COVID-19, AND BEYOND: NEXUS, FRAGILITIES AND ENDEMICITY
PREAMBLE

As it has done regularly in the past, in connection with complex, multi-factor and potentially long-lasting crises, the Groupe URD has begun to:


In this framework, the team of the COVID-19 Observatory has produced a series of briefing notes on specific subjects:

- Health;
- Food, agricultural and economic security;
- Social cohesion and social tensions;
- Migration and mobility;
- Education;
- Conflicts;
- The Emergency-Development Nexus.

This is the tenth note produced by the COVID-19 Observatory. It presents our analysis of the challenges of COVID-19 post-crisis management, using a "nexus" approach and paying particular attention to the heterogeneity/diversity of situations worldwide and the challenges surrounding the probable endemicity of the virus.
SUMMARY

The pandemic known as COVID-19 highlights the diversity of situations and political choices made to face off against a major health crisis. It highlights all the more clearly a complex world in which it will be necessary to find original, adaptable solutions in response to the various environmental, sanitary, socio-economic and political problems that will emerge. Unfortunately, there is no linear, easily prescribed formula to be applied to each and every country to respond to the problems of the near future, despite the often clear and pressing nature of these problems today.

First to be confronted with the rapid increase in transmission rates, China and several other Asian countries, as well as continental Europe, seem to have brought the situation more or less quickly under control, in spite of the frequent clusters of recontaminations which needed careful monitoring. This success can in large part be attributed to their extremely harsh measures of confinement, the full economic and social cost of which has yet to be estimated. However, the multitude of resurgences and the regular appearance of new areas in which the virus is actively circulating are worrying. The kinetics of contamination in the United States, linked to the laissez-faire attitude many states have adopted, remain highly alarming. Nor is this rapid transmission limited to the U.S.: in fact, it is a phenomenon which has been observed in the Americas more widely, as well as in Australia, India and certain countries in the Middle East (notably Israel, the Gulf states and Iran), for reasons which experts remain unsure and divided about. Finally, the dynamics of transmission in Africa remain very difficult to guess, where some countries still seem relatively untouched while in others contamination is spreading quickly.

In countries where the number of cases is high, compulsory binding measures such as containment are needed immediately as they make it possible to reduce the number of new cases within a few weeks. Beyond this measure, the preventive measures that have been put in place in countries in which widespread confinement was respected, as observed in China, South-East Asia and Europe, are designed to eliminate the need to resort to confinement in view of its enormous economic, social and mental repercussions. The strategy now in use is a mix of generalized, “lighter” measures such as physical distancing, hand washing and wearing masks, complemented with more stringent but geographically limited measures which rely on effective warning systems.

The countries of the global South have a much higher percentage of vulnerable populations but also have all the more reason to oppose generalized restrictive measures given their lack of state capacity to finance job losses or even additional medical staff, the impossibility of keeping social distances in overcrowded neighbourhoods or reaching war zones, and due to an oft-witnessed mistrust of political authorities. Fragile countries have enormous challenges to overcome, but they also have a unique window of opportunity to implement a more balanced approach centered somewhere between emergency aid and general development. Just as these countries have moved directly to mobile phones without ever needing fixed phones, there is a possibility for some countries to innovate in the face of the emergency that COVID-19 has created in all affected countries so far. By investing directly and heavily in the development of health policy centered on the adoption of affordable and widespread barrier measures, these countries can likely avoid the political gamble of implementing draconian measures, prevent deaths and build their resilience, as these measures will remain useful in the long term for all other epidemics.

