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COVID-19 and the Community: Kerala's Response to the Pandemic with reference to the Kumaramputhur Grampanchayat

Internship Report

by

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Abstract

The COVID-19 pandemic has spread throughout the globe, demanding prompt response mechanisms to combat the same. These mechanisms vary from nation to nation, State to State. This study looks at the response to the pandemic in the State of Kerala, India, which is attempted by analysing the local self-governing institutions and community structures. It analyses the response framework put forth by the state government, the formulation of practical implementation mechanisms at the local governance level in accordance to the framework and the actual implementation on the ground by leveraging the participation of various community groups and structures. The study finds that the Kerala government envisioned the local self-government (LSG) institutions as the key bodies of the implementation of the response effort. A certain level of autonomy was given to the LSGs to figure out the best implementation strategies taking into the account the characteristics of the population they govern, meaning that the same program can have different groups and stakeholders involved in them in different LSGs. The study also documents the active participation of various organisations in the community like the political parties, Arts & Sports Clubs, Volunteers as well as the community driven programs of the State including Kudumbashree, ASHA and Anganwadis. It records that the active participation of people was vital in the response effort to the pandemic and that various state mechanisms were successful in eliciting the ground-level participation of the people in the community.

CONTENTS

1. Introduction

The novel Coronavirus, later renamed the SARS-CoV2 appeared in the city of Wuhan in the Hubei province of China by the end of December 2019; following a pneumonia cluster of unknown origin was reported. It then spread to China's Southeast Asian neighbours – Thailand, South Korea, Japan and Singapore. As it began spreading to a large number of countries, the WHO declared it a 'Public Health Emergency of International Concern' on the 30th of January, 2020 (World Health Organization, 2020).

It is on the same day that the SARS-CoV2 virus entered the shores of Kerala when the first positive case was confirmed to be a person who had flown back from Wuhan to Kochi. In this China-centered first wave, three positive cases reported in the State, which were the only cases in the country. All three made a successful recovery until the second wave, of which Europe was the epicentre, brought the virus back into the State, resulting in far more cases. As the virus spread to more and more countries, including the Middle-eastern nations, infections, in the State also started to rise commensurately. New cases, around 502, were reported during this wave which was brought under control by April End. Throughout the last week of April and the first week of May, the number of recovery cases overshadowed the number of new cases. By the 8th of May, there were only 16 active cases in the entire State. The third wave of cases started to peak when expatriate Keralites were allowed entry to Kerala. Flights carried natives back from foreign nations, ships ferried people from nearby island nations, railways reopened, and road transport provided a way for those who could arrange their transportation to come back. Until the 14th of May, 2020, fifty-five more positive cases were reported (Government of Kerala, 2020).

The present study aims to look at the state response to this pandemic and the role played by the local communities as well as the local self-governing institutions. In the first stage, the study tries to map the various schemes, programs and activities announced by the state government, which served as the framework for the ground-level response. The research then shifts the focus to the Grampanchayat as the focal point to analyse ground level responses. Implementation of the programs at the local level, together with logistical and organisational structures put in place to coordinate all such activities are

examined. Lastly, the study also looks at the response of the local community at large. The roles of the various community groups, institutions and organisations are studied, to examine the dependency on the state structure to carry out said relief activities. The study does not seek to address the effectiveness, efficiency or performance of said measures. On the contrary, the research examines structures and mechanisms put in place during the pandemic and how it interacted with the local community.

2. Literature Review

Kerala has the track record of effectively implementing decentralisation and devolution of state powers in the 1990s after the 73rd and 74th amendments to the constitution. The Kerala Panchayat Raj Act of 1994 and the subsequent rules bring this devolution into practice. Functions of local self-governing institutions, including Agricultural activities management of Krishi Bhavans[1], water supply schemes, government pre-primary and primary schools, primary health centres, immunisation programs, Anganwadis, sanctioning of welfare pensions, general supervision of the public distribution systems, organisation of co-operative societies comes within the third schedule of the Act.

The People's Campaign for Decentralised Planning (started in 1996) leveraged this new system of local self-governance to introduce a planning framework where people, through gramsabha, could directly participate and decide the activities as well as schemes of the Panchayati Raj Institutions (Isaac & Harilal, 1996). Simultaneously, there was also a push for the strengthening and decentralising of the public health system which set up a robust primary health network and ensured grassroots penetration of the health system (Elamon, Franke & Iqbal, 2004). During the People's Planning Campaign, the government allocated 35 to 40 per cent of its budget to LSGs. Further, LSGs could spend about 40 per cent of its budget on health and education (Thomas & Rajesh, 2011). Participatory initiatives like the Kudumbashree[2], which grew out of the People's Campaign for Decentralised Planning movement, have strengthened the voices of women, who were marginalised actors, in the local politics and power spaces.

[1] Krishi Bhavan is an office under the Department of Agriculture which deals with the implementation of various state level programs at the panchayat level

[2] Kudumbashree is a community organization of Neighbourhood groups, launched in 1998, aimed at empowerment of women closely linked to economic empowerment

Involvement of the women through the Kudumbashree units in participatory planning and day-to-day activities of the local self-government institutions was integral to the process (Williams, Thampi, Narayana, Nandigama & Bhattacharya, 2011). The People's planning campaign had also given importance to strengthen the existing schemes aiming to facilitate community participation. Seema (2001) notes how the semi-structured questionnaires given to resource persons during the initial stages of the People's Plan movement had reference to the social welfare structures, particularly Anganwadis[3]. The process was able to identify various problems of the Anganwadi centres and develop solutions for it in the plan. Apart from Anganwadi workers under the ICDS[4] scheme, in Kerala, there is a proliferation of ASHA[5] workers under the NRHM.[6] The National Health Mission (2009) mentions the progress made by the community mobilisation of ASHAs in the process of efficient and effective implementation of the mission within the State of Kerala.

Decentralisation and participation work in tandem with each other at the community level. Kuriakose & Iyer (2016), in their case study of the democratic decentralisation in the Malappuram district of Kerala, notes how the Anganwadi centres work closely with the primary health centres and ASHA workers on immunisation and health checkups for the children. Kudumbashree units tasked with supplying the nutrimix powder for children in Anganwadis. Panchayat officials and Kudumbashree members observed to be participating in the welfare committees of Anganwadi centres. These indicate the proximity and dependency in the operation of these community programs on the ground.

The strong ground level network inculcated into the social fabric of Kerala has come handy in earlier viral outbreaks in the State. The Nipah virus caused one such outbreak which occurred in the districts of Kozhikode and Malappuram in 2018. In response to this virus, the health sector focused on isolation and mapping of the positive cases. At the same time, representatives from local bodies, humanitarian assistance organisations

[3] Anganwadis (Courtyard Shelters) is a type of rural child care centre which provides nutrition education and supplementation as well as counselling services to women and children.
[4] Integrated Child Development Scheme. It was launched in 1975 to provide food, preschool education and primary healthcare to children under the age of 6 and their mothers.
[5] Accredited Social Health Activist is a community health worker selected from among the women of the same village where she is appointed.
[6] National Rural Health Mission was launched in 2005 to address the health needs of underserved rural areas.

and religious organisations along with NGOs were taken on board to spread awareness, allay fears and giving humanitarian assistance to affected families (Rahim & Chacko, 2019). Thomas & Rajesh (2011) highlights the help provided by women SHGs to healthcare activists in the universalisation of immunisation and public health awareness programs. Further, it was noted that SHGs acted as a support system for the effective implementation of the Pulse-Polio campaign and in the eradication of epidemics like Dengue and Chikungunya.

It is clear from the literature that Kerala has a robust local governance system and active community level network which work together well. However, the case of COVID-19 is unprecedented in the 26 years of decentralised governance in the State. Rate and scale of the spread of the disease are unlike the past experiences of Dengue, Chikungunya or Nipah. COVID-19 deaths are more likely to occur via the overwhelming of public health system rather than the deadly potency of the virus by itself. Therefore, there is a need to examine the systems in the context of the new pandemic.

