# COVID-19 and Inequality in the Global South

## 5/26/20

Good afternoon, everyone. My name is Padmashree Sampath, and on behalf of myself and the Berkman Klein Center, I am pleased to welcome you all to today's seminar. So today's seminar on COVID-19 and inequality in the global south is I'm really pleased to welcome two very eminent panelists here with me today, Dr. Madani Bocar Thiam, who is the chief of health and nutrition in the Myanmar office of the United Nations Children's Fund, and Miss Yvonne MacPherson, who is the US director of BBC Media Action and a Berkman Klein Center affiliate.

Before I start, as the moderator, I'd like to begin by offering a few thoughts to structure my discussion and to sort of lead our thoughts on the seminar today. So now, the discussion on COVID-19 in the global south, a lot of it has focused on disease vulnerability. And in many cases, as we have seen, there have been low counts because we see younger populations on the continent in Africa, in India, and other countries. And there have been immediate and effective responses because of lockdowns that have been imposed, and this has led to protect the overburdened health care systems in these countries, and it has also reinforced low infection rates.

But what we don't see, and what I think is really important to frame the discussion today, is that such lockdowns, while controlling the spread of the disease, have unforeseen socioeconomic outcomes, and they particularly affect extremely vulnerable groups in these countries, such as women, informal laborers, and other vulnerable groups. To begin with, the lockdowns have left millions of informal laborers without safety nets, homes, and employment. In India, for instance, around 415 million informal migrant workers were left stranded for weeks without the possibility of returning home.

This is a wider phenomenon. It also happened in Dhaka, but it happened in other mega-cities in Africa, for example, where 70% of the people are either self-employed or wage employed. Weak global demand has led to supply chain disruptions in all low-income countries in different global value chains, whether you take coffee, you take cut flowers, or you take ready-made garments.

This picture here is a picture of women who are basically the 1 million, mostly comprising of the 1 million workers who lost their jobs in Bangladesh. They gathered on the 16th of April on the streets of Dhaka to actually protest and ask for their wages which were due to them. The ready-made garment sector in Myanmar is another example, where, between April and May, more than 25,000 garment workers were already laid off in April, and now, more than 60,000 factory workers in Myanmar have lost their jobs.

In Africa, we are seeing similar outcomes. The World Bank estimates that sub-Saharan African economies will lose somewhere between $37 billion and $79 billion in output losses in 2020 due

to COVID alone. This is because of low demand, weakening global trade, and fragmentation of supply chains, on which a large number of people in low-income countries rely for their employment. The region, it's forecasted, could also face a severe food security crisis, because agriculture production is going to shrink between 2.6% and 7%. And these will have large repercussions on employment and well-being.

So while we talk about socioeconomic disruptions of this nature, what we have to bear in mind is that they have long-term implications for health, well-being, equality, and development. They worsen the particular vulnerabilities of specific groups of people because they already plague on resource-constrained health care systems. They constrain access to water, food, and sanitation, which is already constrained and unequally distributed in these countries.

Then they challenge already weakened institutional systems to combat this kind of rising inequality and unemployment. They push back already accomplished victories in eradicating poverty. There is a UN study recently which shows that we might go back 30 years in our struggle for poverty if we do not take on board these kinds of impacts of COVID-19.

And they also challenge health care in ways that go beyond the infection rate itself. Here, on the right side, is a very small commentary that I wrote, which has recently been published. It's available, a live link for that, on our website, as well, on our BKC website, for this event. I invite you to look into that, which looks at these issues and takes a much deeper analysis.

But for the purposes of this seminar, with this introduction, I would like to first welcome our panelist Dr. Madani Bocar Thiam, who, as I mentioned to you, is the chief of health and nutrition in the Myanmar office of the United Nations Children's Fund. He leads UNICEF support to improve the demand for and access to essential health and nutrition services for women and children, especially those most in need. He will be speaking to us today about his experience in looking at health care outcomes after COVID-19 in the field. So Madani, without further ado, I pass on [INAUDIBLE] to you.

Thank you, Padmashree and fellow panelists and participants. So thanks for this opportunity. And so what I'm going to do now is really very quickly share some thoughts or facts, I guess, from Myanmar with regards to the impact that COVID-19 has had on the health system there. So I will share my screen now.

So this is really just to give you an overview of how the epidemic has progressed in Myanmar. So on the 4th of Jan, Myanmar was notified by the WHO, and the next day, they started measures to look at looking at points of entry and measures in place like temperature screening and so on. And on the 31st of January is when their first person under investigation was detected, meaning having a fever and detected at a point of entry, likely, if I recall correctly, at Yangon International Airport.

Now, between end of Jan and late Feb, all testing that was being done in Myanmar was done remotely or was sent to Bangkok because the capacity was not in country. But as of 20 February, Myanmar developed that capacity and started testing in-house themselves. On the 13th of March,

just to give you a sense, the National Central Committee to Prevent, Control and Treat COVID-19 was developed. And it is chaired by the state councilor, so [INAUDIBLE].

