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Covid-19: Key Considerations for a Public Health Response

Background

The Covid-19 pandemic is more than a health crisis. Its long-term economic and societal effects may well outweigh its initial public health impact. It is therefore essential that responses are socially sensitive and attuned to mitigating these secondary effects. This briefing draws upon lessons learned by development actors during previous epidemics. It considers the similarities and differences of the Covid-19 pandemic compared to other recent epidemics, casting a critical eye on the social and public health aspects of the responses. Furthermore, implications for development actors are presented, with proposed actions and lessons for policy- and decision-making. These look to align short-term responses aimed at disease treatment and control with those aimed at mitigating secondary impacts on health and livelihoods; and support for recovery and longer-term development approaches, taking account of the political dynamics involved. Specific attention is paid to Ireland's overarching policy priority to reach the furthest behind first.

Covid-19 vs other epidemics

Covid-19 is continuing to spread across the world. As of 3 September 2020, there were more than 26 million confirmed cases and over 863,000 people have died as a result.[1] The spread and impact of Covid-19 around the world has been very uneven. The majority of cases are in the Americas and Europe, with the US, Brazil and the UK reporting the highest death tolls. By comparison, up to July 2020 Africa and Asia had suffered far fewer cases, although this is increasing in both regions. The reasons for lower numbers of cases and deaths are the subject of debate, and have been variously attributed to proactive control measures, under-testing or lack of testing capacity, demographic differences, the effects of pre-existing immunities or health conditions, or being at different points on 'the peak' within and across societies.

Melissa Leach, Jessica Meeker, Hayley MacGregor, Megan Schmidt-Sane and Annie Wilkinson

COVID-19:
Key considerations for donor agencies

Prioritise those furthest behind first

Support those most marginalised to protect themselves and stay resilient throughout the crisis. Engage well-placed community partners to analyse and design holistic responses that address key issues: food insecurity, loss of livelihoods, housing insecurity, and access to basic health services.

Localise and collaborate

Understand and adapt to the political dynamics at national and local levels, to identify where interventions can help to build positive solidarities that support those furthest behind. Adopt more adaptive, flexible, and collaborative approaches for organisations with substantive community ties. Be prepared for less short-term and more long-term measurable impact.

Establish firm foundations for comprehensive social protection

Link support for social protection with policies and investments across complementary sectors – infrastructure, education, health and nutrition. Prioritise disproportionately affected groups, such as children, informal workers, rural agricultural households, pastoralists, migrants, internal displaced persons (IDPs), and refugees.

Build the resilience of food systems

Increase the capacity of food systems to withstand shocks and safeguard sufficient, appropriate and accessible food for all. Support holistic responses, informed by diverse voices, which address nutrition through multi-sectoral approaches, including gender, food security, WASH, and social protection.

Lay the groundwork for transformative approaches in the immediate response

Ensure that short-term responses address vulnerabilities and are focused on meeting the needs of people and groups marginalised by multiple, intersecting inequalities. This can lay the groundwork for resilient systems in the recovery and post-crisis phases.

Coordinate with key actors and across sectors

Agencies and departments must work together to get money to where it is needed and improve efficiency of spending. Ensure messages are aligned and that governments and civil society groups work together. Forming regional alliances may ensure better coordinated responses.

Strengthen health systems

Focus on maintaining core essential services in health systems struggling to cope during the outbreak – including maternal and child health and essential immunisation programmes – so that no one is left behind. Engage community partners in strengthening basic services to meet longer term health needs.

Covid-19 is the latest in a series of major epidemics, often occurring in and affecting fragile and low-resource settings. These include SARS (2003), H1N1 influenza (2009), Zika (2015–16), HIV (1970s onwards) and Ebola (including the major 2013–16 West Africa outbreak; and the 2018–20 outbreak in North Kivu, Democratic Republic of Congo – DRC). Covid-19 has a lower fatality rate than SARS or Ebola, but the rate of transmission from human to human is higher (before widespread control measures were put in place, Covid-19 had an estimated reproductive rate of 3.28).[2] Like SARS and influenza, Covid-19 is more serious for those with underlying health conditions; however, a key difference is the increased risk of mortality with age, with the young very unlikely to suffer with severe symptoms. Unlike SARS or Ebola, Covid-19 transmission can occur before the onset of any symptoms. There are also reports of cases remaining asymptomatic throughout the infective period. Asymptomatic and presymptomatic individuals may be unaware that they are infected and so may take fewer precautions (e.g. self-isolation, mask wearing and physical distancing) than those who have symptoms. Therefore, asymptomatic and presymptomatic individuals might be major drivers for the growth of the Covid-19 pandemic.[3]

The impact of Covid-19 has far outstripped previous outbreaks. It has resulted in more deaths worldwide, with cases in all global regions and, as of September 2020, does not have a vaccine or highly effective treatment. However, while diseases have a variety of modes of transmission and spread through societies differently with different implications for control and impact, cross-cutting insights and themes from previous epidemics can be drawn upon and taken into consideration for the Covid-19 response.

Development response

The scale and scope of the Covid-19 pandemic presents a major challenge for development agencies, multilateral organisations, donors and philanthropic actors. In responding, options for public health and development actors fall into three, overlapping categories and time frames:

- Controlling and mitigating the disease through adaptations to ensure an appropriate and proportionate **public health response** in the short term.
- Managing and balancing tensions between the impacts of Covid-19 (of both the disease and the public health response to it) and its effect on other health issues and on livelihoods (so called '**secondary health and societal impacts**') in the short and medium term.
- '**Building back better**' through approaches to health systems strengthening and broader recovery and development in the medium and longer term.

This briefing addresses each point in turn. However, this does not imply that these are separate responses or that responses would necessarily follow a linear progression. Rather, there is a need for them to be aligned, so that short-term responses lay the ground for (and do not compromise) longer-term approaches. Given Ireland's priority focus on those furthest behind, a particular challenge is to ensure that short-term responses address (and do not increase) vulnerabilities and are focused on meeting the needs of people and groups marginalised by multiple, intersecting inequalities. This can then lay the ground for transformative development approaches in recovery and post-crisis phases that support resilient systems (for health, care and beyond) and put the furthest behind first.

The public health and development response to Covid-19 has already been enormous, as existing agencies with relevant mandates have mobilised and others have 'pivoted' their activities. Any development donor or partner addressing Covid-19 must therefore operate in a crowded field involving many other agencies, operating at different levels, identifying their niches, and coordinating accordingly. Annexe 1 summarises basic information on this range of agencies.

