Coronavirus: we are risking a covid-19 tragedy in Europe’s refugee camps, writes Nasar Meer

Urgent action is required to protect the inhabitants of over-crowded refugee camps in places like Greece from coronavirus

Two things public health experts routinely tell us about Covid-19 are that prevention is better than cure and that this pandemic does not respect geographic boundaries. Neither of these messages is being heeded in the response to refugees and displaced populations.

For the millions of people in official camps and informal settlements, the pandemic poses a terrifying threat that lays bare the inadequacy of current approaches. Take the Cox’s Bazar camp in Bangladesh for example, home to more than 855,000 Rohingya refugees, living in small and confined shelters and where the population density is such that 40,000 people share a single square kilometre. Social distancing there is impossible, and handwashing stations, triage centres, and isolation facilities are lacking.

The dangers are similar the world over, from those internally displaced in Syria and Venezuela, to the recent swelling of numbers of refugees in Idlib province, Al Hol in Syria, the Zaatari camp in Jordan, the Bekaa Valley in Lebanon and Ciudad Juárez in northern Mexico, to name the most obvious. These

populations have typically endured the worst of possible hardships, caught infectious diseases and developed respiratory conditions in the course of merely surviving in camps without planned sanitation or access to decent health care. Now add to this few means of Covid-19 prevention, little treatment for those infected and virtually no means of disease control.

Yet it is here, in Europe, that an entirely avoidable catastrophe unfolds. Lacking the most basic sanitation, including soap and clean running water, thousands face a perilous fate, sleeping in close proximity in overcrowded camps that they are prevented from leaving. On the Greek island of Lesvos, once a transit route for those crossing from Turkey, around 20,000 people are squeezed into an unfit makeshift encampment, originally intended for no more than 3,000. The outcome? Roughly one water tap between 1,300 people and entire families made to occupy spaces of little more than three square meters (and the entire population squeezed into less than one-tenth of a kilometre squared).

Increasingly desperate pleas

This means, as Dr Hilde Vochten, Médecins Sans Frontières' medical coordinator in Greece, makes plain, "recommended measures such as frequent hand washing and social distancing to prevent the spread of the virus are just impossible". Hence MSF has called on the European Union to work in partnership with Greece to close the camps and resettle people before it is too late.

From the residents of the Moira camp on Lesvos, meanwhile, we hear increasingly desperate pleas that if not all can be evacuated then priority be given to the elderly and vulnerable. Medics on the ground report horrific conditions. Speaking to the British Medical Journal, Siyana Marhroof

Shaffi, director of the UK-based charity Kitrinos Healthcare, which runs a medical clinic on Lesvos, says that many of the camp's residents already have respiratory infections and indeed that, in 21st Century Europe, scabies is "rampant" in these camps.

The situation is no better on the other Aegean islands of Chios, Samos, Leros, and Kos, where formal and informal camps have swelled since the EU-Turkey deal (signed in 2016) commenced to prevent onward movement from the camps.

While this treaty was designed to prevent the movement of asylum seekers into Europe, it was matched by a hardening in approach to those who had already arrived. Typical is the Pyli facility in Kos, an open structure to which thousands have been left to pin makeshift shelters with no organised water, sanitation or prospect of medical provision.

Overall however these are relatively small numbers of people – they run into the tens of thousands in a continent of over 740 million, and so could easily be absorbed if there was a political will to close the camps.

A disease that affects everyone

The call for urgent action however does not need to rest on altruism and goodwill but law: 1951 Refugee Convention insists that asylum-seekers and refugees should not be penalised for having entered or stayed irregularly and, most pressingly in light of Covid-19, the UN High Commissioner for Refugees (UNHCR) has a clear protocol for identifying and addressing vulnerability of asylum seekers and refugees. This is more relevant than ever and must now be heeded.

There are positive lessons we can draw on from elsewhere, including the recent decision of the Portuguese government to treat asylum seekers and refugees in Portugal as permanent

residents with access to health care, at least during the present crisis.

