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National Recovery and Preparedness for the Pandemic

Photo: AIDMI.

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About this Issue

The COVID-19 pandemic emerged to be the greatest challenge confronting humanity in recent times. This pandemic morphed from a public health emergency into a crisis that impacted the entirety of our social and economic systems. While the adverse impacts of this crisis have permeated into every aspect of human endeavour and experience, there is still a greater focus on the health and mortality related impacts of the pandemic. This in turn leads to a blind spot in formulating effective recovery and preparedness strategies against the pandemic. Therefore, we need to consider the larger impacts of the COVID-19 pandemic beyond the spheres of public health and economic slowdown.

As we stagger towards an era of normalcy, it is imperative to reckon the impacts of the pandemic on our social and economic systems. Only after such a reckoning, can an honest attempt towards sustainable recovery and preparedness be made at the national level. This issue of *Southasiadisasters.net* is titled 'National Recovery and Preparedness for the Pandemic' and focuses on the question of 'national recovery and preparedness for the pandemic'. It questions our underlying beliefs about recovery and preparedness and offers newer paradigms. ■

- Kshitij Gupta, AIDMI

INTRODUCTION

National Recovery from COVID-19: Key Opportunities

*By **Mihir R. Bhatt**, All India Disaster Mitigation Institute, India*

The COVID-19 pandemic has had tremendous consequences for the world. Not only did the pandemic exact a heavy price on human mortality and morbidity, it also brought entire national economies to a grinding halt. More importantly, in developing countries the pandemic set back hard-earned development gains of the past decade for the poor and disaster affected vulnerable people. As every country staggers towards normalcy, greater thinking is required to address the national pandemic recovery and preparedness challenges. From AIDMI's work with a range of stakeholders at the national level, — from the UN agencies such as UNICEF and WFP to subnational agencies such as KSDMA and ASDMA to national agencies such as NIDM — the following key issues have come up.

- **Opportunity to localize all future health crisis**
  Our experience of the pandemic has taught us the importance of localization. Contextualized approaches of building awareness and raising knowledge about the health crisis have proved to be highly effective. AIDMI worked with UNICEF India to promote safe-school re-opening across Ahmedabad public schools. This experience of working with students, teachers, parents, education department and other stakeholders helped AIDMI in understanding the importance of localizing approaches for effective recovery and preparedness from the pandemic.

- **Opportunity to democratize all future health crisis**
  Another feature of AIDMI's work has been our constant engagement with at-risk populations and marginalized communities. During the COVID-19 crisis, a lot of top-down decision making was witnessed. Our work with small-scale commodity farmers in Gujarat, Maharashtra and Madhya Pradesh has taught us the importance of a democratic and inclusive decision-making process to address the challenges of any future pandemics.

- **Opportunity to humanise all health crisis data**
  The health emergency brought on by the COVID-19 pandemic has generated a wealth of data which needs to be humanized to ensure better preparedness and recovery. In India, a health crisis could quickly push several vulnerable families into a deep economic hardship and deprivation. We need contextualized data that highlights how poor and vulnerable people can access health services and the costs with it.

- **Opportunity to rethink health care, medicare, and wellbeing**
  The long-term recovery from the pandemic also presents with an opportunity to think of newer paradigms of healthcare and well-being. Digital approaches to healthcare proved to be a boon during the pandemic in increasing the access of affected populations to health services.

AIDMI's work with small-scale farmers on pandemic recovery and preparedness highlighted how it is important to establish a clear case for the use of digital approaches for accessing healthcare.

- **Opportunity to strengthen links between health, work, and habitat**
  The pandemic has forced the people to reassess the where, how and why of work and life to be able to blend both personal and professional responsibilities in more manageable ways for leading a fulfilling life. AIDMI's work with small scale women entrepreneurs in semi-urban and rural Gujarat highlight the importance of linking health security, livelihood security and habitat security for achieving sustainable development goals.

The above five are key opportunities to move ahead at national level. But how do we do so!

We need to understand, analyse, and monitor the short-term and long-term national impact of the pandemic on the most vulnerable populations and localities such as people in delta or coastal areas, migrants, and minorities of all types.

