THE IMPACTS OF COVID RESTRICTIONS IN LOW AND MIDDLE INCOME COUNTRIES: A COLLABORATIVE STATEMENT OF IMPACTS AND ACTIONS

From April 25-27 2023, a group of 30 scholars, social activists, and experts in the field of development and global health met at King's College London (KCL) to discuss the impacts of Covid restrictions in Low and Middle Income Countries (LMICs). Scholars from Angola, Argentina, Bolivia, Cape Verde, Colombia, Ghana, Guinea-Bissau, India, Kenya, Mozambique, Nicaragua, Nigeria, Turkey and Vietnam were represented at the event.

The first two days of the event saw discussions on the themes of healthcare, education, economic impacts, gendered impacts, political authoritarianism, rural and urban dynamics, and lessons for the future. On the final day, participants divided into 4 groups which considered the following themes:

1 -- The Impacts of Restrictions: Lockdowns and Human Rights

2 -- Global Institutions, Community Health, and Education

3 -- Political Authoritarianism and Public Opinion/Public Discourse in the Covid Pandemic

4 – Pandemic Preparedness: Plans and Alternatives

In the weeks following the conference, each group prepared a short draft statement summarising these findings. The conference attendees now share these findings, in the hope that they can contribute actively to policy discussions about appropriate measures in response to future public health emergencies.

1: The Impacts of Restrictions: Lockdowns and Human Rights

This working group contained colleagues from Argentina, Mozambique, Nigeria, and Vietnam. It considered the impacts of restrictions on healthcare, economic and cultural life, and human rights. A principal concern was that human rights conventions that guarantees expression of humanity were negated during the enforcement of lockdowns, while child labour in some instances was surreptitiously promoted as children were recruited to earn for family's survival. Memories of authoritarianism in previously notorious countries was re-awakened with great fear that triggered demonstration toward guarding their liberty.

The COVID-19 Pandemic that came with several interventions in two major categories: pharmaceutical and non-pharmaceutical, included universally applied restrictions that were disproportionate to known risks of the disease. We examined restrictions from the lens of lockdowns, human rights, the effects on young and adult persons in LMICs.

We found that:
1, there was an initial risk of spread of a new virus for which no remedy was immediately available; however,
2, universalism in the implementation of lockdowns in LMICs took place outside the context of the disease's epidemiology, local socio-economic, cultural, peculiar health systems and indeed the unique contexts of each country. Therefore,
3, lockdown as applied resulted in huge collateral damages and a reconsideration of the processes of implementation and enforcement is critical in future pandemic management.

With relation to lockdowns' immediate socioeconomic impacts, we concluded that:
1, Lockdown brought immense economic deprivation in most LMICs countries with fragile economies and where the huge informal sector that drives the economy was disrupted: the toll due to lost earnings and its effect on dependents could not be cushioned.
2, The economic loss was irreparable given the unique nature of these businesses, dependent on daily activities and earnings.
3, Furthermore, supply chains for vital healthcare products manufactured internationally was disrupted with concomitant scarcity and increased cost of accessing the available products.

With relation to lockdowns' socio-cultural and educational impact, we found that:
1, Restrictions grossly exacerbated existing class divides between the haves, deprived and unsupported.
2, Children could not interact socially within themselves while play/sport activities that helps their development were stopped. This formed a missing activity in the development of children in the entire period of the restriction even as they were introduced into new mode of education using online classes that was devoid of the required personal interactions and group work activities that provided healthy competition and impactful learning environment for intellectual development.
3, Family cohesion, including marriages were also affected following absence of **safety nets** to support livelihood; and the un-contextualized prohibition of children from interacting with their grandparents that affected bonding between the children and their grandparents.
4, It was an indescribable psychological trauma to bear. Connected to this was the mental health impact of the resultant idleness, fear of duration of lockdowns on earnings, lost jobs, bankrupted businesses etc.

With relation to lockdowns' impacts on healthcare, we found:

1, Health facilities were locked up due to the absence of personal protective equipment (PPE), healthcare providers could not access their facilities due to restrictions of movements, especially in settings where private sector-driven transportation could not operate, health product scarcity etc.

2, Health inequities grew massively, with the narrow focus on COVID and neglect of diseases such as malaria, cholera, HIV/AIDs, Tuberculosis etc,. Patients with pre-existing chronic illness such as hypertension, diabetes could not access their periodic refills of medications and so suffered while regular clinics and booked surgical procedures could not be done.

