

Statement on post-3rd May 2020 measures against Covid-19 Pandemic

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Background

The Central Government has persisted with the Lockdown as the main, if not, the only strategy against the spread of COVID-19. Underway since March 25th, this lock-down has seen two extensions, one on April 20th and now again on May 3rd. These one-size-fits-all country-wide lock-downs are badly planned and poorly implemented with measures imposed on the country by the Government using centralizing powers under the Disaster Management Act.

More than 28 Joint Statements released till now by [Jan Swasthya Abhiyan](#) and [All India Peoples Science Network](#) (JSA-AIPSN) have been released. These statements explain in detail why such all-encompassing restrictions of movements and activities that India has executed is a fundamentally mistaken approach with limited and temporary benefits, that fails to factor in Indian socio-economic realities. This will lead to many long-term adverse consequences.

WHO, public health experts and best practices of many countries all agree that population lockdowns are at best temporary, locale-specific, emergency measures which need to be accompanied by other more important health-related and socio-economic measures which we list as follows:

- extensive and rigorous contact tracing, wide-ranging and purposive testing, quarantining and isolation as required, and hospital treatment of infected persons
- building up preparedness of health systems using the lockdown leeway to respond to the anticipated high case load arising from Covid-19
- ensuring that the health system caters simultaneously to non-Covid health needs especially relating to maternal and child health, chronic or life-threatening ailments and needs of the elderly, disabled and other vulnerable sections
- ensuring reliable supply of and access to essential goods and services, especially to meet needs of the poor, elderly, disabled and other vulnerable sections
- financial and other special provisions for those who would lose essential incomes and jobs, such as migrant workers, daily-wage earners, the self-employed and workers in the unorganized and SME sector
- humane, effective and non-stigmatizing approach towards infected and suspected cases, and the economically worst-affected populations, with participation of community volunteers and civil society organizations as appropriate
- effective coordination between Centre and States/UTs, as the latter is being starved off revenues while also coping with demands arising from the Covid-19 epidemic.

However, although the lockdown is being implemented vigorously, none of these parallel measures have been implemented in the required scale and intensity. As a result, the capacity to undertake public health and economic measures to cope with the inevitable increase of infections when the lock down is lifted, are still not in place. The lockdown itself has also been imposed and implemented in a non-transparent manner without the epidemiological evidence required to inform both the classification of areas and the choice of activities to be restricted.

Current Status: The Central Government and its departments/agencies including the Ministry of Health and ICMR have been making various often unsubstantiated claims about the success of the lockdown, such as that many more cases would have occurred without it, that the rate of new cases is becoming linear, that no community transmission is taking place, and so on. The reality is that cases are fast rising especially in certain States/Districts, with surprisingly high fatality rates in some. There is substantial uncertainty about the true extent of spread given low testing rates, among the lowest in the world at around 0.4 tests per thousand population compared to the global median of 5.9 tests per thousand. Further, symptomatic cases without contacts have been largely excluded from testing by protocol. Infection is certainly spreading to new areas through what is euphemistically termed “large outbreaks of local transmission” by the government. There are significant numbers of cases without any connection to persons with travel or known contact history. The rates of increase remain significant and accelerating. Whereas it took 10 days to go from 5000 to 15,000 cases it took only 5 to 6 days to go from 25,000 to 35,000 cases.

However, these all-India numbers mask the stark reality that the case load varies widely between States and also within States. At the time of writing the statement, 5 of the total 36 States/UTs have zero cases, 130 districts have been classified as “red zones”, 284 districts as non-hotspot “orange zones” and 319 districts in 25 States reporting no new cases in the past 21 days as “green zones”. This colour-coding of districts and containment zones is not based on clear, stable and transparent epidemiological criteria, and yet forms the basis for policy recommendations for containment measures.

On top of this, within the red zones even more intensive “containment zones” or hotspots have been identified based on even weaker and more opaque evidence, but where even stricter forms of lockdowns have been imposed.

