

April 2020

HAI AP News

Penang, Malaysia

Web: <http://www.haiasiapacific.org>

Chair: Dr Niyada Kiatying Angsulee <[niyada.k.ang\[at\]gmail.com](mailto:niyada.k.ang[at]gmail.com)>

Ed: [Beverleyfsnell\[at\]gmail.com](mailto:Beverleyfsnell[at]gmail.com)

HAI AP Est. 1981

Health Action International (HAI) was formally founded in Geneva in 1981 and coordinated from Penang by Action for Rational Use of Drugs in Asia (ARDA). In 1995 Health Action International Asia Pacific (HAI AP) was formed as a collaborative network in the Asia Pacific Region to increase access to essential medicines and improve their rational use through research excellence and evidence-based advocacy. HAI AP is committed to strive for health for all now. *HAI AP News* is the organ of Health Action International – Asia Pacific and presents the happenings in the regional campaigns for more rational and fairer health policies and carries material in support of participants' activities.

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Vale Martin Khor

In this issue we pay Tribute to Martin Khor, TWN's Chairman and former Director and a much-loved friend of HAIAP.

At the time of preparing this issue the whole world is struggling with a pandemic caused by a coronavirus known as COVID 19. The impact of this pandemic varies greatly as do the responses. Without going into case numbers, we share stories that reflect impact and responses in countries in our region, and provide current information about, for example testing, treatment and other related issues. The situation changes day by day so the information in HAIAP News is at April 23.

We acknowledge World Health Day April 7, which focuses this year on nurses and midwives, by sharing a contribution from Dr Humera Naeem from the Health and Nutrition Development Society (HANDS) Pakistan and from Dr Manzur Kadir Ahmed discussing the role of midwives and paramedics in the Gonoshasthaya Kendra program in Bangladesh.

On April 2, we heard from TWN: It is with the deepest sorrow that we share the news that Martin Khor (1951-2020), TWN's Chairman and former Director, passed away peacefully in the early hours of 1 April 2020 in his home in Penang, Malaysia. He had lived with cancer since 2015 but worked even harder as the inspiring mentor, strategic and action-oriented thinker, indefatigable advocate and wonderful husband, father and grandfather.

We cannot even begin to reach out to all of Martin's friends and supporters who over decades, young and old, have marched with him to reject injustice and inequity among peoples especially of the South, and to defend nature again and again. In his memory let us all continue on the journey that Martin helped to chart. <https://www.twn.my/>

Martin was a wonderful human and a huge support to all who are working in advocacy to promote equity and fairness in lower and middle income countries.

From Dr Zafrullah Chowdhury: 'I am besides myself at this shocking news!! I have not gotten over my grief at not having visited Mohammad Idris one more time. We in the People's Health Movement have recently lost two guiding stars, Amit Sengupta and David Sanders. And now this.

'We are losing the very best amongst us, and that too at a time when we need to consolidate our collective strength and put up an effective resistance. Martin had the capability to provide the intellectual clarity, the discipline of persisting, the writing skills to communicate clearly and above all the conviction, passion and

perseverance to continue the fight for a better world. I have lost a comrade, a fellow fighter and guide.'

A poem by Nizam Madhar

A life well lived...
A friend, a brother, a mentor,
A comrade, of many, well-fought battle,
A teacher that makes sense of life, a complicated world
full of mess, he simplified and gave us hope,
The other brightened, peaceful soul,
Another proud and to be proud of Malaysian,
A life well-lived,
Wish I could live, such a fulfilled life,
You will be missed my brother,
Martin Khor Kok Peng

Memories of Martin from friends and colleagues

We have lost on April 1, Martin Khor, a rare public intellectual who spent his life time in serving the public interest on issues of economics, ecology and equity; his work with the Consumers Association of Penang (CAP) of which he was still Secretary; Sahabat Alam Malaysia (SAM); Third World Network (TWN). Most significant too, he served as head the international SOUTH CENTRE based in Geneva, which promoted and protected the interests of the third world against global hegemony by imperial economic and geopolitical powers. He took over the position from Manmohan Singh who moved back to India to eventually become the Prime Minister.

Even Tun Mahathir invited Martin to brief the Cabinet, a rare thing for civil society activists.

Although always appearing with a serious deep thinking demeanour he had a warm heart as reflected in his most recent and last book which was titled HAPPINESS and dedicated to his granddaughter. His father Khor Cheang Kee was one of the greatest journalists in Penang having headed both the New Straits Times and the Star. Martin instead took his writing skills to the whole world. Malaysia and civil society have lost an outstanding writer and activist."

Dato Anwar Fazal, Former President of Consumers International and currently Director of the Right Livelihood College and Chairman of Think City

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It is with sadness and a sense of loss I read the tragic news about Martin passing away and share it with family, friends and colleagues of TWN.

I have known Martin from the time he was in CAP with Uncle Idris,¹ then with TWN, South Centre and his return to Penang and valued his engagement with complex issues of unjust international trade, TRIPS, Rational Use of Drugs and in the last few years his deep involvement with issues related to Anti Microbial Resistance (AMR).

Martin could analyse always from the perspective of the people of the South, write about them and articulate them in a way that even those not familiar with the issue could comprehend the key message and thrust, and find themselves engaging.

Not every one is blessed with the capacity to analyse, write and speak consistently and convincingly to engage so many.

I think carrying forward the work, the concerns and engagements of Martin, would be a great tribute to his memory - especially heightened at this time of COVID Pandemic - access to essential medicines, diagnostics and vaccines and their rational use, the need for use of TRIPS Flexibilities, comprehensive Primary Health Care, concepts of strengthened Public Health and Universal Health Care, and mostly concerns related to Anti Microbial Resistance (AMR).

It was the AMR issue so close to his heart that brought many of us in the last few years to collectively engage with Martin and TWN. All India Drug Action Network and those of us associated with International Peoples Health Council (IPHC) and founding of Peoples Health Movement will miss Martin personally as well as for his initiatives for health and equity.

Dr Mira Shiva, AIDAN, India

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With Deep Sorrow and grief I condole the demise of Martin Khor to his family, colleagues and friends in TwN, HAIAP, and PHM. Wishing his soul rest in peace .

Dr. M.A. Barzgar, Iran

¹ [HAIAP News August 2019](#)

It is so sad to hear of Martin Khor's passing. I first met him in Sri Lanka in April 17-19 2003, at a WTO/Trips workshop organised by TWN. Hearing him speak, he was so articulate. I last met him last year in June, in Penang.

As he spoke, he would always acknowledge the pioneers as Doyens, paying great respect to them.

It is fitting to remember Martin as a Doyen of TWN. Such a man of great knowledge and humility. He has left a great legacy not only for the immediate family but for the TWN family at large. Sincere condolences and sympathies to family and friends. May his soul repose in eternal peace.

Vali Karo. Papua New Guinea

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I am extremely sorry for this huge loss. In my limited capacity as a recent recruit to your community, I was so highly impressed by Martin that I kept looking for him in Malaysia last year (and did manage to talk for a couple of minutes). From speaking truth to power, to getting the work done, getting civil society involved in the bigger platform, I was highly impressed by his stature, his work ethics and his nature.

Such was his scale of work that I remember being told in depth about him, as a person, as an individual who could fill a sense of responsibility and motivate people to do furthermore. Rarely do such people exist. Martin's contribution is so much that his name, his work, his attitude always used to find a mention. While this is something that might sound odd, I will say this - I envy all of you who could get to know him personally and could learn from him. I wish I could.

This will remain a regret.

I stand with all of you in this sad moment. Stay strong. In solidarity

Nafis Faizi, India

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For Martin, everyone mattered. I recall that when I met you [Nafis] and told him how excited I am by your passion and commitment, and that you would be working with Gopa on the India piece of the AMR work, he was very happy. Every new generation of activists would add an extra sparkle in his eyes. We loved him dearly and over the past two days since he left us we have been deluged by so much honouring and love and tears from all over the world. Thank you again.

Chee Yoke Ling, Malaysia, [TWN]

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<http://malaysiansmustknowthetruth.blogspot.com/2020/03/ex-director-of-third-world-network.html>

Martin Khor Publications

Stories by Martin are listed by the Inter Press Service News Agency

<https://www.ipsnews.net/author/martin-khor/>

His TWN publications listed below, can be downloaded
<https://www.twn.my/book.htm>

2020 - TWN Climate Change Series no.4: The Equitable Sharing of Atmospheric and Development Space: Some Critical Aspects

Tackling the climate change crisis demands urgent actions to cut atmospheric emissions of the heat-trapping greenhouse gases that are causing global warming. The responsibilities this entails should at the same time be divided equitably between developed and developing countries, as recognised in the United Nations Framework Convention on Climate Change (UNFCCC).....

2018 - The Malaysian Economy: Structures and Dependence

An analysis of the structures of the Malayan and the Malaysian economies using the perspective of dependence. It analyses the structures of dependence in colonial Malaya established by the British during the colonial era, in foreign ownership of key sectors, in trade, finance, the public sector and technology. The book then examines the post-colonial situation.....

2019 - AMR001: The Global Threat of Antimicrobial Resistance and the Challenges and Needs of Developing Countries

Antimicrobial resistance (AMR) is possibly the most serious public health threat of our time. Recognising the gravity of the problem, the international community has moved to address a phenomenon that could undermine prevention and treatment of an increasing

range of diseases and lead to millions of deaths. This global response, stresses this paper, must centrally involve the developing countries, where the impact of the AMR crisis would be greatest.

2018 - TND42: A Summary of Public Concerns on Investment Treaties and Investor-State Dispute Settlement

International investment agreements, specifically bilateral investment treaties and the investment chapters in free trade agreements, have come under the spotlight for what are seen as skewed provisions that grant excessive rights to foreign investors and foreign companies at the expense of national policymaking flexibility. Of particular concern is the investor-state dispute which enables foreign investors to sue host-country governments in opaque international tribunals....

2018 - When Medicines Don't Work Anymore

Antimicrobial resistance is the world's greatest public health risk and threat. We are now so used to using antibiotics that it is almost unthinkable what would happen to our state of health if there were none available. Or if the antibiotics don't work anymore – a looming 'catastrophe' so widespread that we would be back to a pre-antibiotic era when many diseases could not be treated.

2014 - Compulsory License and 'Government Use' to Promote Access to Medicines: Some Examples

This book describes the experiences of a number of developing countries in exercising their rights to use compulsory licensing, especially a license for 'government use' under the Doha Declaration on TRIPS and Public Health that was adopted by the WTO (World Trade Organization) Ministerial Conference of 2001.....

World Health Day – April 7

Nurses and midwives

World Health Day and the Antimicrobial Challenges of COVID-19



GENEVA – April 7th of this year marked the occasion of the 70th anniversary of the observance of World Health Day. The special awareness day was established in 1948 by the first World Health Assembly (WHA - the governing body of the World Health Organization (WHO), the sponsor of World Health Day.

Typically, the WHO 'organizes international, regional, and local events' for World Health Day devoted to a selected theme. The theme for this year is 'Support Nurses and Midwives.' However, given the current Coronavirus pandemic, the day was largely observed primarily, if not exclusively, via digital media.

