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A grim picture ahead for Dhaka

More tests and restrictions needed to avoid a possible catastrophe

IT is worrying that the number of Covid-19 cases has been increasing alarmingly in Dhaka, with over 85 percent of all confirmed cases recorded in the division. As of April 23, the country had a total of 4,186 confirmed cases. While one of the reasons for such a high number of cases in Dhaka could be that comparatively more tests are being conducted here, other reasons include ineffective restrictions, lack of awareness among people, population density in the region, etc. Even though Dhaka has the highest number of Covid-19 cases, it does not at all reflect the real picture as the number of tests being conducted here is still very low. Also, with far fewer tests being conducted in other divisions of the country, it cannot be said that the condition of the rest of the country is any better. There are reports in the media of people dying all across the country with Covid-19-like symptoms every day.

Since the outbreak is gaining pace in Dhaka with a surge in deaths and new infections, health experts have warned that if rigorous measures are not taken immediately, the situation can be far worse than we can imagine. What we need now is increased testing, proper contact tracing and isolation efforts. We need to test as many people with symptoms as possible and also trace the contacts of all the positive cases. According to health professionals, every Covid-19 patient represents a cluster of around 20 people who might also be infected. So, all these people should be traced immediately and kept in isolation. Failing to take these steps will mean more deaths and infections in the coming days. Although eventually people would gain herd immunity but that "can be challenging to induce through unchecked infection as there would be a very high rate of serious illness and deaths" (according to Global Alliance for Vaccination and Immunization)—with our health system overwhelmed well beyond its capacity.

As the outbreak is approaching its peak in Dhaka, no one should be allowed to come out of their home for the next few weeks. Only by increasing the number of daily tests, contact tracing, detecting the hidden cases and strictly enforcing the lockdown measures, can we avert a possible public health catastrophe.

Pandemic exposes gaps in education system

Internet inequality a huge obstacle to distance learning

WITH the number of coronavirus cases in Bangladesh jumping by around 300-400 per day and the ongoing nationwide shutdown extended to May 5, it is clear that we still have a long way to go in dealing with this crisis. Academics have warned that this prolonged shutdown will lead to a significant increase in session jams at public universities.

Many universities across the world have responded to the global shutdown by introducing online classes. However, the sudden shift to remote learning has exposed education inequalities within countries, including internet inequality—and Bangladesh is no exception. According to a report published in this daily, top administrative officials from public universities said that lack of facilities at institutions and uneven internet access for students, many of whom are now in their village homes, make it impossible to introduce online education. Bangladesh Bureau of Statistics' data shows that only 37.6 percent of households have access to the internet by any device from home, and only 5.6 percent of households have a computer or tablet.

In this situation, it is likely that introducing online education will further exacerbate the gaps in access to education, placing underprivileged students at a huge disadvantage. However, we must also question why the institutions themselves do not have the facilities required to provide distance learning. Last year, a World Bank report revealed how Bangladesh spends less than the South Asian average on education, and in this moment of crisis, it is apparent that this consistent underspending has taken its toll. Now more than ever, we need to rethink the archaic systems that are still in place in some of our best public universities and push for education that is more dynamic, utilising teaching tools and methods used around the world.

The Ministry of Education and university authorities must work together to come up with a solution that is more concrete than simply adding on extra classes once public universities are allowed to open. This may involve identifying the most underprivileged students and finding ways to improve their internet access in collaboration with telecom companies. It could also involve rethinking systems of assessment at public universities and moving away from the current exam-centred methods. It might not be possible to implement all solutions in the midst of the pandemic, but the current lack of access—depriving our students of their right to education—should lead to long-term changes in education policy that will aim to make it more accessible and equitable.

LETTERS TO THE EDITOR

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The heroes behind burials

It is a pity that we are living in times when, even during the final moments of a patient, their dear ones are reluctant to approach the deathbed. The fear of the Covid-19 has gripped us all and, in some instances, morphed our humanity to an extent that people are even resisting the burial of a Covid-19 patient in their neighbourhood, forcing the family to abandon the body.