In light of this situation, the following steps are urged in the coming period:

- i. Strengthen the disease surveillance mechanism, inclusive of COVID 19 surveillance, with appropriate design for collection, flow and analysis of information so that it can inform decision making for epidemic control at national, state and local levels as well as

provide information on collateral costs in lives lost and morbidities due non-COVID causes.

- ii. Zero case reporting should not be made the exit criteria for lock-downs or basis for any zoning. Such unnecessary and unrealistic criteria run the danger of systems suppressing data to report zero cases. The realistic objective is to achieve a manageable number of infections or case increase rates at any point so as not to overwhelm the system and to reduce deaths by protecting those that are particularly vulnerable to severe disease.
- iii. Many restrictions have no rationale in public health such as the country-wide restriction of movement after 7 pm. The specific rationale for such measures should be explicitly stated and subject to audit and review by impartial watchdog bodies.
- iv. Adopt a framework of participatory governance for determination of criteria for restriction of movements and activities, and guidelines for implementation of relief measures and allocation of resources. This could subsequently become part of a legal framework that would mandate functional consultative mechanisms involving public health expertise, health care providers and civil society organizations including of working people, all of whom would be affected. Such legislated provisions would also mandate watchdog bodies to ensure that the sweeping powers given under the Disaster Management Act are used in consultation with affected people and groups, and that the participatory framework is maintained.

Restrictions on Movements and Activities: It is strongly urged that a calibrated and graded easing of restrictions on movement and social and economic activities takes place, with broad guidelines within which States may decide on the extent of these restrictions. The main principle for making and implementing restrictions is that this must not call for creating or strengthening police raj using Sec 144 and other coercive measures. The public should be treated in a humane manner and as partners in the process, and not as criminals or subjects under colonial rule.

Relaxations should aim at reviving economic activity, especially in the unorganized and small-scale sector while continuing to practice physical distancing and other precautions, improving services required by common people especially the elderly and vulnerable sections , considerably strengthening the health system to handle both Covid-19 and pressing non-Covid issues, and stepping up efforts at containment through expanded and rigorous testing, tracing, isolation or quarantining, and treatment. We note that several restrictions such as on agriculture, agricultural markets, fisheries, forest produce etc., as well as on enterprises in rural areas and activities by plumbers, electricians and carpenters in urban areas, have already been relaxed.

The following (indicative not exhaustive) additional relaxations beyond those already permitted since 15 April are urged, with States to decide on fewer relaxations in “red zones” if felt necessary:

- i. Inter-State and inter-district movement of all goods should be freely permitted in view of the current severe shortages and supply-chain constraints impacting even food, medicines and other essential goods, besides other manufactured goods;
- ii. Students, tourists, and families that are separated and others who have been stranded by the lockdown should be allowed to book tickets in suitable public transport arrangements including special buses, trains and flights which are organized for this purpose, and facilitated to reach their destination within the next few weeks. Migrant workers should be transported to their native villages free of cost, so as not to add to their enormous burden they have already had to take on due to the lockdown. Those with symptoms suggestive of COVID 19 should be checked before travel and retained pending observation and subsequent clearance. . Further restrictions on public transport must be eased based on evidence
- iii. All small-scale manufacturing and service enterprises be permitted to function in urban areas with suitable guidance on work-from-home where possible, proportion of personnel attending per shift, use of own or company transport, physical distancing and provision of protective measures such as washing stands, sanitizers, masks etc
- iv. All home-based enterprises, self-employed occupations and services such as care services, air-conditioner servicing/repairs, water purification and provisioning, neighbourhood laundries and pressing, courier services, roadside vegetable/fruit vendors, florists, and other similar categories should be permitted. Only exceptions can be stated such as where services providers are numerous with crowded clientele making social distancing difficult
- v. Skeletal public transport and a limited number of taxi services should be made available and personal vehicles be permitted for essential purposes like access to healthcare and for the vulnerable. Many of these should be decided locally and not micro-managed from the central MHA.
- vi. Types of shops allowed to function from local markets may be expanded to include hardware stores, electrical supplies, sanitary ware stores, cell phone repair, bakeries, hosiery and undergarments, stationery etc., and small restaurants for home delivery.
- vii. Based on data related to social mixing and disaggregated infection rates, several countries have worked out risk criteria for different types of services according to which certain services like cinema halls, malls and pubs are kept closed for the time being while some other services such as restaurants operating at 50 percent of less occupancy with physical distancing norms are allowed to open.; some countries have opened up primary schools, others have allowed public transport and so on. Similar risk-criteria may be evolved for India and services opened up accordingly

