Need for Ensuring Proper Enforcement of Legislative Control during COVID Pandemic: Bangladesh Perspective

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Abstract

The outbreak of COVID19, a pandemic disease that had its root in novel coronavirus called SARS-CoV-2, has brought a massive global emergency on the worldwide health condition and managing the regulatory measures for the nations. Bangladesh, like many other affected countries, came into the claws of this infectious disease because of the global connectivity. Bangladesh has also faced the absence of a proper regulatory framework to manage the country's public & private health sectors, which has created an overwhelming situation for the country and its law and order system to cope with. The overall impact of COVID-19 had brought a massive national emergency to its Government and frontline professionals that have yet to recover from the aftershock of this unprepared battle with this pandemic. Situations got aggravated due to late enforcement of the Infectious Disease Act 2018 and proper regulatory framework to handle public, private hospitals, and public service institutions for not assuring proper resource allocation during the pandemic. Instead of providing equal service in health care and other services, hospitals and public service-providing institutions provided the priority to elites, and the middle class & low-income citizens were neglected. In addition, the regulatory remedies that the government ought to have made in order to limit the mismanagement of government and public health services were disregarded. The causes were various and varied; in some places, it was due to a lack of a solid framework, and in other places, it was due to the overwhelming pressure of population and the number of patients that overloaded the administrative capacity and human resources in hospitals. Although Bangladesh was unable to enforce any kind of stringent limitation, there were thousands of people walking throughout the streets, especially in Dhaka. It would seem that maintaining a social distance while using public transportation and living in the suburbs is rather difficult. The implementation of social distance, which was advised by the WHO but appears to sound fancy but unrealistic in the context of tremendously crowded and lower-middle-income nations like Bangladesh. When the crisis arose during the pandemic, the High Court of Bangladesh ordered the Government to include COVID as an infectious illness in its 2018 act. Despite this ruling, the appropriate bodies in Bangladesh were significantly slower in enforcing the legislation than they were when it was first introduced.

This article underlines the need for necessary changes in the Infectious Disease Act 2018 and that reinforces more working regulations on discrepancies of public servants and relevant authorities for ensuring proper distribution of service and resources to people on an equality basis, where proper framework to handle the process and penalty mentioned in the law will be imposed.

Keywords: *COVID-19, Infectious Diseases Act, 2019, Judiciary, WHO*

Introduction

The COVID-19 pandemic has strained health care systems, especially intensive care units (ICUs), in industrialized, developing, and emerging countries. Due to its vast population and poor health care, Bangladesh is an unfortified country. Covid-19 will identify areas for improvement in our health care system, and recruiting enough healthcare authorities and employees will reduce the shortfall in Bangladesh. Reflecting on how global health law will emerge after the COVID-19 pandemic, it will be necessary to assess the COVID-19 reaction and the changes needed to reconstruct global health institutions while safeguarding human rights, the rule of law, and

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global solidarity in the face of unprecedented challenges. Bangladesh can learn from its absence of a regulatory structure under rigorous rules to guarantee efficient healthcare services. The health sector or hospital workers should be taught and placed under a legal framework to resolve differences. This article will highlight the Infectious Disease Act 2018, its breadth, and the absence of regulatory measures by enforcing it, providing alternatives, and reflecting on previous errors to provide a future reference.

