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Pandemic and Public Health Challenges in Bangladesh

"But tell me, your physician in the precise sense of whom you were just speaking, is he a moneymaker, an earner of fees or a healer of the sick? And remember to speak of the physician who really is such…"

– Plato (*Republic* 341C)

"You cannot fight a fire blindfolded"

- WHO Director General Dr Tedros Adhanom Ghebreyesus at a press briefing on 16 March, 2020

INTRODUCTION

Cherished ideas disappear fast, so is the Alma Ata Declaration, the visionary approach to Primary Health Care (PHC) endorsed by World Health Organization in 1978. The significance of Alma Ata Declaration lies in its comprehensiveness, setting health within the broader context of socio-economic, cultural and political conditions and realties. Health is not merely a medical condition, but outcome of all factors of human life and activities.

However, Covid-19 recalls not only the modern debates around the responsibility of the government to peoples' health, but on more fundamental queries regarding our idea of healing and healers, as Plato asked. We could hardly step out of the capitalist market relation that determines our relation as patient to the medical establishment.

Financial incentives and disincentives impel health service providers to become money-makers for themselves and money-savers for their corporate employers or investors. Physicians primarily are sellers of a commodity and not the healers as Plato said they should be if they were to be *true* physicians. Ethical consequences of commodification of health are enormous and the report we are presenting about the ongoing pandemic in Bangladesh, hope fully will compel us to rethink some of the fundamental concerns of humanity. We hope this will also force us reclaim the ethical grounds to our role as healers, to members of the society, who are distressed and need care. Health and medical care must not be treated as commodities; professional ethics and the care of the sick must not be distorted. Needless to mention, we are facing difficult challenge of how to resolve contradictions created by the market oriented medical practice.

A drastic shift in the paradigm of health and caring did take place since 80's with economic austerity, structural adjustment programmes and profit maximizing market principles, evolving into what we now know as neo-liberal rationality of health governance. The promise of Alma Ata declaration rapidly faded globally and casted collapse of public health everywhere. The shift soon became sharper. Bangladesh felt the brunt of the demise of public health.

The Alma Ata declaration envisaged socialization of health and emphasized socio-economic, cultural and political measures to manage biological and psychological health of the population; the responsibility of maintaining good health was collective and therefore public health featured prominently that could address most of the disease conditions of the population. Individual belonged to social collective and not as individual cases outside society. Socio-economic, cultural and political determinants of health constituted the paradigm and governance of good health. A patient indicates not an individual medical conditions, but symptom of wider social malaise that should be addressed to prevent disease.

In contrast, neoliberal agenda asserted medicalization and commodification of health and health services. It is a sector of investment to make profit. Health is defined as absence of clinical conditions of individuals with hardly any implication for socio-economic, cultural or political determinants. Curing replaced the rationality of prevention, marginalizing social prevention of disease, infection or epidemic pushing to the edge of priorities. Medical professionals and associated health personnel soon knowingly or unknowingly transformed from being caregiver into service provider in exchange for money. Health became a commodity as one buys and sells in the market. The transformation affected corrosively on public health systems. Common people felt it is almost impossible for them to get service from public health institutions and infrastructures; it became equally impossible for them to purchase health with very high price. And then appear the Covid-19 pandemic.

In Bangladesh, the introduction of the User-fees in the public hospitals was the turning point to neo-liberal governance of health of the population. It was an exercise to make the patients pay for the health services even from the government facilities run by the taxpayer's money. Privatization and commercialization of the health services paced very rapidly since 90s. Now, less than 30 per cent of the health care is provided through government hospitals at tertiary, secondary and primary level with only 607 government hospitals. Private sectors have taken over the health sector with 5023 registered private hospitals and clinics and 10,675 registered private diagnostic centres under the Directorate General of Health Services. The number of hospital beds under government hospitals is only 49,414, while the private hospitals have 87,610 taking the total number of beds to 137,024 (DGHS, Health Bulletin, 2017, 2017). The private health care, which is mostly profit-oriented, provides about 70 per cent of the health care services at a high cost. The inequitable healthcare system of Bangladesh favours the wealthy and discriminates against the poor. 'Only those who can pay get the service' is generally the rule in the private healthcare system. It is very likely that most of the poor and disadvantaged patients will go undetected and unattended, when COVID-19 takes an epidemic turn in Bangladesh. Very little can we expect from this system to meet the challenges of the COVID-19 pandemic.

Bangladesh public health expenditure is one of the lowest allocations in the world; in 2015 it was 2.9% of GDP. At the same time, patients pay for the health services in the public sector (out-of-pocket expenditures) is 67% of total health expenditure, which is one of the highest proportions in the world. Annually, about 4% of households are pushed into impoverishment due to high out-of-pocket expenditures on health. (Islam, Ashadul, Md. Akhter Shamima and Islam Mursaleena, 2018) .

In the public healthcare system, from community clinics, upazilla health centres to district hospitals; common people get outdoor treatment and get free medicine for common ailments such as fever. Very

few patient get advice for further tests to diagnose the diseases. For acute respiratory infections, which may require support of oxygen, are referred to the district hospitals or to Dhaka. Every day, hundreds of patients come in critical conditions to the tertiary level hospitals such as Dhaka Medical College Hospital, Bangabandhu Sheikh Mujib Medical University, Suhrawardy Hospitals, etc. They need cardiac care and services offered in intensive units, oxygen and ventilator supports. Despite its reduced presence, the public health services are the only means for the poor to get proper and professional health care.

This is the fourth report from UBINIG (Policy Research for Development Alternative) on the practical response to Covid-19 pandemic. We tried to put forward the overall picture of how the pandemic has devastating effects in Bangladesh, not necessarily by the virulence of the contagious virus, but due to the inefficiency, lack of responsibility and accountability and incessant corruption of the people who are in charge of managing the pandemic crisis. In addition to the collapse neoliberal dismantling of public health, Non-communicable disease has already overburdened Bangladesh, on top of it corporate competition to turn crisis into profit-making opportunity will further aggravate the crisis precipitated by Covid-19 pandemic.

