Governance Challenges in Tackling Corona Virus Crisis
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Executive Summary

1. Background and Rationale
The ‘Corona virus disease, 2019’ (COVID-19) is new species of corona virus that is highly contagious and infects people. On 31 December 2019, the Chinese government informed the World Health Organization (WHO) of an unknown cause of pneumonia in Wuhan Province. On 6 January 2020 China identified a new species of corona virus as responsible for this unknown pneumonia. On 30 January 2020, WHO issued a global public health warning about the virus, and on 11 March, declared it an epidemic, and later a pandemic. Sample testing for the virus started in Bangladesh on 21 January, while the first 3 cases were found on 8 March, and the first death occurred on 18 March. The total number of Corona-infected population is 7.8 million worldwide and over 87 thousand in Bangladesh, and the number of death is over 431 thousand worldwide and 1,171 in Bangladesh (up to 14 June 2020).

The World Bank estimates that the corona virus will cause some 50 million people worldwide to fall into extreme poverty. The Asian Development Bank fears that due to the outbreak Bangladesh will lose about 1.1% of GDP, and about 10 million people will be unemployed. According to the Centre for Policy Dialogue (CPD), the impact of corona is declining incomes, due to which the number of poor people has increased, and the overall poverty rate has risen to 35 percent.

Transparency International Bangladesh (TIB) identified various types of good governance challenges in disaster management and emergency response in its previous studies. Realizing the challenges of existing good governance in implementing various activities to deal with corona virus, the government has already taken various precautionary measures. However, reports have been published in the media about the government’s lack of preparedness, lack of planning, lack of skills and capacity, and irregularities and corruption in various areas in dealing with the virus. Under these circumstances, TIB is conducting this research to help implement various government activities to be more effective, transparent and accountable.

1.1. Objective
The objective of this study is to identify the governance challenges in different initiatives undertaken by the government in tackling corona virus crisis before and after its spread.

1.2. Research Method
Mixed methodological (qualitative and quantitative) techniques have been applied in this research. Direct data collection methods and data sources include collection of information through online checklists. Health related information has been collected from 47 (33 district hospitals, 9 Medical College Hospital and 5 other types of hospitals) hospitals from 38 district covering all divisions across the country using convenient sampling method, and information on relief distribution from 43 districts from local citizens (journalists, teachers, professionals). Interviews with doctors and journalists have also been done. Indirect data collection methods and information sources include
review of relevant policies, laws and regulations, information published in the information window of various government and non-government offices, and reports published in the media (print and electronic). Information related to the distribution of relief has been collected from eight national level media (print). Data was collected during 15 April - 14 June 2020.

1.3. Scope and Analytical Frame
The scope of this research includes:
1. Strategic preparedness and response plan to prevent corona
2. Corona Case detection (laboratory capabilities, preparation and testing activities);
3. Clinical Management (hospital capacity, preparation and service);
4. Infection prevention and control (safety of health workers at the hospital level);
5. Prevention and control of community transmission (screening, isolation, quarantine, lockdown);
6. Incentive program to combat the effects of corona virus;
7. Relief and social security programs.

Analysis of data has been done following different indicators of governance, i.e., rule of law, responsiveness, capacity and effectiveness, coordination and participation, accountability, transparency, and control of corruption.

2. Key Findings
A number of steps has been undertaken by the government for tackling corona virus crisis. For instance, various events such as the scheduled events on the occasion of Bangabandhu Sheikh Mujibur Rahman’s centenary birth anniversary, Independence Day and New Year celebrations were postponed to ensure social distance. The Prime Minister emphasised her position of “Zero Tolerance” in cases of corruption in the distribution of relief. Likewise, the government took action against the culprits in the case of published irregularities and corruption. Various types of incentives were declared, among which there were incentives worth BDT 103 thousand 117 crore to face the possible economic crisis, financial incentives and health insurance for health workers and other government officials, and cash assistance to 5 million extremely poor families. The government also set a target for procurement of paddy in excess of 200 thousand tons than the previous year. The commodity prices were also kept relatively stable during the crisis.

