The Daily Star
FOUNDER EDITOR
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DHAKA TUESDAY APRIL 28, 2020, BAISHAKH 15, 1427 BS

Bangladesh has very little social protection

Policies must be revised to prioritise the jobless poor

IT is worrying that a UN position report has found that Bangladesh has the fewest social protection initiatives in the Asia Pacific region. The report assessed the measures adopted by governments in response to the Covid-19 pandemic. At a time when weeks of lockdown has led to large scale unemployment of people from low income groups, the government must take immediate measures to mitigate the effects of job losses. Already, there are reports of people going hungry and resorting to begging after their source of income has disappeared. The government's stimulus packages aimed at reducing the economic fallout of the crisis are yet to reach many of these vulnerable groups.

Social protection, according to the report, includes unemployment protection, preventing job losses, supporting those who lost their jobs, ensuring income security during sick leave, benefits for the elderly and disabled, measures to boost affordable healthcare, providing income support through social assistance and cash transfers, among others.

The reality of Bangladesh is that even before the pandemic, such social protection has been negligible at best and non-existent at worst, exposing the weaknesses in policymaking and implementation of social safety net programmes. These weaknesses are now glaringly apparent as more and more people are losing their income source and having to spend their days in extreme hardship.

The report assesses that 45 percent of Bangladesh's population is vulnerable to falling into poverty, and garment factories are crucial for providing incomes to the "near poor". Many smaller garment factories are closing down due to the pandemic, resulting in job losses. Most of these garment workers are women.

The report has warned against targeted social protection schemes which require recipients to meet various criteria that may make them more prone to corruption. We have already seen how some unscrupulous individuals have been involved in pilferage of relief food during this crisis.

The report criticised "targeted social protection schemes", by some governments—which are schemes where the recipient has to meet a large number of criteria to receive social protection—as being prone to corruption.

The suggestion to register informal groups and bring them under formal mechanisms could be an effective way to ensure that the millions of individuals in the informal sector and those outside any formal coverage can also benefit from government relief. It is also crucial to monitor the stimulus packages to make sure that those who need it the most are benefitted. The government must review existing budgetary priorities and policies so that resources and schemes are directed to address the huge economic impact on the poor and vulnerable, both in the short and long term.

Asymptomatic carriers pose severe risks

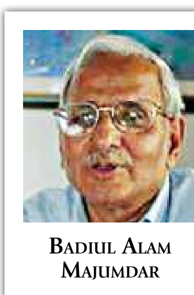
Experts fear actual figures are much higher

CORONAVIRUS infections in Bangladesh crossed the 5,000 mark recently. To make matters worse, the silent spread of the virus is beginning to take a toll as more and more asymptomatic cases are being detected. According to official data, of the 5,416 coronavirus cases detected till very recently, 1,250 individuals did not show any symptoms—a frightening fact that gives Covid-19 an upper hand in our battle against it. As a result, experts have warned of the possibility of a large number of concealed cases silently transmitting the deadly virus across the nation.

Recently, four members of a family in Tangail and two relatives of a virus-infected doctor in Brahmanbaria tested positive for the virus, but none of them had any symptoms; six of the seven people who tested positive for the virus in Pirojpur had no symptoms as well. Twenty-five staffers of a private hospital in the capital tested positive for the virus and did not show any signs. Additionally, 28 devotees at the Iskcon temple in Swamibagh who were infected were asymptomatic; eight IEDCR staffers tested positive without displaying any signs of infection. This shows that the severity of silent transmission is indeed on the rise. According to experts, we have now reached the fourth stage— highest level—of virus transmission, where community transmission is rampant. And if it spreads amongst the low socio-economic groups such as slum dwellers, the consequences can be devastating.

Tests are mostly conducted on those who are symptomatic, which does not give us the real picture. Time and again, we have emphasised on how crucial mass testing is so that those who are tested positive (including the asymptomatic) are isolated and treated while others are protected. Currently, the country has a capacity of testing around 3,500 samples a day. Although the number of testing facilities have been increased, the lack of coordination and manpower still remains a grave problem. As samples are not being collected properly, more doctors, nurses and technicians need to be recruited and trained immediately. The consequences of underestimating the scale of the outbreak has already proven fatal, not just here but across the globe. Therefore, the more tests are done, the better equipped (in terms of knowledge) we are to combat the virus.

Community-level intervention is the answer



BADIUL ALAM MAJUMDAR

ON April 16, as coronavirus continued to spread through the country, the government declared all of Bangladesh to be at risk from the pandemic. The declaration was a tacit admission that Bangladesh is now deep into the stage of "community transmission"—meaning the virus has quietly spread to every corner of the country, remaining undetected because of inadequate testing and many infected but asymptomatic persons. None of us are safe now. Unless effective measures are taken urgently, we may be unable to prevent large-scale deaths.