News about patients who lost their lives due to the coronavirus and have been ignored by family members are becoming shockingly common. And in such dire times, members of Al-Markazul Islami, a volunteer organisation, have taken on the responsibility to carry out the burial rituals for the deceased. Away from their respective homes, the members reside at the organisation's head office and continue to serve the bereaved families from various religious communities maintaining their specific rituals. Not to mention, everything is done free of cost. I salute these heroes from the bottom of my heart. I believe by acknowledging and honouring them, we can help to keep their spirits up. It's the least we can do for their selfless acts.

E M Sayem Nomany, *Narayanganj*

Confronting Covid-19: A blueprint for emergency preparedness

This is the second article of a two-part series. The first part was published yesterday.

SABIHA HAQUE *and* SAMIRA MARZIA

AS there is no universal antidote yet, Covid-19 is here to stay for the long haul. Even when the virus subsides, there is a danger of a second wave and greater economic and social pandemonium.

From Madrid to Mumbai, from Detroit to Dhaka, no place on earth is currently immune from the reach of the coronavirus. But the outbreak, spread and eventual subsidence of the coronavirus will vary from region to region. In part 1 of this article series, published by *The Daily Star* on April 23, we looked at the strategies of four countries with a high success rate in managing the virus. In this part, we will identify and analyse possible schemes that can be implemented in Bangladesh, and can be both effective and fitting in our social and economic contexts.

The most crucial thing to consider is how to gradually regularise everyday public activities with proper safety measures, utilising the resources we have. Provided that all variables remain constant, it is possible to keep the infection rate low with timely policies and pragmatic steps. For example, a community of 50,000 Chinese in Prato, Italy, who went under lockdown even three weeks before the confirmation of Italy's first Covid-19 case, kept their infection rate at less than 50 percent than that of the whole of Italy.

As the virus slowly spreads its insidious tentacles in Bangladesh, the country stands on a vulnerable precipice. With a high transmission rate, especially in densely populated places, it becomes a challenge to tame the numbers of people getting infected.

There are many measures already underway in Bangladesh. The country has been under lockdown since March 26, suspending all modes of inter-city transport and shutting down institutions, offices, and businesses. Testing for Covid-19 infection is now being conducted in 14 labs: 9 in Dhaka and 5 in different districts (as of April 18). Private groups have started to set up temporary hospitals around Dhaka to accommodate the growing number of infected people. Several awareness campaigns are already in circulation on social media, television, and newspapers. While these developments are crucial to tackle the crisis, for a coordinated response we need to formulate a "Covid-19 Management Action Plan" from the national to the neighbourhood levels.

Besides scarcity of funds and resources, and well-trained personnel who can deal with the virus, Bangladesh faces other challenges too, such as shortage of approved testing centres and treatment facilities, lack of prevention and hygiene awareness, and social inequity. This could become more of a trial if we are to face a surge in cases of both virus transmission and hospitalisations. Bengal Institute researchers believe that we can still keep the death rate low with a choreographed community and government support.

The show should certainly go on. Even during a pandemic, the need for basic amenities and services does not vanish. Essential services such as wet markets and groceries, banks, ATM booths, and regular hospitals need to be accessed by the people. Additional health screening and/or sanitising should be a priority for such points of congregation.

At a national level, controlling modes of transportation and mobility holds the key to preventing future infections. At present, there are 18 national highway gateways to Dhaka city. Besides, there are airports, private helipads, train stations, and bus stations connecting the capital to the rest of the country and the world. Strict border control and inspection at gateways can cut down a lot of foreign-borne contamination.

