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We have to know when infections will peak

Let the health experts lead

WE are extremely worried by the exponential increase in infection rates and the rising number of daily deaths due to Covid-9. What is even more concerning is that we seem to be going into a blind alley with no clue regarding when the infection rates will peak—which is essential to predict the downtrend. Experts have alluded to the government's "unscientific" and "vague" strategy as the cause for this uncertainty, which has left us completely in the dark regarding how long it will take for infection rates to fall.

Calling the lockdown from March 26 extending to May 30 a "holiday" for example, led to confusion and indiscriminate movement of people, thus spreading the virus to the districts. Then, announcements of partial reopening without clear guidelines brought another influx of people, mainly garment workers, to join the factories. Despite efforts to enforce lockdowns, with police trying to ensure social distancing, people have been moving about within their localities, crowding kitchen markets and other public places, as well as moving in between the districts and the cities.

In the last 14 days, the DGHS officially reported 40,366 Covid-19 cases and an official death toll of over 1,200. Unfortunately, the actual numbers are most likely many times higher due to the low rate of testing. Without widespread testing, how can we determine the infection rates and the number of deaths due to Covid-19? Measures such as hoisting red flags in front of buildings with Covid-19 patients by the police have resulted in many people hiding their symptoms to avoid being stigmatised, complicating the situation further.

At this point, the government must listen to public health experts and adopt a scientific, specific strategy with clear guidelines to the public. The categorising of areas into red, yellow and green zones must be done in an organised manner, and the level of testing must be scaled up according to the rates of infection.

We urge the government to heed the advice of health experts, which includes immediately forming a national committee headed by such experts with at least 500 subcommittees to oversee the various zones, and include local police, administration and representatives, with health officials taking the lead. These sub committees would be responsible for all the steps needed to contain the spread of the virus—identifying positive cases, contact tracing, ensuring daily necessities for city dwellers as well as hospital facilities for critical patients, and so on.

Communicating these strategies to the public is crucial since there are still major gaps in understanding among people regarding the importance of lockdowns and social distancing. People also have to have confidence that the government is taking the right steps to contain the virus. Only a well-planned out, coordinated strategy that is based on a holistic, scientific approach with the help of experts and other specialised groups can lead to progress in the fight against Covid-19.

Nurse dies after being denied treatment at her own workplace

Hospitals still not held accountable for turning away patients

AT a time when our healthcare sector is entirely overwhelmed and struggling to provide treatment to the escalating number of patients (Covid-19 positive and negative), we are disheartened to learn about the demise of yet another frontline worker, who was refused treatment at her own workplace because the doctors feared she was coronavirus positive—Habiba Sultana, a 22-year-old nurse of Ibn Sina Hospital who graduated from Ibn Sina Nursing Institute's diploma programme in nursing and midwifery in 2018.

On June 10, Sultana suffered a stroke and was admitted to the National Institute of Neurosciences (NINS), but soon enough, her condition deteriorated and she required immediate ICU support. As there was no bed available at the institute's ICU, her family took her to Ibn Sina Hospital hoping they would admit her, since she was their employee and also because she tested negative for Covid-19. Upon reaching the hospital, Sultana's family realised that her Covid-19 test report was missing. While she lay unattended fighting for her life, her family tried desperately to convince the doctors at the emergency to give her some primary treatment. Despite the doctors from NINS confirming to Ibn Sina doctors that Sultana was Covid-19 negative, they refused to treat her for hours. Finally, her family called the 999 emergency hotline and officers from Dhanmondi Police Station arrived, but by then it was too late, and Sultana had already passed away.

There has been an alarming regularity of reports about patients being denied treatment at different private hospitals across the country, despite the health ministry's circular stating that all private hospitals and clinics should have separate arrangements for treating "suspected" Covid-19 patients and that they cannot refuse any patient if they have the particular treatment facilities, and that failure to comply with the order will result in legal action. The health sector is already struggling to cope with the huge number of coronavirus cases, and we need all hands on deck—no hospital can leave resources unutilised and refuse care to the people who need it because of fears of coronavirus. The government must hold to account the hospitals that are blatantly ignoring their duty of care, and mandate the hospitals to accept patients requiring emergency medical services. There is an urgent need to ensure uninterrupted delivery of healthcare services to every patient during this critical time.

