COVID-19 Second Wave and Cities

Photo: AIDMI.

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ABOUT THIS ISSUE

The second wave of the COVID-19 pandemic hit India in the beginning of April 2021. What followed were two months of a dystopian nightmare unfolding in India's cities where the outbreak of the virus was so widespread and complete that hospitals ran out of space to accommodate the ever-increasing number of patients, crematoriums ran out of space to burn the piling dead bodies, harried family members of the sick ran from pillar from post to procure oxygen cylinders and the newspapers were filled with an interminable list of daily obituaries.

While the anger against the systemic failure of cities was palpable among the masses, the only silver lining to this dark cloud emerged from spectacular performance of private citizens and citizen groups in alleviating the suffering. Twitter, Instagram, WhatsApp and Facebook all became mediums to raise requests and forward leads to hospital beds, medicines and oxygen cylinders. Many people volunteered their time and resources in procuring the necessary lifesaving medicines and equipment for others.

This issue of *Southasiadisasters.net* is titled 'COVID-19 Second Wave and Indian Cities' and highlights how India's cities were impacted from the second wave of the pandemic. In doing so, there are also indispensable lessons to be imbibed on how to be better prepared for any upcoming wave of the pandemic. Themes of social justice, inclusion, citizen empowerment, food security, water security, shelter security, livelihood security as well as the idea of empathy in the urban setting permeate all the articles included in this issue.

If India's cities need to protect themselves from the onslaught of another wave of the pandemic then the lessons highlighted in this issue need to be remembered well. ∎

COVID-19 SECOND WAVE AND CITIES

Crying for Justice in Cities

*By **Mihir R. Bhatt**, AIDMI, Ahmedabad, India*

"My son died not because of lack of medicine or hospital or money, but because of the continued injustice that we have faced in this city", said the casual labourer from Chitrakoot in Uttar Pradesh who lost his son to COVID-19 Second Wave in Ahmedabad.

"We have faced injustice everywhere, in our wages, in our access to health, in having access to enough food, in being able to find a safe place to live, and in our access to water for our daily ablutions", he added.

And this injustice is not limited to cities in India, as Sameera Noori from Kabul reports.

What more can be said about the avoidable Second Wave of COVID-19 in cities of India? One can call for more awareness among the city dwellers about the protective measures. One can demand more direct investment in public and community health and shelter for the next twenty years. One can call for performance rating of plans, or the lack of plans, for the city governance of the pandemic; and one can aim to build ways to participate in the process of city preparedness. But none of the above is enough for almost any city of India. Cities continue to be unjust to its citizens, especially the poor and vulnerable citizens. Banashree Banerjee gives us a direction to think about this.

What is needed is a new look at our cities by the authorities, businesses, and civil society so that cities do not only prosper, not only be inclusive, but also be just: just to its own citizens, all citizens, men and women and all other human beings, and also to non-human living beings.

This separation of health and wellbeing from the other remaining aspects of any city is no longer a valid approach to just cities. Kavita Anand points to education as one ways to start thinking about justice in cities.

Just cities reach out to all citizens, at all times, across all sectors, in all circumstances, and make special efforts to put the last living being first. Our cities do not do so. The Second Wave is not the last wave as is pointed out by Dr. Paromita Chakraborty.

There is no justice possible in our cities without love for one's self and same love for others, as there cannot be any love without justice. It is love for our cities and all citizens that lets our heart speak justice. And one way is to plant the seed of justice in the local resilience capacities that Duncan Shaw and David Powell suggest.

Cities most actively offer justice to its citizens: in family, across each other, and in relation to nature. Our cities can do more on this count when you read Arvind Unni and others in this publication.

We cannot have our cities turn away from justice, marching into a wilderness of human spirit so violent that we may not find our way to justice. This is possible as we saw that our cities stand away and aloof as millions of workers marched out to safety without due wage payment, food, water, and a hope during the lockdown. We cry for return to justice in our cities. ∎

Responding to the Second Wave of the COVID Pandemic in Indian Cities

*By **Aravind Unni,** Thematic Lead, Urban Poverty Reduction team;*
***Proshin Ghosh,** Capacity building coordinator – Climate Change Innovation and UDRR; **Savita Verna,** Capacity building coordinator – Community Led Action and Youth Leadership; Indo Global Social Service Society, New Delhi, India*

We are nearing the end of the second wave in India, and it was barely a month ago that India had peaked the COVID-19 pandemic and was clocking more than 400,000 cases and 4000 deaths a day. Like the first wave, the surge in cases brought to the fore the lack of health care infrastructure and preparedness. However, the second wave was also different in many respects from what transpired in the last year. There was no official pandemic related centralised 'lockdown'; therefore, the state responses, particularly to the needs of the marginal and poor, were limited in scale and types, thereby exacerbating the economic losses and marginalisation of the poor. The images of migrants who had gone back to their States of origin from big cities in 2020 again came to public memory, but not at the same scale. Despite measures to control the current pandemic and a more state-level decentralised approach at handling the pandemic, lack of preparedness in the urban areas remains the biggest stumbling block for this and the subsequent COVID pandemic we await.

