GUIDING PRINCIPLES FOR CONDUCTING GLOBAL HEALTH ACTIVITIES

Renewing Relationship

Essays as We Evolve and Emerge from Pandemic

CHA
Catholic Health Association of the United States

The global nature of the COVID-19 pandemic offers an unprecedented opportunity for those of us involved in global health to look at current philosophy and practice.

We've had a universal experience of isolation, of shortages, fear and new rules. How might those shared realities help us consider new ways to renew our solidarity with our partners in low- and middle-income countries and to assist us as we build something different through our global health strategies?

"The pandemic is a crisis and we do not emerge from a crisis the same as before: either we come out of it better or we come out of it worse. We must come out of it better, to counter social injustice and environmental damage. Today we have an opportunity to build something different," said Pope Francis.*

In order to come out better, we will need to identify where breakdowns occurred when travel was banned and consider if new paths need to be created. Many public health and access challenges have become more evident, requiring lengthy research and analysis, but, overall, how do we emerge from quarantine with greater meaning and purpose? What are we learning from all that is happening amid this global pandemic?

The following essays are an offering to set the stage for collective consideration of how the complexities and challenges of the pandemic create an opportunity for us to rethink, reset and renew our global health relationships. While COVID-19 and the isolation we have experienced inspires more questions, they provide us with renewed hope and inspiration to do it better in the future. We hope you will take this time "apart" to reflect on our future opportunity to be brother and sister to our global neighbors.

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**From Pope Francis' General Audience on Aug. 19, 2020.*

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(BC-AC)

BEFORE COVID-AFTER COVID

FINDING MEANING

IN A POST-COVID WORLD

(BC – AC)

Before COVID-After COVID Finding Meaning in a Post-COVID World

BY NEERAJ MISTRY

Never before in human history as we know it has almost the entire world been unified in action as we are experiencing now in the COVID-19 pandemic. Irrespective of class, creed, culture or religion, we are all practicing social distancing and hunkering down in place. The impact of these stay-at-home policies varies based on where we live, our economic status and whether or not we live alone, with family or with friends. Yet, what is clear is that our engagement with the world has changed and the uncertainty of our future is a shared experience.

The systems and mechanisms of social life, work and leisure in the Before-COVID (BC) world, through which we derived our self-worth, meaning and contribution, halted almost in an instant. These systems represented both the best AND the worst of humanity. Best in terms of creativity and ingenuity, advanced technology, economic growth, globalized trade and travel and even space exploration. Worst in the ever-growing inequalities, growing racial divides and ethnic conflicts, and at times, blatant disregard for human life and dignity. And so dominant and pervasive were these systems on our human psyche that we felt helpless and like victims of these divergent systems, constantly trying to keep up on the treadmill until … the world stopped with COVID-19.

Frederich Nietzsche said, "To live is to suffer, to survive is to find some meaning in the suffering." Various articulations along this theme are consistent across other philosophies and theologies, and now we have with this pandemic, the opportunity to derive deeper meaning into our existence. In fact, we have the rare opportunity to reset the human experience in the After-COVID (AC) world.

With "man being the architect of his own fate," what in the AC world will we choose to prioritize? Based on an analysis of many online discussions, media coverage and conversations with friends and family, here are some thoughts:

We're all in this together: No country or group of people has been spared from the reach of COVID-19, and this global infectious outbreak is not the last of its kind.

We're All in This Together: No country or group of people has been spared from the reach of COVID-19, and this global infectious outbreak is not the last of its kind. Our common vulnerability is an opportunity for solidarity in action, especially in a world that is swinging toward nationalism and nativism. A global pandemic requires global action built on trust and collaboration to strengthen the institutions that represent our collective good. The United Nations and all its family of organizations, for example, was created in the aftermath of the world wars for that specific purpose. Through active participation and support of these institutions, we have a vehicle of working together. This was clearly evidenced in all national responses to COVID-19 that highlighted the need for ventilators, swabs for testing, disinfectant and sanitizers, gloves, face masks and other personal protective equipment. It became immediately apparent that the supply chain was a vast global network, highlighting the interdependence we all have as nations and people. We will not be able to respond to these needs if we don't work together, pool resources and coordinate a response. The BC world we lived in was rife with competition, territorialism and suspicion. Can we in the AC world move to collaboration, openness and trust?

Human Connection Is Paramount: What we certainly took for granted BC was our ability to pick up and go out, whether for sport, entertainment, food and drink. We also took for granted how we work with others, often forgetting the people involved, but channeling efforts toward tasks and deadlines. With close contact in lockdown, the depth of engagement among families, children and friends has reintroduced us to

In an AC world… [will we] find ways of connecting on our shared humanity?

meaningful relations. It is heart-warming doing the "check-in" at the start of every conference/video call. It speaks emphatically to "I see the human in you." In an AC world, can we transcend the valuation of people based on their income, qualification, social status or education to find ways of connecting on our shared humanity? There is always something that any two people randomly paired will find in common. Will we in an AC world take the time to look?

Nature and the Environment Can Bounce Back: We have been bad custodians on this planet, and with pride in our intellect and technological advancement, we have consumed resources, polluted the environment and produced more waste than ever before. Social distancing has reduced road and air travel. Cities which remained in a haze of smog for decades, are suddenly seeing blue skies and the return of birds and wildlife. People are literally taking a breath of fresh air. Not being able to perceive this level of intervention with social and commercial shut down, the effort to curb climate change could not have even dreamt of this level of environmental rebound. It is comforting to know this resilience of the environment, yet humbling to realize our role and impact. How do we, in an AC world, respect and give consideration to the environment and appreciate that the daily engagement with nature is actually enriching to our life journeys?

Systems are Man-Made and Can Be Reset: The systems that shape our life experience and worldview condition us from the time we are born and depend on our geography and social context of development. Whether it is a system of market-based products and services, a welfare state, equity-driven policies or survival of the fittest approaches, what we should realize is that there is no absolute system and single ideology that applies to everyone. This elusive quest has in fact driven apart societies on political, religious and racial lines. Yet, various systems do have positive attributes and benefits. We don't have to be beholden to a singular approach, but can create hybrid systems drawing on different ideologies, based on a society's or population's needs and priorities. We can have social safety nets and enjoy the creative competition of markets at the same time. We just need to be open to have that conversation, which means we need to remove our political and ideological labels as preconditions to discussion. Can we in an AC world talk as just human beings trying to better the human experience for everyone?

Re-evaluating Work and Labor: Because of the market-based capitalist view of the world BC, premium was placed on jobs and professions associated with money. These included banking, finance, property and commercial business. However, as we lock down and provide care, support and treatment at home, in the community and in health centers, with the support of "essential" services to keep people safe, fed, and healthy, it has shone a light differently on which jobs keep society functioning. Health workers, childcare professionals and educators, utility workers and trash collectors, agriculture and livestock workers and truckers are some of the behind-the-scenes jobs that are poorly paid in the shadow of wealth concentration in finance sectors and senior management. Can we in an AC world think and act more with intentional trickle-down of wealth through equitable policies and place more monetary value on jobs and professions with high social impact?

Strengthening Baseline Health: The coronavirus biology, transmission and disease manifestations are complex as we learn more every day about this virus. A consistent feature though, has been that there is an increased vulnerability that some population groups may have, particularly those with underlying medical conditions and socioeconomic environments associated with poor health. Diseases such as hypertension, obesity and diabetes, which predispose to more advanced heart disease, fatty liver disease and kidney disease, have been associated with more severe manifestations of COVID-19 infection and higher death rates. Can we, in an AC world, pay closer attention to our baseline level of health through proper routines and diet, good lifestyle choices, exercise and weight control and reduced stress and good relations?

Mindful Action: Mindfulness is the "quality or state of being conscious or aware of something." To prevent the subsequent waves and continuous transmission of COVID-19, reopening society is going to require careful social engagement, ergonomic design, workplace interactions and leisure contact. Even with the best interventions lack of attention to detail, blind situational awareness, cavalier and careless attitudes and distracting activities will put people at increased risk of contracting and transmitting the coronavirus. Mindful engagement with people and the environment may be the most important change we

Mindful engagement with people and the environment may be the most important change we make in an AC world…

make in an AC world. Can we reprogram our busyness and multitasking, and be present and aware in the moment?

At a deeper level, mindfulness, like other theological and religious beliefs, is the psychological process of purposely bringing one's attention to experiences occurring in the present moment without judgment. Could the absence of judgment be the most important lesson we learn and the truest meaning we find from the suffering we are enduring through this COVID-19 pandemic? Detaching from judgment allows us the openness of heart and mind in everything we do. This would form the basis of authentic engagement with each other and the environment, something from which we have strayed away for a long time.

After the world wars, there were moments in the collective consciousness of "never again," yet we soon forgot, resulting in what Socrates said was the "unexamined life is not worth living." We have with COVID-19 in the AC world an opportunity to examine our life and make it worth living. Will we?