On the 24th of March is when the government imposed 14 days quarantine for incoming travelers from a number of countries. Now, actually, that quarantine is 21 days for people coming in in a government facility, whether it's a hotel or actual health facility, and another seven days at home. And finally, one other key point is that, on the 22nd of April, Myanmar developed its Health Sector Contingency Plan, which I will go into in a couple of slides.

So I just wanted to give you a quick sense of what the dashboard that has been developed by the Ministry of Health looks like. And I'm just going to exit for one second and bring you to that.

So hopefully you can see this. And here you see it's a Ministry of Health and Sports dashboard that shows relatively real time. It's updated two or three times a day. Here, you can see the latest update was at 8:00 PM on the 26th, which is about four hours ago, I would say, or three hours ago. And you can see that there are 206 confirmed cases out of 20,000 tests, which comes up to about a 1% positivity, which I guess is within the range, but clearly there is a need for more testing, because 20,000 tests, if you think about it, is a fairly low number. So let me go back now to my presentation.

So as I mentioned, the government of Myanmar developed this Health Sector Contingency Plan with support from partners. And this plan really aims to help manage in a comprehensive way the health sector response to COVID-19, and gives guidance on priority areas and actions to be taken so that there is an adequate prevention and response to what they would see as a probable community transmission of this virus, which is the worst-case scenario.

Seven areas of focus are coordination, surveillance, and points of entry, looking at national laboratory system and the capacity in that, the clinical management and infection prevention and control, non-pharmaceutical interventions, such as stay-at-home orders or closing schools and so on, risk communication, and logistics and operational support.

Now, at UNICEF Myanmar, we've looked at it in five different ways in how we are supporting the response of the government. The first one is on risk communication and community engagement, where it's really important to look at targeted-- ensuring that there's targeted and accurate information to mitigate rumors, reduce stigma, and engage communities.

The next area of support is around critical supplies, diagnostics, and logistical support. Given our comparative advantage in our capacity, we have a very large supply division in Copenhagen that manages global procurement and has access to global markets. And so that has helped us to help procure PPE and masks and test kits, sanitizers and soap and disinfectants and oxygen concentrators and ventilators. Continued access to critical services. This is where we have the ability to support, whether it's helping to ensure that there's continued institutional delivery of essential care, the treatment for diarrhea and pneumonia, immunization, which I will get into a little bit later, nutrition, water and sanitation.

Now, what we can see, given some of the approaches, such as physical distancing, well, that has an impact on a number of services. And so, given that UNICEF has a mandate to look also at child protection, well, we're trying to see how we can mitigate the impact on accessing child protection services, as well as supporting alternative systems for continuous learning. And finally, on social science research, one thing that we are looking at is to try and assess socioeconomic impact and support emergency social protection response, likely, potentially, piloting a health micro-insurance scheme, and expanding existing cash-based interventions.

So broadly, the impact on the health system, what we've seen is that health care workers, equipment and facilities have really been reassigned to look specifically at the response for COVID, whether it's screening at points of entry, contact tracing, collecting samples, managing quarantine facilities and actual facilities, secondary and tertiary level hospitals, being repurposed as a quarantine facility. So we can see how that has an impact.

A bit of the detail in terms of the demand for services, of course, the movement restrictions and reduced public transport and quarantine in place orders in some of the townships in the country is really affecting people's access to services. And we know that Myanmar already has a quite high level of out-of-pocket health expenses. It's above 70% of total health expenditure, which is enormous, and one of the largest in the region. And we can see how the perceived risk/benefit calculation by individuals deciding to seek care will have an impact on if they actually go to seek services. So all of these come into play in how they have an impact on the demand for services.

A way to mitigate that is that the government has set up a COVID-19 hotline, where they have medical experts that are doing virtual triage. And so this is really to look at COVID and non-COVID. And they're able to refer to specific facilities or specific interventions. And also, for nutrition, there are preparations for an infant and young child feeding hotline, recognizing that there's an important aspect there.

Quickly, on service delivery, before COVID, in reality, there was only just over 50% of health care worker posts that are filled. So we can see how, with all this reassignment and prioritization around COVID, how this is having an even greater impact on the availability of health care workers there and their ability to provide services. So we've seen some essential reproductive maternal and child health and nutrition services reduced or paused. And one example is immunization, which I will get into in a few slides.

The reduced or no space at the higher level of referral facilities, as I mentioned, a number of these have been transformed into quarantine facilities. So the ability to refer for special cases has been reduced. There has been a bit of an impact on support to affected internally displaced populations in camps due to the movement restrictions. But when it comes to nutrition, what we've seen is that that is less affected because those services are mainly delivered by camp staff that have been trained. And also, some key lifesaving services, such as the treatment of SAM continues [INAUDIBLE].

