Criticality of **Lockdown & Containment measures**

**India Projections and Actual**

Without Lockdown & Containment measures:
- 8.2 lakh cases by 15\textsuperscript{th} April (*similar to Italy’s progression*)

Containment measures but no Lockdown:
- 1.2 lakh cases by 15\textsuperscript{th} April (**projected with peak growth rate before lockdown**)

Nation-wide Lockdown & Containment measures (Current):
- 5,194 confirmed cases
Case trajectory: India vs. Other countries

Days since 100th case
(21 days till 7th April for India)

Source: European Center for Disease Control as of 7th April 9 pm, IST
India's Public Health Response – Proactive, Pre-emptive, Graded

Flights Screening
Advisory to States

WHO Declares Pandemic

Social Distance Advisory

Country-wide Lockdown

Janta Curfew

All Int’l passenger Flights banned

New Cases
Cumulative

7 Jan – China identifies new Coronavirus

Actions Taken
Screening & Travel Restrictions

Social Distancing

Lockdown
### Pre-emptive, Decisive Action – Ahead of Others

<table>
<thead>
<tr>
<th>Passenger Screening</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>India:</em> Active <strong>screening</strong> and <strong>isolation</strong> of travelers started <strong>18th Jan</strong></td>
<td></td>
</tr>
<tr>
<td>o <strong>12 days before</strong> the <strong>first case</strong> was reported on <strong>30th Jan</strong></td>
<td></td>
</tr>
<tr>
<td><em>Global:</em> Started screening in Stage II &amp; Stage III of infection</td>
<td></td>
</tr>
<tr>
<td>o <strong>Italy</strong> after 25 days of first reported case</td>
<td></td>
</tr>
<tr>
<td>o <strong>Spain</strong> after 39 days of first reported case</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lockdown</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>India:</em> <strong>Partial Lockdown</strong> after <strong>52 days</strong> and at Stage II (451 active cases)</td>
<td></td>
</tr>
<tr>
<td>o <strong>Complete Lockdown</strong> on <strong>55th day</strong> of the outbreak</td>
<td></td>
</tr>
<tr>
<td><em>Global:</em> Mostly at Stage III (community outbreak), with cases ranging between 4,000-12,000</td>
<td></td>
</tr>
<tr>
<td>o <strong>Italy</strong> partial lock down after 6,000 cases</td>
<td></td>
</tr>
<tr>
<td>o <strong>US</strong> partial lock down after 4,663 cases</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17th Jan</td>
<td>1st Travel Advisory - <strong>Avoid</strong> travel to <strong>China</strong></td>
</tr>
<tr>
<td>5th Feb</td>
<td><strong>Visa facility suspended</strong> for <strong>China</strong></td>
</tr>
<tr>
<td>26th Feb</td>
<td>Refrain from <strong>non-essential travel</strong> to 5 affected <strong>countries</strong></td>
</tr>
<tr>
<td>2nd Mar</td>
<td><strong>Visa suspended</strong> for - <strong>South Korea, Iran, Italy and Japan</strong></td>
</tr>
<tr>
<td>10th Mar</td>
<td>Entry of Cruise Ships prohibited</td>
</tr>
<tr>
<td>10th Mar</td>
<td><strong>Visa suspended</strong> for <strong>France, Germany and Spain</strong></td>
</tr>
<tr>
<td>11th Mar</td>
<td>All existing <strong>visas suspended</strong></td>
</tr>
<tr>
<td>16th Mar</td>
<td><strong>Prohibition of Flights</strong> from EU, Turkey &amp; UK</td>
</tr>
<tr>
<td>19th Mar</td>
<td>All <strong>Incoming Flights</strong> prohibited</td>
</tr>
</tbody>
</table>
Hospital Preparedness

- **Guidelines** issued - **Surveillance & Contact Tracing**, Sample Collection, Packaging & Transportation, Infection Prevention Control & Clinical Management Protocol

