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The potential impact of COVID-19 on poor and conflict-ridden communities in Sub-Sahara Africa (SSA): A reflective paper

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Abstract

Sub-Sahara African (SSA) countries are affected by an array of health and social welfare related problems ranging from the weak infrastructure of their health system to shortages of equipment and qualified personnel in hospitals and other facilities. This makes it difficult for systems in Sub-Sahara Africa to withstand the COVID-19 pandemic which has led to the rapid infection of the population. Furthermore, low instances of professional interventions have resulted in other health and social problems affecting the populations in these countries. COVID-19 is likely to impact particularly hard on populations living in Sub-Sahara Africa. This paper sets out to explore the potential impact of COVID 19 on poor and conflict-ridden communities in Sub-Sahara Africa. It reflects on the possible impact of COVID-19 and the subsequent action of lockdown to contain the situation. The paper concludes that governments in sub-Sahara Africa must initiate clear, implementable policies for pandemic management and for social work professionals who work with vulnerable communities. It also recommends the commissioning of research into the development of low-cost infection prevention work and technology.

Keywords: COVID-19, poverty, conflict, global challenges, sub-Sahara Africa

1. Introduction

The first cases of the novel coronavirus disease (COVID-19), previously known as 2019-nCoV, were reported in late December 2019 in Wuhan, China (Wu et al., 2020). The virus then spread to Malaysia and Thailand and eventually to the Americas, Europe, Australia and Africa. On the 11th of March 2020 the World Health Organisation (WHO) declared the COVID-19 a global pandemic.

The rate at which the pandemic has and continues to accelerate has the potential to fatally affect millions of people across the globe, particularly in developing countries south of the Shahara where there is high prevalence of poverty, conflicts, and diseases. In response to the pandemic many governments launched unprecedented public health and economic response programmes (Narayan, Phan and Liu, 2020). Individual countries rolled out strategies based on guidance from the WHO. Strategies varied according to availability of resources in each country and aimed to tackle the pandemic. They have attracted critical attention from public health and social work practitioners, especially in regions affected by poverty and social unrest such as sub-Sahara Africa (Wemesa et al., 2020).

Generally, COVID-19 is an acute and resolvable disease, but it can also be deadly, with a 2% case fatality rate (Xu et al., 2020). Severe onset of COVID-19 may cause death due to crippling alveolar damage which progresses to Acute Respiratory Distress Syndrome (ARDS), which may in turn lead to respiratory and organ failure (Huang et al., 2020). The condition is likely to impact more in sub-Sahara African countries owing to structural poverty and weak health

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systems. These regions experience a shortage of health and social work professionals along with related resources and equipment.

Fatalities from countries with robust health systems like Italy, United States of America, United Kingdom, and Spain have increased. Statistics as of 18 April 2020 showed 22,745, 32,823, 15,464 and 20,162 deaths for the aforementioned countries respectively (Wilson et al., 2020). Although some countries have shown signs of controlling the pandemic, eradicating the disease is still a far cry away, especially with reported negative cases testing positive again (Onder, Rezza and Brusaferro, 2020). The impact of the pandemic, especially with stifling lockdown measures, has the potential to go beyond mortality and morbidity, to impact on the socio-economic status of the countries and population. Most seriously affected are poor communities in Sub-Sahara African settings that are not supported by robust economic and social packages during lockdowns. McKibbin and Fernando (2020) assert that amidst the slowing down of the Chinese economy, which is the leading world exporter and with interruptions to production, the functioning of global supply chains has been disrupted. This has impacted on multi-national companies across the globe, regardless of size. This has also impacted upon Sub-Sahara African countries whose economies mainly depend on the functioning of more robust global economies. Many countries have started experiencing contractions in production which has resulted in some companies going into administration (McKibbin and Fernando, 2020). With restrictions and limitations of transport in various countries the global economy has slowed down. This has severe implications for populations of sub-Shahara Africa where high unemployment and disease pre-existed COVID-19. Numbers of poor households and unemployment levels are expected to increase (Haider et al., 2020) bringing with it rises in social unrest and mental health concerns which the welfare systems are ill equipped to address.