Indo-Global Social Service Society (IGSSS), along with its partner networks in cities, analysed the situation and identified the following as the significant challenges for working with the urban marginalised population – first, Health infrastructure is increasingly inadequate and needed immediate augmentation; Second, urban livelihoods suffered increasingly as lockdowns halted mobility and incomes in numerous states; Third, the crisis has brought about access to food and basic necessities as a major concern in select population groups that are marginal and undocumented – like urban homeless, migrants, minorities and other excluded groups. Fourth, the misinformation on COVID has seeped deep into communities through social media – WhatsApp leading to stigma and vaccine hesitancy. Fifth, lack of information flow and emerging situation of changing guidelines, regulations, helplines and so on were not available to the people. Finally, the absence of strong and decentralised local institutions in the rural areas like PRIs was missing altogether in the cities. Also conspicuous by the absence was the lack of trained volunteers and task force teams as part of preparedness teams for disasters.

IGSSS response and intervention framework in the COVID second wave response for the most vulnerable urban poor, COVID-affected population in 13 cities

Distributing of dry ration and hygiene kits in Guwahati Assam. These relief distribution exercises are also used to spread awareness on COVID appropriate behaviour and vacation.

located in 9 states of India. The intervention focused on three broad objectives at three levels and scales. First, to ensure Increased availability of nutritious food and sanitation kits to 20000 targeted urban poor and vulnerable households to ensure food security and safety through the provision of emergency Food Relief, Hygiene Kits at the family / individual level. The lists were prepared with community participation, and doorstep delivery was executed mostly with trained community volunteer task force. The selection criteria were based on numerous marginality parameters identified and shared beforehand to identify the neediest objectively. Second, supporting 150 urban poor communities to have facilitated access to awareness towards COVID, vaccination, sanitation, micro containment measures at the community level and early detection of infection with support to COVID infected families. This was executed by developing a community task force through community helpdesks

led by the community youth guided by city-level teams. This effort required community-level preparedness meetings and plans, with the training of volunteers on disaster preparedness and psycho-social support for effective implementation. Third, at the city level, the intervention included facilitating awareness campaigns and actions for information through helplines. These acted as voluntary coordination centres managed with local CSO networks and collaborated with disaster management agencies for a coordinated response. The main aim at the city level was to keep the information flowing from the communities to city level CSO coordination forums and sharing with authorities for immediate redressal. The helplines also provided critical support to people in distress and sent in coordinated CSO support where required. IGSSS also is playing a critical role as one of the key members in the NGO coordination group established by National Disaster Management

Authority (NDMA) and actively sharing national – state level developments with over 200 CSOs working in the urban areas to guide for more coordinated COVID response.

Going forward, IGSSS and its partner networks wish to institutionalise these voluntary arrangements as part of city disaster preparedness and its plans. We hope to engage within the framework of disaster preparedness and aid cities to draft their disaster mitigation plans ground up with community participation, with the inclusion of marginal groups and their needs. Also, to build trained community volunteers with basic knowledge on disaster response, who can in times of need reach out and support communities in times of crisis. Thereby, hoping to develop numerous informal settlements as model settlements showcasing disaster preparedness lead by people themselves. ∎

URBAN INNOVATION

May this be the Last Wave of COVID-19 in India

By **Dr Paromita Chakraborty,** *Associate Professor, SRM Institute of Science & Technology, Chennai, and*
Dr Girija Bharat, *Director, Mu Gamma Consultants Pvt Ltd., India*

Several countries have reported wastewater-based epidemiology (WBE) as a useful tool to assess the prevalence of the SARS-CoV-2 virus in sewage treatment plants (STPs). WBE gives a broad estimate of the spread of infection in the associated catchment population, in an early and cost-effective manner. A study on wastewater surveillance for detection of SARS-CoV-2 in the raw sewage/sludge samples of STPs, sewage pumping stations (SPS) and in the surface water of Adayar and Cooum rivers and canals in Chennai

city during the partial and post-lockdown periods in July-October 2020, gave interesting insights of the potential use of WBE as an early warning system and instrument to inform public health policies.

SARS-CoV-2 genetic material is seen to be present in the influent of STPs, river water in Chennai city. Furthermore, the presence of caffeine, carbamazepine, and other pharmaceutical and personal care products (PPCPs) in these samples suggest that the samples were from

direct discharge from the surrounding population. Caffeine showed concurrence with the viral load even in diluted condition. Monitoring and surveillance on a regular basis can alert and help us prepare for likely onslaughts in the future- the third wave, new strains of the virus, or other viral infections.

As we have recently seen, the second wave of COVID-19 has hit India very hard, stretching its health care infrastructure beyond limits. As on 30th May, 2021, the cumulative

confirmed cases of COVID-19 are 27.89 million and 325,972 deaths (WHO). The recent news of a large number of COVID-19 infected dead bodies floating in the river Ganga is a wake-up call for concerted action by all stakeholders, so that this pandemic does not create further havoc to the public health.

There already exists a wastewater monitoring system in India. We have used similar surveillance for diseases such as poliovirus and other enteroviruses to track effectiveness of polio immunization campaigns. However, waste water monitoring has not been used in in India to detect the appearance and spread of SARS-CoV-2 among the population. It is very important to:

1. Strengthen our disease surveillance programmes by including WBE for detecting SARS-CoV-2. Once a reliable SARS-CoV-2 wastewater monitoring system is established, wastewater data might be used to indicate and show a roadmap for tracking disease, intensifying testing, re-introducing public orders related to social distancing or quarantines, and even lifting restrictions once a cessation of infection is confirmed.