We must encourage local initiatives to scale up pandemic recovery and preparedness now in order to prevent, anticipate, and prepare, for and respond to the various long-term consequence of the pandemic. Such local initiatives can include local pandemic early warning system, restoration of ecosystem that matter to the pandemic; developing pandemic resistant agriculture farmers and labours. Adopting such measures will help in resilience to pandemics at all levels of society. ■

LOCAL LEVEL RECOVERY

Oxfam's Role in Promoting the Pandemic Preparedness

*By **Basab Sarkar**, Humanitarian Programme Coordinator, Humanitarian Hub, Oxfam India*

The COVID-19 pandemic has created an unprecedented, once in a century, public health, social and economic emergency. It has disrupted lives, impacted the economy and brought into focus prevailing social and economic inequality in the country and world. India has a small window of opportunity to implement prevention measures to stop and delay the further spread of the virus. 30% of the world's deaths during the 1918 pandemic came from India, an experience we have to avoid at all cost. We fear that the epidemic will push millions, particularly women, further into poverty. A pro-poor and sensitive response that recognizes structural inequalities in society will not only minimise the impact of the endemic, but also create a fairer, equal and just society.

Oxfam has been part of India's growth story since 1951. The organisation has played a key role in assisting the country to recover from famines, earthquakes, cyclones, tsunamis, wars and conflicts. Oxfam India continues to work on building people's resilient livelihood, access to education and health and a gender just society. We remain firmly committed to doing as much as we can to accelerate India's recovery from the COVID-19 pandemic.

Oxfam India responded in 16 States with different activities as part of COVID-19 response programme. Oxfam India provided life-saving medical and diagnostic equipment to 150 District Hospitals, 172 Primary Health Centres, and 166 Community Health Centres in 16 states and eight oxygen plants (Maharashtra, Chhattisgarh, Bihar, Jharkhand, Assam, Uttar Pradesh) have been set up and made operational across the country. In the second phase when the whole country was gasping for breath and people were losing their loved ones due to lack of oxygen, we decided to set up oxygen generating plants. We set up seven plants in Bihar, Uttar Pradesh, Chhattisgarh, Maharashtra, Telangana and Karnataka.

Oxfam India reached out to more than 64,993 ASHA workers across 10 states for capacity building and providing crucial equipment. This meant that we reached out to almost 6% of ASHAs in the country with thermal gun with batteries, pulse oximeter, 5 sets of nasal masks, 100 surgical masks, 2 sets of reusable gloves, and 20 sets of disposable gloves each.

Oxfam India provided unconditional cash assistance to more than 12000 households amounting to more than Rs. 5.44 Crore. Multi-purpose cash assistance is provided to individual household as emergency relief which while meeting their basic unmet needs also helps in protecting or re-establishing their livelihoods. Through 15 other significant projects, Oxfam India helped more than 1.5 million people, comprising mainly *Dalits*, *Adivasis*, and women and girls in 9 states, 25 districts and approximately 300 villages. Oxfam India has been working with government and communities during the biggest crisis in the

history of independent India. During these tough times, our teams have been helping to strengthen the government and civil society's relief work and ensuring that no one is left behind.

The state and union governments in India launched various schemes and initiatives to help people during the pandemic. But many communities and underserved areas were left to fend for themselves in the middle of a pandemic due to gaps in the government effort to provide relief. Oxfam India's efforts have helped to fill these gaps. This included the provision of relief material (dry ration Kits) to migrant workers walking back home, migrant fisher folk community (Gujarat), trans persons (Kolkata), Sex workers in West-Bengal, homeless population (Delhi), sugarcane workers (Maharashtra), tea garden workers in Assam and West-Bengal , tiger and crocodile widows in Sundarbans, Cyclone-affected families (West Bengal and Odisha), rag pickers, manual scavengers in Delhi and Tamil Nadu, artisans such as weavers (Assam) and dholak makers (UP), domestic workers (Delhi), Goldsmith in East Medinipur, West Bengal, Pak Hindu refugees (Delhi), Particularly Vulnerable Tribal Groups (Chhattisgarh), Cancer patients (Delhi), Leprosy patient in Bankura, West-Bengal, migrant workers (Bihar) and daily wage workers.

Awareness building programme were conducted in 16 states to reduce exposure by ensuring communities adopt COVID-appropriate behaviours and practice infection prevention and control, including avoiding crowds and maintaining physical distance from others; practicing proper hand hygiene through at the appropriate times, the correct and rational use of masks.

