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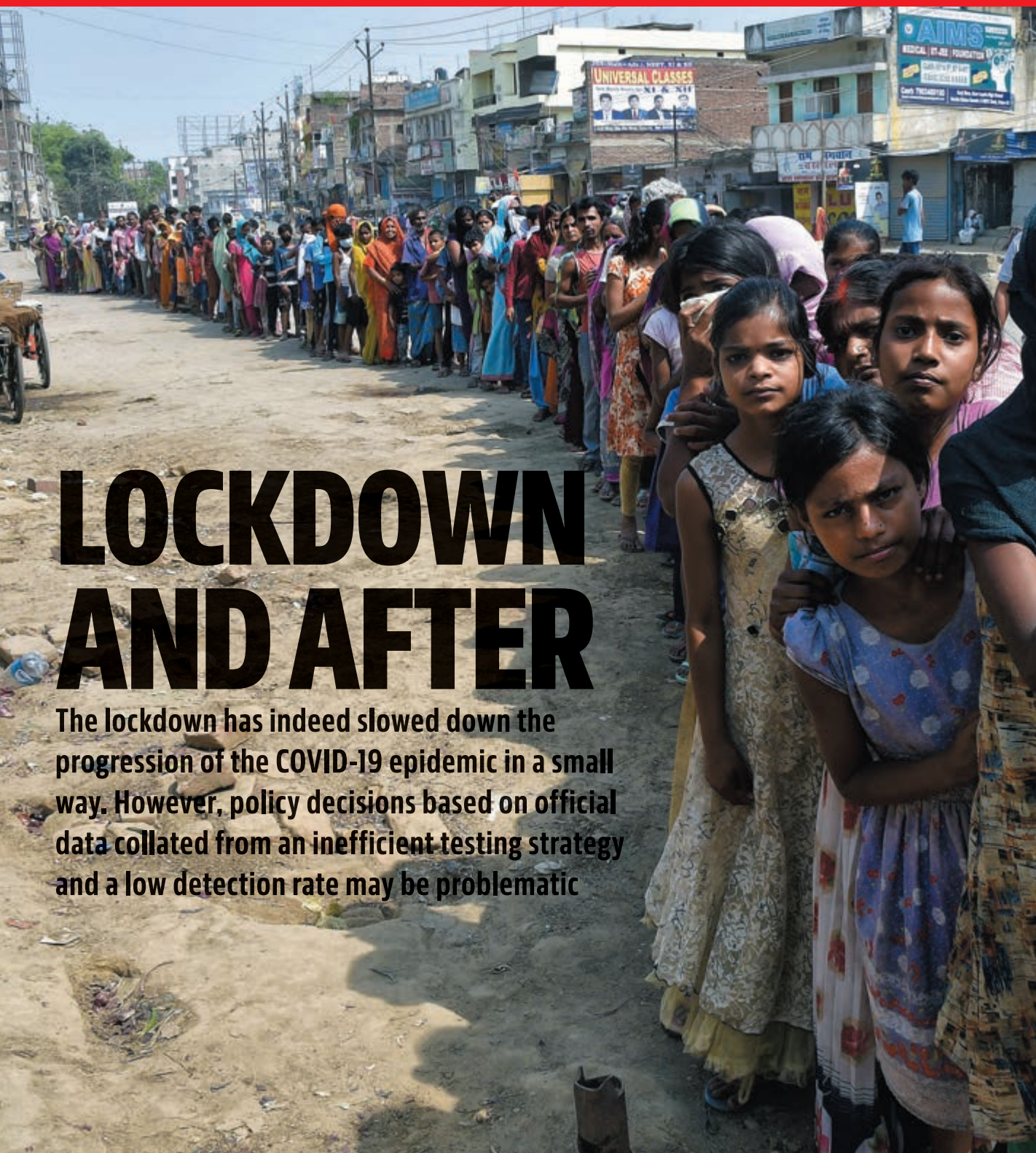

LOCKDOWN AND AFTER

The lockdown has indeed slowed down the progression of the COVID-19 epidemic in a small way. However, policy decisions based on official data collated from an inefficient testing strategy and a low detection rate may be problematic

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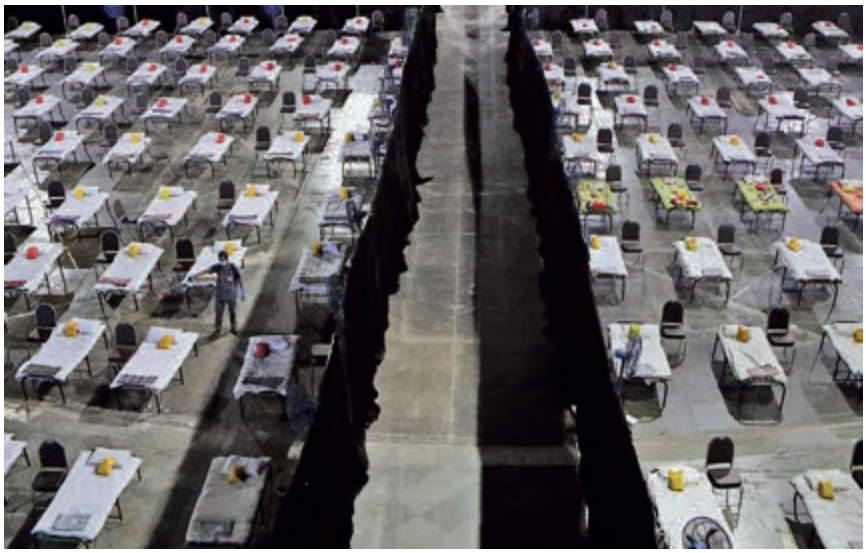
COVER STORY

Lockdown and after

In India, decisions on strategies to contain COVID-19 are being made on the basis of unreliable data, but two things are clear: the number of infections is still on the rise and once the lockdown is lifted there will be a resurgence of cases. **4**



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On the Cover

The long wait for food during the lockdown, in Patna on April 15.

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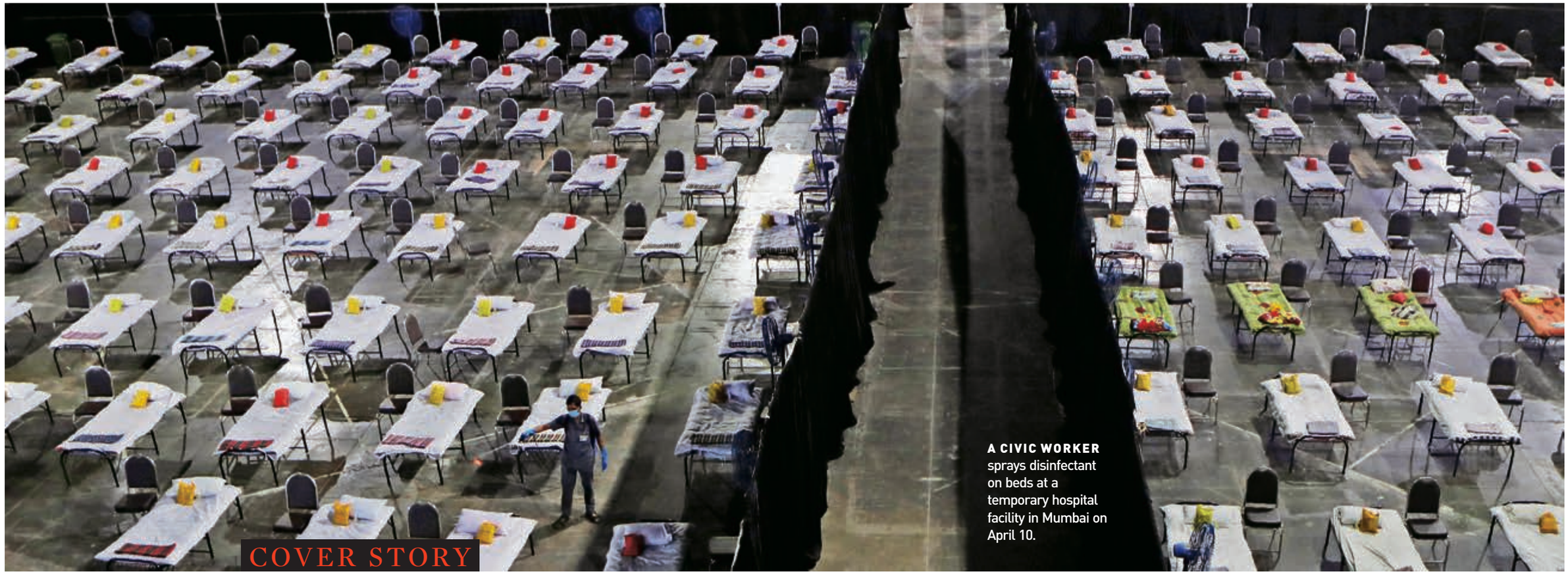


A CIVIC WORKER sprays disinfectant on beds at a temporary hospital facility in Mumbai on April 10.

RAJANISH KAKADE/AP

LOCKDOWN AND AFTER

In India, decisions on strategies to contain COVID-19 are being made on the basis of unreliable data, but two things are clear: the number of infections is still on the rise and once the lockdown is lifted there will be a resurgence of cases. The government needs to come up with a calibrated approach to manage both in the post-lockdown period.

BY **R. RAMACHANDRAN**

AT THE END OF THE FIRST WEEK INTO THE second phase of the country's extended lockdown (April 21), the number of confirmed COVID-19 cases, the number of those recovered and the number of deaths stood at 18,601 (14,759 active), 3,252 and 590 respectively.

The rates of increase both in the number of confirmed cases and in the number of deaths (in percentage terms) have come down to single digits (Figures 1 and 2). The plots in Figure 2, which is on a logarithmic scale (with each unit on the y-axis increasing by a factor of 10), are linearly increasing, which is what they would look like if the number of cases (and correspondingly the number of deaths) are still on an exponentially increasing curve.

The two phases of lockdown have certainly achieved their objective of slowing down the transmission of the infection in the population. This, as mentioned above, is also evident from the fact that the rate of increase in the number of infections has been coming down since the lockdown began. In the second phase, in fact, it has come down from a 10-15 per cent rate of increase to under 10 per cent, a little flattening of the curve. That this should happen is intuitively obvious when physical distancing between people and person-to-person contacts are minimised; the chance of one individual passing the infection to another has been greatly reduced.

But the growth factor (the ratio of the changes in the number of confirmed cases between two consecutive days), that is, the slope of the curve, is still consistently above 1, which means that the curve of infections is still exponentially increasing, though a little slower than before the lockdown, and the country is still far from peaking and then declining. Only when the slope stays around 1 for some days can one say that the curve has hit the inflection point from where the slope will become less than 1; the peak number can be expected to be around twice the number of infections at the inflection point.

DOUBLING TIME

Another way of looking at the progression of the epidemic in India is the so-called doubling time: the number of days it takes for the number of infections on a given day to double itself. It is this metric that the government is using to show the efficacy of the lockdown. In its press update of April 20, the Health Ministry said: "The doubling rate of COVID-19 cases calculated using growth over the past seven days indicates that India's doubling rate for the week before lockdown [March 18-24] was 3.4 and has improved to 7.5 as on 19th April, 2020 (for the last seven days)."

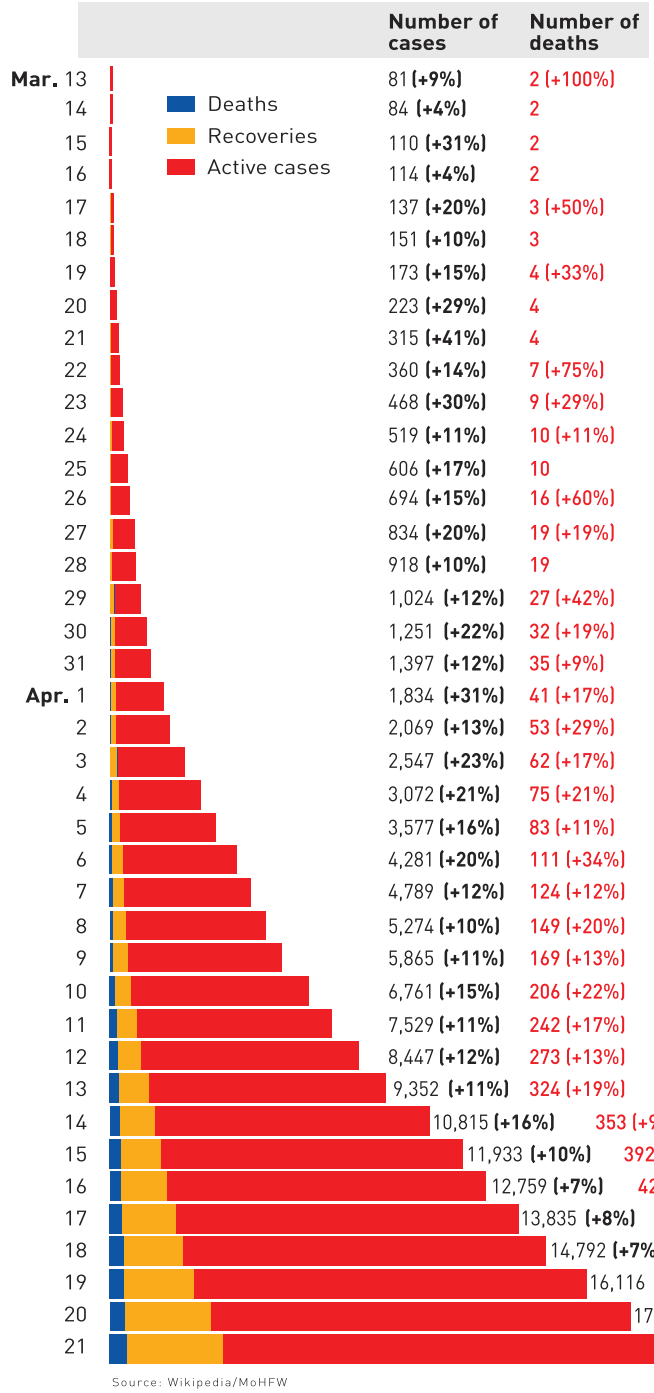
This is not surprising because, as pointed out above, if you cut off nearly all possibilities of transmission of infection by totally switching off social/societal interactions, this will naturally happen.

At the State level, however, there is a wide dispersion in doubling times as is evident from the Ministry's April

19 data (see table). The Chennai-based National Institute of Epidemiology has on its website presented a nice way of looking at this with data for eight representative States: Andhra Pradesh, Delhi, Kerala, Maharashtra, Rajasthan, Tamil Nadu and Telangana (Figure 3; unfortunately, this graph has not been updated with latest data, and the plots are only up to a few days before April 19).

The growth has been plotted beginning with the (normalised) day "zero" for these States, which is when the number of confirmed cases crossed 50. For comparison, plots of growth with doubling times of three and five days have also been given in the same graph. As can be seen, except for Kerala (which is clearly an outlier in this set), although most of them were curving towards the five-day doubling curve, some slower than the others, there are problematic States such as Maharashtra and Delhi. When this plot is combined with the Ministry data, it is clear that if States such as Delhi, Rajasthan and Tamil Nadu have managed to improve their doubling times—that is, their plots have gone below the five-day doubling curve—this has happened only in the last few days.

COVID-19 cases in India FIGURE 1



	Number of cases	Number of deaths
Mar. 13	81 (+9%)	2 (+100%)
14	84 (+4%)	2
15	110 (+31%)	2
16	114 (+4%)	2
17	137 (+20%)	3 (+50%)
18	151 (+10%)	3
19	173 (+15%)	4 (+33%)
20	223 (+29%)	4
21	315 (+41%)	4
22	360 (+14%)	7 (+75%)
23	468 (+30%)	9 (+29%)
24	519 (+11%)	10 (+11%)
25	606 (+17%)	10
26	694 (+15%)	16 (+60%)
27	834 (+20%)	19 (+19%)
28	918 (+10%)	19
29	1,024 (+12%)	27 (+42%)
30	1,251 (+22%)	32 (+19%)
31	1,397 (+12%)	35 (+9%)
Apr. 1	1,834 (+31%)	41 (+17%)
2	2,069 (+13%)	53 (+29%)
3	2,547 (+23%)	62 (+17%)
4	3,072 (+21%)	75 (+21%)
5	3,577 (+16%)	83 (+11%)
6	4,281 (+20%)	111 (+34%)
7	4,789 (+12%)	124 (+12%)
8	5,274 (+10%)	149 (+20%)
9	5,865 (+11%)	169 (+13%)
10	6,761 (+15%)	206 (+22%)
11	7,529 (+11%)	242 (+17%)
12	8,447 (+12%)	273 (+13%)
13	9,352 (+11%)	324 (+19%)
14	10,815 (+16%)	353 (+9%)
15	11,933 (+10%)	392 (+11%)
16	12,759 (+7%)	420 (+7%)
17	13,835 (+8%)	452 (+8%)
18	14,792 (+7%)	488 (+8%)
19	16,116 (+9%)	519 (+6%)
20	17,656 (+10%)	559 (+8%)
21	18,985 (+8%)	603 (+8%)

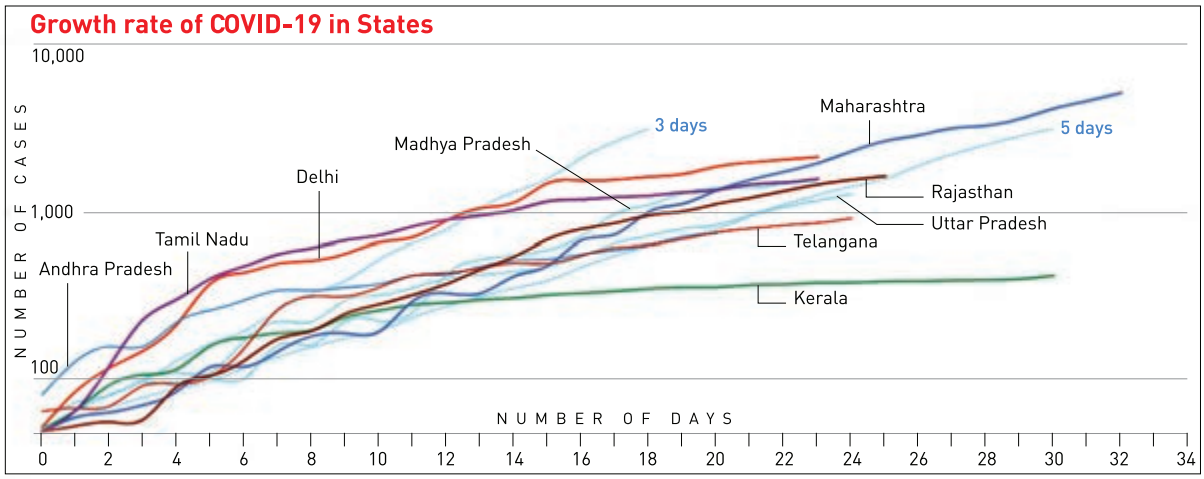
Source: Wikipedia/MoHFW

The important question at this juncture, however, is, What is the planned strategy of exit on May 3 when the second phase of lockdown ends? But before one addresses that question, one has to keep in mind an important caveat while interpreting all the data above and in the accompanying graphs. The caveat is that all the official data about doubling times, and so on, should be taken with a huge dose of salt because it is well known that the surveillance and testing strategy in India has been grossly inadequate. According to model estimates (see separate story), the infection detection rate in India is only about 2 per cent, though it is improving slowly (Figure 4) with the adoption of the newly broadened criteria and the ongoing efforts at widespread deployment of rapid sero-testing kits (notwithstanding reported proneness to error).

So, what is the sanctity or even remote accuracy of the baseline caseload data from which doubling times are being calculated? For example, many of the cases that get picked up on a given date could actually not be new cases at all; they could be old (probably a few days into the incubation period or subclinical/mild and asymptomatic) cases that were not picked up earlier—because of the inefficient testing strategy and very low detection rate—and are now being detected either by chance or because of the gradually improving detection rate. Unfortunately, all policy decisions, including strategies such as lockdowns to contain the spread of infection, are based on such extremely unreliable and inaccurate data; thousands of undetected and mild/asymptomatic cases are probably spreading the infection without the virus carriers actually aware that they are infectious.

When Dr T. Jacob John, the well-known virologist formerly with the Christian Medical College (CMC), Vellore, was asked what he thought the impact of the lockdown was, he said in an email response: "Lockdown has two parameters. Lockdown will flatten the curve; that is for sure, knowing epidemiology. [But] first, what you call lockdown, was it truly lockdown or lockdown in name, too many leaks and not truly lockdown but partial lockdown. Second, how exactly can we measure flattening of the curve? I haven't heard of an *a priori* method defined/designed to monitor flattening of the slope. So, we don't have good evidence for either, not because they are ineffect-

FIGURE 3



Number of days since the 50th confirmed case

SOURCE: MOHFW

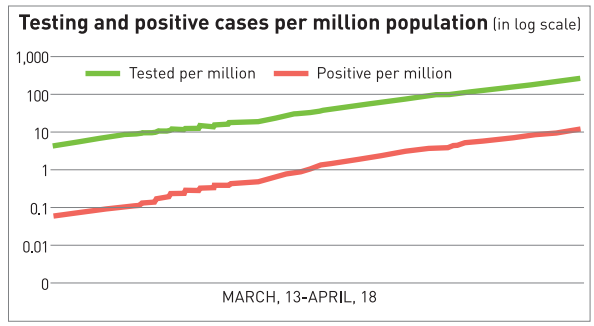
ive, but we don't have criteria to measure.... Our daily counts are not any sign of "flat curve" except in Kerala (well managed) and in Goa (well managed and some luck too, I suspect). Whatever happened till two weeks under lockdown, I will assign to infections occurring before lockdown; after that, infections [occurred] under lockdown. So, yes, some speed acceleration should be expected."

Returning to the question about the post-May 3 strategy, extension of the lockdown is not a viable solution, according to Dr Jayaprakash Muliyil, an epidemiologist also from the CMC: "The virus is out there; you cannot stop it. Studies have shown that subclinical infections are as high as 50-80 per cent of the total infections, many of which go undetected. So, the question of containing the virus does not arise. You cannot keep the country under lockdown for a year or more till a vaccine is developed. The social and economic costs of that would be a disaster for the country."

"The only solution to get rid of the virus," Dr Muliyil said, "is by achieving a certain level of herd immunity. Roughly 60 per cent of the population needs to get infected to achieve that. This is what happened with the other pandemic, H1N1. When you lift the lockdown, there will be resurgence [of infections] because the virus is there and because of the lockdown a large number are still susceptible [to the virus]. The population will get infected."

When he was asked about the consequent mortality in the population that this would lead to, Dr Muliyil said:

FIGURE 4



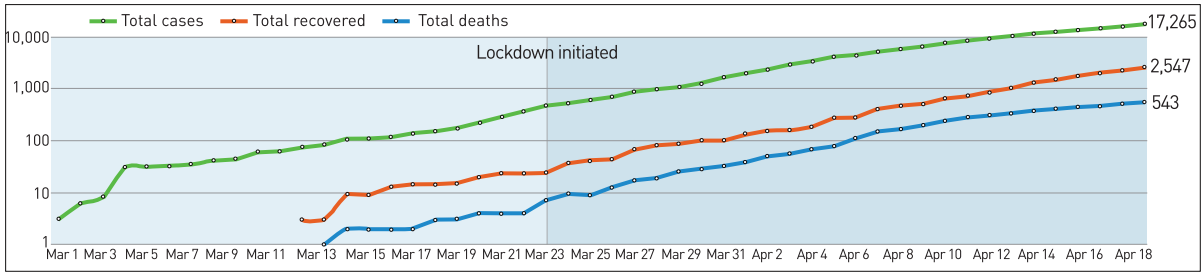
Population reference-1,380 million (projected)

Source: MOHFW, GOI.

"Fortunately, the virus seems to affect only the elderly, above the age of 60, severely. So, you have to ensure that the elderly are well protected. You don't have to cut them off entirely, and the burden of securing herd immunity should be taken by the young. It may be a tough ask, but there is no other alternative. We have a demographic advantage there. Only about 10-15 per cent are old requiring to be protected from the virus unlike in Europe. You let the young go about their normal work—but, of course, following all the safe health practices like social distancing, washing hands, etc.—they will get infected but most of them will come out of it unscathed. A small fraction of the young may require hospitalisation, and some requiring ICU [intensive care unit] facilities. Hopefully, the country is now prepared after the lockdown to extend proper health care to this younger lot who may get affected severely. With this strategy, herd im-

Cumulative COVID-19 cases discharges and deaths in India

FIGURE 2



> "The only solution to get rid of the virus," Dr Muliyil said, "is by achieving herd immunity. Roughly 60 per cent of the population needs to get infected to achieve that."

munity can be achieved." Dr John echoed this view as well. "If life gets back to pre-lockdown situation," he said, "I will give 4 weeks [for resurgence]; if 'calibrated', [it will be] slower. If all our seniors and 'vulnerables' are cocooned (reverse quarantined) for calibrated lift of lockdown, and if all wear mask in all situations of human interactions, even if physically distanced, then we can be a bit bolder to speed up lockdown-lifting. If we can be smart and innovative, I will begin serologic surveys for IgG antibody (not difficult to make and scale). Had we started in January, we would have that [antibody kits] in hand by end March. Every COVID case points to 4 infections without symptoms. So, we must have a huge number of immune persons. If they are so certified [by IgG tests], they can kick-start economic activities."

In the context of achieving herd immunity in India, there is an eye-opening piece of new research work from the United States' Centres for Disease Control and Prevention (CDC), which is yet to be published but is available on its website. By systematically and carefully re-examining the dynamics of the spread of infection in Wuhan in the early phase of the epidemic (January 15-30) and based on data in 140 confirmed case reports obtained from the China CDC, Steven Sanche of the Los Alamos Laboratory and others have re-evaluated the basic epidemic parameters, in particular the basic reproduction number (R_0, or "R-nought"), which gives the number of infections that a single index case can potentially lead to. It is thus a measure of the contagiousness of the disease. Chinese researchers had earlier estimated this parameter to have a value of 2.2 to 2.7, somewhat higher than the figure for influenza, which is about 1.3. This new work, however, revises this number drastically. Assuming a serial interval (the time between onset of symptoms in the index case to the onset of symptoms in the infectee) of six to nine days, the new value for R_0 that Sanche's team obtains is 5.7, which means that the virus is highly contagious. "With a high growth rate of the outbreak, R_0 is, in general, high, and the longer the latent and infectious periods, the higher the estimated R_0," write the CDC authors. This indeed seems to be the case for the new virus causing COVID-19, which one can note empirically from the speed with which the infection spread around the world, within just four months. Its known longer incubation period also ties in with the higher value of R_0, as the CDC team noted.

Now a higher value of R_0 has an immediate implication for both pharmaceutical and non-pharmaceutical intervention strategies. For example, as the paper points out, the threshold for vaccine efficacy and herd immunity for disease extinction is given as $[1- 1/R_0]$. For an R_0 of 2.2-2.7, the earlier value, this threshold is only 55-63 per cent. But at 5.7 the threshold rises to 82 per cent. That is, for herd immunity to be achieved to stop transmission, over 82 per cent of the population has to be immunised, either by getting exposed to the virus or by vaccination. The question, therefore, is, what is the implication of this new R_0 for countries, India in particular?

"This data on R_0 cannot be immediately extrapolated to the Indian situation," said Dr Muliyil. "We have a very complex situation in India. Firstly, R_0 depends on population density as well. We have nearly 70 per cent rural and 30 per cent urban population and at the same time 80 per cent work in urban areas. There will be a wide variation in R_0. I guess, it could be more than 2.4-2.5 but would be less than this new number. In any case, going from 60 per cent getting infected to 80 per cent will happen very quickly since we have no control over the virus. It will happen in about 3 months [after the lockdown ends]," he added. "Higher the R_0, higher the herd immunity needed for good herd effect. [But] without a reliable IgG antibody survey in the community, we do not know the current 'infection prevalence'," Dr John pointed out. "Since we started late with infection, we would have been slow to infect people widely; however, we do not know what proportion is already infected. In any case, I allow two months for graph catching up with natural path kept 'frozen' by lockdown," he added. □

"18 States that have shown improvement in doubling rate as compared to the national average of 7.5"

STATES	No. of days
Doubling rate: Less than 20 days	
Delhi (UT)	8.5
Karnataka	9.2
Telangana	9.4
Andhra Pradesh	10.6
J&K (UT)	11.5
Punjab	13.1
Chhattisgarh	13.3
Tamil Nadu	14
Bihar	16.4
Doubling rate: Between 20 and 30 days	
A&N (UT)	20.1
Haryana	21
Himachal Pradesh	24.5
Chandigarh (UT)	25.4
Assam	25.8
Uttarakhand	26.6
Ladakh (UT)	26.6
Doubling rate: More than 30 days	
Odisha	39.8
Kerala	72.2

Goa: All COVID-19 patients discharged from hospital after recovery, and Goa has no active case as of April 19.

SOURCE: Ministry of Health & Family Welfare.

Data discrepancy

A couple of studies use naturally occurring control groups—passengers in the Diamond Princess and those who returned to Wuhan after foreign travel—and COVID-19 mortality data to calculate the Infection Fatality Ratio and with that work backwards to arrive at the true caseload in a country, which is far higher than the official numbers put out by countries. BY **R. RAMACHANDRAN**

ATHIT PERAWONGMETHA/REUTERS

THE DIAMOND PRINCESS cruise ship, in which dozens of passengers tested positive for COVID-19, arrives in Yokohama near Tokyo, on February 16.

THE LACK OF KNOWLEDGE ABOUT THE TRUE number of COVID-19 positive cases in any country or region seems to be the elephant in the room in the ongoing COVID-19 pandemic. The severity of any epidemic has two aspects: one, how infectious or contagious the causative pathogen—in this case, the coronavirus SARS-CoV-2—of the disease is; and, two, how dangerous it is; that is, how many in a cohort group of COVID-19 patients the disease will kill, and equivalently, what the chances are that a person who becomes positive for the virus will eventually die.

A measure of the first is given by a parameter called the Basic Reproduction Number, denoted by R0 (pronounced "R-nought"), which is the number of people that an infected person is likely to transmit the infection to. In a new and growing epidemic, R0 is usually greater than 1;

that is, one person is likely to infect more than one person, and the secondary infected persons will each go on to infect R0 more number of persons, leading to an exponential growth in the number of infected persons.

R0 is not a fixed number; it is a dynamic parameter that can be brought down by reducing the chances of the infection being transmitted from person to person by measures such as physical distancing among people, hygienic practices such as regular washing of hands, isolation of infected persons, self-quarantine and so on. Once R0 becomes less than 1, the infection spread will decline and eventually die out. Scientists estimate R0 by constructing models of transmission of infection in a given social setting.

The second aspect is intrinsic to the pathogen in a situation where there is no treatment for the disease or any degree of innate immunity to it in populations (as is the case with any new epidemic/pandemic such as COVID-19) and can be taken to be a constant factor across populations assuming country-to-country differences in health care settings to be not very significant. As is obvious, the number of deaths that is likely to occur for a given number of infections would be a measure of this. This is called the Case Fatality Ratio or Rate (CFR), which is the number of deaths divided by the total number of infections, generally given as a percentage. Of course, since the severity of the disease has been found to be age-specific, with the elderly being more susceptible, age-stratified CFR will be of more epidemiological significance. Also, CFR will be higher where the health care system is relatively poor, and less where it is otherwise.

As earlier mentioned, in any growing epidemic, the major epidemiological problem is that one does not have a handle on the denominator, the true caseload. Early on in an epidemic, the more severe cases tend to get detected and so the CFR will be high, which will decline as less severe cases, too, begin to get captured in the diagnostic testing network of the operative health care system in a given setting. But even in an expanded testing network, many cases could go under the radar because mildly symptomatic or asymptomatic cases are not likely to show up in hospitals and clinics for testing. That asymptomatic cases, and transmission of infection by them, do occur is now an accepted fact.

While earlier pieces of evidence may have had other confounding factors obscuring such an inference, there is now clear evidence from data of people aboard the cruise ship Diamond Princess and, more recently, the aircraft carrier USS Theodore Roosevelt. These captive populations were equivalent to control groups where everyone is tested for SARS-CoV-2 irrespective of whether they are symptomatic or asymptomatic, and these fortuitously occasioned control groups have thrown up significant numbers of asymptomatic cases.

So the naive or crude CFR does not reflect the true ground situation. How close the detected number of cases is to the true caseload will depend on the adequacy of the testing strategy, in particular the criteria adopted for testing the population—that is, how accurately it picks up most of the infections, including undiagnosed and asymptomatic cases.

In such a situation, the criteria for testing have to be much broader than they are at present in many countries, notably in India. The narrower a country's testing strategy, the poorer its Detection Rate (DR) and, consequently, the higher its crude CFR (the number of deaths divided by the detected—rather than the actual—number of cases).

ICMR study finds evidence of community transmission

A RECENT research work published in *The Indian Journal of Medical Research* (IJMR), a journal of the Indian Council of Medical Research (ICMR), has found evidence for the community transmission (CT) of COVID-19 infection at least in some districts of India, even as Indian health officials and the ICMR spokesperson at the daily media briefing continue to deny the possibility.

The latest daily situation reports of the World Health Organisation (WHO) classify the Indian situation as "Clusters of Cases", as they have done for countries such as China, South Korea, Japan and Australia. Transmission classification, according to the WHO, is based on a process of country/territory/area self-reporting.

There are, of course, countries such as the United States, Canada, Brazil, Iran and South Africa, whose situations have been classified as CT. There are also many other countries, the classification of whose situations is stated as "Pending", such as the United Kingdom, Italy, Spain, France and Germany. The remaining WHO classification categories are: "No Cases" and "Sporadic Cases".

The WHO's current (as of April 9) definition of CT is:

"Countries/area/territories experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to:
* Large numbers of cases not linkable to transmission chains
* Large numbers of cases from sentinel lab surveillance
* Multiple unrelated clusters in several areas of the country/territory/area."

The WHO's definition for CT until April 9 (since this classification was started on February 28) essentially included the first two criteria mentioned above. The other categories until April 9 were: "Local Transmission", "Imported Cases Only", "Interrupted Transmission" and "Under Investigation". India was classified as "Imported Cases Only" until March 4, when it was changed to "Local Transmission", which remained the case until April 8.

What is interesting, however, is that until April 9, the WHO situation reports did not classify any country (including China, Italy, Spain or the U.S.) in the CT category (even according to the old definition) even though it was known through studies in countries with rapidly escalating case load that CT was occurring. In India, too, epidemiologists have been saying at least since early March that CT must be occurring.

In a sentinel surveillance study among patients with severe acute respiratory illness (SARI)—a hallmark condition of COVID-19 in the context of the ongoing pandemic—initiated by the ICMR to identify the spread and extent of transmission of the disease, researchers have found that 40 among a total of 104 (over one-third) COVID-positive cases in a sample of 5,911 SARI patients had no history of international travel or contact with any known COVID-19 case.

The sampling was done from 41 sentinel surveillance sites across 52 districts in 20 States/Union Territories. The 40 cases with no apparent link to identifiable source of infection were from 36 districts in 15 States, and that is a large fraction (69 per cent) of the identified districts for surveillance. [Sentinel surveillance refers to a system covering selected sites (where good laboratory facilities and trained staff are available) with a high probability of seeing cases of the disease in question which the routine passive surveillance system may miss.] Even though the ICMR research paper does not explicitly state that this is evidence for CT (the reason for that is not clear), this clearly is evidence of that, and satisfies the second criterion in the WHO definition of the category, unless the ICMR considers the sample size of 104 COVID-19 patients as not "large".

Coronavirus disease 2019 (COVID-19) cases among severe acute respiratory illness (SARI) patients by source of exposure, India, 2020 (n=102)

Source of exposure	Number of cases (per cent of total)
No foreign travel/contact with known laboratory confirmed COVID-19 case	**40** (39.2)
Contact with a known laboratory confirmed COVID-19 case	**2** (2.0)
History of foreign travel	**1** (1.0)
Data not available	**59** (57.8)

The first COVID-19 case in India was reported on January 30 in Kerala. The initial routine testing strategy adopted by the Government of India following the ICMR recommendation was only to test people with symptoms who had undertaken international travel, symptomatic contacts of confirmed cases of COVID-19 and symptomatic health care workers who were managing SARI patients. However, following WHO's recommendation, stored samples of SARI patients who were hospitalised between February 15 and March 19 (965 in all) were tested for COVID-19 under the Virus Research and Diagnostic Laboratory Network (VRDLN) under ICMR. From March 20 onwards, the routine testing strategy was broadened to include all SARI patients as well from which set the study accessed data of 4,946 SARI patients.

The sentinel surveillance study thus analysed the data of SARI patients over a seven-week period between February 15 and April 2 from 104 SARI testing laboratories. In all, 5,911 (965+4,946) SARI patients were tested, of which 104 (1.8 per cent) tested positive for COVID-19.

While in the first set of samples up to March 19, only 2 (0.2 per cent) were found to be positive for COVID-19, in the latter set of 4,946 samples, 102 (2.1 per cent) were positive. The 40 cases that have no apparent identifiable causal link to COVID-19 source belong to the latter set (39.2 per cent). So the timeline also gives an idea of the progression of the disease in the country, and it would seem that CT may have set in at least around early March, if not earlier, if you allow for around a two-week period from the time of infection to development of severe symptoms in this set of 40 COVID-19 positive SARI patients.

The 36 districts (from 15 States) from where these 40 cases were identified should be prioritised to target COVID-19 testing, containment and mitigation efforts, say the authors of the study. However, an important limitation of the study pointed out by the authors is that the sentinel hospitals in the surveillance were all in the public sector and that too in urban areas. The data and the conclusions would therefore not truly be representative of the entire district.

Significantly, of the remaining 62 COVID-19 positive SARI patients, only two reported any contact with a confirmed COVID-19 case and one had a history of international travel, and data on exposure history for the rest 59 (57.8 per cent) is simply not there (Table). It is, therefore, eminently possible that a number of these 59 cases may well have no history of contact or international travel, and hence the spread would be due to CT. This only would mean a more widespread CT than the study concludes on the basis of hard data-based evidence alone.

R. Ramachandran

Temperature not a factor in COVID transmission

WITH the worldwide spread of COVID-19, which began in November-December 2019 and unfolded into a pandemic in the following months with the number of confirmed infections scaling the two-million mark and consequent deaths hitting 1,50,000, it was widely hoped that higher temperatures and increased humidity during the summer months would bring down the strength of the causative virus, SARS-CoV-2.

A recent study, submitted to the White House by the Standing Committee on Emerging Infectious Diseases and 21st Century Health Threats of the U.S. National Academy of Science, Engineering and Medicine, has cautioned against pinning hopes on such a possibility. The report is based on a scrutiny of available evidence from recent investigations on the subject by different research groups. These works offered varying degrees of evidence, but, analysed together, the evidence is not sufficient to make a conclusion unequivocally one way or the other.

Countries of South and South-East Asia are already well into summer, and significant parts of India in particular are expected to experience heat waves. The India Meteorological Department (IMD) has forecast "normal to slightly above normal heat wave conditions... in the core heat wave zone [CHWZ] during the season". So, in the light of the U.S. Academy study, India is unlikely to see any respite from the spread of infection on account of the hot weather. That has to come only from other health-related measures that are observed both at a societal and individual level.

The Academy's nine-page report of April 7, titled "Rapid Expert Consultation on SARS-CoV-2 Survival in Relation to Temperature and Humidity and Potential for Seasonality for Pandemic COVID-19", said in its summary: "[A]lthough experimental studies show a relationship between higher temperatures and humidity levels, and reduced survival of SARS-CoV-2 in the laboratory, there are many other factors besides environmental temperature, humidity, and survival of the virus outside of the host, that influence and determine transmission rates among humans in the 'real world'."

The report observed that while there was some evidence to support a potential decline in the number of cases in warmer and more humid seasons, none was without major limitations. "Given that countries currently in "summer" climates, such as Australia and Iran, are experiencing rapid virus spread, a decrease in cases with increases in humidity and temperature elsewhere should not be assumed. Given the lack of immunity to SARS-CoV-2 across the world, if there is an effect of temperature and humidity on transmission, it may not be as apparent as with other respiratory viruses for which there is at least some preexisting partial immunity," it said.

It further noted that pandemic influenza strains had not exhibited the typical seasonal pattern of endemic/epidemic strains, thus emphasising that disease in a pandemic assumed a different pattern of spread and pathogenic virulence. "There have been 10 influenza pandemics in the past 250-plus years–two started in the northern hemisphere winter, three in the spring, two in the summer and three in the fall. All had a peak second wave approximately six months after emergence of the virus in the human population, regardless of when the initial introduction occurred," it said.

Corresponding to the two questions that the academy assessment set out to answer— (1) survival of the SARS-CoV-2 virus in relation to temperature and humidity; and (2) potential for seasonal reduction and resurgence in the number of infections—the report divided the research work analysed into two categories: (a) laboratory experiments that involved deliberate dispersal of laboratory-grown virus under controlled environmental conditions and subsequent sampling; and (b) what it called "natural history studies" which looked at disease transmission in different locations and times of the year and sought correlations with environmental conditions such as temperature and humidity.

Although environmental conditions could be controlled in experimental studies, they almost always failed to adequately mimic those of the natural setting, the report said. On the other hand, in natural history studies the conditions (naturally) reflected the real world, but there was practically little control of environmental conditions and there were too many "confounding factors".

Giving an example of the relevance of laboratory conditions to real-world conditions, the report said that many of the experimental survival studies used virus grown in tissue culture (TC) media. "Virus from naturally infected humans," it pointed out, "when directly disseminated to the nearby environment has different survival properties than virus grown in TC media, even when the latter is purified and spiked into a relevant human body fluid such as saliva." But it also noted that environmental dispersal of clinically relevant human fluids, such as saliva, respiratory (including nasal) mucus and lower respiratory tract airway secretions, urine, blood and stool, will be more predictive of the real-world situation than environmental dissemination of TC-grown virus in TC media.

According to the report, the laboratory results assessed so far indicated reduced survival of SARS-CoV-2 at elevated temperatures. This temperature sensitivity also depended on the type of surface on which the virus was placed. "However," the report said, "the number of well-controlled [laboratory] studies available at this time on the topic remains small."

As for "natural history studies", the report said that published research so far have had conflicting results regarding potential seasonal effects. They are also hampered by poor data quality, confounding factors, and insufficient time since the beginning of the pandemic (which raged mostly in temperate regions during the winter months) from which to draw conclusions.

"There is some evidence to suggest that SARS-CoV-2 may transmit less efficiently in environments with higher ambient temperature and humidity; however, given the lack of host immunity globally, this reduction in transmission efficiency may not lead to a significant reduction in disease spread without the concomitant adoption of major public health interventions," it added. Significantly, the report also pointed out that the other coronaviruses causing potentially serious human illness, including SARS-CoV and MERS-CoV, had not demonstrated any evidence of seasonality following their emergence.

According to the report, problems with data quality in the "natural history studies" included the estimates of reproductive rate, assumptions about infectivity period, and short observational time windows. Importantly, the report pointed out that there were other issues relating to the geography of locations with higher temperature and humidity that were studied: access to and quality of public health and health-care systems, per capita income, human behavioural patterns, and the availability of diagnostics. "As a reflection of these confounding factors," it said, "those studies that show a significant correlation between temperature, humidity and disease transmission, also show that the two factors explain only a small fraction of the overall variation in transmission rates."

In contrast, a latest study by W. Luo and others has argued against any seasonal differences from its findings which show sustained transmission despite changes in weather in various parts of China with climates that ranged from cold and dry to tropical.

However, this work, too, suffers from the same limitations as others with regard to data collection and case reporting. The authors of the study conclude that changes in weather alone will not necessarily lead to declines in cases without extensive public health interventions.

