



## THE VALUE OF VIGILANCE: COSTA RICA'S FIRST-YEAR RESPONSE TO COVID-19, 2020

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### SYNOPSIS

In early January 2020, when the World Health Organization announced that SARS-CoV-2 had spread beyond Wuhan, China, and represented a public health risk of international concern, Costa Rica was better prepared than other countries in its region. The Central American nation had years earlier developed preparedness and response plans to deal with swine flu, avian flu, Ebola, and other infectious diseases and had updated them in 2018. There was high confidence in both the country's universal health-care system and the government health-care teams that served even the remotest regions of the country. Doctors had access to an up-to-date database of medical histories that covered more than three-quarters of the population of about 5 million. However, the country also had some vulnerabilities: more than a fifth of the populace lived in poverty; many jobs were associated with international tourism—a sector likely to be hit hard in a pandemic; and the government was wrestling with a fiscal crisis that had started years earlier. Weeks before Costa Rica confirmed its first case of COVID-19, ministries and national institutions began work to procure medical supplies and equipment, set up financial and social assistance programs, and develop a road map to build resilience for the tourism industry. When the virus appeared in early March, the national government declared a state of emergency within days to ensure that every ministry and institution could contribute effectively to the pandemic response. Initial confirmed infections were relatively low in number, but as case numbers grew through 2020, collaborations with partners both national and international led to innovative solutions to avoid a nationwide lockdown and make Costa Rica the first country in Latin America to safely reactivate commercial air travel and international tourism before year's end.

## INTRODUCTION

When the first signs of a possible COVID-19 pandemic appeared in late 2019 and the early days of 2020, Daniel Salas felt concern but not fear. As health minister of Costa Rica, Salas trusted that his country's relatively robust health-care system, emergency preparedness, and recent experience in managing infectious disease outbreaks—starting with swine flu (H1N1) in 2009— could cope with the novel coronavirus.

A constitutional republic with a presidential system, Costa Rica had enacted in 2005 a National Law on Emergency Management and Risk Prevention, which established frameworks for interinstitutional coordination and decision making and laid out response protocols. As provided in that law, the government already had established a National Commission for Risk Prevention and Emergency Response and a color-coded alert system it usually applied to warn of weather-related hazards. Its health-care system had a thousand government medical teams that provided primary care throughout the country and whose members visited individual homes—even in remote communities—and it managed digital health records for about three-quarters of the population.

Costa Rica also had introduced a conditional cash transfer program that covered a high proportion of families in need.<sup>1</sup> But the nation of 5.1 million also had vulnerabilities. Although income per capita—adjusted for purchasing power—was double or triple that of most other countries in the region, about 1 million residents lived below the country's poverty line. Geographic proximity to countries affected by political conflict and high rates of crime had recently spawned a surge of migrants seeking to settle within Costa Rica's borders.<sup>2</sup> Further, any significant disruption of international travel could jeopardize trade and a growing tourism industry, with significant economic consequences. Since 2012, tourism revenue as a percentage of GDP had grown steadily.<sup>3</sup>

In January, the risk and emergency commission, led by its executive president, Alexander Solís, began to assemble plans for a whole-of-government response should the new coronavirus arrive in Costa Rica, though primary responsibility for health policy and preparedness remained with the health ministry. As news of community transmission emerged from China, where the virus originated, the World Health Organization (WHO) and the Pan American Health Organization (PAHO) issued their first epidemiological alerts and urged countries in the Americas to prepare to detect infections. Health Minister Salas called on the commission to activate an emergency operations center, and on January 29, the center launched on a provisional basis in preparation for a potential epidemic.

As the international picture darkened through February, Costa Rica's health ministry and risk and emergency commission laid the groundwork for a coordinated response and issued guidelines to public and private health centers as well as airports and other ports of entry with regard to the screening of travelers and tourists for signs of the disease.

On March 6, Costa Rica confirmed its first COVID-19 cases, and the government shifted into high gear.

## THE CHALLENGE

Despite Costa Rica's substantial planning for a coordinated disease response, the country still faced significant challenges beyond the tasks of trying to track and reduce COVID-19 transmission, contain outbreaks, and help people keep themselves safe. Managing the national health crisis required a strategy to protect the entire population—including those most vulnerable—not only with regard to physical health but in social and economic ways as well.

An effective pandemic response required alignments of policies and actions across all levels of government as well as across national agencies. At the time, Costa Rica had 82 cantons or municipalities led by mayors and 8 remote *intendencias* (administrative departments)—led by municipal councils and local leaders. (Costa Rica's seven administrative provinces had no elected governors or legislatures.) Although the country had a unitary system of government, health care was partly decentralized in order to improve responsiveness and flexibility.

Moreover, although the country's health-care system had an international reputation for its high quality, it did not have some of the resources needed to meet anticipated needs. Specifically, it lacked the number of intensive care units (ICUs) and specialized health personnel that would be required to treat high numbers of patients with severe respiratory disease. The health minister said the country had only about 30 beds in ICUs available for COVID-19 patients. But expanding that capacity would require time and money.

The likely social and economic impacts of strong public health measures such as business closures and stay-at-home orders attracted special concern. Costa Rica's average living standards were among the highest in Central America (gross national income per capita, adjusted for purchasing power, was about US\$19,830 in 2019, according to the World Bank),<sup>4</sup> and only about 3% of the population lived on less than the international poverty standard of US\$3.20 per day, yet many were economically vulnerable, living on the brink. Roughly 21% of residents lived below Costa Rica's own national poverty line, defined as a monthly income of 112,317 colones (approximately US\$190 in 2020).<sup>5</sup> Complicating the challenge, most of the poor lived in far-flung rural areas, and many were among the million or so people not covered by the Unified Digital Health Record, a national database of patient medical records.

In addition to anticipated economy-wide effects of reduced income, a growing tourism industry dependent on international travelers created a special vulnerability. The Costa Rican Tourism Board said the country had received more than 3.1 million visitors in 2019,<sup>6</sup> estimated to have generated about US\$4 billion—approximately 5% of GDP.<sup>7</sup> Based on estimates from the National Institute of Statistics and Census, the tourism board also said the industry directly employed 170,879 people, or 6.8% of the country's total workforce, and

combined with jobs related indirectly to the industry, the sector employed 482,927, or 20.8%.<sup>8</sup> Government actions to curb COVID-19 transmission from the outside world could devastate this part of the economy.

Complicating matters, Costa Rica also depended on fellow Central

American countries to introduce and implement policies to limit disease transmission. Truckers and migrant workers, who were essential to commerce, regularly crossed its borders (figure 1). Moreover, violent crime and political conflict in the region had caused a surge in the number of migrants fleeing to safety, and by 2020, Costa Rica, the region's success story, was hosting 121,983 refugees and asylum seekers—many of them from Nicaragua or Venezuela—in addition to the more than 300,000 Nicaraguans already living legally within the borders as well as 125,000 unauthorized Nicaraguan residents.<sup>9</sup> The government had only police units to enforce border controls because Costa Rica had abolished its military in 1948.

Finally, when economist and former human development and social inclusion minister Carlos Andrés Alvarado became Costa Rica's second-youngest president in April 2018, he confronted a fiscal crisis. The budget deficit was over 5% of GDP that year and reached almost 7% the next—well above the average level in member countries of the Organisation for Economic Co-operation and Development (OECD), including nearby Mexico.<sup>10</sup> The OECD, which Costa Rica sought to join, had called for further steps to broaden the tax base and to reduce costs by streamlining the public sector.<sup>11</sup> Alvarado and the legislature had enacted a fiscal reform law that increased income taxes on salaried employees and instituted a new capital gains tax.<sup>12</sup>

## FRAMING A RESPONSE

When the WHO alerted the international community on January 20 that COVID-19 could be transmitted from person to person, Health Minister Salas directed government agencies to monitor guidance from the UN organization and PAHO, which provided scientific and technical expertise on health matters to countries in the Americas.

Salas, a physician who had worked in the health ministry for many years and specialized in epidemiology and public health, had been elected president of

**Figure 1. Costa Rica in Central America**



PAHO's executive council just a few months earlier, and he began to meet regularly with PAHO as well as his counterparts in the health ministries of neighboring countries. Worldwide, early information and reports were muddled. As the picture became clearer, the commission and the ministry provided further information for public and private health-care institutions and centers as well as airports and other ports of entry, which helped the entities identify potential cases.<sup>13</sup>

Salas said it quickly became evident that the situation could become a pandemic. As cases increased significantly in Wuhan, China, and as other countries started reporting their own infections—most of them related to international travel—it was logical that the disease was already in many other countries, although yet undetected. Salas said the disease's continued expansion was only “a matter of time.”

On January 30, when the WHO declared COVID-19 a public health emergency of international concern, Costa Rica's health ministry established provisional guidelines—based on those followed during flu outbreaks—in order to help government officers and residents prepare.

