TPWKY	This is Exactly Right.
Erin Welsh	"I am a public defender. I practice in a small area of the state that is not one of the epicenters for the coronavirus. There are parts of my state that have been hit hard and there have been cases in and around my area. A great deal of my time and energy has been devoted to my currently incarcerated clients. Often when I see articles on social media about coronavirus in jails and prisons, there are a lot of comments along the lines of, 'Well it's their own fault for being there.' This frustrates me a lot. First, not everyone who is locked up has been convicted of something. Many of my clients are locked up because they could not make bail. Also minor crimes should not carry a death sentence.
	When courts went to restricted schedules in mid March, my office started filing motions for bond for clients whose cases had been continued. One of my colleagues contacted the local jail to find out information on male inmates abilities to social distance and maintain hygiene. Female inmates are housed elsewhere and we did not receive information on their situation. We found out: one, showers and toilets are shared with one shower for 16-17 inmates. Two, clothing is washed twice per week, linens are washed once per week, and blankets are washed monthly. Three: two or three inmates sleep on the floor of a pod designed for 14. Four: there is no access to hand sanitizer. Five: there are limited supplies of soap, toilet paper, and tissues. And six: there is not enough physical space to allow inmates to maintain three foot separation as was the recommendation at the time.
	The judge hearing our motions was, and at the time of writing this still is, of the opinion that inmates are safer in jail than out on the streets. Of the approximately 20 bond hearings that we did the first day, two or three were granted. For our next round of bond motions, my colleague went to court with an article from a national newspaper and a PowerPoint presentation, both written by an epidemiologist who studies disease in jails and prisons as evidence that one case in a jail or prison would spread like wildfire throughout the inmates and corrections staff. But since there wasn't a peer reviewed study and the epidemiologist was not physically in court to present her research, the judge would not let my colleague admit the article or PowerPoint.
	The lack of scientific consensus is a roadblock we keep running into. News reports say studies show various underlying conditions cause greater risk but we have no way to present that evidence as evidence, so the judge does not consider it when making determinations. We have tried to proffer what we have read in news reports but the prosecutor objects and the court does not accept our attempts. In all, the jail population has been reduced about 15% which is not bad but it does not fix the hygiene issues or the fact that inmates cannot physically maintain the now recommended six foot distance. I do not know how many inmates are immunocompromised nor how many have other health issues which would put them at greater risk if they were infected. I do know there are inmates in those situations, I represent some of them. I do not know what measures the jail is taking to screen inmates who may be showing symptoms. The local hospital is small and already has coronavirus patients.
	I get multiple calls a day from incarcerated clients asking if they can have a bond hearing or furlough motion. Some I can file, most are not eligible. Many of my clients have read in the paper about inmates in other jails getting out which is true but my clients are not in those other jails. They are where they are with judges who still believe they are safer locked up. A few jails in my state have now had outbreaks. So far we have not had a positive case in our jail but I believe it is only a matter of time."

Erin Allmann Updyke	"I am a daughter to two Mexican parents who migrated to the U.S. when they were very young. Before the pandemic began, I was working in the ophthalmology department at a large network of clinics in the California central coast. My life was pretty ordinary. I got to work at about 7:30am, got a coffee at the café across the way, worked 8-9 hours, then headed home. On the weekends I did a lot of hiking with friends, walking downtown, or going to cafes to read or hang out. Just before the start of the pandemic, I had accepted the admission offer into the PhD program, began making plans to move, and in the process of starting a research position at the institution in May. Unfortunately all of those plans have been put on hold due to COVID-19.
	I am passionate about public health and had been volunteering at my county's public health department so I heard about the novel coronavirus shortly after the first incident was reported to the WHO. I began to worry about my parents when I saw that patients who seemed to be impacted most severely and also dying were older people with underlying conditions. My mom is a breast cancer survivor and also has an underlying heart condition, and my dad just recently fell sick from pesticide exposure. I am constantly telling my parents to be careful, wash their hands, etc. but it's difficult when you can't be there and they're struggling, both financially and health-wise. Add on their undocumented status and it really amplifies the fear.
	When you're undocumented, moving through society undetected feels like the key to survival and a lot of times seeking professional medical attention feels like a risk too big to take. At the start of the pandemic I felt hopeful because I trust our leaders in scientific research spaces as well as our medical and healthcare staff. But I quickly came to realize how much impact the administrative and political side of things has on science's ability to save lives. Aside from my worry stemming from the lack of leadership coming from people in positions of power, I was also just really stressing out about the fact that most people I knew or was connected to via social media had no idea how to get reliable information. Another big stressor is money but I think there are a lot of people stressing out about that right now.
	Like a lot of people, I don't have an income now but I still have rent and bills to pay. I also regularly help my parents financially but I can't do that now either. I think the message that I wanna drive home the hardest is, number one, there are populations in the countries who have been victims of exploitation, who have dedicated their lives to becoming true Americans, who had selflessly given their labor and their bodies to prove that they can be and are productive members of this national community, who will unfortunately not be granted access to aid during this pandemic. And these are decisions that have been purposely made by the people who have been elected to lead. Not only is this a humanitarian crisis in our country, but it also costs a lot more money to disenfranchise communities and limit their access to healthcare than to grant them the tools and services they need to stay healthy.
	Number two: there are a lot of healthcare providers and staff who are putting their lives on the line for our communities and they're also probably experiencing some level of oppression. They really need the support of their community, they need to feel that their community is behind them, backing them up when they are expressing concerns regarding their safety and working conditions. It is pretty obvious now that the fight against this pandemic will have to be led by the people on the ground who hold no administrative power but care enough about preserving human life to take on the fight. But those of us who will be stepping up to make homemade masks, organize donation drives, and offer free meals and services must remember to make an intentional effort to consider and include the most marginalized folks in our communities."
TPWKY	(This Podcast Will Kill You intro theme)
Erin Welsh	Wow.
Erin Allmann Updyke	Wow.

