The Hindu Analysis: 24 April 2020

1) Protection for protectors: On safety of healthcare workers-

CONTEXT:
Since the first case of novel coronavirus infection in India was reported in end-January, many healthcare workers have been subjected to abuse(bad words) and violence in the line of duty.

HEALTHCARE PERSONNEL:
Most of the attacks have been on healthcare personnel sent to localities to collect samples from people who are suspected to have been infected or have come in contact with those who have tested positive for the virus. Some doctors returning home from duty have been prevented from entering their homes and in some cases, even asked to vacate their premises.

While such acts have been widely condemned, nothing much changed on the ground. The dastardly(extremely bad) act of a few people in Chennai who not only attacked healthcare workers but also prevented a decent burial of a neurosurgeon who died of COVID-19 complications on April 19 shook the nation’s conscience(moral sense).
ORDINANCE:

Though belated, the Union Cabinet’s decision to promulgate an ordinance to amend the Epidemic Diseases Act, 1897 to make acts of violence against medical personnel a cognisable and non-bailable offence and also provide compensation in case of injury or damage or loss to property is thus commendable.

(TRIVIA- Ordinances are laws that are promulgated by the President of India on the recommendation of the Union Cabinet, which will have the same effect as an Act of Parliament. They can only be issued when Parliament is not in session. They enable the Indian government to take immediate legislative action.

The Epidemic Diseases Act, 1897 is a law which was first enacted to tackle bubonic plague in Mumbai in former British India. The law is meant for containment of epidemics by providing special powers that are required for the implementation of containment measures to control the spread of the disease)
FEAR AND IGNORANCE:

Very often, the abuse and violence against healthcare workers after the outbreak of COVID-19 in the country has been due to fear and ignorance. The communal colour given to the COVID-19 epidemic after the large religious congregation(group of people assembled for religious worship) was held in mid-March by the Tablighi Jamaat in Nizamuddin, Delhi initially led many in the community to avoid coming forward to get tested.

In many cases, the fear of stigma(disgrace) and isolation resulted in attacks on healthcare workers who had gone to collect samples from those who were part of this congregation.

NEGATIVE MESSAGING:

In other instances, the wrong messaging that getting infected by the virus meant certain death, in order to achieve maximum compliance with the shutdown, unwittingly led to a fear psychosis(severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality).

Negative messaging, especially of the kind that induces(gives) fear and stigma, has always been counterproductive, as seen in the early days of the HIV/AIDS awareness campaign in the country. Awareness-building exercises became easier and more effective when negative messaging and stereotyping(typecast) about HIV/AIDS was shunned(avoided).

EMPATHY:

Doctors, nurses and other healthcare workers who are forced to work long hours treating patients infected with the highly infectious virus, and even when protective gear in the form of gloves, face mask and personal protective equipment are scarce, need more empathy(feeling what the other person feels), compassion, unmitigated(absolute) support and
cooperation from the society.

CONCLUSION:

Symbolic gestures (actions) such as clapping hands and lighting candles in recognition of their selfless service during these trying times do not bolster inspire their morale as much as understanding and support does. Healthcare workers should be allowed to work in an environment free of violence and abuse.

2) Rapid failures: On antibody testing kits-

Significant error rates for COVID-19 antibody testing kits underscore the need for caution.

CONTEXT:

Rapid testing kits that State governments have been using to detect antibodies to the novel coronavirus have proved unreliable, making the shift to normal life after the lockdown ends on May 3 more difficult.

(TRIVIA- An antibody (Ab), also known as an immunoglobulin (Ig), is a large, Y-shaped protein produced mainly by plasma cells that is used by the immune system to neutralize pathogens such as pathogenic bacteria and viruses.

Rapid tests are designed for use where a preliminary screening test result is required and are especially useful in resource-limited settings)

ACCURATE BLOOD TEST:
Governments around the world have been looking for an accurate blood test that can tell people if they have immunity through past COVID-19
infection, and can therefore return to their duties to kickstart the economy.

While the diagnostic **RT-PCR test** to confirm the presence of the virus using a nasal swab in a laboratory setting is considered reliable, attempts to design a rapid test that uses a blood sample to find antibodies after past infection have thrown up errors in as much as a third of cases.

(Reverse transcription polymerase chain reaction (RT-PCR) is a laboratory technique combining reverse transcription of RNA into DNA and amplification of specific DNA targets using polymerase chain reaction. It is primarily used to measure the amount of a specific RNA)

A study in the U.K. showed that they were high on specificity — accurate in cases that they found to be antibody positive. But they still missed about 30% of positive cases, showing low sensitivity.

