INDIA'S PUBLIC HEALTH RESPONSE TO COVID-19 WITH DR. EDMOND FERNANDES, MD

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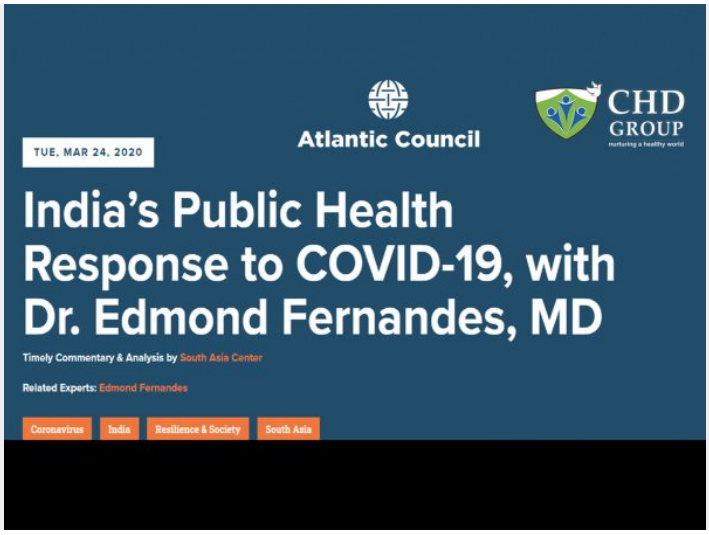

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Let's just start with the basic facts. To the best of your knowledge as of this evening, March 24, 2020, what is the situation in India right now. What are the total number of infections, what has been the main origin, is there community spread occurring in India as far as you can tell, and what is the basic testing capacity? Do we have the capacity to know what the situation truly is?

This morning the Ministry of Health Website reported 415 positive cases but when I checked the Ministry site again just a while ago it reported 402 cases, which is interesting enough. If you had cases that were discharged you should have technically shifted and increased the numbers, but now the question is are the tests going into false negatives, or false positives? Are we testing false positive cases that are suddenly reading as negative? That's a point of contention as well.

In terms of community spread, I think the Indian government has realized just on time that a lockdown is necessary for survival. Otherwise, this virus is going to force a lockdown in the next one month. From that perspective, India has been very lucky. China, Iran and South Korea were affected

first, so we had reasonably time to understand the methodology of the virus, to understand the containment measures, to understand what the chances are that things will get worse. Yes, our health system is not that great and the world knows that fact. But at the same time, how do we really protect our citizens in a complex nation of 1.2 billion? This is a litmus test for our health system, for policy makers, and for the government itself.

Given that litmus test analogy, are we really prepared? Do hospitals have the necessary emergency capacity – whether that be beds, staff, personal protective equipment, the supply chains for ventilators and masks? Are hospitals and public health centers, the front lines for health workers, getting the support that they are going to need as this gets worse?

In one word, no. The need for increasing diagnostic tests is imminent. What we are proposing to state, national and even district level administrators is to contain this… we need to make COVID-19 exclusive wards, and if achievable, COVID-19 exclusive hospitals. Right now in a state like Karnataka, Bangalore has declared that they've converted Victoria Hospital to a 1,500 bed COVID -19 hospital in preparation. But even a Tier II city like Mangalore has positive cases for COVID now. What is our methodology other than social distancing and lockdown? We will need to do more than that.

Additionally, what the government could have done – instead of bringing in authoritarian egoism – is engage proven civil society organizations to spread authentic messages. Every NGO working in different sectors has a sizeable database which could have pushed genuine, authentic communication to the masses and lead to a decrease in panic. What intrigues me the most is that people are still trying to understand where they can get masks and what type they need, while in reality, you really do not need a mask. This isn't the best of times, but a little bit of grandmother's sense would have done things a lot better for India.

I mean, we're still at four hundred fifteen cases compared to other countries. But if you extrapolate from the data from Lombardy, Italy and apply it to our population numbers, Karnataka would probably see around 80,000 cases in Bangalore alone, of which 2,000 to 3,000 would probably need ventilator care, let alone those in Tier II and III cities and rural areas.