The risk and emergency commission, which operated under the aegis of the presidency, began working with the health ministry to develop a strategy for containing the spread of infection. To provide technical support, the commission's executive board brought together essential ministries—health, the presidency, public security, transport, housing, environment, and finance—as well as organizations that dealt with border control, migration services, airport police, and health research, plus the International Red Cross. The commission already had set up thematic working groups to monitor and analyze health, social, and economic data.<sup>14</sup>

The commission's provisional operations center established a situation analysis room, which also monitored health, social, and economic data and reported the information and analysis to the full commission. (The situation room was a virtual operation until June, when it moved into the National Stadium, a modern sport and event arena in the capital, San José, that was big enough to accommodate distanced face-to-face meetings.)

Based on information and analysis from the commission's thematic working groups, Solís presented the board's recommendations to the president,<sup>15</sup> who assembled cabinet ministers and heads of selected public agencies to review the proposals and help coordinate institutional responses. Implementation of the resulting health policies was the responsibility of the Costa Rican Social Security Fund, the country's primary public health system administrator. The fund shared responsibility for data collection and analysis along with the risk and emergency commission.

Activity accelerated after Costa Rica confirmed its first COVID-19 case on March 6. The patient and her husband, visitors from the United States, were placed in quarantine, and contact tracing started for the approximately 150 other passengers that had been aboard their flight.<sup>16</sup>

On March 8, when total confirmed cases rose to nine, Salas and Solís activated the green-yellow-red alarm system established earlier to respond to natural disasters; they set the level to yellow, signaling increased danger for the entire nation.

The next day, President Alvarado presided over the official opening session of the now permanent emergency operations center and stressed that public health considerations would drive the country's response.<sup>17</sup> And on March 16, he declared a national state of emergency. The executive decree establishing the national emergency set forth the rationale and the legal argument for the government's actions. Solís said, "We could not face the consequences of an event of this nature with ordinary mechanisms, ordinary budgets; and we were required to take extraordinary measures." (See text box 1.)

The state of emergency authorized the release of additional funds and facilitated a variety of nationwide public health measures, including a two-week

### **Text Box 1. Executive Decree on National State of Emergency**

On March 16, 2020, Costa Rica's president signed Executive Decree 422227-MP-S, declaring a national state of emergency. The decree stipulated that the National Commission for Risk Prevention and Emergency Response and the Ministry of Health would be "in charge of planning, directing, controlling, and coordinating programs and activities" for the pandemic response. The Social Security Fund would work jointly with the commission to "establish contingency measures as necessary." In addition, the commission would be able to accept donations to the National Emergency Fund "from public and private entities" and disburse them as required.

The decree allowed ministries and other institutions to activate their own institutional states of emergency in order to act "to the fullest extent of their capabilities" and contribute with resources and support to the commission and health ministry, which were responsible for coordination.

The operations center, now permanent, coordinated the pandemic response. Its national situation analysis room monitored and analyzed vital epidemiological data, hospitalization numbers, international analyses, and economic and mobility updates. The situation room presented its findings to the board of directors, which had technical and advisory staff from seven ministries—health, the presidency, public security, transport, housing, environment, and finance—and included the International Red Cross. Alexander Solís chaired the board and reported directly to President Alvarado.

The president also established a policy working group, which he led and met with daily. The idea was to facilitate closer coordination between institutions; inform discussions through expertise and reliable data; and strengthen decision making in relation to health measures, restrictions, other policies, and implementation. Known as the "political COE" (emergency operations center) or the "presidential working group," it comprised the ministries of health; the presidency; public security; economy, industry, and commerce; and tourism; the Fund; and Solís. Ministers often had deputies and advisers in attendance, and whenever required, other ministers and institutional executive presidents were invited to participate in the sessions.



school closure, a ban on large public gatherings, suspension of most international travel, mandatory 14-day self-quarantine for returning residents, and a work-from-home order for most public officials and many businesses. Some public child care and food programs continued to operate.<sup>18</sup> The decree gave the health ministry, working with the police, the authority to close businesses that failed to comply with the rules.

Measures established immediately after the decree were critical to contain the early spread of the virus, said Román Macaya, a scientist who had served as ambassador to the United States and was executive president of the Social Security Fund: “We needed to buy ourselves time—time to build infrastructure, time to care for COVID-19 patients, time to receive what we had purchased in terms of personal protective equipment and durable equipment, time to learn about this new virus.”

## GETTING DOWN TO WORK

The president’s declaration empowered ministries and government agencies to activate their own emergency operations, to coordinate with national and international organizations, and to develop and implement health measures, strategies, programs, and sectoral responses. Among the priorities were the establishment of overall national policy, coordination with frontline nationwide health services, localization of the response, effective communication with an uncertain and restless public, development and management of actionable data, development and distribution of social and economic assistance, addressing of challenges confronting business and tourism, and financing of the response.

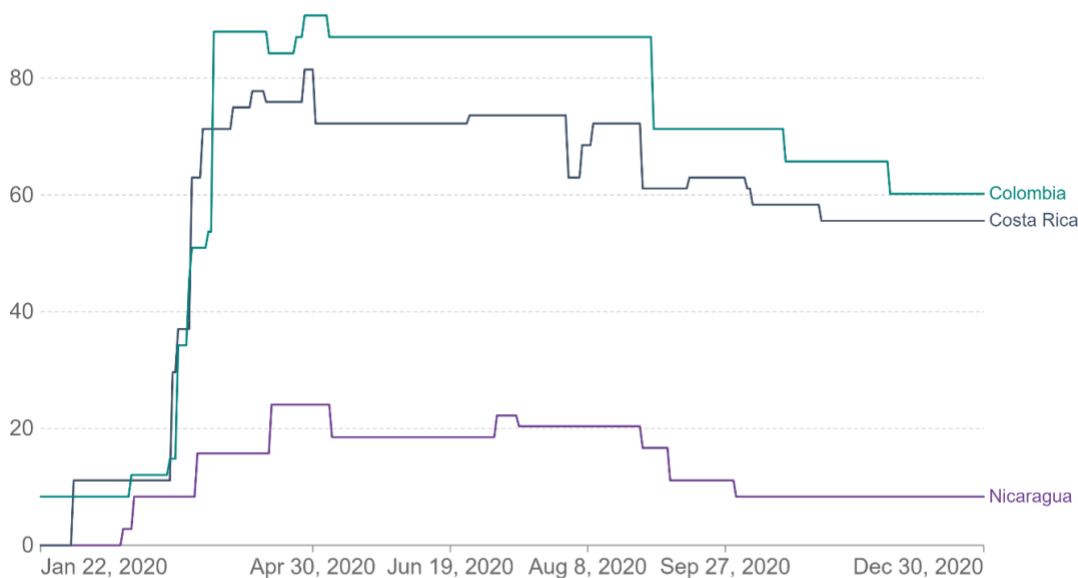
### *Setting national policy*

In accordance with the 2005 National Law on Emergency Management and Risk Prevention, decision makers developed a three-stage response led by the health ministry and the risk and emergency commission, which together were in charge of planning, directing, controlling, and coordinating programs and activities. All public institutions were asked to assist as best as they could. The first of the three stages aimed to contain and control infections; strengthen health services; secure drinkable-water supplies; purchase and distribute cleaning and disinfection supplies; protect health-care and frontline workers; start epidemiological surveillance, diagnoses, and treatment of patients with COVID-19; and furnish any necessary humanitarian aid to the population. The second and third stages were rehabilitation and reconstruction/recovery, which could have a duration of up to five years.

Health Minister Salas stressed that the national strategy would focus initially on protecting vulnerable populations and slowing the spread of the virus.<sup>19</sup> In line with WHO guidelines and the practices of other countries, the aim of the first stage was to reduce the risk of transmission by implementing strong containment measures. Before most other countries in the Latin America region did, Costa Rica restricted the entry of foreigners, mandated quarantines for

**Figure 2. Policy stringency****COVID-19 Stringency Index**

The stringency index is a composite measure based on nine response indicators including school closures, workplace closures, and travel bans, rescaled to a value from 0 to 100 (100 = strictest). If policies vary at the subnational level, the index shows the response level of the strictest subregion.



Source: Oxford COVID-19 Government Response Tracker, Blavatnik School of Government, University of Oxford – Last updated 28 December 2021, 08:50 (London time)  
OurWorldInData.org/coronavirus • CC BY

travelers coming from other countries, banned large public gatherings, encouraged physical distancing and working from home, prohibited public servants from traveling abroad, closed many schools, and curtailed the use of shopping centers and theaters by 50%. Venues such as bars, clubs, casinos, and amusement parks were ordered closed.<sup>20</sup> At the end of March, the risk and emergency commission introduced a 10 p.m. to 5 a.m. curfew for privately owned vehicles, and it closed beaches, temples, and religious services (figure 2).<sup>21</sup>

The more-stringent lockdowns that certain other countries put in place were inconsistent with Costa Rican law and enforcement capacities as well as the country's distinctive *zeitgeist*, Solís said. First, he said, the police, who had to enforce such measures, were *civilista*, and by law their training and deployment differed from the preparation militaries received. Second, he said, he and others in government had no experience with implementing so-called extreme measures because “none of us who have had to make decisions in this pandemic” were born before the abolition of the military 70 years earlier.

