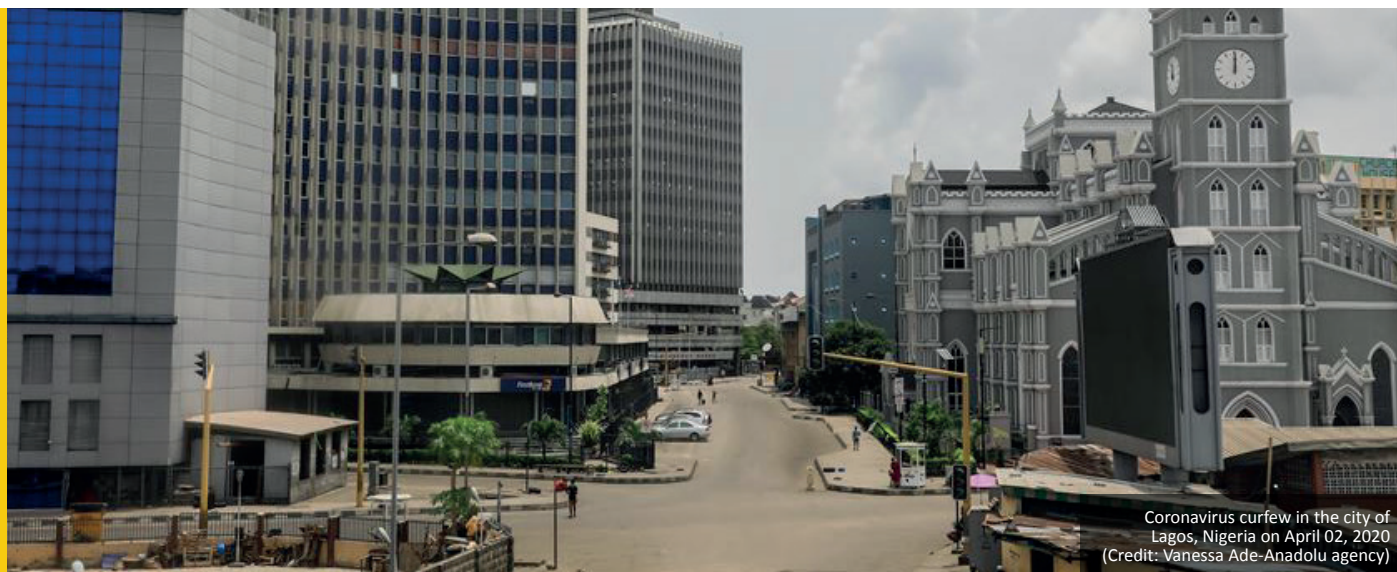# COVID-19:
Locking in solutions while in lockdown

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Coronavirus curfew in the city of Lagos, Nigeria on April 02, 2020 (Credit: Vanessa Ade-Anadolu agency)

Key messages

- Lockdown strategies must consider governance constraints that can dangerously limit the emergency response to Covid-19, risking both lives and livelihoods

- The intensity of lockdowns depends on two critical interdependent variables: a feasible testing and treatment strategy for that context which in turn has to take into account the organisational capacity to scale up responses

- Governance and corruption related constraints that can hinder scaling up can be mitigated with an innovative anti-corruption approach involving mobilisation of multiple providers for each delivery goal, and not just relying on one system such as the public health system

- The incentives generated to work for a national emergency can provide a framework for cooperation and to deliver cost-effective rapid results particularly if the strategy scales up providers who perform better.

- With lockdowns used to scale up feasible testing and treatment strategies, less restrictive lockdowns become possible minimising the joint effects of disease deaths and the severe effects of economic deprivation

What is ACE?

The Anti-Corruption Evidence (ACE) research consortium takes an innovative approach to anti-corruption policy and practice. Working with a multi-country coalition of 12 partners over five years, ACE is responding to the serious challenges facing people and economies affected by corruption by generating evidence that makes anti-corruption real and using those findings to help policymakers, business and civil society adopt new, feasible, high-impact strategies to tackle corruption.