We may summarize some of the salient feature of the crisis as follows:

a. The public healthcare provides only 30% of services, but COVID-19 shows the need to have greater control of the public health services.
b. The Pandemic has resulted in the denial of health services both by the public and private hospitals; a major ethical and human rights concern that must be addressed immediately.
c. The state of unpreparedness and lack of coordinated plan for handling a pandemic like COVID-19 has already aggravated the crisis. The low tests and the mismatch of the death figures and manipulation of numbers are leading to false impression about the situation of the pandemic. A number game seriously undermines the need to respond appropriately to the pandemic and prevents taking of appropriate health measures.
d. The private hospitals and clinics are using the opportunity of providing the COVID-19 treatment services as commercial commodity and want to maximize exuberant profit taking advantage of the fear of the people of the potential fatality of about COVID-19 infection.
e. The health workforces are the most essential front-liners to fight against COVID-19, but the private sector is exploiting human resources. On the other hand government failed to provide them protection with necessary PPEs and is silencing them if they speak out about the mishandling and mismanaging the crisis.
f. Reproductive health, particularly women delivering child during the lockdown and lack of access to hospital services are shocking and must be resolved immediately.
g. The community health workers and the traditional birth attendants are important alternative healthcare forces that can provide services to women at the time of their need.

LACK OF PREPAREDNESS

By now crisis triggered by COVID-19 pandemic[1] in Bangladesh has spilled over to economic, social, cultural and political sphere. The socio-economic challenges are obvious; the difficulty of keeping the

[1] Coronavirus disease is an infectious disease caused by a novel strain of coronavirus named as Covid-19. “Most people infected with the COVID-19 virus experience”, WHO describes is “mild to moderate respiratory illness and recover without requiring special treatment. Older people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness” (WHO, 2019) . It can be fatal in severe cases.

daily lives functioning with minimal disruption of livelihood of people, particularly of the poor and the vulnerable are vividly apparent. The cultural crisis are manifesting in stigmatizing the infected people. The fear of being infected, caused by ringing unnecessary alarms had tolls. There has been hardly any educative persuasion, to mobilize co-operation from the people. Dictatorial orders to force people to "stay-at-home" does not work, when livelihood questions are made uncertain and people feel they have been suddenly thrown into dark holes and alleys, hardly knowing how to survive.

Nevertheless, from the beginning the immediate challenge was to take prevention strategy by protecting against the virus infection and reducing the stress on health services by preventing rapid spread of infection. The Covid-19 is a novel virus, and appropriate knowledge of medical management is still hardly in place; health professionals are learning only through their day-to-day experiences.

Non-communicable diseases (NCDs) already overburden healthcare facilities. According to the Centres for Disease Control and Prevention (CDCP), the top 10 causes of death in Bangladesh include: (1) cancer 13 per cent; (2) lower respiratory infections 7 per cent; (3) chronic obstructive pulmonary disease 7 per cent; (4) ischemic heart disease 6 per cent; (5) stroke 5 per cent; (6) preterm birth complications 4 per cent; (7) tuberculosis 3 per cent; (8) neonatal encephalopathy 3 per cent; (9) Diabetes 3 per cent; and (10) Cirrhosis 3 per cent (CDC, 2010). These diseases are yet to be brought under control and the services available for treatment is very inadequate.

The prevalence of hypertension was 17.9% (95% CI: 16.2–19.7), based on the original JNC 7 guidelines. Using the 2017 ACC/AHA guidelines, the prevalence of hypertension among Bangladeshi adults increased to 40.7% (95% CI: 38.5–43.0); i.e. by 22.8% (Jessica Y. Islam1, M. Mostafa Zaman, Syed Atiqul Haq, Shamim Ahmed, Zahid Al- Quadir, 2018).

Morbidity status has direct implication for Covid-19 pandemic. According to the Health and Morbidity Status Survey 2014, more than one-third of the population (39.21%) is suffering from communicable diseases and while nearly two-thirds (60.79%) of the population is suffering from non-communicable diseases (NCDs). (BBS, Report on Health and Morbidity Status Survey, 2014, 2015)

The morbidity among the elderly population (64+ years) is arthritis (77 per cent), high blood pressure (52 per cent) diabetes (36 per cent). The normal cough/cold/fevers are common diseases among all age groups in the country. According to prevalence, fever of unknown origin (FUO) was highest in ranking and its prevalence per 1000 population was 52.2 and acute respiratory infection ranked 8th out of 10 diseases with 4.9 per 1000 population (BBS, Health and Morbidity Status Survey, 2012, 2013).

COVID-19 Detection

Already with a huge burden of CDs and NCDs, Bangladesh could not succeed enough in preventing COVID-19 spread and detection. As of 29 May, 2020 Bangladesh has 40,321 confirmed detected cases and 559 deaths, making the country second highest after India, in detection and third highest in deaths after India and Indonesia within the Southeast Asia region (SEAR, 2019) .

Bangladesh is among the top three worst affected countries in South Asia, yet it is in the list of the lowest testing countries. It is third among the least tested countries with 240 tests per million population and only above Afghanistan (165) and Myanmar (113) in the region and second on the list of the least testing per confirmed cases (Maswood, Bangladesh far behind South Asian countries, 2020).