- **Dedicated COVID-19 hospitals** - 508 ready

  | 82,795 isolation beds | 8,182 ICU beds | 4,935 ventilators |

- **Additional Health facilities** - 5,110 ready

  | 1,13,315 isolation beds | 27,641 ICU beds | 12,867 ventilators |

- Union Government providing funds under **NHM** for upgradation

- **Railway Isolation coaches** - 2,500 coaches with 40,000 isolation beds
<table>
<thead>
<tr>
<th>PPEs</th>
<th>N95</th>
<th>Ventilators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependence on imported cloth – now <strong>20 domestic manufacturers</strong></td>
<td><strong>Exports Banned</strong> on 31st Jan</td>
<td><strong>Domestic</strong> manufacturers developed</td>
</tr>
<tr>
<td>Exports <strong>Banned</strong> on 31st Jan</td>
<td>9 lakhs initially available</td>
<td>8,400 initially available</td>
</tr>
<tr>
<td>2.75 lakhs initially available</td>
<td>20.4 lakhs supplied to states</td>
<td>16,500 available now</td>
</tr>
<tr>
<td>2.94 lakhs supplied to states</td>
<td><strong>Orders</strong> placed for <strong>2.13 crore</strong></td>
<td>Orders placed for <strong>49,000</strong></td>
</tr>
<tr>
<td><strong>Orders</strong> placed for <strong>1.7 crore</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Testing Labs

- **1 Lab** in Jan expanded to **223 Labs**
  - 157 Public + 66 Private
- **1,15,000** samples tested
- **Rapid Antibody Test** initiated
  - ILI patients in Containment Zone
- Innovative Test Collection models
Capacity building for healthcare personnel

- Dec 2019 – Training on managing high hazard pathogens
- 6 Mar – National-level Training of Trainers
- 9 & 11 Mar – States-level trainings
- District & Facilities-level training completed
- 21 Mar – Web-based training on ventilator management by AIIMS
- 22 Mar – Mock Drill for Corona preparedness in all hospitals across country
- Series of Trainings by AIIMS Delhi:
  o IMA members and Private Doctors
  o Designated Hospitals
## Migrant Labourers – Status (4 Apr)

<table>
<thead>
<tr>
<th>Component</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relief Camps / Shelters set up</td>
<td>27,660</td>
</tr>
<tr>
<td>Number of sheltered individuals</td>
<td>12.5 lakhs</td>
</tr>
<tr>
<td>Workers given shelter by industry</td>
<td>3.6 lakhs</td>
</tr>
<tr>
<td>Additional Food camps</td>
<td>19,460</td>
</tr>
<tr>
<td>Persons provided food</td>
<td>75 lakh</td>
</tr>
</tbody>
</table>

To augment funds with States, **Rs 11,000 cr** released from **SDRF** by **special dispensation** in advance on **3 Apr** for crisis management.
Migrant Labourers

• 14 Mar: States allowed to use SDRF for setting up quarantine facilities, testing labs and equipment

• 28 Mar: SDRF permitted for setting up relief camps, providing food etc to homeless

• 27, 28, 29 Mar: Detailed advisories to States for providing food, water, shelter, healthcare to migrant laborers – directing them to:
  o Keep in nearest shelter / quarantine facilities, ensuring arrangements of food etc
  o DC and SP of district made responsible for enforcement of these orders

• 31 Mar: 2 PILs in Hon Supreme Court on welfare of migrant labourers - apprised of steps taken:
  o Hon’ble Court expressed satisfaction with the steps taken by GoI
Health Sector – Rs 15,000 cr

- Package of **Rs 15,000 cr** for health sector
- Scheme approved & funds tied up

Front-line Medical Providers – Insurance Protection

- Insurance Scheme for over **22 lakh workers** in **Government Hospitals, Health Care Centres & Labs** - ward staff, cleaning personnel, technicians, Asha workers, Para-medical staff and doctors
- Risk Coverage & Scheme **operationalized** w.e.f. 30 Mar 2020
Pradhan Mantri Garib Kalyan Package – Rs 1.7 lakh cr

