Combating the COVID-19 pandemic in a resource-constrained setting: insights from initial response in India

GRID COVID-19 Study Group

ABSTRACT
The low-and-middle-income country (LMIC) context is volatile, uncertain and resource-constrained. India, an LMIC, has put up a complex response to the COVID-19 pandemic. Using an analytic approach, we have described India’s response to combat the pandemic during the initial months (from 17 January to 20 April 2020). India issued travel advisories and implemented graded international border controls between January and March 2020. By early March, cases started to surge. States scaled up movement restrictions. On 25 March, India went into a nationwide lockdown to ramp up preparedness. The lockdown uncovered contextual vulnerabilities and stimulated countermeasures. India leveraged existing legal frameworks, institutional mechanisms and administrative provisions to respond to the pandemic. Nevertheless, the cross-sectoral impact of the initial combat was intense and is potentially long-lasting. The country could have further benefited from evidence-based policy and planning attuned to local needs and vulnerabilities. Experience from India offers insights to nations, especially LMICs, on the need to have contextualised pandemic response plans.

INTRODUCTION
In the absence of a specific treatment or vaccine for a global crisis like the COVID-19 pandemic, combative interventions are time-sensitive and resource-intensive.1 2 About 85% of the world’s population (6.4 of 7.6 billion, 2018) reside in low-and-middle-income countries (LMICs).3 Methods such as social distancing, personal protection, aggressive contact tracing and isolation, and mass movement restriction seem untenable in LMIC contexts given the socioeconomic disparities and living conditions.1 Healthcare resources are scarce and surge capacity weak.3 Vulnerabilities (predominance of unstructured employment, limited employment security and health protection, inadequate health awareness and care access) remain high and underassessed.1 3 With a population of ~1.4 billion, India’s response to COVID-19 directly affects 17.7% and 21.8% of the global and LMIC populations, respectively.3 This paper aims to provide a descriptive account of India’s response to the pandemic in the initial months, that is, from 17 January (when it issued its first travel advisory for COVID-19) until 20 April (initiation of graded relaxation of the nationwide lockdown). We build the analysis on India’s LMIC context.

COLLATION OF INFORMATION
Setting
India has a semifeudal democratic governance system. The Constitution of India vests the responsibility of ‘health’ in its states, and that of preventing the spread of infectious diseases from one state to another concurrently with the Government of India (GoI) and the states.6

The GRID COVID-19 Study Group
Our group (n=55) has members located across 40 institutions in India (21 of 28 states and 3 of 8 union territories (UTs). These include teaching faculty (n=47) and residents (n=3) in departments of community medicine in medical schools, full-time public health researchers (n=3), monitoring and evaluation expert (n=1),

Summary box
► Low-and-middle-income countries (LMICs), where 85% of the world’s population reside, need context-relevant approaches.
► We analysed India’s (an LMIC) initial response to the pandemic (from 17 January to 20 April 2020).
► India’s variegated epidemiological, sociopolitical and systemic vulnerabilities make its pandemic response complex.
► India could leverage pre-existing legislative provisions to adopt a collective combat, with states taking the lead with support from the union government; the pre-emptive stringent nationwide lockdown had benefits as well as uncovered vulnerabilities.
► Insights from India’s initial response will help in response preparedness and planning for future pandemics, especially in the LMIC context.
and a pharmacoepidemiologist (n=1) in academic research organisations. The members were identified based on their engagement in COVID-19 pandemic containment in various capacities (as programme advisors, implementers, members of rapid response teams, researchers) in respective states/UTs and at the national level. The group kept track of COVID-19 developments in respective and neighbouring states and UTs.

**Data sources**

The group members pooled government communications (e.g., public orders, circulars, advisories, guidelines, press releases, updates on official websites), guidance documents from stakeholder constituencies (e.g., professional associations, local authorities), and excerpts from leading national and local newspapers (on open-ended Google Forms), social media resources (‘MyGov Corona Newsdesk’ on the Telegram app) and relevant reports by sharing them to a common group created on WhatsApp (a popular social media app used on mobile devices).

For data on cases (number of active cases, recovered/discharged, deceased and migrated, at the national and state level), we archived information from the Ministry of Health and Family Welfare (MOHFW; mohfw.gov.in) every day between 22:00 and 23:59 India standard time to capture updated statistics.

