Maintains

Research supporting social services to adapt to shocks

Initial COVID-19 responses in Bangladesh, Kenya, Pakistan, Sierra Leone, and Uganda: Documentation and learning from March to May 2020

COVID-19 Series: Brief

Debbie Hillier, Tom Newton-Lewis, Rithika Nair, and Christoph Larsen

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About Maintains

This five-year (2018–2023) operational research programme is building a strong evidence base on how health, education, nutrition, and social protection systems can respond more quickly, reliably, and effectively to changing needs during and after shocks, whilst also maintaining existing services. Maintains is working in six focal countries—Bangladesh, Ethiopia, Kenya, Pakistan, Sierra Leone, and Uganda—undertaking research to build evidence and providing technical assistance to support practical implementation. Lessons from this work will be used to inform policy and practice at both national and global levels.

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Contacts

✉ maintains@opml.co.uk

Maintains Webpage

@MaintainsProg

www.linkedin.com/company/maintains/

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Executive summary

Introduction and approach

COVID-19 has been an unprecedented challenge globally. This is an executive summary of the full report that documents the experiences and challenges of scaling up the response to COVID-19 in the first three months of the outbreak – March to May 2020 – in five countries: Bangladesh, Kenya, Pakistan, Sierra Leone, and Uganda.

This work was undertaken under the DFID-funded Maintains programme, to inform Maintains' research, technical assistance, and learning agendas. The primary objective was to see what Maintains can learn around the national ability to scale up in response to a shock. This will consider the governance of the outbreak and its impacts across social sectors, with a focus on the health sector.

Rapid analyses were undertaken by country teams who reviewed documentation issued by government and other stakeholders, and interviewed a range of government and partner organisations (to the extent feasible under lockdown conditions), following a pre-designed standardised research framework. This was further strengthened by secondary data collection and the findings synthesised into this report to support comparability and identify key themes and learning. This work was undertaken in a rapid fashion, in a fast-moving context, and attempts to summarise a broad array of impacts into a concise analysis; it therefore cannot tell the full story in all its complexity but rather seeks to provide pointers and early lessons.

The pandemic has played out differently in the five countries. Pakistan and Bangladesh were hit first (26 February and 8 March respectively) and hard (with the highest number of both confirmed cases – 72,000 and 47,000 by 31 May respectively – and cases per capita). Lockdowns were imposed, but then significantly eased due to economic pressure after about two months, during May, even whilst daily cases were continuing to rise.

The first cases were confirmed slightly later in Kenya, Uganda, and Sierra Leone (13, 21, and 31 March respectively) and all three of these countries have far fewer confirmed cases – all below 2,000 by the end of May. They all took swifter response measures – with hand-washing at Freetown airport from January and Uganda going into lockdown even before the first case – and lockdowns in Uganda and Kenya have been slower to ease. Sierra Leone's response has been severely limited by resources, and it has the highest fatalities per capita. In all countries, cases per capita have measured highest in the capital city.

An analytical framework has been developed for this report that will be further tested and developed during the life of the Maintains programme. The framework analyses the response through three broad domains, as follows, which are further broken down into response attributes and key factors and summarised in the table below:

1. The overarching **governance** of the response, across all sectors, which includes leadership, plans, legal frameworks, partnerships, financing, trust, and accountability.
2. **Mitigation of secondary impacts**. We have focused on how the social systems that are core to Maintains – social protection, nutrition, and education – can respond to the

secondary impacts of the pandemic, and take a particular look at impacts on gender equality and social inclusion (GESI). This section also considers the impact and implementation of movement restrictions, which affect every other part of the response.

3. How the **health system** and been able to maintain existing essential health services, as well as scale up to respond to the epidemic with stringent infection prevention and control. Other key aspects of the health response include the health workforce, information systems and surveillance, supplies and logistics – all of which require strong surge components – as well as genuine community engagement.