The panic among consumers and companies has distorted normal consumption patterns and created stampedes and anomalies in the demand for basic commodities and products deemed essential to protect individuals from infection (Guerrieri et al., 2020). In some cases, supermarkets have witnessed sales figures predicted for the year being achieved in the first quarter of 2020 (Fernandes, 2020). On the other hand, non-essential retailers are falling on hard times with a number having to close their doors for the last time. The world stock markets have responded with plunging indices and financial markets (Ozili, 2020). Prolonged periods of such economic turmoil are likely to have a profound impact on many poor communities in sub-Sahara Africa.

This paper explores the potential impact of COVID-19 on poverty stricken and conflict-ridden communities in Sub-Sahara Africa. In doing so, the paper also explored the implications for health and social welfare professionals working with these communities, including recommendation for future policy development.

2. Predictions for a pandemic

There is evidence that population health, as measured by life expectancy, infant and child mortality including maternal mortality, is positively related to economic welfare, growth, peace and tranquillity (Pritchett and Summers, 1996; Bloom and Sachs, 1998; Bhargava and Docquier, 2008). There are a wide range of ways an infectious pandemic like COVID-19 can influence the social order, the economy, education, and social work provision in a given country. Health and social work professionals work with the direct and indirect costs of illness, treatment and interventions. They are often the subject of economic studies relating to the burden of disease (McKibbin and Fernando 2020). A conventional approach indicates that death rates (mortality) and prevalence of illness that limit productivity (morbidity) are used to estimate the loss of future income due to death and disability (Troeger et al., 2020). Such conventional methods underestimate the true economic cost of pandemics, particularly in relation to populations with long term health and social care needs relating to conditions such as HIV/AIDS and SARS. Lessons learned from these earlier pandemics provide a formula to predict the potential harm and implications of pandemics like COVID-19. The WHO produced Health Emergency and Disaster Risk Management (EDRM) Framework in 2018 derived from global 'good practices and achievements' (World Health Organisation, 2019) in previous situations. There was a broad focus on improving the health outcomes and well-being for at risk communities in various contexts including 'fragile, low- and high-resource settings' (World Health Organisation, 2019).

3. Social disorder and the COVID-19 economy

As of 30 March 2020, 46 of sub-Saharan Africa's 49 sovereign states imposed partial or full closures of their borders; 44 closed schools, banned public gatherings, or put in place other social distancing measures; and 11 had declared a state of emergency (Haider et al., 2020).

Following the COVID–19 outbreak, many governments in the developed world provided survival packages for businesses and individuals to keep them financially viable during the lockdown period (Liu et al., 2020). The United States of America injected two trillion dollars into its economy (Grech, Grech and Fabri, 2020). In the United Kingdom, the government introduced a furlough system for individuals and small to medium sized businesses to help businesses to cope with the downturn in sales as a result of the anticipated lockdown measures. This meant that employees of affected businesses received eighty percent of their salaries (Schaeffer and Dickinson, 2003). However, it is important to remember that contingency funding schemes have limitations; for example, furloughing employees creates a financial burden on the state and may adversely affect the mental health of

vulnerable populations (Mimoun, Ben Ari and Margalit, 2020). In addition, such schemes may be curtailed, leaving employees without jobs to return to.

This situation designed to delay significant economic downturn is nonetheless preferable to the situation in the developing world where emergency measures designed to delay economic crises are less common. Only South Africa, Kenya and Ghana produced economic stimulus packages. South Africa provided USD6.2 billion and Ghana USD1.2 billion (Ozili and Arun, 2020). Uganda provided limited food rations (6 kgs of maize meal and 3 kgs of beans per household) to vulnerable people (Gentilini, Almenfi and Orton, 2020). These interventions were not only insignificant but do not align with the idealistic goals set out by the WHO in 2019 goal. The commitment to safeguard citizens and serve vulnerable people during emergencies to ensure "no one is left behind" (World Health Organisation, 2019, p. 5) has rapidly become unobtainable.