R. Ramachandran

> The narrower a country's testing strategy, the poorer its detection rate and the higher its crude CFR (number of deaths divided by the detected number of cases).

Notwithstanding the fact that the sample sizes of such naturally occurring control groups will be relatively small, since the number of infections in them is accurately known and they can be closely monitored, they can provide a fairly good estimate of the real fatality ratio, called the Infection Fatality Ratio (IFR), which will be a true measure of the intrinsic severity of the pathogen. So if one knows the exact number of deaths owing to COVID-19, which is likely to be the case in most contexts, the IFR so determined from control groups can be used to determine the true number of infections in real-world situations.

Actually, the number of deaths at a given point of time will give the total number of infections a little in the past because there is a time lag between the time a person tests positive for COVID-19 and the time of death, which has been found to be a little over two weeks.

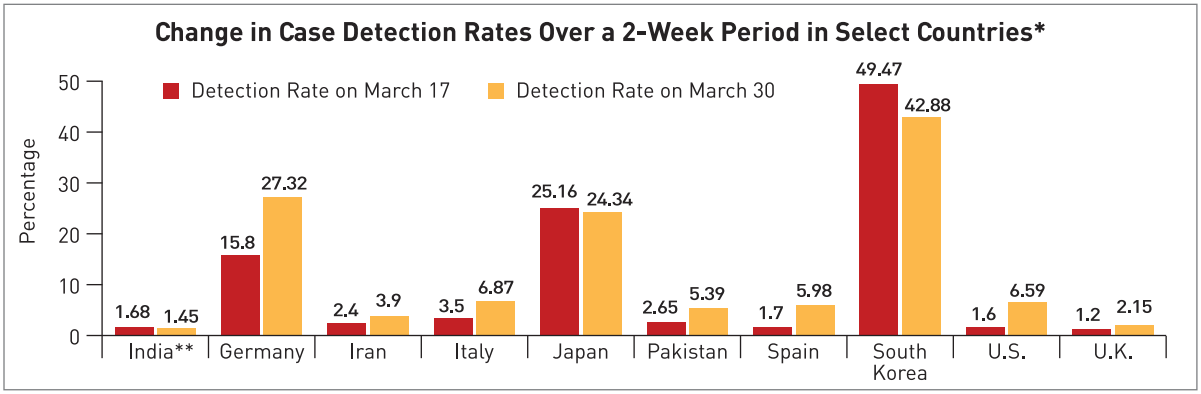
The question, however, is how good is such an IFR for it to be used across populations and across usual health care settings to work backwards from the number of deaths and arrive at the true caseload?

Settings such as Diamond Princess and USS Theodore Roosevelt are unlikely to reflect the real-world situation because of better-than-normal health care that the passengers are likely to have received both while on board and later.

However, a recent research work by a British team of scientists led by Robert Verity, and published in the journal *Lancet Infectious Diseases*, has provided (age-stratified) data about another similar control group where everyone was tested for the virus. This is the set of people who were returning to Wuhan, the Ground Zero of COVID-19, after international travel. They were all tested for the virus on entry at the airport and COVID-19 positive cases quarantined and their conditions monitored.

There were six such international flights that brought people back to Wuhan and by combining age-stratified infection and disease data from mainland China with the data of people on the repatriation flights, the group presented age-specific IFR for the first time. By combining data from mainland China and outside, this study also estimated the average time from onset of COVID-19 symptoms to death to be approximately 18 days.

Arguing that this age-structured IFR data given by



** India's DR as on April 4 was about 2.5%

SOURCE: *S. Vollmer & C. Bommer, University of Göttingen: https://www.uni-goettingen.de/en/606540.html

Robert Verity and his team is likely to be more reliable than crude CFRs, and that these can be treated as benchmarks for projecting to other settings and contexts after making country-specific demographic corrections, the researchers Sebastian Vollmer and Christian Bommer of Gottingen University have laid down a template for obtaining the total caseload that was back-dated two weeks from the mortality data on a given date. The researchers have allowed for an average of four days to pass from the day of onset of symptoms to being tested.

The Gottingen University researchers used the demographic data for each country from the United Nations population database to yield country-specific IFRs.

This country-specific IFR is calculated as a weighted sum of age-stratified IFRs given by the British study, with weights determined by the population shares in each age strata respectively for each country as given in the U.N. population data. In this manner, they worked out IFRs for as many as 40 most-affected countries, including India.

So, for example, the COVID-19 mortality data of any country on April 14 when divided by its IFR will yield the real number of infections on March 31. Their findings show that a vast majority of infections go undetected in most countries. According to them, on the average, the official numbers of confirmed cases put out by different governments on a given date actually represent less than a tenth of the actual number of infections.

For China as a whole, the IFR determined by the British team was 0.66 per cent. Based on the age-stratified data of China, the IFR projected in the Gottingen University study work for India as a whole is 0.41 per cent.

The corresponding IFRs for Germany is 1.3 per cent, Iran 0.43 per cent, Italy 1.38 per cent, Japan 1.6 per cent, Pakistan 0.29 per cent, Spain 1.21 per cent, South Korea 0.96 per cent, the U.K. 1.09 per cent and the U.S. 0.96 per cent. The vast differences in the unstratified country-specific IFRs reflect the widely different demographic structures of the countries.

For India, this means that, given that the COVID-19 mortality data on April 19 was 507, the total number of infections two weeks earlier on April 5 was 1,23,659 as against the official figure of 3,577, which means that official figures on that day represented only about 2.9 per cent, or 1/35th, of the real caseload. That is, the DR of infections is only about 2.9 per cent, which is indicative of grossly inadequate testing. Actually, this was a significant improvement over the DR that the researchers found on the day they wrote their paper.

The Gottingen University researchers published their work on April 6 and had calculated country-specific infection figures for March 17 based on mortality figures of March 30. They arrived at country-specific DRs as on March 17 by dividing the officially declared confirmed cases on March 17 by the real number of infections on March 17 that they calculated with the respective IFRs. According to those figures (Table 1), on March 17, India's DR was only 1.68 per cent.

Corresponding DRs for Germany was 15.8 per cent, Iran 2.4 per cent, Italy 3.5 per cent, Japan 25.16 per cent, Pakistan 2.65 per cent, Spain 1.7 per cent, South Korea 49.47 per cent, the U.K. 1.2 per cent and the U.S. 1.6 per cent. According to the researchers, the huge differences in DRs may explain the vast differences that one notices in the crude CFRs that one sees across countries, in particular the low CFR for South Korea corresponding to its significantly high DR.

Of course, the DRs are bound to change depending upon how each country responds to progression in the epidemic; the DRs could drop if the testing network cannot keep pace with increasing number of infections or it could increase if either the testing is ramped up or if a country had crossed the peak of the epidemic and infections had begun to decline. Accordingly, the Gottingen University team updated its work on April 14 by calculating country-specific DRs as on March 30. Interestingly, India's DR on March 30—based on mortality figure of 358 on April 13—had dropped to 1.45 per cent from the earlier 1.68. In comparison, Germany's DR had increased to 27.32 per cent, Iran 3.9 per cent, Italy 6.87 per cent, Japan 24.34 per cent, Pakistan 5.39 per cent, Spain 5.98 per cent, South Korea 42.88 per cent, the United Kingdom 2.15 per cent and the United States 6.59 per cent (Table 1). The fact that India's DR has now increased to 2.9 per cent is indicative of testing being ramped up in the country, but it is still quite low. □

In search of a strategy

There is a lack of clarity on the epidemiological basis for the extension of the lockdown and an information gap at various levels on containment procedures. BY **T.K. RAJALAKSHMI**

PTI

TESTING in Bhopal on April 4. Madhya Pradesh has seen a spike in the number of cases.

ONE OF THE DISTINCTIVE FEATURES OF THE Central government's response to the outbreak of COVID-19 has been in the nature of dealing with it as a law and order problem in successfully implementing the nationwide lockdown and in comparing the mortality and morbidity rates in the country with that of developed countries where they have been high. Prime Minister Narendra Modi's address on April 14 announcing the extension of the lockdown had little to offer by way of assurances on how the outbreak was being handled save for an exhortation to adhere to the lockdown at any cost.

Informed sources told *Frontline* that the National Task Force for COVID-19, which comprises medical experts, including from the Indian Council of Medical Research (ICMR), was not consulted before extending the lockdown. Hence, what the epidemiological basis was for continuing with the lockdown is not known. "While the lockdown is appropriately a political decision, taking many factors into account, the considerations we would reasonably expect to inform the decision-making are evidence and scientific assessments. To disregard these is problematic, particularly with the stakes involved," said a public health expert.

The spread of the epidemic by and large has been in

cities in States that report a higher per capita income than others. This is akin to the international pattern of least developed and developing countries reporting fewer cases than Western democracies. The Central government, in its daily briefings by representatives from the Health and the Home Ministries, says that everything is under control, yet there have been reports of shortfalls in protective gear for medical personnel, and overcharging, even denial of health care, by the private sector. There were reports of a doctor being terminated from service in a government hospital for raising the issue of shortage of personal protective equipment (PPE). He apparently secured it from a source and distributed it in the hospital he worked. On April 15, five lakh rapid antibody testing kits arrived from China, but Raman R. Gangakhedkar, head of the Epidemiology and Communicable Diseases Division at ICMR, told the media that it was not for diagnosing COVID-19 but for surveillance purposes.

MIGRANT WORKERS and homeless people wait for food outside a government-run shelter in Delhi on April 9.

GETTY IMAGES

THE TREND SO FAR

There is little disagreement on the point that the lockdown has limited the spread of the epidemic, but inadequate testing remains an issue. The government still maintains that there has been no widespread community transmission. However, between March 25 and April 10, there was a sevenfold increase in the number of COVID cases in the country. Maharashtra, Madhya Pradesh, Rajasthan and Gujarat accounted for nearly 47 per cent of the total number of cases in the country and the number of active cases continued to indicate an upward trend in Maharashtra, Madhya Pradesh and Gujarat. In Madhya Pradesh, the number of cases saw an upward spiral from March 29, while in Gujarat it rose steeply between April 7 and 16 and showed little sign of slowing down even beyond that date.

On April 16, two days after the lockdown was extended, Kerala became the first State in which recovered cases outnumbered active cases. In fact, the Central government has fallen short of acknowledging Kerala's success in containing the spread even before the lockdown was announced on March 25. On the other hand, the Bhilwara model, where an entire district in Rajasthan was sealed after a doctor in a private hospital passed on the infection to a patient who died later in Jaipur, was the focus of all the attention.

As many as 22 States have reported COVID-19 cases. As of April 18, the four contiguous States of Maharashtra, Gujarat, Rajasthan and Madhya Pradesh accounted for 48.5 per cent of all confirmed COVID-19 cases, 67 per cent of all deaths and 31.9 per cent of recoveries. In contrast, the hill States and those in eastern and north-eastern India, except West Bengal, accounted for 2.8 per cent of all the cases, 1.67 per cent of the deaths and 7.8 per cent of all recoveries.

States in the north-western region, like Punjab and Haryana, too have relatively lower number of cases. The situation in Delhi and Tamil Nadu, after seeing a spike, seemed to be plateauing in the past few days. The number of positive cases in these two States had gone above a thousand. As many as 1,080 of the 1,640 positive cases in Delhi were listed as "under special operations", a term that was used to refer to cases relating to the Tablighi Jamaat congregation in Delhi.

As of April 17, of 18,784 persons who were tested in Delhi, 1,640 were found positive, 14,692 negative and the results for 2,251 were pending. Some 2,571 persons were in institutional quarantine, and 30,983 "contacts" of positive cases were in home quarantine. Some 1,825 samples were collected from cluster containment zones after house-to-house surveillance. The number of people in intensive care units and on ventilators in the State numbered 34 and six respectively.

Tamil Nadu, which reported a large number of cases from among people who had attended the Delhi event, used the term "single source". On April 15-16, it dropped using this term. Apparently, a section of the media and several others had brought it to the government's attention that religious profiling of infected persons was against international norms, including that of the World Health Organisation (WHO). The obsession in some quarters to link the spurt in cases in the country with the congregation, however, could not explain the spike in cases in Maharashtra, Madhya Pradesh and Gujarat.

HOTSPOTS AND CLUSTERS

Meanwhile, the Central government has listed "hotspots" to describe areas that have reported a large number of cases or a cluster of cases.

After initially refusing to reveal the hotspots , on April 15 the government issued a list classifying districts. Of the 170 districts classified as hotspots, 123 had large outbreaks and 47 had several clusters. A district is declared a hotspot-free zone, or a green zone, if it has been free of any case for 28 days. There are 207 such districts.

Tamil Nadu had the largest number of hotspots (22), followed by Maharashtra, Andhra Pradesh and Rajasthan with 11 each; Uttar Pradesh and Delhi with nine each; Jammu and Kashmir, and Kerala six each; and Gujarat and Madhya Pradesh five each. The largest number of green zones was in Uttar Pradesh, followed by Telangana, Madhya Pradesh, Maharashtra, Gujarat, Haryana and Karnataka. In eastern India, West Bengal had four hotspot districts.

In eastern parts of India and the north-eastern region there has been no large outbreak. Narendra Gupta, a public health expert from Rajasthan with years of experience in working among tribal people, told *Frontline* it was quite possible that there were not too many COVID cases in these States. "There is a lot of respiratory illness in rural India due to tobacco chewing and the smoke emitted during cooking, and generally in winter people sleep next to lit fires inhaling all that smoke. There is a lot of mortality from chronic obstructive pulmonary disorder. Until such time it is not diagnosed as COVID-19, one will never know. And the majority of the poor do not even reach a public health facility," he said.

All States have been told to set up dedicated COVID hospitals apart from containing cases with severe acute respiratory illness and influenza-linked illnesses. The Central government has declined to give details of the location of the dedicated COVID treatment hospitals. This would create panic, said Joint Secretary (Health) Lav Agarwal. However, this has resulted in COVID hospitals and beds going literally empty and being inaccessible to persons with critical illnesses other than COVID. With no new government hospitals being set up for COVID cases, it is the existing ones that have been converted into COVID treatment facilities. The downside of this is that primary health centres (PHC) are getting overcrowded as people seek secondary and tertiary care at these PHCs.

Logistics is another problem. The advisory issued by the Director, Public Health and Family Welfare, in Telangana, for instance, asks people who develop "flu like symptoms irrespective of travel history/contact history" to report to the nearest government facility. This is easier said than done since all forms of public transport have been curtailed. The only State perhaps where health services were taken to the public was Kerala.

LACK OF TESTING

Experts from Jan Swasthya Abhiyaan (JSA), a broad coalition of public health experts, expressed concerns about the rise in the number of cases in Madhya Pradesh, especially in Indore, Bhopal and Ujjain divisions. Indore alone accounted for 70 per cent of the deaths in the State. While the national ratio of deaths in cases with an outcome (death or recovery) owing to COVID-19 was 22.5 per cent, in Madhya Pradesh it was close to 50 per cent, JSA experts said. In Rajasthan this ratio was 8.33 per cent. "If there was proper screening, quarantine and testing strategies, this could be stopped," they said, requesting special focus on early identification in Indore.

A report compiled by JSA activists Amulya Nidhi, S.R. Azad and Shamarukh Dhara says that Madhya Pradesh was not doing as many tests as it should have. It had eight testing facilities (four in Bhopal, one in Jabalpur, two in Gwalior and one in Indore division) and had done 10,481 tests (as of April 13) as against 31,804 in Rajasthan and 39,735 in Maharashtra. The testing rate in Madhya Pradesh was only 143 per million, when the national average was 170 tests per million. The rates of testing were 347 per million in Maharashtra and 461 per million in Rajasthan.

As of April 16, a total of 2,90,401 persons were tested in the country, an addition of 30,043 over the previous day and the majority were from the ICMR network of laboratories. Only 28 laboratories in the private sector were involved in testing for COVID-19. The overall testing rate was 220 per million, the death rate 0.09 a million and the case rate was 10 cases per million people. This is being touted as a success story.

HOW OTHER COUNTRIES FARE

Compared with India, Germany, Spain and Italy have done close to 20,000 tests per million, while in the United States, which has reported the highest number of cases and deaths, it was slightly over 10,000 per million people. Countries in the developing world that have conducted more tests than India include Pakistan (383 per million), Sri Lanka (223), Egypt (244), Nepal (542), Rwanda (482), Jamaica (481), Venezuela (9,442), Trinidad and Tobago (916), and Guatemala (402). Countries that fared worse than India in terms of testing were

High-risk warriors

Vulnerability of health care workers during the crisis and the lessons to be learnt on their care according to Dr Zarir Udwadia. BY **LYLA BAVADAM**

AN editorial in *The Lancet* on March 21 gave voice to a neglected crisis that has been growing alongside the spread of COVID-19. It said: "Worldwide, as millions of people stay at home to minimise transmission of severe acute respiratory syndrome coronavirus 2, health care workers prepare to do the exact opposite. They will go to clinics and hospitals, putting themselves at high risk from COVID-2019.... Reports from medical staff describe physical and mental exhaustion, the torment of difficult triage decisions, and the pain of losing patients and colleagues, all in addition to the infection risk."

The risk of infection for health care workers following exposure in hospitals is now a hard reality. The number of health care workers infected in Mumbai as on April 11 is 100. The multi-specialty Saifee Hospital in south Mumbai was among the first to report cases of doctors and nurses showing symptoms of coronavirus infection. A senior doctor of the hospital contracted the virus and died in another hospital subsequently in late March. The 250-bed hospital suspended its outpatient department services, and became a dedicated COVID-19 facility. Bhatia Hospital, whichwas under containment after a few nurses and doctors tested positive, has been sealed. Other private hospitals such as Shusrusha, Jaslok, Wockhardt and Breach Ccandy stopped new admissions after health care workers showed symptoms of infection. Breach Candy is operating minimal emergency services. With smaller hospitals and nursing homes also shutting down, the city is left with fewer beds.

A pandemic is a huge burden on a health system. The burden increases when the ratio of doctors to patients is low, as is the case in India. According to government's 2019 figures, there is one doctor for every 1,445 Indians, far below the World Health Organisation (WHO) norm of 1:1,000. The problem is compounded when health care workers themselves take ill.

Dr Zarir F. Udwadia, a leading pulmonologist in Mumbai, in a paper co-authored with Dr Reyma Sara Raju, clinical assistant in Mumbai's Hinduja Hospital, says: "From the very start of the epidemic it has been recognised that health care workers (HCWs) managing this potentially lethal airborne disease are a uniquely high-risk group."

The research paper titled "How to protect the protectors: 10 lessons to learn for doctors fighting the COVID-19 Coronavirus", was published by Elsevier on March 31. Dr Udwadia has shared it with *Frontline*.

He writes: "There are numerous reports of front line HCWs, both physicians and nurses, contracting the disease from their patients and several have succumbed to it. In the index outbreak in Wuhan, thirteen hundred health-care workers became infected; their likelihood of infection was more than three times as high as the general population. Figures from China's National Health Commission show that across China more than 3,300 health-care workers (HCW's) have been infected as of early March and, according to local media, by the end of February at least 22 had died. In Italy, the virus has infected more than 5,000 doctors, nurses, technicians, ambulance staff and other health employees and resulted in the deaths of 41 HCWs. The majority were on the frontline in the badly affected northern regions around Lombardy and contracted the illness at the start of the outbreak when protective equipment was lacking."

Udwadia says four questions rankle health care workers: what is the route of transmission of COVID-19? How infectious is it compared to influenza? Do asymptomatic patients exist and are they a source of infection? And finally, how do we ensure physicians do not end up becoming patients themselves?

While it is established that the virus spreads through "aerosolised droplets that are expelled during coughing, sneezing, or breathing, there are also concerns about possible airborne transmission. Faeco-oral transmission has also been reported in a few cases, with viral isolation from the faeces of some patients."

As far as the comparison with influenza goes, Udwadia says: "The transmission dynamics of COVID-19 have been studied and reveal the estimated basic reproduction number (R0) to be 2.2 (versus 1.3 for common influenza), demonstrating the potential for the virus to spread to two additional persons from a single infected person. It is to be noted that unless the R0 falls less than one, the outbreak cannot be halted."

The spread of infection via asymptomatic patients, he says is "a new and worrying dimension to the spread of the pandemic". Udwadia explains this: "What is more worrying is that significant numbers of these totally asymptomatic patients are contagious for up to two days before they develop symptoms. Thus, it is ominously clear that people who are asymptomatic or mildly symptomatic may be responsible for more transmission than previously thought, making efforts at control even more difficult."

Udwadia says there is no need for casually exposed health care workers to go in to self-quarantine. Citing a paper from Singapore, he writes: "41 HCWs were exposed for four days to a critically ill patient before he was eventually diagnosed with COVID-19 infection.

Despite the high-risk nature of the exposures, including intubation, ventilation and regular intensive care, none of the workers became infected. 85 per cent of these exposed workers had used only surgical masks (not N-95). All had, however, adhered to proper hand hygiene. The important message that emerges is that universal precautions of strict hygiene must be adhered to, with N-95 masks and full PPEs then being conserved for procedures where respiratory secretions can be aerosolised and for known or suspected cases of COVID-19. For medical staff who are inadvertently exposed to a patient who unexpectedly tests positive, the quarantine recommendation should be based on the duration of exposure... People who have had brief, incidental contact are just asked to monitor themselves for symptoms. Contrast this with the recent panic in Mumbai when a large hospital was shut down after it was detected that an asymptomatic doctor and another outpatient who had a CT scan in the radiology department of the hospital had both tested positive. If health care workers are quarantined after even casual exposure and hospitals shut down, there will be no one left to treat patients!"

Udwadia says "The emotional needs of HCWs must not be ignored." He writes: "A study conducted by Chinese doctors and published in *The Lancet* showed that 70 per cent of health workers on the frontline in Hubei suffered from extreme levels of stress, 50 per cent had depressive orders, 44 per cent had anxiety and 34 per cent insomnia." .

It is pertinent here to recall the remarks made in *The Lancet* editorial: "Health care systems globally could be operating at more than maximum capacity for many months. But health care workers, unlike ventilators or wards, cannot be urgently manufactured or run at 100 per cent occupancy for long periods. It is vital that governments see workers not simply as pawns to be deployed, but as human individuals."

Bangladesh (103), Myanmar (59), Indonesia (132), Libya (102), Niger (183), Bolivia (187), Honduras (203), Uganda (168), Namibia (142) and Kenya (179). Economic reasons account for the low testing in these countries. Those that have been really low in testing according to the Worldometers website are Malawi (18), Nigeria (24), Ethiopia (47), Haiti (32), Zambia (92), Mozambique (27) and Algeria (77).

While the government continues to maintain its defined criteria of testing, tracing and isolation, some questions still remain. One such is the absence of the National Centre for Disease Control (NCDC), the premier agency dealing with outbreaks, from the scene. Linked to this is the Integrated Disease Surveillance Programme (IDSP), which is a part of the NCDC and whose primary job, like the Centres for Disease Control and Prevention (CDC) in the U.S. or the Chinese Centre for Disease Control and Prevention, is to collect and track communicable disease data. The tests conducted by the IDSP have not been shared.

There has also been some concern over objectivity in the process of designating clusters within districts. There were serious issues in terms of stereotyping certain communities as being carriers of the virus. The government has done little to assuage those apprehensions.

UPDATED CONTAINMENT PLAN

On April 17, the government released an updated containment plan for large outbreaks. It defines a large outbreak as one where there is a localised increase of 15 or more cases or where there is a progression of cases in a cluster. The plan recommends a geographic quarantine, or cordon sanitaire, where a single large outbreak or multiple foci of transmission have been noticed. The plan includes drawing a defined perimeter and containment strategies such as tracing, isolation, treatment and physical distancing within the perimeter.

The document says that the evidence for implementing geographic quarantine was drawn from the 2009 H1N1 influenza pandemic which showed that well-connected big cities with substantive population movement reported a large number of cases whereas rural areas and smaller towns with low population densities and relatively poor road/rail/airway connectivity reported fewer cases. The current geographic distribution of COVID-19 "mimics" the H1N1 pandemic influenza, says the containment plan. This suggested that while the spread could be high, it would not be uniformly affecting all parts of the country.

But the success of the containment strategy, the document cautions, depends on various factors, including the density of population and access to basic infrastructure and essential services.

The plan refers to an analysis released by the Chinese Centre for Disease Control and Prevention, which reported the largest cohort, wherein 81 per cent of the cases were found to be mild, 14 per cent required hospitalisation and 5 per cent required critical care and management. Deaths occurred among the elderly who had co-morbidities. This pattern has been noticed in India as well.

There is little clarity at present about the trajectory of the infection in India and whether at the end of the lockdown period, things will get back to normal. What is known, however, is the immeasurable damage the lockdown has done to lives and livelihoods, with the government having done little about this. Advisories to industry to not sack employees have fallen on deaf ears. The "health costs" for the economically marginalised and the jobless go way beyond the risks and consequences of being infected by COVID-19. □

Raw deal to States

When cooperation and trust are the keywords for governments in the fight against COVID, the ruling dispensation at the Centre has, against the principles of federalism, undermined even the State governments' spaces for negotiation. BY **VENKITESH RAMAKRISHNAN**

ONE OF THE KEY POINTS THAT THE HISTORIAN Yuval Noah Harari stressed in his seminal essay "The World After Coronavirus" (published in March 2020) was the need to build "a spirit of global co-operation and trust" in order to make a concerted effort to overcome the unprecedented human crisis caused by COVID-19. "Countries should be willing to share information openly and humbly seek advice, and should be able to trust the data and the insights they receive," he said. Later, talking to Indian audiovisual media, Harari pointed out that the attacks on the Muslim minority in the country on the basis of unfounded perceptions would only weaken the initiatives to overcome the crisis. In a larger sense, he was highlighting the distrust that prevailed in the Indian society, and this observation, inarguably, was an indirect message to the political dispensations of India to build societal trust. It was also a sort of reiteration of his message to "share information openly and humbly seek advice". Seen from a national perspective, Harari's message should function primarily at the level of the interactions between the Central and State governments and between various State governments.

However, as India goes through its second phase of lockdown—from April 14 to May 3—Harari's insights seem to have met with mixed reactions among the political class. The spirit of sharing and acceptance is more often observed in the breach, especially by the Central government and its political leadership. In fact, a number of important steps taken by the Narendra Modi-led Bharatiya Janata Party (BJP)-National Democratic Alliance (NDA) government in the second lockdown period clearly overlooked the pleas and demands from a number of States. Several State governments, including Kerala whose exemplary performance in combating COVID-19 has been acknowledged globally, pointed out that some of the Central government's stipulations during the lockdown have done away with the space for negotiation and manoeuvres that existed for State governments before the crisis set in.

VIOLATION OF PRINCIPLES OF FEDERALISM

A case in point several States have highlighted in this context is the Reserve Bank of India's (RBI) announcements on April 17, which the political leadership of the government has touted as its second major drive to strengthen relief work and stimulate the economy. The Prime Minister was quick to laud it as something that would greatly enhance liquidity and improve credit supply, helping small businesses, farmers and the poor. RBI itself claimed that the move to increase the limits on the ways and means advances would help all States. But the response from State governments, including those led by BJP's associates such as the Janata Dal (United) and its erstwhile partners like the Shiv Sena, did not reflect this optimism. The leaderships of these governments were of the view that the Centre's measures were grossly inadequate and openly violated the powers vested in the States by the principles of federalism.

Kerala's Finance Minister Thomas Isaac pointed out that the announcement meant that a State like Kerala would only get Rs.729 crore additionally as part of the ways and means advance. "Once drawn, this will have to be repaid quickly also. What we actually need are more substantiative fiscal relief measures such as waiving of agricultural loans and extended moratorium for other types of loans. The present moratorium of three months means nothing, as the interest will return and it would be of no use. Also, existing loans to all small traders and business should be restructured. These are the kind of concrete finance sector steps that we need. Instead, what we are getting is period rhetoric praising the people of the country, and at times the States, for observing lockdown without demur," he said.

Many other opposition-led State governments have pointed to the Centre's undermining of federalist principles amidst COVID relief activities. Leaders of these governments underscored the fact that subjects such as health, sanitation, testing, quarantine, relief—which are of great importance during the COVID crisis—are in the State List of the Constitution. But the Central government has prohibited State governments from borrowing to purchase equipment and machinery relating to COVID-19 relief. Former Union Minister and Senior Congress leader P. Chidambaram said that by this the Centre had assumed all powers and the States had been reduced to the status of supplicants. Letters of several Chief Ministers pleading for funds had gone unanswered for weeks, he said.

Samajwadi Party (S.P.) president and former Uttar Pradesh Chief Minister Akhilesh Yadav spoke to *Frontline* on the unjustifiable restrictions on State expenditure in vital areas in the battle against COVID. "What we are seeing is absolutely pathetic crisis management, devoid of well-thought-out designs and plans as well as meticulous implementation on the ground. A sense of drift is the hallmark of the Union government as well as its replica in the country's most populous State, Uttar Pradesh. In between, we are being made to witness rambling speeches accompanied by calls for dramatic performances from the powers that be. Real issues, obviously, get sidelined in this lackadaisical approach," Akhilesh Yadav said.

TROLLING RAHUL GANDHI

Along with these transgressions at the level of governance, the ruling party's politicking betrays rampant undermining of the spirit of sharing, seeking and acceptance. The treatment meted out by BJP leaders, including spokesperson Sambit Patra, as well as the troll armies of the BJP, to former Congress president Rahul Gandhi's press conference of April 16 show the levels to which the ruling dispensation and its associates in the Rashtriya Swayamsewak Sangh (RSS)-led Sangh Parivar have sunk to in these times. Through the hour-long video press conference, Rahul Gandhi sought to make constructive suggestions, making it clear that he did not wish to engage in a political slugfest with the BJP. He said that though he did not agree with Prime Minister Modi on most things, now was the time to put differences aside. The Prime Minister, he said, "has a certain style of functioning, but we can find a way around it".

Even in the face of a sensational question seeking to know whether he thought India's democratic set-up would change in the post-coronavirus era, Rahul Gandhi responded saying "it could" but qualified the statement with this comment: "Don't worry, we know how to make sure India is democratic but we need to fight the virus first....We can defeat the virus if we fight it together, we lose if we fight with each other."

He then went on to flag a "two-flanked" strategy

PTI

PRIME MINISTER Narendra Modi, wearing a protective mask, chairs a meeting with Chief Ministers on COVID-19 lockdown via video conference on April 11.

PTI

CONGRESS LEADER Rahul Gandhi addresses a press conference on COVID-19 via video link on April 16.

focussing on public health and the economy. On the health front, Rahul Gandhi asserted that the lockdown by itself was "not a solution" but was at best a "pause button" against the virus. He added that the country needed to ramp up testing and sought a course correction of the current strategy of "chasing the virus" by testing symptomatic patients to "pre-empting the virus" by random sampling. He also said that India's current testing rate of "199 people per million of population or 350 tests per district" was "in no way enough" and cautioned that the virus would make its way back into the community once the lockdown was eased "if we do not put in place the resources and architecture to fight the virus strategically when it picks up again".

On the economic front, his suggestion was to develop a "safety net" even as the battle on the health front was being carried out relentlessly. As part of this "safety net" he demanded higher amounts of cash transfer and universal public distribution of foodgrains to the marginalised and a special package for small and medium enterprises that would offer job security to India's massive population of migrant workers. He also pointed to the callous treatment meted out to the migrant labourers in forcing them to take long and tortuous journeys on foot back to their native villages from the big cities they were employed in.

By any yardstick, Rahul Gandhi's media interaction of April 16 had many pluses, both in the manner in which he steered clear of political sensationalism and how he delineated the terms of the concrete steps that the government should take in this hour of crisis. However, the BJP propaganda apparatus chose to ridicule Rahul Gandhi by drawing on the two words he had frequently used in the press conference —strategic and dynamic. Sambit Patra tweeted thus: "I like strategic laughing as we can create a positive atmosphere by raising both hands above the posture of laughing and talking about dynamically rolling on the floor."

BJP general secretary B.L. Santhosh joined him in asking why the States ruled by the Congress chose to extend the lockdown even before the Centre announced it if Rahul Gandhi believed that the lockdown was not an effective tool to fight the virus. Evidently, these two leaders completely overlooked the larger points in terms of planning and detailing that Rahul Gandhi sought to make.

Several Congress leaders, including former Minister Manish Tewari, pointed out that the top brass of the BJP and the government had made fun of Rahul Gandhi's warning of February 12 calling on the Centre to put in place necessary systems to combat the imminent dangers that the pandemic could pose to India, but the con-

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CHIEF MINISTER Pinarayi Vijayan after a COVID-19 media briefing at the Secretariat in Thiruvananthapuram on March 18.

sequences of such contemptuous dismissal were evident to all now. "The BJP had accused him of spreading panic, senior Ministers at the Centre claimed there was no health emergency and the Sangh Parivar's troll army called him all kinds of names. But now India is under an extended lockdown. Thousands have tested positive for the deadly virus and approximately 550 have succumbed to it till the 20th of April," he said. Tewari added that what Rahul Gandhi had presented was a well-meaning and well-thought-out action plan, which the government should have accepted honourably. "Instead, what we have seen is unwarranted ridicule, which smacks of crass assertion of political power and sectarian political games," he said.

PRAISE FOR KERALA

It looked as though three of Congress' senior leaders, including Rahul Gandhi, have followed Harari's prescription of "willingness to share and acceptance of advice" without sectarian considerations. Rahul openly praised the Left Democratic Front government, led by Pinarayi Vijayan of the Communist Party of India (Marxist), in Kerala as an exemplar in the fight against COVID-19 and practically dismissed the reservation his party colleagues in Kerala had expressed about the State government. Former Union Minister Shashi Tharoor also dismissed the criticisms against the State government and said repeatedly that its work was nothing short of a global model.

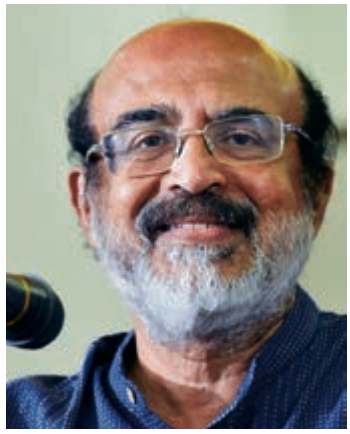
Chidambaram suggested to the Modi government that it should constitute a task force consisting of economists such as Raghuram Rajan, Arvind Panagariya, Esther Duflo, Arvind Subramanian, Himanshu, Jean Dreze, Sajjid Chinoy and Thomas Isaac.

Clearly, such bipartisan gestures do add value to Rahul Gandhi's optimistic assertion about "knowing how to keep India democratic", but he may have to drive home the same lessons to some of his colleagues in the Congress in Kerala, including seasoned leaders such as State party president Mullapally Ramachandran and Leader of the Opposition Ramesh Chennithala, who have embarked on a virulent and largely ludicrous campaign against the State government and its COVID-related initiatives. But even as this tragi-comedy unleashed by the Congress in Kerala continues apace, the deeply insidious and divisive agenda of the Sangh Parivar is also gathering greater momentum on the ground, especially across north Indian States. Undoubtedly, this developing situation underscores that the Indian democracy and the people who represent it have much work to do on the lines of Harari's insightful and lucid thoughts on global cooperation based on human compassion and well-being. □

‘It is going to be a time of big social problems’

Interview with Dr Thomas Isaac, Kerala Finance Minister. BY **R. KRISHNAKUMAR**

DR THOMAS ISAAC, KERALA’S Finance Minister was a Professor of Economics at the Centre for Development Studies, Thiruvananthapuram. As a Member of the State Planning Board subsequently, he was a key figure in Kerala’s acclaimed People’s Plan Campaign for decentralisation of powers and resources. He had also served as the State Finance Minister during 2006-2011.



T. SINGARAVELOU

Thomas Isaac spoke to *Frontline* in detail about what distinguishes Kerala’s response to COVID-19 from that of the Centre and other States; the Centre’s “muddled-headed” strategies; why there cannot be a lockdown without ensuring minimum subsistence to the people; and finally, Kerala’s extreme scenario strategy and why it is going to be a time of big social problems in India when all have to work together.

Excerpts from his interview:

What did Kerala do to contain the impact of the pandemic so effectively?

I think you have to start from the strength of the public health system in Kerala. It is a long history, a legacy of the past. But the present Left government has paid much attention to strengthening the public health system. An investment of around Rs.4,000 crore has been made from KIIFB [Kerala Infrastructure Investment Fund Board] towards improving buildings and equipment, so that now every medical college has an oncology department, every district hospital has a cardiac department, and every taluk hospital has at least 20 dialysis machines, and so on. The Kerala government has also launched the Aardram mission which focuses on primary health care centres, transforming them into family health centres. These are very similar in concept to the wellness centres under the Ayushman Bharat scheme, but the similarity is only conceptual.

The top 12 primary health centres (PHCs) in the country today are in Kerala and 68 PHCs in the State have got national accreditation. There has also been a very rapid increase in the palliative network and the activities of hospital development committees. Such is the strength of the public health system, which has functioned remarkably well in the post-flood crisis and also when Kerala tried to contain the Nipah outbreak. The system has by now established protocols for dealing with crises. So the moment the news about Wuhan came, immediately a control room was opened by the Health Department, mock drills were carried out, training was given, and all preparations started in earnest. All the students who returned from Wuhan were quarantined, without a single case of spread outside. Then things went out of hand with the second influx from the Gulf and Europe, when some people dodged quarantine. But now that problem also has been successfully tackled.

There are many specific factors in Kerala’s handling

That key difference between Kerala and other States is “preparedness”. We were always prepared. We are preparing for the worst scenario. The lack of preparedness is a major weakness in India but it is different in Kerala.

of the corona virus threat that stand out in contrast to the rest of India. First, intensive cycles of testing, tracing all the contacts, then testing again, quarantining again —these cycles that we followed haves been very effective. In fact, the creation of route maps was an innovation of Kerala. For every infected person found positive, a route map of his/her activities in the previous two weeks was immediately created, and then published in newspapers and elsewhere so that everybody who was in their vicinity was alerted; and people began to be cautious. This has been very effective and this is what has been lacking in the country, because no testing is being done. You can see some of the States with a high mortality rate do not have that many COVID-19 positive patients. It indicates that many infected patients are not detected. And that is a gap that can only lead to calamity.

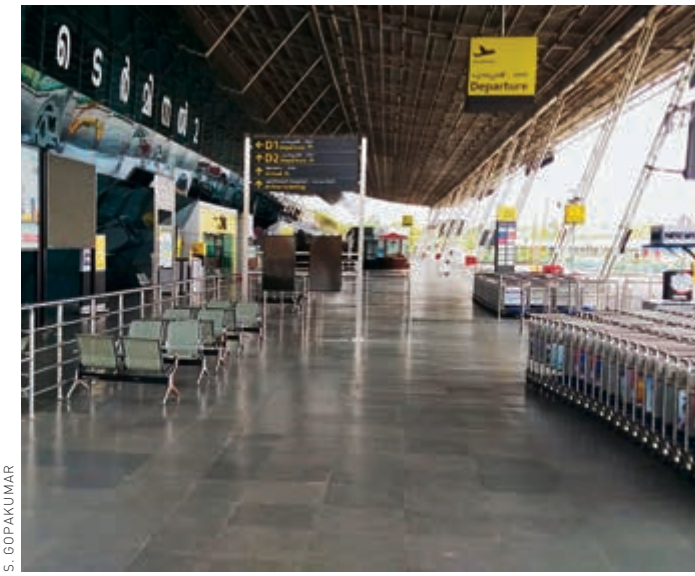
Secondly, I must add that the "'Break the Chain'" campaign launched has been very successful. Keralites have a tradition of betel- chewing, which means spitting on the road is common. That has now disappeared, because of the grass-roots spread of the campaign. The "Break the Chain" campaign has ensured that people are using sanitisers and soap at every corner. While we have not taken to wearing masks, I am sure that will also become popular in the next stage. From the medical perspective, I attribute Kerala's success to these two key factors.

Kerala was also the first State to announce a livelihood package, in spite of the serious economic troubles it already faces. What prompted the State to do it so early in the COVID-19 crisis?

Kerala is a State that has powerful social movements which will demand it [livelihood package] if the State fails to provide it. There will be agitations. I think it is a very positive thing that there is tremendous pressure from below. It is not just the benevolence of the State government. There is such pressure from below that no government can ignore it. And the State also realises that you cannot have a lockdown without ensuring minimum subsistence to the population whose livelihoods are also shut down as a result. If we don't do that, or pay attention to it, we now know what the result will be—the whole lot of migrant workers fleeing from the cities, undermining the very logic of this lockdown.

This is something that the government of India has to understand—that without guaranteeing the people bare minimum of necessities, it won't be possible to insist on their compliance. Therefore, even before the Central Government announced its meagre measures, we announced our Rs. 20,000-crore package. But the State cannot raise Rs. 20,000 crore outside the Budget. We have hard budget constraints. Therefore, all that was done was, we "'front-loaded'" our borrowing and what we are spending. It may not be considered prudent because you don't know what will happen later in the year, and that too in an election year. But that was not our consideration.

Now the paramount consideration is fighting the disease. Therefore you have to pay attention to the needs of the people. This is something unparalleled. We provided Rs.8,500 each to 55 lakh elderly and disadvantaged people. Almost an equal number of workers who are members of the welfare funds have been given Rs.1,000 to Rs.1,300 each and anybody who is needy and does not come under these groups has been given Rs.1,000 each. In addition we are providing additional grain from the State government funds and also a Rs.1,000-worth food kit to every family irrespective of whether they are rich or poor. That is because there is absolute food scarcity—we are a food-scarce State. It is not a measure for poverty alleviation.



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AT THE TERMINAL of the Thiruvananthapuram international airport. Tourism, one of the State's main revenue earners, has been badly hit.

And all along the State, we have started some 1,300 community kitchens that provide free meals every day to anybody. You make a call and it is delivered at your doorstep; or you can come to the counter and take the packet. So we ensure all the migrant workers are provided food at least. Even the homeless who have been sleeping or wandering in the streets are put into camps. That is how we ensure that there is nobody on the streets and everybody is provided food. And I think it is remarkable.

THE RETURN OF EXPATRIATES

The return on a large scale of Keralites who are now in many COVID-19-affected countries, especially in the Gulf region, is now a distinct possibility. How prepared is the State and how big a challenge will it pose?

This is going to be Kerala's next big challenge. One does not know how many will come back. I think the State should expect between one lakh to three lakh people. And you don't know how many among them may be COVID-19 positive. So it is clear we have to quarantine

every one of them for 21 days. We have decided that our quarantine period will be 28 days, because there are asymptomatic persons among them. So we have identified and requisitioned for disaster management in all hotels, hostels, colleges, even houses and flats lying empty in preparation…and everything is now geotagged so that we know what is happening where. Once they [the expatriates] come, two things are possible. One, we quarantine them and there is no secondary spread. Two, whatever we do, there may be secondary spread, in which case we are thinking of a strategy of reverse quarantine—all elderly and vulnerable people, who are at risk because they have other diseases, may not be allowed to move around and will have to stay indoors. Other people may be allowed to move out because lockdown will be lifted after a while. But the vulnerable sections will stay indoors. We will regularly monitor them so that those persons developing any symptoms will be moved to hospitals. We will not allow them to die of COVID-19. Younger persons may have relatively lesser risk. But all of this requires meticulous planning.

We have accessed World Health Organisation data on Kerala of more than 2.5 crore people—about two-thirds of the State's population—and are integrating it with new information for filling the gaps. This is a huge data set which allows you to anticipate various scenarios about the prospective situation under certain circumstances, with good [degree of] accuracy. One can also plan for districts and regions on what should be done. We are now working on this big data analysis. A whole lot of IT start-ups are cooperating with the government in this.

