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Community mobilization during epidemic emergencies: Insights from Kerala

M Rashmi
Department of Social Sciences, Vellore Institute of Technology (VIT), Vellore, India

V Nair Lekshmi
Department of Humanities, Indian Institute of Space Science and Technology (IIST), Trivandrum, India

Abstract

The present paper describes the strategy to mitigate and control epidemic contingencies in the backdrop of Kerala's Covid-19 containment plan. I have purposefully selected Kerala, the southernmost state of India, because of its globally acclaimed experience in efficiently managing the cases of coronavirus that were reported. Even tackling the Nipah and Zika virus cases in the pasts, makes it an exemplary unit of study. Moreover, the past experience of the state points to the fact that the containment strategy adopted is the result of an evolved practical approach. I came across certain innovative strategies implicating community mobilization like community kitchens, social surveillance, large scale production of face masks etc. by utilizing the hidden productive capacity of communities that extended from women self-help groups, youth clubs and even prison inmates. Moreover, the state's controlling and containing measures were mentioned by international media and agencies like the BBC and the World Health Organization (WHO).

Corresponding author:
M Rashmi, Department of Department of Social Sciences, Vellore Institute of Technology (VIT), Vellore, Tamil Nadu, India.
Email: pmrashmi87@gmail.com

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Introduction

The health ministry of India released an official statement on March 13, 2020, stating that Covid-19 was not a health emergency and there was no need to panic. One day later, I received an official notification from the University declaring a mandatory shutdown of campus until further information. It was at this moment when I realized the actual gravity of the situation. Although Covid-19 had no direct impact on me other than causing a brief state of consternation, it made me think how this pandemic will affect people and how as a social being I can contribute to support the worldwide efforts. Therefore, I grabbed the opportunity of unfolding some exceptional interventions and determined efforts to exemplify a synergy between the society and the Government of Kerala. The state of Kerala is in the southwest corner of the Indian subcontinent and globally recognized for its investment in healthcare and education (Kutty, 2000). Despite being one of the poorest regions in the world in terms of per capita income, the health indicators of the state are almost at par with the developed nations (Varman, 2008). The socio-economic development witnessed by Kerala is commonly classified as high social development with low per capita income. Kerala can be considered as the best example of a state that has shown unparalleled success in poverty alleviation achieved through investments in human capital (Parayil and Sreekumar, 2003). Compared to the rest of India, this state has higher literacy rates and better health index.

The insights I gained helped me to understand the systematic approach adopted by the state to contain and mitigate the spread of the virus. International media and agencies like the BBC and the World Health Organization (WHO) have also mentioned the state's innovative strategies. Hence, through this essay, I will reflect upon the containment strategy employed by Kerala. Information from news and expert interviews including medical experts, ministers, bureaucrats, politicians, police officials and social work researchers form a major share of my insights and it is further supported by my participation in Covid-19 interventions. I will begin by discussing the various strategies adopted by Kerala and the methods founded upon social work practice. In conclusion, I will summarise and reflect on the underpinning aspects which controlled and sustained Kerala's response towards Covid-19 pandemic.

Pandemic and Kerala's response

Although I was aware of the devastation caused by Covid-19 in China, it came as a complete shock when I heard that the first reporting of a case in India was in the

Thrissur district of Kerala on January 30, 2020. It included three Indian students from Wuhan (Kurien, 2020). The following weeks saw an increase in the number of infections and I could not resist asking myself, 'How is Kerala going to face this?' The state had already faced two consecutive floods and Nipah virus outbreaks during the year 2018 and 2019, which had already caused severe apprehensions in the minds of its people. But within a few weeks, I realised that the same experience in dealing with these issues resulted in high improvisation at the early stage of response towards Covid-19. Kerala's initial strategy focused on surveillance and screening of all incoming passengers from China and others who had come in close contact with these travellers. The government utilised this method of route mapping to track primary contacts during the Nipah outbreak.

Even though anxiety and fear had made a strong foothold in people's mind but as a sociologist, I was relentlessly observing the social changes around me. As stated by Chetterje (2020), India too responded to this epidemic emergency through 'non-pharmaceutical interventions' like lockdown, social distancing, quarantine and isolation. Therefore, cities, beaches and public spaces became deserted and looked clean with less plastic. Indian marriage functions which used to be visible sites of extravagant consumption, competition, conservatism and wastage now resembled small family affairs. Although there were positive changes, I could also see hunger, poverty and helplessness of daily wage workers and business people. When India imposed lockdown, Kerala became the first Indian state to announce a USD 2.7 billion package to support informal sector labourers, daily wage and unemployed workers.

Social distancing is a widely accepted and medically endorsed method to curb the spread of coronavirus, but it gradually transformed itself into the form of social stigma. People started looking at each other with suspicion. Initially, I could not tolerate strangers near me while visiting grocery stores. This came out of the fear of contracting the disease and hence, being labelled as a social outcast. News reports and social media were extensively filled with such cases. The patients identified as Covid-19 positive were sanctioned by stigmatizing them as violators of some social norms. They were held responsible for causing chaos by spreading the virus.

Role of the government health department

A systematic investment for strengthening the health infrastructure had already begun in 2016 with the launch of the *Aardram* mission to deliver patient-friendly, quality health care services in Primary Health Centres (PHCs) and local government hospitals. As a result, the government became equipped to provide Covid-19 treatment due to the subsequent improvement in hospital facilities. During the initial phase, at least two dedicated hospitals for the isolation and treatment of positive cases were set up in each district with the help of trained staff from every speciality. Airports and seaports across the state ensured the early screening of all incoming passengers. When the cases increased, the government installed screening

facilities at bus and train stations. The state health department took up the systematic and painstaking method of contract tracing and publishing the route map of the Covid-19 patients. This method helped early identification and isolation of all the people who fell into the potential risk category. The solutions initiated by Kerala showed relevance for future applications with the launch of the telemedicine portal *e-sanjeevani* meant for ensuring effective consultation platform for the patients to have a direct interface with doctors during Covid-19 restrictions.