The EU could, for example, offer Greece debt relief in the first instance and then partner up with international agencies to help rehome people. There is an appetite to help.

We have seen in recent years how national level intransigence has been thrown into sharp relief by municipal, local or city-level initiatives.

This attitude has an older pedigree in the International Cities of Refuge Network, the Cities of Sanctuary, the Save Me campaign and the Eurocities network, each of which elevates the role of the cities to accommodate refugees.

In all the risk and uncertainty accompanying Covid-19, it is easy to forget safety is a relative concept and so while Covid-19 is a disease that can affect everybody, it will not do so equally.

Whatever else transpires in the coming weeks and months, what remains certain is that these camps are European constructions and all the responsibility for what befalls in them rests not with those who contract this illness, but in the failure of Greek and EU leaders to honour their obligations to the most vulnerable.

This article was originally published in The Scotsman (7 April 2020).

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Coronashock capitalism: the unintended consequences of radical biopolitics, writes Stefan Ecks

2020 is a significant year for the social sciences. Not only because COVID-19 changed how we think about global connectedness and local distancing. By some strange coincidence, 2020 also marks the 100th anniversary of Max Weber's death. He was only 56 years old when he died in Munich on June 14th, 1920. Weber was one of millions of victims of the Spanish flu pandemic that followed the First World War. Between 1918 and 1920, this strain of influenza killed up to 100 million people, more than the 40 million attributed to WWI. Some places were so severely hit that all social and economic activity collapsed. In Western Samoa, then under British rule, 95% of the population got infected and 22% died within a few weeks (McMillen 2016: 91-92). The Spanish flu was unusual both for its staggering death toll and for the demographics of its victims: "healthy young people in the age interval 15-40—not frail patients, nor children or elderly" (Karlsson, Nilsson & Pichler 2014: 1).

Weber was working on his great *Economy and Society* when he died. No other sociologist was as attuned to the gap between the intention of action and its consequences in the long run. The founders of Protestantism did not intend to create secular capitalism, and yet this was the accidental outcome of the Reformation. In his last years of life, Weber also wrote much about the economic impacts of WWI. But he never wrote about the economic shock of the flu pandemic. In 1919, Weber was

part of the German delegation to Versailles. He anticipated that the Treaty of Versailles would spell the ruin of the German economy (Radkau 2009). Meanwhile the scale of the economic damage of losing millions of people in their healthiest years was hardly noticed. In Germany, the authorities censored press reporting about the death toll (Witte 2003). Weber might have written about the pandemic if he had had the same flood of news that we have about COVID-19 (Engelmann 2020). The economic consequences of the Spanish flu were never studied in detail, either in Weber's time or since. The Great War drowned out historians' recognition of the flu.

How is the COVID-19 pandemic affecting the economy? In terms of GDP and stock market performance, COVID-19 is an all-out disaster for capitalism. The world is staring at the worst recession in nearly a century. Businesses are going bankrupt and people are losing their jobs at catastrophic rates. In the UK, one million people made new jobless claims within two *weeks* of the country's lockdown coming into effect. Compare this to the 2007-08 financial crisis: back then, one million people lost their jobs over three *years* after the downturn (Financial Times, April 2, 2020).

The economic disaster is *not* caused by COVID-19 itself. The 1918-1920 flu pandemic and the 1980-1990s AIDS pandemic strained economies because these viruses killed people of working age. The current economic disaster is entirely caused by the biopolitical response to the virus. Governments opting for strict lockdowns are putting population health above economic wealth. In Asia, Europe and the US, governments are "deliberately inducing one of the most severe recessions ever seen" (Tooze 2020). Government attempts at stalling the health disaster accept that this does unfathomable harm to the economy.

