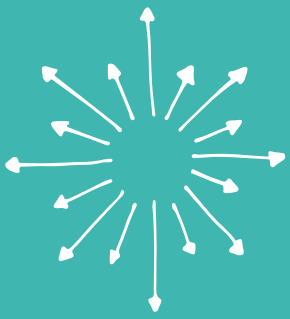

RAPID RESPONSES

COVID-19 IN THE GLOBAL SOUTH

Impacts and Responses

EDITED BY
PÁDRAIG CARMODY
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Published in association with the Development Studies Association of Ireland

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BRISTOL UNIVERSITY PRESS

dsaIreland

First published in Great Britain in 2021 by

Bristol University Press
University of Bristol
1-9 Old Park Hill
Bristol
BS2 8BB
UK
t: +44 (0)117 954 5940
e: bup-info@bristol.ac.uk

Details of international sales and distribution partners are available at bristoluniversitypress.co.uk

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN 978-1-5292-1588-5 ePub
ISBN 978-1-5292-1727-8 OAPDF

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List of Abbreviations

4IR – Fourth Industrial Revolution
AIDS – Acquired Immunodeficiency Syndrome
BAME – Black and Minority Ethnic
BBC – British Broadcasting Corporation
CARES – Coronavirus Aid, Relief, and Economic Security Act
CDC – (African) Centre for Disease Control
CDSH – Commission on Social Determinants of Health
CoE – Council of Europe
COP – Conference of the Parties
COVID-19 – coronavirus disease 2019
DE – Development education
DEF – *Documento di Economia e Finanza*
DESA – Department of Economic and Social Affairs (of the United Nations)
DPP – Director of Public Prosecutions
DPT3 – Diphtheria, Pertussis and Tetanus
DSAI – Development Studies Association of Ireland
ECLAC – The United Nations Economic Commission for Latin America and the Caribbean
EU – European Union
FDI – Foreign Direct Investment
FGM – female genital mutilation
GBV – gender-based violence
GDP – Gross Domestic Product
GFC – Great Financial Crash
GOK – Government of Kenya
H1N1 – swine flu
HICs – high-income countries
HIV – human immunodeficiency virus
HRP – Humanitarian Response Plan
HRW – Human Rights Watch

HSRC – Human Sciences Research Council
IASC – Inter-Agency Standing Committee
ICJ – International Court of Justice
ICP – infection, control and prevention
IDEA – Irish Development Education Association
IFIs – international financial institutions
IFPMA – International Federation of Pharmaceutical Manufacturers & Associations
IGC – International Growth Center
IHR – International Health Regulations
ILO – International Labour Organization
IMC – International Medical Corps
IMF – International Monetary Fund
IOM – International Organization for Migration
IRC – International Rescue Committee
IRLI – Irish Rule of Law International
JEE – Joint External Evaluation
KES – Kenyan shillings
LDCs – Least Developed Countries
LGBT – lesbian, gay, bisexual, and transgender
LGBTIQ – lesbian, gay, bisexual, transgender, intersex, queer
LMICs – low- and middle-income countries
MERS – Middle Eastern Respiratory Syndrome
MOH – Ministry of Health
MSF – *Médecins Sans Frontières*
NDCs – Nationally Determined Contributions
NGO – Non-Governmental Organization
NHS – National Health Service
ODA – overseas development assistance
OECD – Organisation for Economic Co-operation and Development
OHCHR – UN Office of the High Commissioner on Human Rights
ONS – Office for National Statistics
PEP – post-exposure prophylaxis
PHE – Public Health England
PHEIC – Public Health Emergency of International Concern
PPE – personal protective equipment
QALYs – quality-adjusted life years
R&D – research and development

REPSSI – the Regional Psychosocial Support Initiative
RTÉ – *Raidió Teilifís Éireann*
SALC – South African Litigation Centre
SARS – severe, acute, respiratory syndrome
SASSA – South African Social Security Agency
SDGs – Sustainable Development Goals
SDI – formerly Slum/Shack Dwellers International
SEA – sexual exploitation and abuse
SMEs – small and medium enterprises
TB – tuberculosis
TPO – Transcultural Psychosocial Organization
UK – United Kingdom
UN – United Nations
UNAIDS – The Joint United Nations Programme on HIV and AIDS
UNCTAD – United Nations Conference on Trade and Development
UNDRR – United Nations Office for Disaster Risk Reduction
UNECA – United Nations Economic Commission for Africa
UNEP – United Nations Environment Programme
UNESCO – United Nations Economic and Social Council
UNFPA – United Nations Population Fund
UNICEF – United Nations Children's Fund
UNODC – United Nations Office on Drugs and Crime
UNU-WIDER – United Nations University World Institute for Development Economics Research
US – United States
WB – The World Bank
WFP – World Food Programme
WGSS – women and girls safe spaces
WHO – World Health Organization
WTO – World Trade Organization
XDR TB – extensively drug-resistant tuberculosis

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Foreword

By Ciarán Cannon, Minister of State for the Diaspora and International Development, Republic of Ireland

The COVID-19 pandemic is much more than a health crisis, as the diverse contributions to this timely book make abundantly clear. Dr Michael J Ryan, Director General of the World Health Organization (WHO) Emergency Programme, has observed that "Nobody on this planet is safe until everyone is safe". An unprecedented spirit of global solidarity is required to overcome the multiple threats COVID-19 poses to our health, economies and societies, particularly in resource-poor settings.

In Ireland, we have a strong sense of community – *meitheal* – coming together to work collectively for a better future. This clear sense of global citizenship underpins Ireland's development cooperation, as outlined in our international development policy, *A Better World*. Ireland is playing its part in building and contributing to a coherent, effective and integrated global response to COVID-19. Our overarching priority is to reduce the incidence and mitigate the impact of the pandemic among vulnerable populations, in line with our commitment to reaching the furthest behind first.

As the contributors to this book outline from a range of different perspectives, these efforts are unfolding in a highly dynamic, interconnected and changing world. Pre-COVID-19, we were already facing unprecedented levels of humanitarian crises, with over 134 million people in need of assistance and protection. Protracted crises are becoming the new normal. New threats are emerging to peace, and geopolitics is becoming increasingly complex and volatile. To overcome these challenges and achieve the UN (United

Nations) Sustainable Development Goals (SDGs), poverty needs to be addressed from a multidimensional perspective. This includes the way the international community approaches and applies research, evidence, knowledge and learning.

'Research and Learning' is identified as one of the five key criteria for action in *A Better World*, acknowledging the need to prioritize learning and to situate research and evidence centrally within Ireland's development cooperation programme. We recognize the intrinsic value of research as a global public good, but also its role in better understanding approaches that work most effectively to reduce poverty. Together with learning from experience, reviews and evaluations, research is the basis on which we build knowledge and evidence for our work in international development – and nowhere is this more important than when working in conflict and fragility, where the context can and does change rapidly.

Our work with research partners is an essential part of our efforts to achieve the ambition of *A Better World*. We have supported the work of the Development Studies Association of Ireland since 2012, with good reason. The DSAI occupies a unique position in Ireland: it provides a national platform to harness knowledge from higher education and civil society, and bridges the gap between development research, policy and practice. Its members are key contributors to Ireland's development knowledge base.

Since the outbreak of COVID-19, the DSAI has provided a dedicated online space for pooling experience and expertise about the impact of the pandemic on the developing world. It has enabled knowledge sharing through an easily accessible blog format, hosting opinion pieces from independent authors covering a wide range of thematic and geographic perspectives. I am delighted to see these expanded into book chapters and, along with other contributions, brought together in this new publication. It makes an important contribution in helping us to better understand COVID-19 and offset its impacts, drawing on work across disciplines and silos. It also underscores a core principle of Ireland's foreign policy and development cooperation – that it is only through collective action with others that the great challenges of our time can be addressed.

The development and rollout of a safe and effective vaccine to reach 7 billion people worldwide is one such challenge. As we work towards this goal, Ireland's priority is to mitigate the widespread effects of COVID-19 in line with our key policy priorities. We will protect peacebuilding efforts. We will work to ensure the ongoing delivery of critical humanitarian, livelihood and nutrition assistance. We will advocate for scaling up social protection to protect the most vulnerable. We will support the protection and promotion of the rights of women and girls and prioritize gender-based violence risk mitigation in our response. We will encourage ongoing engagement with civil society in line with international human rights norms and standards. We will learn from experience and link recovery from COVID-19 to building greater resilience to future hazards.

As the contributions to this book articulate so clearly, building back better post-COVID-19 does not just mean returning to the status quo. We must work together to accelerate transformative action to achieve the SDGs, putting the furthest behind first and utilizing robust evidence to address and mitigate the deeper, underlying causes of vulnerability and marginalization.

In the Organisation for Economic Co-operation and Development's (OECD's) *Development Cooperation Peer Review* published in May of this year, Ireland is praised as a trusted partner to civil society, and a strong voice for sustainable development, leading and supporting policy dialogue at both local and international levels. By working in that spirit of *meitheal*, we must continue to share evidence, expertise and experiences to strengthen our collective efforts in tackling the impacts of COVID-19. I thank the DSAI for their contribution to this endeavour, and for creating a space where voices from across the globe can learn with and from each other.

Introduction

The world has been convulsed by the COVID-19 (coronavirus disease 2019) pandemic. The virus has caused untold misery both directly and indirectly to people around the world and its effect on societies and economies globally has been catastrophic. International travel has ground to a near halt, the global economy has stalled and many countries around the world are in government-enforced 'lockdowns'. Numerous countries have entered deep recessions and many global value chains have experienced massive disruption as a result of both demand, and in some cases, supply shocks, sending reverberations through the value chains of suppliers with negative multiplier and accelerator effects. Such economic shocks are largely an outcome of government policy responses to the pandemic and will have cascading effects both socially and economically for many years to come (OECD, 2020). Notwithstanding the billions of lives that have been adversely affected and the hundreds of thousands of deaths resulting from it, the pandemic has also exposed further serious flaws in the architecture of international development.

In the Global North, the purpose of lockdowns has been to slow the spread of the disease and prevent healthcare systems from being overwhelmed. The countries of the Global South appear to be affected differently, although this is changing as the geographic epicentres of the disease shift. In the developing world, lockdowns were put in place quickly, with often severe livelihood consequences given high levels of dependence on the informal sector for survival, and the general absence of widespread health, social security and public policy assistance measures. Thus, the 'secondary effects' of the crisis are more evident in the Global South, although many countries, as of mid-2020, have now lifted their lockdowns. These countries

are also particularly vulnerable to systemic, structural effects (Hulme and Horner, 2020) and their amplification through interaction with wider contradictions and tendencies.

Proponents of unregulated global economic integration argue that this model is universally beneficial for all market participants. However, COVID-19, along with the previous 'global' financial crisis and the coming climate one exposes the contradictions and vulnerabilities of unmanaged interconnection. In a sense we can view connection as contradictory, temporally, as it generated economic growth, but is now associated with synchronized worldwide economic downturn – the most severe since the Great Depression. The contagion of COVID-19 was mirrored by the financial contagion in the first decade of the 21st century. This in turn has been layered upon more regionally specific crises, such as the persistent developing world debt crisis and adverse effects of the International Monetary Fund/World Bank structural adjustment programmes, which eviscerated healthcare and education systems in the countries in which they were imposed. A widely applied model of austerity in the aftermath of the North Atlantic financial crisis of 2008 further undermined many attempts at socioeconomic development around the world.

The so-called 'secondary impacts' of the pandemic in the Global South then are all the more severe as a result of the layering of cumulative crises, like a palimpsest, in Least Developed Countries (LDCs). This is most visible in the predominant economic form that exists in LDCs, the informal economy. Indeed, if we include subsistence agriculture as part of this, more than 85 per cent of the labour force in Africa, for example, are found in that sector. This is partly a result of the hollowing out of the formal sector (both public and private) arising from the aforementioned processes of globalization (debt, enforced adjustment and austerity). The marginal productivity of labour in the informal sector is low and so people who work in it tend not to have much in the way of savings, leaving them vulnerable to shocks such as COVID-19 and the inability to earn a living in life under state lockdown. At the same time, the dominance of the informal sector makes for low tax returns across the Global

South and the consequent under-funding of health and social care systems. For example, China's donation of four ventilators to South Sudan during the pandemic reportedly trebled the number available in that country and ten African countries were reported to have no ventilators at all (McLean and Marks, 2020). Thus, crisis compounds crisis and systemic vulnerability is accentuated by exposure to and incorporation into a global system characterized by combined and uneven development.

This collection explores a number of the issues that arise for the Global South in the grip of a global pandemic. Contributors have been drawn from various sectors and contexts and have specialist knowledge of a range of issues relevant to the impact of this pandemic on the Global South. Contributors focus on the medical impacts, gender equality, migration, economic inequality and (among other issues) the accentuated risks faced by vulnerable populations, such as those in prison or working in the 'gig' economy. The contributors also consider appropriate responses across scales and time. In the first phase of the pandemic – and thanks largely to warnings from Chinese doctor Li Wenliang and staff at the World Health Organization (WHO) – the public health response was properly recognized as being the most immediate challenge. In subsequent phases, economic effects and interactions with public health and care systems assumed greater prominence. Both phases require appropriate responses and changes in governance, public policy (both locally and globally) and shifts in the culture of public responsibility. It is these issues and the responses that this book analyses.

The pandemic is rapidly evolving and its multiple impacts across geographies and societies are, as yet, not fully clear. In the Global South, the impact is set to reshape life experiences in the long term, with more profound and complex implications, and with a depth and scale of disruption that demands unprecedented solidarity and international cooperation. If we are to build a more just and resilient world post-COVID-19, we need to understand, debate and chart the issues involved and what effective responses are.

Pádraig Carmody and Gerard McCann, 14 August 2020

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Part I

Perspectives on the Pandemic

1

COVID-19 Pandemic Ignorance and the 'Worlds' of Development

Su-ming Khoo

This contribution reflects critically on what it means to 'learn' from the Global South. The starting point is why the 'Global North' appears to have learnt so little about pandemic response from the 'Global South', despite relevant knowledge being in plain sight. The ongoing global COVID-19 pandemic is an opportunity to learn because it disrupts the labels dividing different 'worlds' of development and places a magnifying glass on critical issues of local and global equity and justice. As COVID-19 is a novel disease, it is unsurprising that not enough is known about it. Yet a surprising ignorance has emerged in its wake about how governments should respond, and who is most vulnerable and likely to suffer or die. This ignorance about differential impacts and vulnerabilities cannot exactly be said to be an *absence of knowledge*. Rather, it is a problem of *un-knowing* that maps interestingly onto central debates in critical development studies about the proper focal objects, subjects and purposes (the whats, the whos and the whys) of 'development'.

How and why have issues of local and global inequity and injustice become actively (rather than just accidentally) under-emphasized and ignored? Cognitive frames that present 'development' as a question of 'Northern' knowledge and competence versus 'Southern' lack of knowledge or competence are deeply complicit in the active production of global ignorance, with serious effects.

The worldwide COVID-19 pandemic has surfaced a renewed appreciation of the value of public health systems as national and global public goods. It has laid bare the problems accompanying the promotion of 'development'

policies and practices complicit in marketization, which erodes and fragments the capacities of public health systems (McCoy, 2020). Countervailing struggles to maintain and reestablish systemic health capacity and equity have become entangled with difficult questions about how to best manage major socioeconomic disruption and economic contraction. A trajectory shift for global 'development' has become suddenly thinkable, an opportunity and lesson for development studies itself. It is time for the field of development studies to give up embedded, uncritical frames of separate, ranked 'worlds' of 'development' in favour of a shared transformative vision. Such a vision entails the responsibility to address widening inequities and injustices that have been hiding in plain sight, beginning with efforts to stop unseeing the gaps and deprivations facing the 'South within the North', as well as the obligations of the 'North within the South' to support and resource equitable health systems, and not wreck or plunder them.

What the 'Global North' already 'knew' – equity deficits in pandemic preparedness

Previous global pandemics, such as H1N1, Ebola and SARS, have led to heightened awareness about the need for global pandemic preparedness. Just before the current outbreak, the World Health Organization (WHO) had issued dire warnings:

> a very real threat of a rapidly moving, highly lethal pandemic of a respiratory pathogen killing 50 to 80 million people and wiping out nearly 5 per cent of the world's economy. A global pandemic on that scale would be catastrophic, creating widespread havoc, instability and insecurity. The world is not prepared.
>
> (WHO, 2019: 6)

This frightening prediction mobilized major efforts to devise a global pandemic preparedness index and league table ranking countries by levels of preparedness. The Global Health Security Index ranked the United States (US) and

United Kingdom (UK) at the top, being 'best prepared', Asian and Latin American countries around the middle and African countries at the bottom. The reality, to date, has been quite the opposite as the UK and US have experienced some of the highest levels of infection and mortality. The index's unintended effect was to create the impression that drastic measures taken by China to control the outbreak in January 2020 were due to its lack of preparedness, while countries with high preparedness rankings, such as the US or UK, did not need to act with the same thoroughness, with resulting higher infection and mortality rates costing possibly many thousands of lives (Bissio, 2020; LePan, 2020).

Prior reviews of US pandemic preparedness found that a lack of concern with health disparities led to predictable, preventable and socially unjust illness and deaths. They recommended reducing health disparities and lowering barriers to healthcare access as pandemic preparedness priorities (Kayman and Ablorh-Odjidja, 2006; Lurie et al, 2008; DeBruin et al, 2012). This recommendation coincided with the rise of the social determinants approach to health in the 2000s (Commission on Social Determinants of Health, 2008). Although the UK was a leading force in the social determinants approach, the appalling impact of social gradients, for example on Black and Minority Ethnic (BAME) communities in the ongoing COVID-19 pandemic (PHE, 2020), seemed to take the UK government by surprise. Out of the many potential differences and inequities in population groups, only age and comorbidities were considered. The UK government showed a surprising inattention to social gradients and vulnerabilities, focusing instead on individualistic behavioural psychology (to predict individual behavioural non-adherence to public health restrictions) as the only additionally relevant social factor. Other social gradients were ignored in this highly resourced country with an iconically unified public health system and world-leading, nuanced knowledge base about social gradients in health.

Critical development thinking

Critical development thinking has always concerned itself with questions about the right referent object of 'development'. Is it the economy or the people that we should care about and who or what counts for more or less in a given accounting or ranking exercise? The current pandemic has brought these perennial debates starkly to the fore. Governments that seem too slow to impose public health movement restrictions or are too quick to relax them have been accused of callousness, 'playing roulette with the public's lives' (Horton, 2020). Utilitarian reasoning is seriously questioned (Burke, 2020), as vulnerable people point out that trade-off modelling between economic recovery and population infection looks a lot like 'social eugenics' (Williams, 2020).

Similar questioning around the limits of economic rationality and potential inhumanity sparked the rise of development ethics and the human development paradigm (Ul Haq, 1995), enabling development studies to think more fruitfully about human vulnerabilities and wellbeing and to consider the socially, economically and politically marginalized, discriminated and disadvantaged. The COVID-19 pandemic has resurfaced these questions about populations-within-a-population such as older people, migrants, people with disabilities and workers in low-paid, but essential, service and personal care sectors. It has highlighted the vulnerability of the institutionalized, who are stuck behind doors – such as prisons, care homes and migrant and refugee detention centres – as well as those who lack secure doors and shelter, such as informal housing residents, migrant workers and people experiencing homelessness. All these groups have fared worse in being protected, counted, diagnosed, treated, becoming ill and dying. The root of these injustices is a lack of social-democratic equality, dignity and rights and the centrality of economic thinking premised upon structurally valuing some types of persons, labour and lives as lesser, requiring less protection and less deserving of consideration, respect and recompense.

Agnotology of development

Critical development studies point to fundamental problems surrounding schemas for thinking that are not just accidentally ignorant but seem to actively produce ignorance. A social constructionist approach highlights that all knowledge is power. The power to un-know is as important as the power to know (Santos, 2007; McGoey, 2019). Agnotology addresses general and systemic ignorance as something that is socially, politically and culturally produced. Lack of knowledge is a social construct that emerges either through selective choice and cultivation, or through neglect and intentional acts of deception. Proctor (2008) has documented the deliberate, organized production of health-harming non-knowledge and fake knowledge by the tobacco, asbestos, and pharmaceuticals industries. Proctor particularly problematizes the impact of commercialization on scientific research, while McGoey (2019) criticizes the broader impact of 'strategic ignorance' and 'regulatory anti-strategies' in pharmaceutical regulation, philanthropy and economic thought. This history resurfaces in the current debates over individualized 'tech fixes' versus community prevention measures to address COVID-19 (Meek, 2020).

We come to the current pandemic in a state of complex, broad-based *epistemic crisis* and disruption of the global social organization of knowledge and science attributed to political polarization, declining trust in institutions, and asymmetric media ecosystems (see Dahlgren, 2018; Miller and Kirwan, 2019). Amid such crisis, incoherent authoritarian-populist leadership and public health denialism combine with deadly effect, as earlier warnings about inequity and social injustice are ignored. South Africa battled with AIDS denialism in the late 1990s and early 2000s (O'Reilly, 2016), yet few lessons have been drawn from this experience. Few efforts been made to learn from Asian and African experiences with SARS, Ebola and MERS (MacCormaic, 2020; Sirleaf, 2020). Health professionals in the UK seem baffled by governmental reluctance to seriously consider China's advice to act decisively (*The Lancet*, 2020). The US government's attempts to shift the blame onto China (Geall, 2020), or

the UK's resort to claims about 'the best science' (Adam, 2020) substitute discursive deflection for action based on actual global experience. Excess deaths and suffering and deepened vulnerabilities and discrimination stand as deadly exemplifications of pandemic agnotology.

Neoliberalism and public ignorance

The ideology, policies and effects that cluster around neoliberalism include right-wing authoritarian-populist government, narrowing of knowledge and scepticism towards expert and professional knowledge. President Donald Trump and other right-wing leaders' rejection of expertise (Müller, 2020) merely continues agnotological trajectories laid down by neoliberal policy entrepreneurs and think-tanks, who have been concertedly engineering the *public* out of political common sense since the 1920s. Public interest, public science and public education have been presented as corrupt, lazy, irrelevant, failing and wasteful of taxpayers' money, while private, for-profit companies with political connections have been promoted as heroic, effective, efficient and entrepreneurial replacements for public services. The very concepts of the social and the public were disowned by neoliberal ideologues, who sought to make them un-known.

In the social sciences, public and welfare economics, comparative and institutional studies that learn from different experiences and explore different political and social choices have become marginalized under a stigmatized label of 'heterodoxy'. These were replaced by an orthodoxy of abstract models, including behavioural approaches combining and conflating depoliticizing methodological individualism and politicizing methodological nationalism. Social democratic models balancing individual and collective welfare have been replaced by anti-collectivist, anti-redistributionist understandings of 'Social Choice' (List, 2013), and 'Public Choice', representing oxymoronic, bad-faith, morally blind (Caplan, 2005) and anti-democratic (MacLean, 2018) ways to un-think the meaning of publicness. The neoconservative redefinition of 'relevance' has enabled research funding to

be radically narrowed to favour politically influential large businesses and military interests. The purpose of education has been similarly redefined to make competitive individuals fit for selected markets and countries fit for tax-competitive globalization.

Returning to the Third World

The question of categories and rankings, implicit or explicit, sits at the heart of the development imaginary and thus its theories, policies and practices. The Cold War classifications of 'First', 'Second' and 'Third' Worlds have never become completely defunct. Their replacement with the geographically improbable 'North versus South' division remains similarly unsatisfactory – old labels for 'development' remain sticky as the desire for analytical simplification trumps the willingness to see existing internal and global inequities and address the politics of inequality and polarization.

The decolonization critique in development studies focuses mainly on issues of epistemic dominance and the imposition of dominating forms of knowledge. This critique is central to understanding how domination leans on the will to ignore. The ranked, stagist theory of development is sticky because the desire to assume that the First World must be earlier, more and better developed persists. The progression theory implies that knowledge and experience lie with the first 'world' and congratulates it for having already arrived while simultaneously ignoring the historical precedence of indigenous First Nations, who continue to be stigmatized as a kind of internal 'Third World' within the 'First'.

However, the 'Second World' did not exactly rank second since 'second' was a negative category signifying the political 'Other', against which the positive category of the 'First World' could assert itself. To be 'Third' in the Third World was never a question of ordinal ranking, but a claim on history. Catching up was not a question of steps to be hurriedly followed, but an accounting for power and resources taken and a demand for *reparations* for past misappropriations and for structural reform, rights and justice. Alfred Sauvy, who

coined the term '*tiers monde*', saw it as analogous to the Third Estate of the 1789 French Revolution. 'Third' denoted a mass of population beginning to recognize itself as a coming political force and demanding to be reckoned-with as such. Being 'Third' was about an opening space of political self-determination, and a rejection of hegemonic domination by the 'First' or competing 'Second' world superpower (while that lasted). Beyond securing political independence from the colonizing power, the next moment of political self-determination begged the question of *what might come next*.

This returns the critical reflection on pandemic circumstances to broader questions of how to survive, modify or replace capitalism, as a system with long taproots in five centuries of imperialism, colonization, Eurocentrism and racism, which structurally negates the possibility for the world's majority, wherever they are, to participate equally, and benefit from, social democracy. How might this moment be used to articulate new political, economic, social and cultural expectations and how might people and countries plan to fulfil such expectations? These questions have always been the real stakes defining the subject matter of 'development' and they arose in the context of negotiating a new world order where historical inequalities now demanded to be accounted for.

The writer, Arundhati Roy (2020) suggested that 'the pandemic is a portal'. Its appalling vital inequalities of health and life are simply the newest crisis manifestation of the demand for reckoning opened by the 'Third World' struggle. A historical thread connects anti-imperial and anti-colonial struggles, demands for a New International Economic Order and Right to Development and social democratic struggles everywhere. This thread connects questions about ignorances with questions about justice – what remains unasked and unknown about the experiences of Africa or China, about the relationship between capitalism, socialism and democracy, and about what might be done about the Third 'World' within the 'First'. These critical development questions are uncomfortable and difficult, but they are also good and necessary trouble, for thinking through the world order today.

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2

Climate Change and Coronavirus

A Confluence of Crises as Learning Moment

David Selby and Fumiyo Kagawa

A tale of two crises

2019 was the year of climate emergency declarations. Around the world, 1,750 jurisdictions in 30 countries declared states of emergency in response to a rapidly changing and increasingly volatile global climate so that, today, 820 million people, or one in ten people on the planet, live in places covered by climate emergency decrees (Climate Emergency Declaration, 2020). 2020 has brought the COVID-19 emergency. Declared a pandemic by the World Health Organization (WHO) in March 2020, COVID-19 has spread rapidly around the world with devastating impacts on human life patterns, livelihoods, everyday expectations and public health systems. The global economy has been brought to its knees.

The level of attention afforded to the coronavirus contagion has made it easy to overlook that, not so long ago, WHO (2015) identified climate change as the 'greatest threat to global health in the 21st century'. On that account, some have adversely compared the 'lacklustre' or 'faltering' pursuance of climate change adaptation and mitigation with the intense and robust response to coronavirus across most jurisdictions (Paoletti and Vinke, 2020; *The Lancet*, 2020). The generally low visibility of climate change during the coronavirus crisis notwithstanding, the authors argue that the two crises share much by way of provenance and that, in their intersection, they are in many respects mutually exacerbating. The authors also argue that measures taken to allay either crisis can positively but also negatively impact on efforts to alleviate the other.

In short, there is not only confluence but also collision. In studying current and emerging proposals and initiatives, the confluence of pandemic and climate breakdown is examined as presenting a potentially significant learning moment on the road to resilience.

Common provenance

Both crises are widely perceived as having their origins in human violation of nature (Kolinjivadi, 2020). Encroachment upon the natural world in the name of development is seen as escalating climate breakdown while opening the door to a succession of diseases with the potential to assume pandemic proportions. Unrelenting urbanization, mining, logging, development of transport infrastructure and 'slash and burn' agricultural expansion all degrade and shrink natural habitats and further reduce biodiversity. They intensify carbon release while reducing the global carbon sink, the consequent stoking of global surface temperatures further eroding the resilience and health of the shrinking natural world. Such activities also have the effect of corralling wildlife in ever-closer proximity to human communities. Human expansion into wild spaces in consequence facilitates the transmission of pathogens from wildlife. It is estimated that 75 per cent of new infectious diseases detected in the last 30 years have had zoonotic origins; that is, they resulted from the spread of bacteria, viruses, fungi or parasites from wild or domestic animals to humans (Anderson, 2020; Walzer, 2020). The recent procession of zoonotic contagions includes SARS, MERS, Ebola, Avian Influenza and, latterly and most devastatingly, COVID-19, which has been described as 'an entirely predictable result of humanity's destruction of nature' (Anderson, 2020). Many zoonoses are likely to flourish in a warming climate (UNEP, 2020a). Exacerbating the threat of zoonotic pandemic is the continuing international trade in wildlife and 'wet market' trade in wild meat, a factor of poverty and food insecurity but also in many cases of longstanding food acculturation (Carrington, 2020; Price, 2020). It is from a wet market that COVID-19 is believed to have emerged.

The two emergencies are also widely identified as inevitable outcroppings of the prevailing global economic growth model. For Kolinjivadi (2020), both crises are rooted in neoliberal pursuit of 'infinite growth at the expense of the environment on which our survival depends'. In Chang's view (2020), the crises call for a 'fundamental reconsideration of our development model' based on an understanding of 'how global capitalism has operated in the last decade'. The coronavirus crisis, he explains, amounts to a continuum of the 2007–2008 crisis of global capitalism when it was bailed out by state injections of funding before once more continuing to expand by wreaking further growth-focused havoc on the environment (Chang, 2020). The question then arises as to whether, post-coronavirus, there will be a headlong rush to shore up the capitalist system and so restore 'business as usual' or, alternatively, a push for a green, resilient and inclusive future.

