COVID-19 RESPONSE

Creating a lasting legacy of collaboration across South Asia

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IN February 2021, Covid-19 numbers started rising again in South Asia with the official daily case counts rising beyond 400,000 in India, 6,000 in Pakistan and 7,500 in Bangladesh, straining their health systems. The massive surge in India soon spilled over across the border into Nepal, leading to "apocalyptic" scenes of overwhelmed hospitals.

This virus knows no borders. Containing it has necessitated global cooperation among scientists, policymakers and society. Despite wide variation in how nations have responded to the pandemic, the most successful strategies find commonality in their adherence to science and attention to local context.

The deadly surge in 2021 makes a regionally-coordinated, evidence-driven strategy even more critical. The virus continues to challenge us with its mutations and new lines of attack. If we are to move at the speed of the virus, it is necessary to construct multi-stakeholder regional coalitions to devise new solutions and frugal innovations that can be applied across South Asia. Given our shared and mostly similar social, economic and cultural contexts, local successes must find means to be amplified across the region.

But is that possible, given the troubled history South Asian countries share? The mutual mistrust appears to have hit a new nadir, as SAARC has not even managed to hold a summit since 2014. But today we write a positive, hopeful story about a new consortium we are involved in, with core team members from India, Pakistan, Nepal, and Bangladesh jointly developing Covid prevention strategies. The emerging consortium provides an example of how neighbours can work together for mutual benefit despite political differences.

Every country in South Asia has struggled to ensure consistent mask-wearing to stem the spread of Covid. Beliefs, priorities, traditions, and aversions to behaviour change are more similar across South Asia than we care to admit. These commonalities mean that interventions that are successful in changing behaviour in one place are highly likely applicable in other parts of the subcontinent. We have experienced this with Community-Led Total Sanitation (CLTS) campaigns to solve the problem of open defecation—originally developed by Bangladeshi NGOs in partnership with an Indian consultant—now broadly applied across South Asia and beyond. The Grameen Bank microcredit model was an indigenous South Asian innovation that spread rapidly. BRAC's recent "Graduation" programme targeting the ultra-poor in Bangladesh was replicated with success in India and Pakistan. India's digitised social protection ecosystem with Aadhar IDs and Jan Dhan accounts serves as a model (albeit with cautionary notes) for other countries in the region. E-governance programmes in Pakistan, like eVaccs and Citizen Feedback Model, have been replicated and provide strong models ready to be deployed regionally and globally.

The new pan-South Asian consortium in response to Covid-19 evolved out of an experiment conducted in Bangladesh that successfully changes social norms around mask-wearing in rural communities. The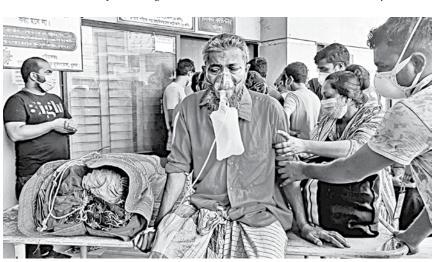 four-part NORM intervention was originally examined in a cohort of 350,000 individuals across 600 villages. A combination of free mask distribution, information, reinforcement in public spaces, and role modelling by community leaders lead to large, sustained increases in mask usage that persisted beyond the period of active intervention. BRAC is implementing the model to reach 81 million people across Bangladesh.

The team is now partnering with

The deadly surge of Covid-19 in 2021 makes a regionally-coordinated, evidence-driven strategy even more critical.   PHOTO: **DIPANKAR ROY**

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several organisations across Pakistan, India, Nepal, and Bangladesh to start adapting the model to fit each country's context, and set up partnerships to pilot, implement, tinker, and learn. The Self Employed Women's Association (SEWA) quickly implemented the model to reach over one million members in Gujarat. An additional 1.5 million masks were shipped from Bangladesh to support SEWA's outreach to other states. Lahore's Commissioner worked with our research team to adapt the NORM model to an urban setting, and devised new creative ideas to improve effectiveness. For example, they have prepared to deliver masks at doorsteps using Pakistan's postal service, and are targeting beneficiaries on the basis of billing information from utility companies. Philanthropists and private corporations are sponsoring the masks. We are re-importing some of these innovations back to Dhaka,

inspiring further scale-ups in Dhaka, Chattogram, Rajshahi and Nepal's Kathmandu.

Effective mask promotion requires visits to thousands of remote villages, and those same visits can be used to prepare for more effective community-based healthcare responses. To that end, a host of physicians, scientists and community-based organisations created the Swasth Community Science Alliance, committing to pragmatic, science-based protocols to manage mild and moderate cases of Covid-19 in rural India, where institutional health care access is limited. These guidelines (available at https://science.swasth.app) were translated to training tools for healthcare workers by digital health innovators like Noora Health, making them widely available across the region.

NORM implementation teams based in Lahore, Ahmedabad, Peshawar, Hyderabad, Dhaka, Kathmandu, and Delhi are learning from each other's successes and failures. The process usually starts with the original research team sharing evidence-based insights with implementing agencies, as the implementers adapt the design, co-create localised implementation protocols, and are threaded together in a collaborative environment across countries where each implementing

team iterates while learning from others' prior iterations, and all our sub-teams are connected in an active learning system that allows us to course-correct in real time. This coalition is poised to change mask-wearing norms amongst hundreds of millions of people across all of South Asia.

The CSA is working with partners across rural, tribal belts around India. A team of physicians from India and the Indian diaspora work with local implementing partners to support design, implementation and monitoring of home-based programmes and Covid-19 centres providing rigorously protocolised treatment for moderate cases, with oxygen, proning and steroids.