That reminds me: the third and key difference with regard to Kerala vis-a-vis other States is "preparedness". That is what distinguishes the State [from others]. We were always prepared. We are preparing for the worst-case scenario. When they came first, our health system was prepared. We were ready for the second wave. Preparedness is very important. And that preparedness is lacking in many States, even with regard to the Government of India. Had the government of India been prepared we would have had many more tests. But they woke up very late. Kerala is a State government, and yet the test rate here is very high. The lack of preparedness is a major weakness in India but it is different in Kerala.

Could you tell us more about the WHO data collection on Kerala you mentioned?

The WHO has data collected for its [Global] TB programme and so on. It is a huge set of data, collected over a long time. It has been storing it and graciously made this collection available to us. We might as well make use of it after ensuring protocols are in place for data security.

About the return of migrants from the Gulf, do you think a number of them will return for good?

We don't know when they will go back. A large number of people in the Gulf are losing their jobs. So they will come back. Many are temporarily laid off. One doesn't know when they will go back.

What kind of an impact will it have on Kerala's economy?

It will be very big. One, the government will have to help them, and that will be a huge burden on the public exchequer. Two, it will have an adverse impact on remittances, which have a reverse multiplier effect on the regional economy. So you will find that the factors that characterised Kerala economy from the late 1980s until now, enabling it to grow faster than the national average for three decades—and that is how Kerala, a State with one of the lowest ranks in per capita income, is today set at 60 per cent above the national per capita—that scenario is going to, or is likely to, change.

There is also the issue of inter-State migrants, who want to go home.

They want to leave because they don't have jobs under the lockdown and there is no income. But you cannot walk all the way to Bengal from this corner of India. So while we cannot send them home, we are trying to provide humane conditions of living, food, and so on. And we need them here in Kerala—as long as Keralites are going out to work in Europe and the Gulf, you need a lot of other workers to come. It is not like they are parasitic or something. The Kerala government does not think so. They play a very useful role in Kerala.

Do you think they will come back in such large numbers?

They will come back. As long as Kerala's wage rates remain what they are today, they will come back.

But a large number of Keralite workers and labourers in the rest of India are returning to their home State at the same time. Will that not make a difference?

The reserve price of people who come back from the Gulf is going to be high at least for some time. They won't work below certain wages. And that standard is set with reference to their earnings in the Gulf—not fully, but with some relation to that, except in the case of women. The female workforce is available, but males… it is a very different wage system for the males. And therefore, these inter-State migrants will have to come back. But I think, not to the scale… for if construction activity in Kerala takes a dip, there may not be that kind of demand either. But that is temporary. They will be coming back.

THE CENTRE'S ATTITUDE

These are early days and thus far, the State has been able to cushion the impact of the COVID-19 and lockdown on the vulnerable sections through cash transfers, provision of essentials, and so on. How long will Kerala be able to sustain such support?

The government of India will have to provide it. They cannot be silent spectators. All States, whether they are ruled by BJP or the Congress, they are all saying that there is no money in the States. There is zero income. Therefore, the Central Government will have to respond.

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AT A BANK in Thiruvananthapuram where welfare assistance was distributed during the lockdown.

After a while, there will be serious fiscal crisis. See, what we are going to have is a long slump, and India is not going to get out of it. The world is not going to get out of it. And without the cooperation of the Centre, the States we will not be able to address this slump. It is not like the Centre transfers a whole lot of money and the economy will pick up. That is not going to happen. That is for relief only. You have supply chains broken. An agenda has to be drawn up, by the Centre and the States together and the Centre will have to raise the deficit ceiling of the State, at least to four or five; pay all the GST arrears that are due to the States, and also pump in money into the health system. That they will have to do and I am certain they will be forced to do it.

Why do you think the Central government is reluctant to do it, if it seems to be such an obvious thing to do?

It is simply ideological. There are some people who are still lost in the old neoliberal paradigm and who think that any increase in fiscal deficit will lead to inflation, higher interest rate and so on, which does not apply here at all. So it is simply lack of clear thinking. It is muddled-headed thinking. Look at the world. The world is changing. The Indian government also will have to change somehow with it.

And you have been complaining that while governments now need to spend more, the Centre is forcing the States to cut expenditure.

That is what they have been doing. They have not been giving [funds]; if you add the month of March, the Central Government owes to the States GST arrears alone of around Rs.50,000 crore. Come April, it will be even more because there will be no GST income at all and they won't pay. The Centre's fiscal deficit has gone above four. But it won't allow the States to borrow more. So most State governments have chosen the easy path of cutting expenditure. Many development schemes are being given up. Five States have deferred the payment of salaries. This is absolutely crazy: while the Central government is expanding the expenditure, it is forcing the State governments to cut expenditure. It does not make any macro-economic sense. The States and the Centre should together have a programme for stimulating the economy.

What is the purpose of the seminar of State Finance Ministers that Kerala is planning to organise?

We are organising a webinar on April 27 and 28, because the Central government is not paying attention to what is being said. So I have requested all State Finance Ministers to come together on a webinar platform. There are no decisions to be made but to exchange views. I don't know how many will participate because definitely they will have political considerations. But I don't see any reason for 10 or 12 Ministers not to come. We are also calling academics, experts, financial bureaucrats, even journalists. It will be telecast live so that everybody can log in and see. I hope it will help bring the issues involved to a national level discussion.

Do you think other States are in agreement with you and have the same grievance?

In private, everybody agrees. In public, many Bharatiya Janata Party-ruled States do not want to join in a forum which they think will have anti-Centre overtones, even though they have the freedom to say what they feel like. But that has not happened in the past, whenever Kerala has made an initiative. Then there are non-BJP States who think they don't want to annoy the Centre. But I hope the Congress-ruled States, Delhi, and hopefully Andhra, Telangana and Orissa will join.

TEST KITS

It is well understood that widespread testing is the key to controlling the spread of COVID-19 in any society. Compared to other States, Kerala has conducted a higher number of tests. But isn't the number of tests done still too small? Do you think it is enough to conclude that the State has everything under control?

No. Now we have hit the barrier, for lack of testing. We don't manufacture test kits. And [United States President Donald] Trump is cornering all those test kits that China or Korea can make. Already we hear some States in India, for instance Tamil Nadu and Delhi, complaining that the U.S. has taken away the test kits that they had bought. Tests have become very scarce in the world now. That is a major problem for us.

But India is an important economic power. We should go on a war footing. It is not such an insurmountable technological challenge. The Indian biomedical industry should be given money and helped to expand to produce the test kits that we require. In fact, developing the Indian pharmaceutical industry, both public and private, can be a major element of India's exit strategy

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WAITING at a ration shop.

from the lockdown. If we do it fast, like China has attempted to, we can have a market.

Are States buying test kits on their own now, and from where?

[They are buying] from China, South Korea. Now the government of India has said States cannot source it directly and that we have to go through the Centre. So we are totally at the mercy of the Central government. I think the States should be given this freedom. Let the Centre acquire it, by all means. It is not a situation where anybody will say you have acquired too many ventilators or too much medicine. There is therefore no reason why the Centre should monopolise and create bureaucratic hurdles. So let that process go on and let any State that can procure more do it, too.

Kerala is a consumer State and has faced severe food shortages in the past. Do you think the State will be facing a shortage of essential supplies in the long term?

Yes. Because it is a consumer State, even in the short-term we are going to face serious problems. All the goods traffic has been disrupted. When the lockdown continues, shelves go empty, and many things will become scarce. Even food has to be sourced from outside. But we are stocking food supplies as much as possible. But then it also provides an opportunity for Kerala to become self-reliant in some ways. So we have started this campaign, "Grow Your Own Vegetables", during the lockdown, when people are at home—who knows, you may even get the paradoxical result of people of Kerala returning to farming again after the lockdown.

The COVID-19 crisis has led to job losses on an unprecedented scale all over the world. What will be the impact on jobs in Kerala?

It is going to be the greatest slump in history. It is already there. This quarter, all advanced economic countries, including China and the U.S., have registered negative growth. So this year, if COVID-19 is controlled in two or three months, it will be minus four, five or six percentage growth. But if the pandemic continues, then we have a huge problem. Huge. An economic disaster from which it will take the economy a long time to recover.

And the impact in Kerala?

In Kerala, it is definitely going to be negative growth. Our GDP is about Rs.7.5 lakh crore. We may lose half of that.

Which sections are going to be impacted more?

The biggest impact will be on tourism and service sectors, which depend on outside factors. Then all export industries will be in doldrums because the market is gone. We are producing a lot of intermediate goods, chemicals and so on, whose demand is gone. So, one doesn't know. The all-India demand of commercial crops is going to go down and import from outside will increase once the lockdown ends, because prices are trash in the international market. Kerala is going to face a big problem. It is going to be a tough time for the unorganised sector also.

One cannot imagine or map what exactly would be the scenario unless you have sense of how long this situation will continue. If it is prolonged, that is a situation you cannot imagine or plan for. But we will have to provide the bare minimum for everybody, get people to understand what is happening. It is going to be a time of big social problems where everybody has to be together. This has not happened in our lifetime, so one doesn't really know. In happened in the beginning of the 20th century and in the medieval ages. What will happen when a pandemic occurs in a globalised world? We don't know. It is going to take a long time for it to come out, and Kerala or India wouldn't be alone.

What are your immediate priorities when, as you said, you are going to "strike a balance between containing COVID-19 and enabling the economy to function"?

Now the focus is on containment alone. To stamp it out. We are already on that path. And then we have an exit strategy. That is being done. But we will keep our eyes upon what is going to happen when the next wave of return migrants arrives in Kerala. It is a very fluid situation in the State. So we will have contingency plans for each scenario. And that is what is required. We cannot plan for one situation alone. Suppose it is prolonged, how do you open the economy? You cannot close it down permanently. Therefore, then we can do nothing else but introduce reverse quarantine. Quarantine and protect the elders and the vulnerable people and allow others to go out and work. But that is an extreme scenario. There are other variants of it. We have to look at these options carefully. □

Rural distress

A countrywide survey of rural households during the lockdown confirms widespread distress and reaffirms the importance of public provisioning of food and other essentials, and of the urgent need for cash payments to stricken households. BY **A SPECIAL TEAM**

This report is based on telephone interviews of 43 informants from 21 villages across 10 States. Detailed socio-economic surveys have been conducted in these villages during the last decade by the Foundation for Agrarian Studies (FAS) under an India-wide programme of village studies, titled the Project on Agrarian Relations in India (PARI). The project involves the creation of a detailed database on villages of diverse agro-ecological and socio-economic regions of the country. PARI, which began in 2006, now covers 27 villages in 12 States.

For the Rapid Assessment Survey to study the impact of COVID-19 on rural India, we covered 19 of the 27 PARI villages. The list of villages is: Katkuian (West Champaran, Bihar), Nayanagar (Samastipur, Bihar), Alabujanahalli (Mandya, Karnataka), Siresandra (Kolar, Karnataka), Zhapur (Kalaburagi, Karnataka), Gharsondi (Gwalior, Madhya Pradesh), Warwat Khanderao (Buldhana, Maharashtra), Hakamwala (Mansa, Punjab), Tehang (Jalandhar, Punjab), Palakurichi (Nagapattinam, Tamil Nadu), Venmani (Nagapattinam, Tamil Nadu), Khakchang (North, Tripura), Mainama (Dhalai, Tripura), Muhuripur (South, Tripura), Harevli (Bijnor, Uttar Pradesh), Mahatwar (Ballia, Uttar Pradesh), Amarsinghi (Malda, West Bengal), Kalmandasguri (Koch Bihar, West Bengal), and Panahar (Bankura, West Bengal). In addition, we have also conducted three telephonic interviews in two villages, Adat and Chittilappilly, in the Adat panchayat of Thrissur district of Kerala. The characteristics of each village is provided here (http://fas.org.in/event/impact-of-covid-19-on-rural-india/).

The survey team selected two to three informants from each village, making sure to identify at least one manual worker and one peasant household. The questionnaire canvassed with each informant had three broad sections: on health, on household employment and incomes, and on government benefits. Each respondent was informed of the purpose of this exercise, and interviews were conducted after getting consent.

The interview team: Arindam Das, Gaurav Bansal, Ranjini Basu, Soham Bhattacharya, Deepak Johnson, Rakesh Kumar Mahato, Shruti Naghbhushan, Mrityunjay Pandey, Subhajit Patra, Jancy Rani, C.A. Sethu, Shamsher Singh, V. Surjit, and L. Vijay Kumar. The team was coordinated by Sandipan Bakshi and Tapas Singh Modak with support from Parvathi Menon.

TO UNDERSTAND THE IMPACT ON RURAL India of the unprecedented lockdown of normal life and work announced on March 24 as a measure to halt the spread of the COVID-19 pandemic, the Foundation for Agrarian Studies (FAS) canvassed a set of questions among 43 residents of 16 villages in 10 States across India. An FAS team conducted the COVID-19 survey between April 15 and 18.

The respondents represented a cross-section of village society—from large landlords to agricultural and manual workers, from ASHA (Accredited Social Health Activist) workers to individuals engaged in large and small businesses and other non-agricultural activities. The questions sought broadly to understand how a three-week lockdown period, which sought to pare down economic activity to a minimum, impacted the life, work and economic status of rural families.

Rural India not only has been grossly underserviced for decades in terms of civic and social amenities, but also sustains cruel and inbuilt socio-economic disparities of class, caste and gender that in even "normal' times create unconscionable levels of deprivation for the majority of rural dwellers.

On this low existing base of human well-being the lockdown has come as a body blow. While a total shutdown was necessary to mitigate the impact of a highly

COURTESY: FOUNDATION FOR AGRARIAN STUDIES

WITH collected fodder in Harevli, Uttar Pradesh.

infectious disease for which there is yet no vaccine or cure, its impact, as this survey shows, has disproportionately hit those sections whose coping mechanisms have already been rendered fragile.

Any crisis or disaster, let alone the gale-force of a pandemic, throws the working rural poor into further cycles of deprivation and debt.

The FAS rapid survey on the impact of the lockdown on rural India is not the first attempt to turn the spotlight of inquiry on rural households and livelihoods during this phase.

Despite the restrictions on travel, there have been insightful media reports and some valuable institution-led surveys on this issue. However, this is perhaps the first systematic study based on telephonic interviews with select residents of villages already surveyed in detail under the FAS's Project on Agrarian Relations in India.

Thus, there already exist baseline data that have provided us a picture of the agrarian structure and economy of the villages in which our respondents live. Further, the personal familiarity of the investigator with each respondent has allowed for a more layered interview than cold-call telephone interviews allow for. Despite the limitations imposed on travel and contact, our survey has provided snapshots of lived experiences in these unusual times.

The questions can be categorised under three broad heads. The first relates to information on pandemic-awareness among individuals, and whether a basic health infrastructure to meet the challenges of a COVID-19 outbreak is in place. The second set of questions relate to how the basic needs of households are being met during the lockdown. They elicit information on how families have provisioned themselves for this period, the availability of and access to food, whether they are eating less, the amount of cash they have, whether they have taken loans to tide over this period, and whether there has been any provisioning of food and financial resources by the state or any other institution. The third set of questions relate to incomes and employment. They are on the kinds of jobs that have been lost and why, and how much household incomes have been hit as a result.

The lockdown-impact survey has thrown up much interesting information and some tentative conclusions. Some of these are broad and apply to all States and regions, notwithstanding the regional diversities of crops, cropping patterns and ecological features. We have highlighted such conclusions. The survey has also given us a more fine-grained picture of regional and State-specific aspects of and responses to the lockdown, which we have not included in this write-up.

COVID-19 AWARENESS AND PREPAREDNESS

On health issues, we found that primary information about the pandemic and the lockdown came through TV, the Internet, social media (WhatsApp), and to a lesser degree through the village panchayats and ASHA work-

WEAVING a saree in Pahanar, West Bengal.

ers. While there is widespread awareness of physical distancing, the use of masks, the necessity of hand hygiene, the symptoms of COVID-19 infection, and the number to call in case of an emergency, the observation of COVID-19 prevention protocols are not uniform across the country. In Gharsondi village of Gwalior district, Madhya Pradesh, a respondent who is a manual worker was aware of the need for washing hands frequently but said he could only do it "with mud or sand".

Enforcement of physical distancing is strong in preventing inter-village mobility, although at the village level, compliance is patchy and respondents speak of informal gatherings that are not reported. In some villages suspicions against the returning migrant as a possible source of infection are strong—and in some instances from northern India it is compounded by communal hostility. However, returning migrants in all cases have been quarantined. From the perspective of health care, enabling the flow of information seems to be the foremost strategic response of the state to the disease. Both awareness through information flows and a fear of the unknown have led to the overall success of the lockdown.

In respect of institutional preparedness of the health system, state administrations have used the existing health delivery system to meet the new health challenge. Thus, the strengths or weaknesses of the pre-existing system have determined the robustness of the response. Respondents from 15 of the surveyed villages (in Karnataka, Maharashtra, Madhya Pradesh, Punjab, Tripura, Bihar and West Bengal) said their village had no primary health centre (PHC). In these villages, ASHA workers have performed the task of awareness building: Tripura and West Bengal, in particular, appear to have an active ASHA-based outreach. In Tamil Nadu and Punjab, medical teams from larger medical centres near by have conducted COVID-19 awareness programmes. By and large, the picture that emerges is of inadequate emergency services, including ambulances, even though respondents are aware of the resources they must marshal, including private vehicles, in case of an emergency. An exception to this is the experience of Kerala (see box).

INCOMES AND EMPLOYMENT

Two patterns have emerged in respect of the impact of the lockdown on agriculture. In rain-fed villages, this is normally the lean season and there is no standing crop, so there is little direct effect on agricultural operations and production. In Siresandra in Kolar district of Karnataka, where there is employment in vegetable cultivation during the lean period, Aparna, an agricultural worker, says she would normally have been labouring out "but there is no work now as cultivators are using their family labour". The cauliflower and tomato crop withered in the fields here as there was no labour to harvest the crop.

In irrigated villages, this is the harvest period, normally the busiest time of the year, and a peak work season for agricultural labour. In such villages, where the harvest is either just over or will begin this month, respondents report a dramatic drop in work, whether on the fields

AT A FARM in Hakamwala, Punjab, a file photograph. Relatively better-off landowners are making do with machines and family labour during the lockdown.

VILLAGERS involved in MGNREGA work in Hakamwala, Punjab.

or in non-agricultural activities. In villages where harvesting is yet to begin, particularly in the wheat belt of Bihar, Punjab, Uttar Pradesh and Madhya Pradesh, landowners use combine harvesters or family labour for harvesting operations. In West Bengal, there is a concern about adequate labour for the harvest of boro paddy due in May.

In Bihar, because workers cannot migrate or have returned to their villages, their numbers have increased in the village labour force, forcing wages down. In Katkuian of West Champaran district, a village with a tradition of out-migration, a Scheduled Caste wage-worker respondent tells us that the piece-rate for harvesting wheat has fallen from Rs.150/cottah to Rs.100/cottah (a cottah in Katkuian is 0.075 acres). In Nayanagar village, daily wage rates for sugar cane harvesting were Rs.200 for men (down from Rs.250), Rs.150 for women and Rs.50 for children. A large landowner from the same village said he faced "no shortage of labour".

A small peasant and manual worker from Harevli in Uttar Pradesh said he got three or four days of employment after the lockdown on sugar cane planting, where he says there is a decline in piece rate contracts from Rs.500-600 a bigha last year to Rs. 400-500 a bigha this year (a bigha in Harevli is 0.2 acres).

Respondents from West Bengal and Bihar have reported police enforcing the lockdown by not allowing workers into the fields.

NON-AGRICULTURAL EMPLOYMENT COLLAPSES

The pre-monsoon lean season is already a period of low incomes, particularly for manual workers. Non-agricultural economic activities that usually absorb surplus labour in the lean agricultural period like construction activity, businesses, brick-kilns, have almost totally stopped. In Kilvenmani and Palakurichi villages of Nagapattinam district, for instance, men and women in manual worker households who worked at different types of non-agricultural labour in nearby towns are now

STANDING jute crop in Kalmandasguri, West Bengal.

unemployed. "The stone quarries are closed," said workers from Zhapur, a rain-fed village of Karnataka. In almost every village, respondents from manual worker households had no non-agricultural employment.

In West Bengal, the breeding and sale of fish in village ponds is an income-earner in the lean season. Although there is good local demand for fish, this year this avenue of employment has been restricted severely by movement restrictions and the partial closure of markets.

There has been no daily-wage employment through schemes like the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGA). With the exception of one respondent from Warwat Khanderao village in Maharashtra, who said that NREGA work took place during the lockdown, although for a limited number of days and involving a limited number of people, there has been no non-farm wage employment activity carried out in the survey villages by any branch of the Central or State administration. For tribal households in

Why Kerala stands apart

THE measures taken up in Kerala differ from those in other States in three respects: (1) effective health measures, (2) successful distribution of food, essential supplies, and income support measures, and (3) active State support for agricultural production. These aspects of public administration were already in robust and functioning form and had only to be reoriented and resourced to address the challenges of the lockdown.

First, the respondents across different classes spoke about a functioning public health centre in their village panchayat, at a distance of around 3 km from their respective villages. They had phone numbers of the health centre, of ASHA workers, or of the State helpline to seek emergency medical services. While the respondents (like those in all the other villages) in general were aware of COVID-19 and related health issues through TV and newspapers, the respondents themselves were following the prevention protocols to slow down the spread of the disease. This is a reflection of the fact that the Government of Kerala went into detection-and-prevention mode in January itself, when the first case of COVID-19 was detected in the State. The respondents pointed out that wash basins with soaps and sanitisers were installed in common public places. They were not aware of specific COVID-19 tests being undertaken in the village, but all respondents noted that quarantine measures were followed strictly by those who had returned from abroad with the help of regular monitoring and instructions from health workers in the village panchayat.

Secondly, all respondent households had access to the public distribution system and had received the free ration of 15 kg rice per household at the time of the survey. This stands in contrast to the situation in other States; many of them are yet to even distribute food grains, according to respondents. The Kerala respondents were also aware of a functioning community kitchen run within the village panchayat building from where cooked food was being distributed to eligible households.

While the distribution of grocery kits containing 17 essential items had not yet begun in Adat village, the respondents were aware of this and expected to receive the kits soon. Respondents stated that their family members had received welfare pensions for two months in advance.

Thirdly, the State procurement system had covered all farmers, and an assured price was offered for rice, the major agricultural produce of the village. This measure immediately protected farmers from price fluctuations. The price of rice was fixed at Rs.26.95 a kg, higher than the Centrally-announced minimum support price (MSP) of Rs.18.15 a kg. The respondents had sowed rice in 2019 and were preparing for harvest operations when the lockdown began. The government had assured cultivators that harvest and procurement operations would not be affected. Despite the shortage of migrant workers, who had either gone home before the lockdown or were moved to camps, the State authorities arranged the required number of combine harvesters for harvesting rice in the village. They also made arrangements, where required, for workers to move from their accommodation facilities to the fields. The respondents who completed the harvest were able to do so without much difficulty.

DURING paddy transplanting in Alabujanhalli, Karnataka.

Khakchang village of North Tripura, the NREGA is in normal times the most important source of agricultural as well as non-agricultural employment in the village. It is also a major source of cash flow into the otherwise cash-limited upland village economy. The closure of all NREGA work in the lockdown period was a major cause of people running out of cash, according to survey respondents from Tripura.

The class of manual workers and the rural poor has had to bear the brunt of the lockdown on agricultural and non-farm employment. It has not been as severe on landowners or those with alternative sources of regular income. The lockdown was announced when the winter harvests over a large part of India had already been completed. In those States where the harvest is yet to take place, or is currently under way, as in the wheat belt for example, it would appear from our survey that the labour shortage has been managed by large cultivators by the use of harvesters and of family labour.

The massive contraction in employment and incomes for manual labourers in the lockdown period had an almost immediate impact on the quantity and quality of the dietary intake of rural families. It is not just a matter of having less money in the wallet for food. Poor farming families have been hit by the rise in prices of vegetables and other commodities (although in a few vegetable-growing villages, like Muhuripur in South Tripura, and Siresandra in Karnataka, vegetable prices have fallen).

Many respondents from such backgrounds reported eating less, and less healthily. In some families potato or cheaper vegetables have replaced green vegetables, or vegetables in general are less frequently eaten, while meat, poultry and fish are off the menu. Grocery stores, other village shops, and ration shops, from where residents can buy food, are open for a few hours in all villages—if of course they have the money to do so.

The responses we received on the functioning of the public distribution system (PDS) system in general, but more importantly, during the lockdown period, in meeting the requirements of those eligible for rations, reveals a mixed picture. In Bihar, three respondents from one village reported hearing rumours of getting a three-month consolidated ration, plus a Rs.800 subsidy for a gas cylinder free of cost, but said they had not received anything yet.

In Tamil Nadu, which has a well-functioning PDS, ration shops distributed an extra month's rations free of cost. In Karnataka, too, respondents said they received rations for two months, 5 kg of rice per head per household per month. Respondents in Tripura also received an extra month's rations. In West Bengal, ration card holders received just two kilograms of rice and two kilograms of wheat per head extra. Some respondents noted problems with the validity of their ration cards, and therefore were unable to gain access to rations.

With a few exceptions, including Tamil Nadu and Kerala, rations in States comprised only cereals. The only two States that reported distribution of cooked meals during the lockdown period were Kerala and Punjab. In Kerala, Kudumbashree-run kitchens have been providing food for migrant camps, while in Punjab the long tradition of langars serving free food has been reinforced during the COVID-19 crisis.

The picture was also mixed in respect of the distribution of dry or cooked food from anganwadi centres and schools to those eligible for it. Respondents from Karnataka and Kerala reported that the share of the infant/child/pregnant or lactating mother who was normally entitled to special food was delivered as dry grain to the family. By failing to ramp up the existing PDS network in terms of its reach, the Central and State administrations have showed negligence towards those hardest hit by the lockdown.

The picture that emerges from the country as a whole

A RURAL dwelling at Palakurichi, Tamil Nadu, a file photograph.

RUBBER being processed in Mainama, Tripura,

MAKING baskets at Nayanagar, Bihar, a file photograph. All non-farm activities and sources of income in the countryside were halted during the lockdown.

JHUM CULTIVATION, also known as slash and burn agriculture, in Khakchang, North Tripura, a file photograph. For tribal households in the village, the NREGA is in normal times the most important source of agricultural as well as non-agricultural employment. The closure of all NREGA work in the lockdown period was a major cause of distress.

is of a weak PDS that distributes non-uniformly across States, with beneficiaries not knowing how much or when they will receive their rations. Kerala has shown that in times of crisis, the number and range of commodities on the PDS basket can be expanded; this is a lesson for all States.

RISE IN INDEBTEDNESS

Income-poor respondents report a widespread rise in indebtedness, mainly to meet expenses on basic needs such as food. Loans are taken mostly from private, informal sources, including grocery shops from where food is bought. Most manual-worker or poor-peasant respondents reported having very little cash in hand when the lockdown was announced. They had to buy essentials for the house, and many took these on credit from the shop. Fewer than half the respondents reported getting sums of money ranging from Rs.500, in their Jan Dhan Yojana accounts, to Rs.2,000, in the case of those with registered land in their names who received the amount under the PM-Kisan scheme. In addition, the Government of Tamil Nadu distributed Rs.1,000 as lockdown relief. Respondents said that they had stopped paying EMIs (equated monthly instalments) and other money due to banks and microfinance creditors.

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In the images of thousands of desperate migrants thrown into hunger and hopelessness when their precarious world of work suddenly caved in, we saw the worst of the unequal impact of the lockdown. In rural India, too, it is the differential social impact of the lockdown that emerges as the hard conclusion from our survey. In a situation where social safety nets are not in place, the lockdown has a multi-dimensional impact on the life, work and well-being of the rural poor.

In the light of the social devastation that a pandemic could potentially unleash, the lockdown was unavoidable, and our respondents without exception were in full agreement with the necessity of such a drastic measure.

Large landowning households have not suffered as much as manual workers. In many regions, the major winter harvest is over, and the produce sold. In States where the harvest is yet to commence, as in Punjab, mechanised harvesting and a state procurement agency that has already swung into action will ensure that harvest losses are restricted. In the same regions, however, the impact on poor peasant and manual labour households is drastic. As our respondents have told us, such households face job losses and the collapse of incomes, growing food deprivation, increased borrowings and indebtedness, and rising food prices.

The survey highlights the need for the state to provide adequate public support through cash and food transfers and employment generation while maintaining individual distancing. Kerala presents an alternative experience with respect to meeting the challenges of the COVID-19 crisis –from medical preparedness to social provisioning of food, essential commodities and shelter. That experience offers important lessons to the rest of the country. □

Angling for a swap line

India's central bank is in talks with the U.S. Federal Reserve for a swap line that will give it access to dollars at a time when it is experiencing large foreign capital outflows owing to the COVID-19-induced global economic crisis. BY **C.P. CHANDRASEKHAR**

THE RESERVE BANK OF INDIA IS REPORTEDLY in discussions with the United States Federal Reserve to put in place a rupee-for-dollar swap line. If the Fed accedes, this would be a first for India but not for the Fed, which has had temporary and standing swap arrangements with chosen foreign central banks for many decades. With trade and financial transactions overwhelmingly denominated in dollars, governments, firms and households across the world are constantly in need of dollars to settle transactions. Periodically, some governments and firms, especially those not earning adequate dollars from their own exports, face dollar funding shortages. The Fed's swap arrangements are aimed at providing central banks in partner countries access to dollars to meet demands in their jurisdictions.

Under a swap arrangement between the Fed and a foreign central bank, the latter can access dollar funding in exchange for the domestic currency of the applicant. The swap involves two transactions: the first one is the sale to the Fed of a specified volume of the applicant's domestic currency for dollars at the prevailing market (spot) exchange rate, and the second one is a buyback on a specified date in the future of the domestic currency with dollars paid by the foreign central bank at the same exchange rate. When the second transaction is completed, the foreign central bank also pays interest at a market-related rate, which depends on the duration for which it has drawn on the swap line.

As an arrangement, a swap line allows central banks that have been provided the facility, to access dollar funding at short notice. They can use those funds directly or lend it to financial institutions in their jurisdictions in need of dollar funding and unable to access them easily from markets. The credit risk on such lending is carried by the foreign central bank, and the U.S. Federal Reserve does not enter as a party in any form in those subsequent transactions. In addition, the Federal Reserve is not faced with any foreign exchange risk on the capital provided since the sale and repurchase of the foreign currency to and from the Fed is at the same exchange rate.

The strain in dollar-funding markets tends to be severe in times of economic difficulty when the foreign

OLIVIER DOULIERY/AFP

THE U.S. FEDERAL RESERVE building in Washington, D.C. The Fed is central to the management of financial markets worldwide by virtue of being home to the world's reserve currency, considered "as good as gold".

exchange earnings of many countries fall and financial investors move their funds into the safe havens that both the U.S. and the dollar tend to be. Such strains have only intensified after financial globalisation, which enhanced the presence of foreign investors in financial markets in developed and emerging markets, with most transactions denominated in dollars. If investors choose to pull out, dollar availability reduces. In response to this changed situation, the Fed has tended to aggressively deploy its swap instrument in times such as the global financial crisis of 2007-08, when dollar-funding markets broke down, straining the financial system in foreign locations. It has also chosen to rely on this instrument in the current COVID-19-induced crisis that has overwhelmed both the real economy and financial markets the world over.

This has created a paradoxical situation. Both at the time of the 2007-08 crisis and in the still developing COVID-19-induced economic crisis, the U.S. was or is the or one of the epicentres of the crises. Yet, that country and its central bank have become crucial to mitigating the effects of such crises. This is because the Fed is central to the management of financial markets worldwide by virtue of being home to the world's reserve currency, considered "as good as gold", and because the dollar still reigns supreme and is the favoured safe haven for financial investors. Crises notwithstanding, the dollar dominates and remains the world's reserve currency and so does the Fed as the institution that manages the dollar.

Besides the collapse in world trade and commodity prices, the dollar shortage in the current crisis is being driven by two factors. One is the exit of financial capital. The Institute of International Finance has estimated that capital flight from emerging-market assets was $83 billion in March alone. Since January, the outflow has totalled around $96 billion, compared with the $26 billion outflow during the financial crisis of 2008. The second is the demand for dollars from corporates across the world to service the dollar debt they had accumulated during the years of cheap and easy dollar liquidity that followed the 2008 crisis. The Bank of International Settlements has estimated that the dollar debt of non-bank institutions outside the U.S. is around $12 trillion, up from around $6 trillion at the end of 2009. Dollar liquidity is therefore crucial to manage currencies and support financial markets.

Seeing the benefit in swap arrangements, the Fed had put in place standing dollar liquidity swap lines since October 31, 2013, with a selected few central banks: the Bank of Canada, the Bank of England, the Bank of Japan, the European Central Bank and the Swiss National Bank. The standing arrangements constitute a network of bilateral swap lines that "allow for the provision of liquidity in each jurisdiction in any of the five currencies foreign to that jurisdiction, should the two central banks in a particular bilateral swap arrangement judge that market conditions warrant such action in one of their currencies". The choice clearly reflects the importance of a country in the pecking order of market economies and its role as a source of or an intermediary in the flow of global wealth. At its peak, in the week ending December 10, 2008, the use of these swap lines by central banks other than the Fed took the sum outstanding to more than $580 billion, or around 25 per cent of the Fed's total assets.

However, with the COVID-19-induced global crisis wrecking financial markets, on March 19, the Fed entered into temporary (six-month-long) U.S. dollar liquidity arrangements (swap lines) with a host of other countries. According to the Fed, these new facilities will support the provision of U.S. dollar liquidity in amounts of up to $60 billion each for the Reserve Bank of Australia, the Banco Central do Brasil, the Bank of Korea, the Banco de Mexico, the Monetary Authority of Singapore, and Sweden's Sveriges Riksbank and $30 billion each for the central banks of Denmark, Norway and New Zealand. This brings in emerging markets such as Brazil, South Korea and Mexico; European nations such as Denmark and Sweden; and less important global financial centres such as Singapore. The total amount of $450 billion available to these countries is still small when compared with the swaps totalling more than $580 billion that the Fed's five leading partners availed themselves of more than a decade ago.

Yet, this is a change from the situation in the past when foreign exchange stringency or scarcity forced most countries to turn to the International Monetary Fund (IMF). With an increase in the number of central bank swap arrangements, countries can turn to the Fed instead, though that option is even now open only to chosen emerging markets besides some developed market economies. India is seeking similar access as it experiences large foreign capital outflows, in the form of exit of portfolio equity and debt funds, which totalled $15.9 billion in March this year and $1.1 billion in the first 13 days of April. As a result, foreign exchange reserves with India's central bank have fallen by $13 billion: from $487.2 billion on March 6 to $474.7 billion on April 3.

The strength of the dollar, the Fed and the U.S. these developments reflect is, again paradoxically, proving to be a problem for the U.S. The crises and the resulting flight to the dollar, of the world's wealth holders and financial institutions, have strengthened and are strengthening the dollar *vis-a-vis* other currencies and triggering a crash in global markets. A strong dollar does not suit the U.S.'s trading interests since it raises the foreign currency price of the country's exports and cheapens imports in U.S. markets. But more importantly, a strong dollar that triggers capital flight from global financial markets pulls down those markets, upsets the calculations of the world's wealth holders, and damages the U.S. firms that dominate global finance. The Fed's moves are, therefore, not driven by altruism aimed at helping out central banks in other jurisdictions but are motivated by its own interest and the interests of those it protects and promotes.

The motives of the Fed have also changed over time. From the 1960s until 1998, swap lines were standing arrangements with a set of central banks aimed at providing access to dollar liquidity for foreign exchange market intervention meant to manage and stabilise exchange rates. These were phased out in 1998. But the Fed revived and aggressively used swap arrangements with foreign central banks in 2007 and 2008, when the global financial crisis damaged access to dollar-funding markets. In response to the ongoing COVID-19-induced crisis, in mid March, the Fed first modified its then-prevailing standing swap arrangements with five foreign central banks by reducing the interest rate on use of the swap lines to near-zero and making funds available for longer periods of up to 84 days. A fortnight later, to widen the set of countries that could access dollar liquidity, it allowed countries to exchange their holdings of U.S. Treasuries, which are leading instruments to park foreign reserves, for dollars, enhancing quick access to dollar liquidity. It then widened the set of countries for which it had swap arrangements with central banks, bringing in some emerging markets as well.

> The Institute of International Finance has estimated that capital flight from emerging-market assets was $83 billion in March alone.

But still there are few developing countries that have been afforded this privilege. India is as yet not among them. This is forcing developing countries to turn to the IMF and the World Bank to help them face the current crisis. According to *The Wall Street Journal*: "More than 90 countries have inquired about bailouts from the IMF—nearly half the world's nations—while at least 60 have sought to avail themselves of World Bank programs. The two institutions together have resources of up to $1.2 trillion that they have said they would make available to battle the economic fallout from the pandemic."

India is the recipient of the largest COVID-19-related World Bank assistance programme, which as of now is $1 billion, to be used for screening, contact tracing and laboratory diagnostics, for producing personal protective equipment, and for setting up isolation wards. But it needs more dollar liquidity to manage the rupee and its financial markets. However, as of now India is excluded from an arrangement in which the U.S. and the dollar dominate, and a few countries have privileged access to dollar liquidity. If it fails to persuade the U.S. to accommodate it with a swap arrangement, it may have to borrow from the IMF, which may impose conditions that will limit India's options when dealing with the economic impact of the COVID-19 crisis. This strengthens the case for India to join those developing country governments demanding that the IMF increase its issuance of Special Drawing Rights so as to increase the supply of international liquidity to all member countries without conditions. □

GETTY IMAGES/ISTOCKPHOTO

THE COVID-19-INDUCED global crisis has wrecked financial markets.

‘If government does not spend now, when will it?’

Interview with Keshav Desiraju, former Union Health Secretary.

BY **R.K. RADHAKRISHNAN**

KESHAV DESIRAJU, A 1978-batch Indian Administrative Service officer of the Uttarakhand cadre, will be remembered for the systematic changes he tried to usher in during his short tenure as the Union Health Secretary. He joined the Ministry of Health and Family Welfare as Additional Secretary in 2010 after completing his tenure as Chief Secretary of Uttarakhand. In a message in the first report of the Sector Innovation Council for Health, brought out by the National Health Systems Resource Centre of the Ministry in 2013, he stated: “While India has a tradition of innovation in pharmaceuticals and in health informatics, much more needs to be done for innovation in medical devices and in health systems development and health care delivery. Even in our traditionally strong areas of pharmaceutical and information technology, the emerging challenges cannot be addressed unless continuing innovations are made possible. Making more investments in the health sector without creating a culture that permits innovations would diminish the effectiveness of the additional investments.”

P. SENTHIL KUMAR

In this interview to *Frontline*, he talks about the basic issues in the health sector. Excerpts:

Different parts of India suffer from one epidemic outbreak or the other every year. Outbreaks of measles, dengue and malaria are almost a regular feature, and there was SARS (severe acute respiratory syndrome) in 2009 and before that cholera. Now, it is COVID-19. The public health delivery system in India is the aggregate of all State health systems and there are massive differences in the quality of health care available in the States. In this situation, how big a challenge does COVID-19 pose to the people and the public health delivery system?

COVID-19 is a huge challenge because of the infection rate and the lack of a proven treatment. As of now [April 11], Maharashtra [with 1,574 cases] and Tamil Nadu [with 911] have the highest numbers. Fortunately, these are States where, on the whole, the public health system works better. Of course, this presumes that all the States are testing and collecting data in a like manner; this may not actually be the case.

Our systems on the ground are flimsy, despite massive investments since 2005, under the National Rural Health Mission [NRHM], later the National Health Mission [NHM]. Investment in public health is not a one shot operation as some donors and some corporate social responsibility [CSR] activities would have us believe. Unless there is continuous and systematic investment in building both human and physical infrastructure, we will not have a public health system that has the ability to respond quickly and effectively to a crisis. Ideally, every four-bed Primary Health Centre [PHC] should have at least one well-trained doctor, at least two trained nurses, the required complement of allied health staff and a reliable and regular stock of all medicines on the state-approved essential list. In such a PHC, a wide range of complaints would be attended to, both communicable and non-communicable, and normal deliveries would take place. Standard pathology tests would be possible and doctors would have the experience to make correct referrals. In the absence of a system working at this level of efficiency, COVID-19 poses a massive problem.

As investment in primary care needs to be continuous and systematic, only the government can do it, without expectation of returns in the short run. The government has assured us that health and wellness centres [HWCs] are being supported, as the underpinning to hospital-based, insurance-supported secondary and tertiary care.

In September 2019, the Government of India said [Preeti Sudan and Indu Bhushan, "In one year, PM-JAY has created a framework for comprehensive universal health care", [*The Indian Express*, September 23, 2019] that "more than 20,000" HWCs had been set up. Even assuming that they are all fully functional, a dodgy assumption at best, we should remember that there are about 24,000 PHCs and over 1,56,000 subcentres, all of which are potentially HWCs. These broad-brush, macro-level figures need careful scrutiny, a look at State-wise allocations for this purpose, and on-ground verification. I am told, for instance, that the HWCs in Puducherry are working very well. But this will probably not be true of Uttar Pradesh.

In a situation such as the one posed by the rapid spread of COVID-19, what should be the role of the Union government? Should it merely be a facilitator and supporter of State governments' actions or should it involve itself in all facets of disease management and control, right from procurement of personal protective equipment [PPE] and test kits to directing what tests should be carried out on whom and when? Or, should it only step in in places where the State governments are floundering?

It is not a question of one or the other. A federal setup at its most productive needs both Central and State governments doing what they can do best. The virus does not respect State boundaries and there is no need for anyone else to do so. Traditionally, the Centre has laid down broad policy directives and has coordinated the implementation of, and also significantly funded, disease-oriented programmes. It is the Government of India that is in close and regular touch with the World Health Organisation [WHO] or with agencies such as the Centres for Disease Control and Prevention [CDC], Atlanta, United States. But State governments have to run the hospitals, they have to coordinate with doctors and health personnel on the ground and they have to do the testing. At present, they have to enforce the lockdown.

States can, and do, exercise their right to decide for themselves on a State subject. Take, for instance, Odisha's unilateral decision to extend the lockdown. Or Tamil Nadu, which has not appointed ASHAs [accredited social health activists] as it has always had village-level health workers. But more often than not, the fact that the Government of India provides the funds means that the States fall in line. If States develop the ability to find budgetary resources for health care, they can show more independence in decision-making. The often-cited figure of 3 per cent of gross domestic product [GDP] for health care includes both Central and State allocations. States must begin to allocate more for health care.

Clearly, procurement-related matters should be left to the States but it depends on who is paying, and, sadly, we know from experience that medical procurements can lead to big corruption. I would say that we should leave it to whoever can do it more efficiently. Some years ago, Tamil Nadu and Rajasthan had well-structured procurement corporations. These were held up as an example for all States. I do not know if they have retained their reputation for efficiency and integrity.

The involvement of a research body, the Indian Council of Medical Research [ICMR] in all aspects of handling the coronavirus disease pandemic raises questions such as where are the infectious diseases experts in the country and what should be the role of institutions such as the National Institute of Communicable Diseases? Is there a protocol in place in the event of an epidemic? If not, why is there none?

The ICMR is a natural choice to provide technical leadership at this time. The National Institute of Epidemiology, Chennai; the National Institute of Virology, Pune; and the National Centre for Disease Informatics and Research, Bengaluru; are all ICMR-affiliated institutions. There is also the National Centre for Disease Control [until July 2009 called National Institute of Communicable Diseases] under the direct control of the Central Department of Health and Family Welfare, which is responsible for the Integrated Disease Surveillance Programme [IDSP] with the objective "To strengthen/maintain decentralised laboratory-based IT-enabled disease surveillance system for epidemic-prone diseases to monitor disease trends and to detect and respond to outbreaks in early rising phase through trained Rapid Response Team (RRTs)".