3. Methods

A qualitative methodology was adopted to conduct the study. For data collection, in-depth interviews, using an interview guide, was adopted. Telephonic interviews have been relied on for data collection due to the restrictions on travel.

Figure 3(a): A Map of the Mannarkkad Circle

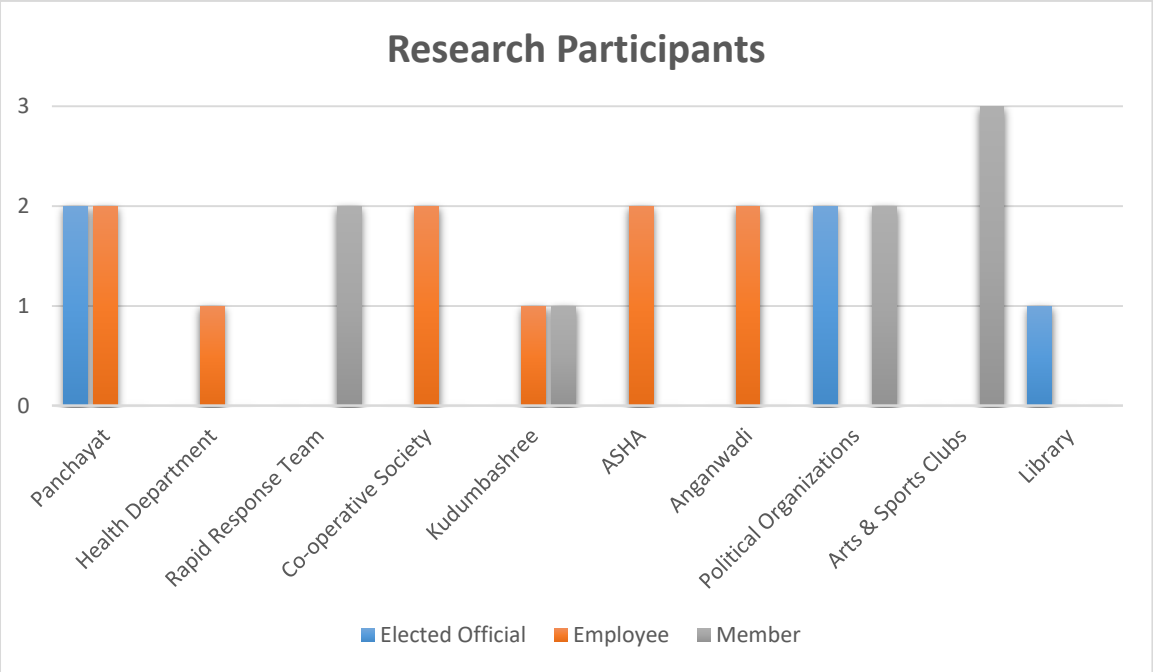
The Kumaramputhur Grampanchayat in the Mannarkkad Taluk of the Palakkad District of Kerala was the focus of the study. It consists of an area of 37.25 sq.km, divided into 18 wards. About 16,000 people live in the panchayat in around 3500 houses. The panchayat share boundaries with the Kottopadam and Karakurissi gram panchayats and the Mannarkkad Municipality (Refer Fig. 3 (a)). A community health centre exists in the Nechully ward of the panchayat, and the Taluk Headquarters Hospital in the neighbouring Mannarkkad municipality. To understand community response analysis was delimited to the 7th and 8th wards of the panchayat – Chungam and Chakkarakulamb wards. These two wards gain particular importance because the administrative centre of the panchayat lies in these wards, and the National Highway 966 which connects Palakkad and Kozhikode passes through these wards. Besides, the Community kitchen, the Maveli store[7], the fire force office, the main offices of the banking co-operative societies and other institutions are located in these two wards.

Both purposive and snowball sampling methods were adopted to select participants for the study. Panchayat officials, Health Officials, members of Community organisations

[7] Maveli stores are ventures of Kerala Civil Supplies Corporation (Supplyco) which sell various products at subsidized rates to consumers.

and Community Workers formed participants of the study. Fig. 3(b) presents, the composition of twenty-three participants interviewed as part of the study.

3 (b). Distribution of Participants of the Research



Data collection was carried out from April 15, 2020, to May 15, 2020. As the number of cases is increasing response efforts are changing to meet new challenges. Therefore, the study does not claim to provide a complete picture of the response efforts.

4. Analysis

Te first section examines the response of the state government and its departments, followed by the response measures taken by the panchayat and, the third section presents the community organisations and groups responding to the COVID.

4.1 The Response of the State

One could examine the State government responses by dividing the response effort into three phases, corresponding to each wave of active cases recorded in the State, from January to May. Phase-I, covering mid-January to early March, could be defined as the response to the China-centric wave of infections. The Phase- II, could be defined as the period corresponding to the increasing number of cases coming in from the European continent as well as the Middle-East, which lasted from mid-March to early May. The Phase III, beginning from early May, could be defined as the response to the increase

in cases post the return of expatriates after the relaxation of lockdown measures. Each Phase is analysed below.

4.1.1 Phase One –The China Centric Wave

In January, as the virus was spreading within China and reaching its Southeast Asian neighbours, the state health department was already taking pro-active measures to monitor airports and asking people who have been to China to reach out to the District medical officers. During screening at the airport and seaport, people with symptoms were sent to isolation wards, and others kept under house monitoring for 28 days; advisory for this was valid from January 22nd.On a Facebook post, dated 24th January, the Minister for Health K.K Shailaja Teacher announced the promulgation of the Corona Response Guidelines for all hospitals in the State, which detailed the setting up of Isolation wards, usage of Personal Protective Equipment and sending of samples for testing. 'Disha' a helpline named was installed to answer queries related to the present situation (Shailaja Teacher, n.d.).

First positive case of the coronavirus was confirmed in Kerala on 30th January in a student who had travelled back from Wuhan on 23rd January. As the measures were already in place, the student was already in isolation after she had arrived. By February 3, the number of positive cases had risen to 3 and subsequently, after the State Disaster Management Authority (SDMA)[8] apex committee meeting, the situation was declared a state disaster. It was retracted on February 7th as there were no new cases and all three patients were recovering. The strategy to 'identify, isolate, test and treat' was put into place. National Institute of Virology, Alappuzha was equipped with the facility to test COVID. Health workers were entrusted with the task to monitor people with a travel history to affected countries, and various awareness programs were started (Jacob, 2020). By February 20, all three positive cases had recovered, with no new cases reported; thereby, ending the first wave of the disease. However, checking at airports, monitoring activities, and awareness programs continued. On the contrary, as the virus

[8] Constituted under the Disaster Management Act, 2005 in each state. For more details: https://sdma.kerala.gov.in/about-ksdma

became widespread, monitoring was strengthened to include all passengers arriving from abroad.

The notable feature of this phase is the focus of the health department in early response. Protocols improved as the epidemic spread globally. The fact that Kerala had students in colleges in Wuhan also contributed to the alertness of the government. At that point, there were only 3 cases, which was effectively isolated and thereby leading to a stage where recovery was possible without any new infections. Due to the efficiency of the health department, everyday life and functioning of the institutions and economy were not affected.

4.1.2 Phase Two – Europe, Middle-East and Contact Spread

On March 8th, five new cases were tested positive for COVID, set off by a family who had returned from Italy on the 29th of February; marking the second wave of the disease. Cases quickly rose to 12 within two days. While the previous protocols were in place, the fact that the infected had travelled widely and could not be isolated soon enough meant the health department had to prepare and publish route maps of all patients with a travel history inside the State. The intention was to help people, who might have come in contact with the affected, report themselves.

By Mid-March, the number of active cases shot up to 27. Accordingly, the State moved past just medical solutions and started social containment measures. The government suspended classes in schools up to 7th standard, and public programs cancelled. In the following days, more measures were put in place to contain the spread of the virus, which ranged from movement restrictions to delivery of mid-day meals of children to their homes to a 40% increase in the Internet Bandwidth. It was a clear sign from the government to the people indicating them to stay at home as much as possible.