The public health response

Public health refers to all organised measures (whether public or private) to prevent disease, promote health and prolong life among the population as a whole. Public health measures include ensuring surveillance and containment through testing, tracing and isolation of cases; and providing treatment appropriate to the local health-care system and resources, while ensuring that other essential health services are maintained.

Context-specific approaches

While the World Health Organization (WHO) provides global guidelines, learning from past and current epidemics shows that guidance should not be applied as a one-size-fits-all approach: guidelines always need to be adapted to suit national and local contexts.[4] Moreover, there is a need to ensure that responses are not implemented in a health security silo, but that there is adequate community engagement, and transparency. It is vital to know the shape of the epidemic, including social and biological vulnerabilities, in national and local terms and to plan proportionate responses that protect and build on national capacity as well as existing health infrastructures. These are all elements of the 'localisation' of a public health response.

The Covid-19 pandemic has already shown the importance of local context related to both epidemic control measures and the impact of those control measures on social and economic outcomes. Many control measures require behavioural changes, such as wearing a mask, regular handwashing or physical distancing. These practices have different social and cultural meanings in different contexts, and the ability to follow recommendations also depends on physical, social and economic contexts.

Physical distancing measures can also affect food security. Markets in low-income settings can be the sole source of food in the absence of supermarkets and refrigeration, and informal traders are important sources of food in informal settlements.[5] Adaptive measures are needed to assess if markets and traders can operate with physical distancing, and hygiene measures can be important for maintaining sources of food and livelihoods.

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The importance of context

South Africa was lauded for its swift medical response. However, this response did not initially consider the social context, and control measures have exposed and exacerbated underlying social and economic inequalities. The urban poor in particular faced a crisis of food insecurity, which the government attempted to address through emergency relief and social protection measures. City-level and civil society initiatives also mobilised to provide food and cash transfers through local efforts. Informal settlement residents in different parts of the world are innovating ways to mitigate these crises, by distributing food to those who need it, pooling resources and conducting active surveillance of Covid-19 cases.

Source: SSHAP (2020)[6] and Writers' Community Action Network (2020)[7]

Contextually appropriate responses might include shielding, providing home care, or focusing on test, treat and isolate. Shielding (a measure to protect extremely vulnerable people from coming into contact with the virus, by minimising all interaction between them and others) might be a particularly important public health response in settings where full physical distancing is challenging or disproportionate, and health-care capacity limited. Issues such as multi-generational households and large households sharing limited space will make this challenging. Solutions for safe and effective isolation and quarantine can be instituted through local organisations.

Trust and state–society relationships

It is now widely acknowledged that trust is imperative to effective epidemic control. At times of great uncertainty and strain people are asked to believe authorities, follow their instructions and make sacrifices. Less widely acknowledged is how deeply rooted levels of trust are in state–citizen relations and the political dynamics in any given setting. Trust is both a measure of state–citizen relations and an enabler of response to diseases and development more generally. This was highlighted in the 2013–16 West Africa Ebola outbreak, where people in Guinea, Liberia and Sierra Leone avoided health facilities and, in some cases, actively resisted public health teams, because they associated these with state institutions which historically they distrusted; rebuilding trust here, as elsewhere, is essential to the effective functioning of health systems.[8]

Voluntary approaches are preferable to coercive approaches (or the largely disciplinary approaches seen in many African states in the Covid-19 response thus far) when seeking compliance with movement restrictions, quarantining and physical distancing. Coercive movement and trade restrictions, as well as forced social distancing, may infringe on individual freedoms and undermine livelihoods. Enlisting community support through social networks is important: churches, social clubs, schools, labour unions, professional organisations and so on can take responsibility for prevention and home care activities. Travel restrictions usually work best when they are managed and implemented by local communities and institutions.

In some settings, Covid-19 responses are feeding into and amplifying conflictual relations between state and non-state actors. The control of Covid-19 and the emergence of exit strategies are a massive test of authority and accountability, and the need to be inclusive of all citizens.

Voluntary vs coercive measures

Quarantining in the 2013–16 West Africa Ebola epidemic was at first coercive. In Liberia, it involved the military, and communities did not understand why quarantining was necessary. This coercive attitude was met with resistance and underreporting of cases. In Sierra Leone, a three-day enforced lockdown was imposed in September 2014. Many ignored the quarantine, and the government then allowed people to go to prayers, resulting in better cooperation with lockdown rules. Similarly, the closure of markets in Liberia meant people did not know where to get their food from, fuelling resistance to quarantine measures. Coercive measures are thus often ineffective, and in parallel, they create a significant disincentive for people to admit to having been in contact with an infected person or to disclose their illness to outbreak control agencies.

Source: Ripoll *et al.* (2018).[8]

Political dynamics of the response

The public health measures required during a significant disease outbreak can shift state–citizen relations in a way that does not build trust. States of emergency have historically been used to extend power and abuse rights in the longer term; and today there is evidence some leaders are using Covid-19 to do just this.[9] States such as the Philippines, Cambodia and Thailand have used Covid-19 as an opportunity to pass legislation giving emergency powers to the president, censor the media, impose curfews, break unions and round up dissenters.

The Covid-19 response maps onto existing national and geopolitical realities, making the public health response at national level prone to politicisation. At a time when cohesion is important to containing Covid-19, politicisation can drive a further wedge between state and society, particularly affecting or driving away the marginalised. It can also affect regional or global collaboration, as political allegiances take priority.

In some countries, we have seen a heavy-handed response that tends towards repressive authoritarianism. In Southeast Asia, the pandemic has been used as a way to expand state power in states with authoritarian tendencies. Both the Philippines and Malaysia have passed additional control measures that give the national governments sweeping emergency powers.[5] Indonesia's response, some argue, has been based on military strategy marked by a lack of transparency and a crackdown on political opposition. On the other hand, Vietnam has managed the Covid-19 response well, in part due to strengthened state capacity, improved governance and central–local government coordination. It was this carefully constructed relationship with local governments that enabled an effective response.[12]

A top-down approach to public health management, when implemented by an authoritarian regime, can have consequences beyond public health. In South Africa, some feel the country's disciplinary power is being flexed, raising concerns for democracy and development. Public health mandates in the country have been unevenly implemented, with residents of informal settlements disproportionately impacted by police enforcement.[13]

Conversely, Covid-19 has exposed glaring inequalities in society and potentially opened avenues for improving social protections. Some citizens have been driven to protest for social change after socioeconomic realities became increasingly untenable in the wake of the pandemic and public health

Political dynamics and draconian measures

In Uganda, opposition politicians are leading Covid-19 response activities in parallel to the national government. The government has used this as a reason to detain, arrest and imprison opposition members. Meanwhile, citizens have petitioned the court to suspend the 2021 presidential election until the government gains control over Covid-19. In some contexts – including in several African countries – draconian responses appear to be disproportionate to the level or stage of the epidemic, and driven more by political than health considerations.