I cannot immediately say if there is an up-to-date, technically valid protocol with the Ministry of Health but I am well aware of the WHO "Pandemic influenza preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits", approved at the World Health Assembly [WHA] in 2011, which in itself is following a WHA resolution of 2007. [https://www.who.int/influenza/resources/pip_framework/en/]. This has much detail on how national institutes and laboratories need to coordinate with the [six] WHO National Collaborating Centres on Influenza, etc., but, of course, it won't help if one looks at the document for the first time when the pandemic is upon us. Systematic investment in surveillance and response systems over the years would have enabled better compliance with what the WHO Framework advises. I am somewhat struck by the fact that in all the relentless editorialising about COVID-19, no one is talking about this.

There is another point here. The ICMR need not have been the focal point for the COVID-19 response if the Directorate General of Health Services [DGHS] had been more effective. The DGHS has its origins in India's pioneering work in communicable disease control, and was a great organisation. It is still described as the technical arm of the Department of Health and Family Welfare but simply does not pull its own weight. The head of the DGHS should have been the face of the government response in this crisis. I remember commissioning a detailed report by one of my predecessors on the revitalisation of the DGHS, but the report, with readily implementable suggestions, has been buried, with the active support of the DGHS.

As the DGHS was not playing its public health role,

B. JOTHI RAMALINGAM

THREE PATIENTS being discharged from the Government Kilpauk Medical College Hospital, on April 11.

the Public Health Foundation of India [PHFI] was set up, with strong commitment from the government and the private sector. The PHFI was expected to set up a chain of Indian Institutes of Public Health to train public health cadres at all levels in the States. This did not happen as quickly as was desirable. The PHFI was not allowed to function and there were also serious problems with its governance structures. It is only now that things are changing. Hopefully, when this crisis has passed, the government will find a way to strengthen the DGHS and the PHFI.

Perhaps, the best experience we had in preventing and treating infectious diseases was in the National AIDS Control Organisation [NACO]. But NACO has been effectively shut down on the grounds that the prevalence of AIDS has come down, even if there are still large numbers living with the disease. We have lost the enormous experience gained in civil society participation in disease control.

In 2012, the Government of India constituted the Epidemic Intelligence Service on the lines of a similar organisation in the U.S. It appears that nothing has happened since the on-paper approvals were made. During your tenure as Union Health Secretary, was there any move towards reviving this or making this part of some other organisation?

You are quite right. The National Centre for Disease Control [NCDC] began training programmes as well, but my understanding is that they have all wound up basically because State governments showed no interest in sending people for training. It is all down-to-earth, hard-to-do, solid public health work. No one wants to do it. Maybe after the present scare things will change.

On the basis of this experience, would it be prudent to invest in a communicable diseases hospital-chain infrastructure, on the lines of, say, the Employees State Insurance (ESI) hospitals? What are the other options available for a country like India, which cannot spare massive resources for a dedicated chain, which might be of use, say, once in a decade or so?

There is no need for a chain of communicable disease hospitals. There is no need to recommend new construction activity because then that will become the objective of the activity itself. Every district hospital [there are about 750 across the country] should be fully geared to handle epidemics, sudden increase in number of patients, etc. A district hospital is where a person goes or ought to be able to go with any complaint, with communicable or non-communicable disease, for delivery, during an emergency, after an accident, for elective surgery, for eye and dental care and for routine check-ups. A good district hospital is also one where difficult surgeries can take place; this means surgeons and anaesthetists are needed, and there is a functioning blood bank. It will also need a qualified nursing team, with specific categories such as intensive care unit [ICU] nurses. There are quite a few across the country that meet these standards. If a district hospital is well staffed and well run, it will develop the capacity to convert its wards into isolation wards when called upon to do so.

I think there is a standing decision that district hospitals will be converted into medical colleges. This is not a bad thing if it will increase bed strength and increase the facilities available. But there is also a talk that these hospitals will be handed over to the private sector, which will invest in upgrading the facility to a teaching college

and, presumably, collect the profits raised from fee collection. The immediate consequences of this for the general health care seeking public are unclear and probably bad. If this is done, then the hospital will not be available to you in an emergency.

We see a lot of health versus economy debates happening in the country. The argument is that the economy should not be allowed to be on a free fall until such time the public health issue is fixed. Is there a way to strike a compromise or is there a middle path?

A lockdown situation cannot be indefinite. It is not just a question of losses on account of reduced economic activity. The consequences of being thrown out of work and being forced to leave the cities for "home" can be ruinous from the point of view of the health and well-being of thousands of workers, in both formal and informal sectors, and of their families. We do not willingly recognise that substantial numbers of those suddenly laid off work belong to the backward and Scheduled Castes. We do not know enough about how the threat of disease, the loss of family income and the return home of migrant men has affected women in rural India. There are already reports of increased domestic violence and the real possibility of unwanted pregnancies.

Clearly, people are going to have to return to work, but this raises a huge ethical dilemma. The urban middle class can probably continue to "work from home" or "work flexi-hours"; with some minimal adjustments, ensure that food and security are not a problem; and continue to self-isolate. The more vulnerable working class person, who has to go back to work because he/she needs to earn and whose daily work is not such that can be done from home, is going to have to break isolation and expose himself/herself to infection.

You talk of a middle path, but it is quite unacceptable if the middle path is one where people like us continue to protect ourselves from the risk of infection and the less privileged have to expose themselves to infection "because the economy has to be kept moving". If there is a risk, all citizens should share it.

Clearly, governments have to spend money on food and wage subsidies, paid to people at the place where they have isolated themselves. Several experts have called for Food Corporation of India [FCI] surpluses to be distributed; for MGNREGA wages to be paid out *even if there is no work;* and for efforts to be made to keep workers from migrating by setting up large camps in cities using public lands and buildings for the purpose or by requisitioning private spaces, if necessary.

When the threat of infection has abated, then all workplaces can start functioning. All this will cost money, but if the government does not spend now, when will it?

From a public health standpoint, as well as from the standpoint of society, what lessons can we draw from the events that have unfolded so far, across the world and in India? Does the force of this pandemic finally settle the public sector versus private sector health care debate in favour of the public sector?

The world has been transformed, and significantly for the good, by advancements in technology, information technology, and human ingenuity as manifested in the marvels of the modern world. The possibilities of AI [artificial intelligence] and advancements in scientific research are breathtaking. But what the present crisis has taught us, in our hubris, is that everything can be thwarted by pestilence and disease. Like the plagues of old, COVID-19 has brought the world to its knees. This is a lesson we should never forget.

A second lesson is that when a disease strikes it does not recognise religion, class, caste, income or nationality. It is tragic that this lesson needs to be repeated.

We are also learning at this time that we do not necessarily get from all our citizens the degree of responsible cooperation that is wanted at a time of national crisis. It is true that for a naturally undisciplined people, the urban middle class has observed, or has been forced to observe, lockdown reasonably well; but the newspapers regularly report disgusting, reprehensible behaviour by persons in authority and other citizens. This may not change even after the crisis has passed but we may hope that we will learn some lessons in collective well-being.

I hope we learn that India has to invest in the training of doctors, nurses and public health workers such as auxiliary nurse midwives [ANMs], ASHAs and Anganwadi workers. For 30 years we have believed that the private sector will take care of medical, nursing and dental education, with calamitous results for public health and the availability of qualified health personnel in public services.

The Central and State governments should invest in medical and nursing colleges, and take the lead from States such as Tamil Nadu. The Allied and Healthcare Professions Bill, 2018, pending in Parliament needs to be passed at the earliest and mechanisms put in place to systematically train young people in the recognised allied health professions and make them fit for service. A similar exercise is required for the range of public health services.

Tough decisions will be needed on how best to use the existing army of front-line workers, how they should be trained, how they should be supervised and how they can be absorbed into government service.

The present situation has also taught us something that we should never have forgotten. When it is the government's responsibility to handle a crisis, it is government institutions that come to the front. It is for this reason that the government must invest in its institutions and not seek to outsource its responsibilities. We have had enough of the tedious differentiation between "providing" and "provisioning for" health care. No one disputes the fact that some degree of tertiary care can be insurance funded, but to pretend that the substantial responsibility for health care can be so funded reveals a fundamental lack of understanding of India's public health realities. If this lesson is learnt from the COVID-19 pandemic, it would be, even at a high price, a lesson well learnt. □

Alternatives & advisories

The Ministry of AYUSH keeps pushing its treatment and prophylaxis protocols for COVID-19 even though there is no evidence to suggest that they are effective at keeping the virus at bay. BY **T.K. RAJALAKSHMI**

ON APRIL 3, IN A DISTINCTLY CURIOUS communication, the Secretary, Ministry of Human Resource Development (HRD), wrote to various educational bodies outlining the measures to deal with the COVID-19 outbreak.

They included the following: installing the Aarogya Setu application developed by the government to help in the fight against COVID-19; following the protocol developed by the Ministry of AYUSH to boost immunity to enhance the body's natural defence system; and, finally, lighting a candle on April 5 at 9 p.m. as suggested by the Prime Minister to "realise the power of light" and to "highlight the objective for which we are all fighting together".

The letter included the detailed protocol of the Ministry of AYUSH, titled "Ayurveda's immunity boosting measures for self care during COVID19 crisis".

Although AYUSH stands for ayurveda, yoga and naturopathy, unani, siddha and homoeopathy, the protocol the HRD Ministry was promoting and what the Prime Minister himself focussed on in his address on April 14 was ayurveda, yoga and naturopathy.

"Ministry of AYUSH recommends certain self-care guidelines for preventive health measures and boosting immunity with special reference to respiratory health. These are supported by Ayurvedic literature and scientific publications," the HRD Ministry's letter stated.

Pictorially depicted, the general measures recommended to enhance the body's natural defence system involve drinking warm water throughout the day, practising yogasana, pranayama and meditation for at least 30 minutes daily and using turmeric, cumin, coriander and garlic in cooking.

The measures listed, and depicted pictorially, to promote immunity are eating Chyvanprash (10 grams) every morning; drinking kadha, a herbal decoction made from basil, cinnamon, black pepper, dry ginger and raisins, once or twice a day; and, third, drinking "golden milk", that is, turmeric mixed in milk, once or twice a day. The last part of the protocol pertains to two "simple ayurvedic procedures": nasal application, that is, applying sesame or coconut oil or clarified butter (ghee) in the nostrils in the morning and evening, and oil pulling therapy, that is, "swishing" a tablespoonful of sesame or coconut oil in the mouth, taking care not to swallow it and then rinsing it out.

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A HOMOEOPATHY practitioner distributes medicine that can supposedly help prevent COVID-19, in Hyderabad on March 5 .

As one of the symptoms of COVID-19 is a sore throat and a dry cough, the protocol of the Ministry of AYUSH recommends steam inhalation with mint or caraway seeds and ingestion of clove powder with honey. "It is best to consult a doctor if symptoms of sore throat or dry cough persist," it states.

The April 3 advisory to educational bodies such as the University Grants Commission and the All India Council for Technical Education was curious because only two days earlier, on April 1, the adviser and head of the AYUSH Drugs Policy Section issued an order expressly asking all those "concerned ASU&H Regulatory Authorities in the States/Union Territories to stop and prevent

publicity and advertisement of AYUSH-related claims for COVID-19 treatment in print, TV and electronic media and take necessary action against the persons/agencies involved in contravening the relevant legal provisions and the aforesaid guidelines of NDMA [National Disaster Management Authority]".

The head of the Drugs Policy Section explained in an earlier paragraph of the order that in view of the "emerging threat in the country due to COVID-19 outbreak", it was imperative to "implement various measures for maintaining public safety in all aspects and to control dissemination of misleading information about AYUSH drugs and services".

His order referred to the twin orders that the Ministry of Home Affairs and the NDMA issued on March 24 instructing State governments and Union Territories to take effective measures under the Disaster Management Act, 2005, "including making of false claim as punishable offence". It was clear that misleading information was not to be disseminated, especially as there is no cure as such for COVID-19. The treatment protocol for the disease as detailed in government documents is that if anyone develops symptoms of a flu accompanied with difficulty in breathing they are to consult a doctor immediately.

On April 10, in contravention of the letter issued on April 1, the AYUSH Ministry reiterated its advisory on "immunity boosting measures for self-care during COVID-19 crisis".

Interestingly, a press release from the Press Information Bureau said: "In addition to the above advisory, the Ministry of AYUSH has also proposed to include AYUSH solutions in the district level contingency plans being drawn up to contain COVID-19 in all the districts across the country. The Ministry has also put together the draft guidelines for practitioners of different AYUSH systems in the wake of COVID-19, which is expected to be published shortly, after vetting by public health experts."

People began to question the immune-boosting claims of AYUSH as early as March when the cases began trickling in. On March 23, an Additional Secretary in the AYUSH Ministry wrote an angry letter to the editor of a leading national English daily complaining about a certain columnist who he claimed had used derogatory terms when writing about AYUSH. The affront, he said, was worse as the article was published on the day of the Janata curfew the Prime Minister had asked citizens to follow. The columnist had apparently "devaluated [*sic*] the health care potential of AYUSH" by likening its practitioners to "quacks". There were more than 702 AYUSH colleges, the Additional Secretary wrote, imparting five-and-a-half-year degree courses and three-year postgraduate courses apart from eight lakh registered practitioners with more than 28,000 public dispensaries and 3,200 hospitals.

Even before the scientific community in India had formulated a position on COVID-19, on March 1, none other than Vaidya Rajesh Kotecha, Secretary, Ministry of AYUSH, confidently wrote to the Chief Secretaries of all States and Union Territories in reference to the 30 positive cases that had been reported at the time in the country. He said that "there was no panic response warranted, AYUSH being one of the important Ministry [*sic*] equipped for providing appropriate response to the circumstances arose [*sic*] due to this public health challenge, it is worthwhile to associate with other stake holders in eliciting AYUSH based public health response considering the strength and evidences of these systems".

A detailed advisory the Ministry issued on March 3 stated that homoeopathy had been used to prevent epidemics of cholera, Spanish influenza, yellow fever, scarlet fever, diphtheria, typhoid, and so on, and that the Genus Epidemicus (homoeopathic medicine indicated for a majority of patients affected by an epidemic disease) had been used for the prevention and spread of chikungunya, dengue, Japanese encephalitis and cholera with good results. The advisory went on to give details of medicines under the AYUSH systems for the prevention, prophylaxis, symptom management of COVID-19-like illnesses and some other interventions in conventional care. And on April 14, while announcing the extension of the lockdown to May 3, Prime Minister Narendra Modi listed out seven things to be done by citizens, one of which was to follow the AYUSH Ministry's immunity-boosting instructions.

If there was evidence of the efficacy of the AYUSH Ministry's treatment and prophylaxis protocols at keeping the virus at bay, the Union Ministry of Health and Family Welfare would have incorporated them in its "Updated Containment Plan for Large Outbreaks", released on April 17, a copy of which is available with *Frontline*. The plan clearly states that "due to paucity of scientific literature based on community studies, the available data on host factors is skewed towards hospitalisation".

Under the section "Clinical Management", the document specified that the hospitalised cases would require symptomatic treatment for fever. "Paracetamol is the drug of choice," the document states. It further laid down that for patients with severe acute respiratory illness (SARI), oxygen therapy, pulse oximetry, non-invasive and invasive ventilator therapy would be required. All suspect and confirmed cases would need to be hospitalised and kept in isolation in dedicated COVID-19 hospitals and blocks. Severe cases would require critical care facilities.

In the section titled "Pharmaceutical Interventions", the document specified that hydroxychloroquine (HCQ) had been recommended as a chemoprophylaxis drug for asymptomatic health workers managing cases or asymptomatic contacts of confirmed cases under medical supervision. A combination of HCQ and the drug azithromycin was advocated for use in severe cases but only under medical supervision. Non-pharmaceutical interventions included quarantine, isolation and respiratory etiquette. There is no mention of any of the preventive treatment measures recommended by the AYUSH Ministry. □

Targeting a community

The COVID-19 crisis brings out the communal polarisation of society that has been on the rise in the past few years. BY **DIVYA TRIVEDI**

THE BATTLE AGAINST COVID-19 IN INDIA metamorphosed into Muslim-bashing very quickly. Antagonism towards the minority community, which had already spread its tentacles in society, intensified amidst the nationwide lockdown. By singling out an Islamic religious congregation as a major source of the spread of the infection, the authorities inflamed communal tensions and reports of Islamophobia poured in from various quarters across the country. Northern India was particularly affected.

Doctors at a government hospital in Rajasthan's Bharatpur district refused to attend to a pregnant woman in labour after finding out that she was a Muslim, alleged her husband, Irfan Khan, 34. They were apparently asked to go to Jaipur, and the couple started out in an ambulance. She delivered on the way; the baby did not survive. In a lawful society, this would be termed a case of criminal negligence, but not, it appears, in contemporary India, where Muslims are routinely demonised. A huge drama unfolded with barbs and counter barbs over the veracity of the incident, and the State Health Minister ordered a probe.

In Ahmedabad, Gujarat, the Civil Hospital reportedly segregated COVID-19 patients on the basis of religion apparently after some patients expressed discomfiture. The State Health Department, however, denied the charge.

The communal polarisation manifested itself during the lockdown in a range of aggressive actions, from economic boycotts to threats of violence. In Belagavi, Karnataka, two mosques were targeted by mobs because they did not switch off their lights on April 5 in response to the Prime Minister's call for lights out for nine minutes at 9 p.m. Twenty-two people were arrested for heckling and abusing the muezzin and other persons inside the mosques. In Jind, Haryana, an argument ensued between a Muslim family, which kept its lights on, and its Hindu neighbours. In the same area, four Muslim brothers were attacked with sharp weapons for "disobeying" the Prime Minister.

Adding to this were several reports of violence and boycott from across India in the days following the announcement of the lockdown. A middle-class neighbourhood in Delhi held a meeting to enforce an economic boycott of Muslim vendors. A man could be seen asking for vegetable sellers' Aadhaar cards in a video that went viral on social media. If they were found to be Muslim, they would be beaten up and warned to never set foot in the area, the man could be heard saying in the video.

In Uttarakhand's Haldwani, Muslim fruit sellers were asked to shut their shops. Posters were put up in Mangalore, Karnataka, and places in Assam calling for a boycott of Muslim traders. Muslim truck drivers were beaten up in Arunachal Pradesh. Families of Gujjar Muslim milk sellers were socially boycotted in several villages of Hoshiarpur, Punjab. They were not allowed to sell their milk (a commodity listed as "essential"), which they had to throw into the Swan rivulet. Mobs stopped them from grazing their cattle and threw taunts at them, saying they were dirty and spread the Coronavirus infection.

Four people were arrested for having fired shots at a mosque in Gurugram's Dhankot village. A mosque inside a graveyard in Mukhmelpur village of Alipur in North West Delhi was ransacked.

In Karnataka, a spate of reports of attacks on Muslims forced the Chief Minister to issue a stern warning to perpetrators. A mosque in Bagalkot had been attacked, fishermen in the Krishna river were assaulted, and Swaraj Abhiyan volunteers were beaten with cricket bats while they were distributing food to stranded migrants in Bengaluru.

At Kailancha gram panchayat in Ramanagara district, an elderly man was hired to beat a drum and alert residents against allowing Muslims to enter their village, Kylancha; two people were booked for it. Muslim volun-

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A BANGLADESHI couple who allegedly attended the Tablighi Jamaat congregation in Delhi, being taken to a quarantine centre in Bulandshahr, Uttar Pradesh, on April 9.

teers of Karwan-e-Mohabbat, a non-governmental organisation (NGO), were rudely turned away from Hindu settlements when they tried to distribute rations.

Much of the hatred was directed at adherents of the Tablighi Jamaat, who participated in a religious congregation in mid March at their headquarters in Delhi's Nizamuddin area, which was subsequently identified as a COVID-19 "hotspot".

On April 5, Dilshad Mohammad, a 38-year-old shopkeeper in Uttar Pradesh's Una district, who had returned from the Jamaat conference, slit his wrists before hanging himself in his home. He had been taken into quarantine but had tested negative for COVID-19. His death is under investigation, but some newspapers reported that he might have taken the extreme step because he could no longer bear the taunts and ostracism by his neighbours.

THE TABLIGHI JAMAAT FACTOR

A week later, a 30-year-old Assamese man who tested positive for COVID-19 slit his throat in a washroom at the isolation ward of a hospital in Maharashtra's Akola. He, too, had attended the conference in Delhi, and reportedly approached the hospital after he developed symptoms of COVID-19. A near lynching took place on the outskirts of Delhi when 22-years-old Dilshad Ali was dragged to a field in Bawana and thrashed. He had just returned from a religious gathering of the Jamaat in Bhopal, and his attackers were convinced that he was deliberately spreading Coronavirus to non-Muslims. While assaulting him, they reportedly asked "who were the others behind the conspiracy to infect Hindus". After giving him a merciless drubbing, they allegedly took him to a temple and forcibly tried to convert him to Hinduism. He was later quarantined in a Delhi hospital as a "Corona suspect".

The attacks on and suspicions against members of the Tablighi Jamaat were the direct result of a campaign in a section of the media accusing them of deliberately spreading the virus. Social media platforms were flooded with fake news and hashtags such as "Corona jihad", "Muslim means terrorist", "Corona terrorism", "Corona bombs Tablighi", and so on. Minister for Minority Affairs Mukhtar Abbas Naqvi said the Tablighi Jamaat had committed a "Talibani crime" by going ahead with the congregation in Delhi at a time when the World Health Organisation's guidelines on COVID-19 were already in place.

The fake news busting site Alt News said: "Ever since Delhi's Nizamuddin was identified as a corona virus hot spot, several old and unrelated videos showing the Muslim community in poor light are being circulated on social media. We have observed a deliberate pattern to delegitimise the community. Earlier this week, a video of a group practising a ritual in Sufism was falsely shared as intentional sneezing inside Nizamuddin mosque. Another old video, which was initially viral in Singapore and UAE, was shared with the claim that a Muslim man was spitting on food. All these videos have been used to call for a boycott of the community, especially the lower economic sections of the society such as vegetable and fruit vendors. This act of communalising a pandemic is disturbing as well as dangerous."

Leaders of the ruling party such as Mahendra Bhatt, the MLA from Badrinath in Uttarakhand, legitimised the economic boycott of Muslims. He advised the people of Uttarakhand not to buy vegetables from Najibabad and asked people to think twice before patronising shops of barbers and shoemakers, occupation groups that are traditionally Muslim. The BJP leader Kapil Mishra, known for his hate speeches and accused of instigating the violence in North East Delhi in February, tweeted: "Tablighi Jamaat people have begun spitting on the doctors and other health workers. It's clear, their aim is to infect as many people as possible with corona virus and kill them." By the time the rumour was proved to be false, it had spread like wildfire.

Maharashtra Chief Minister Uddhav Thackeray warned of strict action against people trying to polarise the narrative. "There is another virus of divisiveness apart from the coronavirus. I warn such people that I will ensure that no law will save you," he said. The Centre expressed concern and issued a note to all States regarding "polarising public opinion on religious lines". Yet, without naming Muslims, it indirectly blamed them for the situation as they did not comply with the lockdown orders. In the backdrop of "ill-treatment" and "noncooperation" meted out by a particular community to health-care professionals, the note called for adequate security for the professionals.

The Tablighi Jamaat is a century-old orthodox Islamic sect based out of India and currently operating in more than 150 countries. The missionaries roam from place to place, urging young Muslim boys to return to the "right path" of Allah. The most strident critics of the Jamaat are educated Muslims themselves, who dislike the Jamaat's stress on living life as in the time of the

NARINDER NANU/AFP

THE HOLA MOHALLA festival was allowed to take place in Amritsar on March 10, with thousands attending it.

Prophet Mohammad and segregation of women and its general conservativeness. Several such Muslims told this correspondent that when they were in college they used to "run away from" Tablighi Jamaat people. Their chief grouse against the Jamaatis was that they were unconcerned about worldly affairs or politics and were preoccupied with how to get closer to God and worried only about the wrath of God.

The Tablighi Jamaat came into the limelight in the West when their name cropped up alongside some terrorist attacks, including 9/11. The Western press has noted with apprehension that militants misuse the group to move around and cross international borders without being detected. No proof of the Tablighi Jamaat's involvement in any criminal activity has ever been found, and the claims have been denied by them and also the larger Muslim community. But depoliticising young Muslim men and encouraging them to move away from society makes them ripe candidates to be exploited by radicals. Terrorists, in fact, have often recruited from the ranks of the Jamaat.

As far as the Coronavirus is concerned, Tablighi Jamaat gatherings have acted as "super spreaders" not only in India but also in Muslim-majority countries such as Indonesia, Malaysia and Pakistan. Given the circumstances, the Jamaat cannot claim innocence and play the victim and there is no denying that it should be more careful. Having said that, it is unfair to haul all its followers over the coals and exploit the situation to fan Islamophobia in the subcontinent.

It was the Union Home Ministry, after all, that allowed the convention in Nizamuddin to be held from March 13 to 15.Around 8,000 participants had been allowed to travel from all over the world. The Delhi government's order of March 13 that banned any gathering of more than 200 people did not extend to religious gatherings. Only on March 16 the Delhi government issued a notification to close all religious institutions.

The NGO Bebaak Collective pointed out that filing first information reports (FIRs) against members of the Jamaat was an attempt to cover up the lackadaisical approach of the administration, which was unprepared to tackle the COVID-19 outbreak. The NGO distanced itself from the Jamaat's views but expressed concern about the vilification of the Muslim community in the media and the state's apathy in dealing with the pandemic.

The Jamaatis transmitted the virus inadvertently when they left the convention for their towns and villages. More than 27,000 Tablighi Jamaat members and their contacts were quarantined in about 15 States. The Tablighi Jamaat, incidentally, was not the only religious organisation to hold a mass gathering.

On March 11-12 in Punjab, a Sikh preacher, Baldev Singh, did not follow self-quarantine after returning from Italy and participated in the Sikh festival of Hola Mohalla attended by thousands of people. He infected 19 of his relatives and later died from COVID-19-related causes.. Because of him, 40,000 people had to be quarantined.

Several Christian priests in Kerala tried to organise masses. Hindu pilgrims continued to throng places of worship. Delhi's Kalkaji Temple was open until March 21, in complete violation of the Delhi government notification of March 16 prohibiting gatherings of more than 50 people. Tirupati Tirumala closed only on March 20 after a COVID-19 case was suspected.

The Indian government, meanwhile, continued its hounding of Muslims by introducing a new domicile law in Jammu & Kashmir that allowed citizens of mainland India to buy land and apply for government jobs there. The authorities continued to arrest students of Jamia Millia Islamia and Aligarh Muslim University and activists in Assam who had exposed a rice scam.

The Jamiat Ulema-e-Hind petitioned the Supreme Court against sections of the media that were giving a communal colour to COVID-19 cases linked to the Tablighi Jamaat event. A bench comprising Chief Justice S.A. Bobde and Justices L. Nageshwara Rao and M.M. Shantanagoudar refused to pass any order as it would lead to a "gag" on the media. "If it's a question of killing or dying, your remedy is somewhere else. But if it's a question of larger reporting then the Press Council of India has to be made a party.... I think you add the Press Council as a party to your case," CJI Bobde said.

The U.S.-based South Asian organisation Equality Labs demanded that the WHO and the Indian Prime Minister condemn and curb communal language linking Muslims to COVID19. Thenmozhi Soundararajan, executive director of Equality Labs, said: "Since March 28, tweets with the hashtag Corona Jihad have appeared nearly 300,000 times and potentially seen by 165 million people on Twitter.... Just weeks after the Delhi pogrom where hundreds of Muslim houses and shops were vandalised, an uptick in misinformation and harmful communal language are leading to violence. The threat of another pogrom still looms. The violence we're already observing as a result of online campaigns seen by millions are even more concerning during a pandemic when people need to be engaging in collective care and making efforts to socially distance." □

Calling out fake news

The COVID-19 crisis sees a spurt in fake news posts and videos targeting the Muslim community. BY **ZIYA US SALAM**

EVEN AS THE WORLD GRAPPLES WITH THE COVID-19 pandemic, in India the fight seems to have got much tougher with an upsurge in communal polarisation. There was an explosion of fake news relating to the Tablighi Jamaat congregation, and Muslims were the target. Spit, sneeze, lick, hit or throw, Muslims were seen doing all this and much more in a series of fake videos that went viral on social media. From a video showing men licking spoons allegedly to spread the virus to another where a man is shown spitting on fruits to infect buyers to yet another where a policeman, allegedly Muslim, is seen hitting a Hindu priest, there was no depth too low for the fake news factory to stoop to. Worse, many of these spurious news items were given space by the electronic media. The news agency ANI kept them enthusiastic company. The result was not just overwhelming confusion about the veracity of such videos and news items, but a genuine threat to communal peace and harmony at a time of grave danger to humanity.

Professor Mohammed Talib, a noted sociologist who teaches at Oxford, felt that the Tablighi Jamaat was just a pretext. "The media have been targeting a particular community for long," he said.

The circulation of fake news started early in the pandemic with a provocative video of Muslims licking utensils. Within hours, the video had been shared or "liked" thousands of times and in middle-class residential localities, it was shared on colony WhatsApp groups, with many residents sharing it with the tagline 'Spreading Corona'. Others wrote, "Stay aware, stay safe. Coronavirus is not spreading in India but it is being spread in the country. An example of this is Nizamuddin."

The fact-checking website AltNews ascertained that the video was four years old and showed Dawoodi Bohras who lick spoons and utensils to avoid wasting even a morsel of food. Around the same time, there surfaced a video of a vendor spitting on fruits. The video was from February and had nothing to do with any "deliberate" spread of the virus. The man, though, was arrested.

On March 21 came a 45-second video showing a man, purportedly Muslim, spitting on food before delivering to customers. Mahesh Vikram Hegde, founder of Postcards News, which often peddles fake news, shared the video and wrote: "What's the use of Janata Curfew when we have deadly sadists like this man? Arrest this lunatic immediately." As reported by AltNews, this was retweeted over 2,000 times. Right-wing propagandists were quick to latch on to it without bothering to check on its authenticity. Roop Darak, Telangana State spokesperson of the Bharatiya Janta Yuva Morcha, the Bharatiya Janata Party's youth wing, tweeted the video and called for a boycott of "such shops". Sonam Mahajan, a BJP supporter, tweeted it, too, to justify an earlier incident in which a man had refused delivery from a Muslim executive of Zomato. Her tweet was re-tweeted over 1,200 times.

Mahesh Vikram Hegde had picked a video that was dated, had nothing to do with COVID-19 and had originated abroad. AltNews, which did a detailed search for the video, wrote on its website:

"AltNews broke the video into multiple key frames and performed a reverse image search of one of the frames on Google. We found that the video was uploaded by a YouTube on April 27, 2019. After rummaging through various reverse image search results on Google and Yandex, we discovered that the video has been circulating recently in several countries in light of the

T. VIJAYA KUMAR

DIRECTOR GENERAL OF POLICE Gautam Sawang launches a WhatsApp helpline number to deal with social media abuse, fake news and derogatory trolling, in Guntur, Andhra Pradesh, on April 15.

coronavirus pandemic. A March 22, 2020, report in *Gulf News* said, 'Abu Dhabi Public Prosecution has confirmed that a viral online video of a worker blowing into a plastic bag containing food was not shot in the UAE.' The report also stated that the video of a man blowing into a food bag was traced to an 'Asian country'.

"A March 19, 2020, article by *Complain Singapore* reported that a complaint was filed with the Singapore Food Agency (SFA) based on the clip. Several people believed that the incident happened in a restaurant in Singapore. *Complain Singapore* published a statement by SFA: 'We note that the video is not new as it was posted on social media last year.' SFA debunked social media claims that the stall's name is 'Best Muslim Food Stall'...

"Both the reports from UAE and Singapore claim that the man blew into the food packet. There is no mention of intentional spitting.

"In fact, the video was also viral in Malaysia last year. A May 1, 2019, report by *Feed Me*, a Malaysia-based lifestyle website, said, 'The location of the mamak (open-air food restaurant) remains a mystery despite the post has gone massively viral, gathering over 11,000 shares....'"

Amid the chaos surrounding the congregation organised by the Tablighi Jamaat in New Delhi, another video of Muslim men sitting on their knees and praying started doing the rounds on social media. The video was shared widely with the claim that the people were sneezing deliberately to spread the Cronavirus.

In reality, the video was of a Zikr session undertaken by members of a Sufi order wherein they inhale and exhale energetically even as they chant the name of Allah. "Since Zikris usually performed at a Dargah, it is highly likely that the video could have been filmed somewhere else and not at Nizamuddin mosque which is also known as Tablighi Markaz or Bangle Wali Masjid," analysed AltNews. The Nizamuddin dargah rubbished the claims by AajTak that it had anything to do with the Markaz.

Another video doing the rounds showed a Muslim policeman hitting a Hindu priest during Ram Navami in Reva, Madhya Pradesh. This, too, turned out to be case of fabrication as the policeman in the photograph was not Superintendent of Police Abid Khan as claimed but Station House officer Rajkumar Mishra. Also, the priest was found doing the puja not alone but with a large group of women whom he had invited despite the lockdown.

Soon after this, ANI shared news of the Hindu community being denied groceries in Karachi. The report, which had great potential for causing social tension, turned out to be false. Investigations by The News found that in Rehri Goth, some 10 kilometres from Ibrahim Hydar in Karachi, supposedly the area in which Hindus were deprived of food, there was no population of Hindus, though some Hindus did own a few shops there. Santosh Maharaj, a local sanitary inspector, said: "To say that Hindus did not get ration is not right at all as there are none in Rehri Goth." He said that the government had indeed not provided any rations in Ibrahim Hydari but Hindus had not been singled out for denial or discrimination.

More recently, the Hindi film director Vivek Agnihotri, a well-known peddler of the Hindutva agenda, tweeted a video of men performing namaaz on the terrace of a building. Within hours, it was re-tweeted 5,000 times. Agnihotri asked in the caption, "Any idea where is this? Quarantine!" The assumption was that the video was of Indian Muslims worshipping together. A fact check by AltNews found that the video was from Dubai.

Vivek Agnihotri had neatly cropped some of the buildings in the background, making the video unrecognisable as having been shot in Dubai. On the Facebook page HukkaBukka, it was shared 400 times with the caption, "It can be loyalty towards the religion, but isn't it being a traitor to the country?"

Pratik Sinha, co-founder of AltNews, said: "The pattern of misinformation started when the Coronavirus was limited to China in December-January. Then we had a case where four videos, including one of a bike accident, were merged to show police killing people suffering from the disease. One of the videos was much older. When the pandemic reached India, initially the misinformation was about health. How if you consume garlic or ginger, and use all those home remedies, it could help combat the disease. Then around the time Janata Curfew was announced, so many videos were shared of foreign countries of bodies lying in a row to show how bad the things were around the world. Things were bad but the videos were false. There was fear-mongering. By March 31, the Tablighi thing happened. After that, there has been an overwhelming amount of communal misinformation. It was not restricted to social media but was also extended to mainstream media. The whole society was stressed. When you have such fear across the society, it is easier to fall for misinformation. If you have certain biases, you are more likely to fall for some fake news."

The Jamiat Ulema-e-Hind filed a petition in Supreme Court seeking directions to the media to refrain from spreading fake news. The petition stated: "The present petition is necessitated on account of the communal colour being given to the outbreak of the COVID-19 pandemic by certain sections of print, electronic and social media posing a threat to the life and liberty of Muslims infringing their fundamental rights under Article 21 of the Constitution. The demonisation is also an infringement of the right to live with dignity which is also covered under Article 21 of the Constitution."

It drew attention to communal headlines and taglines like "Corona Jehad" and bigoted statements demonising the entire Muslim community and even implicitly blaming it for the spread of the virus in the country. The petition submitted that some old unrelated videos were being spread to promote ill will against the Muslim community. The court refused to restrain the media and advised the Jamiat to approach the Press Council of India. The bench headed by Chief Justice of India said, "We cannot curb the freedom of press." □

Students in limbo

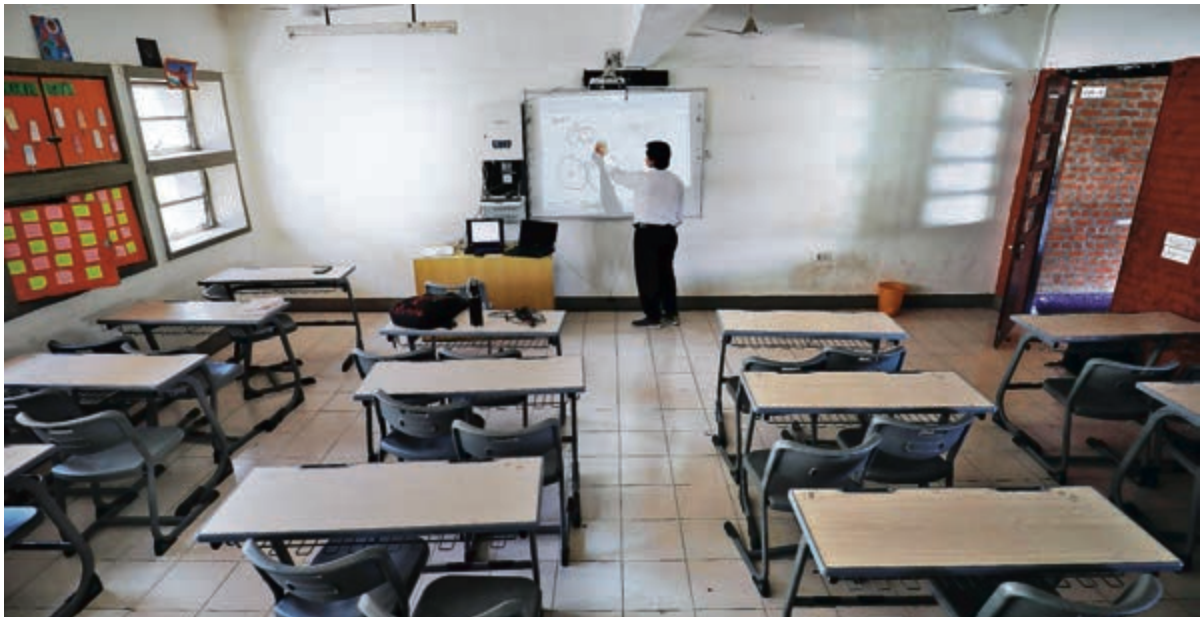
High school students on the threshold of their careers stare at an uncertain future because board exams and the entrance exams for various professional and other courses have been postponed indefinitely. BY **PURNIMA S. TRIPATHI** IN NEW DELHI

Ever since the COVID-19 outbreak, much has been written about the plight of daily-wage workers, migrant labourers or those employed in medium or small-scale enterprises, but nothing about the plight of lakhs of school students who are on the threshold of joining various professional colleges after finishing school. And these are impressionable young minds, easily distractable, prone to anxiety pangs, especially when they start preparing for their careers, sometimes as early as in Class VII or VIII. Today, they find themselves staring at an uncertain future, not knowing when their derailed career plans will get back on track.

Over 31 lakh students taking the Class X and XII board examinations conducted by the CBSE have got stuck midway because of the pandemic. Another 2.5 lakh students of who take the exams conducted by the Council for Indian School Certificate Examination (CISCE) find themselves in a similar predicament. In addition, over 15 lakh students who were to appear for their Joint Entrance Examination (JEE) Advanced test and another 14 lakh who were to appear for the National Eligibility cum Entrance Test (NEET) for admission to medical colleges across India suddenly find themselves grounded. Lakhs of students who take the school board exams conducted by the State education boards are in the same boat.

North East Delhi, too, which witnessed riots in the last week of February, students could not appear for their board exams. The CBSE had announced that these exams would be held after the regular board exams are over. But now, their exams are also indefinitely delayed.

The plight of these youngsters is unimaginable: holed up inside their homes, they have no outlet for their frustrations. “My son has retreated into a shell, does not eat properly or pay attention to what I tell him. He



AMIT DAVE/REUTERS

A TEACHER takes an online class in Ahmedabad during the lockdown.

becomes easily irritable and snaps at people without provocation. I have no idea how to deal with this," lamented the mother of a 17-year-old who still has to complete four papers of Class XII CBSE and was to appear for his JEE Mains. With everything on hold, this teenager has lost interest in everything. And this correspondent came across similar complaints from many parents whose children's academic plans have gone awry.

A senior official of the Ministry of Human Resource Development (MHRD) told this correspondent that even if the board examinations get over by the second week of May, evaluation and tabulation of the results will take another three to four weeks. The admission process for professional courses will take another three months, so the new academic session can only begin in September. And this is the best case scenario. "The MHRD will revise the academic calendar for schools, colleges and professional institutions as soon as we have a clear idea. But, frankly speaking, we don't know ourselves," said this official. According to him, the Prime Minister has been discussing this with heads of educational institutions and bodies like the CBSE, the University Grants Commission (UGC), the All India Council for Technical Education (AICTE), the National Council of Educational, Research and Training (NCERT) and the Union Public Service Commission (UPSC). "But no clear picture has emerged so far," he said. Another round of high-level meetings with the Prime Minister is slated to take place on April 17.

Academic activity went into a tailspin on March 19, when the Prime Minister gave the call for Janata Curfew followed by the nationwide lockdown. Since all schools, colleges and universities were shut down, all school boards and universities postponed their exams and entrance exams like the JEE, NEET, the Common Law Admission Test (CLAT), the Bar Council exam and the entrance exams for business schools. The Services Selection Board (SSB), which recruits personnel for the Army, Navy and Indian Airforce, postponed its course which was to start from March 20.

Students who were about to complete their professional education and had placement offers through campus recruitment have been the worst hit because their job offers are now stuck in limbo. "The MHRD has been talking to various industry leaders, advising them that they should honour the placement offers whenever the situation normalises, but that is easier said than done. By the time the lockdown is lifted and normal business activity resumes, who knows what the state of the industries will be?" says a senior member of the MHRD monitoring committee, which is trying to figure out a solution. HRD Minister Ramesh Pokhriyal Nishank had recently urged companies to not cancel job offers to graduates from IITs. "But that is just his wish," says an officer who was part of the deliberations.

The only saving grace in these grim circumstances is that the country is ready to take the entire gamut of school, college and professional education online, "from KG to PG" as a senior official put it. This means classroom learning, at all levels, can be shifted online immediately. This has been possible mainly because distance learning in India has quietly been part of the mainstream for quite sometime. The National Institute of Open Schooling (NIOS), in collaboration with the CBSE and the NCERT, has been working on projects to make academic content available to learners across India through the digital medium or through the direct to home (DTH) mode.

BY SPECIAL ARRANGEMENT

PROF C.B. SHARMA, Chairman NIOS.

The CBSE has developed a portal called DIKSHA through which lessons in various Indian languages are posted online for both students and teachers. Students can register on the portal for free and access content in their own language. Similalry, the NIOS has developed content for secondary and senior secondary classes on the Swayam portal of the MHRD Ministry (www.swayam.gov.in/nios). Through this portal, students can study the course of their choice, watch related videos and take an online test. The portal will also have a coordinating teacher to answer students' queries.

ONLINE LEARNING PLATFORMS

Four DTH TV channels on the SwayamPrabha bouquet of channels is yet another intiative of the NIOS. Channel 27, Panini, is dedicated to secondary classes, channel 28, Sharda, is dedicated to senior secondary classes, channel 30, Gyanamrit, is dedicated to sign language while channel 32, Vagda, is dedicated to live, interactive sessions. "The Information & Broadcasting Minister has recently directed all private service providers to make these channels available on their platforms too. Any student, sitting anywhere in India, can now learn through these channels and also ask questions through the live, interactive channel," says Prof C.B. Sharma, Chairman of NIOS.