On March 15th, the health minister announced a campaign titled ‘Break The Chain’. The campaign designed as a community-led initiative where kiosks containing water and soap, or sanitiser were to be set-up at the entrance to each building and office in the State. Organisations were encouraged to set up such kiosks at places where people congregate such as railway stations, bus stands and markets. In government offices,

such facilities were made mandatory. Heads of residents' associations and private office heads were also requested to set up the same. The campaign was initially slated to run for 14 days but continued as a long running social initiative.

Meanwhile, as the disease spread across the world, the chances of more cases popping up skyrocketed as the virus hit the Middle-East. In the State, 52 positive cases were reported during March 21-23, all having a travel history to the gulf region (COVID-19 pandemic in Kerala, n.d.). Kerala imposed a complete lockdown from March 24, 12.00 am, which was followed by a nationwide lockdown was announced till May 17. There were significant shifts in the response by this time, as it took on a more wholesome approach, with the Chief Minister taking over the daily media briefings. New schemes and programs announced required involvement and partnership of various departments of the government including Civil Supplies, Health, Home, Revenue, Information & Broadcasting and Agriculture. The tagline 'Physical Distance, Social Unity', was adopted for the response efforts, marking a significant departure from the response efforts in Phase I. The focus was not only on the isolation of detected cases but the prevention of new infections originating within the State and preventing community spread. Physical distancing was adopted to flatten the curve, which required shutting down all economic activity and thus a massive loss of livelihood for a majority of the population. The economic impact of lockdown was addressed through a slew of schemes and programs to provide social security nets to the State population. Following schemes/programs were announced considering the situation in the State (Vijayan, n.d.), (COVID-19 Kerala, n.d.):

1. LSGs to ensure normalcy in the life of those in quarantine and to guarantee supply food and medicine. Care for geriatric and palliative patients and guest workers to receive additional attention. With the participation of community groups, ASHA workers, Anganwadi workers, Junior Health Inspector/Junior Public Health Nurse or Government employees awareness activities to be strengthened.
2. The government announced Rs. 20,000 crores as an economic package to facilitated early disbursal of welfare pensions (till April) and relaxation for taxes

and bills. Further, funds were made available to disburse interest-free loans via Kudumbashree, provide free ration for all families for a month, setting up of 1000 eateries serving food at Rs.20, clear all government dues and an allotment of Rs. 500 crores for the health sector.

3. Conduct of exams, operation of interstate bus services, functioning of beverage outlets and bars were terminated.
4. Kerala Epidemic Diseases Ordinance 2020 promulgated, giving special powers to the government.
5. The government initiated 'Sannadham' a portal for online registration of volunteers; 'GoK Direct' for updates from the government; 'Kerala Citizen Centre' a website for collecting information of people coming from outside the State, caregivers, health officials and people with vulnerabilities. Further, 'COVID19 Kerala' Whatsapp and Telegram channels for information dissemination, were started.
6. Civil Supplies to start Free Ration Distribution as well as food kits to all families in the State. Guidelines for the same issued to avoid a rush at ration shops and to keep physical distancing.

One major announcement made during this period was the direction from the state government to all LSGs to open Community Kitchens under them in partnership with Kudumbashree. This kitchen would provide free meals to vulnerable sections and subsidised meals to those who were able to pay but unable to cook for themselves. Government fixed the price of a meal at Rs. 20. The LSGs were encouraged to run the kitchens on sponsorship or to find special funds for the same; the state government allotted no additional fund.

By 15th of April, when the central government mandated timeframe of the first lockdown period ended, Kerala had already started reporting more cases of recovery than new positive infections for a week. For the second lockdown period till the 3rd of May, except in Hotspots, the State relaxed lockdown conditions. Districts in Kerala was categorised into four zones, based on the number of COVID cases. At one point Kottayam & Idukki was Green as there were no cases; Alappuzha,

Thiruvananthapuram, Palakkad, Wayanad & Thrissur were Orange B where there were very few cases; Pathanamthitta, Ernakulam & Kollam where Orange A as there were a few more cases but still in single digits and; Kasaragod, Kannur, Kozhikode & Malappuram was categorised Red which recorded the highest number of infections. The zones were dynamic; their designations changed according to the number of cases reported. Similarly in hotspots restrictions were imposed proportionately to the cases reported in the area. The earlier announced schemes continued throughout this 2nd lockdown period.

From the 3rd lockdown period prescribed by the central government (May 3 – May 17), the number of active cases kept falling in the State in the initial days, reaching an all-time low of 16 on May 8th. Also, only one new case was reported from May 3rd to May 8th within the State (Government of Kerala, 2020). As the control measures could flatten the infection curve, this could be the end of Phase II response to the pandemic.

4.1.3 Phase Three – Return of the Expats

Phase Three of the response was with the relaxation of lockdown conditions, especially the travel restrictions. The central government began the 'Vande Bharat' Mission to bring back expatriates via Sea and Air from the 9th of May. The Indian Railways also resumed services on 12th of May on a trial basis. The State permitted road travel to those wanting to return to their native states. Expecting a lot of people coming back to the State from COVID affected areas, the state government implemented a protocol for effective screening and quarantine of all those coming into the State. The screening was compulsory at Airports, Seaports, Railway Stations and six road checkpoints where entry into the State was possible.

NORKA[9] facilitated the registration of Keralites wanting to come back. All those coming to the State were to obtain a pass for travel by submitting an application to their respective district collectors through the 'COVID19 Jagratha' online portal. The issuance of the pass to an applicant was after a multi-level examination process. The district administration passes the information of the applicant after a preliminary

[9] Department of Non-Resident Keralites Affairs, formed in 1996 to address the grievances of Non-Resident Keralites.

inspection to the concerned panchayat, and then to the respective wards. A team then examines whether there are facilities for the person for home quarantine (a single bedroom with attached bathroom) and whether there are any medically vulnerable persons at home. If home quarantine is not possible, the nearest quarantine facility is looked into, whether it can accommodate the person. Each panchayat was to set-up quarantine facilities within its area. Subsequently, the district administration takes a decision on the approval of the travel pass based on the data provided by the local body. The entry pass is valid for entry on a specific date at a stated entry point, where the person will have to turn up. The entry pass is issued based on a priority basis, with economically and medically vulnerable returnees given higher priority. At the entry point, everyone needs to undergo a mandatory medical checkup, and persons are shifted to a medical centre if they have any symptoms. For persons with no symptoms, are expected to observe a 14-day home quarantine. People coming from abroad are to spend seven days in institutional quarantine and tested for COVID virus on the 7th day. If the test is negative, they can spend the remaining seven days in home quarantine.

As per government data, 1,66,263 persons within India have registered to return to the State, while from abroad, 4,42,000 persons have registered (Vijayan, n.d.). Due to this influx of people from COVID affected areas, the number of active cases in the State has also started growing. From 16 active cases on May 8th, the number has gone up four times to 64 by May 14th. In Phase 3, the focus has again shifted to the containment of the spread coming from outside the State. The aim is to prevent it from reaching the community once again, and so strict monitoring and quarantine followed. The government also aimed to open up the economy and stimulate income generation slowly. Aim of measures like an increase on tax levied on alcohol up to 35%, a stimulus package for MSME[10]s is directed at this front. It would be fair to expect this dual approach to continue for more weeks to come until the active cases decrease, and this phase can be closed down.

Local self-government and state-supported community initiatives like Kudumbashree figure prominently in the response efforts, especially in the latter two phases. The

[10] Micro, Small and Medium Enterprises

community health networks have been employed and actively participating in all three phases. We shall examine these response efforts at the LSG and community level in detail in the next two sub-sections.

4.2 The Response of the Panchayat

The panchayats of Kerala have good experience in managing, overseeing and coordinating welfare activities of the community in almost all sectors as seen in the review of the literature. It is only natural that the state government made the panchayat the critical body in the execution of its plans statewide. This section is the story of the setting up of the committees within the panchayat to coordinate and execute the various tasks entrusted to it by the state government.