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COVID-19 AND THE FUTURE OF GLOBAL HEALTH: CHALLENGES AND OPPORTUNITIES

COVID-19 and the Future of Global Health: Challenges and Opportunities

BY PETER CARD. K.A. TURKSON

The coronavirus pandemic started as a health care emergency causing the loss of many lives and went on to become one of the most disruptive events of recent human history. It has wreaked havoc on the economy, forced millions out of jobs and adversely affected lifestyles. Subsequent lockdowns, while helping to control infections, have aggravated the isolation and loneliness of many, especially the most vulnerable, cutting off their food supplies and medical services. It has undeniably affected all spheres of human life and culture. One of the major questions now is how do we emerge from a crisis of such magnitude? What are the lessons that can help us shape a better future, especially with regard to the health of populations in the global context?

It is rightly said that times of great challenges can also be moments of discovery of our significant opportunities. That is why Pope Benedict XVI could write the following about the financial crisis of 2008 – 2009: "The complexity and gravity of the present economic situation rightly cause us concern, but we must adopt a realistic attitude as we take up with confidence and hope the new responsibilities to which we are called by the prospect of a world in need of profound cultural renewal, a world that needs to rediscover fundamental values on which to build a better future. The current crisis obliges us to re-plan our journey, to set ourselves new rules and to discover new forms of commitment, to build on positive experiences and to reject negative ones. The crisis thus

becomes an opportunity for discernment, in which to shape a new vision for the future. In this spirit, with confidence rather than resignation, it is appropriate to address the difficulties of the present time."[1] How true are the words of the Pope about the current crisis of the COVID-19 pandemic: "The current crisis obliges us to re-plan our journey, set ourselves new rules and discover new forms of commitment to build on positive experiences and reject negative ones!"

The pandemic has reminded us of the vulnerability of life and the fragility of human existence.

The pandemic has reminded us of the vulnerability of life and the fragility of human existence. It has exposed the limits of our health care systems: their accessibility and affordability, their robustness and preparedness; and it has badly exposed the shortfalls in our eldercare structures. But, most importantly, it has exposed the role of politics and governance in health care policy formulations and their possible conflict with science and health experts. Moreover, the fact that COVID-19 is the latest in a series of zoonotic infections prompts us to ask why such infections have increased and what ought to be done to detect, reduce and control future outbreaks.

Taking a cue from Pope Benedict XVI, let us begin by *adopting a realistic attitude* toward the pandemic, dispassionately studying the consequences and the breakdowns that occurred during its outbreak (challenges). This will dispose us for the next step of *taking up with confidence and hope the new responsibilities* before us.

A Realistic Attitude Toward the COVID-19 Pandemic: The Challenges

The Emergence and Re-Emergence of Zoonotic Diseases

Scientists claim that "about 75% of the new diseases that have affected humans over the past 10 years have been caused by pathogens originating from an animal or from products of animal origin."[2] COVID-19 is the third zoonotic coronavirus, after SARS-CoV and MERS-CoV. Recurring outbreaks of zoonotic infectious diseases like Ebola, SARS, Avian influenza and now COVID-19, prompt us to strongly consider the interconnections between human health and the environment in the efforts for health promotion, disease prevention and control. It has been observed that the emergence of

several new infectious pathogens has coincided with the increased destruction of wildlife habitats and the violation of ecosystems at unprecedented rates in history.

The coronavirus tragedy should be a wake-up call for countries to finally walk the talk about strengthening health care systems and making services accessible!

The Weakness of Health Care Systems

The current COVID-19 pandemic has overwhelmed public health and health care delivery systems in almost all the affected countries, revealing their low level of preparedness for a pandemic, and the limited equipping of the health care systems. Most health care systems were found to be lacking in health care personnel. Countries had to call into service retired personnel and volunteers. Governments were caught unprepared, having badly cut and reduced budgets for health emergencies. The predictable occurred: there has been high incidence of infections and deaths among health workers due to lack of personal protective equipment (PPE) at the beginning, meaning heavy workloads and high stress for the remaining personnel. In many places, there were uncertainties about the availability of test kits and drugs, PPE and ventilators. The high infection rates caused not only Wuhan, but Italy, the United Kingdom and New York to develop emergency hospitals and to even use medical ships. Many hospitals ran out of beds, especially in the intensive-care units, and prescribed death for patients who arrived at hospitals with other debilitating diseases such as diabetes, cancers, obesity, etc. Even old age (over 80) became an exclusionary criterion.[3]

The COVID-19 pandemic created an unprecedented influx of patients that overwhelmed many health systems and taught a lesson: "improved performance in controlling emerging and re-emerging diseases…is dependent on the quality, equity and efficiency of health systems."[4] The coronavirus tragedy should be a wake-up call for countries to finally *walk the talk* about strengthening health care systems and making services accessible!

The Shortfalls in Elderly Care Systems

On April 23, 2020, Hans Kluge, the director general of the World Health Organization for Europe, expressed his concern about the tragedy caused by the coronavirus in the long-term care centers for the elderly. He declared in an interview that a "deeply concerning picture is emerging about residents of homes for the elderly … up to half

of those who have died from COVID-19 in Europe were residents in long-term care facilities. This is an unimaginable human tragedy." He went on to say, "this pandemic has shone a spotlight on the overlooked and undervalued corners of our society."[5]

The high death rates in care centers have caused concern on the part of many relatives whose outcry has caused the establishment of groups of fact-finding experts to inquire into the causes of deaths. One may readily identify reduced immune system as a cause, but there could be several other factors involved. The one thing, however, which relatives and non-relatives are quick to observe is that COVID-19 exposed the sorry state of many homes for the elderly and the living conditions of the elderly in our society. The balance between *care* and *economics* (finance) was always the key. In many countries, resources dedicated to elderly care have shrunk dramatically; and those to whom we owe our lives and who are responsible for the establishment of the many structures on which our own lives now depend are made to feel that they are dispensable and victims of a prevailing *throw-away culture!* [6] But, the right to health is a fundamental right that the elderly in our communities should not be denied.

Still about the elderly, COVID-19 has also revealed what poor care some elderly people received in their own homes from family members.[7] I have just learned of a case in a European country, where an elderly mother is held at home and prevented from going to a care-home, because the sons wish to claim the benefit of a visiting nurse! There are growing cases of abandonment and ill treatment of the elderly by family members. "COVID-19 has also brought out of the shadows how many elderly people have simply been abandoned by families."[8]

Opportunities: Re-planning Our Journey, Setting New Rules for Ourselves and Rediscovering Fundamental Values and Commitment for a Better Future

When shortly before Easter Pope Francis constituted an Inter-Dicastery Vatican Commission for COVID-19 and entrusted its management, operations and activities to the Dicastery for the Promotion of Integral Human Development, he charged the Commission, as a matter of priority, to be prophetic and to "prepare the future," the future of a post-COVID-19 world. Accordingly, the Vatican Commission has set up a fund-raising group and four working groups to help it envision a post-COVID-19 future.

Working Group One, since Easter, has held video conferences with bishops, health care operators of the Church, religious congregations in health care and chaplains of prisons about the experience of COVID-19 in their areas of ministry: their challenges and needs. The Vatican Commission extends the solicitude of the Holy Father (Holy See) to all of these groups to affirm them as local actors and protagonists and to lend support necessary for their protagonism and strengthening of the health care structures. It is about creating synergies and a world Church-based network of actors to overcome COVID-19. They are given a sense of not being alone, of being a part of a worldwide Church group acting in solidarity to offset the effects of COVID-19.

Working Group Two, through its task forces on ecology, economic, public health and security, has created networks with centers of research and learning over the world to collect data on the four areas of study, and is analyzing them with a view to making forecasts and describing broad trajectories along which a post COVID-19 world may travel to humanity's surpassing dignity and vocation.

Working Group Three is the communication group. It brings the world to the Commission through a survey of prominent international news outlets, and brings the work of the Commission to them.

Working Group Four represents the Vatican, as a state, and with other state actors it shares information and data from Working Group Two with a view to building an advocacy force for policies, decisions and positions conducive for the outcomes and proposals of the task forces of Working Group Two.

Concerning Zoonotic Diseases

Following the claim of scientists that "about 75% of the new diseases that have affected humans over the past 10 years have been caused by pathogens originating from an animal or from products of animal origin," the works of the Taskforces on Ecology and Public Health recommend an urgent need to re-balance our relationship with the environment and wildlife. We need to take care of our common home, for "societies cannot be healthy unless the planet and its ecosystems are healthy."[9] In this regard, the Vatican COVID-19 Commission proposes, among other measures, that the Vatican as a state engage other state-actors in favor of stronger global policies to protect the environment and the ecosystem. At the heart of the Vatican's engagement are three actions:

1. to "put nature and the climate at the center of post-pandemic reconstruction;
2. to end the wildlife trade to help prevent the spread of zoonotic diseases;
3. and to link increased agriculture production with an ecosystem protection."[10]

These are but some of the ways our common action can help to reduce the pressure of human activity on the natural world and its damaging consequences, both for the benefit of the planet and of global human health.