On immunization, just very quickly, immunization was halted for the months of April and May because, again, health care workers had to prioritize the response to COVID-19. This is resuming on June 1st, and has actually resumed at the hospital organization level since the middle of May.

We can see how, for immunization, there is an increased risk of VPD's given the lower level of coverage, especially in some areas that are harder to reach and where there has been some outbreaks in the past, such as of polio, vaccine-derived polio virus in 2019 in one part of the country.

There's a potential decrease in community demand because of the instructions to avoid mass gatherings and exercise social distancing, and also that community fear of infection. With that being said, we've observed also that there is concern from parents of their children are missing out on their immunization, and there is demand for that, as well.

There's potential vaccine wastage, as you know, the multi-dose policy, where, because of the hiatus, some doses are actually going to be lost because they wouldn't be able to be used and expire during the break. And finally, a risk of vaccine stock-outs because of the limited global and regional transport options. We have not seen that because Myanmar has a fairly good buffer, but that is a real risk.

But this presents an opportunity because what has happened is, with the planning for the resumption of routine immunization, there's been an updated SOP developed. And this SOP puts more emphasis on better hand hygiene and compliance with standards for organized immunization at the community level. As well, the lower level staff are better reached through video conferencing, and actually getting a lot more instruction that way. And there's a shift also to data collection and reporting through an electronic system, which is much more efficient.

On supply chains, quickly, the global demand and global supply has been affected. There's been a surge in prices. The largest impact we've seen is for the transport of essential commodities for routine services, given the prioritization of the COVID-19 on key supplies, such as PPE and test kits. And in Myanmar, there is a lower buying power and a lower domestic production. So that really just is compounding the ability to ensure steady supply. And there is little domestic production, and anyways, whatever is there is diverted to COVID-19.

On communications, what we can say is that, in Myanmar, the MHOS Facebook-- I mean, Facebook is king in Myanmar much more than anything else. So Facebook is really the platform, the social media platform to reach people. And before COVID, the Ministry of Health website, for example, had only 300,000 page likes. And that dramatically increased more than 10 times, as it seems to be now. But that Facebook page is really useful to providing official statements and communication materials, guidance, a lot of that risk communication to the population.

So very quickly, you will probably be aware that the Lancet just put out a few days back early estimates on the indirect effects of COVID on maternal and child mortality. And looking at the scenarios that they have, if that is applied to Myanmar, what we see is the potential to have between 200 and 1,400 additional child deaths per month and between 16 and 77 additional maternal deaths per month. So the potential there is huge. And obviously, that looks at a mix of coverage and also wasting in children under five.

So very quickly, before I finish, look a bit at this socioeconomic rapid monitoring that we have been doing through the intersection with UNICEF. Looking at the way this has been done is

recognizing that, as Padmashree mentioned, beyond the public health response and impact, we have to really look at the socioeconomic side of things. And it's been recognized also by the UN. The UN has put forward a framework to look at how to mitigate that impact, given that this is an impact that would affect countries over the longer term.

And so in order to get a sense of how, at the household level, that COVID is having an impact, we've identified 120 households that are across the country in some of the more vulnerable or affected areas. So a mixture of vulnerability, mixture of actually where there are a number of COVID cases, such as Yangon, the capital, and a mixture of ethnic backgrounds and a mixture of urban and rural. Much more urban than rural, given what we've seen in terms of the epidemic in Myanmar. The average household size is just over five, and there's an average of about two children in each household.

So what we see, quickly, is that 50% of respondents of the households reported that they were still working. However, half of those were also reporting that their work situation had changed. So they were still working, but maybe they were doing another job or doing two jobs or so on. What we've also heard from them is that 50% of respondents said that products are more expensive, and that about 25% said that products are actually unavailable. So that gives a sense of the ability to consume, or the access to things to consume. And that's where we're seeing a bit of an impact.

I must preface, though, that this, again, is a very small sample. It's the first round of four planned rounds. It's a very small sample, 120 households. So the representativity of this, we're not going to get into that, but this is really to give us a snapshot of what we're seeing. 100% have heard of COVID, which is good. I think that means that the awareness is high, and social media plays a big role in that. One thing that we noticed was that the household noticed an increase in respiratory disease cases in the last six to eight weeks. Now, whether that is an actual increase or if it's the fact that households and caregivers are more attuned to what respiratory disease might be because of awareness, that remains to be seen.

If we look at children, 84% of children spent their time at home, and the vast majority of children spent their time indoors. What we have seen also-- it's not here-- is that it seems that children are actually happier. So spending more time in the home, spending more time with their families and parents and siblings, somewhat of a positive impact there.

A less positive impact is that 73% of women said that their chores or share of housework had increased. So you can see how the stay-at-home orders and children being at home and the care for children and for family members is a reality. And then lastly, just because I think I'm over time, one thing that they looked at is about consumption in terms of food. 75% said that there was no real change in what they ate.