**Quality check and archiving**

A group of nine coordinators provided oversight. Two coordinators (ArM and SB) curated the repository by removing duplicate documents and verifying authenticity through triangulation from multiple sources, including government documents and websites. Data were archived chronologically according to date and with labels for easy retrieval.

**Synthesis and analysis**

We designed a timeline of key events related to the pandemic in India by sequencing major government circulars and interventions. Between 21 and 26 April, the group members reviewed the repository of resources.

pooled and submitted 92 nominations for the most prominent initiatives by GoI and respective states/UTs in response to the pandemic during the study period. The members provided the source reference (as available) for the nominations they made. We did not reject any nomination; the coordinators validated each of these by reviewing the reference provided, searching for additional information on the internet and contacting the contributing member for clarification, if needed. Two coordinators (ArM and SB) carefully examined each nomination for its content, free-listed the phrases, and moved similar phrases together through discussion and mutual agreement. If the same initiative had been nominated multiple times, it was clubbed together. The two coordinators placed the nominations under relevant themes according to the WHO 2018 updated checklist for pandemic influenza risk and impact management.7 They paraphrased the nominations for clarity and brevity in track changes mode to trace the edits. The coordinators (MB, PC, PK, BR, SS, AS, MKS) independently reviewed the paraphrasing and theme assignment and made edit suggestions as and where necessary. Subsequently, over sessions of video meetings, all the coordinators resolved the suggestions through discussion, review of references and consensus. The list was circulated back to the study group, and suggestions were addressed by reiterating the process before finalising for approval. Finally, 87 initiatives were identified, of which 44 were at the national and 43 at the state level. Critical analyses of the interventions and developments regarding combat of the pandemic in the initial months were done using a SWOT (strengths, weaknesses, opportunities and threats) framework through multiple rounds of feedback and editing to build consensus using the process described above. Figure 1 shows the flow diagram of the study.

INDIA’S INITIAL RESPONSE

Figure 2 presents a timeline of events, and box 1 provides a list of initiatives undertaken in the initial 3 months by the union, and states and UTs to combat the pandemic.

Preparing for an emergency

India reported the first three cases between 30 January and 2 February—all returnees from Hubei Province, China. After a hiatus through February, cases started increasing from early March. Starting mid-January (17–21 January) through mid-March, India issued advisories against non-essential international travel and suspended pre-existing visas in a graded manner at its ports of entry: air, sea and land.8 By mid-March, states/UTs had started prohibiting mass gatherings and levying curfew in selected areas. The public were advised to observe social distancing, hand hygiene and cough etiquettes, and to stay at home. On 22 March, GoI called for a voluntary citizens’ curfew. The country went under a 21-day complete lockdown on 25 March (with just about 3.5 hours’ notice on 24 March).9 The lockdown was extended thereafter.
Box 1  List of some of the prominent initiatives/interventions in India in response to the COVID-19 pandemic (based on WHO 2018 checklist for pandemic influenza risk and impact management)7