- **Rs 1.70 Lakh cr Package** (26th Mar)
- Immediate Relief for most-hit: Kisan, Majdoor, Gareeb, Peedit
<table>
<thead>
<tr>
<th>Component</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grain</td>
<td>• <strong>Free 5 kg Food Grain</strong> per month for 3 months</td>
<td>• <strong>Lifting</strong> commenced – 7.42 LMT / 40 LMT</td>
</tr>
<tr>
<td></td>
<td>• 80 cr poor beneficiaries</td>
<td>• <strong>Distribution</strong> started &amp; to conclude by <strong>end Apr</strong></td>
</tr>
<tr>
<td></td>
<td>• Additional to existing PDS supply</td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td>• <strong>Free 1 kg Pulses</strong> per month for 3 months</td>
<td>• Supply of pulses started &amp; to be completed by <strong>25 Apr</strong></td>
</tr>
<tr>
<td></td>
<td>• 19.4 cr poor families</td>
<td></td>
</tr>
<tr>
<td>Cooking Fuel</td>
<td>• Free LPG gas cylinders for 3 months</td>
<td>• <strong>43 lakh</strong> cylinders <strong>booked</strong></td>
</tr>
<tr>
<td></td>
<td>• 8 cr poor Ujjwala beneficiary</td>
<td>• 19 lakh cylinders <strong>delivered</strong></td>
</tr>
<tr>
<td></td>
<td>Households</td>
<td></td>
</tr>
</tbody>
</table>
## Cash Support - DBT

<table>
<thead>
<tr>
<th>Component</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
</table>
| **Senior Citizens, Widows & Divyang** | • Rs 1,000 each  
• 3 cr poor senior citizens, widows, divyang | • 1st instalment of Rs 500/- disbursed to 2.8 cr beneficiaries |
| **Farmers**                | • Rs 2,000 each (PM KISAN)  
• 8 cr Farmers            | • Rs 12,771 cr disbursed to 6.4 cr beneficiaries |
| **Women**                  | • Rs 500 per month for 3 months to all woman PMJDY a/c holders  
• 20.4 cr poor women     | • 1st instalment of Rs 7,825 crore credited into 15.65 crore women PMJDY accounts |
| **Workers**                | • EPF contribution (24% of salary) for 3 months  
• 80 lakh workers earning less than Rs15,000 | • To be credited into EPF accounts on 15 Apr & then in May and June |
<table>
<thead>
<tr>
<th>Component</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
</table>
| Building and other Construction Workers Welfare Fund | • States advised to utilize Rs 31,000 cr in Fund for worker welfare  
• 3.5 cr worker beneficiaries                  | • 31 State / UTs announced **cash benefits** (from Rs 1,000 to 6,000)  
• 2.1 cr workers received Rs 3,000 cr          
• 29 lakh workers given food relief             |
| District Mineral Fund                           | • States advised to utilize DMF for augmenting medical facilities      | • Rs **13,500 cr** available                                           
• Rs 45 cr spent                                |
## Other Measures

<table>
<thead>
<tr>
<th>Component</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
</table>
| **MGNREGA**        | • MNREGA **Wage Rate** increased, providing incremental **Rs 2,000** per worker over year  
• **13.6 cr** poor beneficiaries | • Increased wages **notified**  
• 19.56 lakh Person-days generated in current financial year |
| **Self-Help Groups** | • **Collateral-free lending** to SHGs doubled to **Rs 20 lakh**  
• **63 lakh** SHGs to benefit | • NCTGC approved extension of Credit guarantee to SHG loans between Rs 10-20 lakh |
| **EPF Withdrawals** | • EPF rules amended to allow non-refundable advance under covid  
• **5 cr** organised workers | • **93,465** subscribers have availed online withdrawal of **Rs 122 cr** |
Institutional Response Framework

- Hon’ PM daily Monitoring & Oversight
- Continuous engagement with Chief Ministers and State Health Ministers
- Group of Ministers (GoM) Monitoring
- Health Ministry Review Meetings & Advisories to States since 17th Jan
- Committee of Secretaries (CoS) coordinating response
- Regular interaction with States by Government of India
- 11 Empowered Groups formed by Government of India for Integrated Response
- National Task Force of eminent medical & public health experts guiding Strategy
- Senior Officials deputed to States to act as a continuous Link
Hotspots - engaging the Cutting-edge

VC conducted by Cabinet Secretary with all Districts Collectors, Municipal Commissioners, Surveillance officers, SPs and States

- Orientation on Containment Action Plan
- Best practices shared by districts
- Focus on over preparedness at district level
- Continued focus on surveillance, contact tracing, patient management
Steep rise in cases due to Tablighi Jamaat Incident

Total cases: 4067

With Tablighi Jamaat

Total Cases: 4067
Doubling Rate: 3.6

Without Tablighi Jamaat

Total Cases: 2622
Doubling Rate: 5.4

Overall 21 states / UTs affected

Source: NCDC data as of 09pm, 5 April
Doubling rate calculated based on last 7 days data.
How is India's Fight Against COVID-19 Being Managed On the Ground?

