

KEY CONSIDERATIONS:

INDIA'S DEADLY SECOND COVID-19 WAVE: ADDRESSING IMPACTS & BUILDING PREPAREDNESS AGAINST FUTURE WAVES

INTRODUCTION

Since February 2021, countless lives have been lost in India, which has compounded the social and economic devastation caused by the second wave of COVID-19. The sharp surge in cases across the country overwhelmed the health infrastructure, with people left scrambling for hospital beds, critical drugs, and oxygen. As of May 2021, infections began to come down in urban areas. However, the effects of the second wave continued to be felt in rural areas. This is the worst humanitarian and public health crisis the country has witnessed since independence; while the continued spread of COVID-19 variants will have regional and global implications.

With a slow vaccine rollout and overwhelmed health infrastructure, there is a critical need to examine India's response and recommend measures to further arrest the current spread of infection and to prevent and prepare against future waves. This brief is a rapid social science review and analysis of the second wave of COVID-19 in India. It draws on emerging reports, literature, and regional social science expertise to examine reasons for the second wave, explain its impact, and highlight the systemic issues that hindered the response. This brief puts forth vital considerations for local and national government, civil society, and humanitarian actors at global and national levels, with implications for future waves of COVID-19 in low- and middle-income countries.

This review is part of the Social Science in Humanitarian Action Platform ([SSHAP](#)) series on the COVID-19 response in India. It was developed for SSHAP by Mihir R. Bhatt (AIDMI), Shilpi Srivastava (IDS), Megan Schmidt-Sane (IDS), and Lyla Mehta (IDS) with input and reviews from Deepak Sanan (Former Civil Servant; Senior Visiting Fellow, Centre for Policy Research), Subir Sinha (SOAS), Murad Banaji (Middlesex University London), Rose Angom (Oxfam India), Olivia Tulloch (Anthrologica) and Santiago Ripoll (IDS). It is the responsibility of SSHAP.

SUMMARY

- Despite warnings from some scientists that infections were rising in February 2021, **the national government failed to act and prepare for the second wave**. The public health communication by the government was mixed and proved ineffective in communicating the risks and failed in arresting the second wave.
- **Short-, medium-, and long-term response measures are required**. Short-term measures should focus on immediate relief, provision of critical care and equitable and universal vaccine rollout, while medium- and long-term measures must build robust processes to deliver effective responses, guarantee rights to basic needs and safeguard rights, such as rights to protest and dissent. New advisory bodies with expertise can be set up to monitor human rights violations, and existing bodies can be empowered to function independently.
- The second wave resulted in **high mortality across the Indian population**. It is set to deepen adverse impacts registered under the first wave. Vulnerable and marginalised people such as informal migrants and those living in rural areas have been hardest hit in terms of access to healthcare and livelihoods. Special relief measures are needed for vulnerable groups such as the elderly, single mothers, pregnant women, people with disabilities, children, and marginalised communities such as Dalits, tribal and migrant populations.
- The incidence and scale of the second wave were exacerbated by **systemic issues that compounded its effects**, such as gross neglect and underinvestment in the public health system. There is an urgent need to rapidly scale up oxygen capacity, **ensure essential emergency and critical care**, and stabilise the supply of medicines and medical equipment.
- Lack of data transparency led to **under-reporting and undercounting of both cases and deaths**, with severe implications for an effective and proportionate response. Failure to accurately record mortality and misleading uses of available data fuelled the complacency that preceded the second wave. The government must ensure that states and local bodies record and report data accurately and make it widely accessible to the public. Data on testing, active cases, hotspots, deaths, availability of medical facilities, and vaccination can be pulled into a National Surveillance Dashboard to give a real-time feed of the virus spread, improving forecasting accuracy and enabling officials to make data-driven decisions.¹
- **A one-size-fits-all approach to the COVID-19 response does not meet diverse needs** and contexts. Community- and district-level working groups should be empowered to respond locally, receive government funds, and coordinate the local health system. This requires national and state governments to invest in public health and be accountable to citizens and civil society.
- **Poor coordination between the states and central government** has affected vaccine rollout. Several states were unsure if there would be an adequate supply of vaccines from national government-issued global tenders. After much criticism, the Government of India has finally centralised the procurement of vaccines to supply them for free to state governments. Twenty-

five percent of supplies are reserved for the private sector, although the sector has been criticised for underperformance, especially in rural areas.²