Table 1: Analytical framework for the report: response attributes and key factors

Governance		
	Response attributes	**Key factors**
	Competent leadership and multi-disciplinary team	✓ Competent, flexible leadership, clear roles and responsibilities, multi-disciplinary team with capacity to deliver with good representation of women, including in senior positions.
		✓ Close and effective coordination at national, provincial, district, and local levels
	Adaptive plans and solid policy and legal framework	✓ Prior to the outbreak, strong public health planning, policy, and preparedness actions have been undertaken
		✓ A flexible operational plan with estimated resource requirements, surge capacity, and regular operational reviews
		✓ Existence of applicable, up-to-date legal framework
	Collaboration, coordination, and partnerships	✓ National government agencies partner with: ✓ Development partners, donors, UN agencies, and international stakeholders; ✓ Private sector – health and non-health; ✓ Scientific bodies, institutions of learning, traditional leaders and local influencers, non-governmental and faith-based organisations, civil society, and women's rights groups
	Timely, flexible, and adequate access to crisis financing	✓ Swift, flexible access to additional financing
		✓ COVID-19-related financing and expenditure are subject to accountability mechanisms and public scrutiny by the legislature
	Trust, transparency, and accountability	✓ Being seen to implement a proportionate and accountable response, with public health above all other agendas
		✓ Evidence-based, transparent communication to garner public consent and build trust in the response

Mitigating secondary impacts		
	Response attributes	**Key factors**
		✓ Clear guiding principles on movement restrictions are in place; frequent, transparent reviews; and a special focus on vulnerable groups

	Pro-poor implementation of movement restrictions	✓ Movement restrictions are implemented consistently and enforced with proportionality
		✓ Basic needs of those subjected to lockdown – including access to food, water, and essential health care – are met
	**Ensuring gender equality and social inclusion (GESI)**	✓ GESI is mainstreamed within all COVID-19 approaches and interventions, with an explicit GESI analysis, disaggregated data, and extra support provided for women and girls and the most vulnerable groups
		✓ Specific additional strategies are established to protect women and girls from physical, sexual or psychological violence, with a particular focus on increased vulnerabilities due to movement restrictions
		✓ Stigma, discrimination, racism, and xenophobia are not tolerated and transgressions are publicly dealt with, including state-supported legal redress
	**Providing social protection**	✓ Social assistance cash and in-kind schemes are expanded and adapted swiftly, with new delivery and enrolment modalities as necessary to successfully target and support vulnerable people
		✓ Market-based interventions are put in place to further protect both households and small businesses
	**Adequate nutrition and food security for all**	✓ Cash and in-kind social protection systems are expanded and adapted swiftly, to successfully meet the immediate food and nutrition needs of vulnerable people
		✓ Introduction of stimulus and support packages for food production and supply
		✓ The health system response for malnutrition prevention and treatment is strengthened
	**Accessible, equitable, and inclusive education**	✓ A policy to oversee education at all levels while institutions of learning are closed
		✓ Distance learning should be provided in ways that optimise accessibility, equity, and inclusion
		✓ Educational institutions should work with the government to ensure that other services provided by them (e.g. school feeding programmes) are provided in other ways

Health systems

	Response attributes	Key factors
	**Service delivery: Quarantine, testing, isolation, treatment, and contact tracing**	✓ Dedicated quarantine processes have been set up for international arrivals and are achieving high coverage and compliance
		✓ Standardised, routine protocols for free testing of suspected and confirmed COVID-19 patients are in force
		✓ An effective isolation policy is in place for confirmed cases (either institutional or at home) and is achieving high coverage and compliance; high-dependency care capacity has been augmented
		✓ Contract tracing systems and institutional or self-quarantine procedures for identified contacts established and achieving high coverage and compliance