2. Strengthen coordination between natural and social scientists to enable translation of scientific findings into public health policies and implementation plans.

3. Accelerate investments in early warning systems (EWS) for averting disasters and minimising their impact on vulnerable populations.

The study also uncovers practical insights to the local government and public health experts for decision making, especially to identify the zones that need immediate attention to combat the spread of this pandemic. The leading stakeholders such as State Pollution Control Boards (SPCBs), Urban Local Bodies (ULBs) and the District Health departments of the respective Districts could collectively synergize efforts to monitor the river water. The Standard Operating Procedures (SOPs) developed for river water monitoring in this study, could be leveraged by the respective institutions. Capacity building of the technical professionals can be arranged by the experts for monitoring and surveillance programs. The pandemic has provided sufficient evidence that environment, health, and development issues need to be addressed comprehensively through science-informed policies. Development initiatives need to be dove-tailed with synergistic approach, stakeholder participation and accountability, so that a third wave of COVID-19 pandemic can be alerted, controlled and managed in the most effective way in India. ∎

The Second Wave and Reflections on City Planning

*By **Banashree Banerjee**, Urban Planner, New Delhi, India*

The second wave of COVID-19 has come as a reminder that we are dealing with an as yet uncontrollable pandemic, that can continue to disrupt lives, livelihoods and mobilities across the world for an indefinite period in the future. As with past epidemics, city populations are worst affected; and as in the past, we are asking ourselves how can planners better design cities that can deal with and even avert health emergencies? This question has tremendous relevance today and for times to come when an increasing number of people in the world, and in India, will live in urban areas and when natural disasters shaped by climate change will inevitably trigger different kinds of emergencies, including public health, hunger, loss of livelihoods and forced population mobility.

There is no escape from reassessing urban health infrastructure and its accessibility to all sections of the population. Can planning for health use methods such as future scenario-building to see how a city should work during normal times and how
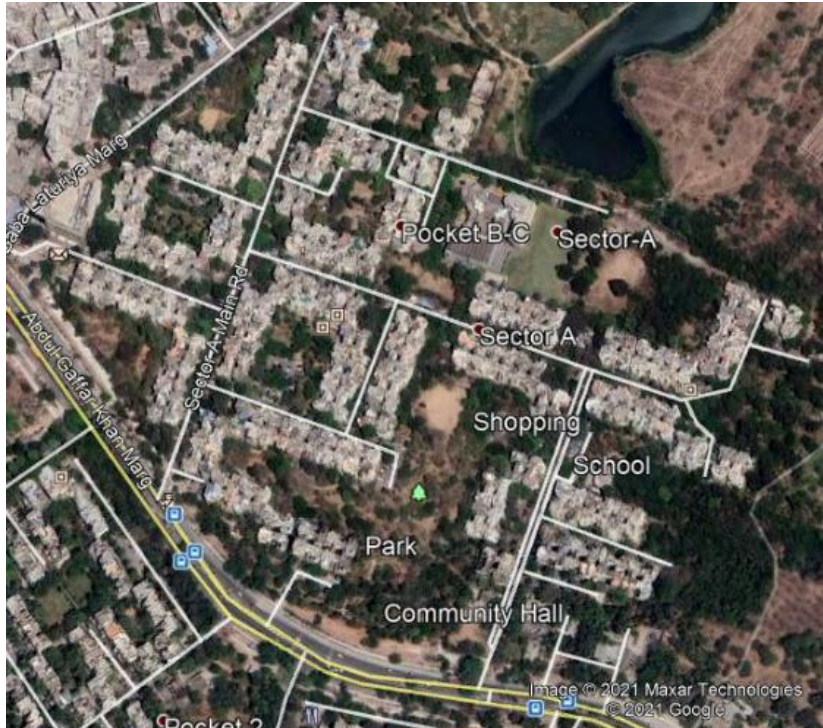
Delhi: A planned residential neighbourhood.

it can respond to public health emergencies, particularly COVID-19, with minimum disruption to the wellbeing of citizens?

The initial knee-jerk reaction in condemning population density as the key determinant for the spread of

the novel corona virus shows that we have a lot to learn. The successful examples of containment in the densely packed Dharavi slum in Mumbai, high density cities like Singapore and Hongkong as against sprawling American suburbs tell us that we have yet to understand what works and what does not. Now is a good time, then, to carry out research to future proof cities against hazards.

The second wave did not provoke migrants to start walking back to the village, yet they did crowd into public transport terminals to somehow get back. Not stopping public transport and keeping state borders open was a lesson learnt quickly from the first lock down. This needs to be reinforced with understanding the complex web of mobilities and flows of people, goods and supplies that nurture city life —

Delhi: Population distribution in different housing typologies		
Typology		**Population %**
Unplanned	Squatter settlements	15.0
	Squatter resettlement colonies	10.5
	Unauthorised colonies	16.5
	Regularised unauthorised colonies	5.2
	Rural villages	8.6
	Urban villages	6.4
	Sub-total Unplanned	**62.2**
Planned	Individual housing	16.5
	Multi-family housing	17.0
	Government employees housing	4.3
	Sub-total Planned	**37.8**
Total		100
Source: Based on Master Plan for Delhi 2001-2021- Shelter, present scenario.		

migrants from rural areas, commuters from near-by towns, daily office and school goers, international travellers, patients to hospitals; supply and distribution of food and medical supplies. What are the essential flows that must continue and how can planners design cities so that the least disruptions occur? How can we effectively use technology — GIS, the internet of things and artificial intelligence- to plan cities around multiple mobility scenarios?