Concerning Health Care Systems

The COVID-19 crisis has underscored the need for stronger health systems so as to enhance universal health coverage and health security, especially for vulnerable people. Countries must invest more in health in order to guarantee access to quality and affordable health care, which is a fundamental human right. Besides ensuring access, health system strengthening will boost the capacity to prevent, detect and treat emerging health threats.[11] In many developing countries the disease burden is aggravated by avoidable health conditions. If these were addressed by a stronger health system, there would be immense benefits to individuals and societies. Unlike high income countries, developing countries are still lagging behind in improving health outcomes. Therefore investing in health will have significant economic payoff for these nations.[12]

In his Message for International Nurses' Day (May 12, 2020), Pope Francis urged "leaders of nations throughout the world to invest in health care as the primary common good."[13] And this invites policymakers to address the problems and needs at the various levels of the system. These include, among other things: poor stewardship and governance; inadequate human resources;[14] lack of access to essential medicines, vaccines and technologies; inadequate financing; poor infrastructure and service delivery; poor health information systems; low investment in health research; and lack of community ownership and participation in health care delivery. These make one thing very clear: in dealing with all crisis situations, the concurrence of politics and science, government and public health experts in providing direction is crucial. Moreover, the public and private sectors will have to work together to build resilient health care systems. In many developing countries, the private and not-for-

Countries must invest more in health in order to guarantee access to quality and affordable health care, which is a fundamental human right.

profit health institutions are the primary partners of the state in health services delivery, especially in hard-to-reach areas, inhabited by the most vulnerable populations.

Concerning the Shortfalls in Elderly Care Systems

Just last January, Pope Francis invited humanity to reflect seriously on the plight of the elderly in our society. He observed that: "the indifference and rejection that our societies manifest toward the elderly demand … of all of us, a serious reflection to learn to grasp and to appreciate the value of old age."[15]

The health crisis caused by the pandemic highlighted and aggravated pre-existing structural problems in the elderly care sector. Some priorities for action are:

1. Enhance government oversight in the elderly care market to ensure a functional system of funding, standards, measuring and enforcing continuous improvement in the quality of care across all service providers. Risks faced by the elderly in accessing services, age discrimination, neglect, maltreatment and violence should be monitored and addressed. Indeed all have a moral and ethical responsibility to denounce abuses on the elderly.
2. Address the structural problems of underinvestment, staffing and safety.
3. Health care is a human right and every life has equal value. Thus, health care decisions concerning the elderly must be guided by a commitment to dignity and the right to health.
4. Integrate mandatory educational standards for gerontology in every health care curriculum, expand the availability of formal home-based care and empower caregivers, especially those in home- and community-based care, through appropriate ongoing formation.
5. Family caregivers remain important in many countries. However, government oversight and specific funding models are needed to support the elderly and their families.
6. Today we have an increasing number of older people in our families and communities. The civil society and communities have a role to play by promoting volunteer services that form a network of closeness and support to the sick and elderly in our society.

The harms that COVID-19 caused to the elderly, their families and caregivers are troubling. This leaves us with a responsibility to address the problems identified in long-term care homes, so as to avoid additional situations of abandonment and denial of rights. We hope that the attention drawn to inequalities experienced by older people during the pandemic will blossom into stronger commitment for social justice and health equality.

Conclusion

This pandemic with no boundaries has reminded us that we share a common home and daily depend on each other. Inhabiting the Earth as a common home "requires solidarity in accessing the goods of creation as a 'common good,' and solidarity in applying the fruits of research and technology to make our 'home' healthier and more livable for all."[16]

In conclusion, I wish to reiterate the words of Pope Francis that underscore the awareness we have come to as a human family during this pandemic:

> *… we were caught off guard by an unexpected, turbulent storm. We have realized that we are on the same boat, all of us fragile and disoriented, but at the same time important and needed, all of us called to row together, each of us in need of comforting each other… we have also realized that we cannot go on thinking of ourselves, but only together can we do this.*[17]

This awareness and concern for our common destiny requires collaboration among nations, from actors at all levels and from each one of us, to embrace the common responsibility for the health of humanity through appropriate policies, strategies and actions. We are in the same boat and we can only overcome the disaster through cooperative efforts.

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5 Michael Birnbaum and William Boot, in https://www.washingtonpost.com/world/europe/nursing-homes-coronavirus-deaths-europe/2020/04/23/d635619c-8561-11ea-81a3-9690c9881111_story.html accessed on 16/7/2020

6 In his Day and in the face of an emerging culture of euthanasia, abortion, assisted suicide, etc., St. Pope John Paul II identified in them a culture of death, and affirmed in opposition to these trends a respect for the sanctity of life of all people, including the unborn (Evangelium vitae). In our day, Pope Francis has affirmed again the sanctity of life of all people, including the unborn and the poor in our midst. By contrast to this and in opposition to it, Pope Francis describes a throw-away culture that considers everything dispensable! (Laudato sì).

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14 It is estimated that health workforce shortage can amount up to 9.9 million physicians, nurses and midwifes globally by 2030. Moreover, given the current population growth, ageing societies and changing disease patterns, there will ever be greater demand for well-trained health workers. Cfr. WHO, Global Strategy on Human Resources for Health: Workforce 2030, Geneva 2016, pp. 44ff.

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16 Peter K.A Turkson, We must think of the aftermath of COVID-19 so we are not unprepared, Interview by Massimiliano Menichetti, accessed on 17/7/2020 at https://www.vaticannews.va/en/vatican-city/news/2020-04/turkson-think-covid19-aftermath-to-not-be-unprepared.html

17 Francis, Extraordinary Moment of Prayer, Sagrato of St. Peter's Basilica, 27 March 2020.

BUILDING A NEW CULTURE OF GLOBAL HEALTH: A COVID-19 PERSPECTIVE

Building a New Culture of Global Health: A COVID-19 Perspective

BY CAMILLE A. GRIPPON

The practice of global health is bountiful in terms of groups, agencies, institutions, organizations and independent actors addressing a myriad of focus areas related to specific diseases, outbreaks and emergencies on any given day. The free movement of people, information and resources across national boundaries was naturally expected for those practicing global health interventions. At least it was, until COVID-19.

COVID-19 has challenged many global health experts, and has further revealed that there are many cracks in the practice and execution of global health that require optimizing. This unprecedented time gives the opportunity to all involved in global health practice to examine breakdowns during COVID-19 and envision new paths toward a post-COVID-19 reality.

Global Health: A Matter of Justice

The literal definition of global health is an "area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide."[1] The word equity is embedded in its definition and is perhaps a reason to pause to appreciate its deeper meaning. Equity is a matter of justice. Therefore, to attain "equity in health for all" implies that regardless of race, creed, sexual orientation,

nationality, social, political or economic status, all people in the world should have the potential to achieve their full health. All people.

For those who practice global health interventions, the definition conjures up an ideal that we are all united under one common home, the *globe*; and for one common cause, *health*. When disease strikes only one nation or geographic region at a given time, perhaps that ideal is easier to follow than during a global pandemic.

Regrettably, in some countries like Peru and Haiti, many communities and families are fending for themselves.

Global health is a matter of justice and a pandemic requires a unified global response. In a July 13, 2020 appeal, the WHO Director General, Dr. Tedros Adhanom Ghebreyesus, called for global unity, solidarity and a cohesive global response to COVID-19.[2] Regrettably, in some countries like Peru and Haiti, many communities and families are fending for themselves.

In Peru, the first case of COVID-19 was reported on March 6, 2020. By April 2020, there were widespread shortages of medical gloves and masks due to exports of supplies being delayed or re-routed to other countries.[3] The prices of these essential products not only increased six-fold but "market manipulation was widespread, with stocks frequently sold to the highest bidder."[4]

This major breakdown in the lack of global coordination and early commitment from industry and governments to increase manufacturing led to a sharp decrease in the ability of countries to cohesively respond to the crisis and also lead to the sharp increase in black-market solutions. For example, oxygen is a scarce resource in the fight against COVID-19 in Peru. Desperate families are turning to the black market to purchase oxygen from informal vendors at a 1,000% markup.[5] Similarly, in Huancayo, Peru a private company with a troubled history in that region is now purchasing oxygen for the families of COVID-19 patients. According to Sr. Rosalinda Pajuelo, former Country Leader for Peru for the Congregation of Bon Secours (CBS), the company is "taking advantage of human suffering. They purchase the oxygen today, and tomorrow the company will ask for a payback from the community to continue corrupt operations in their towns."[6] In Piura, Peru, family members of COVID-19 patients in the region of Piura who have been turned away from private clinics for lack of available beds are asked on their way out for a bribe in order to access a bed or oxygen at the same exact clinic.[7]

Patients are literally dying in the streets of Peru, so people are doing anything to get access to health.

Haiti, an especially fragile country, cannot fend for itself during COVID-19. The United Nations has been calling for a united response from the international community to COVID-19 in Haiti. It has expressed that Haiti "cannot face the pandemic alone. It requires unflagging support from its humanitarian and development partners… including, first and foremost, regional partners, to increase financial, technical and political support for Haiti during these challenging times."[8]

Many groups like Medecins Sans Frontieres (MSF) are sounding the alarm. Other groups working to deliver maternal care in Haiti like Midwives for Haiti are sharing some of the current challenges. According to Jane E. Drichta, Executive Director for Midwives for Haiti, "the challenges around COVID-19 continue. As of now, Haiti is reporting over 6,000 cases, but they have abandoned almost all testing, so this number is off, probably by thousands of cases. The stigma around the virus is very strong and people have been killed when word got out that they were infected."[9]

Similarly to Peru, Haiti faced early challenges with securing supplies. For Midwives for Haiti, they "ripped through their supplies of PPE, and with prices rising they had to make tough decisions on what medications and other medical supplies to purchase" due to the lack of funds and product availability. [10]

While COVID-19 is far from over, there is still potential for a cohesive global response. The valid question that is still open is what can we learn from the pandemic? For Dr. Kui Muraya, a global health expert and principal investigator at KEMRI Welcome Trust Research Programme, her hope is that "after the pandemic, global health will truly be global. That we will realize our interconnectedness as humanity…when one part of that whole suffers, we all suffer. I hope this revitalizes our need to champion even more vigorously for equity in health for all people worldwide."[11] Therefore, rallying around the ideal of global health is not only a matter of justice, but a matter of survival.