Maintaining delivery of essential services	✓ Essential routine healthcare services are sustained throughout a public health emergency
	✓ An infection prevention and control risk assessment has been conducted at all levels of the healthcare system and high-risk community spaces, leading to application of additional protection guidelines.
Dedicated health workforce with surge capacity	✓ Human resource provisions are in place to provide surge capacity, and to adjust roles and actions as needed, assisted by ongoing capacity building.
	✓ Health workers are motivated and supported by occupational health programmes, training, remuneration and insurance, and psychosocial support, leading to high levels of interpersonal trust; the differentiated needs of women and men are taken into account.
Efficient information systems and surveillance	✓ Robust and timely data analysis supports risk assessment and operational decision-making; daily situation reports and data are made available to all government levels, international partners, and the general public
	✓ Health system actors have successfully applied risk communication protocols through traditional and social media, and health advisory hotlines
High-quality supplies, logistics, and infrastructure	✓ All COVID-19 healthcare facilities have continued access to essential equipment, drugs, reagents, and supplies, including personal protective equipment (PPE) and respiratory support, in accordance with their designated level of care.
Genuine community engagement	✓ Health system actors have successfully engaged recognised local authorities, leaders, and influencers, including women leaders, to enhance the community uptake of culturally appropriate preventive community and individual health and hygiene practices in line with national public health recommendations

Governance

COVID-19 is a highly complex challenge for all governments, especially those with limited state capability. It requires a coordinated and adaptive 'whole of government' and 'whole of society' approach.

Different countries have enacted different **leadership** and structures: only Bangladesh continues to lead its response from the health ministry. In Uganda, emergency responses are led by the Department of Disaster Preparedness. Sierra Leone's response is now led by the Ministry of Defence, which stakeholders felt had created tensions and divided opinion as to whether this weakened or strengthened national coordination. In Kenya, the National Emergency Response Committee, a highly centralised body accessible only by top government officials, has public health in an advisory role only, and there are disconnects between national and county levels. Pakistan's leadership has been disjointed, with different approaches being advocated by the federal government, provincial governments, military actors, and religious leaders. Leadership of women in the response is low – in Kenya, Pakistan, and Uganda, women make up 29%, 8%, and 22.5% of key response committees respectively, often with men holding the most influential positions. Thus, these committees are less likely to consider women's and men's different experiences when shaping responses, which is expected to deepen gender inequality.

Most countries created national **response plans** to govern the response. Kenya had a head start, producing its first COVID-19 preparedness plan in December 2019, but by May the

response plan seemed to be still under preparation. Bangladesh and Sierra Leone based their response plans on existing pandemic influenza response plans and Sierra Leone utilised its existing Emergency Operations structure. Uganda is the only country to not have a publicly available response plan. A strong response requires an up-to-date **legal framework** – this is in place for Bangladesh and Kenya, Pakistan has had to use disaster rather than public health legislation, Uganda's legislation is old but functional, and Sierra Leone's public health legislation is outdated. **Preparedness** can support response; Uganda and Sierra Leone have the most experience of managing major outbreaks, have recently undertaken Ebola simulation exercises, have active One Health approaches, have national action plans for health security, and final or draft pandemic influenza preparedness plans. Uganda's strengths have been seen in case management and surveillance, and less so in terms of mitigating secondary impacts.

In terms of **partnerships**, so far the role of development partners has been more focused on financial support than on technical and logistical capacity. In Kenya, donor engagement was initially strong, but reduced substantially when the COVID-19 response was re-routed through the new government structure. All Maintains governments are working with their private sectors, with particularly strong engagement from the vibrant private sector in Kenya. And whilst most countries have recognised the role of civil society, which is crucial for communicating epidemic risks and achieving behaviour change, its potential is not yet fully realised, particularly that of women's rights organisations. In Bangladesh, Kenya, and Uganda, religious leaders have played a very positive role, but in Pakistan religious leaders made unilateral statements about mosques opening, against government lockdown orders, creating confusion.