Faced with the many uncertainties that surround the evolution of COVID-19 and the high probability of SARS-CoV-2 endemicity, emergency programmes will continue to be necessary since outbreaks will continue to occur. Nonetheless, they may necessitate a much smaller scope and duration if they are designed to complement development initiatives centered on public health systems and the preparedness and quality of warning systems: in short, a real nexus between emergency and development aid is needed.
INTRODUCTION

To date, the dynamics of the pandemic remain extremely complex and unpredictable. By the end of May, more than 90% of the world’s population had not yet been exposed to the virus. Since then, things have moved in very different directions depending on the country. According to WHO, the pandemic has infected more than 13 million people and caused more than 570,000 deaths worldwide since the end of December 2019. China, continental Europe and several other Asian countries, which were the first to witness the rapid acceleration of transmission, seem to have more or less rapidly brought the situation under control (despite the frequency of recontamination “clusters” which need continuous supervision), thanks to extremely stringent containment measures, the economic and social cost of which has yet to be estimated. However, the multitude of resurgences and the regular appearance of new areas in which the virus is actively circulating are worrying. The kinetics of contamination remain extremely worrying in the United States and, more generally, in the Americas, as well as in Australia, India and certain countries in the Middle East (notably Israel, the Gulf States and Iran). Finally, the transmission dynamics remain very difficult to grasp in Africa, where some countries seem to be relatively unaffected while, in others, contamination is quickly accelerating. In many countries the lack of systematic and reliable information still leaves the door open to multiple assumptions, hypotheses, controversies and continuously changing response measures.

Like the great pandemics of the pre-Christian era and the Middle Ages, the virus follows and will continue to follow travellers and population flows. Its seasonality has not been established, nor has the strength and duration of acquired herd immunity. It is therefore in the face of uncertainty about future dynamics yet with presumptions of endemity in a large part of the world that we must think about the future: what will the “world of tomorrow” look like, in the health, social, environmental, economic and political fields?

But we must first reflect on the dynamics of the ongoing pandemic, both in its forms today and in the possible dynamics it may adopt tomorrow. We will try to conduct this reflection not in a general way, but rather rooted in the complex and diverse geographical dynamics taken by the pandemic throughout the world.

1. THE DIVERSE DYNAMICS OF THE PANDEMIC IN DIFFERENT CONTINENTS

If the pandemic created by SARS-CoV-2, known as COVID-19, teaches us one thing in terms of health crisis management, it is the diversity of health impacts, of response capacity and of political choices even within the same country. It will require great agility and creative imagination to find appropriate solutions to the different and ever-changing health, socio-economic and political problems resulting from the interaction between the pandemic and the measures taken to manage it.
The COVID-19 epidemic throughout the world (This map shows the presence and magnitude of the pandemic and identifies the countries most affected since the beginning of the epidemic; it does not, however, allow an estimate of the day-to-day situation).

1.1. THE AMERICAS

The American continent is now at the heart of the pandemic, especially the United States, which has turned into a colossus with feet of clay. The USA is the most affected country with more than 135,000 deaths as of mid-July 2020, and the scenes of mass graves on Hart Island, near New York City, have left their mark on people’s minds. Next come Brazil (more than 70,000 dead) and Mexico (31,119 dead). In these countries, which are among the richest on the continent, the characteristic feature of the response has been the "non-response", or even the extreme politicization of "non-response" by the highest state authorities, sometimes against the advice of health personnel and of decentralized authorities.

Latin America, which was relatively untouched until recently, became the new epicenter of the pandemic at the beginning of June, suffering, as in northern countries, from a sudden explosion of cases in large cities such as Sao Paolo, Brazil; Lima, Peru and Santiago, Chile. It is the oversaturation of emergency systems, and even funeral systems (mortuaries, cemeteries) that has led these countries to understand the gravity of the pandemic. It was the appearance of clusters (many patients in a relatively limited area in a short time) that led to the decisions being taken. The alarm bells began to be rung in Ecuador as in New York by the dead who could not be managed by hospitals or funeral homes.

It is through this saturation of emergency and funeral systems, and in light of the large differences in impacts between social groups that these countries have begun to understand the seriousness of the pandemic and the need to adapt measures to local realities.
1.2. AFRICA