Talking to *Frontline*, Sharma says all this digital content has been available for sometime but people did not know about it. "You hear about learning platforms like Byjus and Unacademy. We have been around for far longer but, unfortunately, we did not advertise ourselves. This lockdown has given us the opportunity to reach crores of school and college students and we should make the best of it." According to him, school teachers and principals, who were haphazardly trying to create online learning material should avoid doing that because they do not have the proper training. "Instead, they should access the content already available on these portals as this has been created by experts who have the requisite skills. Parents and teachers/principals should instead try to provide counselling and remedial lessons to children," he says.

The need of the hour, says Sharma, is to immediately create a task force which can devise ways to take online learning to every nook and corner of India, make use of community radio and FM channels and popularise learning through other digital mediums like YouTube. □

Bracing for next wave

After achieving significant success in combating the outbreak, Kerala prepares to handle a wave of reverse migration from the Gulf countries in the near future. BY **R. KRISHNAKUMAR** IN THIRUVANANTHAPURAM

"ONE CANNOT IMAGINE OR MAP WHAT EXACTLY the scenario would be unless you have a sense of how long this situation will continue. If it is prolonged, that is a situation you cannot imagine or plan for. But we will have to provide the bare minimum for everybody, get people to understand what is happening. It is going to be a time of big social problems when everybody has to be together."

These words of Kerala's Finance Minister Thomas Isaac, in an interview to *Frontline* perhaps encapsulates the thinking of the State authorities on how Kerala should move forward if and when the situation deteriorates.

Kerala seems to be acutely aware of what is in store if the pandemic continues and the economic disaster that will follow.

Yet, despite its extreme budgetary constraints, it was the first State to announce an economic stimulus package of Rs.20,000 crore and deliver welfare payments including Rs.8,500 each as arrears to 55 lakh persons. It also provided free rations and a kit of household provisions to each and every family.

The government has extended a consumption loan package through banks to poor households under the Kudumbashree network, apart from launching around 1,000 budget hotels serving meals at Rs.20 each and about 1,300 community kitchens that provide free meals.

It opened special camps for the large migrant population and destitute wanderers on the streets and provided them free food. This ensured that migrant workers remained inside their camps, except for one instance where some migrant labourers came out briefly onto the streets in a village near Kottayam demanding transport facilities to return home.

Kerala also ensured that even as it fought the spread of the disease, it delivered on the social welfare front too ('Kerala model', *Frontline*, April 10).

The largest crowds during the lockdown were of people from disadvantaged sections queuing up outside banks for cash assistance.

BY SPECIAL ARRANGEMNT

CHIEF MINISTER Pinarayi Vijayan at his daily evening press conference, flanked by Health Minister K.K. Shailaja and Revenue Minister E. Chandrasekharan.

The first State to report a COVID-10 case (on January 30), Kerala had the highest number of patients at one point of time, but on April 15 it had only 167 positive cases.

In one of his daily press briefings, Chief Minister Pinarayi Vijayan announced that Kerala had the highest recovery rate, with 218 of 387 patients having recovered. With just two deaths reported so far, the State also had the lowest mortality rate of 0.58 per cent.

Of the 387 positive cases, 264 had returned from overseas or from other States and 114 contracted the infection through contact with them.

Of 16,745 samples sent for testing, 16,002 were negative. After the spread showed signs of a spike, Kerala had 97,464 people under quarantine, 96,942 of them in their

S. GOPAKUMAR

S. GOPAKUMAR

AT A LEASE-LAND FARM on the suburbs of Thiruvananthapuram where vegetables were harvested. Farmers have been unable to sell their produce owing to the lockdown. (Right) Idling fishermen and boats at the Vizhinjam fishing harbour. The fishing sector has come to a complete standstill, affecting thousands of people.

own homes.

On April 15, only one new positive case was reported in the State—in Kannur district, where a person contracted the disease through direct contact.

On whether Kerala has "broken the chain", Pinarayi Vijayan said: "To say that and for us to relax, some more time will have to pass... . If we start thinking that we have made it already and start allowing concessions, if we lose our hold, the situation could spin out of control. We have to be very cautious that such a situation does not arise. We have to be vigilant and realise that even now it can all go haywire."

Kerala is still bracing for its biggest challenge since the start of the crisis—a third wave of possibly widespread infections is likely when those working in COVID-affected countries, especially the United Arab Emirates (UAE) and other Gulf nations, return in large numbers when lockdown restrictions are lifted.

The worsening pandemic conditions in the UAE and other Gulf nations led to shrill demands from hundreds of Keralites working there for special flights to return home. But the Government of India announced that flights to bring back such workers could be resumed only after the end of the lockdown period.

Moreover, Kerala has to ensure that enough quarantine and medical facilities are in place and make arrangements for strict surveillance and testing at airports and other entry points.

The first wave was composed of students of Wuhan University in China who returned home in January-February while the more potent second wave of migrants arrived from Europe and the Gulf in March.

Kerala is recalling retired doctors and hiring new ones and paramedical staff and requisitioning public and private buildings, including private hospitals, hotels, educational institutions and so on, to establish over 1 lakh additional beds and provide special quarantine facilities in every panchayat, with special attention for the most vulnerable groups, including the elderly.

As per an estimate quoted by the State Planning Board in 2019, nearly 34 lakh Indians were working in the UAE, of whom 8.3 lakh or so were from Kerala. The total number of Indians in all the Gulf nations was an estimated 85 lakh, 25 per cent of whom are from Kerala, according to Prof. Irudaya Rajan, a leading scholar in migration studies at the Centre for Development Studies, Thiruvananthapuram.

Emigration from Kerala to the Gulf has been on the decline and reverse migration on the rise, but over 50,000 persons migrate every year, he said. He also said that nearly 60 per cent of the migrant workers in the Gulf live in poor conditions in labour camps where the chances of spread of the disease are high. Also, at least 10 per cent of Indians may not have proper documents. Such people must feel trapped as they cannot return or even go to a hospital without identity cards, he added.

Prof. Irudaya Rajan estimated that two to three three lakh persons would return to Kerala when restrictions were lifted. Kerala is also worried that expatriate remittances, a major component of its economy, would dwindle as a result.

According to the State Level Banker's Committee data, non-resident Indian (NRI) deposits in public sector banks in Kerala as of March 2019 totalled Rs.93,321.3 crore, while the amount in private sector banks was Rs.95,046.65 crore. Remittances from these expatriates are also the major source of income for their family members numbering nearly 80 lakh, according to Prof. Irudaya Rajan.

ECONOMIC DISTRESS

The impact of the crisis is already visible in Kerala's other important revenue sectors: the tourism industry and the service and export sectors. The State's tourism industry, which generated Rs.45,000 crore last year, is set to lose Rs.20,000 crore in revenue, according to an early estimate by the Confederation of Kerala Tourism Industry.

The lockdown has badly hit several disadvantaged sections, with loss of livelihoods and jobs, indebtedness and other signs of economic distress clearly visible.

"You won't realise how so suddenly it has turned the lives of people upside down, for instance, in the suburban villages around Thiruvananthapuram city," said Rufus Daniel, a former panchayat president still actively engaged in the welfare of small farmers and farm workers.

He said the lockdown was introduced right when hundreds of lease-land farmers were beginning to recoup their capital from an intercrop of amaranthus, bitter gourd, snake gourd, long beans, elephant yam, taro root, sweet potato and many such perishables grown in post-harvest paddy fields.

These villages are well known for the extent of informal arrangements for lease-land farming, with individuals or groups, including women, spending Rs.50,000 to Rs.70,000 an acre a year to grow a variety of crops. "Their meagre profits, which many had to share within their group, came mainly from the intercrop of vegetables, which needed to be harvested at the right time. You can imagine their plight when suddenly they are asked to stay indoors, with a rich harvest threatening to rot in the fields, and they lose access to their only markets in and around Thiruvananthapuram and small towns and villages extending up to Kollam. State buses and autorickshaws, their only means of transport, have stopped plying, they can't sell door to door, and informal markets at road junctions are all under lockdown," he said. In the Kuttanad region, often called the rice granary of Kerala, harvesting is done with machines brought on rent from Tamil Nadu and Karnataka by groups of farmers. The lockdown was announced just when the summer crop of Uma and Jyothi paddy varieties were ready for harvesting within the required 120 to 130 days in upper Kuttanad. The first bout of summer rain had already threatened to spoil the crop. Rows of harvesting machines lay idle, with nobody to operate them, as drivers and labourers abandoned work and returned to their States nearby.

"Normally over 300 harvesters work the fields of upper Kuttanad, but this year only 110 machines could be brought here because of the lockdown and harvest was delayed even beyond 140 days," said Sam Eapen, president of the Upper Kuttanad Karshaka Sangham.

The loss of marketing avenues and access to farm inputs were troubling farmers in the other agricultural district of Wayanad, which had the least number of COVID-19 patients. Communist Party of India (Marxist) MLA C.K. Saseendran told *Frontline* that timely intervention by the government helped it procure the harvest at a reasonable price. However, over 5,000 farm workers from Wayanad who had gone to work in the ginger fields of neighbouring Karnataka remained trapped there following the lockdown and efforts to bring them back proved futile even after 22 days.

Even in normal times, there were several pockets of deprivation in the State, especially among the Scheduled Castes and Scheduled Tribes, fisherfolk, potters and artisans. Among the most affected groups in the lockdown, the fisherfolk in the 222 marine fishing villages and 113 inland fishing villages of Kerala faced extreme distress, "with 100 per cent loss of income", according to T. Peter, general secretary of the National Fish Workers' Forum.

Fishing literally came to a stop after fish auctions were banned in the landing centres, traditionally dominated by big-time auctioneers and traders. There are thousands engaged in allied activities, most of them women. Many of the fishing households are likely to fall prey to profit-hungry moneylenders, whose grip on them will continue for a while. "It is growing into a big social problem, with many families on the verge of a social and economic breakdown," Peter said. Curiously, he said, not a single positive case has been reported in any of the fishing villages.

Of the 76.99 lakh households in Kerala, 63.19 lakh (82.08 per cent) live in rural areas. Of these, 10.32 per cent belong to the S.C. community and 1.63 per cent to S.T.. Out of the total number of rural households, 19.16 lakh (30.33 per cent) were already officially "deprived". The highest deprivation rate is in Palakkad (42.33 per cent), followed by Thiruvananthapuram (38.36 per cent) and Wayanad (36.33 per cent) districts.

Moreover, 57.66 per cent of S.C. rural households and 61.68 per cent of S.T. rural households are also included in the "deprived" category. In most of these households, the major part of income came from manual casual labour. □

Surprise surge

In Maharashtra, Mumbai is emerging a hotspot, but the people are generally happy with the government's efforts to contain the virus and ensure that people's needs are met during the lockdown. BY **LYLA BAVADAM**

ON APRIL 14, MAHARASHTRA'S TALLY OF coronavirus cases more than doubled in a matter of six days. With 352 new cases detected the previous day, the State's tally reached 2,690. As many as 178 deaths were recorded until April 15. By April 17, the number of cases had soared to 3,202 with and 194 deaths.

Mumbai still leads in the number of coronavirus positive cases with 2,073 cases and 117 deaths. Apart from Mumbai, there were 350 cases in the Mumbai Metropolitan regions. Pune had 473 cases; Malegaon had 40; Nagpur had 56, Aurangabad and Ahmednagar had 28; and Sangli had 26.

Malegaon in Nashik district has seen a surge in the number of coronavirus cases. On October 13, 14 cases were reported from the area, taking the tally to 29, and by October 17 it was 40. It is being looked at as another cluster where the spread has spiked. The district authorities, in conjunction with the municipal council, are looking at demarcating containment areas in the city. Government officials are not ruling out the possibility of the presence of Delh-returned Tablighi Jamaat members in the area.

Mapping the virus shows an interesting progression. The State took 30 days to cross the 1,000-case mark on April 7, while it crossed the 2,000 mark in just six days. However, the State Health Department is not unduly worried about the increase in cases. A ward-level doctor, requesting anonymity, said: "The spread of the virus is still at stage 2. This means [it is restricted to] people who have had a history of travel or those who have come in contact with an infected person. It is easier to detect these cases and those around them through contact tracing."

Government spokespersons have said the spread of the virus is not exponential and is under control. Cluster containment plans of the government, such as the one applied at Mumbai's Worli-Koliwada, where the entire locality was sealed, seem to be getting results. The government is confident that the current growth is a natural one and that it is not out of control. About 3,000 tests are being done on a daily basis to try and monitor the progression. Until April 17, 56,673 tests have been carried out and more than 20.50 lakh people have been screened. As many as 71,076 people are in home quarantine and 6,108 in institutional quarantine. State Health Minister Rajesh Tope attributed a large number of the deaths to comorbidity issues—underlying ailments like diabetes and poor kidney and heart health.

Conducting 3,000 tests every day is indeed a valiant operation, but daunting when compared to the untested population. The Public Health Department says government and private labs have, until April 15, tested 45,142 samples. Of these, 44,808 (98.83 per cent) have been negative and 2,334 (5.17 per cent) were positive.

Shortage of testing equipment, personal protective equipment (PPE) and manpower remain the main hurdles. "Sealing off and quarantining entire localities where cases have been detected is actually the only way forward," said a ward-level medical officer. He said the administration was hesitant to take that route because it would be politically unpopular. However, another official in the State government said, "The BMC [Brihanmumbai Municipal Corporation] is overthinking things. The Chief Minister is in no mood to think of politics. He is genuinely working to contain the virus."

Dharavi is the other hotspot in the city where the first case was found on April 1. Again, lack of testing kits was a problem but a system had been put in place. There were 71 positive cases from the area on April 16 and eight deaths while 215 residents are in institutional quarantine. The addresses of the affected have been mapped and five pockets within Dharavi have been marked as red zones, their residents segregated as far as possible and door-to-door screening carried out. These zones have a population of about 50,000 people. Dharavi's total population is 8.5 lakh. Until April 15, of the 13,250 people thermally screened, 113 were sent for testing to a private lab that the BMC has tied up with; 1,381 residents have been found to be high risk contacts and 3,450 as low risk. People with high-risk display typical positive symptoms and they are institutionally quarantined. People with low risk are asymptomatic cases and are permitted to stay home.

KUNAL PATIL/PTI

MIGRANTS sleep under a flyover next to rail tracks near the Lokmanya Tilak Terminus in Kurla on March 31.

When the BMC appealed to private doctors for help, 24 local doctors came forward. They were provided with basic equipment and have been working with residents who are more amenable to local doctors being involved. A sports complex, a municipal school and a local hospital have been taken over as quarantine centres. Clearly, the administration expects the numbers to rise rapidly.

People were hoping that the lockdown will be lifted on April 14, but with the number of cases still on the rise, Chief Minister Uddhav Thackeray had no option but to extend the date. But the government will have to make special provisions for certain sectors and in certain areas. While the specifics are not yet announced, it is known that there will be no relaxing of rules in the Mumbai metropolitan area or in Pune. Some industries will be allowed to start on the condition that they accommodate the workforce in or near the factory.

District officials have been asked to send reports on the economic activities that can be allowed in their areas which will not assist the spread of the virus. It is understood that all the districts will be colour-coded to indicate the infection levels, starting with red (high) to orange (cases less than 15) to green (zero cases). Small and medium enterprises will be allowed to function with basic hygiene and physical distancing norms. While this is viewed with anticipation, the real challenge lies in arresting the spread of the virus so that the main industrial areas, currently in the red zone, can start functioning.

Agriculture is expected to get urgent assistance. Horticultural harvests are already being drastically affected and farmers are tense because there is no way to get the produce to the market. In Sangli, which is famous for sonaka grapes, farmers are literally dumping entire harvests by the roadside. Attempts to dry them and sell as raisins also do not seem to be working because of the huge quantities involved.

The general perception of the State government's efforts continues to be favourable. Public support flagged a bit when the April 30 and May 3 extensions were announced. The government needs to ensure a continuous supply of provisions, for which the factories need to work and the farmers' produce need to be picked up. There have been brief phases when, for instance, the Agricultural Produce Market Committee's (APMC) yards were shut with no warning and no explanation, causing panic-buying. Things levelled out when it was known that the reason was that a trader had tested positive. Loaded trucks, meanwhile, were directed to another location, where the temporary market continued. The APMC and grain and spice markets are expected to begin operations on April 16.

If the government has been found wanting it is in the logistics of getting food from the farms to people's homes. A bureaucrat agreed, saying: "That chain of farmer-trader-retailer-buyer, that's what we're working on.... That needs sorting out. All we ask is that the public do their bit: stay home and keep physical distance."

Physical distancing, masks, working from home, no public transport, it is all being mostly applied, but the virus is still spreading. The final word on this goes to Dr. Zarir Udwadia, the eminent pulmonologist: "There is little option. Quarantine and lockdown as a containment strategy against the coronavirus is all we have." □

Mumbai's ticking bomb

RAJANISH KAKADE/AP

OUTSIDE their homes during the lockdown at Dharavi on April 3.

"IF we don't die from the disease, we will die of starvation," says Lakshmi Umape, 45, who lives in the sprawling Geeta Nagar slum near the World Trade Centre in Mumbai. "They (police) have been patrolling our lanes ever since the lockdown started. They allow us to go to shops only within the slum. Those shops charge us three times the price for rice or *dal*. We heard the Prime Minister saying all food will be available at fixed price. But the shopkeepers charge us whatever they want. It is robbery."

Lakshmi Umape works part time as a cook. Recently widowed, she supports three children, a daughter-in-law and two grandchildren. When the lockdown was announced, her employers gave her a month's wages and asked her to stay home until the situation normalises. She is not sure whether she still has a job. But the immediate worry is food and mobility. "The police are constantly beating or chasing people. It is very tense here," she says.

Geeta Nagar is a slum of nearly one lakh people. Large families are packed into tiny one- or two-room structures that stand cheek by jowl along narrow lanes. Public toilet facilities are present only on the main roads that border the slum. Its diverse population is engaged in daily-wage labour, fishing, as domestic helps and so on.

Naturally, the cramped spaces, the lack of constructive activity and the unavailability of food is causing resentment and a restiveness. The extension of the lockdown made it worse. Residents of several slum areas that *Frontline* spoke to say the mood is down. "If high prices are bad enough, we have to buy gas, oil and milk in the black market," says Mahesh Pujari, a waiter at a restaurant. "We are given two hours in the morning to use the public toilet and when we get there, the lines are very long. If there is a time frame to the lockdown we can manage it somehow," says Pujari. "We do not even know whether we still have work" he says. He makes about Rs.10,000 a month and sends a small amount to his mother living in a village in Karnataka.

Barely 100 metres away are buildings that house some of the richest in the city. "Physical distancing and lockdowns are for the rich. In the beginning, we thought it was temporary. If we do not get work when the lockdown lifts, there will be a rebellion. Politicians have not dared to show their faces around our area," says Pujari. An office-bearer of the nearby Cuffe Parade Residents Association acknowledges the disparity. However, the representative of the society says the government has given strict orders to restrict entry for part-time staff, many of whom come from Geeta Nagar. In fact, they can file a case if the society is seen violating the rules, so our hands are tied, says the representative.

Mumbai's slums have become one of the most challenging aspects of addressing the pandemic. The density of their population and the insanitary conditions are ideal for the spread of the disease. As Mumbai becomes one of the hot spots in the country, there is a very real fear that if the disease hits the slum pockets, the city will be grappling with a health crisis it is not equipped to handle.

According to the 2011 Census, 41.3 per cent of Mumbai's 1.84 crore population live in shanty towns. The Maharashtra State government is aware of the slums becoming tinderboxes and seems to be making an effort via the Brihanmumbai Municipal Corporation (BMC) to control the situation. However, it will require a mammoth effort to keep the disease under check if it starts spreading in these areas.

At present three slums have been sealed because of residents testing positive. Sections of Dharavi, South Mumbai's Worli-Koliwada and Asha Nagar have been completely sealed.On April 16, Dharavi recorded 71 positive cases and eight deaths. Worli-Koliwada had six positive cases and Asha Nagar reportedly three. Mumbai recorded over 2,000 positive cases on April 16 and approximately 100-plus deaths.

"Densely populated, poor sanitation and hygiene levels are draws for the virus to attack. Sadly, it is an imported disease and for no fault of the poor they will be victims," says a doctor in Dharavi. "In spite of the government's efforts, it will strike here and people here do not have the wherewithal to survive this disease unless the government helps. But even if the government wants to help, it does not have enough resources given the numbers, he says. Census figures peg Mumbai's population density at an average of 21,000 per square kilometre. Not only does the city have the highest density of population in India, but it is among the top three most populated cities in the world.

Mindful of the slums' vulnerability and the stringent lockdown rules, municipal workers have been visiting affected pockets to take swab tests and carry out door-to-door checks. Deputy Municipal Commissioner Ramesh Pawar told the media that this is also being done to ease the load on laboratories and to prioritise testing,. The BMC says they have the capacity to test up to 2,200 patients a day. Two government laboratories along with five private ones are currently authorised to do the tests. Two government hospitals and three private hospitals will be dedicated COVID-19 treatment centres. Additionally, asymptomatic patients will be admitted to isolation centres in Nagpada, Bandra, Andheri, Powai and Shivaji Nagar. Observers say that while these arrangements are assuring, they are not enough to meet the likely demand. There are 381 containment centres in Mumbai.

Vinod Shetty, a labour lawyer and activist who runs ACORN, a non-government organisation (NGO) that works with children in Dharavi, says: "It is like a concentration camp there. No one is allowed in or out without a special pass. In spite of porous borders, the police have managed to seal it extremely well, leading to the feeling that the government has the resources to do these things but when people really need help, the government turns a blind eye. I hear that the free rations that the Prime Minister announced is not reaching the areas of the COVID-19 affected people. The migrant labour issue, which is already showing signs of exploding, is a problem in the slums as well. Many have rented homes on short-term leases. If they cannot pay the rent next month, the landlords will throw them out. Tension is brewing. They were not given any warning of the lockdown. All they want to do now is go back to their villages. It is tragic and will lead to a bigger tragedy. The misery is palpable. I think if the law enforcement authorities and local politicians are more communicative, people may calm down."

Anuj Lakra, 35, a security guard who lives in Nala Sopara, was ready to leave for his village in Chhattisgarh on April 15 when the lockdown was to end. He told this correspondent that he and his friends had decided to hire a bus and leave the city as they had no money to survive another month. Besides, the climate in the colony was tense and he said they could not live like that anymore. Lakra lives with eight other men in a single-room structure in a slum located in the northern belt of Mumbai. They work in shifts, four working at night and the other four during the day. When he was informed that crossing two State borders was impossible, that it would be a danger to his health and that travelling in a group would not be allowed, he broke down. "All I want is to go home. I will walk if I have to," he said.

There seems to have been a misconception that the lockdown would be lifted on April 15 and trains would ply to take people to their villages. That is perhaps why thousands gathered at the Bandra station on April 14, says a corporator from the ruling party who did not wish to be named. "The feeling we got was that there would be an exodus. Disappointment has led to unrest within the bastis [slums]. That is why the police have stepped up patrolling." There has been a noticeable ramp-up of security personnel in Mumbai ever since the lockdown was extended.

"I cannot go out and buy anything, police vans and patrols are all over our chawli [slum]. The other day, BMC people came to spray disinfectant in the area and we saw some screening. We have no idea what is happening, but have been told to stay indoors," says Amit Shengenkar, a taxi driver who lives in Worli. "In our area, local boys are now helping the police patrol. It has helped because people are familiar with the boys and they feel reassured. But we cannot get anything where we are," says Laxmi Kamble, a social worker who lives in Dharavi. The people who are very badly affected are those labourers who work in the textile and leather units in Dharavi. They are all daily-wage migrants from Uttar Pradesh and Bihar. They thought the trains would operate on April 15, but now everything is at a standstill.

Mumbai's slums occupy just 10 per cent of its geographical area but some wards such as Dharavi have a population density of 66,190 a sq. km. Mumbai's most dense area has 91,991 living in a sq. km.

Anupama Katakam

Community efforts

While non-governmental organisations step up to meet the food needs of migrant workers, the lack of adequate testing and the inordinate focus on Bengaluru remain worrisome. BY **VIKHAR AHMED SAYEED**

ON APRIL 12, AROUND 80 VOLUNTEERS gathered at St. Joseph's College in central Bengaluru to support the non-governmental organisation (NGO) Hasirudala's initiative to provide dry rations to waste pickers and other vulnerable communities in Bengaluru and other parts of Karnataka.

They got busy packing two kinds of kits. The larger kit contained 25 kilograms of rice, 5 kg of dal, a litre of oil, 1 kg each of sugar and salt, 500 gm each of chilli powder and tea powder and two bars of soap. The smaller kit contained 10 kg of rice and 2 kg of dal and the same quantities of the other items.

The volunteers said the large kit could sustain a family of four or five people for slightly over a month, while the smaller kit could sustain a family for 10-15 days.

Even before Prime Minister Narendra Modi announced the 21-day lockdown on March 24, Hasirudala began to galvanise its network to provide rations to waste pickers.

"Initially we worked from the Agricultural Produce Market Committee (APMC) yard in Yeshwantpur before moving to St. Joseph's College on April 3. Commodities bought wholesale are packed and distributed from here. Now, we are also reaching out directly to rice mills as the APMCs do not have sufficient rice," said Lakshmi Karunakaran, programme director at Hasirudala.

Leading an alliance of NGOs called With Bengaluru, Hasirudala utilised donations from both individuals and corporates to sustain this initiative, which extended beyond the network of waste pickers identified by it.

As of April 12, the last day of the initiative, it had distributed nearly 20,000 large and small ration kits in Bengaluru and a few other towns in Karnataka, thus taking care of the food requirements of 75,000 to 80,000 persons.

One of the main challenges was coordinating with other relief organisations so that there was no overlap of targeted beneficiaries. Additionally, the aim of With Bengaluru was to reach out to large numbers of the working population who were below poverty line and not beneficiaries of the public distribution system (PDS). "Ideally, all this should not be done by private citizens. We are just filling the gap before the government steps in," said Karthik Natarajan, who works with Hasirudala.

Shahin Shasa, who coordinates relief activity for another organisation, said: "We have received 320 requests for food since the lockdown began, meaning roughly around 6,000 people, as each request represents a cluster of people. Since the lockdown began, we have been able to partially close only around 150 requests. It is beyond our ability to handle this scale of demand as civil society volunteers."

STRANDED SECTIONS

NGOs had to step in to provide relief because of the sudden announcement of the lockdown from March 25 that left lakhs of vulnerable sections of the population stranded.

As the the State government did not have the field intelligence required to gauge and manage the colossal demand for essential commodities, the economically weaker sections were left in the lurch.

PACKING DRY RATIONS for the Hasirudala initiative.

BY SPECIAL ARRANGEMENT

The Karnataka government initially announced that it would provide dry rations to all households whether they had ration cards or not, but in practice only rice and wheat are being provided to BPL beneficiaries.

A large section of the population, especially migrant labourers, was left out.

Recognising that dry rations were not reaching the needy, the Bruhath Bengaluru Mahanagara Palike (BBMP) came up with a scheme to provide cooked food that would be directly delivered to wards, and appointed BBMP officers to coordinate with the needy in each ward.

Some of these officers told *Frontline* that there was a serious shortage of cooked meals. Ahmed (who gave only one name) is responsible for liaising with the BBMP from Ward No. 49 (Lingarajapuram) in north Bengaluru. After his phone number was circulated widely from the beginning of April, he received between 50 and 100 calls every day asking for food, he said.

"I apprised the nodal officer regarding this and requested for at least 300 food packets to be sent to Lingarajapuram, but only 100 packets have been sent today [April 12] after so many days," he said.

According to Ahmed, it is mostly construction workers from places such as Assam, Jharkhand and northern Karnataka who have been making desperate calls to him.

The BBMP claimed that 58,000 kits for migrant labourers, with rations for a week, had been distributed. However, many groups of migrant labourers continue to besiege NGO helplines with requests for rations.

Critics of the State government said it had not adequately used the Indira Canteens infrastructure to provide free meals to the needy.

There are around 260 Indira Canteens all over the State. With one Indira Canteen in each ward, there are 198 of these subsidised canteens in Bengaluru alone that provided three meals a day. Chief Minister B.S. Yediyurappa initially said that free food would be served in these centres from March 24, but the government stopped this within a week citing large crowds ofpeople who were not maintaining physical distancing norms as the reason.

When the canteens reopened in the first week of April, meals were priced at the usual subsidised rate of Rs.5 for breakfast and Rs.10 each for lunch and dinner.

INDIRA CANTEENS

During the few days when free meals were served, the government distributed 2,78,985 food packets in the Indira Canteens in Bengaluru, but this demand crashed by almost 80 per cent as soon as the meals were priced, indicating that people were unable to even afford this meagre sum without their daily wages.

When this reporter went around Indira Canteens during lunch time on April 12, there were hardly any takers for the vegetable pulao packets, only 49 lunch packets had been sold. As per information available from the Indira Canteen of Ward No. 63 in Jayamahal, only 67 lunch packets were sold on April 11. A month earlier, this canteen served, on an average, more than 400 meals during lunch.

Vinay Sreenivasa of the Alternative Law Forum in Bengaluru, who has been following the issue of food security in Bengaluru during the lockdown, said: "Indira Canteens should be used for providing free food as they already have the infrastructure and spread all over the city."

Some activists have also urged the government to use these canteens to distribute dry rations.

There are also reports that there is discrimination on the basis of religion, caste and region in some areas where essential commodities are being distributed. Reports also said that the public health system has been disrupted, with even cancer patients needing radiology turned away from the Kidwai Memorial Institute of Oncology.

With the extension of the lockdown until May 3, many persons are raising questions over the government's ability to provide adequate relief.

FALL IN CASES

The State government, meanwhile, has been patting itself on its back on reducing the rate of COVID-19 spread. K. Sudhakar, Minister of Medical Education, said in a statement: "If you see the States surrounding us where the numbers are spiking, Karnataka has done a better job as the numbers are not spiking here."

In an earlier interview, Sudhakar had said that Bengaluru was "flattening the curve", signifying a fall in the daily number of cases of persons testing positive.

In terms of the number of cases, Karnataka stood third on March 29 but has since fallen to 12th place..

However, it is too early to exult as the number of tests being done in Karnataka is lower than some States.

According to information from the Health Department, Karnataka had tested 12,184 samples as of April 15, of which 279 tested positive; 13 patients had died until then. Extrapolating from this data, Karnataka has done

M.A. SRIRAM

MYSURU CITY CORPORATION personnel disinfecting a bylane on April 14.

178.14 tests per million people with 2.3 per cent of the samples testing positive. As far as the number of tests is concerned, Karnataka's number is slightly lower than the national average.

Among confirmed cases, 44 per cent of the patients have some travel history while 39 per cent are their primary contacts. Of the remainder, 7 per cent are victims of severe acute respiratory infections.

Karnataka saw its largest single-day spike in cases on April 16 with 34 new cases. The total number of cases by afternoon stood at 313, with 17 new cases reported in Belagavi district alone.

The Karnataka government insists that the State has not entered the stage of community transmission, but the question arises as to how persons with no travel history or any contact with the victims have fallen prey to the virus.

Dr C.N. Manjunatha, a cardiologist who is the nodal officer of the COVID-19 task force in the State, said: "At this point, with persons with no case of travel history getting the infection, we can say that we are in the third stage [ofcommunity transmission]."

The Health Department has widened the protocol of testing from April 7 to include symptomatic persons in containment zones. The State government ordered one lakh testing kits on April 5.

Dr Srinivas Kakkaliya, a doctor based in Mangaluru who follows public health issues, said: "Karnataka has done an excellent job so far in containing the spread of COVID-19 as they have been quick in contact tracing and quarantining patients with travel history and primary contacts. The problem is that random sampling, prescribed in ICMR guidelines, is yet to start to figure out whether community transmission has taken place. This is such a disease that 80 per cent of the victims show mild to no symptoms, so random sampling is a must to understand its spread. If severe acute respiratory infections due to COVID-19 start rising in the days to come, that would also indicate rising spread in the community."

SITUATION IN THE DISTRICTS

In line with the decision of the Union government's Department of Health and Family Welfare to divide districts all over the country into hotspots or red zones, non-hotspot districts and non-infected districts, in Karnataka, Bengaluru Urban, which has 76 cases, the highest number in the State, Mysuru and Belagavi have been designated as red zones with large outbreaks. Within Bengaluru city, 38 of 198 wards have been designated as hot spots as they have reported positive cases.

Dakshina Kannada, Bidar, Kalaburagi, Bagalkot and Dharwad districts have been identified as hotspot districts with clusters of cases.

Ballari, Mandya, Bengaluru Rural, Davangere, Udupi, Gadag, Tumakuru, Kodagu, Vijayapura, Chikkaballapura and Uttara Kannada have been designated as yellow zones or non-hotspot districts that have reported at least one case.

The remaining 11 districts are green zones as they are districts with no reported cases.

Karnataka has identified 18 government hospitals and 27 private hospitals in Bengaluru for COVID-19 patients. The coverage in the districts beyond Bengaluru is fairly poor, with only 34 hospitals in 28 districts designated to treat positive cases.

While it seems that Karnataka has managed to control the spread of the pandemic, things will become clearer only if large-scale random sampling is done to gauge the spread of the disease. □

Bumpy road

Despite posting impressive recovery from a sharp spike in COVID-19 cases, Tamil Nadu is worried about losing a battle as lack of adequate testing kits has hampered aggressive testing during the lockdown.

BY **ILANGOVAN RAJASEKARAN**

AS ON APRIL 20, TAMIL NADU RECORDED 1,520 positive COVID-19 cases, which included 33 children below the age of 10. Seventeen deaths were reported until April 20, which works out to a case fatality ratio (CFR) of 1.1 per cent against the national ratio of 3.34 per cent. As many as 457 persons who tested positive have recovered, for a recovery ratio of 30 per cent.

As on April 20, 2,10,538 passengers who came from overseas and other States were under home quarantine, of whom 1,07,103 persons were in 558 confinement zones and the rest at home. Some 47,710 persons had been tested. The highest number of tests in a day was 6,109 on April 20, of whom 43 were positive.

Calling the virus an "imported infection", Chief Minister Edappadi K. Palaniswami claimed that due to sustained and dedicated efforts of the government, the infection ratio had started falling from its steep jump mainly from a "single source". "In the past three days, i.e, from April 14 to April 16, we have been seeing less number of positive cases," he said. He said confidently that in another four or five days the State would achieve "zero positive".

R. RAGU

CUSTOMERS throng to buy fish without adhering to physical distancing in Chennai on April 19. Such congregations could lead to a spike in the number of COVID-19 infections, undoing the gains made by the State so far.

His heightened optimism seems to have stemmed from an impressive list of details and statistics he was given and which he shared with the media on April 16. The Chief Minister told the media that his government had upped the ante against the virus from the last week of January itself on multiple fronts. It had stocked adequate quantity of medicines and emergency equipment. It had also augmented its health care infrastructure besides adding additional services such as isolation wards.

Surveillance at airports was put in place on January 23 though the first infection was reported on March 7. Subsequently, on March 15, places of public congregations such as malls, cinema halls, places of worship and educational institutions were closed. A prohibitory order under Section 144 of the Criminal Procedure Code was promulgated on March 23, a day ahead of the first nationwide 21-day lockdown announced by the Centre, he said.

The Chief Minister has entrusted the task of dealing with the emergency situation caused by the pandemic with a 12-member Task Force consisting of senior Indian Administrative Service (IAS) officers headed by Chief Secretary K. Shanmugam.

A senior bureaucrat at the State Secretariat said there was no interference with the team's work. "The Chief Minister listens to them, consults them and makes suggestions, if any, to them," he said.

Besides, a 19-member medical expert committee has been formed to offer medical and technical suggestions. Multiple sub-squads, headed by bureaucrats and police officials, were formed to monitor other related works in all districts.

More than 500 doctors, 1,000 nurses and 1,500 medical technicians were appointed on a priority basis to bolster the public health system. Special incentives were announced for those working in the front line of the battle against the virus.

The Chief Minister said the State had 3,371 ventilators, of which 2,501 were in government hospitals. It was in possession of 65 lakh three-layered routine masks and three lakh N95 masks and two lakh units of personal protective equipment (PPEs). A total of 1.95 lakh reverse transcription-polymerase chain reaction (RT-PCR) test kits were available, of which 68,000 were disbursed to the districts.

Tamil Nadu received 24,000 rapid test kits on April 18 as the first instalment (from China), and an additional 12,000 kits from the Centre. The test kits were sent to Erode and Coimbatore zones immediately. Testing commenced in Chennai, Coimbatore, Salem and Erode under the first phase.

Health Minister C. Vijayabaskar and Health Secretary Dr Beela Rajesh share the Chief Minister's optimism. They maintained that Tamil Nadu was still in stage II of the pandemic and had not entered the community spread phase. After the "single source" spike, Tamil Nadu started recording fewer number of positive cases, suggesting that the State is yet to reach its peak load, which can occur only when the community spread starts. Vijayabaskar said, "We are prepared for any eventuality." The State has 33 laboratories with a combined testing capacity of 6,000 a day. Its hospitals, both government and private, have 29,074 beds.

A senior public health official said: "We are ready for the emergency situation if the case load peaks. Buildings have been identified to have an additional capacity of one lakh beds."

But the top-level bureaucrats who are coordinating with health officials on the ground maintain that it is too early to lower the guard. One of reasons for their caution is that around 30 cases, though a negligent number in the overall total, did not have any known travel or contact history.

On April 8, the local media reported the death of a 45-year-old man, who had no contact or travel history, at the CMC Hospital, Vellore. The report from the Health Secretary was silent on this. Another report said that those who worked in a mall in Chennai tested positive. The first COVID-19 positive patient, a sales girl in the mall, had a contact history with a Kerala source who had travelled to Sri Lanka and back. Thus, his contacts could not be traced. The girl's colleagues, too, tested positive subsequently. The government put out a request to those who visited the mall during that time in March. Some 3,000-odd people turned up for tests. None tested positive.

"But we did not have the exact numbers of people who visited the mall during that period. We tested those who turned up," the public health official said. "Though these cases with no records are few and far between, we are still worried," he said. Heath officials said the State did not fudge statistics as alleged by some people but they had no answers to the crucial question of ramping up testing.

THE SINGLE SOURCE SCARE

There was a spike in the number of coronavirus infection cases in Tamil Nadu after some of those who returned from the Tablighi Jamaat event in Delhi tested positive. Subsequently, their primary and secondary contacts also tested positive. The government prefers to call it "single source" infection.

As per statistics provided by the Health Department, other than the "single source" infections, almost all the other positive cases shared in the public domain had travel or contact history.

"When the 'single source' infection jacked up the total, we were first worried. From the last week of March to April 12, the graph showed a steep upward trend. But after contact tracing and testing we realised that they were not super spreaders, as feared. The participants at the conference, after some initial apprehensions, came forward and submitted themselves for screening and testing," a senior IAS officer, who is a core member of the Task Force, said. A total of 1,302 had tested positive as on April 16.

In fact, the exercise of testing, surveillance, contact tracing and quarantining of those from the "single source" was relatively easy, since they happened to live in

K.V. SRINIVASAN

ONE OF the many walk-in testing booths set up by the Greater Chennai Corporation.

specific pockets in cities and towns. This particular source of infection was found to be largely confined to primary and secondary contacts.

Beela Rajesh said during one of her media briefings that the task of identifying each and every person of the source and bringing them to hospitals for mass testing and monitoring was being done at an exponential rate. "Combined teams of police, revenue, health and local bodies in each district were involved in the exercise of door-to-door verification and to identify and trace out the last contact in the link," she said.

What she, however, failed to mention was that the job could not have been accomplished but for the cooperation of the minority community, which was pilloried by majoritarian fanatics as "super spreaders". Elders and youths of the community volunteered to accompany the officials in their endeavour to trace and test the primary and secondary contacts. These "volunteers" spoke to frightened women and children in houses and convinced them that it was essential to undergo screening and testing for the "health of their families and society overall". In Coimbatore, they accompanied health workers and paramedical staff, who were also Muslim women, to complete the task of contact tracing, screening and testing.

"We were thus able to trace almost all primary and secondary contacts of the single source now. The result is that we could see a significant drop in the total number of cases," the health official said.

A study of the reported positive cases since April 1 shows the trend. On April 1, a total of 110 positive cases were recorded of which a major portion was traced to the single source.

Similarly, the figure was 102 on April 3, 86 on April 5, 96 on April 9 and 106 on April 12—a majority of the cases were attributed to the single source. When almost all the primary and secondary contacts were brought under the surveillance radar, tested and quarantined, the total number of cases stabilised and started showing a downtrend. On April 14, there were 31 cases, on April 15 it was 38, and on April 16 it was 25.

SHORTAGE OF KITS

One virologist said: "We are confining ourselves to those who have travel history and contact history besides the single source infection, which was an unexpected one. We have to come out of the comfort zone. To understand the harsh reality, we need to go for mass testing at the community level. And to identify and ascertain the source of infection one needs to broaden the testing for which adequate testing kits are needed."

Greater Chennai Corporation's Commissioner G. Prakash told the media on April 14 that about 37.11 lakh households were surveyed in Chennai since April 5. But the exercise that continues to date is confined to jotting down a few bare details, such as names and age of the inmates, whether anyone in the surveyed household is a diabetic and has symptoms of flu and fever. With no test kits available, the Corporation could identify 695 cases of influenza like illness with symptoms of flu and fever, of whom 404 were referred for further screening and monitoring.

Before the door-door survey was undertaken, the civic body had placed an independent order for 50,000 rapid test kits with a Chinese firm in the first week of April. The hard fact is that in the absence of testing kits, the Corporation lost the opportunity offered by the lockdown to carry out aggressive testing. "How could we do testing when we don't have kits to study the prevalence of the virus in the community?" the virologist asked.

However, Beelah Rajesh, downplayed concerns about inadequate stocks of test kits, saying the State has enough stock of RT-PCR kits. She said rapid test kits were meant only for preliminary screening in the community and could not confirm the prevalence of the infection. "It is not finality. We have adequate RT-PCRs, which are more than enough as of now," she said.

THE CENTRE'S INTERFERENCE

The Centre did not allow the States to decide on their needs and requirements independently. It mooted the idea of centralised purchase and distribution. The Union Ministry of Health and Family Welfare in its notification issued on April 2 told Health Secretaries of all States and Union Territories that "State governments and Union Territories may not go for procurement of crucial medical equipment and these should be procured centrally by the Ministry of Health and Family Welfare and distributed to the States." The notification further said that the

R. RAGU

A GROUP of temporary workers engaged by the Greater Chennai Corporation for door-to-door general health census, on April 16.

Ministry had to "revisit the actual requirement of crucial medical devices for COVID-19 management such as PPEs, N93 masks and ventilators and to aggregate the States' demand and come up with a special figure on a rational basis". By appropriating such vital powers of the States, despite health being in the State List, the Central government stalled any independent purchase by the States. When a journalist asked Shanmugam on the non-arrival of rapid test kits on April 11, he said the kits were "diverted to United States of America from China." "You know better," he said sarcastically. In his videoconference with the Prime Minister on April 10, the Chief Minister told him that the State urgently needed Rs.9,000 crore for the management of the pandemic and that funds meant for the State had not been disbursed so far. He sounded exasperated when he told the press that, "We [States] are in a position to receive and they [Centre] are in a position to give." That the State remains underfunded is a serious concern in the fight against the virus.