WHO and its partner organizations have compiled the first State of the World's Nursing Report ². The report provides a global picture of the nursing workforce and supports evidence-based planning to optimize the contributions of this workforce to improve health and well-being for all.'

Globally, 70% of the health and social workforce are women. Nurses and midwives represent a large portion.

Nurses and midwives have a relationship with their patients that is based on trust; knowing the full picture of someone's health helps improve care and saves money. They also know the traditions, cultures, and practices of their communities, making them indispensable during an outbreak or emergency.

Achieving health for all will depend on there being sufficient numbers of well-trained and educated, regulated and adequately supported nurses and midwives, who receive pay and recognition commensurate with the services and quality of care that they provide.

HAIAP partners Health and Nutrition Development Society (HANDS) in Pakistan and Gonoshasthaya Kendra in Bangladesh share inspiring accounts of the work of nurses and midwives in their communities.

² https://www.who.int/hrh/nursing_midwifery/state-of-the-worlds-nursing-and-midwifery-2020-get-engaged.pdf

Nurses and midwives

HANDS initiatives and activities

Dr Humera Naeem shares the story

HANDS: Community Midwifery School Jamkanda Bin Qasim town Pakistan

The Maternal Mortality Ratio in our part of the world is alarmingly high and the percentage of deliveries attended by a Skilled Birth Attendant - SBA, is low. The concept of Community Midwifery is based on the fact that all deliveries need to be attended by a Skilled Birth Attendant-SBA.

HANDS Community Midwifery training is a 24 months residential training where a matriculated girl is trained in the principles of obstetrics.

The Training School - Jamkanda - in Bin Qasim Town was established by HANDS in the year 2002. It is registered with the Pakistan Nursing Council and provides 24 months residential training to willing and committed local community females who have passed matriculation examination. After successful completion of this course the graduates provide services to their respective communities. The school is attached to a 20 bed hospital that delivers 24 hours' service - including maternity services. It includes boarding, lodging, accommodation and food along with theoretical and skilled base training.

Since the initiation of midwifery training a total of 360 candidates have enrolled and out of those 301 (83.6%) have succeeded in completing the course. Out of successful candidates 143 (47.5%) have established their Birthing Stations and are providing services to the communities.

Currently, HANDS Community Midwifery School Jamkanda BQT is providing training to 40 CMW Students.



We celebrate the International Day of the Midwife on May 5 each year. This day is celebrated to honour the midwives for their contribution towards the maternal and child health. At HANDS the midwives day is celebrated with a special theme each year - such as 'the world

needs midwives now more than ever with the essential care they provide to mothers and their newborns’.



The Minister of Health visited HANDS CMW School Jamkanda in 2019 and CMWs Students participated in a walk for promotion of Breast Feeding.

Case Study of a Midwife

Self belief and hard work will always earn you success.

Ms. Shumaila D/O Kamal Khan is a 22 years old young woman living with her parents in Steel Town situated in Bin Qasim. Her father works as labour in a steel mill - earning about Rs. 20,000 (about \$US 125) month. The economic condition of the family was not healthy and Shumaila was working in a small private clinic to support her family. Working at the clinic she realized that she needed to have a proper training and certificate to work and came to know about the Midwifery training course. It was very difficult for her as she was supporting her family and could not keep her job if she enrolls for training. She thought for some time and talked to her parents who supported her and allowed her to go for the training as they also knew that once trained Shumaila will be able to serve better. Shumaila quit the job and joined the training course.



During the training Shumaila worked very hard and excelled in all her class tests and assignments. She worked especially hard to improve her writing skills and participated in extracurricular activities as well. Her

behaviour in the classroom, clinics and ward won her laurels. During the 24 months training course there were a few occasions where her patience and commitment were tested but Shumaila did not give way and with full determination she finally succeeded in the exam with honours and got the diploma.

She has established a Birthing station in Soomar Goth, a small village in Karachi, where there is no health facility for deliveries. Today she is a confident young Community Midwife serving for the betterment of maternal and child health and contributing to improve the maternal and child health and contributing to decrease the maternal and infant mortality in the country. She is not only serving a cause but is also financially stable and her self-determination has made her a symbol of women’s empowerment for her fellow community women.

BANGLADESH

Why paramedics and midwives matter

<https://www.dandc.eu/en/article/gk-non-governmental-health-service-provider-bangladesh-knows-how-reduce-maternal-mortality>

Manzur Kadir Ahmed



Pre-natal care at the village level: GK-paramedic checking a pregnant woman’s urin probe.

Gonoshasthaya Kendra (GK) has proven that it is possible to reduce maternal mortality substantially. The main issue is to ensure that all pregnant women get competent assistance, though not necessarily from a university-trained physician.

As GK’s coordinator and chief executive officer, I am confident that we will achieve the global Sustainable Development Goal of fewer than 70 maternal deaths per 100,000 live births in the near future, well before the 2030 deadline.

Our organisation serves some 1.2 million people throughout Bangladesh. They are not a representative cross-section of the nation, of course, but our

experience is relevant, nonetheless. We work in rural as well as urban areas, paying particular attention to poor and disadvantaged communities.

GK is something like the prototype of the solidarity-based national health service least developed countries like Bangladesh needs.³ We charge patients from different social strata different rates, ensuring that all families who sign up get reliable and affordable health care. We reach out to our nation's poorest communities.

Paramedics are the backbone of our system. We run up-to-date vocational training to ensure they are properly skilled. The plain truth is that Bangladesh simply does not have enough university-trained physicians to serve everyone. We believe that health coverage is a universal human right, so everyone must be covered.⁴ Moreover, GK has always considered reproductive health particularly important, and we have a history of promoting family planning and contraceptives. Our government has copied many of our measures.

Most of our paramedics are young women with eight to 12 years of school education. GK runs more than 40 health centres that provide services to more than 630 villages. The health centres are supported by six referral hospitals.

Every member family of GK is visited at least once per month by a paramedic. If needed, the health workers visit more frequently. Among other things, they provide reproductive health care and family-planning services:

- They register pregnant women and provide ante-natal care. For example, they measure the women's weight, height and blood pressure. They also check for oedema, jaundice, anaemia and diabetes. They examine eyes, ears and teeth as well as foetal movements and foetal heart sounds.
- They distribute iron and calcium tablets and immunise pregnant women against tetanus. To reduce child mortality, they immunise infants against diphtheria, whooping cough, tetanus, polio, tuberculosis and measles.
- They identify high-risk mothers and refer them to medical professionals. They get special attention. If needed, babies are delivered by Caesarean section in the referral hospitals.
- The paramedics advise families on healthy and balanced diets.

- They discuss the possible causes of maternal death as well as preventive measures with families and the local community.
- They file detailed reports of all cases to the head office, so GK has compiled extensive and long-term statistics over the decades.

GK officers regularly monitor the paramedics' work. Statistical data and field reports are checked for inconsistencies, which helps to ensure high-quality services. Antenatal and postnatal care are very important. Mothers, after all, have a vital role to play in their families and in society in general.

GK cooperates with traditional birth attendants (TBAs), ensuring that the women's skills are up to date. It is essential that every birth is attended by a competent person and that high-risk deliveries take place in hospitals. On the other hand, it is plainly unaffordable to deliver all babies in hospitals in a least developed country like Bangladesh. Well trained paramedics and midwives are up to the task.

We believe in community-based action and involve local people in health matters. Every infant and maternal death is discussed in the community to draw lessons. The idea is to improve health services as well as household and community action. More generally speaking, health education in villages matters very much.

In recent decades, Bangladesh has made good, but insufficient progress on reducing maternal mortality. The country cut the number of deaths per live births by almost two thirds from 1990 to 2015, but the Millennium Development Goal (MDG) was to reduce it by 75 %. According to government data, the figure for 2015 was 181 maternal deaths per 100,000 births. The MDG mark was 143 per 100,000. Among the GK clientele, the ratio was 141 per 100,000. To be precise: we recorded 18 deaths per 12,731 live births.

Bangladesh also missed the sub-target of having 50 % of births attended by skilled staff in 2015. The share rose from five percent in 1990 to 40 % in 2015. Once more, this progress was good – but not good enough, and not as good as the services we provide. Our member families are taken care of systematically, after all. In any case, the trends show that the MDGs were within reach and should be achieved soon. The SDG on maternal mortality is more ambitious of course. In our experience, it is achievable, nonetheless. GK will certainly achieve, and hopefully our country will too.

Manzur Kadir Ahmed is the coordinator and chief executive officer of Gonoshasthaya Kendra (GK). He is a medical doctor.

gkhealth.org@gmail.com

<http://www.gonoshasthayakendra.com/>

³ See Rezaul Hoque in e-Paper 2017/05, p. 28 / print edition 2017/05–06, p. 20

⁴ see interview with GK founder Zafrullah Chowdhury in 2012/03, p. 126

COVID 19 in our region

COVID-19 is a test of societies, of governments, of communities and of individuals. It is a time for solidarity and cooperation to tackle the virus, and to mitigate the effects, often unintended, of measures designed to halt the spread of COVID-19. Respect for human rights across the spectrum, including economic and social rights, and civil and political rights, will be fundamental to the success of the public health response.

<https://www.ohchr.org/EN/NewsEvents/Pages/COVID19Guidance.aspx>

Vulnerabilities and Resiliences

Addressing Vulnerabilities and Resiliencies, Dr Chan Chee Khoo spoke at the 2nd Global Consultation on Migrant Health in Sri Lanka in February 2017

‘The migration landscape in Southeast Asia is overwhelmingly characterized by **temporary labor migration**. Southeast Asia is home to major labor-exporting countries (Indonesia, Philippines, Myanmar) as well as labor-receiving countries (Malaysia, Singapore, Thailand, Brunei).

‘Undocumented migrants are especially vulnerable to exploitation, intimidation, and abuse by employers, labor contractors (brokers), and enforcement personnel and management of novel and other infectious outbreaks (e.g. Sars, MERS, dengue,[COVID 19,] is made more difficult when undocumented migrants have a strong incentive to avoid contact with government agencies.’

‘We have not seen the last of this particular vulnerability in South East Asian countries (not to mention India, with its huge domestic labor migration graphically portrayed recently by Arundhati Roy and P Sainath), with its 2-4 million *undocumented* migrants who continue to have strong incentives to avoid contact with government agencies including those tasked with contact tracing in this Covid-19 pandemic.’

INDIA and COVID-19

<https://www.bbc.com/news/world-asia-india-52350544>

<https://timesofindia.indiatimes.com/india/coronavirus-lockdown-what-will-be-open-april-20-onwards/articleshow/75232160.cms>

India has a population of about 1.3 billion and 90% of the workforce works in the unorganised sector. India's lockdown has turned into a human tragedy. All over India, millions of migrant workers have fled the cities, trekking home to their villages.

COVID 19 and migrant workers

In India almost one million children die of diarrhoea, malnutrition and other health issues every year. There are hundreds of thousands of tuberculosis patients (a quarter of the world's cases), and anaemia and malnutrition contribute to make the population vulnerable to many other illnesses that can prove fatal. It is impossible for India cope with the 'normal' health situation so a pandemic crisis like that in Europe could be insurmountable.