An overlaying of crises

Across the Global South, COVID-19 is overlaying and exacerbating climate-induced crises, thereby attenuating coping capacity. As Phillips et al (2020: 586) have predicted: climate-attributed risks 'are likely to intersect with the COVID-19 crisis all around the world, with many already causing disruptions or likely to do so over the next 12 to 18 months'. In the countries of West Africa, climate change in the form of drought is depleting agricultural yields. Pre-coronavirus, the World Food Program had anticipated a rise in food insecurity that would affect 21 million people. With the COVID-19 outbreak it now anticipates a further 22 million people becoming reliant on food aid. A climate change-fuelled crisis, already overlain by jihadi conflict, has thus become a three-pronged crisis. Efforts to counter COVID-19 such as lockdowns and travel restrictions are hampering the distribution of food aid to drought-affected areas (Akinwotu, 2020). In Sierra Leone, disaster management faces a 'perfect storm'. Recurring manifestations of a changing climate include worsening dry seasons with increased wildfire and

drought followed by unpredictable and often torrential rainy seasons marked by flash flooding and landslides that threaten to overcome poverty-stricken communities and make tackling COVID-19 decidedly more challenging. Not only are poor communities more disease vulnerable to coronavirus but the usual way of protecting flood-engulfed communities, that is, moving the affected to designated shelter, flies in the face of measures such as social distancing, needed to contain the virus (Miles, 2020). In East Africa, the appearance of plagues of locusts of biblical proportions, widely attributed to warmer seas generating the exceptionally wet weather on which locusts thrive, is threatening food security and pushing very poor communities deeper into poverty. Hampering what needs to be a mobile response to combatting locust swarms are governmental restrictions on movement targeted at containing coronavirus. Put baldly, the region faces a choice between stopping the spread of the locust and stopping the spread of the virus (Oxfam, 2020). Among the islands of the Pacific, the confluence of coronavirus and climate change as manifested by an April 2020 category five cyclone has led to a 'moment of reckoning' that has thrown open the fragility of Pacific economies and exposed the shortcomings of current economic structures (Samuwai, 2020). Taken together, the two crises have hit tourism hard and laid bare the vulnerability of tourism dependency.

Climate-induced migration in the Global South is interfacing with COVID-19 in multiple and complex ways. At least 15 million people per year are being displaced by climate-related disaster. They tend not to move far and often to the nearest city where they are typically housed in what can quickly become a crammed temporary evacuation space; a solution that with COVID-19 presents a dangerous public health risk. 'The measures needed to cope with a sudden episode of displacement are exactly the opposite of those required to contain the spread of COVID-19' (Randall, 2020). Those who wish to migrate from hazard-prone rural areas may be forced to remain where they are because of lockdown in urban areas. Alternatively, as in India, lockdown can force thousands of out-of-work migrant workers to leave cities and trek to their villages where they are likely to face

high exposure to drought and food insecurity (Paoletti and Vinke, 2020). During the recent super-cyclone affecting Bangladesh, displaced people faced an 'impossible choice' between 'braving the cyclone by staying put, or risking infection in a shelter' (Ellis-Petersen and Ratcliffe, 2020).

Crises as opportunity

Many are suffering from the conjunction of the two crises. But many are seeing the COVID-19 experience as offering an insight into, first, what a retreat from potential climate breakdown would look like and, second, what governments, steeled to respond to emergency, can achieve. Reduced greenhouse gas emissions and pollution levels with shutdowns in industrial activity, few flights, reductions in road traffic and noticeably bluer skies have given many intimations of a different world (Clark, 2020). 'Amid tragedy we have had a sniff of a cleaner, safer future' (Clark, 2020). Hand in glove with this perception, it has dawned on many that the radical and urgent response to COVID-19 on the part of government sells the lie to past climate change prevarication and foot dragging in the name of maintaining business as usual. The coronavirus outbreak, writes Pantuliano (2020), has demonstrated that 'what was previously deemed impossible seems attainable'. 'Last year', writes Powell (2020), 'governments around the world declared a "climate emergency" and did pretty much nothing to act as if it is one. Now here's COVID-19 and this is what an emergency response looks like'.

Although early days, it is possible to discern a range of proposals and initiatives arising out of what Anderson (2020) calls the 'creative confusion' marking 'this shared time of pestilence'. Explicitly or implicitly, each walks the interface between the two crises. Taken together, the proposals and initiatives amount to a significant learning moment in pursuance of a more resilient future. These are looked at under three headings: nature-based responses; resetting economic and social systems; and a deeper cross-sectorial approach for a multi-hazard world.

Nature-based responses

'It is time for nature' was the recurring theme running through the wide-ranging Environment Day 2020 speech by the United Nations Environment Programme (UNEP) Executive Director (Anderson, 2020) as he advocated nature-based solutions to biodiversity loss, climate change and zoonotic pandemics, solutions that include preservation of remaining wild spaces, an end to deforestation, reforestation, ecosystem restoration of degraded land and habitat-sensitive agriculture. A vehicle for such nature-based responses is the 2021–2030 UN Decade on Ecosystem Restoration designed to help in the race against climate change and biodiversity loss by reversing the degradation of ecosystems (UNEP, 2020b). Anticipating the decade, in East Africa, UNEP, alongside partner organizations, has adopted a 'pay to grow' tree-planting scheme employing workers from the most disadvantaged communities on the frontline of the climate crisis and out of work because of COVID-19. Green recovery is also the hallmark of the 'Ten Billion Tree Tsunami Project' in Pakistan, a five-year tree-planting program begun in 2018 and now employing labourers who have lost their jobs because of coronavirus lockdown to plant millions of saplings in an effort to roll back the climate change threat (Khan, 2020).

Resetting economic and social systems

Wishing otherwise, philosopher Slavoj Zizek fears that, post-coronavirus 'barbarian capitalism will prevail' (Horton, 2020); that, for instance, the excesses of the marketplace will be redoubled with zombie investment in cheap fossil fuels and unsustainable 'shovel ready' projects being resorted to as an accelerant of growth and means of putting people back to work. Pantuliano (2020) is more upbeat, detecting the potential emergence post-COVID-19 of a new order, a 'more sustainable and equal path'. 'We won't go back to normal because normal was the problem', she asserts while pointing to three critical areas where there is 'no option but change': reducing emissions in rich economies while

ensuring just transitions to low carbon economies in lower-income countries; addressing the ubiquitous plague of deep inequalities; enhancing human rights protections as the antidote to draconian pandemic action on the part of government. The World Economic Forum calls for a 'great reset' of the global economic and social foundations of capitalism in response to coronavirus and to the likelihood that climate and social crises will be exacerbated. It identifies three key components: steering the market to fairer and more equitable outcomes; investment in shared goals such as equality and sustainability; harnessing innovation to best address the global public good (Schwab, 2020). In the Global North, talk of a post-coronavirus 'Green New Deal' or 'green recovery' to address environmental degradation and the climate crisis is becoming commonplace. According to Perry (2020), most 'Green New Deal' proposals overlook the irreparable harm caused by colonizer, industrialized nations in the Global South and the respective position of the Global North and Global South as greenhouse effect perpetrator and frontline victim. Perry considers that for a globally equitable 'Green New Deal', the international community must give serious consideration to reparations, taking into account the social and economic impacts of historic colonialism, the environmental destruction that has been wrought by climate change, and the consequent level of vulnerability to the ravages of COVID-19.

A deeper cross-sectorial approach for a multi-hazard world

Evidence is emerging that COVID-19 is causing a rethink of cross-sectorial policy and practice in addressing multi-hazards, especially at the United Nations (UN) level. Take the field of disaster risk reduction, for instance. The *Sendai Framework for Disaster Risk Reduction 2015–2030* (UN, 2015) includes reference to biological, epidemic and pandemic threats but this has not generally been reflected at national and regional operational levels. There are the first indications that the COVID-19 experience is leading to policy reformulation: the United Nations Office for Disaster Risk Reduction

(UNDRR) Africa (2020) called for the mainstreaming of health pandemics in disaster planning and for prioritization of long-term, climate smart solutions 'as climate change impacts combine with COVID-19 to affect the poor and most vulnerable'. COVID-19 is presented as providing both the opportunity for strengthening collaboration and partnerships for integrated cross-sectorial action and for 'transformational and green recovery' (UNDRR Africa, 2020). The same holds true for UN climate change developments. At the heart of the agreement forged in Paris at Conference of the Parties (COP) 21 in 2015 was the commitment of each signatory country to present a review of its actions, future action plans and commitments as its Nationally Determined Contributions (NDCs). NDCs were due to be presented at COP 26 in late-2020 only for the conference to be postponed until 2021 on account of the coronavirus emergency. Countries are now being urged more than before by the United Nations Environment Programme (UNEP) to integrate coronavirus-related and environmental health threats into their 2021 NDC submissions. UNEP is also partnering with UNDP (United Nations Development Programme) in a Climate Promise initiative to assist with 'country-level engagement on climate change and climate action in the context of COVID-19' (UNEP, 2020c). Other evidence of deeper cross-sectoriality is furnished by the developing One Health, EcoHealth and Planetary Health approaches that in their different ways coalesce, inter alia, human, ecological and climate health (Lerner and Berg, 2017).

Conclusion

Nature-based initiatives, a resetting of economic and social structures and a deepening and more thoroughgoing cross-sectorial framing of issues are all called for if the world, as Nobel prize winner Joseph Stiglitz puts it, is to avoid leaping 'from the COVID frying pan into the climate fire' (Beament, 2020).

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3

International Human Rights and Global Welfare in the Midst of the COVID-19 Pandemic

Gerard McCann and Féilim Ó hAdhmaill

The notion of universal human rights, applicable to all and promoted as an answer to future global peace, security and sustainability after World War Two, continues to be a work in progress in a deeply divided and unequal world. Attempts to establish international human rights standards and enforcement mechanisms by the UN and then other regional bodies such as the Council of Europe (CoE) have been beset by a range of different obstacles. Different cultures, ideologies and socioeconomic contexts, geopolitical rivalries and the unequal distribution of power and wealth globally all influence the establishment of 'rights' and their realisability. In the Global South, the legacy of colonialism and ongoing neocolonialism have often contributed to weak states, dictatorial rulers and gross inequalities, exacerbated by a dominating global market system. In such circumstances, even the most basic human rights – such as the rights to life, health and education – have been denied to large sections of the population. Massive global inequalities exist in access to rights – whether civil and political, but especially social and economic. It is therefore not surprising that as states have struggled to cope with the COVID-19 pandemic, human rights concerns have emerged in terms of what governments have and have not done, and how global institutions have fared in ensuring human rights protections in the global community. This chapter explores some of the impacts of the COVID-19

pandemic on international human rights globally and on the whole notion of the universality of human rights.

Human rights protection and COVID-19

When COVID-19 was declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO) on 30 January 2020, governments reacted differently and at varying paces in response. Measures taken, or not, were informed by a mixture of political, economic and ideological influences weighed against sometimes conflicting advice from national and international scientific advisers. Concerns for the impact on the economy, education, mental health and normal life had to be weighed against the need to contain the spread of a deadly new virus about which the world knew very little and for which there was no cure or vaccine. Lockdown of the economy, education, childcare, leisure facilities, as well as restrictions on movement, social distancing and quarantine, challenged individual rights' protections in the name of the right to life and health of the society, and particularly of those most susceptible to the virus.

Concerns for the rights of citizens at nation state level overrode ideas about international solidarity. Narrow national responses led to the unilateral closure of borders in many states to prevent the inflow of people from elsewhere, including the cancellation of the European Union's (EU) programme to resettle refugees from Syria. The notion of 'free' trade was shelved as governments prevented the export of or used their economic power to corner the market for respirators, personal protective equipment (PPE) and drugs. In July 2020, the US cornered almost all the global supply of Remdisivir – the most promising drug to emerge at the time in the fight against the virus. At the same time, the EU Commission announced that it was in discussions with the drug's producers, the US company Gilead, 'to reserve doses of Remdisiver for EU member states' (*Irish Times*, 6 July 2020: 12). This of course led to concerns by those states, particularly in the Global South, who may not have the economic clout to challenge rich states in the marketplace for

the necessary drugs and equipment to fight the virus. It also raised questions about who would have access (and when, and to what extent) to any vaccine that might be produced at a future date. US President Trump, for example, made it clear that he intended to ensure that Americans would get access to any potential new vaccine before anyone else in the world. Such pharmaceutical protectionism would have a catastrophic effect on many countries in the Global South unable to prepare for this pandemic without appropriate medical resources.

Globally, concerns were also raised about the potential use of the pandemic as an excuse by some states to curtail hard-won freedoms. Human Rights Watch (HRW), for example, listed 111 countries where it said that governments had used the crisis to introduce media suppression, controls on civil society, or legislation that was intended to silence oppositional voices. Lockdown became an excuse in some countries to adopt emergency powers or martial law decrees, or to monitor populations under the guise of limiting contagion. It also opened the window for the suppression of ethnic minorities and permitted political persecution to thrive on a wide scale (HRW, 2020).

Although restrictive regulations are undoubtedly necessary at times of public health emergencies, some governments used the opportunity to circumvent or change human rights legislation. While states are allowed under international human rights law to derogate from many of the rights in a time of emergency, the extent of restrictions to rights should be appropriate to the particular circumstances at that time and should be lifted when the emergency dissipates. There are always concerns though that once restrictions on rights are in place it may be difficult to get them removed in the future as states become comfortable with this 'new normal'. The 2015 imposition of emergency decree laws in Turkey, for example, showed that: '…the longer the emergency regime lasts, … the lesser justification there is for treating a situation as exceptional in nature with the consequence that it cannot be addressed by application of normal legal tools' (Venice Commission, 2016: 41).

Rights violations have become widespread in the Global South since the announcement of the pandemic. President Duterte of the Philippines, for example, threatened to shoot anyone violating his pandemic restrictions and public animal cages were erected for public humiliation; in South Africa, the police enforced violations of restrictions with beatings, water cannons, rubber bullets and mass imprisonment; in India, migrant workers were lined up and sprayed with disinfectant; others had 'keep away from me' forcibly written on their foreheads; 15 people were shot dead by police enforcing the curfew in Kenya; in Iran, Amnesty International reported 36 killings of prisoners protesting about health concerns around the virus (Delvac, 2020: 1). Fundamentally, what has been challenged in many countries has been the right to liberty. Under the restrictions imposed during the pandemic, restraints have been placed on whole populations in terms of what they can and cannot do, where they can travel, shop or spend leisure time, who they can be in contact with and how closely and for how long. In particular, restrictions have been placed on the most vulnerable: the elderly, the ill, those with underlying health issues and those in need of institutional care. Health protection and public safety have been the primary concerns, but proportionality is important, as is the rebuilding of rights-focused approaches post-COVID-19.

A thin line exists between the need to protect communities from the spread of the virus and the right to freedom of movement and behaviour. In some countries, such as the US where the primacy of individual freedom and limited government regulation is promoted, the conflict between individual rights and the collective rights of communities to good health has precipitated the spread of the virus. As a result, the deleterious effects of the pandemic have been most severe on the rights to healthcare, education, freedom from hunger, and so on.

The welfare states which emerged after World War Two in many European countries, with comprehensive public health services, free education systems, income and other social protections, were not replicated in most of the Global South or indeed even in rich countries such as the US. When the pandemic emerged, while some health services (such as in

Germany) appeared better prepared than others, many, even among those with comprehensive welfare systems, struggled to cope. Lack of adequate supplies of PPE, respirators, medical staff, drugs, hospital facilities and testing capabilities were experienced throughout Europe with some health facilities overwhelmed with the numbers infected. That so many healthcare workers and elderly residents of care homes were to die was an indictment of both the lack of preparedness of some states and the virulence of the virus. In the US, the lack of a comprehensive public health service and a reluctance to interfere in the market or individual rights for the collective good, alongside poor political leadership, meant that one of the richest countries in the world suffered the most in terms of total deaths throughout much of 2020. In particular, it was the poor, the disadvantaged, the elderly and ethnic minorities that bore the brunt of this.

It emerged early in the pandemic that large numbers of workers in specific employment sectors, such as the meatpacking industry, were contracting the virus. Dependent on mostly migrant labour, on poor wages and living and working under congested conditions, this raised questions about work practices and conditions in such industries. It also raised questions about the effectiveness of travel controls supposedly established to prevent the spread of the virus from state to state. Bus drivers, care workers and taxi drivers were also groups especially affected by the virus. When states began to lockdown to try and curtail the spread of the virus, those first to lose their jobs were often those who were in low-income employment or with precarious contracts – those with little or no labour rights. As the lockdown restrictions start to be lifted and economies begin to function again, it is those same workers that will most likely suffer the most in the accompanying global recession.

In the Global South, the impact of disruption to global trade has added to economic precarity. Prior to the pandemic there were already more than 820 million people who went to bed hungry in the world. Quarantine regulations, partial port closures, border closures and travel restrictions causing disruption to the global food market will exacerbate this. ‘Well-nourished citizens in wealthy countries may weather a

couple of months without some fresh or imported produce, but in the developing world, a child malnourished at a young age will be stunted for life' (Dongyu Qu, 2020).

Most states were quick to close schools and colleges early on in the pandemic, believing that young people were possible 'super-spreaders' of the virus. Education went online, to a greater or lesser degree. This in turn reinforced already existing educational inequalities for those on lower incomes or with learning difficulties. Lack of access to computers, the web, reliable broadband, dedicated technology for personal educational purposes, space, educational support, and the general environment in which education takes place, are all issues. The closure of schools also meant there were no school meals for millions of children across the world – 85 million in Latin America and the Caribbean alone (Dongyu Qu, 2020). The right to education has been put into question on a global scale.

The response of international organizations

One may well ask, where have the international institutions been during this pandemic, and to what extent have they been able to marshal a global response which protects the rights of all? The WHO, set up as an agency of the UN in 1948 with the task of promoting global health and organizing international responses to global health emergencies, announced the pandemic on 11 March 2020. At the time there were already 118,000 cases of the coronavirus illness in over 110 countries and territories around the world, and in retrospect it admitted that it had been too slow on the announcement since the first cases were identified in the Chinese city of Wuhan on 31 December 2019. One major problem had been the lack of information about and understanding of the new virus, which led to slow and confused reporting from countries affected. The WHO set in motion a global COVID-19 Strategic Preparedness and Response Plan which identified the major actions countries needed to take and the resources needed to carry them out. This continues to be updated in line with scientific evidence from around the world. Although not a

human rights oversight body, the WHO has been heavily involved, prior to the pandemic, in the promotion of the right to health globally and the UN Sustainable Development Goals (SDGs), especially Goal 3 relating to attempts to promote health. In more recent times, it has attempted to provide a coordination role in the dissemination of information which may help prevent the spread of the virus, and in the promotion of the development of treatments and vaccines to combat it. Ironically, in the middle of the crisis, US President Trump launched several public attacks on the WHO for what appeared to be domestic political reasons, announcing that the US was withdrawing from the WHO – the only UN state ever to do so – and removing its funding by 2021.

In terms of international human rights law during the pandemic, there are a number of oversight bodies in existence in relation to various civil and political rights, as well as the social, economic and cultural rights contained in the various UN rights treaties. The most obvious oversight role is that held by the UN Office of the High Commissioner on Human Rights (OHCHR) and the monitoring committees associated with each of the human rights covenants and conventions. Their role is mainly to report on rights abuses and progress towards both the protection and promotion of rights in each state which has ratified these treaties. Their oversight role is mainly one of persuasion rather than enforcement. There is also the International Court of Justice (ICJ) at the Hague, whose role it is to give judicial opinions on aspects of international law, but again it has no enforcement powers. The only UN body with the ability to enforce human rights is the UN Security Council. It can potentially invoke UN economic sanctions and even war; however, historically, such decisions have usually been more influenced by the national and geopolitical interests of the big powers rather than concerns about universal human rights protections.

The UN did introduce a US$2 billion COVID-19 Global Humanitarian Response Plan across 51 countries in the Global South to strengthen health services and combat the spread of the virus. It also highlighted a number of specific groups as being vulnerable to political interference in human rights standards, including persons in detention; women;

lesbian, gay, bisexual, and transgender (LGBT) persons; and migrants, all groups that – in light of widespread derogation of human rights conventions – were being harassed or abused in many states across the Global North and South (OHCHR, 2020: 3). Nevertheless, the UN also recognized that some rights, such as the right to movement, needed to be curtailed in order to protect other more fundamental rights, the right to life and the right to health.

Conclusion

The COVID-19 pandemic has resulted in exceptional circumstances for populations around the globe. The imposition of emergency powers and curfews have placed immense pressures on the architecture of human rights protection, which coupled with recent derogations and reversals globally has complicated the drive for human rights-based approaches to international development. The urgency of rebuilding is critical for the lives of billions of people, but particularly the most susceptible to human rights abuses: minority ethnic groups, women, LGBT communities, the elderly and sick. International coordination and cooperation need to remain central for reestablishing the consensus on the importance of human rights across all societies. The Council of Europe offers some internationalized conscience to easing out of this emergency situation, with forward thinking that is globally applicable:

> Even after the acute phase of the crisis, our societies will have to find the means to repair the social and economic damage and further enhance trust in our democratic institutions. Among other things, a broad reflection will need to be initiated on the protection of the most vulnerable individuals and groups in our societies and about the means to safeguard their rights in a more sustainable and solidary governance model.
>
> (Council of Europe, 7 April 2020: 9)

The pandemic has raised questions about a range of other rights, such as the right to health, education, income, freedom from hunger. Indeed, some of the actions and inactions of states may well have contributed to disproportionate levels of deaths and severe illness among some sections of society. For example, why was it that many older people in care homes, frontline healthcare staff and unequal numbers from ethnic minorities died in societies with comprehensive public healthcare systems? Why was public healthcare withdrawn in many regions of the Global South? Decisions by some states also potentially targeted certain minorities as 'problem' groups. Questions also remain as to whether it was appropriate or humane to force elderly people or those with underlying health problems to self-isolate and restrict their freedom to associate, even when they were very ill or dying, often while others in the general population were free to move around.

With the rush of nation states to protect their own interests, their establishments and that of their own citizens, concepts of human rights, which are supposed to be universal to all humans and provided globally, have often been lost. However, at the least, the continuing existence of international bodies, such as the WHO and the OHCHR, provide some level of hope that in a world less afraid and recovering from the pandemic, concepts and actions of global solidarity will return.

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4

Development Education, COVID-19 and Neoliberalism

Stephen McCloskey

Development education (DE) is a sub-sector of international development which aims to tackle the underlying causes of poverty, inequality and injustice in the Global North and South with an interactive learning methodology that supports active global citizenship. Based on the radical pedagogy of the Brazilian activist, educator and philosopher, Paulo Freire (1996), DE has its roots in the Global South but has inspired educational practice across the world (Bourn, 2012: 25–26). Development education is defined by the Irish Development Education Association as 'an educational process which enables people to understand the world around them and to act to transform it. It works to tackle the root causes of injustice and inequality, globally and locally to create a more just and sustainable future for everyone' (IDEA, 2020).

Central to this definition of DE practice and Freire's methodology is the concept of praxis – a combination of reflection and action. As Freire argued, 'to surmount the situation of oppression people must critically recognize its causes, so that through transforming action they can create a new situation, one that makes possible the pursuit of a fuller humanity' (Freire, 1996: 29).

What appears to be lacking in the response of the international development sector to the COVID-19 pandemic to date has been an analysis of its root causes. There has been a similar studied omission with regard to the climate emergency, despite suggestions that both crises – COVID-19 and climate change – are 'inevitable outcroppings of the prevailing global economic growth model' (Selby and Kagawa, 2020: 106). This chapter argues that in order to respond effectively to the

coronavirus pandemic, we need to understand its connections to the neoliberal growth model that has underpinned 'development' since the 1970s. As Reid-Henry (2012) argues: 'in terms of development policy, neoliberalism often boiled down to the belief that an intensified globalization was itself development, the two being inseparable sides of the same virtuous coin'. The outcome of the alignment of development with neoliberalism has been disastrous with 2,153 billionaires controlling more wealth than 4.6 billion people and almost half of the world's population living on less than US$5.50 a day (Oxfam, 2020: 7). With governments planning expenditure of US$9tn in stimulus packages to 'rescue their economies from the coronavirus crisis', a neoliberal response to a neoliberal-created crisis is likely to deepen the climate crisis and inequality (Harvey, 2020). The chapter proposes that a reimagination of economic planning based on sustainability and human wellbeing is the most appropriate response to COVID-19.

The 'tyranny of GDP'

Applying DE's problem-posing methodology to the origins of COVID-19 links its rapid transmission and devastating impact to the global trading network and market system created under neoliberalism. COVID-19 is believed to have been initially transmitted in the wet market of Wuhan, China and the trade in wild meat which has created new pathogens or zoonoses that cause viral infections in humans from animal origins (Spinney, 2020). As Spinney (2020) argues: 'Covid-19 wouldn't emerge in food markets if it wasn't for factory farming, globalised industry and rapid urbanisation'. The virus has spread so rapidly around the world because of the increasingly interdependent, interconnected and deregulated trading system that has been spawned by neoliberalism. As Lent (2020) suggests, 'coronavirus is revealing the structural faults of a system that have been papered over for decades as they've been steadily worsening'. Neoliberalism has not only created the economic conditions for the spawning of COVID-19 but has also systematically privatized public health

services, rendering many of them unequal to the challenge of fighting a pandemic (Tansey, 2017; Campbell, 2020).

If the coronavirus pandemic has compellingly demonstrated the absolute necessity of a publicly funded health service, it also placed a premium on public-facing occupations that the market economy's yardstick of Gross Domestic Product (GDP) under-values and poorly remunerates. The 'tyranny of GDP' results in a moral vacuum which considers 'speculation, pollution and gambling as being good for the economy' because they turn a profit (Elliott, 2017). In 1968, US presidential candidate Bobby Kennedy said this about GDP:

> It measures neither our wit nor our courage, neither our wisdom nor our learning, neither our compassion nor our devotion to our country, it measures everything in short, except that which makes life worthwhile.
>
> (cited in Rogers, 2012)

If GDP dictates what our talent deserves, then what price now should be put on the labour of a nurse, a carer, a driver, a refuse collector, a supermarket worker or a cleaner, all of whom have been indispensable to our surviving coronavirus? Oxfam estimates the annual monetary value of unpaid care work carried out globally by women aged 15 and over at US$10.8 trillion (2020: 6). Using the GDP metric, this labour holds little or no monetary value and, yet, it is priceless to the elderly, sick and people with disabilities across the world lacking social care. 'It is absurd', suggests Elliott (2017), 'to believe that GDP provides the best – or even an accurate – picture of how well the country is really doing'. Our experience of COVID-19 affords us an opportunity to finally decouple human development from GDP and the neoliberal growth model to prioritize services critical to the wellbeing of society and the environment.

The United Nations Rapporteur on Extreme Poverty and Human Rights, Philip Alston, has suggested that social justice and human rights should become central to the ways in which we implement and measure human development (Alston, 2020). 'Rather than resolving to address the inadequacy of their public health and social protection systems in response

to the pandemic', argues the Rapporteur, 'many governments have seen COVID-19 as a passing challenge to be endured' (Alston, 2020: 9). The Rapporteur recommends a raft of measures that could help address endemic poverty in the Global South including: bringing equitable taxation and redistribution front and centre; large-scale debt forgiveness for low-income countries; closing tax havens that support tax avoidance by multinationals; ensuring universal social protection for low-paid, vulnerable workers; and embracing participatory governance that listens attentively to the needs of the poor (Alston, 2020).

Rethinking 'development'

The COVID-19 pandemic should represent a line in the sand where we resist and roll back the marketization of services that have no business in private hands: healthcare, education, utilities and transportation. Wolfgang Sachs suggests that '"Development" is now a plastic word, an empty term with no positive meaning' (2020: 67). 'Development', Sachs argues, 'is more often about survival now, not progress' (Sachs, 2020: 68). With that in mind, civil society groups, governments and international Non-Governmental Organizations (NGOs) need to look beyond the short-termism of overseas aid, emergency appeals and public 'clicktivism' to focus on the long-term needs of humanity. Economies, to function properly, need to be put at the service of society's needs, not the needs of the market. That means critically interrogating the concept of 'development' in the light of coronavirus to debate what it means in a future that is likely to be clouded by recession, increased inequality and an ever-looming climate crisis. A United Nations' working paper estimates that as a result of COVID-19 'there could be increases in poverty of a substantial magnitude – up to 400 million new poor living under the US$1.90 poverty line, over 500 million new poor living under the poverty lines of US$3.20 and US$5.50' (Sumner et al, 2020)

Those at greatest risk of falling under the poverty line are workers in the informal economy, with the International

Labour Organization (ILO) describing the world's 1.6 billion informal workers as 'the most vulnerable in the labour market' (2020: 1). As ILO Director-General, Guy Ryder, said: 'For millions of workers, no income means no food, no security and no future' (cited in Bronswell, 2020). The international development sector should draw upon DE's critical thinking skills that support a demystification of the world to challenge some of the sickly myths about coronavirus.

