PRESSEERLÄRUNG

AMNESTY INTERNATIONAL

6. APRIL 2020

PROTECT HUMAN RIGHTS DURING THE PANDEMIC

Bangladesh

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In a situation where the COVID-19 virus has overwhelmed some of the world's best-resourced healthcare systems, Bangladesh—like other developing countries—must brace for the worst. Any hopes that the country may somehow avoid the crisis have been dispelled by the confirmation of 70 cases and eight deaths. One report written by Bangladeshi epidemiologists and public health academics estimates that half the country could ultimately be infected, and the final death toll could rise to as high as half a million. As leaders around the world are discovering, their quick and timely response to this crisis is crucial, and given people's lives and healthcare are at stake, it's all the more important that human rights are at the centre of the response.

Everyone has the right to "the highest standards of physical and mental health," as guaranteed by the International Covenant on Economic, Social and Cultural Rights, to which Bangladesh is a state party. The state's obligations include efforts to prevent, treat and control the effects of the COVID-19 pandemic in the country.

While there was initially only one testing centre in Bangladesh, there are now finally nine Polymerase Chain Reaction (PCR) laboratories in Dhaka and another five outside of the city.

From late January until April 2, around 1,900 people have been tested, which amounts to approximately 11 people per million. There have been reports of many people who said they are showing symptoms and wanted to test but were not allowed to do so. More recently, private donors have donated testing kits and masks to Bangladesh (for example, The Jack Ma Foundation has dispatched 30,000 testing kits and 300,000 masks), which while positive, won't make up for Bangladesh's shortfall.

There are similar shortages in personal protective equipment (PPE), increasing the hazards faced by health workers on the frontlines of this crisis. While some of the wealthiest countries are also facing shortages, the situation in Bangladesh is especially dire. Health workers have no choice but to risk their health and lives, and those of their families, to save others. At Sir Salimullah Medical College and Mitford Hospital in Dhaka, medical staff were blithely told to buy their own facemasks. In Sylhet, the staff at one hospital went on strike because of the lack of PPE. At least 10 physicians have self-isolated after exhibiting symptoms associated with COVID-19. Two teachers, who decried the shortage of PPE in Facebook posts, have

been suspended by the government in a further assault on freedom of expression online. It eventually fell to the High Court to order the government to acquire and provide PPE.

Last week, Cox's Bazar reported its first case, raising fears for over a million Rohingyas who languish in flimsy tents tightly squeezed together across the refugee settlements. In the camps, sanitation is a constant challenge, health facilities are rare, and emergency facilities can be non-existent. The only way to protect the refugees is to relocate them to areas where social distancing is possible, where water, soap and sanitisers are in inadequate supply, and with suitable medical facilities nearby. However, any relocation and redesign of camps must be done after ensuring meaningful participation of those affected.

In recent weeks, Rohingya refugees have been startled by rumours that they could be put to death if they contract the virus. Or they worry they have been stigmatised as carriers of it. In this crisis, the authorities have a responsibility to provide accessible, accurate, evidence-based information that counters this sinister misinformation campaign. Instead, a telecommunications blackout still hangs over the area.

There are an estimated two million people living in 14,000 slums across Bangladesh who have similar reasons to be fearful. According to one study, more than 40 per cent of slum dwellers have no choice but to use unhygienic and unsafe toilets. Many also lack access to sufficient and safe water that is essential for protection against COVID-19. The informal settlements are home to many low-wage garment workers, street vendors and rickshaw-pullers on daily wages whose livelihoods are imperilled by the current crisis. Because of their inability to make ends meet during the lockdown and access affordable and timely healthcare, they are at high risk of both infection and starvation—harrowing prospects that neither the government's public health nor economic response appears prepared for.

Bangladesh has the most crowded prisons anywhere in South Asia. On average, there are more than twice as many prisoners as detention facilities. There is only one doctor for every 10,000 prisoners. The authorities have taken the welcome step of releasing the leader of the opposition for six months, but they are yet to implement measures that several other South Asian states have taken to reduce overcrowding. About 70 per cent of the country's prison population is still awaiting trial (pre-trial detention is meant to be used as a restrictive measure of last resort) and there should be a presumption of release in such cases. They should also consider early or conditional release for those most vulnerable to the infection, including older detainees, or those who have already served a portion of their prison sentence and those who qualify for early parole, if they no longer pose a threat to public safety. Prisoners who remain in detention must also have access to the same standards of health care that are available in the community, including when it comes to testing, prevention and treatment of COVID-19.

We don't know what the true impact of the COVID-19 crisis will be. What we do know, however, is that the wealthiest countries are struggling to cope. For Bangladesh, which has neither the economic means nor the public health resources needed, there is even less room for failure. This makes it all the more important that its response protects everyone, including those who are at the greatest risk.