In search of a road map

It is now increasingly clear that the government did not think through and provide for the consequences of the lockdown. BY **T.K. RAJALAKSHMI**

THE UNION GOVERNMENT HAS BEEN TAKING pride in its supposedly graded, pre-emptive and proactive approach in tackling the COVID-19 crisis. Yet a close look at the way the authorities have gone about the task gives the lie to these claims. India's case fatality rate (CFR) has been very low and it has been possible to slow down the rate of "doubling" of new cases. Yet, this does not really show the real picture. The comparison with European countries such as Italy or Spain that have had an abnormally high spread of the infection and case fatalities owing to demographic factors makes little sense. Any comparison should ideally have been made with countries with similar populations and demographic indicators like age and stages of development. In fact, fatalities have been low in much of the developing world—in Africa, South and South East Asia and also Eastern Europe.

Unlike in many other countries where the epidemic is ebbing, it is still on the rise in India and has in fact spread significantly in May. Testing capacities have been stepped up to around 95,000 a day. Yet, according to data available on the website of Worldometers, a global COVID-19 online tracker, India ranks 14th among countries with the highest number of cases but its testing per million population is much lower than that of countries with fewer confirmed cases such as Vietnam, Taiwan and Thailand.

V.V. KRISHNAN

PHYSICAL DISTANCING means little for these residents of Haridas village in Najafgarh in the National Capital Territory as they grapple with water scarcity.

LOCKDOWN IMPACT

The government now belatedly realises the consequences of a blanket lockdown for people with non-COVID morbidities such as diabetes, haemophilia, cancer and for patients requiring critical care such as dialysis and blood transfusion. The consequences of the suspension of immunisation services and hurdles created in the check-up of pregnant women requiring antenatal care are also sinking in.

The violation of government advisories issued to private hospitals not to deny care or insist on COVID testing before administering care indicates the government's complete lack of control over private health care operators. The private sector now accounts for the bulk of health care services in the country.

On April 28, Union Health Secretary Preeti Sudan wrote to the Chief Secretaries of States and Union Territories regarding the importance of providing non-COVID medical services such as reproductive and child health (RCH) services, immunisation, dialysis, and treatment for communicable diseases like tuberculosis and leprosy and vector-borne diseases as well as noncommunicable diseases like cancer. She recalled that detailed guidelines and SoPs (standard operating procedure) had been issued earlier for dialysis and blood transfusion.

She also wrote that on April 20 the Union Health Minister had communicated to all State Health Ministers to ensure uninterrupted blood donation and transfusion services for people suffering from rare blood disorders such as thalassemia, haemophilia and sickle cell anaemia. (India has approximately two lakh haemo-

philia patients and around 1.5 lakh thalassemia patients, the highest in the world. Sickle cell anaemia is prevalent among tribal populations in the southern, central and western parts of the country.)

The Health Secretary noted that the Ministry had received reports that "many hospitals in the private sector" were "hesitating in providing critical services such as dialysis, blood transfusion, chemotherapy and institutional deliveries to their regular patients either on account fear of contracting COVID-19 or they were keeping their hospitals/ clinics closed". In many places, she wrote, hospitals and clinics were insisting on testing people for COVID-19 before providing services. She referred to a letter sent by the Ministry of Home Affairs on April 15 that all health services should be functional during the lockdown.

"I request you to ensure that above measures are taken in consultation with the health fraternity in your State/UT to allay the fears, alleviate uncertainty and to ensure that all the health facilities, especially those in the private sector, both clinics and hospitals, do remain functional...," she said. She also marked a copy of her letter to a member of the NITI Aayog for "taking up issues with the private sector."

PROFITEERING IN A CRISIS

The high markup charged on personal protective equipment (PPE) and testing kits is a cause for concern. The government has explained the shortfalls in PPEs and N-95 masks saying that prior to the crisis these had always been imported and were never manufactured domestically. The exorbitant overpricing of test kits came to light only when a dispute involving two firms, an importer and a distributor, reached the Delhi High Court.