In a recent reflection on COVID-19, Bruno Latour argues that we are not witnessing a new form of politics but a rerun of nineteenth-century "statistics" in the sense of "population

management on a territorial grid seen from above and led by the power of experts" (Latour 2020). He holds that COVID-19 made an older form of politics return: "we are collectively playing a caricatured form of the figure of biopolitics that seems to have come straight out of a Michel Foucault lecture" (Latour 2020). Foucault characterized biopolitics as "focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes […] Their supervision was effected through an entire series of interventions and *regulatory controls: a bio-politics of the population*" (Foucault 1978: 139; emphasis in original). Biopolitics justifies interventions by whether they enhance the health of the population. Foucault never clarified if biopolitics takes health as supreme value, or if enhancing health is just a means to enhancing wealth. We should distinguish two modes of biopolitics, moderate and radical. In moderate biopolitics, health is enhanced in order to enhance wealth. This is what Foucault described. But the response to COVID-19 is far more drastic. When population health becomes the supreme value and economic wealth becomes subservient it, biopolitics turn radical. I agree with Latour that what we are seeing is biopolitics. I disagree with him that this is a "return": instead, we have never seen biopolitics on such a scale. 2020 is the birth year of radical biopolitics.

Previously it looked like economic wealth would always trump population health. The "return" of biopolitics comes long after neoliberalism seemed to have displaced it. In the 2000s, when neoliberalism was the only game in town, it appeared as if governments had ceased to rule over life and death. Back then, Nikolas Rose argued that liberal governments do not "claim—or are given—the right, the power, or the obligation to make such judgements in the name of the quality of the population" (Rose 2006: 254). In neoliberalism, individuals are to take responsibility for their own health while the state is "no longer expected to resolve society's need for health" (Rose 2001: 6). Arguably governments never ceased to

exercise power over life, at any point. But biopolitics were moderate, and easily subsumed by neoliberal economic policies. Now, coronashock has induced a radical turn.

Both the US and the UK are currently run by right-wing parties. Both the US and the UK dithered and delayed their responses to COVID-19. Both governments only turned to radical biopolitics when the exponential spread of the infection became a "tsunami" threatening to make health systems collapse. From January until the beginning of March, both Trump and Johnson declared their countries would "stay open for business." Both denied that COVID-19 was much to worry about, and both failed miserably in preparing for the coming wave of infections. In neoliberalism, governments are not meant to disrupt the market for the sake of health. Dominic Cummings, the UK prime minister's chief adviser, perfectly summarized the strategy: "protect the economy, and if that means some pensioners die, too bad" (cited in Walker 2020). Similar arguments were made in the US (e.g., Katz 2020). Letting the virus "run its course" while protecting the economy is a neoliberal response. Moderate biopolitics do not threaten wealth. Free movement and free markets are more important than saving lives. If there is something like "neoliberal eugenics" (Comfort 2018), they are not about "making live" but about "letting die."

The vast majority of people who are dying with the coronavirus are older than 65 years and most have multiple chronic health conditions. Sharon Kaufman's *Ordinary Medicine* (2015) shows the bioethical dilemma of how unevenly resources are allocated: older people take the most drugs, they receive the most treatments, they have the most complex multimorbidities, and they use up 90% of healthcare resources. Johnson and Trump initially responded to COVID-19 in a neoliberal mode: people are dying every day of natural causes, let them. COVID-19 mostly kills people deemed to be a burden on healthcare and welfare. From a neoliberal point of view, most COVID-19

victims are economically expendable. But the threat of skyrocketing death rates forced both governments to take a u-turn into radical biopolitics. Even pro-market governments opted for shutdowns and enacted tax-funded stimulus programs larger than any intervention since WWII. Even neoliberals could not put economic profits over population health any longer. Sticking to the neoliberal script would have been political suicide.

Radical biopolitics cannot last long because the economy is hurting too much. True to form, Trump tweeted on March 23: “WE CANNOT LET THE CURE BE WORSE THAN THE PROBLEM ITSELF” (emphasis in original). What will come after the lockdown? The corporate sector will try to recuperate lost profits. Corporations are already calling on governments to bail them out with public money, in the same way as during the financial crisis 2007-2008. COVID-19 might also turn into an occasion for “disaster capitalism” (Klein 2007). Vincanne Adams (2020) argues that COVID-19 can be read as disaster capitalism because it exposes pre-existing inequalities and because it threatens the profiteering of industries in its wake. In the short run, radical biopolitical interventions are an unmitigated disaster for capitalism. In the long run, the catastrophic consequences of radical biopolitics could be used to justify sweeping pro-market reforms and to slash welfare and social security.