Early Landscape of COVID Surge in Bangladesh

The early case of COVID 19 was first identified in Bangladesh on March 8 2020[1]; while the number of cases was still under control, the high court division of Bangladesh ordered some directories to all the ports of the country to follow, and the disease was considered a seriously communicable one. High Court gave directions to the Ministry of Health & Family Welfare (MoHFW) and the Directorates of Health to take necessary steps in all international ports for testing the health conditions of citizens & foreigners coming from other countries. To ensure the testing of their health conditions, the honorable high court ordered checking on 'how and who' are doing the tests on incoming migrants. In addition, the capacity of the test kits or machines is told to be checked by the responsible authorities to report to the high court for authenticity. The hospitals in the country were ordered to take immediate preparation to ensure separate cabins & medical kits & necessities for possible COVID cases. The hospitals where tests for COVID 19 will take place ordered to ensure an ample amount of testing kits, and advised the Government to ensure the import of necessary kits and protection gears for hospitals. Monitoring in pharmacies and dispensaries was ordered to control any sort of discrepancies out of people's need for emergency products such as hand sanitizers and masks. Moreover, Health Department announced COVID19 as a Pandemic on a public notice under the Infectious Disease (Prevention, Control, and Elimination) Act 2018 (hereinafter termed as Infectious Diseases Act, 2018).

However, the situation worsened when the directions and laws were not followed. People coming from abroad were not following any quarantine rules, responsible authorities in ports were letting the 'pass' to all incoming migrants to enter the country, taking speed money, quarantined immigrants were protesting the rules, and businessmen and pharmacy owners started unscrupulous profit-earning schemes by creating an unreal-scarcity of goods. As a result, people also started unnecessary stocking of daily goods, creating an imbalance of supply in the market. While the COVID cases were surging, a group of dishonest personnel in hospitals was increasing the cost of tests and selling medical services to elites, and fake pass-on test results were being distributed. In these circumstances, the Government announced zero tolerance to corruption in health sectors, and any breach of the Infectious Diseases Act 2018 and hindrance to the duties of respective personnel in duty for prevention, control, and elimination of COVID 19 will be taken as a punishable offense based on section 25.[2]

The lack of proper enforcement of the Infectious Disease Act 2018 and irrelevant measures resulted in severe consequences through increased COVID 19 cases. The number of death tolls, rush in hospitals, and economic downfall came to its course due to the regulatory handle on this situation. The series of lockdowns to minimize the spread of the disease had inertia on the country's overall situation. Regular affairs of the people had come to a standstill, and a national crisis arose due to the long-term lockdown causing the shutdown of industries, enterprises, and individual businesses, creating a massive economic loss. Facing the rough impact of COVID, the Government imposed a halt on the movement of citizens, which had a remorseful impact on people's mental and physical health.

Regulatory Responses Taken on Pandemic

As a part of the COVID19 mitigation tool and addressing the relevance in regulatory response, it is vital to evaluate existing legislative provisions that establish the Government's responsibilities and obligations to mitigate and prevent the spread of infectious illnesses. Where the Penal Code, 1860, and the Infectious Diseases (Prevention, Control, and Elimination) Act 2018 are applicable for decoding the underlying acts.

The Penal Code, 1860 explicitly prohibits careless and malignant propagation of contagious illnesses and quarantine order breaking. Due to the extraordinary proliferation of the new Coronavirus, any negligence that leads to its dissemination would have fatal effects. Sections 269 and 270 of the Code relate to negligent and malignant behavior, respectively. Section 269 stipulates that a person may be imprisoned for up to six months, penalized, or both if they do an act that is 'likely to transmit a disease harmful to life. The virus may be devastating even without definitive proof of the COVID-19 mortality rate. 'Likely to transmit' and 'has reason to believe' has a wide scope of applicability, especially in light of domestic and international calls to contain the infection. Section 271 imposes a six-month jail sentence and/or a fine for breaching any law placing boats in quarantine or regulating the interplay between locations where an infectious illness dominates and other places'

While the Penal Code imposes criminal culpability on people, the 2018 Act focuses on the prevention, control, and eradication of the infectious disease. It aims to handle public health crises, reduce risk, and raise awareness. Section 4 of the 2018 Act lists disorders covered by the act, however, the list is not comprehensive. By official gazette, the Government may proclaim an emerging or reemerging illness an infectious disease under the Act. On March 18, 2020, the High Court Division ordered the Government to declare novel coronavirus a contagious illness under the 2018 Act. The 2018 Act allows the Directorate of Health to investigate any location, clinic, hospital, or diagnostic lab that treats infectious illnesses. It may also direct anybody with illness knowledge to tell the Directorate. To control the illness, the Directorate may quarantine or isolate any suspected patient in a hospital, temporary hospital, business, or residence. The Act may also ban domestic travel and the entrance of planes, ships, buses, trains, and other vehicles.