Chief among them is the idea that when it comes to coronavirus, we're all in this together. It goes something like this: coronavirus is a great leveller that has plunged rich and poor into turmoil, insecurity and isolation. We are all equally susceptible to contracting the virus, which does not distinguish between its victims in terms of class, race and occupation. The reality is a lot different. According to the Institute of Fiscal Studies, the better-off may actually increase their savings during the crisis as spending on forbidden activities falls (Crawford et al, 2020). But poorer households spend much more of their limited income on necessities, leaving them vulnerable to sudden falls in their incomings (Crawford et al, 2020). 'So save us the platitudes of coronavirus as the great leveller', suggests Jones (2020), 'abandon this sickly myth that we are all in this together'. In addition to class and income, race and occupation have also been found to be important determinants in the number of cases of COVID-19. By April 2020, 119 National Health Service (NHS) staff had died as a result of coronavirus in the UK, 64 per cent of whom were members of the Black and Minority Ethnic (BAME) sector yet only 20 per cent of NHS staff are from an ethnic minority background (Bailey and West, 2020). But, as *The Lancet* suggests, 'essential work extends beyond health care'. '[M]illions of workers have jobs that cannot be done at home … These people leave their homes to help maintain a semblance of normality for others, at great risk to themselves and their families' (2020: 1587). These are the kind of occupations that are vulnerable in a post-COVID-19 economic recession, but as *The Lancet* argues: 'Essential workers are just that – essential – and by protecting their health, we protect the health and wellbeing of us all' (*The Lancet,* 2020).

Degrowth and a Green New Deal

It may seem absurd to propose degrowing the global economy as countries across the world have been forced to shut down their economies at some point in 2020 to contain the coronavirus pandemic. The International Monetary Fund (IMF) has warned that the 'great lockdown has triggered the worst recession since the Great Depression and forecasts global output losses of US$12 trillion in 2020–21' (Gopinath, 2020). Bouncing back to 'normal', however, with a massive injection of capital stimulus into carbon-based industries responsible for over 70 per cent of global emissions, will only deepen the climate emergency (Riley, 2017). Degrowth activists suggest that despite the name, they are not seeking the kind of economic contraction attended by recession and austerity but 'a thoughtful, democratic, managed and equitable downsizing of the economy' (Seaton, 2020). Degrowth advocates suggest that the endless pursuit of growth as an objective of the global economy, rather than the social wellbeing of citizens, is harvesting the natural resources of the planet at an unsustainable level to produce consumables, many of which are unnecessary, wasteful and designed to satiate the needs of the market rather than enhance the quality of our lives.

However, degrowth alone will not ensure the social and economic protection of low-paid essential workers who have sustained us through the coronavirus pandemic. Green New Deal advocates, including Naomi Klein, have argued for the introduction of a basic annual income – 'a wage given to every person' – with the 'benefit of creating much needed economic security in the frontline communities' (2019: 94). The idea of a Green New Deal has been proposed by progressive social movements and political actors to decarbonize the global economy, invest in renewables, and ensure a just transition for workers threatened by 'the economic and political shift from an extractive economy to a regenerative economy' (Climate Justice Alliance, 2020). Inspired by Franklin Delano Roosevelt's New Deal response to the Great Depression in the United States in the 1930s, which combined public investment in services with social welfare, employment rights,

banking regulation and supporting the natural environment, the Green New Deal needs to be no less ambitious.

Conclusion

UNICEF has warned that the COVID-19 pandemic could cause significant mental health problems for the most vulnerable in society, particularly young people. The agency has highlighted that 'the mental health and psychosocial impact of restricted movement, school closures and subsequent isolation are likely to intensify already high levels of stress, especially for vulnerable youth' (UN, 2020). A survey by Barnardo's of a thousand young people in the UK suggests that climate change is already a source of anxiety and stress for young people. The survey found that: 'More than half (54 per cent) said climate change was one of the most important issues facing the country over the next three to five years, with 42 per cent saying older generations don't seem to understand or be interested in this issue' (Barnardo's, 2019)

With its capacity for compassionate action, critical thinking skills and deeper understanding of global issues, DE can provide what the Irish NGO, Children in Crossfire, describes as 'an emotional literacy framework for preparing young people to participate in the world as compassionate global citizens' (2015: 4). This includes providing teachers and community educators the training and resources needed to address the complexity of COVID-19 and the climate emergency in a way that offers young people a sense of empowerment and hope based on their own capacity and agency for change.

DE's radical pedagogy with its central concept of praxis, combining reflective learning and active citizenship, is ideally positioned to support the kind of social and economic change demanded by the twin crises of COVID-19 and climate change. It seems unconscionable that society can revert to the same high-growth 'normality' that created the economic conditions which spawned COVID-19 and precipitated the climate crisis. Underpinning these global emergencies and the grotesque levels of inequality that have followed the 2008 global financial crisis is neoliberalism; 'the ideology', suggests

George Monbiot, 'at the root of all of our problems' (2016). The identification of international development with the high-growth, GDP-measured production and consumerism of neoliberalism is no longer tenable if the development sector is serious about tackling the root causes of poverty and climate change. What is required instead is a just transition to degrowth and a Green New Deal with a people and planet-centred plan for development (Klein, 2019).

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PART II

Social and Economic Impacts

5

Prisons in a Pandemic

The Malawi Experience

Kate Gauld

Worldwide, there are currently 11 million people in prisons (Walmsley, 2018). In mid-July 2020, the advocacy body Penal Reform International released a report indicating that since the global outbreak of COVID-19, over 100,000 prisoners had been infected in 88 countries. More than 1,500 prisoners in 36 countries had died due to COVID-19. The day this report was released, Malawi confirmed its first case of a prison officer testing positive for the virus, and the following day its first prisoner tested positive some 600 kilometres away.

In Malawi, one of the world's poorest countries, over 14,000 people are in custody, with prisons operating at 260 per cent capacity (Prison Inspectorate of Malawi, 2019). This means prisoners sleeping side by side on the ground. It means walking past a small police cell and seeing more bodies than the eye can immediately comprehend. Then there is poor ventilation, limited access to adequate nutrition and the lack of basic hygiene facilities. This means no access to running water, no flushing toilets and relying on visitors for meals. Before the outbreak of COVID-19, you would be hard-pressed to find a bucket of water and soap available to the prisoners. In other words, Malawi's prisons are the perfect incubator for COVID-19.

As with any prison population, there are people with acute and chronic illnesses, pregnant women and elderly prisoners, making them especially susceptible to the virus. In the context of Malawi, 61 is the average life expectancy for men, almost 10 per cent of the adult population have HIV, rates of tuberculosis are especially high among people with HIV, and these rates are higher in custody than the general population (WHO, 2019). Then there is the healthcare system, reported

in April 2020 to have only 25 intensive care beds and seven ventilators in a country with a population of over 18 million people (Vidal, 2020). It is no surprise that Malawi has been classified as one of the top ten most vulnerable countries in Africa to respond to COVID-19 (Surgo Foundation, 2020).

The problem of overcrowding in Malawi's prisons is not new. Back in 2004, the Malawi Prison Inspectorate, which includes a High Court judge, the Ombudsman, the Commissioner of Prisons and a Chief Resident Magistrate, released a report noting that congestion was the most serious problem facing the prisons. In 2009, Malawi's Supreme Court found it unconstitutional to place inmates in overcrowded and poorly ventilated prisons. The court's language paints a vivid picture:

> In this case we hold the view that packing inmates in an overcrowded cell with poor ventilation with little or no room to sit or lie down with dignity but to be arranged like sardines violates basic human dignity and amounts to inhuman and degrading treatment and therefore unconstitutional.

Prior to COVID-19, despite long-term advocacy efforts by human rights and civil society organizations, attempts to turn these findings into wholesale institutional reform had not been achieved. As the global organization Dignity notes, this is part of a wider trend by countries who resort to 'deprivation of liberty as the first response to all sorts of criminal and social phenomena, disregarding fundamental human rights principles. The COVID-19 crisis has accentuated these shortcomings' (Dignity, 2020: 13).

And so to COVID-19. In late March 2020, with the virus already changing the global landscape, Irish Rule of Law International (IRLI) along with a number of NGOs released a press statement noting the deadly risk that the virus represented to those in custody, especially for older prisoners and those with underlying health conditions (IRLI, 2020). We recommended a number of preventative measures: to decongest the prisons by releasing prisoners who met certain criteria, relaxing bail conditions to get people out of custody

and back into the community, encouraging police to not arrest and detain people for 'petty offences', and for the Ministry of Health to supply prisons with basic handwashing supplies.

The first reported case of COVID-19 occurred on 2 April and the then President Mutharika announced various measures to mitigate the impact of the virus. He called for a list of prisoners that included juveniles and those who had served a significant portion of their sentences for 'moderate crimes', with a view to process their release. We issued another press release the next day noting that although this was a welcome development, that list also needed to include people serving any period of time in custody for petty offences regardless of how much time they had served, along with people with a terminal illness, tuberculosis and other chronic illnesses.

On 14 April, a three-week lockdown was announced, taking effect days later. The day before it was to be implemented, a human rights coalition launched a unique, and at first blush controversial, injunction and application for judicial review to halt the lockdown. Those interim requests were granted in the High Court's chambers hours before the lockdown was to start. It was not the concept of a lockdown per se that concerned the human rights coalition, but how it was to be implemented.

In court, their primary argument was that there were procedural irregularities in the lockdown declaration amounting to a substantial derogation from fundamental rights under the Constitution. In public, they cited various statements made by the police threatening violence and mass arrests in implementing the lockdown (South African Litigation Centre (SALC), 2020). They noted that in Nigeria, more people were killed by police implementing the lockdown in its first few weeks than by COVID-19 itself. They were also concerned that police would conduct mass arrests in enforcing the lockdown, further overcrowding the prisons, and further increasing the risk of COVID-19 spreading through the cells. Again, these fears were not unfounded. In Angola the police arrested and detained almost 300 people in one 24-hour period for violating state of emergency rules, and by mid-April in Sri Lanka, over 34,500 people had been arrested for violating curfew orders.

The human rights coalition painted a stark picture of the practicalities of a lockdown where the majority of the population live below the global poverty line, where 90 per cent of households rely on water from outside their homes, 61 per cent of households do not have toilets in their homes, and where there is already a high prevalence of household hunger (SALC, 2020). They noted: 'This does not necessarily mean that a lockdown is not the correct approach to address the COVID-19 pandemic, but a one-size-fits-all approach which ignores the lived realities of our people might well be' (SALC, 2020)

In late April, the High Court upheld the stay on the lockdown. The matter is now with the constitutional arm of the High Court, which is yet to hear the matter. There is currently no legal basis for enforcing a lockdown in Malawi.

But while COVID-19 had seized almost the entire news agenda in much of the world, the central issue concerning the majority of Malawians was the June 2020 presidential election. Numbers of confirmed cases remained low throughout this period and hopes remained that Malawi had somehow escaped the worst of the disease. Public gatherings, rallies and protests continued in the lead-up to the election, as did the perception that this was a virus only brought in by foreigners. By mid-July, this perception was changing as COVID-19 numbers began increasing at an alarming rate. At the time of writing, over 4,600 cases have been recorded, including 118 prisoners and 21 prison officers. 146 deaths have been recorded, including one prisoner.

In response to COVID-19, IRLI has advocated from before the first case as to the urgency of decongesting the prisons. To be in any way effective in doing this, it has required an intimate knowledge of who is in custody and why. We know that roughly 20 per cent of people in custody are on remand: they have been charged but are yet to be tried or even convicted (World Prison Brief, 2019). Some have been waiting for up to ten years for their trial, charged with offences that could not possibly result in a sentence, if convicted, of that long. We know that close to 8 per cent of people in custody are children. About 1 per cent are women, including women living with their children in custody, and some charged with

infanticide for having miscarriages and stillbirths. We know there are too many people in custody with chronic mental health conditions, with no access to treatment. This provides a useful framework for advocating who should be released.

Effective advocacy has also involved a thorough understanding of how the criminal justice system functions in Malawi, including why certain seemingly obvious challenges have remained unsolved. Law reform in and of itself is a useful start, but it is the mechanics of implementation that are the real challenge, and where civil society can make a meaningful difference. We know that not all magistrates, who deal with the vast majority of criminal cases and dispense an overwhelming number of custodial sentences, are required to have formal legal qualifications. Understandably they can encounter difficulties in applying precedent, an essential component of their job: judgements are not widely reported, while the judiciary lacks the capacity to operate a systemic case law resource.

The Legal Aid Bureau and the Director of Public Prosecutions (DPP) both face stark resourcing challenges. The Central Region, home to 7.5 million people as well as the nation's capital, has only nine DPP advocates and eight legal aid advocates for both civil and criminal cases. As a result, most people who appear before the courts are unrepresented, without an advocate to persuade the magistrate that there are alternatives to a custodial sentence. There are delays and infinite adjournments, often with no defence lawyer to call the state to account. Worse, it is not uncommon for files to go missing, which results in people remaining in custody indefinitely without any future court date. Meanwhile it is the police prosecutors, often with no legal qualifications, who conduct the vast majority of criminal cases, including sexual assault matters.

Then there is the police service, who lack the resources to transport inmates to court. This in part explains why detainees are often held in custody for far longer than the legislated 48-hour period, the maximum holding time before they must be brought before a magistrate or released on bail (known as the '48-hour rule'). Meanwhile, various development initiatives have at times missed the mark, such as written guidelines for

police drafted only in English, which is not the first language of the significant majority of Malawians.

In response to these challenges, Irish Rule of Law International (IRLI facilitates 'camp courts', where we essentially bring courts to the prisons. This allows magistrates to process large numbers of bail applications in a single sitting. We have drafted a legal commentary on bail case law to assist magistrates and advocates, reinforcing that custody is a last resort. We facilitate workshops for the DPP, legal aid and police prosecutors, conducted by local advocates, on topics that promote access to justice for accused and convicted people. We conduct a child justice programme, diverting children away from the criminal justice system. We monitor police cells to ensure that children are not placed in detention and that the '48-hour rule' is upheld. We educate the wider community on due process rights and conduct human rights education workshops.

How have we responded to COVID-19? We have increased some of our existing work, such as organizing more 'camp courts', assisting those most vulnerable to COVID-19 to obtain bail. We continue to monitor the police cells for breaches of the '48-hour rule' and children in detention. We have worked with the Chief Justice to develop a directive to magistrates to strictly enforce pre-trial custody limits and to consider bail and non-custodial sentences wherever possible. We have also worked in new ways, working with other civil society organizations to get soap, buckets and face masks to prisons, and have been much more forthright in our advocacy efforts.

We have kept track of how many people have been released from prison in response to COVID-19. Following the President's announcement, it appears that over 1,800 people have been pardoned, while the numbers of people actually released has been difficult to verify. A separate review by the Prison Inspectorate in April 2020 saw over 1,400 people released whose sentences were close to expiring. Our best estimate is that Malawi has reduced its prison population by just over 12 per cent. Neighbouring Mozambique has reduced its prison population by nearly 26 per cent and Zambia by nearly 25 per cent. Not only is Malawi's overall percentage

comparatively low, but as Malawi's prisons are some of the most overcrowded in the world, these releases are entirely insufficient to reduce the prison population to capacity. Meanwhile, many new people continue to be admitted to prisons, including for petty offences.

What more is to be done? As far as we can ascertain, the government has only pardoned people with six months or less to serve on their sentences – a fraction of the categories identified by the World Health Organization for conditional release, including the elderly, the sick, pregnant women and prisoners at low risk of reoffending. The presidential pardoning process must be more transparent so that civil society knows what categories of people are being slated for release compared with who is being released. While the initial call for the prisoner list under the previous government was promising, the process from there has been opaque and ever-shifting. In mid-July, it was reported that three children are living with their mothers in one prison. The children are aged four months, 18 months and two years, and the latter two have both spent over a year in custody. Indicative of how poorly resourced the prisons are, prison authorities are reportedly asking 'well-wishers' to provide the children with food, clothes, nappies, blankets, shoes and more. All these women remain bail refused. There is clearly much more to be done.

We are also calling for the new President to use his full powers under the Constitution and the *Prisons Act* to remit appropriate sentences, taking into account restorative justice principles by releasing early those who have significantly rehabilitated while in custody. We are urging the prison services to take all necessary healthcare precautions to ensure the safety of their staff and those in prison. We are asking the government to allocate sufficient funds to the criminal justice sector to effectively respond to COVID-19.

The next challenge, given the deteriorating climate, is how prisons will navigate a raft of public health and human rights issues. In response to the first positive cases in custody, the Malawi Police Service made the commendable move of designating isolation centres in each region of the country for new remandees. However, this came at the expense of

moving all female prisoners in one prison up to 350 km away, essentially preventing their families from providing them with food and basic necessities. Family visits have been banned, with no plans announced as to how prisoners will now be fed. Meanwhile, there remains a lack of isolation rooms for suspected and confirmed cases within the prisons and an overall shortage of test kits, so mass testing of prisoners and custody officers is impossible. While official numbers of prisoners and officials with COVID-19 continue to climb, in reality numbers will be far higher.

Is there a chance of broader, structural reform to the criminal justice sector? If we did not think so, we would be in the wrong business. Many magistrates and judges nationwide have visited police cells to ensure police are adhering to legislative provisions regarding detaining accused people. With the Chief Magistrate's directive issued to all magistrates, we are hopeful that there will be a decrease in custodial sentences, and that that trend will continue in the long term. With greater scrutiny on the custodial sentences handed down for petty offences, we hope this too may be an opportunity to decriminalize these offences, significantly reducing the prison population. With more masks and soap in prisons than ever before, a heightened awareness of the role of handwashing and a greater focus on prison officers as default frontline workers, we are hopeful there may be long-term improvements to the standard of hygiene, while other infectious disease outbreaks, such as tuberculosis, may be reduced. Use of video technology in court proceedings was not on the radar in any meaningful way in 2019. 2020 has shown it to be possible.

Moreover, there is a broader international civil society movement calling global attention to prison conditions and international human rights law the world over. With 124 countries reporting overcrowding, it is not an issue confined to the Global South (Dignity, 2020). Recommendations to reduce pre-trial detention, increase non-custodial sentences and decriminalize certain offences are just as appropriate in the US as they are Malawi. Calls for countries to adhere to international law standards on decreasing the overall use of imprisonment are equally pertinent to countries across the

globe, as are reminders that custody is always a measure of last resort.

It is not just civil society organizations calling for reform. In May 2020, the WHO, Office of the United Nations High Commissioner for Human Rights (OHCHR), the Joint United Nations Programme on HIV and AIDS (UNAIDS) and United Nations Office on Drugs and Crime (UNODC) released a joint statement on COVID-19 in prisons and other closed settings (WHO et al, 2020). It called for overcrowding to be reduced in prisons and urged states to respect the human rights of people deprived of their liberty. The UN Assistant Secretary-General for Human Rights, Ilze Brands Kehris, has argued that the pandemic demonstrates the 'urgent need for institutional reforms and societal transformation where human rights must be front and centre' (Brandze Kehris, 2020).

In response to COVID-19, there are reminders of the reform that is possible the world over. In Nigeria, prisoners serving sentences where fines are no more than around €100 have been released early (Dignity, 2020: 21). In Ethiopia, thousands of prisoners convicted of minor crimes serving sentences of up to three years were pardoned by the President (Dignity, 2020: 23). In Morocco, prisoners have been pardoned on the basis of advanced age, precarious health, time served and their conduct in custody (Dignity, 2020: 24). Bangladesh released over 20,000 adults from pre-trial detention in ten working days, and, using virtual hearings, 343 children were released in just seven working days (Ali, 2020). Unlike most other countries, Afghanistan has successfully released a significant percentage of women in custody (Rope, 2020).

The change of government amid the COVID-19 crisis, just as the situation deteriorated, makes any predictions about long-term systemic reform even more difficult to assess. The new government has made strong pronouncements on the rule of law and measures to tackle corruption. There is a respected and independent judiciary who have more than proved their credentials in recent times. Now is the time for President Chakwera to decongest Malawi's prisons.

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6

The Challenge of COVID-19 in Informal Urban Settlements and the Need for Co-produced Local Responses

Annie Wilkinson

COVID-19 emerged in China and spread first to high and middle-income countries. Many of the initial control recommendations (to wash hands, self-isolate and physically distance) assumed access to essential services (for example, water, space). These protective measures are not equally possible in low- and middle-income countries (LMICs), and especially not in informal settlements because of limited infrastructure. With one billion people living in informal settlements – 30–70 per cent of inhabitants in some cities (Satterthwaite et al, 2020) – there is an urgent need to consider how to appropriately address the pandemic in these areas[1].

Urban growth has been increasingly unplanned in many countries, with poverty concentrated in informal settlements. Cities are often segregated along wealth and social lines (including race). Images of 'slums' depict them as chaotic, dirty and disease ridden, and as a social, environmental and developmental threat to the rest of the city. Such views have informed attempts to deny residents tenure and carry out evictions. A defining challenge of informal settlements and 'slums' is the lack of data about them prior to, and during, emergencies. Due to their illegal or informal status there are often no reliable data about the number of people who live there or their health. This makes it difficult to prepare for an outbreak and could lead to inappropriate and harmful responses.

Vulnerability: what is known and what is not known

The first half of this chapter outlines different forms of vulnerability and identifies groups that may be more severely affected by COVID-19.

Epidemiological vulnerability

The people most vulnerable to severe disease and death are those over 70 years or with cardiovascular disease, diabetes, chronic respiratory disease, hypertension or cancer (Jain and Yuan, 2020). Men appear almost twice as likely to die from COVID-19 than women (Purdie et al, 2020). Although the population of LMICs is young when compared to that in high-income countries (HICs), they account for 69 per cent of the global population over 60 (Lloyd-Sherlock et al, 2020). There is a perception that cities have younger populations than rural areas; however, age distributions between urban and rural populations in LMICs are similar (DESA, 2017). Each city will have different age distributions, but it would be unwise to discount the age-related risks.

Levels of hypertension, cardiovascular disease, diabetes and cancer are poorly documented in informal settlements, though they are increasing in LMICs and are sometimes higher than in HICs (WHO, 2011). Accurate evidence of disease burdens in informal settlements is limited by the residents' reliance on private and informal health providers. Respiratory disease is a major concern due to high levels of indoor and outdoor air pollution, poor housing quality, occupational exposure and waste burning (Checkley et al, 2016). A reliance on precooked, often fried, street food in many settlements results in consumption patterns that can cause diabetes and heart disease (Tacoli, 2017). It is plausible that there are many relevant chronic conditions, often undetected and poorly managed, that put large numbers of people at risk. In addition to the high-risk comorbidities identified so far, there may be other diseases that lead to worse outcomes, and that are disproportionately prevalent in LMICs and informal settlements, for example HIV.

Transmission vulnerability

This encompasses vulnerability related to social mixing, housing and infrastructure, where conditions could foster increased transmission:

- **Density:** Population and housing density is often high, which limits options for physical distancing. A modelling study of influenza in Delhi estimated contact rates based on density in slums and found they were associated with higher and quicker epidemic peaks (Chen et al, 2016). However, peri-urban settlements tend to have lower densities.
- **Household and social structures:** Disease transmission often occurs within households, but composition can be flexible, with people moving between homes, sharing food or sleeping space. Control strategies and responses based on assumptions about household units may fail. Children are often cared for by grandparents or older family members and this poses an elevated risk of transmission.
- **Mobility:** Mobility within and between cities is frequent. Residents in cities often maintain strong ties with home regions, sending revenue home and travelling between urban and rural settings frequently for work and social reasons. It is also common to travel when sick and, in some countries, to return the deceased to their natal home (Campbell, 2017). This could spread COVID-19 to rural areas. The reasons for mobility and the implications of urban–rural linkages must be considered in control strategies.
- **Livelihood imperatives:** People who live hand-to-mouth often cannot afford to be sick and may work despite illness. Given the mild onset of COVID-19, infected people may follow established norms that prioritize work and daily survival.
- **Ventilation:** Unventilated and confined spaces increase transmission risk due to the limited circulation of air. Home types and ventilation will vary by settlement but

should be taken into consideration when developing local plans.

- **Water:** Access to water is inadequate in most informal settlements, and residents usually do not have their own supply. Instead, water is often bought from private providers at high cost, which can prohibit handwashing. Shared water points could undermine spatial distancing (for example, when queuing and collecting) and isolation (for example, the need to leave the house for collection).
- **Toilets:** Toilets are usually outside people's homes in shared facilities. Evidence is still emerging about how long the virus persists outside of the body and on which surfaces. Although there has been no evidence of faecal transmission, shared toilets conceivably pose risks.
- **Sanitation:** Waste disposal is often inadequate, and contaminated waste in the street poses biohazard risks, especially to waste collectors.

Health system vulnerability

Availability of formal health providers (for example, government or NGO clinics) is low in most informal settlements. Instead there is a wide variety of informal, unregulated and private providers, including pharmacists, petty drug sellers, community health workers, and resident healthcare workers. For common symptoms such as cough and fever, self-medication is popular, with care sought at larger clinics or hospitals when severity increases (if costs allow). Barriers to access (for example, cost and distance) and aversion to hospital care suggest that sick people may remain in their community for some time, where they need advice on self-isolation and home or community-based care, with all the challenges this implies. Private providers may be key to detecting spread, but also to facilitating spread, and should be engaged in any response. These patterns of health-seeking behaviour make it likely that cases may go undetected, and efforts should be made to mitigate this.

Direct vulnerability to control measures

Control measures considered here are those being widely implemented: for example, quarantine, lockdowns, self-isolation, travel bans, and the closure of schools, markets, churches, mass gatherings, food outlets and social spaces. A major impact is on livelihoods as people live hand-to-mouth with very limited savings. Control measures which have limited people's ability to travel for work, or demand for work, have had disastrous impacts. Action is needed to maintain people's livelihoods, or provide protection if lost. This must include people working in the informal sector, which can be the majority in informal settlements. This is an area where evidence is lacking but where countries are developing emergency approaches. The Brazilian government took the step of paying a temporary monthly salary to informal workers (Ribeiro, 2020) and other governments used direct cash transfer (often digital) systems (Rutkoski et al, 2020). The success of these measures depends on the strength and coverage of existing government or NGO social protection systems, and the extent to which they include the informal sector.

Access to food is another consideration. In poor settlements, households generally have no capacity to store food, and source most of it from informal markets and street food vendors. Where movement was restricted, markets closed and street-food vendors banned, people's ability to access food was severely reduced.

Systemic vulnerabilities

Risks in informal settlements are multidimensional, including overlapping issues of health (for example, both chronic and acute disease); social concerns (for example, violence, persecution, intimidation); natural factors (for example, floods, rain, heat); and technological and infrastructural problems (for example, accidents, fires, building collapse). COVID-19 will be experienced alongside these risks and interact with them. Potential systemic risks include care networks, as older people often provide this (for example, to

grandchildren and orphans). If they are unable to do this it may contribute to vulnerability among those they care for, or restrict others' capacities (for example, parents' ability to work). People with disabilities rely on care from others, as do some people with chronic health conditions. They are exposed to contracting the virus (as they are less able to self-isolate) and to the threat of losing key relationships that allow them to perform basic day-to-day functions. An increasing number of displaced people live in informal settlements rather than camps. These populations may be less well connected to local support structures, and evidence suggests that they face challenges accessing services and information (Walnycki et al, 2019). Gendered impacts include increased caring burdens for women and girls; uneven impacts on the earning potential of men and women; and increased rates of gender-based violence (GBV) (Wenham et al, 2020). Social tensions and security threats, linked to strained socioeconomic conditions, could be exacerbated. The precarious position of migrant workers has been highlighted acutely. Millions of people providing low-paid, insecure labour in cities far from their original homes have found themselves unemployed, without employer or state-provided safety nets. These people have been omitted from response plans, detained or forced to return home, treated inhumanely and stigmatized (Liem et al, 2020).

Enabling local action

Lessons from previous humanitarian and health crises (Satterthwaite, 2017) in informal urban settlements, as well as non-urban settings (Richards, 2016) highlight that locally led, co-produced and adaptive responses that take account of diversity and complexity in urban settings are key to reduction of harm.

Local organization and strategies for COVID-19 control

Informal settlements can be highly organized, with a range of local groups and community structures providing and

advocating for services. Many settlements also have traditional leadership structures. It is crucial that responses to COVID-19 are organized through these groups and leaders with local legitimacy. They are particularly well-placed to consider options for decentralized forms of care, isolation, movement control and physical distancing. Each settlement has physical characteristics that make movement control more or less feasible (for example, the number of entry points, physical barriers, road networks, housing density), and strategies need to be determined by residents. In many cities, grassroots groups and networks have sprung up, providing food relief and support to vulnerable residents. Financial and non-financial resources (for example, information, equipment, supportive policy) are urgently needed to enable residents to develop and implement strategies that are feasible and effective.

Social media and radio are important tools for communication. Special efforts are required to communicate with vulnerable groups, including the elderly and people with disabilities who may be less well connected and to ensure opportunities for two-way dialogue. Specific guidance is needed for people who cannot stop working or provide essential services for the city (for example, garbage collectors). Protective equipment should be provided. Local unions (formal and informal) could be influential here.

As cases rise, urgent consideration of burials, including deaths occurring in the community and in hospitals potentially far from family, is needed. Plans should be made with communities about how to ensure there is either safe burial locally (if space allows) or respectful and timely burial elsewhere.

Data needed for planning epidemic response

A range of data is required for epidemic response planning, including for the modelling of disease impacts and control measures, and for delivery and monitoring of relief. This includes basic demographic data; health and health service data (for example, prevalence of relevant non-communicable diseases); economic data on livelihoods; spatial data and maps of areas and facilities; and social data and knowledge about

behaviour and culture, including kinship, mobility, social roles and status, social support structures, and how such factors may influence transmission.

