



Chronic Poverty Report 2023 Pandemic Poverty

Lives versus livelihoods:
the trade-off between
public health restrictions
and resilience

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Chronic Poverty Advisory Network

CPAN is a network of researchers, policy makers and practitioners across 15 developing countries (Afghanistan, Bangladesh, Cambodia, Ethiopia, India, Kenya, Malawi, Nepal, Niger, Nigeria, Philippines, Rwanda, Tanzania, Uganda, Zambia, Zimbabwe) focused on tackling chronic poverty and getting to zero extreme poverty and deprivation, and by sustaining escapes from poverty and preventing impoverishment. It is looking to expand this network to the 30 countries with the largest numbers of people in poverty. It has a 'hub', which is currently hosted by the Institute of Development Studies in the United Kingdom.

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Of course, responsibility for the contents of the report rests with the authors, and the report does not represent the views of IDS, the Covid Collective, or of FCDO.

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Key messages



In managing a pandemic, the objective of saving lives needs to be balanced against maintaining resilient livelihoods and boosting resilience – wide variation in decision-making structures and processes shapes this balance.



Mitigating measures need significant strengthening in future pandemics and crises more broadly, especially in LICs – decision makers need a menu of mitigating measures that they can adapt to different contexts in future pandemics and crises.



Public expenditure on the pandemic varied greatly – adequate additional aid to fill financing gaps, especially in LICs, was not forthcoming.



Investment in health systems prior to a pandemic will open options for managing a pandemic, as will good macroeconomic management.



Excess mortality was not clearly related to the stringency of restrictions, but in LICs was associated with the strength of mitigating measures – this finding questions any uniform or imposed approach to managing pandemics.

2.1 Overview

The majority of countries across the world responded to the Covid-19 pandemic with a public health rationale, which generally involved restricting people’s movement and social interactions to minimise transmission of the virus and loss of life; and, in some cases, with a containment rationale, testing, identifying and isolating cases. Some countries followed these approaches more strictly than others, as measured by the Oxford Coronavirus Government Response Tracker (OxCGRT) project’s Stringency Index, which captured nine metrics: ‘school closures; workplace closures; cancellation of public events; restrictions on public gatherings; closures of public transport; stay-at-home requirements; public information campaigns; restrictions on internal movements; and international travel controls’ (Mathieu *et al.* 2020).

Fewer countries in the global South compared to the global North responded with serious measures to counter or moderate (mitigate) the very considerable (and predictable) impact of these common restrictions on livelihoods and

freedoms, which could have preserved livelihoods and whatever resilience had been achieved, alongside minimising loss of life and prolonged illnesses. We constructed a Mitigation Index, which included indicators of measures to mitigate the effects of the restrictions and have a bearing on the wellbeing of people in the bottom half of the economic distribution in low- and lower middle-income countries, and for which data is widely available:

- The duration of full and partial school closures in the weeks between February 2020 and 30 April 2022) – the emphasis here is the opposite of the Stringency Index measure: the fewer closures, the better.
- The share of children reached through school feeding programmes in 2021.
- Current health expenditures as a share of GDP between 2019 and 2020.
- Covid-19 vaccinations per 100 people (max. value between 2020 and January 2023).
- Provision of cash-based transfers in 2020 and 2022.
- Wage subsidies in 2020 and 2022.
- The breadth of household debt relief in 2020 and 2022.

Box 2.A: Equity in pandemic preparedness



The Institute of Development Studies’ report *Pandemic Preparedness for the Real World* (IDS 2023) identifies five priority action areas outlined below.

Priority action areas	Equity considerations acknowledged
‘Professionals: Identifying, supporting and rewarding key people in critical infrastructures introduces much-needed reliability into uncertain and complex contexts.’	<ul style="list-style-type: none"> • Draws attention to empowering people • Acknowledges importance of health worker interactions with local government officials, traditional leaders, religious groups and others

Continued:

Priority action areas	Equity considerations acknowledged
<p>‘Knowledge: Creating opportunities and building mechanisms to account for diverse knowledge, expertise and evidence facilitates preparedness which is better adapted and more responsive to local contexts and acceptable to communities.’</p>	<ul style="list-style-type: none"> • Acknowledges class, race, age, occupation and other social dimensions in shaping responses and transmissibility of Covid-19 • Supports amplifying voices of local people, especially those marginalised and in poverty, including through participatory research
<p>‘Resilience: Redressing the inequitable underlying conditions that leave people and communities vulnerable to crises in the first place is the best route to ensuring they can withstand shocks.’</p>	<ul style="list-style-type: none"> • Emphasises the need for long-term structural change to mitigate vulnerability • Supports investments in health and social systems more broadly • Supports collective action
<p>‘Institutions: Addressing the crisis of confidence in state institutions is part and parcel of pandemic preparedness.’</p>	<ul style="list-style-type: none"> • Decentralises decision-making and resources • Addresses human rights, power inequities, exclusionary politics
<p>‘Ethics: Policymaking and decision taking for pandemics necessarily embrace a wider set of issues than accounted for by conventional bioethics and its focus on individual rights.’</p>	<ul style="list-style-type: none"> • Decolonises efforts in global health • Account for context-specific societal issues, including power inequities and resource allocation at different levels

Source: Summarised from *Pandemic Preparedness for the Real World: Why We Must Invest in Equitable, Ethical and Effective Approaches to Help Prepare for the Next Pandemic*. 2023. IDS.

Vaccination was clearly a potentially very important mitigating measure. Global pandemic response leaders in WHO and elsewhere promoted vaccine equity, and the rapid development of vaccines was a triumph for the global scientific and technological communities. Widespread vaccination allowed

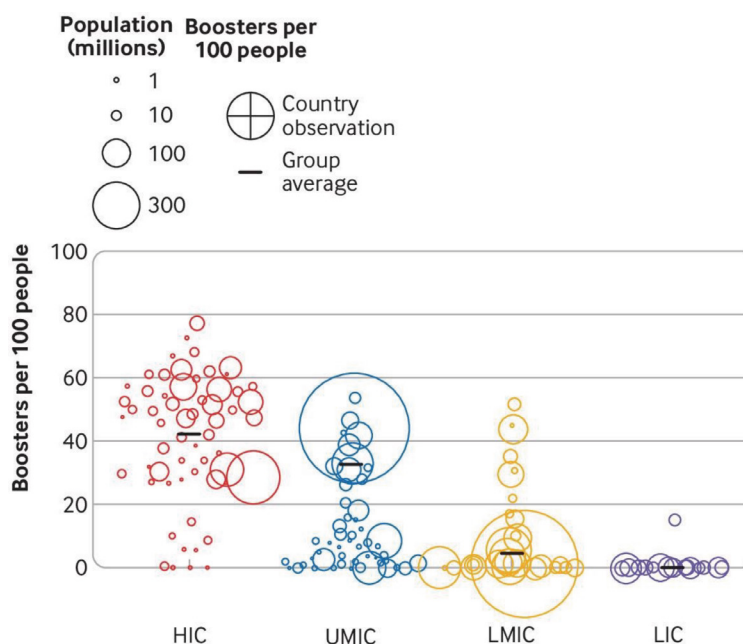
economies and education sectors to be reopened, and provided protection to individuals, averting many potential deaths in the process. However, the wisdom of an exclusive or dominant emphasis on vaccination against Covid-19 compared with other, regular vaccination programmes has been questioned,

given the age structure of low- and lower middle income countries. This is surely a case where a cost benefit analysis could usefully have been carried out.