Getting suitable preventive public health measures in place quickly was important. The Easter holidays, when a large part of the population traveled to vacation locations, were fast approaching in mid-April. With case numbers rising rapidly, businesses and members of the public alike had to modify their plans in order to stay safe, but at the time, they could still move about during daytime hours, shop for groceries, and meet in small groups outdoors.



The risk and emergency commission moved to extend curfews, and it introduced a campaign called Stay at Home (Quédate en Casa).<sup>22</sup> The new rules kept entertainment venues closed, restricted capacity at others, and imposed detailed safety requirements on tourist destinations and services. Violation of the measures could lead to fines as well as imprisonment for as long as three years. Michael Soto, the minister of public security who in Costa Rica also served as minister of interior and police, noted that his ministries would uphold entry restrictions at the borders and would act to prevent mass gatherings anywhere in the national territory.<sup>23</sup>

#### *Coordinating health services*

Although the health ministry and the national risk and emergency commission had primary responsibility for setting health policies, the Social Security Fund, known as the Caja (cash register), was the “muscle behind the policies,” said its executive president, Macaya. The fund’s main responsibility was to implement policy within the health-care system and ensure medical care for those infected with COVID-19.<sup>24</sup> The fund managed the country’s 1,000-plus Basic Comprehensive Health Care Teams, operated 30 hospitals, and coordinated with 250 private clinics.

The fund, which worked closely with the health ministry and the risk and emergency commission, had activated its own Emergency and Disaster Assistance Center in late January,<sup>25</sup> and it began developing protocols for public and private health-care centers on how to manage the care of patients with the virus, even though reliable information was scarce during the early months of 2020.

The fund’s Basic Comprehensive Health Care Teams were fundamental to the response. The four-member teams comprised a physician, a nurse assistant, a primary care technical assistant, and a database technical assistant. Some teams also had a pharmacy assistant who dispensed medication. Costa Rica had 1,057 such teams, which represented the health-care system’s first point of contact, each of them caring for 4,000 to 4,500 people. The primary-care technical assistants, who routinely updated each patient’s medical record within the national digital record, were central figures in their communities.<sup>26</sup> Their familiarity ensured that teams knew when to provide medical follow-ups or medications and when vaccines were due.

During the pandemic, the teams actively monitored and tested people possibly ill with COVID-19, cared for them if they had confirmed cases of the disease, and referred them to hospitals if their conditions deteriorated.<sup>27</sup> The testing raised no significant opposition. Most tests were administered to sick people who were visiting their doctors and had symptoms that indicated a likely COVID-19 infection.

*Procuring supplies*

Obtaining tests and essential supplies was mainly the responsibility of Costa Rica’s Social Security Fund, the same organization that managed frontline health services. The president’s declaration of a state of emergency enabled the fund to tap resources reserved for crises. Macaya, who directed the fund, created a task force charged with building a strategic reserve of medical equipment and managing distribution. The task force also managed donations from public and private contributors, national and foreign institutions—including the US and Chinese governments—and regional institutions, corporations, and universities.<sup>28</sup> But acquiring diagnostic tools, personal protective equipment, ventilators, and other medical supplies was not easy. In April, a disaster response team from private logistics company DHL helped set up a central warehouse and an inventory management system and assisted with procurement.<sup>29</sup>

“As in the rest of the world, the logistics were chaotic. Deliveries were delayed, purchase orders were canceled, prices increased,” Macaya said. When “the entire world synchronized its demands for these products, wanting to purchase the same goods from the same manufacturers at the same time on a global scale,” problems were rife. The fund scored some victories, regardless. Crucially, within four months, the number of available ICU beds increased more than 10-fold to 359.

A few alternative pathways were explored, often with little or no success. For instance, the UN Development Programme resident representative in Costa Rica, José Vicente Troya, said the agency provided US\$37,500 to fund attempts to develop alternative protocols for diagnostic kits. That collaboration included the health ministry; the Ministry of Science, Innovation, Technology and Telecommunications; the risk and emergency commission; and the National Center for Biotechnological Innovations, as well as other scientific institutions and private firms.<sup>30</sup> The effort never reached its goal.

To ease procurement problems, the fund challenged Costa Rica’s business and academic communities to invest in innovation and produce the needed supplies themselves. There were some early wins. For example, the National Liquor Factory switched to production of a disinfectant alcohol gel, which the post office then distributed throughout the country.<sup>31</sup> The Costa Rica Institute of Technology, a publicly funded engineering and advanced-science research university, developed designs for personal protective equipment.<sup>32</sup> In the months that followed, local businesses began to produce face masks, and the government shared the design with other Central American countries that were confronting international supply constraints. Other academic institutions created prototypes for mechanical ventilators, which Costa Rica’s health ministry tested and approved for emergency use.<sup>33</sup> The University of Costa Rica used 3D printers to make the nasal swabs needed for COVID-19 diagnostic tests. Production continued in a collaboration with the clinical laboratory of the National Children’s Hospital, and the private sector also contributed.<sup>34</sup>

### Text Box 2. Vaccine Procurement

On August 21, with 32,124 confirmed COVID-19 cases and 340 deaths caused by the virus, the Social Security Fund, together with the ministries of health, foreign relations, planning, and finance, began to assess the technical, legal, and cost requirements for Costa Rica to purchase COVID-19 vaccines then under development.<sup>1</sup> Under normal circumstances, the National Commission on Vaccination and Epidemiology—an interinstitutional body that included the health ministry and the fund—determined which vaccines would be administered, and the fund purchased the doses required. These were not normal times, however. The vaccines in question were still in clinical trials, and none came with a guarantee of successful performance.<sup>1</sup> Because neither the vaccines nor their prices had yet been established, the only option was to pay in advance, but prepayment carried risk. Moreover, other legal difficulties were involved in planning to purchase a product that did not yet exist.

The risk and emergency commission decided to proceed with the process in the hope of placing advance orders that would get Costa Rica to the head of the international queue. Senior public health officials read the scientific research with care. Scientists analyzed the clinical results of vaccines that were in development, sometimes from the earliest phases. Decision makers also monitored whether a regulatory body known for its high standards approved the vaccines under Costa Rica's consideration. They also considered logistical challenges, such as requirements for especially cold storage. And they examined various available payment options.

Macaya said that based on this assessment process, Costa Rica committed to orders even before the vaccines in question got approved by the Food and Drug Administration in the United States and the European Medicines Agency. It ultimately chose Pfizer–BioNTech and Oxford–AstraZeneca based on their promising efficacy in clinical trials. It purchased enough Pfizer–BioNTech vaccines for 1.5 million people (3 million doses).<sup>1</sup> And later, it signed a similar contract with AstraZeneca for a million doses, which could cover the vaccination of half a million people.<sup>1</sup>

The national government had reserved 7.2 billion colones (approximately US\$12.3 million in 2020) for the purchase of COVID-19 vaccines through an extraordinary budget. The risk and emergency commission made the purchases. When the doses became available, the Social Security Fund would receive and store the vaccines, ensure quality control, manage distribution, and enlist its medical personnel to conduct inoculations. The plan was to start with vulnerable populations, as defined by the vaccination commission.

Costa Rica also joined the COVID-19 Vaccines Global Access initiative known as COVAX.<sup>1</sup> Macaya said that the decision to diversify procurement was an effort to reduce risk at a time when “the entire world would be buying the same doses and there was not enough production to necessarily guarantee deliveries on specific dates.” The foreign affairs ministry negotiated with COVAX to secure vaccines for at least 20% of Costa Rica's population, and the prepayment, some US\$6.3 million, was made in October.<sup>1</sup>

The vaccination campaign was implemented to a large extent by the basic comprehensive health-care teams. Planners prioritized older people, health-care personnel, law enforcement, firefighters, and other frontline workers in the distribution of doses.<sup>2</sup> But the aim was to reach everyone, including rural communities so remote and so difficult to access that health-care workers required helicopters or lengthy treks on foot in order to reach them. The private sector supported the campaign by allowing centers to be set up in their properties.

Because it already had the Unified Digital Health Record, Costa Rica was able to log COVID-19 vaccinations into patient records and was in a good position to respond when work started to develop the international vaccination certificates that became common worldwide in 2021.