Although much of the above is typically missing in informal settlements, there are locally led alternatives. Networked savings and community-based groups such as SDI (formerly Slum/Shack Dwellers International) collect sociodemographic data about their settlements (for example, households, income, services, physical infrastructure and space). As these groups consist of residents, they also have in-depth social knowledge about their communities.

Partnerships and coordination

It is crucial to connect and support local efforts. The approaches of SDI have been used to engage with local community structures, leaders and authorities to provide support during emergencies. In some cities these relationships are well established, and groups have regular dialogue with authorities. Given the urgency of COVID-19, the most impactful thing to do would be to engage these groups. Many international networks connect governments and agencies with local and community-based groups.

Access to basic services and implementation of public health interventions will depend on the involvement and capacity of city authorities and municipalities. There is variation in access to resources in different cities, and the extent to which authority has been decentralized. Nevertheless, mayors and local government have an important role to play in tailoring the response to their city contexts and connecting key stakeholders by building on experience in co-production for urban development issues such as water/sanitation and citywide planning.

Long-term challenges: politics and inequality

Fundamentally, many of these considerations relate to poverty and inequality. Residents of informal settlements tend to be the poorest and most vulnerable, but there is variation,

including pockets of wealth and pockets of marginalization. This means that there will be varied vulnerability profiles. When wealth and poverty are side-by-side (within informal settlements, and relative to the rest of the city), perceptions of injustice can be palpable and could hinder collective action. In settings where rationing and ill-equipped health services are the norm, people are not used to their health being considered a priority. Sudden interest in particular diseases or standards of public health can arouse suspicion or resentment. Historically, informal settlements and their residents have been stigmatized and blamed for problems they have little control over.

It is important to understand community power dynamics and political histories. In some urban settings, top-down control measures may be perceived as being used to oppress or marginalize residents or curtail political opposition. Many cities already impose unrealistically high regulatory standards – about public health, building standards, trading, and so on – which residents cannot meet. In practice, these rules are ignored and can become the focus of repressive enforcement by authorities. If COVID-19 control regulations are impractical and out of sync with people's realities, they risk repeating these patterns of avoidance and crackdowns.

Conclusion

Informal settlements face considerable challenges around the control of COVID-19, but locally developed and co-produced strategies could go some way to mitigate the worst of the outbreak. Top-down and externally imposed strategies risk doing additional harm if they ignore the specific needs of informal settlements. Public health interventions must be balanced with social and economic interventions, especially in relation to the informal economy, on which most people depend.

Note

1. A longer version of this chapter has previously been published in *Environment and Urbanization* (Wilkinson, 2020).

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7

Policy Milieu for Combatting COVID-19 and Sustainability of African Economies

Olawale Emmanuel Olayide

Context

COVID-19 has spread around the world, infecting millions of people (Li et al, 2020; UNCTAD, 2020). The socioeconomic impacts of the pandemic have become realities around the world and poor and developing countries in Africa have received a significant shock as a result. The unique context of Africa is due to the large population in poverty and the high burden of disease (principally, malaria). The burden of malaria in Africa is responsible for over 380,000 deaths per year, with the continent accounting for 93 per cent of global malaria cases (213 million cases out of 228 million cases), and 94 per cent of 405,000 deaths globally from malaria in 2018 (WHO, 2019). Furthermore, almost all of the 55 countries in Africa are classified as low- or middle-income, with only the Seychelles in the high-income category (World Bank, 2019). Worse still, the two largest economies (Nigeria and South Africa) are home to significant poverty and inequality.

The wide geographic spread of the coronavirus has necessitated policies and guidelines for containment (Medinilla et al, 2020; Olayide, 2020). The policy guidelines on containment of coronavirus have centred essentially on prevention and on social and hygiene practices, including: staying at home; regular washing of hands or use of sanitizer; social and physical distancing; wearing of protective mask and kits; limiting the number of people in public gatherings; restriction of human and vehicular movement or

curfew or travel ban; and total or partial lockdown (WHO, 2020). It is instructive to note that the policy measures to contain the spread of coronavirus range from individual to international levels (Figure 7.1).

Similarly, one of the first policy measures taken by many African governments in curtailing the spread of the virus was placing a travel ban on their citizens and foreigners coming into the continent (World Bank, 2020a). Generally, lockdown was at the centre of containment measures, with Rwanda being the first African country to adopt this (Mugabi, 2020). This was followed by Egypt, Morocco and other countries like Malawi, Botswana and Nigeria banning public gatherings and closing down schools (Kondowe, 2020). At the subnational level, African governments placed restrictions on intra and inter-state movement of people and goods, allowing only food, health materials and other essential materials to be moved. Activities that were seen as non-essential to the wellbeing of the communities at large, including nightclubs and night movements, were also banned. There was a shutting

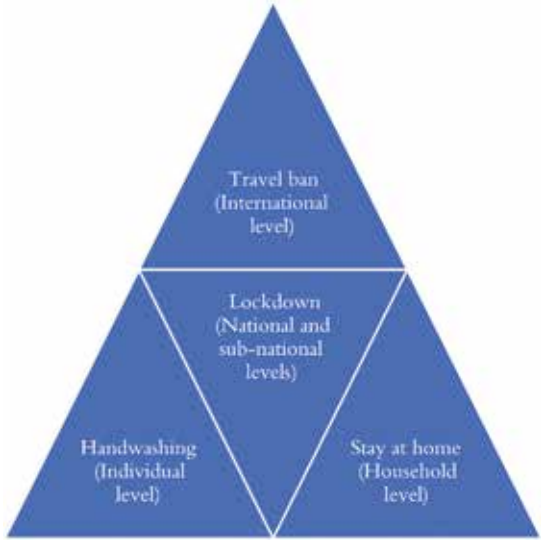

Figure 7.1 Schematic representation of policy measures for containing coronavirus

(Source: the author)

down of many establishments in both informal and formal sectors, including schools and learning centres.

It was also advocated that individuals should take responsibility for their actions. The use of facemasks and hand sanitizers was enforced in many countries, alongside regular washing of hands with soap under running water being recommended. Although handwashing is crucial to combatting the spread of coronavirus, it was doubtful if citizens could fully comply as African countries have the highest proportion of the population with no access to handwashing facilities and materials (Mirkuzie et al, 2020).

Implications of the policy measures on sustainability of African economies

Given the adverse secondary effects of lockdowns, the easing of these will have implications for different dimensions of sustainability in Africa, including economic, social, and environmental (through ecosystems services), as of course do the impacts of the pandemic itself.

Implications for economic sustainability

The following aspects of economic sustainability are impacted: financial flows and remittances; technological adoption and innovation; physical infrastructure and housing; and employment, entrepreneurship and wealth creation. Migrant remittances are a very important source of financial flow into Africa, but this has declined drastically during COVID-19 (WFP, 2020a, 2020b). Projections of foreign direct investment (FDI) have been dramatically revised downwards. Tourism has also suffered through imposition of border closure, lockdown and travel bans. Cabo Verde lost 43.4 per cent of income that could have accrued from tourism inflows, the Gambia lost 19.9 per cent while Senegal lost 11.4 per cent in the first quarter of 2020 (WFP, 2020a, 2020b), to mention but a few.

Overall, African economies are projected to contract as a result of the pandemic with the African Union predicting that

the continent's economy will shrink between 0.8 per cent and 1.1 per cent in 2020. The contraction will affect over 20 million African workers whose jobs are going to be at risk. The fall in the price of crude oil has particularly impacted mono-product economies like Nigeria, Libya and Angola dependent on it for export receipts. Hence, the need for diversification of sources of income for these economies is even more evident than it was previously. Worse still, most of the countries lack adequate infrastructures and social safety nets that could serve to cushion the impact. Physical infrastructures like low-cost housing schemes for low-income earners are grossly inadequate. Those Africans who are homeless and internally displaced are at a particular disadvantage during this period (Ozili, 2020). Those who have been displaced at one time or another due to natural hazards, environmental disasters or communal conflicts look to governments which often cannot, or do not, provide shelter for them. Many aged persons and those with underlying illnesses also suffer from lack of essential services.

Implications for social sustainability

The social sustainability aspects of the impacts of the pandemic are noticeable in education and schooling; health and sanitation; social protection and human rights; and gender, peace and security. Governments in Africa enforced the closure of schools and learning centres with the aim of containing the spread of the coronavirus. This action created disruption. Although UNESCO's suggestion of distance/online learning has been widely accepted, implementation in Africa is very slow. Schools, teachers and parents are at a disadvantage because the majority of them do not have internet-enabled phones and lack digital readiness. Some universities are now experimenting with on-campus and online blended teaching and learning system (see Figure 7.2).

It is expected that as the on-campus and online blended teaching and learning system becomes the new normal in the post-COVID-19 era, some of the lingering challenges of access to and cost of higher education in Africa may be eased. However, there are concerns about the availability

Figure 7.2 A university in Nigeria announces on-campus and online admission due to COVID-19 pandemic

(Source: the author)

of financial resources and teaching infrastructure to deliver online teaching in schools, especially in rural areas. Therefore, the new normal of online teaching may aggravate the existing inequality of access to education and compound the problem of social exclusion and out-of-school children.

Further, there were concerns about the effectiveness and uncertainties surrounding healthcare delivery systems and general sanitation of African countries as a result of slow investment in healthcare, wellbeing and welfare of the population. Prior to lockdown, the rich engaged in medical tourism outside the continent, leaving Africa's healthcare delivery system in a sorry state. Also, the countries in the continent rank poorly in healthcare indicators, including hospital beds and physicians per 1,000 people (World Bank, 2020b). However, the coronavirus pandemic has led to building of more healthcare facilities, which will remain even after the pandemic. Hence, the opportunity to restructure

and reform the health sector in Africa beckons. According to the United Nations (2019), Africa's healthcare system is weak and short of equipment, but this situation could be reversed with a greater emphasis on fighting health threats specific to maternal health, child mortality, malaria, tuberculosis, Ebola and HIV/AIDs in particular, and also now the coronavirus. However, with the poor financial status and poverty on the continent, there is apprehension that the pandemic might witness the coming of an even worse scenario (Dettmer, 2020; NRC, 2020).

Similarly, the pandemic has affected major segments of the African populace, most especially through social interactions among people. Many Africans are still living below the human development index standard of an average income of US$2 per day as a result of poorly functioning economies. With the introduction of this new disease, the majority of Africans may fall below this benchmark. Thus, there was a need for African leaders and governments to provide for their citizens while they were locked down in their homes, as has been practised in many developed countries of the world. However, the distribution of assistance was not properly and adequately implemented in many African countries. This was hampered due to fiscal constraints, and many African countries not having adequate data on actual populations, living areas and living standards (Olayide, 2020). Essentially, there was no adequate framework for social response and distribution of assistance. Thus, interventions from the government could not reach the poorest of the poor and most vulnerable in many instances. The mismanagement of distribution of palliatives and misappropriation of funds in some cases resulted in further hunger and poverty. There have also been increases in gender-based violence (see Guidorzi, this volume), and in some extreme cases a breakdown of law and order, including banditry.

Implications for environmental sustainability

The environmental sustainability aspects impacted include food and agriculture and waste management. The lockdown

impacted negatively on agricultural and rural activities and intra-African trade. Many coastal fishers could not bring their produce inland. Farmers who live in rural areas could often not bring their produce into the cities and bigger towns for sale, and those who were able to often did so at high transport costs due to the travel restrictions and the risk of being arrested or extorted by security agents. This situation, therefore, resulted in more farm produce being left on the farms unattended, poorly harvested or not properly stored. The overall implication of this in Africa was high cost of foods and scarcity of some commodities, such as perishables. Losses also accrued to farmers since harvesting and sales of farm produce could not be carried out due to inter-city lockdowns and curfews imposed by governments. The inter-state lockdowns and curfews also had implications for the environment. For instance, areas where people usually congregate for economic, social and religious events were vacated without activities due to restrictions imposed by COVID-19 prevention protocols on public gatherings and social distancing. Hence, public places became overgrown with weeds and residential areas often accumulated municipal waste.

Conclusion

This chapter has explored the different policy measures taken by African governments in the containment of the pandemic. The contextualization of the policy measures for the containment of the coronavirus pandemic underscored the challenges and opportunities posed, with a view to emerging economically stronger, to build back better and sustainably by considering the implications of the coronavirus pandemic on social, economic and environmental issues in Africa. Lockdown and other measures used have been found to be stringent and have not worked well in a continent that has poor data systems, insufficient social safety nets and palliatives for the most vulnerable in the society, and weak economic bases. Similarly, deficits in social and physical infrastructure (including, education, transportation, healthcare delivery systems, food and agriculture) have revealed areas of

opportunity for development. Despite all the measures put in place by African governments, there was still the ongoing reality of the unresolved high poverty rate, and high disease burden of malaria, coupled with and complicated by the COVID-19 pandemic.

Concerted public action and investment can improve the proportion of the population with improved access to handwashing materials, hospital beds and physicians, and generate a reduction in the burden of disease, including malaria, on the continent. In the same vein, the post-COVID-19 era could lead to the development of complementary vaccines for malaria since some of the frontline and earliest recommended drugs for the treatment of coronavirus have been linked to its treatment, although this is in need of further research and verification. These drugs include the pharmaceutical hydroxylchloroquine and herbal mixtures. The coronavirus disease pandemic could be a 'blessing in disguise' by drawing global attention to the burden of illnesses like malaria and the socioeconomic milieu in Africa.

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8

Africa and the Economic Pathologies of the COVID-19 Pandemic

Howard Stein

In December 2019, news of yet another deadly respiratory disease arose – this time from Wuhan, China. Unlike recent zoonotic diseases like Ebola that suddenly and enigmatically emerged locally, African governments had time to prepare. On 27 January, after four Asian countries reported cases, the African Centre for Disease Control (CDC) initiated an emergency operations centre to coordinate the response. The first case was not detected on the continent until 19 February. Within a few weeks, many governments began to impose travel restrictions and mandatory quarantine periods for people arriving from Asia and Europe. In the following weeks, over 40 countries closed borders (Loembé et al, 2020).

On 28 April 2020, the US hit a million infected people with 2,000 deaths per day. Africa had recorded only 32,000 cases and 1,400 total deaths to that point. Influential publications like the *Financial Times* suggested: 'Maybe, just maybe, the continent could be spared the worst of the pandemic' (Pilling, 2020: 1). The article continued to point to all the positive factors including 'early lockdown', 'less dense population', 'the effect of ultraviolet', 'a climate that meant people spent more time outside' and 'Africa's youthful population'.

The optimism has quickly faded. While Africa took 93 days to hit the first 100,000 cases, the number doubled only 16 days later on 7 June. By the end of June, the numbers had roughly doubled again to nearly 400,000 cases and close to 10,000 deaths. By the third week in July, they again doubled to almost 800,000 infections with nearly 17,000 deaths. On 6 August, it surpassed the milestone of 1 million cases with 22,000 people deceased, exceeding an estimated 15,000

deaths from all recorded Ebola cases (1976–2000). However, the numbers in reality are significantly higher (Africa.news, 2020; Africa CDC, 2020, WHO, 2020). On 29 June, the *New York Times* proclaimed in their headlines that the 'Coronavirus is Battering Africa's Growing Middle Class' (Dahir, 2020).

This chapter will argue that that the optimism followed by the growing realization of the severity of the impact on the continent is part of a false narrative that has become popular in orthodox circles. The narrative argues that African countries that followed the neoliberal dictates of the international financial institutions have been rewarded with growth and prosperity in their open integration into the global economy, as evidenced by their growing 'middle classes'.[1] In contrast, it will argue that it is precisely how Africa is situated in the global order that has left it more vulnerable to the pandemic's health and economic impact. While African governments wisely put in place measures to mitigate the impact of the virus in the early stages of the pandemic, it is these underlying systemic conditions and the pathologies inherent in the economic strategies that have created these vulnerabilities that ultimately exacerbate the impact of the pandemic.

The concept of economic pathology

Pathology is generally associated with the scientific study of disease. The construct has also been used to describe an illness or sickness in a particular discipline or approach to a discipline.[2] Others have focused on the harm and even diseases generated by the specificities of socioeconomic structures.[3] Drawing on both ideas, Swann (2019) argues that economic pathology should be conceived as a duality. There can be a pathological condition in the economy and one in the discipline of economics. The two are interconnected. Bad economic theory can drive public policy, which can create pathological effects on the economy. Moreover, if the economics discipline accepts a pathological condition in the economy as quite normal, then this can buttress the pathological tendencies of a field. It is possible to also take this concept a step further

to consider how the pathological nature of the economics profession in this duality leads to situations where it creates the structural conditions which contribute to the proliferation and vulnerability to diseases in the medical sense. Hence, we can think of how economic pathology intersects with disease-focused pathology and in turn how it feeds back into economic pathology. The remainder of the chapter will focus on illustrating the multiple interactions embedded in the economic pathology of the coronavirus pandemic in Africa.

The pathology of the economics discipline and its consequences: the rise of monoeconomics in Africa

Theorizing about the nature of African integration into global capitalism and the domestic policies needed to enhance development were once at the core of the economics curriculum of African universities. Debates on the types of government strategies to be used drew from a variety of theoretical traditions (such as institutionalists, Marxists, structuralists). As pointed out by Hirschman (1981), the very nature of development economics of the post-independence period directly challenged the 'monoeconomics', or orthodoxy, which dominated before the Great Depression. Orthodoxy in economics states that 'in a market economy benefits flow to all participants whether they are individuals or countries, from all voluntary acts of economic intercourse' (Hirschman, 1981: 4).

Stein (2021) traces how the crisis of African universities partly generated by the structural adjustment project of the World Bank created the opportunity to undermine development economics and to expand and institutionalize neoclassical economic orthodoxy on the continent. This created the economic pathology of bad economic theory driving policies that created the economic and health vulnerabilities to the coronavirus pandemic.

Economics education in the neoclassical economics tradition emphasizes models of pure competition, optimality, indifference curves with utility maximization, equilibrium and marginal analysis. The emphasis is on learning the language

of economists and getting students to think like economists. Education is largely drawn from textbooks that purportedly reflect the latest advances in the field but are typical variations on the same macro and microeconomic constructs embedded for years in the neoclassical economic doctrine. Promotion and recognition in the field are measured by publications in a set of neoclassical economic journals that draw on the same constructs.

During the structural adjustment period of the 1980s and 1990s, the World Bank and other donors used the crisis in the universities to rebuild 'weak' economics departments in the image of the orthodoxy of Western countries. They understood this as a powerful mechanism to infuse policymakers and academics with a shared set of economic priorities and theories that justified the adjustment agenda.

As Mkandawire (2014) points out, donors carefully rigged both sides of the market to provide the incentives to participate. On the one hand, they provided stipends to retrain old faculty and supported a new generation of students in neoclassical economics through organizations like the African Economic Research Consortium. At the same time, they ensured that the 'technical skills' of these economists were demanded in aid packages that required the hiring of local experts to produce reports with lucrative contracts to supplement low academic wages. Local consultancies were organized to supply economists for projects requiring 'local expertise'. This empowered what Mkandawire terms an 'epistemic community' of local economists as the trusted purveyors of the international agenda.

There were profound pathological consequences in the economy. Adjustment with its focus on liberalization, privatization, macrostabilization and user fees in health and education was supposed to lead to prosperity from static efficiency gains as rational actors made improved decisions in reaction to undistorted prices. Unfortunately, the results were very different. Public expenditure cutbacks and the privatization of social services worsened healthcare and education. Sylla (2018) reminds us that the World Bank and IMF are still seen as 'agencies of misery, poverty and social distress' by Africans due to adjustment. There is little

doubt that countries' health systems were put on the wrong trajectory relative to their ability to deal with the public health needs of a pandemic.

There were even more profound economic consequences. Adjustment led to the deindustrialization of the continent and returned African to its colonial-style extraction economy with its problematic boom and bust commodity cycles. In 1995, roughly 88 per cent of exports were in primary commodities and 12 per cent in manufactured goods. By 2008, the figure was 93 per cent and 6.5 per cent, respectively. Fuel-focused commodities dominated the growth and went from 40 per cent to 72 per cent of total commodity exports over that period. Little has changed since with primary commodities still at 91 per cent of the total in 2018. Deindustrialization was also evident from the GDP figures. The manufacturing share of GDP fell from an average of 22 per cent in the 1980s to 12 per cent in the 1990s to only 9 per cent in 2000–06. In 2008, if fell to only 7 per cent and was back to 9 per cent only in 2018 (UNCTAD, 2020).

Africa is at the bottom of the global value chain. Neoliberalism removed the restrictions on capital flows, privatized state enterprises and liberalized trade, which both increased the reliance of African countries on the export of unprocessed raw materials while encouraging the deindustrialization documented above. It also demobilized the ability of governments to alter the terms and conditions of international exchange. Value in production has increasingly shifted to developed countries and offshore tax havens buttressed by international institutional structures, like the World Trade Organization (WTO), which reinforce the financial and technological power of transnational corporations. Data from the United Nations Conference on Trade and Development (UNCTAD) indicates that exports in the 2000s in Africa and other developing countries increased substantially without a comparable expansion in domestic value added (De Medeiros et al, 2017).

The tools at the disposal of mainstream economists today have delimited their capacity to comprehend the structural and institutional challenges underlying the dynamics of development; these challenges have become even more acute

as many African countries, while at the bottom of global supply chain, are subject to the vicissitudes of commodity markets. Orthodox economists see liberalized Africa as naturally following their comparative advantage. Here we have a prima facie example of a discipline that accepts a pathological condition as normal. How has this economic pathology intersected with the disease-focused pathology of the coronavirus in Africa?

Economic pathology and the pathology of the coronavirus: examples

In the absence of a vaccine, governments can undertake a number of measures to mitigate the health and economic impact of the disease. How do the economic pathologies discussed above affect the options available to African governments? To begin with, battling the disease requires significant financial resources not only for medical supplies and equipment for testing, treatment and the protection of medical workers, but to be able to support populations that are forced to isolate following stay at home orders or as the result of exposure determined through contact tracing.

The economic downturn exposes the financial fragility of African countries. Commodity prices have generally been falling since their peak in January 2011. In December 2019, the commodity price index was only 60 per cent of the 2011 level. Since then, the decline has been precipitous with a fall of an additional 30 per cent to April 2020, before slightly recovering in May (Index Mundi, 2020). The more recent plummeting is evident in some of the price indexes of key African export commodity types. For example, the price of energy fell by 48 per cent between the last quarter of 2019 and the second quarter of 2020 and was nearly 60 per cent below the level of 2018. Base metal prices are down by nearly 25 per cent since 2018 and key agricultural export crops like cotton are down by nearly 30 per cent, leading to a plummeting of export revenues and access to vital foreign exchange (World Bank, 2020d).

African countries have increasingly relied on remittances from millions of people that have left the continent in a desperate search of livelihoods. Between 2000 and 2018, remittances expanded ten-fold and are now as important as overseas development assistance (ODA), but are expected to fall by 23 per cent in 2020 (World Bank, 2020a, 2020b). The decline of financial flows and fall in prices and demand from commodities from the global depression are rapidly putting African governments into financial stress and another debt crisis. The pattern prior to the arrival of the virus was increasingly disturbing. The stock of total external debt went from US$301 billion in 2010 to US$580 billion in 2018. The external debt/export ratio has climbed from 75 per cent to 135 per cent, with countries like Ethiopia now exceeding 400 per cent. The reserves to external debt stock fell from 52 per cent to only 28 per cent over the same period (World Bank, 2020c).

Since then the situation has deteriorated further, forcing most African countries to turn to the IMF for relief. As of the end of June 2020, 36 sub-Saharan African (SSA) countries have taken loans from the IMF under the General Resource Account, Poverty Reduction and Growth Trust, or newly created rapid credit facilities for debt relief. This was up from 23 countries at the end of 2019 and only 19 countries in 2018 (IMF, various years). Hence, the majority of SSA countries are back in the grip of the IMF with the economic pathology of its neoliberal conditionality (Bretton Woods Project, 2020)

Economic pathology, including the relative absence of manufacturing, has affected the trajectory of the coronavirus in many ways. As the number of cases expanded in Africa, the absence of testing capacity and materials to undertake them became apparent. By the end of May, South Africa had tested 655,000 people, but still had a backlog of 100,000 partly due to the shortage of reagents. Elsewhere the situation was far worse. Nigeria had only undertaken 58,000 tests in a population of 200 million. Chad had only been able to test 105 per million people and Malawi 170 compared to 38,000/million in the US – a total considered woefully inadequate by experts. In all, only 2 million tests were undertaken in Africa by the end of May. As one correspondent noted: ‘The

shortages, especially in testing materials, have jolted African authorities into facing uncomfortable truths: Richer countries are elbowing them out in the race to obtain crucial supplies, and the continent relies almost entirely on imports for drugs and other medical items' (Anna, 2020). The director of the African CDC, John Nkengasong, warned: 'We have to have made in Africa materials … We cannot keep importing basic things' (Anna, 2020). This was partly in response to the restriction on the export of medical supplies by 80 different countries to the end of April (WEF, 2020).

Shortage of personal protective equipment (PPE) and oxygen put health workers and patients at risk. By 12 June, the World Health Organization (WHO) was reporting that almost 5,000 health workers in 47 African countries were infected, with many dying (Meldrum and Fox, 2020). Most African countries lacked the capacity to produce medical oxygen, which is vital for keeping patients alive. Oximeters are scarce. Alternatives like oxygen concentration machines with few exceptions are not produced in Africa, leading WHO and other organizations to frantically attempt to secure machines to send to the continent (McNeil, 2020; Zhu, 2020). The incapacity of African countries to manufacture goods vital to the health and welfare of their population is a prima facie example of how economic pathology has affected the pathology of the disease on the continent.

Conclusion

This chapter has attempted to look more deeply at the structural conditions underlying the vulnerability of Africa to the coronavirus. The focus is on transcending a narrow biological understanding of the disease or a simple analysis of the influence on incomes and livelihoods to look at the more profound economic pathology of the disease. Economic pathology is linked to both the pathology of the economics that has come to dominate the discipline in Africa and the policies and domestic and economic structures that have arisen in its path. While African countries will recover from the virus, sadly the economic pathology that creates the

vulnerabilities that exacerbate the impact of these and other diseases will likely remain omnipresent.

Notes

1. For a critique of the concept of the middle class in Africa, see Melber (2016).
2. See for example the critique of the usage of rational choice theory by Green and Shapiro (1994).
3. A good example is the work of Paul Farmer and his 'Pathologies of Power', which focuses on the 'structural violence' against poor people created by how economies are organized.

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9

Ride-hailing Drivers Left Alone at the Wheel

Reflections from South Africa and Kenya

Elly Otieno, Malte Stein and Mohammad Amir Anwar

From Washington DC to New Delhi and from London to Cape Town, platforms like Uber and Bolt are connecting drivers with customers for taxi rides. This is commonly referred to as 'ride-hailing' and has emerged as one of the main alternatives to public transport in the low- and middle-income regions or the Global South. Ride-hailing provides income-earning opportunities for workers who cannot find jobs elsewhere. Yet, this work is also fraught with risks. The current pandemic has shown that in commoditized and market-mediated employment relations, the risk is borne by labour who cannot work from home (Anwar, 2020). At the same time, ride-hailing companies such as Uber and Bolt misclassify drivers as self-employed, thus avoiding regulation (Kessler, 2018). Therefore, this chapter examines the livelihood impacts of the pandemic and lockdown on ride-hailing drivers in Kenya and South Africa, two of the biggest markets in Africa for these services.

The ride-hailing sector has grown tremendously in the last few years in Africa. An estimated 81 ride-hailing platforms now enable movement of people from one place to another. While estimates on the number of people working in this sector are hard to come by, the 2018 figures suggest 216,000 workers in the ride-hailing sector in just seven countries on the continent (Insight2impact, 2018). Alongside some of the big international companies (for example, Uber, Bolt, inDriver), several local platforms have emerged as well, for

example, Oga Taxi in Nigeria, Safe Boda in Kenya, and Yookoo Rides and Hailer in South Africa. Having said that, Uber and Bolt dominate the market with operations in most major economies of the continent: Uber currently operates in 24 cities across nine countries, while Bolt has operations in 64 cities across seven countries. These two companies (both foreign in origin) have become go-to platforms for drivers.

The growth of the ride-hailing sector is part of the wider trend in the gig economy across Africa which has emerged as an alternative to traditional employment (Anwar and Graham, 2020). While various gig economy sectors (including ride-hailing) are equated with precarious employment in the Global North (Rosenblat and Stark, 2016; Cant, 2019; Ravenelle, 2019), it is often received with overly positive connotations in the Global South (see Rockefeller Foundation, 2014; Kuek et al, 2015). African governments have also enthusiastically supported the new gig economy jobs (for example, Ajira Digital Programme in Kenya and South Africa in Digital Age are two key examples). There is now a growing scholarly interest in the ride-hailing sector in Africa (Carmody and Fortuin, 2019; Giddy, 2019; Pollio, 2019). This chapter not only contributes to this emerging literature but also presents one of the first accounts of the pandemic's impact on gig workers in Africa to highlight the unstable nature of livelihoods associated with it.