As Figure 2.1.1 and Box 2.B illustrate, there was an unacceptably high level of inequity among and within countries in the

distribution of vaccines, system of patents and withholding of the formulae for making them. Based on the distribution of mortality (see analysis below), vaccines should have gone first and foremost to LMICs rather than HICs. However, the opposite was in fact the case.

Figure 2.1.1: Vaccine inequity, by country income group



Source: Booster coverage of population by country, income and population size. 2023 Pandem-ic. Used under CC-BY-4.0 licence.

Box 2.B: Vaccine inequity between and within countries



There were inequities in: production – manufacturing was concentrated in HICs, China, India and Cuba; allocation – the international COVAX scheme was inadequately supported by rich countries and vaccine producers, and faced several internal obstacles; affordability – the cost of vaccines varied significantly more or less inversely to countries’ income; and deployment – the capacity of health systems to deliver vaccinations was highly variable. Nicaragua illustrates the inequities: the US refused to supply the country with vaccines for political reasons, but delivered surplus vaccines to other countries in the region, meaning that Nicaragua had to rely on COVAX, leading to a six-month delay compared with its neighbours. But Nicaragua’s excellent community-based health system allowed it to both counter misinformation and vaccine hesitancy, and quickly vaccinate the population once vaccines were available.

Inequities in vaccine distribution within countries are less well documented, with the US being the major source of information in a 2022 review (Bayati *et al.* 2022).

Continued:

Different groups were privileged or excluded in different countries: older people and carers were sometimes privileged; there could be gender and urban-rural inequalities. Such micro-level factors were present in many of the countries included in the review; macro-level factors included the presence of vulnerable groups, state of the health system and vaccination infrastructure, higher GDP and human development, and prevailing political opinion.

Combatting global inequities would require: empowering countries to vaccinate the most at-risk groups as a priority, while ensuring that the vaccine programme did not harm existing vaccination programmes against endemic diseases; increasing bilateral donations and donations to COVAX of vaccines that were well within date; intensifying support to low- and lower-middle-income countries' vaccination programmes; and the global decentralisation of vaccine production, with initiatives already underway in South Africa, Kenya and elsewhere.

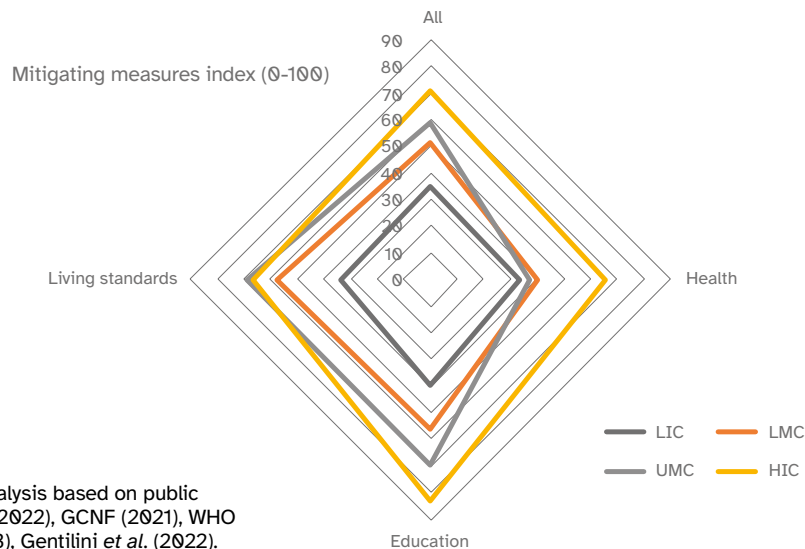
Source: Yamey *et al.* (2022)

Figure 2.1.2 shows the extent of investment in mitigating measures across country income groups compared to the stringency of restrictions imposed. What is remarkable on the mitigation side is that education scores for all countries other than HICs are similarly low, reflecting the enormous challenges all but the richest countries have faced developing teaching and learning systems that do not rely on face-to-face interaction in crowded classrooms. The logistical obstacles to e-learning in LMICs and for people in the

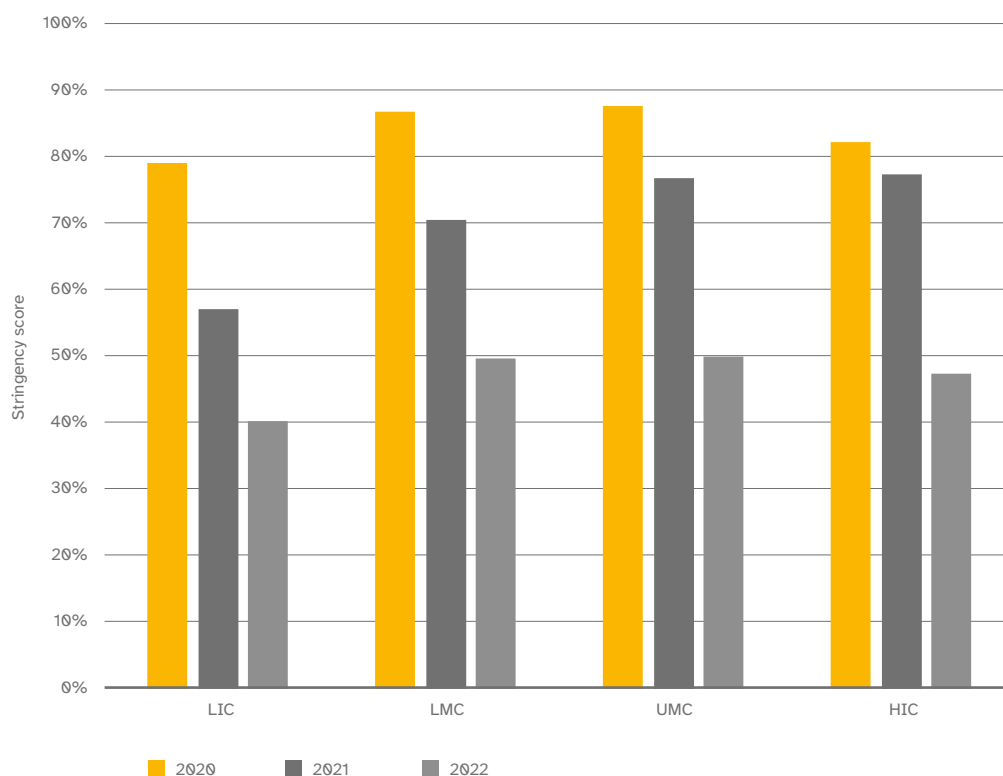
bottom half of the income distribution are massive – in terms of limited electricity, internet and phone access, in particular. The majority of the world's children were not only failed massively in this respect, but many of them subsequently dropped out of education (see Chapter 6).