During the past year of the pandemic many city-dwellers have realised the value of well-planned neighbourhoods. In Delhi, for example, residential areas designed with Master Plan norms have parks, community halls, primary schools, convenient shopping areas, all within a few minutes walking distance. Life could be carried out without too much inconvenience in these areas. It is interesting that public health, walkability and convenience were instrumental in shaping the norms for planning these areas. However, vast areas of cities are built by people without any of these facilities. More than half the population of Delhi lives in what are classified as "unplanned areas" in the Master Plan[1]. People, especially low-income communities, will continue to build cities in the foreseeable future and urban planning will need to recognise and work with them to find ways to ensure that public facilities are provided for urban living.

Public space is important enough for urban life, but it assumes a critical role in disaster and crisis management because of its potential adaptability. Last month Delhi Development Authority identified a number of community halls and vacant lands for temporary allotment to cater to the demand for setting up COVID-related facilities. The present and past epidemics and natural disasters have provided us with innumerable examples of schools, community centres, stadia and parks being converted into shelters, quarantine places, food disbursal points and field hospitals. It will be paramount to consciously plan, design and provide flexible and adaptable public space at different levels and dispersed throughout the city so that cities become resilient. ∎

The Second Wave: Loss and Damage to Education

*By **Kavita Anand**, Co-Founder and Director, Adhyayan Quality Education Foundation and an Ashoka Fellow, Maharashtra, India*

The onset of the second wave didn't strike most people as significant. When it was announced, it appeared to be spiking in a few places in the country and the official line was one of apparently having beaten back the virus. So when the numbers began to leap off the charts and the actual success of the virus's mutant new avatar became apparent, it meant that 400 million children were looking at a bleak time yet again. Their schools had already been closed for a year and the second wave meant more months of closure. For those in their final school examination years, the decision to cancel examinations has meant living in limbo, with no clear understanding of how they can take next steps for getting work or getting into higher education and vocational schools.

For the urban child, the pandemic months have also been about living in constant fear and in lockdown with illness in the family and the neighbourhood. For many, it has been learning from an experience of death at close quarters. They have seen their parents either losing jobs or if lucky, working from home, albeit with the greatest difficulty. Some children have had to pack up their homes and accompany their families as they walked back to their villages or accepted the possibility of being infected in trains and buses packed to capacity. Whether they went or stayed, the loss of friends, play and the mid-day meal further added to their miserable loss of learning.

Those that have stayed on in the cities have borne the brunt of being with their families 24/7, often in small flats or housing that has in some cases, shared toilet facilities and low water availability. Worse, the parents' loss of income combined with immobility has had children becoming easy targets for adult frustration. There is alarming news of increasing spouse and child abuse. While child helplines have reported a spike in calls, nearly 92,000 SOS calls in March and April last year on The Child line India helpline asking

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[1] Master Plan for Delhi 2001-2021.

for protection from abuse and violence, the truth is children need to borrow their parents phones to make those phone calls. Most children have been unable to speak with anyone outside of their family, and in cases where both parents have been ill, have also had to take over the management of the family's daily living and care.

While more than 50% of urban children would normally have been attending private schools, the numbers of those who have been able to pay their fees and get access to their teachers online is relatively low. Children with devices of their own that they can dedicate to their education are usually secondary or higher secondary students except in the high fee paying schools. The others have had to make do with a shared device, getting at most 30 minutes a day of instruction and that of variable quality. Contrast this with the 5 to 6 hours of daily instruction that they were used to, and the loss of learning becomes obvious. Those in the government schools have to be satisfied with televised education or radio programmes. For more than 14 months WhatsApp messages are what has passed for education. All this is increasing the likelihood of dropouts and early marriages especially for the girl child.

For their teachers too, life has been full of uncertainties and hardships of having to figure out ways to reach as many students online as possible.

The urban teacher has had to deal with the trauma of learning tech skills in full view of their families, teaching while looking after their own children's education, and letting their students' families into their homes. Many teachers of affordable private schools mushrooming in cities have lost partial or their entire income. Schools have been at loggerheads with parents over fees and the courts have had to intervene.

The tuition teachers who had kept the students' learning going in many towns and cities have been more cautious during the second wave. Consequently, WhatsApp has become the "teacher" that most certainly cannot discriminate between truth and fiction. Rumours therefore, abound. Rumours about the greater impact of the second wave on children are making families fearful of sending their children anywhere, not even for learning. Rumours about the "dangers" of vaccination and the difficulty of booking their turn on the app have meant greater reluctance and often plain inability to create the conditions that will stop a third wave.

A student from a Government school in Goa using the computer with educational activities at the Panchayat Centre.