It could also happen that COVID-19 becomes the springboard for alternative politics. It might be “a portal, a gateway between one world and the next” (Roy 2020). Klein (2007) is wrong to imply that neoliberals have a monopoly on shocks. COVID-19 is a shock for everyone, and the shock can be channeled into other politics. Socialized health care and universal basic income have become far more plausible. Governments’ decree that citizens must selfisolate show that health can never be privatized. Adams (2020) hears her daughter say that, if “people with COVID-19 are going to get free tests and free

hospitalizations and the government was going to send checks to fill in the gap for missed wages, then it might make [US Americans] think that [socialism] actually could work." Instead of bailing out polluting industries, a Green New Deal might look like a better way to restart the economy. Dolphins are swimming in Italian ports and sea turtles are hatching on Brazilian beaches. The coronavirus has achieved a greater reduction of carbon emissions than decades of environmental politics.

Max Weber was cremated. In 1920s Germany, cremation was still rarely practiced among Protestants and strictly forbidden to Catholics. There was a heated contemporary debate about cremation. An argument made in favor was that it helped Nature. The experts believed that cremation would "enrich the carbon dioxide content in the atmosphere and thereby promote the growth of vegetation" (Radkau 2009: 549). They thought that burning human corpses could bring new life to plants. This morbid little detail of Max Weber's death may give you hope: perhaps death can be turned into life, maybe the disaster can be a portal. It may also make you despair: how could the experts ever be so wrong? How can the consequences of social actions be so drastically different from what they were intended to achieve?

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economics.

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COVID-19 and philanthropy in Africa: a stitch in time? By Kenneth Amaeshi

Globally, there are concerted efforts by the private sector to find creative ways of contributing to tackling the pandemic. Some businesses are adapting their manufacturing systems to produce some of the essential materials and equipment required to combat the pandemic such as sanitisers, ventilators, testing kits, et cetera. Others, especially those in the biochemical and pharmaceutical industries, have intensified their Research and Development (R&D) efforts towards a solution. It is literally all hands on deck!

The corporate sector in Africa is not left out. Given the paucity of manufacturing and R&D capabilities in the continent, local businesses are crowding in their capabilities in different forms through donations of funds, construction of isolation centres, and collaboration with governments and third sector organisations, amongst others. It is literally a matter of life and death and a race against time!

Whilst these good deeds are appreciated, they call for some reflections. Why does it take a crisis of monumental proportion for businesses to truly appreciate that they are part of society and need to contribute positively to it? Why is it unattractive for businesses to collectively contribute to institution building in Africa, instead of spending energy on ad hoc, in some cases tokenistic, individual corporate philanthropic initiatives?

Many more questions could be asked. However, one thing remains unquestionable – the reality that businesses love one thing in particular; more money! And even better when it comes with good reputation. Business leaders understand this and often do

their best to protect this interest. This understanding and philosophy is at the heart of the Corporate Social Responsibility (CSR) industry and practice – especially in Africa, where CSR is still mainly seen as voluntary corporate philanthropy (Adeleye et al., 2020[1]; Ezeoha et al., 2020[2]).

As the name suggests, corporate philanthropy is mainly "*an act of giving back to society at large*" (Amaeshi, et al., 2006[3]). This has included donations to schools, hospitals, local communities, prisons and orphanages; construction of roads and decoration of public spaces; economic empowerment and poverty alleviation.

However, the other side of the equation that is not often explored in the CSR debate is the idea that CSR should be a business philosophy, which takes the private governance of externalities seriously. Externalities here connote the positive and negative impacts arising from corporate entrepreneurial activities that are borne by some third parties who are unconnected to the business. This could be at the production, sale or consumption point.