That the stigmatisation of infected people and of health care workers is a serious issue is also a belated realisation. There were attacks on members of the minority community after people who had attended the Tablighi Jamaat congregation in Delhi were found infected with the virus. The government did little to convey that communalising of the problem would not be tolerated. In fact, for several days government spokespersons used terminology specifying the religious denomination of those infected and the data too was suspect. In Madhya Pradesh, for instance, the percentage of those infected from the Delhi event turned out to be not more than 4 per cent.

The campaign of ostracism did not stay limited to the community and was soon directed at health providers and members of the majority community. The "social distancing" campaign seemed to take a toll on health workers. By the government's own admission, people refrained from reporting symptoms and were hostile to health workers as they feared getting quarantined in some faraway government facility.

There has been poor reception of the government's efforts to make people instal the Arogya Setu application on mobile phones. People are uncomfortable with the idea of being constantly monitored and worried about possible quarantining in the event of COVID-19 infection. That apart, the use of the application raises issues of privacy.

From the beginning, the government's emphasis was on the strict enforcement of the lockdown in order to break the chain of transmission of the virus: "stay home, stay safe".

This approach continued more or less until late April. On April 25, however, V.K. Paul, a leading member of the NITI Aayog and chairman of an empowered group on COVID-19 control, said that the number of fresh cases would be down to zero on May 16. Yet, as each day throws up over 3,000 cases on an average, there seems to be little basis for the pronouncement.

M.P. HEALTH BULLETINS

Both the Central and State governments have been economical with data shared in the public domain through regular bulletins. Testing protocols have so far relied on the screening of people with travel histories, their contacts and those showing symptoms of severe acute respiratory infection (SARI) and influenza-like illnesses (ILI). Union Health Minister Harsh Vardhan recently said that surveillance for SARI and ILI cases should be "intensified in unaffected districts which have not reported cases for the last fourteen days".

On May 6, reviewing the situation in Maharashtra and Gujarat, he expressed concern about the high fatality rate in some districts and said that "testing of SARI and ILI cases need adequate attention as this may prevent the spread of the infection". However, the proportion of SARI and ILI cases in the total number of samples tested has not so far been made public.

Most State governments did not put out regular bulletins with daily details of the number of samples tested and the test results. While there were regular bulletins in Maharashtra, Kerala and even Delhi, most of the States ruled by the Bharatiya Janata Party (BJP) were laggardly in this matter. A wide variation was noted across States in the numbers tested. This was mainly owing to the assumption that cases were still confined to clusters within districts without community transmission. In some States, in Madhya Pradesh for instance, the figures did not always add up.

The State's daily COVID-19 health bulletins have been reporting sample-testing figures (under Serial No. 5 in the bulletin). Until April 26, the bulletin followed a format with five different numbers for the relevant date along with the previous day's figures.

The first number was of the total number of samples collected until date, which in turn were divided into the number for which test reports had been received and the number for which these were awaited. The number for which reports were received was in turn divided into numbers for which the reports were positive and those which yielded negative results or were rejected.

On April 26, the five numbers were consistent: the total number of samples reported was 38,708 of which reports had been received for 30,269 while 8,439 reports were awaited. The figures for positive and negative/rejected results were 2,090 and 28,179 respectively, which added up to 30,269 or the number for which reports had been received.

The issue that had invited attention until then was the exceptionally large proportion of samples for which results were pending. On April 27, the reporting format was changed, and the testing numbers were listed under Serial No. 2. From that day until May 1, only three numbers were reported—the number for which test reports had been received and the numbers that had tested positive or negative respectively.

According to that day's bulletin, however, reports for only 27,009 samples had been received by that date, 3,260 less than what had been stated in the previous day's bulletin. Clearly, at least one of these figures is wrong. All the more curious, reports of 8,439 samples were awaited on the previous day, about which nothing was mentioned in the April 27 bulletin. In other words, a total of 11,699 samples simply vanished into thin air.