The National Reference Laboratory in Bangladesh, which is a BSL-2 laboratory at the IEDCR in Dhaka has been the sole authority for the COVID-19 tests and the diagnosis is based on real time RT-PCR at IEDCR with concurrent checking in WHO reference laboratory. (Azad, 2020)

WHO Director General Dr Tedros Adhanom Ghebreyesus at a press briefing on 16 March, 2020 said: "You cannot fight a fire blindfolded. And we cannot stop this pandemic if we don't know who is infected. We have a simple message for all countries: test, test, test. Test every suspected case." At that time, the data provided by Institute of Epidemiology, Disease Control, and Research (IEDCR), showed Bangladesh has tested 1,602 samples from suspected Covid-19 patients against a total population of over 161 million. This is about 67 tests a day since regular testing began on March 8, after the first three cases of Covid-19 were confirmed in the country (Tithila, Bangladesh coronavirus test rate lowest in the world, 2020). Despite the assertive warnings by WHO, Bangladesh's effort in testing is dismal and demonstrate severe lack of preparedness and negligence to public health.

Wasted Time for preparation

After the COVID-19 pandemic in Wuhan, China, Bangladesh had enough time to prepare for the pandemic. The government could take the benefit of the knowledge gained from the experience of how other countries are containing the infectious virus. The country had substantial time of at least two months since January, 2020 to prepare the healthcare system for facing the inevitable challenge of the pandemic.

Instead, government made the situation worse by centralizing and controlling the information. The Institute of Epidemiology, Disease Control and Research (IEDCR) of the Directorate General Health Services (DGHS) was the sole authority to give updated information on COVID-19 situation.

In the beginning in March, Government claimed that they were ready to tackle an outbreak of COVID-19 with a four-level emergency plan to prevent the spread of the virus. The various safety measures included i. the contact tracing sources by temporarily cancelling visa-on-arrival services for passengers initially from Mainland China and most European countries and later from all other countries; ii. Setting up the thermal scanners and screening facilities were set up in airports, iii. The provision of health declaration forms containing information about passengers' recent travel history, whether they have symptoms of COVID-19 and self-isolation for 14 days, iv. Free testing facilities and follow-ups, multiple hotline services for passengers, and v. mass campaigns for the prevention of coronavirus. The government has also set up thermal scanners at all land ports and isolation units at public hospitals of all districts in order to halt the deadly coronavirus. Initially, the government has only prepared two hundred beds at the Kuwait-Bangladesh Friendship Government Hospital and established two isolation units at Kurmitola General Hospital and the Dhaka Infectious Disease Hospital (Star, 2020). Later on, Governemnt included more private hospitals for coronavirus treatment.

Despite the claim of the government, the lack of preparedness is obvious. There were serious lack of Intensive Care Unit (ICU) beds with facilities with ventilators, shortage of Personal Protective Equipment (PPE) for health care workers, testing kits and other resources, including a national fund to fight the COVID-19 outbreak, (Sakib, 2020).

According to the Directorate General of Health Services (DGHS), there are 508 ICU beds in government hospitals and 737 ICU beds in private hospitals. It was also alarming and precarious that only 29 ICU beds have been prepared at Dhaka's five hospitals to combat the pandemic, when elderly people infected with corona virus need ICU support the most. There is no ICU bed in any hospital outside Dhaka (Tajmim, 2020).

The Health Minister Zahid Maleque informed the Press on 28th March that at present 500 medical ventilators are available, besides, more 450 ventilators will arrive within a short time. The ventilators, according to the minister are already distributed to different hospitals (Desk, 2020). This is all about the preparedness of the health sector to tackle the COVID-19 pandemic.

According to WHO, ICU and ventilator support is needed by 20% of COVID-19 infected patients; among them 15 percent with strong symptoms and five percent in critical condition – need ICU and ventilator support. Additionally, elders with other chronic diseases require ICU support. However, there are a total 13,984 isolation beds at dedicated Covid-19 hospitals across the country – of which 399 are ICU beds. Many Covid-19 patients are suffering every day and many are dying due to a lack of space at ICUs. (Tazmim, 2020)

Bad reputaion: Dengue pandemic in 2019

Unpreparedness and disregard to public health is not new; Bangladesh has already earned a bad reputation from its handling of the dengue outbreak in 2019. According to the US-based Johns Hopkins University, in terms of tackling the outbreak of a disease, Bangladesh ranked the worst among South Asian countries in the 2019 Global Health Security Index[2] (GHS Index, Global Health Security Index: Building collective Action and Accountability, 2019). Bangladesh ranked 113 among the 117 countries with overall score of 35 only (average was 40.2), below the average scores. In the prevention of the emergence or release of pathogens, GHS index ranked Bangladesh 116 with a score of 27.3 (average being 34.8).

The lack of coordination, accountability, clear descriptions of roles and activities of government bodies, healthy decision-making and command protocols, the poor monetary support, irregularities, inadequate preparedness in the health sector, as well as poor health infrastructure, all these pitfalls together compounded the 2019 dengue situation in Bangladesh.

In 2019, the dengue broke out in Bangladesh again. The Aedes mosquito-borne viral infection, also have no cure or vaccine yet. It first appeared in Bangladesh in 2000, when 93 people died of the disease. Since 2003, the death rate has gradually declined with zero fatalities in some years, according to data from the Directorate-General of Health Services (DGHS). Bangladesh has seen more than 6,000 cases of dengue only three times in the last 20 years, in 2002, 2016, and 2018. In 2019, the number of cases of dengue fever has broken all records. From January through July 30, DGHS data officially recorded 15,369 dengue patients. In July alone, 13,182 patients were diagnosed with dengue. Dengue has spread to 63 out of Bangladesh's 64 districts, affecting 1,845 patients outside of Dhaka. But DGHS records show that over 88 percent of the dengue cases in the country are reported in the capital city (Mahmud, 2019). Dengue caused 179 deaths in 2019 breaking all the previous records (Myupchar, 2020).