The efficacy and effectiveness of the “containment areas” approach is questionable on epidemiological and other grounds and measures implemented within these areas are highly arbitrary and unrealistic. If essential needs like outpatient healthcare or food purchases are disallowed, then people are forced to breach the containment perimeter by subterfuge to meet these needs. Further, once these areas are opened up, they are as vulnerable as before to infection from nearby areas. Whereas neighborhood spread is not a feature of the epidemic, such forms of containment may actively lead to it. This is essentially a policing approach that cannot be a substitute to contact tracing by community health workers with active community participation.

Hospitals and health care: Focus of the government hitherto has been almost exclusively on preparing public hospitals dedicated to Covid-19 care, to the extent that other important health services have been sidelined causing enormous problems to persons suffering from various chronic or life-threatening ailments and increasingly even to maternal and child health. Earlier JSA-AIPSN Statements have elaborated on this issue in considerable detail. Government claims that sufficient beds are now available for handling Covid-19 patients, but ground realities are that hospital beds have mostly been diverted from other non-Covid requirements, and ICU Units properly equipped with oxygen and ventilators are in extremely short supply even in metropolitan cities, for instance in Mumbai. OPD and many other services in public hospitals have also been suspended with, for example, outstation patients and their caregivers stranded in makeshift shelters in Delhi for over a month waiting for cancer or other treatment.

It is also notable that medical professionals and other health workers and auxiliary personnel have become infected by Sars-Cov-2 in sizeable numbers and hospitals have themselves become major “hotspots” for infection spread for a variety of reasons, most of which were avoidable.

In light of this situation, the following steps are urged in the coming period:

- i. Urgently expand the number of beds and well-equipped facilities for isolation and initial treatment of Covid-19 patients through non-hospital re-purposed facilities such as sports stadia, conference halls, panchayat bhavans etc, including by erecting purpose-built field facilities, so as to reduce pressure on hospitals . Where the patient is COVID 19 positive, institutional isolation with suitable medical care must be the only option. Home isolation can only be considered in exceptional circumstances.
- ii. Better equip dedicated Covid-19 hospital facilities for management of severe disease.
- iii. Stop the conversion of functional multi-speciality public hospitals currently working on full capacity, leading to denial of access to essential healthcare for close to half the population in many medical disciplines. Where there are no other under-utilized public or private hospitals that can be re-purposed, with segregation of one wing of the public hospital and entrance through a separate gate, while ensuring all other departments

function in same volumes as before could be a temporary arrangement. But in parallel- the government must rapidly build up new public hospitals.