Informal workers are the backbone of the big city economy, constructing houses, cooking food, serving in eateries, delivering takeaways, cutting hair in salons, making vehicles, plumbing toilets and delivering newspapers..... Escaping poverty in their villages, most of the estimated 100 million informal workers live in squalid housing in congested urban ghettos.⁵

On March 24, at 8pm, India's Prime Minister Modi announced that, from midnight onwards, all of India would be under lockdown. Markets would be closed. All transport, public as well as private, would be disallowed. A nation of 1.38 billion people would be locked down with no preparation and with four hours' notice.



Informal workers don't get a monthly pay cheque or bank transfer. Their cash flows are dependent on them working

People driven out by their employers and landlords, with nowhere to go, and with no public transport in sight, began a long march home to their villages. Some died on the way.

Many villagers are so afraid of COVID-19 that they would not let their own migrant workers enter their own villages, even their own homes.

On April 2 in India, there were almost 2,000 confirmed cases and 58 deaths - surely unreliable numbers, based on few tests - and expert opinion varies wildly.

Writing for the Financial Times Arundhati Roy explained:

⁵ <https://www.bbc.com/news/world-asia-india-52086274>

'On March 11 the World Health Organization declared that COVID-19 was a pandemic. Two days later, on March 13, the [Indian] health ministry said that corona 'is not a health emergency'. Finally, on March 19, the Indian prime minister addressed the nation. He hadn't done much homework. He borrowed from France and Italy. He told us of the need for 'social distancing' and called for a day of 'people's curfew' on March 22. He said nothing about what his government was going to do in the crisis, but he asked people to come out on their balconies, and ring bells and bang their pots and pans to salute health workers. He didn't mention that, until that very moment, India had been exporting protective gear and respiratory equipment, instead of keeping it for Indian health workers and hospitals.'

The government said there would be packages of food and increased allocation of food grain for the displaced workers. However, the system of target distribution of goods means many people who are deserving and who are the poorest do not have documents and these people are left out of programs. People are not sure whether they will die from the pandemic but they are quite certain that in the lockdown they might die of starvation or of economic hardship.

State governments have shown more understanding in the crisis. Trade unions, private citizens and other collectives are distributing food and emergency rations.

As the lockdown continues supply chains are broken, causing all supplies - including essential medicines - to be running low. Thousands of truck drivers are still stuck on the highways, with little food and water and crops, ready to be harvested, are slowly rotting.

Physical distancing has literally been internalized as social distancing, at a time when social bonding and social solidarity is required.

Lockdown extended to May 15 – renourishing the worst enemy - hunger

Rounak Kumar Gunjan | April 12 [News18.com](https://www.news18.com)
Read the whole story here ⁶

- In Jharkhand state in North East India it's been three days since Chandrawati Devi, 32, had anything to eat. Her family of eight in Jharkhand's Garwa district has been starving ever since the lockdown. She is now afraid that if left unattended, they might die out of hunger. 'I can't even go out to beg because of the lockdown. We've used up everything we had to feed the children,' she says.

- Late Somaria Devi used to live with her 72-year-old husband in Garwa district's Bhandariya village. The

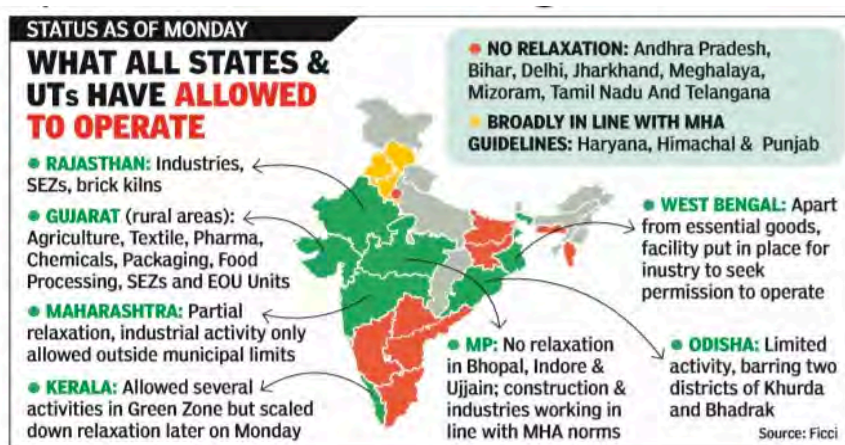
couple had no children, no source of income and were not registered under any government scheme. Their nephew, living in the nearby village, used to check on them once a week to buy essentials. Ever since the lockdown, they were left alone. Nine days later, Somaria Devi breathed her last. 'She died because of starvation,' says her husband, Lachhu Lohra, who survived only because the villagers were alerted of his wife's death.

- A survey, of which economist John Dreze is also a part, by Right to Food Campaign conducted in the first week of April across 50 blocks in 19 districts of Jarkhand S tate found some grim details. Fifteen of the 50 blocks reported specific cases of hunger or of shortage of food in hamlets of marginalised people such as particularly vulnerable tribal groups. Twenty-one of the 50 blocks witnessed many cardholders in the area still waiting for their April rations. In at least four blocks, even March rations were yet to be distributed.

Some restrictions eased from Monday April 20 ⁷

From April 20 India eased some restrictions with most targeted at easing pressure on farming, fishing and plantations which employ more than half the nation's workforce. To restore the supply chain in these industries, cargo trucks would also be allowed to operate across state borders to transport produce from villages to the cities - all businesses and services that reopen would be expected to follow social distancing norm.

But none of the restrictions will be lifted in areas that are still considered 'hotspots' for the virus – that includes all major Indian cities.



Times of India April 22

⁶ <http://www.haiasiapacific.org/wp-content/uploads/2020/04/Hunger-and-StarvationJharkhand-Covid-19.pdf>

⁷ <https://www.bbc.com/news/world-asia-india-52350544>

Who decides what to reopen?

State governments would decide where restrictions could be eased. And several state chief ministers, including Delhi's Arvind Kejriwal, said that none of the restrictions will be lifted in their regions. So nothing changed for the majority of informal workers. From April 20, millions of poor Indians who migrated from villages to cities in search of livelihood remain stranded far away from home, with no jobs, food or money.

Read more at:

http://timesofindia.indiatimes.com/articleshow/75232160.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

KERALA

Kerala Covid-19 response model for emulation⁸

Physical distancing, social solidarity in Kerala

Kerala state in south-western India, with a population of 35 million, has become 'a model state in the fight against Covid-19'. Its government was among the first to introduce precautionary state-wide measures against the coronavirus threat.

Returning migrants

Despite Kerala's long-standing achievements in education, health and science, highly educated Keralans tend to migrate to work out of state and they have been returning.

Kerala is also the destination for a large number of Indian internal migrants. With the nationwide lockdown, non-residents, equivalent to almost 5% of Kerala's population, have returned, causing a surge of new infections.

Such unusually high movements of people have made the state more vulnerable. Despite some controversy, the state appears to have handled the migrant issue very well, especially compared to other state governments and the central government.

Through appropriate and effective early actions, it has successfully slowed the spread of infection in the state, largely by promoting physical distancing and mainly sanitary precautionary measures, and providing better protection for health staff well before the hugely disruptive and draconian lockdown imposed in India in late March.

The Kerala State Government invited religious leaders, local bodies and civil society organizations to participate in policy design and implementation, considering its specific socio-economic conditions, including urban slum environments.

⁸ <https://www.newframe.com/kerala-is-a-model-state-in-the-covid-19-fight/>

The State Government communicated effectively in different languages to educate all, including migrants, and to prevent stigmatization of those infected, even opposing the term 'social distancing', which has caste connotations, with 'physical distancing and social solidarity'.⁹

Subin Dennis and Vijay Prasad writing for The New Frame provided this account of Kerala's response on April 10 [Coped as fair use]¹⁰

KK Shailaja is the health minister in Kerala.. On 25 January 2020, she convened a high-level meeting to discuss the outbreak of COVID-19 in Wuhan, China. What had particularly worried her was that there were many students from Kerala studying in that province of China.

Shailaja had won widespread praise for the swift and efficient way she had steered her department through the Nipah virus that hit Kerala in 2018. She recognised that there was no time to be lost if the coronavirus spread from Wuhan; the government had to set up mechanisms for identifying possibly infected persons, and then for testing, mitigation, and treatment. On 26 January, her department set up a control room to coordinate the work.

Kerala's Health Department, using the precedent of the Nipah virus campaign, went into action. They set up 18 committees to get to work and held daily evening meetings to evaluate their actions; a key feature of the work was the daily press conferences after these meetings, where Shailaja calmly and rationally explained what was going on and what her department was doing. These press conferences – and later those of the Chief Minister Pinarayi Vijayan – provided the leadership needed for a population that first needed to be educated about the severity of the virus and then needed to participate in a mass campaign to defeat its lethality.

A medical student who was in Wuhan who had the coronavirus returned home and was tested positive on 30 January; subsequently, two more students came back with the virus. The system set up by Kerala's Health Department located them; they were tested and put into isolation. They recovered from the virus, and there was no secondary or community spread.

⁹ <https://www.ipsnews.net/2020/04/kerala-covid-19-response-model-emulation/> by Anis Chowdhury and Jomo Kwame Sundaram

¹⁰ <https://www.newframe.com/kerala-is-a-model-state-in-the-covid-19-fight/>

By March, the numbers of coronavirus positive cases increased, largely as people came to Kerala from Europe. The population of Kerala is extraordinarily mobile, with large numbers of its people studying and working across the globe. This international character of the population makes the state susceptible to pandemics.

Break the chain

'Break the Chain' was the slogan given by the government in Kerala. The idea is simple: a pandemic is spread when individuals who are positive for a virus come into contact with others, who then come into contact with even more people, and then the virus spreads further very fast. If those who are carrying the virus do not come into contact with others, then the chain of dispersal is broken.

Contact tracing and testing

The government of Kerala has tested the highest number of samples for the coronavirus in India so far. In order to 'break the chain', the government has been conducting rigorous 'contact tracing', or studying who the infected person has been in contact with and then who that person has been in contact with so that the entire chain of possibly infected people can be informed and put into isolation. Route maps - widely disseminated through social media, and through GoK Direct, the government's phone app - showing the places that the infected persons have been to - are being published, and people who were present at that time at those places are asked to contact the health department so that they can be screened and tested.

Local government officials and Accredited Social Health Activist (ASHA) health workers (women who are the pillar of local public health) are doing the groundwork of finding people who are infected and making sure their contacts are also in isolation.

Physical distance, social unity

As soon as it became clear that the virus lingers on surfaces and carries through the air, the state government mobilised resources to produce hand sanitisers and masks. A public sector company started producing hand sanitiser. The youth movement - the Democratic Youth Federation of India - and other organisations also, began to produce hand sanitiser, while women's cooperative units (Kudumbashree - 4.5 million members) began to produce masks.

Local administrators formed their own emergency committees and set up groups to clean public areas. The mass fronts of the Communist Party of India (Marxist) sanitised buses, and set up sinks in bus stations for passengers to wash their hands and faces. The Centre of Indian Trade Unions (Kerala) has appealed to workers to disinfect public spaces, and to

assist their fellow workers who face distress as a consequence of the quarantines. These mass cleaning campaigns had a pedagogical impact on the society, since the volunteers were able to instruct the population about the social necessity to 'break the chain'.