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The COVID-19 crisis could be with us for at least 18 months, with lockdowns relaxed or tightened at intervals. It will only end when we have an effective treatment or vaccine, or enough people are infected and recover to achieve herd immunity (though the human cost of this would be high). Meanwhile, striking the right balance between lockdowns and relaxations is now a major concern for poor countries. As Heather Marquette has noted , we have to get this right.

Lockdowns aim to manage the flow of patients into health facilities by slowing disease transmission, but the consequences have been devastating in developing countries. Their economies are already poor, with limited safety nets for people out of work, while their health services cannot cope with any influx of extra patients.

No lockdown strategy can be determined without considering the elephant in the room: the governance constraints that limit the emergency expansion of basic COVID-19 testing and treatment facilities. If we don't, the trade-offs will be dire. Even if developing countries could find emergency funds, governance weaknesses and corruption may constrain the emergency scale-up demanded by COVID-19. Existing governance and corruption problems will become more crippling if countries have to expand their health capacity at speed. These problems must be addressed if lockdowns are going to do their job: slowing the transmission of disease to the point where some relaxation is possible, while reducing the loss of life.

Lockdowns buy us time. But what should we do with it?

As Figure 1 shows, deaths from COVID-19 depend on the trade-offs implicit in the 'lockdown strategy'. If the lockdown is too loose, existing health facilities may be unable to cope with the rate of infections, leading to many avoidable deaths. If the restrictions are too tight and prolonged, however, many deaths may be caused by the impact of economic deprivation.

Figure 1: Trade-offs in the COVID-19 response
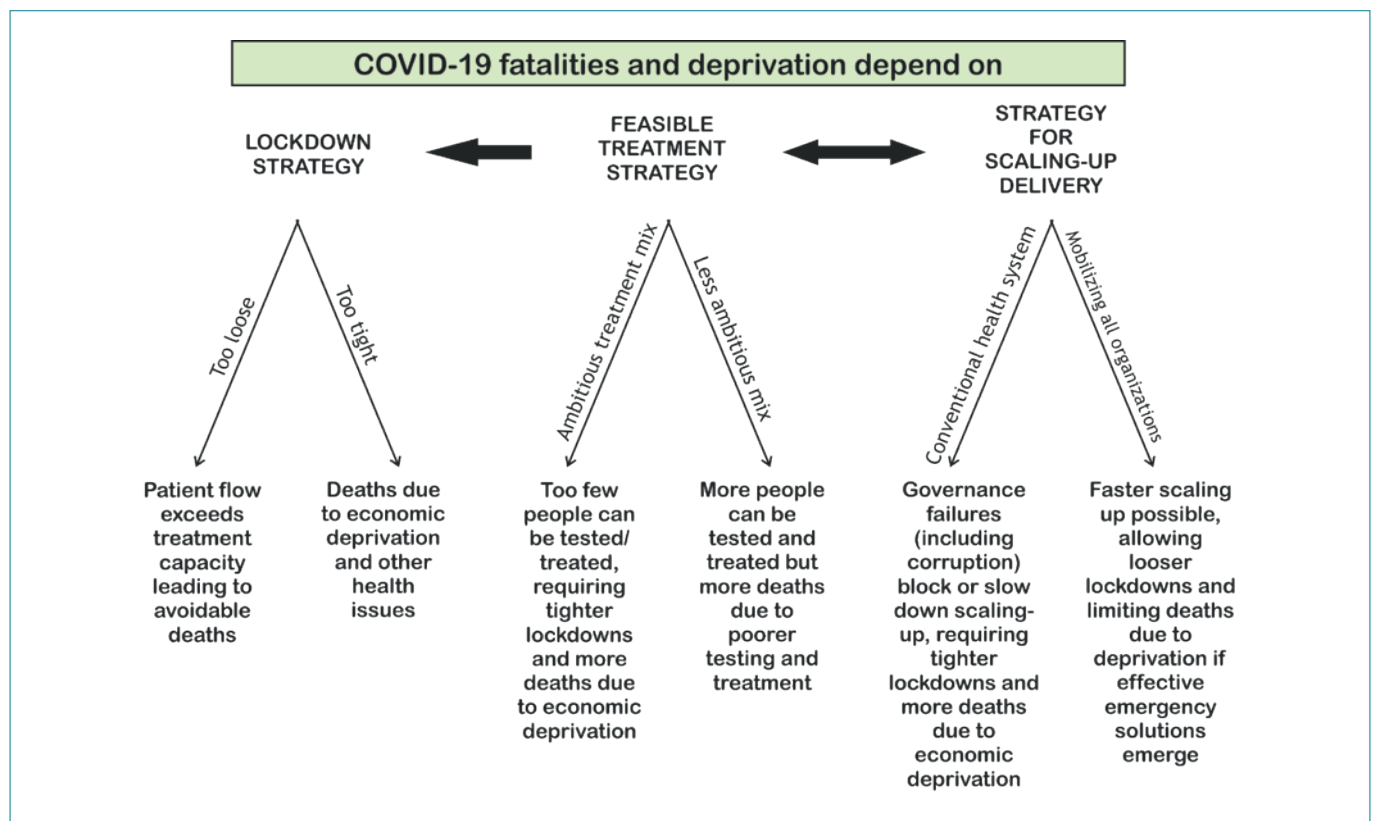
Source: The authors

