

Covid-19 in South Asia: Welcome & Field Reports from India, Sri Lanka & Bangladesh

Brown University, Center for Contemporary South Asia (CCSA) & School of Public Health

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Welcome remarks from Brown University Faculty: Ashish Jha, Ashutosh Varshney and Prerna Singh

The conference began with opening remarks by Ashish Jha, Dean of the School of Public Health. He highlighted the need for a day-long event like this one which digs deeper into the trajectories of the pandemic across South Asia. While 450,000 deaths have been officially declared in India for instance, ground reports tell us that these numbers cannot be right. We need a clearer understanding of the levels of disruption caused by the pandemic and what the path forward for South Asia will be.

Prerna Singh, Professor of Political Science, Brown University added that this was a sobering event for many, acknowledging the personal losses to many even at the event. She echoed the need to add substantively to the official numbers and to listen to those who had their eyes and ears to the ground during this period. The focus on comparing the pandemic's path and government responses across South Asia prompts us to look at variations and what is driving them more closely. The first session will take a comparative look across these three countries - India, Bangladesh and Sri Lanka as well as within these countries and across socio-economic groups.

Barkha Dutt, New Delhi, India (Mojo Story & *The Washington Post*)

Barkha Dutt highlighted how during the first national lockdown, India was the only country to stop public transport with four hours notice. No trains, buses or planes were permitted during this time and even streets were no longer places where one could find cheap food or shelter. Drawing on her journey across 15 states of the country in the two waves of the pandemic in India, Dutt's presentation reflected voices from the ground, challenging what she called, the "biggest cliché that has defined the pandemic" that the virus is a great equalizer, that it is unifying in its lethality, that it doesn't recognize caste, class, religion or gender. However, in reality these inequalities were exposed like never before.

The first wave was dominated by the humanitarian crisis when migrants walked hundreds of kilometers from cities where they were working to their villages and hometowns on foot. She shared images of the people she met as she travelled across the country, families that had their lives tied up in bundles often carrying nothing else but a water bottle and a few packets of biscuits. There were many tragedies along the way: heart attacks, deaths due to exhaustion and babies delivered on the side of a highway. One child walking home with her parents when asked what she wants to be when she grows up said, "when I grow up I have decided I refuse to be poor. This is happening to me because I am poor". Another child of a migrant worker when asked if she knew what COVID was said "Yes, it means I don't get food". A domestic worker remarked that COVID was brought into the country on a plane and to the countryside by those who were walking. Another tragic case was that of Mukesh Mandal, who came from Bihar to the national capital region. He lived in a slum tenement in Gurgaon and made a subsistence living by painting houses. Unable to meet the expenses for his family, he sold his mobile phone for Rs 2000 to buy a ceiling fan. Anxious about the survival of his family, he was

driven to suicide soon after making the purchase. He is survived by his young wife Poonam and four children.

These inequities are not unknown to us in India but were laid bare during the pandemic. Dutt pointed out how in the first wave, people were instructed to constantly wash their hands but this was not possible in many places where water supply itself was faltering. In a village close to the national capital itself, the village water supply was so contaminated, water had to be purchased.

Another case she shared was that of Sher Chand, a sweeper in the Municipal Corporation of Delhi. When his wife fell sick, he tried his best to ensure she got the best medical treatment. He sold the small piece of land he owned in his village and some pieces of jewelry. He admitted his wife to a private hospital which ran out of oxygen in the second wave of the pandemic and she eventually died. Sher Chand said, “now I am left with no land, no wife”. As a daily wager, he is steeped in debt and doesn’t know how he will educate his children. In South India, women at a cremation ground outside Salem in Tamil Nadu also shared their grief and narrated harrowing accounts of how they had taken loans to get their family members treated and then to claim the dead bodies which hospitals refused to release without full payment. Then there was the case of a woman who had delivered a baby the previous day and was COVID positive. She was sitting in the back of an auto riksha after the delivery because hospital beds were full. Hospitals were making people sign pieces of paper saying if the hospital ran out of oxygen they would not be held liable. In Bhopal, in a settlement which was ravaged by the Union Carbide fatal gas leak in 1984, lived Jyoti and her husband who was an auto riksha driver. Jyoti’s parents were killed by the gas leak. Jyoti’s husband tested positive for COVID and had driven himself to find a hospital bed but died on the way. He was not counted as a COVID fatality. He couldn’t make it to the inside of a hospital facility where he could be counted.

In the first wave of the pandemic in India, there was the invisibilization of migrant workers. In the second wave, it was the invisibilization of rural India. Dutt termed this wave the “9/11 of the health sector” where there has been a gross undercounting of deaths. She referred to the images of shallow graves and bodies floating in the Ganga between Bihar and Uttar Pradesh. These bodies had been abandoned because of stigma and because people just didn’t have the money to perform the last rites. There were many eyewitness testimonies of people who had seen these bodies and yet there was denial by the state and national government.

Dutt’s intervention was significant because it drew narratives out of the numbers that we have been looking at to assess the scale and size of the tragedy. There has been an erasure of these stories from media and official numbers. The official statistics still say zero oxygen deaths.