The pandemic is affecting the livelihoods and wellbeing of millions of workers around the world, especially in the Global South. The International Labour Organization (ILO) estimates that around 1.6 billion jobs globally are at risk in the near future due to the pandemic (ILO, 2020). In the context of Africa, where 85.6 per cent of the employment is informal (the highest in the world) and welfare provisions are minimal, many will be pushed further into poverty. Our argument is that the pandemic and the subsequent lockdown will accelerate some of these trends (unemployment and poverty) with profound implications for workers in the Global South, particularly those in the informal sectors, including ride-hailing. The chapter draws on 26 in-depth interviews with Uber drivers in South Africa and Kenya conducted between April and June 2020, highlighting drivers' loss of livelihoods

in the immediate aftermath of the lockdown and their deep discontent towards the ride-hailing companies and the state. There is a brief discussion of drivers' mitigation strategies which show resilience and solidarities among workers in the gig economy. The conclusions outline the need for a better regulatory system that holds platform companies accountable and collective bargaining to improve the material conditions of workers in the Global South.

Lockdown effects in Kenya and South Africa.

Loss of livelihood

The pandemic-induced lockdown went into effect in Kenya on 25 March 2020 and in South Africa on 27 March 2020. Most economic activities closed down and only essential services were allowed to function, but under restricted working hours. Ride-hailing drivers we spoke to told us that they were allowed to work during the lockdown but were getting fewer fares. As a result, we found evidence of a sharp decline in their incomes. A driver, Dumele, in South Africa told us that he would previously have ended the week with around R7,000 (US $414). On 8 April he returned home after nine hours searching for fares on the roads of Johannesburg and said, "Today, I earned nothing". In the week of 30 March to 6 April, Dumele worked for around 60 hours to earn ZAR 3,500 (US$207), while in the first week of February he was earning well over ZAR 5,500 (US$325) for the same number of hours. Similarly, a driver, Dennis, in Kenya told us that his weekly earnings dropped from KES 15,000 (US$140) before the pandemic to KES 5,000 (USD$46) after the lockdown.

Due to the loss of income, drivers had a really hard time meeting their daily expenses. Ownership of cars remains low in Africa and drivers often rent cars from owners on a weekly basis (for example, Graham and Anwar, 2018), to whom they could now no longer afford to pay weekly rent and so they lost access to these cars. As a result, drivers experienced high levels of stress due to hunger, threats of eviction and being made homeless. Drivers who were unable to pay rent for housing

were (illegally) threatened with evictions by their landlords. One driver, Mohammad, in South Africa was able to use his security deposit to pay for his rent in April and May, but his landlord tried to force him out of his flat later. He told us, "there is no way for my wife and five children to be out of this house. Where must I go to? I cannot end up on the street".

Lack of regular income also meant drivers had to change their food consumption habits. Bulk buying was one of the options available. In Nairobi, some drivers would go without breakfast and sometimes even lunch. For drivers with families and young children, this is a disturbing trend and may contribute to an unhealthy lifestyle. There is already evidence that though life-expectancy has improved in Africa over the last two decades, people's health often remains poor (Wiysonge, 2018).

Mitigation strategies

Livelihoods derived from the gig economy are unstable and precarious because workers rarely have bargaining power or control over work activities (see Carmody and Fortuin, 2019; Anwar and Graham, 2020). After the lockdown, drivers have had to find alternative ways to earn a living. Ride-hailing drivers' livelihood strategies and mitigation tactics (just like other informal workers in Africa) are built to diversify their income sources and find support in their interpersonal networks in the form of borrowing from friends or informal lending activities, such as stokvels or chamas (see Callebert, 2017, Hutchison, 2020). A driver in Kenya has kept two cows whose milk he sells. Some drivers were branching out to try online work such as marketing and teaching. Others resorted to selling agricultural goods on the roadside, while a few depended on family members, for example partners or wives who run corner shops.

Drivers' interpersonal networks run deep in the community and members often help each other in difficult times. Dumele's landlord, from whom he also rents his car, waived the car rental fee during April and May and gave him one meal a day. He also sold some of his livestock for R2,400 (US$125) to help him cover some of his daily expenses for

the car (for example, fuel, data, airtime, hand sanitizer). One driver from South Africa relied on donations from a friend that owned a tuckshop (also known as Spaza shop) and twice sent him groceries for his family. A local shop owner sold him basic supplies (flour, sugar, pasta and rice) on credit.

In several cases, drivers simply stopped working. Tsietsi, in South Africa, stopped driving around as it is not economical. He said the weekly rental costs for the car, paying for fuel and buying airtime and data to support the ride-hailing app – which can come to around R5,000 (US$260) a week – far outweigh the potential income from fares during the lockdown. In early April and mid-May, when we interviewed him several times, he was earning less than R200 (US$12) a day.

Discontent towards the state and the platform companies

Drivers are misclassified by ride-hailing companies (for example, Uber) as 'independent contractors' and not employees. This means that they are excluded from welfare provisions and other social protection measures that normally are available for regular workers in both countries. Most informal workers (and the unemployed) in Africa are without adequate social security measures (that is, social assistance [cash grants] and social insurance [health and unemployment insurance]) (ILO, 2017). Hence, informal workers find it hard to cope after a shock. The South African government introduced the Temporary Employer/Employee Scheme which replaces some of the lost income due to COVID-19, but this is only for registered businesses and workers. The government also introduced a COVID-19 Social Relief of Distress grant to include individuals who are unemployed and do not receive any other form of social grant or Unemployment Insurance Fund (UIF) payment. Migrant workers, who form a substantial portion of the global gig economy, do not qualify for this because they do not have permanent residency or refugee status (Markham, 2018). Even South African citizens had problems applying because they could not provide documents, such as bank statements or proof of residential address. So far, the government has paid this grant to about 1.2 million claimants (South African Social Security

Agency (SASSA), 2020). The South African government also distributed food parcels but these only reached a handful of beneficiaries (Anciano et al, 2020). A driver in Cape Town had applied for food parcels when the lockdown began but was frustrated that he never received anything. He said, "Honestly, since my last food parcel application I lost faith with the government". On the other hand, the Kenyan government introduced a raft of fiscal measures (for example, tax relief) and reportedly set aside KES 10 billion (US$92m) for cash transfer to the elderly, orphans, and other vulnerable members of the society. However, there was no support programme for informal workers or independent contractors such as ride-hailing drivers.

The drivers interviewed were particularly demoralized by the loss of livelihood and lack of alternatives for them. They expressed deep discontent towards the seeming absence and lack of commitment from the ride-hailing companies to help drivers. Drivers were particularly anxious about the risk of catching the coronavirus from passengers, yet ride-hailing companies are offering little. Despite Uber's lacklustre efforts to offer mask and sanitizers to drivers, the respondents were of the opinion that it should provide basic financial support to survive. Some say that this would show that the company cares for its drivers. One driver in South Africa said, "We work for Uber. My source of income is Uber". Another driver suggested the company should at least waive its 25 per cent commission from fares in places facing lockdowns.

Uber did release a financial assistance policy to support drivers during the pandemic, but with strict limitations. To be eligible, a person must have a confirmed case of COVID-19 or have been individually ordered by a doctor or public health official to self-quarantine. While this may be easier for drivers in parts of the world where testing is common (for example, Denmark), in Kenya the testing rate is around 3.45 per 1,000 people and in South Africa is about 27 tests per 1,000 people (Our World in Data, n.d.).

Conclusion

The pandemic affects the marginalized segments of our societies the most. People who are at most livelihood risk are informal workers (for example, ride-hailing drivers, delivery workers, waste collectors, street vendors), a majority of whom live in low- and middle-income countries. Ride-hailing drivers in Africa fall into this large swathe of informal workers struggling to make ends meet – for whom the pandemic and lockdowns are particularly hard to bear. They just cannot work from home. Because their already poorly paid jobs are not sufficiently formalized or lack social protection, they cannot survive for long without a daily source of income. In the face of these challenges, ride-hailing drivers in Africa are doing their best to adapt: borrowing from friends and family, appealing for support where possible and strategizing on possible ways to make ends meet. But under the conditions of lockdown and feeling abandoned by the ride-hailing companies and the state, their options are limited.

There have been numerous suggestions put forward to deal with the pandemic and support informal workers, through cash transfers (Strohm, 2020) and debt relief (United Nations Economic Commission for Africa (UNECA), 2020). While these measures can definitely help workers in the Global South, the pandemic has exposed broken employment relations and the brutal everyday reality of worker exploitation found within the wider informal economy sector. Therefore, there is an urgent need for radical overhauling of the commodification of work, informalization and casualization of labour that characterize the global gig economy. One of the key elements is that effective regulatory systems need to be put in place that can hold platform companies accountable. Platform companies have shirked their responsibilities to workers for too long. Challenges to Uber's business model and operations in the US and the UK provide hope that this is possible and that the states can rein in the advances of capital over labour. At the same time, effective regulation will require much-needed collective representation of workers in the global gig economy (Webster, 2020). There is some evidence of new forms of worker organization and solidarity

emerging already (for example, Anwar and Graham, 2019; Tassinari and Maccarrone, 2019). At the time of the writing this chapter, the App Drivers and Couriers Union have been listed as a registered trade union in the UK after years of struggle by drivers and delivery workers. This will open up doors for collective bargaining in the ride-hailing sector. For workers in the Global South (including Africa), this could help build wider political responses and social movements at the ground level for similar but distinct collective organization and mobilization strategies in the gig economy.

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10

COVID-19 in Latin America

Uneven Responses, Uneven Impacts, Shared Challenges

Barry Cannon

The ongoing crisis created by the arrival of the COVID-19 virus (the Corona crisis as some have labelled it) has revealed and exacerbated pre-existing inequalities throughout the world in terms of income, gender and race. This is illustrated graphically in Latin America, considered by the World Health Organization (WHO) at the time of writing as an 'intense zone' for COVID-19 transmission (UN News, 2020). According to Sánchez-Ancochea (2020):

> 80% of individuals in the bottom quintile of the population work in the informal sector. Almost one fourth of all Latin Americans have no access to potable water, a third has no access to the internet, and many live in low quality housing – with dramatic consequences not only for their income opportunities but also for their health during the pandemic.

This graphic situation of inequality presents difficult choices for Latin American governments in their policy responses to the pandemic, particularly with regard to the most severe of these 'lockdowns' – that is, national shutdowns of all but essential economic and social activity combined with stay at home orders for most of the population. On the one hand, not imposing lockdowns can risk the rapid spread of the virus; on the other, the stark context of inequality alongside poor-quality, sparse and badly equipped and funded health and public services make lockdowns difficult to implement in an effective manner, and may exacerbate poverty and inequality further. Additionally, their cost may add to existing state debt burdens already being repaid with great difficulty and

at a high social cost. All these issues have contributed to the uneven outcomes of virus management efforts in the region.

This chapter will briefly examine these issues in the context of Latin America in the following order: the political, social and economic background preceding the emergence of COVID-19 in the region; the range of measures used to contain the virus, particularly lockdowns and any compensatory policy packages introduced to mitigate their negative socioeconomic impacts, assessing the impact and effectiveness of both; and, some policy responses being discussed for the medium to long term on how to address the inequalities made more urgent by the pandemic.

Context and background

The COVID-19 pandemic hit the region in a period of 'economic weakness and macroeconomic vulnerability' (The United Nations Economic Commission for Latin America and the Caribbean, ECLAC, 2020a), with regional growth falling in the aftermath of the Great Financial Crash (GFC) from 6 per cent in 2010 to 0.2 per cent in 2019; average gross public debt increasing between 2011 and 2019 from 29.8 per cent of GDP to 44.8 per cent, with interest rate repayments negatively affecting health spending and public spending in general; and low tax takes compared to most developed countries (OECD, 2020). These factors, added to reductions in foreign direct investment, tourism and migrant remittances, leaves the United Nations Economic Commission for Latin America and the Caribbean (ECLAC, 2020a: 2) to conclude that there is 'little room to increase spending' even though the 'pandemic will lead to the most severe contraction in the region's history' (ECLAC, 2020a:7), the latter conclusion shared by the IMF (Werner, 2020) and the World Bank (2020).

This is bad news for a region with the highest level of socioeconomic inequality in the world, a situation which, in the months preceding the pandemic, led to widespread demonstrations (Ferreira and Schoch, 2020). Despite impressive reductions in inequality under the 'pink tide'

left-wing governments that ruled most of the region from 2002 to 2016, average income inequality for 15 countries in 2018 stood at 0.465 on the Gini index (ECLAC, 2019), still well above the OECD average of 0.318 (ECLAC, 2019). Moreover, those whose income situation improved from 2002 onwards, remained highly vulnerable 'to falling back into poverty due to changes prompted by unemployment, a decline in their income, or other catastrophic events such as grave illness or disaster' (ECLAC, 2020b: 4).

Emergence of coronavirus

The first case of coronavirus identified in Latin America was in Sao Paulo, Brazil, on 26 February 2020. By 5 July, 2.5 million cases and more than 100,000 deaths due to the virus had been recorded in the region (BBC News, 2020), although this is probably an underestimate and the pandemic there had not reached its peak by then. The most badly affected countries were Brazil, Chile, Ecuador and Peru and the least affected Guatemala, El Salvador, Costa Rica, Nicaragua, Cuba, Venezuela, Argentina, Paraguay and Uruguay, with the rest somewhere in between. An important policy response by some Latin American governments was the use of lockdowns; however, as Levy Yeyati and Malamud (2020) point out, the benefits of this approach for 'developing countries with prohibitively high financing costs and a low prevalence of a formal salaried workforce' are not so clear as 'the same containment strategy may yield drastically different results' compared to wealthier contexts.

Jones et al (2020) identify five preconditions for a lockdown to be feasible in a developing country context: household access to electricity, clean drinking water, adequate sanitation, a phone and the household head being employed. Without these in place, the authors warn, the most basic hygiene and social distancing regimes cannot be followed, and more importantly without adequate social safety nets and access to food, people simply won't be able to remain at home, which may lead to hunger and social unrest. Moreover, the state must be able to provide both adequately provisioned and

staffed public health systems and the capacity to implement and coordinate lockdowns effectively (Piper, 2020). This chapter briefly and incompletely tests these assertions here by examining four individual cases in the Latin American context, with the use or not of nationwide lockdowns and the lowest and highest infection rates among these as the key selection criteria. In this scenario, the country opting for a nationwide lockdown with the lowest levels of infection rates per 100,000 inhabitants is Cuba, while that with the highest infection rate is Peru. Similarly, the country not using a nationwide lockdown with the lowest infection rates is Uruguay and the highest, Chile (see Table 10.1).

In this exercise, Peru emerges as the most vulnerable of the four, with lower levels of rural electricity (83.7 per cent) and sanitation provision (74 per cent), higher average household sizes (3.8), higher poverty levels (20 per cent) and more people employed in vulnerable work (almost 50%).[1] Chile, Uruguay and Cuba have better and relatively similar situations in most categories. Reviewing these figures, it is not unreasonable to think that Chile's outcomes would be similar to those of Uruguay's, given that neither operated full lockdowns, and both score relatively similarly on most of Jones et al's (2020) variables. Yet Uruguay's low infection outcomes are closer to Cuba's, while Chile's high infection outcomes are even greater than Peru's.

A possible explanation for these differing outcomes could be, as Piper (2020) indicates, state provision for health. The WHO recommends that middle to high-income countries should spend a minimum of 6 per cent of GDP on state health systems. Cuba and Uruguay surpassed this level in 2017 with

Table 10.1 Lockdown use and COVID-19 infection rates in Latin America: selected countries

Country	Infection rate × 100,000
Chile (non-lockdown)	1561.8
Cuba (lockdown)	21.0
Peru (lockdown)	918.1
Uruguay (non-lockdown)	27.5

Sources: Author's own elaboration based on data from WHO COVID-19 Dashboard.

the Cuban state spending 10.475 per cent of GDP on health and Uruguay 6.585 per cent (World Bank Open Data). Chile and Peru, on the other hand, spend below the recommended level with 4.497 per cent and 3.165 per cent respectively for the same year (World Bank Open Data). Additionally, both Cuba and Uruguay have higher skilled medical personnel density with Cuba at almost 155 health personnel per 10,000 population and Uruguay at 97.68 as opposed to Peru with 26.09 and Chile 11.78 (WHO Global Health Observatory Data Repository). These high staffing levels in Cuba and Uruguay were crucial for the rigorous testing, tracing and treating regimes these states put in place, viewed as crucial to fighting COVID-19.[2] Investment in public health provision then could be a key explanatory variable for low infection outcomes, with or without a lockdown. Indeed, lockdowns may have been counterproductive in some cases, such as Peru, where tens of thousands of people fled Lima for their homes in the countryside when the lockdown was announced, hence increasing the possibilities of contagion rather than reducing it (Chávez Yacila and Turkewitz, 2020). This underlines Jones et al's (2020) point that pandemic responses should be tailored to local realities on the ground, and not one-size-fits-all blueprints put forward by international organizations such as the WHO and often amplified uncritically by both international and local media (Ogola, 2020).

Range of social compensatory measures taken

A further policy element seen as necessary to counteract the restrictions brought in by governments to fight the virus is social compensation for loss of livelihood for both formal and informal workers. Measures for formal workers introduced in the region were the same as those in developed countries: teleworking, furlough schemes, unemployment insurance, reduced working hours, etc. Measures for informal workers, the majority in many states, were more varied with ECLAC (2020b: 7) identifying 126 social protection measures applied in 29 countries, including increasing existing cash transfers, introducing new cash transfer programmes,

providing food and medicines, and postponing or paying utility bills. While these measures reached around 58 per cent of the region's population (ECLAC, 2020b: 1), 'the amount and coverage … [were] not generous and broad enough', according to Blofield and Filguiera (2020: 1), despite acknowledging the speed with which they were implemented.

Proposals for the future

ECLAC (2020a: 1–2) estimates that the impact of COVID-19 will lead to a rise in poverty of about 28.7 million people on top of the existing 214.7 million (34.7 per cent) of the region's population. Both ECLAC (2020a: 1–2) and Blofield and Filguiera (2020) recommend the institutionalization of a universal basic income in response to this. ECLAC (2020a: 19) also emphasizes the need to ensure the right to health, by 'resolving the current fragmentation, hierarchization and commodification of health systems [and] … address[ing] the social determinants of health and, in particular, food and nutritional health requirements'. We have already seen that demonstrations against inequality swept the region in the period immediately preceding the pandemic, and the actual experience of the pandemic may have increased popular support for stronger state action in that respect, even among business elites (Mellizo, 2020). With the market in commodities, which financed many of the social improvements during the 'pink tide' period, in the doldrums, Latin American governments have two possible means to enact such policies: increasing taxes and/or debt reduction or forgiveness, both of which may prove difficult to achieve. With regard to the first, left-wing parties and movements, throughout the region, have made proposals for taxes to be imposed on the rich to pay for this social provision but these calls are being resisted by dominant right wing governments, some of whom instead are implementing cuts to public sector workers' salaries to pay for assistance measures (O'Boyle, 2020).

With regard to debt reduction or forgiveness, a profound change of heart among the multilateral institutions – that is, the IMF and the World Bank but also the G7 and the

G20 – would be necessary. However, geopolitical sparring between the US and China at the Spring IMF meeting led the US to stymie a massive increase of the Fund's Special Drawing Rights (Tooze, 2020), a type of tradeable global currency, which would have allowed member states to free up their currency reserves to boost COVID-19 related public spending. Moreover, the majority of Latin American countries are middle-income countries and therefore cannot avail of the 12-month debt repayment suspension for Least Developed Countries agreed by the G20 (Tooze, 2020). Additionally, the IMF and the World Bank continue to recommend 'fiscal consolidation' measures in the medium term (Bretton Woods Project, 2020) despite urging developing countries to 'spend, spend, spend' in the shorter term (Georgeiva, 2020). The outcome of the COVID-19 crisis could well be, the Bretton Woods Project (Bretton Woods Project, 2020) concludes: 'a solidification of dominant powers and commercial interests, aided by the IFIs' (international financial institutions) rather than fundamental reform to promote greater equity. Nevertheless, as Harvey (2020) notes, the outcome of this crisis will depend on how long it lasts, and, the longer that is, the greater the possibility that popular pressure will demand old orthodoxies to be discarded.

Notes

1. Based on figures from UNDP Global Human Development Indicators; Population Reference Bureau (PRB); World Bank Open Data; World Bank Poverty and Equity Data Portal.
2. See Boseley (2020) and Taylor (2020).

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Part III

Responses

11

The 'Shadow Pandemic'

Addressing Gender-based Violence (GBV) During COVID-19

Brianna Guidorzi

As cases of COVID-19 increased and the World Health Organization (WHO) declared a pandemic, reports on the gendered impacts of the virus streamed in. While acknowledging that there have been higher mortality rates among men, women's rights organizations called for attention to other, less initially visible repercussions faced by women and girls. Due to their disproportionate representation within the healthcare sector, for example, women may be at higher risk of exposure to COVID-19 (CARE, 2020). That women are still the primary caregivers within the home could also increase their likelihood of exposure, not to mention jeopardize women's financial security or career progression as schools and paid care options close shop with unclear plans for reopening (Topping, 2020). These few examples are the beginning of a longer list of gendered repercussions that some say may set back gender equality progress by decades (Topping, 2020.).

In the wake of this reality, Simone de Beauvoir's warning continuously comes to mind: 'Never forget that a political, economic or religious crisis will be enough to cast doubts on women's rights. These rights will never be vested'. Barring the omission of 'pandemic' from de Beauvoir's list of crises, her words unfortunately could not be truer, even a half a century since they were written.

Without a doubt, the most grievous violation of women's rights during COVID-19 is the rise of gender-based violence (GBV). GBV is any harmful act that is perpetrated against someone's will and based on socially ascribed gender differences and can include acts of physical, sexual or mental harm, and threats or acts of coercion in public or private (Inter-Agency

Standing Committee, 2015: 5). The detrimental impacts of GBV should not be understated: they can be life changing and long term, causing forced pregnancy, physical injuries, mental health issues and even death.

Although anyone can experience GBV, women and girls are at greater risk than men and boys (Inter-Agency Standing Committee, 2015: 5), and persons with intersecting identities – such as women and girls with disabilities, ethnic minorities, and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer (LGBTIQ) persons – may face higher rates of GBV (OutRight Action International, 2020). The commonly cited statistic from the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) is that one in three girls and women will experience physical or sexual violence by an intimate partner or sexual violence by a non-partner within their lifetime. This figure is a static average, though, and therefore does not capture repetitions of violence that women and girls experience or geographical variances in GBV prevalence.

The shadow pandemic

Across the world, as shelter-in-place or lockdown orders came into effect, there were spikes in reports of GBV. In Bogota, Colombia, police saw a tripling of calls to its 24/7 domestic violence hotline, while all other crime reports were down (Janetsky, 2020); in Australia, Google searches on domestic violence went up by 75 per cent (Hegarty and Tarzia, 2020). Media pieces from countries across the globe highlighted increased reports of GBV, particularly domestic violence (RTÉ, 2020). The reality is that many people – women and girls in particular – are stuck in close quarters with an abusive partner, parent or family member and previously existing tensions and equalities are exacerbated.

It is important to note that changes in reported rates of GBV are difficult to interpret in the short term, as there may have already been a previous upward or downward trend depending on context. Much of the data are likely incomparable, coming from various locations, sources and

services, such as hotlines, hospitals or police data. Regardless, actual prevalence rates of GBV are difficult to obtain ethically in any context, and the initial statistics coming in are alarming. Reported cases are usually lower than the actual prevalence of GBV, because many survivors do not seek help or report due to shame, stigma or fear of retaliation (Peterman et al, 2020: 1). As shocking as the increases in reported GBV may have been for newsreaders across the world, however, they were unfortunately not surprising. Already existing gender inequalities – as well as prejudice based on disability or ethnicity and race – worsen during crises due to added stresses and tensions, resulting in the perpetration of GBV at increased rates.

In the case of COVID-19, the difficult irony is that the very measures meant to protect the vast majority of the population – shelter-in-place and lockdown orders – are the same that endanger women and girls at the hands of perpetrators. So globally universal is the increased risk of GBV during COVID-19 that UN Women has called it the 'shadow pandemic' (UN Women, n.d.). It is apparent now more than ever that no society is immune to GBV and that crises call into question the protection of women, girls, and others vulnerable to violence.

Impacts of the shadow pandemic in the Global South

While the shadow pandemic is affecting women and girls across all corners of the globe, its impacts are particularly concerning in the Global South. In many low- and middle-income contexts, data show a higher tolerance towards violence against women and girls in society – as measured via an indicator of percentage of women who agree that a husband/partner is justified in beating his wife/partner under certain circumstances – coupled with fewer legal protections around domestic violence and rape (OECD, n.d.). The anticipated global economic downturn may have a more acute impact on livelihoods and poverty in the Global South, especially in areas with weak social protection systems, leading to financial or personal stresses that could exacerbate

already violent interpersonal relationships. These contextual factors, coupled with relatively low availability of, or access to, health services and psychosocial supports for survivors of violence, suggest that women and girls in the Global South may not receive the help they need. Gaps in the availability of essential healthcare are highest in sub-Saharan Africa and Southern Asia (WHO, 2017).

In humanitarian contexts characterized by breakdown of social structures and impunity for perpetrators, women and girls were already at incredible risk of experiencing GBV prior to COVID-19. In addition to high rates of intimate partner violence, displaced women and girls are at risk of trafficking (IRC, 2015; IOM, 2019). Additionally, sexual exploitation of women and girls – for example, requiring sexual favours in exchange for goods – by humanitarian personnel is pervasive across food, shelter, cash and water and sanitation distribution and yet remains largely unaddressed (Global Women's Institute, 2020). If left unaddressed, these forms of violence could become worse during COVID-19.

The pandemic will also have severe impacts on girls in the Global South. While children across the globe are facing school closures that are predicted to have adverse impacts for years to come, girls in settings where child marriage and female genital mutilation (FGM) are practised face the gravest consequences. As girls are out of school and financial pressures within families mount, the United Nations Population Fund (UNFPA) predicts that there will be 13 million additional child marriages, as families seek to reduce expenditures (UNFPA, 2020). Equally worrisome for girls, due to humanitarian and development programme disruption as a result of COVID-19, UNFPA has estimated that two million more girls than usual will undergo FGM over the next decade (for reference, normally it is estimated that approximately three million girls and women undergo FGM annually) (UNFPA, 2020; World Health Organization, n.d.). In the approximately 30 countries where FGM is often practised – primarily across the Horn of African and East Africa, as well as parts of the Middle East – this would amount to reversing what has been decades of positive progress in reducing rates (UNICEF, 2016).

Responses to previous health emergencies have neglected the needs of survivors of GBV

Not only are women and girls in crises more likely to experience GBV, but previous public health emergencies point to alarming shortcomings regarding addressing the needs of survivors. When an epidemic arrives, there is the tendency for governments and aid agencies to shift their focus and resources almost entirely to the primary health response to the virus or disease, which can impact negatively on other routine services such as pre- and post-natal care and sexual and reproductive healthcare, for which resource allocation is already scarce (CARE, 2020).

In the case of the Ebola outbreak in Guinea, Liberia and Sierra Leone, Davies and Bennett (2016) found that maternal mortality rates rose by 75 per cent within 18 months. The impact on women's health during the Ebola epidemic was widespread. The International Rescue Committee (IRC) conducted research on the Ebola outbreak in the Democratic Republic of Congo and found that survivors of GBV were less likely to seek care at clinics if they were bleeding, out of fear that they would erroneously be channelled through an Ebola Treatment Centre and consequently be exposed to the disease (McKay et al, 2019: 18). During the Zika epidemic, as another example, Oxfam (2017) found that among the women they surveyed in the Dominican Republic who suspected that they had the virus, 73 per cent did not seek medical help. According to focus group discussions, it was suspected that this high figure was due not only to difficulties in paying medical fees but also testimonies by women of abuse experienced within hospitals and high levels of GBV experienced on public transport (Oxfam, 2017).

In the above instances, the needs of survivors of GBV or increased threats of violence faded to the background within the primary health response to the virus, offering a warning to humanitarians as they respond to the COVID-19 pandemic. The discussion of the impact of violence on women's rights and survivors of GBV is also relatively absent in the literature: Davies and Bennett (2016) conducted a search on Scopus and found that only 1 per cent of articles between

2014 and 2016 explored the human rights or gendered impacts of Ebola and Zika. In sum, past experience does not bode well for the health and rights of survivors of GBV during COVID-19.

Global outcry in response to GBV: will it result in action?

Despite the shortcomings of previous health crises regarding the protection of those who are vulnerable to GBV, the rhetorical response to the shadow pandemic on the part of global and multilateral leaders has been swift. In early April, United Nations Secretary General António Guterres said that 'violence is not confined to the battlefield and that for many women and girls, the threat looms largest where they should be safest: in their own homes'. Although evoking war language that many feminists view as problematic during a health cris (Enloe, 2020), this speech was received positively by many women's rights organizations and feminist humanitarians, particularly because it called for specific action. Guterres urged all governments to 'make prevention and redress of violence against women a key part of their national response plans to COVID19' (Guterres, 2020a).

Shortly after this, the Director-General of the WHO, Tedros Adhanom Ghebreyesus, also made a press statement, stating that, 'There is never any excuse for violence' and calling on countries to 'include services for addressing domestic violence as an essential service that must continue during the COVID19 response'. Of particular importance is that Ghebreyesus referred to domestic violence services as *essential* services, which is indeed how the WHO classes them, despite the fact that they are often sidelined. These essential health services include emergency contraception, post-exposure Prophylaxis (PEP) to prevent HIV for survivors of rape and sexual assault, as well as psychological first aid and referrals to additional supports if desired or necessary for survivors of any form of GBV (WHO, n.d.).

Now is the time to act

If women, girls and vulnerable people are not considered throughout all aspects of the COVID-19 response, evidence from previous health crises indicates that this pandemic will be the next story of who was left behind. Given that GBV services are an essential health service, action must be taken to ensure that life-saving services for GBV survivors do not fall by the wayside but rather are maintained or implemented during the COVID-19 humanitarian response.