THE COLLAPSE OF PUBLIC HEALTH SERVICES

A striking scenario emerged from the reports published in daily newspapers during March and April, 2020, all the public hospitals, which used to be very busy, were almost empty. Under normal circumstances, getting a bed in a government-run hospital was very hard due to the inadequate number of beds in proportion to the high demand for services. The situation has changed dramatically after the pandemic began. Since March, after first declaration of COVID detection cases, most of the hospitals were reluctant to admit any new patient because of the fear of the virus. Most hospitals refused to admit patients with fever and breathing problem. Even patients with other ailments were also required to show 'covid-19 negative' certificate to be admitted into the hospitals. As a result, not only patients returned from the hospitals without any medical service, they also could not do necessary diagnostic tests.

The sheer denial of the gravity of the danger of pandemic manifested clearly, when government declared "General Holidays" instead of the 'lock down', undermining the danger of the infectious virus.

[2] The GHS Index scoring system includes three tiers. Countries that score between 0 and 33.3 are in the bottom tier (also called "low scores"), countries that score between 33.4 and 66.6 are in the middle tier (also called "moderate scores"), and countries that score between 66.7 and 100 are in the upper or "top" tier (also called "high scores").

Government's policy of shutdown of the public transports also prevented patients from coming to the hospitals. Even if they manage to reach hospitals, the refusal of health care forced them to go from one hospital to the other. Hospitals denied admitting new patients for the fear of covid-19 virus. Many cases have been found where patients died in the road without being admitted into the hospitals (Akhter, COVID-19 and healthcare denial , 2020). In a situation like this, pregnant women, patients with cancer, cardio-vascular diseases or kidney complications including patients requiring dialysis and other seriously ill patients of known or unknown etiology have become the worst sufferers.

According to newspaper reports, in the Capital city the two major public hospitals, Bangabandhu Sheikh Mujib Medical University (BSMMU) with 1,904 beds and Dhaka Medical College hospital with 2600 beds, the number of patients has decreased by 45% in both indoor and outdoor units. Another spectacular scenario emerged in one of the major maternal and child health care facility, Azimpur Mother and Children Hospital: The hospital's 370 beds remained mostly empty, except only 42 patients in the gynecology and 55 patients in the pediatric department.

The National Institute of Diseases of the Chest and Hospital (NIDCH) used to have 600-700 patients every day at the outdoor unit, reduced to only around 150 patients per day at the outdoor. Due to the suspension of the transports, patients cannot come to the hospital. Hospital treated only the emergency patients.

COVID-19 infection fear has also grabbed the public hospitals in major hospitals in divisional and district level. Khulna Medical College Hospital has 500 beds, and 1500 patients per day, reduced to 50% of their capacity. The patients admitted there also left the hospital after taking permission from the doctors for the fear of being infected with Covid-19 virus. Rangpur Medical College Hospital with 1000 bed and having 2500 patients reduced to only 700 patients admitted at the hospital. Rajshahi Medical College Hospital with 1000 beds finds only 500-550 patients at the indoor units. Chittagong Medical College Hospital with 3000 beds find only 1200 patients admitted in the indoor. The same reduction of patients is experienced by Mymensingh Medical College by 70 percent. Usually around 9000 patients used to receive healthcare services in this hospital including indoor, outdoor and one stop services everyday. The districts and Upazilla hospitals around the country with 100 beds to 250 beds are also empty (correspondent, 2020) .

Diagnostic services

Most of the diagnostic tests were unavailable during Lockdown as most of the diagnostic centers were closed. People did not even go to the handful of few diagnostic centers which are open for the fear of contracting Covid-19 infection. Hospitals are considered potentially dangerous place for contracting Covid-19 virus by the patients so they tend to avoid coming to the hospitals. But those who come for urgent needs were not getting proper diagnostic services.

Once the government has allowed the private hospitals to test COVID-19 cases, they started charging price almost double of the public hospital rate as fixed by the government. At present (May 2020) 52 labs are Testing COVID-19 cases. According to DGHS COVID-19 Integrated Control Room private hospitals could collect samples for COVID-19 tests from inpatient department only at a government-fixed charge cost of Tk 3,500 (including the cost of kit) (correspondent S. , 2020). The government hospitals such as BSMMU charges Tk.1500. The government permitted the private hospitals and diagnostic centres to carry out COVID-19 tests using the RT-PCR tests.

In addition to the government fixed rate for RT-PCR testing fees for indoor and outdoor patients at Tk 3,500, and Tk 1,000 can be additionally charged for collecting samples from home.

Of the 17 private testing facilities, 14 are in the capital. They are: ICDDR,B, Evercare Hospital, Square Hospital, Ibne Sina Medical College Hospital, Prava Health Bangladesh Limited, Enam Medical College Hospital, United Hospital, Anwer Khan Modern Medical College Hospital, Biomed Diagnostics, Bangladesh Institute of Health Science and General Hospital, Lab Aid Hospital, Care Medical College Hospital, DMFR Molecular Lab and DNA Solution Limited. Until late March, the tests were centralized at the IEDCR in the capital. In May, 39 government labs were testing samples collected by the DGHS (Corespondent, 2020) .

The health workforce: Front-liners of fighting the virus

Health sector in Bangladesh has always faced an acute shortage of medical professionals—doctors, nurses and technicians. According to WHO, Bangladesh's doctor-to-patient ratio is 5.26 per 10,000 people. Moreover, there is a mal-distribution of health-sector workers, with 78% of Bangladesh's population living in rural areas, while 70% of doctors are stationed in urban areas (UNDP, A reality check for Bangladesh's healthcare system, 2020).