And if it comes to breastfeeding, of 25 women, 21 said that there was no change in breastfeeding. And I think two or three said that they-- I can't remember exactly, but the level of change there is not really representative. So not much of a change in breastfeeding. But again, this is a preliminary observation on a small sample, with a few questions. So we're really looking

forward to additional rounds, and looking at how do we gauge this in terms of what we can glean from it.

And lastly, in terms of child poverty, the Myanmar Living Conditions Survey in 2017 estimated that 30% of children were living in households that were poor. And some modeling was done based on that information, based on recent information, looking at the fact that, when the impact of COVID, if we say that there is a reduction in one unit of income, the modeling suggests that there isn't a commensurate reduction of one unit of consumption.

The modeling says that that reduction is between 0.2 and 0.35 units. So if we model that according to that 0.2 lower bound and 0.35 upper bound, at a three-month lockdown, we see that the level of child poverty would increase from the baseline of 31% to about 40% in a three-month lockdown, and potentially up to 41.7% in a six-month lockdown.

Now, what this is also hiding is that, although there is 30% of children that are deemed to be in poor households, there's another 30% that are in the bracket right above, which is non-poor and secure. So we can see how that can have a drastic impact in terms of shock to those families that COVID would have. So there's a sense that the level of poverty may double because of COVID. But again, this is modeling that is very preliminary, that still requires consultation. But I thought it would be useful to share as part of this discussion. And so I will leave it at that, and thank you for the opportunity.

Thank you, Madani. Thank you for that. I was just told, by the way, that my slides didn't show up when I introduced. So apologies for that. Slight technical glitch. There were only four slides. The most important part was already written up, and thankfully up on a commentary, which is available at our BKC website.

So now, I will move on to introduce our second panelist, Miss Yvonne MacPherson, who is the US director of BBC Media Action, the international charity of the BBC to use media and communication for development. Yvonne is also a BKC affiliate, and she has been working on covering the Ebola crisis, previously, and now, COVID-19. And she will be talking to us about the impact of COVID-19 on vulnerable groups in the countries that she's been working in. Yvonne, the [? panel ?] is yours.

All right, well thank you all for joining this seminar, and thanks to Padmashree for inviting me to share some observations of how we are seeing the impact of COVID-19 on the communities in the global south that we're interacting with. I work for BBC Media Action, which is the international organization created by the BBC to use media and communication for development and humanitarian response. And why we've been asked to share in this forum it is because a big part of our job is to understand the lived realities of the people that we are creating content for.

We are producing and disseminating COVID-19 content to millions of people in the global south. And I'm not going to go into the work that we do, and instead I can share some links of that work in the chat. Instead, I want to focus on a bit of a needs analysis, and provide some examples that illustrate that vulnerable populations in the global south face multiple overlapping challenges. We are seeing now how population needs are quickly transitioning from basic

communication around prevention, symptoms, treatment to more complex and nuanced secondary impacts affecting livelihoods, security, psychosocial well-being, and so much more.

I've been asked to speak about what we're seeing in refugee communities. And here, I'll focus on the Rohingya refugees. There are about a million of them living in camps in Bangladesh. They have access to the basics, such as food and shelter and limited health care, but they're still extremely vulnerable. They're exposed to dangers of monsoon elements. Women and children face issues around security and exploitation. And they're completely dependent on aid. The first cases of COVID-19 were just confirmed in the last couple of weeks, and people are naturally worried.

Here are some images of the camps. You see makeshift homes with common walls that are packed in. Alleyways are narrow, and water and sanitation areas are communal. Standard advice around maintaining physical distancing and washing hands regularly are clearly going to be difficult in this context. Aid agencies and the government have added triage areas in primary care facilities and isolation in treatment centers, and our teams have been working hard to explain the concepts of isolation and quarantine. In the photo on the right, we showed a video of what an isolation center looks like in order to help demystify the concept.

We also track rumors and collect community feedback and perceptions of the Rohingya and the Bangladeshi host community, and we publish these in bulletins like the ones you see here on the screen. And we share these with the community and the humanitarian aid organizations to better orient their activities to respond to the needs and preferences of the communities. And again, I'll put the links to these bulletins in the chat, in case you're interested in reading them. And we're publishing them continuously and regularly.

So here's some of the feedback that we've gathered recently from some of this feedback mechanism. So first of all, in addition to the fear of the virus, the Rohingya people said they were concerned about movement restrictions, which is preventing them from earning money that they use to supplement the aid they get. Many say that the food aid that they get is not enough to meet their family's needs.

And because of these difficulties, they're saying that maintaining hygiene and distancing is not a priority for them right now. Instead, they're just looking for scope to earn money. And some have said that this lack of earning ability is causing an increase in crime, like robbery. And as my co-panelist already said, the Rohingya and the host community are worried about their children's education. They don't have reliable, or any, internet or the proper devices that would enable students to work online.