The risk of civil unrest grows in sub-Saharan Africa as the population defy lockdown orders. Blame for social unrest focuses on people living in poverty who cannot survive harsh lockdown measures. Curfews imposed by the government in Zimbabwe (Kihato and Landau, 2020) increase the risks for people who have no choice but to try and feed their families. Staying at home from 7:00 p.m. to 6:00 a.m. is not an option.

The most detrimental effect on these populations is loss of income. Market traders and street vendors are most affected as they cannot earn an income during movement restrictions and the curfews instigated to control of the spread of COVID-19. The effects on small traders is illustrated in a case study by Tarisayi (2014) in Chitima Market in Masvingo, Zimbabwe after the Ebola outbreak in West Africa. Tarisayi estimates that 5.7 million people were engaged in small or medium enterprises as their sole income with 5.4 million in the informal sector. Precautionary measures were put in place to prevent the spread of disease through contaminated second-hand clothing. The result was that because of public perception of risk, second-hand clothing traders lost between 50-75% of their income through a drop-in sales and up to a 50% decrease in sales prices. In respect of these early experiences, lessons have not been learned. Since COVID-19 social distancing measures have been implemented, and consequently millions of African city inhabitants are working in 'unrecognised and illegal markets and economies' (Kihato and Landau, 2020, p. 3)

Clashes between the security forces and the public have been reported in Liberia, and there have also been cases of looting food in South Africa (Muanda, Dandjinou and Sampasa-Kanyinga, 2020). In sub-Sahara Africa instances of gender-based violence are high and rose during the 2014-2016 Ebola pandemic (John et al., 2020). The impact of COVID-19 lockdown may also see a rise in domestic violence affecting women and children. Social disruption is experienced against a backdrop of poor welfare provision as ill-equipped professionals struggle to support communities.

COVID-19 isolation and lockdown measures are more likely to be implemented in urban areas where around 40.18% of the SSA populations live (Magadi, 2011). Individuals are already confined to housing that is cramped and lacks adequate facilities. WHO advice on physical distancing 'is a cruel joke' (Kihato and Landau, 2020, p. 2) to those residing in homes with limited access to water and space in informal settlements (Kihato and Landau, 2020). There is wide gap between the aspirations of policy documents and what can be achieved at local level.

4. Poverty and public health

A study undertaken in Sabon Zongo, Accra (Owusu, 2010) explores how poor sanitation and waste management in urban communities affect the mental wellbeing of their populations in developing countries. The existence of communal bathroom and toilet facilities, for example, disadvantages the youngest members of the community as they are unable to plan the walk to the toilet and perhaps also be able to queue until they can use the toilet. When shared facilities are the only option, there are concerns around how the areas are being kept sufficiently sanitised and how the COVID-19 social distancing advice is being followed. As the living conditions are cramped the impracticability of social distancing becomes apparent. Lockdown introduces environments that are fertile grounds for new infections such as communicable diseases, including HIV/AIDs because of this forced confinement to shared living space. Policy interventions that are intended to increase adherence to social distancing guidelines have the unintended consequence of causing the situation to deteriorate further and serves to 'exacerbates the vulnerability associated with economic and spatial marginalisation' (Kihato and Landau, 2020, p. 3).

Lim et al. (2012) discovered that 85% of diarrhoea mortality is caused by inadequate water, sanitation and hygiene practices. This has a domino effect on the outcome of uncontrolled, tropical diseases which in turn lead back to malnutrition. Malnutrition in under-fives is not the preserve of urban areas but also dramatically affects rural areas, especially in countries like the Democratic Republic of Congo (DRC) where income is dependent on the mining industry. The Food and Agricultural Organisation (FAO) point out that malnutrition causes delayed physical growth, poor motor development, lower intellectual quotient, behavioural problems, deficient social skills and susceptibility to disease. All of these are necessary for health literacy and independent decision making that degrade the quality of life. In a crisis such as the COVID-19, they have implications for the inability to implement advice and suggested precautionary measures.