Erin Welsh	Those were excellent firsthand accounts.
Erin Allmann Updyke	Thank you so much for writing in.
Erin Welsh	Yes, yes. So those are two firsthand accounts that people sent to us when we were asking people to fill out the form and we really, really appreciate you taking the time to write that out and share your story with us. I think it's very interesting and important to hear all these different perspectives.
Erin Allmann Updyke	Yeah, thank you so much. Man. Also so well written.
Erin Welsh	So well written! I know! It's amazing. Hi, I'm Erin Welsh.
Erin Allmann Updyke	And I'm Erin Allmann Updyke.
Erin Welsh	Welcome to another episode, the eighth episode in our series on COVID-19 which we're calling Anatomy of a Pandemic. This week we're talking about the disproportionate impact this pandemic is likely to have on populations that are already vulnerable and what we are currently doing to try and minimize that impact.
Erin Allmann Updyke	But before we get into that, we have a few pieces of business to get into. First off, firsthand accounts, which you just heard two of. We're gonna keep doing these episodes and that means we're gonna need more firsthand accounts from you. If you're willing to share how this pandemic has impacted you and you're okay with us featuring your story as a firsthand account on upcoming episodes, we're asking for you to go to thispodcastwillkillyou.com and click on COVID-19 FIRSTHAND to fill out the form there and we can get back to you.
Erin Welsh	Second, alcohol-free episodes. On our website we have made a special playlist that has our episodes with the quarantini talk edited out. We're providing these for anyone who for whatever reason doesn't wanna hear us talking about alcohol. Don't worry, our normal episodes will still have quarantinis and you'd actually have to go out of your way to listen to the alcohol-free ones.
Erin Allmann Updyke	(laughs) Lastly, business-wise, if you've listened before you probably know that we have a Goodreads list which Erin Welsh pretty much curates.
Erin Welsh	(laughs)
Erin Allmann Updyke	I'm not big on the Goodreads list.
Erin Welsh	It's also user contributions.
Erin Allmann Updyke	That's true, it's a great list. It's a really good list. But now we also have an affiliate page on bookshop.org which is an amazing online bookstore that works with independent bookstores to support them financially. So you can find that link on our website along with links to books on bookshop.org in our reference section for each episode.
Erin Welsh	Yeah, we really love the idea of bookshop.org and the listener who sent that to us, thank you very much.
Erin Allmann Updyke	Yeah.

Erin Welsh	So on Bookshop we have a few different lists. So I'm thinking now maybe to separate them into nonfiction, fiction, and memoirs. But in any case you can find all of the books that we have read in our episodes there and then we'll also throw in some more that we have read and liked or that other listeners have recommended.
Erin Allmann Updyke	Yeah.
Erin Welsh	And then I also want to just give a little friendly reminder that even though public libraries are closed, if you have a library card and an appropriate device, you can still check out eBooks, you can still check out audiobooks, you can still check out magazines. And there are also a ton of other amazing resources on libraries online, so you should check out your local library website.
Erin Allmann Updyke	Awesome.
Erin Welsh	All right well, is it... What time is it, Erin?
Erin Allmann Updyke	I believe it's quarantini time.
Erin Welsh	I believe you are right. (laughs)
Erin Allmann Updyke	Checking my watch now.
Erin Welsh	Here we go. So Quarantini 8.
Erin Allmann Updyke	Quarantini number 8.
Erin Welsh	Quarantini 8 has bourbon, apple brandy, grenadine, and lemon juice.
Erin Allmann Updyke	Yum!
Erin Welsh	It's pretty good.
Erin Allmann Updyke	That sounds good, I don't have those ingredients so I haven't tried that one yet but sounds tasty.
Erin Welsh	It's not bad. I can vouch for its decentness.
Erin Allmann Updyke	Decentness. (laughs) Just what everyone wants in a qurantini.
Erin Welsh	(laughs) No, no, it's better than decent. I think it's tasty. But you know, people have different tastes. So anyway.
Erin Allmann Updyke	It's so true, so true.
Erin Welsh	Yeah. Okay, all right, so moving on.
Erin Allmann Updyke	All right.