We were unable to *contain* the spread of the coronavirus because we failed to take effective measures early on. We could have prevented the virus from going beyond the first stage—during which it is imported by people traveling from coronavirus-affected countries — through aggressive quarantine of incoming travellers (citizens, expatriates and foreigners alike) and isolation of those with symptoms. However, our lax quarantine policy and the repeat travel of millions of Dhakaites to and from their villages led to a lost opportunity for us to stop the virus in its tracks. Now, as no approved treatment or vaccine is available, we can only concentrate on *mitigation*, which will require resisting the virus locally, at the community level and to the last person—our very last line of defence. With a local solution, based on community solidarity and action, we should be able to flatten the curve.

But, if we fail to take appropriate community-led measures, the virus can spread like wildfire, quickly turning our country into an inferno. Once it reaches the final "epidemic" level, Bangladesh will experience large numbers of deaths.

About two-thirds (63 percent) of Bangladesh's population is rural. The majority of Bangladesh's cases are concentrated in Dhaka and the surrounding areas, although the virus has already spread into the villages, by the government's admission. Therefore, preventing the further penetration of coronavirus into our villages is now of utmost urgency. We must turn our villages into fortresses against this invisible enemy, as we did in 1971, to protect our motherland.

We must appeal to the self-interest of our citizens who, in order to safeguard themselves and their loved ones, must safeguard their neighbours. The wellbeing of one household depends on the wellbeing of the surrounding households. This self-interest-driven, society-wide initiative must be undertaken primarily on a voluntary basis, especially by the youth. The voluntary organisations can inspire and mobilise villagers in their own work areas using their facilitation skills, offering the villagers a sense of ownership of the initiative. The driving force at the heart of it must be neighbourly feeling combined with self-preservation. The voluntary organisations, using their local volunteers and staff, can also build bridges using mobile and information technology. The Union Parishad chairs and members, as local leaders, can play catalytic roles in this effort. For successful implementation, the government must partner with voluntary organisations and involve them in coordinated action for preventing further spread of the virus.

If we fail to take appropriate community-led measures, the virus can spread like wildfire. ILLUSTRATION: KAZI TAHSIN AGAZ APURBO

Three specific actions must be taken by the volunteers to prevent the further outbreak of the coronavirus in their villages.

First, in the absence of any approved treatment or vaccine, our most important tool for saving lives at this time is awareness creation—promoting life-saving health and hygiene behaviour, including frequent hand-washing and social distancing. Volunteers conducting awareness activities must also maintain social distancing to protect themselves. Union Health Clinics can assist in creating awareness among the villagers, but only if their personnel are adequately equipped. Concerns have been raised that some of these workers are already infected due to lack of protective gear.

Second, those who are infected or suspected of being infected must be identified, offered medical support, and isolated. Isolation is necessary to protect others from being infected, but it must be explained so as not to create fear. The volunteers must also work to prevent stigmatisation and harassment of infected people. This can only be done at the local level, by appealing to villagers' social/family connections and brotherly spirit—every infected person is the loved one of another villager. The villagers must also be vigilant in preventing violence, especially against women. To speed up testing, the Upazila Health Office should be engaged in collecting samples from suspected people, which would require enhancing its capacity and equipping a small laboratory on premise.

Thirdly, we must remember that the coronavirus pandemic is not only creating a health emergency but also an economic crisis. Already, innumerable Bangladeshis have lost their livelihoods, the vast majority from the informal sector. Most live hand-to-mouth and have little or no savings. Due to the lockdown and lack of work, many now face food insecurity. Unless help is urgently provided, some may die of hunger, if they are not already killed by the virus. The villagers must stand by their neighbours—including migrant labourers returning to their place of birth—who, having lost their livelihoods, are on the verge of starvation. The volunteers can make a list of everyone requiring assistance and help those eligible to enrol in government's social safety-net schemes. Others may be helped by community philanthropy or mutual aid efforts organised by volunteers.

By capitalising on the inherent empathy and goodwill human beings have for one another, we can bring together all the "forces of good" in our society, ultimately saving many lives from coronavirus' aggression. Thus, *"ashun shobai milay shopot kori, sthaniyabhabay coronaviruskay protihoto kori,"* (Let's all commit to resist coronavirus locally)—such an initiative will not only protect people at the grassroots from possible death from coronavirus, but also protect them against food insecurity and death from starvation. We are pleased that volunteers of The Hunger Project have already undertaken such initiatives in about 1,500 villages to resist coronavirus in their villages and the leaders of SHUJAN are assisting.

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Can Bangladesh cope with covid-19 medical waste?