Evidence-based responses are needed to use the time provided by lockdowns to improve these trade-offs. This is because over time, these trade-offs depend on developing treatment capacity during the 'breathing space' provided by each lockdown. If testing and treatment capacity does not expand during lockdowns, the eventual opening up will mean a new surge of deaths resulting from infection and poor treatment. And any subsequent lockdowns will just repeat the cycle. For a lockdown strategy to be feasible and actually reduce deaths, governments must use this time to improve their COVID-19 treatment capacity. In many countries, however, politics and governance get in the way.

Pre-existing sectarian prejudices and fake news have affected responses in large countries like India and Nigeria, while the determination to show that everything is under control is distorting data in some other countries. There is evidence that developing countries with experiences of previous epidemics, especially in Africa, have better organisational responses. Evidence from most developing countries shows that many lives may be pushed to the edge if the lockdown strategy is calibrated incorrectly, particularly if the effects on the poor are ignored. But no amount of calibration will help if there are no good choices to be made, and nothing is done to improve these choices.

An effective response must address the two other variables shown in Figure 1 that enable more sustainable lockdown strategies and save more lives: the strategies for feasible treatment and scaling up.

Determining the feasible treatment strategy

This refers to the tests, treatments, quarantine arrangements, and equipment for health workers that the health system can feasibly deliver with loans from international financial institutions, grants from donors and their own resources. It is a medical issue, but also depends on the country's economic, organizational and professional capabilities. Being over-ambitious in selecting the desirable mix of test and treatment can be as deadly as being too lax. The selected mix should be good enough to save lives but not so good that it is impossible to deliver. And it should be possible to scale up at speed.

Scaling-up capacity

The judgement on the treatment mix is therefore tied to the most critical variable from a policy perspective: how to scale up capacity as fast as possible. Long-standing governance and corruption problems can become severe constraints on emergency scale-up. Pumping new resources through weak systems on an emergency basis can mean significant wastage as a result of bureaucracy, inefficiency and corruption.

The cost of scaling up particular types of testing, treatment, and quarantine facilities depends on the capabilities of the agencies delivering the expansion *and* their internal leakages and inefficiencies. For example, the rapid increase of quarantine beds through 'normal' procurement processes in public healthcare facilities may trigger huge increases in unit costs in developing countries that have more corrupt healthcare systems. The true cost of an extra bed or testing kit includes not just the direct cost but the cost of resource wastage and corruption in the organization delivering it. Sadly, evidence is emerging that corruption becomes 'easier' in a crisis when money has to be spent quickly to procure emergency material.

Standard anti-corruption measures, like linking new lending to reform measures, are even less likely to provide immediate results in such conditions, though the experience of what a weak health system can do may well improve the chances of reform over time.

Three lockdown strategies

If governance and corruption failures prevent the scaling-up of capacity, lockdowns have to be harsh to stop the uncontrollable spread of disease, inflicting enormous hardships on poor people without offering any hope of immediate respite. These lockdowns may well break down because of deprivation, allowing the disease to re-emerge with devastating consequences and further harsh lockdowns. The only answer here is to ramp up cash transfers and other poverty mitigation strategies (which should happen anyway). But transfers alone are unlikely to address deprivation in poor countries and may miss many people.