Speaker	Text
Erin Welsh	So we got some emails from listeners asking us to clear up a few things about COVID-19 from our previous episodes, so we're gonna do that real quick before we dive into the interview. The first is about herd immunity. So in one of our COVID-19 episodes, we said something like, 'Herd immunity as a strategy is a terrible strategy'. Which is retrospect may have been a bit confusing because we usually talk about the importance of maintaining herd immunity in preventing outbreaks. So why would herd immunity be a bad strategy? Well first, let's just go over the definition of herd immunity. Herd immunity is simply that if there's a large proportion of people who are immune to a particular pathogen, outbreaks of that pathogen are less likely to happen because the chain of transmission can't be maintained. It's the way that we achieve herd immunity that makes it a good or bad strategy.
Erin Allmann Updyke	Right.
Erin Welsh	So you can achieve herd immunity by either vaccinating people or through actual infection with a pathogen. Right now we don't have a vaccine for the virus that causes COVID-19 so the only way to achieve herd immunity for that would be through having everyone get infected. But if we were to do that, an unbelievably number of people would become severely ill or die, our hospitals would be overburdened even more than they currently are, and so that is why herd immunity for COVID-19 at this point is a bad strategy.
Erin Allmann Updyke	Right.
Erin Welsh	It's sort of just the way you get herd immunity. Does that make sense?
Erin Allmann Updyke	Yes, excellent explanation, Erin.
Erin Welsh	Thank you, thank you.
Erin Allmann Updyke	Okay. The second thing that people have written in about is about the R0 and this idea that we've talked about of bringing down the R0 of SARS-CoV-2. So usually on this podcast when we talk about the R0 of a pathogen, we describe it as kind of an unchanging inherent characteristic of that pathogen. For example, we've said that the R0 of measles is between 12 or 18, or the R0 of smallpox is between 3.5 and 6. So when we talk about bringing it down, bringing the R0 down, how can we even do that? How is that a thing?
	It has to do with how the R0 is calculated. These numbers - and again the R0 is the reproductive value of a pathogen - these numbers are estimates that are based off of a particular kind of idealized scenario in which one single infected person goes into a community of fully susceptible individuals where no one else that they're around has immunity to that pathogen. The number of people infected from that one person in that community would be the R0 value. That would be the basic R0. The effective R0 depends on how many people in that community are immune or on how much people change their behavior to actually decrease their exposure. So both of these numbers are context-dependent. The basic R0 of measles is 12-18, but the effective R0 in a community that has high rates of protection against measles, for example high rates of vaccination, is much, much lower because there aren't enough susceptible people in that community to actually sustain that chain of transmission.
	So in the absence of an effective vaccine such as we are living right now with COVID-19, we can still drive down the R0 by breaking the chain of transmission through changes in our behavior. Which brings us to a very important discussion in this interview today.

Speaker	Text
Erin Welsh	Yes. If you have listened to the podcast before, you know that our sign off is 'wash your hands, you filthy animals'. And throughout this pandemic, hand washing has been hammered over and over again as a good way to reduce your chances of getting infected with the virus and passing it along to others. And it is a really good way to prevent that from happening but what if you don't have clean water? Or soap? What if you're not able to shelter in place because you're fleeing from a war? Or what if you can't practice social or physical distancing because you live in a slum or refugee camp?
Erin Allmann Updyke	These are the questions that Dr. Jonathan Whittall, who is the Director of Analysis at Medicines Sans Frontières, aka MSF, aka Doctors Without Borders, brought up in his amazing article titled 'Vulnerable Communities are Bracing for Impact of COVID-19'. We brought him onto the podcast to talk about how this pandemic is likely to impact populations that are already vulnerable or whose health and safety is constantly under threat, and to discuss what we can learn from working in past public health crises with limited resources.
Erin Welsh	You'll hear from him right after this break.
TPWKY	(transition theme)
Jonathan Whittall	My name's Jonathan Whittall, I'm the Director of the Analysis Department for Doctors Without Borders, so I work on global issues related to forced migration, conflict and humanitarianism, health policy issues. We have a team of people that are digging into each of these broad thematics to try and help our projects and our teams that are working in the field understand the environment that they're trying to navigate. At the moment I'm talking to you from Beirut in the Middle East and what I'm working on at the moment is 190% COVID-19. (laughs)
Erin Welsh	Yeah, yeah. So what kind of projects are you working on there or what specifically are you doing in Beirut?
Jonathan Whittall	So what we're doing... Well I'll talk more broadly than on Lebanon, but what we're doing on COVID-19... So Doctors Without Borders, just for your listeners to have a little bit of background, I'm sure many of them know what we do but we're an emergency medical organization. So our goals are saving lives, alleviating suffering, responding to emergencies, we work in 70 countries around the world, we respond to epidemics, so this is not something new for us in the sense that we do work on epidemic response. But we also respond to neglect, people that are excluded from access to healthcare, and the impact of conflicts, disasters, etc.
	So with COVID, we've been responding since the beginning when it started in China and the epicenter, as you know, has now shifted to Europe and North America. And what's interesting is that for the first time in MSF's history, we are conducting a major medical emergency response in Europe. So the crisis, the emergency has overwhelmed the health system in Europe and there was a need for MSF to respond to this emergency. So we're now working in Italy, Spain, Belgium, France, a few other countries in Europe. And this kind of epidemic requires work on multiple different levels from community levels right up to hospital care and very sophisticated hospital care. But what we've seen in Europe is that the health system is a very individually-based model, so focuses very much on the individual and it's very hospital-focused. So for example, if you have cancer you would want to be in Europe to receive treatment. If you're facing a pandemic, it's something that Europe hasn't dealt with for 100 years.