Oxfam India empowered rural communities to lead or be part of the response decision-making process by reinforcing risk communication and community engagement approaches that can reinforce local solutions, increase trust and social cohesion, and ultimately a reduction in the negative impacts of COVID-19.

Source: Oxfam India.

Capacity building of frontline worker had been organised both offline and online communicating with, engaging, and empowering communities. Oxfam India also promoted awareness on vaccination as there were more hesitancy to take vaccine in rural areas. Oxfam India ensured vaccine positioning readiness in 16 states and all populations, by communicating, though COVID-19 vaccination campaigns, enhance vaccine acceptance and demand based on priority groups, taking into account gender and equity perspectives to leave no one behind.

Oxfam India established free helpline centre (COVICALL CENTRE) in partnership with Indian Society of Health Professionals (ISHP) for free telemedicine and guidance provided by the registered medical practitioners to the COVID-19 patient and their family members. The nine states (Uttar Pradesh, Bihar, Jharkhand, Delhi, Madhya Pradesh, Odisha, Karnataka West-Bengal and Maharashtra) was covered with six languages (English, Hindi, Maratha, Odiya, Kanada, Bengali). Information on facilities such as oxygen suppliers, food supplies, Covid centres, ambulance, volunteer support to elderly, doctor's consultation on Covid related reasons, and vaccination awareness were provided.

At one point there was a huge concern of a wave of COVID-19 that would adversely affect children, especially since vaccination for children hadn't yet started. To be prepared for an untoward situation, Oxfam India provided 17 pediatric units with all medical equipments for children and neonatal set up in 6 state hospitals (Maharashtra, Tamil Nadu, West Bengal, Assam, Uttar Pradesh, Bihar) in India.

Oxfam India coordinated and worked closely with the State health department along with the CMO (Chief Medical Officer) at district and BMO (Block medical Officer) at the block level for effective health services to the most vulnerable people in pandemic situation. Oxfam India also coordinated with State Inter Agency Group in the state and Sphere India for smooth implementation and avoid duplication of work.

There is still much to understand about COVID-19 and its impact in different contexts. ■

Pandemic and Climate Change: Priority is Preparedness

Mr. Vishal Pathak, *AIDMI, India*

COVID-19 not only posed extreme challenges to the healthcare system, the entire societies also experienced the implementation of substantial non-pharmaceutical interventions such as case isolation, tracking, home quarantine, social/ physical distancing, closure of schools and care home facilities and more to contain and mitigate the spread and infection rates. Only strict implementation of these measures by individuals and families in the society support the healthcare systems by not overwhelmed during the pandemic time. The response to the pandemic provided useful lessons to prepare the society better for such emergencies.

A further challenge for the healthcare system is to deal with more frequent and severe health effects caused by climate change. Compared to pre-industrial times, the global average temperature has risen by about 1 C. In connection with this, hot days, heat waves and tropically warm nights are already occurring and will certainly continue to occur more frequently and for longer periods. The occurrence of extreme heatwaves will very likely increase in Asia. Projections show that a sizeable part of South Asia will experience heat stress conditions in the future -high confidence.[1] The poor have limited access to healthcare and often work in the informal sector as daily wagers or street vendors or farm labours, meaning they are exposed to extreme heat in their working hours. The success of the heat action plan of Ahmedabad can be gauged from the fact that there were fewer than 20 casualties in the city during the 2015 heatwave as opposed to 1344 additional deaths reported in the 2010 heatwave. Heat waves are the main cause of premature climate-change-related deaths, especially in the senior citizens and chronically ill (IPCC 2018). Humanitarian actors should develop their understanding of complex impact of extreme heat on livelihoods[2].

The overlap has been observed largely between population groups vulnerable to the effects of heat stress and those at higher risk for severe COVID19 (elder people, Pre-existing health conditions: Chronic respiratory, heart and kidney diseases, diabetes, people working outside, people taking certain medication etc.). The pandemic has shown the need for strong health systems as a foundation for health emergency preparedness and to address the growing health impacts of climate change. Vulnerable populations such as the elderly, people with pre-existing health conditions, ethnic minorities, and indigenous groups, as well as poor people who are at higher risk for pandemic, are expected to be amongst those bearing the brunt of the health impacts of climate change. At number of locations, the vulnerable populations in India and in South Asia faced multiple emergencies at a time along with pandemic response. Examples includes – dengue spread, heat waves, floods, and cyclone.