4.2.1 The Rapid Response Team

The state government, in its plan, took into account the need for volunteers on the ground to execute the various interventions it announced in Phase II of the response. To facilitate this, a centralised website called 'Sannadham' was set-up for the registration of volunteers. Individuals between 22 to 35 years are eligible to be registered as a volunteer, and the respective panchayats are provided details of volunteers. A preliminary meeting was held in the Kumaramputhur Grampanchayat, to plan how the response activities in the panchayat were to be coordinated and executed. This meeting included the elected members in the Grampanchayat, the government officers under the Grampanchayat as well as representatives from the various political organisations working within the Grampanchayat. It was decided in this meeting to set up 10-member Rapid Response Teams in each ward which will be responsible for all the coordination efforts. The Sannadham volunteers were supposed to work closely with these teams. In the Kumaramputhur Grampanchayat, this would mean that 180 volunteers would be appointed, which would conflict with the spirit of the lockdown and the strict physical distancing measures. As a response, the district collectorate issued an order that caps the number of volunteer ID issued in each panchayat at 10; limiting the number of Rapid Response Team at the panchayat level. This revision of the process has left a little confusion on what to refer to this new committee as. Some participants referred to as Rapid Response Team (RRT) while some insist that it is not RRT, but 'Volunteer

Committee'. Since RRT is usually in official literature, it is used in this study as well. The next question was on who would become the members of this team. The Sannadham list was raw data and no means of a good selection within the list as possible.

What the panchayat went with was scrapping the Sannadham list and forming the team with representation from the youth wings of all political organisations within the panchayat – 2 members nominated from the AIYF[11], two from DYFI[12], two from Youth Congress[13], two from Youth League[14] and one from Yuva Morcha.[15] The tenth member was the Youth Club Coordinator of the Grampanchayat. There could be two ways of looking at the situation. Firstly, political organisations constitute the primary means of collectivising people within the panchayat and have been first to organise relief activities in a crisis, when no NGOs are active. It was imperative to bring together all these organisations who are often competing with each other owing to their different outlooks, ideologies, and philosophies. Also, by bringing all political organisations and giving them equal representation, the panchayat has ensured an excellent ground-level network that these organisations have used for the disbursal of schemes. Another observation was that the Sannadham registered volunteers primarily belong to one political party or the other, who has been continuously working with (for & against) the panchayat body for various local issues. Whatever be the take, the outcome was that an individual with no prior connections or party affiliation would be left out from the response activities, thereby reinforcing political ties as the 'proper' way to get things done within the panchayat.

The RRT formed mainly worked with the Community Kitchen, in the packing and delivery of food packets. In addition to this, they served as first responders and contact points for people wanting services within the panchayat. Further, the services of volunteers were sought to help with the activities of other departments and groups within the panchayat. The team held review meetings once every week. In hindsight,

[11] The All India Youth Federation – the youth wing of the Communist Party of India
[12] The Democratic Youth Federation of India – the youth wing of the Communist Party of India (Marxist)
[13] The Youth Congress is the youth wing of the Indian National Congress
[14] The Youth League is the youth wing of the Indian Union Muslim League
[15] The Yuva Morcha is the youth wing of the Bharatiya Janata Party

this team ensured a controversy-less response effort at the political front. As all political parties shared responsibilities, everyone was satisfied with the working of the RRT as well as representatives of other political parties within the RRT. Thus, from a consequentialist standpoint, the decision to organise the RRTin this manner turned out to be the right decision.

4.2.2 The group on Guest Workers

Another critical target group during Phase II of the response identified by the state government were the Guest Workers (the official term used to refer to Migrant labourers). A group consisting of the Panchayat President, Secretary and 2 Ward Members was formed in the panchayat to look at the issues of guest workers specifically. This group contacted each ward member to locate camps of the guest workers, visited each camp and took stock of the supplies there. There were 211 guest workers in the panchayat. The group also reported that there were bulk food supplies stored in the camps. The panchayat organised a meeting of contractors[16] of the guest workers. In this meeting, the contractors agreed that they would be responsible for their workers and would provide the required food materials to them. The decision was also in line with the state government direction that contractors should be the ones taking primary responsibility for their workers.

Still, there were 5 – 6 individual guest workers who were staying independently and one family whose contractor was unable to come due to the lockdown. The panchayat made arrangements to provide food materials to all these workers. Further, contractors were offered support as and when required to ensure food materials to workers.

4.2.3 The Community Kitchen Monitoring Committee

Handling accounting and logistics of the Community Kitchen is the mandate of the committee. The Welfare Standing Committee Chairman of the panchayat was the head of this committee. This committee was in charge of keeping the accounting books of the kitchen, which held three separate registers. The committee followed the direction

[16] Contractors are the people who bring the guest workers to the state to work under them. Usually, they are the ones who arrange the jobs, accommodation and other necessities for the workers.

of the government in the pricing of the meals – free for the identified vulnerable people, Rs. 20 for those who can pay and Rs.5 extra for home delivery. The committee was also in charge of procuring and storing materials for the operation of the kitchen. Materials to the kitchen were mostly through sponsorships. The committee had a constant oversight of the working of the community kitchen and took decisions on how the kitchen should operate. For example, initially, the kitchen was slated to produce two meals, one in the morning and one in the afternoon, daily. However, the registrations for the morning meals were very low, coming to single digits, in the first week. So, it was decided to provide food supplies to these families, and the kitchen stopped giving breakfast. From then on, meals were served one time – in the afternoon. The committee also kept track of the beneficiaries and ensured food is available for those who have registered. To ensure regular access to food beneficiaries were required to register with the panchayat and preference were given to registered beneficiaries over those who are unregistered. 120-150 packets of food were prepared daily, on average. The kitchen was started on the 26th of March and produced meals daily till it closed on the 3rd of May.

4.2.4 The Health Officials

Another crucial area of work for the panchayat which required diligence was the interfacing with the health department officials. Junior Health Inspectors were part of the initial meetings organised in the panchayat. Every day, the panchayat receives details of the statistics of people in quarantine within its borders from the health department, thereby keeping them in the loop. The health department has its network in place, consisting of ASHA workers.

In Phase I of the response effort, the emphasis was on quarantine. The panchayat and health officials were vigilant in this phase as there were students who were studying in China in the Grampanchayat. In phase II, little coordination existed between the efforts of the health department and the panchayat. The panchayat focused on addressing the issues of the socially vulnerable persons within its ambit. In contrast, the health department focused on the care of the medically vulnerable persons within its ambit. However, it is worth mentioning here that both panchayat and health department used the networks of the ASHA workers, Anganwadi workers and the volunteers. When the

State moved to Phase III, it mandated more extensive collaboration among the two groups in setting up of quarantine facilities for the returning expatriates and the surveying of facilities of those (originally from the panchayat) applying for return passes to the State. The panchayat has also mandated setting up of committees at the ward level comprising of the ward member, ASHA workers, Anganwadi workers, Health Inspectors and Retired Government officials to address any needs that may occur during the Phase III.

With these committees and responsibilities in place, it is really up to the community workers and organisations to ensure the reach and performance of the activities. The next sub-section looks at the response to these programs from the community.

4.3 The Response of the Community

This section examines the implementation of the framework set by the state government, which were concretised into workable plans by the Grampanchayat at the community level. It looks the various stakeholders in the implementation of the programs announced and how these ground level networks work with each other in getting the tasks executed.

4.3.1 The Community Kitchen

The Community Kitchen was the flagship program of the phase II response of the Kerala government, started on the 26th March. In the Kumaramputhur Grampanchayat, the community kitchen was set-up in an already existing Kudumbashree 'Ruchi' canteen on the premises of the panchayat office building. The Kerala government announced the community kitchens needs to function in association with Kudumbashree to leverage such hotels which already exist all across the State. In having an already existing hotel, the panchayat saved logistics charges and efforts in finding and collecting the infrastructure to start such a kitchen. An initial assessment was done in the panchayat to find those who required free food. Anganwadi workers surveyed the elderly (persons aged 60 and above). A decision was made to provide free food to all

families under the 'Ashraya'[17] scheme and also to elderly people living alone. In the panchayat, 80 households received one free meal per day. Including those who paid for the food, the kitchen produced 120-150 meals on an average per day in the afternoon. The traders of essential items, whose shops were allowed to be open during the lockdown, mostly relied on the paid food provided by the kitchen.