5. Mortality and morbidity

The significance of poverty on the prevalence and incidence of communicable and non-communicable diseases in SSA has been featured in numerous studies (Harries et al., 2008). Various research data evidences that disease, poverty, failed political leadership, persistent drought, locust

infestations, natural disasters and conflict belong to an intricate network that influences the outcomes of disease management and ultimately affects mortality and morbidity (Cahill and Annan, 1999). It is against this backdrop that the COVID-19 pandemic measures to control and stem the incidence of new cases are being introduced. This presents new challenges to populations and communities already affected by a myriad of health problems because of conflict and poverty (Kneebone and Berube, 2013). Each of these skews the equilibrium of health care provision against the exposed social group in the population. The necessary COVID-19 restriction on movement and social distancing produce new, unintended complications particularly because of poor support of the vulnerable population ridden by conflict and poverty.

In order to understand the extent to which these populations are affected, it is necessary to revisit some of the findings of studies specifically exposing the relationship between non-communicable and communicable diseases. This includes the migratory patterns of rural populations to urban areas who are later documented as being at further risk of a new set of conditions that lower morbidity and mortality rates. Chow et al (2013) states that 50% of the Sub-Sahara African population live in poverty. They define poverty as earnings of $2 per day or less. Factors such as employment, education and housing influence health opportunity which is directly proportionate to health literacy, accessibility to health services and the availability and detection of diseases (Brundisini et al., 2013).

Evidence from many developing countries including SSA has shown that whilst dwelling in urban areas increases accessibility to health care, individuals are exposed to other chronic conditions for example, hypertension due to obesity and overweight as a result of a change in diet (Critchley, 2009). Furthermore, co-morbidities increase the risk of more severe complications from any infections, which implies that the severity of COVID-19 infections is heightened. The migration of populations from rural to urban areas is set to expand in each of the SSA countries as they develop, and more opportunities become available in cities and towns (De Brauw, Mueller and Lee, 2014). The low levels of disease control due to the unaffordability of the required long-term treatment, influences individual incomes and economies as non-communicable disease is said to have a greater drain on resources than communicable diseases (Critchley, 2009). In a cross-section survey of urban and rural communities in SSA, Hendricks et al. (2012) found that Black Africans in Lower and Middle-Income Countries (LMIC) have a higher risk of organ damage, because of uncontrolled hypertension, than their Caucasian counterparts in High Income Countries (HIC). The findings predict that as populations expand, so will the incidence of hypertension and subsequently diabetes. This group is also at risk of complications of diabetes and hypertension which are both linked to obesity. Because of poor monitoring and treatment, the resultant complications lead to disability that affects employment and productivity. Mbanya et al. (2010) explore diabetes in SSA and highlight a list of complications that are a result of poor diabetes management. Whilst comparative figures of HIV/AIDs infections in the towns and rural areas are not available, it is safe to assume that where they exist, there will be corresponding incidents of diabetes as a side effect of anti-retroviral medication which is believed to cause metabolic syndrome (Oliveira and Rondó, 2011)

The urban populations are also at risk of obesity and being overweight as they change from traditional diets to westernised diets. 27% of adults over twenty years are overweight and 8% are obese (Liu et al, 2020). This exposes them to the potential development of type 2 diabetes, certain cancers, musculoskeletal disorders and cardiovascular disease. In their paper on obesity and the nutrition transition in Sub Saharan Africa, Steyn and Mchiza (2014) define nutrition transition as the shifts in community dietary patterns from famine to reduced famine then to malnutrition related chronic conditions. This last phase is associated with improved income or affluence. These shifting populations represent changes in disease profile that is related to socioeconomic development phenomena such as malnourished children in the same household as an obese adult. The entire household is at risk. There is also an increase in fat, sodium and sugar intake as this is more readily available through the urban food supply chains (James, 2008). Malnutrition can cause pancreatic calcification which causes diabetes, it also devastates the individual health that increases vulnerability to HIV/AIDS and adversely affects the outcome of existing infections (Magadi, 2011). Malnutrition compromises the immune system and therefore increases the risk of HIV transmission and other infections. This makes them vulnerable to infections, such as the highly contagious COVID-19, which they are most likely to contract; this places a double fold burden on health service efforts to curb infections.