In the immediate term, it is important to maintain as many GBV-related services for women and girls as possible. In the first half of 2020, NGOs globally quickly closed in-person supports for women and girls and scrambled to scale up remote services such as hotlines or virtual meeting spaces. Since then, however, there has already been crucial learning on this challenge. The International Medical Corps (IMC), IRC and Norwegian Church Aid issued joint guidance indicating that, wherever possible, in-person, life-saving services such as women and girls safe spaces (WGSS) should not be closed at first sight of COVID-19 but instead adapted with safety measures. This guidance has particular salience when considering that certain estimations – such as the aforementioned increases in child marriage and FGM – are calculated partially on the disruption or halting of existing programmes.

In the medium and long term, as the COVID-19 response is scaled up, governments, NGOs and humanitarians must work together to apply a gender lens to all programmes. Given the heightened risk of GBV in crises, this issue should feature prominently in the global Humanitarian Response Plan (HRP) and accompanying indicators. Such high-level attention would promote donor funding of GBV programmes, which represented only 0.12 per cent of the $41.5 billion allocated to humanitarian response during 2016–2018 (IRC, 2019). Furthermore, increased funding allocated to violence against women and girls at an international and institutional level would in turn push NGOs to more seriously implement GBV response, prevention, mitigation and mainstreaming plans.

Finally, the shadow pandemic also serves as a reminder for aid agencies to look within. First, there is a need for aid organizations to ensure that their own personnel are not perpetrating sexual exploitation and abuse (SEA) against fellow staff members and beneficiaries (IASC, 2015: 8), a problem which seriously calls into question the effectiveness of international aid and commitment to the principle of 'do no harm'. Second, as global movement is reduced and Western-based organizations are not able to easily deploy their surge capacities, now is the time for aid agencies to take more seriously the commitments of the Grand Bargain on localization, which aims to get more of committed humanitarian resources directly to those in need. This includes working with local women as knowledge bearers and agents of change within their communities. Now is the time to move the rhetoric of the potential transformative nature of humanitarian response into action.

Crises should not cast doubt on women's rights

COVID-19 is not only a crisis but a test. Risk of GBV rises during health crises, and COVID-19 has already proven no different – if anything, shelter-in-place and lockdown measures render these crises more dangerous to women and girls who are trapped in close quarters with an abuser. Women and girls living in the Global South may face disproportionate impacts due to relatively higher social tolerance of violence in many contexts as well as inadequate access to healthcare, including psychosocial supports.

Time will crucially tell whether the rhetorical ambitions of multilateral leaders are realized. Now and into the foreseeable future, there is a need for continued leadership – from multilaterals, governments, NGOs and communities – for the protection of women, girls and other vulnerable groups to remain at the fore of the global response to COVID-19. Violence should never be accepted as an inevitable symptom of a pandemic, and no crisis should cast doubt on the rights of those who are vulnerable or marginalized. The needs of survivors of GBV during COVID-19 must not be forgotten.

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12

Psychosocial Implications and Programming Responses Against COVID-19 in Africa

Patrick Onyango Mangen and Angela Veale

In January 2020, the World Health Organization declared the outbreak of the novel coronavirus disease, COVID-19, a Public Health Emergency of International Concern. In Africa, COVID-19 cases continue to rise rapidly across the entire continent. Implications of the COVID-19 public health response have exposed families, including children and youth, to multiple vulnerabilities. In Phase 1, lockdown, the economic and health impact of the infection, control and prevention (ICP) public health responses has been severe, and in the longer term may even be 'catastrophic' (*The Lancet Global Health*, 2020: 612). This chapter describes the psychosocial implications of COVID-19 for African communities, drawing on case studies from Uganda and South Africa.

The Ugandan government in particular showed leadership by responding quickly and decisively to the impending threat of COVID-19, drawing on preparedness responses developed in relation to other viral outbreaks such as during the Ebola crisis. In Uganda, lockdown restrictions were introduced on 18 March 2020 just before the first case of COVID-19 in the country was detected. Public and private transportation was banned, public gatherings were suspended, shopping malls were shut down and a 7 pm curfew was instigated. Anguyo and Storer (2020) noted that among the 80 per cent of 'hand to mouth' workers employed in the 'gig' economy and informal sector, COVID-19 responses significantly disrupted

people's ability to earn money. South Africa also implemented tough public health measures. Citizens could only undertake essential trips to buy groceries or seek medical assistance, and in some cases lockdown was enforced by the use of rubber bullets (*The Guardian*, 2020). The social aspects of infection, control and prevention severely stressed collective coping responses through impact on trust and reciprocal support. An increase in social isolation and loneliness has also been a marked feature of the impact of COVID-19 lockdown restrictions. A recent South African survey carried out between 13 April and 14 May during lockdown by the University of Johannesburg and the Human Sciences Research Council (HSRC) found that 60 per cent of South Africans surveyed suffered from stress. The second most cited emotion was fear or feeling scared (45 per cent). Feeling depressed or irritable accounted for 29 per cent of responses, 18 per cent of respondents were angry and 12 per cent happy. Importantly, compared to those aged 25 year and older, 18–24 year-olds were more likely to report loneliness, boredom, anger and irritability (Bohler-Muller, 2020).

Survey responses also captured the economic impact of the crisis on South Africans. Between 85 and 89 per cent of respondents reported they were very concerned about the economic impact of the lockdown on their circumstances, while 60 per cent strongly agreed with the statement that they had difficulty paying their expenses (University of Johannesburg & HSRC, 2020). Economic factors also affect ICP compliance. In African contexts, in the Ebola crisis, the ability to act upon correct knowledge often conflicted with having access to resources to do so (Abramowitz et al, 2017). In the South African survey, the percentage of respondents who ran out of soap or hand sanitizer in the time period of the survey increased from 31 per cent to 40 per cent (University of Johannesburg & HSRC, 2020).

One of the most important findings from this survey, however, was that hunger emerged as a key mediating factor with respect to psychosocial wellbeing. Over the time period of the survey, the proportion of respondents who reported having gone to bed hungry increased from 33 per cent to 43 per cent (University of Johannesburg & HSRC, 2020).

Those individuals that reported that they or their families had gone hungry experienced more stress and depression. In early June 2020, calls to South African 'Childline' increased by 25 per cent over the previous two weeks, reaching over 11,000 calls (UNICEF, 2020a). Children reported being worried about high levels of physical and emotional abuse, with new complaints relating to parents' substance abuse at home. Children were anxious about hunger, returning to school and a loss of livelihoods – all of which were compounded by safety concerns (Huijbregts, 2020; UNICEF, 2020a). According to Save the Children (2020: 24): 'One of the biggest risks for children in Sub-Sahara Africa remains the risk of COVID-19 becoming a hunger and livelihood crisis ahead of a public health crisis'.

These factors are likely to place severe stress on African communities in response to the crisis, straining collective resilience. An African definition of community resilience put forward by Ebersöhn (2019) draws on the metaphor of 'flocking' – that is, a community identifies those that are vulnerable and manages the distribution of its social resources. Flocking mobilizes social capital (for example, psychosocial support), cultural resources (in good times when we celebrate, as well as bad when we mourn together), collective resources (for example, food, labour, a car to collect groceries for each other or to take someone to the hospital), and economic resources (for example, small loans to begin and sustain businesses). Wherever possible, flocking assists individuals and families to get up again, to recover from adversity and not to be dependent on others. However, the survey cited previously suggests that community resilience was challenged by lockdown. While 70 per cent of South Africans surveyed supported lockdown, in response to a question whether, in the immediate future, COVID-19 will be more likely to make South Africans feel more united and supportive of each other or alternatively more suspicious and less trusting, less than half, 48 per cent, believed South Africans would be more united, 28 per cent responded 'more suspicious', while 16 per cent did not know and 8 per cent said neither. Furthermore, over half of respondents (53 per cent) believed the worst was yet to come.

In summary, lockdown public health responses required to mitigate the impact of coronavirus have severely stressed collective and locally relevant resources and coping responses. Supporting community resilience is an overlooked strategy in efforts to mitigate public health emergencies (McKay and De Carbonnel, 2016), yet the learning from the earlier Ebola crisis in East and West Africa indicated the importance of engagement with communities 'Efforts in the direction of awareness and community involvement could prove to be a better strategy to control the [Ebola] epidemic and root the response in social participation' (Pellecchia et al, 2015: 2) using existing community support networks and local government social services structures. A key priority therefore in developing an effective public health response to COVID-19 is to understand the impact of ICP measures on community resources and how resilience can be built back through local support systems.

The case studies presented in the analysis below are based on two organizations with whom the first author works with. TPO Uganda engages with communities to improve mental health and socioeconomic wellbeing. The Regional Psychosocial Support Initiative (REPSSI,) based in South Africa, is a regional organization encompassing 14 countries whose mission is to mainstream psychosocial support into programming in East and Southern Africa. Both organizations are involved in leadership roles in developing psychosocial support for COVID-19-affected communities.

Psychosocial impact of COVID-19 on communities and programming responses

Families affected by HIV/AIDS and impact on vaccine-preventable diseases

In a TPO Uganda project targeting children and families affected by HIV and AIDS in South-Western Uganda, persons living with HIV and AIDS have not been able to access routine services due to COVID-19. The most affected are patients that need assisted support to meet clinic appointments. The

7 am to 7 pm curfew has restricted the number of activities field staff can implement. Since travel by public means is constrained, caregivers cannot find their way to health centres. The most affected are caregivers of children that are undergoing treatment. People have become scared of visiting health centres due to fear of infection[1]. Parental fears about potential exposure to COVID-19 is also negatively impacting Diphtheria, Pertussis and Tetanus (DPT3) vaccination rates. In South Africa, for example, April 2020 vaccination rates for DPT3 were 20 to 30 per cent below that of months preceding the implementation of ICP public health measures (UNICEF, 2020a). Similarly, there has been a sharp decrease in measles coverage, sparking fears of an outbreak in the North West and Western Cape (UNICEF, 2020b).

Impact on sexual violence survivors

The public health system for mental health services is quite under-resourced in Uganda. In a TPO project supporting survivors of violence in northern Uganda they require, at a minimum, a three-point service delivery structure; a functional health structure to provide screening and post-event prophylaxis; a social worker to provide psychosocial support and trauma counselling; and legal aid support in addition to law enforcement. In a normal environment, TPO facilitates the coordination of a harmonized response. However, with COVID-19, this service structure has been disrupted and rendered ineffective. Survivors of violence are taking longer to access the minimal service package as providers are unavailable, while need is increasing.

Impact on mental health and wellbeing of refugee youth

TPO Uganda undertook a study to assess the impacts of the COVID-19 pandemic on the mental health and wellbeing of young people in Kiryandongo refugee settlement.[2] Focus group discussions were carried out with the youth in July 2020. A total of 25 youth (15 males and 10 females) ranging from 13 to 28 years participated. They were taken through a series of questions about young people's experience of how the

pandemic has affected their mental health and their opinions on how best the government, NGOs and community could help them cope.

Alcoholism: From the discussions, it was noted that the youth have resorted to taking alcohol because of the disease, as it has no cure, and they believe they have to enjoy their last days on earth.

Early marriage: Closure of schools has left many young people idle and with no hope for the future. They are stressed and think reading books when they are not going to do exams is waste of time. In addition, they have been hearing rumours that they are likely to repeat their classes and they would rather drop out of school. Most girls now think the only option is to get married. One of the girls had this to say: "Before coronavirus while at school we were given some necessities like sanitary towels, now schools are closed I don't know what next. I even talk to myself a lot because of the many thoughts corona has brought and the only option I have is to get married and get such necessities".

Early pregnancy: Many young girls are getting pregnant and some have had abortions, putting their lives in danger. One of the girls said:

'We are stressed by poverty and when some men promise to buy us some basic needs we may end up sleeping with them. In addition, you see churches were closed which were keeping us busy since we would spend time there singing and fellow-shipping. This has forced some young people to join bad company and end up having sex.'

Fear and phobia of police: Young people have developed a fear of the police as a result of the COVID-19 preventative measures guidelines which they enforce. Most young people panic and run away when they see them.

Separation between parents and children: Some parents and children were separated in different counties and districts due to lockdown and border-crossing closures causing a lot of stress.

Poverty in homes has increased, which has led to misunderstandings among families and this in turn affects young people. The youth reported that they have become desperate due to lack of basic necessities. Some youth such as *bodaboda* (motor bike taxi) riders have resorted to stealing due to loss of employment.

Despite the adverse impacts of coronavirus on the mental health of young people, the focus group participants reported that the crisis has also had some positive impact. As they are not in school, children and youth are helping parents in gardens and this has increased crop production. Some youth reported that the crisis has brought them closer to their parents as they are getting to spend more time with them. They have been able to work with parents as 'apprentices' such as in the construction of houses and some young people feel they can use these skills in the future. The recommendations made by young people to address the challenges they experience included provision of initial start-up capital for small businesses to revive those lost since capital has been used to meet basic needs; to provide sanitary towels to girls even when they are not at school or training them on how to make them; to enforce laws that govern selling of alcohol, especially to persons below the age of 18; to enforce laws against early child marriages; provide them with radios to get clear communication and also help them learn during this period as schooling had moved to radios and online; devise all possible means how they can do their exams and avoid repeating their classes; give permits and transport assistance for people stranded in other districts to reunite with their families. The young people argued that the fact that the pandemic is new and has affected every sphere and aspect of life means it needs a collective effort from all community members. They themselves would welcome a chance to participate in or volunteer to support any project that would aim to support their mental health needs.

Psychosocial responses

Rapid ethnographic research is central to appreciating local understandings related to COVID-19. In the Ebola crisis, there was a failure to take sociocultural beliefs, narratives and practices seriously, which impeded infection prevention, compliance and control (Abramowitz et al, 2017; Manguvo & Mafuvadze, 2015; Wilkinson & Fairhead, 2017). Adherence responses to ICP public measures health across a range of disease outbreaks in Africa shows varied practices as a result of different understandings of quarantine protocols, social pressures and cultural factors (Webster et al, 2020).

In both Uganda and South Africa, TPO Uganda and REPSSI are seeking to maximize the use of radio and social media to enhance behaviour change and reduce stigma. Radio has a greater reach than social media as many households do not have internet access (UNESCO, 2020). Pre-recorded psycho-education messages, parenting and positive coping messages are being used to reach out to communities with ICP COVID-19 information to address misconceptions and cultural risk practices (greeting by shaking of hands, hugging, coughing and spitting in public). This utilizes research from reliable sources (WHO, Ministry of Health) on common means of transmission, prevention measures, signs and symptoms, behaviours and practices that encourage the spread of the coronavirus disease, benefits of timely diagnosis, caring tips for a person who has recovered from COVID-19 and emergency contact numbers. Radio messages are designed differently for women, youth and men (preferences regarding programming style, languages, theme music for programme signature tune, times of day) and use humour, drama and personal experiences to emphasize key points and messages. Given the demands of physical distancing in the context of increasing psychosocial stressors, TPO Uganda has responded with the development of telecounselling. This innovation grew exponentially from April to July 2020.

Conclusion

COVID-19 and public health mitigation efforts have had a devastating effect on the livelihoods and psychosocial wellbeing of Ugandans and South Africans. Although deaths are concentrated among older people, youth aged 18 to 25 years – who make up over 60 per cent of the population of Uganda – have been significantly affected in ways that have been so far poorly understood. The analysis here indicates that school closures due to lockdown and containment strategies impact girls and boys differently. A key priority is mainstreaming psychosocial concerns in multi-sectorial responses so rapid ethnographic assessment can inform these in culturally appropriate, cost-effective ways.

Notes

1. Anti-retroviral Therapy Coordinator, Kabale Regional Referral Hospital, Uganda, June 18 2020.
2. TPO Uganda Report, *Impact of COVID-19 on Mental Health and Well Being of Youth, Kiryandongo District, 5 July 2020*. Survey and report compiled by Kakai Bridget, Norah Nabwire, Twongyeirwe Amon and Rachael Atuheire, TPO, Uganda.

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13

The Economics of COVID-19 in Italy and Lessons for Africa

Giovanni Farese

In early 2020, Italy was badly hit by coronavirus. For several weeks it was the epicentre of the pandemic in Europe. It was then the first liberal democracy to implement restrictive measures (the 'lockdown') to fight the spread of the virus, and also the first to see positive results from it. As the situation improved week after week, it became possible to draw some lessons from the Italian case for countries which are still suffering spikes in cases. This chapter will look at the economic consequences of, and responses to, the virus, trying to shed a light on the analogies and differences with African countries in particular. By leveraging Italy's case, the ultimate aim of this chapter is to provide a compass to navigate through the complexities of this multi-faceted crisis.

There is a general belief about a coronavirus trade-off between economics and health (livelihood or lives?). The truth is that the lockdown has different meanings and impacts in different contexts, and lockdown is not necessarily the only solution, nor the best – depending on available equipment, the spread of the virus, and other factors (the now famous three T's: testing, tracking, treatment). Equally, unlocking does not immediately nor necessarily spur economic recovery as social distancing measures and, in general, uncertainty over the future continue to limit spending and investment (Sorrentino, 2020). This is why the study of specific cases with their own specific conditions is so important.

Dealing with it

To begin with, it would be useful to look at a chronology on how the virus spread in Italy. In January 2020 there were the first two cases in the country (two Chinese tourists, who were quickly isolated and treated). A six-month state of emergency was then declared by the government one day later (in May it was prolonged until the end of 2020). The Italian 'patient zero' was reported on 21 February in Codogno, Lombardy. The first so-called 'red zones', where quarantine was enforced, were established a few days later. The lockdown (so-called Phase 1) started 9 March 2020. It ended on 4 May (so-called Phase 2) when a partial unlocking started. On 1 May, most businesses were permitted to reopen. By the end of July 2020, the total number of cases was around 240,000, with around 35,000 deaths. It is notable that more than two-thirds of the deaths were from the north of Italy (Italy's best-equipped area in terms of health provision and its richest area) and about half of them from one region only, namely Lombardy. This geographical divide is one feature of Italy's case. This of course affected responses, with some regions implementing stricter rules within the framework of national guidelines.

The Italian health system – one of Europe's most advanced – was put under stress very quickly and after two decades of disinvestment in the sector, it struggled. Hospitals and other buildings were converted into dedicated coronavirus treatment centres. Doctors, nurses and volunteers unremittingly supported much of the effort and this saved many lives, but a key weakness was that the number of tests was insufficient and results took days to process. This took precious time away and many lives were lost as a result. This caused anger and grief, and some social unrest. All in all, Italy's response in these early days of infection showed that an immediate lockdown is critical (even though we now know that the virus had been circulating in Italy from at least January). Furthermore, there is a lesson that adequate availability of medical equipment, particularly PPE, and preparedness are essential. International cooperation is also fundamental. Masks had to be imported from developing countries where production had been relocated previously due to globalization. Stocks were

sometimes confiscated by exporting countries trying to meet their own needs. The geopolitical implications of exporting medical equipment was also a part of the story, with China at the forefront through its so called 'donation diplomacy'. Not surprisingly, the EU now aims at recovering what is termed a 'strategic health sovereignty' (French-German Initiative, 2020).

The public's understanding of what was going on was an important factor. The flow of information from public authorities was, on the whole, regular and transparent. However, it was not always consistent from one region to another, nor always prudent, with leaking of the imminent lockdown causing massive flows of people from the north to the south of Italy. Overall, however, it was effective. Citizens responded well to the confinement and showed a sense of discipline. Information in general played a crucial role in shaping a positive response. But some sources, especially on the internet and on social networks, were deliberately inaccurate. This was not just an Italian feature. It is important to know that misinformation or 'fake news' quickly became part of a larger geopolitical battle around the nature, responsibilities and consequences of the virus aimed at weakening liberal democracy, its response capacity and its values. Tackling misinformation is thus an essential feature of the battle (European Commission, 2020). There is also a constitutional-legal and, in perspective, political issue not to be overlooked. This is not the topic of this paper, but it is worth noting that in many places, the pandemic provided an occasion to introduce various forms of restriction upon freedoms. In Italy, everything happened within the framework of the Constitution; but the fact that most of the measures were taken, for reasons of urgency, through prime ministerial decrees rather than law-decrees (by the government), or laws (passed by the Parliament), nurtured a debate on the effectiveness, role and limits of government in liberal democracies vis-à-visauthoritarian regimes. This can create a prospective problem, especially if the pandemic strikes back and if liberal democracies fail to face it, thus paving the way for forms of illiberal democracy.

The economic and social impact

In Italy, the economic consequences will be severe. GDP was expected to fall by about 10–12 per cent in 2020 (IMF, 2020). Unemployment will rise from 10 per cent in 2019 to 11.6 in 2020 and is expected to only partly reduce in 2021 (to 11 per cent). Italy is anticipating losing half a million jobs. Note that after the Great Recession, one million jobs were lost between 2007 and 2013 and it took some four years to recover them. The economic consequences of the pandemic will thus remain for a long time. The crisis has precipitated a dual shock to demand and supply, due to the disruption in supply chains – including time-lags – and the lockdown. It seems to be common to all countries affected by the virus. The economies affected by it number 170 in 2020 (Gopinath, 2020), but the shock is clearly asymmetric because the impact is different around the world. Three factors – apart from openness to trade – can make the impact different. They are relevant for Italy and – on a different scale – can be relevant for other countries, including African countries.

The *first factor* is the scale and dimensions of the informal sector. In Italy, it accounts for about 15 per cent of GDP (in Africa, 85 per cent of workers are in the informal sector [ILO, 2018]).

To reduce the economic impact on workers not covered by automatic stabilizers, the Italian government introduced an 'emergency income'. Moreover, in May 2020, at the end of the lockdown, it passed a law for the regularization of undocumented foreign workers, meant for farmhands (but also caregivers and domestic workers) needed for harvesting. It was also meant to deal with dangerous situations such as illegal tent camps in the countryside of Apulia and Calabria where migrants live in dire sanitary conditions in the midst of the coronavirus emergency – the vast majority of farmhands in Southern Italy come from Africa. The law has three goals: supporting the economy; promoting human rights; and improving health conditions and welfare. It was accompanied by a harsh debate within Italian public opinion and marked the first positive cultural shift in migrant policy in many years.

The *second factor* is the share of small and medium enterprises (SMEs) in the total. In Italy, this share is particularly high (98 per cent) in the European context (where the average is 90 per cent). In Italy, 95 per cent of them are micro-businesses with fewer than ten employees. This is one of the reasons why the impending economic crisis will be more severe in Italy than in other places, such as Germany (Doerr and Gambacorta, 2020). SMEs are the backbone of African economies, too. Their survival is, therefore, absolutely vital. SMEs' financial resilience is on the whole limited. Granting them access to credit is crucial not only to safeguard productive capacity, but also jobs, and, in the medium run, state fiscal capacity itself. On this front, the Italian government introduced a state guarantee on new loans for firms of all sizes affected by the crisis. The guarantee is 100 per cent for small loans up to 25,000 euros. Capital injection through the Loans and Deposits Fund (a public bank) in medium-sized enterprises was also allowed. This was possible under the new State aid Temporary Framework recently approved by the European Commission. These are ways in which the state can take action, but they all affect our third factor.

The *third factor* is fiscal space. The cost of this crisis will be mainly borne by the public sector (Draghi, 2020) in the long run, which is the opposite to what happened with the Great Recession, when the burden was, once the financial crisis was considered to be over, shifted to the private sector via austerity measures to reduce the public debt. Yet, Italy's fiscal space is limited. This year, Italy's deficit will bounce from 2 to 10 per cent of GDP, so public debt will rise from 135 to 155 per cent of GDP (DEF, 2020) as interest payments accumulate. These developments were possible thanks to the activation of the general 'escape clause' in the EU's Growth and Stability Pact, which normally imposes strict constraints on public finances. The European Central Bank is also playing an active role in supporting state financing with its new pandemic emergency purchase programme. Future tensions in financial markets and over sovereign bond spreads must be watched closely. Italy will have to rely substantially on one or more of the European ad hoc funds and instruments available. The Recovery Plan, in particular, could sustain Italy's much-needed investment in

infrastructure and other public goods. As with all countries caught in the wave of this pandemic, public spending needs to be qualified and reoriented properly. As a side point, the lack of health equipment perhaps exposed the toll of widespread tax evasion on public finances. Fiscal space is further limited in developing countries and many African countries in particular. At a time when governments' budgets are under pressure to deal with the health crisis and its economic consequences, debt payments could be a serious diversion of scarce resources.

There is also a huge difference on this point between advanced countries, such as Italy, and developing countries. High levels of savings (and this is particularly true for Italy with 4 trillion euros of financial assets held by households), financial depth and low interest rates enable them to mobilize huge fiscal resources without raising interest rates too much or facing hyper-inflation. Notwithstanding the relative advantages of being an advanced country, Italy's public finances will still need to be managed prudently to prevent future shocks. Furthermore, a lot is being done by non-state actors. In Italy, the Catholic Church and NGOs like the Sant'Egidio Community have been key in supporting the homeless, migrants and those in need in general. Private donors are playing their part with generosity. As we know, community solidarity is one of Italy's strengths, also on the financial side. It is clear that Italy, as with countries across the Global South, will need much more, including substantial support from international governmental and financial organizations. This is clearly in the interest of the EU, for example, as a whole. If Southern Europe collapses, then Northern Europe may collapse too. This brings in a more general lesson. This is the first truly global crisis. The Great Depression of 1929 was not, and even the world wars were not. During the pandemic, Pope Francis said that "we are all on the same boat". It is crucial to understand that 'all' means the human family, while the 'boat' is the entire planet.

Looking forward

As said above, the consequences of the pandemic will stay with us for a long time and they will alter and shape in new ways economic and social developments for many years to come. There are of course many points of concern. Here, we will only mention a number of pressing ones. In keeping with the nature of this chapter, they primarily apply to Italy, but their lessons can be generalized and are presented for the Global South to consider. The *first concern* is the risk of an increasing economic and social divergence within the country, between regions (the economic gap between North and South Italy is rooted in its history), between productive sectors (tourism, for example, which represents 13 per cent of Italy's GDP and was badly hit), and between workers, especially those in the informal sector or with short-term contracts and those in more secure employment. The impact on low-skill services from this crisis will be huge. They have historically played the role of an employment buffer in Italy (Viesti, 2020).

The *second* concern is the risk of weakening the long-term accumulation of human capital. School closures have been mandated by 143 countries with 130 countries imposing country-wide closures (*Africa's Pulse*, 2020). Less than 20 per cent of the African population has access to the internet, compared with 90 per cent in advanced countries. But socially and geographically differentiated access to the internet is everywhere. This is a problem for all, even though access to the internet does not necessarily equal human capital formation. It is just an example of how limited access to resources can limit human rights.

The *third* concern is the risk of a stronger populism taking control of national politics and, consequently, of international politics. The coronavirus has hit the world during a historical phase in which nationalist and populist leaders are already powerful in some countries and could strengthen in others, especially if and when economic and social conditions deteriorate. International cooperation is of the essence, but also economic solidarity to deal with the crisis, and a 'me-first' attitude will do nothing but exacerbate dangerous economic and political conditions. Few voices have been raised to

stress this point, or provide practical and viable solutions (Berglof et al, 2020). What we need is good information, good governance and good international relations (Savona, 2020). Good governance, in particular, needs what in monetary policy is referred to as 'forward guidance'. We need to distinguish again – as in Franklin Delano Roosevelt's New Deal – relief from recovery and recovery from reform, both at the national and the international level. Failure to do so will hinder reconstruction. Proper programming and sequencing of these different stages (these three R's: relief, recovery, reconstruction), which partly and inevitably overlap, will require different approaches and resources, and are essential to guide the public's expectations, to manage new consumption patterns and to target investment in times of uncertainty. These lessons are pertinent to Italy and the countries of Africa alike.

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14

COVID-19 Lockdowns in Africa

Their Effects and Challenges

Nazarius Mbona Tumwesigye, Claire Biribawa, Jackline Mosinya Nyaberi, Cissie Namanda, Glorious Atukunda and Lillian Ayebale

It is necessary for African leaders and policymakers to utilize the rare opportunity opened up by the COVID-19 outbreak to unite behind a common purpose and strengthen public health systems and disease surveillance. Such a unity against the pandemic will make it easier for the World Bank and other donor or lending institutions to mitigate its negative effects. Strengthening regional cooperation of all health institutions in Africa and activation of stricter policies at the ports of entry, such as screening, testing and isolation of confirmed cases, will go a long way to forestall unexpected outbreaks. This chapter provides a general overview of how a few selected African countries have responded to COVID-19 and a critical view of the effects of the responses in six countries (Uganda, Rwanda, Kenya, Malawi, Nigeria and South Africa). These countries were selected based on the intensity of the COVID-19 response, their alarming COVID-19 situation and national events that could have affected the epidemic curve. By 30 March 2020, Uganda, Rwanda and South African government mitigation and response measures were rated above 90 per cent stringency according to the University of Oxford COVID-19 Government Response Tracker (University of Oxford, 2020). Kenya and Nigeria are among the top ten countries in Africa with the highest number of COVID-19 cases. Malawi was among the last African countries to confirm

COVID-19 cases, and after it held its presidential elections on 23 June 2020 there was a rise in the number of cases.