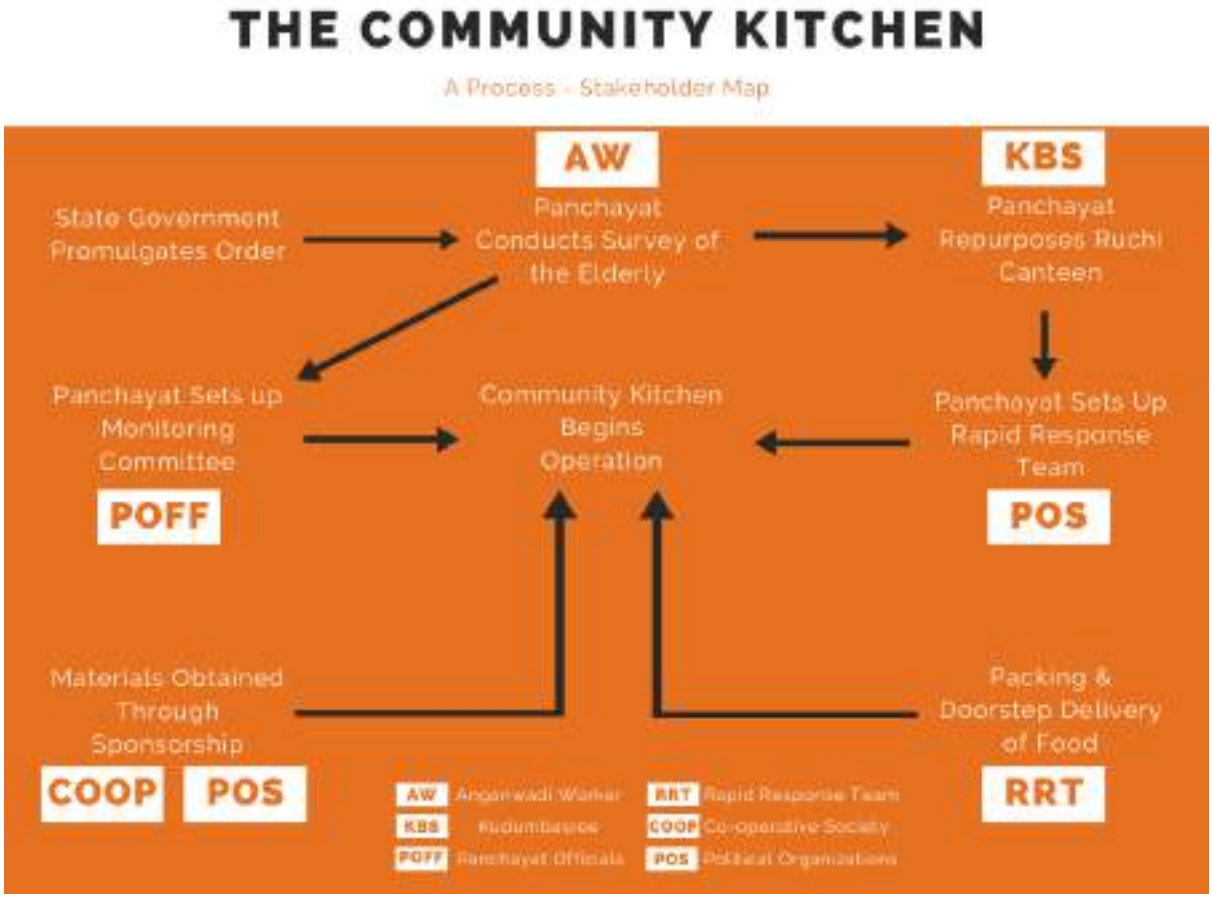
The panchayat is responsible for finding the funds required for running the kitchen. The government, in its direction, has encouraged to run the kitchens under sponsorship as much as possible. Sponsorship opened up the possibility of philanthropy which kitchen primarily relied on to procure materials for its operation. In Kumaramputhur Grampanchayat, the kitchen relied on materials sponsored by various organisations, institutions as well as individuals within the panchayat. The sponsorships usually come in the form of bags of rice, vegetables, pulses as well as chicken. People have also sponsored the cost of the working of the kitchen for a day. All political parties in the panchayat and co-operative societies supported either meals or materials to the kitchen. A few Kudumbashree units have also supplied vegetables required for the operation of the kitchen. Many individuals, private firms, traders and informal groups contributed to its working. A small amount had been taken from the panchayat development fund to procure small amounts of some materials like Dal in the early days. Still, there has not been any day where an adequate amount of materials were not available and at no point has the panchayat had to look for emergency sources of income or divert funds from any other program or department.

The kitchen was a unifying factor for all response efforts on the ground. As can be seen in Fig. 4.3.1 (a) below, it had a wide variety of stakeholders in various stages of its operation. The Anganwadi Workers, Kudumbashree Units, Rapid Response Team, Panchayat Officials, Political Organisations and Co-operative Societies played critical roles in its function. The canteen operated within the premises of the panchayat

[17] Ashraya is a scheme under the Kudumbashree which identifies destitute families and offers rehabilitation. The scheme was operationalized in 2002. Families were identified by the Neighborhood groups of Kudumbashree, verified by their Area Development Societies, eligibility checked at the Community Development Societies and finally approved by the Grampanchayat. For more details, refer https://kudumbashree.org/pages/795

building. Therefore, it made the building the literal epicentre of response operations during phase II.

Figure 4.3.1 (a) Process-Stakeholder Diagram of the Community Kitchen



The community kitchen was closed on May 3rd, which was the last date of the second lockdown period. One of the main reasons given for the closure is that the committee saw no dire requirement for the continuation of the kitchen given the better conditions within the Panchayat. Another reason cited is that financially it was becoming infeasible to run the kitchen as sponsorships had started drying up and extra funds were hard to find. However, the kitchen ran successfully for 38 days relying mostly on support received from the community in the forms of money, material and human resources.

4.3.2 Break The Chain

'Break the Chain' conceived as a community driven campaign, was directed to individuals, organisations and institutions in the community to stop the spread of the virus. It elicited participation within all quarters of the panchayat, as shown in Fig. 4.3.2

(a). The officials did not have to take any explicit, forceful enforcement actions to ensure the success of the scheme. The health officials did monitor the overall implementation of handwashing facilities and disinfection campaigns, but at no stage did any enforcement have to take place.

Figure 4.3.2 (a) Stakeholder Diagram of Break The Chain

The Campaign initially slated to run only for 14 days. Still, it has transcended that period and continued to be a part of the community efforts throughout the different phases. The use of masks and hand washing has started to become a routine activity in the lives of the people, indicating a measure of success of the efforts undertaken in the community related to the program.

4.3.3 Containment & Awareness Efforts

One can analyse the Containment & Awareness Efforts in the panchayat in the same three phases employed for the analysis of the effort of the state government.

In Phase I, the Corona Response Guidelines was promulgated by the state government very early in the response effort. The response within the panchayat also got off to a quick start as there were people who were home-quarantined during the first china-centric wave within the panchayat. These were some medical students who had returned from China. During this phase, the focus was on identifying people who had come back from outside the country and keeping them quarantined. The health officials also started awareness campaigns in this phase, like the 'Handkerchief campaign' centred around schools; revived in the COVID scenario, although initially designed as part of the anti-Tuberculosis campaign. As part of this, health officials held sessions within schools in the panchayat to promote the use of handkerchiefs while sneezing and coughing, thereby arresting the spread of droplets.