6. Poverty and chronic conditions

As COVID-19 continues to spread, ‘challenges for maintaining the HIV care continuum’ (Jiang, Zhou and Tang, 2020, p.309) are of particular concern for regions with weak health-care systems. In the early 80s to late 90s HIV/AIDS virus affected families and businesses through changed labour supply decisions; efficiency of labour, household incomes and support of the disabled, and children orphaned by AIDS, (Haacker, 2004). Although the effects of AIDS are long-term, there are active programmes that minimise risks of new infections and lessen the negative effects of the disease on the socio-economic fabric of society. The success of these prevention and education programmes in both developed and developing countries is well documented (Cornish and Campbell, 2009). Treatment is available in the form of effective antiretroviral therapy (ART) which improve the lifespan of individuals living with HIV to normal life expectancy. The implementation of COVID-19 measures such as quarantine, social distancing, and lockdown have reduced access to routine HIV testing (Jiang, Zhou and Tang, 2020). In addition, provision of ART ‘might be deterred or delayed

because hospitals are prioritising the treatment of patients with COVID-19' (Jiang, Zhou and Tang, 2020, p. 308).

Many developing countries prematurely mimicked lockdown measures being deployed in developed countries, without developing country-specific programmes to address their unique circumstances or considering capacity of the populations, to live through lockdowns. Their lockdown measures were enforced without social welfare preparations to alleviate the problems experienced in poor and conflict-ridden communities in their custody (Cohen and Kupferschmidt, 2020). For example, more than 60-70% of the working age population are unemployed in Sub Sahara Africa (Woolard and Leibbrandt,1999). The rate of savings in Sub Saharan Africa stands at just 18.2, compared to 33.4% in upper middle-income countries (Shiferaw et al., 2014) With little or no savings, the capacity of communities in Sub-Saharan Africa to survive through a lockdown is quite limited. Sub-Sahara Africa is home to two thirds of the world's population living with HIV, this same populace is also affected by a myriad of other chronic conditions such as diabetes and hypertension, induced or worsened by lifestyle and poor health systems (WHO, 2020). Some of these communities live in conflict spots where the population is affected by abject poverty and very unhealthy conditions. The gravest examples include Goma, Democratic Republic of Congo as well as South Sudan (Mugisa, 2010). The aforementioned adverse conditions increase the vulnerability of these communities to chronic non-communicable diseases and highly contagious localised outbreaks or pandemics such as COVID-19. In Uganda, there has been an outcry from people living with HIV/AIDS because they cannot access ARVs, given the ban on private and public transport and stringent approval processes to obtain an exception for private transportation. All these problems are a result of poor economic and inadequate social support packages from governments.

According to Marsh et al. (2019), developing countries report incidence of 90% of the new HIV/AIDS infections globally. Coupled with these persistent numbers, are complications caused by malnutrition and opportunistic infections. Gillespie, Kadiyala and Greener (2007) associates income inequality with HIV prevalence and notes that risky behaviour such as transactional sex is used to procure food in some of the most impoverished areas. Where income is restricted and the opportunity to buy food is limited, risky behaviour will prevail. The need to buy food outweighs the threat of COVID-19 infection, in the same way that sex workers are more likely to defy movement restrictions in order to satisfy basic needs. This is the predicted behaviour in LMIC where governments did not have support packages for its vulnerable social groups.