- The **vaccine rollout has been patchy and inaccessible** for those who lack access to the internet and smartphones, particularly in rural areas. The government should provide vaccines free of charge to all age groups and should use appropriate modes of communication (radio, local media) to reach vulnerable and marginalised groups.
- To deliver an **effective response, active collaboration between civil society and government is required**. Various civil society organisations stepped up to help with critical care provision. However, their activities were severely hampered due to limited access to funds, mainly because of the stringent Foreign Contribution (Regulation) Act (FCRA) conditions that prevent organisations from accessing foreign funds. To facilitate this move, the government should consider withdrawing FCRA regulations without delay.
- To ease the distress and suffering of marginalised and vulnerable groups such as migrant and informal labourers, **opportunities for robust livelihoods recovery must be found and linked** with the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), which has helped lift people out of poverty in the past. These groups also need guaranteed social protection in terms of food (especially for children) and basic income.
- Rather than treat COVID-19 as a public health disaster, the national and some state governments treated the pandemic as a law-and-order problem, **criminalising dissent, using force, and imprisoning critics, journalists, and those who failed to comply** with the stringent lockdown rule, undermining democratic values and human rights. Constitutional values of the right to free speech and dissent must be upheld. **Given the risk of COVID-19 infection due to overcrowding of Indian prisons**, political and undertrial prisoners should be released on bail.³
- **A formal commission of inquiry should be set up to investigate every aspect of COVID-19 response** in India from the beginning of the pandemic, including the sudden lockdown, the flawed vaccine policy, the mobilization of resources through PM-CARES (the Prime Minister's fund), allocation of medical supplies between and across states, and data collation practices on tests, recovery, and morbidity.
- **At the global level, vaccine equity is urgently needed** to prevent future waves in India and other LMICs. The WTO should follow calls to waive intellectual property rights for COVID-19 vaccines so that vaccine production can be decentralised, and production capacity can be ramped up.
- **There is an opportunity to learn from what is already being done and scale it up where appropriate**. While the situation in India remains grim, several inspiring cases of rapid response have emerged from across the country.

OVERVIEW OF INDIA'S SECOND WAVE OF COVID-19

In early May 2021, the B.1.617.2 variant of SARS-CoV-2, now known as Delta, was classified as a variant of concern by the WHO.⁴ This and other highly transmissible variants are believed to be responsible for accelerating the second COVID-19 wave in India.⁴ More transmissible variants have driven the scale and intensity of the second wave in India, while political and social factors have further enabled the current surge.

In January 2021, the Indian Government declared that India had beaten the pandemic and began to relax the restrictions and loosen standard public health protocols.⁵ Despite warnings from some scientists that infections were rising in February, the government failed to act and prepare against the possible next wave. As late as March 2021, even as cases in many parts of the country were rising exponentially, the Health Minister claimed that “*we are in the end game of the COVID-19 pandemic in India.*”⁶ As per official records in June, India was approaching 3 million active cases of coronavirus and 200,000 people had died.⁷ It is now widely acknowledged that the figure could be three to ten times higher.⁸ The scale of the tragedy showed that the Indian government was unprepared and heeded few lessons from the first wave.⁹

The speed and scale of the second wave was such that the system was overrun within weeks.¹⁰ With no clear guidelines and an overwhelmed health system, citizens were left to their own devices to procure critical medical supplies and arrange for beds. In urban India, many took to Twitter and other social media platforms to ask for help and critical support.¹¹ The first wave affected India's poor and marginalised more than the middle class and elites (see [SSHAP brief](#)).¹² In contrast, the second wave has affected everyone, including urban elites, though the long-term impacts will disproportionately affect the poor and marginalised. We have seen untold devastation: images of burning pyres across North India, crematoriums running out of space and wood, and dead bodies floating in the River Ganges. These images of citizens dying due to the lack of hospital beds, oxygen supplies, and lifesaving medicines shocked the world. Over 40 nations came forward to support India's fight against the second wave of COVID-19 and the government decided to accept foreign aid for the first time in 17 years.¹³

Meanwhile, global concerns over COVID-19 vaccine equity have come into view in India. Inadequate vaccine coverage and ineffective measures to slow the spread of the virus increase the likelihood to new and even more dangerous variants of the virus will arise. Various medical professionals have warned of an impending third wave in the country, as AIIMS chief Dr Randeep Guleria called this inevitable.¹⁴ This poses a risk of further waves of COVID-19 in India and across the world, particularly in Low- and Middle-Income Countries (LMICs). It is thus important that India and other LMICs build an agile and coordinated response that can be rapidly deployed during future waves of COVID-19.¹¹