SHAILAJA CHANDRA | 01.04.20

GLOBAL
Total 1430453
Deaths 82133
While COVID-19 ravages the world, little is known about the disease’s spread in India’s rural hinterland and congested urban areas. More importantly, how is it being managed? Will India follow a similar, or even worse trajectory as China, Italy and Iran? What would that mean in a country of 1.3 billion people, which is often depicted as bumbling and chaotic, with poor health facilities and desperately short of medical manpower?

Perhaps India’s saviour may not be a miraculous vaccine, but the efficiency of its administration and public health responses to a crisis.

Two-thirds of India’s 1.3 billion population is rural, spread over 728 districts in about 650,000 villages. By Tuesday (31 March) evening, 1397 cases had been reported, with 146 new infections in the past 24 hours across the country – and a death toll which rose to 35. This, despite taking stout measures long before most people were even aware of how lethal this disease could be and the way it affects human beings, who can easily succumb once it spreads in the community.

Also Read: Coronavirus or British Raj Officials: RBI’s Challenges in 85 Years
Health Crisis Management at the District & State Levels

India ordered an early embargo on international arrivals, including Indian citizens, and cancelled all domestic flights. The Indian Railways, which annually carries the equivalent of the entire world's population, imposed draconian checks on movement. A nation-wide lockout was imposed on 25 March, banning people from leaving their homes – except in pairs, only for essential provisions and medicine.

Under the Indian Constitution, health is governed at the State level. But when it comes to epidemic control, the Health Ministry's directives must be and indeed are observed by all states. With the enforcement of the National Disaster Management Act 2005, the administrative system has been reinforced. Indeed, political wrangling has abated considerably, as all states have understood what is at stake.

India's administrative system — the division of the states into districts themselves, each comprised of tens of thousands of villages — is run by an organisational structure unparalleled anywhere in the world.

The district administration was inherited from the colonial government run by British officers who once toured the districts
on horseback. The horses have disappeared, but the framework remains in place throughout the country. Except that now, it is digitally proficient, precise and swift (albeit mostly in times of crisis). Every district is headed by a district magistrate (DM) or collector who represents the civil administration, and who has the authority during disasters to commandeer virtually anyone and anything within the district.

Also Read: Fighting COVID-19: Why Women At Grassroots Level Must be Mobilised

How a Single Line of District Authority Helps Get the Job Done

At times like this, the DM’s authority is unquestioned and total: they (the DMs) can requisition empty buildings, privately owned transport, hotel space, and even manpower, and can order a halt or diversion of all movement, order house visits and establish systems for documentation and reporting. These are executed by line departments and enforced by the police, who themselves report to the DM. No other country has a network where administrative tentacles can activate so rapidly, and that can penetrate every house, rural or urban, rich or poor.

In health outbreaks, a much whittled-down but still dependable public health machinery gets ramped up, and
the ASHAs, ANMs, the male multipurpose workers, are used for house visits where needed.

Because of a single line of district authority which, crucially, does not depend on political actors during disasters, what is otherwise viewed as a slow and unresponsive administration, responds to crisis situations with incredible efficiency. That is how India managed to rehabilitate the districts affected by some of the worst floods, cyclones and earthquakes in the world, as well as eradicate polio, contain HIV/AIDS, and even the plague. Not to speak of small-pox which remains its most shining moment.

Also Read: How Did a Jamaat Conference Make Nizamuddin a Coronavirus Hotspot?