Who qualifies for Covid-19 testing?

In a densely populated region of the world, quarantine is not an easy matter. The government has taken over vacant buildings to set up care centres to quarantine patients, and it has made arrangements for people who need to be quarantined at home, but are in overcrowded homes, to move to facilities set up by the government. Everyone who is in quarantine and in these centres will be fed and treated by the local self-governments, and the bill for the treatment will be paid by the state.

Impact on mental wellbeing

A key problem with physical isolation and quarantine is mental distress. The government has set up call centres with 241 counsellors who - to date - have conducted about 23,000 counselling sessions for those who are afraid or nervous about the situation. Chief Minister Pinarayi Vijayan's, press conferences are calm and collected. In them, he refers to people who must use the government facilities with kindness and dignity. 'Physical distance, social unity - that should be our slogan at this time,' said Vijayan.

Relief

Kerala's chief minister, on the same day as India's PM Modi's divisive speech, announced a relief package worth \$270 million. The package includes loans to families through the women's cooperative Kudumbashree, higher allocations for a rural employment guarantee scheme, two months of pension payments to the elderly, free food grains, and restaurants to provide food at subsidised rates. Utility payments for water and electricity as well as interest on debt payments would be suspended.

Money was rushed to bolster the relatively strong state public health system, which had been revamped during the tenure of the Left government from 2006 to 2011.

Vigilance

In Kerala, the institutions of society remain relatively intact; the political world was able to summon the spirit of volunteerism among party members and members of mass organisations to give their time and energy in the fight against the virus.

COVID-19 and our shared future

The fight against COVID-19 is not over. Vigilance is necessary. Vaccines need to be tested and authorised; better cures need to be studied and shared. But even as one is vigilant, the lessons from places like Kerala should be absorbed.

Kerala's response: Less disruptive, less costly, more effective

Jomo Kwame Sundaram

<https://www.networkideas.org/news-analysis/2020/04/kerala-covid-19-response-model-for-emulation/>

Some key features of Kerala's response, undertaken by a government with very limited fiscal resources, are instructive.

All-of-government approach: involving a range of relevant state government ministries and agencies to design measures to improve consistency, coordination and communication, and to avoid confusion.

Whole-of-society approach: wide community consultations, including experts, to find the most locally appropriate modes of limiting infections, along with means to monitor and enforce them.

Social mobilization: communities were provided essential epidemiological information to understand the threat and related issues, ensure compliance with prescribed precautionary measures, and avoid panic.

No one left behind: adequate supply of essential commodities, particularly food and medicines, has been ensured, especially to protect the most vulnerable sections of society.

To make things more difficult for Kerala, the state has been discriminated against by the central government's disaster relief fund on specious grounds. The largely agricultural state has modest fiscal resources of its own as state governments in India have limited fiscal rights and resources.

Credible leadership

The Kerala government has set up 18 committees and holds daily evening meetings to evaluate the situation, issuing media updates about those quarantined, tested and hospitalized.

At these meetings, the state Health Minister and Chief Minister calmly explain what is going on, including what the government is doing. They thus provide credible leadership on the difficult issues involved, securing strong public participation for its mass campaign of containment.

Kerala's approach has proven less disruptive, less costly and more effective than most others. After recording its first COVID-19 case on January 30, its infection and death rates have been kept relatively low despite much more tracing and testing.

SINGAPORE Migrant workers affected

During the third week in April, Singapore experienced a dramatic increase of Covid-19 confirmed cases, most specifically among the around 300,000 migrant workers (mostly from south Asia) working in construction and maintenance and housed in dense dormitory complexes on the outskirts of the city. Tightly packed dormitories housing thousands of foreign workers have emerged as Singapore's biggest challenge in its fight to contain the spread of the coronavirus.

Singapore reported a record 142 new infections on Wednesday April 15, and at least 40 of those were linked to clusters at foreign worker dormitories that house mainly low-wage workers in construction and other sectors. By April 19 those groups accounted for 253 infections across nine facilities, more than 15 per cent of the country's 1,623 cases, according to Ministry of Health data. The move to quarantine potentially exposed workers living in close proximity has raised questions about whether the conditions will allow for social distancing – one of the key strategies utilised around the world to contain the outbreak's spread.¹¹

Although Singapore is providing on-site support, including food and essential supplies, and preventive measures are being put in place in the dormitories 'the key vulnerability, crowding, is not really being addressed with sufficient determination,' said Alex Wu, Vice-president at Transient Workers Count Too, a registered charity that helps low-wage migrant workers. For example, in Westlite Toh Guan facility, a total of 6,800 residents are spread across 687 apartment units with an average of eight to 10 occupants per room, according to emails with Centurion Corporation, which owns the buildings. The units include bathrooms, a kitchen, showers and dining space.

By April 22, 4,700 cases who are clinically well but still test positive for the virus were isolated and cared for at special facilities. Indonesia's Temasek Foundation sent bed frames, mattresses, mattress covers, bedsheets, pillows, pillowcases, and blankets – to supplement the existing supply used at community isolation facilities.¹²

More will be shipped over depending on future needs, as part of a partnership between the Indonesian embassy in Singapore and the philanthropic arm of Singapore's sovereign wealth fund The foundation said it will continue to work closely with partners to respond and support the needs of the community.

¹¹ <https://www.reuters.com/article/us-health-coronavirus-singapore/singapore-reports-942-new-covid-19-cases-in-biggest-daily-jump-total-reaches-5992-idUSKBN2200B7>

¹²

BANGLADESH:

Gonoshasthaya Kendra response

Dr Rezaul Haque, Senior Director, Health Program

During any kind of national/international disaster, Gonoshasthaya Kendra (GK) tries to respond as early as possible through rescue, medical services, reconstruction of damaged houses, and food distribution (including safe drinking water).

COVID-19 is creating a threatening situation in Bangladesh. Bangladesh is under total lockdown. Almost 10 million poor people (especially jobless day labourers) cannot earn any income/wage to support basic food demands for their families. Some are risking their lives to work. Although the Government of Bangladesh is providing support, the private sector needs to step up.

In such situations, GK has taken the initiative to support 100,000 people but preliminarily we are supporting 10,000 people with the help of GK Trust - but we want to support that number - 100,000. So, we require help from you.

At this moment, we provide 10,000 families with monthly meal supplies. We want to raise enough financing to provide monthly meal supplies for at least 100,000 families. For this, we are asking for support.

If anybody would like to donate to the GK program directly they can send it to our mother bank account:

A/C Name: Gonoshasthaya Kendra

A/C No: [0100003101155](#)

Bank Name: Janata Bank Limited

Branch Name: Dilkusha Corporate Branch

SWIFT Code: JANBDDHDCB

Routing Number: 135271933

*Bank account is tax-exempt by [nbr.gov.bd](#)

bKash Account (Personal)

01881818153

[01765274312](#)

Please share this with your friends so that we can fight this COVID-19 situation together.

Thank you.

Dr. Rezaul Haque
Senior Director, Health Program
Gonoshasthaya Kendra, Savar, Dhaka

GK test kits ^{13 14}

By early April GK had obtained the necessary reagents to manufacture their own test kits with the aim of producing 100,000 kits. The kits were submitted to

Government for approval and finally got permission to trial them on April 22.

Dr Zafrullah Chowdhury said 'We will collect samples at Kurmitola General Hospital on Thursday and test those with the kits we have developed'.

MALAYSIA

Dr Chan Chee Khoo, in a letter to the Star, March 14, 2020 ¹⁵

EPIDEMIOLOGISTS attempt to model quantitatively the course of an infectious outbreak by plotting the number of cases over time in a curve-fitting exercise whose shape reflects parameter values like the reproductive number (average number of secondary infections produced by a typical existing infection) and incubation period (duration between exposure to an infectious organism and the emergence of noticeable symptoms).

It was on the basis of such fitted epidemic curves that Dr Bruce Aylward, team leader for the WHO-China Joint Mission on Coronavirus (Feb 16 to Feb 24, 2020) assessed that the Chinese government may have averted hundreds of thousands of additional infected cases through their extraordinarily robust containment efforts in Wuhan, Hubei, and other cities and provinces.

The mainstays of these containment efforts were:

- Isolation and treatment of virus positive cases;
- Contact tracing and quarantine of close contacts who were untested or who tested negative; and
- Massive social distancing in various forms, all carried out in unavoidably disruptive ways but which nonetheless allowed for the basic living essentials and needed care, by and large, to be delivered.

Malaysia, however, has specific demographic characteristics that are not easily modelled upon such simulations of epidemic dynamics, most specifically the large pools of undocumented migrant workers (easily a million in the Klang Valley) who have strong incentives to avoid contact with government agencies, making contact tracing more difficult in an outbreak situation.

Nonetheless, most fatalities and severely ill cases that might occur among undocumented migrants presumably would come to attention at some point, but this would be much delayed, which greatly complicates efforts at containment and mitigation, not to mention treatment.

The Citizens' Health Initiative (CHI) ¹⁶ knows that our Health Ministry is aware of these potential spill-over

¹⁵ https://www.thestar.com.my/opinion/letters/2020/03/14/covid-19-and-contact-averse-undocumented-migrants?itm_source=parseapi

¹⁶ Citizens' Health Initiative CHI is an informal grouping of individuals seeking to promote citizen involvement in healthcare reforms and health policy in Malaysia.

¹³ <https://www.newagebd.net/article/103275/gonoshasthaya-hopes-to-produce-1-lakh-coronavirus-test-kits-by-mid-april>

¹⁴ <https://www.newagebd.net/article/104924/gonoshasthaya-gets-permission-for-kit-trial>

scenarios through previous discussions with Dr Chong Chee Kheong (formerly director of disease control and currently deputy director-general for public health) as well as via recent communications with senior officers of the WHO and UNU-International Institute for Global Health in Kuala Lumpur. What is less clear though is the proactive measures and contingency plans the Health Ministry may have for coping with such scenarios.

Are there, for example, initiatives to engage more closely with those channels of healthcare access that undocumented migrants resort to when in need of care, like voluntary clinics such as those run by Tzu Chi Foundation, Pertiwi Soup Kitchen, Teddy Mobile Clinic and Global Doctors Hospital Mont Kiara (assuming they also cater to unsuccessful asylum applicants and undocumented migrant workers in addition to refugees)?

These laudable non-government endeavours operate as de facto 'safe(r) spaces' which could supplement the Health Ministry's efforts in outreach and communication with marginalised communities, especially those that need some assurance of sanctuary when accessing needed care.

Beyond that, civil society organisations, migrant networks and communities, UN agencies and indeed embassies of the labour-sending countries could assess the information and health communication needs of the respective migrant communities, and translate and disseminate useful, actionable information for individual as well as community coping responses.

How might we know if the Covid-19 outbreak in Malaysia has spilled over into the undocumented migrant population?