Traditionally, the burden of governing corporate externalities has always been borne by the State. In order to curtail negative externalities, the State uses such regulatory mechanisms as taxes, subsidies and quotas. But institutions in many African countries are weak, hence the inefficiencies in the system. A classic case is the apparent revelation of the poor health system in many African countries in the evolving face of COVID-19. As the rich and poor confront their common demons, it makes much sense to now appreciate that we are all victims of the system. Unsurprisingly, these institutions need to be strengthened; and this is where true CSR comes in. This will require more collective action than isolated corporate initiatives.

CSR post-COVID-19 will need to be radically different. It

should focus on addressing the root causes of many of the inefficiencies in Africa, which are strongly linked to bad governance and weak institutions. To meet this goal, Corporate Social Responsibility, as corporate philanthropy, needs to become Collective or Collaborative Social Responsibility, where businesses will need to work with each other, and other possible partners, to address the weaknesses in the system.

The focus should primarily be on strengthening the public service in most African countries to function effectively and efficiently. And businesses will have to learn to overcome this challenge and find new ways of extracting value from collective or collaborative social responsibility.

By implication, the dominant view of CSR as corporate philanthropy amongst most African businesses needs to be seriously challenged. And there is no better time to do that than now. The good crisis should not be allowed to waste, as they say!

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Stay calm, be active: simple ways to boost your physical activity during COVID-19 – By Coral Hanson, Paul Kelly, Alice Pearsons, Chloe Williamson, Sheona McHale, Steven Hanson & Lis Neubeck

The COVID-19 global pandemic is rapidly changing the way that we live. Suddenly, large numbers of people are working from home, leisure facilities are closed, and we're social distancing from our family and friends. The benefits of physical activity for health are well known and emphasised in the 2019 UK physical activity guidelines.[1] Understanding how to build some physical activity into your new stay-at-home reality can help keep you healthy, calm, and connected.

Every time you are active, your mental health improves

We gain short-term mental health benefits from each bout of activity, so doing even small amounts is worthwhile. Physical activity of any intensity is good for your mood.[2,3] It does not matter what type of activity you choose. Different forms of exercise; walking,[4] cycling,[5] yoga,[6] dance aerobics,[3] tai chi[7] and running[8] all trigger similar positive mental health benefits. If you are unable to go out, changing your normal activities to something that you can do indoors will help your mental health. For example, replacing your normal cycling activity with an online dance aerobics

class will also help maintain your aerobic fitness, while replacing it with yoga will help with strength, balance and mental health. Anything is good, but more is better. This means that whatever your starting point, doing a bit more activity will help to combat social isolation and anxiety.[9]

Breaking up sitting time

A major change to physical activity levels for those now working at home is the loss of active commuting to work or other journeys, and the incidental activity of moving around the office. In normal times, office workers spend approximately 70% of an eight-hour workday sitting.[10] The move to home working could potentially increase this. Workplace studies have examined how to increase incidental physical activity while at work- and these same principles apply to working at home. Evidence indicates that using three different strategies can help; **standing up** (if you are able) at least every 30 minutes; **sitting less** by aiming for approximately equal amounts of sitting and standing time, and **moving more** by increasing the type of physical activity you do just from one activity to another.[11] Some practical tips are that you can set reminders (use your online diary or phone) to stand up every 30 minutes, walk to get water regularly, or stand when you feel uncomfortable and need to change position. If you have an adjustable desk at home, try to spend equal amounts of time standing and sitting. If not, you can sit less by standing during online meetings and telephone calls. Be creative and use other things in your home to make a standing desk. We found that cardboard boxes on top of our desks work well. If you are chairing an online meeting, initiate a standing culture at the beginning. Move more by combining every other 30-minute stand up with walking laps around your house. If you have stairs, make sure that you include them in your lap. If you have more than one toilet in your house, use the one furthest from where you are working.