- iv. Conduct independent audit of hospital procedures and protocols to prevent hospital acquired infection using standard quality accreditation guidelines as well as COVID specific guidelines in all hospital, public or private, irrespective of whether they are seeing COVID 19 patients.
- v. Rigorously identify and test all symptomatic patients for Covid-19 infection, as also all patients with co-morbidities that are known for association with COVID 19 infection.
- vi. Provide appropriate PPE for all health care and auxiliary personnel in hospitals handling both COVID and non COVID patients.
- vii. Extend training, PPE and other support measures commensurate with requirements to ASHA workers and other community health workers, sanitation workers, police personnel, administrative staff, social workers, and volunteers working in potentially high-infection environment.
- viii. Ensure continuity in care, including access to diagnostics and medication and out-patient and in-patient care for serious. chronic and life-threatening ailments
- ix. Ensure safety of doctors and other health-care workers through provisioning of PPE in requisite quantities and quality standards
- x. Ensure adequate ambulances and/or other vehicles for speedily bringing patients requiring hospitalization for both Covid-19 and non-Covid19 cases
- xi. Induct volunteers of recovered Covid-19 patients for interfacing between the public and the health care workers with periodic testing as required to ensure there is no recurrence.
- xii. Provide mental healthcare services as required to health workers, Covid-19 patients and their families, and to address mental health issues among school children, adolescents and others arising out of lockdown.
- xiii. Strongly come down on the touting of fake cures and remedies, “immuno-boosters” and other similar gimmicks, including their advertisement on television and other media

Quarantine: Contact tracing and quarantine of asymptomatic contacts of Covid- 19 is an essential **component of epidemic control**. However in densely populated slum and low-income areas in cities, there is little scope for home quarantine due to over-crowding, poor health systems support and lack of trust between authorities and residents. Recent instances of persons being kept in large numbers in a single room in Delhi with a common, dirty toilet, or of poor people being kept in UP like caged animals with food being thrown at them, show the utter callousness and carelessness with which quarantine is being viewed, except for the well-off who may stay in their own homes or even in hotels on payment.

In light of this situation, the following steps are urged in the coming period:

- i. Institutional facilities for hygienic, effective, dignified and humane quarantine must be sharply increased for all classes and categories of persons, with adequate provision of nutritious food and other essentials.
- ii. Clear standard norms of institutional quarantine that includes medical and public health features as well as considerations of comfort, convenience, privacy and human dignity should be urgently drawn up, disseminated and rigorously monitored, including through community based people friendly mechanisms.
- iii. Such facilities may be created in repurposed public buildings, schools, college and university campuses, and other requisitioned private/institutional buildings or purpose-build facilities as required.
- iv. As many of these facilities as possible should be community managed, often engaging recovered patients from that very community in the management, so that there is trust and humanity in the way this is dealt with. Assistance of civil society organizations may be promoted and utilized in a coordinated manner.
- v. In situation where it is reasonable to accept compliance and there is good community support and linkages with the health system, home quarantine can be permitted.

Testing and Tracing: The recommended relaxation of restrictions should be accompanied by expanded and more rigorous tracing and testing of all suspected cases, so that quarantine of contacts, and isolation and treatment of the infected are vigorously pursued towards breaking the chain of infection. In so-called red zones suspected cases, based on clinical symptoms and contacts of known positive cases need to be pro-actively identified through door-to-door surveillance contact-tracing and contact tracing. Yet despite all the time gained by lock-downs the access to testing remains far below what is required for both individual patient management and for epidemic control.

In light of this situation, the following measures are urgently required:

- i. **Testing protocols** currently specified by ICMR need to be revised to permit testing of all persons with symptoms suggestive of Covid-19 infection (mild, moderate or severe) as well as asymptomatic contacts. It could be further scaled up to include asymptomatic people without contact history if infection is high enough to label it a “containment” hotspot. Some of those at high risk like health workers in the COVID frontline may require periodic testing, while others may require testing if they develop symptoms.
- ii. Access to both viral antigen testing and rapid antibody testing needs to expand. **Rapid antibody testing** is very useful tool that clinicians can use to rapidly confirm diagnosis within a clinical setting, and for sero-surveillance including in so-called “green zones” for understanding spread of infection and the development of herd-immunity. In many clinical settings viral antigen tests would be required even if it is more difficult to access.