3, Healthcare was worsened in LMICs where the manufacturing sector for essential commodities is weak and highly dependent on overseas manufacturing. This was also evident in the manufacturing of medical commodities for LMIC health conditions such as malaria rapid tests, where global manufacturing capacity was redirected towards more lucrative and highly in-demand COVID tests. Reproductive health products, in another instance among many others (nasal masks, latex hand gloves, dressings, medicines etc) could not be accessed, leading to a clear increase in unwanted pregnancies and its consequence of a ballooning and unplanned population explosion.

The lessons learned from the restrictions with imposed lockdowns in LMICs include but not limited to:

a. Contextualization of lockdown across geographic, disease risks, settings, countries' peculiarities should be considered before imposing lockdowns.
b. Bottom-top approach with community engagement is critical to scoping the magnitude of lockdown or any kind of restrictions to be imposed.
c. Communication of accurate, honest, information and messages on reasons for any restrictions is imperative; more acceptable options with less collateral damage must always be considered, and enforced where possible, and messages should promote public trust.
d. Open and inclusive public engagement, and debates including disadvantaged persons should be done before any restriction is proposed in the future. Parents/Caregivers would be able to express their fears, for example on the options and/or effect of new mode of learning would be best for their wards.
e. Respect for individual/human rights
f. LMICs should develop their manufacturing base for production of essential products and commodities in healthcare services. State-supported industrialization will prove beneficial for industries to be retrofitted to produce needed commodities.

2: Global institutions, community health, and education

This working group drew on the experience of the pandemic in Angola, Cape Verde, India and Turkey. It examined the role of international organizations in the pandemic response, and what lessons can be learnt from this – especially in relation to the interaction with national governments.

Its core finding was that the pandemic response cannot be seen in isolation in national or historic terms. It must be understood holistically as a global event, in which the working dynamics of international organizations faced a stress test – and largely failed. This requires rethinking the organisation and funding of global healthcare and education.

The Working group made 5 core recommendations:

1 – International organizations must build an understanding of diverse contexts into policymaking. During the Covid-19 pandemic international agencies made the same set of recommendations for all countries. However, a range of recommendations is more suitable, providing more freedom for countries to decide what they should do. It's important to bear in mind that poorer nations had a whole other set of problems compared to richer countries; and had fewer resources to implement everything anyway, while suffering more from the after-effects of indebtedness and the cost-of-living crisis. Several problems resulted, particularly with resources and staff being diverted away from existing health programmes – TB monitoring, HIV, childhood immunisation, etc.

2 – Aid conditionalities can be harmful in shaping crisis response. These conditionalities played a role in the way some nations felt coerced into making policy decisions that had negative health and socioeconomic impacts for their populations. They often meant that national decision-makers felt that they could not withstand the supranational recommendations in the interests of their own most marginalised people.

3 – Representation from LMICs and voice in international forums and global institutions like the WHO and WB is vital. Regional WHO offices should be mobilised to enable a more subsidiary process of decision-making. International agencies need to focus on interlocking harms: e.g., the impact on global supply chains of medicines through the imposition by one country of trade or travel restrictions needs to be factored into decision-making. This will be best achieved when LMICs have a strong voice in these forums. Economic sanctions at the time of lockdowns also caused further harm to the most marginalised people in sanctioned countries.

4 – Individual nation-states must develop and implement plans customised for their own situations and building on past experience. Within individual nation-states, in both LMICs and HICs, representative processes were often not used; this led to flawed decision-making. For example, in Angola, Cape Verde, and India communities were not consulted and public health officials with past experience in more severe epidemics such as cholera and dengue fever were marginalised. Autonomous relationships with supranational institutions is vital to ensuring that national governments can make empowered decisions.

5 – The social experience and mental health of youth and children must be considered in any medical emergency. In education there was the problem of widely varying circumstances, challenges and capacities. In LMICs, access to devices and data is low, meaning that hundreds of millions of youth and children were permanently lost to education. Thus, school closures are

widely recognised to have been disastrous. Policymakers needed to take more account of questions of balances of disease risk, social experience, and mental health – alongside associated risks of school closures in LMICs such as forced marriage and child labour. Schools are not only about specific learning outcomes but the overall social experience of schooling, for which digital learning is no replacement. Children, especially from low-income families, need access to that physical and social space and infrastructure in order to benefit holistically from schooling.

3: Political Authoritarianism and Public Opinion/Public Discourse in the Covid Pandemic

The Covid 19 pandemic accelerated the pre-existing global trend towards authoritarianism through closely interrelated mechanisms. Policy makers viewed the pandemic as an opportunity to introduce new legislation or utilized existing laws to grant emergency powers to the state and the security apparatus, and manipulate public opinion to support these authoritarian measures by exploiting the fear about the pandemic.