Moving for 1-2 minutes half an hour is enough to break up your

sitting.[12] You can perform body weight exercises in small spaces and with little equipment. For example, calf-raises, knee to elbow and standing wall press-ups target strength, flexibility, coordination and balance. More advanced exercise such as lunges, squats and sit-ups are alternatives for those who are already active. If you do not have any fitness equipment, look around your home and see what you can use instead. For example, you can use tins of food as hand weights for upper body strength exercises.

Physical distancing, social connectedness and the use of technology

The new guidelines about social distancing mean that it may be impossible to be active with friends. Technology offers those who are self-isolating a way to connect with friends, family and colleagues. Studies using mobile apps have shown that texting has a positive effect on increasing physical activity.[13] You can encourage your friends and family to be more active via telephone, text or social media. If you want to know how much activity you are doing, mobile apps that count steps and press-ups are almost limitlessly available. Regardless of starting levels, there are a range of beginner to advanced online resources such as yoga workouts or entertainment dance apps that you can use at home. If you normally use a leisure facility, check whether they are offering online classes or look for established commercial virtual classes. Creating a definite schedule for activity by signing up to join a timetabled session will help to establish a routine.

Take the opportunity to engage with those self-isolating with you (your family and pets). Play fetch with the dog in the garden if you have one, have a quick game of hide and seek with your children or grab a paintbrush with your partner to repaint that bathroom ceiling. It does not matter what you do, how much you do or how you do it, any increase in physical activity accompanied by increased connection to those around

you will benefit your physical and mental health. Keep up to date with government guidelines about being active outside. If regulations allow, walk solo/with those you live with responsibly. Remember to keep a distance of two metres from anyone that you do not live with.

Being physically active during COVID-19: an infographic for the public

To make sure that **the general public** becomes or remains active during this global pandemic, we created this infographic using evidence-based principles on how to construct and deliver messages to promote physical activity.[14] We encourage you to share it with your channels.

Who is this infographic for? The infographic is for all adults aged 18-69 years who are working from, or staying at home. This population may have recently lost access to active travel, gyms etc. Some of these individuals may also be facing being at home with their children, and have the added challenge of keeping their children active.

What is the aim of the infographic? The aim of the infographic is to give people some ideas about how to remain active safely during the COVID-19 outbreak and to motivate them to do so. We hope this can encourage and improve one’s confidence to be active during this pandemic.

What is the content of the infographic? Evidence supports the use of gain-framed messages (information on the benefits of physical activity) with particular focus on the short-term social and mental health benefits. We have positively framed messages on links between physical activity and productivity, mood, stress, energy levels/fatigue, depressive symptoms, and anxiety. We have given practical examples or “how to” remain active during COVID19.

Our call to action! We encourage you to share this infographic with your friends and family using your social channels

(Twitter, Facebook, WhatsApp etc.). You could also print it out and stick it on a wall at home to remind you to remain active!

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This post was originally published in the British Journal of Sports Medicine

> *Stay calm, be active: simple ways to boost your physical activity during COVID-19*

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Covid-19 laboratory preparedness in Africa: lessons can be learned from the Ebola outbreak, write Dr. Ann H. Kelly, Eva Vernooij, and Dr. Alice Street

As Covid-19 pandemic expands its global reach, increasing testing capacity has taken centre stage in government and international agendas. Drawing on research and policy engagement in Sierra Leone, the DiaDev (Investigating Diagnostic Devices in Global Health) team at the University of Edinburgh show the critical importance of investing in laboratory capacity. New diagnostic devices are only effective insofar as they can be integrated into the broader health system and supported by continuous supply chains, trained medical staff and closely aligned information systems.

"We have a simple message for all countries" declared Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization. "Test, test, test." Accurate diagnosis is essential to mitigate the increasingly disastrous impact of the COVID-19 outbreak. Without knowing who among the general population is sick or has previously been infected, policy makers are flying blind, facing unpredictable surges in cases, health workforce shortages and an interminable cycle of lockdowns and forced closures.

But while the economic and public health rationale of mass testing is irrefutable, if the past two months of this pandemic has taught us anything, it is that following Tedros' mandate is hardly straightforward. Rapidly developing tests

from scratch and deploying them widely demands clinical, commercial and regulatory coordination and, above all, a sufficiently-prepared and well-integrated laboratory system.