In the following sections different governance challenges under different indicators have been identified.

2.1. Rule of Law
Deficiency in following relevant laws has been observed in tackling COVID-19. Neither The Disaster Management Act, 2012, nor the Communicable Disease (Prevention, Control and Elimination) Act, 2018 were properly followed. As The Disaster Management Act, 2012 and the Standing Orders for Disaster (SOD) were not used, the opportunity of utilising different institutional set up, ministries and departments could not be used; rather only a few committees at district and upazila levels were instructed to take action.

Likewise the Department of Health did not declare the entire country as an ‘Affected Area’ following The Infectious Diseases (Prevention, Destruction and Eradication) Act 2018, but declared the country as ‘Risky’, which weakens the basis for taking action on law enforcement at the field level. Even when the COVID-19 was included in the law, by then community transmission has already started.

2.2. Responsiveness
The concerned authorities could not respond quickly to the emerging situations in the wake of corona virus epidemic. There was lack of control over the influx from abroad due to the spread of infection. After declaring the corona virus as an epidemic, the decision to block entry to Bangladesh was delayed – resulting in the arrival of 624,843 passengers from around the world between 21
January to 18 March. About two months later, it was decided to suspend all international flights. However, although flights from Europe were suspended from 15 March, and flights from all affected countries from 21 March, flights from United Kingdom, China, Thailand and Hong Kong continued. All international flights except from China were shut down from 28 March. The screening of Chinese nationals arriving at Hazrat Shahjalal International Airport began on 21 January, and from 7 February, all passengers were screened at all the international airports, seaports and land ports of the country. However, this was done through hand-held thermal scanner which can only identify high temperatures of the passengers, and as a result the corona-infected persons could not be properly identified and separated.

The planning and formation of committees was delayed. The technical committee with specialist doctors was formed a month and a half after the onset of infection (April 18). Disruption of infection prevention and medical management occurred due to delayed adoption of the ‘National Preparedness and Response Planning for COVID-19 in Bangladesh’, almost one and half month after the warning from WHO.

Failure to control internal traffic and people’s gatherings was also seen. The public transport was not closed although all educational institutions were put on holidays since 16 March, and general holidays was declared across the country on 24 March. As a result a large number of people left Dhaka and became infected. On several occasions there were huge public gatherings (Khaleda Zia’s bail, fireworks on the occasion of Centenary of Mujib). The Election Commission also behaved irresponsibly through planning a number of city corporation and parliamentary bi-elections. There was also delay in instructing not to assemble for praying (April 6).

Deficiency in laboratory preparations was also observed. Despite WHO emphasised more on testing of all suspects to prevent the spread of the virus, till 25 March only one laboratory was testing. Despite the availability of a number of public and private laboratory capacity in Dhaka and outside, they were not allowed to test. Although more than 500 thousand people contacted through the IEDCR hotline, only 794 tests were done. The expansion of laboratory (testing) facilities outside Dhaka was done only after community transmission had started (25 March).

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Number of laboratory</th>
<th>Test/day</th>
<th>Test/day/lab</th>
<th>test per call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 25 March</td>
<td>1</td>
<td>23</td>
<td>23</td>
<td>639:1</td>
</tr>
<tr>
<td>26 March-15 April</td>
<td>17</td>
<td>170</td>
<td>38</td>
<td>143:1</td>
</tr>
<tr>
<td>16-30 April</td>
<td>30</td>
<td>636</td>
<td>111</td>
<td>25:1</td>
</tr>
<tr>
<td>1-15 May</td>
<td>41</td>
<td>1380</td>
<td>156</td>
<td>18:1</td>
</tr>
<tr>
<td>16-31 May</td>
<td>52</td>
<td>2534</td>
<td>179</td>
<td>22:1</td>
</tr>
<tr>
<td>1-14 June</td>
<td>60</td>
<td>13695</td>
<td>232</td>
<td>13:1</td>
</tr>
</tbody>
</table>

