Prioritising the global response to curb the spread of COVID-19 in the fragile settings of the Global South

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Background

Globalisation impacts the epidemiology of communicable diseases, threatening human health and survival globally. The ability of coronaviruses to spread, quickly and quietly, was exhibited with Severe Acute Respiratory Syndrome in 2002–2003 and, more recently, with COVID-19. Not sparing any continent, the World Health Organization declared a COVID-19 pandemic on 11 March 2020.\(^1\)

Despite high-income countries being inordinately impacted, due to the increasing number of COVID-19 cases, SARS-CoV-2 continues to represent a looming threat to the Global South, leading the World Health Organization to previously state that ‘Our biggest concern continues to be the potential for COVID-19 to spread in countries with weaker health systems’\(^2\) and that Africa could become the next epicentre. However, while academics, public health experts and macroeconomists discuss among themselves, using collaborative strategies to reduce morbidity, mortality and economic devastation, these discussions have not involved low- and middle-income countries.\(^3\) COVID-19 may cause unprecedented humanitarian health needs in countries already subjected to unaffordable, fragmented and fragile health systems; as COVID-19 unfolds a worldwide economic crisis, with the poor and other vulnerable groups affected disproportionately, building health system resilience, through an urgent and coordinated global response, that allocates resources and funds efficiently, must be prioritised in this dynamic and shifting pandemic.

Global health threats

Weak health systems and governance

Health system performance depends on a country’s economic performance. Low-income countries spend $41 per person on healthcare compared to $2937 per person in high-income countries.\(^4\) According to the World Health Organization, those aged over 60 years, and those with underlying medical conditions, are at highest risk of COVID-19;\(^5\) 69% of those aged 60 and over reside in low- and middle-income countries.\(^6\) With limited specialist expertise for older people and finite domestic and external funds, health systems in low- and middle-income countries focus less on this population.

There is a deficit of 2.4 million healthcare workers across Africa;\(^7\) Africa has 2.3 healthcare workers per 1000 while the Americas have 24.8.\(^7\) COVID-19 has overwhelmed health systems worldwide; even the wealthiest countries lack sufficient personal protective equipment, ventilators and hospital beds to meet pandemic demands. An inadequate response in low- and middle-income countries will lead to more acute shortages and adverse effects, including COVID-19 transmission to healthcare workers, further reducing numbers on the front line. Furthermore, the USA is readily accepting international medical graduates.\(^8\) Despite acute demand, this is likely to cause an exodus from low-income countries, worsening the already-existing healthcare worker deficit.

Indecision and ambiguity in implementing containment measures is an important issue. In Bangladesh, for example, the government initially declared ‘holiday’ to keep its citizens indoors. However, this was taken in its literal value and families rushed to tourist sites and to their country homes. Similarly, for political reasons, the government took a long time to effectively restrict mosques to offer congregational prayers.\(^9\) In the mitigation front, the slow expansion of testing facilities leads to an unclear picture on the actual state of the disease. Added to this is the shortage, and often poor quality, of personal protective equipment.

Disease burden

Tuberculosis, human immunodeficiency virus, malaria and other communicable diseases...
disproportionately affect sub-Saharan countries. Lassa fever is endemic in Nigeria and Guinea. The health systems of Sierra Leone and Liberia were recently challenged by Ebola, causing over 11,000 deaths. Additionally, non-communicable diseases account for 45% of Eritrea’s mortality.

Burdened by communicable diseases and malnutrition, sub-Saharan and South Asian countries are particularly vulnerable to outbreaks. The world’s poorest populations are at a heightened risk of co-morbidities, increasing their risk of severe COVID-19 illness, poverty-related out-of-pocket payments and catastrophic health expenditures. Furthermore, diverting resources into the emergency response will perpetuate additional adverse effects, including increasing morbidity and mortality from other diseases.

**Dense populations, man-made and natural disasters**

The health security of millions around the world is at risk due to state fragility and the inadequate global response to conflicts and social unrest. While COVID-19 public health measures are basic, implementation in low- and middle-income countries remains challenging. Many low-income countries lack access to water supply, sanitation, hygiene and affordable sanitisers. Social distancing and isolation are proving to be impossible in densely populated areas, including slums, where 66.2% of low-income country urban populations reside.