According to HRH Data Sheet, 2014 of the MOHFW, there are 75,514 registered graduate doctors, out of which 61,921 are available in the country. The public health sector employs about 27,065 doctors, while the private hospitals employ 34,856 doctors. The number of registered diploma nurses is 38,452. There are only 1498 laboratory technologists and 11,000 diploma pharmacists under DGHS (MOHFW, 2015)

In the beginning of privatization of healthcare, the health workforce was supplied by the public medical colleges and nursing and paramedical institutions. The supply of trained & qualified doctors is still provided mostly by the public medical colleges and post-graduate medical teaching institutes, but nursing institutes, medical assistant training schools are mostly run by private companies controlled by the pharmaceutical and medical supply industries.

The health workforce initially reacted negatively against the virus fearing being infected and therefore did not want to treat patients in their private chambers and in the hospitals. But later on, after receiving the protective gears, PPE, they risked their lives and devoted themselves to the treatment of the COVID-19 patients.

The government needed the doctors, nurses, technicians, ward boys, cleaners to provide services to the Corona positive patients in the Isolation units, institutional quarantine and most importantly in ICU with critical patients. They were known as the Health Front-liners in the fight against the deadly virus. Necessary protective gears were not available to the health front-liners. They had to stay away from the families during the time of their duties with the patients. Instead of taking protective measures for the health workforce, the DGHS issued several notices violating the rights of safe working conditions.

Notices issued on the Health workforce

1. On 19th March, 2020 the Khulna Division DGHS office issued a circular to all hospitals to arrange health protective clothings such as Gown, Mask, Cap etc. on their own initiative. The circular was signed by Dr. Rasheda Sultana, Director (Health Services), Khulna Division
2. On 15th April, 2020 the Directorate of Nursing and Midwifery, under the DGHS, issued a notice that no staff under the Nursing and midwifery Directorate can give any information, comment, statement to any newsmedia or any other source without the permission of the authorities. This notice was signed by Siddika Akhter, Director General, Nursing and Midwifery Directorate on 15 April, 2020.
3. On 25th March, 2020 the Health Services Division of the MOHFW issued a circular for taking legal actions against the doctors declining to provide services to non-COVID patients. The

Circular was signed by Rokeya Khatun, Deputy Secretary, Health Service, MOHFW. Later this circular was withdrawn amid protests by the medical professional groups.

4. On March 25, 2020 an order signed by Director (Hospital) Aminul Islam, said a doctor must treat a patient with symptoms of COVID-19 first and then refer him or her to another doctor, who has PPE, for further treatment. PPE consists of protective clothing, gloves, helmets, goggles, or other garments or equipment designed to protect the wearer's body from infection. It drew huge criticisms as the first doctor would become vulnerable to coronavirus infection. Later in the night the order was suspended. (correspondent S. , 2020).

It may be noted that 523 doctors have been infected while treating COVID-19 patients according to the Foundation for Doctors for Safety, Rights and Responsibilities (FDSR), out of which 389 were from different hospitals in the capital city, Dhaka. These infections were due to lack of protection by quality PPEs and also due to community transmission (Correspondent, 2020).

A junior doctor at DMCH reported that they were not getting enough PPE against the number of junior doctors who work at their department every day. “At least 30 people work in one shift in my department, but only five PPE sets are provided every day. Because of this, I personally buy mine at Tk230 from an online shop every working day,” (Tithila, Coronavirus: Inadequate protective gear leaves Bangladesh health workers at high risk, 2020).

In Bangladesh, at least 422 doctors have tested positive for Covid-19 with 49 doctors infected over 24 hours on April 28, around two doctors every hour. Bangladesh recorded its first health care worker death from Covid-19 on April 15. Several hundreds of other front-line health care workforces have been infected including 116 nurses. Front line HCWs work in overcrowded environments and have poor infection prevention and control mechanisms, making them more susceptible to contracting Covid-19 (Riashad Monjur , Md. Zakiul Hassan , 2020).

The experience of Dr. Moyeen Uddin, an Assistant Professor at the Sylhet's Shaheed Shamsuddin Ahmad Hospital became the first COVID-19 death case of a health workforce dedicating himself for the treatment of the COVID-19 patients. He was tested positive for the virus on Apr 5 and had been isolated at his home in Housing Estate ever since. After he experienced breathing difficulties on April 7, admitted to the hospital in Sylhet, but he needed mechanical ventilation and was subsequently shifted to the capital's Kurmitola General Hospital a day later. He died on April 15, 2020 (Correspondent S. , 2020).

Undue domination of the private corporate hospitals

It is obvious that private sector has more facilities and resources compared to the number of population they need to take responsibility of. Over 70% of health services are provided by the private hospitals making gradually weakening the public health sector for the majority, who cannot pay for their services.

The first reaction to COVID-19 of the private hospitals in Dhaka city and around the country was to stop providing services to patients. The hospitals, clinics were empty of patients and doctors during the last week of March. The number of patient visits decreased from 500 to 34, and the number of doctors from 30 to 5 in one of the eye hospitals of the city. In the Diagnostic centers tests have reduced drastically, ultra-sonogram, echocardiogram, ETT etc are not done. The indoor patient care has also reduced to at least two-third in major private hospitals in the city (রাহাত, 2020), (হায়দার, 2020). Numerous reported and unreported cases of such turning down of services to people in need of health care in the private hospitals occurred.