The pre-existing trend towards authoritarian rule had its roots in a push-back from the elite and the more privileged sections of society against liberal democracy and the welfare state, paralleled by the growing power of corporate capital over national governments and global institutions in the era of neoliberalism. For the most part, the elected leaders of these autocratizing regimes successfully linked the societal dissatisfaction which resulted from the worsening conditions of life under neoliberal globalization, with religious or ethnic differences or some other constructed enemy to consolidate their control. To such rulers, the pandemic proved to present an opportunity to push through pro-corporate measures that both curbed labour rights, and abridged freedoms, especially of working people, migrants and all marginalized sections of society. Meanwhile, liberal democracies also witnessed widespread restrictions of freedoms, significant increases in wealth inequality, and the securitization of the covid response.

In many countries a pre-existing draconian law for disaster management or emergency rule was invoked to strengthen an overpowering central power. In others, new laws which gave sweeping powers to the state executive and security forces were quickly legislated and courts often acquiesced.

However, it is also true that there was considerable popular support from all sections of society, and much more so from the upper strata for these draconian measures. Such public opinion arose because of

a)   Highlighting of the actions of the government and the perceptions of the elite by the media. These groups were in fear of their safety and quick to attribute the disease to the "other" and perceive the greater threat as emanating from the poor and the marginalized.

b)   The projection of science as the source of authority and legitimacy for the repressive actions of the state, so that any questioning of government measures was portrayed as questioning "science" itself. In this context, scientific authority acquires a religious quality, in that it is not open to question and requires faith. This, of course, led to the contestation of who speaks for science and which authority is valid. Such reification of science and its utilization for legitimizing authoritarian practices and human rights abuses becomes a greater problem, when scientific advice shifts as new evidence emerges and better studies improve our understanding. Far from seeing such changes as part of the reflexive, self-corrective, ad hoc nature of scientific knowledge, especially when there is so much uncertainty and ambiguity in what stands for science- it leads to a growing mistrust, even a complete rejection of science. And this rejection of science leads to a polarization that can squeeze out the middle ground. Authoritarianism of the right and the left could align with either extreme.

c)   Gaslighting non-mainstream opinion. Alternative thinking around the Covid restrictions were framed as an aberration and swiftly caricatured. In some places in Africa for example, the rejection of measures such as lockdowns and experimentation with herbal medicines were framed as dangerous. The Global South more generally was denied agency in responding to the pandemic in its own way despite their relative success in dealing with similar pandemics in the past.

d)   Poor quality of public health advice:

a. Experts failed to realize that many of these restrictions are near impossible to implement and affect the poor and marginalized sections of society much more negatively.
b. The social, economic and public health costs of restrictions were not weighed against their benefits. Instead of limiting interactions with high risk of transmission, many countries strived to eliminate all possibility of transmission. The high level of uncertainty and the unwillingness of those in power to confess to this uncertainty led to an excessive sense of precaution . Governments implemented some restrictions such as night curfews that clearly had no impact on transmission reduction because they fell on pre-established patterns of security policies that had been developed in response to political unrest to tackle a public health crisis.
c. Public health communication was carried out very poorly.
    i. Much of the messaging took the form of a hygiene theatre - dramatizing and overemphasizing irrelevant and ineffective hygiene measures.
    ii. The few effective measures were often lost in the long list of personal safety measures, most of which could not be implemented by the majority of the population.
    iii. There was little focus on identifying the appropriate mix of message, medium and communicator for each audience segment. There was widespread victim-blaming, whereby the government and the elites shifted the responsibility of illness and death onto the individual. There was also no focus on explaining the rationale for each non-pharmacological method and social restriction. Indeed, some measures such as night curfews had none.
    iv. Excessive emphasis was placed on enforcement through punishment and penalties, which led to stigma and denial.

Recommendations:
1. Improved decision making with regard to all proposed social restrictions. Each restriction must be independently justified and explained, and those who have to disproportionately bear the costs of the decision must be supported and compensated.
2. Public messaging must provide clear guidelines on civil liberties and legal rights in the context of such widespread restrictions and the channels that are open to the public for expression and redressal of grievance.
3. Engagement with and inclusion of voices from the Global South in crafting international pandemic responses sensitive to their geographical contexts.
4. Regular updates on up-to-date evidence along with a clear expression of uncertainty and ambiguity with regard to what is known and how the government is handling this ambiguity.
5. Risk communication that is estimated and communicated appropriately to different social groups and advice on protective measures that is also evidence based, appropriate to social groups with different levels of vulnerability.
6. Building up a more demystified, critical and appreciative public understanding of science- as a method along with its limitations.
7. Much greater role for decentralized application of social restrictions and relaxations wherever they are required, by community institutions which are informed by both the evidence on transmission as well as the local balance of risks from the disease as compared to the disruption of normal life.