Source: Authors' own, based on Human Rights Watch (2020)[10] and Kigongo (2020).[11]

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regulations. In Latin America (Argentina, Brazil, Chile), there have been protests calling for improved working conditions during the pandemic. In Chile, protestors also called for additional food assistance from the government.[14]

Covid-19 will have a lasting impact for generations to come, and in certain circumstances politicisation might have 'started reorienting peoples' relationship to government, globalisation and to others in society.[15] In some countries, rather than increasing political polarisation, there has been increasing unity in the Covid-19 response.[16] Donor agencies need to be aware of, understand and adapt to such political dynamics, and the ways they are playing out in particular settings. This is key to avoiding interventions unwittingly playing into processes that increase marginalisation and discrimination, and to help identify where interventions can help to build positive solidarities that support those furthest behind.

Conflict and non-state actors

In Myanmar, a patchwork of competing state and non-state actors are facilitating or blocking humanitarian aid to varying degrees. There are more than 20 ethnic armed organisations in the country, and many of these control significant portions of land. Some of the largest groups have their own health departments, which have taken the lead in implementing their own Covid-19 responses. These local complexities have complicated wider Covid-19 public health measures and delivery of food assistance or other types of support. International non-governmental organisations and United Nations (UN) agencies are restricted from travelling to many of these areas.

Source: Wilkinson *et al.* (2020).[17]

Health systems: adapting to local realities and engaging with a range of stakeholders

Public health responses and guidelines for home and facility-based care in the event of disease outbreaks need to be tailored to national and local health systems and available resources. Treatment for severe symptoms is likely to remain well beyond the reach of those furthest behind in most least-developed countries and in fragile contexts, and so treatment in the community might then be the key focus.

Health systems are made up of a plurality of actors, informal as well as formal and private as well as public. Private doctors, pharmaceutical shop owners, herbalists, healers and so on are often people's first port of call when sick. These providers may be the first to perceive increases in patients with symptoms with medical doctors often scarce. Prior to the 2013–16 West Africa Ebola epidemic, Sierra Leone had an estimated 140 doctors in a country of six million people.[18] In areas where medical doctors or staff are unavailable or not trusted, other kinds of health providers reach patients more frequently.

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community led, and to ensure they are engaging the multitude of actors involved in the local health system, and in wider society. While local civil society and community-based organisations will be best placed to co-design and implement such responses directly, donor agencies can provide vital forms of support, such as small, flexible grants targeted at civil society organisations (CSOs); the co-convening of platforms in-country to share learning and experiences among different CSOs; and liaison functions with national and local government processes.

Building on existing relationships has been fruitful; for instance, the local networks of Slum/Shack Dwellers International in Asia and Africa have been an important bridge between vulnerable residents in informal urban settlements, community leaders and city authorities. In some urban areas and cities, these relationships have been established through years of participatory development and advocacy, and local groups maintain regular dialogue with authorities. Given the urgency of the Covid-19 situation, development actors could potentially achieve high impact by engaging with such groups.

In relation to urban settings, a number of international networks exist that connect governments and agencies with local and community-based groups, including Women in Informal Employment: Globalizing & Organizing, Habitat International Coalition, Huairou Commission, the Asian Coalition for Housing Rights, the Global Platform for the Right to the City (GPR2C), UN-Habitat's Participatory Slum Upgrading Program and the Global Water Operators' Partnership Alliance. Several have already begun to organise and are developing messages and solutions for their constituencies (e.g. waste pickers, water operators).[6]

Supporting formal government-led primary health systems is also essential in a public health response. WHO provides guidance on strengthening health systems and rapidly reorganising service delivery to respond to Covid-19 while maintaining core essential services, such as maternal and child health or essential immunisation programmes, across the continuum of care so that no one is left behind. Where health systems are functioning, supporting and protecting health-care workers is vital. Aside from reducing disease transmission, provision of and training in the use of personal protective equipment (PPE) is a key element in building trust within the workforce.

Testing health workers and their families might also be prioritised. Some countries choose to increase wages for health workers, seen as 'danger money'. However, these measures may backfire if the payments are

Engaging with traditional healers

In the 2018–20 Ebola epidemic in the DRC, traditional healers were the first point of contact for most individuals. They are well-respected individuals, particularly in communities where health facilities are hard to reach, or health workers are not trusted. Traditional healers were not, at the time, being effectively engaged in the Ebola response in neighbouring Uganda; in one district, healers were invited to a government-run training course on Ebola prevention and identification, but none attended. In Uganda, traditional healers are subject to regulation and are afraid of being arrested. Many were wary of engaging with government authorities, either because of regulation or because they have been pointed to as the source of epidemics. Traditional healers should be engaged in epidemic responses, as their social capital and networks are vital for improved case referral, case surveillance, communication of prevention messaging and building of trust.

