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Invoking the Epidemic Diseases Act of 1897 was a Jugaad Approach to Systemic Crises Like Covid 19 Pandemic in India

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Opinion
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Abbreviations: COOP: Continuity of Operation Plans; ERPs: Emergency Response Plans; CCC: Covid Care Centres; DGHS: Directorate General of Health Services; NCDC: National Centre for Disease Control; DHR: Department of Health Research; ICMR: Indian Council of Medical Research; NDMA: National Disaster Management Agency; NIV: National Institute of Virology.

Opinion

The world's most trusted English dictionary Oxford has officially accepted the word 'Jugaad' in their 2017 update. According to the dictionary, noun Jugaad means a flexible approach to solve a problem that uses limited resources in an innovative way. People living in North India, especially in the states of Uttar Pradesh, Haryana, Punjab, and parts of northern Rajasthan, have seen this vehicle on the highways, in villages and small towns, carrying people, livestock and agricultural produce. This transport makes use of the front part of an old motorcycle (BMW, Harley-Davidson Street Rod, Yamaha SR400, Norton Commando etc) attached to wooden planks that are used to make a carriage at the back to transport materials or with some sitting arrangements for transporting about 8-10 people for short distances. The word commonly used in Hindi/Urdu means an innovative fix or a simple work-around, used for solutions that bend rules, or a resource that can be used as such, or a person who can solve a complicated issue. Jugaad simply means something that is made to serve a purpose on temporary basis. Countries around the world are beginning to adopt jugaad to maximize resources' [1].

India's Covid-19 count recently crossed 2.3 million cases and 45,000 deaths, while 1.6 million cases recovered from the infection, with no end to the horror in sight. Modelling analysis from MIT predicts that by early 2021, India will overtake the US and Brazil to have the most Covid cases in the world, with 2,90,000 new cases every day as compared to around 60,000 cases per day in the first week of August 2020. This would be the right time to assess errors made along the way, since crucial lessons for the future are inherent in them [2].

"Whether caused by conflict, natural disaster, climate-related events, or some combination of the three, crises have been steadily increasing in frequency, severity, and complexity. While the nature and incidences of these crises vary significantly, they affect millions of people, particularly the most vulnerable. Poor people have fewer assets to support their livelihood, consume close to subsistence levels, and often cannot rely on savings to ensure health and education outcomes are maintained during periods of crisis" [2].

The current COVID-19 situation is not just systemic at the country level, but it is systemic at the global level. We are seeing contraction in both developed and developing countries simultaneously, something that has not been seen since the depression. This is presenting a new challenge for all of us throughout the world.

This Experience has Manifested as:

- Loss of income, Depletion of savings, Negative coping strategies like reduction in food intake or sale of productive assets, borrowing to support consumption because of job loss.
- Widespread shock, the duration of which is prolonged and systemic in nature and the impacts look more like a financial crisis. In a natural disaster like floods, earthquakes, the shock is often one-off and highly localized in a state, region or in specific sectors like agriculture.
- The systemic nature of the shock means there are also severe impacts on firms, or what we often call the "real economy," and the financial institutions that serve them. In such firms, social distancing and closures are having significant effects, both short and long term.

While not all sectors will be affected equally, there is no question that travel, leisure, and service industries will be greatly impacted. Other sectors, like agriculture, may show delayed effects. Firms without the cash flow to withstand long-term closures are likely to shutter their doors or their owners may be forced to find alternative livelihoods.

- With regard to financial services provider institutions that serve the most vulnerable in any country unorganized labour like drivers, road side vendors, retail vendors, manual labours etc are the most likely to be forgotten by stimulus packages and, like the people they serve, are already vulnerable to shocks. The financial institutions like microfinance institutions, cooperatives, some banks, even some fintech's, that serve unorganized sectors – are all highly vulnerable to systemic shocks and are likely not to benefit from central bank stimuli. The effects of crisis manifest most immediately on staffing and the ability of the institution to respond to the needs of their customers. A slowdown or halting of repayments and an increase in defaults for credit providers Liquidity shortfalls [3].

To Respond Such a Situation Each Country Including India had to: [4]

a) Review and modify emergency operations plans to align with COVID-19 guidance to include social distancing, travel restrictions, fiscal impacts, reduction of government services, and potential impacts to supply chain

b) Review and update Continuity of Operation Plans (COOP) to continue essential functions and address vulnerable population needs.

c) Assess the level of training of their emergency officials and health professionals and inventoried skill sets within the community.

d) GOI and State Govts had to plan to prioritize resources to stabilize emergency and ongoing communications, the lifeline to initial and ongoing response to catastrophic event.

e) Govt and private health facilities had to purchase and stockpile necessary response equipment, such as personal protective equipment (PPE, masks, gloves), Oxygen concentrators, Ventilators and fuel for generators, and other necessary reserve equipment. Had Emergency Response Plans (ERPs) reviewed with necessary utilities, such as power, wastewater, water, electric, and internet service providers?

f) Since this pandemic challenged urban population unlike many other epidemics, the municipal government had to identify appropriate Covid care centres (CCC), mobilizing hospital beds in private sector, negotiating cost of the care etc, shelter locations and enhancing capabilities.

g) See that the necessary contractual agreements were in place, for disposal of dead bodies, used PPE kits, masks, Gloves debris removal, temporary facilities, transportation of vulnerable citizens and those needed medical attention.

h) Consider the extra time it may take to evacuate given the need for social distancing, while simultaneously addressing the specific needs of vulnerable and at-risk populations.

i) Negotiate to engage non-profits and small businesses, professional (Nursing, Laboratory course) institutions to discuss and involve their students in responses to mitigate the need of extra human resources.

j) Increase Speed of detection and management of SARS-CoV-2 Infections [4].