Many questions remain about the different pandemic scenarios for Africa. In fact, the pandemic has been progressing very slowly for months, raising many hopes. Unfortunately, an acceleration of transmission rates has been witnessed since mid-June. The WHO was the first to point out that “It took 98 days to reach the 100,000th case [of coronavirus in Africa] and only 18 days to pass the 200,000th case mark”. While the acceleration is evident, there is still considerable heterogeneity in infection levels and transmission rates between countries. According to the Africa CDC (attached to the African Union, which coordinates the various African Centers for Disease Prevention and Control), five countries alone accounted for 63% of new cases: South Africa, Cameroon, Egypt, Ghana and Nigeria. Clearly, given the state of hospital emergency and management systems, a situation getting out of control would be catastrophic. As a result, most governments have put in place a mix of preventive measures that can go as far as confining entire areas, especially in urban contexts. For the bulk of the populations, especially among the poorest who survive on a few dollars a day, the impossibility of working to feed their families is obviously unsustainable and the markets and construction sites in African cities remain very active, even if masks are beginning to appear. In the countryside, the virus still circulates relatively slowly and it is worth noting that the virus has arrived mainly due to outside visitors, chiefly from China or Europe.

1.3. ASIA

Though the virus contagion may have originated in China, it very quickly took extreme measures to respond to it, first on January 20th in Wuhan (the capital of the Hubei province, where Covid-19 appeared), and then throughout the country. More than 60 million people were quarantined in Hubei, and it is estimated that nearly 600 million Chinese lived for several weeks in strict confinement. The resurgence of the pandemic in some areas, including Beijing in June and in some areas close to North Korea and Russia, shows that the crisis is not fully under control. Some countries, such as South Korea, Taiwan and Singapore, based on the experience gained during the SARS epidemics, are very quickly putting in place a thorough control of traveler flows, early and systematic screening, an effective search for contact cases in order to quickly identify outbreaks of contamination, ad-hoc quarantine and transparent communication via technological means. This has allowed populations to be kept informed and held accountable, and has enabled the effective management of the pandemic.

Countries with less technological means but with fairly authoritarian regimes, such as Cambodia and Vietnam, very quickly took effective measures, such as compulsory testing and quarantine as well as border closures (especially between Vietnam and China), the introduction of tests and case finding/contact tracing. The Khmer New Year holidays have been cancelled. In these countries, the health crises of the past and the high level of urban pollution have made the mask an object already in the daily panoply and it has been very easy to encourage people to wear it. Similarly, the customs of greeting from a distance (especially the Asian “Way” with two hand joint in front of the face) help to avoid hugs and other highly contaminating interactions. Health ministries have based all their efforts on prevention at the community level. Nevertheless, there are significant civil society concerns about human rights issues surrounding the implementation of emergency laws taken in response to COVID-19.
1.4. EUROPE

Europe has been a very diverse area in terms of pandemic dynamics and health response. For some countries, faced with the rapid growth in the number of cases and the saturation of emergency services, the strategy has been total and strict confinement to "flatten the curve" and reduce the pressure on health systems. In others, a more flexible attitude has been chosen, proposing general but non-mandatory measures, as seen in Sweden and in the U.K. This gamble hoped to achieve herd immunity while avoiding disastrous economic impacts. Nonetheless, serological studies show that after several months, less than 10% of the population developed antibodies, well below the 80% required to achieve the desired effect. The resurgence of highly contaminated areas, known as "clusters", which have led to new confinements in Germany, Italy, Spain, amongst others, shows how far the pandemic is from being contained. While there is currently no massive second wave, epidemiological vigilance must remain the norm, while risky behaviour should be avoided. Alas, we are a long way from the ideal. The virus continues to circulate, and this is likely to accelerate with travel related to summer holidays. The behaviour of the coronavirus in the autumn, with its cooler climate and return to more confined spaces, remains unknown, but the concerns are significant.

Consequently, whether for these reasons or others besides, in the absence of sufficient natural or vaccine-acquired immunity, it is irresponsible to relax control measures only in view of the static improvements of recent months.