Dr. P. Sarvanamuttu, Colombo, Sri Lanka (Executive Director, Center for Policy Alternatives)

Dr. Sarvanamuttu began with statistics on the course of the pandemic in Sri Lanka: 479,664 infections, 10,995 deaths, 49628 recoveries, 2900 infections and 200 deaths a day. He attested to Sri Lanka’s robust public health system which had risen to the COVID challenge in both wave one and wave two. However, the occupation of political office by the military during this time has been deeply concerning.

The current President took charge in 2019 after winning the war against the LTTE. Dr. Sarvanamuttu pointed out that that he had never held political office before he became President

and that he took charge on a platform of strong, tough, decisive leadership. He was expected to be advised by professionals. However, the default of the current President has been to constantly turn to the military. Key leadership positions during the pandemic were taken over by military personnel such as in the National COVID task force and Ministry of Health. Medical experts were also brought in to fight the pandemic but they found their advice at odds with the military leadership. A number of medical experts have resigned because their technical expertise had not been sought or was ignored.

This was also reflected in the management of the pandemic. When there was a religious festival there was no question of a lockdown. Instead, the government has been talking about creating bubbles in which to bring tourists to the country. Experts have warned that this will spark off another wave.

Lives and livelihoods were pitted against each other and livelihoods were prioritized but the justification was not clear. Sri Lanka's economy was struggling prior to the pandemic. There is a mounting debt crisis and a refusal to go to the IMF. The currency is crashing and import controls have been brought back in. While the suffering because of COVID may not be as great as in other countries in South Asia, internally the upheaval continues because of soaring prices and the failure to support agriculture for instance.

Dr. Sarvanamuttu's presentation focused on growing majoritarian support for the current government of Sri Lanka and the deepening of anti-Islamic sentiment. He argued that the pandemic was used to continue the majoritarian program. He also talked about the circumvention of parliamentary processes during the pandemic which did not meet even once to vote on funds for a relief package. The petition filed by his organization, the Centre for Policy Alternatives, was dismissed. The takeover of important pillars of government by military personnel along with the entrenchment of dynastic political leadership has been an alarming development in Sri Lanka. Dr. Sarvanamuttu's talk brought out striking similarities between Hindu nationalism in India and Sinhalese nationalism and the destructive relationship between exclusionary politics and a viral pandemic.

Dr. Maliha Mannan Ahmed, Dhaka, Bangladesh (Founder and Executive Director, Organikare Bangladesh)

Mannan began with a set of competing narratives that have sought to characterize the Bangladeshi response to the pandemic: "we managed the pandemic better," "we got lucky," "the numbers are not accurate," "we are resilient". Her presentation provided a deeper look into the "mysterious resilience of Bangladesh".

The second wave in Bangladesh came much later in March. With lockdown from April to June. During this period there was an 18% test positivity rate. The third wave came soon after because of the delta variant. Given Bangladesh's position, surrounded by India on three sides, 16 of its districts were badly affected. The focus during this time was on protecting Dhaka

There was an increase in testing and hospital capacity between 2020 and 2021. From centres only located in Dhaka in 2020, the number of centres and hospital increased and expanded to the rest of the country. The highest concentration of cases however, remained in Dhaka, which is the most densely populated city in the country.

Mannan shared death statistics by gender and age. More deaths took place in government versus private hospitals. This is attributed to the absence of health insurance and high out of pocket expense in private hospitals. People avoid private hospitals. Maliha pointed out that the death numbers will seem very low but emphasized that this is not because deaths are not recorded. Instead this may be because people stopped going to hospital during this time even for chronic and non-communicable illnesses. Also there may be those who died of covid like symptoms but also didn't go to hospitals.

Bangladesh has done well on vaccinations because of its strong mass immunization program that has been built over the last 4 decades. Seven vaccines have been approved for use in Bangladesh. Most vaccines in Bangladesh have been bought from China.

In terms of relief packages, the government has extended support to the export industry, and agricultural sector in the form of loans for farms. Social security for informal workers, the elderly and other vulnerable groups was prioritized. The total relief and recovery package amounted to \$14.28 billion. Despite these interventions, the number of “new poor” has increased and a number of other gains in gender and education has been reversed as a result of the pandemic.

There have been some positive developments which included strong IT systems which ensured communication remained uninterrupted especially for public messaging, high take up of vaccines, strong masking mandates and compliance, protection of the agricultural sector, high remittances and 3.5% GDP growth. Mannan ended by pointing out the need for countries like the United State to provide vaccines for the rest of world drawing a sharp contrast between the need for 155 million vaccines in Bangladesh and 15 million wasted doses in the US.

Discussion

This discussion brought together thoughts from the audience and panelists on hope and despair. Dutt's response was that the story that emerges from the pandemic depends on which dimension one focuses on. There are several positive developments too such as relief efforts by civil society and the success of vaccination campaigns on the back of a strong mass immunization infrastructure. The role of the state as “absent” or “indifferent” was also discussed. The role of China was also raised. Panelists responded by acknowledging its presence on several fronts. The pandemic can also be seen as a disruption in the geo-political configurations. The global production and supply of vaccines has become an important factor.