Sadly, the reluctance of both parents and children to wear masks and maintain the appropriate physical distance in crowded streets and marketplaces, means that the population remains ignorant of safety protocols and vulnerable to the mutation of the virus. Till schools re-open, primary school students are unlikely to get the remedial support they need to be able to learn at their level. And secondary school students will continue to report an increasing addiction to social media. ∎

COVID-19 Impact on the Small, Medium, and Very Small-micro-enterprise

States across India have developed actions over the past ten months to protect and now stabilize the small, medium, and very small-micro-enterprise. They are the key to local economy and markets. And they have suffered the most due to COVID-19 pandemic impact. What measures can be taken to improve the market access, develop business and entrepreneurship, adopt new tools and technologies, and access to savings and credit in a way so that the coming months do less harm and in fact create opportunities for recovery? Be in touch with AIDMI (bestteam@aidmi.org) if you have interest. ∎

Impact of COVID-19 on Urban Environment in India

*By **Amrita Singh**, Assistant Professor, Faculty of Architecture, SSU, Odisha; and*
***Vatshala Kuanr,*** *5th year Architecture Student, PMCA, Odisha, India*

Balance is one of the most crucial principles of life. Every action bears a certain consequence to maintain the balance of life. With every imbalance, created in the normal functioning of nature, nature redials the methods of self-healing. With the outbreak of COVID-19 and onset its new waves, the self-healing process has been on track again. While every action has a consequence, every process consumes something to produce something.

The **competitive exclusion principle** sometimes referred to as **Gause's law,** states **that two species competing for the same limited resource cannot coexist at constant population values.** Either of the one extinct or a behavioral shift toward a different ecological niche is observed. The working of this principle can be seen from the current scenario of the pandemic. People infected with the virus fight till the last breath by either adapt to the virus by overcoming it with self-built antibodies or the virus wins over the life of the fighters.

Similarly, the COVID-19 pandemic has also left some of its visible footprints on the Urban Environment, ranging from both positive to negative impacts, in every possible aspect, which are further highlighted in this article.

The pandemic's **positive** impact on the urban environment can be witnessed through 3**E**s Concept i.e.
1. **Enhanced** environmental conditions
2. **Emphasis** on sustainable Living
3. **Established** sense of cohesion

"3-E" CONCEPT
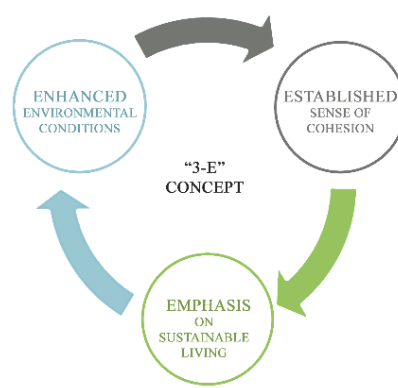
Further, it includes enhanced environmental conditions directing towards the improving health of Mother Nature and her children. Improved quality of air and rivers are rejuvenating. The Ganga's and Yamuna's water along its most polluted stretch in Uttar Pradesh is carrying more dissolved oxygen and fewer nitrates. Improved life style and condition both on ground and underwater can be seen, since the return of animals and birds and their concentration in the surrounding nature has increased, as Turtles at Gahirmatha Beach, Odisha thus adding towards

SD-Goal 6: Ensure availability and sustainable management of water and sanitation for all. It targets towards improved water quality by reducing pollution, eliminating dumping.

Goal 3 of SDG, ensure healthy lives and promote well-being for all at all ages. Due to the pandemic, the life styles of people of all age group, have taken a turn towards better mental and physical practices, such as the awareness for regular hygiene and performing yoga and exercise.

The social interaction has known the importance of isolation as well as cohesion among each other. Information and medication technologies and facilities have improved, both in the urban and rural society. Increase in awareness of responsibility among the people of cities as well as the vulnerable population towards nature and its components, somewhat promises a better future in terms of health and social relationship.

However, **negative** impacts, the loss the wave has brought to humanity cannot be ignored, in term of economy and health. The loss of departed souls' families in terms of finance and mental state can be well-noticed. The education and employment conditions are predominantly balancing at stake.

The pandemic's **negative** impact on the urban environment can be witnessed through 3**F**s Concept i.e.
1. **Feeble** mental and physical health
2. **Failure** of proper educational systems
3. **Fall** in economy and resource sectors.

Hence, the reboot route of Mother Nature, under an update is continuing to form the ebb and flow of living conditions for her children, but with proper response with either embracement or enhancement. ∎

Impact of COVID-19 Second Wave in Cities of Tamil Nadu – Special Reference to Elderly Population

*By **Renaldo S Rajkumar**, PhD Scholar; and **Dr. F.X. Lovelina Little Flower**, Professor and Head; Department of Social Work, Bharathiar University, Coimbatore, Tamil Nadu, India.*

The COVID-19 pandemic is in different stages in different countries. India with 140 million older people (census, 2011) is the second largest populated country in the world has witnessed a brutal second wave in the months of April and May 2021. According to the COVID-19 Second Wave Control Strategies report published on 15th may 2021 by ICMR it is estimated that at the height of the second wave, more than 4000 people were affected by the virus on daily basis and for every minute three persons died due to the virus in India. The virus has impacted the nation's economy, living standard which has increased the growth of poverty and unemployment impacting the lives of vulnerable and disadvantaged population.