In India, a climate-resilient, solar powered COVID19 facility for testing, isolation and treatment was built to provide better insulation, natural lighting, 24/7 power, and improve healthcare quality is an example of integrated response to pandemic and climate crisis.[3] There is one priority on which the community needs to deliver. It is about reducing the probability of new pandemics emerging. It is really about investing in the necessary medical and nonmedical preparedness so that we bring down the probability of such pandemics, bring them down massively. The science tells us that these kinds of pandemics can happen more frequently now than they used to happen. It is appalling how little we are investing into preventing this risk. It is time to build preparedness in priority sectors that already identified under dealing with climate change challenges. Simply, we can see the logic that we not required tens of trillions for preparedness that we have spent in the response of the pandemic. ■

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[1] IPCC Report – Climate Change 2022 (Asia): Impacts, Adaptation and Vulnerability. Contribution of Working Group II to the Sixth Assessment Report of IPCC. https://www.ipcc.ch/report/ar6/wg2/downloads/report/IPCC_AR6_WGII_Chapter10.pdf.

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[3] Dorey, Stephen Geoffrey Rabie, Tamer Samah Gracheva, Maria E. (2021), Report - Climate Smart Health Care: Health Sector Opportunities for Synergistic Response to the COVID19 and Climate Crises. World Bank Group.

ENVIRONMENT AND PANDEMIC

Environmental Agenda for the Pandemic Preparedness in India

***Ms. Dhriti Pathak** and **Dr. Anish Chatterjee**, Consultants – UNDP India*

The COVID-19 pandemic witnessed the complexity and interconnectedness of overlapping risks such as climate impacts, extreme events, disasters along with existing social conditions of poverty, access to basic services such as water, electricity, etc. The localized nature of climate risks coupled with outbreaks of health related risks at the ground level tested local resilience systems across the world. This brought to the fore the importance of sub national and local actors whose proximity to the affected areas made them the first line of defense against these risks.

The nature of these risks is overlapping and quite often compounding, i.e., these are not isolated events that can be issued by targeted interventions over a period of time. They come together and often need to be tackled simultaneously and in an integrated manner. For instance, during the pandemic there were cyclones that hit the state of Orissa along the eastern coast of India. Local preparedness systems such as cyclone shelters and safe houses along the coast which could provide safety from such disasters could not ensure the mandated 'social distancing' norms of the pandemic.

Current local systems are equipped to handle isolated risks in silos. However, as the nature of these risks are changing, risk management systems especially at the local levels need to be upgraded to deal with them. The prevailing system of addressing risks is based on separate departments undertaking their respective mandates along the direction of the existing disaster management apparatus of the state or UT. This needs to be integrated in a manner that taps local knowledge and enables capacities to undertake appropriate action addressing compounding risks. The existing systems require enhanced capacities for understanding the nature of integrated risks, finance for enabling interventions that can deal with such risks and an institutional framework that can streamline the process.

This will also provide towards building capacities of local communities to deal with risks faced in their areas. Extensive cooperation between local government bodies, inter-state collaboration and the identification and training of resource persons will be crucial in this regard. Additionally, building resilient infrastructure to support such needs and improved adaptive capacities will catalyze the process as the burden of losses and damages on available resources will be reduced. The development of a financing mechanism for sustaining the process in order to address the challenge of losing institutional memory, among others, will be a key aspect in enabling the process.

The pandemic also witnessed thousands of migrant and informal sector workers return to their villages after losing their daily wage jobs in cities, resulting in significant reverse migration. The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), considered as one of the biggest social welfare programmes in the world, aims at generating 100 days of work for any willing individual, in rural areas, has attained considerable recognition, in recent years as the one of the world's largest adaptation programmes.