Source: Authors' own, based on Schmidt-Sane *et al.* (2020)[19] and Holley (2014).[20]

not timely, and there is anecdotal evidence of staff in Liberia not attending work when these payments fail. Further, women are disproportionately involved in direct care as nurses, midwives, traditional birth assistants, and caretakers of the sick within a family. Lessons from the 2013–16 West Africa Ebola epidemic demonstrate the need for the public health response to be gender responsive and to include programmes for women such as tailored information campaigns and/or provision of PPE designed for women.[21]

Community engagement and two-way communication

Community engagement is critical to the success of epidemic control, affecting trust in the response, uptake of public health measures, and ultimately, the spread of disease. Past epidemics such as Ebola have shown the value of learning from the experiences and practices of indigenous populations and local communities, including their knowledge and 'cultural logics' about disease causation, prevention and transmission.[22] This can be the basis of respectful dialogue with communities to ascertain what is considered to be a 'proportionate response', and 'appropriate care'. Lessons from HIV are also useful here, whereby key populations were engaged via community-based organisations that centred on HIV prevention, care and treatment.[23]

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However, while international agencies have acknowledged the importance of communities in the Covid-19 response, they frequently still follow a top-down approach and have struggled to adapt programmes to community dynamics.[24] Special efforts are required to communicate with vulnerable groups, including older people and people with disabilities who may be less well connected or not online. Effective strategies can include communication through multiple channels (e.g. TV, radio, social media, print media and flyers), working through local groups and giving information on how to join them; and establishing focal points for case identification and reporting, social protection, general information and so forth.[25] Faith-based organisations are often a trusted source of information and should be regularly engaged to disseminate information to their congregations. Faith leaders can also be involved in community engagement activities, to bolster community involvement through these trusted sources.

Secondary health and societal impacts

The current pandemic has laid bare the cruel reality that epidemics follow societal fault lines of inequality. This has created challenging scenarios for response agencies and highlighted complex tensions between epidemic control and the need to also respond to the secondary impacts of public health measures. These impacts are social and economic, as well as being related to health. The importance of paying careful attention to mitigation measures in parallel to those oriented towards viral control has been underscored by reports of widespread hunger in African settings, where movement restrictions have decimated incomes and access to food. The World Food Programme has increased its projections for the number of people facing acute food insecurity from

135 million in 2019 to 318 million in 2020, with the increase driven primarily by the impact of Covid-19.

Public health measures need to be proportionate and take into account social justice and human rights. Social protection measures are a key consideration and a clear illustration that public health measures need to integrate with responses across other sectors. Furthermore, a vertical public health response that draws all attention to one disease can lead to an increase in morbidity and mortality from other prevalent illnesses, especially in contexts where disease burdens are high (Hrynick, Ripoll and Carter 2020).[26] A response that can integrate efforts across sectors will depend on state capacity; and support might be required from donors and development actors to institute programmes to address secondary impacts, especially for the most vulnerable.

Social difference and inequality

Epidemics are often said to mirror societies. They frequently reveal a highly unequal world, often the result of long histories of marginalisation. The impact of historical inequalities paved the way for HIV to disproportionately impact marginalised communities and we are seeing much the same with Covid-19.[27] Many epidemic diseases (including influenza and SARS) are syndemic, meaning they work in conjunction with other diseases: tuberculosis, smallpox, measles, pneumonic bacteria, HIV/AIDS and malnutrition – diseases which are much more prevalent in low-income countries.

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Remote communities may escape or delay infection; yet remoteness may also mean that if infection happens, medical treatment is far away.

While rural areas have a higher percentage of people living in extreme poverty, Covid-19 impacts in some countries can disproportionately affect urban populations, both in terms of the spread of the disease and loss of informal and formal livelihoods. Health staff and carers are at greater risk of being infected, with these roles more often being undertaken by women. Differences and inequalities are emerging in the way people develop Covid-19, whether by age, gender, underlying health conditions, geography or socioeconomic factors. Some populations may also be left out of a response. For example, a particular social group may be stigmatised and face difficulties in accessing health care.[28] Fear of discrimination may mean that they might not seek formal health care even when it is accessible.

Access to safe sexual and reproductive health services

Women of reproductive age may have difficulty accessing sexual and reproductive health (SRH) services during the pandemic, with 'non-essential' medical procedures limited. For example, lockdowns in Nepal and India have forced clinics to close. Disruption in the provision of SRH services has led – and will lead – to unwanted pregnancies, higher maternal mortality and/or unsafe abortions.[29] Lessons learned from the Ebola outbreak in Sierra Leone show that decreases in maternal and newborn care due to disrupted services and fear of seeking treatment during the outbreak contributed to an estimated 3,600 maternal deaths, neonatal deaths and stillbirths.

Source: Riley *et al.* (2020).[29]

Inequalities are revealed not only in relation to disease burdens, but also in how people are affected by disease control efforts. While there are understandably heightened fears about the potential for uncontrolled Covid-19 transmission in 'slums' and informal settlements, for instance, control measures have hit residents and the informal economies upon which they depend hard. These people and their livelihoods have been systematically undervalued, undercounted and thus rendered invisible.

Some groups may face additional risks under physical distancing measures as a result of their social vulnerability. Restrictions due to the pandemic have disrupted the HIV continuum of care and prevention – that is, testing, pre-exposure prophylaxis and primary care.[30] HIV patients who seek treatment confidentially may no longer be able to find safe mechanisms to leave home in pursuit of treatment, which could have long-term and life-threatening impacts. Supply chains are struggling to continue providing essential medicines such as antiretroviral therapy drugs for the treatment of HIV. In Pakistan, the common management unit for AIDS, TB and malaria, in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other partners, is working to ensure the uninterrupted supply of antiretroviral therapy for people living with HIV.[31]

Victims of sexual or domestic violence may be at greater risk if both the victim and their abuser are confined to the house. Individuals whose living depends on transactional sex may experience a collapse in income and or accept greater risks to offset this loss of income.

Hunger and malnutrition

Covid-19 is already having a major impact on food supply chains, disproportionately affecting the most vulnerable, and increasing the risk of conflict and displacement. Quarantines, lockdowns, market closures and restricted travel all impact food systems. 'In a matter of weeks, Covid-19 has laid bare the underlying risks, fragilities, and inequities in global food systems, and pushed them close to breaking point.'[32]

Children who rely on food programmes could lose access to the only nutritional support available to them because of the suspension of education and access to school feeding programmes.

The crisis is also affecting the quality of people's diets. People are shifting towards greater consumption of heavily processed items (as a result of panic buying of foods with a longer shelf life, and supply chain disruption), with fresh fruits and vegetables often less available. This could create vicious cycles: diabetes and other diet-related non-communicable diseases are risk factors for Covid-19 mortality.[33] Children who rely on food programmes (e.g. street children or those living in extreme poverty) could lose access to the only nutritional support normally available to them because of the cessation or suspension of education and access to school feeding programmes.

Secondary health impacts

In epidemic situations, a diversion of health-care resources and factors such as movement restrictions and fear of contracting disease can lead to a decline in accessing health services. Medical supplies for chronic diseases and conditions such as HIV can be disrupted, access to safe childbirth can be reduced, nutrition programmes may collapse, and the detection of new diseases can be delayed.

