Running behind the Epidemic – the Indian Saga

By the first week of April '21 the reported new cases of Covid 19 breached the mark of one lakh/day. The rising curve of infection is rather steep with no certainty where it could lead to and how long this trend will continue. However this is not an unexpected phenomenon. That second wave is more likely to come was written on the wall but some of us hoping against the hope and many were waiting to visit the second wave with little urgency to track the course of the epidemic and to make necessary preparation accordingly. This sort of lacklustre attitude on the part of the government departments and many other research institutes in the country is difficult to explain. As if we all are sitting on a living volcano and waiting for the eruption to happen. This is perhaps linked to our culture of 'wait and watch' and even some of us were in the denial mode. In retrospection if we revisit our epidemic control plan and programme during the first wave of the epidemic we could trace the same or similar approach and attitude in dealing with the pandemic. During the first phase of the epidemic we delayed intervention till it spreads across states and then we suddenly took the decision to implement lock down with no home work, not adequate assessment and nature of the spread infection. It highlights lack of planning and adequate preparation before the implementation of one of the strictest lock down in the world.

Thanks to media, we have been made to believe that lock down is a panacea which could halt COVID pandemic. It was not clear to many that the objective of the lock down is to flatten the peak of the epidemic and to buy times to strengthen the existing heathcare delivery system to cope with the load of COVID cases which in turn could reduce death among the hospitalised patients. Needless to mention that planning and implementation of any health intervention programme is context specific. Secondly, we have to be very clear about the efficacy and limitation of the strategy. Before implementing an intervention one needs to assess the sociodevelopmental perspective of the country, population density, demographic profile, existing infrastructure in addition to behaviour and cultural more and practices of various communities .The population density in metros like Kolkata, Delhi and Mumbai is extremely high where sixty to eighty thousands people live per square mile area. Almost half of the population live in slums and around 20% on streets. Our cities are not designed to ensure physical distancing between any two individuals, be it in the offices, shops, restaurants or the public transport system. Poor infrastructure and constraints of spaces is everywhere which are characteristics of our living and working environment in our cities. Our cities are not comparable with cities in Europe or in America where the efficacy of implementation of lock down could be to the tune of 80% to 90%.Keeping all these factors in consideration modellers of ICMR predicted that, imposition of lock down in Indian cities could be effective to the tune of 50% of its potential at best and as per their projection this could flatten the epidemic curve by 26% only. We have to be innovative in designing interventions. It is a question of how we could optimise between time and available spaces. Where space is limited we have to expand the time span to carry out essential activities thereby spreading individuals over a longer period of time be it in work places, offices, market or in malls to ensure physical distancing. To help this approach to succeed, appropriate transport systems has to be designed. Transport services could be made available throughout day and night as human activities are stretched over a longer time period. At least some attempt could have been initiated to implement pilot project to test this strategy selecting some cities. Restricting time of operation for these essential human activities didn't work. However the intervention strategists of our country never moved out of the binary of 'lock down' or 'no lock down' ignoring all other plausible strategies of intervention. The penal code of the Disaster Management Act [2005] was invoked followed by our policy makers happily handed over the baton of epidemic control in the hands of police and administration. The science of epidemic control and monitoring of programme activities took the back seat.

This has ever happened in other disease control programme in our country. There are no less than two dozens of health intervention programme which are in operation since last twenty to fifty years. These programmes are designed and implemented based on the up to date knowledge and scientific methodologies, which are monitored, assessed and evaluated regularly. On the other hand COVID 19 intervention programme and strategies hardly followed the basic principles of scientific scrutiny. Our responses are primarily adhoc in nature and we sprang into action when we got challenged by the rise of infection what is happening now.

Secondly much of the success of the lock down depends on how effectively cases are identified followed by isolation of contacts and quarantine of cases. Due to our compromised capacity we could not carry out number of tests in large scale during the stricter phases of lock down which has further reduced the efficacy of lock down. The steady rise of cases during these phases of lock down is not a surprising outcome. However in the initial phases government officials claimed success of the lock down by comparing the number of cases detected against the projected numbers put by the modellers. This is in no way a rational approach to monitor and assess programme implementation. Projected numbers of infection based on the models can't be considered as 'gold standard' which proved to be true as the actual number of cases detected during the peak of the epidemic was 10-fold lesser than the projected numbers.

We are fortunate that the second wave of the pandemic came later in India and by the time we came up with the discovery of preventive vaccines. We should be proud that we are one of the major vaccines producing country in the world and a significant capacity to export. Unfortunately due to lack of adequate planning, poor monitoring and lack of 'urgency' on the part of the respective department we could not make best use of our strength. Government department found to ignore the occurrence of vaccine hesitancy even among the frontline workers including healthcare professionals and no appropriate steps were taken to address this challenge. Side by side there was no push on the part of the policy makers for quick expansion of the vaccine delivery programme which is linked to production of vaccine, maintenance of supply chain and putting jabs to recipients. It look longer for the government department to comprehend that this kind of large vaccination programme can't be left to public healthcare delivery system alone. There was not enough work on genetic sequencing to track emergence of mutant strains and to follow the spread more closely. This has happened not due our incapacity but lack of planning and not putting due importance to follow mutagenic change which is a known phenomenon for this kind of virus. There is a mounting fear that in response to vaccines, COVID19 will be mutating itself in the direction which will bypass the existing testing tools and could make the vaccine less or not effective at all. So we need a quick coverage at the shortest possible time which calls for a development of a robust vaccine delivery programme and system guided by appropriate policy and strategy of implementation.