There was also lack of clinical management and preparation. Despite it was claimed by the government that all preparations were there up to upazila level, it is found that 44 percent of the hospitals included in the study started preparations during the third stage of infection, while 21 percent of the hospitals had not made any needs assessment. It is further revealed that all healthcare service providers in 22 percent of the hospitals received training, whereas in rest of the hospitals only a few received training. According to a survey conducted by BGNS and SNSR, two nurses’ organisations, 86 percent nurses do not have any training on infection and prevention control (IPC).
Although a total amount of BDT 103 thousand 117 crore in 19 incentive packages was declared (worth 3.3% of the GDP), these were mainly business-friendly, followed the policy of increasing loan support and decreasing interest, and there was no guarantee of reaching out to the people of all classes and professions. There is no adequate system to overcome the fall of aggregate demand. There was absence of funds, or lack of adequate cash assistance to meet basic needs and increase the purchasing power of essential goods. There was no plan for allocation for 50 million unemployed day labourers and workers in the informal sector. The allocation to ensure food security was also insufficient – only 10 per cent of the boro paddy was announced to be procured. There was no incentive for small and sharecroppers, no declaration of waiver of agricultural loans. There is an opportunity for the middlemen to take more loans and incentives for the defaulters. Moreover, loan defaulters were given the opportunity to take a share from these incentives.

With regard to relief and social security programs, according to the information from 43 districts, no prior preparations were made for the distribution of relief in 20% of the area. In 22% of cases, the list of beneficiaries was updated. Relief less than the actual needs was distributed in 82% of the areas, while in 90% of the areas, more than half of the people eligible for relief received assistance.

2.3. Capacity and Effectiveness

Although nine types of committees have been formed at different levels, there is a noticeable deficit in the functioning of these committees. The first meeting of the National Advisory Committee was held on 3 March where it discussed only dengue issues, and no information is available on following meetings. The committee chairman informed that he was not aware of many decisions (for instance opening and closing of garments industries, entrance in Dhaka). The preparatory meetings at district and upazila levels were not held even in the first week of March. Although the meeting of the advisory committee is regular, it is up to the bureaucrats to take decisions on various important issues (shopping mall / garment game, withdrawal of lockdown).

Despite the expansion of testing facilities, Bangladesh has the lowest number of tests in South Asia, which does not provide a clear picture of the spread. In terms of testing Bangladesh is 149th among all countries. Although Bangladesh is claimed to be the equivalent of a developed country with regard to healthcare services, it lags far behind in terms of examination rate.

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of population are tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maldives</td>
<td>5.36</td>
</tr>
<tr>
<td>Bhutan</td>
<td>2.66</td>
</tr>
<tr>
<td>Nepal</td>
<td>1.01</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>0.38</td>
</tr>
<tr>
<td>India</td>
<td>0.39</td>
</tr>
<tr>
<td>Pakistan</td>
<td>0.37</td>
</tr>
</tbody>
</table>
This is largely due to the lack of laboratory capacity, which have not been increased despite huge demands – only 500 thousand tests were done against 101 million phone calls in the hotline (up to 31 May). About 57% of the hospitals included in the study were able to carry out tests less than the demand. As the number of laboratories in Bangladesh increased, most of them are Dhaka-based – 27 out of 60 laboratories are located in Dhaka city. At present there are testing facilities in 21 districts, which results in the delay of 2 to 8 days in receipt of test report. Moreover, all the laboratories cannot keep up with the pace continuously.