This is the phenomenon worrying India, which has imported several hundred thousand rapid testing kits, and its experience is shared by the U.S., U.K., Spain and other countries. Rajasthan had laboratory-confirmed COVID-19 positive cases not being detected by rapid testing kits. Several States have independently ordered thousands of kits, mainly from China, and are in a quandary.

**ICMR GUIDELINES:**

The ICMR has advised States, to whom it distributed kits, that they could be used for surveillance testing, rather than to make medically important decisions. Narrowing down the test to reliable methods is the challenge, and the WHO along with its collaborating centres is working to identify them.

The results will be crucial and all countries, including the U.S. White House Coronavirus Task Force, are looking at **serosurveillance** (monitoring of the presence or absence of specific substances in the blood serum of a
population), the process that will determine the status of the population on COVID-19.

An exit from lockdown and other public health measures depend on such testing. India should remain focused on identifying tests that work well. This requires close integration with efforts launched by diagnostics regulators in the U.S., Europe and China who have used emergency provisions to allow early use of kits; the kits themselves are under evaluation.

There are reports indicating that some vendors of rapid testing devices in China have run afoul of regulators in that country since they have no prior expertise in the field.

**CONCLUSION:**

Making purchase decisions, therefore, calls for rigorous review. In the immediate context, the message should go out to States that rapid tests cannot substitute for RT-PCR to diagnose infection.

It is by no means clear that antibodies developed in response to COVID-19 provide long-term protection against reinfection. Yet, a good test to certify a large section of the population as having developed immunity seems to be a promising tool to reopen the economy with some confidence.

**3) The COVID-19 paradox in South Asia-**

**CONTEXT:**

The oldest and largest democracies in the world are often compared. This time is different. The first person tested positive for COVID-19 on January 21 in the United States and on January 30 in India. Roughly three months
later, on April 20, the total number of infections was 7,23,605 in the U.S. and 17,265 in India, accounting for 31.2% and 0.75% of the world total.

The number of COVID-19 deaths was 34,203 in the U.S. and 543 in India, making up 21.7% and 0.33% of the world total. The share of the two countries in world population, by contrast, is about 4% and 18%, respectively.
## The Size of Coronavirus Lockdowns

Number of people placed on enforced lockdown due to the coronavirus pandemic, per country (in million people)

<table>
<thead>
<tr>
<th>Country</th>
<th>Ongoing</th>
<th>At height of outbreak</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>1,380</td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>760</td>
<td></td>
</tr>
<tr>
<td>United States*</td>
<td>297</td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td>Russia</td>
<td>142</td>
<td></td>
</tr>
<tr>
<td>Philippines</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>UK*</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

* At least partly enforced

Source: Media reports
It is even more surprising that a comparison with South Asia — Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka — yields similar results. In Nepal too, it was in late January that the first person tested positive for COVID-19, though it was end-February or early-March in the other countries. On April 20, South Asia, with a share of 23.4% in world population, accounted for 1.25% of infections and 0.5% of COVID-19 deaths in the world.

Before the pandemic, it would have been impossible to predict, let alone imagine, such a reality. Income per capita in South Asia is just 16% that of the world, and a mere 4% of that in industrialised countries. One-third of the world’s poor live in South Asia, so absolute poverty is high and nutrition levels are low.

Population density in the subcontinent is among the highest in the world. The poor, who live cheek by jowl(living very close to each other) in urban slums and in cramped(congested) spaces in rural areas, are most susceptible to a virus that is contagious. Public health systems and facilities are perhaps the worst in the world.

(Population density is a measurement of population per unit area, or exceptionally unit volume; it is a quantity of type number density. It is frequently applied to living organisms, most of the time to humans. It is a key geographical term)

OUTCOME:

The outcome, then, is puzzling, if not paradoxical(contradictory). Compared with North America, Western Europe and East Asia, or their own population size, the number of infections and deaths in South Asia is far lower.

Of course, it is plausible(valid) to argue that, unlike those parts of the world, South Asian countries are in the early stages where community transmission has not gathered momentum. An explosive growth in
infection numbers could yet surface later, or in a second round. But it is simply not possible to assess probabilities or make predictions.