To meet the substantial **financing** needs to cover the direct response measures and reduce the economic and social impacts, all countries have obtained additional financing. There has been a heavy reliance on substantial soft loans from development institutions (principally the Asian Development Bank, International Monetary Fund, and World Bank), which has provided valuable quick funds but will increase debt levels. Budget reallocations have also been swiftly implemented, but they will leave gaps elsewhere, and Sierra Leone has seen some debt restructuring. It is hard to ascertain whether the available financing is sufficient to meet the needs. There are also concerns as to whether there are sufficient expenditure controls to manage the fiduciary risks that are exacerbated by emergency procurement.

Finally, institutional **trust** between communities and government is crucial in pandemics to ensure cooperation and behaviour change. This has been challenged due to perceptions that some governments have exploited the pandemic for political gains, that Kenya took an enforcement rather than public health approach to quarantine,[1] and that Bangladesh has repressed freedom of speech and protest.[2] The strictly enforced curfews in Kenya and Uganda not only punished transgressors, but also collectively reinforced people's fears of state caprice and coercion.

[1] African Arguments (2020) 'Kenya: We cannot police ourselves out of the pandemic', https://africanarguments.org/2020/06/03/kenya-we-cannot-police-ourselves-out-of-the-pandemic/
[2] Taiwan News (2020) 'Bangladeshi lecturer arrested over Facebook coronavirus post', www.taiwannews.com.tw/en/news/3947954

Mitigating secondary impacts

It has been particularly challenging for countries to balance the trade-offs inherent in **movement restrictions** required to slow the spread of COVID-19 with the related multi-layered economic, educational, social, and health-related risks and Maintains countries have taken different approaches to these trade-offs. Uganda quickly imposed a strictly enforced nationwide lockdown and curfew, which was still ongoing as at the end of May, whereas Sierra Leone implemented partial restrictions and just two three-day lockdowns, in recognition of the precarious economic situation of poor households.

Lockdowns have had a range of severe consequences. Initial enforcement of the curfew in Kenya led to 12 deaths and in Uganda there were multiple reports of beatings, the use of live ammunition, and arbitrary arrests of rule breakers. Meeting basic needs has been difficult, as many people living in informal settlements in Sierra Leone do not have either savings or storage facilities for water and food for three days. In Bangladesh, people's savings were estimated to last just 1–2 weeks. Humanitarian aid staff in refugee camps in Cox's Bazar report that the drastic reduction in operations capacity has affected their ability to perform even those services deemed 'critical'. The strictly enforced lockdown in Uganda has led to reports of women bleeding to death, attempting to get to hospital.

In the race to respond, inequities in needs, impacts, and access to services have been overlooked, deepening structural **inequalities**. There has been an increase in violence against women and girls, amplified by movement restrictions and lockdowns, school closures, and transactional sex. There are reports of significant rises in gender-based violence among refugees in Bangladesh's camps and across Uganda, while Kenya has reported a tripling of gender-based violence. Stigma, discrimination, racism, and xenophobia arising from, or exacerbated by, COVID-19 have also increased.

For most Maintains countries, the COVID-19 response plan refers to vulnerable groups, with Pakistan providing a strong example, but implementation is weak across all countries. Bangladesh, Kenya, and Pakistan have not provided any funding or made any policy commitment for gender-based violence, sexual and reproductive health services, provision of childcare, or support to mitigate the economic effects on women. There are also major gaps in the response to vulnerable groups including children, refugees, displaced people, and prisoners. Systematic monitoring is also missing, as well as on-the-ground task forces to mitigate domestic crime; courts in all countries have stopped or reduced hearings with wide impacts, particularly for the vulnerable.

Increasing **social protection** has been a key strategy to protect vulnerable people from economic impacts. In all Maintains countries, over 80% of workers are employed in the informal sector, going up to 93.7% in Uganda, with mostly higher rates for women, meaning that protecting informal livelihoods needs to be a high priority. However, targeting has been a challenge, as countries do not have up-to-date social registries or sufficient socio-economic information about large sections of their populations.