1. Preparing for an emergency.
1.1. Planning coordination and resources.
► Gol constituted 11 empowered groups and a coordination group for pandemic response.
► States formed multidisciplinary taskforces and advisory panels.*
► Gol solicited public and private donations for PM’s National Relief Fund.
► Gol launched the PM CARES Fund—individuals, PSUs and corporates contributed funds.
► India proposed the creation of SAARC COVID-19 Emergency Fund to neighbouring nations.
1.2. Legal and policy issues.
► Epidemic Diseases Act, 1987 invoked—international travel suspended; states gained increased administrative power, started locking down before declaration of a nationwide lockdown.*
► Disaster Management Act, 2005 invoked—Gol declared the pandemic as a ‘national disaster’, increased fund access to states and UTs; nationwide lockdown implemented from 25 March.
► Section 144 of Criminal Procedure Code, 1973 activated prohibiting public assembly of ≥4 people.*
► States drafted respective COVID-19 pandemic regulations.*
1.3. Ethical issues.
► ICMR released the national guidelines for ethics committees reviewing biomedical and health research during COVID-19 pandemic by second fortnight of April 2020.
1.4. Risk communication and community engagement.
► Religious leaders, celebrities and social influencers engaged in social mobilisation.
► Caller tunes set in regional languages on prevention of SARS-CoV-2 and stigma.
► MOHFW, states released information materials and daily updates on COVID-19 situation.
► MOHFW created a central repository of SOPs, guidelines and resources developed by it.
► MOHFW and state representatives conducted regular periodic press briefings; Press Information Bureau, GoI made media releases actively.
1.5. Points of entry.
► Airports: travel advisories issued against non-essential travel to high-risk countries (17 January); screening of passengers coming from high-risk countries scaled up (17 January); pre-existing visas suspended; universal screening initiated (4 March); mandatory 14-day quarantine on arrival (11 March); Indian citizens evacuated from affected countries.
► Sea ports: in sync with International Health Regulations, 2005, the Ministry of Shipping issued advisories, quarantine and entry protocols (28 January).
► Land checkpoints: immigration checkpoints with neighbouring countries shut down; cross-border passenger train and bus services, and border local markets suspended; those with influenza symptoms or travelling from afflicted countries quarantined.
1.6. Travel restrictions.
► International travel advisories issued against non-essential travel from January.
► By mid-March, most pre-existing visas suspended.
► International and domestic commercial flights prohibited.
► During nationwide lockdown, passenger trains suspended, mass movement restricted, and interstate and interdistrict borders* sealed.
2. Surveillance, investigations and assessment.
2.1. Laboratories.
► Testing scaled out from NIV to 51 ICMR centres, with additional 50 collection centres (16 March).
► Private labs roped in; existing facilities upgraded.
► Sample collection kiosks and mobile COVID-19 testing vans set up.*
► ‘Made-in-India’ coronavirus testing kits released to the market (end of March).
2.2. Surveillance, outbreak investigation and monitoring.
► ICMR centres checked random samples (symptomatic but without travel history to outbreak zones) for community transmission between 15 and 29 February (20 samples in total), and then from 16 March (each of the 51 centres tested 10 samples each week).
► ICMR estimated proportion of COVID-19 cases based on SARI and ILI sentinel surveillance.
► IDSP network leveraged for community-based surveillance.
► Testing criteria revised as per need for information and evolution of the pandemic.
► Private sector engaged for sentinel surveillance.
► Over-the-counter sales of cold and influenza medications monitored.
► Drones used for monitoring sanitisation, public movement and surveillance.*
► Call data records used to track COVID-19 clusters and those returning from ‘super-spreader’ events.*
► Citizens under home quarantine tracked with a tool, the ‘COVID-19 Alerting Tracking System’.*
► Mobile app released for reporting SARI by private providers.*
► Cluster containment strategies adopted to assess and counter risk.
► Village taskforce constituted to monitor and report COVID-19 cases and enforce lockdown.*
► Civil society organisations helped in identifying hotspots and in mitigating stigma.*
► Contact tracing and surveillance undertaken with engagement of community medicine experts and other personnel of medical colleges.*
BOX 1  Continued

2.3. Risk and severity assessment.
► Fever and influenza clinics set up at health facilities for risk assessment and triage.
► Active and passive surveillance intensified to identify geographical hotspots and suspects.
► Front-line workers conducted home visits to identify and inform individuals with comorbidities.*
► Rapid response teams constituted at national and state levels.
► Aarogya Setu mobile app launched for risk communication and tracking.15
► Released plan for graded relaxation of lockdown from 20 April using colour zoning (based on case load and case doubling rates) for surveillance and cluster containment strategies.