The big Corporate private hospitals in the capital city, such as Square hospital Ltd., United Hospital remained less than 50% of its 400 bed capacity and the number of patients in the outdoor reduced as well. In other private hospitals such as Labaid hospital, only 25 percent of the 275 beds were occupied. Similar situation prevailed in all the private clinics and hospitals all over the country (Correspondent S. , হাসপাতালে যাচ্ছে না সাধারণ রোগীরা, 2020). According to Dr AM Shamim, managing director of LabAid Group, "Almost three quarters of the more than 90,000 beds at private hospitals across Bangladesh are empty, as patients are not coming" (Abdullah, 2020)

With the gradual increase in the Covid-19 infection cases, the need for using private health facilities became important, but the private hospitals did not respond to such needs, except 4 hospitals engaging in negotiations with the government about their payment. One private hospital has asked for 17 crore (170 million) taka per month, another private hospitals demanded food and accommodation cost of the doctors and staff during their duties for Covid-19 patients. These hospitals are more concerned about earning profit than providing the most needed services. Out of the four private hospitals only one has started giving services with government help, the rest are in the negotiations. They will have Memorandum of Understanding (MOU) with the government according to their demands. They demand 41.3 million Taka for salary, and for mechineries/equipments about 8.9 million Taka per month (রাব্বি, 2020). Most of the private hospitals decided to suspend their operations during the pandemic and did not pay the salaries of their staff, particularly of the doctors.

An Online survey, run by Bangladesh Doctors Foundation (BDF) during May 13 to 15 with responses from 519 doctors revealed that at least 61 percent of doctors at private hospitals have not been receiving their salaries on time amid the coronavirus shutdown; 83.8 percent of doctors were yet to get the bonuses for Eid-ul-Fitr. The incidents of back pay, partial payment of salaries, downscaling of duty rosters and terminating doctors altogether have increased during the health crisis. According to one of the private medical hospitals, "Salaries will go unpaid for the foreseeable future. We can't do anything about it. All salaries and allowances will be paid when things return to normal." (Masum, 2020)

A handout was issued on 27th May, 2020 of the Ministry of Health and Family Welfare about providing treatment to both Covid and Non-Covid patients under separate arrangement in all private and public hospitals having 50 or more beds, clinics, and diagnostic centres" (UNB, 2020).

On the other hand, the big corporate conglomerate Bashundhara Group, having no previous affiliation with the business of healthcare, has proposed to build a 5,000-bed hospital to treat the coronavirus patients. The proposal included converting its four convention centres and a trade centre in capital's Kuril area into a hospital to join the government's fight against the novel coronavirus (TBS, Bashundhara offers to build 5,000-bed coronavirus hospital, 2020).

On 21 April, the Press Release from Bashundhara said, "The makeshift hospital will have 2,013 beds in the isolation units and 71 Intensive Care Units". The group has dedicated its trade centre with 150 thousand square feet and four convention centres with 90 thousand square feet to set up the hospital. Medical ventilators will be supplied from the central medicine reserve of the government. Bashundhara Group will provide utilities -- gas, water and power supply to the hospital (Report, 2020).

Companies producing harmful products such as Tobacco, started giving out oxygen cylinders hiding the crime they are committing to produce and sell tobacco products, known to be causing more risk to the people for COVID-19.

MISMATCH OF DEATH STATISTICS

The first Corona death was announced by IEDCR on 18th March, within 10 days of coronavirus detection in the country. It was a case of a man (over 70 yrs) with co-morbidity of COPD, diabetes, high blood pressure, cardiac and kidney complications. He was in contact with a returnee from abroad. The IEDCR has taken the responsibility of his burial, so that it is spread at the community level. "However, we do not want to discuss further on this issue" (প্রতিবেদক, করোনাভাইরাসে বাংলাদেশে প্রথম মৃত্যু, আক্রান্ত বেড়ে ১৪, 2020), Mirjadi Sabrina Flora, Director, IEDCR.

The death figures announced everyday in the Press Briefing of the IEDCR/DGHS do not match with corona-deaths (information from other sources) occurred during the same time period. As of 13th May, the DGHS announced deaths were 269. But the information received from different graveyards and pyres in Dhaka shows 237 funerals and in other districts including Narayanganj, Chittagong and Munshiganj had 155 funerals. This is about 392 cases of death, far more than declared by DGHS (DBC, 2020).

On 29th March, the IEDCR declared there were no new cases of COVID 19 detection and no new case of deaths reported in last two days. However, during the same time period, at least six people died with symptoms similar to that of COVID 19 in Khulna, Barishal, Rajshahi, Manikganj and in Lalmonirhat. No tests were done to determine contagion before their deaths. Three of these six patients were treated at isolation centers at hospitals in the districts and others were denied treatment (Maswood, 2020)

There were many corona 'suspected' deaths with cold-cough and respiratory problems. At least 11 persons died with such symptoms in 24 hours (2 April) and their samples were sent to the Bangladesh Institute of Tropical & Infectious Diseases (BITID) Dhaka for testing (প্রতিবেদক, 2020). The 'suspected' cases are not tested before death but had identical symptoms. But no follow up news was available whether those were real corona deaths or not.

Deaths with fever, cold-cough/ corona like symptoms

During 17 March to 14 April, there were 180 deaths due to fever, cold-cough, diarrhea, and respiratory problems. Samples of 128 patients after death were collected and tested for Corona; 85% were Corona-negative and 10% were Corona positive. More such cases occurred in other areas of the country but the samples could not be collected before burial due to delay in administrative procedure (Amanur Rahman Roni, Mizanur Rahman, 2020) .

According to the latest report based on the enumeration of various independent research indicates that at least 1000 people died from corona-like symptoms, compared to 672 claimed by the Government. Official enumeration left out these deaths by corona-like symptoms from official numbers (Rabbi, 2020).

Deaths without treatment

The first death case caused by denial of treatment was Nazma Amin (24), a young Bangladeshi returnee from Canada, who died due to some gastrointestinal complications; her final hours were allegedly a blur of unintended negligence of Dhaka Medical College Hospital doctors. It was in mid-March after the declaration of the first few cases of coronavirus among the returnees from Italy — the country most affected by the coronavirus. She was not taken to the hospital without any symptoms of COVID-19, yet because she was a foreign returnee, the nurses, ward boys and doctors of DMCH were reluctant to provide services. Unfortunately, they were not briefed adequately about the COVID-19 symptoms, nor were they equipped to test patients for the virus. The medical staff did not have protective suits; so they allegedly refused to approach the patient until it was too late. Since then, more similar incidents took place in and outside Dhaka.