How can Dhaka become more resilient to future pandemics?

THE GRUDGING URBANIST

ADNAN ZILLUR MORSHED

CITIES have generally been the epicentres of the devastation caused by Covid-19, fuelling debates around the world on how to make cities more resilient against future pandemics. A range of questions are being asked—What can we learn from the ways cities responded to past pandemics? How do we achieve quality public health through city design? How would the nature of public squares be complicated by the needs of "social distancing"? How do we minimise the risks of such disease hotspots at high-density public transportation, markets, workplaces, schools and entertainment venues? How do we reimagine the relationship between cities and nature as a way to make cities greener and healthier? How can we leverage urban data to provide efficient and equitable public health services? What kind of urban lifestyles can city design foster that would reduce pre-existing health conditions of vulnerable people? And how can we employ urban design to mitigate economic, social and racial injustices that the coronavirus crisis has both revealed and augmented?

There is, of course, no universal formula for a city's pandemic preparedness. Cities vary in terms of their population density, culture, economy, public health, governance and resources. Dhaka's preparation strategies may not be the same as those for New York City. For example, social distancing can present a very different set of urban meanings and public receptions in different cities. How would you socially distance yourself if the space isn't there in the first place? In a poverty-stricken, ultra-congested slum, social distancing could be a cruel joke. If the footpath is four feet wide, how do two people stand six feet apart, as recommended by public health officials?

Yet, there are shared experiences that could be instructive for cities across regions, economic geographies and cultures. For instance, learning from history matters for all. Crises inspired creative solutions in the past. In the mid-19th century, the urban impacts of the Industrial Revolution were revealed by the shockingly unsanitary living conditions of the working class poor who came to cities to work in the factories. Infectious diseases, particularly cholera, were rampant. One author wrote in 1883 about the human horrors inside the workers housing in London: "Every room in these rotten and reeking tenements houses a family, often two. In one cellar a sanitary inspector reports finding a father, mother, three children, and four pigs!" In his novel *Oliver Twist* (1837-38), "the spokesman of the poor" Charles Dickens hauntingly portrayed the dark underworld of London.

In response to deplorable urban conditions, the cities of London, Paris and New York sought housing reform and modernised their sewage infrastructures to contain cholera epidemics. These metropolises gradually devised new urban zoning laws to prevent unhygienic overcrowding that frequently led to disease outbreak. Thus, the modern era of urban sanitation began. At the height of anti-British agitation in India, Gandhi proclaimed: "Sanitation is more important than political independence."

The birth of urban planning was tied to the growing awareness of sanitation as the foundation of public health around the turn of the 20th century. The discipline emerged as a result of the overlapping works of three groups of people: architects, public health professionals and social workers. Architects were concerned with improving and reorganising the physical conditions of the city. Public health professionals focused on the city's poor infrastructure—water supply, sewage collection or waste disposal—as a way to prevent epidemics. And, social workers sought to improve the lives of the urban poor by promoting housing reform and reducing their gruelling work hours. The efforts of these groups ushered in the idea of comprehensive urban planning, powered by a universal sense of moral economy.

That was over a hundred years ago. Today, we have become accustomed to the concept that each city has its own political economy, social and cultural character, and anthropological challenges. It is in this context we need to reimagine post-Covid-19 cities in Bangladesh.

Most importantly, we should see city design as a public health initiative, wherein "public health" implies a fusion of physical and mental wellbeing, aesthetic and cultural fulfilment, the ability to live life without fear, and social conditions in which all people have equal access to opportunities. When public health is understood as a collective social contract, hospitals, urban trees, playfields, footpaths, clean rivers and *kacha* bazars can all be considered public health amenities.

Speaking of *kacha* bazars, we all know how important they are in our cities as "informal" marketplaces that serve as community junctions where local people buy fish, meat, spices or vegetables at affordable prices. The alleged origin of Covid-19 in a Chinese *kacha* bazar or wet market in Wuhan has provoked questions as to how safe it is to allow this type of informal, and almost always unsanitary, marketplace inside dense urban neighbourhoods.