A decline in routine vaccination could also have significant ramifications. A recent United Nations Children's Fund (UNICEF) report on the DRC highlighted that the redirection of attention and investment towards Ebola resulted in nearly 6,000 children dying of measles in 2019. Cases of polio have flared

up in regions that have been free from the disease for decades because vaccination campaigns have been disrupted by Covid-19.[34] International agencies' fears are well founded that in many countries deaths due to such secondary health impacts will vastly outnumber those directly linked to Covid-19.

Balancing public health measures with social and economic imperatives

Distancing measures can be unrealistic in many low- and middle-income country settings. For fragile economies, sustained distancing measures may have profound negative long-term wider health and socioeconomic consequences that, unaddressed, have the potential to outweigh the immediate health effects of Covid-19. Financial considerations can influence people's willingness and ability to comply. This has the potential to exacerbate already existing inequalities and inequities.

It should also be noted that many informal workers (such as market sellers, seamstresses, domestic workers, nannies, cleaners and cooks) are women, sometimes very young girls, and this group could be greatly affected. The International Labour Organization (ILO) estimates that globally 1.6 billion people in the informal sector have experienced significant impacts on their livelihoods, with an average decline of 60 per cent in earnings.[35]

It may be more prudent to focus efforts on protecting and isolating the most vulnerable in society, rather than encouraging possibly untenable distancing measures for whole populations. Nonetheless, actions to encourage feasible physical distancing measures can help to slow the spread of disease and should be considered in conjunction with other basic public health measures such as handwashing and wearing masks. Messaging should consider the effects and practicalities of physical distancing in any given context.[36]

Social protection

At a time when strict lockdown measures have left millions without their livelihoods, social protection systems are an essential way of protecting the most economically vulnerable. The ILO has stated that governments, together with social partners and other stakeholders, should use the Covid-19 crisis as a wake-up call to strengthen their social protection systems.[37]

Covid-19 presents an opportunity to establish firm foundations for more comprehensive social protection systems for years to come, including leveraging greater domestic expenditure and international assistance. Countries with existing systems should consider scaling up and adapting existing programmes with donor-financed contingency funds routed through existing administrative structures. Programmes should prioritise groups who are disproportionately affected, such as informal workers, rural agricultural households, migrants, internally displaced persons and refugees, pastoralists, women and children.[38]

As of June 2020, 195 countries had either introduced or modified social transfer programmes in response to Covid-19. Shock-responsive social protection can and should be delivered as part of humanitarian response activities. The majority of programmes introduced worldwide in response to the pandemic are cash transfers and evidence shows

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that these can also be effective as part of humanitarian responses.[39] The policy choice to provide cash transfers, which are far less prone to leakage and are more cost efficient than food provision, must be balanced with the need to reach as many vulnerable people as possible. It is more efficient to deliver cash and cost effective compared to food aid; however, cash transfer programmes rely on functioning markets. In areas where market access is limited, cash should be supplemented with food aid.

'Building back better' in the longer term

The concept of 'building back better' in humanitarian and disaster studies[40] emphasises not just recovering and returning to the status quo, but linking recovery to building greater resilience to future hazards, especially at community level. This is critical in a world in which future shocks, whether because of epidemics or in other arenas, are bound to occur. If 'better' development is also to put the furthest behind first, then approaches also need to address and mitigate the deeper, underlying reality and causes of vulnerability and marginalisation.

There are several areas in which the Covid-19 crisis has revealed fault lines in social, economic, and political systems, and where the crisis now presents opportunities for transformative development approaches. These include:

- **Inclusive, caring economies:** Covid-19 and its impacts reveal problems with conventional market-led, growth-focused development models, highlighting the importance of approaches that value and support people's essential wellbeing, socioeconomic needs, livelihoods and the relationships – between people, and with the environment – on which these depend. There are needs and opportunities to foster more collaborative, caring economies that factor in a wider range of values than growth alone, and which build on informal as well as formal economic practices and community-level solidarities. This has implications for policies and investments in areas such as social protection and food systems, as well as those related to climate change and the environment.
- **Equitable societies:** the Covid-19 crisis has revealed the significance of multiple, intersecting inequalities. The effects of the disease, control measures and secondary impacts have been felt unevenly across societies, feeding off and amplifying structural differences and vulnerabilities linked to gender, class, ethnicity, age, disability, geography and more. Development approaches need to focus centrally on fostering more equitable societies, through investments that target gender and other forms of equality, and which actively seek to prioritise the needs and interests of those furthest behind.
- **Accountable state–citizen relations:** as the Covid-19 crisis has unfolded in diverse political contexts, so challenges have emerged in state–citizen relations, from lack of trust and accountability to actions by political leaders and elites that undermine people's rights. At the same time, positive forms of citizen-based solidarity and rights-claiming, civil society mobilisation, and effective responses by local and national state actors have emerged. These offer pointers towards more multi-layered accountable state–citizen relations in the future, with many implications for investments in governance. A political economy approach allows us to identify the actors and institutions to work with, potential champions of change and windows of opportunity to look out for.

– **Adaptive, plural learning approaches:** the uncertainties, rapid dynamics and diverse contexts affecting the unfolding Covid-19 situation have proved a poor fit with top-down, linear, blueprint-style approaches to development and planning. Instead, they highlight the need for more flexible, adaptive approaches attuned to particular contexts and which can evolve iteratively over time as things change. There is also a need for plural forms of knowledge and expertise (from both social and natural/medical sciences, and vitally, the local knowledge of people living at the margins or otherwise 'behind') to inform continuous learning and the navigation of uncertainties.

Key areas of consideration for donor agencies

To address the multiple challenges of Covid-19 and plan a variety of responses, there are a number of key considerations for bilateral development agencies and partners. These can be grouped into the following areas, which cross-cut the overlapping categories and timescales explored above.

Localisation and collaboration in all responses

Whether controlling the disease, mitigating secondary impacts or supporting recovery, responses need to be localised. This includes attention to specific national settings, support for bottom-up, community-led action, and responsiveness to the many locally felt uncertainties pervading the epidemic. Donor agencies need to understand and adapt to the political dynamics at national and local levels. This requires adapting the standard top-down approaches advocated by many international agencies (and, indeed, typical of much mainstream development) and instead taking a more adaptive, flexible and collaborative approach. Such an approach would include support for building multi-tiered coalitions within partner countries, encouraging collaboration between development partners and community organisations.