Further, while the number of positive cases reported on April 27 had increased to 2,165 from the previous day's 2,090, the number of negative reports on the same day stood at 23,500—4,679 less than the number reported as negative/rejected on the previous day. Since positive reports had gone up by 75 and negative ones had come down by 4,679 the net decrease in the sum of positive and negative reports was 4,604, still 1,344 more than the 3,260 by which the total number of test reports received had come down. This meant that on April 27, the sum of positive and negative reports (2,165+23,500 = 25,665) was 1,344 less than the number of test reports supposedly received.

This discrepancy continued to be present in every bulletin until May 1, reaching a maximum of 9,271 on April 30. On May 2 and 3, the reporting format was changed slightly and at first sight this offered an explanation for the discrepancies observed previously in the sum of positive and negative reports being lower than the total number of test reports received.

In addition to reporting positive and negative test report numbers, the bulletins on those two dates also said that the rest of the samples for which reports had been received were rejected/invalid. No specific numbers were given for these rejected/invalid samples but by inference the number would have been 2,510 on May 2 and 2,352 on May 3.

Both these figures were considerably lower than the discrepancy of 9,271 in the April 30 bulletin and marginally lower than the discrepancy of 2,514 observed in the April 28 bulletin.

From May 4 onwards, the reporting format was changed again—in addition to mentioning the cumulative number of test reports received until that date, only that day's number of positive, negative and rejected/invalid reports was mentioned along with the percentage of positive cases. The cumulative total of positive cases appeared in a different section of the bulletin.

The numbers in the three bulletins from May 4 were consistent in this respect except for what appears to be an inadvertent error in the May 6 bulletin. However, this means that the inconsistencies of earlier dates remain unresolved and unexplained.

The CFR has been very high in Madhya Pradesh, reaching as much as 10 per cent at one point. As of May 5, the death rate in the State was 5.77 per cent. The backlog of pending samples was also high.

Jitu Patwari, former Cabinet Minister for Youth Affairs, Sports and Higher Education, wrote to the Chief Minister that the pendency rate of sample-testing was as high as 22.5 per cent. Amulya Nidhi and G.D. Sharma, health activists in Madhya Pradesh associated with the Jan Swasthya Abhiyaan, wrote to the Union Health Secretary expressing concern about the discrepancies in the State's bulletin figures.

They also wrote that COVID-19 had spread to 35 out of the State's 52 districts with high death rates in Ujjain, Dewas and Khandwa. The State's testing numbers are low compared with those of Maharashtra, Delhi, Gujarat and Rajasthan.

There were only 13 labs compared with 45 in Maharashtra, 20 in Gujarat, 23 in Delhi and 19 in Rajasthan. "For a State with a population of 8 crore, the number of labs are very few," they wrote.

Amulya Nidhi said: "People are not being cared for in the isolation centres, which in Indore is in a private medical college. The takeover plan was good but it has been to give the benefit of Ayushman Bharat to private institutions. The AIIMS at Bhopal is lying empty. More deaths have taken place in private institutions." He said that the huge backlog of pending samples was because there were "few labs and fewer microbiologists".

Narendra Gupta, a public health expert associated with Prayas, a non-governmental organisation (NGO) based in Chittorgarh, Rajasthan, said: "It is a study in itself how China controlled the spread beyond Wuhan and Hubei. We need to learn from them rather than stretch the lockdown period. It is causing an immeasurable amount of misery to migrants. I see swathes of them every day on National Highway 27, which is called the East West highway stretching from Porbandar to Silchar. Many of them are factory workers who reside in the village here. They are from Madhya Pradesh, Uttar Pradesh, Bihar and Jharkhand. Following the COVID-19 scare, the villagers are now driving them away."

Observers have cited the examples of Qatar, Singapore and Vietnam, countries that have controlled the spread. The government no longer talks about the "doubling rate". Every passing day makes it clear that fresh cases are not going to come down to zero by May 16.

In constantly laying stress on the containment strategy and justifying the lockdown, the government seems to be talking in circles. There has been some recognition, however, that stigma and fear have resulted in the "suppression of information" and that there has been "community discrimination" and ostracism of COVID-19 patients. □