Rallying around the ideal of global health is not only a matter of justice, but a matter of survival.

Rethinking Global Health Interactions

From the onset of COVID-19, when restrictions on travel were imposed and the free movement of people stopped, it was clear that normal global health interactions would need to evolve quickly. There would be no more fly-in missions and no bringing in the troops. This emergency was like no other and created a much overdue reckoning or rethinking of normal operations vis-à-vis international partners and vice versa.

Bon Secours Mercy Health's longest standing Global Ministries' countries of focus are Peru and Haiti. Our partners, CBS Peru, the Global Smile Foundation, the Catholic Medical Mission Board, and Midwives for Haiti have shared many lessons from COVID-19 that will help instruct new paths toward a post-COVID-19 reality.

Rethinking Local Leadership

With the travel ban, Global Health interactions had to move to a virtual reality. Global Ministries had deployed personnel to Peru in times of natural disaster in the past but this outbreak made travel impossible. Sr. Rosalinda Pajuelo reflected on what that meant at the onset of COVID-19 stating:

> *"In the past, when we faced adverse situations, we felt accompanied not only spiritually but physically by partners who were quickly here to be a united force with us...but this time it was not the case. This pandemic gradually took over our country and we had to face this harsh reality ourselves. I asked myself, how will we do it? Together with our partners, we learned to use and implement our virtual presence to reach many in need of health care, education or spiritual accompaniment."*[12]

In the case of our partnership with CBS Peru, COVID-19 accelerated our need to build capacity. Through online workshops, training and technical back-up, local leaders led and they successfully and independently moved their hospital operations online to a virtual platform.

Rethinking Local Gaps

Another partner in Peru, the Global Smile Foundation, is a major cleft care provider in many countries. In Ecuador and Lebanon, the Global Smile Foundation actually serves over 50% of all patients born with cleft lip. For an organization that fills such a huge gap not currently addressed by local resources, going virtual is not necessarily possible.

In the short-term, Dr. Usama Hamdan, President of the Global Smile Foundation, stated that "COVID-19 forced us to adjust our missions and to fortify telehealth. Unfortunately, telehealth is just a short remedy for our ability to care for these patients — their cleft lip/cleft palate is not going to be addressed virtually."[13] Once they are able to travel, the Global Smile Foundation expects to double up on the number of cases in 2021.

In the long-term, the Global Smile Foundation will continue to "empower local talent with hands-on training, fellowship programs, and international comprehensive cleft care workshops that the organization holds annually and through Augmented Reality Surgery."[14]

Rethinking Local Expertise

An additional partner, the Catholic Medical Mission Board (CMMB), expressed that local leaders in government should learn to listen to local experts and not rely on looking to the West for solutions. Dr. Ariel Frisancho, CMMB Peru Country Director, reflected on some COVID-19 lessons so far, stating:

> *"The government response [in Peru] drew more on 'looking outside' copying the Western hospital-centric approach and neglecting the importance of the primary care level. We lost the opportunity for local, community-based, patient detection, follow-up and contact tracing. One size doesn't fit all, especially in countries with diverse realities and cultures like we have. COVID-19 communication and preventive measures were oriented toward urban contexts not necessarily rural or periurban settings. We neglected 'looking inside.'"* [15]

The post-COVID-19 reality will challenge all global health practitioners to develop multi-directional partnerships that include multiple stakeholders. Not only the traditional bi-directional relationships such as donor-NGO, or NGO-recipient but rather communities themselves will need to become active participants as local experts in the decision-making process.

Rethinking Local Sustainability

One of the most difficult aspects of global health interactions is to constantly reassess if the activity is sustainable. Many organizations do not want to shift, adapt or learn, but COVID-19 is forcing many groups to rethink their operations and sustainability over time.

Drichta is not afraid of that process for Midwives for Haiti. She shares that:

> *" … we have had to make significant changes to several aspects of our programming and systems structures. One of the most obvious changes over the past six months is the drop in volunteers. We were unable to have volunteers for most of the spring and fall due to civil unrest, and then of course, COVID-19 hit. This was a blow to our capacity in Haiti, but also to our bottom line. We have learned that volunteers are not a sustainable revenue source, nor should we be counting on them for supplies and donations."* [16]

Building a New Culture of Global Health

Dr. Tedros mentioned that COVID-19 was a test in global solidarity and global leadership.[17] We have collectively witnessed the devastation and disruption this has already caused as well as the isolationism, divisiveness and misinformation of some nations, all of which are counterproductive to a global response. Yet, as the WHO says, we are not too late.

As we hopefully shift from divisiveness to solidarity and from isolation to cooperation, so should there be a shift in optimizing global health practice. It will be necessary to ensure that local leaders lead and partners build local capacity. It will also be necessary to assess if there is a real gap to be filled, and if there is not, then there should be a willingness to pivot away.

There is also a post-COVID-19 opportunity to create a new culture of global health. A culture that does not deviate from the ideal that shapes the very definition of global health. One that is a matter of justice for all people. A new culture could be created that moves some global health interactions from dependency to empowerment, from superiority to humility and from silos to complementarity.

A post-COVID-19 reality affords all of us the opportunity to see one another as global citizens sharing a common home. It gives us the opportunity to accept our deep interconnectedness and interdependence. Culture is shaped by a common set of beliefs, experiences and behaviors. COVID-19 has produced a common global experience. What will we do with that painful experience? Will we embrace fear and isolationism or come together to address human suffering? Will we emerge with a new culture? A world united for the common good?

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JESUS IS WITH US IN THE BOAT — A PERSPECTIVE FROM MUMBAI

Jesus is With Us in the Boat — A Perspective from Mumbai

BY SR. DR. BEENA MADHAVATH, UMI, WITH
M. THERESE LYSAUGHT, PH.D.

In February 2020, three COVID-19 cases were reported in Kerala, India. As we watched what was happening in China and Italy, those of us working in the medical sector in India were quickly gripped with fear and anxiety. How would we be able to manage this crisis, given India's socioeconomic context and fragile health care infrastructure, with the wide gap between the poor and the rich, rural and urban, profit-oriented medical treatment offered by corporate hospitals, our fragmented medical supply chain and our shortage of trained medical personnel?

These past six months certainly have been and remain fraught with difficulties. COVID-19 has made glaringly visible issues we already knew all too well. But it has also provided many moments of grace and hope, including new possibilities and paths forward for advancing our original mission — to serve the needs of a multi-layered community that once had too little access to quality health care. Here we reflect on the pandemic from the perspective of one hospital providing care in India, which is a member of Catholic Health Association of India (CHAI), a network of more than 3,500 member institutions, providing a wide range of services from primary care to tertiary care across India. The experiences of our ministries — the Holy Family Hospital Bandra in Mumbai, India run by the Congregation of Ursulines of Mary Immaculate, and the Navjeet Community Health Centre — provide a distinct vantage point for reimagining new priorities and practices for global health on the other side of COVID-19.

COVID-19 Storms Holy Family

Holy Family Hospital Bandra is a 268-bed public, charitable, trust-run hospital and center of medical excellence that serves the health care needs of Mumbai's vast suburbs, with 15,000 in-patient and 80,000 outpatient visits each year. With a strong research and teaching culture, the hospital is a pioneer in cardiac diagnostics, treatment and research, with the Holy Family Heart Institute and the Hybrid Cath Lab providing cutting-edge cardiac catheterization, MRIs, cardiac CT scans, as well as a host of basic and clinical research initiatives and continuing medical education. The Navjeet Community Health Centre provides integrated health care, comprehensive education and community development projects for the rural and urban poor. Navjeet partners with disadvantaged communities to develop projects that are driven by the community — projects that improve health by addressing acute environmental and social problems and equipping communities with skills, knowledge and access to information and government resources.

We were one of the first hospitals in Mumbai to follow infection control measures, including fever clinics and training.

As the storm of the virus surged over the globe, our hospital management team recognized that the novel coronavirus was going to be a major pandemic and would severely affect our country, especially Mumbai. Planning and follow-up action began immediately. We were one of the first hospitals in Mumbai to follow infection control measures, including fever clinics and training. When many hospitals went into lockdown in fear of the pandemic, we started to offer triage and referral services. Later, in mid-March, we procured high-quality personal protective equipment (PPE), to provide the best possible protection to our medical team. Intensive training and motivation-building sessions were conducted regularly for doctors as well as for other employees. Standard operative protocols were prepared.

It took almost one month to operationalize the COVID-19 ward and ICU, since the regulations for isolation wards required major changes in our existing setup. We were one of the first hospitals to partner with the government in the battle against COVID-19, when we signed an official Memorandum of Understanding with local authorities and started a COVID care center. Thereafter, we allotted 25 hospital beds exclusively for the

care of COVID-19 patients, including 12 ICU beds. Today, due to the spiraling number of cases in Mumbai, we are caring for around 130 COVID-positive patients a day, with 26 on ventilators.