1.5. THE MIDDLE EAST

The Middle East had emerged both weakened and strengthened from the MERS crisis (Middle East Respiratory Syndrome), linked to a variant of coronavirus, which hit it from 2012 onwards. The MERS-CoV exhibited characteristics which could have led it to be classified amongst the causes of emerging diseases that could potentially develop into a pandemic. This obviously alerted the WHO and the CDC, who therefore rapidly targeted it in their epidemiological monitoring. Due to its highly pathogenic nature and the symptoms it causes, MERS-CoV was compared from the very first reports concerning it to the Severe Acute Respiratory Syndrome (SARS) that had nearly concurrently struck Asia, again with suspicion of an animal origin. Two years after the identification of MERS-CoV, more than 15 countries were still affected by it, for a total of 937 cases including 341 deaths. As of 16 June 2015, the WHO announced a global total of 1,293 contaminated cases (+34% per year) and 458 deaths (+31% per year), spread over 25 countries (in the Middle East, but also in Africa, Europe and Asia). Although it proved to be quite fatal, with a lethality rate of a little more than 33%, it was finally judged to be relatively not very contagious, despite strong concern when the first case appeared in the United States. A number of restrictions had already been put in place in 2013 to limit the risks during the Great Pilgrimage of Hajj and Umrah (small pilgrimage) to Makkah, with the Ministry’s recommendations targeting the elderly and those suffering from chronic diseases such as diabetes, respiratory problems and diseases affecting the heart and kidneys. It was thus in a context of high political sensitivity to the risk of epidemics that COVID-19 hit the Middle East.

Still marked by the MERS, the reaction of some governments to COVID-19 was resultingly rapid and highly proactive. The member states of the Gulf Cooperation Council (GCC) quickly built field hospitals for the treatment of victims, while countries such as Jordan put in place not only confinement measures but also a severe curfew with the threat of prison sentences in cases of non-compliance. A major challenge has been to put in place measures in houses of worship, as well as during Ramadan, in which measures had to be put in place to prevent transmission during prayers and evening reunions for the breaking of the fast. Generally speaking, however, a relatively strong individual and collective discipline has prevailed, largely inspired by fears related to the MERS crisis, but also to the rather authoritarian nature of many regimes in the area.

The major area of concern is centered on Iran, where the pandemic appears to be taking on worrying proportions; the countries around Iran as well have been touched, particularly Afghanistan, where the health system is very weak, as well as Syria, in which conflict continues. In fact, relatively little information on the dynamics
of the pandemic filters out of conflict-stricken countries. Iran officially confirmed its first cases of coronavirus in February and took a number of measures as a result, but it remains the country most affected by the pandemic in the Near and Middle East. By mid-July, Iran had passed 12,500 deaths. While the authorities are considering the reimplementation of restrictive measures in the capital Tehran to contain the spread of the virus, the pandemic has reached dramatic levels and measures to manage it will have a devastating impact on populations whose daily economic survival has already been severely undermined by US-imposed economic embargoes.

In Israel and in the Palestinian territories, the situation is quite complex. After reacting fairly quickly with border blockades and the imposition of quarantines following the arrival of COVID-19, the Israeli government, with the help of security forces, has set up a rather controversial electronic contact tracing system. The military, and more generally the security forces, have been at the forefront of the response, including through their distributions of masks and respirators. However, the complexity of Israeli society reveals strong resistance to barrier measures, particularly in the most traditional communities, which quickly have become a large part of the affected population. While the situation had improved considerably from May onwards, on July 6th there was a new surge in the number of people contaminated, with 1,000 new cases per day and an alarming increase in the number of deaths. The government is in the process of adopting a new set of restrictions. Efforts are being made to allow equipment and medical personnel to enter the Gaza Strip, where the first death was reported in early May, to facilitate the management of the pandemic.

1.6. A COMPARATIVE ANALYSIS: MORE QUESTIONS THAN ANSWERS

The varied nature of the ongoing crisis observed is the source of many misunderstandings on the part of both leaders and populations, which makes crisis management and reflections on eventual futures very complex. No one had any idea that Italy would become such an important hotspot for the virus, nor that Spain and France would follow. There is no totally convincing explanation to explain that the southern half of France has a very different epidemiological behaviour from the north, that the Dominican Republic has 15 times more cases than its poorer neighbor Haiti, which has a dilapidated health system, or that there are important differences between Panama and its neighbor Costa Rica.