The scale and scope of the fiscal policy response to the Covid-19 pandemic has been unprecedented. Rapid measures have been implemented at country level, which will likely lead to large fiscal deficits.[41] Paired with a decreased tax base, this will set up countries for fiscal problems down the road. Key actors in the fiscal space include multilateral agencies, bilateral agencies, national governments, global alliances (e.g. G20) and private philanthropic organisations (e.g. the Bill & Melinda Gates Foundation). There will be key priorities in this space, from fighting viral spread to emergency financial and economic relief.

In particular, donors should consider flexible funding mechanisms or core institutional funding for organisations with strong, substantive community ties, either directly or through UN agencies they work with. In-country expertise can be drawn on to identify such organisations. A pool of Covid-19 response funds for small community-based organisations could also strengthen existing work that is already going on in low-income countries' most vulnerable settings. However, small community-based organisations and non-governmental organisations (NGOs) with the strongest community ties are also those least likely to have the infrastructure to monitor, evaluate and report on programme indicators.[42] Donors may therefore need to direct funds towards programmes that do not have a measurable impact in the short term.

Onerous reporting and measurement of programmes' reach may hinder efforts in

the short term to deliver aid where it is most needed. Alternatively, larger NGOs could be encouraged to develop collaborative links with smaller organisations, to maximise community reach. Where resources are limited, a good route for small bilateral donors would be to target small flexible grants to local CSOs and community-based organisations, which could be both low cost and high impact, providing most support to those furthest behind.

Support for programmes to mitigate health and social impacts on the most vulnerable

While the health crisis is wide-ranging, a key consideration for the development response is how to maintain essential services while also directing funds to target the social and economic impact of the pandemic (both the outbreak itself, and the impacts of public health and control measures such as lockdowns), aligned with approaches that will build back better in longer-term recovery. By looking beyond immediate Covid-19 public health needs, development donors are well placed to address issues such as food insecurity, loss of livelihoods, housing insecurity and access to basic health services that address wider health issues. This means a renewed focus on sustaining and building effective systems for health, food, social protection and livelihoods.

There is a need to invest in system resilience, through recognising and supporting multiple institutions and the connections between these, encouraging adaptation and flexibility. Given the inequalities and vulnerabilities exposed by Covid-19, and in the context of priorities to put the furthest behind first, donors might focus on making systems and services more accessible, and on complementing universal coverage and access to basic services with carefully targeted programmes. Needs and priorities will vary by context and over time, underlining the need for approaches that engage community partners in analysing need and designing responses, and which build in learning and adaptation.

Coordination across responses between key actors and across sectors

As development agencies design individual plans to address the Covid-19 pandemic, it is also important to coordinate responses both between agencies and with other key actors. In planning and resourcing the public health response and mitigation programmes, coordination is essential between agencies and departments (both international and national) to ensure there are no gaps or duplication, to get money to where it is needed, and to improve efficiency of spending.[43]

Given that people move and can carry infections with them, coordination is needed between geographical and administrative jurisdictions, including regions and countries, to ensure the effectiveness of surveillance or movement control. It is needed between arms of the response (e.g. case management, surveillance and social mobilisation), and between health and socioeconomic measures to ensure that response activities and messages are aligned. Coordination is also needed between governments and civil society. This can be particularly challenging in conflict-affected settings where governments and civil society may have hostile relationships.

During the Covid-19 pandemic, there have been major challenges to the coordination of the response, raising issues of national and global health governance more broadly.

A key consideration for the development response is how to maintain essential services while also directing funds to target the social and economic impact of the pandemic.

Coordination of the response

In the 2013–16 West Africa Ebola outbreak, the initial response showed a 'fragmentation of international efforts to support health systems in the developing world that [led] to overlapping efforts and reporting requirements, a lack of coordination, and a significant reduction in aid effectiveness'.[44] In response to these initial challenges, the UN Mission for Ebola Emergency Response (UNMEER) was set up to enhance coordination. Indeed, UNMEER succeeded in creating a common operational platform for the response, engaging politically with the affected countries in an inclusive way and incorporating a much-needed regional approach.[45] Yet according to a Harvard University/London School of Hygiene & Tropical Medicine review, some coordination problems persisted and lack of coordination was a problem throughout the response.[46]

Source: Authors' own, based on Ripoll *et al.* (2018)[46] and UN High-Level Panel (2016)[44]

Growing US–China tensions and lack of global leadership have presented barriers to pandemic coordination and response, which is usually managed by WHO.[47] Temporary alliances have arisen to frame evidence, and coordinate resources and response operations, such as the Joint Summit Working Group formed by the Organization of American States and the Pan American Health Organization.[48]

Donors are particularly well placed to contribute to coordination mechanisms within countries; for example, by supporting platforms to link development partners and CSOs, or encouraging countries that do not have a coordinating mechanism to develop one.

The African Union (AU)'s Africa Centres for Disease Control and Prevention (Africa CDC) have been working closely with WHO. Such a regional approach would be useful to assist in tailoring the response to various low-income and fragile contexts.

Development donors could encourage the formation of such regional alliances. They are particularly well placed to contribute to coordination mechanisms within countries; for example, by supporting platforms to link development partners and CSOs, or encouraging countries that do not have a coordinating mechanism, such as a national task force, to develop one. In fragile and conflict-affected settings, to ensure a well-coordinated response, temporary ceasefires or temporary collaborations might need to be established.

Annexe 1: Multilateral and international agencies involved in the Covid-19 response

Multilateral organisations

WHO plays a global role in coordinating the pandemic response. At national level, it supports countries to prepare and respond with a Covid-19 strategic preparedness and response plan, which identifies countries' actions and the resources needed. It works closely with governments to prepare their health systems and respond to Covid-19. In early April 2020, the UN launched the UN COVID-19 Supply Chain Task Force, coordinated by WHO and the World Food Programme (WFP), to scale up the supply of essential PPE, testing and diagnostics supplies, and biomedical equipment. WHO is training and mobilising health workers around the world through its OpenWHO platform. WHO's efforts are also focused on searching for a Covid-19 vaccine and/or an effective treatment.

The UN response is structured around three pillars:

- Humanitarian: global humanitarian response plan (United Nations Office for the Coordination for Humanitarian Affairs – OCHA)
- Health: strategic preparedness and response plan (WHO)
- Development: socioeconomic framework (United Nations Development Programme – UNDP).