Schemes like these, become all the more important in such situations as they have the capacity to deal with compounding risks – enabling livelihoods while also ensuring environmental sustainability through works focused on rain water harvesting, reservoir building, de-siltation of existing water storage structures, among others. We have to plan and implement more such schemes to diversify the livelihoods of the rural vulnerable population to build their resilience to any adversity - physical, mental, emotional, social and financial. ■

Ms. Juliet Parker, Director, ALNAP and Mr. Mihir R. Bhatt, AIDMI, discuss how each has informed the other to move ahead to gain small but specific steps for improvement.

STATE LEVEL PANDEMIC PREPAREDNESS

Agenda for the Pandemic Preparedness in Uttar Pradesh

*By **Dr. Bhanu Pratap,** MBBS, DTM&H, M. Med, and **Brig. PK Singh,** VSM, India*

Uttar Pradesh recorded first Covid-19 case on 5th of March 2020 in Ghaziabad and almost 7 months later there were more than 5 lakhs cases and more than 7000 deaths reported in October 2020. Relief Commissioner Office (RCO) was nodal for the Government of Uttar Pradesh and provided all information.

WHO appreciated the efforts of Uttar Pradesh especially in tracking high-risk contacts, more than 70,000 front-line health workers across the state were engaged to reach out to high-risk contacts of positive cases.

Mr Ofrin, WHO, said, “Systematic tracking of contacts through a proper mechanism is the key, along with a well-trained health workforce to implement the surveillance activities. The WHO team provided technical support to the state government to boost contact tracing efforts and strengthen the capacity of field teams through training."

Even during the first wave of the pandemic, WHO cited UP Chief Minister’s contact tracing formula as an example which should be emulated by other states and praised his Triple T (Trace, Test and Treat) strategy to control Covid-19 during the second wave of the pandemic.

The UP-State Disaster Management Authority issued a very comprehensive document for establishment of Covid-19 Relief Camps. Guidelines were also promulgated for areas with dense population, more essentially the aspects of hygiene and cleanliness and adherence to the Covid protocol. A stage-wise strategy for re-opening/re-commencing of activities was also prepared and shared with the Government.

Department of Home-guard managed transit camps and 15 days dry ration to all returning migrants. Community kitchen was a continuous process throughout the state and government was providing DBT (direct benefit transfer) of rupees 1000 each family. In this process more than 2 million families received direct benefit transfer support.

The existing emergency operation centre was converted into state integrated disaster control centre (SIDCC), and was accessible to people to share their feedback and grievances through 24 X 7 helpline number 1070.

New apps were developed to map incoming migrants and Parvasi Rahat Mitra app was used to map skills of migrants and this way 3.5 million migrant’s skill was recorded.

SIDCC was connected to all state departments, 18 Divisions and all 75 districts. It has coordinated with central Government, Voluntary Agencies and private sector. It was sharing information on real time basis including daily reports to Ministry of Home Affairs, NDMA.

The Pravasi Rahat Mitra app has recorded personal information of migrants with 94 different types of skills. This was being done Urban and rural areas. Data Collection process for Pravasi Rahat Mitra app was being done at collection points which included shelter size points, person's place of residence and map the skills of more than 5 million migrants.

Real time monitoring of Shelters and transit camp, 2792 community kitchens were working regularly, 55 lakhs packets of food were distributed daily, this way a total of 66 million food packets were distributed till July 2020.

A total of 18420 shelter homes, out of which 2068 at district level, 4472 at block level 11880 at village level where setup total capacity was to shelter 1.47 million people.

In a very short time, the Uttar Pradesh Government has successfully been able to ramp-up 250 MT (metric tonne) of oxygen supply to 1,000 MT. This is the highest oxygen supply increase by any state across the country.

The MIS (Management Information System) was used for daily monitoring of actions taken against grievances, provision of supplies, groceries, milk, distribution of ration, pre-cooked food deliveries, status of people living in the facilities, quarantine both in rural and urban areas etc.

Conclusion: The Covid 19, spread across the world, is difficult to predict. The health, humanitarian and socio-economic policies determine the speed and strength of the recovery and there must be a human-centered response. ■

PANDEMIC PREPAREDNESS IN NORTH-EAST

The Pandemic Preparedness: An Assessment by NEADS

*By **Tirtha Prasad Saikia,** Assistant Director, North-East Affected Area Development Society (NEADS), Jorhat, Assam, India*

Assam Faces 'Twin Disasters' of Pandemic and Floods

At a time when people of Assam are battling with the COVID-19 pandemic, the same were also preparing to tackle the multiple waves of rising floods. Many rivers were flowing above danger marks causing threat to communities' lives and livelihood. Floods in times of COVID are in fact challenging, and this worsens the capacity of the people to cope. Severe flooding in the north-eastern state of Assam had submerged croplands and villages, pushed thousands of people into relief camps.