Another victim in Dhaka was Almas Uddin, an elderly person suffering from a stroke. He was taken to five hospitals, and spent 16 hours in an ambulance, without being able to get the health care needed for him because he was also having fever and diarrhoea. Hospitals refused to admit him with such symptoms. Finally, one hospital in which he was admitted, denied services as they found signs of pneumonia. The reason was the fear of COVID-19.

News are pouring in from different districts that patients are not being admitted into hospitals with cold/cough/fever symptoms. No doctor, nurse or any healthcare provider are approaching them in fear. A young man with coronavirus like symptoms were denied treatment in different hospitals and finally died in Rajshahi Medical College Hospital on March 28, 2020. (Akhter, COVID-19 and healthcare denial , 2020)

The death of a Dhaka University student Suman Chakma died at his Khagrachari residence; his father alleged that he was a cancer patient, but was denied treatment at reputed hospitals of the country suspecting him a COVID patient (Kamol, 2020).

COMMUNICABLE DISEASE LAW IN BANGLADESH

Bangladesh updated "INFECTIOUS DISEASES (PREVENTION, CONTROL AND ELIMINATION) ACT, 2018" on communicable diseases. In 3(k) section of the ACT describe "keep or quarantine any suspected person infected with an infectious disease, at a specific hospital, temporary hospital, establishment or home". This law empowers government in notification, isolation, quarantine, sample collection and testing in emerging diseases. The law forms an advisory committee, headed by Minister, MoHFW, including Ministry of Agriculture and Ministry of Fisheries and Livestock, according to the National Preparedness and Response to COVID-19, Bangladesh.

The health service wing under Ministry of Health and Family Planning issued a gazette with a retrospective effect from March 08, 2020. With the issuance of the gazette, the government has got a legal power to take action against the people not following the government's direction (FEOnline, 2029).

National Committee on COVID-19

Government formed a multi-ministry and multi-sectoral National Committee for prevention and control of COVID-19 with the Minister of Health & Family Welfare as the chair. Bangladesh Medical Association (BMA) and Swadhinota Chikitshok Parishad (SWACHIP) are represented as professional medical practitioners organizations in the committee. Although government claimed it is a national committee but the Doctors Association of Bangladesh (DAB), another major medical professional body is excluded for partisan reasons. The Bangladesh Private Clinic and Hospitals and Bangladesh Private Medical Practitioners Association are also represented in the National Committee.

The other committees include the National Technical Committee for prevention and control of COVID-19 mostly represented by technical institutions and Committee in Division level for prevention and control of COVID-19 represented by bureaucrats, police and other forces without any representation from the community. A top down bureaucratic approach, obviously, served no purpose.

REPRODUCTIVE HEALTH CARE: WOMEN FACED DENIAL OF SERVICE

In Bangladesh, an estimated 2.4 million babies will be born under the shadow of the COVID-19 pandemic. The country ranks at number 9 in terms of the highest expected number of births for the period

of 9 months from the date of the pandemic declaration on 11 March. Only 33 district hospitals in Bangladesh are performing all key functions of emergency obstetric care out of 63.

“Despite the pressure on the health system due to COVID-19 situation, routine lifesaving services for the pregnant mothers and newborn babies need to continue with proper infection prevention and control measures. UNICEF is working with the Government of Bangladesh to save lives by ensuring that pregnant mothers and sick newborn babies receive the required care in the months to come,” said Tomoo Hozumi, UNICEF country representative in Bangladesh. An analysis of data in the Directorate General of Health Services dashboard shows that since the beginning of the COVID-19 crisis, there is a significant reduction in the uptake of maternal and newborn health services from the health facilities (Reuters, 2020).

Few incidents appeared in the newspapers creating a lot of sensation among the common people about the cruel denial of services to the pregnant women giving birth to the babies. The scenario is almost same in other divisions of the country like Khulna, Chittagong and Sylhet. However, it is much worse in the Upazila level.

Due to the lockdown and suspense of the transports, many patients cannot go to the hospitals. Many people are avoiding going to the hospitals for the fear of contracting Covid-19 virus. The ministry of health has acknowledged the fact that in many cases patients, especially pregnant women have been denied health services in the hospitals and condemned the practice as ‘immoral’.

Incident 1: Pregnant woman with acute labour pain denied admission

On April 24, Tania, a pregnant woman was denied admission there for her childbirth at the Maternal and Child Health Training Institute, Azimpur. Tania having suffering from acute labour pain, went to three hospitals accompanied by her husband and aunt. None of them admitted her suspecting her to be infected with Covid-19 virus as she had slight fever.

Then they went to Ad-Din Hospital, facing the same denial of admission. Her husband requested them to test her for COVID-19, but the hospital authority paid no heed to that request of them either. At this point, as Tania screamed out of fear that she might die out of acute labour pain, her aunt decided to go to Dhaka Medical College Hospital (উজ্জ্বল, 2020)

Incident 2: C-Section patients uncertain

Sabina Islam, who is due for a C-section within the month, cannot get admitted to hospital as she lives in a neighbourhood marked as a coronavirus hotspot. “I have been in a little pain for the last two days. So, I went to the doctor to know about the plan for a C-section. But they simply refused to see me when they found out that I am from Wari. Now I have no clue where I should go at this stage.

Incident 3: Pregnant woman fail to continue regular check-ups

Shahjida Najnin Surovi, a teacher of University Laboratory School with five-month pregnancy, used to visit a hospital in Dhanmondi. After Lockdown, she goes to a nearby hospital of her Azimpur residence for the routine check-up and vaccination. She is anxious whether she would be able to do her scan test required to perform in 21+ week. The doctor would only see patients only with emergency needs. As she can neither visit the doctor nor is she willing to go to other doctors, she is now relying on the internet for various information.