If the Director of Health or a vested authority determines that a disease cannot be controlled or eradicated, they may declare the region infected and ban access under Section 11 of the Act. If there is cause to suppose an infected person may spread the illness, the Director or another authorized authority might have that person isolated or moved. According to Section 20, everyone who dies of a contagious illness must be buried or disposed of as directed by the authority. The Law also requires health practitioners, owners, and employees of hotels, boarding(s), or residential places to notify the Civil Surgeon of any contamination under Section 10.[3]

Communicable Disease Act and Failure to Establish a Framework

This state law is known as the Infectious Diseases (Prevention, Control, and Eradication) Act. It outlines infectious illness and discusses strategies for preventing, controlling, and eradicating infectious diseases in Bangladesh. Article 4 of the Act contains a list of ailments within its description. It entails a list of infectious illnesses including malaria, kala-azar, filariasis, Japanese encephalitis, dengue fever, influenza, avian flu, Nipah, anthrax, MERS-CoV, rabies, Nipah, HIV, viral hepatitis, encephalitis, diarrhea, TB, respiratory tract infections Vaccination-preventable illnesses, including typhoid, food poisoning, meningitis, and Ebola, Zika, and Chikungunya. The definition mentioned above of infectious illnesses under the Act is not exclusive.

Consequently, it stipulates that the Bangladesh government may declare any emergent or problems reemerging as infectious illnesses via announcement in the official gazette according to article 4. In order to monitor the spread of infectious respiratory ailments, the Government is authorized to take action against those who disobey official directives, as stated in the gazette. Health Directorates must address public health crises, mitigate health risks, and prevent, control, and eliminate infectious illnesses. It proposes steps to reduce needless antibiotic usage in infectious illness treatment; inspects residences, other housing, clinics, and hospitals. The section of this act allows for worldwide notifications and mutual aid to be sent in the event of an infectious disease epidemic to strengthen risk management. In addition, International Health Regulations and WHO publications may be adapted to encompass education, infectious disease propagation, and rights protection.

Nationwide hospitals and clinics at primary, secondary, and tertiary levels, community hospitals and clinics, Non-Governmental Organizations (NGOs), and International Donor Agencies (IDOs) that offer public healthcare are directed by the Ministry of Health Care and Family Welfare (MOHFW) as a part of Government's policymaking organ to outlay the strategies through Health Services Division and Medical Education and Family Welfare Division. These hospitals and clinics offer outpatient and inpatient promotive, preventative, and curative treatment, and hospitals and institutions in rural divisional cities and the capital city offer tertiary healthcare. In distant locations, Union and Ward offer community healthcare; they are privately financed, for-profit hospitals and clinics with high-quality international hospitals. As NGO- and IDA-funded hospitals and clinics are rare in Bangladesh, wealthier patients frequently travel to private hospitals and clinics, while poor and middle-class Bangladeshis rely on public healthcare facilities. Article 15 of Bangladesh's 1972 constitution[4] requires the Government to provide primary healthcare and medical demands to its citizens.

Inadequate human resources in technical positions, infrastructure, equipment, labs, long-term planning, inefficiencies, research funds, and monitoring worsen the healthcare system.