And then the other thing I'd like to share is just the sheer fear and stigma that is increasing in these communities. As infection rates increase in Bangladesh, there is growing fear and stigma. And what we're seeing is that, in rural communities, this suggests that people are not allowing outsiders to collect water from shared water sources for fear that they may have the virus. So they're sort of hoarding certain common resources.

People said that whole families are being ostracized if one of their family members is suspected of being infected. And they could even be told to leave the local area all together. There was even a case of a community sabotaging the construction site of a proposed temporary hospital for COVID-19 patients.

And if this context was not challenging enough, last week, a cyclone hit Bangladesh and eastern India. So Bangladesh as well versed in cyclone preparation, but no one has experience preparing for a cyclone in the time of a global pandemic. So just imagine, across Bangladesh, people had to make some tough choices. This is a case where a country facing the evacuation of nearly 2 million people in the coastal areas into crowded cyclone shelters also risks spreading COVID-19. Or, do they continue to restrict physical proximity and risk people dying from the storm?

So we've been working on preparing for natural threats like cyclones in Bangladesh for nearly a decade. And to think that all this work done by us and the government and other organizations is potentially undone by COVID, this work to get people to seek shelter to prepare for a cyclone is potentially undone is disheartening, because now people just doubt what they should do, though we are working on materials to help kind of remessage in this area. The cyclone did not hit the area where the refugees are directly, but the camps have been affected by high winds, heavy rains, and flooding, which in turn impacts food production and sanitation. And this will go on, as the monsoon season in a lot of Asia runs from May to September.

And when we consider the idea of compounding threats on top of vulnerabilities, through our community feedback service for Rohingya, we learned that families feel an added sense of fear and insecurity in the monsoon for unexpected reasons. Yes, there's flooding, which impacts livelihoods and sanitation, but there's also insecurity of women and children. We were told that the sound of the heavy rain on the makeshift tented homes makes people fear violence and kidnapping because the sound would mask any calls for help. So during this monsoon, people will be in their homes more because of COVID-19, livelihoods will be threatened, and the fear of crime will increase.

And with that, I'll turn to the impact COVID is having on women and girls more generally in the global south. So early data indicates the majority of rates from COVID-19, the mortality rates for COVID-19 may be higher for men, but the pandemic is having a devastating effect socially and economically on women. And it's now very well documented that lockdowns place women at higher risks of domestic violence. This is not specific to the global south, but generally, support services will be lacking. And we're seeing in our sexual and reproductive health projects in places like South Sudan that there's an increased risk of sexual abuse and unplanned pregnancy with girls who are forced out of school because of the lockdown.

Dr. Madani already mentioned maternal deaths that tend to increase during health crises due to the redirection of health resources away from reproductive health care to pandemic containment. We also know that 70% of frontline health workers worldwide are women, putting them at greater risk of COVID-19. Malnutrition among women and girls can also increase as a result of reduced household income and disrupted food supply chains. In our data from Bangladesh, again, in the rural areas, it's quite common for women to feed their husbands and the male

members of their family first, and wait to eat before they have their own meal. And many women have told us that there just isn't enough food left for them to eat.

In countries where adolescent pregnancy and marriage are common, we know that temporary school dropouts often become permanent for girls, as they take on new roles such as caring for children, the sick, the elderly. And then finally, UN reports that, with nearly 60% of women around the world who work in the informal economy, many of them are experiencing the economic shocks as a result of the pandemic. And we can talk more about those. But at the same time, their unpaid care work is increased as a result of school closures and the elevated needs of older people.

These are just a few examples of how the pandemic is impacting women and girls and refugees. And I hope what I've done is to highlight the fact that, for so many vulnerable communities in the global south, they have to contend with multiple and complex challenges all at one time. And for many of these challenges, the solutions are not simple. This has implications for the global community, which I hope we can unpack in the discussion, but one thing that is critical in all of this is that the health and the humanitarian aid sector needs to listen constantly, involve and respond to the needs of the people that they're trying to serve. Thank you.

Thank you, Yvonne. Thank you. So from both of you, I hear certain common themes, and I think these are really important. So one common theme is that health and socioeconomic challenges, they compound each other. What we see in the case of COVID-19 is really an enhancement of certain poverty and impoverishment routines, which can have very serious impact on children's health and, in this case, refugees and women's health outcomes, Yvonne.

And I now see one question here from Emily. And this question is about-- well, it's a comment, actually. But before we get to that point, I would like to actually, before we get to other questions, I'd like to ask the two panelists to reflect on something. From the work that you've been doing, do you really see how the global community could help more? Do you see parallels between what you've been doing and broadly in other countries, where you have colleagues working? What can we do more, and how can we actually get policy and global policy to bring to bear on these interlinkages between socioeconomic challenges of COVID-19 and health care outcomes?

Ladies first.