"We have received just Rs.510 crore from the Centre. It is a tough job for the State government to manage a pandemic with no concrete support from the Union government," a spokesperson of the ruling All India Anna Dravida Munnetra Kazhagam said. However, party spokespersons have been instructed not to criticise the Centre openly on media platforms. S. Venkatesan, Member of Parliament from Madurai and a Communist Party of India (Marxist) functionary, helped Madurai Rajaji Government Medical College Hospital to procure equipment such as PPEs and masks from local manufacturers under his Member of Parliament Local Area Development Fund. "The exercise was completed swiftly before the Centre could suspend the scheme. They have usurped Rs.750 crore allotted to the Tamil Nadu MPs' local development funds," Venkatesan said in his statement.

The presence of a few cases with no traces of contact is worrying since the pace of transmission in a highly urbanised State such as Tamil Nadu could not be predicted. A senior doctor says that cases of acute respiratory syndrome, dengue and even malaria are getting reported now.

"It is a bureaucratic myopia. We need an open and straightforward dialogue with opposition parties," said K.G. Gopikumar, State secretary of the Centre of Indian Trade Unions (CITU). He urged the government to show the PPE and masks stored in its Medical Corporation godowns to the media to counter the claim of opposition parties that the stock of PPEs and masks were insufficient and were of substandard quality. "We cannot ignore the fact that 13 doctors have tested positive, so far," he claimed.

The uncertainty and unpredictability has forced the Chief Minister to not relax the lock-down regulations in Tamil Nadu. "How long can we continue like this? Like dengue and malaria, this virus is going to be there with us. We have to learn to live with it. Hence we need to plan accordingly," an IAS officer said. Transparency about what is happening will go a long way in building confidence in the minds of the people about their safety. □

Jolted to a start

After initial denials and reckless statements, the Chief Ministers of both Telangana and Andhra Pradesh have attempted to rise up to the COVID-19 challenge and its economic fallout. BY **RAVI SHARMA**

THE TELANGANA GOVERNMENT LED BY Kalvakuntla Chandrashekar Rao could not have had a more controversial start in tackling the COVID-19 crisis. Cornered by the opposition Congress in the Assembly as news trickled in of COVID cases, the Chief Minister said nonchalantly that the virus did not survive in temperatures above 27 °C and that paracetamol tablets were enough to treat the ailment. He was, of course, forced to retract that statement, later clarifying that he had only quoted a scientist. From that point Chandrashekar Rao has attempted to put in place several steps to steer Telangana through a maze as the number of people turning up positive for the virus in the State keeps growing.

Admittedly, the Telangana government was the first to request Prime Minister Narendra Modi to ban the arrival and take-off of all international flights in order to mitigate the risk of people coming from abroad carrying the virus and spreading it locally. It was also the first to suggest the sealing of inter-State borders, a ban on public transport, both intra- and inter-State, and urge Modi to extend the lockdown by another two weeks from April 13.

With government estimates indicating that Telangana has over 3.26 lakh migrant labourers (working in the construction and poultry sectors, irrigation projects and rice mills) and most of them keen to go back to their native places, the Chief Minister announced a one-time package consisting of 12kg of rice and Rs.500 a person to tide over the lockdown. Migrants will also be provided with shelter and medical aid.

The Telangana government also announced a relief package of 12kg of rice and Rs.1,500 a family to the poor, destitute and marginalised, and orphans and aged persons, most of who come under the umbrella of the nearly 88 lakh food security cardholders.

The opposition parties and COVID-19 Advocacy Lockdown Collective, a civil society organisation which has been working with affected people, have highlighted inadequacies in the implementation of the government's initiative, pointing to delays and discrepancies in the distribution of free rice among poor families and migrants. They have also alleged that none of the food security cardholders have received the promised Rs.1,500 financial assistance. The civil society organisation has also requested the Chief Minister to extend these benefits to non-ration cardholders as well, since a large number of people who had applied for ration cards were yet to receive them.

G.N. RAO

A DOOR-TO-DOOR survey at Khilla Bazar in Khammam, Telangana, on April 9.

Civil society organisations have also questioned the government's decision to peg the number of migrant workers at 3.26 lakh. They claim that the number of registered building and construction workers alone in Telangana exceeded 8.5 lakh.

Chandrashekar Rao has been urging the people of the State to relive the "Sakala Janula Samme"'(total lockdown) movement, a tactic that was effective during the separate Statehood agitation. And while lockdowns and physical distancing are being enforced, albeit patchily, the real weapon against the virus, which is widespread testing and identifying and isolating those who have the virus, has been woefully below par. The government has authorised 17 government hospitals and laboratories, including the Centre for Cellular and Molecular Biology, Hyderabad, to conduct COVID-19 tests. But the number of tests needs to be exponentially scaled up from the present capability of 1,100 tests a day if the Chief Minister's apprehensions over the shutting down of the rural economy and employment are not to come horribly true.

Telangana has more than 50 lakh acres of agricul-

tural lands, and harvesting is just around the corner. The government has promised to procure the entire yield at the villages itself at the Minimum Support Price. The State also has around 8,500 acres under horticultural cultivation. Officials from the Horticulture Department said that around 10,000 small and marginal farmers, mostly in Rangareddy, Medchal, Vikarabad, Bhongir Yadadri, Suryapet and to a lesser extent in Siddipet and Medak, depended on floriculture for their livelihood. Flowers such as marigold, chrysanthemum, lily, jasmine, and other locally grown variety have no buyers because of the wholesale cancellation of functions following the lockdown. With the investment required to grow flowers ranging anywhere between Rs.50,000 and Rs .1 lakh an acre in open cultivation and between Rs.3 lakh and Rs.4 lakh to raise orchids, carnations and roses in poly/green houses, the lockdown has meant huge financial losses.

NAGARA GOPAL

AT A ration shop in Khairatabad, Telangana, on April 6.

Another sector to be badly hit by the lockdown is Telangana's poultry industry. Around 60 to 70 per cent of the eggs produced in Telangana and Andhra Pradesh are sent to other States. The lockdown was another unexpected blow to the sector which was initially hit by rumours linking the consumption of chicken with contracting COVID-19. With demand and supply for both eggs and broiler chicken drastically reduced, distress sales and culling of birds have become a common sight.

Though Chandrashekar Rao was one of the first Chief Ministers to push Modi for an extension of the lockdown, he is acutely aware of the need to keep the State's economy ticking. The near paralysis of the economy has resulted in Telangana's tax and non-tax revenues dwindling: compared with the proportionate monthly revenue of Rs.4,000 crore, the actual accrual has been Rs.100 crore. Given this bleak situation, the Chief Minister, in a letter to Prime Minister Modi dated April 11, has asked for the implementation of "Quantitative Easing" and the effective use of "Helicopter Money". (While quantitative easing is a method used by central banks to increase the money supply/liquidity in the financial market, helicopter money entails the printing and distribution of a large sum of new money among the public in order to stimulate the economy during a recession or when interest rates fall to zero.) Citing the fact that this approach is being followed by all the global major central banks, including the Federal Reserve, Bank of England, Bank of Japan, People's Bank of China and the Reserve Bank of Australia, the Chief Minister suggested that "Quantitative Easing" should be at least 5 per cent of India's GDP. With the Central Statistical Office pegging India's GDP in 2019-20 at Rs.203.85 lakh crore, the Chief Minister would like "Quantitative Easing" to be at least Rs.10.15 lakh crore.

Officials in the Health Department said that the situation in Telangana was "more or less under control" until the return of the attendees of the Tablighi Jamaat's Nizamuddin Markaz to the State: the number of positive cases rose from under 100 on March 31 to 644 (including 18 fatalities) in a 14-day period. The government has begun the process of identifying and isolating the markaz returnees.

On April 16, Hyderabad alone reported 25 fresh cases, with the total going up to 307 here. The total number of positive cases in the State was 700. Telangana Health Minister E. Rajender appealed to all Nizamuddin Markaz returnees and those who came in their contact to immediately report themselves to the health authorities for a check-up.

With the Greater Hyderabad Municipal Corporation (a high population density area of 55 sq km) becoming the epicentre of COVID-19 in Telangana, the government is planning to divide the city into 17 zones, with each zone being treated as a unit headed by a special medical officer, municipal officer, police officer and revenue officer. At present there is only one district medical and health officer in Hyderabad City. The Chief Minister has reiterated that his State is "fully geared up and prepared to facilitate treatment of 60,000 patients", with a total of 11,000 beds being readied in isolation wards of hospitals, and another 1,400 beds in ICUs.

BAD START IN ANDHRA PRADESH

Business as usual, was what Andhra Pradesh Chief Minister Y.S. Jaganmohan Reddy envisaged, even advocated, when the first cases of COVID-19 surfaced in the State. Given this line of thinking, the government got off to a bad start in tackling the crisis. In mid March, Jaganmohan Reddy claimed that applying bleaching powder for six hours on items used by suspected coronavirus-affected people would kill the virus. He added for good measure that the use of paracetamol tablets would improve the condition of patients. And that it was dangerous only for people above 60 years and those who were predisposed to diabetes, high blood pressure, asthma, liver and kidney diseases.

Jaganmohan Reddy also flung himself into another controversy with the removal of the State Election Commissioner (SEC) Nimmagadda Ramesh Kumar from office. Ramesh Kumar's decision in March to defer elections to urban and rural bodies in the State by six weeks citing "genuine supervening difficulties and exceptional circumstances" owing to the threat of COVID-19,

K.V.S. GIRI

OUTSIDE the Government General Hospital in Vijayawada, Andhra Pradesh, on April 12.

V. RAJU

DRYING the harvested paddy crop at fields near Nunna village in Vijayawada on March 31.

was not to his liking. The election process had already been notified and Jaganmohan Reddy's political outfit, the YSR Congress Party, had won quite a few seats unopposed. After insinuating that the SEC was playing sectarian politics since he belongs to the same Kamma caste as Jaganmohan Reddy's bete noire, Chandrababu Naidu, the Andhra Pradesh government unceremoniously retired Ramesh Kumar. To this effect an ordinance was promulgated, amending Section 200 of the Andhra Pradesh Panchayat Raj Act, 1994, reducing the tenure of the SEC from five to three years.

Andhra Pradesh Governor Biswabhusan Harichandan then appointed a former Madras High Court judge, Justice V. Kanagaraj, as the new SEC. Ramesh Kumar has sought judicial intervention questioning his removal. The Andhra Pradesh High Court has asked the government to file an affidavit. The ugly showdown between the State legislature and the SEC has taken away from the State's fight against the pandemic.

INADEQUATE TESTING

Opposition leaders and non-governmental agencies also accuse the government of under-reporting the number of COVID cases. There are also fears that the State has been unable to ramp up testing, contact tracing, and even implement social distancing. In most cities and towns across the State, the lockdown is relaxed every morning between six and nine, when the authorities seems to have given citizens a carte blanche. Also, there are only seven designated government centres authorised to test for COVID-19. So far, hardly 10,000 tests have been conducted. The private sector has not been allowed to test.

Jaganmohan Reddy was rudely jolted out of his initial inertia after attendees of the Tablighi Jamaat conference returned to Andhra Pradesh and the number of positive cases more than doubled in one night (from 44 to 101 in the intervening night of March 31). As of April 16, Andhra Pradesh had detected 534 positive cases, with 14 deaths. The districts of Guntur (122), Kurnool (112), S P S Nellore (59), Krishna (48) and Prakasam (42) have borne the brunt of COVID-19 cases. Sixty cases have been detected in a radius of 60 km around Vijayawada. Srikakulam and Vizianagaram districts have seen no positive cases.

The government has announced a relief package of Rs.1,000 and 5 kg of rice and 1 kg of dal (pulses) to every family in the below-poverty-line category. The opposition Congress has demanded that the government increase the amount to Rs.5,000.

Said Narreddy Tulasi Reddy, working president of the Andhra Pradesh Congress Committee: "The government is not doing enough. People are suffering. Jagan Reddy is more interested in electoral politics and in switching the State's capital. Because so few people are being tested the real picture in the State is not out. More cases are being recorded, but in my opinion this is only the tip of the iceberg. In actual the State will have 100 times the number that is being recorded. The State government needs to involve the private sector. Even social distancing is not being properly implemented."

Added Sake Sailajanath, president of the Andhra Pradesh Congress Committee: "Jagan Reddy is not taking the pandemic seriously. The government promised to release Rs.400 crore towards relief for poor and marginalised persons. But so far only Rs.50 lakh has been released. Frontline warriors have not been given PPEs [personal protection equipment], face masks, etc. In Anantapur district, four doctors and two nurses at the Government Hospital, Anantapur, and a mandal revenue officer tested positive because they had not been given the necessary equipment. Any official who raises this is suspended. Jagan Reddy had announced that 4.5 lakh government volunteers would go from house to house and distribute rations. With this not happening, people are crowding ration shops. Hardly a few metres from my house in Anantapur I can see it happening. Not even 500 tests are being conducted every day; we need to at least double the number immediately."

The Andhra Pradesh government has decided to distribute 16 crore masks to every one of its 5.3 crore population. Each individual will receive three masks in a bid to "provide some safety from the virus". With the agriculture, horticulture and aquaculture sectors suffering on account of the lockdown, Jaganmohan Reddy has written to the Prime Minister asking for a partial easing of the lockdown. □

Season of distress

The lockdown in the middle of the harvest season is bound to have a devastating effect on the State's economy as most of the COVID-19 "Red Zone" districts lie in western U.P., which accounts for more than half of the State's overall agricultural production. BY **VENKITESH RAMAKRISHNAN**

ASSESSMENTS IN THE UTTAR PRADESH government in mid April were that the State machinery had achieved a fair amount of success in handling the COVID-19 pandemic. As on the morning of April 17, the State's tally was 796 confirmed cases, 13 deaths and 74 recovered. In terms of the number of confirmed cases, the State stood in the seventh spot. Senior government officials, especially those in the Health and Home Departments, were of the view that the control measures adopted were fairly good, given the fact that Uttar Pradesh is the most populous State in the country.

A senior Home Ministry official told *Frontline* that the exodus of migrant workers from Delhi, Gurgaon and other urban centres had a big impact on Uttar Pradesh, especially its vast rural areas. "Considering all this, we are pulling up rather respectably," he said.

However, one of the major worries in the administration is with regard to the economic impact in the short, medium and long term. Of the nine districts (Agra, Gautam Buddh Nagar, Meerut, Lucknow, Ghaziabad, Saharanpur, Shamli, Firozabad and Moradabad) identified as "Red Zone" with a high incidence of cases, barring Lucknow the rest are in western Uttar Pradesh or in areas contiguous with it.

Since western Uttar Pradesh is practically the driver of the State's economy, concentration of cases is this region has raised an alarm. For decades, the State has consistently contributed around 20 per cent of the national foodgrain stock and accounted for about 15 per cent of the total livestock population. A large majority of the State's population survives on farming activities, growing wheat, rice, pulses, oilseeds, potatoes and sugarcane. In terms of agricultural output, official data on various parameters suggest that western Uttar Pradesh accounts for more than half of the State's overall production.

In this context government officials and social, political and economic observers point out that the restrictions placed in the wake of the pandemic and the setbacks suffered by the region as a consequence could cripple the State's economy. This bleak outlook is not without basis. *Frontline* had a first-hand experience of the situation on the ground in several parts of the region. It is the harvest season of almost every major produce of the region, ranging from wheat to vegetables such as potato, spinach, carrot and beetroot. Field reports gathered from different parts of the region indicate huge shortfalls in terms of harvesting, procurement and distribution. This in itself is disastrous, but the lack of government support in every one of these operations has made matters worse. There are enough indicators to show that the promises made by the government on various fronts are not being followed up and implemented effectively. More importantly, interventions by government bodies such as the National Dairy Development Board (NDDB) are ineffective in giving tangible help to farmers.

Reports from wheat farmers across the region highlight this aspect. A large number of farmers have been unable to hire harvesters or agricultural labour to complete the harvesting on time. The State government had announced a procurement drive for wheat from April 15, but there were no signs of this taking off even two days from that date.

SHENSHAR PAL and his family harvesting wheat at Bilsni village in Bulandshahr district.

VENKITESH RAMAKRISHNAN

Shenshar Pal, a wheat farmer belonging to Bilsni village in Bulandshahr district, was in the middle of harvesting, along with his wife and son, when *Frontline* met him. Pal has access to harvester, but the machine developed a snag and repairs have not been possible because of the lockdown. Agricultural labour, too, was unavailable. As a result, the harvesting operation is running behind schedule.

In the absence of government procurement, Pal and other farmers in the neighbourhood are selling their produce to private procurers at a reduced price of Rs.1,780 a quintal. The government announced a minimum support price (MSP) of Rs.1,925 a quintal. Up to April 17, Pal had sold around 60 quintals to private procurers, resulting in a direct loss of around Rs.8,700 against the MSP. "This is not a small shortfall for medium farmers like me. But, we are braving it because the whole world is going through trying times. We hope that things will turn around soon and that the government will intervene positively to mitigate our suffering." Similar sentiments are echoed by other wheat farmers. Sarabjeet Singh of Saharanpur flagged a major worry in the farmers' minds in the context of the delay in government procurement. "With every passing day without government procurement, private procurers will get emboldened to fleece us. The prices per quintal will come down further in such a situation. The government should take note of this at the earliest. Otherwise, we will be done for."

Bharat Singh, a carrot farmer and truck transport operator of Gaindpur Shaikhpur village in Bulandshahr district, has been hit by a double whammy. His transport operator business is in a shambles since he does not get enough orders to transport produce to the market. On an average, he used to send 15 truckloads of produce to the market in the harvest season. Now he is able to send only two truckloads. This has led to a loss of several thousand rupees every given day. Moreover, the price of his carrot produce slumped dramatically. "Before the lockdown our high-quality red carrots were sold to the market at Rs.25 a kilogramme. Within a day of the lockdown declaration, the price fell to Rs.10 a kg. The second and third quality

> U.P. accounts for 20 per cent of India's foodgrain stock and about 15 per cent of the country's livestock population.

VENKITESH RAMAKRISHNAN

BHARAT Singh Gaindpur, a truck operator and carrot farmer of Shaikhpur village in Bulandshahr district.

carrots are normally procured by the sauces, pickles and edible pulp industry. Since those factories are shut down, there are no takers for them. We are now feeding these carrots to cattle."

The predicament of two Hapur-based beetroot farmers, Ravinder and Sunil, is worse. "A kg of beetroot was sold for up to Rs.20 during the harvest season last year. Now, we are forced to sell them at Rs.2 or Rs.3 a kg. We are resorting to distress sales in order to provide at least a day's meal to our families," they said. As marginal farmers, belonging to Dalit communities, Ravinder and Sunil have neither financial back up nor their own land. Their land is taken on lease as are the equipment/machinery required for every farming activity. For their beetroot cultivation they had taken 90 bighas of land (around 15 hectares) on rent for Rs.7,20,000. Since they could not pay the rent, they took a loan from a private moneylender at 36 per cent interest. They pay a monthly interest of Rs.21,000 to him. Cumulatively, the production cost, including the rent, loan interest and other services such as labour, for every kg of beetroot would come to approximately Rs.12. "When we sold it for Rs.15 to Rs.20 we made a marginal profit. You can imagine our situation when we distress sell it at Rs.2 or Rs.3."

Professor Sudhir Panwar, Samajwadi Party (S.P.) leader and president of the Kisan Jagriti Manch, a collective of activists and academics addressing policy on agrarian issues, said marginal farmers were likely to bear the brunt of the economic impact of the COVID crisis. "Put simply, it is horrifying to imagine what this section of the population will go through in the days to come. The government must address the health concerns on a war footing first and parallelly start addressing the economic issues with a special focus on incentives and plans for marginal farmers and agricultural labour. One misstep and we could hurtle towards dark times," Panwar told *Frontline*.

Ironically, the price quoted for a kg of beetroot at an outlet of "Safal"—a vegetable and fruit retail chain run by Mother Dairy, affiliated to the National Dairy Development Board (NDDB)—in the National Capital Region was Rs.79. The NDDB's claims on its website that the organisation is "rooted in the conviction that our nation's socio-economic progress lies largely on the development of rural India" and that "the Dairy Board was created to promote, finance and support producer-owned and controlled organisations" and that the "NDDB's programmes and activities seek to strengthen farmer cooperatives and support national policies that are favourable to the growth of such institutions". The beetroot farmers of Hapur are not part of the producer-owned and controlled organisations, but does it mean that their distress situation should be exploited? What they sell at Rs.3 gets sold in the consumer market at Rs.79. What are the additional costs that go into this massive increase between procurement and sale? An email sent to Mother Dairy seeking to know the average procurement price of different vegetables and their selling price at "Safal" evoked the following response. "At Safal, we follow a fair price mechanism, which is governed by the principle of offering fair returns to the farmers while ensuring competitive prices to the consumers. It is pertinent to note that the prices of fresh veggies fluctuate widely due to various factors such as arrivals in local market, harvesting, demand, etc." Interestingly, the list of vegetables and their relative actual prices were not given.

Panwar said suitable steps should be taken to streamline the functioning of agencies such as the NDDB and NABARD to make them adapt themselves better to the requirements of poor and marginal farmers, including dairy and poultry farmers. "Unfortunately, the lockdown period has coincided with the most intense farming operations and economic activities in northern India. In western Uttar Pradesh, while wheat is getting ready for harvesting, the sugarcane season is coming to a close and planting for the next season has to commence. The imposition of lockdown not only halted the supply chain but also farming operations. Sensing the impact of the blockage of the agri-products supply chain, the Central government issued advisories exempting farming operations from the lockdown but with little or no effect, which is evident from the repeated directives to State governments. The stimulus announced by the Central government, including transfer of Rs.2,000 from the Prime Minister's Kisan Samman Nidhi to the beneficiaries by March 31, and Rs.25,000 crore to NABARD for infusion of liquidity will not improve the situation.

Indeed, western Uttar Pradesh is at the core of the burning fields of Indian agriculture, which is, by all indications turning into a catastrophic ball of fire." □

‘Too low’ on testing

Lockdown failures, charges of data suppression on cases and deaths, very low testing, lack of protective equipment for health care workers and the need to have at least some sections of industries up and running are some of the issues Mamata Banerjee has had to wrestle with.

BY **SUHRID SANKAR CHATTOPADHYAY**

WITH 10 DEATHS AND 144 “ACTIVE” CASES OF COVID-19 (according to the State government’s official bulletin of April 16), and with Chief Minister Mamata Banerjee and her administrative machinery making all the right noises and taking prompt decisions, West Bengal gives the impression that it is doing reasonably well in dealing with the Coronavirus outbreak. However, the COVID-19 data put out by the government have led to questions about the low number of tests that have been carried out so far. As of April 16, only 3,811 tests had been done in a State with a population density of 2,670 persons per sq mile, among the highest in the country. Its rate of testing, at around 33.7 per million (as of the second week of April), is among the lowest in the country.

The number of deaths caused by the virus has also become a point of dispute. On April 2, even after the taskforce of doctors set up by the State government announced the number of fatalities to be seven, Chief Secretary Rajiva Sinha announced that it was actually three. Four of the deceased had been hospitalised with co-morbidities and their deaths were “yet to be established as COVID deaths”, he said. On April 5, the government set up a five-member committee to “ascertain the cause of death of a person who has tested positive for COVID-19”. The State administration, however, did not divulge how many cases had been referred to the “Audit Committee”. When asked at a press conference on April 16, the Chief Secretary could not give the figure.

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WORKERS disinfecting on coaches converted into isolation wards for COVID-19 patients, at Tikiapara Rail workshop in Howrah district on April 6.

This attempt to locate the cause of death for COVID-19-positive patients in pre-existing medical conditions has drawn strong reactions from opposition parties. Surjya Kanta Mishra, Polit Bureau member and State secretary of the Communist Party of India (Marxist), said: “In our State we know how many deaths have taken place through information filtering in from areas outside the purview of the government, and one thing is certain, the number is more than what the State government claims it to be.”

Mishra, who is a doctor, said the death of anyone who tested positive for coronavirus must be seen as a COVID-19 death, whatever other illness the patient might have had. “But that is not what is happening in West Bengal. It is a known fact that those with co-morbidities are more susceptible if they get infected with Coronavirus. So it is pointless to insist that a particular COVID-19 patient died of kidney problems or other ailments. He would not have died had be not been afflicted with COVID-19,” he said.

The Bharatiya Janata Party (BJP) also attacked the State government on the issue. On April 6, Amit Malviya, who is in charge of the BJP’s IT (information technology) cell, posted on social media: “What is Mamata Banerjee hiding? No medical bulletin from the Bengal government on 2nd, 3rd and 5th Apr. Curiously number of Covid related deaths missing in the bulletin released on 4th.”

Predictably, there exists a discrepancy between the

figures presented by the Centre and the State. According to the Ministry of Health and Family Welfare, the total number of confirmed cases in West Bengal stood at 231 as of April 16. But the State government bulletin, which only puts up the number of "active" cases, put the figure at 144.

The BJP also alleged that Mamata Banerjee was playing vote bank politics when at a press conference she refused to answer a question relating to participants from Bengal in the Tablighi Jamaat meeting in Delhi. The BJP posted on social media: "Mamata Banerjee when asked for an update on Tablighi cases said, 'Don't ask communal questions.' Jamaat cases have exploded across, but no clarity on the latest numbers in Bengal. How many of them traced and tested. Results? No update at all! Has she made this about vote bank?"

The Chief Minister responded by announcing on April 8 that 177 people who had taken part in the Jamaat had been quarantined in the State, and 108 of them were foreigners from Malaysia, Indonesia, Thailand and Myanmar.

According to administrative sources, Mamata Banerjee's often brusque dismissal of probing questions is meant to pre-empt panic rather than willfully conceal information. "A little secrecy is needed in the functioning of a government.... If I see some news is liable to cause panic in a particular community, why will I spread that?" she herself said recently.

"TESTING KITS AVAILABLE"

The government has been facing criticism, particularly from the opposition, over the low number of tests carried out in the State. Initially the government said it did not have enough testing kits but subsequently acknowledged it had received kits. However, when asked about it in a press conference on April 11, Mamata Banerjee said: "We have asked for 50,000 kits from the Central government. We will start our operation when they give it to us.... Moreover, according to the guidelines of the ICMR, if there are no symptoms then there should not be any test. So we are following the guidelines of the ICMR."

However, according to Shanta Dutta, Director of the National Institute of Cholera and Enteric Diseases (NICED), the nodal body of the ICMR in Kolkata, there are enough kits lying with NICED, which the State government has not been utilising. "In the eastern region, we are the depot for kits for the ICMR, and already we have 27,500 kits in our stock.... I do not think there was ever any shortage of kits," she said to a national news channel on April 11. She further said that the number of tests conducted in West Bengal was "definitely low" compared with other States, and "too low" considering the high population density. "Heath is a State subject, so they have to take the action, and if they increase [the tests], we are ready to test the samples if they send them to us," said Shanta Dutta.

She said that initially the State government was sending 80-90 samples a day, but the number had reduced drastically of late. According to her, NICED received only 18 samples on April 9, nine samples on April 10, and around 20 samples on April 11. Shanta Dutta added that the ICMR had revised its guidelines and now recommended tests for even those showing mild COVID-19 symptoms.

From quite early on, the State government had focussed on setting up quarantine centres and hospitals across the State and had roped in even private establishments. Mamata Banerjee directed that each district should have a hospital dedicated to COVID-19 cases. At present the State has 66 COVID-19 hospitals and 582 Institutional Quarantine Centres. As of April 16, a total of 12,196 people were kept in these centres and 36,982 people were under home observation/surveillance. The total number of persons admitted under hospital isolation until April 16 was 2,714, of whom 489 people were under observation.

Even if there are hospitals and quarantine centres there are still not enough personal protective equipment (PPEs) and proper masks for doctors and other health care workers. A significant number of doctors and nurses in the State have tested positive for COVID-19—nine doctors, five nurses and eight health workers since April 1 and as of April 14. "It is not just lack of medical equipment that is causing the disease to spread among health workers and doctors, but also at times late detection of cases. In most of the private hospitals, any patient is now being treated as a potential COVID-19 patient, and measures are being taken accordingly. Having said that, it cannot be denied that there is a major shortage of protective gear for the medical staff," said a highly placed source in the medical sector. According to him, at present there are 1,452 beds for COVID-19 patients. "The government requires 4,000 beds soon, and so we can expect more private hospitals and establishments being roped in to combat the situation," he said. On April 16, the Chief Secretary announced that 3.47 lakh PPEs, 2.23 lakh N95 masks, and 15.7 lakh ordinary masks had been distributed.

LOCKDOWN ENFORCEMENT

Right from the beginning Mamata Banerjee had insisted that the lockdown be enforced in a "humane" manner with as little trouble for the common people as possible. Although the lockdown has been largely successful in the State, violations of the government order have undeniably taken place and norms of physical distancing flouted, particularly in marketplaces and ration shops and banks. However, the police have made hundreds of arrests and have been seen to be vigilant and persuasive in dealing with people. In certain areas, the administration faced violent opposition while enforcing the lockdown. The government identified certain "sensitive areas" in Howrah, North 24 Parganas, Kolkata, and Purbo Medinipur districts. Apart from these areas, certain areas in Paschim Medinipur, South 24 Paraganas, Nadia, Jalpaiguri and Darjeeling districts are under close observation. The "sensitive areas" have been divided into "core" and "buffer" zones, with "complete lockdown" in

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A KOLKATA street on April 13.

the core zones. The State government has also through an official order made wearing of masks mandatory for anyone stepping out of home. Schools and other educational institutions will remain shut until June 10.

While the State government claims that its police and administration have been enforcing the lockdown successfully in a strict but humane manner, the Centre has sent two notices over lockdown violations in the State. A Ministry of Home Affairs letter dated April 10 said: "As per further reports received from security agencies, gradual dilution of lockdown has been reported from West Bengal, with an increase in the number of exceptions being provided by the State government.... There is no regulation in vegetable, fish and mutton markets where people have been thronging in complete violation of social distancing norms, in Rajabazaar, Narkel Danga, Topsia, Metiaburz, Gardenreach, Ikbalpur, and Maniktala in Kolkata."

Incidentally, the places highlighted by the Home Ministry happen to be Muslim-dominated, though violations have been taking place in other places as well. Political observers see this as an insinuation that the State government has been indulging in "vote bank politics" while enforcing the lockdown. The Home Ministry's observations drew criticism from even the CPI(M), the Trinamool Congress's bitterest political enemy. Surjya Kanta Mishra said: "The letter of rebuke that the Centre sent to the State government is wrong. It should not be interfering in such matters. It is doing so with a communal agenda." On April 12, the Home Ministry sent another letter.

Early in the lockdown, Mamata Banerjee directed the district administrations to ensure that no one starved. The administration, along with non-governmental organisations, clubs, political parties and private individuals, has provided relief for the poor and the destitute by setting up community kitchens and distributing food. The State government announced free ration for families below the poverty line for six months and essential items at concessional rates for the poor. However, in several places there have been instances of a nexus working between the ration dealers and local leaders of the Trinamool, which has affected the disbursal of rations, resulting in protests by the poor.

Mamata Banerjee claimed that her government was taking care of around two lakh migrant workers from other States who were stranded in West Bengal. Meanwhile, it is estimated that well over one lakh mirgrant workers from Bengal are stranded in other States. Mamata Banerjee had written to 18 Chief MInisters with an appeal that labourers from Bengal should be looked after.

There was no sign of improvement of the plight of industrial workers and of those in the unorganised sector as the lockdown entered its third week. In order to provide some relief, Mamata Banerjee relaxed lockdown rules for certain industries, such as beedi and tea, but it did not help much. In Murshidabad district, around 12 lakh people are dependent on the beedi industry and beedi-binding, done by the women, is practically a cottage industry.

An influential Trinamool leader from Jangipur, Imani Biswas, who is also the owner of Howrah Beedi, one of the biggest beedi companies in the State, told *Frontline* that the situation was pathetic for beedi workers. "Hundred per cent of the beedis made by the bigger companies go to other States. Under the lockdown we cannot transport them even to Kolkata despite the relaxations allowed by the State government. The people working in the beedi industry are now dependent on government relief and the kindness of the people."

On April 9, the State government allowed the tea gardens of North Bengal to resume work, but with only 15 per cent of the workforce in any given shift. Mamata Banerjee had earlier refused to allow the tea gardens to open, even though the Centre had given its nod. The tea unions, however, feel that the State's decision increases the risk of the spread of COVID-19 in the gardens. "We had demanded that all workers be paid a stipend during the lockdown, but that demand was not heeded," Basudeb Bose, West Bengal general secretary of the All India Central Council of Trade Unions (AICCTU) told *Frontline*.

JUTE AND AGRI PACKAGING

The lockdown landed Bengal's jute industry with its 2.5 lakh workers in a crisis. There are 61 operational jute mills in the State, with a total production capacity of around 3,000 tonnes of jute goods a day in normal times. Although the industry falls under the Essential Commodities (EC) Act, the State government did not allow the mills to function. The possibility of an acute shortage of jute bags was real and the worst-hit would have been the farmers who were getting ready to harvest the Rabi crop.

At the insistence of the Centre, Mamata Banerjee, on April 15, relaxed the restrictions: all 61 mills were allowed to function but with 15 per cent of the workforce. On April 13, Union Minister for Textiles Smriti Irani had written to the Chief Minister with the request that a "basic minimum" of 18 jute mills should be allowed to operate in the State to meet the demand for packaging of foodgrains. "These 18 mills will be asked to put only 25 per cent of the workers on roster basis," Smriti Irani wrote. □

Chief without a plan

Chief Minister Shivraj Singh Chouhan, caught in the middle of a pandemic without a Cabinet, appears clueless with nearly 50 Health Department officials in quarantine, and the BJP's attempt to help out with a task force only sharpens the criticism as the situation on the ground continues to worsen. BY **ANANDO BHAKTO**

ON MARCH 11, WHEN THE WORLD HEALTH Organisation (WHO) declared COVID-19 a pandemic, Bhopal, the State capital of Madhya Pradesh, was bustling with political activity. The opposition Bharatiya Janata Party (BJP) leaders were making nervous preparations, not to build a coordinated campaign against a quickly spreading disease, but to topple the elected Congress government of Kamal Nath. While they were successful in their efforts and formed the government on March 23, crucial days were lost as the number of people infected by the coronavirus in the State began to increase steadily. As on April 16, the State had 1,000-odd positive cases and reported 55 deaths, the second highest casualty figure after Maharashtra in the country. As the new Chief Minister Shivraj Singh Chouhan is yet to expand his Cabinet, the State does not have a Health Minister.

Senior State Congress leader Shobha Oza told *Frontline* that as early as March 12, Kamal Nath (who was Chief Minister then) called for the shutting down of schools, colleges and malls. "We had alerted all District Collectors and hospitals were being prepared. But the BJP mocked us. Shivraj Singh Chouhan said we were doing *natak* [drama] while another BJP leader referred to our preparations mockingly as *darona* [alarmist]. In fact, at a time when the whole country was pushed to the wall, the Centre wasted almost two weeks between the WHO declaration and Prime Minister Narendra Modi's announcement of a lockdown on March 24. This [the delay] was to enable his party's Madhya Pradesh unit to grab power," she said.

Shobha Oza alleged that even after assuming office, Shivraj Singh Chouhan's priority was not to fight against the pandemic. "He was more keen on resetting the bureaucracy and doing away with key appointments made by the previous dispensation to suit his political agenda. All of a sudden everything was disturbed. The Collector of Indore was changed, the Deputy Inspector General of Police was changed...," she said.

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PATIENTS with symptoms of COVID-19 wait outside the OPD of the Government J.P. hospital in Bhopal on March 23.

Indore, the financial capital of the State, has emerged as a major COVID-19 hotspot in the country. There were 83 new positive cases on April 14 and 42 more on April 15, taking the city's tally of positive cases to 586 (as on April 16). The number of deaths was 39 on April 16. Two doctors died on consecutive days in the city—a 62-year-old physician on April 9 and a 65-year-old Auryveda doctor on April 10.

The State's Health Department is in a shambles. Close to 50 of the top Health Ministry officials in Bhopal are quarantined or in isolation wards or intensive care units. Among them are Pallavi Jain Govil, Principal Secretary (Health), J. Vijay Kumar, Managing Director of Madhya Pradesh Health Corporation, and Veena Sinha and Pallavi Dubey, key

GAGAN NAYAR/AFP

WOMEN maintain physical distance as they wait outside a bank to collect their pension in Bhopal on April 15.

executives of the State's coronavirus control room.

Their lackadaisical approach to the pandemic protocols became evident when some of them refused to go to hospitals for isolation. A correspondence between the Director of All India Institute of Medical Sciences (AIIMS), Bhopal, Dr Sarman Singh, and Pallavi Jain Govil gave a clearer picture of this aspect. In a letter addressed to Pallavi Jain Govil, Sarman Singh noted: "This is about the telephonic call received from your good self and Shri Faiz Ahmad Kidwai, Health Commissioner, regarding the unwillingness of some of your officials who are asymptomatic to get hospitalised at AIIMS." Sarman Singh then recommended home quarantine for them. (Kidwai was appointed as the Commissioner of Health Services on April 1.)

The public sector health infrastructure in the State appears to be in bad shape. During a media briefing in Bhopal on March 31, Prateek Hajela, who was Health Commissioner then, said there were merely 800 ICU beds and about 450 ventilators in the State, with half the number of beds and about 130 ventilators available in private hospitals. On the very day Hajela made these observations, he was removed from the post and made Principal Secretary in the State Secretariat.

The Congress maintains that although the Kamal Nath government (which was in power until March 19) was among the first governments to announce shutdown of colleges, schools and malls, its initiatives were affected because Tulsi Silawat, who was Health Minister, was among the Congress rebels supporting Jyotiraditya Scindia who were removed from the scene and taken to Bengaluru. The new government does not have a Health Minister yet.

With pressure mounting on Shivraj Singh Chouhan to appoint Cabinet Ministers, the State BJP came to his recuse and announced a 11-member special task force on April 13, to tackle the public health scare. The BJP State president and Member of Parliament V.D. Sharma heads the task force, which includes Silawat, and senior BJP leaders Kailash Vijayvargiya, Narottam Mishra and Rakesh Singh. The task force will ensure regular review of measures suggested to tackle the pandemic and smoothen coordination between the State government and various subsidiary bodies relating to health.

The Congress called the formation of the task force a half-hearted measure made in haste to create an illusion of managing the crisis. Abbas Hafeez, the Congress State spokesperson, told this reporter: "It is nothing short of an eyewash. In Maharashtra, the task force came into existence by an order of the government and it comprises eminent doctors, health officials and experts who have the know-how to deal with the crisis. Compare that with the Madhya Pradesh task force, which is not an initiative of the government but that of the party. The announcement was made in the BJP's letter head; it is chaired by the BJP's State president and all those who have been named executives are legislators and former Ministers. In view of the lack of any medical expert in that team, it is clearly ill-equipped to make any discernible impact. It almost seems the BJP came out with the task force to temporarily appease its leaders who are obviously upset with the delay in Cabinet formation."

Kamal Nath came down heavily on the Shivraj Singh Chouhan government over its "inadequate preparations to deal with the pandemic". "Madhya Pradesh is the only State where there is no Minister for Home and Health. The national lockdown was imposed 40 days after Congress MP Rahul Gandhi expressed concerns. The Centre's engagement in toppling the Madhya Pradesh government led to delay in taking steps to tackle COVID-19," Kamal Nath said in a press statement. He said, "(The) Cabinet (has) yet to be formed. On March 12, I ordered the closing of malls and other places but no action was taken after my resignation."

The absence of a Home Minister became glaring as news of violence against health care workers both by the public and the police began to pour in. On April 1, women doctors in Indore were attacked while they were out on the field to screen people for symptoms of coronavirus infection. The District Magistrate of Indore told the media that the provisions of the National Security Act were invoked against four people for assaulting the doctors. While this news became a prime-time feed on national television the role of the police were ignored.

On April 8, the police allegedly beat up two junior resident doctors of the AIIMS when they were returning home. The doctors, a male and a female, were reportedly stopped at Bag Sevania in Bhopal and thrashed with batons. The administration later said an inquiry had been ordered into the incident.

On April 3, the police allegedly beat 65-year-old Tigoo Adivasi to death at Gujari village in Dhar district where he had gone to buy some essentials. The victim was a resident of Mandleshwar in Khargone district, located 4 km from the spot where he was killed. Raju Adivasi, his son, said the police beat his father accusing him of violating the lockdown. He died on the spot, Raju claimed. The police denied the allegation. □

In fits and starts

After the initial lethargic response to the sudden migrant onrush, the State government retrieves lost ground to launch containment and surveillance measures, besides providing relief to the stranded migrants. BY **DIVYA TRIVEDI**

VISUALS OF MIGRANT WORKERS MARCHING towards their home towns from Delhi will haunt the memory of the nation for a long time to come. Those who could not leave the National Capital Region and scavenged for discarded food or slept under the flyover along the Yamuna, will find it hard to trust the city again. They were made acutely aware that their only value in the city was labour with no cushion to fall back on in the absence of social protection. It was only in their own villages that they would find their identities.

Following the sudden imposition of a lockdown by the Centre, the ruling Aam Aadmi Party (AAP) in Delhi set up 658 hunger relief centres and 62 temporary relief shelters in government schools. Government representatives rescued workers stranded in Kudesiya Ghat, Kashmere Gate and other places and shifted them to shelter homes. But this was hardly enough.

Adding fuel to an already distressed situation, three porta cabins of the Delhi Urban Shelter Improvement Board (DUSIB) that were housing migrant labourers were gutted. The previous day the migrants given shelter there had a confrontation with the civil defence staff over food distribution and space. Some said a crowd of rioters came from outside and set fire to the cabins. The matter is under investigation. Seven people have been arrested in this connection.

With over 1,500 COVID-19 cases, Delhi became the second worst-affected region in India. As on April 16, the total number of cases touched 1,640 with 38 deaths. Fifty-two persons recovered. Delhi had its task cut out: to control the spread of the virus and provide relief to the stranded.

Chief Minister Arvind Kejriwal read the writing on the wall. After images of hundreds of migrants gathered at the Anand Vihar Bus Terminal amidst the lockdown stung his government, he decided to get his messaging right. He welcomed the extension of the lockdown until May 3 and asked the migrants to stay put. He told them not to believe rumours that inter-State buses would ferry them across the border. He also told the media that he would conduct online briefings until the lockdown was lifted.

To create awareness about the pandemic, the government issued full-page colour advertisements in leading newspapers and put up hoardings on roads. Kejriwal planned to visit some containment zones to take stock of the situation.

PRASHANTH VISHWANATHAN/BLOOMBERG

PEOPLE WAITING on the banks of the Yamuna to be transferred to a temporary shelter in New Delhi on April 15.

The government announced a five-point plan to deal with the infection,, including treating 39,000 patients and undertaking "rapid random" testing in hotspots.

"We need to learn from other countries how to tackle this disease. We need to be three steps ahead of the disease.... We will monitor people who have been asked to quarantine themselves and also seal areas that see a spike in cases to reduce the spread. We have also tied up with the police to track the mobile phones of those who are in home quarantine to ensure that they followed the protocol," Kejriwal said.

He surmised that if the number of cases in Delhi went up to 30,000, the government would take over 8,000 beds in hospitals, 12,000 hotel rooms, and accommodate about 10,000 patients in banquet halls and dharamshalas. He directed the District Magistrates to identify paid quarantine facilities in their areas. His government booked 767 rooms in three hotels—Welcome Hotel, Vivanta by Taj and Piccadily—where the beneficiary could pay Rs.3,100, excluding taxes, for quarantine.