During the phases of unlocking processes similar things could be observed. Permission was given to open offices, factories, mines in addition to shops and malls. As a result of which within days bus terminals were transformed into a crowded place with the presence of huge numbers of commuters as the combined strength of public and private bus services appeared inadequate to carry this load. To make things worse government decided not to resume local trains and metro services which are the lifeline of metros like Kolkata, Delhi or Mumbai. Under these circumstances to practise physical distancing which is essential to reduce transmission of COVID19 seems improbable. Commuters found to jostle in catching buses except a few who could drive their own car or two wheelers. Individuals who enjoy economic and social security were vociferous against the government policy for not extending lock down even longer. Police and administrators seem angry in dealing with 'irresponsible' behaviour of the commuters as many of them were travelling without masks and not keeping physical distance which was impossible to practise. There was hardly any serious attempt to delve into these issues and to think beyond the boxes. There was no serious attempt to restrict and

regulate number of participants whether it relates to social, religious or political programme also. And in between four major states in the country goes to poll which draws huge number of participants involved in various kinds of campaign programmes and very few found to follow COVID19 specific norms and practices, neither relevant authority issued appropriate guidelines and to get it implemented. No one seems bother about the spread of infection then why to blame only commoners?

Positioning lock down as the only and standalone intervention is a major mistake. Our main focus was to calibrate lock down and the unlocking process ignoring all other issues with special focus to influence human behaviour to reduce transmission. It was extremely important to incorporate appropriate strategies to inculcate behavioural change and to provide adequate support to sustain this change of behaviour which could have been the cornerstone of COVID intervention programme. Barring one example in Dharabi [in Mumbai] where an intervention was mooted for behaviour change through creating a supportive environment for a large slum population and it proved to be a successful intervention programme. However National Government neither propagated this success nor captured the lessons from this intervention programme with a view to emulate in other communities and cities elsewhere in the country. There could be any debate that to address COVID, we have to implement behaviour change interventions through engaging different communities. India succeeded in preventing HIV transmission through mobilising and empowering the most marginalised communities like sex workers, transgenders including HIV-infected individuals. To implement behaviour intervention strategy there is a need to create supportive environment for vulnerable communities. In public health parlance it is coined as 'creating enabling environment' which we have mastermind in HIV intervention programme and taught to the world how to strategise and implement this element of intervention. It is sad that we ignored the rich experience of our country while dealing with COVID19 pandemic.

It is an established fact that lock down comes with a huge cost both in terms of human life, livelihood and economy of the country. In India 54 major and medium sized cities altogether contribute more than 40% of countries' GDP .Repeated and longer period of lock down will not only cripple our economy but will kill lakhs of people who will die out of hunger and under nutrition. We have to draw a balance between death and damages out of COVID19 and death due to hunger, undernutrition and for other kinds of illnesses [who failed to receive critical healthcare services due to lock down and for non-availability of hospital beds, etc, which were blocked for the patients of COVID19]. A recent publication in Lancet which is based on the meta-analysis of forty publications concluded that COVID19 pandemic has worsened the maternal and foetal outcome with significant increase in maternal death, stillbirth and ruptured ectopic pregnancies. Due to lack of adequate research it is left to the guesstimate of researchers regarding the type, nature and quantum of lateral health damages caused by COVID19 epidemic in our country. As reported in many other countries people suffering from other major illnesses eg, TB, HIV or malaria who could not receive adequate services due to COVID19 and lock down, we don't know how many new cases of TB, HIV left undetected and how many resistant strains had emerged in connection to TB and HIV due to interruption of services which will further complicate the already stretched National health intervention programmes for these diseases.

More than 91% of our work force [ILO's estimate is forty-one crore] belong to informal labour sector who do not enjoy any 'out of job' benefit, neither they are covered under any sensible social security programme. For them and for their family no work means no food, no medicine, etc, unlike their European and American counterpart who receive living salary and other benefits while they were out of job due to Covid 19. In our country informal sector workers remained invisible till the lock down was imposed. In the process the interstate migrant workers [numbering seven crore] were forced to make themselves visible as it impacted their life and livelihood, which is cause of unplanned lock down.

Imposing one more lock down to address the second wave of the pandemic could bring disaster for these kinds of families.

We made similar mistakes like many other countries in the west through blindly following their narratives focussing only on hospital beds, medicine, ventilators, etc, as the sole issue of epidemic control. The medical and pharmaceutical industry has swayed us in the direction which benefit them. COVID19 containment strategy shouldn't be boxed in this discourse. We have to frame epidemic control not just from the lens of health but looking from the broader development perspective of the country. We need to expand the canvas of epidemic control through incorporating social and ecological elements–which calls for a paradigm shift and a long term vision of present and plausible many other future epidemics. It demands collective ownership and self confidence which is the precondition to build self reliant India. The sooner we recognise it the better.

Fortunately death among the COVID infected individuals during the second wave is less in comparison to first wave. It appears that mutant strains are more infectious but not lethal–which is explainable as per the law of nature. There is no quick fixed solution for COVID. We have to live with it. We need to adopt a combination prevention strategy which should include behaviour change intervention, rapid expansion of vaccine programme and introduction of context specific strategy to ensure physical distancing. Top down approach hardly works in public health interventions. Communities like migrant workers, slum dwellers and others must be incorporated to play their role not just as service recipient but an implementer and gate keeper of COVID intervention programme. We have to change our gear from police and administration led approach to bottom up community centric programming to reduce transmission and to mitigate impact of the epidemic.

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