OK, sure. Yes, there were a lot of subquestions in there. And yeah, I also wanted to just acknowledge the comment of Amy Yi that absolutely the Bangladeshi government has been doing cyclone preparedness for decades. And cyclone preparedness is very well entrenched among the Bangladeshi community. So yeah, so I just wanted to agree with that wholeheartedly. But what I was trying to illustrate was that this has never happened before in a global pandemic. So we've all had to rethink how to do this, you know, the government, but also agencies that are used to supporting the government to prepare for cyclones. But thank you, and very much agree with your point.

Coming to your question, Padma, about what the international community can be doing better, I can speak more to the issue of communication and the provision of information. And an observation that I have is that, oftentimes, there's an expectation that something is created centrally by an international organization in the global north, and then just disseminated to the global south. And we often get this suggestion from people who support our work to just make it once, and then translate it into lots of languages.

And we're constantly having to push back on that idea that there's just this one-size-fits-all communication for everybody and handwashing means the same thing to everyone. I mean, that's such a classic example where it doesn't. And so every piece of communication needs to be completely grounded in the context of the people that need to know about that particular health message or piece of communication.

And so we need to be much more thoughtful and deliberate about involving the very communities that we're trying to communicate in to understand what their information needs are, to have them involved in the creation of this content so that it's culturally relevant, that the linguistic idioms are correct, because something that is produced in northern Europe and disseminated in Southeast Asia, for example, is really not going to resonate.

We've seen examples, where we have images of handwashing from sinks, and a lot of the people that we reach don't have running water in their homes. They get water from communal pumps, so those kinds of representations, I think, are important to make sure that they're relevant.

Absolutely. Thank you, Yvonne. Madani?

Yeah, maybe just to touch on the last point that Yvonne mentioned is the different levels of education and literacy. I think within Myanmar, on top of that, we also have a fair number of different ethnic groups. So it's different cultural realities. It's different levels of literacy, and so what we have tried to do is to support the government in preparing a lot of this risk communication that is tailored to a particular community, so we've helped them developed standard handwashing messages and so on in, I think, 80 different languages.

So it's about tailoring for the community to make sure the message gets across, leaving no one behind really focusing on the ones that are hardest to reach. And so a strong part of our focus has been looking at some of those areas that are hard to reach, be they geographically are harder to reach because they're more remote or socially harder to reach because of those differences, as I mentioned, literacy or access to services. So that's one area we've looked at, and we're working also through local organizations to reach some of these communities because some of those communities the government can't reach, so it's really about how do we ensure that those key services are still able to reach the most vulnerable.

A couple other points. The UN has-- I mean, again, COVID-19 is a public health emergency, but it's leading to a socio economic emergency. The impact is immense in terms of the countries are moving back in their development. I think the human development report just came out-- COVID-19 and human development report, which is showing that for the first time since 1990,

there is showing a backtrack. So it's clearly having a major impact on the broader development lens.

And so how can we support governments that are gradually recognizing this? The UN has developed the framework to look at how do we support addressing the impact-- the socio economic impact-- of COVID, and so all the UN is coming together at country level to look at all the key areas, the different pillars, be it health itself. How do we help the government to improve strengthen its system, use this opportunity of COVID to expand and accelerate the strengthening of the system, all the different pillars.

Be it looking at social protection. How do we support that in the COVID-19 context and beyond? Nutrition. Nutrition is so multi sectoral that it's about agriculture, it's about private sector, it's about education, it's about social welfare, so how do we bring all of that together to support nutrition from a multi sectoral angle and ensure that the food system actually is able to cope and respond and not suffer from this, because we're seeing that the potential that that can have. So this framework that the UN has developed, and there's a few other pillars and we'll get into them is really designed to bring the UN together for this unprecedented situation and how do we support various countries in looking at this as an opportunity to advance and strengthen systems and look at the short term, look at the covert response but with the thought of what are the longer term changes and dangers.

And I think Ebola started to do that in West Africa, where many of the big donors there be it the UK or US and countries in Europe looked at that as an opportunity, but I'm not sure to what extent that has actually led to changes within the systems in West Africa, the countries that were affected. So we're hoping we can learn from that and ensure that this is a massive opportunity. There's massive amounts of resources. There's a lot of generosity. The UN Secretary General has called it global solidarity. How can countries that are already affected in the global north also continue to support countries that are affected in the global south?

Yeah. Thank you. Thank you, Madani. So we've got a number of questions here. A couple of them are very similar, so I'm going to try and paraphrase that for both of you to respond to. I think one important question which is also something that comes up more frequently in my work is what is the role of the internet in each of these contexts in terms of promoting communication, improving health outcomes, and trying to understand the socioeconomic challenges of COVID-19 in different context and remote work. For instance, what I find is that we tend to look at the lower rates of infection and assume that these countries are not as much affected. There is really the impact is felt elsewhere, which is the topic of the seminar, but I would like both of you to try and reflect on something like that.

Madani?

[LAUGHTER]

Am I on your left in the screen?