<sup>1</sup> Ministry of Health of Costa Rica, “Costa Rica firma acuerdo con AstraZeneca para suministro de vacuna candidata contra el SARS-CoV-2,” November 12, 2020, accessed November 23, 2021; <https://www.ministeriodesalud.go.cr/index.php/centro-de-prensa/noticias/741-noticias-2020/1982-costa-rica-firma-acuerdo-con-astrazeneca-para-suministro-de-vacuna-candidata-contra-el-sars-cov-2>

<sup>2</sup> Ministry of Health of Costa Rica, “Costa Rica firma acuerdo con AstraZeneca para suministro de vacuna candidata contra el SARS-CoV-2,” November 12, 2020, accessed November 23, 2021; <https://www.ministeriodesalud.go.cr/index.php/centro-de-prensa/noticias/741-noticias-2020/1982-costa-rica-firma-acuerdo-con-astrazeneca-para-suministro-de-vacuna-candidata-contra-el-sars-cov-2>

Anticipating challenges in the acquisition of vaccines, once they became available, the risk and emergency commission, working with the health ministry and the Social Security Fund, debated the advisability of placing orders early, even though products did not exist or had not yet been fully tested. Strong procurement rules and budgetary concerns presented potential hurdles, but the presidential working group decided the country should get ahead of the curve—especially when it came to vaccines. (See text box 2.)

The Social Security Fund also supported scientific research on possible COVID-19 treatments. For example, the University of Costa Rica's Clodomiro Picado Institute research center, which normally specialized in snakebite antivenoms, tried to develop experimental treatments that used neutralizing antibodies generated by inoculating horses with small amounts of the virus. George Mason University in the United States and Charité–Universitätsmedizin Berlin, a university hospital in Germany, tested the efficacy of the treatments, which were in phase 2 clinical trials in Costa Rica during 2021. Other treatments were in preclinical trials, and the US National Institute of Allergy and Infectious Diseases and the Costa Rican Biomedical Research Agency launched a collaborative study to assess the character of the protection or immunity of people who had recovered from COVID-19.

Macaya said one of the few positive consequences of the COVID-19 pandemic was that it stimulated interest in scientific research and applications of all kinds. He said the fund had approved a regulation to promote further scientific research—“a postpandemic legacy to, hopefully, continue growing research activity within the institution.”

#### *Localizing the response*

As the pandemic response continued, it became clear that nationwide public health restrictions were failing to meet the distinct needs and challenges of regions and municipalities that had differing levels of infection and transmission. The national risk and emergency commission needed a more localized and more flexible approach. Implementing such a hot-spot strategy required better data than was initially available, a modified alert system, and improved coordination with local officials, which response leaders called a *shared-governance model*.

During the early weeks of the pandemic response, modelers had only limited information to evaluate patterns of infection and project their impact. As disease surveillance improved, the commission developed a localized risk index that considered each canton's attack rate, defined as a function of the percentage of the population at risk of infection during a specified time interval, the location's positivity index (the percentage of confirmed COVID-19 cases), and the hospitalization rate. Solís said the cantonal risk index both facilitated decision making with regard to which health measures and restrictions to adopt in a given municipality and provided people with better information about the conditions in their cantons. For example, when the system first came into use, the commission implemented tighter restrictions on permissible vehicle travel in

the northernmost cantons—those closest to the border with Nicaragua—where the government had decided not to try to contain the pandemic.<sup>35</sup> (Nicaragua’s president, Daniel Ortega, said the disease affected mainly foreigners and that conditions in the country were fine, even while health-care workers were falling ill.<sup>36</sup>)

COVID-19 infections continued to grow in June, raising concerns that the numbers would overtax the health-care system. The alert apparatus was being carefully monitored to help determine when to strengthen and when to ease the measures in each canton and district according to the canton’s risk category.

The color-coded alert system remained in place, informed by the new cantonal risk index, but beginning in the middle of July, a fourth color, orange, was added to give residents a better sense of conditions in their areas. The color-coded maps ranged from green (least dangerous) to red (most dangerous), with yellow and orange in between. In regions designated orange, only essential businesses—supermarkets and other food stores, as well as services such as hardware stores, laundries, automobile repair shops, banks, and funeral homes—could be open.<sup>37</sup>

Although geographically differentiated policies had many advantages, they also produced unexpected complications. Because of Costa Rica’s small size, residents often had to travel through several cantons every day in order to reach their workplaces. If the cantons had different levels of risk and different measures in place, then plotting travel in a way that respected the rules of each became a complex task, as did law-enforcement decision making. Moreover, many mayors objected to the health measures and restrictions that the national government had implemented in their communities on the grounds that the measures did not take into consideration specific aspects of local contexts or measures the municipal governments had already put in place.

Implementation shifted further toward the local level in August, when the risk and emergency commission introduced a new model, Costa Rica Works and Takes Care of Itself (Costa Rica Trabaja y Se Cuida). The new program authorized local governments to coordinate safety measures for local parks, public areas, beaches, businesses, and venues and to develop their own communication campaigns with their own individual branding. Ministry officials helped cantons train local businesses in how to implement health and operational protocols and supervise their implementation. Municipal emergency committees, which coordinated local preparations and emergency responses, took on stronger roles. Together with the Joint Social Welfare Institute (an independent agency that reported to the Ministry of Human Development and Social Inclusion), health ministry representatives, and the Social Security Fund, the committees reviewed assistance to COVID-19 patients every two weeks and assessed business compliance with health measures monthly.<sup>38</sup> To assist with the new collaboration, the risk and emergency commission created online materials that included guidelines on COVID-19 prevention, health measures, and restrictions; instructions regarding the shared-management model; communication strategies; and tools for self-evaluation.

*Communicating with the public*

Both the health ministry and the risk and emergency commission understood the importance of public communication during emergencies and crises. Health Minister Salas said it was crucial to get the word out—loud and clear—as soon as reliable, actionable information became available. In addition to sending clear messages about the current status of the pandemic and required and recommended safety measures, other aims were to make residents aware of the preparations and to provide explanations in language that was easy to understand.

The need for public communication became acute in early March, when Costa Rica confirmed its first COVID-19 case, the nationwide alert was set at yellow, and the president declared a state of emergency and implemented significant restrictions on businesses and individuals.

Salas, together with Solís of the risk and emergency commission, began to convene daily press briefings in order to explain WHO recommendations and PAHO's International Health Regulations and provide information and guidance. In the absence of vaccines or specific therapies, they stressed the need to wash hands thoroughly, maintain physical distance, and avoid crowded public spaces. Similar advisories were available on the websites of the office of the president, ministries, the Social Security Fund, the commission, and other institutions. Salas and Macaya, the fund's executive president, said the briefings provided a valuable service for an uneasy public.

"It was actually well appreciated by the population at that moment," Salas recalled. "Trying to convey calm in the middle of a crisis—confidence, explaining things and terms that are complex to the population in the simplest way—was very important." Macaya said, "There was considerable acceptance from the citizenry to follow these guidelines."

Communication received a boost in April, when universities began to assist in monitoring the pandemic and created digital platforms that helped users visualize official data, check health measures in effect, and understand the reasons for the policies.<sup>39</sup> And the health ministry made various other aspects of its information systems available to the public.<sup>40</sup>

The emergency operations center also communicated with employers, shippers, and others that had to modify their operations in response to imposed health measures. The cooperation of those stakeholders was crucial for containing the virus. Solís said members of the presidential working group communicated closely within and between various sectors to coordinate activities. Ministries reached out to their respective industries and communities and to civil society organizations as well as religious communities.

"People need to be heard," Solís said, adding that social and psychological perceptions were important—especially because no one knew when the pandemic would ease.



In June, when the number of confirmed COVID-19 cases started increasing rapidly, the use of face masks on public transport, during meetings, and in locations providing services became mandatory instead of just recommended. The mask requirement was extended to other settings later that month, when confirmed COVID-19 cases rose to 2,277, with 12 deaths.<sup>41</sup> But public fatigue began to set in after several months of COVID-19, when many Costa Ricans began to chafe at restrictive health measures and financial hardships. Some of the country's business associations and chambers of commerce worked with a civil society group to protest restrictions and in August organized a caravan of vehicles bearing placards showing objections to the government's pandemic policies.<sup>42</sup>

The national emergency operations center worked to adapt its message and the ways the message got across to the public. Ministries created infographics that were easy to understand and follow, and they recruited a wide variety of spokespeople, including sports stars, cultural personalities, social media influencers, academicians, health experts, and former health ministers. They also engaged corporations and civil organizations to help communicate information and policies. Salas said the engagement of people from many different communities to provide a consistent message strengthened the response by underscoring the unity of the country, and provided "a powerful lesson" for those fighting the pandemic.