Phase II marked the spread of infection across Kerala, which was a direct result of people returning from outside the State and abroad. In response, stricter surveillance measures, for those returning and mandatory home quarantine for 28 days, was adopted. The health officials coordinated with ASHA and Anganwadi workers to collect information and monitor cases. People breaking quarantine were warned, and the police arrested perpetual offenders. The ASHA workers were responsible for monitoring those in quarantine. If anyone showed symptoms, an Ambulance was available by dialling 108. They would be taken to the Taluk Headquarters Hospital to take a swab and would be dropped back to their homes in the ambulance. The result would take three days to arrive, and according to test results actions were taken. The panchayat also undertook awareness measures during this phase. Panchayat conducted announcements on COVID prevention measures in all neighbourhoods. Information relating to Break the Chain as well as the importance of the lockdown, physical distancing and the importance of staying indoors made rounds. There were also efforts made by the panchayat representatives to visit the SC and ST colonies and give awareness about the pandemic as well as the lockdown situation. As the lockdown progressed, inter-district travel was banned. Therefore, anyone found breaking this travel restriction was moved to institutional quarantine in Corona Care centres under the district administration. There were cases in the panchayat of quarantining people who tried to reach Tamil Nadu border by foot, and those who have travel history to other districts. Such measures were

adopted to allay fears within the community. As an ASHA worker recounted an incident, “A vegetable vendor in Kulappadam went to Coimbatore to bring vegetables early in the morning one day without informing anyone. Somehow this information got out into the community, and a mob assembled to destroy the vegetable shop that he ran. Both health officials and police had to intervene to maintain order and moved him into quarantine”. Such incidents show the necessity of safe and efficient quarantine to ensure the well-being (both mental & physical) of the community.

In Phase III, the focus again shifted from lockdown and preventing community spread to containing the virus at the borders of the State. Unlike Phase I, however, the local government and health officials in the panchayat had a larger role in the response effort, by assessing the material situation of the applicants before they even entered the panchayat. The focus was heavily on preventative measures and stopping the virus at the source. This phase also required better coordination between the LSG and health officials, both in the assessment as well as setting up quarantine centres within the panchayat; panchayat established two centres in schools. ASHA workers were deployed in the panchayat to survey all the expatriates in their area. Anganwadi workers also supported the survey. Survey results were submitted to the Panchayat to facilitate necessary monitoring. During Phase III, the State demanded additional responsibilities from ‘Sannadham’ volunteers. For instance, in a meeting convened by health officials, volunteers were asked to be ready to work in quarantine centres, in case of human resources shortage.

In all the three phases, the panchayat did not report any COVID positive cases. Due to this, the panchayat never fell into the red zone category, although three adjacent panchayats were in red zones at one point in Phase II.

4.3.4 The Assurance of Food

While the community kitchen assured cooked meals for the most vulnerable sections within the panchayat, the state government has also announced 10 kg of free rice to all families within the State, through ration shops. The distribution of this free rice was done in a phased manner to avoid crowding at the ration shops. Towards this purpose, days of ration disbursal was arrived based on the last digits of the ration card number.

For instance, weaker sections were allotted the morning slot and others the afternoon slot. In addition to rice, the Civil Supplies Corporation provided a grocery kit consisting of 17 items including Wheat, Dal, Urad Dal, Pulses, Sunflower oil, Coconut Oil, Salt, Toilet Soap and Washing Soap free of cost to all ration cardholders. Distribution was in a phased manner, with the beneficiaries of the Antyodaya Yojana[18] receiving them first, followed by the BPL sections and the others receiving last. The packing of these kits required a lot of manpower as there were more than 10,000 beneficiaries within the panchayat. The civil supplies corporation delivered the materials in bulk. These had to be separated, weighed, classified, packed into separate kits and then assembled into a single kit of 17 items. The AIYF voluntarily did this task within the panchayat, which took 30 workdays to complete.

Anganwadis under the ICDS scheme continued to attend to the nutritional needs of children under six, pregnant & nursing mothers as well as adolescent girls. As per the state government directions, the Mid-Day Meals was to be home delivered to children registered under Anganwadis. However, the panchayat did not implement this. Instead, once in 15 days materials for cooking, rice, wheat, oil and pulses, were given to households. Those who could come to the Anganwadi collected from materials, while for others home delivery were arranged. Supplies, such as wheat, ragi and pulses, were also provided to pregnant women and nursing mothers.

In addition to these three government mechanisms of Community Kitchen, Public Distribution System and ICDS, several organisations and groups took it upon themselves to ensure vulnerable sections receive sufficient food materials. The distribution of food and vegetable kits was an activity taken up by various community groups within the panchayat. The process commonly involved pooling or collecting donations for the money required, then buying in bulk, segregating the items into single kits containing each item, identifying eligible beneficiaries and finally delivering them to the said beneficiaries. In the distribution, Souhrudham Arts & Sports Club, Youth

[18] It is a scheme to provide highly subsidized food to the poorest of families.

Congress, Kudumbashree Neighborhood Groups and a few informal neighbourhood/friendship groups in the panchayat were involved.

4.3.5 The Assurance of Medicine

Another vulnerable group affected by the lockdowns in Phase II was the medically vulnerable population. These include the pregnant & nursing mothers, those under treatment for lifestyle/age related diseases and palliative care patients. The health officials coordinated the care activities for this section through the Community Health Center. The list of all under the medication and palliative care were available with the Health Center. Anganwadi workers surveyed those above 60 years. ASHA workers were responsible for collection and delivery of the required medicines from the Health Center to the patient's home, as well as monitoring the health of these patients and act as first contact points in case of any immediate need. To this end, ASHA workers created Whatsapp groups of family members of the patients to facilitate better communication. The ASHA workers routinely took the help of the Rapid Response Team members for medicine delivery.

The Banking Co-operative also played an emergency role in this effort when the Health Center ran out of medicines a few weeks into the lockdown. The Health Center then requested the co-operative to help by sanctioning emergency funds for buying medicines. The bank not only sanctioned Rs. 15,330, but also purchased the required medicines and delivered them to the Health Center.

Anganwadi workers also play a crucial role in ensuring the nutrition of the demographic they serve, as mentioned in the preceding sub-section. In addition to this, they also offer counselling services to women. Due to the lockdown, these counselling activities had not stopped but shifted to the telephonic medium.

Other organisations have also delivered medicines for those who were undergoing treatment, but not with the Community Health Center. The Rapid Response Team members and The Fire Force were at the forefront of this medicine delivery. They take the prescription and money from the patient, go to a required medical dispensary, buy the prescribed medicine and deliver them to the home of the patient. While the Rapid

Response Team members limit themselves to this panchayat and the neighbouring ones, the Fire Force has been able to deliver medicine which was only available from other Taluks or even other districts.

In health efforts, workers heavily rely on the cooperation of the public. For monitoring of quarantined and vulnerable cases, ASHA workers heavily rely on family members or neighbours to provide any updates to them as they happen. If anyone breaks quarantine, the neighbours are relied upon to report to the ASHA worker. As an ASHA worker stated, “There have been cases where people coming from out-of-state do not report voluntarily to the worker anxiety and sadness for the workers.” An effective community network is essential in the functioning of these response efforts.

There has also been blurring of roles on the ground when people tend to contact workers for help which they are not officially responsible. Since all these organisations and structures work in closely with each other, they often take charge of relaying the tasks to one another. A primary reason for the blurring of roles results from the fact that the same person serves multiple functions in the community. ASHA/Anganwadi workers may also have membership in Kudumbashree or elected Ward Member serves the role of ASHA worker/Kudumbashree Member/Anganwadi worker. Similarly, RRT members may be working in a Co-operative Bank, many with are affiliation in political organisations or/and active in Arts & Sports Clubs. Such multiple roles often result in better co-operation between different organisations at the time of crisis. Another reason could be that the above organisations and programs work closely with each other as well as with the panchayat. Also, being a rural area, the community is close-knit. These two reasons lead to people knowing each other well. Anganwadi workers, ASHA workers, Kudumbashree leaders and political workers know each other both personally and officially.

Close communication and blurring of roles are illustrated in a case described by an Anganwadi worker where a person in the purview of her locality required medicines. The mandate of the Anganwadi worker did not include any medicine-related work. Still, the person chose to contact her probably due to the familiarity of the community with the worker. The worker relayed the request to the Ward Member, whom she had worked

with before and knew well. The Ward Member was herself an ASHA worker and understood the process of medicine delivery well. Still, the requirement was not for a person who was under the treatment of the Community Health Center. So, she provided the number of a Rapid Response Team member (who was a member of the same political organisation) to the Anganwadi worker. The Anganwadi worker already knows the RRT member and relayed the request to him. The RRT members were already fulfilling similar requests for medicine delivery all over the panchayat. So, he was able to address the request promptly. The case effectively shows how various mechanisms envisioned as separate verticals work well together and blend while acting at the ground level.