The Shoals of Global Health

Implementing these changes required us both to redirect our resources to meet the demands of the pandemic and to incur substantial new, unplanned costs. But, as in so many other countries, it has also brought into glaring relief underlying problems in the system. One is the for-profit nature of global health care. For example, due to the realities of the supply chain, we, like so many others, faced acute shortages of critically-needed items. And to make it worse, many vendors used these shortages to increase prices exponentially.

The pandemic also made visible and exacerbated the precarious existence of the poor and those who live on the margins. We anticipated a tsunami of cases in thickly populated cities like Mumbai, especially in its slums. Flattening the curve in Asia's largest slum — Dharavi, located in Mumbai — was almost mission impossible. Almost 1 million people live within Dharavi's one-square-mile boundary: families live and sleep together in ten-by-ten-foot quarters, sharing public bathrooms. Not only is social distancing culturally foreign, it is nearly impossible to do. Yet through a coordinated government effort, the pandemic within Dharavi was remarkably contained, with only 2,000 cases and 79 deaths by mid-June. Will we be able to maintain these numbers now that the lockdown has been lifted? Only time will tell, but we remain vigilant.

Not only is social distancing culturally foreign, it is nearly impossible to do.

However, following the law of unintended consequences, the very measures which stemmed the tsunami spawned a new humanitarian crisis. In India, as elsewhere, few anticipated the economic and social ramifications of physical distancing and social lockdown. With the immediate closure of our society and economy, the poorest among us — the unorganized sector of the Indian economy of migrant workers and daily-wage laborers who flock to the cities for work, and sleep in slums like Dharavi — lost their livelihood. Overnight they found themselves homeless and jobless, with no means to provide even daily sustenance. After it became clear that the lockdown would last longer than a few weeks, we suddenly saw an egress of migrant workers — some half a

This pandemic provides powerful new evidence that caring for each person is crucial for the well-being of the whole community.

million — rushing back home. With no money in their hands and with train service cancelled, many walked for several days, some 100 kilometers, to reach their home villages. Desperate to be back home and deprived of even primary health care, at least 22 died on the way. Many who made it met discrimination and stigmatization when they arrived. The neighbors at home were not entirely wrong: many who had left Mumbai asymptomatic carried the disease with them, seeding peripheral outbreaks from the city epicenter.

These experiences have only cemented our fundamental belief that affordable health care is a basic right for every person. This pandemic provides powerful new evidence that caring for each person is crucial for the well-being of the whole community. But it also raises questions about a paradigm of public health or global health that focuses almost exclusively on disease or diseases. Masks, PPE and physical distancing are important and effective measures. However, the protocols for containing the virus have either overlooked or ignored the complex social, economic and personal realities that make them almost impossible for people in poor communities to follow.

Technological Developments Improve Well-Being

Yet while this humanitarian crisis continues to grow in India and across the globe, we have seen an outpouring of creativity in a variety of arenas, particularly technology and caring for caregivers.

TECHNOLOGY: The converging of digital technologies like mobile phones, the cloud, analytics, robotics and artificial intelligence has had impacts across the health care spectrum. India's experience mirrors that of many other countries. Many hospitals have seized this opportunity to initiate teleconsultation. Paired with online delivery of medicines, telehealth has helped millions of people during days of lockdown restrictions. Online medical purchases and online payments are becoming the new normal in our hospital and society at large. Some departments — like our finance team and hospital information system teams — are working from home. In just five months we have become accustomed to virtual meetings and tele-CMEs on Zoom and Google Meet platforms. We have been using smartphones in isolation wards to bridge the gap between patients and their family members. Certain corporate hospitals are using robots to

disinfect areas and to deliver food to patients. Various social media platforms have enabled us to raise public awareness and education. WhatsApp groups have been created within health care organizations to enable management to disseminate information and communicate important policies to the medical team and other hospital employees. Many educational institutions have started offering online training programs for doctors and nurses —both regular classes or CMEs. In fact, via a collaboration with CHAI, about 50 Sister Doctors from India have completed an online certificate course in COVID-19 from the University of Melbourne!

CAREGIVER WELL-BEING AND MENTAL HEALTH CARE: As in many other countries, we quickly recognized the many ways that fear and stress were affecting our staff. We strove to provide adequate PPE, but while it protects, wearing PPE in Mumbai's hot humid weather is suffocating; we are drenched in sweat within minutes of putting it on and we find it difficult to move around. Protective goggles mist up and blur our vision. Wearing an N95 mask requires us to speak loudly to be heard, making it very tiring to communicate with patients and other medical team members. In addition to this, a lot of information has to be given over the telephone, as anxious relatives cannot come into the isolation ward.

These work stresses are compounded by family concerns. To protect their families, some staff members have had to miss important family celebrations and events — even to postpone their own wedding dates! And family members of our medical team, far away from loved ones, are worried. Horrifying news updates about COVID-19 in Mumbai flood news channels. Many of our nursing staff from southern India have been compelled by their parents to resign from their jobs, creating an additional burden on those who remain. Yet, again, those fears are not entirely unfounded. About a month ago a doctor and three religious sisters from my team started showing COVID symptoms. They tested positive and were admitted to the same isolation ward. The news of their sickness was deeply distressing. Certainly, we are so worried about their well-being, but we have to admit — we are afraid of contracting the illness ourselves, and we stress about managing the COVID ward with such an acute shortage of personnel.

With all these difficulties, no wonder frontline warriors are feeling exhausted and stressed. Therefore, we have engaged a counselor to accompany the staff. The management team also spends a lot of time listening to, reassuring and motivating our caregivers. To address the pandemic's broader mental health burden, we have partnered

with CHAI in a project named *Corona Care Life*. This is a web-based platform with a call center facility for anyone who wants to talk about the coronavirus over phone. Infected people looking for comfort and support or people with fear and suspicion about their own condition can avail this facility. An online platform was launched to provide counseling sessions in different languages jointly by CHAI, Project Vision, Billion Lives, Sister Doctor's Forum of India and several other organizations.

After the Storm Ends: Collaboration and Caring

COVID-19 has left the world in extraordinary disarray. It has jolted our very basic social, economic and political frameworks. However, even as the grip of the virus is evolving, it has begun to open up new possibilities for how we think, live and interact. This indeed is an inflection point. The pandemic has in many ways ignited and paved new pathways and breakthroughs within social, pastoral, environmental and cultural spheres and calls us to imagine more. Let us briefly name two.

The pandemic has in many ways ignited and paved new pathways and breakthroughs within social, pastoral, environmental and cultural spheres and calls us to imagine more.

First, when travel restrictions are finally eased, we will need to continue to collaborate and to develop new partnerships leveraging technology to share the wealth of knowledge and experience across borders. How might an INDO-U.S. partnership build on all of these online educational and collaboration technologies to more intentionally and intensively expand opportunities to train doctors, nurses, paramedics and community health agents to meet local needs, especially in remote villages? And how might those in the U.S. benefit from hearing the interesting stories of how we managed COVID in India with our limited resources, fragile health care system and fragmented medical supply chain?

Yet technology is only part of the answer and has its own downsides. As mentioned earlier, PPE, physical distancing and virtual meetings are technological solutions that are important and effective. But they are clearly exacting an extraordinary toll on persons and communities. Our experience with this pandemic has only reaffirmed the patient-centric approach that has always been central to our spiritual mission. While state-of-the-art diagnostic and therapeutic interventions are important for healing, we have always

believed that by building a personal rapport with every patient we strengthen our bond with the community we serve. Now we see even more clearly the need to consider the *human* dimensions of our technological medicine. Going forward, we are going to need to develop much greater ability to attend to the spiritual, mental and emotional health of our patients, our caregivers and our communities — an area in which there is a dire shortage of trained professionals across many countries of the Global South.

Jesus is With Us in the Boat

The battle is not over. Even though we are putting in our best efforts, we still are not able to give optimum care to our patients given our billon-plus population in India. The disease is spreading fast from cities to the rural areas. The government hospitals in certain states do not function well and do not have modern equipment, essential drugs or other medical supplies needed to manage critically-ill patients. As we write, India currently stands third globally for total number of cases, at 2.9 million (behind the U.S. and Brazil) and fourth globally for total number of deaths, at almost 55,000 (behind the U.S., Brazil and Mexico). Given the Indian socio-economic status and resource constraints, we have so far responded rather well, although recent news suggests that COVID-19 is now spreading faster in India than in any other country.[1]

Yet there are reasons for hope. We have watched as people from all strata of society, irrespective of caste, creed and economic status have come together to pool their resources and help each other. Goodwill abounds and caring and sharing has become the norm. Love your neighbor is the new culture. It is heartening to witness the plethora of doctors, nurses, researchers, scientists, government leaders, religious leaders, economists, corporations, civil societies, hospitals, institutions, philanthropists, church volunteers and many more coming together and giving their best to fight against this virus. In many ways, it has generated a new globalization of solidarity and interconnectedness.

We have watched as people from all strata of society, irrespective of caste, creed and economic status have come together to pool their resources and help each other. Goodwill abounds and caring and sharing has become the norm. Love your neighbor is the new culture.