3. Health services and clinical management.
3.1. Health services.
► Health service continuity: ~US$2 billion emergency financial package for healthcare by GoI; free-of-cost testing and treatment for COVID-19 under the national universal health insurance scheme (‘PM JAY’); patients with chronic diseases given medicine refill stock for 3 months in advance; home delivery of 1 month’s antituberculosis medicines*; amendment of telemedicine practice guidelines by GoI (24 March); attacks on HCWs engaged in COVID-19 response made promptly punishable under law; PPE given to HCWs with a guidance plan on reuse; rationing of HCWs engaged in COVID-19 care (stand-by staff, staff rotation).*
► Facilities: military hospitals engaged in preparing dedicated COVID-19 facilities, including ICUs; upgrading/modifying existing public hospitals and private hospitals as COVID-19 hospitals*; converting hotels, train coaches, sports stadiums, schools and so on into isolation/quarantine centres.*
► Personnel: additional healthcare personnel appointed on ad-hoc basis; release of advance/increased salaries for HCWs engaged in COVID-19 response*; deployment of medical and paramedical students in screening, contact tracing and other services*; more than thirty thousand doctors (including retired, armed forces, private doctors) volunteered in response to GoI request; volunteers deputed in service delivery to elderly, differently abled, children and transgenders*; teams engaged in community activities provided with non-contact thermal screeners, masks and gloves*; accident insurance for HCWs and front-line workers involved in COVID-19 response.*
► Essential medicines, supplies and medical devices: India’s car makers helped to produce low-cost ventilators, masks and protective equipment; GoI with state government increased production and procurement of PPE, N95 masks and ventilators; Ministry of Textiles, MSMEs and workers’ (eg, weavers) association increased production of masks; price of masks (two-ply/three-ply surgical masks, N95) and hand sanitisers capped by Essential Commodities Act, 1955; early delivery of medicines and medical equipment was incentivised*; military transport fleet engaged in logistics support; civil society organisations helped in delivery of public healthcare/hygiene services.*
► Managing mortality: MOHFW released guidelines on dead body management. Guidelines issued for relatives and crematoria staff involved in final rites.*

3.2. Clinical management.
► Treatment and patient management: stock appraisal of drugs, PPE, critical care infrastructure and demand forecasting*; SOPs by apex medical centres and disseminated (through webinars and website) on various aspects of patient management (triage, testing, admission, discharge and so on); hospitals conducted mock drills for emergency response for handling COVID-19 cases*; hydroxychloroquine endorsed for COVID-19 prophylaxis and treatment and declared as Schedule H1 drug, thus restricting its over-the-counter sale; influenza desk made mandatory at all health facilities*; online trainings offered to increase clinical management capacity among personnel.
► Infection prevention and control: administrative procedures eased for procuring PPE, masks and sanitisers; work distribution and PPE matched to work profile*; SOPs prepared for hospital infection prevention and control—establishments adapt/prepare SOPs as per local needs; crowd management in hospitals to minimise mixing of those with and without COVID-19 risk profile.

4. Preventing illness in the community.
4.1. Non-pharmaceutical countermeasures.
► Personal interventions: IEC initiatives for spreading awareness on social distancing, hand hygiene, cough etiquettes, movement restriction and stigma mitigation; incentive for self-registration and home quarantine for those returning from international travel; time-stamped route maps of each patient with COVID-19 released to the public (for general awareness)*; videos hosted on MOHFW website on making of masks at home, appropriate method for donning and removing them, and on hand hygiene; launch of self-assessment interactive apps for COVID-19*; governments posted guidance on preventive measures (dos and don’ts) on official web portals and in print and social media for wider dissemination.
► Community interventions: shutting down public places, for example, offices, schools, malls and so on; advisories for work-from-home and shelter-in-place; nationwide lockdown (from 25 March); release of prisoners from decongest jails*; waiving off school examinations*; wearing masks made mandatory during outings*; floor marking for social distancing in queues; hand sanitisers and thermal scanners at shop, residential society and office entrances.

5. Maintaining essential services and recovery.
5.1. Essential service continuity.
► GoI recommended states and UTs to use the State Disaster Response Fund for providing food and shelter to migrant workers during the lockdown period.
► Shrines volunteered to offer cooked meals and share costs incurred by government for surge.*
► RBI (India’s central regulatory bank) took initiatives to expand liquidity.
► GoI announced US$22.6 billion relief package for poor, rural and migrant population (Prime Minister’s Poor Welfare Scheme; PM GKY).
► Increased share and subsidies on rations distributed through the public distribution system.
► Disbursement of advance/increased pensions for retirees, differently abled, widows and elderly.*
► Subsistence amounts given to construction workers.*

Continued
Surveillance, investigation and assessment
Community-based surveillance activities were scaled up across India by end of March. The number of testing and collection centres was increased, testing criteria were extended, and private laboratories were engaged. On 4 April, free-of-cost testing and treatment for COVID-19 was mandated under the national universal health insurance scheme (Pradhan Mantri Jan Arogya Yojana), further expanding testing outreach. Geographical areas with higher number of cases were labelled as hotspots, and aggressive cluster containment strategies were adopted. Areas were earmarked as red (hotspots), yellow and green zones in descending order of case load; while stringent restrictions continued in the red zones, others were conditionally eased from 20 April. Some states extended the lockdown without relaxation.