REASONS BEHIND THE SECOND WAVE OF COVID-19

SCIENTIFIC WARNINGS ABOUT THE SECOND WAVE WENT UNHEEDED

The national government ignored scientists' early warnings about a potential second wave.¹⁵ Instead, the government's response was marked by poor communication and lack of transparency in decision-making. The government also paid more attention to, and encouraged, high-profile self-styled "*Babas*" who are anti-science, frustrating the work of doctors and scientists and leading to high profile resignations.¹⁶ For example, India's top virologist, Dr Shahid Jameel, who resigned from the scientific advisory group to the Indian SARS-CoV-2 Genomics Consortia (INSACOG) went on record to say that scientists in India face a "*stubborn response to evidence-based policymaking [...] authorities were not paying enough attention to the evidence as they set policy.*"¹⁷

THE MISSED OPPORTUNITY TO BUILD ROBUST HEALTHCARE INFRASTRUCTURE BETWEEN THE TWO WAVES

The government did not use the window of opportunity between the two waves to bolster public and private healthcare infrastructure. A report by the parliamentary Standing Committee on Health and Family Welfare in November 2020 identified several vulnerabilities in the COVID-19 response, including oxygen and medicine shortages, inadequate healthcare spending, and inadequate healthcare infrastructure (e.g., hospital beds, ventilators, oxygen).¹⁸ In April 2020, the government cleared funding for building resilient health systems for future disease outbreaks.¹⁹ However, the Government did not release the tender for oxygen plants until October 2020, and only 33 were set up by April 2021, which was insufficient.

Similarly, the government's insistence on *atmanirbhar* Bharat, the principle of self-reliance, made India slow to approve and purchase foreign vaccines.²⁰ The government began exporting vaccine doses without ensuring enough for Indian citizens despite having options to both produce vaccines locally and procure from other countries. Through June 2021, only 3.7 percent of India's 1.38 billion population was fully vaccinated, and currently, vaccine stocks are minimal.²¹ After five months of India's vaccination drive, only 66 percent of healthcare workers have been fully vaccinated.²² As of June 19, while 16.3% of the country's population has received at least one dose, only 3.6% are fully vaccinated.²³

MASS GATHERINGS AND RALLIES BECAME SUPERSPREADER EVENTS

The Prime Minister, Home Minister, and other politicians ignored the warnings and participated in and allowed hundreds of thousands of people to gather in crowded events such as election rallies (in states like Assam, West Bengal, Kerala, and Tamil Nadu) and religious festivals like the Kumbh Mela (a large public celebration on the Ganges) without following adequate public health protocols. About 9 million people attended the Kumbh Mela in March and April in Uttarakhand. After the event,

the state witnessed an 1800% increase in Covid-19 cases.²⁴ Similar data about the exponential rise in cases was recorded from other states where large election meetings were held.

IMPACTS OF THE SECOND WAVE

The second wave of COVID-19 has had devastating impacts across all of India. This wave is different from the first wave in two ways: firstly, the daily infection rate is significantly higher due to the circulation of more transmissible variants of the virus and increased testing capacity, and secondly, it has overwhelmed the Indian healthcare system as more health workers and infrastructure are needed. The cumulative impact has led to high mortality across the Indian population in addition to the social and economic devastation, more acutely felt by vulnerable and marginalised people.²⁵

Deepening economic distress and massive unemployment: The UN has forecast that India's economy will grow by 7.5% with the caveat that the outlook is “highly fragile” because of the brutal COVID-19 second wave.²⁶ The first wave of COVID-19 has already pushed 230 million below the poverty line (Rs. 375 per day) and increased informality, poverty, debt, and inequality in India (see [SSHAP brief](#)).¹² The second wave has further deepened this distress. Economists have warned that depleting household savings and falling incomes will have an impact on domestic consumption, which accounts for almost 60% of GDP.²⁵ Furthermore, the impact of the pandemic on the informal economy in terms of poverty and employment is not wholly captured in existing data.²⁷ The second wave has also triggered a fresh wave of unemployment in the country; over 7 million jobs were lost in April 2021.²⁸ Again, it has hit India's poor and vulnerable informal workers, especially women, hardest. These are daily wage workers working in construction, agriculture, street vending, and other home-based workers.

Informal workers face the greatest precarity: Similar to the first wave, the second wave also saw an exodus of migrant workers from cities to towns and villages as soon as states started announcing containment measures and lockdowns.²⁹ The sudden spike in cases of COVID-19 and lockdown in states like Gujarat, Maharashtra, and Delhi resulted in many migrant workers stranded in railway stations, bus terminals, or at their places of work.³⁰ These workers are often excluded from formal government support and have limited to no access to basic facilities such as food, water and sanitation.