At the moment, [March 14] the Health Ministry is relying on its existing sentinel surveillance for influenza-like illnesses (ILI) and Sari (severe acute respiratory infections) to also detect sporadic cases of SARS-CoV-two positives as a red flag for community viral transmission with no traceable contact history. This could be how infected undocumented migrants might directly or indirectly come to attention.

Somewhat reassuringly, the sentinel surveillance so far has not detected any sporadic cases. The reported first case of a presumed sporadic case has now turned out to have a contact history traceable to a known infected case, as reported in 'Sporadic no more: Source of Covid-19 infection traced to religious event' (The Star, March 12¹⁷).

We should treat this as a wake-up call for the urgency of an 'all of government' effort led by Prime Minister Tan

Sri Muhyiddin Yassin to respond proactively to an escalating emergency. [snip]

Response to the letter

S Jemilah Mahmood, Tunku Puteri Intan Safinaz, Lilianne Fan¹⁸

Special measures needed to curb Covid-19 in refugee and migrant communities¹⁹

March 19 — Malaysia is experiencing exponential growth of the COVID-19 pandemic. We have seen excellent leadership from the Ministry of Health, especially by the Director-General of Health Datuk Dr Noor Hisham Abdullah in handling the outbreak. The Movement Restriction Order is welcomed in efforts to flatten the growth curve. However, immediate efforts are needed to increase outreach and communication to some of the most vulnerable communities, including refugees and undocumented migrants, who face specific barriers to accessing health services in the country.

Widespread person-to-person transmission in the community

The vast majority of new positive cases of Covid-19 are among participants of the Ijtima Tabligh gathering at the Sri Petaling Mosque that was held from February 27 to March 1. The Ministry of Health (MOH) has sent a clear message to attendees of the event to come forward for Covid-19 testing and is working around the clock to trace all participants. It is reported that up to 16,000 people attended the event. As of March 16, 8,776 participants have been tested. As of March 17, there have been 433 participants tested positive for Covid-19, with one fatality. It has also emerged that a small number of refugees and migrants also attended the Tabligh gathering. While considerable measures are being taken by MOH to trace attendees from refugee and migrant communities, this cannot be the responsibility of the MOH alone, and requires support from other ministries and civil society groups. Ultimately, providing urgent detection, testing, and appropriate and accessible care is essential.

¹⁸ Tan Sri Dr Jemilah Mahmood is Under Secretary General for Partnerships of the International Federation of Red Cross and Red Crescent Societies (IFRC) and the founder of Mercy Malaysia.

Datuk Seri Diraja Tan Sri Tunku Puteri Intan Safinaz Binti Almarhum Sultan Abdul Halim Mu'adzam Shah, Tunku Temenggong Kedah, is the National Chairman of the Malaysian Red Crescent.

Lilianne Fan is the Co-Founder and International Director of Geutanyoe Foundation and the Chair of the Rohingya Working Group at the Asia Pacific Refugee Rights Network (APRRN).

¹⁹ <https://www.malaymail.com/news/what-you-think/2020/03/19/special-measures-needed-to-curb-covid-19-in-refugee-and-migrant-communities/1848140>

¹⁷ <https://www.thestar.com.my/news/nation/2020/03/12/sporadic-no-more-source-of-covid-19-infection-traced-to-religious-event>

Major issues to be addressed

- **Migration and inequality**
- **Universal health coverage for refugees and migrants**
- **Need for immediate whole-of-society measures**

The Government must act quickly and decisively to impose special protective measures to support refugee and migrant communities in its bid to curb the spread of COVID-19. Firstly, the Government must respect the right to health of all individuals by removing barriers that will prevent non-citizens from accessing healthcare services. Testing and treatment for COVID-19 must remain free for all citizens and foreigners alike regardless of their legal status. Information on this policy must be circulated widely in the native languages of refugee and migrant communities, particularly Burmese, Rohingya, Bengali, Arabic, Farsi, Somali and Nepalese, through the channels of communication that these groups utilise. In order to ensure effective health education, the Government should work closely with non-governmental organisations (NGOs), UNHCR, places of worship, refugee and migrant community-based organisations, and employers to develop and disseminate health education in the native languages of refugees and migrants. NGO mobile clinics should be permitted by the Government to continue operations during the Movement Restriction Order period. The Government should ensure that employers respect the rights of workers and provide paid sick leave for their refugee and migrant employees.

Close coordination and alignment are required between the Ministry of Health and the Ministry of Home Affairs. Heavy-handed approaches that penalise communities would further discourage refugees and migrants from accessing health services, putting them, their families and communities, and the greater Malaysian public at risk. For example, immigration raids would cause the community to retreat further into hiding. The best approach would be to build trust and work in partnership with refugee and migrant communities to manage the crisis. An immediate halt to all immigration raids and an amnesty from arrest, detention and deportation due to immigration offences should be declared to encourage undocumented migrants with Covid-19 symptoms to approach healthcare centres for testing. The Government should also initiate a plan of action to prevent and detect outbreak at immigration detention centres.

In the longer term, the Government should ensure that laws and policies respect every individual's right to health regardless of their immigration status. The Government should develop a legal framework for refugees to provide documentation, that would also make it easier for the Government to trace communities,

and enable access to basic services such as education, health and employment. Covid-19 has underlined the necessity of a robust refugee policy to enable the Government to include this vulnerable population in management of public health and safety. Ultimately, we must realise that the only way Malaysia will overcome this pandemic is through an approach that engages and addresses all members of our society. In the words of Mahatma Gandhi, 'the true measure of any society can be found in how it treats its most vulnerable members'.

Writing in the Green Left on April 6,²⁰ Jeyakumar Devaraj²¹ said:

Malaysia is said to be handling the health crisis much better than many other countries. However, the second aspect of the crisis was that many lower- and middle-income Malaysian households had already run out of their meagre savings 10 days into the *Movement Control Order* (MCO) lockdown, which came into place on March 18. They were having difficulty providing food for their families.

The third aspect of the crisis was that *small- and medium-sized enterprises* (SMEs), which employ about 65% of the workforce, were under serious threat.

The lockdown meant the vast majority of SMEs had no income since March 18. Yet, their fixed costs remain: wages, rent, loan payments, income tax commitments, payments to suppliers.

Some SMEs are being forced to fold. This would mean jobs will be in short supply once the lockdown is lifted and that the post-lockdown economic downturn would be deeper and more prolonged.

Given this bleak scenario, several measures would need to be implemented quickly to address each aspect of the crisis. The government's *Caring Economic Stimulus Package* (CESP) is on the right track.

It has allocated another RM1.5 billion (A\$573 million) to the Ministry of Health. This represents 5% of the annual health budget.

Measures for Small and Medium Enterprises

The CESP includes measures to help SMEs survive the lockdown. These measures are timely as these businesses must be kept alive.

They include:

- A moratorium on bank loan repayments for the next 6 months;
- A wage subsidy program where the government pays RM600 (\$230 or 50% of the minimum wage) of

²⁰ <https://www.greenleft.org.au/content/malaysia-covid-19-response-must-confront-three-sides-crisis>

²¹ [Dr Jeyakumar Devaraj is chairperson of the Socialist Party of Malaysia and a former two-term MP for Sungai Siput

a worker's wage if the SME agrees to not terminate their employment;

- Rent exemptions for businesses operating in government and government-linked company premises;
- Discounted electricity bills, especially for smaller enterprises;
- RM4.5 billion (\$1.7 billion) for programs to improve access to finance for SMEs;
- Possible postponement of compulsory savings and retirement contribution payments into the Employees' Provident Fund;
- Exemptions for manufacturing and service companies on levies currently paid into the Human Resources Development Fund; and
- Postponement of tax payments.

The expansion of domestic demand arising from the cash handouts, totalling about RM15 billion (\$5.7 billion), to the poorest 70% of families, single adults, university students, government employees and retirees, grab [similar to Uber] drivers, taxi drivers and others will help resuscitate SMEs.

Hopefully, these measures, and the boost they will give to the domestic market, will be sufficient to save the majority of SMEs from financial ruin.

Dr Devaraj also addressed wide ranging issues including controlling entry to night markets and food markets, budget deficit, drop in oil prices, restriction of international air travel, payments or assistance for staff who have been laid off, development of other employment opportunities, expansion of food production, production of electric-powered buses, solar farms in every district and reforestation of logged forests and rehabilitation of rivers.

She said: We cannot depend on the profit motive to inspire companies to initiate all this.

Just as we cannot expect private hospitals to handle COVID-19, we also cannot expect the private sector to handle the economic fallout from the pandemic. The PSM thinks the government, working with local authorities, should fill the void and set up local or regional-based agencies to carry out these projects. These are important issues, and they are not insurmountable.

The government's handling of the COVID-19 epidemic and the initiatives undertaken in its supplementary budget are reassuringly measured. Now it should be prepared to listen to ideas from the public and engage with civil society groups about how the current crisis should be managed.

Read the full article at ¹

<https://www.greenleft.org.au/content/malaysia-covid-19-response-must-confront-three-sides-crisis>

And a longer version at

<http://links.org.au/socialist-party-malaysia-look-after-poor-self-employed-covid-19-crisis>

PAKISTAN

HANDS COVID-19 Response

Summary of Actions

<https://handspakistan.wordpress.com/2020/04/11/hands-covid-19-response/>

The recent outbreak of Novel Coronavirus has caused massive catastrophes in China, Italy, USA, Iran and many other countries including Pakistan. The World Health Organization's world emergency declaration was followed by an emergency declaration in Pakistan.

HANDS response

Risk Awareness

- A Telephonic Helpline Number reached by nearly 5,500 needy people; callers are facilitated for medical advice, lab test and food ration as per set criteria.
- Nearly 230 field staff, 2100 Community Resource Persons (CRPs), more than 6400 Community Based Organization (CBO) representatives, more than 11,900 School Management Committee (SMC) Members oriented on COVID-19 preventive measures in 20 districts across Pakistan.
- 1,474 awareness raising sessions conducted through Community Health (Marvi) Workers to ensure COVID-19 preventive measures.
- Awareness raising sessions conducted among 175 Community Microfinance Groups regarding the precautionary measures of COVID-19 in 09 districts of Sindh, Punjab and Balochistan
- 196 Health awareness sessions on breastfeeding, hand washing, social distance and other COVID-19 prevention measures.



Health Services

HANDS 40 Health facilities (Public Private Partnership (PPP) Project at district Malir with GOS, BRSP Project with Eni Oil & Gas Company at Jamshoro, with philanthropist support at Mirpurkhas and Shaikhupura

Punjab) are engaged in facility based COVID-19 awareness-raising campaigns. Some centres are also providing Psychosocial counselling.

Isolation wards are established in Sindh Government Hospitals at Ibrahim Hyderi and Murad Memon Goth Malir under PPPs.

Six Ambulances are deployed to isolation centres and quarantine centres of District Malir - under PPP.

A continuous supply of Personal Protection Equipment (PPE) for 34 Health Facilities under PPP Project at District Malir: includes 66,000 disposable gloves; 25,000 surgical face masks; 3,600 head covers; 2,600 long sleeve gowns; 3,600 shoe covers and 650 hand sanitizers. Also:

- 34 HANDS PPP Project Health Facilities District Malir fumigated.

- Nineteen non-technical staff have been appointed for Quarantine Centres of Dumba Goth and Gadap in partnership with UNICEF.

