the pioneer
HYDERABAD | THURSDAY | JUNE 11, 2020

The challenge of unlocking public life

Closing (lockdown) and opening (unlock) of public life is based on two contrasting world views.

In the first view, every life matters, so in an epidemic, public activities should be completely closed. The second view holds that the 'greater good' of the largest number of people should be ensured and complete closure of all public activities is not required — in the trade-off some lives will be lost.

India has followed these two approaches, one-after-another — lockdown followed by unlocking of public life.

The assumption was that during the lockdown a variety of non-pharmaceutical policy interventions (NPPIs; e.g. voluntary quarantine of infected households, closure of schools, ban on public gatherings) would be undertaken at the field level so that the virus would be completely wiped out. The expectation was that once the virus was eliminated the lockdown would be withdrawn. Some key actions required at the field level were — all people at risk should be tested, the person(s) passing on the infection would be identified and treated, all persons they met while carrying the infection would be traced and isolated for a fixed period of time and disinfection carried out in all the areas visited by all the infected persons.

Some key actions required at the field level were — all people at risk should be tested, the person(s) passing on the infection would be identified and treated, all persons they met while carrying the infection

In other words, the complete chain of persons whom the infected person came in contact with would be identified, located and treated over the course of the lockdown.

These tactical interventions had to be designed and implemented at the local level, keeping in view the particular and special needs and resources of the local areas. In order to successfully root out (or at least diminish) the Covid-19 virus, the full range of non-pharmaceutical policy interventions had to be implemented at the same time at all levels (e.g. state, district, taluqs, city/village). Now the Covid-19 cases have been rising and a new set of tactical interventions are required.

These would build on what has already been accomplished, as well as make course corrections wherever required. While the standard protocol of test, trace, isolate, treat, etc. would continue, attention would increasingly shift to confining all pre-symptomatic, as well as less serious cases, to homes. Families would voluntarily quarantine themselves and family members would only leave the house for their most pressing needs.

In order to induce people to stay in their homes, Governments would provide a range of home delivery services, directly or by the private/third-sector.

For this digital means would be extensively used.

SAMEER SHARMA, IAS

Some of these are, (1) early diagnosis (e.g. body temperature, oxygen levels, condition of lungs and throat) and symptomatic treatment using digital means (including medicine delivery), (2) expand the existing Aarogya Setu App to a personal electronic diary (e.g. Singapore) for users to track their own changes in temperature, cough, etc., (3) mandate Work From Home for all government employees.

The success of the use of e-office and teleconferencing holds much promise of maintaining high levels of efficiency in government operations, (4) recent use of organising remote proctored tests for admission to graduate programmes, class teaching, tutorials, group activities and correction of answer sheets by some institutes (such as in the Indian Institute of Corporate Affairs) by combining mobile-based learning management systems (Blackboard - there are others too) with e-office show that near normal working in educational institutes is possible.

There are huge long-term benefits too, such as allowing students to learn when free, giving opportunities to instructors to focus on slow learners, and so on. Of course, issues relating to digital divide and facilities for the differently-abled would have to be addressed by the education departments, (5) home delivery of all requirements by using electronic platforms (kirana stores will also participate), including home delivery of provisions provided by ration shops.

The purpose is to reduce movement of people by delivering all items and services at the household level.

For serious patients, public facilities (e.g. stadia, community halls) would be converted to hospitals. Local sources would provide services, such as supply of beds by tent companies and food by local restaurants. Importantly, private doctors/final year MBBS/MD students and the little used AYUSH doctors (more than 7 lakh) would be roped in to provide medical services in these temporary hospitals.

The tactical plan outlined above draws upon the best elements of the two world-views. The cornerstone is a shift in attention to households. All goods and services would be provided at the doorstep. Only serious cases would be taken to temporary hospitals. All medical personnel would be mobilised and deployed for Covid-19 related work. The key would be usage of digital means. In the medium-run, this is expected to lead to a new way of doing things as well as a different way of living.

(Author is a Ph.D. from USA and a D.Litt. from Kanchi University. The article is based on his research and practice and views are personal)