Incident 4: Pregnant woman fails to manage the tetanus vaccine

Lima Pritom, a pregnant woman from Gendaria of old Dhaka, had to change the doctor she used to visit due to Lockdown. She was required to take two tetanus vaccines of which one she had taken before the lockdown but she still could not manage to take the other one. Amid the lockdown, she has to face problem to commute from her house to the hospital. She faced various questions regarding Covid-19

virus while doing her ultrasonography. However, now she is anxious whether the hospital where from she is now receiving health services will be open during her childbirth due in mid. July, 2020. Due to the lockdown she has to spend extra money for conveyance and other purposes to go to the hospitals.

Incident 5: Pregnant woman refused services because of COVID infested area

Sabina Islam, a pregnant woman from Mirpur-1 who was going to have her delivery within a two weeks but as her home has been locked down due to being situated in a Covid-19 infested area, no hospital is willing to admit her for the fear of contracting Covid-19 virus. She used to visit a hospital in Mogbazar area but after they came to know that she was from a Covid-19 infested area, they did not want to offer her health services anymore. As she had been undergoing pain in her stomach, she went to the hospital for an ultrasonography but they refused to perform the test. As a strategy, now she uses the address of her in-laws house which is in Banasree so that she can get healthcare facilities (রহমান ক. ন., 2020).

Outside Dhaka, similar incidents happened. A pregnant woman went to Gaibandha Mother and Child Welfare Centre in Gaibandha district when her labour pains began. The Family Welfare Supervisor of the clinic refused to admit her and referred her to another hospital without performing a checkup or tests. The woman delivered her child in a CNG-run auto-rickshaw on her way to another hospital. The nationwide shutdown amid the Covid-19 outbreak has made it hard for Bangladesh's expectant mothers to be admitted to hospital and give birth to their children (TBS, Expecting during the pandemic, 2020)

Habibur Rahman Khan, additional secretary, MOHFW said they were aware of the situation. “We have had information that patients are being deprived of health services. We’ve asked the hospitals to provide treatment whenever a patient arrives. Those suspected to have coronavirus can be treated in isolation. ” he said of the government hospitals. “But it’s not possible to fully control the private hospitals. It is unethical for a doctor to deny a woman treatment in the middle of her pregnancy (Rahman, 2020).

In Bangladesh, an estimated 2.4 million babies will be born under the shadow of the COVID-19 pandemic. The country ranks at number 9 in terms of the highest expected number of births for the period of 9 months from the date of the pandemic declaration on 11 March (Sidhu, 2020) .

Normally every year, 31 per cent of babies, or more than 570,000, are delivered in Bangladesh through unnecessary Caesarean sections and 84 per cent deliveries in private hospitals are carried out through C-sections (Correspondent S. , '31pc of babies born in Bangladesh by C-section', 2019).'31pc of babies born in Bangladesh by C-section' Prothom Alo, English, 17 October, 2019. However, there has been drastic change in C-section during the Lockdown as the hospitals refused to admit the patients. During Lockdown, 175,000 children were born and only 4% of these deliveries were by C-section, and the rest 96% were normal deliveries (Bideshe, 2020)

Traditional Birth Attendants

There are also many unregistered Traditional Birth Attendants, popularly known as Dai ma in the villages, are the most closest health providers for the rural and urban poor pregnant, lactating women and women in the reproductive age. They have been ignored and sidelined by the Healthcare system. But in time of fear of COVID-19 and amid lockdown the vast majority of rural expectant mothers gave birth to their babies safely at home. Here is a case study of the Dai mas work under the Dai Ghor activity of UBINIG. (UBINIG, 2016) The information was taken for March and April, 2020 from 9 districts of Kushtia, Pabna, Natore, Chapainababganj, Tangail, Sirajganj, Kurigram, Cox’s bazaar and Bandarban.

As the government hospitals and the private clinics were not functioning during Lockdown, many pregnant women, both from the economically solvent and poor families, are now turning to the Dai Mas for their childbirth.

About a 1000 Dai Mas provide maternal and child health services to pregnant women during their childbirths through 26 Daighors in 9 districts. Among them during March-April, (2020) 97 Dai Mas helped 360 pregnant women with child delivery and all these were normal deliveries. Both the child and mother are healthy, thus played a crucial role in the rural healthcare system of the remote villages. These Dai Mas not only helped the pregnant women during their childbirths, but also they looked after the newborns up to 42 days after their birth. Only 32 cases had to be referred to the government hospitals because of complications.

They can be a big support for the poor women in the villages if the government provides support for the complicated cases which need urgent medical attention.

Community Health workers

The healthcare system includes a large army of over 50,000 community health workers, who serve at the community clinics, the lowest-level static health facility in Bangladesh. With a small salary, they conduct door-to-door health education through community engagement or at the facilities and health care services to different groups of people, starting from married couples, to pregnant women, the newborn, infants, adolescents, and elderly people. They refer patients with critical symptoms to upazilla and health facilities at the district level for better treatment, which they cannot provide. (Nazme Sabina, 2020)

These grass root health workers, are important in the government's primary health care programme and have helped the EPI programmes and health education through the community clinics and the Union Health & Family Welfare centres. Community health workers are intimately familiar with the local people and local conditions and could play a vital role in the community to stop spreading of the infection and disseminating information about the pandemic. Despite the availability of the human resources to deal with the threat of community transmission posed by the Corona pandemic, particularly in contact tracing, they have not been mobilised. They were in the best position to explain the threat to the community, could provide information to the community members about preventive measures against the virus infection. The potential human resources for community mobilization was wasted.

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