[LAUGHTER]

Very quickly, obviously, the role of the internet-- as I mentioned in my presentation, social media is massive in Myanmar. Myanmar went from no cell phones to smartphones, and Facebook has become King. Nothing beats Facebook.

So Facebook is really the medium to reach the masses, and so recognizing this. I think Facebook has also played a big role in supporting a lot of countries in this region, giving them ad credits to facilitate the pushing of information to the masses, but very importantly also, trying to make sure that misinformation is managed, that stigma is not something that continues, but also a lot of the fake news. Make sure that's taken care of, but a lot of it the impact that-- how should I say-- the bullying. Online bullying as well, because we've seen that health care workers are being ostracized in some communities because there is the fear that being infected and bringing the infection to the community.

Myanmar has a lot of migrant workers. So Myanmar nationals living abroad in Thailand or China coming back, and they also have been discriminated against. So it's about how do you ensure that the population is-- there awareness is raised. One thing that we've done, also, is we have a interesting platform called the You reporters, and that is basically a roster of youth that are connected and that we can work with them to push a lot of questions, and so we get a nice sample and check from them about whatever topic you want.

And it's a platform that is there, and we have used that to reach out to youth across the country to ask, OK, what is COVID? How do you contract it? Just to fact check on their awareness, but also you can use that platform to put out questions, and so that's a platform that has been quite helpful.

One last thing I wanted to say is, on the-- maybe it's not about the internet, but Yvonne mentioned about the increase in vulnerability of women and children in this COVID context, be it abuse and so on. So what has happened in Myanmar is that we've actually helped the government put in place mental health and psychosocial support hotline so anyone can call in. It's free to call in.

They can call in and ask for support and speak to experts to say, OK, this is my situation. So you have to virtualize or digitize the kind of support they would have received in a safe space or another environment, and that is something that is being put in place. So using the digital. It's becoming a new norm, and in Myanmar, I think that with the leap that Myanmar has had on the use of the internet and that technology, I think, it's an area that there's a huge potential.

Thank you. There is one question that really nicely follows from this in the Q&A. So we have a question saying, how are digital technologies being used in Myanmar and Bangladesh to tailor the public health response, especially just in contact tracing or immunity certificates, coupled with digital identity initiatives, which are being introduced in many parts of the world. Do you see something similar happening in your contacts, and if they are, are there privacy safeguards that you observe? What are your thoughts on that?

If I can quickly, Myanmar does have an app that they've set up for contact tracing, and I mean, it's anchored in transparency and anchored in respect of data and so on. So that's something that

is being used. Myanmar has really taken this response seriously. The contact tracing is of a technical level that is of the global north.

In each and every suspected or confirmed case, there is a very meticulous contact tracing that's done to go back and identify potential contact points. So I think that technology is there and it's being used, and there are no reported concerns around security of information for those individuals over.

Great. One more question I think which is really interesting for this panel to consider is coming from Leo Cortana of BKC and his question is, the current trend I make as blurred some of the lines and the divide between the global south and the north and how do institutions like the UN or BBC media action work in balancing these perception and sharing best practices of campaigns or solidarity networks coming from the global south and clearly challenging the global north status quo.

You're on my right, so I'll go to you.

[LAUGHTER]

OK, I'm wondering if I could just make a couple of points about the internet as well, because I think there were a couple of questions directed to me on that too and wanted to acknowledge how important the internet and you know platforms like Facebook and other social media platforms are in being able to see what people are talking about and understand what the information needs are and what their misinformation is, and so part of our misinformation and rumor tracking is to keep an eye on social media. And then that helps us to understand what people are saying and maybe what false news needs to be corrected and to point people to more reliable sources of information. And we had a question from Sergio mentioning Whatsapp, which is such a critical platform that and other messaging apps, because again, we know they're very popular among the populations that we work with, and we know that that's a place where misinformation can spread very quickly.

So it's something that we're looking at as well, but for the Rohingya, specifically. So they don't really have great access to the internet. In fact, their access is restricted. So we are having to rely on the community itself and some leaders in the community, but I wanted to speak to another great question related to this, which was around research and how research is changing in the time of COVID.

It's such a great question because we rely so much on being able to interact with our community-based organization partners and the community members themselves, and now, we can't physically go and meet them and ask them questions and interact with them. And so we are having to rely on more electronic ways of connecting and getting information, getting this two way information communication channel established, and so that might be everything from SMS surveys that people can use even on dumb phones. And in fact, we relied on that when we were responding to the Ebola crisis in West Africa.

So we've begun to pick up some of these alternative research practices because of the challenges of COVID. And in fact, my colleague, who is our head of research, has just written a blog on how to conduct research in the time of COVID, so you can see that on our website if you want to learn more about that.

OK, I think we still did not answer the question on the lessons from this crisis from--

That's a tough one.