These fundamental shortcomings and inadequacies in Bangladesh's public healthcare system make it more susceptible to pandemics. Despite the Infectious Disease Act's legislative foundation for pandemic preparation and actions to prevent, control, and eliminate infectious illnesses, the lack of an ethical decision-making framework frequently poses challenges for healthcare professionals and frontline health workers. Staff must decide how, where, and to whom to deliver medical resources. Who will get priority? When should doctors decline or cancel treatments?[5]

Globally, drugs, beds, ICUs, and ventilators are short because of the COVID-19 epidemic. Clinicians struggle to decide who should get limited healthcare resources. Beds, ventilators, ICU beds, and COVID-19 testing are examples. Private hospitals were practically shut down for COVID-19 patients, and after the Government's interference during surging cases, few private institutions now treat COVID-19 patients. Poor and middle-class COVID-19 patients still rely on underfunded public hospitals and wealthy patients. It overburdens publicly financed hospitals. Healthcare practitioners in Bangladesh must decide which patients should get limited medical resources. As demand exceeds availability, most COVID-19 sufferers are refused diagnosis and treatment while elites reserve beds.[6] Many poor and middle-class COVID-19 patients are sent away from hospitals without care;[7] staff decline or cancel treatments.[8] Thus, frontline healthcare workers are susceptible. Healthcare staff is professionally obligated to care for the unwell during a pandemic.[9] However, Bangladeshi policymakers must address the problems of healthcare professionals and frontline health workers who find it challenging to allocate few resources during a pandemic.

Outcome

Due to the lacking of proper utilization of the regulatory responses such as the Infectious Disease Act 2018 and National Preparedness and Response Plan for Covid 19,[10] Bangladesh as a working framework failed to contain the service providers' and receiver's ethics and improper health service distribution for national medical emergencies in hospitals and other health care organizations, during the overflow of COVID cases.

As a result, Bangladesh had to face significant challenges in the following parts:

- **Limited Number of Tests**

  As COVID-19 has no effective cure, it is crucial to test, track, and treat this extremely infectious illness. It was vital to detect the illness early so that urgent contact tracing, isolation of the patient, and quarantine of potential contacts could be assured. In a population of 170 million, 10,000 daily tests are low. Bangladesh's positive instances were rising quickly. Bangladesh could miss more COVID-19 instances due to a lack of diagnostics. Therefore, it was highly encouraged to increase the number of tests for suspicious and asymptomatic persons as soon as feasible.

- **Lack of Protective Equipment**

  Inadequate provision of personal safety equipment (PPE), standard masks, and hand gloves to health care professionals are a vital treatment facility limitation. The lack of safety equipment worried physicians and nurses. Responsible officials imported low-quality protective equipment, and some firms in Bangladesh produced inexpensive antiseptic solutions, facemasks, hand gloves, and PPE. Low-quality healthcare items threaten public health during the COVID-19 epidemic. As a result, many physicians, nurses, and law enforcement officers were exposed to COVID-19 and died.

- **Lack of Skilled Human Resource**

  Using real-time RT-PCR tests to diagnose COVID-19 needs competent personnel and advanced lab equipment. In order to minimize contamination, false-negative findings, and biological threats, the Government did not authorize all hospitals and institutions to do the test. Different universities in Bangladesh produce a large number of biochemistry, molecular biology, microbiology, biotechnology, etc., graduates yearly. Graduates are taught to diagnose COVID-1The Government has neglected to utilize these competent Graduates during the pandemic. A national panel of virologists, biotechnologists and molecular biologists should be organized, trained, and engaged in diagnosing COVID-19 to tackle this kind of pandemic.

- **Limited treatment facilities**

  COVID-19 assessment and therapy in Bangladesh are inadequate. China has 42 hospital beds per 10,000 inhabitants, whereas the US has 29. Bangladesh's health department has done 7,812 tests per million individuals, with 1,598 positive cases. USA, Russia, Italy, Spain, and Pakistan completed more tests and had more positive instances than Bangladesh. Bangladesh has 432 ICU beds, including 110 outside of Dhaka. The private sector has 737 ICU beds for 170 million people. The Government must quickly prepare urban and rural hospitals with enough ICU beds to avoid future emergency hazards.