However, evidence available so far does suggest some flattening of the curve in India, Pakistan, Bangladesh, and Sri Lanka. Infection numbers in Maldives and Nepal are in double-digits and Bhutan’s infection numbers are in single digits.

**TWO POSSIBLE EXPLANATIONS:**

How can we explain this situation in which, so far, South Asia has fared better than many other parts of the world? Past experience of the Spanish influenza in 1918, when India accounted for 18-20 million of the estimated 50 million deaths in the world, or conventional thinking even now, would have led to the opposite conclusion. There are two possible explanations.

First, the reality might be much worse than the statistics suggest because the total number of infections is almost certainly underestimated, as testing has been nowhere near enough, given the scarcity of testing kits and the massive size of populations. Improved statistics might change the numbers but cannot transform the asymmetry emerging from the above comparisons.

Second, the lockdowns imposed by governments in India, Bangladesh, Pakistan, Sri Lanka and Nepal, which started in the last week of March and continue until April 27 or longer, have clearly made a difference. The lockdown in India, straddling its vast geography, is perhaps among the most stringent in the world.

**BREAK THE CHAIN OF TRANSMISSION:**

The common purpose was to break the chain of transmission through physical distancing, which has two dimensions. For one, it confined people to their homes. But this created physical distancing only for the privileged living in homes that have spaces and doors. It was impossible for people in
urban slums in mega-cities, where migrant workers lived in cramped spaces, often as many as 10 to a room.

For another, it meant that people could not move within cities or across States. Migrant workers could not return to their villages, and citizens or foreigners who might carry the virus could not come from abroad.

It did **strangle** potential chains of community transmission, reducing the geographical spread of the virus through contagion, and flattening the curve compared with what it would have been without a lockdown.

**CULTURES, IMMUNITIES, OR CLIMATES:**

This obvious explanation is necessary but not sufficient because other countries which have imposed lockdowns, say in Western Europe, with public health systems that are far superior, have not managed to slow down the phenomenal spread in the number of infections as much.

The impact of diseases can and does differ across countries, possibly attributable to differences in cultures, immunities, or even climates. I am not an epidemiologist or a virologist. But as a social scientist, it is possible to observe an association of attributes.

**A POSSIBLE HYPOTHESIS:**
It has been suggested that countries which have mandatory BCG vaccinations against tuberculosis are less susceptible to COVID-19 morbidity and mortality.

Compare, for example, the Iberian Peninsula countries, Spain and Portugal. On April 20, the former had around 1,960,000 infections and 20,500 deaths, whereas the latter had 20,200 infections and 700 deaths. Is it only a coincidence that BCG vaccinations are mandatory in Portugal but not in Spain, or that the U.S. and Italy, both ravaged by COVID-19, never had universal BCG vaccination programmes?

Obviously, it is only scientific investigation that can establish cause and effect.

But the BCG vaccine seems to have a stimulating (encouraging) effect on the immune system that goes well beyond tuberculosis. For that reason, perhaps, some countries are running trials of BCG against COVID-19, or
thinking of it as a means of protecting health workers.

Similarly, countries are buying hydroxychloroquine in large quantities from India, as a prophylactic(preventive) for health workers and for treatment of COVID-19 patients. In South Asian countries, universal BCG vaccination is mandatory, while immune systems of people have a lifelong exposure to malaria. These could provide possible explanations for the relatively limited spread of COVID-19 in South Asia so far.

LIVES AND LIVELIHOODS:

Obviously, lockdowns have also mitigated(reduced) the spread. In doing so, they have saved lives, but at the same time, they have also taken away livelihoods. In South Asian countries, almost 90% of the workforce is made up of the self-employed, casual labour on daily wages, and informal workers without any social protection.

The lockdowns have meant that hundreds of millions of people who have lost their jobs, hence incomes, have been deprived of their livelihoods, imposing a disproportionate burden on the poor and those who survive just above the poverty line. For them, the trade-off(exchange) between getting sick and going hungry is no choice. Livelihoods are an imperative(need) for preserving lives.

CONCLUSION:

The problem will not vanish after lockdowns are lifted. Economies that have been shut down for six weeks or longer will be close to collapse. In the short-run, it will be a matter of survival for households and firms and stabilisation for the economy.

Economic growth will be zero or negative this year. In the medium-term, it will be about recovery. That will take time.

Rapid economic growth in the past 25 years had enabled South Asian
countries to bring about a significant reduction in absolute poverty, even though it was associated with rising inequality. Alas, absolute poverty will increase once again, while economic inequality will rise further.