Figure 2: Three lockdowns
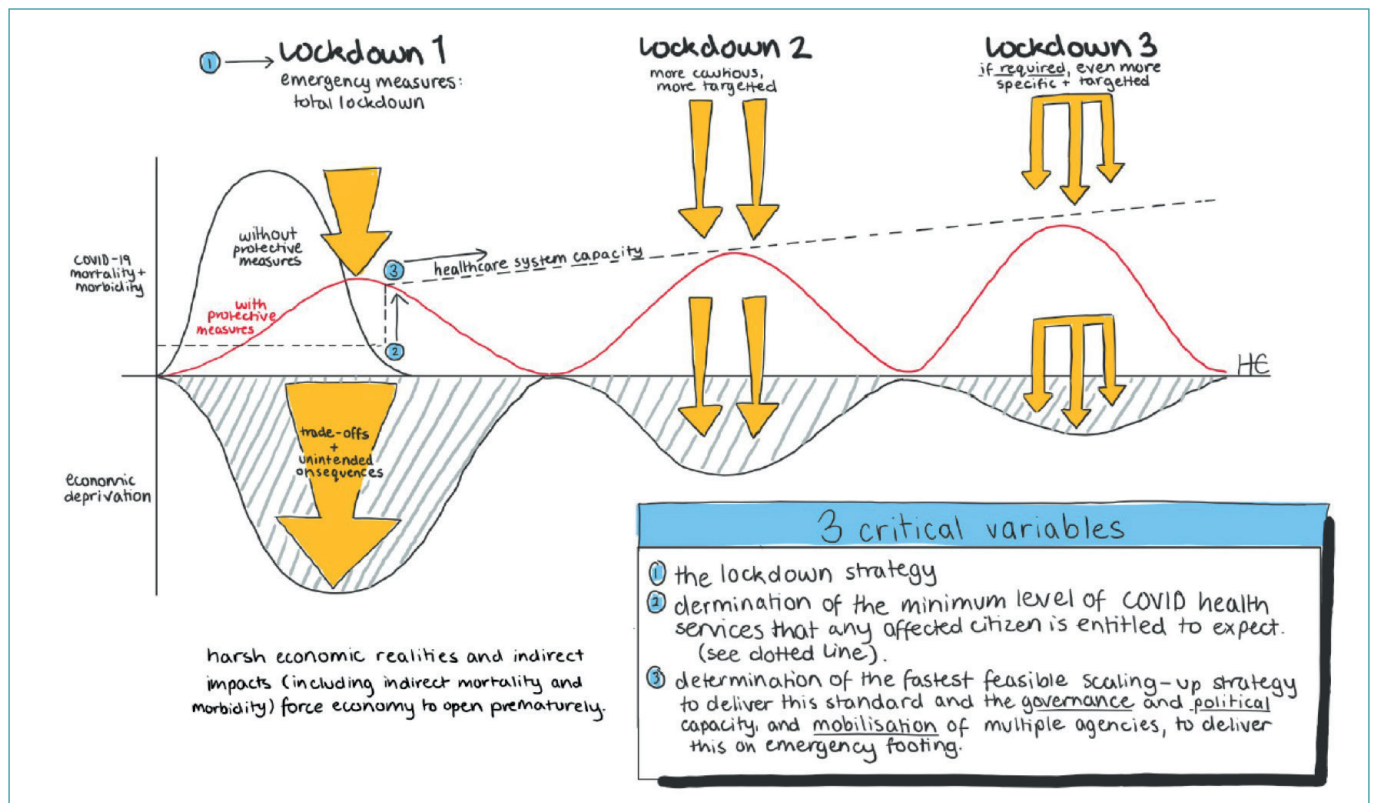
Figure 2, adapted from [Marquette and Evans](), plots the numbers infected in each period under different lockdown strategies (red line in top half) and the associated economic deprivation (bottom half). COVID-19 deaths depend on the gap between the infected number line and health system capacity. Mortality caused by economic deprivation depends on the total number of people falling into deprivation and its intensity in each cycle.