General COVID-19 situation in selected countries

Figure 14.1 shows the cumulative curves for Covid-19 cases in the selected countries. Most countries saw their first cases in March 2020. Cases were generally few in April, but grew most visibly in May 2020. In May and June, the growth in cases was exponential for South Africa and Kenya, but slowest for Uganda and Rwanda. The curve for Nigeria shows a steady and near-linear growth to place the country among those with the highest number of cases. Compared to other East African countries, Kenya had the highest rise in the number of cases. In Malawi the number of infections there has surpassed Uganda and Rwanda. In the paragraphs below we narrate possible explanations for the curves. This is followed by a subsection on possible ways forward for different countries.

South Africa relaxed the lockdown early but reinstated it, with a ban on the sale of alcohol later. The level of stringency of the measures did not correlate with the level of containment of the spread of COVID-19, although statistics indicate that the number of recorded cases of the virus started to soar three weeks after the measures were eased (Brown, 2020). Over time these mitigation measures have been eased in various countries (Figure 14.2). Malawi's intervention has remained lukewarm throughout the COVID-19 pandemic so far.

Details on each country

Uganda

Uganda reported its first case of COVID-19 on 21 March 2020. According to the University of Oxford COVID-19 Government Response Tracker, Uganda rated above a 90 per cent stringency level on measures instituted to tackle the COVID-19 outbreak. The government instituted a partial lockdown by banning transport using public means

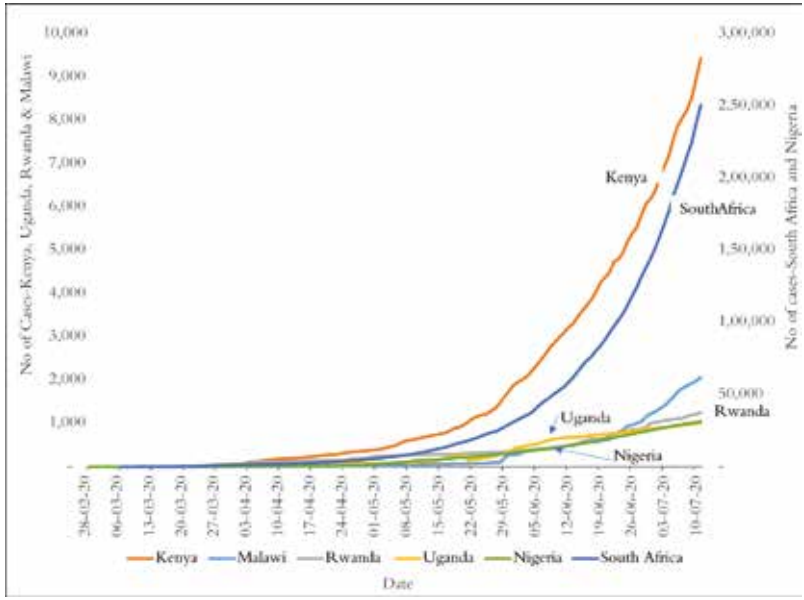

Figure 14.1 Cumulative Covid-19 cases in selected countries

NB: Left-hand vertical axis is for Kenya, Uganda, Rwanda and Malawi while the right-hand vertical axis is for South Africa and Nigeria. Data in the graph were as of 11 July 2020.

Source of data: EU open data portal (EU, 2020).

(14-seater taxis and commercial motorcyclists) on 25 March 2020 and private vehicle transport on 31 March 2020. Only ambulances, vehicles driven by local authorities or people working in essential services were given permits to drive. People in need of emergency care had to request the permission of local authorities to travel, since driving anywhere without express permission could result in arrest and having the vehicle impounded. All businesses were closed except for food markets and essential services like healthcare. Private vehicles and businesses that do not attract crowds were allowed to operate from 26 May 2020.

As of 8 August 2020, six COVID-19 related deaths had been reported out of 1,267 confirmed cases (MOH, 2020a). Most health resources have been redirected and committed to fight COVID-19, with less attention to other services and continuity of care for other diseases (Kamulegeya et al, 2020).

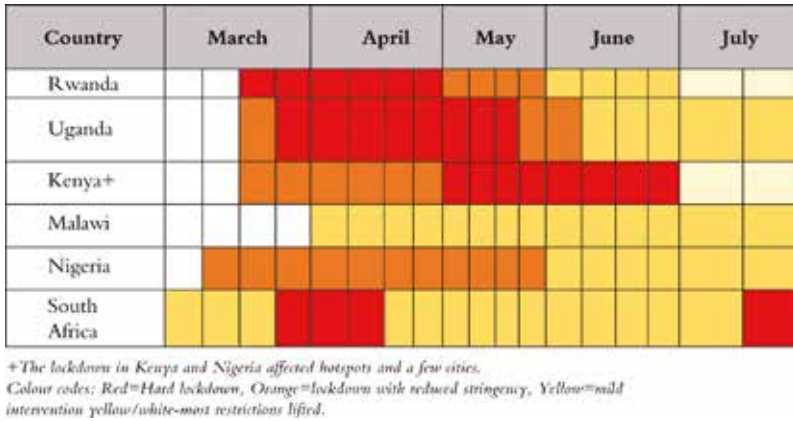

Figure 14.2 Chronology of interventions

+The lockdown in Kenya and Nigeria affected hotspots and a few cities.

Colour codes: Red=Hard lockdown; Orange=lockdown with reduced stringency; Yellow=mild intervention; Yellow/white-most restrictions lifted. Source: multiple online newspapers and reports.

(Source: the author)

Lack of access to health services as a result of restriction/ban on transport led to deterioration in the health of vulnerable populations (Bell et al, 2020). Now that the government has eased restrictions, it is expected that access to health services will improve, but the number of COVID-19 cases are bound to increase because enforcement of COVID-19 guidelines will be more difficult.

The national presidential, parliament and local election process that has started across the country with campaigns may escalate the COVID-19 pandemic on the continent. Malawi is an example of this, where the number of reported cases rose sharply after the recent elections (MOH, 2020b).

Kenya

Kenya recorded its first case of COVID-19 on 12 March 2020 (John Hopkins University, 2020). In March 2020, all schools, institutions of learning and places of worship were closed and working from home was highly encouraged. The lockdown included closure of all borders for passenger traffic, a ban on

shaking hands and approval of a law requiring the wearing of masks in public. Anyone found in public without a face mask risked being jailed or having to pay a fine of Ksh 20,000 (US$200). In April, there was partial lockdown in terms of restraining movements and a curfew from 7 pm to 5 am and a ban on inter-county movement instituted. Screening of truck drivers passing through the borders with Uganda and Tanzania was enforced. The majority of cases reported in counties close to borders were among long-distance lorry drivers. In addition, restaurants and eateries were closed but in late May reopened for takeaway services.

With 25,138 cases and 413 deaths as of 8 August 2020 (John Hopkins University, 2020), Kenya is among the worst-affected countries in Africa and has continued recording high numbers of new cases (Hale et al, 2020). On 7 July 2020, the country relaxed most restrictions, except the curfew that runs from 9 pm to 4 am. COVID-19 restrictions in Kenya did not yield similar effects on the epidemic curve as in Uganda and Rwanda largely because the extent of the restrictions and enforcement were different. Nevertheless, the country could have been worse affected without these restrictions. The country is now experiencing a concatenation of negative effects of COVID-19, including increases in both morbidity and mortality. The health system is overwhelmed, resulting in adopting home-based care for the non-critical cases and the economic effects on businesses are enormous. There is a sharp rise in the unemployment level and mental health challenges, and social stigma associated with COVID-19 and gender-based violence (GBV) has increased (GOK, 2020).

Kenya needs a paradigm shift to revamp its health system building blocks. Secondly, there is a need for context-specific information, education and communication and campaigns in order to demystify misconceptions about COVID-19, such as it being the normal flu, for example. Thirdly, the government should lay out strategies to fight stigma associated with COVID-19 and reduce GBV. Fourthly, the government in collaboration with other stakeholders should institutionalize a fund for responding to the most vulnerable household and individual needs, including food and medical care.

Malawi

On 2 April 2020, Malawi confirmed its first three cases of COVID-19 and had on 27 March closed all its international borders and banned air travel, except for essential health and other supplies and returning Malawian citizens or residents. Malawian residents and nationals arriving from severely COVID-19-affected countries were subjected to mandatory self- or institutional quarantine. Schools and universities were closed. A ban on public gatherings of more than 100 people was imposed (UNECA, 2020). All offices were advised to work in shifts, except those working in essential services. On 14 April, a 21-day lockdown was imposed but was shortly overturned by the courts with an argument that more consultation was needed to prevent harm to the poorest and most vulnerable. By 8 August 2020, the country had 4,624 cases and 143 deaths (John Hopkins University, 2020).

The impact of the response is not yet evident on the epidemic curve. There are many factors to this but the holding of national elections and visible interaction of people without social distancing and use of face masks could have played a role in the increase of COVID-19 cases in the country. The country's healthcare system experienced several financial, infrastructural and human resource challenges. Healthcare financing is highly dependent on external support from international organizations and foreign governments and may face funding cuts from developed countries which have been critically affected by the pandemic (Gadabu, 2020: 413–429). The Malawi government has therefore instituted a COVID-19 Emergency Response and Health Systems Preparedness project, which has received funding. The project will provide funding towards detection, surveillance, response and system strengthening, activities prioritized in the Malawi COVID-19 preparedness and response plan. COVID-19 is known to be particularly dangerous for those with underlying health conditions and, in Malawi, a significant proportion of the population falls into that vulnerable category having been infected by HIV/AIDS (Gadabu, 2020). The way forward for Malawi will be more testing, intensified contact tracing and imposing targeted lockdowns, but with mitigation

measures to protect the most vulnerable populations (World Bank, 2020a). Needed measures include provision of food and basic necessities. Hopefully, the government will borrow or get more support grants from donors to support the COVID-19 fight.

South Africa

With 553,000 cases and 10,210 deaths as of 8 August 2020 (John Hopkins University, 2020), South Africa has the highest number of confirmed cases on the African continent and the fifth in the world. Without intervention, South Africa would likely follow the path of countries that delayed implementing measures designed to slow the pandemic (Arndt et al, 2020). The arrival of the virus in South Africa saw an increase in the dissemination of misinformation about the virus on social media, which delayed preventative actions against the disease (Davis, 2020). The first COVID-19 case was reported on 1 March 2020 (Arndt et al, 2020). From 23 March, the country went under lockdown until 16 April; which was then extended for two weeks. The country instituted an alert system whereby levels of restriction could be imposed by the National Command Council. Under the system, different levels of alert could be declared in specific provinces and districts based on epidemiological trends. This started on 1 May 2020, and from 1 June the national restrictions were further eased. On 12 July, the state of disaster was extended until 15 August 2020 and the alcohol ban was reintroduced along with a new curfew from 9 pm until 4 am (Williams, 2020).

Stringent measures taken at the beginning worked well to reduce the daily number of cases. However, the cost of enforcement was heavy. There were widespread reports of shortages of pharmaceuticals, with many areas seeing panic buying of food and other essential grocery items, with consequent shortages. Business closures had direct and indirect economic effects during the lockdown, which continued after it ended. In informal settlements, people's biggest fear was not being able to return to work and feed their families (Stiegler and Bouchard, 2020). The current rise

in infections could have come from people who moved back to their workplaces (Meldrum, 2020).

Lockdowns targeted at COVID-19 hotspots and risky activities, keeping a ban on bars and other areas that attract crowds, will go a long way to tame the virus. The country has done it before and is able to do it again, while being mindful of the negative effect of the response on the most vulnerable. Provision of basic necessities to the vulnerable will minimize the risk of infection in markets and other places they go.

Nigeria

Nigeria offers another unique example in the COVID-19 pandemic fight in Africa. It has the largest population and largest economy on the continent. Responses to COVID-19 in Nigeria started in January 2020. The National Emergency Operation Centers were immediately activated to trace and test all contacts of those identified as infected, and the Presidential Task Force was inaugurated. Nigeria confirmed its first case on 27 February 2020 and the cumulative number of cases was 46,140 with 942 deaths by 9 August 2020 (John Hopkins University, 2020). The lockdown has been eased as the number of cases continues to rise. The government has taken numerous health, social and economic measures to cushion the impact of COVID-19. These measures include community engagement, heightened surveillance, field epidemiological investigations, rapid identification of suspected cases, isolation, diagnosis, contact tracing, monitoring and follow-up of persons of interests, and conditional cash transfers to poor households across the country (Tijjani and Ma, 2020: 1–4).

Measures taken against COVID-19 did not have visible effects on the epidemic curve, but the situation could have been worse without them. The country has a federal system of government and each state can impose or lift restrictions at any time they see fit. Varying timelines for mitigation measures across different states could have contributed to the high burden of COVID-19 across the country. Complex humanitarian settings of displaced people in the north-east of the country, where there is an ongoing insurgency, will pose

a challenge. Guidelines for protection against COVID-19 are difficult to enforce in such circumstances.

Nigeria needs more engagement with all states to establish a more coordinated COVID-19 response. Delays in implementation by one state may put other states in danger. Within-state lockdowns targeted at COVID-19 hotspots and other affected areas will go a long way to contain the epidemic. However, these measures should include safety nets for the vulnerable. More effort is needed to strengthen the country's disease response and preparedness capability as raised by the World Health Organization's (WHO) Joint External Evaluation (JEE) of International Health Regulations (IHR) core capacities in 2017 (WHO, 2017). There is a need to strengthen the capacity of the public sector across the board. This may be done through continuous training.

Rwanda

Rwanda's public health response to COVID-19 has been impressive and that is why it is the first country in sub-Saharan Africa whose citizens are allowed to travel to the EU. The response was systematic and was backed by the President and security forces (IGC, 2020). Right before its first reported case on 14 March, Rwanda had mandatory rapid temperature screening at all its borders and airport. The country was among the first in sub-Saharan Africa to order a total shutdown, on the 21 March 2020 (DW, 14 July 2020). All non-essential travel outside homes was banned (IGC, 2020). On 4 May, the government eased the lockdown, allowing public administration services and private businesses to reopen, but under strict health and safety regulations (FEWS NET, 2020). Despite these timely measures being implemented, the number of confirmed cases has continued to rise, although at a relatively slower pace compared to many other countries around the world. As of 8 August 2020, a total of 2,134 COVID-19 cases had been registered (John Hopkins University, 2020).

Behind such an impressive performance against COVID-19 there has been great sacrifices. More than half of Rwanda's population (56 per cent) live on less than $1.90 per day

and this segment has suffered disproportionately due to the COVID-19 lockdown measures (World Bank, 2020b). Food prices rose and access to other health services was more difficult for the poor. The way forward for Rwanda will be to sustain its vigilance and its calculated moves against COVID-19. Mitigation measures targeted to improve incomes and the health of the poor and vulnerable populations should allow the country to transcend the COVID-19 crisis.

Conclusion

It is necessary for African leaders and policymakers to utilize the rare opportunity opened up by the COVID-19 outbreak to begin strengthening public health systems and disease surveillance. This is where the World Bank and other donor or lending institutions can mitigate the negative effects of COVID-19. Strengthening regional cooperation of all health institutions in Africa and activation of stricter policies at the ports of entry, such as screening, testing and isolation of confirmed cases, will go a long way to forestall unexpected outbreaks. Countries such as Mauritius and Vietnam have minimized infections through similar measures (Mauritius at 344 and Vietnam at 789 cases as of 8 August 2020 [John Hopkins University, 2020]). The governments also need to strengthen their capacities to respond to epidemics as highlighted by WHO's joint evaluation of International Health Regulations (IHR) core capacities.

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15

COVID-19 and Global Inequality

Gerard McCann and Chrispin Matenga

The impact of the COVID-19 pandemic on the Global South will be formidable and will take decades to recover from. Regions that have historically struggled with development issues have been caught highly exposed to the spread of this particular pathogen. Already straining from under-resourced health and medical provision, climate change and conflict, many of the world's most vulnerable regions will be forced into a mitigation drain that will undermine decades of positive development while accelerating processes of socioeconomic stress that – if not combated at an international level – will lead to further damaging levels of economic decline and deprivation. This chapter will survey the effects that COVID-19 will have on socioeconomic inequality and will highlight the scale of the need vis-à-vis strategies for mitigation.

The new context

COVID-19 has brought forward a series of issues that will have both short- and long-term implications for international development. The various governmental attempts at mitigating the impact of this pandemic have served to highlight persistent systemic fault-lines in a global socioeconomic system where inequality has, yet again, come sharply into focus. The implications of this all too predictable pandemic have been manifest in various ways: through transnational market competition, the scramble for basic medical supplies; the deliberate neglect of the most vulnerable members of society; the pharmaceutical companies' race for a vaccine; an almost total lack of testing and medical intervention

in disadvantaged communities; fear of the virus being used as a cover for human rights abuses; and international organizational withdrawal when it comes to assisting regions of the world which do not have the health and public services to combat such desperate circumstances – this has been most notable in regions in conflict (Human Rights Watch, 2020).

Perhaps most notable in the confusion over mitigating actions has been the way in which governments, internationally, have sought to protect internal vested interests at the expense of confronting persistent, debilitating, global inequality. The pirating of global supplies of COVID-19 relief drugs by rich countries is perhaps the most shocking example of a breakdown in what was an unsteady consensus on global interdependence. The rollout of this economy of privilege can be witnessed most vividly from what has been happening to the poorest individuals, families, communities and Least Developed Countries (LDCs), and increasingly selective policies of development cooperation. Taken in the round, the economic scarring of this pandemic will take decades to recover from; the implications for human life experience will be generational.

Food shortages, caused by the global mismanagement of food security and climate change, and conflicts driven by the corporate privatization of war (the outsourcing of military markets and activities, for example, in Libya, Ukraine, Syria and Yemen), have been met through 2020 by a pandemic that, in particular, affects marginalized groups. Even the epidemiological mutation of COVID-19 seems to be working against the Global South, where the virus – from initial research – seems to be most adversely affecting those of African or Asian descent and those who suffer illnesses linked to impoverishment (ONS, 2020a: 2–4). The United Nations' *World Economic Situation and Prospects as of Mid-2020* report commented on the challenges that the pandemic has created regarding global inequality and paints a stark picture:

> The pandemic has unleashed a health and economic crisis unprecedented in scope and magnitude. Lockdowns and the closing of national borders enforced by governments have paralyzed economic activities across the board, laying

> off millions of workers worldwide … The possibility of a slow recovery and prolonged economic slump—with rising poverty and inequality—looms large.
>
> (United Nations, 2020: 1)

Arguably, the most challenging social issue that has arisen out of the crisis has been that the pandemic has acted as a catalyst for the accelerated divergence in life-preserving public sector interventions between the most and least privileged people around the world. Even within the Global North this divide registers, where the most excluded, the least able to cope – those with learning needs, the elderly in care homes and refugee populations – have become the most exposed to the virus and the least protected. In terms of mortality, one key fact from the United Kingdom's Office of National Statistics is brutal – people suffering socioeconomic deprivation are twice as likely to die of COVID-19 (ONS, 2020b).

Rolled out globally, the reactive model of mitigation, selective shielding (protect wealthier sections of society and siloing those who do not have the means to finance their way through the pandemic), will have significant consequences, with the real possibility of drawing back on years of hard-won development. It could also result in the unravelling of critical gains made through the United Nations (UN) Sustainable Development Goals (SDGs) – particularly SDG-1, which aims for an end to extreme poverty, and SDG-10 on a reduction in global inequality. In the chaos of the pandemic these initiatives have lost substantial ground.

> At the global level, the potential impact of COVID-19 poses a real challenge to the UN Sustainable Development Goal of ending poverty by 2030 because increases in the relative and absolute size of the number of poor … would be the first recorded since 1990 and they could represent a reversal of approximately a decade of progress in reducing poverty. In regions such as the Middle East and North Africa and SSA, the adverse impacts could result in poverty levels similar to those recorded 30 years ago.
>
> (Sumner et al, 2020: 8)

The response to the pandemic from the UN has been to call for additional financial support to help fragile regions struggle through, while addressing ongoing crises such as climate change and the sporadic conflicts afflicting many areas of the Global South. Under the cloud of the pandemic, a UN list of 50 'vulnerable nations in urgent need' now has nine additional countries on it: Benin, Djibouti, Liberia, Mozambique, Pakistan, Philippines, Sierra Leone, Togo and Zimbabwe (Sumner et al, 2020). The reasons for this are multifold but have been a result particularly of fluctuations in global commodity prices; the withdrawal of investment and international financial transfers; mass job losses; protectionism; and the ongoing burden of foreign debt. Analysis of the 2020 situation for the United Nations University World Institute for Development Economics Research (UNU-WIDER) has estimated that an additional 400 to 580 million people will be facing extreme poverty as a result of the pandemic. In this scenario, the multiplying effects of global economic contraction and the breakdown of social and health support systems would be unprecedented (Sumner et al, 2020: 2). On 8 July, the UN Secretary-General António Guterres made an unprecedented call for governments to unite to confront *the* global issue which will reflect responses to this pandemic:

> Inequality defines our time. More than 70 per cent of the world's people are living with rising income and wealth inequality. The 26 richest people in the world hold as much wealth as half the global population. But income, pay and wealth are not the only measures of inequality. People's chances in life depend on their gender, family and ethnic background, race, whether or not they have a disability, and other factors. Multiple inequalities intersect and reinforce each other across the generations. The lives and expectations of millions of people are largely determined by their circumstances at birth.
>
> (Guterres, 2020b)

The World Bank (WB), not known for its sensitivities on equality, has also been alarmed by the turn of events. In an analysis of the impact of the pandemic by some of its

economists, the effects are sobering in every sense of the word: 'With the new forecasts, global poverty—the share of the world's population living on less than $1.90 per day—is projected to increase from 8.2 per cent in 2019 to 8.6 per cent in 2020, or from 632 million people to 665 million people' (Mahler et al, 2020). At a conservative estimate, it means another 23 million people will need emergency humanitarian support. The hardest hit will be those regions that have been historically subject to economic volatility, colonialism and the systemic exploitation of human and natural resources. These regions are largely grouped within sub-Saharan Africa and Asia. They are also the regions least able to cope with any further pressures on under-resourced and under-staffed health and social care systems. What also must be noted here are the effects of the meltdown in public policy in many countries in Southern and Central America, where, by August 2020, some governments could simply no longer guarantee public health provision of any kind in many regions.

From the projections of the World Health Organization (WHO), the pandemic could take up to two years to reach its breadth of contagion, taking millions of lives on its journey. The WHO Africa Region office portrays a difficult scenario for that continent, where: 'Eighty-three thousand to 190,000 people in Africa could die of COVID-19 and 29 million to 44 million could get infected in the first year of the pandemic if containment measures fail' (WHO, 2020). In its survey of health services, based on self-reports by 47 countries to WHO, the situation is compounded by the statistic that there are on average only nine intensive care unit beds per one million people in the Africa region (WHO, 2020). In many countries the health system is non-existent, and the care system by and large remains the family and community network. The mortality rate and lack of capacity for public health services are only the start of the process that will spasm into what could be described as socioeconomic entropy.

Lockdown and economic impacts

With half the population of the world going through varying degrees of lockdown, the outcome of this pandemic will naturally be incremental and sporadic, affecting different regions at different paces. The scale of the lockdown points to global depression, accentuating the well-tread path to underdevelopment in many peripheral regions; mere economic adversity in others. In a word, economies and economic sectors predictably will suffer high levels of stress as a result, the knock-on effects of protectionism and political tension generating further inequality and social dislocation. In its analysis of the possible economic impacts of the pandemic, the International Labour Organization (ILO) estimated that in the region of 25 million jobs could go (ILO, 2020). That was 1 March 2020. By 18 May, 32 million jobs had been lost in the US alone. Furthermore, the disparate models of lockdown, particularly in many LDCs, with food markets closed and labour movement restricted, has been most devastating for those who rely on these two basic things for life security. In communities tied to an economic base of migrant labour pools and street economies, such curfews – usually only limited to wartime – could result in hunger and intercommunity strife due to resource competition and supply shortages. The poor and the poorest will remain dispossessed in every sense of the word. James Thurlow, from the International Food Policy Research Institute, presented the situation in these terms: 'Poor and rural households are also suffering substantial losses, and for them, even a small drop in income can have detrimental and lasting effects … Tighter restrictions on urban markets, for example, could shift more of the burden onto poor consumers and smallholder farmers' (Thurlow, 2020: 1). In response, the global working poor should be factored in as highly susceptible to the economic impact of the pandemic and this should be a central consideration in international strategies for COVID-19 mitigation (ILO, 2020: 5).

Around the world, casual, unskilled, informal labour and those in precarious jobs (particularly women and migrant labour) are losing jobs, if lucky 'furloughed', or forced from

work. In some regions, migrants have again proved easy scapegoats to target blame, victimized for the pandemic and driven from host countries. In some countries, such as India and China, internal migrants have been forced from regions after sectarian and racist attacks. These are also exactly the individuals and their families who are most susceptible to homelessness, forced migration, trafficking and human rights abuses. Indeed, as the United Nations Office on Drugs and Crime (UNODC) revealed, with anti-trafficking services unable to operate, the flow of people has not only continued unabated but has increased (UNODC, 2020).

Beyond the fragile nature of labour rights and forced migration, the most socioeconomically vulnerable are largely without secured healthcare or access to the appropriate medication to deal with the virus. In some regions, COVID-19 is only compounding the pressures already brought in dealing with a new global measles outbreak, the resurgence of Ebola, tuberculosis and malaria. Collectively, this unprecedented period in human history has left the medical health and care sectors across the Global South, as with many regions of the Global North, struggling to cope. When largely unregulated market forces come to bear on this, the situation will become ever-more volatile. The buy-up by the US of almost the entire global supply of the main drug known to relieve COVID-19 symptoms (Remdesivir) gives some indication of where some governments stand on COVID-19 mitigation. The market scrum for PPE at the beginning of the pandemic was also a signifier of self-interest over international cooperation. Furthermore, unless controlled, corporate agents are set to become highly predatory as the pharmaceutical industries enter an East Indian Company-style scramble for public patronage, funds and patents. At the online World Health Assembly on 18 May 2020, Médecins Sans Frontières (MSF) – who responded immediately and heroically to COVID-19 in more than 70 countries – painted a cautionary picture, targeting patronage-based governmental relationships with the global pharmaceutical industry.

> The current monopoly-based pharmaceutical research and development (R&D) system fails to develop, produce

> and distribute lifesaving medical tools in the interest of public health … With control over the market as a result of patents or other exclusive rights, or even the way in which global production and supply chains are organised, pharmaceutical companies have the decision-making power to determine who ultimately has access … When global demand outstrips production and supply capacity, medical tools are often allocated not based on public health need, but on the ability to pay high prices.
>
> (MSF, 2020)

Losing this battle over procurement, production and supply could cost millions of lives. With this pandemic, the glaring paradoxes of socioeconomic divergence and power vacuums can be seen with the quantifiably different mortality rates between those who have access to healthcare and medicine and the most excluded members of society (Neate, 2020; Riley, 2020). The responsibility for addressing the issues of inequality reside largely with political representatives with mandates to apply good practice in governance and propriety in public office. The problematic derogation from these principles has been that for many governments the protection of citizens has remained secondary to the causes of internal control (by quelling protest and curtailing rights), territorial security and power struggles. Across the globe this has led to further divergence between the powerless and powerful – the essential cause of inequality.

> Shockingly skewed illness and mortality rates have tracked and exposed racial and class divides. In some of the world's richest nations, health care systems have proven grossly inadequate, and race, gender, religious, and class discrimination have skewed access to housing, food, education, and technology in ways that have yielded radically different outcomes. Gaping North-South disparities have been exposed.
>
> (United Nations Human Rights Council, 2020: 9)

Conclusion

In conclusion, the dire situation humanity finds itself in demands concerted, targeted and humane interventions – interventions that have not been witnessed on a global scale since the end of the Second World War. Whether governments will rise to this challenge or not is core to COVID-19 mitigation. Oxfam labels the need for international action 'a plan for all' (Oxfam, 2020: 1; UNHRC, 2020: 19), disciplining economies and markets with an underlying rights-based humanitarian model for mitigation. Drawing from calls from key international agencies, such as the UN (UNOCHA, 2020), the WHO and the ILO, any emergency rescue strategy will need: the commitment of trillions of dollars in international development; the cancellation of debt repayments; international aid budgets being increased substantially; universal human rights being enforced at a transnational level; and health and social protection in place for all. This mitigation package could define primary goals for dealing with the scale of the crisis. However, inequality remains, in essence, a default political position and many will suffer because of this. A shift in the mentality of those in power would be a start.

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16

The Health Impact Fund

Learning from COVID-19

Felicitas Holzer and Thomas Pogge

We are living in the shadow of the COVID-19 pandemic – anxious about our families, our friends and ourselves, depressed by worldwide suffering and anxiety, upset by knowing that once more the poor and marginalized are worse affected. Could the rules and practices organizing healthcare around the world have been better suited to this outbreak? Let us consider the Health Impact Fund as a plausible institutional reform of the current regime for developing and marketing new pharmaceuticals.[1]

The pharmaceuticals sector

Medicines are among humanity's greatest achievements. They have helped realize dramatic gains in health and longevity as well as huge cost savings through reduced sick days and hospitalizations. The global market for pharmaceuticals is currently worth US$1,430 billion annually, 1.7 per cent of the gross world product (IFPMA, 2017: 5). Roughly US$800 billion thereof is spent on brand-name products, which are typically under patent (IFPMA, 2017: 51).

Commercial pharmaceutical research and development (R&D) efforts are encouraged and rewarded through the earnings that innovators derive from sales of their branded products. These earnings largely depend on the 20-year product patents they are entitled to obtain in WTO member states. Such patents give them a temporary monopoly, enabling them to sell their new products without competition. Under the protection of their patents, they can raise a product's price far above manufacture and distribution costs while still

maintaining a substantial sales volume. Such mark-ups yield large profits for commercial innovators and enable them to invest in new R&D, currently at a rate of US$189 billion a year (Mikulic, 2020).