But think about it. Who wouldn't enjoy going to the *kacha* bazar in Mohammadpur or New Market in Dhaka and experience their poetic insanity, their intoxicating hustle and bustle? Even though they don't trade exotic animals like their Chinese counterparts, wet markets in Bangladeshi cities warrant a new scrutiny from a public health perspective. With the health hazards of exposed meat and drying blood, severed cow heads kept next to vegetable stalls, and fish stored in polluted water, the traditional *kacha* bazar could easily become a pandemic tinderbox.

Should they be removed from congested urban areas or should they be redesigned to meet public hygiene standards? Like the rickshaw debate (whether they should be taken off city streets or not), *kacha* bazars can present a policy dilemma. On the one hand, the livelihoods of local traders and community values are at stake and, on the other, there are public health risks.

The wet markets are not a problem of developing countries alone. There are over 80 wet markets in New York City. A nonprofit group called Slaughter Free NYC is working to have them banned on the grounds that they pose serious public health risks. We need to start reimagining wet markets in the midst of our cities. Similarly, the placement of public toilets in busy urban intersections should be examined closely. As much as they serve the public interest, they could also be air- and water-borne virus factories. Is the unsanitary public toilet a design problem or a behavioural problem? Would toilet hygiene in our country require a cultural revolution? In 1925, Gandhi wrote: "… a lavatory must be as clean as a drawing-room." It was a pointed critique of South Asia's toilet hygiene.

Another issue that comes up frequently in debates on post-pandemic urbanism is crowding in public transportation. What can Dhaka, Chattogram, Khulna, Sylhet or Rajshahi do about it? Our buses, tempos and trains are jam-packed. Social distancing is both a luxury and an impossibility. Should facial masks be made legally mandatory in mass transit? Alternatively, should we promote personal mobility by means of biking and walking? European cities are aggressively championing biking as a triple-win proposition. Biking is healthy; it reduces crowding in mass transportation; and it doesn't discharge any carbon into the city air. But how safe are our already packed streets for biking? Maybe in Barishal, but not in Dhaka. What will it take for us to reimagine Dhaka as a South Asian Amsterdam?

Walking in our cities has never been a pleasurable or efficient urban activity. Footpaths often either don't exist or are occupied by informal markets. Furthermore, an entrenched bourgeois class element makes walking in city streets a socially incriminating subject. Creating a true pedestrian culture would require no less a behavioural revolution. Urban administrators, planners, architects, healthcare professionals and social workers should come together to re-conceptualise the footpath as a public health infrastructure that can help reduce obesity, resist diabetes, and encourage people to better experience their city. Being healthy means not having preexisting health conditions, thereby reducing people's vulnerabilities during the pandemic. Should footpaths be covered or arcaded, so that people can use them in all seasons, during the monsoon and scorching summer?

Pandemic preparedness would require a careful consideration of the city's economic geography and how it might perpetuate discriminatory public health policies. It is typically the urban poor, ghettoised in their impoverished, unhygienic and overcrowded squatter colonies, who bear the brunt of a pandemic. Covid-19 killed people in the Bronx, the poorest of New York City's five boroughs, at a much higher rate than other boroughs. Grinding poverty, lack of quality hospitals, racial discrimination and social alienation made the Bronx more vulnerable than any other borough. Bangladesh can learn from the Bronx experience.

Urban resilience needs meaningful investment in public health infrastructures, including affordable hospitals. In the 2020-21 budget, Bangladesh's expenditure on health is a little over one percent of GDP (India's is similar to Bangladesh; Norway's is over 10 percent, one of the highest in the world). The truth is that our development vision prioritises flyovers but not public hospitals. As the coronavirus crisis rages in Bangladesh, hospitals, more specifically oxygen, have literally become the fault line that separates the haves and have-nots. Eliminating this fault line would require envisioning a new moral economy as the bedrock of development.

"In a poverty-stricken, ultra-congested slum, social distancing could be a cruel joke". STAR FILE PHOTO

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Holding companies liable for death by negligence

What legal actions can be taken?