Response at the Frontline

The impact of COVID-19 pandemic was being felt everywhere across the state of Assam which was hitting the poor and marginalized the hardest. North-East Affected Area Development Society (NEADS), being a local civil society organisation has been making every effort to anticipate and at the same time work outthe necessary preparations for responding to the impacts in impoverished and vulnerable communities.

NEADS had extended support of immediate relief and life-saving support among the severely hit families of low-income communities across various districts of Upper Assam region. The humanitarian response had aimed to address the needs of the most vulnerable people living in the floodplain, distant area, river island, tea workers families and tribal communities.

NEADS is recognised for its work on humanitarian response & advocacy, disaster risk reduction, climate change adaptation, human rights and sustainable development. A rapid response team was being engaged to carry out all vital services to every extent possible and they stand ready to address immediate concerns in the communities at risk, closely coordinating with the local administration. The organisation was focusing on public health preparedness, protection of peoples' rights and mitigation of larger social and economic impacts in the long term at the face of such unprecedented crisis.

Community Based COVID Preparedness

In order to mitigate the risk of the twin-disasters among the most vulnerable and the marginalized, NEADS started the thought of 'Community Based Covid Preparedness' to its already existing

‘*Duryug Bebosthapana Samiti*’ and further community organisations based in the floodplains. NEADS provided the support of Early Detection of COVID-19 Kit to the frontline health workers as they help to improve the capacity and pandemic preparedness of local communities and imparted capacity building training among the frontline health workers for better handling of covid situations in communities.

NEADS took the effort to promote COVID appropriate behaviour among the vulnerable communities which was critical to break the chain and contain the pandemic from community spread. Community outreach and mobilization was one emerging need in communities which resulted in fighting vaccine hesitancy and boosting demand among people, also to extend our support in the roll out of vaccination campaign on the ground. NEADS was in action to meet such immediate needs with the volunteers’ support among the most vulnerable groups affected by COVID-19 second wave.

Psychosocial Care through Community Based Support

The organisation also organized training on ‘Psychosocial First Aid in Disaster’ in collaboration with National Institute of Mental Health and Neuro-Sciences (NIMHANS), Bangalore among the members of Village Disaster Management Committees, community frontline workers and youths of Jorhat & Majuli. The objective of the training was to build compassionate social care through community based psychosocial support to reduce mental health distress in disaster situations including the COVID-19 pandemic.

Community Centred Vaccine Adoption Programme

As part of the ongoing Covid19 second wave response, NEADS was launching a community centred vaccine adoption initiative - ‘KAVACH’ in partnership with SEEDS. The programme is designed to strengthen collective efforts in the fight against Covid-19 which will reach out to over 1 lakh people across various communities of Assam especially those who are vulnerable and most underprivileged. Covid vaccination programme at the identified blind spots where segment of local communities have not been vaccinated to ensure 100% coverage of all adult population especially those most underprivileged. NEADS was establishing local ground force of community volunteers to work alongside frontline health workers and local health officials.

NEADS Oxygen Concentrators Bank Programme

NEADS had undertaken the 'Oxygen Concentrators Bank Programme' as part of Covid19 Second Wave Response of NEADS with the objective of offering emergency assistance to covid care centers, Public Health Institutions & communities at large. With the mission of improving oxygen availability in the worst-affected areas, NEADS had deployed oxygen concentrators to provide immediate support. The programme was supported by Humanitarian Aid International (HAI), Action Aid Association, and SEEDS. ■

Different Preparedness Measures of Himachal Pradesh during Pandemic

By **Twinkle Thakur** and **Kesar Chand,** G.B. Pant National Institute of Himalayan Environment, Himachal Regional Centre, Mohal-Kullu, Himachal Pradesh, India