- Health Care Providers (HCPs) (930) and 3600 Marvi Workers (MWs) have been trained on effective use of Personal Protective Equipment and corona-related interpersonal communication.

- 1,267 villages of 12 districts were reached to continue Reproductive Health and Family Planning services.

- 47,040 community women received essential health services in their villages over last 13 days.

- 66,770 Women of Reproductive Age attended counselling Services.

- 4,566 Children, Pregnant and Lactating Women's received nutrition supplements that is RUTF, IFA, MNP through seven Out Patient Therapeutic Programs (OTPs) through 95 Marvi Workers and 75 LHWs in district Tharparkar.



One of the HANDS supported Isolation Centres established by Government of Sindh

Food Security & Livelihood (FSL)

Food Ration distribution continues to reach 25,000 families in 30 district across Pakistan, through 'HANDS Food for survival Project' in partnership with Philanthropist (to 6,515 families), Medico International

Germany (to 1300 families), Eni Oil & Gas Company (to 3000 families), Community Based Inclusive Development Network and Saaya Independent Living Centre (to 50 persons with disability).

- 200 beneficiaries received livelihood support Interest free loans in Umerkot and Sanghar during COVID-19 emergency;

- 500 rickshaw drivers in Karachi are continuously being supported in Guza.



Ration distribution at Umerkot, Sind

WASH services at Isolation Centres/Health Facilities

HANDS in partnership with UNICEF Pakistan, has initiated 3 months 'Humanitarian Response for COVID-19' for Isolation Centre / Wards of 22 designated Health facilities located at District Karachi, Sukkur, Shikarpur, Khairpur, Naushahro Feroz, Sanghar, Hyderabad, Jamshoro, Tando Allahyar, Tando Muhammad Khan. HANDS will equip the Isolation Ward / Centre in term of PPEs, deploying the support staff, ensuring orientation and training to use the PPEs. In addition we will also mobilize 700,000 population in relation to COVID-19 through awareness raising sessions.

HANDS has provided Hygiene kits (Soaps 6000; Sanitizers 2000 and masks 2000) for 2,000 families to Provincial Disaster Management Authorities (PDMAs) of Sindh and Balochistan.

Networking

HANDS Participated in National forums including Natural Disaster Consortium-NDC, WASH sector partner's forum, Provincial WASH working groups, National Nutrition Working group, National Humanitarian Network (NHN), START Network- to expand and execute COVID-19 respond.

Health Sector: Dr M. Sarwat Mirza- Chief Health & Research-
sarwat.mirza@hands.org.pk

FSL, WASH & Protection: Ghulam Mustafa Zaor Chief Services-
ghulam.mustafa@hands.org.pk

Coordination: Raheem Marri- General Manager Disaster Management Program
raheem.marri@hands.org.pk

THAILAND

‘Twenty-nine provinces have reported no new cases during the past 14 days and nine provinces have never reported cases; suggesting that transmission in almost half of all jurisdictions (38 of 77) are under control.’

By April 18 Thailand had less than 3000 +ve cases of COVID-19 with less than 50 deaths, (Reliefweb ²²).

A state of emergency was declared in Thailand on March 25 with the office of the Prime Minister working with the national public health system for expediency and integrated management. The State of emergency empowered government to restrict travel, declare curfews, and shut down media spreading false information regarding the deadly virus known as COVID-19.

The Emergency declaration included a description of the symptoms of infection as well information about how it is spread together with the description of restrictions that would be imposed to control the spread of the virus. ‘Selective’ lockdown procedures covering the closure of businesses and institutions and social distancing were put in place.

Regulations and guidelines were introduced - such as prohibitions from entering or leaving certain areas, the control of the use of vehicles, transportation routes and the control of goods and medical supplies. Surveillance, screening, and prevention and control measures were promptly implemented. Forty-six Quarantine Offices (to screen arrival and departure passengers) were established in six airports six seaports and 34 ground ports. Hospital Screening was established for all patients with fever with at least one respiratory symptom, and with risk history.

Community education was initiated throughout the country on how to notify local public health officers or the Department of Disease Control (DDC) (using a special Hotline 1422) when people might be meeting travellers who have a fever with respiratory symptoms such as cough, sore throat, runny nose or shortness of breath; and when arriving from the disease infected zones or the risk areas announced by the Provincial Communicable Diseases Committee.

Those travellers were required to allow officials or health volunteers to implement investigation and monitoring and to impose self-quarantine according to instructions.

On April 3, the government declared a nationwide curfew, banning people from leaving home between 10

pm and 4 am until the end of the month, in an effort to control the spread of the disease.

Thailand Strategic Objectives

- Limit transmission to citizens and health care workers
- Train and equip healthcare facilities to manage large numbers of COVID-19 patients
- Address crucial unknowns regarding clinical severity, extent of transmission, viral shedding, treatment options, and accelerate the development of diagnostics, therapeutics and vaccines
- Communicate risk and event information to all communities and counter misinformation
- Minimize social and economic impact through multisectoral partnerships

Financial Relief and Food Supply

Measures to aid and relieve the impact of the COVID-19 outbreak on the Thai economy were put in place (The Ministry of Finance, Thailand) ²³ and special loans, social security provisions and salary relief were put in place for Individuals. Thailand's food supply strategy focussed heavily on maintaining local food production covering agriculture and processed food. However, distribution of emergency food and other essential supplies was organised with local government and non-government community organisations.

On April 18, twenty-nine provinces had reported no new cases during the past 14 days and nine provinces have never reported cases; suggesting that transmission in almost half of all jurisdictions (38 of 77) is under control.’ ²⁴

The Centre for COVID-19 Situation Administration (CCSA) spokesman Taweasilp Visanuyothin said the government in coming days would discuss allowing some businesses, for example, barbers, mobile phone and appliance shops, general stores and banks, to reopen, albeit with special measures in place.

Dr Tanarak Plipat, deputy director-general of the Disease Control Department, said the reopening of the country will come in tandem with the strategic testing of three groups of people in the 44 provinces that have not reported cases for the previous 14 days.

Experts are considering on how the country should move forward after the government signalled its intention to begin easing restrictions on movement and businesses at the end of this month if the number of coronavirus cases continues to fall. ¹⁹

²² <https://reliefweb.int/report/thailand/coronavirus-disease-2019-covid-19-who-thailand-situation-report-18-april-2020>

²³ <https://www.grantthornton.co.th/campaigns/coronavirus-covid-19/>

²⁴ <https://www.bangkokpost.com/thailand/special-reports/1902570/post-lockdown-roadmap-takes-shape>

NEW ZEALAND: COVID-19 under control

Relief and exhaustion – move to ease lockdown

https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12326278

As a small upper income island country NZ is in a favourable position to manage a pandemic. One particular feature of the approach has been the daily information provided by the Prime Minister Jacinda Ardern. Her initial explanation to NZ people can be seen here

<https://www.tvnz.co.nz/one-news/new-zealand/coronavirus-alert-system-introduced-new-zealand-jacinda-ardern-announces>

At April 20 New Zealand had had 1440 cases of Covid-19. Twelve people had died while 974 people have recovered. From Tuesday April 21, New Zealand would begin easing its national lockdown but only after a five-day extension of some of the world's strictest COVID-19 restrictions. The country would then remain at alert level three for two weeks, before a further government review and decision on May 11 about whether to relax restrictions further.

Prime Minister Jacinda Ardern said the sacrifice New Zealanders had made to date has been huge, but the short extension of level four conditions – to cover a public holiday long weekend – had locked in the gains made and provided added certainty. The PM reiterated New Zealand's goal of eliminating COVID-19:

‘Elimination doesn't mean zero cases, it means zero tolerance for cases. It means when a case emerges, and it will, we test, we contact trace, we isolate, and we do that every single time with the ambition that when we see COVID-19, we eliminate it. That is how we will keep our transmission rate under one, and it is how we will keep succeeding.’

In March, New Zealand had made the big decision to adopt an elimination goal in response to COVID-19 and to go into a very tight lockdown. On April 14 Professor of Public Health at the University of Otago Michael Baker said ‘That move achieved much in terms of reducing virus transmission and giving us time to get key systems working to ensure we can sustain elimination’.

‘The discussion now is all about coming out of alert level four in a way that provides a high level of certainty we will achieve elimination.

‘There are reasons we need to be cautious. The modelling work conducted by Te Pūnaha Matatini suggests we need two more weeks in lockdown to improve the chances of virus elimination. There are also concerns about partial opening of schools and early childhood centres at alert level three when there is uncertainty about the role of children in COVID-19 transmission. That said, the move down to level three on April 28 is probably a manageable compromise. We need to get businesses working again for the health of people and the economy.’

Associate Professor of Epidemiology and Environmental Health at the University of Canterbury Arindam Basu, noted that new clusters will emerge, but COVID-19 is under control. He explained ‘In the absence of a vaccine, New Zealand has been successful in containing the epidemic using strong public health measures. Combine this with increasing numbers of tests and contact tracing: the claim that community transmission is under control and transmission rate is low is fully justified.

We have ramped up our contact tracing at this stage and this will be sure to interrupt the chain of transmission of new outbreaks, as contact tracing and isolation will quickly bring the effective reproduction number under control. We may continue to see some new clusters emerge but they can be quickly addressed and mitigated.

The 2nd edition of *Where There Are No Pharmacists* is now available from Third World Network (TWN) in Penang, Malaysia twn@twnetwork.org

It includes expanded sections on:

Antimicrobial resistance and the need for wise use of antimicrobial medicines. This section includes practical strategies to help health workers manage antimicrobial medicines wisely in their community.

Tuberculosis (TB) TB has become much more difficult to treat because some TB bacteria have become resistant to the medicines previously used to treat TB. This expanded section includes more strategies to help community people understand TB and the best ways to cure the disease completely

Medicines and older people Not all older people are frail but older people often suffer from a number of conditions and need several medicines at the same time to manage their conditions. Their treatment can become complicated. Information is provided to help the health workers, carers and the people themselves understand and manage their conditions.

The use of zinc with oral rehydration salts (ORS) for diarrhoea in children In children, ORS should be given together with zinc tablets. Zinc is a mineral in our body that is lost when we have diarrhoea. Zinc together with the ORS will help a child get better quickly and increase the child's resistance so s/he will not catch diarrhoea again for the next two or three months. This section provides instructions on preparing ORS and zinc to give to a child with diarrhoea.

Waste management Guidelines are provided for having as little waste as possible and for safe disposal of any unavoidable waste. Medical waste can be hazardous; if you do not dispose of it correctly, health personnel, waste handlers, and the community risk being seriously injured or infected.



Treatment for COVID-19

Current clinical management includes infection prevention and control measures and supportive care, including supplemental oxygen and mechanical ventilatory support when indicated.

No therapeutics have yet been proven effective for the treatment of severe illness caused by the coronavirus COVID-19. However very important studies are underway to determine possible treatments and their roles.^{25 26 27} It is important for everyone to follow the lead of scientists.

Rumours on the Internet and social media are the least reliable sources of information as well as being potentially dangerous. Politicians are not qualified to provide scientific advice.