- **Limited Number of Health Service Providers**

  Doctors and nurses are scarcer in Bangladesh compared to other nations, which is a significant issue. Bangladesh has 5 physicians per 10,000 people, whereas Italy has 41

physicians per 10,000 people. 24 In addition, some hospitals, physicians, nurses, and other health officials were hesitant to treat COVID-19 patients, which was unethical and unprofessional on the part of hospital administrators and physicians. As they lack adequate protective equipment, they fear contracting the disease. In this case, secondary and tertiary waves of the illness had culminated in an extensive epidemic that led to a catastrophic scenario for the nation. Recently, the Bangladeshi Ministry of Health appointed 2,000 physicians and 6,000 nurses to combat the COVID-19 outbreak. In addition, the Government is now hiring additional physicians and nurses for the future year to combat the pandemic as a more comprehensive solution to this issue. The Government has proclaimed incentives and health insurance for doctors, nurses, and other frontline COVID-19 combatants. The Government should organize a quick recruitment drive to expand the number of health professionals.

- **Lack of Research Funds**

  The Bangladeshi universities lack appropriate funding for molecular research, which was reflected in the reduced number of scientific publications published annually in international open-access scientific journals. Due to insufficient resources, such as a lack of contemporary laboratory equipment, Bangladeshi researchers were unable to concentrate intensely on this crucial COVID-19 problem. It is vital to emphasize that industrialized nations have invested billions of dollars in research on COVID-19 and other infectious diseases, but Bangladeshi researchers had limited resources during the crisis. Therefore, it is crucial to devote sufficient money from the government and non-government sources to conduct more research and studies on the continuing COVID-19 outbreak and other lethal illnesses in Bangladesh.

- **Lack of Public Awareness**

  As no specific medications and vaccines were invented back then in the earlier days of the pandemic to prevent or cure COVID-19, it was essential that everyone practice cough etiquette, such as concealing coughs and sneezes with disposable tissues or clean clothing, to combat this extremely infectious illness. However, social separation was hard and there was less awareness among people about this unknown disease which led to more infections in a few days.

During the First Wave of Pandemic

Bangladesh's Health Ministry reports 368,690 positive cases and 5,348 deaths to October 4, 2020. Dhaka (142,741), Chattogram (47,473), Khulna (21,936), Rajshahi (20,158), Sylhet (12,685), Rangpur (12,083), Barishal (8399), and Mymensingh (6471). Bangladesh had recovered 281,656 affected persons. Bangladesh's death rate is 1.45% and the recovery is 76.39%. COVID-19 had been becoming more deadly since its first case was identified in Bangladesh on March 8. Cases and deaths were rising daily. Total cases and fatality rates doubled every month until June, then progressively dropped. Bangladesh is overpopulated and under-resourced. Bangladesh lacks diagnostic testing. Bangladesh's pandemic was a huge concern since the virus could infect many individuals quickly. Many impoverished Bangladeshis live in slums and share a toilet and bathroom. As COVID is extremely infectious, a slum with a corona-positive individual is quite deadly. 836,00 Rohingya live in camps. Due to the virus's rapid spread, an infection in one camp could be devastating. Bangladesh lacked testing tools and laboratories for viral detection. Social isolation was impossible in highly populated camps, where many people lived in tiny areas.[11]

After Second Wave of COVID 19 Surge

According to the data, on October 31, 2021, the number of new COVID cases in Bangladesh was 211, with a weekly average of 264. This form of mass infection can be alarming for the country. Despite the vaccines being started in Bangladesh, major foreign fashion businesses canceled orders for millions of dollars in readymade clothes earlier when the pandemic wave was decreasing. It has affected Bangladesh's economy. Many small enterprises had closed as a result, and many individuals were jobless and struggling. Top firms weren't hiring and cutting staff and unemployment reached an unbearable point. (Amit, Sazid 2020)

Educational institutions were shut down for 7 months to control the COVID-19. This made nearly 40 million students out of institutions, and many dropped out even after reopening.