#### *Developing and managing data*

Accurate information on daily numbers of new confirmed cases and patient condition was crucial for identifying where strict safety measures were most needed and for modeling the likely impact of policies on the demand for limited hospital resources and supplies. National health guidelines published in April stipulated that people who showed symptoms of acute respiratory infection—or other specific symptoms such as fever and loss of smell or taste—should be tested to determine whether they were infected with COVID-19. The health ministry was responsible for analyzing the tests. Patients who tested positive had to self-quarantine. The ministry carried out subsequent contact tracing, which included notifying other people who had been in contact with patients in question.<sup>43</sup>

As in many countries, test kits were in low supply in Costa Rica at the start of the pandemic, but health authorities deemed that testing capacity was sufficient to meet initial demands.<sup>44</sup> At first, the government used sentinel surveillance—case identification and reporting by doctors' offices, laboratories, and public health centers or hospitals—in order to track the spread of the pandemic. The Social Security Fund, as health system administrator, soon introduced syndromic surveillance, asking doctors, hospitals, and health officers

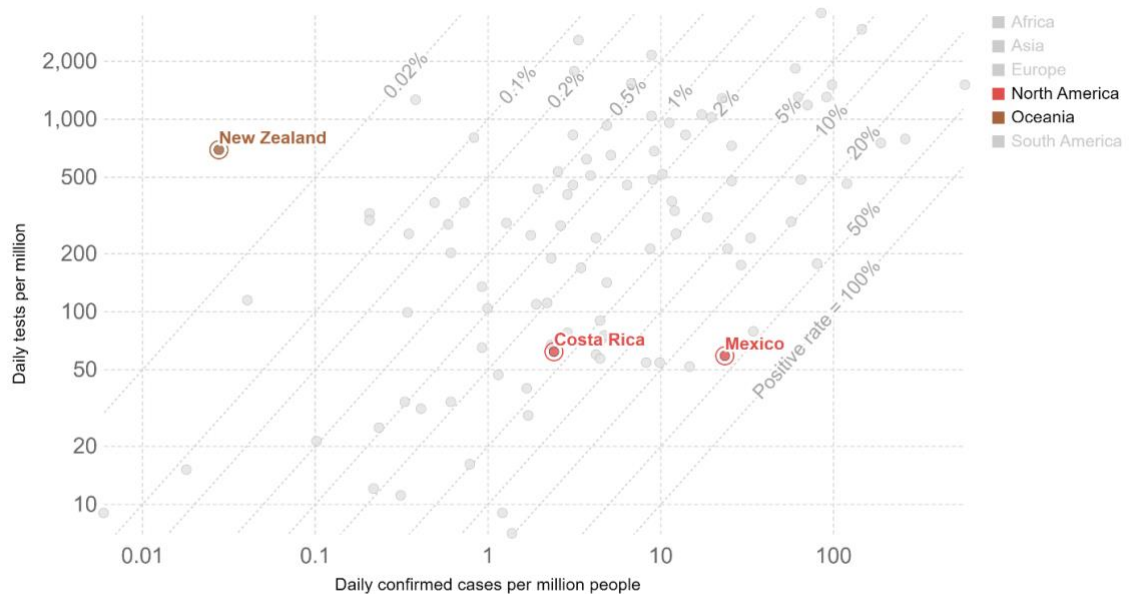
**Figure 3. Tests per million compared with number of confirmed cases in May and December 2020**

(Johns Hopkins University’s Coronavirus Resource Center said in late 2021 that there was no expert consensus on a recommended target for the raw number of tests or whether testing programs should be scaled to the size of the epidemic, not the size of the population. For more, see John Hopkins University, “How Does Testing in the U.S. Compare to Other Countries?” 2021, accessed November 23, 2021; <https://coronavirus.jhu.edu/testing/international-comparison>.)

End of May 2020

**COVID-19: Daily tests vs. Daily new confirmed cases per million**

The figures are given as a rolling 7-day average.



Source: Testing data from official sources collated by Our World in Data, confirmed cases from Johns Hopkins University CSSE  
 Note: Comparisons of testing data across countries are affected by differences in the way the data are reported. Daily data is interpolated for countries not reporting testing data on a daily basis. Details can be found at our Testing Dataset page.  
 OurWorldInData.org/coronavirus • CC BY

to report clusters of symptoms to provide early alerts. This approach enabled epidemiologists to detect changes that required immediate responses. The fund also monitored rates of hospital bed occupancy as signs of serious disease, and it used the national Unified Digital Health Record to identify the health vulnerabilities and strengths of local communities—important for modeling the impact of virus transmission.<sup>45</sup>

Health Minister Salas said that in recent years, the health ministry as well as private-sector hospitals and laboratories had increased their use of the digital record system, which facilitated quick updating and provided easy access to new information while keeping patient data private and protected. During the COVID-19 pandemic, the fund added modules on epidemiological surveillance as well as vaccination, he said, and these helped provide valuable data for public health surveillance, for informed decision making, and for working with

international vaccination certificates. (The Social Security Fund estimated that by May 2021, pandemic response efforts had added the medical histories of another 5% of the population into the system, thereby extending its coverage to include 80% of all legal residents.<sup>46</sup>)

The supply of tests gradually increased in step with laboratory capacity, raising testing to just over 50 tests per million population per day by late May—about the same level as Senegal, a country with a slightly higher proportion of positive tests (figure 3). Initially, the health ministry was in charge of proextended that permission to carefully selected laboratories.<sup>47</sup>

To strengthen epidemiological-modeling capacity, the fund began to collaborate with the Center for Research in Pure and Applied Mathematics of the University of Costa Rica, as well as data scientists at Intel Corporation, which operated a research and development as well as global services center in the country and decided in December to invest US\$350 million and restart assembly and test operations in Costa Rica.<sup>48</sup> Expanded testing combined with sophisticated modeling led to a more-nuanced, targeted response that Macaya said enabled the national authorities to “anticipate where we were going to try to act preventively.”

#### *Providing social and financial support*

Well before the country’s first confirmed case of COVID-19, response leaders realized that the pandemic potentially imperiled two broad groups of people: formal sector workers who lost their jobs and vulnerable households dependent on casual labor or without regular means of support. The response leaders therefore began to develop a plan that would address the needs of both.

The Ministry of Labor and Social Security studied recommendations issued by the International Labour Organization to address the impact of a pandemic on workers. Drawing on that advice, it proposed several measures. First, it encouraged employers to allow remote work in order to reduce the possibility of disease transmission in crowded workplaces and to diminish the need for personal travel. Second, for those who could not work remotely—maintenance workers, for example—it suggested that businesses could grant vacation time to help keep people safe during pandemic surges and accompanying restrictions. The ministry also proposed to reduce layoffs by allowing hard-hit businesses to temporarily suspend employee contracts and reduce working hours, subject to government review. The aim was to ensure households continued receiving at least some income and to enable people to return to their jobs when danger passed. The ministry worked with business associations and labor unions to develop the plans.

Some of the proposals, including the suspension of labor contracts to enable reduced hours, required legislative action. The Legislative Assembly approved the proposals before March ended—less than a month after the national emergency was enacted. The new laws enabled businesses and other organizations to adapt quickly to changing economic conditions, but they had to apply within three days for approval of any contract suspensions or reductions

in working hours that they decided to implement. If grounds for the requests were found to be inadequate, the government could require compensation for affected workers.

Government leaders understood that public health measures, including reduced working hours, could have a severe impact on households' ability to earn a living. Although ministries introduced their own social assistance measures for targeted populations, the centerpiece of the government's work was a collaborative program developed by the labor ministry, at the time headed by Geannina Dinarte, and the Ministry of Human Development and Social Inclusion, headed by José Luis Bermúdez. Called Bono Proteger (often translated as Protection Bonus or Protection Bond), it provided three months of temporary financial assistance for all Costa Ricans whose work was affected by the pandemic.

Dinarte stressed that Bono Proteger was not a poverty alleviation program. Rather, it sought to offset the effects of the pandemic on livelihoods regardless of whether a household was above or below the poverty line. Those who lost their jobs, who had their working hours reduced by more than 50%, or who were engaged in independent or informal economic activities (an estimated 20% to 30% of the labor force<sup>49</sup>) would receive 125,000 colones (approximately US\$210 in 2020). Those whose working hours fell by 50% or less would receive roughly half that amount over the same period. People could apply online, and government employees were on call to help those who lacked internet connectivity.<sup>50</sup>

President Alvarado established Bono Proteger in mid-April through executive decree, and the government authorized the first payments to roughly 70,000 people before the end of April. More than 389,000 people had already applied for help, however, and of those, at least 250,000 reported that they had no regular source of income.<sup>51</sup> The two ministers in charge looked for ways to accelerate and expand the program.

To finance the effort, the president initially drew roughly 16 billion colones (approximately US\$27.3 million in 2020) from available funds—assistance for approximately 46,000 of the estimated 700,000 to 1 million people in need.<sup>52</sup> Using resources from the National Emergency Fund, the Joint Social Welfare Institute, and the labor ministry's employment programs, he was able to boost the expenditure to 21 billion colones, or roughly US\$35.9 million. By mid-May, the government had assisted about half the households that applied.<sup>53</sup>

To provide cash assistance for more people, however, the president had to secure legislative support for an extraordinary budget and a proposal to allow the government to borrow from the National Insurance Institute, an independent agency founded by the government that provided a public insurance option.<sup>54</sup> Introduced during a period when the national government was trying to cut spending, the proposal provoked vigorous debate among legislators, and the government had to pause Bono Proteger transfers for two months.<sup>55</sup> Pandemic lending by the International Monetary Fund eventually made it possible to resume the program.<sup>56</sup>

Social support for especially vulnerable residents was mainly the purview of the Joint Social Welfare Institute, an independent agency that reported to the human development ministry, which Bermúdez led. The institute coordinated the social protection working group at the national emergency operations center, including three technical teams on which civil society, the private sector, and international organizations also had representatives. One team focused on informal settlements, indigenous populations, and migrant populations; another ensured that social assistance programs continued to serve residents; and a third collaborated with social welfare organizations to provide services for vulnerable populations such as older people, disabled people, people with substance abuse disorders, and those requiring palliative care.