Tamil Nadu which is one of the more developed states in India with the

A poster showing the message that vaccines are not available in Erode.
Photo: M. Govarthan.

population of 72 million has nearly 11.2% of elderly population, and it is estimated that 13% of the elderly live alone and 15% are females (census, 2011). According to ICMR report the first wave of COVID-19 which started in the month of February 2019 however has impacted the state to an extreme causing bearable

impact for the government and population. The strike of second wave of COVID-19 in the state has targeted a majority of the population particular the elderly patients putting them at risk due to the scarcity of oxygen cylinders, ventilators and beds in the hospitals. Though the state managed to balance the scarcity, the need grew rapidly high as there was an increase in the number of daily active cases which created medical emergencies throughout the state and country.

A study conducted by Hindustan Times magazine during the first wave of the pandemic reports that the elderly staying in urban slums reported an increase of mortality rate. The study further highlights that the elderly people living in old age homes were reportedly less impacted by the virus, but the impact of the second wave has totally devastated Tamil Nadu. The crushing pandemic and the variation

The elderly remains eager to gain immunity as COVID-19 infections spike in the second-worst hit country in the world. Photo: EPA-EFF.

in virus from alpha to delta have collapsed the state's health care system due to which sustaining and stabilizing the elderly health in the hospitals had become a tough task for the medical practitioners.

The elderly population is likely to be more affected by the virus as they need immediate hospitalization, intensive care and ventilators, etc. which were indispensable to their survival in the second wave. Many studies have also concluded that the virus has created uncertainty among the elderly population resulting in anxiety and disturbance in their mental health. Social isolation, loneliness and fear of death for the virus among the elderly prevailed high, unsettling their well-being and quality of life.

Considering these factors, the state has borne the responsibility of protection of the older people from the virus. From the 1st of March 2021 the Government of Tamil Nadu has initiated to vaccinate the elderly population in the state and among those nearly 39% of the elderly population has taken their first dose of vaccination and the percentage has been increased daily, since the elders are given awareness through mass media and campaigns conducted by NGO's and

A senior citizen getting a shot at the COVID-19 vaccination centre at Rajiv Gandhi General Hospital in Chennai. Photo: Bijoy Ghosh.

Government agencies due to which the elders show voluntary interest to be vaccinated in rural and urban areas increases day by day. As the vaccine supply and allocation smoothens between the States and the Union, health officials of various district are trying to address the issues and the state ensures free vaccination for all the volunteers and stakeholders without any compromise.

Many benefits have been announced and executed in response to the elderly care management during COVID-19. The Government of Tamil Nadu has issued helpline numbers for the differently-able and the senior citizens to avail home vaccination from the PHC and UPHC centres. The government has also announced a relief fund of rupees 4000 for the people including

the elderly to compensate for their survival and livelihood. The Government has implemented several elderly social safety schemes which include pensions, cash transfer, public distribution, health policy, mental health intervention etc. The government has also executed a scientific experimental approach Randomized Controlled Trial (RCT) with an intervention to fight loneliness among elderly living alone. Randomized phone survey on prevalence on symptoms and welfare measures has been addressed regularly for the betterment of elderly wellbeing.

COVID-19 crisis in Tamil Nadu has given an innovative necessity to monitor the elderly and vulnerable group activities and ensure that their life's are safe and secured inside the state. ■

The Vaccine and Humanitarian Action

As the vaccine for COVID-19 is rolling out in countries and communities, humanitarian actors remain uncertain about several matters: how will this "roll-out" affect ongoing humanitarian action? Who will decide the priorities for vaccination in humanitarian camps, victims and aid workers included? Are the victims aware about the vaccine? Are donors making investments into the roll out in humanitarian action areas? How will this roll out be governed in countries and the communities? And what measures are needed to be better prepared for the vaccine roll out as it happen. And what does this roll out tell us about the health care cluster of humanitarian action? The above questions are coming up in the areas and communities where AIDMI is working since March 2020 Lockdown.

(For more information contact Vishal Pathak at vishalp@aidmi.org) ■

Impact of Covid-19 in Kabul – Afghanistan

*By **Sameera Noori**, DDG/ EiE Manager, Citizens Organization for Advocacy and Resilience (COAR), Afghanistan*

Afghanistan being one of the poorest country in the world, has been facing grave challenges as a result of the COVID-19 pandemic, which threatens to undermine the country's peace process and overwhelm its health care system. A weak medical infrastructure with a dearth of medical personnel, a flailing economy with limited physical infrastructure, poor social cohesion and distrust of government due to 40 years of war, along with an influx of refugees returning from Iran and Pakistan without proper quarantine and containment measures are all factors that have compounded the adverse impacts of the COVID-19 pandemic on Afghanistan.

In 34 provinces the most affected cities were Herat, Nangarhar, Kandahar, whilst Kabul remains the most affected part of the country in terms of confirmed cases however, due to the limited public health resources and testing capacity, as well as the absence of a national death register, confirmed cases and deaths from COVID-19 are likely to be under-reported in the country.