Why should someone from a country not yet affected, or where the pandemic is still in an uncertain phase and has not killed anyone around them, follow recommendations from much richer countries that have seen their health systems shaken to their core and brought the most powerful economies of the world to their knees? The stones thrown by some Haitians at ambulances dedicated to COVID-19 intervention ask us this question. Around the world, the number of spontaneous social disorders has increased since the beginning of the pandemic. There have been more than 1,100 new situations of high social tension and unarmed violence in more than 90 countries since March 11, 2020. Demonstrations are more numerous and mainly directed against law enforcement enforcing containment measures, against health workers or even against people simply suspected of being infected. In other contexts, political leaders are denying the reality of the pandemic and adopting risky behaviours. This denial of the importance of the current crisis, made in the name of the primacy of economics over health, have led the British Prime Minister, as well as numerous advisors to the Brazilian, American and Indian heads of state either to the hospital or into quarantine, and have above all incited the population to disregard basic public health advice: masks, physical distancing... This has led to dramatic increases in the number of contaminated persons, of deaths and in the saturation of health systems.

It was believed that the youthfulness of populations, the heat, the resistance acquired in often unsanitary environments or the very frequent use of chloroquine would prove to be effective protections for African countries. It turns out that responding to this threat is not so simple. The pandemic continues along its path, albeit at a slower pace in Africa’s cities, savannahs and forests, often due to travelers from contaminated environments. The coronavirus arrived in the DRC via a traveler returning from Europe, and hit Timbuktu and Kidal hard, through infected UNAMID personnel.
Places classically considered to be at high epidemiological risk, such as the suburbs of Lagos or the shantytowns of Calcutta, did not necessarily see the evolution they dreaded (an accelerated growth in the number of cases), while New York, on the other hand, rapidly saw a dramatic situation develop. Understanding these dynamics is a question of time, say some experts, but time is precisely the variable that is lacking to deal with pandemics.

Political and epidemiological schedules are quite often at odds. Politicians have to act quickly, based on imperfect information, incomplete knowledge and very diverse, even opposing, scenarios. On the other hand, researchers must develop and test hypotheses, set up sound experimental protocols to obtain results that can be discussed with peers and reproduced: a lengthy process. Although the difficulties are enormous in view of the lack of knowledge, there are nevertheless certain actions which can be taken regardless of the temporal evolution of the epidemic. Between scientific certainty and necessary uncertainty in government policy, populations are questioning, worrying and suffering, both from the pandemic as well as from the measures taken to manage it, all of which is present in a time of infodemic (“fake news”), of infodemia (overabundance of information), which spurs a questioning about the reality of the phenomena and the relevance of the decisions taken.

While the difficulties are enormous given the lack of knowledge and politicization of the crisis in many parts of the world, there are nevertheless lessons to be learned and helpful actions to be taken regardless of the temporal evolution of the epidemic.

2. HOW TO MANAGE THE POST-PANDEMIC PERIOD

What the authorities have to fear is not so much the nature of the compulsory measures but rather the capacity of the population to accept them. Binding control measures seem to have been well accepted in some contexts, thanks to the empathy of its leaders - as demonstrated by the Prime Minister of New Zealand. In other countries, it has been through consistency in justification and measurement - as in Germany - or through the obligation without alternative imposed by authoritarian regimes that are used to seeing orders applied without much significant pushback - as in China or Cuba.

Explosive contamination situations will continue to occur, but based on current knowledge, the location of these next high contamination areas is not foreseeable in the medium term. Only a highly sensitive warning system will make it possible to identify emergency situations and take measures to cut the transmission chains as quickly as possible. Global and permanent monitoring, testing the entire population, is not really possible, especially in fragile countries where economic issues but also health system capacity quickly become important barriers.

On the other hand, the establishment of epidemiological investigation systems (identification of case trajectories, testing and tracing of contact cases) with small, well-trained and equipped mobile teams that can be deployed as soon as there is a hint of COVID-19 contamination, although far from perfect, has the merit of being possible, based on past experience in many places, particularly in Uganda in the face of Ebola. This should be integrated to become part of all epidemic control systems.