The optimum utilization of laboratory capacity is not done. An average of 13695 samples were tested in the last 14 days although 24,000 test capabilities in three shifts a day was possible with almost 85 PCR machines in 60 laboratories. The recruitment of medical technologists has been stopped due to a lawsuit. Although the private sector has the capacity of manpower and equipment, it is not being fully utilized – only 15,000 samples were tested with ICDDR,8 till May 31, although it had the capacity to conduct 42000 tests in 60 days (since March 30). There is a lack of skilled manpower for collecting sample and running PCR machines. In many cases the samples become unusable due to the collection of samples by other health workers. Different kinds of harassments in corona virus tests take place due to lack of laboratory and mismanagement. These include contacting the hotline more than once, selection for the test by listening to the symptoms, samples collected late, lack of information on where samples are taken directly, false test report due to weakness and lack of skill, delay up to 8 days to get report, and keeping patients in isolation with corona positive.

Lack of capacity in healthcare system is another limitation. Although it was claimed by the Department of Health that all preparation were there to tackle corona virus, it was found that the hospitals included in the study were underprepared, as different limitations existed. Among these hospitals, 74.5% lacked skilled human resource, 59.6% lacked adequate tools and machines, 51% had low quality protective measures, 51% lacked specialist doctors, and 36.2% lacked protective measures.
Lack of capacity with regard to medical supplies and instruments are also grave. According to expert opinion the ratio of beds in government hospitals the number of ICUs and ventilators are to be 3,500. At present, in against of DGHS claimings of having 399 ICUs, there are merely 140 functional ICUs for covid patients all over the country. As of 26 March, the government claimed that they had 500 ventilators, whereas there were only 29 ventilators in 5 dedicated covid hospitals in the capital. At present, there are only 1,267 ventilators in government and private hospitals across the country. Of these, only 190 ventilators have been allocated for the treatment of corona, of which 79 are in Dhaka and 111 in other district towns.

Hospitals designated for the treatment of covid patients have deficiencies in central oxygen systems and oxygen cylinders, monitors, pulse oximeters, defibrillators, ECG machines, portable ventilators, ACs, dehumidifiers, etc. Some hospitals do not have trained doctors or nurses to manage ICU beds or care for the sick. The required number of doctors and other health workers have not been added in the dedicated hospitals. According to a research report by Imperial College of London, about 20,000 high-pressure oxygen-rich beds and 5,254 ICU beds with ventilators will be needed by June. Due to the lack of human resource and medical instruments, 53% of the hospitals under this study suffered in providing services to non-COVID patients, while in 71% of the hospitals treatment of covid patients are disrupted due to low quality protective gears.

The government claimed to have distributed 2.3 million PPEs across the country till 14 Jun, according to which each of the 75,000 health workers was supposed to receive at least 30 sets of PPE, but many health workers still have not received a single PPE complained. All physicians of 25% hospitals and nurses and other workers of 34% hospitals informed not having received any PPE. Till 14 June, the number of doctors infected of coronavirus was 1190 of which 38 died. As of 14 June, the number of nurses infected was 1102, while 7 died. Among the hospitals included in this study, 64.4% informed that the protective gears supplied to them do not match the standard set by WHO.
Medical waste disposal is another issue of worry. Only 49% of the hospitals reported to burn the waste created due to corona virus treatment, while most of the rest is either thrown away or collected by the concerned city corporation / municipality. The fact is the there is no facility of medical waste management other than four city corporations. The corona virus generates 14,500 tons of infectious medical waste used by health workers and the public. Moreover, health workers lack training on disposing PPE, and disinfection after use.

Restricting the spread of infection at the community level was also poorly done. Only one of the seven thermal archway scanners used at Hazrat Shahjalal International Airport was operational. Initially the Ashkona Hajj Camp was used for quarantine for returning Bangladeshis – a number of 312 Bangladeshis returning from Wuhan, China were kept there for 14 days, and later 164 who returned from Italy. But due to various mismanagement, they were released the next day on their own responsibility. Advice was given to returning passengers for home quarantine, but there was no follow up. Only 8% of returning passengers were at home quarantine during 18 February – 18 March.