Pakistan delivered the fastest scale-up: by 25 April 2020, the government had disbursed US$ 411 million to 5.7 million beneficiaries across the country. Meanwhile the scale-up of social protection coverage in Bangladesh has been remarkable, with a further 24.7 million

people now receiving protection for COVID-19, covering 15.3% of the population.[3] Kenya, Uganda and Sierra Leone have also provided support, but at a slower pace and smaller scale. Kenya is the only country globally to have targeted a scheme specifically to urban slums. For all countries, there remain challenges around targeting processes, adequacy of transfer values, regularity and proposed length of planned transfers, and complaints and accountability mechanisms. It is not clear what analysis has been given to GESI, where timing, targeting, and modality of cash transfers are key.

Most countries have developed specific social protection interventions targeted at **food security**, including food distribution and rice subsidies in Bangladesh and food distribution through public 'utility stores' in Pakistan. However, access to these provisions has been a challenge. COVID-19 has not led to food production problems yet, and the food supply chain is relatively robust in most countries, apart from in Uganda and elsewhere for perishable foods. Across the Maintains countries, local markets have been shut (some intermittently) and there are some reports of increasing food inflation, which will exacerbate the impacts on nutrition. Some 8.3 million children have not received food via school feeding programmes; only Bangladesh has replaced this with high-energy biscuit provision. These issues, combined with major reductions in household income and the reduction in immunisation and child health services, means that we would expect to see a significant increase in the prevalence of under-five acute malnutrition in the coming months.

The COVID-19 pandemic has disrupted **education** provision at an unprecedented scale. Schools in all Maintains countries remain closed, likely leading to a reduction in educational outcomes, reversal in literacy gains, and particularly poor outcomes for girls, in relation to re-enrolment, gender-based violence, teenage pregnancy, and early marriage. While progressive education policies have been produced in all countries, implementation remains weak. All Maintains countries have developed new approaches to be able to continue education provision during the pandemic, with Pakistan and Bangladesh focusing on TV, Sierra Leone focusing on radio, Uganda combining online and radio, and Kenya mainly online. However, many children cannot effectively access distance learning approaches, particularly in rural areas, halting their education for months, significantly affecting their life chances, and deepening inequality.

Health system

In order to slow the spread of COVID-19, to reduce pressure on health services and buy more time for preparedness, Maintains countries have tried – with varying degrees of success – to follow World Health Organization (WHO) guidelines to isolate or quarantine international arrivals, institute widespread testing, isolate mild and moderate cases (either in facilities or at home) whilst hospitalising moderate and severe cases, and trace and quarantine secondary contacts. Countries have relied upon institutional **isolation** (often using repurposed schools to supplement dedicated isolation and treatment centres) rather than self-isolation at home. However, this has been hampered by limited availability, high charges, and poor quality of facilities, leading to limited compliance. As COVID-19 spreads to rural areas, self-isolation may become more feasible. All five countries have attempted to

[3] Gentilini, U. *et al*. (2020) 'Social Protection and Jobs Responses to COVID-19: A Real-Time Review of Country Measures –"Living paper" version 11'.

increase their **testing** rates but per capita testing rates remain low, at under 2.5 tests per 1,000 people compared to over 40 in developed countries, particularly due to lack of key supplies. Countries with experience of contact tracing, such as for polio in Pakistan, have been able to institute systems at the community level.

The scale of COVID-19 is making it extremely difficult for health systems to maintain equitable access to quality **essential health services**. Essential services have been severely restricted, far more so than expected under WHO guidelines during the early stages of the pandemic, as limited health system resources are pivoted for the COVID-19 response and movement restrictions and fear of infection introduce barriers to access. There have already been examples of outbreaks due to suspended immunisation campaigns, such as measles in Pakistan, and immunisation remains suspended in Bangladesh. In Kenya, outreach services were down by two-thirds in March, institutional deliveries down by over half, and maternal mortality had risen. Routine services were down in Sierra Leone even before the first COVID-19 case had been established, while in Uganda all elective medical procedures have been postponed. Indirect effects on mortality and morbidity are likely to be high.