WFP is working with governments to support national health systems through improved supply chains, data collection and targeted nutrition services for the most vulnerable. It has set up a system of air bridges to dispatch essential medical cargo and aid, providing passenger air and medical evacuation services for frontline workers.

UNICEF is strengthening risk communication and community engagement, improving infection prevention and control, and providing critical medical and water, sanitation and hygiene (WASH) supplies, and collecting and analysing social science data for public health decision-making.

UNDP is supporting countries to strengthen their health systems in the face of Covid-19, including procuring urgently needed health and medical supplies, strengthening health infrastructure, managing health waste and ensuring salary payments to health workers.

OCHA is coordinating the COVID-19 Global Humanitarian Response Plan, a joint effort by members of the Inter-Agency Standing Committee to analyse and respond to the direct public health and indirect humanitarian consequences of the pandemic.

The International Organization for Migration is supporting authorities to establish isolation centres and conduct Covid-19 case management for displaced and migrant populations, and the United Nations Refugee Agency (UNHCR) has launched information campaigns to give refugees access to factual information on prevention measures.

The World Bank Group will be providing up to US$160bn in financing tailored to the health, economic and social shocks countries are facing. This includes support for countries to strengthen their pandemic response, increase disease surveillance and improve public health interventions.

International organisations and institutions

The Global Fund to Fight AIDS, Tuberculosis and Malaria is providing immediate funding of up to US$1bn (through grant flexibilities and the Covid-19 Response Mechanism) to help

countries fight Covid-19; mitigate the impacts on lifesaving HIV, TB and malaria programmes; and prevent fragile health systems from being overwhelmed.

The International Committee of the Red Cross (ICRC) is strengthening support to fragile health systems and infrastructure by increasing stocks of essential medical supplies and ensuring that the most critical health centres and hospitals they support can detect, prevent and control the spread of the virus. The ICRC is also advising on prevention and management of the outbreak, particularly in areas of expertise such as in prisons.

Médecins Sans Frontières' Covid-19 response in over 70 countries focuses on supporting authorities to provide care for Covid-19 patients, protecting people who are vulnerable and at risk, and keeping essential medical services running.

Oxfam's priority is to support the most vulnerable people, especially those in higher-risk environments such as refugee camps or densely populated urban areas. Oxfam is increasing the delivery of clean water and sanitation services, and is working with communities on hygiene awareness.

“Many bilateral organisations are also diverting resources to the Covid-19 response, largely by refocusing existing programmes. Their involvement includes livelihood support, humanitarian assistance, food security, behaviour change communication (particularly around handwashing and hygiene) and vaccine development.

The International Rescue Committee has launched Covid-19 preparedness and response programmes in over 40 countries. These include a public health awareness and psychosocial support campaign, and training of health-care workers in refugee camps.

Amref Health Africa is working with ministries of health in eight priority countries, focusing on supporting, equipping and empowering frontline health workers, and on infection prevention at the community level.

Africa CDC is playing a key role on the African continent. In February 2020, it established the Africa Task Force for Novel Coronavirus, to oversee preparedness and response. In April, the AU and Africa CDC launched the Africa Covid-19 Response Fund, to raise funds for transmission prevention, medical interventions and socioeconomic support for vulnerable populations.

Bilateral organisations

A large number of bilateral organisations are also diverting resources to the Covid-19 response, largely by refocusing existing programmes. Their involvement includes livelihood support, humanitarian assistance, food security, behaviour change communication (particularly around handwashing and hygiene) and vaccine development.

References

[1] Johns Hopkins University and Medicine (2020) ***COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)*** (accessed 21 July 2020).

[2] ECDC (2020) *Covid-19 Pandemic: Increased Transmission in the EU/EEA – Eighth Update*, European Centre for Disease Prevention and Control (ECDC).

[3] *Ibid.*

[4] WHO (2020) ***Maintaining Essential Health Services: Operational Guidance for the Covid-19 Context: Interim Guidance***, Geneva: World Health Organization (WHO) (accessed 21 July 2020).

[5] Schmidt-Sane, M.; Ripoll, S. and Wilkinson, A. (2020) '**COVID-19 Management in Marginalised Populations in Southeast Asia**', *SSHAP Briefing*, Brighton: Social Science in Humanitarian Action Platform (SSHAP) (accessed 21 July 2020).

[6] SSHAP (2020) ***Key Considerations: COVID-19 in Informal Urban Settlements (March 2020)***, Brighton: SSHAP (accessed 21 July 2020).

[7] Writers' Community Action Network (2020) '**Cape Town Together: Organizing in a City of Islands**', *ROAR*, 5 June (accessed 4 September 2020)

[8] Ripoll, S.; Gercama, I.; Jones, T. and Wilkinson, A. (2018) '**Social Science in Epidemics: Ebola Virus Disease Lessons Learned**', *SSHAP Lessons Learned Issue* 2, UNICEF, Institute of Development Studies and Anthrologica (accessed 21 July 2020).

[9] Smith, J. and Cheeseman, N. (2020) '**Authoritarians Are Exploiting the Coronavirus. Democracies Must Not Follow Suit**', *Foreign Policy*, 28 April (accessed 19 May 2020).

[10] Human Rights Watch (2020) ***Uganda: Opposition Leader Reported Tortured by Police***, 28 April (accessed 20 July 2020).

[11] Kigongo, J. (2020) '**Court Asked to Suspend 2021 Elections over Coronavirus Outbreak**', *Daily Monitor*, 13 March (accessed 20 July 2020).

[12] Chairil, T. (2020) '**Indonesia Needs to Change Its Security-Heavy Approach to COVID-19**', *The Diplomat*, 30 April (accessed 21 July 2020).

[13] 'One Size Does Not Fit All', unpublished SSHAP Roundtable Report, 26 May 2020.

[14] ACLED (2020) ***Increased Demonstration Activity over Government Responses***, 17–30 May (accessed 21 July 2020).

[15] *Politico Magazine* (2020) '**Coronavirus Will Change the World Permanently. Here's How**', 19 March (accessed 21 July 2020).

[16] Duncan, G. (2020) '**New Zealand's Coronavirus Elimination Strategy Has United a Nation. Can That Unity Outlast Lockdown?**', *The Conversation*, 15 April (accessed 21 July 2020).