--the global north and the global south and where we see things to share. I think that there are similarities between the kinds of things that we observe for low income groups in the United States right now, for instance, and what we are seeing in terms of the outcomes for low income groups and in countries of South Asia, Southeast Asia, Africa, and so on, and I think that-- I mean, there's clearly a need for sharing best practices and trying to evolve global policy responses, which really tackle those that are excluded. And so I want to invite both of you to reflect on that and maybe share some thoughts?

I can quickly share. I mean, if we look at how the pandemic has progressed, the global north has-- in a way-- reacted a little bit late in terms of some of the non-pharmaceutical interventions that could have been taken to, I guess, help to try and mitigate the start and the expansion of the infection in the various countries. Whereas if you look at Africa and other parts of the world, I think, perhaps they had a little bit more time to learn about the potential of not taking certain measures quickly, so you look at many countries in Africa. The fact that they, in general, have put in place measures earlier.

I saw an article the other day that was saying that that is the reason why, or one of the main reasons why, Africa has been less impacted. Yes, there's the issue of testing and ramping up testing to a certain level, but I think there's a lot to learn there from the global south in terms of their ability to respond relatively quickly. I mean, there are obviously some exceptions of some countries, where the leadership is this seems to be in denial about what needs to be done, and then the testing.

I think we've seen the number of countries, whether it's, South Korea and other countries that have really taken seriously and ramped up testing as a measure to test, treat-- test, trace, treat. They've really taken that approach, and we see the impact that that has had. So there is a lot to learn from the global south in terms of this pandemic and how it has progressed, and I think someone would need to maybe take a look at that and put those ideas on paper.

No, you're absolutely right.

Try to contrast the approaches.

No, you're absolutely right.

What we're doing is UNICEF is we're trying to put out these-- at the local level, celebrate successes and celebrate initiatives that are happening, and we've helped, for example, to set

online training for health care workers on infant and young child feeding. IOICF training is something that's really done at the community level and with a group of midwives and mothers, and it's really hands on, and how do you do that in an environment, where there's physical distancing? So we've helped devise ways to do that, and we're helping the government to tweak their guidelines a bit so that we're still able to make sure that those essential services are continued.

Yeah. Living with the disease still circulating outside, I think the south really knows how to do that. So there is really a lot to learn from the south in this case. So we are a bit over time. And I'm really, really thankful to all of you for the questions and for being indulgent with us. So if my two panelists have nothing more to add, no? OK.

I definitely-- I want to answer that question too.

[LAUGHTER]

If they don't have nothing more to add, which they don't apparently. So I would love to--

Oh, I would love to add something if I can.

Oh you would love to? Oh, yeah, OK, sorry yes, you want-- please.

It's a global north and south question, because I think it's a great question. And I think I risk a little bit being on a soapbox with my answer, but I'll try to be quick, which is and maybe from the media perspective is what we've seen in the global north is that there is a-- people are accessing news media, information media during this time, right? Because during a crisis, everyone needs to know what's happening.

And similarly in the global south, people need access to trusted local sources of information and local media, and so I suppose this is a bit of a plug for me on the what's happening to local media in so many countries in the global south, which is they're not being able to survive financially, and it is so important that we have local media to hold governments to account, to hold the international aids sector to account, which includes a lot of global north organizations that are in these countries responding to the crisis. I think media can be a great accountability mechanism and a place for local voices to be heard, and so I think that there needs to be some more attention paid to supporting independent media in all countries.

Thank you, Yvonne. I think we have still one open question for Yvonne, that is, but I'm really aware that we're running out of time. We're almost seven minutes out of time. So Yvonne, would you like to take a quick 30-second stab at this, or--

Is it the one about GBV?

Yes, yes, yes.

Yeah, great. So we have we work on the issue of gender-based violence even pre-COVID. So what we do is we try to understand what are the drivers of gender-based violence, what are some of the norms, and then we'll create content that challenges a general acceptance of certain levels of violence within families. So challenging some norms, and then also promoting discussion, getting experts and people who are trusted. These could be religious leaders or other leaders in the community who can talk about it in a supportive way, and so so much of it is just about bringing the topic to the fore and having it-- and having people who people trust to talk about it and to speak against it and to help really shape and influence some norms around general acceptance of gender-based violence, and then where possible to point people to resources and help.

OK, thank you. Thank you very much. So I'd like to end by thanking you all for joining us at BKC. And I want to particularly thank my two panelists here, Yvonne and Madani who joined us all the way from Myanmar, despite the time difference. So thank you both.

And for all of the participants, I want to invite you to visit our events page after a few days, where the presentations will be live and if you have additional questions, you can always contact us, and we will have the recording of this event live, and I would like to thank the BKC events team, Rubin, Meghan, and colleagues for making this so wonderful. So thank you very much. Thank you, and yeah, OK, with that, goodbye. Goodbye. Thank you all.

Thank you, Padmashree and Yvonne as well for the opportunity. It was a great opportunity. Thank you.