The range of living standards mitigating measures put in place by MICs were closer to those of HICs, while the LICs fell way behind the MICs.

Figure 2.1.2: Mitigation and stringency scores by country income group



Source: Authors' analysis based on public datasets UNESCO (2022), GCNF (2021), WHO (2022), OWID (2023), Gentilini *et al.* (2022).



Note: LIC = lower-income country; LMIC = lower-middle-income country; UMIC = upper-middle-income country; HIC = high-income country.

Source: Authors' own visualisation based on [OxCGRT \(2022\)](#).

Among LICs, health mitigation measures – identified through vaccinations per 100 people by 2022 and share of health expenditure (as a % of GDP) in 2020 – remain particularly low. This is a major issue for pandemic preparedness (as well as health in general): major efforts to raise health spending are needed. We know that ill health is normally the most common cause of impoverishment and, combined with other shocks, can tip people into years of poverty or greater poverty. Nicaragua is a rare example of a country that invested massively in its hospitals and community health system during the decade prior to the pandemic. This meant that its leaders felt they had more options in pandemic management than those of most other countries (see below).

Pre-crisis investment in health will therefore contribute to building absorptive as well as adaptive resilience and, if significant enough, could be transformative. A major example is

Rwanda's health insurance scheme, which reaches 80 per cent of the population, subsidises enrolment of the poor, and provides a high standard of care due to higher-than-usual government investment in health services for a country at its income level.

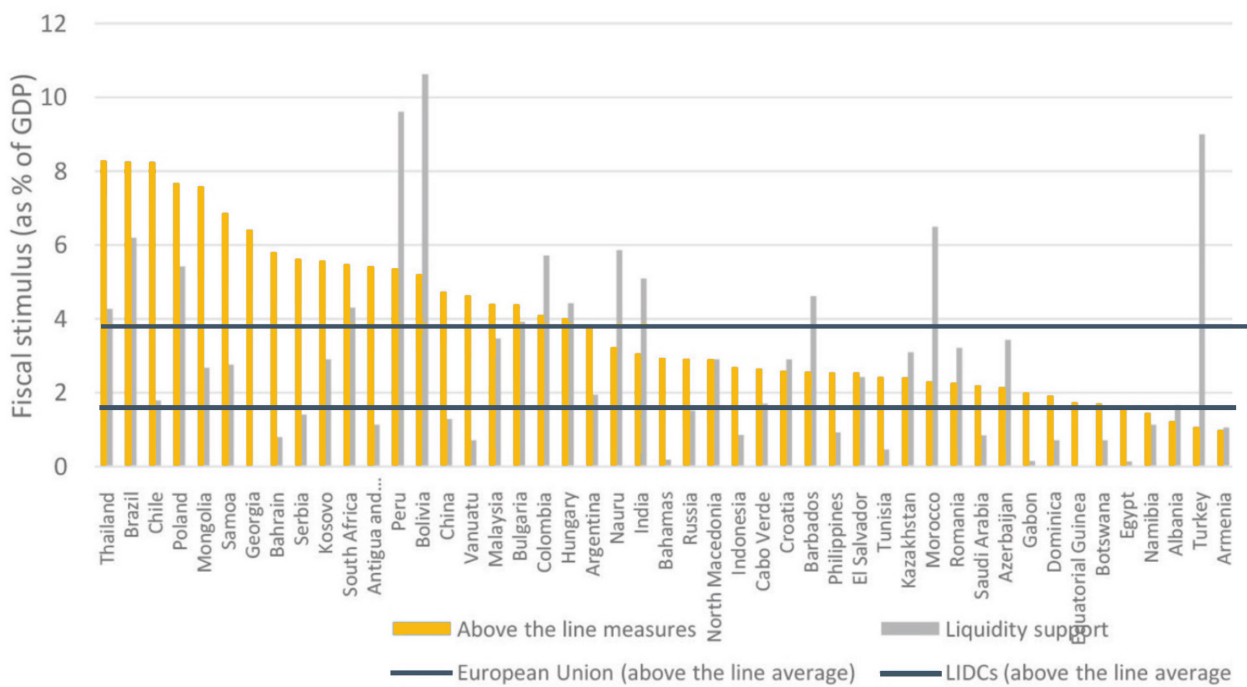
The scale of public finance devoted to the pandemic is clearly an underlying factor in pandemic response performance: in 2020 LICs spent on average 1.6 per cent of GDP, MICs spent 3.6 per cent and HICs spent 12.7 per cent. The low levels in LICs correspond to the underfinancing of progress towards the Sustainable Development Goals, which has been commonly observed (Manuel, Samman and Evans 2019). The financing gap, in the pandemic as with development financing, needs to be made up by aid. However, the assumed global nature of the pandemic (which was in fact highly differentiated among countries), and the retreat to the inward-looking and protectionist politics

and economics of the previous few years, has meant that rich countries preferred to allocate resources first and foremost to their own health services, businesses and populations. Although the absolute amount of aid increased in 2020 and 2021 as a result of spending on vaccines and other Covid 19 related expenses, adequate additional aid was far from forthcoming.

Among MICs there was huge variation (Figure 2.1.3). Clearly, macroeconomic management mattered – this is all