The marginalisation of vulnerable groups: There has been an intensification of the precarity of marginalised groups such as poor women, Dalits, Muslims, and Adivasis, groups and communities in India who have remained largely invisible in India's development policies (see [SSHAP brief](#)).¹² For example, the pastoral communities who cannot afford to remain inside their houses are therefore more vulnerable to COVID-19. A survey from Gujarat found a lack of awareness about symptoms, preventive measures, diagnosis, treatment, and vaccination within these communities.³¹ Children in India have been largely out of school since March 2020, with a range of negative impacts on mental health, child protection, and increased risk of abuse.¹² Education loss affects rural and migrant children the most who lack access to online facilities and there are also additional risks to girls due to early marriage and/or pregnancy.

Rural distress: Rural areas are similarly under distress, with a double burden of increasing cases and poor access to health care.³² There has been inadequate testing, stigma related to the infection and limited awareness of the disease and inadequate testing, leading to major under-reporting of cases.³³ Reports of deaths due to COVID-like symptoms have been recorded from villages around India that have largely not been able to access testing and healthcare.³⁴ Further, vaccine coverage in the rural areas is lower than in urban areas. Rural areas were also severely affected by last year's lockdown due to the movement of goods and services, including adverse impact on remittances from urban to rural areas. The World Bank's survey of COVID-19 Related Shocks in Rural India indicated that rural households were experiencing nutritional and economic shocks, even before the second wave.³⁵

SYSTEMIC ISSUES THAT HINDERED PANDEMIC RESPONSE

DEPENDENCE ON THE PRIVATE HEALTHCARE SYSTEM LED TO UNDERINVESTMENT IN PUBLIC HEALTH INFRASTRUCTURE

The health system suffers from gross neglect and under-investment and this pandemic has revealed the institutional deficiencies of the system. Before the pandemic, the Human Development Report 2020 showed that out of 167 countries, India ranked 155th in hospital bed availability.³⁶ Effectively, this translates to just five beds for every 10,000 Indians. According to the Economic Survey 2020-21, India ranks 179 out of 189 countries in healthcare budget regarding prioritisation accorded to health in government budgets (similar to donor-dependent countries such as Haiti and Sudan).³⁷ India spends only 1.25% of its GDP on health, and the private sector (and community) finances over 71% of healthcare in urban and rural areas. Recent health care reforms have been market- and insurance-based, leaving large gaps in care. In such a context, the poor find it extremely difficult to access public healthcare, a fundamental right.³⁸ In rural areas, which suffer from years of historical neglect, the situation was much more critical because patients had to travel for several hours to access adequate healthcare, and in many cases, courts had to intervene to hold the state government to account.³⁴ Across states, there is considerable variation in the availability of public health infrastructure. Families across India are now in debt due to the high health care costs of those who have recovered and those who have lost their lives during the second wave. The national government could consider incentivising states to improve public health systems instead of the current approach favouring privatised health care through an insurance model.³⁹

LACK OF DATA AND INFORMATION TRANSPARENCY: UNDER-TESTING, UNDER-REPORTING, AND LOW PUBLIC CONFIDENCE

There is strong evidence that India's reported COVID-19 fatalities are a gross underestimate and could be underreported by a factor of between three and ten.⁴⁰ Media reports from states such as Uttar Pradesh, Madhya Pradesh, Gujarat, and Bihar have reported fatality undercounting and, for example, not counting deceased patients with co-morbidities.⁴¹

Data discrepancies were already highlighted by a parliamentary panel report in November 2020, which revealed that data collection systems failed to provide “*complete, timely and accurate data on newly tested persons, the ratio of RTPCR to other tests, COVID-19 related deaths, co-morbidities, antibody, surveillance studies, and hospital bed availability.*”¹⁸ These warnings were ignored by the national government, leading to a false sense of complacency. In addition, mitigation measures (including national lockdown) while causing lots of misery, slowed the progression of the epidemic and prevented healthcare systems being totally overwhelmed. Crucial and accurate data from the second wave on testing, positive cases, hospitalisation, and mortality have not been made public.⁸ This has had severe implications for the adequate provision of necessary medical facilities.