All countries have been working to increase the capacity of the health system in anticipation of an increased caseload, from a low base. In the face of low density of **health workers**, there has been rapid recruitment, leave cancellation, and the mobilisation of retired professionals, combined with initiatives such as special allowances and insurance to motivate and reward health workers. Domestic production of **supplies and equipment** has been started. Yet it appears that limited import availability of crucial items such as ventilators and PPE, combined with the limited capacity of treatment facilities, means that it seems likely that Maintains countries will face supply-side shortages if caseloads increase.

All countries have developed comprehensive and timely **data systems** and dashboards, mostly leveraging government-run health management information systems, displaying real-time data on cases, tests, and availability of beds, medical supplies, and PPE. However, these have not been made public in all countries, undermining the ability to help the population understand risk, influence behaviours, and build trust. In Sierra Leone, key statistics stopped being publicly reported in mid-May. In all countries, telephone hotlines have been established – often building upon existing hotlines such as for polio in Pakistan and Ebola in Sierra Leone – to spread information and provide guidance without risking in person contact.

Health systems need to **engage with communities** as active participants of health response efforts, not just passive recipients. Overall, it was found that the types of community engagement that worked well in Ebola (such as mobilising community surveillance teams, positive engagement with community leaders, and working with women and women's organisations) were not yet instituted in Maintains countries, including in Sierra Leone. Specific difficulties were also identified, including opposition to social distancing by faith groups in Pakistan, low levels of institutional trust in Kenya, and disinformation in Sierra Leone. Such problems will continue to compromise response effectiveness.

Conclusions and implications for Maintains

Governments have directed focus and resources to managing COVID-19 but the complexity of the issues and their multi-sectoral nature has challenged often limited state capability. In particular, it is a clear challenge to balance strategies to contain COVID-19 infection with the secondary effects caused by these strategies. COVID-19 will be a factor for all countries for a long time. A crucial course-correction is needed now to improve the future for vulnerable and disadvantaged groups.

This investigation has illuminated areas and issues to be examined and considered how to deliver a well-coordinated and balanced response to a major shock across social services. Maintains, in keeping with its multi-sectoral mandate, will continue to work with others to refine and strengthen the **analytical framework** used for this report, and address some of the knowledge gaps about shock responsiveness against this framework.

Governance

Countries have had different governance challenges – for some this has been decentralisation, others have not had the benefit of pre-existing public health policies and preparedness, some have squandered community trust, and all have struggled with multi-layered coordination. The gap left by the government responses has led to a range of community schemes, local solutions, and private sector innovations.

Further analysis is required on how different **leadership** approaches (e.g. centralising control through the Ministry of Health, or military, or disaster management agency) affect coherency and coordination, and how the informal rules, values, and norms that shape relationships and interactions among actors underpin the speed and effectiveness of an emergency response. Maintains is currently undertaking a short study to explore the role of traditional leaders in supporting the government's response in Sierra Leone.

The need to increase **availability of financing** to respond quickly to a shock is highlighted by this study. Maintains is undertaking one in-depth study of health shock costs and financing in Sierra Leone, as well as exploring shock financing approaches in other countries. This work, undertaken with close links to the Centre for Disaster Protection, will be synthesised for cross-country and cross-sector learnings.

Mitigation of secondary impacts

The evidence presented in this report suggests that the secondary effects will be substantial and long-lasting, particularly for vulnerable and disadvantaged groups.

Economic consequences are particularly severe due to extremely high rates of informal employment, especially for women. **Social protection** has been the key tool to meet some of these needs, with successes in rapid disbursal and increased coverage in Pakistan and Bangladesh respectively. It is clear that countries with reasonably well-established safety nets for vulnerable populations have found it much easier to expand, adapt, and innovate, pointing to the need for further investment in social protection programmes and social registries for the next crisis. However, even in these countries, social protection schemes are not achieving the effective coverage required to mitigate the disruptive effects of COVID-19.