To reach more residents in special need, the welfare institute moved to maintain, bolster, or repurpose several existing systems. For example, to assist essential workers in the formal sector, more than 1,200 child care centers remained active. School lunch programs expanded to provide food for households in remote and isolated areas, along with materials for at-home education. With support from the UNDP, the institute also expanded domestic violence support and referral services, anticipating that increased economic stress might disrupt families.

*Easing the strain on business and tourism*

Piloting the country through the pandemic to a quick recovery required limiting financial damage to businesses and helping businesses keep employees on their payrolls. Although Costa Rica had a strong reputation as a tourist destination, manufacturing accounted for about 20% of its GDP and 68% of its services. To cushion the effects on those enterprises, which had to operate with reduced workforces, the central bank lowered some interest rates. The government also suspended the value-added tax, the profits tax, and certain consumption taxes and tariffs on imports.<sup>57</sup>

The economy, industry, and commerce ministry began working with businesses to enable them to resume operations safely. The UNDP covered the cost of technical assistance to develop protocols in consultation with firms and public health officials. The government released the protocols in paper form and as videos filmed at locations provided by businesses and companies as part of a public–private partnership.

The president wanted to get the tourism sector back on its feet as soon as safely possible in order to protect hundreds of thousands of jobs at risk and avoid significant economic repercussions. For Costa Rica’s tourism sector, the United Nations Economic Commission for Latin America and the Caribbean estimated that the COVID-19 pandemic would impose losses of about US\$2.9 billion, or roughly 4.9% of GDP.<sup>58</sup>

The Ministry of Tourism invested strategically in the industry and coordinated closely with the private sector through the Costa Rican Tourism Board, an independent agency that reported to a board of directors that included representatives of the government and the private sector and was chaired by the

**Text Box 3.****Health Measures and Operational Protocols for the Tourism Industry**

The Costa Rican Tourism Board, an independent agency that drew its budget from taxes on airfare and worked in close coordination with the private sector, played a central role in developing 16 protocols to keep visitors safe, covering, among other things, lodging, vehicle rental, transportation of tourist groups, water transportation, adventure tourism, restaurants, and casinos. In that effort, it worked closely with the World Travel & Tourism Council, a private-sector forum for the global travel and tourism industries.<sup>1</sup>

One of the council's projects was of special interest to Costa Rican businesses: the first-ever global safety and health seal of quality. The certification process and its stamp of approval would help travelers recognize governments and businesses around the world that could ensure safe travel and service standards.<sup>2</sup>

The tourism board submitted its 16 protocols to the council. All received the organization's Safe Travels stamp. The tourism board then set up its own procedures for reviewing applications for certification from Costa Rican businesses, and when the applications fulfilled the global standards, the board granted them the Safe Travels stamp. The hope was that in the pandemic era, this seal of approval would carry extra weight in the minds of would-be visitors and induce them to travel to the country.

<sup>1</sup> For more details, see World Travel & Tourism Council, "Leading Global Protocols For The New Normal," May 2020, accessed November 23, 2021;

<https://wtcc.org/Portals/0/Documents/Reports/2020/Global%20Protocols%20for%20the%20New%20Normal%20-%20Overview.pdf?ver=2021-02-25-183107-437>.

<sup>2</sup> World Travel & Tourism Council, "Safe Travels: Global Protocols & Stamp for the New Normal," 2021, accessed November 23, 2021; <https://wtcc.org/COVID-19/SafeTravels-Global-Protocols-Stamp>.

minister. In February, representatives of the tourism board met with health officials, port authorities, and diplomats to develop safety guidelines for the sector and to help visitors already in the country navigate their return trips, including self-quarantine for those who showed symptoms of disease or tested positive.<sup>59</sup> They developed an industry road map for introducing health protocols, coordinating compliance, channeling assistance to small and medium enterprises, and reopening borders—a prerequisite for a safe restart. This road map helped structure the activities of the thematic working group on tourism within the emergency operations center (text box 3, exhibit 1).

After the government moved to a shared-governance approach and a hot-spot strategy, tourism minister Gustavo Segura made the case for lifting flight restrictions and reopening airports in order to attract international visitors back to the country. He said the road map the tourism board had developed would keep both visitors and residents safe.

On July 23, the Ministry of National Planning and Economic Policy, together with the tourism board, announced that international flights would resume in August. The government made loans to the hospitality and transportation industries to provide businesses with capital. In addition, it worked with enterprises to verify that they had health safety measures in place.<sup>60</sup>

Costa Rica was the first country in Latin America to lift its international travel ban. It opened selectively to visitors from European countries that had low COVID-19 infection rates and to residents of certain cities in the United



States. Tourists were required (1) to have a negative PCR test (the polymerase chain reaction test, considered highly accurate and reliable) 48 hours before arrival, (2) to complete a digital health document called Health Pass (Pase de Salud), and (3) to be covered by travel and health insurance (the former to ensure tourists could pay for an extended stay in case they had to self-quarantine and the latter in case they had to receive medical treatment and/or be hospitalized during their stay). While in Costa Rica, they had to obey health measures on a variety of topics, including masking and physical distancing.

From August to November, 15,000 people visited Costa Rica—a fraction of previous levels but enough to test whether tourism could reopen safely. Segura said there were no confirmed cases of COVID-19 among international visitors during their stays in Costa Rica during this period. The national government therefore decided to ease some of the measures further in order to attract more international travelers and increase tourism-related employment in rural areas.

The government fully reopened its borders in November. Because the PCR tests did not guarantee that visitors were COVID-19 free when they entered Costa Rica (only that they probably did not have it at the time the test was administered) and because the tests presented an obstacle to potential visitors (for whom the tests typically cost about US\$200), this requirement was dropped, along with the mandatory self-quarantine rule for returnees. Travelers were still required to complete the digital health form and demonstrate they had adequate travel and health insurance. And because many of the tourists' home countries required reentry tests, Costa Rica still had to expand its laboratory network to test departing visitors.

By the end of 2020, international visitors for the year numbered roughly 1 million, Segura said. Although the total was far below the 3.1 million tourists who visited in 2019, it marked a significant upward trend.

With global travel likely to remain sluggish for a time, the government decided to encourage domestic tourism, which before the pandemic had accounted for roughly 20% of all visitors to Costa Rican destinations. The ministry launched a promotional campaign called Let's Take a Trip (¡Vamos a Turistear!), and it negotiated with financial institutions to offer credit and installment payment options as incentives for residents to tour their own country.<sup>61</sup>

### *Financing the response*

The pandemic struck at an especially difficult time for Costa Rica: The government had a fiscal reform program in place in order to balance the budget and reduce debt, and a 2018 law required the government to limit spending. President Alvarado, who had led the movement to adopt the law, now had to seek out more money—and do so while the economy was contracting and tax revenue was falling.

The president's March emergency decree authorized use of the National Emergency Fund and parallel resources within ministries in order to defray the

costs of the initial phases of the response. It also permitted the president to pool support from government agencies and private contributors. But the sum the government had at its disposal was inadequate to cover longer-term expenses. Macaya said the emergency reserve was usually funded to a maximum of 45 billion colones (approximately US\$77 million in 2020)—an amount sufficient to cover the needs of the institution’s longest prior emergency, which was a 2018 union strike that lasted one month.

As resources dwindled during this much longer and deeper emergency, the president appealed to the legislature for two successive increases in pandemic funding. The first extraordinary budget included 150 billion colones (about US\$256 million in 2020) for the financial assistance program. The legislature also approved an additional 125 billion colones (US\$214 million) after extended debate about the wisdom of additional spending.<sup>62</sup> The legislature also agreed to launch a special fuel tax and a transfer of funds from the National Insurance Institute to help cover public health expenses.<sup>63</sup>

In addition, the country received international assistance. As part of a relief program it extended to many other countries as well, the International Monetary Fund approved US\$504 million in emergency financial assistance to Costa Rica to mitigate the economic impact of the pandemic.<sup>64</sup> The French development agency and the Inter-American Development Bank jointly provided another credit totaling US\$380 million—also for Costa Rica’s financing of its pandemic response.<sup>65</sup> And the CAF–Development Bank of Latin America provided Costa Rica with US\$500 million in December.<sup>66</sup>

## OVERCOMING OBSTACLES

Regional dynamics complicated Costa Rica’s efforts to respond to COVID-19. Because the country spanned the Central American isthmus, a constant stream of people and commodities crossed its borders. Avoiding economic disruption during the pandemic meant harmonizing public health policies.