Procedural documents, operational guides and other supporting documents produced after previous pandemics and since the beginning of this one cover a very broad range of measures. The most interesting are those that are particularly useful for a significant number of countries, which in fact fall into two categories:

- States with strong health systems and financial and human resources, but which nevertheless had great difficulty in controlling the pandemic;
- States that lack the technical, financial and human resources must choose measures that are inexpensive and likely to be applied in the long term, even after the discovery of an effective vaccine in case of any mutation or other virus.
This is the arsenal of prevention, which ranges from mass education to early warning mechanisms to the rapid implementation of behavioral guidelines disseminated in communities and supported by local influential leaders. Unlike the medicine that can be taken immediately by a person or the vaccine which can be administered to a more or less large segment of the population according to strategy, relying on barrier measures requires a change in behavior on behalf of the State, which must trust its population; and on the part of the population, which must trust the State. A patient will take a medicine without worrying if their neighbor does the same. On the other hand, a person is likely to be reluctant to wear the mask if their neighbor or their President does not. The widespread implementation of barrier measures, such as the systematic wearing of masks, physical distancing or hand washing take a lot of time and constant reminders. But they have the advantage of being useful even beyond COVID-19, whether for cholera or other contagious diseases, or even to allow for a 30% reduction in antibiotic consumption1.

The most cost-effective investment in terms of money, lives saved and protection of the most vulnerable, even more so for a country without resources, is not in focusing on response but rather on prevention strategies and the long-term development of national plans and programs in which SARS-CoV-2 will have to be considered endemic. Each country must, depending on its culture, type of government and resources, as soon as possible, strike a balance between promoting the preventative measures (barrier gestures and "test-quarantine" systems to keep transmission at a minimum) and preparing and adapting its society, social relations and economy to a new way of life that will take into account this new endemicity.

Emergency response assistance to deal with the pressing aspects of the pandemic is critical, but without including a long-term vision, it will fail to boost the resilience of populations, putting them at risk both in future pandemics and in facing off against the systemic crises of tomorrow. Somewhat counter-intuitively, reducing the number of deaths depends on long-term behavioral changes. The urgency is therefore to strengthen, as quickly as possible, programmes for the development of comprehensive public health systems, from village squares to health services, to find economies and food systems, and to invest in long term change. For example, it will be necessary to find the means to continue to support the networks of local health workers and community agents who will be at the heart of prevention mechanisms and alert systems.

The lack of preparedness throughout the world in spite of the risk of a pandemic was flagrant despite the announcements made by relevant authorities for more than 30 years, as well as the warnings that SARS and MERS provided us. If not tomorrow, in the near future every country in the world is at risk of being affected by a new epidemic.

---

1 https://www.ajicjournal.org/article/S0196-6553(20)30209-1/abstract
COVID-19 has highlighted one of the key paradigms of disaster management: the need to be able to respond quickly to multi-sectoral and multi-dimensional problems. As is the case in dealing with major disasters, taking charge of crisis management, promoting measures to protect populations, managing population flows (managing pandemics often involves managing multiple flows), avoiding compounding accidents, etc. cannot solely involve health authorities. An inter-ministerial approach is needed, drawing on the expertise of ‘civil protection’ type mechanisms and those of the economic and social sectors. This lesson will be crucial for the next epidemic.

**IN CONCLUSION:**

Fragile countries face enormous challenges but also a unique window of opportunity. Just as these countries have moved directly to mobile phones, bypassing the fixed telephone, there is an opportunity for some to avoid the "all for the hospital" impasse, to instead invest heavily in health education at all levels and to strengthen the three-pronged approach "Health Education - Health Alerts - Prevention and Early Adoption of Good Behaviour" in the long term.

This development does not only concern fragile countries. Everywhere in the world, it should be possible to use part of the resources mobilized in response to the COVID-19 pandemic to invest in this strategy, whose proven effectiveness will best help societies in the long term, especially for all other epidemics.

At this stage, in view of the high probability of coronavirus endemicty, countries all over the world should be encouraged to use at least part of the resources mobilized to respond to the COVID-19 pandemic to invest in the three-pronged approach "Health education - Alert and preparedness -Prevention", whose proven effectiveness will best help societies in the long term, especially for all other epidemics.

The countries and the donors who would support this approach would give real meaning to their response strategy by concretizing the concept of the "emergency-development nexus", at home and abroad.