Coming back to your question concerning personal protective equipment, healthcare workers need to use an N95 respirator mask and, if the state of the patient is known and depending on the type of intervention, surgical gowns and suits are also encouraged. There is a currently a shortage of surgical masks, let alone N95 respirators. In primary health centers in rural areas, doctors don't even use masks. This all leads to the point that we are probably buying as much time as possible .

You raised in your last response this issue of behavioral change communication – of getting the right information out. The World Health Organization has described this pandemic as also an infodemic", and our colleagues at the Atlantic Council have been documenting the spread of misinformation about this. India is one of the Ground Zeros for misinformation originating from platforms such as WhatsApp. Just yesterday at the Prime Minister's request there was a voluntary curfew but at the end of the day at 5 pm there was this scene of Indians in masses making noise – in one sense an incredible demonstration of solidarity and community spirit but at the same time, for a lot of observers, scenes of large throngs of people in the street standing shoulder to shoulder seemed like the basic message of social distancing had yet to be understand and accepted. Can you tell us a bit about the most effective ways of communicating these complex ideas about public health to average citizens, many of whom may still be have limited literacy or minimal levels of education etc.?

Our experience as a grassroot level service provider organization, particularly working with the UN and the Government, has been that behavior change can easily be brought about only by creating fear. For example, we were working to reduce the burden of severe acute malnutrition in under aged five children in six districts in India. When we told mothers that their child were severely malnourished, the mothers really did not want to get their children treated for malnutrition or even admit their children into a rehabilitation center. The beauty of a nutrition rehabilitation center is that the government pays the mother for each day. She is given free food. The child is given free food. Medical care is free. In spite of that, they refuse to stay.

What we had to do was tell the mother that if her child continued like this, her child could possibly die in some months. That is when we often observed a reaction. This panic or fear is often a motivation for behavioral change. I recognize as a healthcare provider that it isn't the best of options, but you also need to weigh India in terms of literacy levels and in terms of education and school. Unfortunately, this approach has worked in our favor, and allows us to say, "Okay if your child is going to die you need to provide immediate solutions and this is what you have to do." That has brought on behavior change.

Extrapolate some of that into the Indian setting – just this morning we got a message saying, "okay doctor, you've been doing a lot of things in natural disasters. Do something here. I think we can otherwise probably relax. People are saying it isn't that bad." My response was, "If you say it isn't that bad, then just prepare more coffins, more burial grounds, and we can just dispose of people in the hospitals." And that person immediately remarked, "Oh my god that's scary."

Historically elections have not been won based on the healthcare agenda. Healthcare has never been a priority for politicians or for vote banks. So, you can imagine even a virus of this nature – until it paralyzes your daily lives, that is when you will begin to accept the fact of ownership in health

care. Community ownership in healthcare can only built this way in a country as diverse, complicated, and intellectually mixed as India.

That's a fascinating point. It really illustrates the difficulty that many people have in understanding and assessing risk. I know that you consult and talk to governments all over the world, including of course the Indian government. Do you think that the Indian government has fully grasped the risks associated with COVID-19?

I don't think so. Luckily this time around we have a Health Minister who is a qualified healthcare provider. Otherwise if you look at our bureaucracy, they are not from healthcare backgrounds. Of course, the bureaucracy and the civil service have a certain kind of egoism, and the tendency not to listen to others definitely exists.

Drawing examples, bringing in emotional conversations, and emphasizing stories and narratives are ways attention could be caught. This reminds me a book called *Safe Patients Smart Hospitals* by Peter Pronovost. This was a study done by Johns Hopkins many years ago where he tried to understand how you communicate to the doctors at Johns Hopkins University – who consider themselves to be the best in the world – that they commit mistakes and that patients are dying due to preventable errors. This is a population that can access statistics and data at their fingertips, so what do we do? The only solution effective solution was to call the patients' relatives and tell them to communicate straight what it means to grieve a loss in your own life. This is the only thing that could a cold-hearted doctor or, in this case, a cold-hearted red tape bureaucracy.

We are learning a lot more about which populations are most vulnerable to COVID-19, in particular in terms of fatality. What we're seeing out of Lombardy, Italy is that older people in particular seem more susceptible. As I understand it the initial research out of China and Italy seems to suggest that people with smoking histories and pre-existing health conditions are more vulnerable. In India, especially in the north of India, there is a well-documented pollution crisis that has led to rises in emphysema and other non-communicable disease related to pollution. Does that make India more vulnerable to COVID-19, or does the fact that India for the most part has a younger population mean that there should be fewer hospitalizations and fewer deaths due to the disease?