	But at the same time, Europe is not gonna stay and North America's not gonna stay the center of this epidemic for long and we're extremely worried about what's gonna come next, where we start to see the virus entering into lower resourced countries where the kind of next wave of this pandemic will hit. And there we will face different dilemmas and difficulties more linked to the already weak, overstretched health system. So yeah, grappling with all of these issues from our emergency response as it stands today to preparing for when the next wave hits are what we're really focused on at the moment.
Erin Welsh	Gotcha, yeah. So the COVID-19 pandemic, for so many people, is unprecedented but there are also many other populations that have experienced these devastating outbreaks or epidemics or other just more continuous threats to their health and safety, as you mentioned. And can you talk about what you're seeing in terms of the differences between this COVID-19 pandemic and other public health emergency situations such as cholera outbreaks in refugee camps for example, or Ebola epidemics.
Jonathan Whittall	Yeah. So the biggest difference is scale. This is happening everywhere at once. So I think every health organization, every ministry of health is gonna be pushed to its limits and beyond. And what we're gonna need is a kind of global solidarity. And I think with COVID-19, the outcomes for the severely ill is extremely concerning for us which is why it's so important to break the chain of transmission and to lower the number of critically ill. So in this sense, the community component is quite similar to what we see in other epidemics. We can't wait for patients to reach the hospital to tackle the pandemic, we need to work at a community level, it's a critical part of the overall response and that's very similar to the kind of work that we do for example in Ebola.
	The problem with COVID-19 is that the measures that people need to take to protect themselves are hard or even impossible in some places, social distance, isolating the elderly, the medically vulnerable, hand washing. And the disease is also transmitting when people are mildly sick or even not symptomatic at all which makes the management of tracing contacts, or if one person that's sick has contact with another person, we call it contact tracing, and we try to follow the potential spread of the disease. This is very difficult in COVID-19.
	So usually in an epidemic situation for Doctors Without Borders, if it was happening in one specific location we would deploy the whole scale of our emergency response and supplies and we would set up large scale response in a specific location that identifies people that are sick, traces who they've been in contact with, educates the community about the virus or the disease, makes sure that they're referred to the right place, that they have the right kind of sanitation equipment etc to be able to wash their hands or whatever the case may be to prevent transmission. And we would do that alongside the ministry of health, we'd make sure that we were able to respond in that hospital when patients do become sick, and we'd potentially be able to handle it and bring it under control. In cases where vaccines are available, we'd then be able to do a large scale vaccination campaign to prevent further transmission.
	All of this is needed in the COVID-19 response but it's happening everywhere at once around the world so it's not in a specific confined location and we're facing a lot of supply shortages of protective equipment, of masks, testing capacity is limited so we're struggling to be able to test everyone that needs to be tested, logistical challenges are occurring in terms of flights. So we have to get creative and pragmatic to respond and this is how it's different to some of the other epidemics that we would usually respond to.