There was also failure to ensure social distance among common people due to lack of strict implementation. There was lack of enforcement and misinformation by the government – on one hand it called for maintaining isolation, while public transport, factories, shopping malls were opened on the other hand. A general leave (lockdown) was declared without stopping public transport, as a result of which more than 10 million people left Dhaka and spread all over the country. The overall lockdown became ineffective due to re-opening of garments and mosques on 26 April, and shops and markets on 10 May. Social distance was not taken into account in most of relief distributions.
2.4. Coordination and Participation
The Ministry of Health’s internal coordination seemed to be poor. Although The Disaster Management Act, 2012 provides for the formation of a National Disaster Management Council headed by the Honourable Prime Minister, it was not formally constituted. Here, the Prime Minister herself is giving directions. The key to tackle corona virus is medical management. However, there is no medical expert in the top policy-making position in the field of management. There are more than one instances of issuing circulars on doctors’ responsibilities and withdrawal. There is also an example of providing different information by the Minister and the Department of Health. There are instances of indecisions with regard to engaging Dhaka Medical College Hospital and Suhrawardy Hospital in providing corona treatment.

Lack of inter-ministerial coordination was also evident. Although the Ministries of Health, Home Affairs, Public Administration, Communications, Commerce, and Disaster and Relief are expected to play important roles in implementing various government initiatives to combat the coronavirus, there was a lack of coordination between them and the Ministry of Health. The declaration of general holidays without stopping public transport is an example of lack of coordination between the Ministry of Health and the Ministry of Communication. The Chair of the National Committee who is the Minister of Health complained of taking important decisions without informing him. The Inspector General of Police (IGP) was not included in the National Committee formed on March 1, but he was later included.

There was also failure to ensure participation of the private sector. No specific guideline was formulated for 69 medical college hospitals and about 5,000 private hospitals and clinics in Bangladesh, and there was no initiative for coordination. Although the Private Medical College Association claimed to have prepared themselves for providing treatment for corona virus on 9 April, most of the hospitals failed to realise this claim. They closed down other medical services which caused huge number of deaths and sufferings to the people. The Ministry of Health also failed to monitor the private hospitals although it directed them more than once to provide regular services. Due to the tendency of centralized decision-making and keeping under the control of Health Ministry, a number of private sector initiatives either did not see the light of the day or was delayed (for instance setting hospital by Akij Group, approval of test kit by Gonosasthya). On the other hand, in some cases quick decisions were given (in case of hospital by Basundhara, approval of the use of Remdisivir). Distribution of relief at the local level also suffered due to lack of coordination.

2.5. Transparency
Lack of transparency has been observed in dealing with the COVID-19 crisis. Restrictions under the Digital Security Act 2018 were imposed on all health workers, including all physicians under the Ministry of Health for the disclosure of any statement or opinion in public, in the newspaper or in any other media without the permission of the higher authorities. Sixty-seven cases were filed against 37 journalists for disseminating news of theft and embezzlement in relief distribution in different parts of the country. A surveillance cell was formed by the Ministry of Information to monitor 30 private television channels of the country to prevent propaganda/rumour. Although the decision was later withdrawn, the surveillance continued.

Information of all the deaths from the corona virus is not available, as information of people who did not test, or did not report the death to the authorities in the home quarantine are not included in the official data. There are doubts and distrust among the common people about the official account of the death toll. Moreover, there are allegations of not disclosing all data such as the number of ICUs, ventilators, number of hospitalization etc.

2.6. Irregularities and Corruption
The designated hospitals are accused of negligence in providing services to corona patients. These include not providing treatments, physicians and nurses not going near patients, health workers leaving food packets outside the door, patient’s room not cleaned, oxygen supply not provided in
time, keeping both men and women in the same isolation room. Such negligence was found in 23.1% of the hospitals included in the study.

Corruption is evident at different levels.