[17] Wilkinson, A.; Ripoll, S.; Schmidt-Sane, M. and McLeod, K. (2020) ***Key Considerations: COVID-19 in the Context of Conflict and Displacement – Myanmar (May 2020)***, Brighton: SSHAP (accessed 21 July 2020).

[18] Kassaye, I.G. (2015) ***Traditional Healers – Friends or Foes in the Fight against Ebola?***, UNICEF Connect blog, 28 September (accessed 21 July 2020).

[19] Schmidt-Sane, M.M. *et al.* (2020) '**Challenges to Ebola Preparedness During an Ongoing Outbreak: An Analysis of Borderland Livelihoods and Trust in Uganda**', *PLoS ONE* 15.3: e0230683 (accessed 21 July 2020).

[20] Holley, C. (2014) ***Ebola - Local Beliefs and Behaviour Change***, HEART Helpdesk Report, Health and Education Advice and Resource Team (accessed 21 July 2020).

[21] Menéndez, C.; Lucas, A.; Munguambe, K. and Langer, A. (2015) '**Ebola Crisis: The Unequal Impact on Women and Children's Health**', *The Lancet Global Health* 3.3: e130 (accessed 21 July 2020).

[22] Hewlett, B.S. and Hewlett, B.L. (2008) *Ebola, Culture, and Politics: The Anthropology of an Emerging Disease*, Andover: Cengage Learning.

[23] Rhodes, S.; Malow, R. and Jolly, C. (2010) 'Community-based Participatory Research: A New and Not-So-New Approach to HIV/AIDS Prevention, Care, and Treatment', *AIDS Education and Prevention* 22.3: 173–83.

[24] Allouche, J. and Wandji, D. (2020) ***Responses to COVID-19 Must Focus on Communities and Not Just Past Epidemics***, Africa at LSE blog, 6 April (accessed 21 July 2020).

[25] SSHAP (2020) ***Key Considerations: COVID-19 in Informal Urban Settlements (March 2020)***, Brighton: SSHAP (accessed 21 July 2020).

[26] Hrynick, T.; Ripoll, S. and Carter, S. (forthcoming, 2020) 'Review: Secondary Health Impacts of Vertical Responses to COVID-19 in LMICS', *Review*, Brighton: SSHAP

[27] Sangaramoorthy, T. (2020) '**From HIV to COVID19: Anthropology, Urgency, and the Politics of Engagement**', *Somatosphere*, 1 May (accessed 21 July 2020).

[28] Benjamin, L.M.; Jacques, P. and Dieudonné, E.M. (2015) 'Assessment of Importance of Environment and Activities in Batwa communities of Bikoro area, Democratic Republic of Congo', *International Journal of Innovation and Applied Studies* 11.3: 734–41.

[29] Riley, T.; Sully, E.; Ahmed, Z. and Biddlecom, A. (2020) '**Estimates of the potential impact of the COVID-19 pandemic on sexual and reproductive health in low-and middle-income countries**', *Int Perspect Sex Reprod Health* 46: 73–76.

[30] *Ibid.*

[31] UNAIDS (2020) '**Keeping HIV Treatment Available in Pakistan During COVID-19**', 15 April (accessed 21 July 2020).

[32] IPES-Food (2020) ***COVID-19 and the Crisis in Food Systems: Symptoms, Causes, and Potential Solutions***, International Panel of Experts on Sustainable Food Systems (IPES-Food) (accessed 21 July 2020).

[33] *Ibid.*

[34] UNICEF (2020) ***On Life Support: A Battered Health System Leaves DRC Children at the Mercy of Killer Diseases*** (accessed 21 July 2020).

[35] ILO (2020) ***Impact of Lockdown Measures on the Informal Economy: A Summary***, Geneva: International Labour Organization (ILO) (accessed 21 July 2020).

[36] SSHAP (2020) ***Compliance with Physical Distancing Measures for COVID-19 and Implications for RCCE in Eastern and Southern Africa (April 2020)***, Brighton: SSHAP (accessed 21 July 2020).

[37] ILO (2020) ***The COVID-19 Crisis: A Wake-up Call to Strengthen Social Protection Systems***, 24 April, Geneva: ILO (accessed 21 July 2020).

[38] Devereux, S.; Lind, J.; Roelen, K. and Sabates-Wheeler, R. (2020) '**Covid-19 and social protection responses: time for a global safety net?**', *IDS Opinion*, Brighton: Institute of Development Studies, 14 May (accessed 21 July 2020).

[39] Vaziralli, S. (2020) '**A Social Protection Response to COVID-19 in Developing Countries**', *International Growth Centre Policy Brief* (accessed 21 July 2020).

[40] GFDRR (n.d.) ***Building Back Better in Post-Disaster Recovery***, Global Facility for Disaster Reduction and Recovery (GFDRR) (accessed 21 July 2020).

[41] Blanchard, O. (2020) ***Designing the Fiscal Response to the COVID-19 Pandemic*** (accessed 21 July 2020).

[42] Mayberry, R.M. *et al.* (2008) 'Community-based Organizations' Capacity to Plan, Implement, and Evaluate Success', *Journal of Community Health* 33.5: 285–92.

[43] Leiderer, S. (2015) 'Donor Coordination for Effective Government Policies?', *Journal of International Development* 27.8: 1422–45.

[44] UN High-Level Panel on the Global Response to Health Crises (2016) ***Protecting Humanity from Future Health Crises: Report of the High-Level Panel on the Global Response to Health Crises***, New York: United Nations (UN), 21.

[45] *Ibid.*

[46] Ripoll, S.; Gercama, I.; Jones, T. and Wilkinson, A. (2018) ***Social Science in Epidemics: Ebola Virus Disease Lessons Learned – Background Report***, UNICEF, Institute of Development Studies and Anthrologica (accessed 21 July 2020).

[47] Bernes, T. *et al.* (2020) ***Challenges of Global Governance Amid the COVID-19 Pandemic***, New York: Council on Foreign Relations (accessed 21 July 2020).

[48] Organization of American States (2020) ***Multilateral Entities Coordinate Response to the Regional Impact of COVID-19 at the Level of the Joint Summit Working Group***, 5 April (accessed 21 July 2020).

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Institute of Development Studies, Library Road, Brighton, BN1 9RE, United Kingdom +44 (0)1273 606261 **ids.ac.uk**

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