In **Lockdown 1**, emergency measures are harsh because treatment facilities are limited. Although the infection curve is flattened, the health system cannot cope with the number of infected people and many, if not most, people are affected by economic deprivation. While infections may be contained, temporarily, the negative indirect impacts (economic deprivation, indirect morbidity, and mortality) may outweigh the positive effects of temporary containment. And high levels of deprivation mean the strategy is not sustainable: harsh lockdowns will be followed by unsustainable relaxation.

The looser strategy shown in **Lockdown 2** is possible if response challenges have been addressed and COVID-19 testing and treatment capacities have improved. Emergency restrictions can now be more cautious and targeted, and the infection curve is flattened to within the (higher) capacity of the improved health system while allowing more economic activity. Fewer people face economic deprivation and have more chance of being reached by anti-poverty measures. The direct and indirect impacts of the lockdown produce a better outcome than in Lockdown 1.

If testing and treatment capacities can be scaled up even further, we can imagine **Lockdown 3,** which strikes a better balance between direct health effects and indirect economic deprivation. This lockdown can be even more targeted and limited. As well as resulting in better overall outcomes, it may also be more sustainable over the many months or years that the virus remains a threat as economic deprivation is less likely to spiral out of control.

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1   Thanks to Hamsi Evans for the artwork and Peter Evans for his inputs.

A possible way forward

Governance and corruption are critical constraint that may prevent many societies moving to sustainable lockdowns. A rapid scaling up through established processes may be too slow and too costly. Mobilising multiple organisations may be a feasible, if temporary, anti-corruption strategy in an emergency.

Fortunately, health systems are not uniformly weak at all levels and across all types of agencies. The public health system may have hospitals and clinics at federal, provincial and local levels with different capabilities, there may be private health providers of different types, NGOs may be providing some health services and so on. Each type of provider has strengths and weaknesses in scaling up specific services.

A feasible anti-corruption strategy in an emergency may, therefore, be to coordinate the provision of different elements of the COVID-19 treatment strategy using different types of delivery agencies, recognizing their strengths and weaknesses, to achieve the most cost-effective and fastest possible scaling up. The point is not to try and remove all corruption and governance failures but to reduce the cost of corruption during the emergency to allow a rapid scaling up. This requires an adaptive and inclusive emergency response strategy that can start with trials and rapidly scale up providers based on their efficacy in actually delivering under emergency conditions.

In normal times, innovation can face strong resistance from incumbents. But in times of war, and COVID-19 feels like that in many countries, unusual measures may be possible on a temporary basis.

It is not necessary to *predict* which organizations are better at what. The mobilization of multiple providers for each delivery goal can generate incentives to cooperate and strive to deliver the fastest and most cost-effective results, particularly if the strategy scales up the providers who perform better, and if the strategy is presented to the public as a national emergency response.

The response to developing testing capacity in the UK is one example, with multiple agencies, universities, the private sector and even the army mobilized to deliver a rapid increase in testing capabilities. This was not an anti-corruption measure, but a strategy to accelerate delivery. A similar approach in developing countries could temporarily mitigate corruption and low capacity by involving public and private and NGO actors, hospitals, clinics and testing facilities, enabling scale up on the basis of revealed competence in trials. A SOAS-ACE blog on Uganda suggested that even the smallest private drug shops and clinics could play a role in a coordinated strategy.

The best outcome for a developing country is where out-of-the-box approaches bypass established corruption and governance problems to scale up testing and treatment facilities in this unprecedented emergency, enabling the least restrictive lockdowns on an ongoing basis. In this scenario, a lockdown is a helpful tool and subsequent lockdowns become more sustainable.

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About the Anti-Corruption Evidence (ACE) Research Consortium:

ACE takes an innovative approach to anti-corruption policy and practice. Funded by UK aid, ACE is responding to the serious challenges facing people and economies affected by corruption by generating evidence that makes anti-corruption real, and using those findings to help policymakers, business and civil society adopt new, feasible, high-impact strategies to tackle corruption.

ACE is a partnership of highly experienced research and policy institutes based in Bangladesh, Nigeria, Tanzania, the United Kingdom and the USA. The lead institution is SOAS University of London. Other consortium partners are:

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- Economic and Social Research Foundation (ESRF)
- Health Policy Research Group (HPRG), University of Nigeria Nsukka (UNN)
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