And while the COVID-19 global crisis has caused much anxiety, suffering and uncertainty, it has also

This pandemic indeed has made us all find new ways of gathering in Jesus' name and worshipping the Triune God.

been a time of intense prayer for us. Our sister's communities pray for us daily. Their prayer and support have helped us to gather courage, wisdom and strength in these days of trials. The spiritual and material support from many friends, well-wishers and benefactors has been a tangible experience of God's providence and protection. Their generosity and magnanimity helped our hospital to steer ahead even when we have suffered financial crises. Amid this lockdown, when churches are closed our homes have become sanctuaries and communities are remaining together and connected in prayer and worship. This pandemic indeed has made us all find new ways of gathering in Jesus' name and worshipping the Triune God. And despite the difficulties in our hospital wards, each time a patient recovers, each time a COVID-positive mother delivers a baby, we all experience another moment of joy, affirming the powerful presence of the Divine Healer and his miraculous healing touch.

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RETHINKING ENGAGEMENT IN GLOBAL HEALTH DURING A PANDEMIC: FRANCISCAN PERSPECTIVES

Rethinking Engagement in Global Health During a Pandemic: Franciscan Perspectives

BY FR. THOMAS NAIRN, OFM

In his Message for World Mission Day 2020, Pope Francis stated that in light of "the suffering and challenges created by the COVID-19 pandemic … the invitation from God's merciful heart challenges both the Church and humanity as a whole in the current world crisis. Like the disciples in the Gospel we were caught off guard by an unexpected, turbulent storm. We have realized that we are on the same boat, all of us fragile and disoriented, but at the same time important and needed, all of us called to row together, each of us in need of comforting the other." This "rowing together" is simply another way to express the virtue of solidarity, that (in the words of Pope John Paul II) "all are really responsible for all."

In a variety of ways, depending upon local needs and resources, Franciscan friars throughout the world have shown that other virtues are needed to enflesh solidarity as we all row together for the common good. Franciscan responses to the pandemic have ranged from responding to immediate needs in the spirit of solidarity with the poor to a more systemic analysis of possible meanings of the pandemic in the light of Catholic social teaching and our Franciscan spiritual and theological tradition.

In this short essay, I will describe four Franciscan responses. While each of these examples is an expression of solidarity, each example also highlights a particular Franciscan virtue that builds up solidarity in that particular locale. Taken together, these virtues may offer a way forward in rethinking and re-engagement during and after this pandemic.

Philippines

In the Philippines, the pandemic began while the country was still responding to the Taal volcanic eruption and President Duterte had placed the country under a state of emergency, creating a situation where there was no work, no transportation and little food for the poor. Franciscans developed *Lingap Fransiskano* (Franciscan Aid) and opened their houses and parishes to the homeless and the poor. They also opened their friaries to medical personnel and to other frontline workers who risked bringing the virus from the workplace to their own homes. As Franciscans, they believe that they must be open to the prompting of the Holy Spirit and in the ***spirit of minority*** "respond to God's call of serving the least, the lost and the last."

Guinea Bissau

Franciscans in Guinea Bissau, East Africa, have worked to respond to local needs in practical and innovative ways through ***collaboration***. Working in 30 villages, they have engaged youth volunteers to help in preventing the spread of the virus by going door-to-door to explain the pandemic to local residents. These volunteers provide practical assistance such as food, sanitizers, disinfectant agents and masks. With the friars, the volunteers also educate the local communities, for example, by means of posters instructing how people can avoid contagion. Such posters are especially important since much of the population cannot read. Through such collaboration, Franciscans are able to reach many more people than could have been achieved by the friars themselves.

United States

In the United States, the pandemic began as Franciscans were celebrating the fifth anniversary of Pope Francis's encyclical, *Laudato si'*, with its call for integral ecological conversion. Soon Franciscans found themselves in a perfect storm created by three crises: the ecological crisis described in the Pope's encyclical, a public health crisis created by COVID-19 and a social crisis in the aftermath of the killing of George Floyd.

On the one hand, the pandemic has shown that there is, on the part of most Americans, an adaptability to crisis conditions and a willingness to adjust one's lifestyle in ways we would not have thought possible even a few months ago. On the other hand, each of these crises has been met with resistance and denial, with many seeing responses to the crises as another instance in the culture wars facing the United States.

Although we work toward international solidarity and the common good, we must also be healers who help all our sisters and brothers to be heard and respected and in turn, listen with respect to the other.

As Franciscans in the U.S. have been reflecting on the inter-relation of the three crises and the social upheaval that they have caused, friars see themselves called to engage in ***reconciliation***. Although we work toward international solidarity and the common good, we must also be healers who help all our sisters and brothers to be heard and respected and in turn, listen with respect to the other.

Germany

A Franciscan friar who is part of *Missionszentrale der Franziskaner* (Franciscan Mission Central) in Germany has developed a quite perceptive analysis of the situation in light of the Franciscan tradition. Using St. Francis' embrace of the leper as a template, he has suggested that "God's image changes as we face human misery and the fragility of life." He has challenged his fellow Franciscans to respond to the need for social distancing by envisioning new forms of responsible social closeness, care and solidarity.

Looking at the example of the early Franciscans, he notes that the social conditions of their time — poverty, disease and exclusion — led them to understand, in contrast, a

God who cares about all creatures and fosters life, who offers a gift of compassionate relationship that cannot be acquired through money or power. The current pandemic, he suggests, challenges us to rethink our social and economic relationships and should move us toward a sustainable economy, one that cares for all people, especially the poor. He calls upon political leaders to see that a future-oriented economy must be one that protects the poor and the balance of nature, for without such protection there can be no sustainability.

The Franciscan virtue of ***patience*** is needed to move this vision forward. For Franciscans, patience is not a passive virtue but rather the active force of perseverance and confidence in a difficult time when the end is not yet in sight. Patience keeps an eye on the glimmering light at the end of the dark tunnel and keeps one from paralysis and unnecessary panic. With patience, he believes, the world will not only overcome the current crisis, but also shape a future that is worth living for everyone.

Franciscans see that the crisis caused by the COVID-19 pandemic is a call to greater solidarity. We further believe, however, that it is through the virtuous practice of minority, collaboration, reconciliation and active patience that true solidarity and a more sustainable world order can come about.

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LESSONS FROM COVID-19: THE ROLE OF DIGITAL HEALTH AND THE FUTURE OF HEALTH CARE

Lessons from COVID-19: The Role of Digital Health and the Future of Health Care

BY NATASHA SUNDERJI, MPP

COVID-19 has fundamentally reshaped our worlds and our daily lives. It has also exposed the fragility of our global health care systems. Health care systems around the world have struggled to flatten the curve and fragile, conflict-affected areas are unable to combat a pandemic of the magnitudes we've seen in Asia, Europe and the United States. Haiti has a population of 11 million but only has the ventilator capacity to support 60 people; Sierra Leone, West Africa, has the capacity to support only one. According to the WHO COVID-19 readiness report, only 10 out of 34 countries in Africa reported having adequate capacity to respond to the pandemic. From the lack of rapid responses to the mass shortages of critical health care supplies and health workers, traditional health care systems cannot keep up with the increased demand driven by an acute shock like a pandemic. The consequences will be long lasting.

At the same time, COVID-19 provides us with a unique opportunity to reflect, rethink and restart — to pivot from the traditional, long-standing models of health care surveillance and delivery to more resilient, forward-thinking health care systems. While the specifics of health care systems of the future are highly debated, one thing is certain: the future of health care is digital.

…underserved populations in low- and middle-income countries (LMIC) are likely to miss out on the benefits of digital health in the absence of appropriate investments and capacity building at the global, national and sub-national levels.

Since the onset of the pandemic, digital health solutions have accelerated the world's response to COVID-19, revealing the true potential of technology within the health care sector. Digital solutions have been crucial to flattening the curve in South Korea, China, Israel, Singapore, Japan and the Gulf States. Thanks to the hard-won lessons from the SARS outbreak in the 2000s and MERS in the 2010s, these countries actively built up their digital capabilities. South Korea was able to use artificial intelligence (AI) to quickly mass produce COVID-19 testing kits with Seegene, taking just three weeks to develop a test that targets genes specific to COVID-19. In China, Wuhan Thunder Mountain Hospital used AI-powered medical robots to disinfect hospital wards, measure patients' temperatures and distribute medical supplies, reducing both the workload of health workers and the risk of cross-infection.

Despite such promising examples, not everyone has benefitted equally from the technology revolution underway in health care. While most high-income countries (HIC) have the infrastructure and capacity to implement digital health solutions, underserved populations in low- and middle-income countries (LMIC) are likely to miss out on the benefits of digital health in the absence of appropriate investments and capacity building at the global, national and sub-national levels.

