Indian Public Health Association (IPHA),

Indian Association of Preventive and Social Medicine (IAPSM) & Indian Association of Epidemiologists (IAE)

Joint COVID-19 Task Force

Second Joint Statement on COVID-19 Pandemic in India – Public Health Approach for COVID19 Control

May 25, 2020

A Joint Task Force of eminent public health experts of India was constituted by IPHA, and IAPSM in April 2020 to help the Government of India for containment of COVID-19 pandemic in the country. Subsequently, Indian Association of Epidemiologists (IAE) also joined the Task Force.

The terms of reference of the Joint Task Force was to 1) To review and collate the scientific epidemiological literature pertaining to COVID-19 in India at national, state and district level; 2) To develop consensus amongst the experts regarding COVID-19 disease epidemiology, trends and develop action plan based on the consensus; 3) To widely disseminate the consensus statement and action plan with public health experts, health professional associations and other key stakeholders; 4) To share the consensus statement with the policy makers at highest level at centre and state.

The members of the IPHA, IAPSM, and IAE **Joint COVID-19 Task Force** are as follows: (in alphabetical order)

1. Dr. A. C. Dhariwal, Former Director, NVBDCP & NCDC, and Advisor NVBDCP, MoHFW, GoI
2. Dr Anil Kumar, President, IAE & Dy DGHS (Deafness), Nirman Bhawan, New Delhi
3. Dr. AM Kadri, Secretary, IAPSM
4. Dr. Chandrakant S. Pandav, Past President IPHA & IAPSM, former Professor & Head, Centre for Community Medicine (CCM), AIIMS, New Delhi, and President, ICCIDD
5. Dr. D.C.S. Reddy, Former Professor & Head, Community Medicine, IMS, BHU
6. Dr. Farooq Ahmed, Former Director NEIGRIMS, and Pro VC KBN University
7. Dr. Kapil Yadav, Additional Professor, CCM, AIIMS, New Delhi
8. Dr. M. K. Sudarshan, Chief Editor, Indian Journal of Public Health (IJPH)

9. Dr. Puneet Misra, Past President, IAPSM & Professor, CCM, AIIMS, New Delhi
10. Dr. Rajesh Kumar, Former Professor & Head, PGIMER, Chandigarh
11. Dr. Rajib Dasgupta, Professor, Community Health, Jawaharlal Nehru University, New Delhi
12. Dr. Sanghamitra Ghosh, Secretary General, IPHA, and CMO (SG) Ministry of Defence, Kolcata
13. Dr. Sanjay K. Rai, National President, IPHA and Professor, CCM, AIIMS, New Delhi
14. Dr. Sanjay Zodpey, President, IAPSM and Vice President-Academics, Public Health Foundation of India (PHFI), New Delhi
15. Dr. Sanjiv Kumar, Former Executive Director, NHSRC, and Chairman, Indian Academy of Public Health (IAPH)
16. Dr. Shashi Kant, Past President IAPSM, and Professor & Head, CCM, AIIMS, New Delhi

Executive Summary and Action Plan

Background:

Hon'ble Prime Minister (PM) invited national medical professional associations on March 24, 2020 and sought suggestions for prevention and control of COVID-19. President IPHA, and IAPSM attended the meeting. In the background of these developments, after due internal deliberations, the first Joint Statement[1] was submitted to Hon'ble PM, Hon'ble Union Health Minister, NITI Aayog, Secretary (HFW), and Secretary (DHR) on 11 April 2020.

However, since then the Joint Task Force reviewed new evidences generated globally and within country. The Task Force members also interacted with many other public health professionals working at national, state, and district level. Inputs were also taken from the social media of various professional associations. This is the second version of the joint statement with recent evidences.

Situation Analysis: The ongoing COVID-19 pandemic is a public health emergency with grave implications for the entire world. India as part of the global community has also been adversely impacted with a catastrophic 'double burden': 145,000+ cases and 4,000+ deaths, coupled with a humanitarian crisis that encompasses an estimated 114 million job losses (91 million daily wage earners and 17 million salary earners who have been laid off), across 271,000 factories and 65-70 million small and micro enterprises that have come to a halt.