4.3.6 The Financial Assistance Schemes

One major factor that set apart the COVID-19 pandemic the previous ones the State has experienced is the economic impact of the long-term lockdown and physical distancing norms. The global nature of the economic slowdown only accentuates the crisis faced at the local level. The vast network of banking co-operatives and that of Self-Help Groups of Kudumbashree can help in the recovery of the local economy. There are two financing co-operatives within the panchayat, The Kumaramputhur Service Co-operative Bank and The Kumaramputhur Co-operative Housing Society. These two co-operatives combinedly donated Rs. 30,60,000 to the Chief Minister's Disaster Relief Fund.

The loan schemes announced under these three organisations are as follows:

1. The Chief Minister's Helping Hands Loan Scheme - The primary form of relief coming through the Kudumbashree structure is a scheme announced by the state government, which gives a loan of up to Rs. 20,000 for a member of Kudumbashree. The rate of interest is 9 per cent with a period of repayment of 3 years. There is a moratorium for three months. After this period, monthly instalments have to be paid back for three years. If the group pays all the instalments on time, the government will pay back the 9 per cent interest to the group, essentially making it an interest-free loan. Initially, the government had allotted nine crores to each panchayat as the cap for these loans, but

subsequently, reduced to 2 crores. Almost 260 neighbourhood groups have applied for the loan, with total individual applicants being 2740. However, due to shortage of funds, the panchayat capped maximum limit of individual loans at Rs. 7,100 and much lower than Rs. 20,000 announced.

2. Both Financing Cooperatives offered interest Free Gold Loans in the panchayat for six months. One offers up to Rs.20,000 while the other up to Rs.25,000. More than 60 applicants have already availed these loans.
3. Trade loan was offered by the Kumaramputhur Service Co-operative Bank, for its members who are traders. A trade license and recommendation from KVVES[19] is required, along with two persons standing as surety. Up to Rs.50,000 can be borrowed, with a moratorium for the next three months. It is necessary to make monthly repayments for a year from September 2020. Eighteen traders have applied within the first eight days of May.
4. The Kumaramputhur Service Co-operative Bank offered expatriate Loan for its members who are in foreign countries. The primary aim was to help those who have either returned due to job loss or stuck in the middle-eastern countries due to lockdown post January 1, 2020. A copy of Visa and Passport has to be provided, either physically or via E-mail. Up to Rs.50000 can be borrowed, with a repayment period of 2 years. Twelve applications have come in the first eight days of May.

The State also had decided to disburse the welfare pensions for two months in March. Therefore, the beneficiaries received the assistance from December 2019 to April 2020 in one go in March, which amounted to Rs. 6,100. Co-operative banks are the primary means of disbursing the welfare pensions in the State. The Kumaramputhur Service Co-operative Bank undertook the disbursal of welfare persons through its 18 agents in the 18 wards. Disbursal was completed well before the State went into lockdown.

[19] Kerala Vyapari-Vyavasayi Ekopana Samithi is an organization of merchants formed in 1978

4.3.7 Some Miscellaneous Activities and Experiences

- An allied activity carried out was the distribution of vegetable seeds for cultivation in one's home. The seeds were available through the Krishi Bhavan and distributed by the Rapid Response Team Members. The members made use of social media platforms to announce that whoever wanted the seeds could contact them. Then, they delivered the seeds to those who did contact. The Kumaramputhur Co-operative Housing Society provided another set of seeds, and the DYFI took up the task of distribution of these seeds. As a supporting activity to the seed distribution, Kudumbashree units prepared and distributed grow-bags for planting the seeds.
- During phase III, preparing for monsoon was undertaken. The workers survey houses for spots where water can stagnate, which can serve as mosquito breeding grounds. Bleaching powder is mixed in wells to disinfect them. Presently, all these activities are done, ensuring physical distance and with the necessary precautions.
- Both the banking co-operatives employ 'Day Collection Agents' who visit beneficiaries of the bank to collect rent daily. They are paid a monthly commission according to their collection. However, they could not operate during the lockdown. As a relief measure, the State Co-operative department had ordered to pay commissions for collections in January and February up to Rs.10,000 as salaries for March and April. Both the co-operatives have followed this direction and have paid their collection agents.
- The local library started the home delivery of books when requests came in from a few of its members. The delivery of books was done on Sundays, in teams of 2 or 3 usually comprising the committee members of the Library. A person can request books by calling through phone or messaging via Whatsapp. Although the area covered is within the 7^{th} and 8^{th} wards of the panchayat, the committee was ready to deliver if specific requests come in from other wards. Even non-members were provided with the book delivery service. At the time of this research, local library supplied 250 books to 40-45 houses as part of this initiative.

While it is beyond the scope of the study to infer on the efficiency of panchayat level initiatives, some comments from respondents are presented. It was thought essential to note these comments, leaving it open for the readers to interpret.

"The finances of the bank have not been affected due to slowdown in the last three months. However, we expect it will hit us hard in the next financial year. There will be a lot of loan defaults. That will be a large blow for us." – *Co-operative Bank Employee*

"I won't say everyone has been very active. Look at the village office. It has not opened for a single day. Even the Krishi Bhavan is open only occasionally. Such things are always going to be there." – *Panchayat Official*

"Other activities are being done in the panchayat by other organisations as well. The packing of the ration grocery kits is being done solely by the AIYF. That might be because it is an initiative of the civil supplies department" – *CPI(M), Member*

"I believe there are people who are not old and yet have no means of food right now. Look at family of X. A single mother earns for three children, now that income is also unavailable. They also should have been given free food." – *Kudumbashree Member*

"In my view, the ICDS has not been that active in the panchayat. I intend to raise this in the next meeting. I view this as a fault with the panchayat level officers of the ICDS." – *Panchayat Official*

"When we call up people through the telephone for surveys, people always ask what they are going to receive as part of this. We are seen as harbingers of some new benefit" – *Anganwadi Worker*

"You should have seen the grocery stores on the night before the Janata Curfew[20]. There was a huge rush. People thought they wouldn't be able to get anything after a few days. It's a good thing the state government provided many provisions for us." – *Co-operative Bank Employee*

"One grievance is that some members of the public have paranoia towards volunteers. They are exalting people to stay away from us as well as making comments at us. For

[20] A one-day curfew / lockdown announced by the central government on 22nd of May.

who have chosen to put the society above themselves and work, this is extremely painful. There was no awareness built on it in the larger society" – *INC Member*

"Now, the community kitchen has also stopped working. What will they do? Now food is being given to them from the canteen of the nearby hospital. What else can be done?" – *Kudumbashree Member*

"During the last floods also, we had contributed to the Chief Minister's Disaster Relief Fund. The cuts to compensate for that were still ongoing. May was the last month for the cuts to compensate for it. Now since we have contributed again, another round will start." – *Co-operative Bank Employee*

"A few people, especially women, have informed that they could continue reading if books could continue to be delivered even after the lockdown. The familial and societal conditions make it difficult for them to come to the library and pick out books to take back home. So, we are contemplating the continuation of the book delivery program into the future. The committee is also expecting an increase in membership after the lockdown due to this initiative." – *Library Committee Member*

4.3.8 An Overview in Tables

(a) Engagement with state mechanisms within Kumaramputhur Panchayat

	Community Kitchen	Break The Chain	Ration Distribution	Welfare Pension Distribution	Care of vulnerable patients
Panchayat Officials	**D**	**D**	**I**	**N**	**I**
Rapid Response Team	**D**	**I**	**D**	**N**	**I**
Health Officials	**N**	**D**	**N**	**N**	**D**
Kudumbashree Units	**D**	**D**	**N**	**N**	**I**
ASHA Workers	**N**	**D**	**N**	**N**	**D**
Anganwadi Workers	**I**	**I**	**I**	**N**	**D**
Banking Co-operatives	**I**	**D**	**N**	**D**	**I**