While we should evidently want pharmaceutical R&D to be sustainable, it is worth asking whether our current way of funding is optimal. There are three main concerns.

Firstly, innovators motivated by the prospect of large mark-ups tend to neglect the – mostly communicable – diseases specific to poor people, who cannot afford expensive medicines. The 20 World Health Organization-listed neglected tropical diseases together afflict over a billion people (WHO, n.d.) but attract only 0.35 per cent of pharmaceutical industry R&D (IFPMA, 2017: 15 and 21). Another 0.12 per cent of this R&D spending goes to tuberculosis and malaria, which kill 1.7 million people each year.[2]

Secondly, thanks to a large number of affluent or well-insured patients, the profit-maximizing price of a new medicine tends to be quite high. A typical example is the hepatitis-C drug Sovaldi. It was introduced in the US at a price of $84,000 per 12-week course of treatment while the production cost was estimated at $68–136 (Sachs, 2015) – a near-thousand fold (100,000 per cent) mark-up. In the poorer countries, where the upper classes are less affluent and less well-insured, the profit-maximizing price is lower – at least theoretically. In practice, matters are more complex as firms are well aware that a low price in a poorer country can trigger political pricing pressures in the far more lucrative affluent countries as well as efforts at international arbitrage (where medicines are purchased in one country for consumption in another). Moreover, even when patented pharmaceuticals are sold at lower prices (Sovaldi can now be bought in India for about US$500) they are still unaffordable with the also much lower ordinary incomes there. Sad but true: most people around the world cannot afford advanced medicines – at least until their patents expire, which, with Sovaldi, will start happening in 2032. Every year, millions suffer and die from lack of access to medicines that could be mass-produced quite cheaply.

This exclusion of the poor entails another disaster, specific to communicable diseases: those who avoidably remain

sick continue to spread the disease. In doing so, they often facilitate the emergence of more dangerous drug-resistant strains, whose rise is facilitated by patients who – desperate and short of money – take less than the full course of treatment or self-medicate with drugs in diluted dosage, often peddled by street vendors.[3] Drug-resistant disease variants constitute a rising share of the disease burden and pose a grave danger to public health, as extensively drug-resistant tuberculosis (XDR TB) does in India.

Thirdly, rewards for developing and marketing pharmaceutical products are poorly correlated with health gains. Firms earn billions by developing duplicative drugs that add little to our pharmaceutical arsenal – and billions more by cleverly marketing their products to patients who won't benefit. By contrast, there is no profit in developing new antimicrobials, or vaccines against diseases of poverty, nor in providing even life-saving treatments to the world's poor.

The COVID-19 pandemic brings out these grave flaws in how our pharmaceuticals sector is structured. We need better incentives for innovation and marketing to motivate coordinated global efforts to contain and eradicate diseases. Such efforts must include poor populations: we need good new treatments for the diseases of poverty and must ensure that all people everywhere have access to important medicines and can use them to optimal effect.

Adding new incentives through the Health Impact Fund

To address all these problems, we propose a complement to the present regime: the Health Impact Fund. Each year, this Fund would disburse a fixed pool of reward money. Innovators would be invited to register any of their new pharmaceuticals for participation in ten consecutive annual pay-outs, each of which would be divided among registered products according to health gains achieved in the preceding year. In return, the innovator would agree to sell its registered product at or below manufacturing cost and to license it cost-free for generic production after the reward period expires. Quality-adjusted life years (QALYs), as widely employed and

refined in recent decades, could be used as a common metric for comparing and aggregating health gains across diverse diseases, pharmaceuticals, demographic groups, lifestyles and cultures. To reassure funders or innovators, a maximum or minimum reward per QALY could be stipulated.

With emerging epidemics like swine flu and COVID-19, measurement of health impact is complicated by the fact that we lack here a well-established baseline representing the harm the disease would have done in the absence of the new pharmaceutical to be assessed. For malaria, such a baseline can be established on the basis of a stable disease trajectory observable over many years. In the case of a new epidemic, one must rely on a modelling exercise that estimates the baseline trajectory on the basis of obtainable data about the spread of the disease and its impact on infected patients. This surely is a challenging exercise, which cannot yield precise or uncontroversial results about what damage the epidemic would truly have done if the vaccine or medication in question had not appeared. Still, despite the roughness of such a modelled baseline, the Health Impact Fund would give innovators the right incentives.

The Health Impact Fund might start with annual pools of US$6 billion. This is below 1 per cent of the US$800 billion per annum the world currently spends on branded pharmaceuticals. Because a healthy population and workforce is a common good, the Fund could plausibly be financed from public revenues – for instance, by countries representing one-third of gross world product contributing 0.02 per cent of their gross national incomes. Non-contributing affluent countries would lose the benefits: the price ceiling on registered products would not apply in them. This exclusion would give innovators more reason to register (they could still sell their product with monopoly mark-up in some affluent countries) and affluent countries reason to join the funding coalition.

A commercial innovator would develop and register a product only if it expected to make a profit over and above recouping its R&D expenses. There is some controversy over the size of such R&D outlays per marketing approval. The Health Impact Fund would throw light on this question by

revealing at what level registrations settle. If the Fund hosted about 20 products, with two entering and two exiting in a typical year, this would show that the prospect of US$3 billion over ten years is seen as satisfactory – neither windfall nor hardship. Actual results would vary, of course, depending on the product and on how well it is marketed: some products would earn more by having greater therapeutic value or by benefitting more people.

The Health Impact Fund would attract investment to specific R&D projects that are unprofitable under the current regime: ones expected to produce large health gains among mostly poor people. Most such projects would address communicable diseases, which continue to impose devastating disease burdens mainly upon the poor. In consequence, there would be much deeper and broader knowledge about such diseases, a richer arsenal of effective interventions and greater capacities for developing additional, more targeted responses quickly. Pharmaceutical innovators would thus be much better prepared to supply or develop medicines suitable for confronting emerging threats such as Ebola or the current COVID-19 pandemic.

The Health Impact Fund would also transform how pharmaceutical companies tackle diseases. A firm rewarded for merely selling malaria drugs need not be distraught by the fact that malaria still, each year, infects over 200 million people (WHO, 2019: xii) and kills half a million. A firm rewarded for reducing the malaria burden, by contrast, would aim to stop the proliferation of malaria as rapidly and cost-effectively as possible. This aim will shape both its development and its marketing efforts.

For innovators seeking to profit from temporary monopolies, the ideal product typically is a maintenance drug, which extends patients' lives or makes them feel and function better, without disturbing the proliferation of the disease. The innovator then sets the profit-maximizing price and tries to sell the drug to those who can afford it for as long as they shall live.

By contrast, innovators seeking health impact rewards would ideally want to develop a preventative product (vaccine) or cure, suitable for fighting the disease at the population level.

Collaborating with national health systems, international agencies and NGOs, such an innovator would seek to build a strong public-health strategy around its product, involving diagnostics and other factors relevant to treatment outcomes, bolstered by real-time monitoring to recognize and address possible impediments to uptake or therapeutic success. Such an innovator's highest ambition would be to supply not many patients but – after eradicating the target disease – none at all. If it achieved eradication in year seven, it could enjoy the world's gratitude while still collecting three large pay-outs towards its next R&D project.

The existing regime motivates pharmaceutical innovators to develop marketable products and then to achieve high sales at high mark-ups. We could also motivate innovators to develop effective products and then deploy them to help reduce the disease burden as efficiently as possible. The COVID-19 pandemic makes evident that the decision to give pharmaceutical innovators only the former incentive is profoundly unwise. This bad decision helps explain why, with all our scientific sophistication, all the trillions spent on pharmaceuticals, we have managed to eradicate only one single disease: smallpox, over 40 years ago.

The Health Impact Fund is based on a compelling thought: if the purpose of the pharmaceuticals sector is to help reduce the burden of disease, then let us reward innovators for exactly that and not for something quite different.

Piloting the Health Impact Fund approach

The COVID-19 pandemic offers a natural pilot opportunity. Governments could set aside a multi-billion amount to reward the creation of relevant new vaccines and therapies. This sum would be distributed among participating products according to their assessed impact on the pandemic over the subsequent two years, say, on condition that said products be sold without mark-up and licensed cost-free for generic manufacture and sale.

We have also advocated a much smaller US$100-million pilot that, like the Health Impact Fund itself, would not be

disease-specific.[4]Though too small to incentivize the entire development of even one new pharmaceutical, this pilot would substantiate our approach by pioneering measurement and reward of health gains. Innovators – including non-commercial ones like Drugs for Neglected Diseases Initiative or TB Alliance – would be asked to propose initiatives through which they could achieve additional health gains in poor countries or regions with an existing or new pharmaceutical, priced without mark-up. They might propose an affordable heat-stable or paediatric version of one of their medicines, perhaps, or a fixed-dose combination. The most promising four proposals would be chosen and given three years for implementation. Health gains achieved would then be assessed, and the reward pool divided accordingly. Any such pilot would bring real health gains to poor populations, who are especially under-served by existing healthcare systems, and would anticipate and prepare a permanent Health Impact Fund by showing that health gains can be reliably assessed and that pharmaceutical innovators are able and willing to deliver them quite cost-effectively.

With a pilot available for detailed study, potential funders could then make a well-grounded decision about the Health Impact Fund itself. Even a few major states and foundations would suffice to launch it; and, if successful, it could of course be expanded over time to include more funders and an increasing share of new medications. The Health Impact Fund would bring the world together for the creation of global public goods and would give real meaning to our noble commitment to leave no one behind.

The transformative power of the Health Impact Fund

Monopoly rewards turn innovators into jealous spies, scouring the earth to find possible patent infringers, who may be using their innovation without licence. The Health Impact Fund does the opposite: it encourages innovators actively to promote widespread and effective deployment of their innovation so as to enlarge its impact. Wider deployment can be promoted by adding one's innovation to a patent pool,

for instance, or by subsidizing its use among the poorest even below variable cost. More effective deployment can be promoted by various means that help users get the most out of their product.

In this regard, the Health Impact Fund is superior to compulsory licencing, which relies on generic manufacturers to drive down prices. Compulsory licencing remains caught in the tension between price and promotion: the cheaper the product, the less incentive there is to bring it, in top condition, to remote and impoverished places, with clear local-language instructions and adherence support for patients and medical staff. The Health Impact Fund avoids this tension by giving innovators an interest in both – affordability and widespread optimal use of their product. It does so by enabling innovators to earn more than the sales price from selling a product, by assigning more value to the health and survival of poor people than what they can afford to pay. Doing so is a moral imperative – and it is also collectively advantageous, especially with communicable diseases, which would be central to the Health Impact Fund. By containing and ideally eradicating such a disease among the poor, we protect everyone from the threat it poses, especially through the danger of new drug-resistant strains.

The Health Impact Fund is superior to compulsory licencing also in another respect – by not jeopardizing innovators' recovery of their massive R&D outlays. It is not smart to put commercial innovators on notice that, if any of their innovations is really important, states may appropriate it with token compensation. Promoting access in a way that undermines innovation is no better than what we do now: promote innovation in a way that undermines access. Neither regime delivers what we want, abundant innovation *and* universal access. If we delink the price of pharmaceuticals from the fixed cost of R&D – as we should! – then we should also delink innovator earnings from the sales price. Innovation will flourish only if innovators can recover their R&D outlays and make a decent profit (Hollis and Busby, 2020).

Reducing disease with pharmaceuticals is complicated and involves many stages – from research on specific diseases and computer exploration of molecules, via clinical trials, to

motivating diverse medical staff and patients in many countries and cultures to use a medicine to optimal effect. All these stages and components of disease reduction are interdependent, posing a highly complex global logistics problem. Optimal progress requires not merely the solution of many disparate tasks but also harmony among these solutions. Early decisions about conceiving and pursuing R&D projects should already anticipate the challenges of successful deployment: how to identify the patients who can benefit the most and, for infectious diseases, those whose timely treatment would do most to slow contagion? How to make the product reach and help patients in remote and impoverished locations? How to build a strong collaborative public-health strategy around the product? How to fashion the best plan towards eradicating the disease worldwide?

These great potential synergies suggest that the Health Impact Fund would give rise to actors who can optimally run an entire worldwide operation, R&D plus marketing, though perhaps outsourcing specific subtasks, such as manufacturing. Some pharmaceutical firms are well positioned to reconfigure themselves for this new role. Other existing actors may also be well positioned, for instance certain NGOs or product-development partnerships. Open to all, the Health Impact Fund would, over time, bring forth innovators that really excel at achieving cost-effective health gains through a well-coordinated global strategy of disease containment.

Notes

1. For elaboration and critical discussion of the Health Impact Fund proposal, see *Incentives for Global Health*, www.healthimpactfund.org/.
2. Annual R&D spending is just over US$900 million for tuberculosis (www.treatmentactiongroup.org/resources/tbrd-report/tbrd-report-2019) and US$252 million for malaria (www.who.int/news-room/feature-stories/detail/world-malaria-report-2019), but only about one-fifth thereof is expended by the pharmaceutical industry (IFPMA, 2017: 21). Each year, tuberculosis kills 1.2 million people (https://ourworldindata.org/grapher/the-number-of-deaths-due-to-tuberculosis-by-who-and-ihme-data), malaria 500,000 (https://ourworldindata.org/malaria).

3. Important examples are drug-resistant tuberculosis (https://tbfacts.org/drug-resistant-tb) and malaria (www.ncbi.nlm.nih.gov/pmc/articles/PMC3058555).
4. See *Incentives for Global Health*, www.healthimpactfund.org/en/publications.

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After the Immediate Coronavirus Crisis

Three Scenarios for Global Development

David Hulme and Rory Horner

COVID-19 is transforming national policies on an unimaginable scale: 'austerity' has vanished and (hyper)Keynesian spending is back; neoliberal regimes are making unimaginable welfare interventions; income support is favoured in some countries; and hyper-globalization policies are being reined in. Seemingly everything has changed. The initial pressures for these transformations focused on proximate problems: rapid responses to risks of premature death from a new disease and temporary support for employment, incomes, household food security and the economy. But, at a structural level, the coronavirus pandemic could help transform the institutions and norms that have underpinned global development in the early 21st century, for better or worse.

This may be a critical juncture (Green, 2020), where actions taken now could have legacies for decades to come. The pandemic could be a time for what Naomi Klein (2007) has called 'shock doctrine', where it is exploited for questionable purposes to create an unappealing future, or it could set the course for a better future. In this chapter, we explore three scenarios of 'what' the future might be like, rather than predictions, as an aid for those thinking about how to shape global futures.

Scenario 1. Ugly: global meltdown

The proximate impacts of the coronavirus pandemic have been extremely negative: public fear, increased mortality, loss

of jobs and reduced or cessation (for example, especially for informal-sector households) of income, collapsed businesses, strained public health services, a massive rise in public debt, loss of personal mobility and threats of social and political breakdown. These negative impacts create processes that could greatly increase the likelihood of structural changes that undermine the prospects for human development. At the extreme, they include apocalypse.

Potentially, such a scenario could develop from either the direct health threat of the coronavirus or the indirect impacts of the disease on economic, social and political life. COVID-19 has increased mortality rates for some groups in some parts of the world (Our World in Data, 2020). Potential struggles in developing and making available a vaccine, difficulties of eradicating and potential mutations of the virus can increase such impacts. Yet, the new disease's influence on overall mortality rates seems unlikely to approach those of the two world wars or the 'Spanish flu' (at least 50 million deaths). COVID-19 is also different from HIV-AIDS, which led to South Africa's average life expectancy falling by almost ten years from the mid-1990s to mid-2000s (Low and MacDonell, 2019). This observation does not create grounds for complacency (hundreds of thousands of people dying from a new disease and potentially many more is horrendous), but the likelihood of the direct impact of COVID-19 producing a total societal collapse seems low.

However, when the indirect effects of COVID-19 are explored then catastrophic scenarios can be more readily generated. There are several potential pathways (financial collapse, social breakdown, political paralysis, international warfare) that could theoretically create an apocalypse but, in most scenarios multiple, interacting pathways would be envisioned.

Financial meltdown is perhaps the most likely of the ugly scenario initiators. The contagion effects of a bank run would knock on throughout the sector and one would have to be very naïve or very well-informed to be absolutely sure that a non-sustainable asset or product, like sub-prime mortgages and derivatives, has not already been built into our global financial system.

Putting financial contagion aside, previously unthinkable financial packages of support have been announced in recent months, particularly in higher-income countries, but also on a smaller scale in low and middle-income countries. This could lead to a huge strain on public finances for years or decades to come, which could precipitate a return to austerity, sowing the seeds of further societal decay through poor health coverage, unequal education and failure to combat climate change.

That oft-found crisis tendency of 'socialism for the rich and capitalism for the poor' has been manifest for some very wealthy individuals and companies benefitting from government support, while those most in need struggle for assistance. Moreover, the lack of conditions for recipient businesses, such as the absence of climate change mitigation in the Coronavirus Aid, Relief, and Economic Security (CARES) Act in the US, are a missed opportunity. At the same time, regressive conditionality such as the World Bank's offer for fast-track assistance, 'conditional on structural adjustment policies mandating deregulation (for example, by promoting private markets in health) or trade liberalisation' (as commented on by Kentikelenis et al, 2020), has dark echoes of the 1980s and 1990s.

The social breakdown scenario has many possible origins, but prime among these is that ill-effects from COVID-19 management policies (especially policies that create food insecurity or stop and/or reduce informal-sector workers' daily earnings) lead to mass unemployment, riots, raids on food stocks, police/military over-reaction and an expanding cycle of violence. Political paralysis or breakdown could evolve in democratic situations through the introduction of 'suspended democracy', as with Hungary, when elections are suspended or altered and/or leaders seek to retain power through policies that undermine state capacity. With a muted civil society, authoritarianism could deepen.

Internationally, existing cooperation could break down and, at its worst, involve a descent into warfare. Rather than the problems exposed by the pandemic leading to strengthened international cooperation, nationalistic governments could blame the 'global' and retreat inwards. President Donald Trump added to his earlier withdrawal from the Paris Climate

Agreement, a disregard for the World Trade Organization (WTO) with withdrawal of US funding from the WHO; relatively unthinkable a few weeks previous, it could spread to other organizations (for example, even further disregard for the World WTO). A more severe breakdown of international cooperation could even take the world into some form of 'third' World War, leading to an apocalypse when one or more players decide to use nuclear or biological weapons. Such an international conflict could develop by conventional military confrontation but, perhaps more likely, would be a digital attack – undermining a country's banking system, its health system, electricity supply, access to potable water – and a response that escalates the conflict digitally and then into actual military activity. Would any country be so 'foolish'? With North Korea and Russia around, and the US under Trump, the answer must be 'yes'.

The most likely multi-factor, interacting scenario would see a set of these factors operating simultaneously and cumulatively. The world would see increased mortalities, more rapid economic/employment/food security collapse, social breakdown, confrontational international relations and possibly even apocalypse.

Scenario 2. Bad: unsustainable and unequal world

The 'bad scenario' envisages a future that returns humanity to something like its pre-coronavirus status, something which at this moment seems a 'good scenario'. While this would mean historically 'high' levels of human development and relatively 'low' levels of absolute poverty, a return to this situation is 'bad' as it means that climate crisis, and stark and rising within-country inequality, continue (Deaton, 2013). Human progress is unlikely when faced with these twin threats of environmental unsustainability and the human and political consequences of inequality (unfair societies and elite-captured policy processes). The 'critical juncture', provided by COVID-19, to transition to a low carbon and more egalitarian world will have been wasted. If the end of the Cold War (1989/90), being within a hair's breadth

of global financial meltdown (2008) and a global health pandemic (2020), cannot foster the social transformation (or the plutocrats actually working towards a system change) to sustainability and equity, then it looks like only a genuine World War Three has the potential to move humanity beyond 'business as usual'.

This scenario assumes a recovery (in terms of health, economic growth, stock market valuations and the performance of public institutions) from the current coronavirus situation. These are the standard assumptions that have underpinned private investment for the last two centuries: that in the medium to long term, economic growth will continue as capitalism ensures technological and organizational advances that create products and services that are commercially viable. Within countries, the national policy interventions in the immediate crisis – such as increases in social protection – could be short-lived.

Richard Haass (2020), President of the United States' Council on Foreign Relations, has argued that: 'The pandemic will accelerate history rather than reshape it'. The trends which he sees as already in motion and likely to accelerate are declining US leadership as its hegemonic power recedes, faltering global cooperation and discord among the great powers. For Dani Rodrik (2020), the pandemic brings out 'confirmation bias', solidifying the views we already had. He has argued that:

> The crisis seems to have thrown the dominant characteristics of each country's politics into sharper relief. Countries have in effect become exaggerated versions of themselves. This suggests that the crisis may turn out to be less of a watershed in global politics and economics than many have argued. Rather than putting the world on a significantly different trajectory, it is likely to intensify and entrench already-existing trends.
>
> (Rodrik, 2020)

In this scenario, tackling climate change continues to drift as a priority for the international community (see, for example, Anderson et al, 2020) and the climate crisis accelerates.

Scenario 3. Good: global sustainable development

This scenario envisages the negative proximate impacts of COVID-19 as fostering (or having the potential to foster) positive structural transformations in economic, social and political institutions and norms. There are historical precedents for such optimism. The Black Death of the 14th century (a much more severe pandemic that reduced Europe's population by 30 to 60 per cent) is credited (Acemoglu and Robinson, 2012) with causing a labour shortage in the UK that led to the strengthening of peasant/worker voice and interests, and the initiation of political processes fostering the evolution of more democratic political institutions and norms over later centuries.

The world wars of the 20th century fostered forms of capitalism that shared the growing wealth of industrialized countries more equitably across their societies than in the pre-1919 world (Piketty, 2014: chapter 3). This led to raised incomes and improved levels of human development across Europe and North America as greater public investment in education, health, social housing and welfare improved the lives of tens of millions of people. This idea of a negative 'event' creating longer-term positive effects has become a rallying call for progressive policy change or sociopolitical structural transformation. The case of COVID-19 demonstrates that we live in an era of global development challenges (Oldekop et al, 2020), and must address collective action problems across North and South, such as global public health, global climate change and inequality.

A strengthening of global governance is possible. The IMF, World Bank and United Nations were created at the end of World War Two, although arguably assisted by the context of a unipolar, US-led world. Global governance initiatives this century have struggled to deal with a more multi-polar world, but this crisis could act as a catalyst to re-energize international cooperation (not just in health) without US leadership.

Strong calls have already been made for international cooperation to assist lower-income countries to deal with the current COVID-19 economic crisis. Oxfam (2020) have called for a moratorium by G20 and other creditors on debt interest

payments for poor countries. The G20 have temporarily agreed to suspend repayments on loans from 76 of the world's low and middle-income countries. Considerable private sector debt still exists (Bolton et al, 2020), however, while public debt looms large in the future. Sustained debt relief would permit these financially constrained countries to invest in improved health services, social protection, climate change adaptation and support for small businesses. If a moratorium could run alongside the IMF issuing Special Drawing Rights (without 1980s-style regressive conditionalities), then access to development finance for the poorest countries could be transformed. Such cooperation could not just assist lower-income countries to deal with the immediate crisis, but also remove some constraints on, and act as a positive stimulus to, their future development possibilities.

Strengthened international action to address the pandemic could lead to stronger cooperation not just in health (Kickbusch and Piselli, 2020), but also in tackling climate change and inequality (for example, tax coordination). This would involve much greater commitment to the Sustainable Development Goals (SDGs). The crises of climate change and COVID-19 need to be harnessed together (Oldekop et al, 2020) to raise the prospects for multilateral action that recognizes that national goals (minimizing the effects of new diseases or negative climate change impacts and operating in a stable economic environment) can only be achieved by effective multilateral action (to develop and distribute vaccines, reduce rates of disease transmission, reduce carbon emissions, ensure financial stability, and so on).

Domestically, commitment to greater inclusion could emerge. The pandemic has demonstrated that our public health depends on the least healthy among us, strengthening the case for universal health coverage. As Amartya Sen (2020) has noted, post World War Two, the positive effects of attention to the disadvantaged led to the National Health Service in the UK. Without international support for anti-COVID-19 efforts, then the disease and its effects (beyond health) may linger on and have knock-on effects on trade, mobility and security.

Mariana Mazzucato and Antonio Andreoni (2020) have argued for the need to bail out firms responsibly, rather than the austerity that followed the global financial crisis. This means that firms that are bailed out would retain workers, reduce dividends, prevent share buybacks, and encourage investment in sustainable growth with a reduced carbon footprint (see also Hepburn et al, 2020). Positive signs have emerged in Austria, where airline-industry bailouts are linked to meeting climate targets, and in Denmark, which (like France and Poland) has stated that it will not bail out firms which are registered in tax havens.

But turning crisis into opportunity for global sustainable development through multilateralism is ambitious and complex in a multi-polar world. Back in 2008–2009, it looked as though the G20 (with members representing around 80 per cent of the world population and economic output) might be the new institution that could mobilize global action, but that hope faded quickly and the financial institutions that had created the global financial crisis were allowed to continue. The G20 has virtually met on the COVID-19 crisis but has not taken leadership of an international or global response.

Conclusion

This chapter has briefly explored the good, the bad and the ugly scenarios that could emerge from the coronavirus pandemic. While the negative proximate effects of the disease might encourage many to believe that ugly or bad longer-term outcomes might be expected (such as weakened international financial systems, high levels of public debt, damaged multilateralism), the counter-argument that it creates an opportunity for progressive transformation has some historical support.

Our gut feeling, fuelled by political and economic precedent, is that the world will 'recover' from COVID-19 but back to the bad scenario. This recovery could take some time, as immediate prospects for a quicker return to the world of 2019 through a 'V-shaped' recovery have diminished. That is better than the world remaining in crisis (and it may

look attractive at the present moment), but it would leave humanity on an unsustainable and socially unjust trajectory.

For social scientists, the challenge is to think through 'how' the prospects of 'not wasting the crisis' can be raised. One of the ways is clearly by helping the wider population realize that global problems, now and in the future, will require effective multilateral action if we wish to reduce their proximate effects. But, to improve the likelihood of a shift to the good scenario, progressive analysts will need to create a popular narrative that mobilizes national and global constituencies to demand institutions and norms that will lead to transformation. This may entail new forms of capitalism and/or new and more coherent forms of socialism, but it will need an easy to follow and easy to repeat narrative. Anti-neoliberalism and anti-populism tracts may be applauded by the progressive *cognoscenti*, but they will not energize popular support for the social transformation that an unsustainable and unjust world needs.

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Conclusion

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The COVID-19 pandemic is rapidly evolving. Its impacts have ranged from taking lives to geopolitics with governments engaging in a bitter war of words (and actions) around mitigation and other issues. This disunity is causing concern across the world, not least in the UN system, although it is better that this is being played out in public spats rather than in violent conflict (Steiner, 2020). As Florini and Sharma (2020) argue, the 21st century is set to be one of 'massive disruptions' posing serious threats to society. These range from potential political turmoil to financial fragilities, coupled with climate disruption. COVID-19 has demonstrated the imperative of effective, financed international cooperation to solve or remediate these global challenges. However, the prospects for enhanced international cooperation seem to have diminished in recent years as a result of dialectics of globalization.

The spatial dynamics of liberalization,[1] offshoring and corporate greed have generated reactionary backlashes in some developed economies, such as the US and UK. The rise of right-wing populism globally has been associated with the politics of anti-globalization and protectionism (Gereffi, 2018; Kiely, 2020), and Baldwin (2019) predicts that these tendencies will intensify as middle-class professions are gutted by the technologies of the Fourth Industrial Revolution (4IR), generating further pressure towards 'shelterism' and 'me first' economic policies. These developments could then be further securitized in relation to climate change impacts – an already extant trend (Andersson, 2019; Buxton and Hayes, 2016). To avoid this dystopian, climate-altered and unequal future, we need to both rethink and reinvigorate institutions of global governance to effectively address the challenge of sustainable development, including pandemic

prevention and preparedness. This systemic redesign must be both values-based and outcome focused. Simply returning to the 'old normal' scenario will not be enough to enhance human welfare into the future. Because 'we know that pandemics, economic crises, and environmental instability will hit hard, but we cannot predict exactly where or when, we need to give resilience' of systems more importance (Florini and Sharma, 2020: 50–51). We also need to reorient them so that they serve to achieve desirable outcomes – such as sustainability, equality and human development. How might this developmental 'new normal' be achieved?

After the cataclysm of World War Two, the United Nations was founded. Since that time, it has prevented a recurrence of world wars, albeit aided by the threat of mutually assured destruction by nuclear powers. It has also made numerous other contributions to human wellbeing through its peace-keeping, humanitarian and development interventions. It is sometimes criticized for being too heavily influenced by the 'great' powers and on occasion specialized agencies have foisted inappropriate development policies on the Global South which have exacerbated conflict and inequality in order to revive the economies of the countries in which they operate. The current multi-vector crisis facing humanity – of inequality, poverty, environmental degradation and disease – is arguably an outcome of such policies (Wallace et al, 2020). Mentalities and systems need to change and consequently there is an urgent need to reform global governance to reinvigorate global development policy and practice.

Note

1. Indeed, some argue that the under-regulation of markets generally, including the 'wet' wildlife market in Wuhan where the transfer of the virus to humans is thought to have occurred, is a major reason for the pandemic outbreak (Wallace et al, 2020).

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