments have the financial and logistical capacities to implement such programs on a large scale. There is no empirical evidence to support these assumptions.

The deliberate planning for herd immunity among the young and healthy as a policy goal, instead of an emergent consequence of disease outbreaks including at risk individuals (as happened with H1N1), is predicated on shortening the time required for sufficiently large proportions of populations to acquire immunity through exposure to the virus. They would then be able to return to work, especially if their immune status were certified with serological tests. It would be possible for countries to resume something close to normal economic and social activities. However, LMIC policymakers must consider the downsides of this approach. First, it conflates what is true for a



population (herd immunity) with what is true for an individual; unless everyone has had a serological test, individuals cannot know whether they have acquired antibodies that make them immune to SARS-CoV-2. Second, it assumes that a group of people has the right and infallibility to deliberately expose others to infection, the consequences of which cannot be accurately predicted for individuals. This could raise profound ethical questions reminiscent of the “Tuskegee Experiment” (US CDC, 2020) and the experience in Guatemala (Hensley, 2010). Finally, it assumes that such a policy would survive public scrutiny, which is contrary to the recent experience in the United Kingdom (Hanard, 2020). Policy scrutiny and informed consent should apply equally to all societies.

Shortening the lockdown period for the immediate resumption of economic activities could reduce economic pain and risks of social upheavals. However, it carries a risk of resurgence of outbreaks, loss of confidence in public policies, and prolonged economic downturns.

Expansion of social safety nets would win public support across ideological camps as indicated by recent experience in the United States (US Congress, 2020).

For LMICs, the policy challenge down to the following proposition: in the response to COVID-19, how much of which goal will be sacrificed for other goals, at what cost to whom, and how much political capital can policymakers expend before losing credibility or even political viability? Country-specific modeling and simulations of policy options would be helpful to policymakers.

### **Emerging lessons for Development Assistance for Health (DAH)**

Five key considerations emerge for the future of DAH:

- There is a need for joint learning across countries and regions, with much humility on the part of the “global north”, given the context of early stumbles in the responses to COVID-19 in Europe and the United States (Horton, 2020; Hanard, 2020; Abutaleb et al., 2020) .
- Strong partnerships between the private and public sectors are required to manage disruptions to global supply chains, from production through price negotiation, procurement, allocation decisions, transport, delivery, and distribution to points of use within countries. There is a need to rethink the currently high dependence on a few countries for the production and supply of critical equipment, drugs, and supplies to fight pandemics. The solution may not lie in nationalistic notions that every country should manufacture its own. A combination of strategic



national stockpiles, sub-regional manufacturing hubs, and planned redundancies in supply chains is a plausible solution.

- There is a need to invest a lot more in the infrastructure for critical health services, including physical infrastructure, manufacturing of equipment and pharmaceuticals, supply chain management, and fit-for-purpose hospitals. COVID-19 shows that effective spending on health systems infrastructure is not a “black hole” but a strategic investment.
- With the “north” preoccupied with its own COVID-19 problems, the world is learning the importance of investing in domestic institutions in LMICs before crises arise. For the public health aspects of responses to the COVID-19 crisis, National Public Health Institutes and regional entities like the Africa Centers for Disease Control and Prevention (Africa CDC) are indispensable.
- Innovation this time must go beyond important efforts to deliver new vaccines and therapies. Broader challenges include ambitious ideas like The Global Virome Project ([Carroll et al., 2018](#)) that would identify 99% of the viruses in animals from which most of these pandemics arise and permit more robust approaches to avoid catastrophic pandemics like COVID-19. .

Finally, the time is ripe for a fundamental shift in thinking and practice. The global “north” must become a better listener in conversations with the global “south”. While it is still early days in the COVID-19 pandemic, there is no longer a basis for global health discussions premised on the implicit assumption - and sometimes explicit assertions – that the “north” has it all figured out when it comes to tackling a pandemic.



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