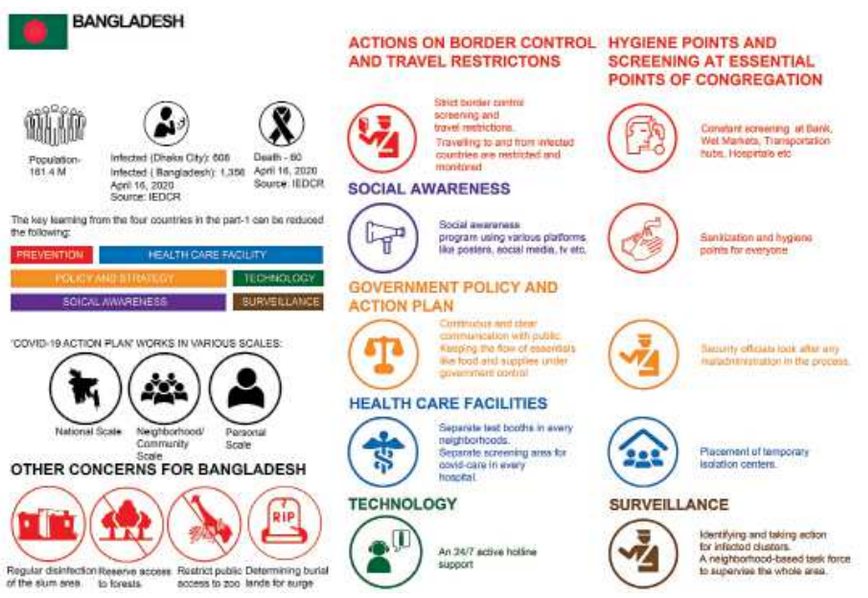
Preventive measures can certainly begin from the national level, but they can be applied to three key scalar conditions: city or town, neighbourhood, and healthcare facilities. For each city or town administration, measures may be taken to locate the critical nodes of the city. At those nodes—such as gateways and entry points—strict screening may be applied. Travel restrictions and control may be applied at city and even neighbourhood levels, which can be eased only with the lowering of transmission and hospitalisation rates. A strategic plan should be in place for establishing temporary hospitals with a focus on the site, emergency transportation facilities, water-electricity access, and key staff. Infected neighbourhoods and areas should be under the surveillance of city and town administrations along with community participation. To make a multi-scalar plan work, it is critical to maintain a close overall supervision by a central task force.

At the metropolitan level, such as in Dhaka, decisive public health and hygiene actions come with a demand for logistics. A surge may not only require setting up of more health centres but also burial grounds. In Dhaka city, there are at least 247 mosques and 22 parks under renovation. With supply of water, some of these places can be potential "hubs for hygiene."

At the neighbourhood level, public spaces can be mapped both for the facilitation of regulated food and wet markets and setting up field hospitals, if needed. Such mapping is important as provision of amenities and facilitates is not equal for every neighbourhood. Points of crowding can also be mapped and measures can be taken for regulating gatherings, as well as setting up sanitisation booths, especially for pedestrians, rickshaw pullers and certain vendors. Such booths may also be set up at the entry and exit points of the main *mohallas* and urban blocks. Houses and other buildings may be sanitised regularly. The awareness momentum should be kept through posters, banners and leaflets.

The business-as-usual approach embedded in existing healthcare facilities will not work in case of a highly infectious disease like Covid-19. Segregation of virus-affected patients from the non-infected patients is critical as far as hospitalisation is concerned. Even such services as testing and check-up for coronavirus should be conducted in clearly designated areas.

While surveillance is always a tricky practice, it is essential to continue to track and trace infected people and isolate them. Apps may be used to trace the infected and their movement patterns. At the end of the day, personal awareness remains the starting point of prevention against Covid-19. The more awareness we can create, the more we can prevent infections.



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The full version of the article will be found on The Daily Star website.

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What past pandemics teach us

ANINDITA ROY

"Infectious disease which antedated the emergence of humankind will last as long as humanity itself, and will surely remain, as it has been hitherto, one of the fundamental parameters and determinants of human history."
– William H. McNeill

FOR the last five weeks, like many others, I have been working from home, living under massive restrictions imposed to "flatten the curve" of Covid-19—which has become the public health mantra for many countries. A lot has been written about this new pandemic, how and where it originated, how quickly it spread across continents, the complex international health diplomacy, if a blanket decision about lockdown was required, etc. The significant impact of this pandemic on the economy is not unknown to us. Financial schemes have been declared by many countries to minimise the damage.

Seeing everyday headlines, it seems the discussion is heavily tilted towards the economic slowdown (some are comparing it to the Great Depression that lasted from 1929 to 1939), how helpful the financial schemes are, the steps that governments should embrace to prepare and respond to the different scenarios emerging from the Covid-19 crisis. But the fragile healthcare systems in many countries, including the industrialised countries, health policies that are not evidence-based, multiple underlying inequalities in healthcare services—these issues are not making as many headlines as the economic concerns. Above all, there is a lack of discussion on what we have learned from our prior experiences. We may not get all the answers from past epidemics as every disease is unique, but many countries have failed to learn from past outbreaks in strengthening their defences to respond to emergencies. Let us take stock of some examples.

