THE INDIA FORUM
A JOURNAL-MAGAZINE ON CONTEMPORARY ISSUES

March 25, 2020

India Cannot Fight Coronavirus Without Taking Into Account its Class and Caste Divisions

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The country must rethink its strategy of fighting Covid-19 by taking into account the lives, the work and the living conditions of the marginalised sections of the society.

How do you discuss self-quarantine with a person sharing a tiny shanty with 10 people in a slum? How do you advise social distancing to a manual scavenger? How do you tell an Adivasi, who struggles for one meal a day, to prioritise hand sanitisers? How do you educate tuberculosis survivors about cough etiquette?

The epicentre for the global pandemic, Covid-19, recently shifted from China to Europe. China's authoritarian regime controlled it by enforcing a lockdown, and Europe and the United States are putting all their resources to use.

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The dominant narrative in India so far has been either about the state enforcing lockdowns or encouraging social distancing, self-quarantine, hand hygiene, and cough etiquette. [The Government of India has now enforced a nation-wide lockdown until 14 April]. Driven by political optics, public perception, and international pressure, these measures are important but coloured with class bias. India must rethink its strategy of epidemic management to be more inclusive of the marginalised sections of the society.

India needs to adopt global lessons to its local context and ask its own questions. How would Covid-19 affect a malnourished patient? What happens when it infects a tuberculosis survivor? In urban slums, what will be the average number of people who will catch a disease from an infected person? What public health measures could be applicable there? What could be an affordable alternative to hand sanitisers? How can accredited social health activists and auxiliary nurse midwives triage Covid-19—or decide the order of treatment of patients—to prevent overwhelming health systems? How do we adapt to provide services for all other diseases while building capacity for treating patients with Covid-19? How do we engage profit-driven private health-care partners to provide care in a people-centric manner?

Socio-economic fallout

Economically, lockdowns, restricted travel, ban on public gatherings, and working from home will result in the informal-sector workforce losing wages. Small shop owners and factory workers will suffer losses as in a recession. Families of daily-wage earners have been forced into poverty, children into malnutrition and workers into unemployment. Moreover, it is a time when unemployment rates are at a 45-year high, India's ranking in the global hunger index is 102, and the economy is in a slowdown. Unless equity is factored into plans for infection suppression, mitigation and care, this epidemic can turn into an economic catastrophe that would insidiously kill more people than Covid-19.

The national capital is still reeling from the violence that broke out in North East Delhi earlier this year. The Covid-19 outbreak has distracted the government from rehabilitation efforts, as is evidenced by accelerated attempts to disband camps set up for the internally displaced, delays in compensation, reduced media coverage, and the declining presence of volunteers on the ground.

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Furthermore, the pandemic is being cited as a reason to end the protests against the Citizenship Amendment Act. This kind of panic will shroud the solidarity of citizenry, but also allow authorities to enforce the agenda of the CAA, the National Register of Citizens, and National Population Register (NPR), causing apprehension and distrust. This does not bode well for epidemic management. [On 25 March, the Government formally decided to postpone both the NPR and the Census 2021 work, which was to begin on 1 April.]

Mitigating the medical, economic, and socio-political aspects of the epidemic will require colossal multi-disciplinary efforts. The marginalised and the vulnerable, both urban and rural, must be at the core of policy design. Learnings should be adopted from epidemic management in similar low-resource settings.

Health systems capacity, including diagnostics, must be augmented to make it accessible in the last mile. Temporary "corona treatment units", modelled along the lines of Ebola treatment units in West Africa, must be built at block levels. Accredited social health activists, practitioners of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy, and nurses should be trained in triaging or deciding the order of treatment for Covid-19, wearing and removing personal protective equipment, and emergency management of the disease.

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Considering the ecology of urban India, municipal bodies, in coordination with concerned stakeholders, should be empowered to design hyperlocal strategies for overcrowded neighborhoods, homeless shelters, and prison populations. Kerala has been an exemplar for all states in equity and inclusion. It demonstrated inclusive leadership by inviting religious leaders, panchayats and urban local bodies, and members of civil society and non-governmental organisations to participate; established communication in languages preferred by migrants to educate and prevent stigmatisation of the disease; and engaged prisoners in producing masks.

Holistic answers

It took years of struggle by Dalit leaders like Jyotiba Phule, BR Ambedkar, Periyar, and Kanshi Ram, to unveil the atrocities of casteism. In this context, we must realise that language shapes cultures and societies, and leaves an imprint on history. Words and phrases for fighting Covid-19 should not leave a legacy whose reversal will require a similar struggle. "Social distancing" has a caste connotation. It must urgently be replaced by "physical distancing".

On the economic front, funds should be allocated for an unemployment allowance, at least until the crisis is over. All states should learn from Kerala and Chhattisgarh and suspend biometric authentication for public distribution system benefits, increase the amount of food rations, and ensure adequate supply of hand sanitisers and disinfectants.

> Viruses and bacteria do not discriminate, but society does.

Viruses and bacteria do not discriminate, but society does. Societal structures shaped by oppressive structural forces of casteism, classism, communalism, elitism, and patriarchy render a certain section more vulnerable than others to the virus. HIV disproportionately afflicts the socially marginalised injection drug users, commercial sex workers and homosexual men. Similarly, malaria kills geographically marginalised Adivasis and forest dwellers, and tuberculosis excessively plagues the economically marginalised. The spread of Covid-19 will be no different, but we have an opportunity to change this. If we want to avoid the old patterns in prevention and care in the case of Covid-19, the time to act is now.

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