Speaker	Text
Erin Welsh	Mm-hmm. Yeah, absolutely. So you mentioned that Doctors Without Borders is an emergency medical response organization and so that experience, you would think, potentially gives them a bit of a leg up or the ability to mobilize or adapt more quickly than some of these other hospitals or regions that haven't been accustomed ever to working under such crisis conditions. So do you think that there are some lessons that these other hospitals in some of these regions that are currently being impacted right now that they can learn from physicians or logistical coordinators that have worked in these crisis situations previously?
Jonathan Whittall	Yeah, I do think there are some experiences that can be exchanged and lessons that can be learned. I think one thing that MSF has had to learn, probably more than hospitals say in the U. S. or Europe, is how to do infection control when you're seeing massive patient volumes. So what a high income country's system is not used to necessarily is organizing patient flow from triage to treatment and to discharge while keeping infected and non-infected areas entirely separate with high volume of patients. And this is something that we're very used to doing with a large quantity of patients and having to manage that infection control at the hospital level. And this is really what we've been helping hospitals with in Italy and Belgium for example and Spain as well, is how to adapt the flow of patients through the hospital and how to think differently about infection control when you're dealing with this volume and scale of and epidemic.
	And then I think there's a more unfortunate lesson that we're able to share and that's how to make tough decisions, ethical decisions about who to treat and who not to treat when you're facing resource limitations. And this is something that sadly MSF encounters in many parts of the world where we work and there are limitations to the resources that are available and difficult ethical decisions have to be made. And this is something that our health workers are unfortunately exposed to and it's something that many health workers in parts of the world have not had to face to the extent that they are today.
	I think the other thing is our role as an organization is always to be advocates for the most vulnerable, to ensure that the most vulnerable are able to receive treatment based on their needs and not based on their ability to pay. And I think many of these vulnerable groups that are often most at risk are overlooked by the health systems that are responding to these needs today. I think maybe one other lesson would be, I touched on it earlier, but on the public health kind of response. I think there's a lot to learn in high income countries about the need to fight an epidemic at the community level before it reaches the hospital.
	And I've mentioned already that we can't only rely on high level medical care to save lives in this pandemic, it helps of course and it's incredible important and needed and Doctors Without Borders is also involved in providing high level care where it's needed, but it's only part of the picture and to win against an epidemic you really need to tackle it in the household, in the streets, in the towns, in the villages, in the neighborhoods and communities. This is something we're very used to doing but it's something that advanced health systems that are much more focused on individual patient care in a hospital have often lost the ability to do.
Erin Welsh	Mm-hmm. Yeah. You wrote this great opinion piece about some of the challenges that are faced by the most vulnerable populations in trying to prevent infection with this virus that causes COVID-19 and you've talked a little bit about some of those challenges. But can you talk maybe a bit more about those and also what those populations are, what the most vulnerable populations are?

Speaker	Text
Jonathan Whittall	Yeah, absolutely. I think what's important about this pandemic is that we're all affected by it but the impact is gonna be felt by some much more than others. And I think the measures that need to be implemented to break the chain of transmission, in many places where we work those measures are a privilege, that's not something that can easily be put into place. So we're rightly telling people and we're rightly being told to wash our hands regularly, but how do you wash your hands regularly if you have limited access to water, you don't have much soap, and you live in a refugee camp in Bangladesh, for example? So refugees are a key vulnerable group that we're seeing. From the islands in Greece to Bangladesh to many other places where they're living in high density conditions with very limited access to basic essentials like soap and water.
	We're also told rightly so to keep social distance, to keep a space between us to reduce the chance of transmission. But how are you gonna do that if you live in a slum in Rio or Johannesburg or Nairobi where again, high density populations, many people living in one building. I'm talking to you from Beirut today and recently I heard of people living in a house in a refugee camp on the outskirts of Beirut where they have to take shifts at sleeping because there's not enough space to sleep because of the density of people living in one room. So keeping social distance when you're forced to live in those kinds of conditions is something that's not very feasible.
	The other measure that we've seen is border closures. This is something that's been implemented all around the world to limit the movements of people, but when you're a Syrian refugee fleeing the conflict in Idlib, it's not something that you can do to stop crossing a border. We also know that people with preexisting health conditions like diabetes or other chronic conditions can be particularly vulnerable to severe illness when they get COVID-19. But we also know that many of these people around the world already don't have access to the lifesaving treatment that they need for these chronic conditions. So we can tell them to take extra care from preventing infection with COVID-19 but they can't access their insulin for their diabetes.
	So I think the thing we're concerned about is that the people that are gonna most suffer from this pandemic are those that are already neglected, those that are already excluded, that are overlooked, and it's gonna be those that fled from war that don't have access to treatment because healthcare is privatized or because there's literally no treatment available where they are. It's those who can't stock up on food and isolate themselves because they're literally living from one day to the next, it's people that have lost social support because of austerity measures that are falling through the cracks in society and the governments are either neglecting or in some cases even targeting. Yeah and it's people that are trapped in conflict under bombing and in siege. And these are the most vulnerable communities where controlling the epidemic is going to be the most difficult.
Erin Welsh	Mm-hmm. Yeah. What are some of the ways that MSF or Doctors Without Borders has been trying to overcome those challenges and to get them the aid that they need?
Jonathan Whittall	So we're currently focusing on responding to the needs of people in the current epicenter of the epidemic and we're paying special attention to these neglected groups that I've mentioned before like migrants. But also what we're seeing a lot is the vulnerability of the elderly who are in old age homes, for example. So we're focusing on those activities in parts of Europe but we're also adapting our existing projects. So we are already working with some of the most vulnerable communities in the world and so we need to ensure that they continue to have access to lifesaving services. But actually we also need to adapt our activities to be able to prevent the epidemic getting out of control in many of these locations.

So we're having to increase our hygiene promotion work, make sure people have access to the kind of water and sanitation that they need to prevent the epidemic. We're trying to put in place some isolation capacity in different places before we reach the peak of the epidemic, so we're able to quickly isolate patients when they've been identified. And we're really trying to also educate people about what is COVID-19, how to protect themselves. I think it's one thing to tell people what to do but it's another thing to explain what this is and how to become an active participant in preventing and protecting yourself and your family. But we know that in many of these places the pandemic is inevitable. It's gonna peak in slum populations and camps, in places that are experiencing conflict, so we really have to prepare for when that happens.