7. Child poverty and COVID-19

The education of children during COVID-19 measures in sub-Sahara Africa has been hampered by poor internet and communication systems. A prolonged lockdown may therefore lead to loss of learning hours which will never be recovered. Poor health and social outcomes for children are anticipated here as predicted by trends elsewhere in the world (Van Lancker and Parolin, 2020). Some of the populations at greatest risk of malnutrition, are the under-fives that live in conflict zones, such as Goma. Conflicts are accompanied by corruption, deterioration of socio-economic conditions, including damage to infrastructure and sanitation provisions. Government resources are focused on the army and related costs to maintain the conflict (Le Billon, 2001). Initiatives to promote economic development, for example, agricultural initiatives are abandoned as funding and resources are diverted to support the conflict. The demands of strict COVID-19 restrictions cannot be enforced as the social patterns of living, working, and socialising have been disrupted. It also implies that meaningful data about infection rates and prevalence of COVID-19 will be difficult to collate. Sidel and Levy (2008) suggest that degradation to the physical environment caused by war disrupts the societal infrastructures that support health initiatives amongst displaced populations. The resulting disrupted health education and health care provision provide poor and, in some cases, non-existent platforms to launch COVID-19 prevention programmes. Such communities find it difficult to follow the lockdown directives owing to unsupportive social and political environments.

8. Limitations of the paper

This paper was written while the impact of COVID-19 was still unfolding in poverty-stricken communities and conflict zones. Inevitably it could not consider all the effects at time of publication. A more detailed paper in the aftermath of COVID-19 pandemic would include an exploration of the effectiveness of individual government response programmes and the impact of COVID-19. The paper is conceptual in nature and therefore lacking in primary data from people with lived experiences. Ideally, a primary study to research the cost of COVID-19 among poverty stricken and conflict-ridden communities would be undertaken.

9. Implications for professionals working in poverty stricken and conflict-ridden communities

Public health and social workers in poverty-stricken and conflict-ridden communities require opportunities to develop protocols and practices to work more effectively within their own communities in emergency situations. The health and welfare of community members with existing vulnerabilities in developing countries like Sub-Sahara Africa must be prioritised. For example, women and children affected by domestic violence experience increased risks during lockdowns and need to be able to access support services. Practitioners may be overly dependent on measures and models created for societies that do not experience their level of structural inequality. Simplified, sustainable, infection control community-based courses of action must be implemented. Training should ensure sustainability, with community leaders being trained to train their community members (Bridges et al., 2011). This is very important in

reducing the health and social impacts of pandemics such as COVID 19. Multidisciplinary working amongst health and social work professionals is essential to make sure that all vulnerable individuals access support during COVID-19 lockdowns. For example, ensuring the individuals with HIV can gain access to medication and support networks. More importantly professionals must advocate for the rights of communities to be adequately supported by their governments as a way of instituting social justice (Barnett et al., 2011). Many vulnerable communities lack the confidence and information to assertively claim their rights. There is a need for health and social work professionals to develop cost effective bespoke plans to minimise the impact of pandemics like COVID-19 where scarcity of resources increases the risks posed to communities. WHO and other emergency focused planning organisations must reconsider contingency planning measures and draw on the repeated patterns of health and social issues given rise to by global emergencies. Governments in sub-Sahara Africa need to institute clear implementable policies on pandemic management. Research into the development of cheap and low-cost infection prevention technology needs to be commissioned. Such research is vital in alleviating the massive, underfunded health services in low and middle-income countries especially in sub-Sahara Africa. Sub-Sahara African Governments need to support vulnerable unemployed and conflict-ridden communities during periods of lockdowns and quarantine in response to pandemics like COVID -19 and Ebola. There is need to increase the existing training capacity of professionals such as social workers and health practitioners to work with communities in developing countries like Sub-Sahara African communities during pandemics.

10. Conclusion

The web of diseases, their interconnectedness and resulting impact on communities in sub-Saharan Africa are undeniable. The relationship between disease, poverty and conflict including its inference on income earning, employment prospects and wellbeing is also quite clear. All these factors make a clear case for the stringent distancing measures recommended by the WHO in 2019 to prevent the spread of infections like COVID-19. However, these same measures put communities at risk of contracting COVID-19 from each other in their confined living spaces. Loss of income leads to malnutrition, particularly in the under-fives and the process of collecting water for household use from a source serving more than 50 families. The risk of poverty, economic recession and collapse and death from starvation and other poverty related maladies is real. LMIC must have support packages for vulnerable populations during pandemics like Ebola and COVID-19. The need for clear policies on pandemic preparedness cannot be neglected any longer.

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