8. Active role by global institutions, especially WHO and the other concerned UN bodies (UNHRC, UNDP, UNICEF etc), in calling out restrictions which make little public health sense , but are there only because of authoritarian reflexes.
9. Emphasis on the implementation of the Siracusa principles on the limitations and derogation provisions in the International Covenant on Civil and Political Rights.

4: Pandemic Preparedness: Plans and Alternatives

This working group considered evidence from 8 African countries, 4 Latin American countries, India, Turkey and Vietnam. We also consulted the former Deputy Head of the Emergency Section of Doctors-Without-Borders (Spain) in arriving at the following clear recommendations building on the experience of the Covid-19 pandemic.

The core finding was that the best approach to pandemic preparedness involves consistent public investment in healthcare and social protection. In health, the focus should be on strengthening primary care and human resources. This should be balanced with investment in secondary and tertiary care, which can provide a population and government the confidence to avoid unnecessary and unworkable restrictions on movement, freedoms and the economy. It is this approach which can ensure that health systems do not need to be restricted at times of crisis, meaning that the negative impacts of delays to routine medical care do not create health emergencies long after any pandemic itself may have passed. Social protection is vital to mitigate the consequences of a pandemic and any restrictions affecting the economy and people's livelihoods. Social protection systems need to be strong and designed or redesigned to allow for flexibility to expand in terms of coverage and depth in a crisis.

This core finding entails the following 4 policy recommendations:

1 – **Health systems require built-in redundancies in order to deal with emergencies.** Neoliberal policies of the past decades have put too much emphasis on efficiency and avoid any excess or surpluses in health care in terms of resources (hospital beds, equipment, personnel, etc.) and services. Nevertheless, the pandemic has reminded us that health systems need some degree of redundancy to be resilient and absorb shocks. This can make sure that health systems do not break down during crisis, leading to the cancellation of routine healthcare – with negative outcomes for general public health. This surplus capacity is unlikely to be met by private market-based systems, and therefore requires sustained public investment over many years.

2 – **Lengthy sustained public investment in social protection leads to better health outcomes.** Medical emergencies lead to changes in human behaviour, whether imposed by government or by individual responses to perceived risks. This leads to great stress on systems of economic and social life which are unlikely to be alleviated by the sudden imposition of new emergency welfare systems, which often fail to reach the point of need. Instead, sustained public investment in expanding social protection systems over many years is required – this system can then expand to meet the additional need at times of health crises.

3 – **During health emergencies there must be a balance between using the decision-making capacity and resources of central (national) authorities on the one hand, and the on-the-ground organisation and expertise of local authorities on the other.** Based on the subsidiarity principle, those on the ground should be empowered by national governments to make the difficult judgments required in their local contexts. Regional and local health authorities and related health facilities depend on governments for accurate information and advice; at the same time, it is local community health teams and local authorities who have the best overview of the context, including geographic, demographic, epidemiologic, political, social and economic situation in their locales, and the competing risks and priorities for the populations under their care.

4 – **Pandemic plans and general health preparedness must allow for the disaggregation of risk.** Both global medical organizations and national health ministries must recognise that levels of risk and everyday priorities vary according to socio-economic conditions, burden of infectious and non-infectious disease, demographic profile and other factors between countries and within countries – and that policy effectiveness will also vary according to these factors. This is why subsidiarity is vital in effective policymaking. What is a crisis for one sector of the population in High Income Countries may seem less important for people in LMICs with other priorities, dealing with the impacts of a range of issues including high disease burden, environmental crises, internal conflicts, chronic pollution, and socioeconomic insecurity.

CONCLUSION

Many of the themes were overlapping. There were areas of disagreement among participants, but the broad conclusions of the working groups were clear.

Clear common themes, essential in mitigating any health emergency, are:
:- The centrality of public investment in healthcare – especially primary healthcare and infrastructure – and in social welfare, to expand at times of need
:- Proportionality and the disaggregation of risk
:- The centrality of human rights and local actors' knowledge and experience – requiring the fundamental attendance to civil society and civic actors in LMICs
:- The importance of an open and accurate flow of information both from central authorities to regional areas, and from the regions to the centre
:- Attendance to socio-economic factors and the social determinants of disease
:- Awareness of the complexity of supply chains and the impacts that disruption can have in access to healthcare
:- Awareness of how policies that aggravate inequality will exacerbate ill-health

We share the collective fruits of our discussions and experiences of the Covid-19 pandemic, in the hope that responses to future health emergencies will not lead to such unequal outcomes in which very few social and economic harms for poorer people, the young, and women were successfully mitigated against in Low and Middle Income Countries.

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