Test kits & PPEs: Test kits and PPEs need to be procured expeditiously in sufficient quantities and distributed to States proportionate to requirement. While government spokespersons have repeatedly released figures of Test Kits and PPE ordered, which was done very belatedly as recent revelations show, delivery has actually been slow. Official statements indicate that the required larger numbers of PPEs and test kits may not be available before end of May or even June, which is totally unacceptable. Poor procurement policies, delayed validation and an over-reliance on one or two foreign suppliers have led to this crisis. Indigenous PPE manufacture has been slow to pick up partly due to lock down related barriers of access to raw materials and labour. Indigenous test kit manufacture has also faced problems of delayed validation and is taking time to scale up to required levels.

In light of this situation, the following steps are urgently required:

- i. Bottlenecks in manufacturing clearances and domestic production need to be urgently addressed, especially as regards supply chains and transportation.
- ii. Financial support should be extended to domestic manufacturers in order to scale-up and speed-up production, with products of adequate standards commensurate with international norms; this should be done with a long-term perspective of building up indigenous capability and eco-system in aspects of the value-chain towards a globally competitive medical equipment industry in India.
- iii. Validation and other clearances should be accelerated for indigenous tests developed (as for example the Chitra Tirunal RT-LAMP test or the CSIR-IGIB test kit) in order to include them into the program and expand the options available.

Stigmatization: The entire approach of the Government as well as its explicit messaging have been founded on creating fear which in turn has been transformed into stigmatization and aversion by a petrified public. Despite all the government-organized clapping and lamp-lighting, doctors, nurses, sanitation workers, testing technicians and even airline pilot and crew have been targets of stigmatization among all classes. Even the dead have not escaped this stigma. Stickers, posters, wall paintings etc. outside the door of quarantined persons have only increased the perception of infected persons as “the enemy,” to be shunned or even fought off. Various tracking apps will only make this worse and add to the surveillance capacity of the government well beyond this epidemic. Without trust and public cooperation they are unlikely to be effective. These tracking apps have therefore been opposed by many civil society organizations, especially those specializing in internet and data privacy.

The communalization of the epidemic, which has itself acquired epidemic proportions, is an extreme form of this stigmatization and needs to be fought back by all concerned, especially by the Government.

In light of this situation, the following immediate actions by the government are required:

- i. Government must actively lead health education (IEC) activities that de-stigmatize the disease and promote a better understanding of how it spreads. Its message should be reviewed to ensure the messaging does promote social solidarity, not fear, guilt or hostility.
- ii. All norms of privacy and confidentiality of individuals and communities must be respected. A serious campaign must be organized to de-communalize the disease
- iii. Government must stop targeting its political dissent and making arrests and restrictions on political grounds using the opportunities provided under the draconian disaster management act and the difficulties in access to court. This is essential for building a broad based trust.

Gender based violence: The lockdown period has aggravated situations of violence that happen to people on the basis of their gender, sex, or sexual orientation-women, girls, trans-persons, children and others. Being restricted within homes/families has meant for many women and others to be isolated with their abusers. It has not only meant being more exposed to ongoing violence but also the inability to move out seeking protection and care. The sudden enforcement of lockdown and subsequent suspension of transport facilities/mobility has predictably led to this scenario as it created barriers for those who would have wanted to move out of situations of violence in the given context. Even before Covid-19 situation, gender based violence has existed as a pervasive issue having enormous impact on lives of survivors including negative health outcomes, thus forming a crisis situation of its own which was completely overlooked given the way lockdown was enforced with least sensitivity to the needs of these survivors. Overlooking one crisis while gearing upto respond to another- is paradoxical at least; and violation of the rights of survivors at large.

There are also, very disturbing instances of violence against women in quarantine facilities and at hospitals being reported must be urgently looked into and dealt with to ensure that no such violations happen in future. At a crucial time when the hospitals, healthcare workers and systems are seeking support of the communities and its varied members for their voluntary cooperation to control the spread of Covid-19, such incidents unfortunately breaches the trust of the communities, particularly women for trusting their well-being with the government systems.