As the outbreak moves into the African continent, the question of diagnostic capacity looms large. A position piece, published last week in the *African Journal of Laboratory Medicine*, offers a key perspective on what is needed for robust diagnostic response in an outbreak and the role tests can play in building resilient health systems. Co-authored by the DiaDev team at the University of Edinburgh and Kings College London and policy-makers, doctors, public health experts, laboratory scientists from Sierra Leone, the paper reflects on efforts to scale up diagnosis during the Ebola outbreak, the longer-term impact of those investments on the health system and provides some key lessons for the COVID-19 response in Africa and more widely.

Diagnostic tests need diagnostic systems

At the root of the 2014–2016 Ebola Outbreak was an inability to quickly diagnose and isolate cases. With unprecedented speed, a range of novel Ebola diagnostic tools, from automated PCR machines designed for laboratory benchtops to rapid test kits that could be used at the point of care, were trialled in Sierra Leone, helping to bring the outbreak to an end. But while important, increasing the availability of tests was only a first step. To safely transport samples, source reagents, dispose of hazardous materials, and correctly interpret and feed-back diagnostic data into clinical and public health decision-making necessitated health system-wide support.

The extent to which laboratory strengthening efforts during the Ebola outbreak have prepared West African countries for Covid-19 remains uncertain. One important legacy in Sierra Leone is a national cohort of laboratory workers with

experience of PCR testing. A number of GeneXpert PCR machines, which can be repurposed for SARS-COV-2 testing, also remain in country. But prioritisation during the outbreak of disease-specific Ebola tests, to the detriment of broader laboratory strengthening efforts, means weak supply chains and waste management systems remain major points of vulnerability across the region.

National experts and institutions need to be fully engaged

When it comes to the ready deployment of global health innovations in Africa, regulatory capacity is often neglected. In an effort to accelerate R&D for Ebola diagnostics, the World Health Organization developed the WHO Emergency Use Listing (EUL) to expedite the evaluation of new tools in the epidemic. While ostensibly the aim was to alleviate the regulatory burden on National Regulatory Agencies (NRAs), without local input or support, national agencies struggled to register the influx of new tests. Regulatory authorities can be advocates for new medical products, but need manpower and expertise to evaluate device performance, guide deployment and procurement and to provide the quality assurance and post-market surveillance essential for safeguarding patients and health staff. The leadership of the Africa CDC in coordinating diagnostic capacity in response to the Covid-19 outbreak has meant national experts are more likely to be heard. A modified EUL procedure launched for COVID-19 places increased emphasis on the role of NRAs, but for regulatory alignment to be feasible this must be accompanied by enhanced resources, training and investment.

Africa’s Diagnostic Futures

Africa is the next frontier for the pandemic. At the time of writing, the number of confirmed cases is near 10,000. What

epidemiological realities lie behind that number is unclear, as diagnostic capacities across the continent differ widely.

Currently, there are more than 100 rapid point-of-care devices for Covid-19 in the pipeline, and the global health organisation FIND is assisting African governments with evaluating rapid tests for Covid-19 coming onto the market. But the emphasis on novel tests, while important, distracts from interventions that are just as critical for a successful response while building capacity for the future.

The Sierra Leonean experience makes clear that investment in new tests is just the starting point. If COVID-19 is going to be contained, substantial investments must be made in national laboratory networks and the supply chains, waste management systems, and health information infrastructures that support them. This is the key to building strong laboratory systems for the next epidemic.

An earlier version of this piece was published on 9th April 2020 on the Kings College London Covid-19 website.

Images included in this essay feature laboratory workers and cleaners working at health facilities in and around Freetown and were taken by Olivia Acland for the DiaDev research project.

Research for this article was undertaken as part of the 'Investigating Diagnostic Devices in Global Health' research project (www.diadev.eu) and was supported by the European Research Council (ERC) under the European Union's Horizon 2020 research and innovation programme grant agreement No 715450.