Governments assembled to discuss their policies under the umbrella of the Central American Integration System, a regional organization set up during the early 1990s to promote peace, democracy, and economic development. Costa Rica, Belize, Guatemala, Honduras, Nicaragua, Panama, and the Dominican Republic agreed to communicate closely on preventive measures, to collectively negotiate purchases of medical equipment and supplies, and to align their requests to international organizations for emergency relief. They also defined shared procedures to guide their respective customs, health, and migration authorities—in the interest of maintaining international trade.<sup>67</sup> (El Salvador did not attend.)

Although Nicaragua, Costa Rica’s neighbor to the north, participated in the meeting, it did not adhere to the commitments, which served to worsen the two countries’ already prickly relations. In 2018, Daniel Ortega, Nicaragua’s president since 2006, had clamped down on political protests with restrictions on fundamental rights and media organizations. Nicaraguans fled the country, and by 2020, more than 100,000 had sought asylum abroad, many of them going

south. In March, an estimated 77,000 refugees and asylum seekers lived in Costa Rica.<sup>68</sup>

Nicaragua's decision to disregard the decisions made at the regional pandemic meeting was in line with its broader policy of avoiding strong public health measures to contain COVID-19. Schools and borders remained open, and the government promoted participation in mass events. Health-care specialists who objected lost their jobs.<sup>69</sup> PAHO and other international institutions expressed concern about this state of affairs.

In May, differences between Costa Rica and Nicaragua worsened when Costa Rica's Legislative Assembly sent a formal notice to the head of PAHO, expressing support for more than 600 Nicaraguan health professionals who had protested poor working conditions, the government's unwillingness to adopt infection prevention measures, and manipulation of data on infections and deaths. Costa Rican legislators argued that the manner in which governments dealt with the pandemic within their own territories could hurt neighboring countries, and they asked PAHO to conduct an external review. The letter and the request brought a furious response from Nicaragua's legislature, which strongly rejected Costa Rica's proposal.<sup>70</sup>

Tensions escalated again later that month, when the Costa Rican government demanded that Nicaraguan freight drivers leave their goods at the border for Costa Rican drivers to transport into the country. Such measures were necessary to prevent the spread of infection, Costa Rican officials argued, after finding that many Nicaraguan drivers had COVID-19 symptoms.

In retaliation, Nicaragua closed its border with Costa Rica. Other countries, such as Panama and Honduras, joined Nicaragua and blocked Costa Rican transporters from crossing into their territories. More than a thousand Central American freight drivers, who were left stranded throughout the region, protested the deadlock. Nicaraguan transporters established their own blockades at borders with Costa Rica.<sup>71</sup> Other regional governments—including Guatemala, Honduras, and Panama—pleaded with Costa Rica to allow normal transportation operations, as did some Costa Rican business owners.<sup>72</sup>

The Costa Rican ministry of foreign trade tried to negotiate a resolution of the dispute, and in early June, countries reached an agreement.<sup>73</sup> Costa Rica agreed to speed the cross-border traffic flow by only spot-checking truckers for COVID-19 rather than administering tests to all. It also agreed to extend transit permits from 48 hours to five days and to allow truckers to take some types of goods directly to purchasers. The foreign truckers, for their part, had to adhere to strict safety rules, follow designated routes, and either allow GPS tracking of their movements or travel in convoys.<sup>74</sup>

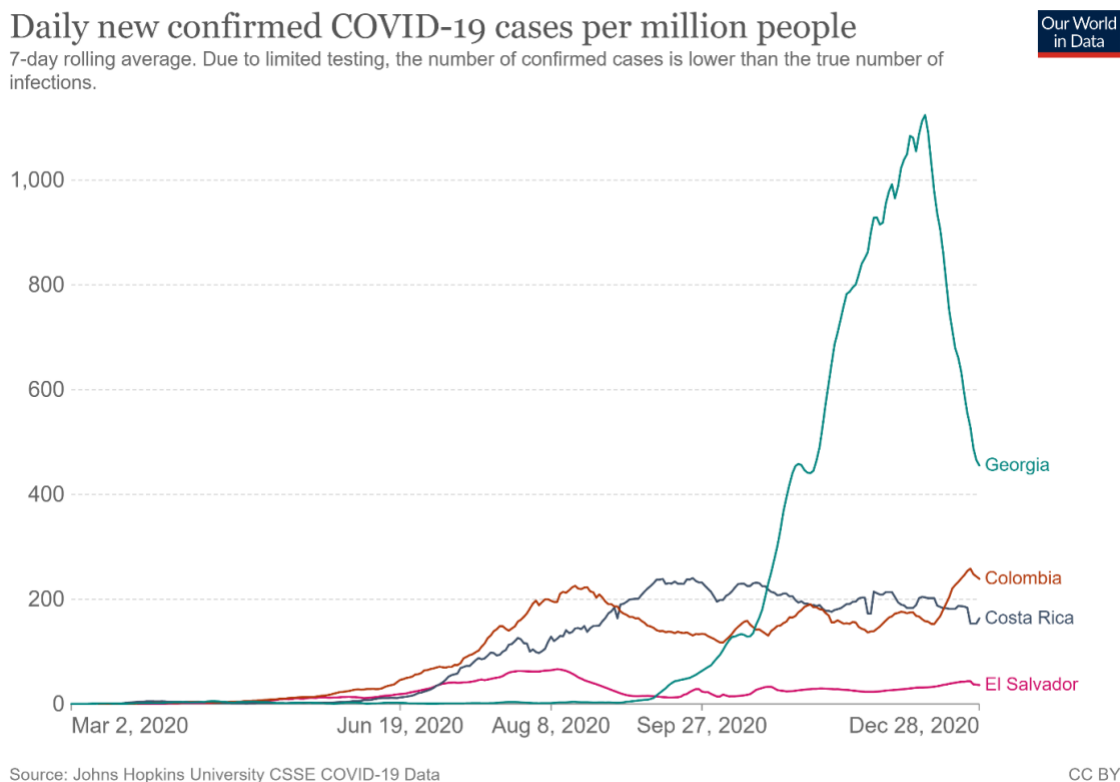
## ASSESSING RESULTS

From mid-June through September 2020, the number of COVID-19 cases in Costa Rica steadily rose to an estimated 237 new daily confirmed cases per million and stayed at roughly that level for the remainder of the year. The number of cases per million slightly exceeded the estimated level in Colombia

for much of the period, but there were none of the sharp spikes that such countries as the Republic of Georgia, a country of comparable population size where tourism also played a similar role, experienced (figure 4).

As in other countries, the accuracy of COVID-19 statistics was subject to debate. Although wealthier, democratic countries such as Costa Rica were more likely to have broader and more-effective testing programs and were less likely to manipulate data for political reasons, much of the country's large, unauthorized immigrant population may have avoided public health services, resulting in an undercount. Still, other data supported the conclusion that Costa Rica was a pandemic success story. The country was one of only six OECD countries where life expectancy did not drop during 2020.<sup>75</sup>

**Figure 4. New confirmed daily cases per million**



In operational terms, Costa Rica demonstrated a number of strengths. It was able to mobilize its coordination system rapidly, thanks to its preexisting natural-disaster-response capabilities, its broad conditional cash transfer program, and the strengths of its public health system, including an extensive network of community-based health-care workers and a national digital health record. It worked with businesses to retain employees by allowing them to cut working hours and then enabled all workers whose incomes were affected to apply for economic support, which was provided through cash assistance deposited into bank accounts. The decision to try to keep people on business

payrolls facilitated efforts to restart economic activity as capacity to pursue a hot-spot strategy improved.

The World Bank estimated that Costa Rica's GDP contracted 4.1% in 2020—the biggest decline in the four decades—and even with government-led mitigation efforts, approximately 124,000 people fell below the poverty line.<sup>76</sup> The mitigation programs worked well, though not perfectly. An Economic Commission for Latin America and the Caribbean study reported that Costa Rica gradually became able to extend social support to about 60% of the prepandemic informally employed population within the first months of 2020 and that the cash transfers it provided were “relatively sufficient in covering households' basic needs,” although it noted that a decision to exclude some of the households already participating in cash transfer programs may have hurt some families.<sup>77</sup> Single-parent households with more than two children were at a disadvantage compared with others.

In late December 2020, Costa Rica's comptroller general published the results of an audit, reporting that 533,689 people had received economic assistance through the Bono Proteger program by June 31, representing 71.1% of the people affected by the COVID-19 pandemic with regard to employment. That level dropped to 59% in July, but the government later reported end-of-year figures that indicated 1,037,386 people had requested financial assistance from April 4, 2020, to January 8, 2021. Of those, 724,330 had received the first bonus, 694,971 the second, and 684,281 the third and final bonus. In other words, the program had fully responded to 69.8% of requests.<sup>78</sup>

Because Costa Rica had a unitary government, it faced fewer difficulties than some countries did in aligning local policies and practices with national strategies. However, when it shifted to a hot-spot strategy, the country's small size posed a distinct challenge: during the workday, people had to traverse multiple jurisdictions—each of them with different curfews and differing policies. Confusion sometimes ensued, until localities began to coordinate with one another.