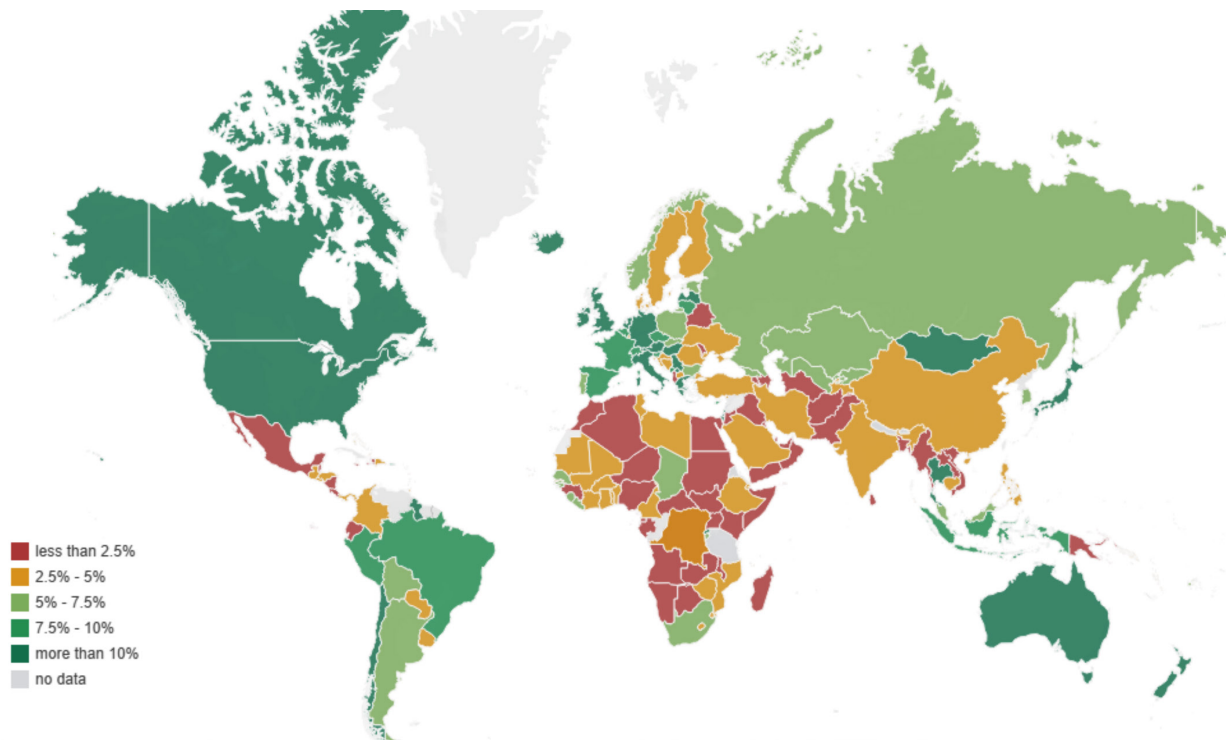
about managing crises, in any case. Countries with fiscal space or borrowing capacity could spend a lot more than others. Chapter 5 illustrates this with a comparison between Cambodia, where there was fiscal space for significant mitigating measures, and South Africa, where borrowing was the solution, though with consequences for the country’s creditworthiness. Fiscal space interacted with political choices about how much countries could afford and capacities in terms of what they could actually deliver.

Figure 2.1.3: MICs’ fiscal stimulus (2020)



Source: The Impact of the COVID-19 Crisis on Middle-income Countries. 2021. © Sage, reproduced with permission via Copyright Marketplace.

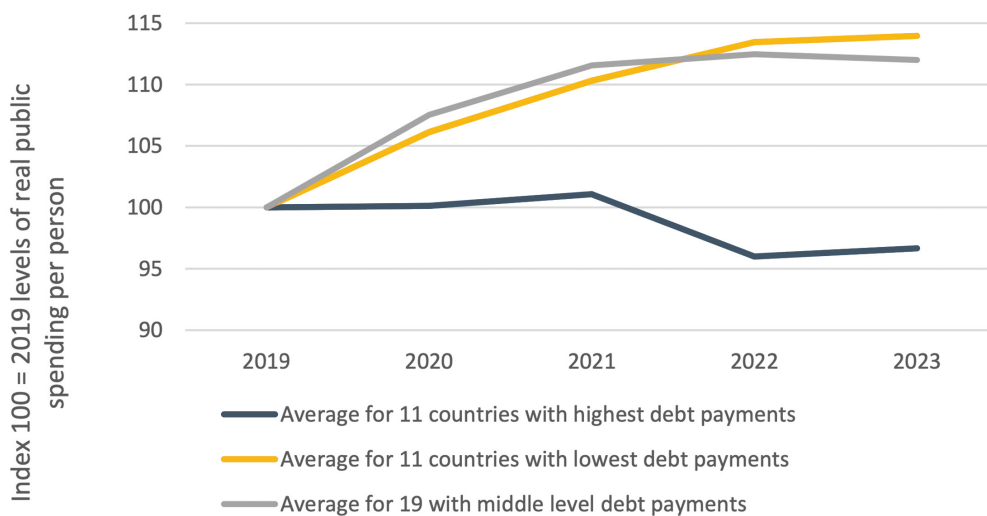
Figure 2.1.4: Additional spending and forgone revenue in response to the Covid 19 pandemic (% of 2020 GDP)



Source: [Fiscal Monitor Database of Country Fiscal Measures in Response to the COVID-19 Pandemic \(October 2021\)](#). 2021. © International Monetary Fund, reprinted with permission.

Fiscal space was related to debt payments, which soared during the pandemic, as illustrated in Figure 2.1.5.

Figure 2.1.5: Index of change in real public spending per person (2019-23)



Note: grouped by the 11 countries with the highest debt payments, 11 countries with lowest debt payments, and 19 countries with middle levels of debt payments.
 Source: [The growing debt crisis in lower income countries and cuts in public spending](#). Debt Justice. Used with permission.

Having the public budget available is one thing; being prepared for a pandemic is another. While this report will not go into detail about the health aspects of preparedness, a summary of the issues that need to be addressed to achieve equitable preparedness is given below. WHO is in the process of developing an international treaty on pandemic preparedness (WHO 2023).

The relative scarcity or low volume of mitigating measures in the global South compared unfavourably with the richer countries of the global North, which provided furlough schemes for citizens who were unable to work, as well as a range of business survival grants from public expenditure, incurring huge public debts in the

process. In the global South, business grants or credit repayment holidays were also quite frequently provided to formal businesses, but these were often on a significantly lesser scale, focused on fewer industries, locations and target groups, and did not reach the micro-businesses that predominate in low- and lower middle income countries.

The only LIC to have broad government debt relief for households was Togo (Table 2.1.1). It was also one of the few LICs to develop a cash-based transfer scheme focused on the informal sector (Debenedetti 2021a; see also Chapter 4). Togo is a dominant-party state (like Cambodia and Rwanda), with a commitment to equity, which includes extending taxation to the rural informal economy, despite its tax

Table 2.1.1: Countries with broad household debt relief in 2020 and 2022, by country income group

High income	Upper middle income	Lower middle income	Low income
Greece	Russian Federation	Papua New Guinea	Togo
Japan	Bulgaria	Kyrgyzstan	
Hong Kong, China (SAR)	China	Sri Lanka	
Croatia	Thailand	Pakistan	
Austria	Guatemala	Mongolia	
Slovakia	Ecuador	Egypt	
Slovenia	Malaysia	Nepal	
Czech Republic		Myanmar	
Spain		Honduras	
Hungary		Lao, People's Dem. Rep.	
Ireland		Bangladesh	
Singapore			

Note: Broad relief includes: freezing financial obligations for households (e.g. stopping loan repayments, preventing services such as water from stopping or banning evictions); 'broad' refers to relief that goes beyond one kind of contract (e.g. stopping loan repayments **and** banning evictions).
Source: Blavatnik School of Government (2023)

inefficiency, to persuade big enterprises that they are not the only taxpayers, and to stay in the system (Beach 2018).

Almost as many LMICs as HICs achieved some debt relief, however. In Bangladesh, for example, in addition to debt relief (loan repayment postponement) through banks, NGOs that provide microfinance became strongly involved in relief in parallel with savings and loans, which meant that some clients were able to maintain their businesses (Murshid and Murshid 2022).