Apart from Ram Manohar Lohia hospital, Safdarjung Hospital and the All India Institute of Medical Sciences (AIIMS) Trauma Centre, which come under the Central government, the government designated Dr Babasaheb Ambedkar Hospital, Deen Dayal Upadhyay Hospital, Guru Teg Bahadur Hospital, Rajiv Gandhi Super Specialty Hospital, Lok Nayak Jayaprakash Narayan Hospital and GB Pant Hospital for the treatment of COVID cases. A private medical laboratory, Dr Dangs Lab, set up a drive-through service to test potential patients in Punjabi Bagh (West) central market at the ICMR-authorised price of Rs.4,500.

While exact figures were not available, independent surveys showed that compared to other States, barring Kerala, Delhi fared well in the total number of tests conducted, helped by the large number ofprivate testing centers.

According to the Delhi Health Secretary,1.5 lakh personal protective equipment units were ordered and 3,500 were procured every day. A tender has been finalised for two lakh more kits and an order issued for five lakh N95 masks, of which 25,000 will be supplied every week for the use of frontline health workers and health professionals.

The government approved the use of plasma technique for treatment on a trial basis to save the lives of critical COVID-19 patients.

As hospitals suspended outpatient departments, the government launched a 24x7 free online medical consultation services, with CallDoc app, to help patients connect with doctors via mobile app for their non-emergency medical needs. Over 100 doctors have offered their services for free via this app, according to Health Minister Satyendar Jain. But the number is far below the actual requirement of non-COVID patients.

As all the major hospitals were converted into exclusive COVID centres, patients with other ailments were asked to vacate their beds at short notice. Cancer and tuberculosis patients requiring urgent attention were left in the lurch. "While it is important to provide best possible care for COVID patients, it should not be at the cost of other needy patients, compromising both ongoing and emergency care that they are entitled to," said V.R. Raman, national convener, Public Health Resource Network.

Dr Vandana Prasad, a public health activist and community paediatrician, said: "Public hospitals should be taking full responsibility of the patients, identify alternative hospitals and beds for them and arrange ambulances to transport them. There is an existing system of free beds available in the private sector. Why were such provisions not utilised?" Despite the government's tall claims on PPE procurement, several health care professionals, including one doctor from Maulana Azad Medical, two from hospitals in Ghaziabad and three employees of Sir Ganga Ram Hospital, contracted the infection. An AIIMS employee told *Frontline* that a person who had tested positive did not reveal this and thereby put the entire casualty ward staff at risk. They had to be quarantined en masse. "They say AIIMS is the

MANISH SWARUP/AP

A WOMAN WHO DIED of COVID-19 being buried in a freshly dug grave at a cemetery in New Delhi on April 16.

best hospital in the country. If this is the situation here, imagine what it would be like in other parts of the country," the person said on condition of anonymity. Although the AIIMS received PPE kits, they were not distributed to all health care workers. Some of them were stitching their own PPE suits, one employee said.

The Delhi State Cancer Institute became a cluster for virus transmission and had to be shut down. More than 45 of its employees were quarantined, of whom 29, including three doctors, tested positive. Four patients, who were admitted to the hospital, and the attendant of a patient also tested positive. The source of infection was traced to a doctor at the institute, whose brother and sister-in-law had returned from the United Kingdom. A two-year-old boy, too, tested positive in the hospital.

While the Centre declared entire Delhi a Red Zone, the Delhi government further identified nine districts as hotspots with 57 containment zones. After declaring an area a containment zone, the government launched Operation SHIELD—sealing, home quarantine, isolation and tracking, essential supplies, local sanitisation and door-to-door checking. Residents in these zones were not allowed to leave their homes. The zones were sanitised using 10 spraying machines imported from Japan and 50 obtained from the Delhi Jal Board. The Delhi Health Department said the SHIELD measures had freed the city's first hotspot, Dilshad Garden, of the infection.

Simultaneously, the government set up the Corona Foot Warriors Containment and Surveillance Force. Members of the task force will visit households in all the districts to identify suspected cases. Each team consists of five members, who include a booth-level officer, a civil defence volunteer, a police constable, a sanitation worker and an anganwadi worker. There will be 13,750 such teams to advise people to practise physical distancing and wear masks when going out.

The government said the Food and Supplies Department had already distributed almost 100 per cent of the entitled allocation for April among public distribution system beneficiaries to meet their requirements during the lockdown. The government received close to 20,000 calls on its helpline in connection with coronavirus, it said.

While Residents' Welfare Associations framed their own rules on a daily basis, stigmatisation associated with the virus gripped parts of Delhi. In Greater Noida, a 25-year-old man, who coughed while playing Ludo, was shot at and injured for "trying to spread" coronavirus.

Two women doctors of Safdarjung Hospital were assaulted by a 42-year-old interior designer who accused them of "spreading coronavirus".

After a pizza delivery boy tested positive for the virus, 72 families of South Delhi were put under home quarantine.

Although there was no official ban, meat was not allowed to be sold. The government tried to launch an odd-even policy along with physical distancing in wholesale vegetable and fruit markets but it was reportedly not followed.

The religious congregation of the Tablighi Jamaat in Delhi's Nizamuddin became a coronavirus cluster with more than a 1,000 cases across 17 States linked to the event. The Islamic sect's leader, Maulana Saad Kandhalvi, was booked for culpable homicide and money laundering. He is expected to join the investigation after his quarantine ends. □

On the right track

The State has been able to keep a lid on the coronavirus infection through a strategy involving setting up of response teams, enforcing containment measures, ramping up testing, and using effectively the experience gained in handling natural disasters. BY **PRAFULLA DAS**

ONE MONTH AFTER ODISHA DETECTED ITS first COVID-19 positive case, 21 of the 30 districts in the State remained safe from the infection. Of the 60 positive cases as on April 15, 46 belonged to Bhubaneswar. The other eight districts recorded one or two cases each, indicating that the spread of the virus was largely contained.

Before the Central government imposed the lockdown on March 24, migrant labourers and travellers from more than 100 countries, and close to 90,000 people from within the country had come to the State.

Odisha's fabulous report card on its fight against COVID-19 did not come easily. It was the well-thought out strategy and untiring efforts of the administrative machinery that helped keep the virus at bay. Expressing his satisfaction over the containment efforts, Chief Minister Naveen Patnaik said in video message on April 14:

"I am pleased to see that the coronavirus statistics are levelling in the State and going down." He thanked all those who were responsible for containing the spread of the pandemic in the State.

Ever since the pandemic alert was issued, the government lost no time in getting its acts together. From bringing in policy changes to constituting high-level COVID-19 response teams and from introducing technology to track COVID-19 suspects and providing solace to weaker sections, all measures were carried out at breakneck speed. Patnaik himself led from the front by staying in regular touch with the core team.

The first COVID-19 patient in the State was identified on March 15, when a student who returned from Italy tested positive. The State added 15 new cases on April 3, followed by 18 more cases on April 5. There was no double-digit jump thereafter. In fact, when the number of positive cases stood at 60, 18 patients had already recovered. Only one person had died.

BISWARANJAN ROUT

VILLAGERS walk home with firewood on the outskirts of Bhubaneswar on April 13.

Known for handling natural disasters of various degrees, Odisha treated the COVID-19 pandemic as nothing less than a disaster. It first ordered a lockdown in five districts and eight urban centres from March 22 to March 29, even before Prime Minister Narendra Modi declared a national lockdown. The March 22 Janata Curfew announced by the Prime Minister was perfect for the State to enforce a total shutdown. Incidentally, it became the first State in the country to announce extension of the lockdown from April 15 to 30, before the Centre extended the period until May 3.

Initially, it was argued that detection of fewer cases in Odisha was due to the test size. Experts agreed this was the case. The testing of coronavirus infection began in Odisha on February 1 and for nearly two-and-a-half months the State was not able to test more than 500 samples a day.

The number of samples tested, however, jumped to 5,537 by April 15 following the introduction of CO-BAS-6800 at the Regional Medical Research Centre (RMRC), Bhubaneswar, and the opening of new testing facilities. The automatic testing facility helped increase the number of tests to a great extent.

In order to allay fears about low test size, the State government, in coordination with the Union Health Ministry, expanded the testing facility from the RMRC to the All India institute of Medical Sciences (AIIMS), Bhubaneswar; SCB Medical College & Hospital, Cuttack; MKCG Medical College; Isphat General Hospital (IHG), Rourkela; and the Institute of Life Sciences, Bhubaneswar. More testing facilities were subsequently added. Samples were collected from urban areas as also from the gram panchayats.

The government set up exclusive COVID-19 hospitals in different parts of the State to cope with any eventuality. Patnaik directed the authorities to ensure at least one such hospital in all the 30 districts with a combined bed strength of 6,000.

To translate these plans into reality, the government partnered with private medical colleges and hospitals and arranged funds from corporate houses. A target was fixed to have as many as 36 hospitals dedicated to COVID cases across the State.

By April 15, 21 hospitals became operational; another 15 are in the process of being readied. In all, 7,034 temporary medical centres/camps were completed in 6,798 gram panchayats with 1,63,528 beds.

Health Department officials claimed that the rate of spread of the virus was low in Odisha since only 60 cases were detected after testing 5,000-odd samples. The State was able to have an adequate stock of essential medicines, including antibiotics, analgesics and anti-inflammatory for five months of consumption. Besides, orders were placed to procure supplies for four more months.

A dedicated COVID-19 website was set up and a helpline number was opened. Call centres were set up with doctors answering calls and inquiring about the health condition of people at regular intervals. The two platforms were used brilliantly to track foreign returnees as well as to keep a tab on people developing symptoms of infection.

BISWARANJAN ROUT

INSIDE a newly set up COVID-19 hospital in Bhubaneswar on March 29.

When the helpline No. 104 was flooded with thousands of calls every day, the government came up with idea of COVID-19 telemedicine helpline 14410. Within two days of the Chief Minister's appeal, more than 300 doctors came forward to provide their services voluntarily to people showing flu-like symptoms.

On the containment front, the State government acted with an iron fist. After two locations—Surya Nagar and Bomikhal area of Bhubaneswar—emerged as coronavirus hotspots. Bhubaneswar, Cuttack and Bhadrak towns observed a 48-hour-long complete shutdown immediately.

After ascertaining that the sudden spike in positive cases was not the phase 3 or community transmission of the virus, but related to certain localities, the authorities lifted shutdown measures, while continuing with the lockdown. The government took no chances. Wherever any new case was detected, containment zones were declared with immediate effect. The administration did not at any point stop the tedious contact-tracing exercise.

The government handled the Tablighi Jamaat issue sensibly. It urged the community members to come forward and participate in the testing and they responded positively. Several persons were arrested for posting false messages on social media platforms, and Patnaik himself warned against communalising the pandemic.

Women's participation was a bright spot in the well-synchronised administrative response. In fact, women virtually took the lead in fighting the pandemic in a big way.

Three major institutions, where COVID-19 testing was carried out are headed by women scientists and doctors. Sanghamitra Pati heads the RMRC, Gitanjali Batmanabane, the AIIMS, and Jayashree Mohanty SCB Medical College Hospital. Interestingly, most of the technical persons deployed are women.

Senior bureaucrats such as Shalini Pandit, Mission Director of National Health Mission; Anu Garg, State Labour Secretary; Yamini Sarangi, Managing Director of the Odisha State Medical Corporation Limited; and Sujata R. Karthikeyan, Director of Mission Shakti, played their part in the State's response to the pandemic.

Besides, thousands of nurses, auxiliary nurse midwives (ANMs) and anganwadi and ASHA workers went from house to house to check the health of the people. Women self-help groups, apart from producing masks, were in the forefront of feeding the poor and destitute across the State.

As a nationwide debate ensued on lockdown versus economic impacts, Odisha adopted a pragmatic approach. In order to revive the economy during the extended lockdown period, the government allowed relaxations with regard to activities relating to agriculture, horticulture, fisheries, forestry, drinking water and e-commerce.

The procurement of rabi crop was resumed and all cold storages and godowns were allowed to run. The government, however, said that all these activities would be carried out by maintaining physical distancing.

People welcomed it when e-commerce companies were allowed to restart home delivery of goods, restaurants were permitted to run home delivery services and dhabas were given permission to have takeaway facility.

The Special Relief Commissioner issued a notification excluding all agricultural activities, including harvesting and selling of rabi crops, from restrictive measures.

Shops and establishments engaged in selling agricultural implements, cattle feed and fish feed and food processing and packaging facilities were allowed to remain open.

Activities relating to the Mahatma Gandhi National Rural Employment Guarantee Scheme, Swachh Bharat, rural housing schemes, and fishing and floriculture were resumed.

The relaxations brought huge relief to forest-dependent communities as March to May is the harvesting season in forests. The collection and marketing of non-timber forest produce also resumed. The Forest Department was also allowed to carry out plantation work and take up construction and repair of waterbodies.

The government engaged nine bureaucrats and four police officers, backed by support staff, to coordinate with other State governments to ensure that migrant workers from Odisha stranded in those States were provided food and shelter. Similarly, arrangements were made for the stay and food requirements of more 77,000 migrant workers from other States who were stranded in Odisha.

The State government also adopted measures to ensure that the poor and needy did not face hunger during the lockdown. While construction workers were provided Rs.1,500 each as financial assistance, the Department of Food Supplies & Consumer Welfare distributed Rs.1,000 each to 51,46,696 ration card holders as cash relief.

According to Food Supplies & Consumer Welfare Minister Ranendra Pratap Swain, over five lakh tonnes of foodgrains was distributed through fair price shops as advance ration for three months.

During the special drive for distribution of ration for April-June, the Department added 51,766 new beneficiaries belonging to 19,059 families under the State Food Security Scheme (SFSS) between March 21 and April 11. Inclusion of eligible beneficiaries was in progress, he said.

In addition, 5 kg of rice and 1 kg dal were distributed free of cost to ration cardholders with Central assistance.

In order to prevent further spread of the virus in Bhubaneswar after 45 positive cases were reported by April 15, the State government assigned senior officials to be in overall charge of containment and prevention of the disease.

The city was divided into three zones and two senior bureaucrats each were assigned to these areas to oversee intensive sampling of primary and secondary contacts of COVID-19 patients, contact tracing, household survey by the surveillance team in the containment zone and supply of essential commodities for households under containment.

Odisha seems to be on the right track in its fight against the pandemic by marshalling its resources in a prudent manner. But the authorities are keeping their fingers crossed as migrant workers stranded in other States were getting impatient to return home. In such a chaotic situation, they have to think out-of-the-box to deal with reverse migration while checking the spread of the virus in the State. □

‘Weaponising’ the virus

As the government continues to punish political leaders in Kashmir, including those who have for long fought for mainstreaming of Kashmir’s polity, there are apprehensions that the authorities may be using the public health crisis to exact political allegiance. BY **ANANDO BHAKTO**

COVID-19 KEPT UP ITS ONSLAUGHT IN Jammu and Kashmir, registering 314 cases as of April 16, and there was no respite for prominent leaders either in the newly designated Union territory from the witch-hunt unleashed against them following the abrogation of Articles 370 and 35A on August 5.

A number of former Ministers and legislators from diverse political backgrounds remain incarcerated while their families fret over their frail health and probable susceptibility to the coronavirus. Among them are former Cabinet Minister Naeem Akhtar, the National Conference’s (N.C.) Ali Muhammad Sagar and Hilal Lone, the Peoples Democratic Party’s (PDP) Sartaj Madani and Mansoor Mir, and bureaucrat-turned-politician Shah Faesal. The government’s decision to release several others, including N.C. leaders Farooq Abdullah and Omar Abdullah, led to the perception that the government would be relentless in assailing those who were unwilling to reconcile themselves to the changed political landscape of Jammu and Kashmir. There is an apprehension that the regime at the Centre may be “weaponising” the prevailing public health crisis to break the will of the political prisoners and extract servility and allegiance.

THE CASE OF MIAN QAYOOM

The harshness meted out to 76-year-old Mian Qayoom, an eminent lawyer with over 40 years’ experience in practising law and president of the Jammu and Kashmir High Court’s Bar Council, seems to point that way. Ever an indomitable and incisive voice against injustices perpetrated in Kashmir, Qayoom was detained before daybreak on August 5 and moved to Agra Central Jail. His health condition soon deteriorated, and after a brief hospitalisation in New Delhi in January he was relocated to Tihar jail. There he remains still, despite his long history of heart ailment and diabetes and recent stroke, which makes him especially vulnerable. The soaring mercury does not make it any easier for someone used to a cold climate.

MUKHTAR KHAN/AP

AT AN area in Srinagar declared a red zone by the government during the lockdown, on April 14.

Qayoom was among the first political prisoners to be slapped with the Public Safety Act (PSA), as early as on August 7, two days after the Centre virtually laid siege to the Kashmir Valley. Speaking to *Frontline*, his nephew, Mian Muzaffar, said: “He [Mian Qayoom] has been a diabetic for the past 26 years, he survives on one kidney, he is scheduled for an open-heart surgery, and we fear he might get infected [with coronavirus] in the absence of health care and nutrition. Leave alone defying New Delhi over J&K’s now-revoked special status, I am afraid he may not be able to practise law.”

In February, the Jammu and Kashmir High Court dismissed a petition challenging Qayoom’s detention. The matter has now been referred to a division bench, but the hearing is awaited. Muzaffar said his uncle had lost more than 10 kg of weight in the past eight months, and back in Srinagar his 70-year-old aunt was alone and inconsolable. “I have not been able to contact him ever since the lockdown was announced on March 24. When I visited him last, he asked me to get him summer clothes. He needs insulin often and survives on diabetic biscuits. I have no idea whether these have been arranged by the jail authorities,” Muzaffar said.

Qayoom has faced the administration’s suspicions before, too. In September 2017, he was summoned three times by the National Investigation Agency in connection with a case of terror-funding. Political observers perceived that episode as an instance of overt and unabashed political harassment aimed at stifling dissent.

Shah Faesal’s wife, Iram Shah, said why her husband was not being released was a “mystery”. “We were hoping that he would be released before everyone else, but it is really sad that eight months have passed since he was booked, and he is not home even in such trying circumstances,” she said over the phone from their Ompora residence in Budgam near Srinagar. She said she had not heard from anyone in the government.

> New Delhi’s misplaced antagonism towards the “unionists” has put fetters on the imagination of many young politicians.

Faesal quit the Indian Administrative Service in January 2019 to foray into politics. During an interview with this reporter at the time, he said: “The idea of engaging with the rest of India is that they need to understand what the problems in Kashmir basically are. I plan to engage not just with the youth of the valley but also mould the opinion of people in the country” (“There is an attempt to weaken regional parties in Kashmir”, *Frontline*, January 11, 2019). In March 2019, he launched his Jammu and Kashmir People’s Movement with the objective of joining the electoral fray and bringing about “change”. But as the political climate turned menacing in the aftermath of August 5, his resolve wavered. On the intervening night of August 13 and 14, 2019, he attempted to board a flight to Istanbul but was apprehended at the New Delhi international airport and flown back to Srinagar, where he was booked under Section 107 of the Code of Criminal Procedure.

A habeas corpus petition filed by one of his party colleagues was later withdrawn at his request. If the intent was to mollify decision-makers in New Delhi, that did not happen. He was slapped with the Public Safety Act on February 14. Iram Shah said it had been over a month since she last visited him at the MLA Hostel in Srinagar, where he remains confined. “I am not able to venture out due to the lockdown. His younger brother, who is a doctor, does. There is no proper arrangement regarding food and even filtered water. While we are worried for his safety there, back home everyone is gloomy and insecure,” Iram said “My [five-year-old] son asks ‘where is Daddy?’ I do not know how to explain things to the child.” Momentarily overcome with emotion, she asked: “At the time of a pandemic, one ought to be with one’s family and everyone would agree to that, wouldn’t they?”

POLITICAL VETERANS

For the families of the PDP’s Naeem Akhtar and N.C. general secretary Haji Ali Muhammad Sagar, the advanced age of the two leaders deepens their fears and

MUKHTAR KHAN/AP

AN ELDERLY MAN carrying wheat flour and sugar for his family in Srinagar on April 14.

anxieties. Haji Sagar's son, Salman Sagar, president of the Youth National Conference and Srinagar's former Mayor, said he was confident of a compassionate hearing in the Jammu and Kashmir High Court on a petition challenging his father's detention. "We expect the court to give a favourable ruling," he said over the phone from Srinagar on April 15, a day before the hearing was scheduled. But his hopes were dashed: on April 16 the court allowed the government an additional 15 days to file its response.

Salman was frustrated over the absurdity of the charges against his father. The PSA dossier stated that the detainee [Haji Sagar] was able to garner votes during troubled times and that proved he enjoyed a formidable support base and could influence people. "How ironic is that?" Salman said.

"Until yesterday New Delhi wouldn't tire of lauding us for ensuring a turnout in elections. How has that now become anti-national, a ground for imprisoning an avowed pro-India politician?"

In November 2019, this reporter had noted a similar feeling of pain and despair coalescing into belligerence during interactions with the families of several political prisoners. A senior PDP leader's relative had said: "We had always offered to mutually work with the government on areas of agreement rather than remain fixated with antagonistic sentiment. Why should we do that now?"

The pandemic has muted that combative rhetoric. Iram Shah said Faesal would not take a line contrarian to New Delhi's. "I am not sure he will continue politics. He might go for higher studies once he comes out," she said. The families of other detainees are similarly irresolute, either reluctant to discuss politics or careful with their words. The question on everyone's mind is: Is the government using COVID-19 to browbeat opponents?

Naeem Akhtar was a prominent face in Mehbooba Mufti's Cabinet. His daughter, Shehryar Khanum, was worried that his indifferent health made him vulnerable to the virus. "My dad has had an open-heart surgery, he has stressed kidneys and is hyper-tensive. We are worried, not so much for medical facilities as because of the virus. My father would be a sure casualty because of his co-morbidities if he, God forbid, catches the disease," she told *Frontline*.

She complained of the poor facilities at M-5 hut on Srinagar's Gupkar Road, where Naeem Akhtar is detained along with two others.

"The government does not provide them any assistance as per the jail manual. They are on their own for food and other essentials. The three of them are visited by their families, and that multiplies the risk of infection. All this when they have done no wrong to deserve detention in the first place."

Salman Sagar had a similar grouse: "I have to travel 14 km to deliver him [Haji Sagar] food every day. The authorities declined my request for a travel permit, and it is very difficult to cart your way out through the checkposts. This government is unable to make any distinction between who is a part of the mainstream and who is a separatist."

A family member of a detained leader, who refused to be named, said it was clear that those who were unwilling to come to a political agreement with New Delhi were at the receiving end: "It is not that an interlocutor from New Delhi drops in with a written pact and asks one to sign it. But there have been persistent efforts to assess one's political resolve, often in the veneer of a casual chat. And that decides one's fate."

New Delhi's misplaced antagonism towards the "unionists" has put fetters on the imagination of many young politicians.

Many of them fear that the government may soon be left with a political wreck that can take many years to rebuild. Waheed Ur Rehman Para, a spokesperson of the PDP, is under house arrest in Srinagar. He said that many people like him had opted for democracy and non-violence even as seesaw battles between pro-India and anti-India elements raged through their adolescent years. "Kashmir is the only region where 8,000 people sacrificed their lives to uphold the Indian Constitution," he said.

"In Uttar Pradesh and other politically fractious hotspots of the country, one sees people dying in riots. But in the Valley, the N.C. and the PDP lost 5,000 and 1,000 party workers respectively for carrying the message of India."

He said he was flustered by New Delhi's reluctance to allow Kashmir's mainstream leaders any operating space. "Whatever we had so far struggled for, whether self-rule or autonomy, it was within the ambit of the Indian Constitution. While the government maintains that Article 370 impeded Kashmir's integration with India, it is clear that abrogating it has not yielded any positives," he told *Frontline*.

His message: "India ought to be reconciliatory." □

Court in COVID times

The judiciary's handling of cases relating to mitigation of the common man's suffering leaves much to be desired. BY **V. VENKATESAN**

THE GUIDELINES ISSUED ON MARCH 24 on the measures that the Centre and the State/Union Territory governments should take for containment of COVID-19 do not specifically suspend the functioning of judicial services, including courts. The list of exceptions to suspended services too does not include judicial or legal services. Such omission is valid because the executive cannot circumscribe the functioning of the judiciary in deference to the doctrine of separation of powers and the independence of the judiciary.

But that does not mean that the judiciary, on its own, cannot adapt itself to changing times. From March 25, the Supreme Court and the High Courts decided to hear matters involving "extreme urgency" through video-conferencing and e-filing of petitions and affidavits during the nationwide lockdown, which now stands extended till May 3.

But the limited functioning of the courts has hampered their contribution to mitigating the common man's suffering. The Supreme Court, for instance, is yet to prioritise hearing of pending cases relating to issues such as the repeal of Jammu and Kashmir's special status under the Constitution, electoral bonds, women's right to worship at Sabarimala, and the Citizenship Amendment Act. The hearing of such cases would require the court to adopt technology in a big way in order to comply with the physical distancing norms. Currently, there are two virtual courts, each comprising two or three judges, even

V. RAJU

SANITATION WORKERS of the Vijayawada Municipal Corporation coming for duty on April 16. A public interest litigation petition was filed seeking directions to give all sanitation workers, a vulnerable lot, protective gear and to test them and their families.

though the effective strength of the court is 33. But the court's response to pleas for intervention by or on behalf of those in distress has not been entirely satisfactory.

MIGRANT LABOURERS' LIVELIHOOD

In *Harsh Mander vs Union of India*, the petitioners Harsh Mander and Anjali Bharadwaj, both social activists, told the Supreme Court that the lockdown caused untold hardship and suffering to migrant workers, who are dependent on daily wages to provide for their families and themselves. It disrupted their daily work and their ability to earn wages. This, the petitioners argued, created panic and resulted in their mass exodus to their villages on foot. Citing news reports, the petition claimed that even those who were in shelter homes were being herded together, which exposed them seriously to the virus.

The lockdown and the subsequent government orders to prevent their reverse migration had subjected migrant workers to unimaginable distress and misery, the petition said. The government has ordered that employers should pay wages to all the labourers employed by them. With employers of migrant labourers not complying with this direction, the state should immediately make direct transfers (in cash, at their doorsteps or through their bank accounts) of at least the minimum wage during the lockdown, the petition said.

On April 7, the bench presided by Chief Justice of India (CJI) S.A. Bobde and comprising Justices Sanjay Kishan Kaul and Deepak Gupta asked the petitioners' counsel, Prashant Bhushan, why the migrant workers needed money for meals if they were being provided meals at the shelter homes. This apparently insensitive question from the bench made one wonder whether the court, having authored landmark judgments in the past espousing the point that right to life and liberty meant more than mere animal existence and involved right to life with human dignity, suffered from institutional amnesia.

When Prashant Bhushan told the bench that they needed not just food but money that could be sent to their families back home, the CJI said the court could not supplant the government's wisdom on providing succour to lakhs of migrant labourers across the country.

The bench also said that it was not an expert body to deal with the health and management issues of migrant workers and would rather ask the government to set up helplines for the needy. In the past, the court had willingly sought experts' help in cases where it felt it lacked the expertise to understand and respond to an issue before it. The petitioners contended that private sector companies might not be able to fulfil the Centre's directives regarding payment of wages as many of them were on the verge of closure. Therefore, the onus of paying their workers was on the Centre and the State governments, they argued.

Their plea, however, met with stiff resistance from the Centre. The Solicitor General, Tushar Mehta, suggested that "PIL [public interest litigation] shops" should close down until the country emerged out of the crisis.

PTI

MEDICAL PROFESSIONALS stage a protest over the inadequate supply of personal protection equipment, at Howrah Orthopedic Hospital in West Bengal on April 16. The court on April 8 directed the Union Ministry of Health and Family Welfare to ensure the availability of appropriate PPE to all health workers in metro cities and tier 2 and tier 3 cities.

The next hearing of the case is scheduled for April 20.

Another petition espousing the migrants' cause too met with a premature end in the Supreme Court. The bench of Justices L. Nageswara Rao and Deepak Gupta *suo motu* converted into a PIL a letter to the CJI by Mahua Moitra, Member of Parliament belonging to the Trinamool Congress, highlighting the distress messages sent by migrant labourers in her constituency, Krishnanagar (West Bengal). The bench heard the case, recognising her as a petitioner-in-person. She sought directions to the executive agencies and employers to release wages to stranded workers along with food, ration and shelter during the lockdown period. However, another bench, comprising Chief Justice Bobde and Justices Nageswara Rao and Mohan M. Shantanagoudar, dismissed the petition on April 13 without stating any reason.

In another PIL filed before the Supreme Court, the social activists Aruna Roy and Nikhil Dey sought payment of wages to workers under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) during the lockdown and issuance of temporary job cards to all migrants who had returned to their villages. On April 8, the bench of Justices Ashok Bhushan and Ravinder Bhat took note of the Centre's submission that Rs.6,800 crore had been paid on April 5 towards arrears of wages and directed the listing of the case two weeks after the lifting of the lockdown.

In *Swami Agnivesh vs Union of India*, the petitioner was aggrieved that during the lockdown the police authorities were not fully implementing the guidelines issued by the Department of Agriculture, Cooperation and Farmers Welfare on March 28. By merely recording Tushar Mehta's statement that there was full monitoring

and implementation of the guidelines and that it would be ensured that the police authorities concerned would follow them, the bench disposed of the petition. Mehta also reportedly told the bench that "this was a self-employment generating petition, and that the court should not entertain such petitions". The bench took note of the fact that on March 28, the government had granted relaxation in the lockdown for activities relating to agriculture and farming.

CHILD CARE INSTITUTIONS

In contrast to what was witnessed in the migrant labourers' wages case, the Supreme Court bench comprising Justices L. Nageswara Rao and Deepak Gupta took *suo motu* initiative to issue directions to ensure care and attention of children in conflict with law and those kept in juvenile homes. "As the pandemic COVID-19 is intensifying in India, it is important that urgent measures need to be taken on priority to prevent the spread of the virus to child care institutions (CCIs)," the bench said. The bench directed Child Welfare Committees run by State governments to consider proactively steps to set up special online sittings or video sessions, initiate preventive measures, counsel families, monitor children sent back to their families, and set up online help desks and support systems at the State level for children and staff in CCIs.

The bench directed Juvenile Justice Boards (JJB) and children's courts to consider whether a child should be kept in a CCI considering the best interest, health and safety concerns. The bench advised JJBs to monitor the situation in Observation Homes on a regular basis for sexual violence, which might be exacerbated in contexts of anxiety and stress produced by lockdown and fear of disease. The bench supplemented these directions with guidelines to support the psychological and emotional well-being of children.

In *Shashank Deo Sudhi vs Union of India*, the bench of Justices Ashok Bhushan and S. Ravindra Bhat initially found *prima facie* substance in the petitioner's submission that the fee of Rs.4,500 fixed by the Indian Council of Medical Research (ICMR) for carrying out screening and confirmation tests for COVID-19 might not be within the means of a large section of the population. The test is free in government laboratories. The bench, therefore, directed the Centre on April 8 to get private laboratories to conduct the test free of cost and decided to consider the question of their reimbursement later. Tests must be carried out in laboratories certified by the NABL (National Accreditation Board for Testing and Calibration Laboratories) or agencies approved by the World Health Organisation (WHO) or the ICMR, the bench said.

On April 13, however, the bench modified its own order in the light of concerns expressed by various stakeholders that the April 8 order was unimplementable. The Centre submitted that around 50 crore beneficiaries covered under the Ayushman Bharat Pradhan Mantri Jan Aarogya Yojana were eligible to avail themselves of testing even in private laboratories. As on date, there are 157 government and 67 private laboratories conducting COVID-19 tests. The bench clarified that the April 8 order was intended to make testing for COVID-19 in private laboratories free for economically weaker sections of society. "We further clarify that the order never intended to make testing free for those who can afford the payment of testing fee fixed by the ICMR for COVID-19," the bench added.

The bench also made it clear that a person can avail himself of the benefit of free testing in a private laboratory only when that person is covered under a scheme like the Ayushman Bharat Yojana. It advised the government to consider whether any other category of persons belonging to economically weaker sections could be given the benefit of free testing for COVID-19. "We are conscious that framing of the scheme and its implementation are in the government domain, who are the best experts in such matters," the bench held.

The order thus deprives the benefit of free testing to persons or families who cannot afford to pay the testing fee and those not covered under any Centrally-approved scheme. The order effectively renders such persons with the option of not testing, and this could be detrimental to the efforts to contain the pandemic.

MEDICAL PROFESSIONALS' SAFETY

On April 8, the Bhushan-Bhat bench, in *Jerryl Banait vs Union of India*, directed the Union Ministry of Health and Family Welfare to ensure availability of appropriate personal protective equipment (PPE), including sterile medical/nitrile gloves, starch apparels, medical masks, goggles, face shield, respirators (N-95 respirator mask or triple layer medical mask or equivalent), shoe covers, head covers and coveralls/gowns, to all doctors, nurses, ward boys and other medical and paramedical professionals actively attending to patients suffering from COVID-19 in Metro cities, and Tier 2 and Tier 3 cities.

Taking note of the reported violence against doctors in Indore (Madhya Pradesh) and Ghaziabad (Uttar Pradesh), the bench directed that necessary police security be provided to doctors and medical staff in hospitals and places where patients diagnosed with COVID-19 or those suspected of COVID-19 or those quarantined are housed. The court also said necessary security should be given to doctors and other medical staff who visit places for screening of people. It also sought action against those who obstructed medical personnel and committed any offence in respect to the performance of their duties.

The bench directed the Centre to explore all alternatives, including the option of enabling and augmenting domestic production of protective clothing and gear and restricting their export. Interestingly, the bench has kept this case pending, rather than dispose it of on the basis of the government's assurances as it did in similar cases. The court's role in ensuring the government's accountability may offer lessons for its intervention in such cases.

During the lockdown, the court was flooded with PILs espousing the rights of sections of society suffering from its impact in different ways. Stating that sanitation workers

handling household waste without any protective gear were vulnerable, especially in COVID-19 hotspots, a petition filed by the social activist Harnam Singh sought the court's directions to ensure that municipal boards, panchayats, cantonment and railway authorities equip them with "long sleeved gowns, boots, masks, goggles and face shield", as recommended by the WHO. The petitioner also sought directions to test these workers and their family members for COVID-19 within 48 hours of the order being passed. On April 15, the Supreme Court disposed of the petition on the Solicitor General's submission that WHO guidelines were binding on the Government of India and were meticulously followed.

SANITATION AND HEALTH CARE WORKERS

On April 15, the Supreme Court bench comprising Justices N.V. Ramana, Sanjay Kishan Kaul and B.R. Gavai disposed of the petitions filed by the United Nurses Association and the Indian Nurses Professional Association seeking directions to the government to formulate a comprehensive policy framework with regard to protecting and safeguarding health care workers. The bench was satisfied that the Centre had set up helpline numbers and control rooms to act on their grievances.

ARUN SANKAR/AFP

A MIGRANT worker and his daughter wait to get food at a camp in Chennai on April 16.

On the right to life and personal liberty, the Supreme Court and the High Courts failed to adopt a consistent approach with regard to grant of bail and release of undertrials. The Supreme Court, in contrast to its own stand on such issues in the past, asked the social activists Gautam Navlakha and Anand Teltumbde to surrender to the National Investigation Agency despite the lockdown and face arrest and incarceration for an indefinite period pending trial, notwithstanding the threat of spread of COVID-19 among prisoners.

It was only on March 23 that the Supreme Court bench of Chief Justice of India S.A. Bobde and Justices Nageswara Rao and Surya Kant had directed all States and Union Territories to set up high-level panels to consider release on parole of all convicts who had been jailed for up to seven years so as to decongest jails. The bench also recommended extension of similar relief to undertrials awaiting trial for offences entailing maximum sentence of seven years.

On April 13, however, the bench of Chief Justice of India S.A. Bobde and Justices Nageswara Rao and Shantanagoudar accepted the Centre's contention that any prisoner suffering from COVID should be subjected to tests and not be released. But if a prisoner who had been released was found to be infected, he or she should be quarantined, it added.

The Centre submitted that except in Bihar, Goa and Delhi some prisoners had been released following the March 23 order. The Attorney General, K.K. Venugopal, submitted that the release and transportation of prisoners would itself result in transmission of coronavirus from prisons or detention centres to locations they were headed to.

The bench observed on April 13:

"We make it clear that we have not directed the States/Union Territories to compulsorily release the prisoners from their respective prisons. The purpose of our aforesaid order (passed on March 23) was to ensure that the States/Union Territories assess the situation in their prisons having regard to the outbreak of the present pandemic in the country and release certain prisoners and for that purpose to determine the category of prisoners to be released."

The bench directed transportation of released prisoners to their destination with due compliance to physical distancing norms. Clearly, while the Centre is reluctant to release prisoners on the grounds that an infected prisoner who is released may spread it to others, the court's concern is that the continued detention of such prisoners in overpopulated prisons could be detrimental to containment efforts. The bench made it applicable to detention centres and correctional and protection homes as well.

On April 9, a division bench of the Delhi High Court comprising Justices Rajiv Sahai Endlaw and Manoj Kumar Ohri directed the release of undertrial prisoners without their having to furnish a surety bond. They could be released on furnishing a personal bond to the satisfaction of the Superintendent of Jail.

The High Court passed the order in order to decongest Delhi jails, as a large number of undertrial prisoners languished in them for want of sureties despite having been granted bail.

Both the Bombay High Court and the Rajasthan High Court refused to consider bail applications as "urgent judicial matter". Such orders hugely disappointed those concerned with using the epidemic as an excuse to curtail precious liberties. Fortunately, the Supreme Court stayed the order of the Rajasthan High Court's Jaipur Bench directing the registry not to list bail pleas and sentence suspension of prisoners as "extreme urgent matters". Insofar as the Bombay High Court order relies on the Jaipur Bench's order, the Supreme Court's stay should apply to it too. □

Tilting at windmills

Political expediency makes U.S. President Donald Trump shift the blame on China and then on the WHO for the poor handling of the COVID-19 crisis. BY **JOHN CHERIAN**


XIE HUANCHI/AP

ALEX BRANDON/AP

CHINESE PRESIDENT Xi Jinping, a March 10 photograph. (Right) President Donald Trump and Dr Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, in the White House press briefing on April 16.

THE DONALD TRUMP ADMINISTRATION will never accept responsibility for the thousands of deaths caused by the coronavirus in the United States. The country has suffered the largest number of casualties so far, already surpassing Italy and Spain. Trump had been ignoring the warnings sent by his senior advisers and administration officials since the beginning of the year. The U.S. National Security Council Office, which is responsible for keeping a lookout for pandemics, had received intelligence reports in the first week of January that COVID-19 was on its way to the country. Soon after, it was suggested to Trump that he should consider closing down big cities such as New York and Chicago.

Peter Navarro, Trump's chief adviser on trade issues, submitted a memo in late January detailing the risks posed by the coronavirus. Navarro warned that the coronavirus had the potential to cause up to half a million deaths and a loss of $3 trillion to the U.S. economy. By February, the top health officials in the Trump administration were all urging the President to take preventive measures urgently. But Trump, encouraged by his evangelical Christian base and alt-right commentators from Fox News and Breitbart, did not take the threat posed by the pandemic seriously. In one of his press conferences, Trump predicted that the virus would go away by April "when it gets a little warmer".

On February 25, Nancy Messonnier, the Director of the U.S.' National Centre for Immunisation and Respiratory Diseases, with the tacit support of senior colleagues like Dr Anthony Fauci, the Director of the National Institute of Allergy and Infectious Diseases, issued a public warning about the imminent danger that the pandemic posed to the citizenry. (Fauci admitted in mid-April that the U.S. government should have acted sooner in response to COVID-19 and saved lives in the process.)

Trump, who was returning from India, was furious that Nancy Messonnier had made the statement without the White House's approval. The statement had a negative impact on the stock market, which fell to a historical low. The President was betting on a booming economy and a stock market to win a second term in office. By the time he acted in mid-March, it was too late. People had started dying in droves and the economy started imploding. Masks, ventilators and other medical equipment were in short supply as the administration had ignored warnings by its own medical experts and made very little preparation.

When things started going out of control, the top echelons of the Trump administration began in right earnest to target China. Secretary of State Mike Pompeo started calling COVID-19 "the Wuhan virus". Trump went a step further and called it the "Chinese virus". He accused China of concealing the outbreak after it was first detected. Senator Tom Cotton, a close political ally of

Trump, said that the coronavirus might have escaped from a biosecurity laboratory in Wuhan.

Trump's Deputy National Security Adviser, Matthew Pottinger, a right-winger who has hawkish views on China, initially encouraged the conspiracy theory. He played an important role in pushing the Trump administration to blame China for the spread of the virus.

In a tit-for-tat response to the continuous baiting by Trump and his senior officials, the Chinese Foreign Ministry spokesman, Zhao Lijian, tweeted in mid-March that the coronavirus might have been inadvertently introduced in Wuhan by a visiting U.S. Army team participating in the world military games last year.

But the Chinese side did not waste much time in defusing the escalating diplomatic tensions. The Chinese Ambassador to the U.S., Cui Tiankai, publicly disavowed the conspiracy theories being propagated on both sides. Cui said that it was "very harmful" for diplomats and journalists to comment on the origins of the virus.

The Chinese Ambassador's statement led to a temporary halt in the mutual recriminations and to an exchange of phone calls between Trump and Xi. According to the Chinese Foreign Ministry spokesman, they agreed that "under the current circumstances, China and the United States should stand united and fight the COVID-19 menace". Xi told Trump that Beijing had maintained "a transparent and responsible attitude" while sharing information about the coronavirus.

For the record, China informed the World Health Organisation (WHO) just before New Year's Eve about a mysterious pneumonia outbreak spreading in Wuhan, an industrial city with a population of over 11 million. On January 3, the head of the U.S.' Centre for Disease Control and Prevention (CDC) received a call and an official letter from his Chinese counterpart, warning about a dangerous virus detected in the city. On January 11, China shared the genetic sequence of the virus with the U.S. authorities.

By the end of January, the Trump administration sent two of its own senior virologists to China to study the situation first hand. When Trump was in Davos in the beginning of the year, he was full of praise for Xi's handling of the situation. On January 24, a month after the virus was discovered, Trump tweeted that China "was working very hard to contain the coronavirus" and that the U.S. "greatly appreciates their efforts and transparency".

During his last conversation with Trump in March, Xi also offered to share the expertise China had gained from combating the virus and also promised to dispatch much-needed medical supplies to the U.S. Trump on his part said that he had "a good conversation" with Xi. Vital supplies are still being flown in from China as the death rates keep on increasing in the U.S. This fact has not gone down well with the anti-China hawks in the Trump administration. A donation of much-needed face masks from China was kept waiting for more than a month as senior Trump administration officials debated whether or not to allow Beijing to advertise the generosity of the Chinese people to the American public.

Many in the Trump administration claim that China is trying to divert attention from its alleged "mishandling of the pandemic" in its initial stages by indulging in donor diplomacy. China being the first state to almost fully recover from the pandemic is once again becoming the "factory of the world". Many leading U.S. politicians have welcomed China's help. Among them is Andrew Cuomo, the Governor of the State of New York, the worst affected so far in the U.S.

Washington has been furiously trying to corner critical medical supplies meant for other countries. The Italian, French, German and Canadian governments are among those who have complained that supplies they had ordered from China and elsewhere were diverted to the U.S. The U.S. government had outbid other governments in its attempt to procure emergency medical supplies.

FABRICE COFFRINI/AFP

TEDROS ADHANOM GHEBREYESUS, Director-General of the WHO.

INDIA'S CAPITULATION

The Trump administration arm-twisted the Indian government to lift the ban on the export of hydroxychloroquine that is used for the treatment of malaria and many other serious diseases. Trump, without the authorisation of medical professionals and scientists, has been touting it as a cure for the coronavirus. After Trump threatened India of consequences if it did not lift the ban, the Modi government capitulated. As a face-saver, it announced that it was sending the medicine to a few other countries. Iran and Venezuela, which are under U.S. sanctions, are excluded from the list of recepients.