On December 2019, the epidemic was identified for the first time in Wuhan, Hubei Province, China and officially announced on December 31st, 2019. On January 30, 2020, the World Health Organization (WHO) announced the corona virus a global emergency. After the huge spread of COVID-19 infections globally, the first case in India was reported in Kerala, on January 30, 2020. The Government of India (GoI) banned travelling to other countries and states. The GoI has issued a national level lockdown under the DM Act 2005 on March 24, 2020 to April 14, 2020, which was further extended till May 3, 2020. The Government of Himachal Pradesh (GoHP) had taken various preparedness initiatives to minimize the impact of COVID-19 in Himachal Pradesh. The first step GoHP has taken to strictly avoid mass gathering, so all educational institutes (Government and private), marriage, social, tracking, tourist, religious places etc. were totally prohibited. The goal was to reduce disease spread and death by stopping or slowing down the rate and extent of disease transmission in a community. Himachal Pradesh State Disaster Management Authority COVID-19 (HPSDMA) state disaster response fund established to provide financial and other immediate relief to people who are adversely affected by the pandemic. GoHP has developed various Information and Technology Initiatives such as KOBO tool, thermal scanning cabins (Figure 1), COVID-19 integrated portal, COVID 19 related Government Orders, Curfew ePass, COVID 19 Quarantine App, E-Sanjeevni, E-OPD, Aarogya Setu App during pandemic. The Government has also carried out several Information, Education and Communication (IEC) programs to increase awareness among the communities. The state Government has provided various financial/relief of essential supplies initiatives for the communities e.g. social security pension, relaxation in procedural parameters for procurement of materials for COVID-19, advanced payment of wages/honorarium to all daily wagers /contract /outsourced employees, shelter and Ration Facilities (at district/sub- divisional level), etc.

Figure 1: In the state of Himachal thermal screening was first used at Bajaura Border in Distt Kullu. Data of every vehicle and person entering and exiting is being managed at borders itself along with compulsory thermal screening through Security Shield: a kiosk to maintain isolation and safety of personnel involved.

Figure 2. Separate Fever, Cough, and Cold camp was established in the campus of Regional Hospital to segregate patients showing respiratory symptoms from normal OPD.

Figure 3. Telemedicine facility is also being provided to avoid people travelling to Hospitals for minor ailments.

Kullu district in Himachal Pradesh is famous for its tourist destinations, where people come from all parts of country and the world. During the COVID-19 scenario local govt. of Kullu district took various preparedness measures to control the virus inflow. To control tourist inflow in the district, district borders were sealed from March 20, 2020. All educational institutes, hotels, restaurants, religious places, government offices etc. were sensitized before Janta curfew. Section 144 of CrPC was implemented in District on 24-03-2020. After the announcement of Curfew task force was developed immediately to gather information about people who are coming from other countries and states with the help of ASHA workers, Anganwadi workers and Panchayat secretary. A team of medical officers such as Patwari and Police Constables deployed to check on people during home quarantine period. Various camps for fever, cough and cold was established in campus of regional hospital to separate patient showing respiratory symptoms from normal OPD (Figure 2). Several facilities were provide such as telemedicine (Figure 3), helpline for ration and food for stranded migrants and tourists as well as needy people, quarantine & isolation houses, campaign for active cases findings, home delivery of groceries, fruits, vegetables and medicines in urban as well as in rural areas which are located far-flung (mountain terrain and scattered population). Apart from ration other daily use items (e.g. milk etc.) were also provided. NGOs (Annapurna) also distributed cooked food to needy people in the district. Other relief/essential supplies provided by the Women self-help groups by preparing cotton mask and personal protective equipment kits for frontline warriors (Figure 4a). These masks were distributed among people through government agencies (Figure 4b). Various awareness programmes and announcements were done in rural and urban areas regarding safety measures and precautions to be followed to prevent COVID-19 infections. Fire brigade vehicles were used for sterilization of streets and roads. Agricultural equipments e.g. pesticide spray pumps etc. for sterilization of houses and other properties using Sodium Hypochlorite, Bleaching powder etc. and foot operated taps were used by people to reduce the chances of contamination. Also, people themselves followed social distancing and wear mask during their agricultural and daily work. All these initiative and measures taken by people and government during the pandemic to minimize the impact of COVID-19 in Kullu district. ■

Figure 4. a) Woman Self-Help Groups preparing cotton mask, b) Distribution of mask through government departments.

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