Over the course of only a few weeks, posts online, the media and politicians turned chloroquine from an unknown drug to a 100% coronavirus cure, misleading the public on its effectiveness and engendering unintended but negative consequences. Hydroxychloroquine and chloroquine as treatments for covid-19 are not yet backed by reliable scientific evidence.*[#]

Attention on (hydroxy) chloroquine as a potential treatment in COVID-19 has become a serious problem:

- the evidence for its usefulness is very weak; the original study has several weaknesses
- this essential medicine is now very hard to get as everybody wants it; the price has increased
- patients who really need it (for treating Lupus or Rheumatoid Arthritis, or for certain types of malaria) are endangered
- the efficacy is doubtful, but the side-effects are real: people taking HCQ or CQ without proper medical advice are at risk of serious cardiac side-effects (QT prolongation)

Several other drugs, eg antiretroviral drugs, investigational antivirals, immunotherapeutic, host-directed therapies are under investigation and in clinical trials. A lopinavir–ritonavir²⁸ trial showed no difference in response between intervention and control groups and the lopinavir–ritonavir treatment was stopped early in 13 patients (13.8%) because of adverse events.

Remdesivir is the most promising broad-spectrum antiviral - originally developed to treat Ebola but found to be ineffective. Trials by the Gilead company are currently underway. The NEJM reported that definitive conclusions from the earlier Gilead trial were not possible due to the small sample size and many uncontrolled factors; but the findings from these uncontrolled data will be informed by the ongoing randomized, placebo-controlled trials of remdesivir therapy for Covid-19.

<https://www.nejm.org/doi/pdf/10.1056/NEJMoa2007016?articleTools=true>

Tocilizumab (an immunosuppressant drug used for rheumatoid arthritis) is undergoing trial in Malaysia.

<https://www.nst.com.my/education/2020/04/583940/um-leads-clinical-trials-tocilizumab-covid-19-treatment>

* Is (hydroxy)chloroquine effective in COVID-19?

The study by Gautret et al that mentions the beneficial effect of hydroxychloroquine (+azithromycin)

<https://www.sciencedirect.com/science/article/pii/S0924857920300996?via%3Dihub>

has been severely criticized by Hulme et al

<https://www.medrxiv.org/content/10.1101/2020.03.31.20048777v1>

and subsequent studies found no clinical benefit

(<https://www.sciencedirect.com/science/article/pii/S0399077X20300858?via%3Dihub>

but did find the well-known cardiac side-effects (QT

prolongation) <https://www.medrxiv.org/content/10.1101/2020.04.02.20047050v1>

These findings indicate that it is necessary to await real randomized clinical trials before procuring or using (hydroxy)chloroquine...

There was a huge demand for hydroxychloroquine after preliminary trials in China suggested it boosted recovery and lowered the severity of the coronavirus disease.

April 9 -The ICMR stated that it won't recommend hydroxychloroquine (HCQ) medicine for Covid-19 patients unless tests show satisfactory results.

<https://www.hindustantimes.com/india-news/icmr-updates-testing-strategy-for-covid-19/story-gXlpBcq40wEiL3QAXFqZL.html>

²⁵ Lancet: Use of antivirals to treat COVID-19 [https://doi.org/10.1016/S2214-109X\(20\)30114-5](https://doi.org/10.1016/S2214-109X(20)30114-5)

²⁶ Discovering drugs to treat coronavirus DOI: 10.5582/ddt.2020.01012

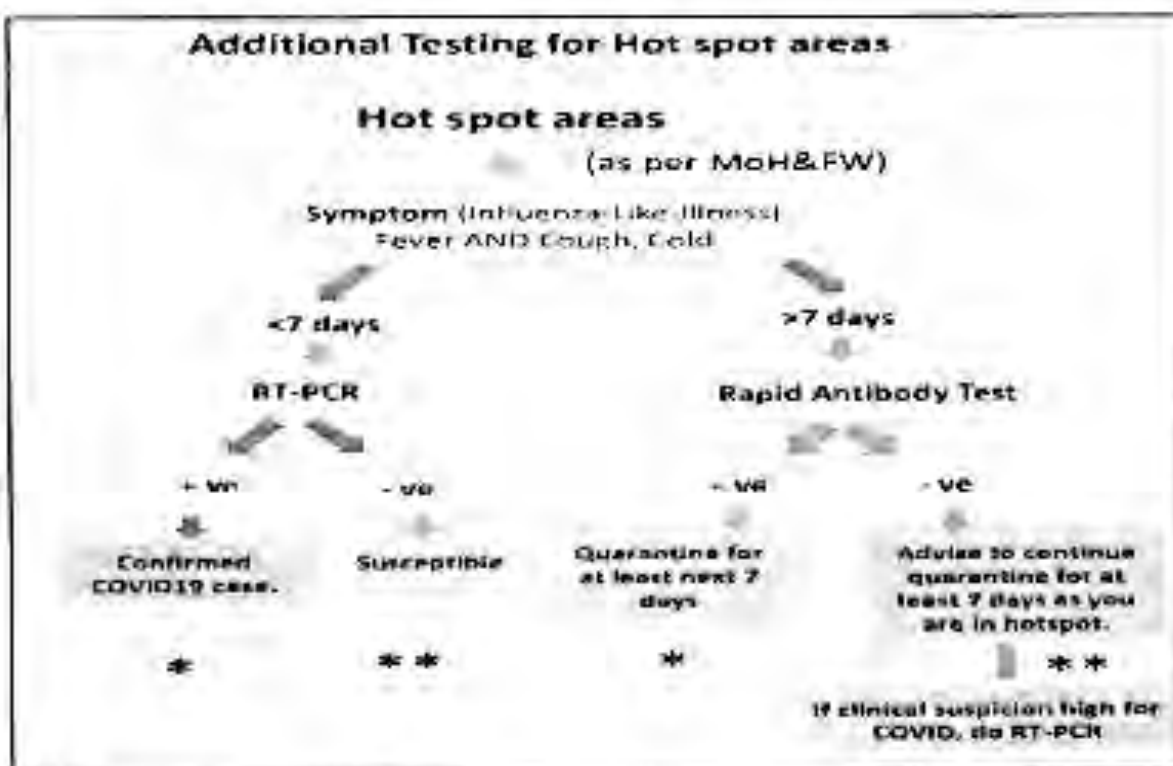
²⁷ Tamiflu_GL-019936.pdf

¹⁷ <https://www.nejm.org/doi/full/10.1056/NEJMoa2001282>

A. COVID-19 Testing Strategy for India (Recommended for the entire country)

Real-Time PCR (RT-PCR) test and Point-of-Care molecular diagnostic assays are recommended for diagnosis of COVID-19 among individuals belonging to the following categories:

- All symptomatic individuals who have undertaken international travel in the last 14 days
- All symptomatic contacts of laboratory confirmed cases
- All symptomatic health care workers
- All patients with Severe Acute Respiratory Illness (fever AND cough and/or shortness of breath)
- Asymptomatic direct and high-risk contacts of a confirmed case should be tested once between day 5 and day 14 of coming in his/her contact

B. Additional (in addition to A) Testing recommended in hot spots

- * Refer to Hospital if symptoms appear / worsen
- ** Follow precautions, social distancing, use masks, frequent hand washing, avoid unnecessary travel)

Testing for COVID 19 ²⁹

What are Rapid Diagnostic Tests (RDT)?

A RDT is typically a qualitative (positive or negative) lateral flow assay that is small, portable, and can be used at point of care (POC). RDT tests may use blood samples from a finger prick, saliva samples, or nasal swab fluids. RDTs are often similar to pregnancy tests, in that the test shows the user coloured lines to indicate positive or negative results. In the context of COVID-19, these tests most frequently test for patient antibodies (IgG and IgM), or viral antigen. In some cases, it can be beneficial to measure baseline (before infection) of IgG and IgM titers. There has been some concern about the accuracy of RDTs and the quality of some has been questioned.^{30 31}

What are Serology-based tests for COVID-19?

Serology testing for SARS-CoV-2 is at increased demand in order to better quantify the number of cases of COVID-19, including those that may be asymptomatic or have recovered. Serology tests are blood-based tests that can be used to identify whether people have been exposed to a particular pathogen by looking at their immune response. The serological test is for the purpose of surveillance to generate data and understand whether people have been exposed to the virus and are recommended by the Indian Council of Medical Research (ICMR).³²

Rapid Antibody Testing

Rapid antibody testing, looks for antibodies to the virus made by the body. Tests are quick and easy to use and offer the opportunity to do widespread testing. They come in kit form and can be used with a finger prick blood sample. However, they cannot accurately detect infection that has been recently acquired and should only be used in assessing whether someone has previously been infected and has developed an immune response.

Why do we need antibodies tests?

These tests can give detail into the prevalence of a disease in a population by identifying individuals who have developed antibodies to the virus.

What are RT PCR tests?

In contrast, the RTPCR tests currently being used globally to diagnose cases of COVID-19 can only indicate the presence of viral material during infection and will not indicate if a person was infected and subsequently recovered. Samples from urine, blood, saliva, sweat, serum, and other fluids can be tested. These tests can be in short supply.

Pooled testing

In this method, multiple swab samples are pooled together and tested using a single RT PCR. If the result of a collection of samples comes negative, then that means all the samples in that group are negative. However, if the result of one collection is found positive, then each of those samples is tested individually. This method makes testing faster, decreases cost and makes the best use of available supplies. The method has been approved by the ICMR.³³

Can RT PCR be negative and IgM positive ?

Serologic tests, as soon as generally available and adequately evaluated, should be able to identify patients who have either current or previous infection but a negative PCR test.

Can we go for viral culture?

For safety reasons, specimens from a patient with suspected or documented COVID-19 should not be submitted for viral culture

²⁹ <https://www.who.int/news-room/commentaries/detail/advice-on-the-use-of-point-of-care-immunodiagnostic-tests-for-covid-19>

³⁰ The reliability of rapid tests has questioned with some doubt about the quality of the tests or the way they have been used,

³¹ <https://www.bbc.com/news/world-asia-india-52378265>

³² <https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/covid-19-icmr-invites-bids-for-antibody-kit-for-virus-diagnosis/articleshow/74818887.cms?from=mdr>

³³ https://economictimes.indiatimes.com/news/politics-and-nation/uttar-pradesh-to-start-pool-testing-for-covid-19-to-expedite-process/articleshow/75122742.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

Related Issues

ACCESS TO SAFE ESSENTIAL MEDICINES

COVID-19 pandemic increases the chance that your other medicines won't work

27 reasons why

Elizabeth Pisani, March 30

<https://medium.com/@elizabethpisani/the-covid-pandemic-increases-the-chance-that-your-other-medicines-wont-work-66b7e272bb20>

Read the 27 reasons in full here:

http://www.haiasiapacific.org/wp-content/uploads/2020/04/PisaniWhyDrugsWontWorkCOVID19_Mar2020.pdf

Elizabeth Pisani: For a couple of years now, I've been working with researchers based in universities and data firms in Indonesia, Singapore, and the Netherlands to figure out why legitimate pharma companies make bad (substandard) medicines, and why people buy and take them. We look at fakes, too. How do the criminals that make them choose what to imitate, and who to sell to? What we've learned allows us to predict how Coronavirus will affect medicine quality globally.