Hospitals and clinics continue to report challenges maintaining or expanding their facilities' capacity to treat patients with COVID-19, whilst also maintaining essential health services. As WHO noted, when health systems like Afghanistan's are overwhelmed, deaths both as a direct result of the outbreak and resulting from other preventable and treatable conditions increase dramatically.

COVID-19 has had grave consequences for people's health and income, and the cost of basic essentials has increased dramatically, leaving at least a third of the population faced with food shortages and malnutrition on the rise. With levels similar to those seen during the 2018 drought, Afghanistan now has the second highest number of people in crisis or emergency food insecurity in the world, and close to one in two children under the age of five are predicted to face acute malnutrition this year. It is estimated that six times the number of people are now in need of humanitarian assistance, as compared to four years ago.

Concurrently, conflict, natural disasters and extreme weather have continued to effect and displace thousands across the country, compounding pre-existing issues faced by these families and the communities they settle in, and leaving them more vulnerable to serious consequences from COVID-19. Harsh summer conditions continue to cause suffering for families in inadequate shelter, and millions are struggling to get by amid soaring poverty driven by the economic shock of COVID-19.

As of 3 January 2020 to, 2 July 2021, there have been 120,216 confirmed cases of COVID-19 with 4,962 deaths, reported to WHO. ∎

Renewal of Community Resilience: Developing a New Local Resilience Capability

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An initial draft of this case study was previously published by LocalGov[2] UK on their local government network[3].

Introduction

As part of its emergency planning efforts, the UK government identifies and develops capabilities and resources that can be deployed in the event of a civil emergency or disruptive event. Anything from mass evacuation and shelter to telecoms is factored into emergency planning as part of the immediate response to a crisis, but thought is also given to the capabilities needed to recover and renew society in the long term, once the initial impact has passed.

It's vital we understand the fragility and strength of these systems, and learn lessons about where their weaknesses lie for the future.

Despite its devastating impact, we can learn a lot from the COVID-19 pandemic. For many of us over the last year, the support of our community has made us realise that we are not alone.

Just over a year on from the UK nationwide lockdown - one strength has emerged in particular. Community response, while not yet formally recognised as a resilience capability, rapidly emerged as an

important lifeline during the pandemic.

What Makes a Community?

Communities are formed from many building blocks and include a wide range of individuals and groups. They also include organisations, SMEs, big business networks, associations, local economic partnerships, and local government.

As we've seen during the pandemic, communities can raise awareness of risks, tackle the cause of problems and identify local needs swiftly. They can also mobilise quickly and harness the skills of individuals to help provide care and support to others.

But community response needs to be coordinated effectively for its power to be fully realised. Many parts of local government work closely with communities to co-develop processes that can help them to understand risks and vulnerabilities

better, putting them in an even better place to respond in the future and to be prepared for disruptions. Communities that are aware of hazards will be engaged to spot risks and be on standby for emergencies, with the governance, knowledge, and resources to act safely and effectively if one came along.

It is important that we now work to maintain this approach beyond COVID-19.

From a Local to National Resilience Capability

During COVID-19, we saw communities respond on a scale that was previously unthinkable. We saw invisible acts of good neighbourliness, donations and the momentum of thousands of mutual aid groups, local businesses finding ways (COVID-secure) to provide essential local services, all while parts of the voluntary sector were organising its own response.

It was impressive to see how swiftly communities rallied together – they were the heart of the response, proving their previously hidden value. Some areas around the UK (such as Essex, and Avon and Somerset) have measured the impact of their community's response by gathering data on registered volunteers, volunteer hours, supported people, services provided,

[2] https://www.localgov.co.uk/
[3] https://www.localgov.co.uk/Community-resilience-A-new-capability-for-local-resilience/52338

organisations involved, donations received, and deliveries made, to name a few. COVID-19 has shown the importance of communities, and harnessing this data will help them to grow in the future.

The Government's Integrated Review of Security, Defence, Development and Foreign Policy[4], shines a light on the potential of our communities to mitigate and manage the effects of emergencies. This points to the need to nurture and enhance this local resilience capability to get all the parts of our communities providing resilience and working better before, during and after emergencies. This could spotlight the role of households in enhancing their own resilience, how groups and community networks can prepare and avoid the harshest impacts of emergencies, the role of local and national businesses in strengthening response, and the glue provided by local government to support communities in coming together to support each other. At the University of Manchester, we are designing a new, local approach to community resilience – based on capabilities – called Local Resilience Capabilities.

Closer local government community partnerships

So, what role can local government play in bringing together the sometimes disparate and distant parts of our community to build resilient behaviours and networks? How can we develop community resilience, beyond the presence of a voluntary sector?

Not all communities react in the same way or have the same capacities – some even struggle with the notion of community altogether. This gives local government and resilience partnerships an important position at the heart of community resilience, and they can occupy a supportive, and enabling role to help communities be supportive of the integrated response to local emergencies. Local government may need to remind community leaders of their position as facilitators, identify and support community linchpins to galvanise the progress already made during COVID-19, and identify and remove barriers for community resilience to flourish. Training may also be needed to ensure productive collaborations are possible between community members and emergency services – so that communities can be viewed as part of the solution offered by local resilience partnerships.