<table>
<thead>
<tr>
<th>Types of corruption and irregularities (% of hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply of low quality ppe</td>
</tr>
<tr>
<td>Negligence of safety measures</td>
</tr>
<tr>
<td>Negligence of duty</td>
</tr>
<tr>
<td>Unequal distribution of duty roster</td>
</tr>
<tr>
<td>Absenteeism</td>
</tr>
<tr>
<td>No distribution of ppe in spite of stock</td>
</tr>
<tr>
<td>Unequal distribution of ppe</td>
</tr>
<tr>
<td>Others</td>
</tr>
<tr>
<td>No corruption</td>
</tr>
</tbody>
</table>

A section of unscrupulous staff in private laboratories collects Tk 1,000-1,500 more than the fee fixed by the government. The serial for testing is often sold and certificates stating ‘free of corona’ are sold by some middlemen.

There are corruption in the purchase of medical supplies. There is a lack of transparency in the procurement process as except for a few senior officials no one else knows anything. There is excessive control of all kinds of procurement in the name of different firms by a syndicate, and there are allegations of involvement of some officials of the Ministry of Health. Costs were not mentioned even in the written work orders. As a result protection materials were supplied with a much higher cost. IEDCR complained on the supply of expired vacuum tubes and disposable syringes for blood test, polythene and testing. Old model PCR machines have been purchased. Although some hospitals initially refused, later they were forced to accept. The demand for new PCR machines was raised despite there were unused machines. Some existing facilities could not be used properly due to corruption in the health sector – 16 ventilators in Faridpur Medical College remained unused for 5 years due to ongoing corruption cases. Similar allegation was made in Chittagong Medical College Hospital. Despite the plan to import ventilators was made with the help of World Bank, it was not possible to issue the work order in 12 weeks due to lack of transparency and alleged corruption in the procurement process.

There were allegations of giving partisan political considerations in preparing the list of beneficiaries for relief in 82% of the areas included in the survey. In all the areas allegation of corruption was raised in distributing the cash support for the ultra poor (Tk 2,500). Affluent close relatives of the public representatives were allegedly included in the list, and one telephone number was used for more than 200 beneficiaries. Social distance during relief distribution was not maintained in 98% cases in the survey areas, and no list was followed in 42% cases.

<table>
<thead>
<tr>
<th>Type of problems in enlisting</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political consideration in enlistment</td>
<td>81.4</td>
</tr>
<tr>
<td>Not having NID</td>
<td>67.4</td>
</tr>
<tr>
<td>Not in permanent address</td>
<td>48.8</td>
</tr>
<tr>
<td>Not paying illegal moneys</td>
<td>7.9</td>
</tr>
<tr>
<td>Nepotism</td>
<td>23.3</td>
</tr>
<tr>
<td>Not facing problems</td>
<td>2.3</td>
</tr>
</tbody>
</table>
A number of 218 incidents of corruption with regard to relief distribution were reported in the media up to 10 June 2020, where elected representatives (30%), local political leaders (24%), dealers (17%) and business people (14%) were involved. A total amount of 4,59,870 kilograms of rice, 30,855 kilograms of sugar, and over 8,000 litres of soybean oil was recovered in these incidents. So far 89 local government representatives (29 UP Chairmen, 54 UP Members, 1 Zilla Parishad member, 4 municipality councillor, 1 Upazila Vice Chair) have been terminated temporarily, and cases have been filed.

2.7. Accountability
Accountability has not been ensured with regard to the failure to properly control inter-district traffic and prevent the spread of the virus across the country. No one was held accountable for not expanding laboratory testing facilities at an early stage despite the opportunity and instructions. No action has been taken against the private medical institutions for not taking part in the drive. No action has been taken against the concerned suppliers in the case of corruption in the purchase of N-95 masks. The officials and employees concerned have not been held accountable, and even the investigation report has not been published, rather actions (transfer, show cause notice, OSD) were taken against four doctors raising questions on the quality of masks and protective gears. It is clear that the limited steps that have been taken are in many cases ‘eye-wash’ (immediate dismissal of 6 doctors of Kuwait Friendship Hospital without due process), and lacked continuity. In some stances steps can be identified as incentives (promotion of recently transferred former Health Secretary). The opportunity of raising questions by journalists at press briefings were also stopped.