We have to understand more about the disease. Keep in mind that this is a new disease for all of us so we're learning as well about the virus so we have to understand which models of care, how do we organize ourselves in the best possible way considering all of these different limitations. And this is really just the beginning, unfortunately. What we're responding to today in parts of Europe and what we're preparing for in other parts of the world is really the beginning of what's to come. We're gearing up for, I guess, the public health fight of our lives.

Erin Welsh

Mm-hmm. Yeah. So have you seen any impact so far in terms of COVID-19 on these vulnerable populations or is that, as you said, sort of yet to come? Or are the beginning stages, are they currently happening?

Jonathan Whittall

I think there are things that are already happening. The lockdown in many places that's being implemented is already creating some difficulties in access to healthcare for populations that are on chronic medication, for a woman that needs to have an emergency COVID-section for example, for pediatric emergencies. So the measures that are being put into place create some challenges in their own right. And then of course in many places the number of cases is slowly rising and hospitals, even though they haven't reached the peak of the epidemic, are already facing extreme pressure, being overwhelmed, even before the peak of this outbreak in many places outside of where it's currently at its worst. So absolutely it's definitely already having an impact on the vulnerable. I think the other thing to keep in mind is that many of these communities, the capacity for testing is so limited that our ability to actually know where it is and where it's growing is hampered as well by those factors.

Erin Welsh

Yeah. Yeah. And so as you mentioned, Doctors Without Borders has recently expanded their efforts throughout Europe but obviously resources are limited. So could you talk about sort of how different groups or activities are prioritized during this expansion and maybe with a typical epidemic or outbreak?

Jonathan Whittall

So what we're doing in Europe is that we're really focusing on reaching the most vulnerable communities. So we're working with the elderly who are the most vulnerable to severe infection from COVID-19. Italy and Belgium, also in Spain we've extended activities to work in nursing homes for the elderly, these are places where people are often living in close contact, the facilities don't usually have specialized care or equipment for if cases deteriorate. And this is a particularly vulnerable and excluded part of the population in many places. And we're also working with homeless people and with migrants.

So as I said, these are communities that have often suffered the exclusion from access to healthcare at the best of times. So in Belgium and France, also in Switzerland, we're working with people that are living in overcrowded conditions, that are on the streets, sometimes in makeshift camps if they're migrants, or in substandard housing in many cases. And yeah, these communities are particularly at risk and so this is how we're prioritizing our role as Doctors Without Borders is to focus on those that are gonna fall through the cracks, who are gonna be excluded, and who have up until now also been targeted by the state.

In Brussels, just to mention as well, working with particularly vulnerable communities is one aspect but also there's a role for us as Doctors Without Borders to plan in expanding hospital capacity. Many hospitals, as I've mentioned, are reaching their limits, they're overstretched, they have an influx of cases they can't manage. So we're expanding that capacity by working, for example, in the emergency room to provide care for moderate cases, to allow the emergency room of certain hospitals to take in the most severe cases. And that's something that's really important is to be able to ensure that the hospitals can focus on the most critical and the most severe and to take the strain off of those hospitals. We've set up a 50 bed facility for example in Brussels that's probably gonna increase to around 150 beds. And this is really again to focus on vulnerable communities of migrants and the homeless and to be able to provide adapted and appropriate care for them as well to then reduce the burden on hospitals.

One other aspect that's a key priority for us, as I mentioned in the beginning, is the infection control aspect. So it adds value that we've found that we have, we were able to support hospitals in finding the best way to manage and prevent and control infection within the hospitals and that's something that's been really well received. But yeah, I mean the volume of our responses is growing by the day. We are really scaling up to respond to where the needs are the greatest. Just recently over the last days we've put more than 200 beds to support the hospital in Madrid in Spain. And yeah, as I've said, these beds are to take the burden off the hospital so that they can focus on the more critical patients. So there's a constant growing demand for our emergency capacity and we're able to scale up but we're also facing challenges and limitations.

Erin Welsh

Mm-hmm. Yeah. So one of the things that throughout our episodes on COVID-19 we have emphasized and said over and over again is that we need to collaborate internationally. So as part of a group that works internationally, can you talk about some of the challenges in coordinating this work at an international scale and why it's so crucial to communicate and work across borders?

Jonathan Whittall

Yeah, I mean I think considering the scale of this pandemic what we need is a kind of border-blind solidarity. We need a response to the needs where the needs are the greatest. We need international organizations, regional bodies, governments of course, everyone to mobilize to meet the needs where they are the greatest. Unfortunately we already saw kind of failure in this international solidarity with Italy where EU member states were slow to provide additional support to Italy when it was in the peak of its own epidemic. And it's difficult to criticize governments that want to keep supplies for their own population but I think it's important as well now to emphasize the fact that our fates are intertwined, that the ability to control this pandemic relies on our ability to control it everywhere. And it's not the time nor is it appropriate for a kind of petty nationalism that would focus our efforts on one specific geographic bordered area when this pandemic is global.

