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A COVID-19 CONTROL PLAN MADE SIMPLE

Relevant for: Developmental Issues | Topic: Health & Sanitation and related issues

The COVID-19 outbreak is not yet an epidemic in India — as of today. From what is happening globally, a huge epidemic, an avalanche, growing bigger week after week, is predictable. Today it is a crisis looming on the horizon, but tomorrow it may turn out to be a disaster of unprecedented proportions.

Culturally we are always optimistic; we do not react fast as most problems, even outbreaks, have a tendency to settle down. So far we have stoically confronted all the new and resurgent communicable diseases that appeared in recent decades. We have shown surge capacity of crisis management during the 2018 Nipah epidemic in Kerala. We handled the Severe Acute Respiratory Syndrome (SARS) scare of 2003 extremely efficiently. The 2009 pandemic influenza H1N1 was also confronted reasonably well. Our weakness in dealing with seasonal influenza is embarrassing: there is no national policy to control seasonal flu. We ignore the high flu death rates reported annually. We manage short-term crisis very well but not long-term disease control — like running a short sprint but with no stamina to go on running a marathon.

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From early February the reality of a very unusual SARS COVID-19 epidemic was known to all Health Ministry officers. In early January only China was known to have the coronavirus, but today more than 100 countries are affected. That speed is about the same as that of the pandemic influenza H1N1 of 2009.

The onerous responsibility of confronting SARS COVID-19 does not rest with the Union Health Secretary who is the administrative head of the Ministry of Health and Family Welfare. It does not rest with the Director of the National Centre for Disease Control (NCDC) unless specifically empowered; The NCDC functions well only when smaller problems erupt in various States. The Director General of Health Services (DGHS) could be the person, but epidemic control is more than health-care service. The DGHS has limited executive powers and there is no competent public health infrastructure under the Directorate. The job of the Department of Health Research and the Indian Council of Medical Research (ICMR) under the unified command of the Secretary Department of Health Research-cum-DG ICMR, is to research all questions identified by the DGHS and the Director of the NCDC. We do need research but priority number one is the control of the epidemic.

The Minister for Health is a key person but this epidemic is more than a medical problem. Many ministries such as those of travel, tourism, industry, education, economics, railways and local governments are all being affected. So this disease avalanche requires responses of unprecedented speed, spread and magnitude.

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All officials listed above have a hundred and one things on their minds all the time. India needs a dedicated disaster management operation for this epidemic. The one person who can, and must, take immediate responsibility and manage the crisis the best possible way is none other than the Prime Minister himself. The Prime Minister should declare a national emergency and establish a ‘war-machinery’, with a ‘task force’ of the best experts in the country, of proven capability and track record against communicable diseases.

The war room should have all necessary facilities and should run a 24-hour control room. The support of the Ministers of all the relevant Ministries and their officers should be accessible to the task force. The job of the task force ought to have one goal: manage the epidemic, to minimise the spread and damage of the virus, and to mitigate the sufferings of all people everywhere.

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Once the task force designs a strategy with tactics, the Ministry of Health as well as all Ministries must implement them. The terms of reference of the task force must include the design of immediate, short-term, medium-term and long-term responses. The absence of such an empowered agency has had serious repercussions.

International airports were instructed by the Ministry concerned to screen all passengers arriving from China. That was fine and towards January-end and early-February, two individuals returning from Wuhan, China, to Kerala were detected to be infected with “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)”. The time to establish a national agency such as the task force to advise the government on all necessary interventions was immediately thereafter. A 24-hour control room should have been operational by the second week of February. The infection was rapidly expanding in various countries. Shortly thereafter some 24 countries outside China, Hong Kong and Macau were known to be infected. When was Italy identified as a potential source of virus in travellers? On February 20, the following countries had reported over 20 infections: Japan, Thailand, Singapore, South Korea and Taiwan. Italy was not in that list.

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The next day Italy had 20 cases; thereafter the daily numbers were 79, 155, 229 and 322. Italy was identified as a potential source for screening of air travellers only on March 1. On February 29 a family travelling from Italy to Kerala did not fall within the screening net. That flaw resulted in a cluster of cases in Kerala — Italy should have been identified as a potential source on February 22 when the number of cases jumped from 20 to 79. All existing agencies and officers have many responsibilities. An agency exclusively for managing a constant and continuous watch on all developments — biomedical and sociological — and to recommend remedial and containment measures is essential in order to face this epidemic.

Public education must be technically correct and timely. Only one agency should be the source of all information; the cacophony prevalent now must be curbed. The ball is in the Prime Minister’s court.

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