'JUSTICE' IN PRACTICE

TAQBIR HUDA

ON May 27, 2020, a devastating fire broke out in the corona isolation unit of United Hospital in Gulshan, which claimed the lives of five patients who were receiving treatment there. On June 6, 2020, the five member committee established by the Fire Service and Civil Defence (FSCD) to investigate the incident reported that they found evidence of "negligence and indifference of United Hospital". Since their report is yet to be made public, we may turn to the evidence of negligence found in prior inspections by the Dhaka North City Corporation mayor and FSCD, as announced in press briefings.

Firstly, the corona isolation unit was a makeshift structure, detached from the main building and made of extremely flammable materials, such as Partex boards, while the presence of disinfectants inside the unit added to the risk of flammability. Secondly, the corona isolation unit did not have any fire exits, fire hydrants or fire extinguishers and was built without obtaining a fire safety clearance from the FSCD. Therefore, the unit was "built in violation of the [National] Building Code", as stated by Debashis Bardhan, deputy director of FSCD, Dhaka Division.

Thirdly, eight out of the eleven fire extinguishers that were available in the main building were expired, while the hospital's fire safety officer was not on duty when the fire broke out. The fourth piece of evidence—the fire service mentioned that they only came to know about the fire at 9:55 PM, 25 minutes after the fire broke out, although the hospital authorities maintained that they had placed the call much earlier.

Finally, two out of the five patients killed in the fire had actually tested negative for Covid-19, but were still being kept in the corona isolation unit despite repeated requests by family members for their transfer. These findings naturally led to widespread discussion on social media about the lack of accountability for corporate negligence in our country. The questions therefore arise—can companies be held to account for causing death by negligence, and how? There are at least three ways this can be done: by filing a criminal case, a writ petition and a tort case.

Under section 304A of the Penal Code 1860, causing death by negligence is punishable by a maximum of five years or with fine or both. While criminal cases are sometimes filed against CEOs or MDs of companies or entities, they often do not get justice. This is because proving that death occurred as a consequence of corporate negligence is extremely difficult to establish in criminal law, due to the higher burden of proof and its general focus on intentional wrongdoing. Even if fines are imposed on the company, this money would not go to the victims' families unless the court converted the fine to an award compensation (which seldom happens). Additionally, since fines are punitive in nature, the amount could never be considered as adequate compensation, even when converted.

The constitution guarantees certain fundamental rights (such as right to life) for all people within the territory of Bangladesh, and relief can be sought by petitioning the Supreme Court when any of these rights are breached, in the form of writ petitions. Previously, such petitions were only filed against public bodies but more recently, private bodies, such as private companies, are also being impleaded. If the Supreme Court is satisfied that there has indeed been a violation of fundamental rights, it can issue any "order or directions" against "any person" as it deems "appropriate", including an order of compensation to be paid to a private party.

In some recent high profile negligence cases, the Supreme Court has exhibited willingness to award compensation quite speedily (such as the road crash cases of Rajib, Jabal E Noor and Greenline, along with the earlier death of four year old boy Zihad). However, there are also other cases where the compensation has not been received despite writs being filed seeking it (such as the Chawkbazar fire case and FR Tower case). Crucially, the Appellate Division of the Supreme Court in Bangladesh vs Nurul Amin made it clear that compensation for violation of fundamental rights through writ petitions will be an exceptional remedy. This is because generally, tort law is considered to be the appropriate forum for filing compensation cases.

The less explored option is a tort case. Tort law is the specific branch of law designed to deal with compensating harms suffered by individuals due to the actions of others. In Bangladesh, while tort cases remain quite rare, the Fatal Accidents Act 1855 (FAA) would allow family members of anyone who has died due to a company's negligence to claim compensation, and such compensation will be assessed at a much higher scale than in writs and criminal cases. In tort law (and therefore FAA), as soon as negligence is proved (and no valid defences are applicable), the court would be bound to award compensation to the victims as a matter of right, which is not the case in writs or criminal cases. Furthermore, in contrast to criminal law, the burden of proof is much lower in tort law and employers can be held vicariously liable for the negligence of their employees. Together, these two differences mean that it would be more possible to prove corporate negligence in tort cases than in criminal cases.

So while there are at least three different ways in which victims' families can hold companies to account for causing death by negligence, the third and most advantageous option tends to remain unexplored in our country. It must be remembered that the law does not require victims' families to choose only one out of the three options as they have the right to bring all three forms of legal action simultaneously.

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