And what's needed is a form of international solidarity that transgresses those borders. And that's where it's key too to be able to coordinate amongst the different actors that have the capacity, that have supplies, to make sure that these supplies are going to where they're needed the most if we're really gonna have an impact on this pandemic. And if we don't have that kind of international solidarity, we risk entering into an endless cycle of this outbreak. And that's... Yeah. That's not something we wanna see.

Erin Welsh

Mm-hmm. Yeah, of course. And in general does it seem like countries are receptive to emergency aid by Doctors Without Borders? Or is it sort of dependent upon regional differences or what the particular crisis might be?

Jonathan Whittall	We are facing... Well, both. So we have governments and countries definitely are receptive to support from Doctors Without Borders in the countries where we're working, more than 70 countries, we're in discussions with all the different relevant authorities to adapt our activities, to scale up. But we also face significant challenges from governments as well in terms of restrictions on movement, in terms of supply restrictions, and these are challenges that we're constantly having to innovate around and adapt to and negotiate our way through.
	So we're spending a lot of time at the moment negotiating exemptions to some of the rules that have been put in place in terms of movements of supplies and people. Cause we need to obviously respond to this as an international organization, we have 30,000 people working for Doctors Without Borders around the world and many of them need to move to different project locations, we need to boost our capacity in certain areas, we need to bring some of them home in other places. We have supplies that need to be distributed to some of the hotspots that have to follow the epidemic curve in different places, and that requires a level of agility that we're very much used to as MSF, it's something that we've built up over 50 years.
	But when we're faced with many of the restrictions that we see that are imposed by governments, it's limiting our ability to move those supplies and those people around. And that's become extremely complex for us in terms of our ability to respond because we are having to negotiate constantly with governments for exemptions to certain rules and what we're finding is that governments are often better at implementing the restrictions and less so at putting together the exemptions that are needed for us to be able to do our work. And this is uncharted territory not only for us as an organization but also for every government that we're dealing with. So we're all trying to find the best way to respond and to be able to move those supplies and people, but it does come with a significant need for creativity, I'd say.
Erin Welsh	Mm-hmm. Yeah. So I know that it's still early on in this pandemic and there's a lot that's going to happen, but I think a lot of people have already started looking to the future to see how this might change the way we handle work, the way we handle public health, the way we handle international collaborations or public health organizations. And so what are some of the changes that you hope to see come out of this?
Jonathan Whittall	I think what COVID-19 is exposing is the inequalities that already exist in our systems. It's demonstrating how policy decisions of social exclusion, of reduced access to free healthcare, and how inequality in general has an impact on our health globally. So these policies that have entrenched inequalities, they're actually the enemy of our collective health and I think this is something that I hope to see out of this pandemic, a greater realization. I think what I also hope is that access to quality healthcare, it has to stop being based on purchasing power. We need to move away from healthcare being a commodity and it needs to stop being treated as such by governments. But I also think that I hope the governments after this are able to rethink the policy-made vulnerabilities that they have created in many cases, whether it's through restricted migration policies that results in people living in overcrowded conditions or without access to healthcare, whether it's in their approach to poorer communities that are unable to pay again for healthcare. I think these policy-made vulnerabilities are, again, it's been shown to affect all of our health at the end of the day.
	So I guess in essence maybe it sounds almost naïve but I would hope that we realize that healthcare must be for all, it's not something that can continue to be restricted as a commodity for some who can afford it. And I think if we can acknowledge that, it's a good starting point for reflecting on what needs to change further.
TPWKY	(transition theme)

Speaker	Text
Erin Welsh	That was fantastic, thank you so much Dr. Whittall, that was just really great to talk with you and thanks for all the work that you're doing.
Erin Allmann Updyke	Another great interview, Erin. Nice work. Seriously though, thank you so much for taking the time to come and talk with us and all of our listeners, we really appreciate it.
Erin Welsh	Mm-hmm, we do.
Erin Allmann Updyke	So what have we learned this time?
Erin Welsh	Yeah Erin, what have we learned?
Erin Allmann Updyke	Well first of all we've learned that this is the first time in its history that Medicines Sans Frontières, MSF, has conducted a major medical emergency response in Europe, which I did not know. Usually they work in locations where public health infrastructure is not nearly as well established as it is in most European countries. In Europe, most hospitals and the healthcare system in general are more set up for individual care, not for dealing with the volume of people that they're seeing now, because this hasn't happened in Europe in recent history. But this is what MSF does best. They work in under-resourced areas with limited supplies all the time. It is literally what they do. And they can use this experience and adaptability to help these other places scale up their infection control efforts and start to fight this pandemic from a community level. And they're doing this while also prioritizing the needs of the most vulnerable populations to protect them from harm as much as possible. Isn't it incredible?
Erin Welsh	Yeah, it really is. Number two. Another thing that we can learn from past epidemics such as Ebola and the way that we have handled them is the need to enact control measures at the community level. So getting communities, neighborhoods, households involved at these smaller scales. We can't just tackle this pandemic at hospitals by waiting for sick people to show up, we have to be proactive. Which is what I think a lot of regions are doing and have been doing, but this isn't something a lot of people have experienced so far and so it can be difficult to organize and get sort of the momentum up and running.
Erin Allmann Updyke	Definitely. Think we're seeing that firsthand. Number three. The things that people are told to do to slow the spread of disease or prevent infections are things like washing your hands, practice social or physical distancing, and often just staying at home as much as possible. And we've talked about some of this before but I think it's really highlighted in this episode. All of these things are a privilege. There are people who lack the clean water or soap to wash their hands and who live in extremely crowded conditions in a refugee camp or who can't shelter in place because they're fleeing war zones or they simply don't have a shelter to stay in, period. To protect these people, every person needs to do what they can to break the chain of transmission, all of us.
Erin Welsh	Yes, exactly. Number four. Even though right now, at the time of recording, the epicenters of this pandemic are in Europe and North America, it's not going to stay that way for long. It's only a matter of time before this disease starts heavily impacting regions that may not have the resources and public health infrastructure of wealthier nations, and when that happens we can't sit back and say, 'Oh well, it's their problem now, we've dealt with it here.' We need a border-blind global solidarity with open exchange of information and resources if there's any hope at reducing the global impact of this pandemic.
Erin Allmann Updyke	Preach. Speaking of preach, number five.
Erin Welsh	(laughs)