Wage subsidies in the formal sector were a lot more varied. A few lower middle income countries (Angola, Egypt, Moldova, Uzbekistan) opted for them in 2020, but had discontinued them by 2022; nine introduced new wage subsidies after 2020 (Benin, Honduras, Lao, People's Dem. Repub., Morocco, Nigeria, Palestine, Tunisia, Ukraine, Vietnam). Only Bangladesh, Cambodia, Lesotho, Mongolia and the Philippines among the lower-middle-income countries introduced wage subsidies that were present in both 2020 and 2022. Among LICs, only Burundi (2022) and Haiti (2020 and 2022) adopted wage subsidies.

In contrast, social protection measures and cash-based transfers, in particular, were prevalent across the majority of countries. These were either extensions of existing schemes (additional money given to existing beneficiaries, coverage of new beneficiaries or both) or new schemes entirely. At both international and national levels in most countries this was the main public policy response to the negative effects of lockdowns and restrictions.

However, social protection provision varied a lot on the ground; many people in need were left out, and payments were often inadequate and one off. Ugo Gentilini's⁴ tracker at the World Bank counted more than 800 new schemes, mostly in middle rather than low-income countries, and over 40 extensions to existing schemes. This is analysed in Chapter 4.

2.2 The trade-off

The trade-off between public health-based restrictions and livelihoods in developing countries, where many people live under or close to the poverty line, was recognised early in the pandemic; for example, in May 2020 with Khan (2020) emphasising a data-/evidence-driven approach and pushing decisions about lockdowns vs opening up down to local level. This 'minority' recognition was not generally translated into effective mitigating measures, perhaps because in many countries the 'right people' were not 'in the room' when policy decisions were made, especially initially. Economic and social decision makers needed to be in the room alongside public health and other medical professions. As the pandemic continued, decision-making processes evolved, more data became available and decentralisation of decision-making on the trade-off did happen in some countries.

Given the very significant impoverishment and reversal of socioeconomic progress in the global South, a major lesson from Covid-19 for future pandemics is the need to balance public health-based measures with livelihood enhancement measures, especially where pandemic management relies on the cruder tool of restrictions rather than precision containment measures. It is not clear why a better balance was not achieved from the outset of the Covid-19 pandemic: a 2019 WHO report on non-pharmaceutical interventions (WHO 2019) aspired to this; lockdowns were barely mentioned, while restrictions were discussed and at times recommended as potentially effective, though the evidence in support of such recommendations was generally low or very low. Green and Fazi (2023) argue that the pandemic was generally managed in this way because it suited the interests of richer countries, with China leading the way, far ahead of the pack

in the stringency of its response, until it collapsed in late 2022.

There were also national factors at play – the decisions made reflected who was empowered to make them. For example, in Zambia, ‘

When covid started, it was challenge because we have 8 neighbouring countries and the number of borders is significant some of the borders don't have official presentation to ensure that the movement of people and goods is controlled... In Zambia we noticed that at the beginning, there was a disjoin in the implementation of policies, first of all, the Ministry of Health was the main institution that quickly saved this issues about the disease and its spread, before other institutions could come in we could see that the interest of the MoH's decision was infringing on the decisions of the other ministries; for example, the interest of the Ministry of Finance was to collect revenue but when the Ministry of Health closed the border, it affected the Ministry of Finance until when the office of the Vice President was tasked to take upon the task, with more authority started to convene meetings to harmonise the decisions of the Ministry and seeing that the office of the Vice President is charged with disaster management and mitigation, that is how the office of the Vice President coordinated the Ministries. (KII in government, Zambia)

Containment measures – contact tracing, testing and quarantining people who tested positive – interrupt economic and social activities less than restrictions. But countries that tried containment, such as South Korea and other East Asian and Pacific countries, after initial success usually found they had to introduce further restrictions at some point as containment failed to suppress the virus, especially with the arrival of the highly transmissible Omicron variant in 2021.

Restrictions were variably imposed and implemented, and strategies varied significantly over time. There were two broad approaches: (1) the ‘zero-Covid’ approach, which aimed to eliminate Covid-19, was largely followed in East Asia and the Pacific, combining strict lockdowns, movement restrictions and closures imposed at progressively lower levels of infection (exemplified by China), with testing, contact tracing and isolation (exemplified by South Korea); and (2) a more common approach that aimed to reduce the incidence of Covid-19 by imposing restrictions and other measures as infection rates increased, and removing them as they decreased (Hale *et al.* 2022) – this could be called ‘adaptive stringency’. To this we might add (3) a more laissez-faire strategy, focused on health sector preparedness, as was pursued in Sweden, and Nicaragua and Tanzania (see below).

Africa had a highly co-ordinated response to the pandemic, guided by the Africa Centres for Disease Control and Prevention, which was formed in 2017. African countries were only too aware of the ravages of epidemics from recent experiences of Ebola and HIV. However, the youthful age profile of African countries in contrast to the older age of vulnerability to Covid-19 meant that relying on previous experience of epidemics to show the way was misguided. Few adjustments were made to WHO or all-African strategies once they had been set in motion.

There were dynamic patterns in decisions to restrict freedoms. International travel restrictions were the first to be imposed; then schools were closed and public events cancelled; then internal movement was restricted; workplaces closed; and, lastly, public transport was shut down. Greater stringency was correlated with having fewer hospital beds and thus the risk of health services being overwhelmed. Developing countries were more stringent

than developed ones (Gustafsson 2020). Again, this was potentially a mistake, as the risks from the virus were so unequally distributed between countries, given their different age structures and climate profiles.

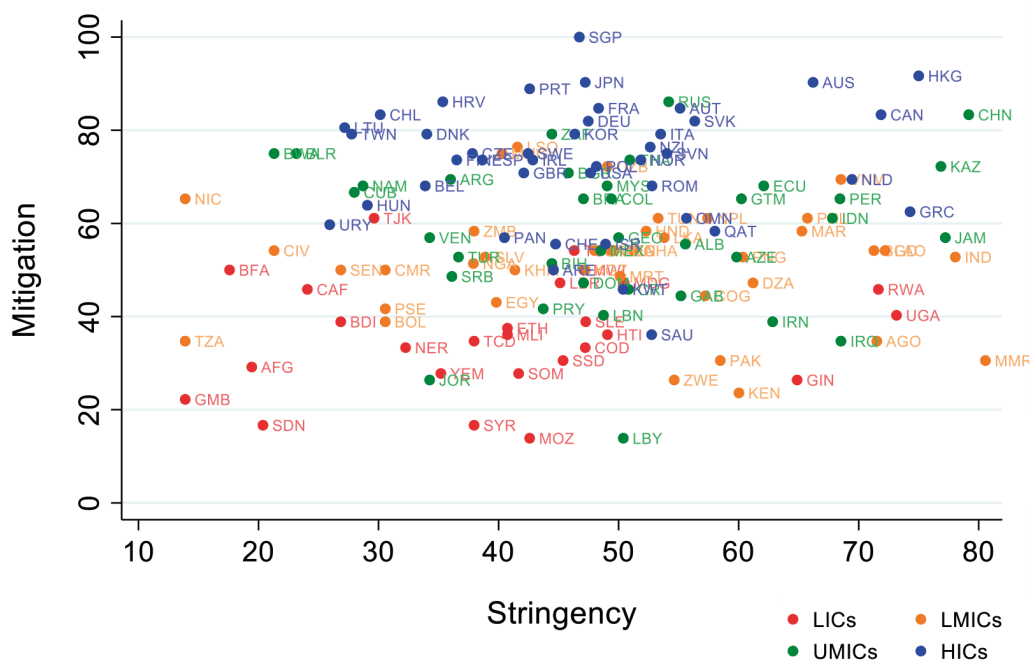
Decision makers in 2020/21 became progressively more sensitive to rates of infection as the pandemic wore on, introducing restrictions earlier in subsequent waves (Hale *et al.* 2022). This sensitivity later reduced as the apparently less acute and much more transmissible Omicron variant dominated in 2021/22.