Serious cases of data suppression have been recorded where the state governments have actively tried to threaten and criminalise ordinary citizens who reported a lack of basic medical facilities and medical infrastructure. For example, in the state of Uttar Pradesh, one of the least developed states, an association of primary teachers claimed that “*1621 government school staff succumbed to COVID-19 contracted while on duty during the Uttar Pradesh panchayat elections and the subsequent counting of votes.*”⁴² However, the Uttar Pradesh Government stated that only three teachers died during the polls.⁴³ Instead of addressing the oxygen shortage, the Uttar Pradesh Government threatened to use the National Security Act (1980) against those who spread ‘rumours’ on social media.⁴⁴

In addition, lack of data transparency and science-informed decision-making has also paved the way for the rapid spread of misinformation. Myths, conspiracy theories, unverified information and medical advice have led to anxiety and uncertainty. The situation was further complicated by the fact that some government officials and ministers have also tacitly encouraged the propaganda of using alternative therapies and home remedies for COVID treatment.⁴⁵ The public health communication measures by the government proved ineffective in communicating the risks and spread of the second wave. Trust is key to effective communication, and it is enhanced when there is a sense of integrity, reliability, and commitment to the message. Communication has been lacking in these qualities, for example, when the national government was preaching social distancing while seeking large gatherings at elections and Kumbh Mela.

SHRINKING CIVIL SOCIETY SPACE

India amended its rules on foreign aid in November 2020, which affected the work of civil society and charities.⁴⁶ To receive foreign funds, charities must now get affidavits with notary stamps and open bank accounts with the government-owned State Bank of India. Many see such regulations and procedures as clamping down on political dissent, ultimately weakening the voice of the civil society actors.

Meanwhile, international donors were encouraged to contribute to government-led charities such as the PM CARES Fund. However, no disclosures have been made regarding the funds collected and the expenditures on various items to date. Moreover, there is no external auditing of the fund (see [SSHAP brief](#)).¹² Corporate Social Responsibility (CSR) funds were diverted to the PM-CARES Funds, which would have otherwise donated to the various Chief Ministers' Relief Funds and local NGOs. PM-CARES ended up with the bulk of corporate donations, given that donations to PM-CARES qualify as CSR, but not donations to CM relief funds.⁴⁷

Box 1. Militarised enforcement of public health measures

Two police personnel were seen brutally thrashing a 35-year-old man for not wearing a mask in public in Indore, Madhya Pradesh. In Uttar Pradesh, Faisal Hussain (18 years old) was detained by police on the charge of violating COVID-19 rules and was beaten severely, resulting in his death.

In addition to such incidents, the numbers in prisons have soared, as 'non-compliant' citizens are arrested in the name of COVID-19 control. Many prisoners are from marginalised sections (e.g., minorities, Dalits, Adivasis, informal workers) and political activists.

Even during the sudden lockdown at the beginning of the pandemic in March 2020, the Government showed a lack of capacity and willingness to cooperate with civil society organisations.¹² In such an environment, an opportunity for dissent and protection of human rights is almost absent. The harsh restrictions imposed on NGOs, especially those obtaining foreign contributions, make it more difficult for those NGOs to engage in pandemic relief efforts.⁴⁸

Rather than treat COVID-19 as a public health disaster, the state has tended to respond to the pandemic as a law-and-order problem, criminalising dissent, using force, and imprisoning those who failed to comply with the stringent lockdown rules. These also include student activists who had been opposing the discriminatory Citizenship Amendment Act of 2019. Indian jails are congested in the best of times, but during the pandemic this congestion led to additional risks and vulnerability to COVID-19. Although the Supreme Court took note of this in May, it was far too little and too late.⁴⁹

WIDER GOVERNANCE CONCERNS

Worsening relations between the national and the state governments, especially those governed by parties opposed to the party ruling at the centre, have created further policy paralysis. One example was the vaccine rollout where the states were initially asked to procure their supplies at a much higher rate without any funding support. Several states such as Maharashtra, Tamil Nadu, West Bengal complained about limited vaccine and oxygen supply stocks during the second wave. In May in Delhi, which was one of the worst affected areas, the daily requirement for oxygen supply was around 976 MT while the average daily supply of oxygen was at 393 MT. This was despite the national government having raised the daily supply quota to 590 MT.⁵⁰

Misplaced priorities: Amid the second wave crisis and underfunding of the health sector, the central government has allocated funds to the Central Vista Redevelopment Project, an ongoing

project to revamp the Central Vista, India's central administrative area in New Delhi. Indeed, the project aims to redesign the area with publicly accessible museums, a new Parliament building, and other amenities. The national government has been widely criticised for allocating funds to the Central Vista Re-development Project amid the raging COVID-19 pandemic.⁵¹ Meanwhile, it is important that the national government makes sufficient funds available to the states for the provision of medical facilities and stop expenditure on non-essential items like the Central Vista redevelopment project.⁴⁸

Box 2. Examples of rapid response and preparedness

While the situation in India remains grim, several inspiring cases of agile response have emerged from across the country, especially at the local and state levels. There is an opportunity to learn from what is already being done and scale it up at a national level if and when appropriate.