Health services and clinical management
The GoI and state governments scaled up provisions for institutional quarantine and isolation centres and COVID-19 hospitals (beds with oxygen and critical care services). Ventilators and personal protection equipment were consigned from vendors in the country and abroad. Training of personnel in the care of COVID-19 suspects and patients was undertaken aggressively. A series of guidelines and standard operating procedures were released by the MOHFW, GoI and the country’s apex medical institutions (eg, All India Institute of Medical Sciences, New Delhi) and disseminated as webinars and video modules. Private providers and facilities were identified and mobilised for institutional surge preparedness. Volunteering was solicited from healthcare professionals. Telemedicine guidelines were launched on 25 March to facilitate access to medical consultations. The Aarogya Setu (Health Bridge) app was launched on 2 April and made mandatory in offices and public places to enable dissemination of advisories, best practices and tracking.

Preventing illness in the community
Non-pharmaceutical interventions were targeted at the individual and the community. These were mainly through public health communication and implementation of social distancing, movement restriction and wearing of mask in public places. The lockdown limited people’s exposure to the virus.

Maintaining essential services and efforts for recovery from the pandemic
Consultations between the union and states prior to and during the lockdown were undertaken for stringent implementation of restrictions while minimising disruption of essential goods and services. The Ministry of Home Affairs, GoI issued guidelines on 24 and 25 March specifying the services that were exempt from the lockdown restrictions. In addition to health and police services, the list included regulated financial markets, and staff engaged in petroleum products, supply chain, cargo, customs, mining, forest, and social welfare department, and others. Interventions to mitigate hardship...
Box 2 Perceived strengths, weaknesses, opportunities and threats in the Indian context during the initial months of combating the COVID-19 pandemic (definitions adapted from WHO documents26,27

**Strengths:** factors intrinsic to India that position it towards a strong performance against the COVID-19 pandemic.
- **Governance:** semifederal, democratic and decentralised governance; consultative decision-making processes (eg, taskforces); multiple channels of public communication; strong engagement with development partners.
- **Existing legislative mechanisms:** (eg, the Epidemic Disease Act, 1897; the Indian Ports Act, 1908; the Drugs and Cosmetics Act, 1940; the Essential Services Maintenance Act, 1968; the Disaster Management Act, 2005); if invoked, these allow special administrative powers to the government.
- **Programmatic outreach:** allows targeted delivery of entitlements to the vulnerable (eg, the public distribution system for food security, zero-balance and minimal documentation bank accounts for direct cash transfer, social security schemes, commitment to universal health coverage and so on).

**Weaknesses:** factors intrinsic to India that impede performance and need change/ investment.
- **Fragile and chronically underfunded health system:** poor infrastructure and tertiary care capacity; inconsistent supplies; data challenges (eg, quality, timeliness, adequacy); limited engagement of private sector; absent/inadequate health insurance cover.
- **‘Missing millions’** (the homeless migrants, illegal immigrants, people in humanitarian crises, disaster-ravaged groups): although not adequately assessed, the numbers are substantial.
- **Limited institutional preparedness for managing pandemics:** India has managed recent infectious disease outbreaks, but protocols (eg, for public health emergency management protocols, public–private collaboration, research engagements) are in evolution.

**Opportunities:** prospects in the current COVID-19 context that could be exploited for effective combat of COVID-19.
- **A better understanding of SARS-CoV-2 and COVID-19:** scientific evidence on disease management, prevention and containment is increasingly available from January 2020.
- **Favourable age pyramid:** only ~8.5% of India are over 60 years of age, majority are under 30. A young population may have a lower risk of mortality from COVID-19 and help in faster economic recovery.
- **Indigenous capacity:** India’s large pharma, research and development, and the information technology industry can contribute to global efforts (vaccine development, delivery, diplomacy).
- **Wide reach of telecommunications and social media:** makes risk communication faster and with outreach for public engagement.
- **Availability of deployable health human resources:** for example, community medicine and public health professionals for technical support, physicians from the Indian system of medicine for primary care coverage, huge network of community-based workers (especially in states with weaker health infrastructure) for outreach, and private laboratories, hospitals and organisations for service scale-out; expansion of tertiary healthcare institutions in recent times.