Erin Allmann Updyke	This is maybe my favorite. Access to quality healthcare needs to be universal for all.
Erin Welsh	I think that's my favorite too.
Erin Allmann Updyke	It shouldn't be political, first of all, but it absolutely should not be tied to your wealth. When access to quality healthcare is tied to your socioeconomic status like it is in this country, it creates a positive feedback loop where the poorer you are, the less you can afford healthcare, making you sicker, making you need to spend more on healthcare, making you poorer, etc. We have talked about this cycle of poverty and how it relates to disease on this podcast before, most recently in our episode on schistosomiasis, which is you haven't heard, it's a great episode.
Erin Welsh	Check it out.
Erin Allmann Updyke	But it bears repeating in the context of this current pandemic. The most vulnerable populations, like the ones mentioned by Dr. Whittall, are the ones that are going to bear the brunt of this pandemic as they have in other epidemics and disease outbreaks, and this will further increase the massive economic and wealth disparities not only among countries but also within them.
Erin Welsh	Yes, exactly. And we've seen this starting to play out already in the U.S. where new reports are showing that the number of COVID cases and deaths broken down by race pretty clearly shows that black people are being disproportionately affected by and disproportionately dying from COVID-19. And this is unfortunately not surprising if you consider the long history of systemic racism and oppression in the U.S. that has led to striking inequality in access to quality healthcare. And you know, these data are new but I think that in the weeks and the months and the years to come, we'll get a much clearer picture that not everyone will feel the impact of this pandemic equally.
Erin Allmann Updyke	Womp womp.
Erin Welsh	Womp womp. (laughs) I mean, yeah. So this is not uplifting information but I think it's really important to talk about these, there are aspects of this pandemic that we cannot ignore and this is one big one.
Erin Allmann Updyke	And I think it's kind of like a call to action and a call to arms, like things need to change going forward and I would hope that something as horrific as this can at a bare minimum lead to some actual change.
Erin Welsh	I hope so. I think that's sort of what a lot of the silver lining thinking I've been doing is like, how is this going to change access, working practices, economics, everything. How is this gonna change the way we handle public health?
Erin Allmann Updyke	Sick leave, yeah.
Erin Welsh	Yeah. So hopefully it will lead to some very positive change and even the discussion now that we're seeing in social median and the news is in a way encouraging, I think. Can be encouraging, I should say. Not always.
Erin Allmann Updyke	Yeah. Well thank you again, Dr. Whittall, for taking the time to talk to us. And hopefully listeners, you learned as much as we did from this episode.

Speaker	Text
Erin Welsh	Yeah. Okay, sources. So we've got just a couple here. We're going to link to that article that I mentioned by Dr. Whittall and you guys should definitely read it, it's an excellent article. And then the other thing that we're going to post is sort of an explanation of how scientists calculate R0 and it's written by an epidemiologist and professor at the University of Michigan.
Erin Allmann Updyke	Awesome. Thank you again to all the listeners who have sent in firsthand accounts so far. And if you're interested in doing that please go to our website, click on COVID-19 FIRSTHAND and thank you again to Duyen Spigelman for helping us get that Google Form set up.
Erin Welsh	Thank you Duyen! And thank you to Bloodmobile for providing the music for this episode and all of our episodes.
Erin Allmann Updyke	And thank you to you, dear listeners, for being you.
Erin Welsh	Yes, thank you. We appreciate you, we love you. Stay safe.
Erin Allmann Updyke	Seriously, so much. Keep sending us your questions too.
Erin Welsh	Yes, please do. Well until next time, wash your hands.
Erin Allmann Updyke	You filthy animals.