- In Nandurbar, a tribal district in Maharashtra (located over 400 km from Mumbai), a model has been created that ensures optimum use of medical oxygen. The district started planning for its oxygen needs in September 2020 and installed three plants over this period. This was made possible because of the foresight of doctor-turned-bureaucrat, Dr Rajendra Bharud, the collector of Maharashtra's Nandurbar, who [anticipated the second wave](#) and installed a liquid oxygen plant of 600 litres per minute capacity at the civil hospital in September 2020. The district administration established two more plants in February and March 2021. Today, oxygen supplies are sufficient, and the district started supplying the excess to other districts.
- During the second wave, Mumbai fell back upon 15 big and 11 smaller Liquid Medical Oxygen [LMO] tanks installed between May and June 2020. The municipality [created that infrastructure](#) without knowing it would be utilised but this is a good example of preparedness. The success of the Mumbai model prompted the [Supreme Court](#) to suggest its replication for Delhi to manage liquid medical oxygen supply.
- Similarly, [learning from the first wave](#), Kerala ordered oxygen producers to increase their output and used tracking of patients and supplies, built a network of health care workers and created coronavirus "war rooms" to [succeed](#) where the national Government has fallen short. Kerala's share of fully vaccinated people is nearly [double the national average](#) of 3%. The role of panchayats and local bodies in Kerala in track and trace, distribution of relief and in vaccinations, is a lesson for other states.

KEY CONSIDERATIONS

SHORT-TERM MEASURES

Rapidly improve global COVID-19 vaccine equity by waiving intellectual property rights and enabling vaccine justice: At the current rate of COVID-19 vaccination, vaccinating 70% Indians will take 8.7 years. The world needs to decentralise vaccine production; it cannot depend on just three or four countries as any vaccine-producing country can be forced to shut down. Therefore, the proposals for a temporary easing of patent protections for COVID-19 vaccines, therapies, and tests (e.g., an intellectual property waiver) is urgently need to be acted upon in order to achieve vaccine equity, slow the spread of COVID-19 variants, and end the pandemic.^{52,53} The next meeting of the World Trade Organization (WTO) must seriously consider these waivers.⁵⁴

“One nation, one tender” policy for vaccine procurement: The government of India has now centralised the procurement of vaccines and will supply them for free to state governments. State policymakers should extend this commitment and limit the role of payment-based private sector administration of the vaccine. Similar actions can be taken for the procurement and provision of essential drugs. Public health authorities can provide clinical management guidance to states and local authorities to ensure an effective response. This would avoid stock outs, as seen with drugs like remdesivir and dexamethasone at the height of the second surge.

Bridge the digital divide and decentralise vaccine deployment. The vaccination race is also exposing India's digital divide.⁵⁵ The Government of India made everyone above 18 years of age eligible for the Coronavirus vaccine from May 1, 2021, in Phase III of the mass vaccination drive but shortages have plagued phase III of India's vaccine drive.⁵⁶ Online registrations for vaccination at the Cowin website mean “No Internet, No Vaccination.”⁵⁷ Door-to-door vaccination campaigns, as well as walk-in vaccine centres must be ramped up to ensure universal vaccination. Context-specific solutions can be identified by state governments to ensure that the vulnerable and marginalised are reached with vaccination campaigns.

The Ministry of Health and Family Welfare (MoHFW) should rapidly scale up essential lifesaving COVID-19 treatments, while ensuring that other critical health services are maintained. In the short term, the health system will need to focus on COVID-19 care, with other essential services maintained. There is an urgent need to rapidly scale up oxygen capacity, ensure basic essential emergency and critical care, and stabilise the supply of medicines like dexamethasone.

The MoHFW should leverage home-based care for non-critical COVID-19 cases and provide clear guidelines for providing care at home.⁵⁸ To ease pressure on hospitals, patients need to be safely cared for at home when possible. State public health authorities can release actionable guidelines for doing this. In rural or slum areas where home quarantine is not a possibility, the government should establish community quarantine centres either with civil society bodies or local government actors such as the Panchayat officials.

Protect grassroots level frontline COVID health workers: It has been recommended to provide a COVID-19 hardship allowance to 2.5 million community health workers such as Anganwadi and ASHA workers of Rs. 30,000 (5,000 per month for six months).⁵⁹ The insurance coverage for “Corona Warriors” needs to be extended to Asha and Anganwadi workers involved in frontline work during the pandemic.⁶⁰ Rural health workers can be better supported to disseminate information on COVID-19, provide home care guidelines for mild cases, and link suspected severe cases to health facilities.