How COVID-19 Crisis Was Managed in Bhilwara, Rajasthan

To understand how COVID-19 gets managed on the ground, consider the district of Bhilwara in Rajasthan (total population 2.7 million) — which has been in the news because of a COVID-19 infected private hospital doctor along with 12 of his hospital staff. A relatively sleepy, largely rural district in one of India’s poorer states, Bhilwara was only known for textiles and scroll paintings. The doctor and staff who had all tested positive have been in isolation. How has Bhilwara — headlined by the BBC as “India’s possible Italy?” — responded? By 26 March, over two million people in the district — 88 percent of the population — had been surveyed through house-to-house visits.
The DM was certain of 100 percent coverage by 28 March. This was indeed achieved, and the entire 26 lakh-plus population of the district has been combed through, followed by quarantining hundreds of families and putting them under daily surveillance – both on phone and in person.

A third survey of the urban areas of the district, as well as a second survey of the rural areas, is underway. A list of beds which have been prepared in hotels, resorts, boarding lodges and the district hospital were provided immediately to me.

The first surveys showed influenza-like symptoms in 2,572 persons in urban areas, but now it has been reported that the number has plummeted to 842 in the second urban survey. Positive cases are beginning to test negative.

**Using Records of National Immigration & Railway Authorities Effectively**

What about other states? The Indian states of Jharkhand, Chhattisgarh and Odisha are ranked in the lowest cohort of states by the UNDP’s Human Development Index 2018. In all three states, front-line health workers visit quarantined cases day and night. Each suspected case, which meets the risk threshold, is transported by ambulance to the nearest health centre, where
samples are drawn, and the suspect and his family are quarantined until the test report is generated. Health Secretaries of all three states corroborate that this continues daily.

Cases were first identified using the records and manifestos of national immigration and railway authorities. The Integrated Disease Surveillance programme, run by the National Centre for Disease Control, tracks the hot spots through a call centre-based reporting system that was first deployed during the H1N1 outbreak in 2010.

The district administration itself runs electronically over mobile phones. In the health sector alone, four groups operate: at the interstate level, within districts, between contiguous districts, and between health Secretaries of the states and the Union Health Secretary – all on phone.

Things can go out of hand as happened suddenly in Delhi with the exodus of thousands of migrants back to their villages. They travelled on foot or anything moving. The reasons why this happened would need more than what this article can include, but the good news is that they are being identified, quarantined and checked – even fed and given shelter – not in thousands but tens of thousands.
India’s COVID-19 Fight Is Using Enormous Human Resources & Technical Prowess

India is actively combating COVID-19 in a way unknown to other countries using enormous human resources and technical prowess.

The Centre, the states and the districts are linked electronically, and the Health Ministry and top officials run daily video conferences.

A generous economic package covering cash transfers, food, pensions and cooking gas has been announced for all poor people who will pay nothing out of pocket. A government sponsored insurance package has been announced for all health workers. Langars (akin to soup kitchens in the west) for anyone hungry have commenced. In Delhi, measures to serve food to everyone who wants it are to begin across the wards by Wednesday, 1 April.

The latest to throw a huge spanner in what appeared to be a manageable story is the news of a congregation of a very large number of people in Nizamuddin, Delhi which has resulted in several confirmed COVID-19 cases. The visitors had travelled to India from other countries and infected people who have since travelled to different states. This was a totally unwarranted assembly, given that an embargo on any gathering of more than
50 people was announced from 13 March in Delhi – long before the countrywide lockdown came into force.

**Deep Roots of Indian Administration Will Leave No Stone Unturned**

Once again, the public health machinery has started combing operations which will now need to penetrate not just to find those who participated in the congregation but who have infected contacts and contacts of contacts.

*To ferret them out is once again dependent on a meticulous public health response – the success of which cannot be forecast. But not for want of trying.*

The COVID-19 crisis will certainly worsen. But it should be everyone’s hope that even as our most trustworthy research organisations, the most experienced clinicians and scientific institutions work in unison, the deep roots of the Indian administrative and public health system will leave no stone unturned in detecting infections and tackling them as set out in the Health Ministry’s directions.

We must salute all the people who are making this happen, and join hands in gratitude that India possesses the leadership, expertise and commitment that this situation demands. This is not the time to berate anyone – least of all the states and districts.
(Shailaja Chandra (IAS retd) has over 45 years experience of public administration focusing on governance, health management, population stabilisation and women’s empowerment. She was Secretary of the Department of Indian Systems of Medicine & Homeopathy, Ministry of Health & Family Welfare (1999–2002) and following that the Chief Secretary Delhi until 2004. She tweets at @over2shailaja. This is an opinion piece and the views expressed are the author’s own. The Quint neither endorses nor is responsible for them.)

