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An appeal for practical social justice in the COVID-19 global response in low-income and middle-income countries



The coronavirus disease 2019 (COVID-19) pandemic hit the world's wealthiest countries first, shaping global public health responses and messaging. As the pandemic escalates in low-income and middle-income countries (LMICs), there is a growing call to identify locally tailored solutions.^{1,2} Because outbreaks are not only public health emergencies, but also political and socioeconomic emergencies, we can learn from African Ebola and cholera responses and avoid "biomedical tunnel vision"³ by actively addressing wider socioeconomic and health inequities.⁴ Otherwise, the pandemic response might do more harm than good. Practical social justice—linking principles of justice with actions tailored to specific contexts—can help to guide decisions. We offer five key points to inform decision making in LMICs grounded in principles of social justice.

First, the self-determination and agency of LMICs are important to uphold and respect, which means that LMICs develop and shape contextually relevant public health interventions, drawing on international partners as needed. Resource constraints should not affect the agency of LMICs to shape their responses. Although international cooperation is essential, regional networks are best placed to assess needs and lead planning. Importantly, while high-income countries are focused on addressing the epidemic in their own countries, international support remains crucial to ensure that development gains are not reversed.⁵

Second, measures to address COVID-19 in LMICs should give priority to the poor and marginalised who have least capacity to absorb the shocks from the pandemic. In India, lockdown has put about 400 million informal workers out of work; many now face deeper poverty and starvation.^{5,6} Essential supplies, including food, rely on informal supply chains that are easily disrupted in lockdowns. Immediate action is needed to maintain food and other essential supplies to prevent families dying from hunger. Cash transfers to such households will be needed to support vulnerable families during quarantine periods, requiring governments to redistribute resources from other sectors.

Third, equity in health-care provision is crucial. In LMICs without adequate welfare safety nets, it

is unclear who will pay for COVID-19 testing and treatment. If left to citizens, people will receive care according to ability to pay, meaning the poor and migrants will be denied services or pushed further into poverty by health-care costs.⁶ Front-line health workers also face economic hardships, reflected in ongoing health worker strikes in many LMICs. In Zimbabwe, for example, some clinical staff have not been paid for several months, and yet they are expected to lead the fight against COVID-19. Many staff have inadequate or no personal protective equipment, training in infection control, or health insurance.⁷ Key actions include lifting health facility user fees, ensuring fair pay, infection control training, provision of personal protective equipment, and COVID-19 testing for front-line staff. As vaccines and treatments are studied, it is essential that LMICs are included and the highest research ethics standards are upheld. Interventions should be tested in least vulnerable populations first with reasonable prospect for direct and immediate benefit for participants. LMIC scientists should be included as equal partners, and clinical care support should be provided.

Fourth, improvements in standards of critical care should not come at the expense of essential care and routine health services. It is vital that immunisation, antenatal care, treatment of malaria, HIV, and tuberculosis, and chronic disease management continue. Failing this, many more people might die from preventable conditions than from COVID-19.⁸ To optimise COVID-19 care, even as intensive care capacity is improved, gaps in affordable essential care that will benefit many should be prioritised because the disparity between the ability of high-income countries and LMICs to provide COVID-19 care is stark.⁹ For example, in Kenya, 42% of general hospital beds lack oxygen supply, and only 16% of hospitals have pulse oximeters.¹⁰ While aiming to provide high standards of care, we should not create new gaps in life-saving care or overlook essential care.

Fifth, outbreaks can worsen existing vulnerabilities, inequities, and distrust in society. When implementing public health interventions, it is important for

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authorities to respect the human rights and dignity of people. Attention to gender-based violence, safeguarding, and exploitation of low-paid workers is especially crucial. For individuals who are homeless, living in overcrowded settlements and migrant camps, physical distancing might be impossible. Implementation of lockdowns without transparency and heavy-handed policing can undermine popular trust. However, trust can be earned by actively engaging with communities to develop and support implementation of COVID-19 measures.⁴

All countries are making decisions on the basis of imperfect and rapidly changing information. We will be more resilient acting together, in cooperation, than in isolation. More effective, equitable global solutions will come from LMIC expertise and leadership, grounded in principles of social justice.

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