Combining the NORM and CSA interventions, our Masking-Treatment-Vaccine Preparation (MTV) approach offers a sensible strategy to mitigate the pandemic until universal vaccination is achieved. These are regional solutions that thoughtfully apply scientifically sound interventions to the local context.
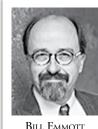
The Covid-19 crisis has increased policymakers' appetite for evidence-informed policy measures that can be quickly implemented to stem transmission. This drive for quick action has created some unprecedented opportunities for enhanced cross-country collaborations that are normally hampered by politics and mistrust. We hope that the consortium that first formed around mask-promotion, and now around science-based treatment approaches, and that developed quickly and organically without regard to national boundaries, can serve as a model for a broader and deeper collaborative ecosystem that endures.

We need to come together to solve problems that affect us all. Let the lasting legacy of this pandemic be a new era of partnership in social innovations that can benefit all South Asians.

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PROJECT ◼ SYNDICATE

Herd immunity is closer than you think

BILL EMMOTT

WHEN will the world have vaccinated 80 percent of all adults (the level presumed by scientists to produce herd immunity against Covid-19)? Most people's answer is 2023 or 2024, which suggests deep pessimism about the progress of vaccinations outside the rich world. That is also why pledges at the recent G7 summit to donate one billion doses to poor countries during this year and in 2022 look to some like generous game-changers.

But despair is the wrong sentiment and self-congratulation by the G7 is the wrong reaction. If the current daily rate of vaccinations can be maintained, the world can reach its vaccination goal by January 2022. The first step toward effective action is to convince oneself that a problem is solvable. To that end, the Global Commission for Post-Pandemic Policy, an independent, non-partisan group of 34 high-level doers and thinkers from around the globe, has done the math to come up with a global vaccine countdown. Surprisingly, we found that the challenge is much more manageable than we imagined, and on a timetable much faster than that assumed by the G7 governments.

The arithmetic is simple, but first you have to decide whether to regard China, the world's most populous country, as an inspiration

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vaccines, we are still nearly there.

Let's look at the numbers. The world's population is 7.9 billion, an estimated 5.85 billion of whom are adults (74 percent). If the goal is an immunisation rate of 80 percent, 4.7 billion will need shots, which on a two-dose vaccine regimen means 9.4 billion doses. As of June 11, 2021, Our World in Data reports that more than 2.3 billion doses have already been administered worldwide, leaving just over seven billion doses. Divide that by a mid-

'The recent increase in supplies and the Global Commission's vaccine countdown indicate that what we need is well within reach.'
FILE PHOTO: **REUTERS**

range daily figure (34 million) and you get roughly 211 days—January 2022.

Yes, seven billion is a very large number. But look at what is happening: every day, China is administering 17-20 million doses; India is administering just over three million; and even Africa is administering nearly 900,000—a 37 percent increase since the start of the month. Moreover, these numbers are still rising in most countries. Though not every middle-income country will be able to match China's pace, that at least should be the motivating goal.

Until recently, the main constraint and source of frustration was the limited supply of vaccines. But production is rising sharply, with the global monthly output of vaccines approved by at least one major regulatory body increasing from 420 million doses in April to 822 million doses in May.

China's two vaccine makers, Sinovac and Sinopharm, accounted for more than half of this total (nearly tripling output from 164 million doses in April to 454 million in May). Output of Pfizer-BioNTech and Oxford-AstraZeneca vaccine doses in the European Union doubled, from 69 million to 140 million, while the number of Pfizer-BioNTech,

Moderna, and Johnson & Johnson doses in the United States rose from 71 million to 105 million. The only disappointing production figures were in India, where output slipped from 76 million doses in April to 62.6 million in May.

In the coming months, the key constraint will no longer be supply shortages but rather financing and logistical challenges, particularly in poorer countries with limited infrastructure and health-care coverage. These hurdles can be lowered if rich countries release their production more quickly for others to buy, and if more bilateral and multilateral aid funding is made available to support public-health systems and vaccine purchases.

Make no mistake: China will likely play a large and perhaps leading role in this process. As the world's biggest producer of Covid-19 vaccines (albeit of a less sophisticated variety than the Western ones), China will have immunised its own population by September or thereabouts, giving it abundant spare production capacity to supply the world (along with funding).

That is why the Western pledges at the G7, welcome as they are, are in reality somewhat behind the curve. The G7 countries are offering their billion doses on a timetable convenient to them, divided between late 2021 and 2022, but actual demand from poor and middle-income countries is coming much sooner than that. This means that China is being given a huge market and diplomatic opportunity of stepping into the breach with perhaps 500 million doses every month during the last four months of 2021.

If that happens, the surprisingly short timescale indicated by our vaccine countdown can actually be shortened further. Rural parts of Africa and unstable parts of Latin America will face the biggest challenges, but these can be overcome with aid from rich-country governments, including China's, and from big philanthropic foundations. Mass vaccination campaigns in the developing world are nothing new. Success depends on generosity, political will, and a belief that the solution is both necessary and achievable.

With new variants emerging rapidly and new outbreaks in places that had seemed to have the virus under control, Covid-19 remains a global problem. We should know by now that it demands a global solution. The recent increase in supplies and the Global Commission's vaccine countdown indicate that what we need is well within reach.

or an exception. According to Our World in Data, China now accounts for 17-20 million of the 33-36 million doses being administered worldwide every day. With China included, the countdown reaches zero in just over 200 days; without China, the time increases to 370 days. That is an important difference, but it amounts to reaching the finish line in July 2022, rather than in January. Even if a higher threshold of 90 percent becomes necessary, owing to the lower efficacy of Chinese

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