As public health students, we learned that the eradication of small pox was a landmark achievement in the history of public health. We successfully eradicated small pox at a time of weak healthcare systems in many countries and at a time of famine and people fleeing civil wars. This extraordinary achievement was possible due to many factors, such as strong surveillance (paper-based) and containment, nations working together towards a common goal and, of course, mass vaccination. Dr Halfden Mahler, Director General of WHO at the time of small pox, described the eradication programme as an outstanding example of management, not of medicine. At the height of the Cold War, the United States of America and the former Soviet Union worked together to eradicate small pox. However, the lack of international collaboration and coordination at the time of Covid-19 is quite glaring.

Instead of taking calm and balanced approaches, nations are busy blaming each other. Countries are battling for Personal Protective Equipment (PPE), which has fuelled price increases and created a frenzy in the market. As we all are working for a common cause, it is time to take a cue from the small-pox eradication programme on international solidarity despite existing ideological and geopolitical differences.

There is no alternative to a strong and effective surveillance system in controlling communicable diseases. The outbreak of Severe Acute Respiratory Syndrome (SARS), first noted in November 2002, was contained by July 2003 by non-pharmaceutical interventions. Strong surveillance, isolating people, rigorous contact tracing, screening passengers at airports returning from affected countries—all helped to contain the outbreak. Taiwan was on alert due to their experience in SARS. They were quick to control borders, scale up surveillance and implement contact tracing which contributed to their low number of Covid-19 cases despite their proximity to the original epicentre (in China). Taiwan successfully used technology for contact tracing. The proliferation of mobile phones has given us an opportunity to track cases and trace contacts more effectively. This has made tracking certain services, such as ante-natal care, pre-natal care and expanded programmes of immunisation, possible. We perhaps need to explore how else technology can be effectively used for preventive care, diagnostics, therapeutics and comprehensive disease management. Needless to say, the utilisation of technology should be carried out ethically, with caution and only for health purposes.

The fundamental criteria of managing any outbreak are the timeliness of detection, completeness of reporting and laboratory capabilities. The experience of controlling the Middle East Respiratory Syndrome (MERS) helped South Korea in flattening the Covid-19 curve. They learned it the hard way—that laboratory testing is essential in controlling infectious diseases. We are yet to see if South Korea can sustain this success because there are still many uncertainties about Covid-19. Unfortunately, not many countries have learned from their experience with SARS or MERS. They were completely unprepared for this current pandemic and did not invest enough in their health systems, despite the fact that there had been warnings about communicable disease outbreaks. Countries did not wake up even after the severe Ebola outbreak from 2013 to 2016.

As long as international trade and the movement of people in different continents exist, the risk of disease outbreaks will remain. If we do not buckle down now, future epidemics will have a severe impact on our health systems and on our economy. We need to recognise the need for a strong healthcare system to counter future challenges. Kerala, a state in southwest India, known as "God's own country", is a shining example of flattening the Covid-19 infection curve. Their investment in public health over many years, improvement in human resources and health system infrastructure helped the state government to handle the outbreak effectively. The experience in controlling Nipah virus in 2018 ensured an effective approach to controlling the novel coronavirus crisis.

Unfortunately, the shining examples are few and far between. It is time to move away from the health vs. economy discussion—both are, after all, interlinked. There is no other alternative than scaling up financial resources for health, building and equipping facilities, ensuring adequate staffing and effective surveillance. Every day we are reading about the lack of healthcare professionals, ill-equipped hospitals and laboratories and weak surveillance systems. Responses to the threats of infectious diseases should be high on the policymakers' agenda. A robust public healthcare system is essential to weather future outbreaks. It will be difficult to close our eyes after realising the economic and human costs of a pandemic.

Recently, I saw a quote in one of WhatsApp messages. It says, "you cannot change the wind, you can adjust your sails". Pandemics will occur in the future and with greater intensity. It is time to adjust our health system. We have the necessary experience, scientific knowledge and technology to prepare better.

Market workers wearing protective gear spray disinfectant at a market in the South Korean city of Daegu on February 23, 2020. PHOTO **AFP**

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