Public compliance with health measures was difficult to assess: 2020 saw 391 fines for violations of health measures and restrictions. Of the total, 259 were against businesses—mainly for violations of opening hours—and 85 involved people who violated self-quarantine orders, according to one report.<sup>79</sup>

The road map for restarting tourism scored considerable success. Tourism minister Segura said the infection rate among visitors was less than 1% from November 2020 through September 2021. He concluded that removing COVID-19 testing as an entry requirement not only aided economic recovery but also proved that international visitors “are not sources of high incidences of infections.”

During the early weeks, public approval of the government's performance increased by 57 percentage points, according to University of Costa Rica faculty member Adrián Pignataro.<sup>80</sup> However, the approval rating later dropped back to earlier levels and hovered close to 20% by the end of 2020—similar to the experience of many other countries.

## REFLECTIONS

“Act early and act decisively when the risk appears, and if you are going to make a mistake, let it be overshooting the response and not the opposite,” advised Román Macaya, executive president of Costa Rica’s Social Security Fund. “At the beginning, it seemed that maybe we were acting too far in advance or exaggerating our response, but those early decisions helped to avoid us falling too short.”

Costa Rica’s whole-of-government response to COVID-19 showed the advantages of having in place a comprehensive health-care system and existing risk preparedness and emergency response protocols. Preparedness was crucial, said Health Minister Daniel Salas. “What was not done in the years before could only be done only with much difficulty during the pandemic,” when time was at a premium, he said.

Keeping an eye on near-term needs was important during the response as well, stressed Alexander Solís, executive president of the National Commission for Risk Prevention and Emergency Response, adding that advance procurement of vaccines was fundamental to the country’s ability to carry out a vaccination campaign. Even if initial procurement was “maybe not in sufficient quantities because our budgets in the middle of a fiscal crisis were limited,” he said, the right timing “did allow us to reserve vaccines.”

Costa Rica’s initial public health strategy, which reduced capacity levels at businesses, imposed curfews, and banned large gatherings, was more modulated than the lockdowns many countries adopted. Solís said the national government’s decision to avoid severe lockdown measures allowed economic activity to continue and eased the impact of the pandemic on livelihoods. The resident representative of the United Nations Development Programme in Costa Rica, José Vicente Troya, noted “the flexibility the government has had between enforcing lockdowns and easing lockdowns,” and said, “Adaptive management of the pandemic has been an element worth highlighting—particularly during the first stages of the pandemic.”

Initial measures that included partial closure of the economy bought valuable time, said Solís. “This period allowed us—even if with a high price in economic terms—to amplify our hospitalization capabilities, contain the spread of cases, and prepare the population to follow health measures and be ready for vaccination,” he added. The subsequent shift to a shared-governance strategy that applied stronger restrictions in hot spots and offered greater openness where infection rates were low was especially noteworthy, Solís said, because locally differentiated pandemic responses facilitated a swifter economic recovery, which was evident in increased amounts of exports and increased numbers of international visitors.

Incorporating social and economic support alongside public health measures was also crucial for meeting immediate human needs and for positioning the country for a rapid restart. “An optimal approach to the pandemic” recognized that although it was “mainly a health crisis, [it was] also a



social crisis,” said Salas, the health minister. Benefiting from lessons learned from past natural disasters, Costa Rica’s national government was able to quickly identify the capacities needed to respond to a complex emergency and to adapt structures and protocols for coordination across agencies and levels of government. Plus, collaboration with the private sector produced a whole-of-society effort to contain the virus.

Leadership was another important aspect of the response. Salas said President Carlos Andrés Alvarado adopted a participatory approach to interinstitutional coordination, whereby informed discussions among ministers and others helped adapt proposals for health measures and restrictions.

This approach was a balancing act, however. Macaya emphasized that it was important to coordinate and manage “the clash of interests that occurs between economic and health interests. Measures may benefit the economy but worsen the health reality, and vice versa. Creating redundant systems and resilience in our business models is something we have to work on before the next pandemic.” And enterprises of all types, whether big or small, profit or nonprofit, public or private should think hard about how to preserve continuity during a crisis.

Reducing supply-chain risks was an important element of this effort. Macaya urged decision makers “not [to] underestimate the global chaos that a pandemic causes at a logistical level in the dimension of everything that is needed to treat a pandemic—from diagnostic kits to vaccines.”

Legislative innovations that provided new labor and employment protections, although designed to respond to the COVID-19 pandemic, could be reactivated during any other kind of emergency, said Geannina Dinarte, who was minister of labor and social security when the pandemic started and, later, minister of the presidency.

In addition to reflecting on preparedness, strategy, and social support, response coordinators highlighted structures and protocols they found helpful and pinpointed unanticipated challenges only imperfectly addressed.

Speed was crucial. Salas said nations need to have mechanisms that take into account the atypical conditions of emergencies in order to better evaluate their response plans. Dinarte recommended that governments should consider legislation to ensure future emergency responders have the flexibility they need to get things done.

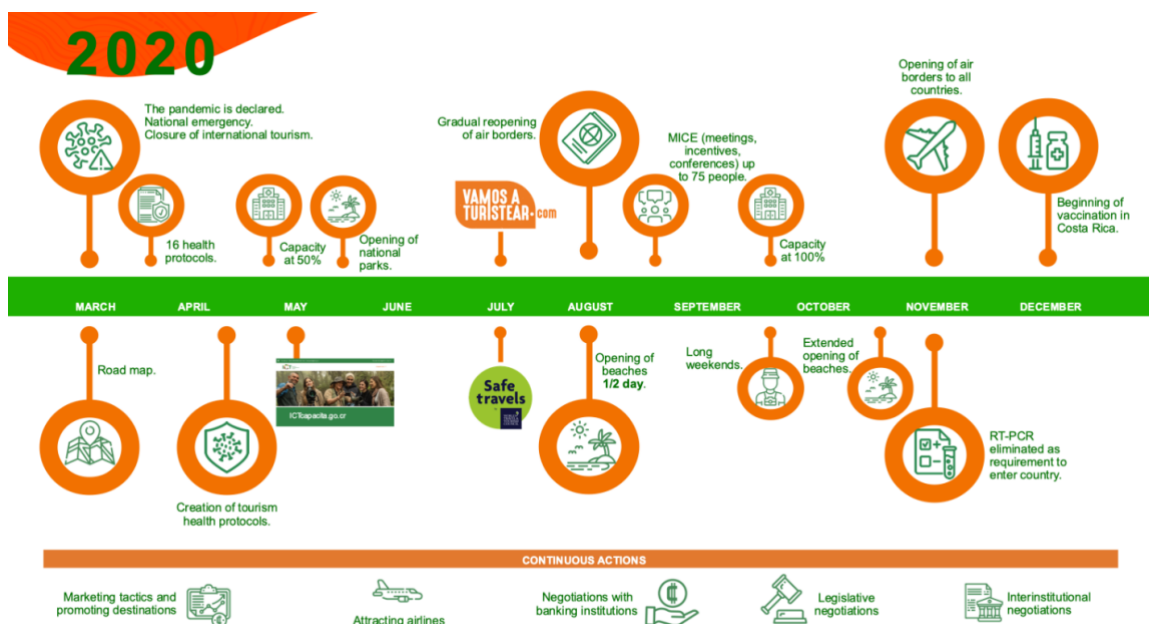
Costa Rica’s systems established to align local actions with national priorities and to apply a hot-spot strategy would likely endure beyond COVID-19, decision makers said. The territorial alert system, with its municipal-level color-coded risk levels, drew some initial public criticism, Solís said, but gradually, people began using the information to adapt their own behaviors and reduce the number of infections in their communities. The shared-governance model enabled a “very important change in the handling of the pandemic,” he added, because local authorities could use specific knowledge of their communities to help contain the virus. In any new emergency, this model would likely be expanded to facilitate a stronger local response, he said.

Tourism Minister Gustavo Segura added that Costa Rica’s challenging fiscal situation at the beginning of the crisis left the national government little leeway to provide financial assistance for small and medium-size businesses that provided much of the country’s formal employment. COVID-19 had left a lesson for businesses—especially businesses in the tourism industry, he said: “During years of prosperity, plan for years with more-modest gains or even losses, and set aside savings appropriately.”

Solís said that developing revised pandemic plans—even amid the ongoing crisis—was an important task because a new health emergency could spread as rapidly as COVID-19. “We should capitalize on all of that experience and establish new guidelines and protocols in order to respond to the next pandemic,” he said. Salas concurred, though he noted that future pandemics “might be very different, have different characteristics, have different dimensions.”

Future responses might further integrate mitigation and recovery plans with the pursuit of other development objectives, as Costa Rica had already started doing. Troya said it became clear that it was possible to “take on the response to the pandemic with a comprehensive character not only with nature, climate, and energy but also with democratic governance, social cohesion, human rights, effective gender equality, and women’s empowerment.”

## Exhibit 1. Tourism recovery road map adapted from Tourism Board original



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