Design a public health risk communication campaign: India needs a robust evidence-based communication campaign.⁶¹ Rather than being driven by politicians, this must be designed and executed by communication and public health professionals, with active participation and feedback from citizens. The government must back science-informed decision-making and ensure transparent dissemination of data about infection rates, mortality, vaccine procurement and delivery. Public trust

must be rebuilt to ensure that these messages translate into effective actions. A robust communication information and communication plan should also be designed to improve vaccine confidence and address myths and misconceptions, which needs to be linked with the rollout plan for vaccination.

Guarantee food security for the poor and most vulnerable: Former civil servants recommended that the government use surplus food stocks to provide free rations to marginalised sections of society, including informal workers who have lost employment opportunities, until the pandemic and related food and livelihood crises abate.⁴⁸ They also recommended special measures for vulnerable groups such as the elderly, single mothers, people with disabilities, and children, and nutrition schemes for vulnerable children and mothers.⁴⁸ The Public Distribution System (PDS) in India is controlled by the Ministry of Consumer Affairs; the Government of India needs to be far more flexible during emergencies to cater to the needs of people without documents, especially migrants.

Create an inclusive democratic space to empower civil society organisations and facilitate community engagement: Centralisation, lack of recognition of the local skills, and command and control hamper India's efforts to deliver timely care.⁶² There is a need to allow civil society, NGOs, and local bodies to set up testing and isolation centres in rural and remote areas with inadequate health care infrastructure.⁶² It is also important to immediately remove the FCRA restrictions imposed on NGOs so that they can avail of funds provided by foreign governments and charities for COVID-19 management and other related activities.⁴⁸ Lastly, there is a need for streamlining government-NGO coordination and collaboration. In the second wave, there were attempts to organise some meetings however, these coordination platforms need to be strengthened and operationalised.

Release undertrial and political prisoners: Due to the ferocity of the pandemic and risks of COVID-19 in crowded jails (see [SSHAP brief](#)), undertrial and political prisoners should be released or placed under home arrest.

MEDIUM-TERM MEASURES

Decentralise essential health services. A one-size-fits-all approach to the COVID-19 response does not meet the diverse needs of different contexts in India. Instead, community- and district-level working groups should be empowered to respond to the local context, receive government funds, and coordinate the local health system.¹² A decentralised model has worked well in Odisha, where the state government entrusted supported community actors, like the Gram Panchayats (village councils) to isolate suspected cases.⁶³

Improve national pricing transparency and reduce out-of-pocket expenditure in hospitals. Essential health services have different costs depending on the negotiating parties, which creates confusion in the sector. Instead, national prices should be transparent. Further, hospital care costs are prohibitive and discourage health-seeking. Many Indians will be in debt for a long time due to the high hospital bills of their recovered and dead loved ones. Instead, out-of-pocket costs should be covered by existing health insurance schemes.⁶⁴ In Tamil Nadu, for example, Chief Minister

Muthuvel Karunanidhi Stalin brought COVID-19 treatment in private hospitals under a government insurance scheme.⁶⁵

Strengthen MGNREGA and support livelihood recovery through sustained and substantial cash transfers: The budget for the rural employment scheme, The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) should be expanded to cover additional entitlements, including programme wages that meet state minimum wage standards. The Government should facilitate automatic enrolment of all MGNREGA workers who do construction work as registered workers under the Building and Other Construction Workers (BoCW) Act to access social security benefits.⁵⁹ Opportunities for robust livelihood recovery must be found and linked with MGNREGA, which has helped lift people out of poverty in the past.¹² Loss of livelihoods is a massive challenge, which can be addressed through cash transfer programmes similar to the support provided by the US and European governments to their populations.⁶⁶

Prioritise the need for a database for migrant workers: According to an ILO report in December 2020, migrant workers in India remain un-enumerated and unrecognised which is a problem because the interface between migrant workers and public systems and services can be established only if there are reliable databases at all levels of governance.⁶⁷ According to a government reply (March 8, 2021) in the Parliament, the central labour ministry is currently developing a National Database of Unorganised Workers (NDUW) to deliver social security and welfare schemes.⁶⁸ Such a database is needed to plan activities during the current wave and prepare against future waves.

Develop a national urban employment guarantee programme: Several states such as Odisha, Himachal Pradesh, Jharkhand, and Kerala have already launched urban employment programmes in response to the pandemic. However, budgetary allocations are limited.⁶⁹ The Centre for Sustainable Employment in 2019 recommended the creation of a National Urban Employment Guarantee Programme for small and medium-sized towns in India.⁷⁰ Policymakers also need to consider a “Decentralised Urban Employment and Training” (DUET) model as recommended by the economist Jean Drèze.⁷¹ This would provide job stamps to approved public institutions to pay workers and directly into a bank account.