A major portion of daily workers was impacted by the decrease in family income during the lockdown and was also concerned about their family members' jobs. Numerous individuals were losing their jobs, and the majority of their monthly expenses were lowered. During COVID-19, numerous private firms were providing a payout of 50%. As a consequence, their capacity to purchase nutritional food for their family started to fall, exposing their children to a variety of malnutrition disorders. As family income had diminished, a number of students were compelled to take up riskier employment in construction, the textile industry, bus driving, and auto-rickshaw driving. Their parents force their daughters to marry at a young age. The Government launched a major $589 million stimulus plan to help farmers and enhance agricultural output. Distributing stimulus assistance to the appropriate farmers at the proper moment is difficult. The Government also provided health exams, sanitary equipment, transportation, and housing for farmers who harvested Boro rice in haor to help secure food security. The foregoing parts showed that Bangladesh faced tremendous hurdles in tackling the deadly COVID-19 outbreak. (WHO) Although the impact of climate on COVID-19 spread and severity are not apparent, infection and fatality rates in tropical delta Bangladesh were low compared to temperate European and American nations. Temperature, humidity, sunshine, and other environmental and demographic aspects are being studied to explain the disease and its changing variants.

Recent Condition of COVID-19

According United Nation's report (2021) on Bangladesh government extended COVID-dedicated beds in existing hospitals and opened a new hospital with ICU beds. UNICEF is installing liquid medical oxygen systems at 30 institutions, including two tertiary hospitals, using a World Bank loan to Bangladesh. DGHS and UNICEF created a real-time dashboard to monitor daily caseload, bed occupancy, ICU, and oxygen equipment. WHO trained 66 doctors and nurses from eight divisions in IPC and helped prepare a guidebook for community health workers, physicians, and nurses at 15 district hospitals. DGHS, UNICEF, MoRA, and IFB worked together to engage religious leaders throughout Ramadan. MoRA released a circular and factsheet on COVID-19 and immunization for Imams. IFB recruited 500,000 Imams in 250,000 mosques. A TV and social media PSA promotes vaccinations during Ramadan. CDGHS, UNICEF, MoRA, and IFB have engaged religious leaders throughout Ramadan. MoRA released a circular and factsheet on COVID-19 and immunization for Imams. IFB recruited 500,000 Imams in 250,000 mosques. A TV and social media PSA promotes vaccinations during Ramadan.

World Health Organization (WHO) has recorded 535,863,950 verified COVID-19 cases, including 6,314,972 fatalities, as of June 17 2022. So far, 11,902,271,619 vaccination doses have been given. WHO reports 1,955,427 confirmed COVID-19 infections and 29,131 fatalities in Bangladesh from January 3 2020 to June 17 2022. So far, 274,923,522 vaccine doses have been given.[12] Rolling

the vaccination out in the whole country decreased the infection rate, and brought the mortalityrate to less than five percent by the end of May 2022.

Recommendations

Bangladesh has a low healthcare budget compared to other SAARC nations with a comparable socioeconomic position. Bangladesh spends less than 2.5% of its GDP on healthcare, whereas the Maldives spends 9% and Nepal more than 5.5%.[13]

The budget allocation in the health sector should be increased to allow necessary researchand allotment for national health emergencies in the country. In addition, there is a dire need of establishing a legislative framework for crisis management under the 2018 act that specifies a central coordinating body (inter-ministerial council or committee) that manages a crisis during pandemics. Enforcing the National Preparedness and Response Plan for Covid 19 for future reference and following regulatory requirements is required to handle national health crises and govern public health institutions.

Proactive and anticipatory crisis management and coordination at the government center will enable public servants to secure foresight and readiness with dedicated resources and specialized employees, as well as systems and strategies for coordinating government action during crises. Belgium, Denmark, France, Germany, and the UK had comparable techniques and national plans for battling influenza pandemics before COVID-19, which aided the present reaction.

Endnotes

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