While this may sound like the 'usual' community resilience, but it is actually quite different. Local Resilience Capability puts the focus on those capabilities that bring community resilience. Through Local Resilience Capability, LRFs can monitor their progress on building capabilities, understand the activation of capabilities, and be confident that the capability is present when it is needed during times of blue and grey sky. So, while community resilience is vague and difficult to assess whether effort is even making a difference, Local Resilience Capability provides clarity on its purpose, measurement, and progress being achieved. Local Resilience Capability puts quite a different focus on how to build those capabilities, and the first steps needed to do so. It requires a different range of work patterns (e.g. being community-based, working with communities in the foreground and emergency planning taking a less prominent role). It requires different skills (e.g. facilitating, clearing blockages, engaging partners in community working). It can involve new partners (e.g. universities and other community-facing services in local government).

Many communities have demonstrated before and during COVID-19 that they can be relied upon when asked to deliver emergency response activities. Establishing community resilience as a permanent local resilience capability requires us to sustain what has already been created by communities, local government, small businesses, neighbours, individuals, social enterprises, the voluntary sector, and so many more hidden networks. Renewal is needed to ensure community resilience is here to stay as a local resilience capability.

The University of Manchester is continuing to develop Local Resilience Capability so get in touch to learn more (duncan.shaw-2@manchester.ac.uk). ■

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[4] https://www.gov.uk/government/publications/global-britain-in-a-competitive-age-the-integrated-review-of-security-defence-development-and-foreign-policy#:~:text=The%20Integrated%20Review%20is%20a,national%20security%20and%20international%20policy.&text=The%20document%2C%20which%20is%20the,a%20vision%20for%20Global%20Britain.

The Global COVID-19 Pandemic – Australian Fire Service's Response

*By **Mark Jones**, Chief Officer, Country Fire Service, Australia*

When COVID19 arrived in South Australia in March 2020, the State's Health Authorities already had in place a series of plans detailing its response to Pandemics and State-wide infections. Against a backdrop of frequent interstate and international travel and an economy which had been hit hard by the "Black Summer" bushfires of 2019/20, the vulnerabilities of Australia were clear.

In South Australia, following on from a series of large fires which burned for many weeks, the Commissioner of Police, who also serves as the State Coordinator when state-wide emergencies occur, asked the Fire Service to put together an Emergency Management Team to oversee the State's response to the growing crisis. The first thing that became apparent was that the Covid19 virus would not conform to the plans which already existed which had been mainly derived from the historic outbreaks of Avian Influenza and SARS.

The "State Command Centre – Health" was created in 2 days and was firstly populated by incident controllers and functional command staff from Fire, Police, Military, Health and the State Emergency Service. Over time, and as the critical nature of the incident morphed into a more sedate emergency situation, the Health Department took on more and more of a leading role to the extent that the emergency services were

able to withdraw and hand over control after a few months.

Some of the more critical activities established by the SCC Health were: control of emergency communications on the pandemic within the state, establishing a reliable contact tracing methodology which pre-dated the use of the (now common) QR code methods and providing a central hub in which all related matters could be processed and analysed. The State has remained in a declared emergency for over 15 months now and the strict controls have worked effectively, with sporadic case clusters keeping the nation on alert (as does the frequency with which returning Australians test positive upon their arrival).

We have had to find new ways of working and consider new complications and risks. Some of the other operations which had previously been routine were

greatly challenged by the responses of each Australian State. One such example is responding across borders. Australia has a long and successful history of both Interstate and International Assistance for large fires and other disasters. With each State having demonstrated its willingness to stringently enforce closed borders to interstate travel and enforce 14 day quarantines retrospectively if required, some rapid policy adjustments and relaxations were required to allow some over-border response to continue.

The impacts of the restricted movement across borders was felt first when we were planning for cross border incident response (South Australia has land borders with 5 other States) but were prolific when Australia received a request from the US for support in mid-2020. The fact that the virus was reported as spreading freely in the USA whilst it had largely been

contained in Australia created significant challenges for those of us who sought assurances for the welfare arrangements for our firefighters.

Throughout the most concerning period, South Australia's Fire Services were able to maintain normal response procedures to "normal" emergencies with only minimal adjustments to responses to aged care facilities for example. When confronted with the prospect of firefighters attending potentially infected citizens, we took a pragmatic approach in South Australia. We decided that we would respond with the normal levels of infection control procedures unless circumstances necessitated that something further

was required. This was risk-based decision which considered the extremely low incidence rate and

the even less significant levels of recorded community transmission. ∎

Universal or Targeted: Access to COVID-19 Vaccine

The pandemic is still a reality. The numbers may be down but the caution and concern much continue. The impact, so far, on all, is devastating. Year 2021 has brought hope, but how far that hope is not clear. It is in this background that AIDMI reached out to key individuals in disaster risk reduction field to find out how best to deal with the roll out of the vaccine for COVID-19.

Leaving no one behind is critical. The pandemic continues to hit the communities, all communities. The pandemic threatens life, and living of poor and vulnerable more directly and more severely. AIDMI argues that twin focus of the roll out is a must: universal access as well as targeted outreach. And the best way to start this twin focus of the roll out is from schools in each city. (For more information contact bestteam@aidmi.org) ∎

The views expressed in this publication are those of the author.   *For Personal and Educational Purpose only.*

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