Given this situation, we call on the government to take the following steps:

- i. Prevention and redress of gender based violence must be made an important aspect of national response plans for Covid-19. The governments must send a clear message against all forms of gender based violence including sexual violence in all spheres of lives including health facilities and quarantine spaces. Public health preparedness, systems and protocols in the current context must take additional measures towards ensuring a dignified healthcare for all women, girls, and other marginalized groups.

- ii. Special emergency fund should be declared and allocated for responding to gender based violence in the current context including the utilization of existing Nirbhaya funds with states- with requisite directives and flexibility to draw up response suitable to different contexts.
- iii. Essential service providers must be recognized at the administrative level-including government helplines, one stop centres, police, protection officers, medical officers, legal services authorities, counsellors, shelter homes etc. and ensure that they remain operational universally.
- iv. Government should call for urgent consultation with women's groups/organisations working on this issue to ensure a concerted/organized effort during the Covid-19 situation.

Migrant Workers: Last but not least, is the terrible situation that migrant workers find themselves in, which is a massive blot on the governance system and the reputation of our country. These workers are the backbone of the Indian economy. They earn their livelihoods however meager with dignity, and do not deserve to be treated as supplicants. This crisis must be resolved urgently and humanely. We note that after a long and inexplicable delay, permission has been given to run special trains for migrants to return, but even this move is as yet inadequate in scale and support systems. Moreover, it has been reported that the workers are being made to pay for their travel back, which is completely unethical. Many migrant workers have already been subject to brutal and hostile quarantine conditions and many are exhausted by hunger, disease, heat and the exertion of trying to walk back home.

In such a context, we call on government to take the following measures:

- i. Arrange adequate number of special trains for returning migrants to their home states, and further buses within the states for them to reach their home village. These should be provided completely free of cost.
- ii. Ensure that those who have symptoms are tested, and allowed to board only if negative. If positive they must be hospitalized at state expense, and when they become negative catch the next train back. Those who have no symptoms can be allowed to return without any further tests.
- iii. Arrangements for proper quarantine according to specifications as discussed above should also be made in their native villages or districts, if they are coming from a higher infection zone to a lower infection zone.
- iv. Transportation conditions should be decent with food and clean toilets ensuring physical distancing.
- v. Whatever meager support migrant workers have been extended by the Centre and by some of the States where they had come to work and live, has been too little and too late. They require to be compensated for loss of income incurred due to the lockdown,

and provided with financial assistance through MGNREGA or other means after they return to their villages.

Relief Measures for all Working People: The government has announced a slew of relief measures. JSA-AIPSN in an earlier statement has pointed out to the inadequacy of many of these measures, both in terms of covering all those who require relief and on the scale of relief provided.

As the government goes into the second extension of the lock-down we note that most of these relief measures are yet to reach the majority for whom it is intended. No further measures from the government have been forthcoming. Only very few states have been able to supplement this package of relief. There are also many categories of workers like non-migrant urban poor staying in the slums, are out of work, and have no access to social security measured and food security entitlements and have no relief package directed at them. A number of NGOs are valiantly try to close the gap with community kitchens,- but the scale of this effort is too small.

In this context we call upon the government to:

- i. First and foremost implement the promises it has made with respect to relief and ensure that bureaucratic barriers and implementation failures do not exclude large sections of those who need relief or fail to deliver the necessary quantity of relief.
- ii. Announce an increase in the resource allocation and use this to expand the scope of relief measures that are provided to the working people, especially the most vulnerable sections who are bearing the brunt of this crisis. The longer such lockdown continues the higher would be such burden on them.
- iii. Expand food supplementation and food security arrangements as called for by the Right To Food Campaign, without any mandatory requirement of Aadhaar. The FCI currently has a stock of over 60 million tonnes of grain, which should be distributed among the population.
- iv. Expand the MGNREGS to reach a much wider section of rural workers and extend it to all urban workers, so that all those in need of employment are able to secure employment for at least 200 days in the coming year, wherever they are resident. The kind of works permitted under MGNREGA should also be expanded and a basic unemployment allowance would be required in many states.

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