How did countries score on the Stringency Index against the CPAN Mitigating Measures Index (Figure 2.2.6)? We find no correlation between country income groups' performance in terms of mitigation compared with the Stringency Index reflecting the wide heterogeneity of implementation of both restrictive and mitigating strategies. We observe a spread of stringency scores across country income groups, though LICs typically on average have comparatively

lower stringency measures, with a few exceptions (e.g. Rwanda and Uganda), and lower levels of mitigation (again, with some exceptions). Instead, the widest range in mitigation scores is observed among upper-MICs, with a strong spread of measures available in Russia but almost non-existent in many conflict-affected upper-MICs, including Iran, Iraq, Lebanon and Libya.

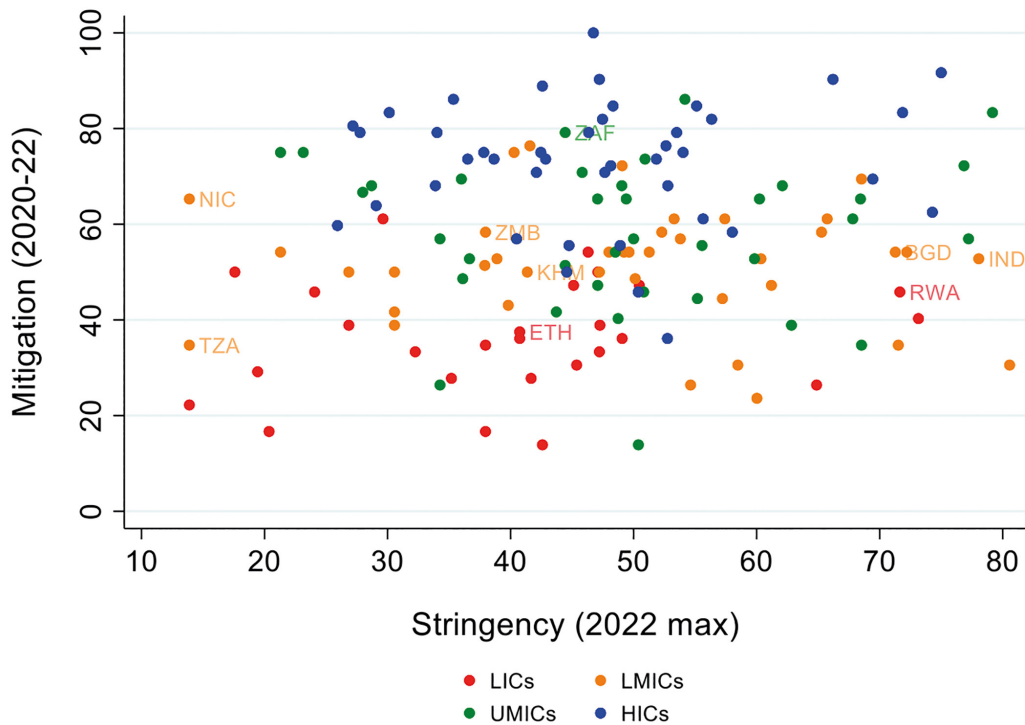
Regionally, many East and Southeast Asian countries (e.g. Australia (AUS), China (CHN), Hong Kong (HKG), Indonesia (IDN), Vietnam (VNM)) had higher stringency scores but these were also often accompanied by stronger mitigating measures. However, there were a few countries in this group that had relatively lower stringency scores and mitigating measures (e.g. especially Afghanistan (AFG); and Cambodia (KHM), moderately). In Africa, there were a few countries with many mitigating measures and comparatively low stringency, such as Botswana (BWA), Lesotho (LSO), Namibia (NAM) and South Africa (ZAF).

Figure 2.2.6: Mitigation vs stringency scores



Notes: for visualisation purposes, stringency index scores refer to their largest value attributed to each country in 2022; LMICs = lower-middle-income countries; UMICs = upper-middle-income countries; country codes are defined in Table A3.1. Source: Authors' analysis based on public datasets UNESCO (2022), GCNF (2021), WHO (2022), OWID (2023), Gentilini *et al.* (2022), OxCGRT (2022).

Figure 2.2.7: Case study countries



Note: LMICs = lower-middle-income countries; UMICs = upper-middle-income countries
 Source: Authors' analysis based on public datasets UNESCO (2022), GCNF (2021), WHO (2022), OWID (2023), Gentilini *et al.* (2022), OxCGRT (2022).

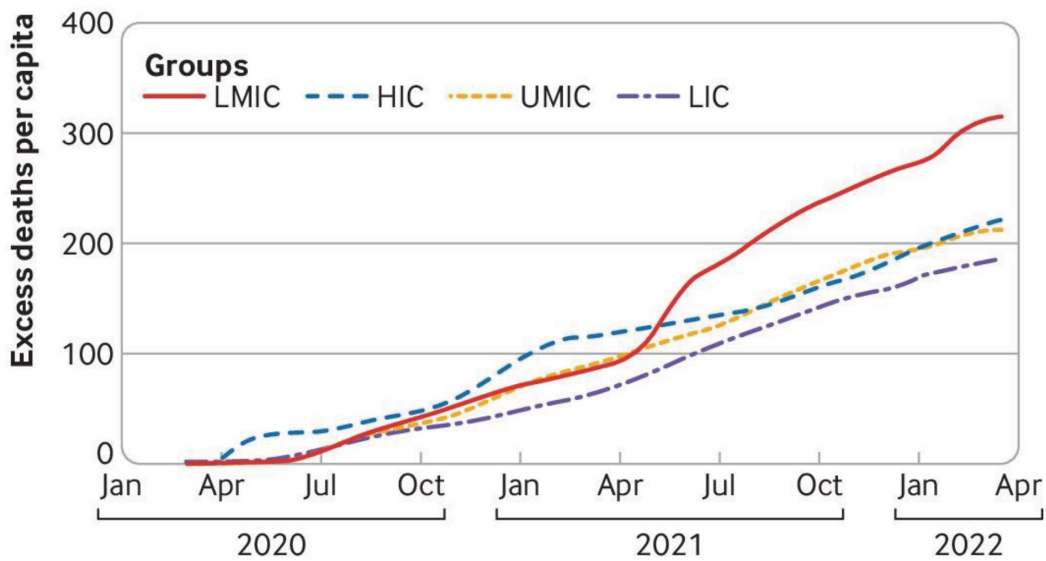
South Africa (ZAF) stands out as high on mitigation and medium on stringency. It had high levels of school feeding, a high government health expenditures, cash-based transfers and wage subsidies, and some form of debt relief at the onset of the pandemic and continuing into 2022. Nevertheless, despite the medium level of stringency, it had a high death rate. Nicaragua is another country featured in our detailed analysis below, which had a range of mitigating measures and low stringency scores, reflecting its high health expenditures, stellar vaccination performance and avoidance of school closures.