Remember in India that up to the point when the prime minister, with less than 4-hour notice, declared the world's largest, longest and most restrictive lockdown in history, there had been less than 500 cases and 10 deaths from the Covid pandemic in India. What then caused the steep exponential rise to the current staggering numbers? Critics argue that India was the only country that lifted its lockdown at a point when the number of cases was steadily rising instead of stabilising. The lockdown was a blunt tool, at best a temporary measure. A lockdown is an opportunity to increase preparedness and shore up medical facilities. But one feels prolonged lockdowns did more damage than systemic strengthening.

Indian Public Health's real roots of this problem lie much deeper, in the chronic underinvestment and neglect of public health in this country. India has one of the lowest allocations to health among all the countries of the world, consistently less than 2% of GDP. This pandemic cruelly exposed our weakest link—badly equipped and understaffed public hospitals, chronic shortages of hospital beds and unmotivated, poorly trained staff. It has one of the lowest densities of health workforce, with a paltry 7 physicians and 17 nurses per 10,000 populations as against the global average of 13.9 and 28.6, respectively. "Excellence without equity looms as the chief human rights dilemma of healthcare in the 21st century in India". The decades of neglect are impossible to be fixed during a few months of lockdown. Indeed, if the deaths of many cruelly disregarded migrants, and the toll from other non-Covid diseases which were neglected because people were unable, or too afraid, to seek medical help are factored in, many more lives may have been lost than saved by India's lockdown [5].

Those countries and leaders who relied on time tested public health principles protected their countries from severe consequences of Covid 19. Others disregarded available public health expertise and principles and made pivotal decisions they were not equipped to make. The

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consequences would reverberate, impacting on lives and livelihoods of millions.

In India along with the novel coronavirus causing the pandemic, a more sinister, bizarre, and unique "second phenomenon" has affected the minds of national leaders complimenting the pandemic. It made them believe that the response to the coronavirus pandemic must be led directly by Prime minister, Chief ministers, Health or Medical education ministers Chief Secretaries, Health and Medical Education secretaries Inspector General of Police, City Police Commissioners, City Corporations Commissioners, popular cardiologist, Pulmonologist, clinicians and so on but no less. Most Indian country and state leaders and bureaucrats fell victim to this phenomenon [5].

As envisaged in our Constitution, pandemic management is the central government's responsibility for which it has several institutions in place: Directorate General of Health Services (DGHS), National Centre for Disease Control (NCDC), Department of Health Research (DHR) and Indian Council of Medical Research (ICMR). These agencies have not functioned harmoniously in the best of times. It was asking too much to expect them to weave into a cohesive unit at this pivotal time. Therefore GOI bypassed them, in designating the country's pandemic response to the National Disaster Management Agency (NDMA) and invoked the Epidemic Diseases Act of 1897, giving the Centre extraordinary powers to mitigate the consequences of the pandemic-as if the pandemic demanded not public health but political, Police and civil administrative responses [5].

Since healthcare is constitutionally each state government's responsibility, India's 28 states and 8 Union territories were conveniently left bereft of a strategic plan and implementation plans at the corporation and district levels. Operational guidance and timely release of adequate funds were missing. The Centre and States took on the role of umpire instead of coach, sending inspecting teams to selected states and districts as if they needed umpiring.

ICMR, India's apex medical research organisation, made several perplexing decisions. In the initial weeks of the pandemic only the ICMR's lab, the accomplished National Institute of Virology (NIV) in Pune, served as the sole testing lab for a country of 1.38 billion people. When apparent that testing capacity needed to urgently expand, only public sector labs were initially permitted, excluding all private labs. Eventually such meaningless restrictions were lifted. India increased its Covid testing capacity from 52 labs to over 1,300 in 4 months by end early August 2020 and only 152 districts of India's 739 do not have Covid-19 testing facilities even today. In other words, approximately 80 per cent of the country's districts have labs which can test for the novel coronavirus. Even today, UP, for example, has just 1 PCR testing lab per 30 million populations.

In the initial months of the pandemic ICMR also insisted all patients be hospitalised, despite it being clear that the majority could be managed with equal success by home isolation. Initial discharge criteria were equally stringent, with 2 negative PCR tests being mandated before a patient could leave hospital, resulting in a waste of precious resources. And the preposterous hype that "India's first indigenous vaccine against Covid-19 would be launched by August 15" went contrary to all available evidence.

What if another pandemic appears on the horizon? Surely our response should be governed by science and strategy and overseen by experts? Now is the best opportunity to create a health management infrastructure that is commensurate with India's needs and potential. Can a country that does not know how to control TB, typhoid, cholera, and malaria (to name just a few diseases endemic in India), learn how to manage a new disease. India has world class experts; why not use them and seize the day? [5].

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