**Threats:** elements in broader environment that could endanger/inhibit progress in the combat of COVID-19.
- **Huge population size and LMIC context:** India’s vast population, poor living and health access conditions, and heterogeneous epidemiological profile increase the risk of spike in COVID-19 cases and of overwhelming system capacity.
- **Economic stagnation:** growth of India’s economy has been slower, of late—could limit fiscal space for aggressive countermeasures against the pandemic.
- **Limited surge capacity** for testing and institutional care (eg, critical care experts, infrastructure, access, space for isolation); inadequate supply of PPE.
- **Implementing prolonged restriction will impede essential services,** lead to loss of livelihoods (job profiles inconducive to working from home; farmers must protect the spring harvest) and cause adverse economic impact. The strategy for exit from lockdown is complex.
- **Sociobehavioural complexities:** risk of some people flouting preventive directives, stigmatisation, misinformation and rumour mongering, violence against healthcare workers and police, hoarding of essentials (PPE, medicines, sanitisers, groceries) and upsurge in psychosocial health issues (eg, depression, alcohol withdrawal, domestic violence).

LMIC, low-income and middle-income country; PPE, personal protective equipment.

among the poor and vulnerable were introduced by the GoI and state governments.16

**INSIGHTS**

**Understanding the Indian context for pandemic response**

India presents a mix of inherent strengths and weaknesses in combating the pandemic (box 2). Thereupon, the COVID-19 pandemic uncovers some perceivable opportunities and threats. An appreciation of these facets will help the reader understand the context and its influence on India’s response.

**Combating risk of importation of the virus**

‘Nobody can be fully prepared to a pandemic’.1 India also could have benefited from even further pandemic response planning and preparedness. The country had its first case on 30 January. Between January and early March, India focused almost exclusively on minimising the risk of importation. In hindsight, it seems that aggressive surge preparedness could also have been undertaken in the meanwhile (especially in February) given that the virus had originated from an immediate neighbouring country and that WHO had already declared it as a ‘Public Health Emergency of International Concern’ on 30 January.17 The graded border control approach using selective screening and travel restrictions in January to February, leading to universal screening, visa suspensions and mandatory quarantine in March, could not adequately counter the risk of importation. Moreover, relying on thermal scanning was not infallible as several cases were afebrile/asymptomatic. Cases started increasing rapidly in early March. Containment and surge efforts followed subsequently (around mid-March).
Meanwhile, COVID-19 was declared a pandemic by WHO. Worsening situations internationally, such as in Italy, UK and Iran, added to India's anxiety. Since mid-March, India has acted swiftly to stem the rising cases of COVID-19. Existing legislative provisions (prominently the Epidemic Diseases Act, 1897 and the Disaster Management Act, 2005) and semifederal governance structure provided due leverage. India thus mobilised resources and provided administrative flexibility to state governments to utilize the disaster funds, enabling contextual action. As a consequence, states could implement mass movement restrictions, access funds, mandate citizens into institutional quarantine and isolation, and regulate industries (implement work-from-home advisories). Alongside, GoI suspended visas and declared a nationwide lockdown.

**Experience with 'pre-emptive' nationwide lockdown**

The first phase of the lockdown (25 March–14 April) in India was unlike any other country in scale, timing and stringency. The lockdown gave India time for surge preparedness especially in testing capacity and institutional healthcare provisions. People also accepted and supported the stringent restrictions (pandemic response may evoke strong support or protests in democratic settings). Prevention, containment, impact mitigation and recovery efforts gradually became concurrent. Administrative decision-making capacity was increasingly strengthened (up to subdistrict levels). To compensate for insufficient testing capacity, the country engaged its massive network of community-based workers and undertook aggressive community-based surveillance, contact tracing and cluster containment strategies. Official channels of communication to stakeholders gradually became structured and consistent, allaying spread of misinformation. Meanwhile, aggressive media coverage increased public awareness.

In the absence of robust epidemiological data and amidst predictions of rapid increase in COVID-19 cases, India locked down 'pre-emptively' and 'nation-wide' at extremely short notice. The lockdown slowed down the spread of infection: the case doubling time (7-day moving average) on 25 March was 3.4 days and on 19 April was 6.2 days; however, the number of cases kept increasing. On 24 March, when India declared lockdown, it had 564 cases and 10 deaths; on 20 April, when graded relaxation
was allowed, there were 17 656 cases and 559 deaths.12
By 20 April, cases had been identified in 31 of 36 states
and UTs and in 402 of 718 districts.21 Twenty districts
accounted for over half the cases and two-thirds deaths—
these were among the most urbanised, affluent and indus-
trialised districts in the country.21 States and UTs showed
variegated epidemiological curves (online supplemental
figure 1A and B).