I think to link pollution to COVID-19 would be very premature. There is very little evidence to suggest that pollution levels have triggered death in patients who have died. Nevertheless, what we need to understand is that living over the years in a polluted environment would definitely leave long-standing respiratory issues.

In terms of the virus, fatality is directly connected with comorbid health conditions, where the immunity level of the body to fight the virus becomes compromised. This is where we lose elderly patients, particularly those with cardiac ailments mixed with diabetes or other respiratory issue. This where you end up eventually putting them on respirators due to breathing difficulties and lose the fight to the virus. But otherwise while air pollution is an issue, in terms of COVID I don't think that connection will go anywhere anytime soon.

If you could advise the government – whether it be the government of Mangalore, of Karnataka, or of India – as to what they should be doing today, what would that advice be? How severe a lockdown needs to be implemented in your opinion? Given the economic consequences of a lockdown, should policymakers be waiting, or is now the time to act?

I think India has already missed the bus. The lockdown should already have occurred two weeks ago. Now we also have imported cases from Indian nationals and also foreign nationals carrying the virus. It can of course still be contained given the lockdown measures now being implemented, but let's understand the fact that we need fourteen days of lockdown. The Janta curfew of one voluntary day is not going to help. Yes, India has invoked the Epidemic Act and Disaster Management Act, rules are being cited, sweeping powers are being granted to bureaucrats – the question that concerns me the most is there is a leakage in all of this that does not seem to have been plugged.

Very recently Karnataka formed a state task force – and I'm sure other states have formed task forces of similar nature – but this ideally would have been formed at a district level. And the district level task force should have involved community health physicians, public health professionals, infectious disease experts – not for heaven's sake Indian Administrative Service Officers. How do you form a task force with IAS officers who are going to quote rule books? You need to listen to doctors at this time. The Indian Government has done surprisingly well but it could have been better than this had they involved NGOs. This has been my major source of advice. I've been trying to advocate for this – engage NGOs in advocacy, in risk communication, in preventive strategies, and in behavioral change strategies. This could itself have snowballing effects among the population.

Rather what is happening now is every person is taking a selfie, shooting some kind of video, pushing it to WhatsApp groups that gets forwarded. People just end up watching all kinds of video and you don't know what is authentic now.

Additionally, the Health Minister could have gone every evening on record addressing the press and country and giving the situation report. That would have been ideal. But nevertheless, participating, networking and collaborating with organizations that have worked with the Ministry before, who have worked with the United Nations, should have also been cast into. Mind you India is a very rich

country in terms of human resource. It may be not be in terms of doctor to patient ratio but in terms of intellectual capital it is. Why are we not cashing it in at the moment?

That's a fundamentally crucial question. You have written elsewhere that this pandemic is likely to change the face of global public health. Can you expand on that idea? What changes do you think will occur because of the lessons we end up learning from COVID-19?

It takes me back some years ago to my conversations with US State Department officials. I floated this idea that every embassy in the world should have a global health expert in the Missions. You look at health, which is demonstrated live through SARS, through MERS, through coronavirus, and you look at natural disasters, which are all transboundary in nature. These issues do not permit any country or any official to say that their country can do it all. So, having global health experts as part of the embassies would work to strengthen humanitarian diplomacy around the world, and would really work in favor of policymakers shaping their agendas through informed risk planning.

As far as how this is going to change the way global health works, you have companies working on artificial intelligence that are now looking at healthcare intelligence. You have remote monitoring, you have video consultations, you have reports being dispatched on official WhatsApp groups being created. This is becoming a new normal as a way of life.

This is even going to change the way schooling in public health works. Some years ago schools would never have considered e-learning. They would have said, "What is that? Kindly report to university or college." But today if you are going to survive through the next two or three months you will do so through e-learning and e-exams. This will really work in favor of the human race. It will free time for family, and It will bring us back to days of appreciating life, of nature, the best things of life. Maybe it will bring us back to those times – I pray.

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