The response of the Government of India after the first case on 30th January, 2020 blunted the rapid progress of the infection and the nation accepted near-total disruption of all facets of daily living. Clinical, epidemiological and laboratory knowledge for control of the novel corona virus indicate that humankind will have to "live with the virus" and operational strategies rapidly need to recalibrate from containment to mitigation. The emerging evidence unequivocally indicates thatCOVID-19 worsened the health inequities, and public health measures need to make that concern central. The global community is collaborating and sharing information to formulate a comprehensive, effective, efficient and sustainable strategy and plan of action to control this pandemic. At the same time each country and regions within the country have to adapt the larger general model to its own specifics. Open and transparent data sharing with scientists, public health professionals and indeed the public at large, conspicuous by its absence till date, should be ensured at the earliest. This will strengthen pandemic control measures, build bottom-up consensus and build an ecosystem of engagement and trust.

India's nationwide "lockdown" from March 25, 2020 till May 30, 2020 has been one of the most stringent; and yet COVID cases have increased exponentially through this phase, from 606 cases on March 25 to 138,845 on May 24. This draconian lockdown is presumably in response to a modeling exercise from an influential institution which was a 'worst-case simulation'. The model had come up with an estimated 2.2 million deaths globally. Subsequent events have proved that the predictions of this model were way off the mark. Had the Government of India consulted epidemiologists who had better grasp of disease transmission dynamics compared to

modelers, it would have perhaps been better served. From the limited information available in the public domain, it seems that the government was primarily advised by clinicians and academic epidemiologists with limited field training and skills. Policy makers apparently relied overwhelmingly on general administrative bureaucrats. The engagement with expert technocrats in the areas of epidemiology, public health, preventive medicine and social scientists was limited. India is paying a heavy price both in terms of humanitarian crisis and disease spread. The incoherent and often rapidly shifting strategies and policies especially at the national level are more a reflection of "afterthought" and "catching up" phenomenon on part of the policy makers rather than a well thought cogent strategy with an epidemiologic basis.

Most COVD-19 infected persons are mostly without symptoms. Even if symptomatic, the symptoms are mild and not life threatening. Majority of the patients do not require hospitalization and can be treated at domiciliary level with a modified "enforced social distancing" imposed on the household. Had the migrant persons been allowed to go home at the beginning of the epidemic when the disease spread was very low, the current situation could have been avoided. The returning migrants are now taking infection to each and every corner of the country; mostly to rural and peri-urban areas, in districts with relatively weak public health systems (including clinical care) .

It is unrealistic to expect that COVID-19 pandemic can be eliminated at this stage given that community transmission is already well-established across large sections or sub-populations in the country. No vaccine or effective treatment is currently available or seems to be available in near future (there are a few promising candidates though). The expected benefit of this stringent nationwide lockdown was to spread out the disease over an extended period of time and effectively plan and manage so that the healthcare delivery system is not overwhelmed. This seems to have been achieved albeit after 4th lockdown with extraordinary inconvenience and disruption of the economy and life of the general public. The case fatality rate in India has been relatively on the lower side, and mostly limited to the high risk groups (elderly population, those with pre-existing co-morbidities etc.). However, the lockdown cannot be enforced indefinitely as the mortality attributable to the lockdown itself (primarily because of total shutdown of routine health services and livelihood disruption of nearly the entire bottom half of the Indian population) may overtake lives saved due to lockdown mediated slowing of COVID-19 progression.

Abundant scientific and evidence-based interventions are available to control the pandemic at state and district levels in India. These measures should be implemented while at the same time ensuring optimal provisions for the livelihood of the poor and marginalized. Simultaneously, provision of health care for all, especially children and women and those suffering from chronic conditions and emergencies requiring medical attention is an urgent imperative.

Recommendations:

Representing a very wide community of public health academics, practitioners and researchers in India we recommend considering the following11point action plan during COVID-19 pandemic:

1. **Constitute a panel** of inter-disciplinary public health and preventive health experts and social scientists at central, state and district levels to address both public health and humanitarian crises.
2. **Free sharing of data in public domain and Public Health Commission:** All data including test results should be made available in public domain (unlinked anonymous) for the research community (clinical, laboratory, public health and social sciences) to access, analyze and provide real-time context-specific solutions to control the pandemic. A Public Health Commission with task-specific Working Groups may be urgently constituted to provide real-time technical inputs to the government. The opaqueness maintained by the Government of India as well as state governments in the context of data so far has been a serious impediment to independent research and appropriate response to the pandemic.
3. **Lift lockdown, replace with cluster restrictions:** The ongoing nationwide lockdown needs to be removed and replaced with cluster specified restrictions (based on epidemiological assessment); reasonable criteria and milestones for control of the current phase of the pandemic in the country should be set, taking into account that successive wave of cases is possible. The *raison d'etre* of the lockdown is health system preparedness; the government needs to come out with clear monitorable benchmarks to this effect.
4. **Resumption of all the routine health services:** It is of utmost importance that all routine health services at all level of (primary, secondary and tertiary) care be immediately started with due measures to ensure protection of HCWs. Ample evidence has emerged that the human cost of disruption of routine health services specially for terminally ill patients, those with life threatening catastrophic health events like myocardial infarctions, stroke, chronic infectious disease like TB and preventable measures like immunization have far outweighed the deaths due to COVID-19. The brunt of disruption of health services may even be higher in days to come.
5. **Source reduction measures through increase of public awareness and practice of preventive measures:** The most effective strategy for control of novel corona virus spread during all stages of transmission is source reduction strategy. Universal use of face mask (homemade and others), hand hygiene (washing with soap and water and hand sanitizers) and cough etiquette, should be adopted by all with special focus to high risk population.
6. **Ensure physical distancing with social bonding, avoid social stigma:** Physical distancing norms need to be practiced to slow down the spread of infection. At the same time enhanced social bonding measures need to be promoted to address mental health concerns of anxiety and lockdown. Stigma and discrimination in COVID-19 tend to be associated with specific population groups (such as religious groups or returnee

migrants) even though not everyone in those groups is specifically at risk. Stigma can also occur after a person has been released from COVID-19 quarantine. Governments, media and local organizations need to be pro-active by making people aware and treating them with empathy and respect.

7. **Sentinel and active surveillance:** It is important to conduct extensive surveillance for Influenza like Illnesses (ILI) through ASHA/ANMs/MPWs, and Severe Acute Respiratory Illness (SARI) through clinical institutions (including private hospitals), daily reporting to identify geographic and temporal clustering of cases to trace transmission foci (hot spots / cluster events). This must be supported by trained epidemiologists from local medical colleges and public health institutions. In future use of already existing HIV serological surveillance platform could be a cost-effective way to do the serological surveillance and also provide an estimate of the burden and trend, needs of vaccine, and impact of other preventive strategies.
8. **Test, track and isolate with marked scaling up of diagnostic facilities:** India has significantly enhanced testing rates though some states continue to lag behind. Benchmarks based on population norms are essential to keep this key pandemic counter-measure on track. Some states have high numbers of backlogs; instituting standard turnaround time is equally crucial. Governments need to support free testing in private laboratories as well. As the number of (potential) contacts as well as returnee migrant populations continue to increase rapidly across the country, home quarantine need to be promoted and protocols followed with active participation and support from frontline health workers and local communities.
9. **Strengthening Intensive Care Capacity:** Intensive care is only to be given by the well trained adequately protected health care providers. Newer evidence is emerging that symptomatic and even SARI cases can be effectively managed with oxygen and other supportive measures. Makeshift (fangkang) hospitals are already being established in Mumbai, Maharashtra, and same may be built in other cities of India to cater to increase in number of patients during the peak of COVID-19.
10. **Optimal PPE for frontline workers:** Nosocomial infection of COVD-19 is a serious challenge affecting safety and morale of health care providers (HCP). This is also important mode of infection transmission amplification and acceleration once HCP become "super-spreaders". Appropriate PPE must be provided to HCP to instill confidence and alternate teams identified to take care of attrition due to fatigue, exposure and quarantine. India has now enhanced capacity to produce PPEs and should continue to ramp up production.
11. **Strengthening of public health system/institutions/discipline:** The historic and systematic neglect of public health as a discipline and non-involvement of public health experts in policy making and strategy formulation has cost the nation enormously especially in the current pandemic. Rapid scaling up of public health (including medical care) -- both services and research -- should be done on a war footing with an allocation of 5% of GDP to health expenditure at center and state level.

We sign out on a positive but cautious note. Evidence based scientific and humanistic policies will help us in overcoming this calamity with minimal loss to human life, social structures and economies. Nature has once again reminded us of our tenuous situation in the wider universe. It is high time that humankind takes note of the warning signals and undertakes midcourse corrections urgently and now. The "One World One Health" approach should be central in ensuring optimal harmony amongst all humans and animals of the world based on principle of "*Vasudhaiva Kutumbakam"* (The entire world is one family). Being respectful and mindful of all animate and inanimate beings of this planet is the way forward in the post-COVID-19 world. Even in the face of the current once in a century humanitarian and health crisis of this proportion, if we do not sit up and take notice and bring about some fundamental changes to our life styles and also in policy making specially in health policy making, we are doomed to face the consequences of same and may see unprecedented human costs in present pandemic and more worryingly see an encore much sooner again.