The rise of digital health solutions during COVID-19 prompts an important question for governments, NGOs, academia, the private sector and for society at large:

> *How can all organizations and communities contribute to and benefit from scalable and sustainable digital solutions to respond to the health care needs of today and tomorrow?*

We can begin to answer this question by reflecting on the lessons we have learned from the use of digital health solutions in the current COVID world:

Lesson 1: Digital has the Power to Strengthen Health Systems

The global response to COVID-19 has fast-tracked unprecedented innovation and is showing us the impact digital health solutions can have on all facets of health care. Six

major use cases emerged during the pandemic, illustrating the true potential of digital to make health systems stronger and more resilient:

1. **POPULATION MANAGEMENT, EDUCATION, AND PREVENTION:** Digital solutions have proven to be instrumental in tracking the spread of the infection and forecasting transmission dynamics with big data from migration maps coupled with machine learning models. In China, Tencent developed an AI platform that uses data from WeChat to model the virus's spread, correctly predicting COVID-19's spillover to Bangkok, Seoul, Taipei and Tokyo in the days following its first diagnosis.

2. **SCREENING AND DIAGNOSIS:** Symptom checkers, chatbots, remote consultations, AI triage tools and diagnosis kits have played a major role in easing the pressure on health care facilities and systems for testing and diagnosis. For example, Baidu's AI infrared thermometer uses facial recognition to identify humans and measure body temperatures of railway and airport passengers passing through Beijing and Shenzhen.

3. **TRACING AND TRACKING:** Digital has enabled health professionals and governments to track the real-time spread of the disease, the development of virus hotspots and the movement of infected individuals. Singapore strongly encouraged its citizens to install TraceTogether, an application that transmits Bluetooth signals between mobile phones to track and notify individuals that were in close proximity to a COVID-positive user over a 14-day period. In Africa, Ghanaian startup Redbird launched a COVID-19 daily check-in app and symptom tracker to enable officials from Ghana Health Service to see a real-time map of self-reported symptoms and ensure efficient follow-up with high-risk patients.

4. **QUARANTINE AND POST-CARE MANAGEMENT:** Digital, supported by Internet of Things (IoT) devices, has enabled remote monitoring of patients (e.g. vitals, symptoms, adherence) during quarantine. Geofences, or virtual perimeters for real-world geographic areas, have helped governments enforce quarantine

measures. Hong Kong introduced a compulsory 14-day quarantine upon entry for all overseas arrivals, enforced by requiring all new arrivals to install the StayHomeSafe app and pair it with a geofencing wristband.

5. **IN-HOSPITAL MANAGEMENT:** Digital medical devices, telediagnostics and robotics are lessening pressure on hospitals and health centers that experience unparalleled demand for health care services. Hospitals in Seattle, which served some of the first U.S. COVID-19 patients, collaborated with Microsoft to develop an online analytics screening tool that rapidly identifies those most likely to suffer from COVID-19, serving over 40,000 patients in the first week alone.

6. **DRUG DEVELOPMENT AND REPURPOSING:** The race to find an effective COVID-19 treatment is on; however, candidate identification, drug development, effective repurposing identification and fast-track or subgroup clinical trials have traditionally taken months to years. Technology is changing the game. For example, Insilico Medicine and BenevolentAI have been using AI models to screen existing and design new molecules that might inhibit COVID-19's impact.

Such examples highlight the diversity of digital health solutions today and its potential to strengthen all elements of health systems.

Lesson 2: There is a Need for Organizations and Communities to Build Capacity in Digital Health to Support the Development, Scale and Sustainability of Solutions

While digital health solutions will serve an increasingly larger role in the post-COVID world, not all solutions can be adopted by all groups of people. Many LMICs still lack the basic information and communications technology (ICT) and infrastructure necessary to support digital solutions at scale. Health care systems in these countries suffer from significant underinvestment in backbone technology infrastructure at the national and health facility level. That, in combination with the high cost of mobile broadband and internet connectivity, creates significant challenges for digital health adoption – particularly for last-mile communities. Digital health education and training also remain key challenges for many LMICs. Education and public learning opportunities are needed to enhance the overall digital literacy of LMIC populations, as

they enable populations to manage their own health and effectively support the design and scale of appropriate digital health solutions.

LMICs have some key advantages to build on, such as a smaller number of existing legacy systems than HICs, which provides them with an opportunity to leapfrog and adopt newer digital solutions faster.

Yet LMICs have some key advantages to build on, such as a smaller number of existing legacy systems than HICs, which provides them with an opportunity to leapfrog and adopt newer digital solutions faster. Mobile phone adoption, e-banking and blockchain applications are all technologies that users in LMICs have adopted faster and more comprehensively than their peers in HICs. Today, the Rwandan Government is partnering with Zipline to support drone-based blood delivery across the country. Zipline relied on recruiting and training local engineers and flight operators to support their work at scale. Similar novel digital solutions are possible in LMICs with the right strategic investments.

Lesson 3: New Models of Partnerships are Needed to Support the Appropriate Design, Tailoring and Delivery of Digital Health Solutions

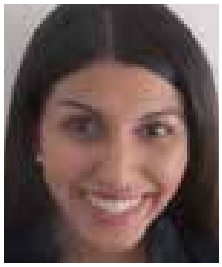
Partnerships enable stakeholders — governments, NGOs, academia, the private sector, civil society and local communities — to draw upon the collective expertise of one another to appropriately design and scale digital health solutions. Partnerships are also critical to ensuring data-driven decision making in health.

Health care systems are increasingly relying on the aggregation of large amounts of dispersed data to drive more efficient, quality care. This includes patient health habits and behaviors, socio-economic data like employment and education and geographic data. Partnerships provide the fuel for high-quality data and COVID-19 has shown us the power of cross-sectoral partnership platforms. For example, the COVID-19 Technology Access Pool (C-TAP), launched by the WHO, compiles COVID-19 health technology related knowledge, intellectual property and data through a global solidarity call to action. Such novel partnership platforms engage cross-sectoral actors and accelerate innovation and digital health solution development to ensure quality health care and access for all.

The Future of Health Care is Digital

Digital health solutions can fundamentally change the cost-quality equation in health care. They can empower patients, health providers, governments and other stakeholders with the information and tools they need to expand access and improve outcomes. Though health care is behind many other sectors in its utilization of digital solutions, COVID-19 has shown us that we can rapidly develop and implement digital health solutions with the right investments and political will. Now more than ever, we must encourage new, innovative solutions to ensure that the world that emerges post-pandemic supports and protects those most vulnerable. Whether we are responding to the health care needs of today or designing the health care systems of tomorrow, digital health must be at the forefront of our solution design. Each of us has a role to play in enabling the right leadership, infrastructure investments, capacity building and partnerships needed for success.

Now more than ever, we must encourage new, innovative solutions to ensure that the world that emerges post-pandemic supports and protects those most vulnerable.



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COVID-19 AND LESSONS FOR PANDEMIC MANAGEMENT

COVID-19 and Lessons for Pandemic Management

BY FR. CHARLES KITIMA, PH.D.

Because of the COVID-19 pandemic, the people of all nations began to see that they are truly one with all the world's people, equal in the face of death. The virus attacked without consideration of one's race, religion, social status or economic status.

Nations soon realized that they were not self-sufficient. They recognized that COVID-19 was the world's common enemy, and that its defeat required global cooperation in the form of sharing knowledge and resources. They called on their countries' private and public sectors to join them in the battle to defeat this new coronavirus. The pandemic has caused the world to focus its attention on the interdependency of human life. The sickness of one affects us all. My survival depends on your health. The spread of COVID-19 will not be curbed without cooperation.

As there is no effective vaccine against COVID-19, no one is immune from its ravages, including health care workers, many of whom have become sick or died. For this reason, many nations provide resources to these workers first.

Because it was determined that the main way that the virus was spread was through human-to-human contact, international air travel was curtailed or halted. At the same time, most countries went on lockdown, in order to limit such contact.

The World Health Organization, through research and dissemination of pertinent data and statistics, has kept nations apprised of COVID-19's march. This forewarning has helped to control the virus. The internet allows for the immediate dispersal of information for prevention, treatment and education.

To defeat the pandemic, the world needed national leaders who could look beyond their own borders for help and who would be willing to offer assistance to their neighbors. To save the weak among them, these leaders must manifest not only strength, but also love and compassion.

With the onset of the coronavirus, people clamored for answers. Leaders turned to science for ways to best combat this pandemic. Many people, however, realized that science alone cannot answer all of the complexities of life. They sought comfort in tradition or in religion.

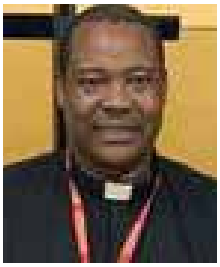
COVID-19 has prompted many to consider their mortality and their place in the world. To counter panic and the feeling of isolation, people turned to their faith for comfort. Spiritual leaders, through prayer and action, offered hope to the healthy and consolation to the dying and their bereaved families. Although people found that their churches were closed, many prayed alone to God, reflecting the words found in John 4:23:

> *But the hour cometh, and now is, when the true worshippers shall worship the Father in spirit and in truth: for the Father seeketh such to worship Him.*

People's dialogue with the Lord, the source of life, helped to conquer their fear and panic. In this way, the coronavirus has caused some to rediscover their religion, and more importantly, to re-awaken the relationship between them and God.

… the coronavirus has caused some to rediscover their religion, and more importantly, to re-awaken the relationship between them and God.

To conclude, one can rightly say that no country was adequately prepared for the COVID-19 pandemic. Each dealt with the pandemic through trial and error. Solidarity and central coordination at all levels of government proved to be the best principle, while transparency and cooperation among nations is the cornerstone for building a strong prevention strategy.