2.3 Restrictions, mitigation and 'excess' mortality

Excess mortality is the best available measure of mortality during the pandemic, as the methods used for reported deaths varied so much from country to country. Figure 2.3.1 shows that deaths were highest in lower-MICs and lowest in LICs

There was wide variation not only in estimates of excess mortality, but also in terms of data points available from different sources (the Institute for Health Metrics and Evaluation, WHO and The Economist via Our World in Data n.d.a). The graphs below have used the maximum value for each estimate of excess mortality, with the rationale that it is better to overestimate than underestimate excess deaths given the gravity of the issue.

Figure 2.3.1: Excess deaths in country income categories



Note: LMIC = lower-middle-income country; UMIC = upper-middle-income country
 Source: [Booster coverage of population by country, income and population size, 2023 Pandem-ic](#).
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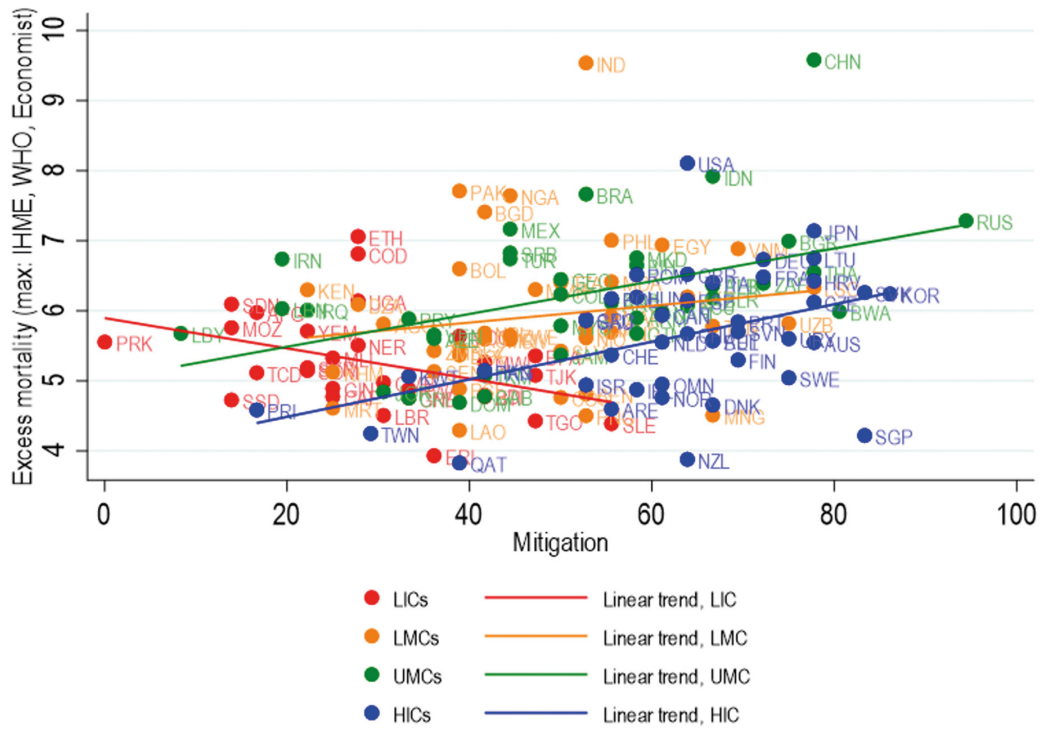
There is a moderate negative correlation between the prevalence of mitigating measures and excess death rates per 100,000 population in LICs (i.e. more mitigating measures typically correlate with lower excess death rates). This suggests that in many LICs, excess deaths were to do with factors other than Covid-19; for example, poverty, food insecurity, and lack of access to health services for other health problems that resulted from the restrictions. Where governments made investments to mitigate the consequences of the restrictions, excess mortality was lower.

This relationship is reversed among upper-MICs and HICs, though. This suggests strong mitigating measures were introduced and implemented in those countries where the effects of Covid-19 were felt strongly in terms of deaths and hospitalisations.⁵

There is no obvious correlation between excess deaths and stringency scores in 2022 (or for other years). This raises a question over the effectiveness of the restrictions in preventing deaths from Covid-19, or during the time of the pandemic, as excess mortality may be caused by other things than Covid-19 infections, not least other diseases and medical problems that remain untreated.

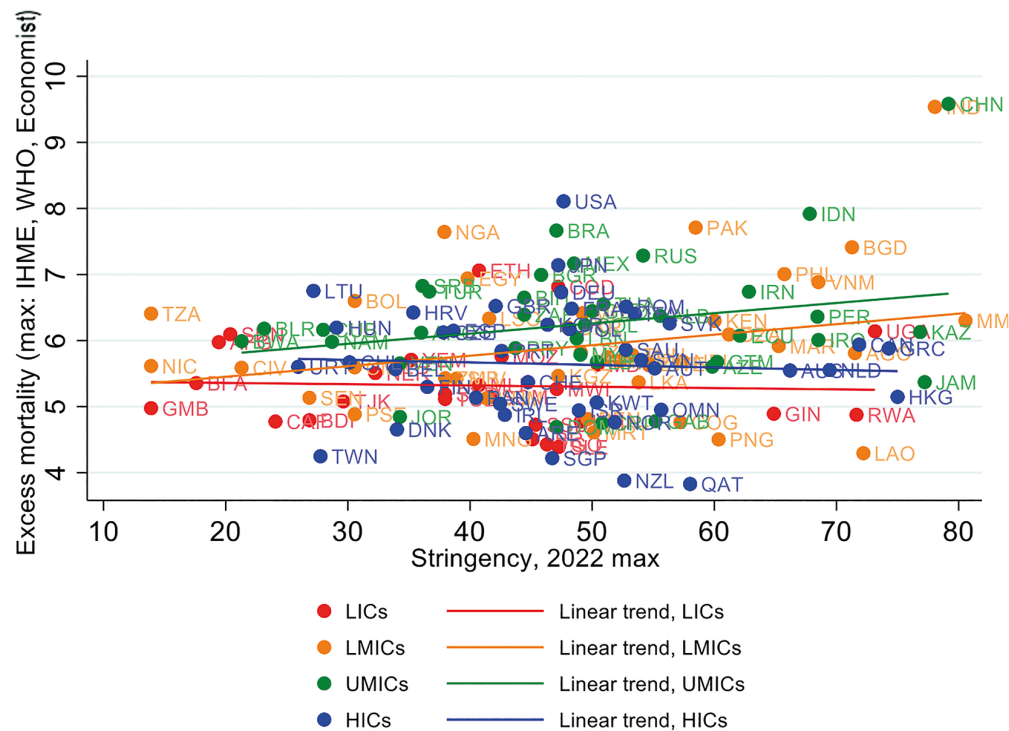
In Chapter 3, we will assess in greater detail the strategies several countries pursued to balance public policy responses in favour of ‘saving livelihoods as well as lives’, but also reducing the intergenerational costs of a pandemic.