Refugees also live in densely populated spaces with limited access to sanitation and healthcare, demonstrating the impact of migration on health. Three of five countries hosting the largest numbers of refugees globally are low-income countries; Pakistan, Uganda and Sudan host 1.4, 1.2 and 1.1 million refugees, respectively. Sudan is also challenged by natural and man made disasters. Due to its proximity and reliance on the Nile River, flooding and droughts occur frequently. In fact, in September 2020, Sudanese authorities designated the country a natural disaster zone and declared a state of emergency for three months over its worst-in-a-century floods that killed 99 individuals, destroyed 100,000 homes and affected over half a million people. According to experts, climate change, which impacts the Global South more severely, is largely responsible for the Blue Nile rising to a record 17.58 metres this year. While the successful 2019 Sudanese Revolution has paved the way for democracy, the country’s long-standing internal conflict and outbreaks of violence have subjected its population to traumatic diseases. Moreover, as international leaders focus on domestic COVID-19 issues, the Security Council postponed its political mission to supporting Sudan’s transition to civilian rule, delaying conflict resolution mechanisms. Hosting 3.7 million refugees, Turkey is the largest refugee host globally; while part of the Global North, ensuring health system resilience in Turkey is equally important. Lebanon and Jordan host the largest numbers of refugees per capita. Hosting 1.2 million Rohingya refugees, Bangladesh’s Kutupalong camp accommodates over 625,000 refugees, rendering it the world’s largest refugee settlement.

Conflicts impact water and food security; 60% of those experiencing chronic hunger live in conflict-affected low- and middle-income countries. The West Bank’s aquifers are controlled by Israel, with 83% of water used by Israel; scarce water supply and the ongoing blockade in the occupied Palestinian territory will facilitate COVID-19 spread among Palestinian populations, aggravating economic and agricultural difficulties while worsening the health and wellbeing of residents. Syria’s Al-Hol camp, sheltering over 70,000 individuals, is of notable concern due to scarcity of water, food and medical services. Since 2015, over 24 million people in Yemen require humanitarian assistance. Additionally, to prevent COVID-19 spread, Yemen’s government has banned international flights, reducing relief efforts on the ground.

Over the last decade, Haiti has been devastated by torrential rains, hurricanes and earthquakes. In 2010, the earthquake killed and injured 222,570 and 300,572 individuals respectively. Approximately 2.3 million people were displaced, 302,000 representing children. The response was further complicated by a cholera outbreak, killing 5899 individuals, and Hurricane Tomas which caused significant flooding and deaths.

**Transport access and vulnerability of women**

Availability and affordability of transport systems represent barriers to healthcare access. Untimely access is common, especially in rural populations; in Malawi, the median travel time from home to a medical centre and a central hospital takes 1 h and 2.5 h, respectively; 5% of COVID-19 patients require critical care, including assisted ventilation, demonstrating the importance of sustainable transport access in reducing mortality.

Real-time evidence demonstrates that men are more at risk of severe COVID-19 illness and death; however, women in low- and middle-income countries may be more vulnerable to COVID-19 due to gender norms and roles, highlighting gender and health
inequalities. Women represent 70% of the health and social sectors.20 During the 2014–2016 Ebola outbreak in West Africa, women were more prone to infection due to their role as front-line healthcare workers and caregivers; with limited transportation, women will, predominantly, become the caregivers of COVID-19 patients, hindering women’s careers and ability to earn. As observed in emergency situations, including Ebola, diversion of resources may also increase maternal mortality.21 Furthermore, increased domestic violence, against women and children, during lockdowns is too well-known.

Harnessing the opportunity

While fragile settings may exacerbate COVID-19 spread and complicate response, there is an opportunity to harness strengths developed by low- and middle-income countries. To date, Africa is the continent least impacted by COVID-19. African governments promptly shut down borders, denying visas and banning entry of passengers arriving from COVID-19-affected countries in mid-March. Returning residents were tested and quarantined.

By widening testing scope, some countries adopted more aggressive and proactive approaches. To detect levels of community transmission, India is testing individuals not traced to coronavirus patients and without symptoms, as opposed to its initial protocol consisting of individuals travelling back from COVID-19-affected countries and immediate contacts.22 Kenya’s Ministry of Health tests all symptomatic individuals and conducts random public screenings.

Misinformation threatens COVID-19 response; countries with large numbers of telecommunication lines have addressed misinformation. Nigeria is prohibiting panic-generating advertisements and those implying that certain products have curative and preventative effects.23 To supplement these efforts, Facebook allowed the World Health Organization and Nigerian Centers for Disease Control and Prevention to deliver coronavirus education on its platform.23

Countries that have faced outbreaks are familiar with public health emergencies and have learned valuable lessons. Due to cultural beliefs, Ebola patients were considered ‘deserving’ of the disease, encouraging stigmatisation, fear, blame, guilt and shame. This was extended to Ebola patient contacts, delaying medical consultation and enabling spread. To reduce fear and transmission, Ebola Survivor Corps was founded.24 Ebola Survivor Corps employed Ebola survivors as health advocates; employees delivered health education to communities and improved access to Sierra Leone’s healthcare, rendering them a trusted health information source.24

Conclusion

An increasingly interconnected world facilitates spread of infectious diseases. As challenging as the COVID-19 situation is in the West, if allowed to spread uncontrollably in fragile settings, a more serious scenario is expected. To end the COVID-19 threat globally, thereby preventing it from continuously re-emerging in countries that are currently facing calamitous consequences, developing a global response through coordinated, sustainable and productive strategies, while harnessing the Global South’s efforts, is mutually beneficial in defeating this virus that respects no borders.

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