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Impossible choices – questioning assumptions behind lock-down in low income and fragile contexts

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COVID-19 response – checking our assumptions for fragile and low capacity countries.

Just under 3 weeks ago, discussing a project proposal, one of us tentatively suggested adding a section on Coronavirus. The small team began to brainstorm the implications of COVID-19 and then we sat in an anxious silence.

Since then, the rich world has moved on into what already feels like a dystopian science fiction novel – lockdown, daily death and infection tolls, queues for food and unparalleled economic support for households and businesses. But what should a poor or fragile and conflict affected country do by way of rapid response? Specifically, should they impose lockdown and curfew. We think there are three assumptions that should be examined in making the case for lockdown. If these assumptions do not hold, then we ask what national response best minimises suffering and death (from any cause) in that context?

Assumption 1: health service capacity

The objective of lockdown is to reduce suffering and death by reducing transmission rates. COVID19 is highly infectious, mild for many, serious for a minority – usually those with underlying health problems and the older population. Currently there is little treatment for milder symptoms. For the very sick, intensive care and breathing machines (CPAPs/ventilators, etc.) are required. Lockdown is necessary to flatten

the curve – to reduce the demand on health systems and health workers because reducing transmission rates limits the number of serious and critical cases. A reduced number of serious and critical cases means that the health system can then provide the specialised treatment required. These actions also protect our health workers by not overwhelming the health system.

While these issues fall within the remit of public health/ epidemiology, a quick review suggests that Malawi has 20 ventilators for population of 19.3m, CAR has three for a population of 4.7m, Liberia (population 5.6m) has none, most Brazilian cities have 10 or fewer ventilators, India has 48,000 for a population over 1.3bn. Until the number of ICU units and breathing machines have been vastly expanded (along with testing facilities, treatment protocols, personal protective equipment, etc.), is lockdown the appropriate response and what could be the exit strategy?

Assumption 2: lockdown reduces suffering and death

If lockdown causes significant levels of hunger and malnutrition due to low levels of savings, financial inclusion or household food inventories, leads to increases in domestic violence, exacerbates underlying health conditions, or results in rising communal tensions, then again, it may not be delivering on its key objective, to reduce suffering and death.

Are we thinking through the implications of lockdowns for those in high density areas, refugee camps, for day labourers, for seasonal agriculturalists, for domestic workers or for those who depend on active and consuming middle and high income classes for their livelihoods? Populations that could previously just get by are losing their livelihoods as businesses shut down and movement is restricted. Where they exist, household savings and food stores are fast depleting and stockpiling of essential commodities is a distant dream for the majority of the population that lives from day to day. How do you maintain ‘stay at home and wash your hands regularly’ in an overcrowded informal settlement with sparse communal water points or find money to pay for the water and soap needed for extra hand washing? What do you eat? How do you pay your rent? The resounding sentiment for many is that going hungry is a much more immediate threat than contracting the virus itself.

Assumption 3: there are, or can rapidly be, safety nets for those in lockdown

For lockdown to work, without increasing suffering and death, governments need to provide necessary and rapid economic support to those who suffer when they must stay home. In much of the high- and middle-income world, we are seeing unparalleled support to businesses and households. In most low income or fragile developing contexts, can we assume governments have the capacity to provide at

least a minimum level of safety net support rapidly to the affected population? Only such safety net support will make a lockdown feasible at the individual household level.

These three factors together – the weakness of the health systems, the capacity of households to survive lockdown and governmental capacity to fund and deliver safety nets – are what determine the appropriateness of broad lock down approaches.

The pains and impracticalities of government lock downs, curfews and stay at home directives are already being felt in numerous countries across the globe as the world strives to contain the pandemic. We have seen physical distancing neglected and pitiful levels of suffering as a mass exodus of domestic workers ensued in India following a lockdown announcement; and reports of despair as a lockdown begins in Zimbabwe where an economic crisis and climatic shocks have already pushed the population to the brink.

Poor and vulnerable people will continue to be driven to keep doing what they need to do to provide food to their families despite the increased risks. One immediate recommendation is that we should use the methodologies we have for remote research (mobile surveys, WhatsApp groups, etc.,) to generate evidence from those enduring lockdown in the poorest countries to inform the response.

The main question however is whether policy makers have transposed recommendations for developed contexts with strong health and social protection systems onto contexts where health systems and economies are weak. Most of the recommendations are rich people/country recommendations – social distancing, stay home, wash your hands with soap more often than usual, etc. etc. Where is the analysis based on a robust understanding of the actual challenges faced in developing contexts? If policy makers had started their analysis from the context of high poverty levels and fragile livelihoods, sparse safety nets with low coverage, weak health provision with high out-of-pocket expenses, massive displaced communities – would they still have recommended lockdown or curfew? Questions are already arising about exit from lockdown in richer countries, what would exit strategies look like in poorer contexts?

This is not for a minute to suggest that the economy is more important than people's lives but to say that where the economy equates to earning your daily bread, this is 'people's lives' for the poor – in the absence of external support. We are trying to understand if there is a way to avoid widespread death, suffering, and disruption to livelihoods in countries that cannot implement global guidance and intervention measures in the same way as middle- and high-income countries? To avoid poor people being caught between the rock of COVID-19 and the hard place of putting food on the table and maintaining their livelihoods often in the partial or complete absence of state support? No intervention is without positive and negative

consequences, but each has to be weighted, and information to answer these questions in low capacity and fragile countries and contexts is lacking.

So, we strongly urge that if lockdown measures are taken, they should be accompanied by rapid and well thought-out social assistance to mitigate the socio-economic impact on poor populations. Where social assistance is in place, government social protection programmes should be rapidly increased and extended. But as these programmes only cover a small minority of the population, humanitarian and development organisations must plan for cash assistance to enable affected populations to meet their basic needs alongside the required health responses – now rather than later. In many low income and fragile contexts, shocks are cyclical and compounding and while affected households will take time to recover from the effects of COVID-19 in the immediate term, there will be potentially longer-term effects on national economies, the next harvest, human capital, health systems, etc. Donors must factor this into their funding plans. This will be just as important a life-saving component of this crisis as the health response.

Finally, this crisis response presents a new opportunity to improve ways of working together, as humanitarian and development actors, to learn how to link humanitarian response to social protection systems and to contribute to the strengthening of the shock responsive element of social protection systems. We also have the chance to explore how humanitarian and development actors can coordinate now and in the future to better assist those affected by co-variate shocks. There are encouraging initiatives already underway and we look forward to seeing many more emerging.

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