Contextual opportunities, for example, a relatively
young population, accruing global understanding of the
virus and the disease, and capacity for generating indige-
nous research evidence, remained underutilised as India
went into a very stringent lockdown. The lockdown uncov-
ered vulnerabilities and triggered cascading effects across
sectors and industries.22 The economy which was already
ailing got further disrupted. The impact was highest at
the ‘base of the pyramid’ (lowest socioeconomic strata)
of the Indian society. People lost jobs and livelihood;
reports of hardship, stress, anxiety and domestic violence
came up. GoI and state governments rolled out initiatives

to mitigate hardship among the vulnerable using pre-
existing institutional mechanisms and programmatic
outreach (eg, validated bank accounts for direct benefit
transfer, network of public distribution system for food
security, and others).23 They were assured of food
and shelter. Nevertheless, the initiatives were inadequate to
check reverse migration. Millions of workers migrated
back home in the absence of any source of continued
livelihood. The ‘reverse migration’ was frequently on
foot and in overcrowded conveyances, thus threatening
to push the virus deeper into rural India where pandemic
preparedness was further weak.24 Given its ramifications
and potentially long-term impact (including that related
to stigma), strategising exit from the lockdown and
subsequent recovery of communities from the pandemic
was challenging.

Critical analyses for practice and preparedness
Given the dynamics of India’s response, our current
account may be non-exhaustive, but captures information
from across the country. Some of the approaches undertaken by India seemed to have worked out in favour, while some needed better planning. We have summarised the insights from India’s response to the pandemic in the initial months in box 3A and B.

CONCLUSION

Within the initial few months, India could mobilise collective leadership and action, and secure public cooperation to undertake stringent combative measures against the pandemic. Apart from isolated incidents, there was minimal public resistance to the stringent nationwide movement restriction norms. Experience from India suggests that the LMIC context could be volatile, ambiguous and uncertain, and hence engaging with the community and other stakeholders is a critical facilitator. It also highlights that LMICs have complex socioepidemiological ecosystems with refractory vulnerabilities that could compromise the sustainability and impact of stringent measures. Combative response to pandemics in such settings is likely to be improvisatory and broad-based (less precise) in the absence of a structured pandemic response plan. Stringent measures must be carefully weighed against alternatives and undertaken with concurrent mitigation and recovery initiatives. A contextualised and updated pandemic response plan with dynamic decision support systems could help in ensuring timely and structured response to national and international epidemiological triggers (scarce resources need efficient planning). Unfortunately, most LMICs either do not have a national plan for pandemic preparedness and risk management or have one that has not been updated recently.\(^\text{25}\) COVID-19 pandemic combat strategies and experience vary worldwide. India is relatively better resourced as compared with other LMICs in several aspects, and hence some of the Indian experience may not be readily extrapolatable to other LMICs. Nevertheless, India shares several challenges and vulnerabilities typical of LMICs (eg, high population, resource constraints, socioeconomic milieu). Going forward, countries and especially LMICs (including India) will find the Indian experience variously relatable for planning response against the current and future pandemics, despite resource inconsistencies, while also appreciating that each country has its unique contextual strengths and weaknesses to account for and leverage.

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Supplementary Figure 1A. 7-day moving averages of number of active COVID-19 cases per million population in high burden states and union territories in India.

Announcement of nation-wide lockdown
Strat of graded relaxation to lockdown
7-day moving averages of active COVID-19 cases per million
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Supplementary Figure 1B. 7-day moving averages of number of active COVID-19 cases in high burden states and union territories in India.
Supplementary Figure 1A. 7-day moving averages of number of active COVID-19 cases per million population in high burden states and union territories in India.

Supplementary Figure 1B. 7-day moving averages of number of active COVID-19 cases in high burden states and union territories in India

- Bombay (Maharashtra)
- Tamil Nadu
- Delhi
- Gujarat

Announcement of nation-wide lockdown
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