We'll get through this! Meanwhile, here's all you need to know about the Coronavirus outbreak to keep yourself safe, informed, and updated.

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Placing a New World Order

The Covid-19 pandemic, by the time it's done, would have set the stage for altering the global power dynamic. International institutions are already coming under severe scrutiny and stress, while the good old nation-state, reeling on strong nationalist sentiments, seems to be taking centre stage.

The reason is two-fold. One, because of the way in which countries are fighting the onslaught of Covid-19 on their own, and two, the failure of global institutions to influence China’s actions and, thus, contain the economic fallout.

While the spread of the virus has been global, the fight against it has been national, with each individual government compelled to devise its own ways to cope with the crisis. Politically governments have largely relied on national resolve — almost like fighting a big war — to deal with the situation, especially the immeasurable loss of human lives.

Uniquely Indian

India has been no exception. If South Korea has fought the Covid-19 battle on the back of its strong public health care network, India has relied on its public administration system. Confounded by its limited healthcare capabilities, its fight has been built around enforcing social distancing and heavy contact-tracing. Three key areas need highlighting. First, the trust on efficacy of the colonial-era district administration system. The trinity of the district magistrate, superintendent of police and the chief medical officer of the district form the core unit eventually ensuring and enforcing the lockdown.

Second, carrying out heavy police-led human-intensive contact-tracing. The massive effort underway to trace the extent of the Tablighi Jamaat cluster in the world’s second most populous country is the best illustration of this approach. If India is able to deal with the unexpectedly big numbers impacted from this cluster, it would be because of its ability to conduct large-scale mass contact-tracing. And the principal reason for that, like it or not, has been the last mile beat policing system.

Third, the relatively more recent working disaster management structure from the district level up. This system has evolved over the past decade and become robust in some states prone to natural disasters. Odisha, for instance, which has had to regularly cope with cyclones, seems to have fine-tuned this system rather well and is able to execute pre-emptive measures better than some other states.

At a broader level, if India is able to pivot through this challenge, it would believe that the oft-criticized administrative structure has actually delivered. In other words, the State has emerged stronger. And this, with national variations, appears to be the holding narrative in most countries as governments have had to look inwards to find ways to protect their lot.

Now, to the question of China and its impact. This not about whether China is responsible for the spread of Covid-19 or not. That would be myopic. The real problem is that the pandemic has brought to the fore the overdependence of the global economy and its supply chains on China.

The world had to first deal with the economic consequences of the epidemic engulfing China. Now, when the situation has improved there, many countries are struggling to secure their medical supplies from China, which is ostensibly playing hard to get amid growing demand.

China-Dependence

In both situations, countries had to play along with Beijing because of the overdependence on supplies and equipment. India, too, has had to explore some sort of a government-to-government arrangement with China to obtain certain urgent healthcare supplies. China’s political clout has been such that neither the World Health Organisation (WHO) nor the United Nations (UN) could get a say in deciding timelines for action, or ensure transparency in the initial phase of the outbreak from Beijing.

As a result, with no international arbiter able to exert influence on either the health or supplies side on China, it was left to the governments of individual countries to literally fend for themselves. India, for instance, did not have a single known manufacturer of personal protective equipment in the first week of February. Now, there are reportedly five or six. The situation forced India to create domestic capacity just like with ventilators where the auto sector has been exploring options.

Many countries, including the US, are beginning to realise that overdependence on China has tied their hands in dealing with the spread of the pandemic. Worse, it has hugely constrained them in fighting the virus in their own countries.

In this backdrop, it’s logical for countries to proactively step up domestic manufacturing and explore politically viable alternate supply chains — not just as a backup but as national necessity. Which is why the world has realised the value of India's post-lockdown strategy has a plan to position itself accordingly — as well as to bear a positive impact on the stressed domestic economic situation.

Politically, a more powerful State facing Covid-19 challenges will push for better data gathering and surveillance on the population. There’s no reason why the Indian State would hold back, given its experience with contact-tracing.

The world as we know it is set for a major change. The manner in which India exits the lockdown will demonstrate how prepared India is, the efficacy of its system, and its reliability as a global alternative for the future.

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