Political Organisations	**D**	**D**	**D**	**I**	**I**
Arts & Sports Clubs	**N**	**N**	**N**	**N**	**N**
Library	**N**	**N**	**N**	**N**	**N**

D – Direct Engagement; I – Indirect Engagement; N – No Engagement

(b) Target Sections of Activities done by various groups in the response effort

	Persons with medical vulnerability[i]	Persons with socio-economic vulnerability[21]	Guest Workers	General Public
Panchayat Officials	**No**	**Yes**	**Yes**	**Yes**
Rapid Response Team	**Yes**	**Yes**	**Yes**	**Yes**
Health Officials	**Yes**	**No**	**No**	**Yes**
Kudumbashree Units	**No**	**Yes**	**No**	**Yes**
ASHA Workers	**Yes**	**No**	**No**	**Yes**
Anganwadi Workers	**Yes**	**Yes**	**No**	**No**
Banking Co-operatives	**No**	**Yes**	**No**	**Yes**
Political Organisations	**Yes**	**Yes**	**Yes**	**Yes**
Arts & Sports Clubs	**No**	**Yes**	**No**	**No**
Library	**No**	**No**	**No**	**Yes**

[21] Includes Persons with existing medical conditions or in need of medical surveillance including requirements related to old age and pregnancy
[22] Includes Persons belonging to marginalised sections along the lines of Caste, Class and Gender

(c) Phase-wise Summary of activities done by various groups in the response effort

	Phase I	Phase II	Phase III
Panchayat Officials	Overview of Quarantine Cases	Coordination of activities for socially vulnerable sections	Setting up and monitoring quarantine centres as well as the returnees, Break The Chain
Rapid Response Team	None	Community Kitchen Medicine Delivery	None
Health Officials	Quarantine, Awareness	Quarantine, Awareness, Monitoring, Break The Chain	Setting up and monitoring quarantine centres as well as the returnees
Kudumbashree Units	None	Food Kits, Growbags, Loan	Loan
ASHA Workers	Monitoring	Monitoring, Medicine Delivery	Monitoring
Anganwadi Workers	None	Ensuring Nutrition, Counselling sessions, Survey	Survey
Banking Co-operatives	None	Loans, Sponsor of Community Kitchen, Break The Chain	Loans, Break The Chain
Political Organisations	None	Community Kitchen, Break The Chain, Food Kits, Ration packaging, Support for RRT Members	None

Arts & Sports Clubs	None	Food Kits	None
Library	None	Book Delivery	Book Delivery

(d) Summary of Activities undertaken in the Panchayat

Panchayat Officials	Community Kitchen, Break The Chain, Meetings with various stakeholders, Setting up quarantine facilities, Forming the Rapid Response Team, Awareness Efforts
Rapid Response Team	Community Kitchen, Food Delivery, Medicine Delivery, Helping Health Officials with Break The Chain, Disbursal of Seeds
Health Officials	Break The Chain, Quarantine & Awareness efforts, Monitoring the medically vulnerable
Kudumbashree Units	Community Kitchen, Mask Production, Growbag production
ASHA Workers	Quarantine Monitoring, Surveying, Monitoring Medically Vulnerable, Medicine Delivery
Anganwadi Workers	Food Material Distribution, Surveying, Monitoring Medically Vulnerable, Counselling
Banking Co-operatives	Community Kitchen Sponsors, Special Loans for affected sections, Distribution of Masks and Sanitisers
Political Organisations	Community Kitchen Sponsors, Rapid Response Team members, Mask Production, Seed Distribution, Disinfection, Ration Packaging
Arts & Sports Clubs	Food Kit Distribution
Library	Home Delivery of Books

5. Conclusion

The study conducted has revealed the varying nature of Kerala's response to the pandemic according to the material realities brought about by the onset and spread of the virus. Broadly, responses could be categorised as evolved in three phases. Each phase differs from one another in the focus, nature as well as the stakeholders involved in the activities. While Phase 1 focused on the quarantine & awareness under the health department, Phase II split the focus between quarantine activities, the protection of socially vulnerable persons and the protection of medically vulnerable persons. Phase III brings it back to entry point detection and early containment, with more significant roles given to the local bodies in the containment process.

The study finds that while the state government planned the nature and framework of the response procedures for the entire State, it is the local self-governments that concretised the plans by transforming it according to the social realities with their region. So, the same program implemented through different mechanisms within the same State. Decentralised governance prevalent in the State for the past three decades, has shaped both the state and local self-government in this mutualistic relationship.

The study also points to the importance of community groups and organisations including those belonging to community intervention programs of the state, particularly the Kudumbashree, ASHA and Anganwadi workers, in the response effort. While the panchayat may be responsible for detailing the plan, it is heavily reliant on the community structures actually to execute them. Further, in the case of the Kumaramputhur Grampanchayat, political organisations have taken the leading role in the interfacing of the panchayat and the people.

The State machinery provided the institutional back up to carry out various COVID related activities and interventions in the community. The participation of multiple organisations in the Community Kitchen, Break The Chain, Food security and Community Health interventions of the State substantiate this argument. It also needs to be noted that individual philanthropy, informal groups and non-government organisations also did play a role in supporting government efforts.

Reading results of this study and the statistics of COVID infections in the State in a comparative perspective, it might be safe to say a community centric, decentralised, participatory, the public model of pandemic response is the one which is better equipped to deal with such crises.

References

COVID-19 Kerala. [@COVID19_Kerala]. (n.d.). *Messages* [Telegram Channel]. Telegram. Retrieved April 24, 2020, from https://t.me/COVID19_Kerala

COVID-19 pandemic in Kerala. (n.d.). In *Wikipedia*. Retrieved May 15, 2020, from https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Kerala

Elamon, J., Franke, R. W., & Ekbal, B. (2004). Decentralisation of health services: the Kerala people's campaign. *International Journal of Health Services*, *34*(4), 681-708.

Government of Kerala. (2020, May 15). *Kerala: COVID-19 Battle.* Retrieved from https://dashboard.kerala.gov.in on May 15, 2020

Isaac, T. T., & Harilal, K. N. (1997). Planning for empowerment: People's campaign for decentralised planning in Kerala. *Economic and Political Weekly*, 53-58.

Jacob, J. (2020, April 18). How Kerala Flattened The Curve. *India Today.* Retrieved from https://indiatoday.in

Kuriakose, F., & Iyer, D. (2016). Documenting Democratic Decentralisation in Kerala with Special Reference to Services to Children Under Six: Case Study of Malappuram District, Kerala, India. *Kerala, India (May 8, 2016)*.

National Health Mission. (2009). *Kerala State Report.* Retrieved from https://www.nhm.gov.in/images/pdf/nrhm-in-state/state-wise-information/kerala/kerala_report.pdf

Rahim, A. A., & Chacko T. V. (2019). Nipah outbreak in North Kerala – What Worked? Insights for future response and recovery based on examination of various existing frameworks. *Indian Journal of Public Health 2019;*63: 261-264

Seema, T. N. (2001). *Performance of Anganwadi Centres in Kerala: An evaluation and experiment to develop a model centre with community participation*. Kerala Research Programme on Local Level Development, Centre for Development Studies.

Shailaja Teacher, K. K. [kkshailaja]. (n. d.). *Posts* [Facebook Page]. Facebook. Retrieved April 24, 2020, from https://www.facebook.com/kkshailaja

Thomas, M.B., & Rajesh, K.B. (2011). Decentralisation and Interventions in Health Sector: A Critical Inquiry into the Experience of Local Self Governments in Kerala.

Vijayan, P. [PinarayiVijayan]. (n. d.). *Posts* [Facebook Page]. Facebook. Retrieved May 15, 2020, from https://www.facebook.com/PinarayiVijayan

Williams, G., Thampi, B. V., Narayana, D., Nandigama, S. & Bhattacharyya, D. (2011). Performing Participatory Citizenship – Politics and Power in Kerala's Kudumbashree Programme, *The Journal of Development Studies*, 47:8, 1261-1280, DOI: 10.1080/00220388.2010.527949

World Health Organization. (2020, April 20). *Rolling Updates on Coronavirus Disease (COVID-19).* Retrieved from https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happ