The World Health Organization has been warning that fake and substandard medicines are on the rise globally. Until recently, the problem has been concentrated largely in countries where most people pay cash for medicines, and where medicine regulation is weak or non-existent. But the hyper-globalised pharmaceutical market is changing that. And the Coronavirus pandemic, an equal-opportunity screw-up of business-as-usual, is about to bring poor quality medicines to your medicine cabinet, wherever in the world you live.

Not just COVID-related meds, you understand. Rising demand, falling supply, public panic, knee-jerk nationalism and distracted regulators will increase the risk of getting bad medicines for diabetes, heart disease, depression, rheumatism, cancer and virtually everything else. In virtually every country.

It's no great surprise that the answer to most of the questions above boil down to money, though political pressures have a role to play, too.

*Criminals thinking about making **falsified medicines** are looking for opportunities to make profits, while minimising their risk of getting caught and punished. Market opportunities are richest when there's a local shortage of a legit product that people desperately want.*

The likelihood of getting away with selling fakes is greatest when:

- buyers (at any point in the supply chain) deviate from tried, trusted and effectively regulated sources, or worse, buy online.

- the regulator in the country of sale doesn't look too closely at medicines once they are already out in the market
- the judicial system is not good at prosecuting or jailing offenders.

It's worth noting that criminals are free of the shackles that bureaucracy, quality assurance costs, research standards, or reputational risk lay on producers of genuine medicines, so they will usually be several steps ahead of legitimate producers in "bringing new products to market".

*Legitimate pharma companies (from big-name multinationals to small generics producers in poorer countries) are also in the business to make money. Squeezed profit margins encourage legitimate manufacturers to cut costs, compromising quality and leading to **substandard production**.*

These substandard meds are most likely to reach patients if:

- the regulator in the country where they are made doesn't do a good job of overseeing production (sometimes because politicians care more about promoting industry than they do about assuring quality, especially of medicines that will go to patients in other countries);
- the regulator in the country where they are consumed doesn't do a good job of checking product quality (sometimes because politicians care more about being seen to provide affordable medicines than they do about ensuring that the medicines actually work).

Most better-off countries are subject to some of these factors, but rarely all of them at once. COVID-19 is changing that. We believe the pandemic is going to put all these risk factors on steroids, for lots of products, in lots of markets. Here's how it will happen:

27 reasons are presented within the following influencing factors as to why shortages will create new market opportunities for falsified medicines:

- Demand will rise while supply will fall (at least for some markets)
- Profits for falsifiers will rise
- Risk of getting caught will fall
- More buyers will step out of regulated and/or secure supply chains
- Regulatory oversight over supply chains will be eroded
- Substandard medicines will be circulated
- Profit margins of legitimate companies will be increasingly squeezed because production and distribution costs will rise while income may fall

- Technical capacity won't always be up to scratch, but errors are less likely to be spotted by regulators

What can we do about it?

Most of these problems are rooted in two fundamental (and intertwined) mismatches in the global economy. First, we increasingly look to governments to ensure that demand for affordable medicines is met, while relying on profit-seeking companies to supply that demand. That leads to procurement and production practices that incentivise cost-cutting and undermine product quality.

Second, we want both the price-lowering (and pollution-outsourcing) efficiencies of a globalised supply chain, while simultaneously demanding security of supply at the national level. As the current pandemic is teaching us, you can't have it both ways.

Fixing those fundamental flaws in the global economic model is way above the pay grade of our research team. But in the meantime, we can use our analysis at least to flag up which medicines are most at risk, right now. None of the factors above is, all by itself, a clear indicator that a particular medicine is overly likely to be substandard or falsified. But when factors 1–15 are combined into an index:

*Indicators of rising demand **and** indicators of restricted supply **and** indicators of good potential profits **and** indicators of low risk of getting caught; for a specific product (and sometimes even a specific brand) in a specific market...*

... then we have a clear indication that the product might well be a fake. Regulators can use the index as an early warning system to trigger inspections, and to warn pharmacists and the public to view particular products or sources of supply with caution.

Ditto for factors 16–27; if a product ticks a lot of those boxes simultaneously, it's at high risk of being substandard. If the national regulator is unable to respond by ramping up inspections and closing non-compliant producers, either because they are politically hamstrung or because they don't have the capacity, a flagging system can at least help buyers to make better choices.

In Indonesia, where some of us are based, we were (before the pandemic struck) working with the national medicine regulator to try out a system that uses market data to flag products at high risk of being substandard or falsified (we call it MedsWatch). We're still in the early stages, but it looks like it works pretty well. Well enough, indeed, to justify retooling our indicators for the 27 risk factors listed above, to develop an early warning system for the quality of medicines affected by the COVID-19 pandemic.

Watch this space. And in the meantime, please don't stockpile meds (which will contribute to lots of problems

for other people), or buy your pills from unregulated online stores (which may well end up being a problem for you yourself).

Written by Elizabeth Pisani, on behalf of the informal MedsWatch research group, currently: Elizabeth Pisani, Amalia Hasnida, Koray Parmaksiz and Maarten Kok, *Erasmus University, Rotterdam*; Yusi Anggriani and Mawadati Rahmi, *Universitas Pancasila, Jakarta*; Aksari Dewi, *The George Institute for Global Health, Sydney*; Steven Harsono, Yee-Theng Ng and Annie Wang, *IQVIA Public Health, Singapore*.

Does BCG³⁴ Vaccination provide some protection against COVID-19

On April 12 WHO issued a statement saying

'There is no evidence that the Bacille Calmette-Guérin vaccine (BCG) protects people against infection with COVID-19 virus.'

Two clinical trials addressing this question are underway, and WHO will evaluate the evidence when it is available. In the absence of evidence, WHO does not recommend BCG vaccination for the prevention of COVID-19.'

WHO continues to recommend neonatal BCG vaccination for prevention of TB. In many countries neonatal BCG is routinely administered and studies have shown BCG reduces the level of virus when people are infected with other viruses. The vaccine also boosts people's 'frontline' immunity, training it to respond to other subsequent infections with greater intensity.

Researchers hope this improved 'innate' immunity could reduce the impact of COVID-19 and provide crucial time to develop and importantly, validate, a specific anti-SARS-CoV-2 vaccine.

The South Australia Medical Research Institute (SAHMRI) is partnering with SA Health and the Murdoch Children's Research Institute (MCRI) Melbourne^{35 36 37}, Australia, in a randomised controlled trial using 4000 healthcare workers directly involved in the care of COVID-19 positive patients from across Australia to investigate whether existing BCG vaccination can reduce the effects of COVID-19 infection by providing an immune system boost to protect against the worst of COVID-19's symptoms.

³⁴ Bacillus Calmette-Guérin (BCG) is a vaccine that was developed against tuberculosis and is still given to more than 100 million babies annually for that purpose.

³⁵ <https://www.abc.net.au/news/2020-04-11/trial-to-test-if-tuberculosis-vaccine-boosts-covid-19-immunity/12142230>

³⁶ <https://clinicaltrials.gov/ct2/show/NCT04327206>.

³⁷ <https://www.sahmri.org/BRACE/>

MESSAGE FROM EPN

Our partner in East Africa

Richard Neci Cizungu,
Executive Director



COVID-19 started in one region and now a global menace. This once again draws our attention to the realities of our health systems, especially in low-resource settings where majority of our interventions are implemented. It also reminds us of the role of infection prevention and control, access and supplies of medical product, healthcare staffing and how ready we are to handle health emergencies in addition to the challenges we already face. It underscores the significance our relentless commitment, partnership and collaboration, and calls us to consistent efforts to strengthen our health systems through our various interventions.

We are also aware of risks arising from such outbreaks, such as stock outs or rise in prices for some items making financial accessibility difficult for health facilities. Such Pandemic periods also serve as a malicious opportunity for pharmaceutical criminals to take advantage. The sale of poor quality pharmaceuticals is an expected risk. We ask our member Drug Supply Organizations to share their availability with us in real time so that we can relay such information to other members. We also recommend that you make sure that the drug supplies for your health facilities are made in accordance with the supply chain systems established in the respective countries.

As part of EPN's strategic priority area; Research and Information Sharing, EPN is going to open an online discussions platform where members can share their views and experiences on various topics. Each open topical discussions will take a period of 2 weeks. The summary of these discussions will be shared with all members.

<https://www.epnetwork.org/statement-on-covid-19/>

Here at the Secretariat, we continue in our course towards promoting access to just and compassionate quality pharmaceutical services. Even so, we have taken necessary preventive measures to protect our staff according to the recommended guidelines and advisory. The EPN staff are now working remotely as we continue to monitor the situation.

We advise and encourage that you stay informed and take necessary measures to stay safe and observe the guidelines provided by WHO and the relevant authorities. EPN will continue to share useful information through our various communication platforms in response to this outbreak and keep you informed. As we continue with our work, we will also keep you updated as usual on our respective projects, activities and events.

The COVID-19 drug pipeline

In the Lancet April 17 Asher Mullard asks 'Do we need 300 trials? Is that a good use of resources?...'?

Read the full article here

<https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930894-1>

For pandemic preparedness experts, this begs crucial questions. "Do we need 300 trials? Is that a good use of resources?" asks Daniel Bausch, director of the UK Public Health Rapid Support Team and infectious disease expert at the London School of Hygiene and Tropical Medicine. 'I would probably say we don't.'

There are good reasons to build up a full pipeline of COVID-19 drugs. Up to 90% of new entrants into clinical trials never make it to approval, and so investigators want to have as many shots on goal as possible. Scientific understanding of COVID-19 is also changing so quickly that it makes sense to keep options open. But other motives, including public relations and financial gain, might also be in play. 'During a crisis, some people will go out of their way to sacrifice their lives, and others will hoard medicines and be complete jerks. On institutional levels, we have the same span of good actors and bad actors', says Bausch. And in the absence of comprehensive trial coordination mechanisms, signs of disarray are emerging. 'The scale of these trials is too small, and the variation in terms of how they are being run is too large', says John-Arne Røttingen, chief executive of the Research Council of Norway and proponent of a more 'These trials aren't really designed to answer the questions that need to be answered.' Clinical trial literature, moreover, is riddled with drugs that looked promising in small trials only to prove ineffective in bigger, more rigorous studies.

Researchers have been finding preliminary antiviral efficacy signals with repurposed agents including hydroxychloroquine for decades, says Bausch. But these rarely translate into clinical success. 'I have no optimism for hydroxychloroquine', adds Bausch. 'I am not opposed to the study of hydroxychloroquine. But I am opposed to what I'm seeing around the world, with this drug being worked into clinical algorithms already'.

WHO has now taken steps to provide greater coordination through its Solidarity trial, a study of four therapeutic approaches for hospitalised patients with confirmed COVID-19. These consist of Gilead's RNA polymerase inhibitor remdesivir, the antimalarials hydroxychloroquine and chloroquine, the HIV protease inhibitors lopinavir and ritonavir, and lopinavir and ritonavir in combination with the immunomodulatory agent interferon beta-1a. First results could be available within 12–16 weeks, insiders say.