One of the recipients is Israel. The country has used its intelligence agency, Mossad, to run covert operations from early March to hoard limited lifesaving medical materiel such as ventilators, coronavirus testing kits and masks. According to a report in *The New York Times*, the Mossad's attempts to smuggle a huge consignment of sanitisers from India was thwarted.

Trump has not used the offending term "Chinese virus" since his conversation with Xi so far. Instead, he has turned his focus on the WHO, the nodal organisation trying to coordinate the global response to the pandemic. In the first week of April, Trump, for the first time, accused the WHO of "totally mishandling" the response to the coronavirus and giving "bad advice" to the international community. They "totally blew it," the U.S. President alleged, saying that the organisation should have declared the coronavirus outbreak a pandemic much earlier.

The WHO declared the coronavirus "a pandemic"

only on March 11. But it had declared the coronavirus a "public health emergency of international concern" on January 30 itself. It has been keeping the American side in the loop from the outset. Anthony Fauci and Robert Redfield, the head of the CDC, were regularly in touch with the WHO since January. The WHO had been advising from that time onwards the urgent need for identifying and isolating COVID-19 cases. The Trump administration, like many other governments in the world, did not heed the advice.

On April 14, the Trump administration took the unprecedented step of completely suspending U.S. contributions to the WHO when it is in the midst of the battle against COVID-19. Trump had threatened to take this action in early April but better sense temporarily prevailed. While making the announcement in the second week of April, Trump said that the WHO had "failed in its basic duty and it must be held accountable" and that it had become "China-centric" in its functioning. The U.S. President did not bother to explain what he meant by the WHO being "China-centric".

As it is, the WHO is short of funds. Many member-countries, including the U.S., have not been paying their annual contributions regularly or in full. The U.S. is the biggest donor though it only pays for specific programmes. Trump has now announced the freezing of nearly $500 million in the midst of a pandemic. The WHO's annual budget is only $2.5 billion, which is the average budget of a large U.S. hospital. The WHO has been tasked with playing the key role in coordinating an international response to the pandemic with such a paltry budget and it is getting brickbats from Washington for all its efforts.

Trump's allies in the Senate and the U.S. Congress have not ceased their attacks on the WHO and its Director-General, Tedros Adhanom Ghebreyesus. They have accused him of acting as a tool of the Chinese Communist Party because of his praise for the Chinese government's "commitment to transparency" and the "extraordinary measures" it had taken Wuhan. Trump, while announcing his decision to suspend U.S. contributions, accused the WHO of promoting China's "misinformation" about the virus.

Ghebreyesus, to his credit, has from the third week of January been holding press briefings almost on a daily basis, repeatedly warning the international community that the virus was spreading rapidly. "We have a window of opportunity to stop this virus. But that window is rapidly closing," he had warned in his first briefing on January 21. He has since been emphasising on this point ceaselessly but evidently to little avail as the coronavirus spread inexorably while governments all over the world were caught napping. All the continents except the Antarctic are affected now.

Only Trump's loyal but shrinking base supported the latest move to deflect the blame from the administration. No other world leader followed in Trump's footsteps though the Prime Minister of Australia, Scott Morrison, and the Japanese Foreign Minister, Aso Taro, supported Trump's accusation that the organisation was too close to Beijing. The Indian government has expressed some misgivings about the functioning of the WHO. Prime Minister Narendra Modi had told G-20 leaders about the need to reorganise the WHO and provide it with more funding.

SOLIDARITY WITH THE WHO

United Nations Secretary-General Antonio Guterres said that this was "not the time" to reduce the resources for WHO operations. "Now is the time for the international community to work together in solidarity to stop this virus and its shattering consequences."

None of U,S.' European allies have supported Trump's stance on the WHO. They have, in fact, called for the strengthening of the organisation. The European Union (E.U.) foreign policy chief, Josep Borrell, "deeply regretted" the Trump administration's move, saying that the world needed the U.N. health agency "more than ever" at this juncture to combat the pandemic.

A spokesman for the Chinese Foreign Ministry urged the U.S. government to fulfill its commitment to the WHO at this critical time. "The decision by the U.S. will weaken the WHO's ability to handle the pandemic, especially the nation's whose capabilities are not well developed," the Chinese official said. China has already given the WHO $20 million for the express purpose of combating the coronavirus.

The African Union (A.U.) Chairman, Moussa Faki Mohammat, said in a statement that the U.S. move "was regrettable". Many Africans think that there is a tinge of racism involved in Trump's targeting of the WHO and its chief, who is an Ethiopian national. Trump had some time back classified many African nations as "shithole countries".

The American Medical Association president, Dr Patrice Harris, urged the U.S. President to reconsider his decision. She called it "a dangerous step in the wrong direction that will not make defeating COVID-19 easier". The philanthropist Melinda Gates tweeted that halting funding for the WHO is "as dangerous as it sounds". She said that the WHO's work "is slowing the spread of the COVID-19 and if that work is stopped, no other organisation can replace them". The former U.S. President, Jimmy Carter, said that he was distressed by Trump's decision, saying that the WHO was "the only international organisation capable of leading the efforts to control the virus".

The WHO chief said that the allegations that he favoured China were untrue and that there was no need to use the pandemic to score political points. "We don't do politics at the WHO," he said. "We care for the poor. We care for those who are vulnerable." He reminded the critics of the WHO that the organisation was not only fighting the coronavirus pandemic but was also "working to address polio, measles, malaria, Ebola, HIV, tuberculosis, malnutrition, cancer, diabetes, mental health and many other diseases and conditions". □

Big fightback

As Venezuela grapples with the pandemic and the devastating economic effects of U.S. sanctions and the drop in oil prices, the U.S. sees this as an opportunity to turn the screws on the country. BY **JOHN CHERIAN**

MANAURE QUINTERO/REUTERS

A TEAM CONSISTING OF CUBAN AND VENEZUELAN health care workers carrying out an inspection on April 9 in a slum area in Caracas during the nationwide quarantine on account of COVID-19.

AT A TIME WHEN THE COVID-19 PANDEMIC IS ravaging many parts of Latin America, the administration of United States President Donald Trump has found it opportune to further tighten sanctions on Venezuela and once again call for regime change. In late March, even as the Venezuelan government was appealing to the international community for help to fight the pandemic, the U.S. called on President Nicolas Maduro to relinquish power and make way for a so-called "power-sharing" government. Such a government would be dominated by the puppets of the U.S., currently led by a lightweight discredited politician named Juan Guaido, the leader of a right-wing coup attempt against Maduro.

The pretender is allowed to roam freely around the world and address meetings inside Venezuela. Very few people now turn up to listen to him and most of the opposition has deserted him. Craving for international credibility, Guaido appears on obscure television channels in many parts of the world. His U.S. handlers recently arranged an interview slot for him on an Indian television channel with close links to the Bharatiya Janata Party. Guaido used the platform to ask the Indian government to withdraw recognition from the legitimate government in Venezuela.

The Trump administration's new plan, with the pompous title "Democratic Transition Framework", called for the setting up of "a transitional government" in Caracas, the Venezuelan capital. Its sole purpose would be to hold

a presidential election before the end of the year even as the country is battling to contain the pandemic. Before the so-called transition plans were formally announced, U.S. Secretary of State Mike Pompeo announced that the Trump administration was offering a bounty for the arrests of Maduro and four senior serving and retired officials, including the current army chief, Gen. Vladimir Padrino. The U.S. government, to the general amusement of many in the region, accused the Venezuelan leader of forging "a partnership in narco-terrorism" with the Revolutionary Armed Forces of Colombia, or FARC, "over the last 20 years".

Maduro termed the charges as "false and racist" and described the U.S. President as "a miserable person". The fictitious accusation against Maduro had very few takers besides the leaders of the 50 pro-U.S. countries in the region that have recognised Guaido as President. According to statistics the U.S. State Department itself has been releasing, Venezuela "is not a primary transit country for drug trafficking" in the region. But facts have never stood in the way of the present U.S. administration. The U.S. has since announced a "naval blockade" of Venezuela.

At a news conference to address the COVID-19 issue in the first week of April, Trump made the announcement of the biggest U.S. naval deployment in Latin America in 30 years. According to U.S. Defence Secretary Mark Esper, the main target of the massive naval build-up "is the illegitimate Maduro regime of Venezuela". National Security Adviser Robert O'Brien stressed that the U.S. would "continue its maximum pressure policy" against Venezuela. The last time there was a U.S. naval build-up of this size in the region was in 1989; it led to the invasion of Panama and the overthrow of that country's President, Manuel Noriega.

Interestingly, retired Major General Cliver Alcala Cordones—a Venezuelan army officer whom the U.S. Department of Justice indicted in absentia in March on several charges, including narco-terrorism—has confessed to being part of an earlier coup plot against the Venezuelan government. The general, who had lived in exile for some years in Colombia, said that the plot was hatched in consultation with Guaido and his "American advisers". He has threatened to reveal more secrets if the Department of Justice brings forward the charges against him. He is currently in the U.S.' custody.

Senior U.S. officials have said that the latest move is part of the "maximum pressure" campaign against the government of Venezuela that the Trump administration has been applying for the last year and a half. It came at a time when the Venezuelan government was carrying out important negotiations with the "moderate" sections of the opposition to prepare for the legislative elections to be held later in the year. In a terror attack on the offices of Venezuela's election commission evidently planned to sabotage the electoral exercise, electronic voting machines were destroyed.

The U.S.' moves have also taken place when global oil prices have hit a historic low because of a dispute between Russia and Saudi Arabia. The threat of U.S. sanctions has scared off big companies like Russia's Rosneft and India's Reliance. Trump's hawkish advisers seem to have calculated that a combination of the coronavirus and growing economic misery caused by U.S. sanctions provides a fertile ground for regime change.

UPDATED 'MONROE DOCTRINE'

Trump's point man in Venezuela is the notorious Elliot Abrams, a dyed-in-the-wool neocon. Abrams was a key player in the Iran-Contra affair and the anti-Sandinista counter-revolution in Nicaragua during the presidency of Ronald Reagan in the 1980s. The Trump administration claims to be implementing an updated version of the 200-year-old "Monroe Doctrine", which was the basis for repeated U.S. military interventions in the region. According to the doctrine, the U.S. is "*primus inter pares*" (first among equals) in the region, and all other countries have to kowtow to it. Cuba was the first country to exert its sovereignty and choose its own path of development. Other countries in the region tried to follow Cuba's lead, but most of their efforts were quashed by the U.S. empire. Hugo Chavez and Maduro are among the handful of leaders who have been able to buck the trend since the end of the last century.

CAROLINA CABRAL FERNANDEZ/BLOOMBERG

CITY WORKERS deliver food to residents in the Chacao neighborhood of Caracas on April 13.

Chavez inspired the "pink revolution", which saw progressive governments being elected throughout the length and breadth of Latin America and the Caribbean. The empire has chosen its time to strike back and has been successful in dismantling many of the left-wing governments in the region. The last casualty was Bolivia where the army overturned the results of a fair and free election with the support of the U.S.

But the tide seems to be turning yet again, as the people in the region have started getting disillusioned with the neoliberal agenda being implemented by the proxies of the U.S. In Argentina, the centre-left has made a comeback. In Chile and Bolivia, the right wing is fighting a losing battle. The crisis caused by the pandemic has

TOM BRENNER/REUTERS

U.S. DEFENCE SECRETARY Mark Esper speaking about the U.S.' military moves against Venezuela as President Donald Trump listens during the daily coronavirus response briefing, at the White House on April 1.

given some right-wing governments some breathing room as protests and mass gatherings have stopped because of quarantine measures or executive fiat. The U.S. would like nothing better than to deliver a body blow to the Left at this juncture, using the crisis triggered by the pandemic as cover to intervene militarily in Venezuela.

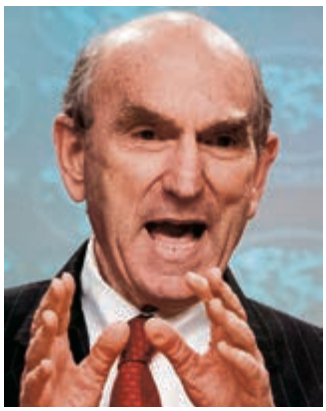
The U.S.' latest efforts to overthrow the popularly elected government in Venezuela started after the International Monetary Fund (IMF) rejected Venezuela's request for a $5 billion coronavirus response loan. The U.S. used its clout in the IMF to ensure that the emergency loan request was denied despite Venezuela getting the backing of the European Union bloc. Guaido has been saying that a financial package is ready for rescuing the Venezuelan economy as soon as there is regime change.

The U.S. sanctions have badly affected the country's medical infrastructure and power grid. This has hampered the working of hospitals and emergency services. There is an acute shortage of essential medicine and equipment required to fight the pandemic. The fall in global oil prices has not helped matters. Venezuela has asked the International Criminal Court to launch an investigation into what it describes as "crimes against humanity" by the U.S. government. Alfred-Maurice de Zayas, a former United Nations Special Rapporteur, has said that some 100,000 Venezuelans have died because of "the impossibility of the timely access to medicines" as a result of sanctions.

All the same, despite the severe constraints, the Venezuelan government, with help from Cuban doctors and medical aid from China, has put up a creditable fight in its efforts to arrest the onslaught of the dreaded virus. Cuba has sent 130 doctors and medical professionals along with 10,000 doses of the drug Interferonalfa-2b. China has dispatched enough coronavirus diagnostic kits to test 320,000 Venezuelans. Russia, too, has sent sizeable amounts of medical equipment and kits. While other countries are sending medical supplies to Venezuela, the U.S. is sending a naval armada to blockade the country.

The Venezuelan government declared a medical emergency on March 11, a day before the first coronavirus case was reported in the country. The airspace was closed to international flights and schools were shut down. Within four days, a national quarantine was announced. A comprehensive national survey was undertaken to identify those who had contracted the disease. The government claims that but for its rigorous testing procedures and the quarantine, the casualties in Venezuela would have been on the high side as is being witnessed in many other Latin American countries. The government has also guaranteed a regular supply of food to the neediest, who constitute seven million people. By the third week of April, there were only 181 reported cases of the coronavirus and 9 deaths.

The worst hit nation in the region is Venezuela's neighbour Brazil. By the third week of April, more than 22,000 people there were infected. There have been more than 1,200 deaths so far. Brazilian President Jair Bolsonaro has made an international laughing stock of himself by taking a highly contrarian view of the pandemic. When the coronavirus came knocking, he was more focussed on destabilising the socialist government in Venezuela than on dealing with the pandemic. In the first week of March, Bolsonaro ordered the withdrawal of all Brazilian diplomats from Venezuela and forced Venezuelan diplomats out of the country. Bolsonaro had made the decision just before he flew to Washington for a meeting with his ideological soulmate, Trump. On the top of their agenda for the meeting was regime change in Caracas.



ANDREW HARNIK/VIA REUTERS

SPECIAL REPRESENTATIVE for Venezuela Elliott Abrams at a news conference at the State Department, in Washington, D.C., on March 31.

In February when Guaido visited Washington, Trump greeted him with all the pomp and ceremony reserved for heads of state. Brazil and Colombia are the main backers of the U.S.' plans to overthrow the left-wing government in Venezuela. Brazil only jumped on the U.S.' bandwagon after the extreme right-wing Bolsonaro was elected a year and a half ago. Colombia has been under a right-wing government for decades and has been the U.S.' closest military ally in the region since the mid-1990s. Colombian President Ivan Duque was in Washington a week before Bolsonaro went there. Right-wing Venezuelan paramilitary groups are being given training in Colombia and Brazil.

The Trump administration is spending millions of dollars in its efforts to get high-ranking Venezuelan military officers to defect or mutiny. The message is loud and clear—Venezuela, the land of Simon Bolivar, will never succumb to the machinations of an imperial nation ever again. □

Everybody hurts

As the economic shock reverberates around the world, hunger and destitution are staring millions of people in the face. It is imperative for governments to come up with bold measures to re-energise the economy and to increase social protection benefits. BY **VIJAY PRASHAD**

ON APRIL 9, KRISTALINA GEORGIEVA, Managing Director of the International Monetary Fund (IMF), said that the world could easily slip into a terrible depression. "The bleak outlook applies to advanced and developing countries alike," she said. "The crisis knows no boundaries. Everybody hurts." There will likely be no recovery in 2020 and only a partial recovery in 2021. This assessment for a partial recovery is based on the hope that the global pandemic will begin to taper off by the second half of the year and that economic activity will restart as a consequence. The duration of the global pandemic is what will determine any recovery from the coronashock.

Half of the planet's population is currently under a lockdown that could stretch out to additional weeks. In the United States, claims for unemployment benefits broke records: three million in one week, six million in the next, and millions more in the queue. Germany's economists estimate that the country's economy will shrink by at least 10 per cent; France's Minister of the Economy and Finance, Bruno Le Maire, compared the situation to the "1929 crisis in terms of its severity, its global nature, and its duration".

Ports across the world have begun to witness "blank sailings": ships that begin their journeys and then do not finish them. Cranes are silent, trucks sit in parking lots, goods are moving but not at the rate at which they moved before the global pandemic. Lockdowns have resulted in congestion at ports as goods remain in containers, unmoved. Cruise ships sit in harbours; the likelihood of that industry starting once the all clear sounds is questionable.

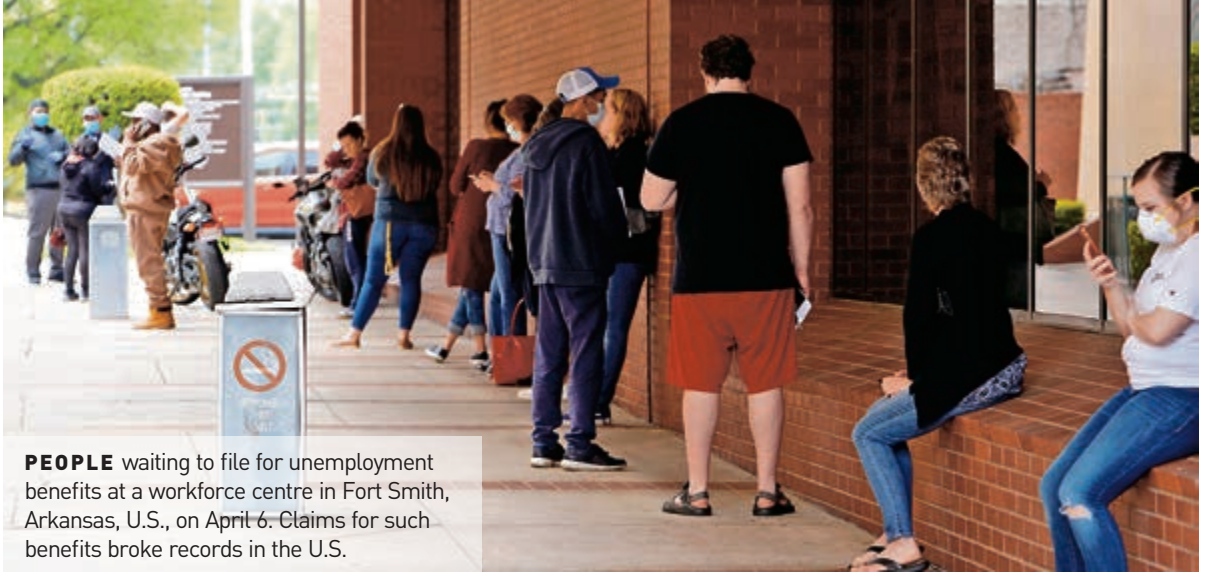
The global supply chain has been damaged by the slowdown of production and of consumption. The World Trade Organisation (WTO) estimates that global trade volumes could fall by 32 per cent (for comparison, global trade volumes fell by 12 per cent during the credit crisis of 2008-09). A study by the multinational bank UBS found that China's exports fell by 17 per cent in January and February; the reason for this, UBS notes, are "fewer working days, production suspension, and strict traffic restrictions imposed after the COVID-19 outbreak".

The slowdown of trade has led to an increase of the costs of trade—moving goods from a factory or a farm to another country—by at least 25 per cent. The margin for profits for online firms and offline firms is between 0.5 per cent and 3.5 per cent, which means that many firms will not be able to make any profit as the cost of trade rises. Many retailers will try to move this increased cost to consumers, who will, as the WTO notes, not be able to absorb it because "demand is strangled by half the globe's peoples being locked down, with many unemployed". This will seriously damage global trade and, therefore, break the supply chain.

The International Labour Organisation (ILO) put out a report that suggested that at least 1.25 billion people were "at risk of drastic pay cuts and layoffs due to the pandemic and related lockdowns". Worse yet is the ILO number of 2.7 billion workers, or 81 per cent of the global workforce, "currently affected by full or partial workplace closures". This is a monumental number. Even larger is the ILO's projection that workers are likely to lose an income of $3.4 trillion. With limited employment protections around the world and meagre disbursements of relief from governments, there is a serious problem before the world of hunger and destitution.

The United Nations released a study on April 8 along with Oxfam that showed that there is the possibility of a 20 per cent income or consumption contraction; this means that the number of those living in poverty will likely increase by between 420 million and 580 million. This will be the first time in 30 years that the numbers of those in poverty will increase, and the first time that the increase will have taken place so rapidly. There is increased pressure on governments to provide relief packages for those who have lost their jobs and slipped into poverty. But thus far what has been provided has been insufficient.

It is important to point out that the U.N.'s Food and Agriculture Organisation has said that there is no global shortage of food. Cereal production will break records; this is the third highest cereal crop since records have



NICK OXFORD/REUTERS

PEOPLE waiting to file for unemployment benefits at a workforce centre in Fort Smith, Arkansas, U.S., on April 6. Claims for such benefits broke records in the U.S.

been kept. Stocks of major grains are almost 100 per cent higher than they were during the credit crisis. The break in the supply chain has certainly impacted processed food and meat products, but local food chains have been re-energised to satisfy demand (pressure to revitalise these local food chains will now increase). Anxiety about the crisis and a lack of money has meant that food prices have been dropping; sugar prices have fallen by almost 20 per cent, while those of vegetable oils have dropped by almost 15 per cent. It is not availability of food as much as it is the lack of money and confidence in the future that has slowed purchases of food, which can lead to an increase in hunger in some countries.

ECONOMIC RESCUE PLAN

Oxfam has produced a six-point Economic Rescue Plan that deserves wide reading. These points come in two parts.

The first part of the plan urges governments to give cash grants to people and to increase social protection benefits. The problem with this cash disbursement effort is that it can lead to price inflation; far better is the approach taken by States such as Kerala and countries such as Venezuela and China where the governments and civic organisations have distributed food directly to anyone who needs it. The second point in the plan is for governments to "bail out businesses responsibly". This is a sensible proposition because once more governments have opened the spigot of cash for corporations and banks who have little intention to start spending immediately. Oxfam asks for priority to be given to small businesses. There needs to be a serious discussion about the nationalisation of sectors of the economy that have once more been seen as essential, such as medical care, and that are now asking for bailouts. If a government is going to pump money into a large corporation, it should certainly demand equity shares in the corporation.

To pay for this vast support, Oxfam asks for the suspension and cancellation of debt for developing countries. To supplement loss of foreign direct investment, Oxfam suggests that aid must increase to the level of 0.7 per cent of the gross domestic product of rich nations although they are now wary of spending in this direction because of their own contraction. Rather than talk about capital controls to firm up control over tax jurisdictions and then wealth taxes on the very rich, Oxfam asks for "solidarity taxes". Such a tepid approach will not raise the kinds of funds necessary to deal with this crisis. What is needed is a much firmer hand that seeks to extract at the least $32 trillion from tax havens towards financing the social problems associated with this crisis.

Finally, Oxfam calls on the IMF to issue $1 trillion in Special Drawing Rights (SDRs) as "a one-off global economic stimulus". This is a very good idea since SDRs are not a form of debt nor would they be absorbed only by the rich nations. When the U.S. and the world's large central banks send cash into the world, it only goes to countries that account for 17 per cent of the world's population. Even SDRs are not necessarily equitable; when the IMF issued 183 billion SDRs in 2009, almost 60 per cent went to the richest countries, while only 8.8 per cent went to low-income countries. Any SDR offering will have to be designed to reach the poorest states and not just the richest. The Centre for Economic and Policy Research (CEPR) in Washington, D.C., has gone ahead of Oxfam and called upon the IMF to issue $3 trillion in SDRs. "We're calling on the G20, and specifically the United States, to support the issuance and allocation of 3 trillion SDRs by the IMF," CEPR co-director Mark Weisbrot said. "This would be a quick and direct way to contribute to all countries' capacity to contain the COVID-19 virus and avoid subsequent waves of contagion. SDRs would be a stabilising force and an economic cushion for the global health emergency."

Boldness is necessary in these times. All eyes should turn to China, which has been able to manage the infection and to put a vast amount of resources towards people's needs in the short term. How China has been able to fund the social programmes necessary during the long lockdowns should be a model for the world, but, of course, the socialist orientation of the Chinese government is far removed from the bourgeois order's callous disregard for its population. Rather than learn from China, the attitude is now to malign China and blame it for the virus in the first place. This attitude is best described as "cutting off one's nose to spite one's face". □

For an inclusive response

The government's response to COVID-19 has a profound impact on the lives of people with disabilities as it fails to recognise their need for adaptive facilities and support mechanisms. BY **MURALIDHARAN**

A PHYSICALLY challenged woman on her way to collect pension, in Bengluru on April 18.

G.R.N. SOMASHEKAR

"The past, like the future, is indefinite and exists only as a spectrum of possibilities."

—Stephen Hawking

THE 1.3 BILLION PEOPLE LIVING WITH disabilities (PwDs) across the world are no strangers to social exclusion. But the COVID-19 pandemic and the lockdown measures imposed to contain it have forced exclusion on the rest of the population. For the first time in our lifetime, a large chunk of the world's population is coming face to face with exclusion, isolation and physical distancing, which has been the norm for a large chunk of the disabled population. A change in working practices, such as work from home (WHF) and flexible working hours (FWH), door-step delivery, and use of video conferencing for judicial services are some of the adaptations that the disabled community has been seeking for long. The pandemic and the consequent lockdown have radically altered society's comprehension of issues and resolution methodologies.

In the past two months, the discourse on the impact of COVID-19 did not focus adequately on issues confronting the disabled, the world's largest minority group, despite there being universal disaster management pro-

tocols addressing their concerns. An attempt is made here to draw attention to these issues.

Having a disability in itself may not be a risk factor, but people with specific disabilities or chronic conditions are more vulnerable. Existing health conditions, such as those relating to respiratory functions, immune system function, heart disease or diabetes, can be a contributing factor. Physical distancing, underlined as a key preventive measure, can be problematic for people with severe disabling conditions. Nipun Malhotra of Gurugram, who has arthrogryposis noted: "We cannot practise it, as we are dependent on caretakers even for basic needs like hand washing." For people like Zamir Dhale, who is deaf-blind, touch is the only means of communication. Keeping a safe distance from caregivers, who play a vital role in meeting the needs of many disabled persons, may not be possible in many cases.

Information is fundamental to fighting the pandemic, but PwDs may confront barriers in accessing vital public information and health care communication messages. Communications from government agencies often are not in accessible formats, such as sign language, same language captions, braille, audio, large print and plain language and easy–to-read formats to process the information.

The pandemic and the lockdown have worsened the existing barriers, leading to further curtailment of the independence of disabled people. Tapas Bharadwaj, a visually impaired student at the Amity Law School, Noida, in the National Capital Region, rues the loss of independence. While earlier he could move between the two floors of his house on his own, today he has to seek assistance, to ensure that he does not touch surfaces while negotiating his way.

For Abhishek Annicca, who has a degenerating congenital scoliosis and a compromised immune system, the closure of most home delivery services has meant that he must depend on friends or neighbours to procure groceries and medicines as he cannot go out on his own.

It is not just access to medicines or groceries that worries Professor Anita Ghai. A polio-afflicted wheelchair user, Anita is a cancer survivor and has various other health issues, including hypertension. She is worried that the public health system has become much more inaccessible for persons with disabilities, with hospitals refusing to attend to other medical conditions in the wake of COVID.

The dimensions are different for those with intellectual disabilities and their caregivers. The IANS reported on April 18 of the killing of an intellectually disabled 45-year-old man in Kolkata by his enraged father for refusing to wear a mask while venturing out. The incident underlines the difficulties people face in communicating a crisis situation with people with intellectual impairment.

Rising inequalities and distress impact women, especially disabled women, more harshly. The experience of lockdowns and isolation in various parts of the world has shown a sharp increase in domestic violence cases. Shampa Sengupta, who has been working on the intersections between gender and disability, opines that the majority of disabled women even otherwise face a lockdown situation, being confined to their homes. "But a government-imposed lockdown brings more worries as they would be unable to reach out to disability rights organisations in times of distress," she noted. She pointed out that the guidelines issued by the Department of Disability Affairs in the COVID-19 situation have failed to address gender issues.

People with thalassemia and other blood disorders have a different set of problems. A thalassaemic requires blood transfusion on a regular basis while those with haemophilia and sickle cell disease require transfusions over a period of time. With hospitals out of bounds and donors unwilling to go to blood banks, people with such disabilities will be left in the lurch. According to the National Blood Transfusion Council, there has been a 50 per cent drop in blood collection.

The neoliberal policies of privatisation of public sector units combined with outsourcing and contractualisation have narrowed the already limited avenues of employment for the disabled. With large sections of the private sector being averse to employing the disabled, reservation in the government sector has been the only solace. In the private sector, "last come, first fire", has been a principle that managements the world over have employed when resorting to retrenchments and layoffs. The disabled are the last to be recruited and the first to be fired.

PTI

A TRAFFIC POLICEMAN helping a physically challenged person with the face mask in Chandigarh on April 9.

A 2016 report of the NITI Aayog states that the employment rate among people living with disabilities is extremely low, that is, 34 per cent. The overwhelming majority of them are engaged in odd jobs, vending on trains or hawking on roadsides. The stigma attached to leprosy prevents many of those cured from getting absorbed into the labour market leaving them to beg to survive.

The sham of a relief announced by the Finance Minister fails to take into account the additional costs that disability necessitates. Purchase and maintenance of wheelchairs, aids and appliances, services of caregivers, hiring of private transport owing to inaccessibility of public transport all entail additional expenditure. The ex-gratia payment of Rs.1,000 over a three-month period announced by the Minister averages to Rs.333.33 a month. It is a cruel joke. Besides, this paltry amount will only accrue to the 10,20,065 beneficiaries of the Indira Gandhi National Disability Pension Scheme. India has a disabled population of 2.68 crore as per the 2011 Census. This data does not accurately take into account all PwDs. Undercounting apart, the 2011 Census recognised only the seven conditions identified at the time of the Census exercise. Since the enactment of the Rights of Persons with Disabilities Act in 2016, 21 conditions have been recognised as disabling.

In a situation of continuous lockdown, boredom, loneliness, fear and anxiety have gripped large sections of society. The loss of employment and livelihood, loss of housing, depletion of support mechanisms and gender-based violence are bound to have an adverse impact on mental health. This could also lead to an increase in the number of suicides. Chabbu Mandal, a migrant worker from Bihar, is reported to have committed suicide in Gurugram.

Dr Nimesh Desai, Director of the Institute of Human Behaviour & Allied Sciences, points out that in any disaster, conflict or pandemic situation the mental health fallout is the worst. The sharp rise in the number of mental health cases reported from Kashmir, post-August 2019, underlines this. Many people with pre-existing conditions are likely to see an aggravation. An inability to access mental health services contributes in no small measure. Desai said "mental health systems should make sure that people are able to access them". This is easier said than done. According to the National Mental Health Survey 2018 undertaken by the National Institute of Mental Health and Neurosciences, Bengaluru, the treatment gap of any mental disorder in India is as high as 83 per cent. The same survey also found that the number of mental health professionals per lakh population remains abysmally low and varies from 0.05 in Madhya Pradesh to 1.2 in Kerala.

Disability rights organisations have been calling for the application of the principles of equality and non-discrimination built into the United Nations Convention on the Rights of Persons with Disabilities as also the Rights of Persons with Disabilities Act, 2016. Experience from the West, however, has been depressing. In the United States as infection rates reached dreadful proportions, States began to unveil procedures to deal with shortage of ventilators. These were invariably to the disadvantage of the elderly and certain categories of disabled.

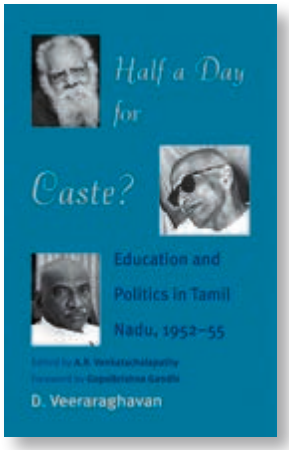
In a document released on April 8 on "Persons with disabilities in the COVID-19 response", the International Labour Organisation said: "All crises bring opportunities, and the opportunity of the moment is to make inclusion of all previously marginalised groups—including persons with disabilities—a central element of all responses. By building on our experience with disability inclusion and deepening partnerships, we can support a sustainable and inclusive response to COVID-19."

In a post-COVID situation, the exclusion experience of large sections of the general population will definitely contribute to ushering in a paradigm. □

Muralidharan is general secretary, National Platform for the Rights of the Disabled.

Politics of education

The Modified Scheme of Elementary Education, which Rajaji tried to introduce in Madras State in 1953, was a lesson in what not to include in education policy. This book is a splendid and highly readable account of the interplay of public policy and politics. BY **ARVIND SIVARAMAKRISHNAN**



Half a Day for Caste?
Education and politics in Tamil Nadu, 1952-55
D. Veeraraghavan
Edited by A.R. Venkatachalapathy, foreword by Gopalkrishna Gandhi
LeftWord Books, 2019
Pages: 166
Price: Rs.250

THIS is a remarkable book - both a political thriller and a superbly researched MPhil thesis submitted to the University of Madras in 1982, and it details highly significant developments in the bitterest battleground in any strongly stratified society, namely, education. Even finding the thesis involved lengthy detective work by two of Veeraraghavan's friends, A.R. Venkatachalapathy of the Madras Institute of Development Studies and V.R. Muraleedharan, a colleague of the author's at IIT Madras. Veeraraghavan, whose untimely death was a blow to Indian scholarship and to all who knew him, had been very diffident about his own work. It turned out, however, that S.S. Kannan, a friend and mentor of the author's (who also translated Veeraraghavan's acclaimed PhD thesis, "The Making of the Madras Working Class", into Tamil), had a barely readable carbon copy of a draft, though the first chapter was missing. Venkatachalapathy has written a poignant prologue and a new first chapter.

The pace is breathtaking, from C. Rajagopalachari's introduction of the Modified Scheme of Elementary Education (MSEE) in Madras State in 1953, through the reactions and the resulting end of Rajaji's time as a Congress heavyweight to a radical change in the character of the State's political life. The book shows the daily cut and thrust of politics over a vital matter in a difficult context. Rajaji headed a minority government not by direct election to the Legislative Assembly but by transfer from the old Legislative Council, with his opponents persistently questioning the legitimacy of his position. The State, for its part, soon faced what became successful separatist demands for the creation of Andhra Pradesh. Rajaji had a powerful party rival in K. Kamaraj, and the rising Dravidian movements, led by Periyar E.V. Ramasamy's Dravidar Kazhagam (D.K.) and the emerging Dravida Munnetra Kazhagam (DMK), posed a comprehensive challenge.

Rajaji moved rapidly, decontrolling food (thereby eliminating the black market), legislating to help small and tenant farmers in Thanjavur, and making the State administration more efficient. Yet his main purpose was to reshape education in Madras State, and Veeraraghavan provides a wonderfully clear account of major educational philosophies in the West and India, from Rousseau through Pestalozzi, Froebel and Dewey to the impact of colonisation and imperial domination on the very idea of education in India; he also maps India's path towards universal education.

The transformation of India from a largely self-sufficient subsistence system into a forcibly monetised source of raw materials for Britain and a captive consumer of British manufactures generated fierce disagreements over education. Gandhi and Rajaji - as Gopalkrishna Gandhi's foreword says, both conservative innovators - were deeply suspicious of standardised education. Gandhi, for whom a mechanised factory economy was inconsistent with a non-violent society, envisaged self-supporting village schools where "Basic Education" - the Wardha Scheme of 1937 - would be imparted. From the age of seven to 14, children would learn a village craft, probably spinning, the main rural industry. They would be in school most of the day, and would also learn core subjects related to the craft concerned, instead of undergoing a deracinating education in an alien tongue and yearning to be-

AUGUST 22, 1964: Vice President Dr Zakir Hussain (extreme right) who inaugurated the Tamil Nadu Basic Education Conference at Rajaji Hall with (from left) Rajaji, G. Ramachandran, N.D. Sundaravadivelu and Chief Minister M. Bhaktavatsalam at an exhibition arranged on that occasion.

come bureaucrats remote from the people. The school would pay the teacher's salaries by selling the children's produce to the State. That scheme, however, proved very expensive; Madras abandoned it in 1952.

Rajaji, in sharp contrast, saw schools as imprisoning children and as doing so for far too long. First, he wanted to reduce the school day; he knew of Christian mission schools where school was only for mornings. Secondly, he would sever the link between school and the child's socialisation outside; in the evenings the children would do agricultural work or craft work for payment. According to Veeraraghavan, Rajaji championed the respective causes of women and untouchables but considered craft-trained teachers inferior to craft practitioners.

Rajaji asked the Madras Education Department to devise a scheme. The department had some objections, but the Director of Public Instruction (DPI), S. Govindarajulu Naidu, did not forward those to Rajaji until just before the end of the school year. On April 16, 1953, Rajaji instructed district education officers to start implementing the scheme when the next school year started in June. Until then, only he knew the scheme even existed. On April 23, the DPI stated an outline to headmasters of Madras city schools. Rajaji did not think it worthwhile to even consult those centrally involved.

The MSEE was meant to transform Madras State's rural education system. The school day would go down to three hours, with children attending in separate morning and afternoon shifts and a single teacher working both shifts. Outside school hours, children would help their parents in their respective occupations, and those from non-occupational classes would be attached like apprentices to village farmers or craftsmen; if needed, craftsmen would be encouraged to settle in the villages. "Willing and capable persons" would form village school councils to arrange craft training.

The reactions were immediate, widespread, and overwhelmingly critical. The South India Teachers' Union said the plan was being imposed without deliberation; its president, S. Natarajan, pointed out that teachers had long included play and crafts in elementary education, that the MSEE would reimpose old rigidities, and that it would raise teacher-pupil ratios from 1:35 to 1:60. Teachers faced large-scale retrenchment, and those retained would become teaching machines, covering the same things in the same unchanging manner twice a day. The shift system had already been tried and abandoned in Hyderabad; Mysore and Rajasthan had seen it reduce attendance by up to 30 per cent. Yet it had been introduced in Madras State in 1949, solely to save capital expenditure.

Rural parents were furious about the MSEE's casteist implications and saw a shorter school day as meaning diminished content. The educationist N. Kuppuswamy Iyengar asked what was wrong with village parents' wish for their children to get office jobs. He argued that the scheme was intended to reduce competition for those jobs by excluding vil-

lage children; the MSEE, moreover, would turn "agreeable simple imprisonment" into "disagreeable rigorous imprisonment", and the ethos of any school would be lost without collective assemblies, games, music, and other activities. Jurists pointed out that child labour issues were involved under the International Labour Organisation Convention, 1921, even though India had not ratified that document. The Gandhian economist J.C. Kumarappa made the observation that good craftsmen seldom make good teachers or trainers.

Veeraraghavan, remarking that most of the criticism came from people of the very castes in whose interest the scheme had purportedly been introduced, notes qualified support for the plan. G. Ramachandran pointed out that younger children liked the idea but that older children, presumably for the same reasons as their parents, did not; Lt. Col. S. Paul, Principal of the Guindy Engineering College, remembered successful craft-related schooling on the Jaffna tea estates.

Political criticism, however, was uniformly fierce. On July 29, the entire elected opposition condemned the scheme as an anti-democratic *fait accompli* that had been rushed into place entirely without legislative scrutiny; the largest opposition party, the Communist Party of India (CPI), said the plan would take the State back to a pre-industrial age. Even the ruling Congress party was divided. After several hours of heated debate with motions and counter-motions clashing like fencers' foils, the Communist Party member K.P.R. Gopalan's amendment calling for the plan to be dropped was lost on the Speaker's casting vote. The phrase "stayed and referred to an expert committee", proposed by K.R. Viswanathan of the Tamil Nadu Toilers' Party, won by 139 to 137, but Rajaji, citing British precedent, rejected the resolution as only advisory. The opposition, challenged by the Chief Minister to propose a vote of no confidence, had failed to reach their "real objective" - his removal.

The D.K., the DMK, and other groups, nevertheless, continued the agitation they had started on June 21. On July 14, several senior DMK leaders were arrested for marching despite a prohibitory order.

Following the July 29 vote, Rajaji, who admitted only to a "tactical blunder" in bypassing the legislature, offered concessions; after-school crafts would be optional and there would be no teacher redundancies.

The weekly *Kalki* stridently supported the plan. The DK organ *Viduthalai* called the scheme "Kula Kalvi Thittam"—the caste-based education scheme; the label endures today. Rajaji, faced with a bitterly divided Congress, resigned on March 26, 1954. The Congress immediately abandoned the MSEE, and Kamaraj easily won the party leadership.

Veeraraghavan details the episode's background factors and its results. The Chief Minister would not subject himself to an election; he made no attempt to create a base within the party; and, forcing his scheme on the State, caused radical changes. The Congress lost its democratic character "forever", at State and national level; Periyar strongly supported Kamaraj as the first "true Tamilian" to rule the State; and the DMK became a parliamentary opposition party. In addition, a far more caste-focussed politics emerged in Madras; Brahmin political dominance was over.

PROBLEMATIC

Education, however, remained a major problem, particularly over enrolment and dropout rates. Kamaraj's determination meant the State used the Five-Year Plans' education funds as intended; between 1961 and 1972 Madras increased education spending from Rs.15 crore to Rs.89 crore. Elementary education was free for all children, and they got a second chance if they failed an annual examination.

Subsidised midday meals were the most spectacular measure, and by 1962 nearly all schools provided them. Vast amounts of money went into building new schools; teachers - essential to the plan - got better pay and conditions. Enrolment figures, even allowing for pressures to exaggerate them, improved remarkably throughout India, thanks to Plan funds. Yet dropout rates remained shocking.

In Madras, fewer than half the 1957-58 Class I cohort - 422,000 out of 874,000 - reached Class V. A Madras Teachers' College study starting in 1957-58 found that out of 1,191 pupils, 930 dropped out before reaching Class V. The Education Commission—like other studies—attributed 65 per cent of the wastage to poverty. Whereas Amartya Sen concluded that income and caste were the main reasons of economic backwardness and that educational backwardness was a symptom of it, C.T. Kurien, whom Veeraraghavan quotes here, was damning:

"[T]he phenomenal increase in education expenditure by 'society' has gone primarily to providing an education or miseducation for a few who are the affluent, influential and powerful while the vast majority of the people have gone away empty-handed."

Even in the mid-2000s, Central government figures showed that the median length of time Indian girls spent in school was 1.9 years. Veeraraghavan is clear: Western educational expansion was "inseparably linked" with the industrial revolution and the emergence of employment and education rights won by working-class movements.

The MSEE, nevertheless, was a lesson in what not to include in education policy and why such policy must be put to genuine public legitimation, or fail on both counts. This outstanding book is a splendid, readable account of public policy and deadly serious politics. □

Arvind Sivaramakrishnan teaches at Indian institute of Technology Madras.

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