Figure 2.3.2: Excess mortality⁶ and mitigating measures



Note: LMCs = lower-middle-income countries; UMCs = upper-middle-income countries
 Source: Authors' analysis based on public datasets UNESCO (2022), GCNF (2021), WHO (2022), OWID (2023), Gentilini et al. (2022), IHME (2022), The Economist (2022).

Figure 2.3.3: Excess mortality and stringency measures



Note: LMICs = lower-middle-income countries; UMCs = upper-middle-income countries
 Source: Authors' analysis based on public datasets OxCGRT (2022), IHME (2022), WHO (2022), The Economist (2022).

2.4 Conclusion

The overall message of this chapter is the need to balance restrictions and mitigating measures so that livelihoods and resilience are not sacrificed: in poor countries, chronic poverty, ill health and mortality are closely connected. How much to sacrifice livelihoods and resilience is of course a matter of judgement for decision makers, and is a political decision. We should remember that at the beginning of the pandemic little was known about the virus – how transmissible it would be in different settings, how quickly the pandemic would be over. Nevertheless, and with some hindsight, a major lesson in the global South is the need to be much more cautious about sacrificing livelihoods in the name of saving lives in the short term, as loss of livelihoods can also lead to loss of lives, physical health and mental health, and can have many other negative consequences in both the short and longer terms. The warning signs were there soon after the beginning of the pandemic, however, for anyone who chose to see them.

When a multidimensional crisis such as a pandemic occurs, the objectives of saving lives and livelihoods, and boosting resilience, need equally strong treatment: the right economic and social decision makers need to be in the room for that to be achieved. In addition to health experts, economic, social and disaster-management experts and representatives are also needed. Crisis management leadership needs to be dispersed among these relevant stakeholders at various levels of government.

While life as usual may not be possible, and economic and social progress may have to be paused, it is important to hold people, institutions and economies as steady as possible, so that they can quickly bounce back as the crisis passes.

This becomes more challenging as crises overlap and come in rapid sequence. Instead of this, panicked decisions about lockdowns and closures quickly impoverished many people in many countries before functioning mitigations of any sort were in place. In some situations in the global South, not many lives were saved initially.

No crisis is the same as the previous one. The pandemic was not the same as the previous global crisis – the financial crisis of 2007/08. Responses, however, tend to carry over from one crisis to the next: the Keynesian fiscal response to the financial crisis was also widely used in the pandemic. It was relevant, but also may have crowded out more adaptive approaches to a very different type of crisis. At national level, responses were also carried over from previous epidemics, such as SARS and Ebola. In the case of the 2014–16 Ebola outbreak in West Africa, some lessons learnt were not carried over into the Covid-19 pandemic: for example, that lockdowns were ineffective due to Africa's informal economic structures and that social scientists were important in developing appropriate responses. Elsewhere, countries may have been familiar with coping with other types of disasters, such as flooding, but their characteristics were very different to those of Covid-19. To support resilience, each crisis needs to be treated as distinct from previous ones until proven otherwise. This means having a significant 'learning' effort alongside any initial measures.

The response to a global crisis is bound to have a global aspect, but policy responses also need to be differentiated by context; for example, because a single approach to resolving the 'lives versus livelihoods' dilemma is not applicable at all levels of income. During the pandemic, poor countries needed to be free to adapt and innovate. There were limits on this, often imposed by national governments

that were erring on the side of caution. Although they were sometimes relaxed as the pandemic wore on, restrictions wore people down.

There is a need to ‘decolonise’ the global response: for example, by avoiding assumptions about impacts being uniform. In the response to the pandemic, early briefings⁷ assumed that the effects in Africa would be devastating before much was known either about the nature of the virus or the capacity of African countries to respond rapidly and effectively with public health measures, which many did. The pandemic has provided a significant opportunity to reshape power dynamics in the provision of aid and management of an emergency. In practice, actors from the global North were heavily constrained in their ability to control processes and new, hopefully more balanced relationships, have begun to develop. To judge by the emerging

assessment of this issue, there is still a long way to go in creating more equitable systems for deciding on resource allocation as well as programme content.

Given the need to tailor responses to context, evidence and data are critical. Data was scarce on the issues people in the bottom half of the distribution, in particular, faced. To some extent, this situation remained unresolved throughout the pandemic as surveys relied on mobile phone users – the poorest people in many countries do not possess mobile phones, and network coverage is very uneven, so many of the poorest and most disadvantaged people and regions were missed out of surveys. National disaster management agencies are used to collecting data under adverse circumstances; but, alongside national statistical offices, they need better preparation and capacity building for future pandemics.

Endnotes

Chapter 2

¹ In this report non-pharmaceutical measures to contain the virus are referred to as restrictions, as that is what they were. In the biomedical literature they are often referred to as mitigations, so there is potential for confusion. In this report we use mitigations or *mitigating measures* to refer to initiatives that compensated for or moderate the effects of the restrictions, or allowed social and economic life to return to normal.

² An Oxford economic support index records measures such as income support and debt relief: <https://www.bsg.ox.ac.uk/research/covid-19-government-response-tracker> (Blavatnik School of Government 2023). It is calculated using all ordinal economic policies indicators. However, the CPAN index is composed of indicators that are especially important for poorer people. Other Oxford indices include a health and containment index, which overlaps with the Stringency Index, and an overall response index, which includes all the indicators.

³ It is worth stressing that the Mitigation Index only covers a small share of potential mitigation strategies with available cross-country data.

⁴ Ugo Gentilini is the Global Lead for Social Assistance with the Social Protection and Jobs Global Practice at the World Bank.

⁵ However, if we rely on the lowest estimate across data from the IHME, WHO and *The Economist*, these correlations across country income groups become weak. So, the result is dependent on the assumptions made.

⁶ The measure is the highest value among the three sets of calculations, the log of deaths per 100,000 people.

⁷ For example, by the London School of Hygiene & Tropical Medicine.



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