Letters to Editor

In the second phase, the average increment in infected cases was 7.17% everyday, with a doubling period of 10.0 days (cases increased from 11933 to 40263) [Figure 2a]. The average increment in mortality was 7.15% per day (ranging from 2.86% to 12.96%). Total 9543 infected cases were recovered, with an average increment of 12.44% per day [Figure 2c].

In the subsequent phase, the average increment in infected cases was approximately 6% per day, with a doubling period of 12 days. Total 1483 patients died, with an average increment rate of 5.82% per day (ranging from 3.9% to 14.0%). Total 22,347 infected cases were recovered, with an average rate of 8.51% per day.

In the last phase, the average increment in infected cases was 5.09% per day, with a doubling period of 14.17 days. The increment in mortality cases was ranging from 3.63% to 5.63% (average increment: 4.28% per day). Total 50,160 infected patients were recovered, with an average rate of 6.95% per day [Figure 2].

Overall, the lockdown strategies seem successful in reducing the transmission of COVID-19 infection in India. The proportion of the young age population (65% below 35 years of age) along with the mitigation strategies had definitely made a negative impact on the transmission.

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Conflicts of interest

There are no conflicts of interest.

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Rigorizing COVID‑19 Blind‑Spotting for Competent Political Leadership and Public Health Cognizance

Sir,

The Multidisciplinary American College of Academic International Medicine World Academic Council of Emergency Medicine Multidisciplinary (ACAIM-WACEM) COVID-19 Consensus Group have synthesized and summarized complex pharmaceutical, economic, and public
threats brought about by COVID-19 using a 14-point list of “blind spots.” The consensus paper posits how ulterior political motives can skew and effectively, blindside the dissemination of evidence-based medical knowledge. Yet, the list of recommendations can be enhanced for policy-making audiences through improved focus and operational refinement of these themes.

First, the “blind spots” appear somewhat arbitrary but could be improved by rearranging them and grouping them by target demographic. For example, generalizing the “scientific community” can be challenging when research and development are being undertaken from the level of private vaccine companies to livestock cultivators. Instead, specific policy directives for corporations, educational institutions, and independent groups could be useful.

Second, the element of surprise during the first wave spotlighted the holes in the current public health system preparedness and resilience. It may be rational to ground these recommendations in a re-examination of existing pandemic protocols and standards under the International Health Regulations (2005) set by the World Health Organization. If the blind spots can be matched with the standards-in-place, it allows governing bodies to translate and transfer updatable points as they prepare for subsequent waves.

Finally, it might be valuable to bring up some solutions that are not commonly seen in mainstream media. For instance, Blind Spot number three (Ignoring simple and effective nonpharmacological measures) is especially pertinent but the emphasis on social distancing and contact tracing has vastly undercut messaging toward perhaps equally useful preventative strategies such as exercise. The effects of exercise on COVID-19 have been proven to improve the immune function and prevent infection.

To conclude, pitfalls exist in using nonspecific language, using context-devoid regulations, and neglect of deceptively obvious messaging. Nevertheless, the value of blind-spotting remains incredibly useful, especially when so many of these considerations remain out of sight.

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