On the occasion of corona virus epidemic, artificial crisis has been created for a number of medicines related to reducing fever and treating colds, and the price became much higher. The service charges were increased manifold by many private hospitals. Even the fair of buses for public transport was officially increased at 60%, which is actually collected more than double from the passengers. However, no concerned authority has been able to take the perpetrators under accountability.

3. Overall Observations
It is observed that there are deficiencies in every indicator of good governance in dealing with the corona epidemic. Lack of planning and coordination in various activities adopted by the government is clearly noticeable. The weak capacity of health sector as a result of long-term lack of planning, lack of good governance and lack of capacity has become wide open during the crisis.

The government failed to take adequate preparations even after getting three months time. On the one hand, failure to identify and control the influx of coronaviruses due to lack of coordination and mismanagement, while on the other hand, keeping large numbers of people out of the test without expanding the laboratory despite the opportunity, and the spread of the infection due to not strictly team-breaking put the country in a catastrophic situation. There has been a tendency to make bureaucratic decisions by ignoring specific opinions in all cases, including lockdows. The private sector has not been allowed to participate properly despite the opportunity, only to control corona testing and medical treatment alone. Due to lack of widespread social participation and proper information dissemination, the government failed to create public awareness which made the lockdown ineffective.

Health workers’ health risks and crisis in medical management increased due to irresponsibility and corruption in the supply of unhealthy protection materials. The actual beneficiaries were deprived due to lack of coordination. On one hand the business-friendly and loan-based incentives, and financial support for the extremely poor is insufficient on the other hand, and the opportunity for debt defaulters to receive incentives – all these make reaching these incentives the least possible to reach the common people.
Finally, the tendency to cover up irregularities, corruption and mismanagement through restrictions on disclosure of information and to bring the whistle-blower to accountability, in a way encourage corruption in various ways.

4. Recommendations
1. The facility of sample testing through proper use of existing equipment and manpower at government and private levels must be expanded to district level. The number of tests needs to be increased through the maximum use of existing capacity.
2. The decision to revoke the lockdown in the event of an increasing infection rate and death of the current Corona virus needs to be reconsidered. Area-wise risks need to be considered in terms of the prevalence of infection through the formulation of logical and precise plans for the withdrawal of lockdowns, and the expansion of testing.
3. Coordination between different ministries and government departments needs to be increased to deal with the corona virus.
4. In order to increase the overall capacity of the health sector at the district level, the allocation in the national budget should be increased (5% of GDP), and the quality of expenditure in the health sector should be ensured.
5. In order to prevent irregularities and corruption in the procurement of health sector, accountability must be ensured and exemplary punishment must be provided.
6. Screening and triage management at all levels of hospitals must be ensured. Adequate supply of quality safety equipment should be ensured for all levels of front line health workers.
7. In the need for integrated treatment, coronavirus treatment should be ensured in all private hospitals by including private hospitals under government rules.
8. All hospitals need to ensure regular medical care for the treatment of corona as well as other ailments. Strict punishment should be provided in case of refusing treatment of critically ill patients.
9. Proper management of medical equipment including used safety equipment should be ensured.
10. Financial assistance should be provided for the very poor, informal sector workers, and day labourers. The current agricultural loans should be waived.
11. The list of relief and social security beneficiaries needs to be updated. The list of beneficiaries of relief or cash assistance must be published on the website.
12. Participation of non-government organizations must be ensured to help the marginalized and backward communities across the country.
13. In order to successfully implement the hygiene rules, it is necessary to take initiative to distribute free masks and sanitizers among the low income groups.
14. Free flow of information must be ensured in order to facilitate the disclosure of information and access to information and to ensure the rights and accountability of the management.
15. The people’s representatives who have been suspended for their involvement in corruption should be given strict exemplary punishment.