Hazardous medical waste management during the pandemic

MOHAMMAD ABDUR RAZZAK

THERE are now almost three million confirmed cases of coronavirus worldwide, and over 200,000 deaths have been reported. Covid-19 is a dangerously contagious disease that has spread in 207 countries across the world at lightning speed. Social distancing has been the principal prevention for the virus; yet, it has already spread into 57 districts in Bangladesh. Patients are being treated in hospitals designated for Covid-19 treatment, and others are being quarantined at home and in designated centres.

Covid-19 is also producing large quantities of hazardous medical waste, with personal protective equipment (PPE) used in hospitals being the main component. World Health Organization (WHO) standard PPE are one time use—every set of PPE becomes hazardous medical waste after being used for a single time. Besides PPE, there are other types of hazardous waste like facial tissue, gauze pieces, masks, oxygen masks, test tubes of nasopharyngeal swabs, saline bags, disposable syringes, needles etc that are being used to treat patients.

As of April 24, the government has distributed 12,50,000 PPE sets to hospitals. These sets, when used, will produce approximately 18,70,000 kilograms of hazardous medical waste. More use of PPE will produce more medical waste, and health care workers are also using PPE that are not part of government supplies. PPE comprises of cover-all (the gown for covering the body), long foot cover, face mask, a pair of hand gloves, mask, goggles and face shield. All these components are one time use, except the goggles and face shield, which experts opine may be reused following standard disinfecting procedure. However, the other components of PPE have no scope of reuse, and they have to be discarded according to standard protocols to ensure the safety of physicians, nurses and technicians. For example, if a physician has attended Covid-19 patients for a couple of hours and goes off duty, the PPE he is wearing shall be discarded in the "doffing" room under strictly controlled procedure. As he enters the doffing room, disinfection of protective gear is to be done first, followed by removal of protective components in sequential order. Then, all these components are to be stored in sealed boxes or biosafety bags. Putting on PPE components is called "donning". It is done in a separate room following the reverse procedure of doffing.

A worker moves medical waste at a hospital in Beijing treating coronavirus patients. PHOTO: AFP

The issues that we should now be focusing on are in-house storage, transportation and final disposal of hazardous waste generated from Covid-19 treatment. Frankly speaking, visits to health care establishments (HCE) in my former capacity as Chief Waste Management Officer of Dhaka North City Corporation portrayed a grim picture about in-house storage arrangements of hazardous medical waste. It has been confirmed from concerned people that these healthcare establishments are not equipped to manage the highly contagious waste generated from Covid-19 treatment. But whatever the state of the HCE, the waste must be disposed. So where can they do that?

One NGO in Dhaka has stepped up to this job. They collect medical waste from hospitals and clinics in open drums and transport them to disposal sites in covered vans. Medical waste is then treated in a plant in Matuail Landfill in Dhaka South City Corporation. The facility, although not modern, is the only option for the people of Dhaka—located 27 km from Kuwait Bangladesh Friendship Government Hospital in Uttara. However, unsealed collection and transportation of Covid-19 waste over such long distances is certainly dangerous, and medical waste workers are also unwilling to handle this waste. If the workers do not collect, how can the hospitals designated for Covid-19 treatment dispose of their waste? We found that some hospitals that have a backyard are putting their waste into a ditch and burning it. Ideally, medical waste must be burnt under controlled environments at more than 700 degree Celsius, and the flue gas should be released into the environment after filtering harmful particles. But since we have not cared to develop our medical waste management systems up to this point, we have to accept the medical waste management during the pandemic is in emergency mode, and our hospital waste management in the capital is making do with whatever limited resources they have. A better situation cannot be expected in other hospitals down the ladder in the upazilas.

But our problems of waste management are not limited to effective waste disposal only; identifying that waste can be as much of a problem as well. Take the issue of cover-alls. There are a lot of look-alike cover-alls found in medicine stores and shops. These look-alikes are used by people not engaged in treating patients. If they are disposed of in the municipal dustbins or dumped on the road side, surely no one can confirm its source. Besides cover-alls, hand gloves and face masks are also regularly found in the municipal bins that eventually go into the landfill. Uncontrolled disposal of medical waste such as this carries direct health hazards, both to society and those who handle it.

Disposal of patient's personal clothing is also another arena that we need to focus on. Who has the responsibility to dispose this—the hospital, or the patient's family? What protocol will they follow? Policy making authorities need to immediately issue advisory guidelines regarding this in the interest of public health safety.

Most importantly, we must learn from this lesson and make a firm commitment to develop state of the art hazardous medical waste management systems. City corporations and municipalities should lead this hazardous medical waste management system with technical advice from the Directorate General of Health Services. Finally, city corporations and municipalities should develop respective organisational capacity to lead waste management systems effectively and efficiently.

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