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COVID-19 AND THE VACCINE HESITANCY MOVEMENT

COVID-19 and the Vaccine Hesitancy Movement

BY ANDREW S. NATSIOS

Two major health crises are headed for a collision course over the next year with serious implication for every country in the world. The COVID-19 pandemic, both because of its health consequences and because of the damage it has done to the world economy, has driven policymakers to provide massive funding for the development of vaccines to combat the virus. These same policymakers will shortly face the Vaccine Hesitancy Movement (VHM) when health care providers, schools and government agencies try to immunize the population with these newly developed vaccines.

The vaccines should be available in the first half or middle of 2021. An intense and politically-charged competition is underway between advanced industrial democracies and China to see which health scientists can produce an effective vaccine first, a competition which is not necessarily bad if the vaccines are developed according to established scientific standards and the public agrees to get vaccinated.

Vaccines are one of the greatest scientific discoveries of the 20th century. We have had vaccines since the 18th century for smallpox, but no one knew how or why the vaccine worked. But they knew it did. In the 19th century German (Robert Koch) and French (Louis Pasteur) scientists developed the modern germ theory of disease which in turn led to the development of vaccines for most major diseases and the immunization of much

More than any other single factor, mass immunization campaigns against most communicable diseases have resulted in increased life expectancy around the world.

of the world's population. More than any other single factor, mass immunization campaigns against most communicable diseases have resulted in increased life expectancy around the world.

The second trend, one that predates COVID-19, is the VHM. Hostility to vaccines has been around since the 19th century, but was accelerated by a British medical doctor named Andrew Wakefield who claimed to have discovered a link between autism and vaccines. His research was published in *Lancet*, the respected British journal, but it was later discovered that Wakefield had an egregious conflict of interest and had manipulated the test results. *Lancet* later denounced his research and withdrew it from their website. Dr. Wakefield was later debarred from practicing medicine in the UK; he moved to Austin, Texas where he continued to spread his anti-vaccine messages.

Domestic politics is now complicating efforts to combat this disinformation campaign of the VHM as elements of the populist left and populist right have united to attack vaccines. The VHM has been concentrated in Berkeley, California, Austin, Texas and Detroit, Michigan, but it has been spread online through the worldwide web and now has a growing following around the world. This has alarmed medical professionals and research scientists because an increasing number of parents are not allowing their children to be immunized. The drop in immunization rates, in turn, threatens herd immunity which has been a central doctrine in public health science for much of the last century and protects the world's population from most major diseases. Herd immunity develops when a sufficient percentage of the population is vaccinated against a disease, which effectively prevents its spread.

Dr. Peter Hotez is one of the leaders of the pro-vaccine movement, which is trying to counter the anti-vaccine disinformation campaign. Dr. Hotez, a Senior Scowcroft Fellow, is one of the greatest health scientists in the world, creator of the Neglected Tropical Disease Movement and Dean of the Baylor School of Tropical Medicine. He has written a powerful book called *Vaccines Did Not Cause Rachel's Autism: My Journey as a Vaccine Scientist, Pediatrician, and Autism Dad,* explaining in lay person's terms the incontrovertible evidence that there is no relationship between vaccines and autism. He has come under vicious attacks by the leaders of the VHM.

The VHM has now intersected with the COVID-19 pandemic to make the situation even more complicated. Many supporters of the VHM generally are organizing to stop the broad mandate to vaccinate everyone against COVID-19 when and if the vaccine becomes available for three reasons: they are suspicious of big pharmaceutical companies that are doing the research and development of some of the vaccines; they are concerned that the vaccines are being developed too quickly and proper protocols are not being followed in the vaccine trials; and finally, they do not trust federal institutions, particularly the Food and Drug Administration's regulatory process.

International politics has complicated the situation even more. Just at the time the international health community had nearly eliminated polio as a disease in the early 2000's — as it had done in the 1960's and 1970's for smallpox — al-Qaeda spread rumors in Nigeria that children who were immunized from polio would be sterile. This stopped the polio vaccination campaign in Nigeria as health care workers were being attacked and killed for immunizing children. The U.S. Agency for International Development (where I served as Administrator from 2001-2006), which was one of the leaders of the polio immunization campaign, counter-attacked by asking the Muslim Doctors Associations around the world to issue Fatwahs — religious edicts with legal authority in Islam — that parents refusing to immunize their children would be in violation of the Quran. Muslim doctors then successfully led campaigns to counteract al-Qaeda's propaganda in their communities to ensure children were immunized against polio (and other diseases). In addition, health care professionals in developing countries enlisted the active support of traditional leaders — village and tribal chiefs — to get the public vaccinated. These traditional leaders retain substantial legitimacy and authority in their communities even when the public distrust of their formal government structures remains very high.

Meanwhile, the Russian government has become involved in the VHM, according to research done by Professor David Broniatowski at the George Washington University School of Engineering and Applied Science. He found that a substantial portion of the internet messaging against vaccines was coming from Russian trolls. The research showed that almost half of these Russian trolls messaging on social media supported vaccines and immunizations, while the other half spread anti-vaccine propaganda. Scholars of Russian electronic warfare argue that this seemingly bizarre contradictory messaging by these

Russian trolls is a deliberate attempt to create what is called "epistemological chaos" in the industrial democracies designed to encourage public skepticism of our institutions, scientists and public authority. The public no longer knows whom to trust, whom to believe or what to do. This strategy feeds into the notion that there is no objective reality, just intellectual chaos. The problem for developing countries is that it is not just the public in advanced industrial democracies reading this material, but people in low- and middle- income communities as well.

The Vaccine Hesitancy Movement in sub-Saharan Africa has complex roots. Charles Shey Wiysonge, a South African health care professional, published a detailed analysis of the movement in his study *Vaccine Hesitancy, an Escalating Danger in Africa*. He argues that vaccines have been highly successful in reducing child mortality rates in Africa. Since the World Health Organization launched its Expanded Program on Immunization in 1974, and today, the percentage of African children who have been vaccinated (it's a three-shot series) against diphtheria-tetanus-pertussis (DTP3) has risen from 5% to 75%. He reports "over the past five years there has been stagnation in coverage across the continent with decreases recorded in some countries." While some of the barriers to immunizing all African children are the logistics of getting the vaccines to and administering them in conflict zones, accessing children in remote areas with no roads and supply challenges are additional barriers in the growing VHM. The movement has manifested itself in South Africa, Cameroon, Mozambique, Zimbabwe and many other countries.

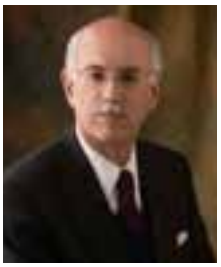
Many of the leaders of our health care systems, governments, academia and the private sector are counting on new vaccines to stop this accursed pandemic. They will shortly be in for a shock when 30 – 50% of the people refuse to be immunized in the United States.

This brings us to the current COVID-19 crisis. Many of the leaders of our health care systems, governments, academia and the private sector are counting on new vaccines to stop this accursed pandemic. They will shortly be in for a shock when 30 – 50% of the people refuse to be immunized in the United States. Add to that, we anticipate increased hesitancy in low- and idle-income countries. This, in turn, will prevent the development of herd immunity. The failure to develop herd immunity will only extend the life of the pandemic.

Traditional leaders in low- and middle-income countries at the local level should be recruited to lead public education efforts. Pro-vaccine messaging can be done using local radio, which penetrates even some of the most inaccessible communities in poor countries, but also social media such as Facebook and Twitter, given the spread of smartphone usage, can be used to get the message out.

Educating parishioners about the need for vaccinations, not just for COVID-19 but for all infectious diseases, may be the greatest service the Church can perform in a period of chaos and crisis in our societies.

For many people in the United States and around the world, the institution they most trust is the Church. Educating parishioners about the need for vaccinations, not just for COVID-19 but for all infectious diseases, may be the greatest service the Church can perform in a period of chaos and crisis in our societies.



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Notes

The current pandemic has highlighted our interdependence: we are all connected to each other, for better or for worse. Therefore, to emerge from this crisis better than before, we have to do so together; together, not alone. Together. Not alone, because it cannot be done. Either it is done together, or it is not done. We must do it together, all of us, in solidarity.

POPE FRANCIS

General Audience, Sept. 2, 2020

Consider how the complexities and challenges of the pandemic create an opportunity for us to rethink, reset and renew our global health relationships:

"We're all in this together: No country or group of people has been spared from the reach of COVID-19, and this global infectious outbreak is not the last of its kind."

NEERAJ MISTRY, MD, MSC

"The pandemic has reminded us of the vulnerability of life and the fragility of human existence."

CARDINAL PETER KODWO APPIAH TURKSON

"Rallying around the ideal of global health is not only a matter of justice, but a matter of survival."

CAMILLE GRIPPON, MA

"The pandemic has in many ways ignited and paved new pathways and breakthroughs within social, pastoral, environmental and cultural spheres and calls us to imagine more."

SR. DR. BEENA MADHAVATH, UMI, WITH M. THERESE LYSAUGHT, PH.D.

"Educating parishioners about the need for vaccinations, not just for COVID-19 but for all infectious diseases, may be the greatest service the Church can perform in a period of chaos and crisis in our societies."

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