Support the needs of children during the pandemic: The government, NGOs, and civil society can identify local strategies for providing psychosocial support to children, provide targeted support to families, including child-headed households, and establish mechanisms to identify vulnerable children and link them to protection mechanisms. Organisations can reach out to vulnerable children who may not return to school and support the mitigation of learning loss (e.g., through remedial programmes) when schools return with particular support for vulnerable students.⁷² The “Mobile Learning Centres” approach established in Bihar can be scaled up to enable children to learn even when they do not have access to any type of digital equipment.⁷³

LONG-TERM MEASURES

Increase public spending on health care: Public spending must be increased from 1% to 2.5 to 3% of GDP on health care to reduce out-of-pocket expenditures from 65 to 30% of overall healthcare

spend. The government must work towards achieving Universal Healthcare Coverage in the long-term, which will require a rethinking of the current health care paradigm. The current approach to government financing of care is a market-based approach that perpetuates inequities and places a greater burden on the poor. Instead, the government may look at other models for care including a mix of public service and social insurance and aim at universal health services.^{74,75}

Improve universal social protection for the poor, marginalised and vulnerable: Moving forward, the national government should enable states to extend social protection measures (universal and portable) for the poor, migrants, and informal sector workers. For emergency use during natural hazard-induced disasters and pandemics, the Public Distribution System, cash transfers, the National Social Assistance Programme (NSAP), and MGNREGA are key. Policy response must start by strengthening these existing programmes and one way of strengthening is integration.

Consider the unique needs of informal sector workers and bolster public support for these groups: Work in the informal sector presents enormous unaccounted risks for migrant workers, such as limited social protection measures such as lack of access to the public distribution system, exclusion from the public healthcare system, poor access to housing and WASH facilities, and financial insecurity.⁶⁷ Women migrant workers are also highly vulnerable to violence and harassment. The migrant exodus during the nationwide lockdown showed the weaknesses of social protection architectures based on fixed residence and non-portable entitlements. Urgent income support needs to be provided to marginalised social groups (Dalits, Adivasis, migrants, urban and rural poor) to tide over this crisis, including a free public distribution system for ration supply and amortization on repayment of all loans.¹²

Develop legal provisions or laws for protecting the rights of the dead: When important processes related to death and dying are denied, there can be significant impact at both individual and societal levels (see [SSHAP brief](#)). There is no specific law in India for protecting the rights of the dead; particular legislation needs to be enacted for upholding the dignity and protecting the rights of the deceased.⁷⁶

Commission an independent system-wide assessment on the handling of the COVID-19 response: An independent assessment of handling the second wave is needed. A formal judicial commission or an all-party committee must take a 360-degree look at how India's COVID-19 management system collapsed. Such an inquiry must investigate every aspect of COVID-19 response in India from the beginning of the pandemic, including the sudden lockdown, vaccine policy, mobilization of resources through PM-CARES, allocation of medical supplies between and across states, and data collation practices on tests, recovery, mortality, and morbidity. There should also be opportunity for bereaved citizens to seek redress and accountability. There is scope for international and human rights organisations to monitor discrimination in relief, loss compensation, and the administration of further economic stimulus.¹² As a first step data system similar to “Bills of Mortality of London,” “Euro Momo” or “Safely Open” can be set up for open, direct, but privacy-protected data availability.

Develop a national plan (a roadmap) for at least three years: India must not miss the opportunity to redesign national plans to prepare for future pandemics.⁶² India requires data-driven, decentralised decision-making and a well-coordinated containment strategy.⁶² It is recommended to incorporate all these aspects in a long-term national plan as planning and guiding document, including for scenarios where multiple disasters occur concurrently (e.g., cyclone and COVID-19).

Safeguarding Indian democracy: This briefing highlights the weakening of institutions underpinning Indian democracy, especially those concerning welfare, health, planning, and science. Future preparedness must involve strengthening democracy itself through institutions so that they are not vulnerable to political pressure. Additionally, the executive and judiciary should remain unbiased and serve the interests of all Indian citizens, especially minorities. It is important that the Indian state respects the human rights of all Indian citizens (especially minorities, critics, activists, and marginalised groups) during the pandemic and beyond.

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CONTACT

If you have a direct request concerning the response to COVID-19, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or (oliviattulloch@anthrologica.com). Key Platform liaison points include: UNICEF (nnaqvi@unicef.org); IFRC (ombretta.baggio@ifrc.org); and GOARN Research Social Science Group (nina.gobat@phc.ox.ac.uk).



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