Maintains has commissioned a study looking across all of its six countries, to explore, document, and evaluate the different social protection approaches taken to COVID-19. In addition, Maintains is undertaking longer-term research in Bangladesh, Kenya, and Pakistan looking at the enablers and constraints for effective shock-responsive social protection in long-term social protection programmes, how social registries can be used for shock scale-up, and how social protection can support nutritional outcomes.

A major gap identified in this report, across countries and sectors, has been mainstreaming **gender and inclusion**. Significant gaps have been seen in leadership, engagement at community level, and in interventions to mitigate impact that will have very long-term impacts and deepen inequalities. Bangladesh, Kenya, and Pakistan have not provided any funding or made any policy commitment for gender-based violence, sexual and reproductive health services, provision of childcare, or support to mitigate the economic effects on women. Women's health, safety, and livelihoods have been severely compromised – some will never recover. Governments should put in place immediate measures to address this significant gap, including the involvement of women's groups in the design, development, and delivery of services.

Maintains is committed to full incorporation of GESI into research plans and methodologies, and has launched new research to assess the impact of COVID-19 and associated government responses on food security, livelihoods, access to and utilisation of health services, education, and awareness and practice related to COVID-19 among poor urban communities in Ethiopia.

Scaling up effective distance learning has been a major challenge, which will exacerbate inequalities of **educational** outcomes and reduce life prospects, particularly for girls. Efforts are required now to strengthen both the content quality and reach, and to invest in catch-up programmes. Maintains will use its research programme in Uganda to develop a better understanding of the impacts of school closures on refugees, particularly girls and those with disabilities.

Finally, no countries appear to be getting ready for the expected increase in **malnutrition** that is just around the corner. Nutrition programmes, services, and screening need to be ramped up now, and school feeding programmes swiftly replaced. In Kenya and Uganda, Maintains is researching how lessons from scaling up community management of acute malnutrition, primarily in situations of drought, can be applied in other shock contexts.

Health system

In pivoting to provide COVID-19-related services, **health** systems have been majorly disrupted, with essential services including antenatal care, immunisation, and institutional delivery severely restricted or suspended – against WHO recommendations. This is likely to cause very high secondary effects on morbidity and mortality.

Whilst countries have been working to expand treatment capacity within national health systems, supply-side constraints mean that it seems unlikely that countries will be able to manage a large number of cases requiring hospitalisation, resulting in high mortality rates. This would also compromise the ability to restart and maintain essential service delivery. It is therefore imperative that countries find ways to minimise the reproduction rate of COVID-19,

whilst also mitigating the secondary consequences of these actions. Improving testing rates and adopting community engagement strategies that proved effective in Ebola are urgent priorities.

It will be important to continue to document the emergent strategies as countries try to both recover from and respond to COVID-19 at the same time – particularly those related to essential service delivery. This will expand our understanding of how low-resource social systems can deal with long-lasting shocks like pandemics, which have such widespread direct and indirect primary and secondary effects, and improve our ability to support countries to learn from COVID-19 and prepare for future shocks.

Health is a primary entry point for Maintains shock-responsive research and Maintains will continue to develop the conceptual framework for a shock-responsive health system that underpins this work.[4] In Ethiopia, Maintains is researching how community-based health workers can support preparedness and strengthen shock responses; in Kenya, Uganda, Pakistan, and Sierra Leone, Maintains is seeking to explore in detail how health systems can better respond to shocks, looking at early warning systems, financing, and the provision of existing services alongside shock scale-up.

[4] Newton-Lewis, T., Witter, S., Fortnam, M., Seal, A., Hailey, P., Nair, R., and Hillier, D. (2020) 'What is a shock-responsive health system?' Maintains Working Paper. Oxford Policy Management, Oxford, https://maintainsprogramme.org/rc/working-paper-what-is-a-shock-responsive-health-system/