Crisis intervention using community mobilization

As I mentioned before, the stigmatization of Covid-19 patients can harm their social relationships and self-esteem. Recent research published by Horesh and Brown (2020) discusses the long-lasting effects of traumatic stress. It can even reduce the possibility of individuals with symptoms to seek treatment. This has also led to several cases of patients/tourists fleeing from hospital isolation wards, forcing government officials to trace them and bring them back. To address such issues, an initiative to provide psychosocial support began under the title "*Ottakalla Oppamundu*" (Not alone, you have company). It started with the support of 1142 mental health personnel including psychiatrists, psychosocial workers, clinical psychologists, social workers and counsellors. Through this venture, the Ministry of Health ensured psychosocial support calls to mentally ill patients, children with special needs, guest labourers, and elderly people living alone (Government of Kerala, 2020). They also arranged counselling services for personnel working in corona outbreak control activities.

On March 17, 2020, the government launched a massive hand washing campaign in the name of "Break the Chain". As an immediate response, the media took up the task of propagating the importance of public and personal hygiene. Within a few days, I observed new water taps and hand sanitizers installed at public spots like the entry and exits of railway stations, bus stations and government offices. I realized that cleanliness had become the new norm and people, irrespective of their socio-economic and cultural backgrounds, began carrying their own sanitizers and washed their hands regularly using soaps. Now, what caused this massive acceptance of the awareness campaign? As a sociologist, I could readily understand that the high literacy rate of the state and the women self-help groups under *Kudumbashree* helped the cause. *Kudumbashree* is a poverty eradication and women empowerment programme implemented by the State Poverty Eradication Mission (SPEM) of the Government of Kerala. The information that I gained from officials showed that virtual meetings of around 2.2 million members were organized to spread information in the form of posters, messages, narrations and videos through various social media platforms. After the Covid-19 cases increased in Kerala, every day seemed like a new mission.

On March 30, 2020, the Government of Kerala announced an innovative initiative named as the community kitchen. For me it appeared as a remarkable movement towards community mobilization, but it required rigorous planning

and effort. This idea was implemented in Kerala during the floods of 2018 and 2019. I was highly sceptical regarding the feasibility of this idea, as community mobilization defied social distancing. I was astonished to know that over 1200 community kitchens were functioning in Kerala under the guidance and coordination of Local Self Government Departments (LSGDs) with the support of *Kudumbashree* (WHO, 2020). Residents' associations, youth clubs and other social welfare groups also adopted this initiative. As a responsible social being, I too took part in one of such community kitchen. This was an opportunity for me to understand social action undertaken with utmost social responsibility. Everybody used masks, sanitizers, and all kinds of preventive measures. Only a few people from close localities entered the kitchen. As a participant, I can proudly say that more than ten million free cooked food packets reached in the hands of the needy, isolated and quarantined people.

The following weeks saw the severe scarcity of life-saving resources which resulted from rising anticipation on the possibility of Covid-19 outbreak. The solutions proposed by the government again astounded me. As the lack of supply accelerated the price of personal protective equipment, women self-help groups, health care volunteers and even prison inmates were engaged to ensure massive production of face masks. The prison inmates of Kerala made over a million masks in the past three months.

Conclusion

My insights on Kerala's containment model would be incomplete if I don't discuss the factors that had outstanding implications on the strategies framed by the state. Some of them seemed to constrain while others supported the cause. Kerala's model of healthcare is community-based, which promotes universalization of access (Azeez and Selvi Anbu, 2019). The interventions implemented by the health care system during Covid-19 proved its competence, and it is because of this health care system we have a high level of health status in Kerala (Kutty, 2000). I should also mention the role played by social workers in communities and localities during this epidemic crisis which extended beyond traditional support. Social work has a long association with the medical profession (Beddoe, 2011), and this was highly recognized by the government. They were engaged in multiple tasks like advocacy, research (Montigny, 2018), psychosocial care (Ryan et al., 2004) and administration. Around 1140 psychiatrists, counsellors and social workers are tracking the everyday activities of children, elderly and infected persons. Community mobilization (Fisher and Kling, 1989) and volunteerism became crucial determinants of Kerala's successful health care intervention. I could observe the collaborative and participative approach undertaken by the government with an utmost commitment towards social inclusion. Such massive dissemination of information and participation was possible for Kerala because of its roots enriched by the power of decentralization. This led to transferring decision making power into the hands of the grassroots. High levels of literacy, especially among women

(Susuman et al., 2014) ensured proper comprehension of information within families. There was a close coupling between social media, print media and electronic media which updated the public, political and government agencies with comprehensive information on the pandemic.

Some of the strengths of Kerala can also be identified as its weaknesses: the major export of the state is its skilled labour, and it receives the biggest share of remittances from abroad than any state in India (The Economic Times, 2019), much of which comes from the Middle East. Kerala is also considered as a pioneering state in tourism (Government of India Planning Commission, 2008). Hence, in the present scenario, the two factors, namely migration and tourism, seem to have become a cause for the greater risk of transmission. Hence, the major hazards that limit the state's interventions are its massive inflow of expatriates from other nations which has increased the recurrence of Covid-19 positive cases. Being a consumer economy with the highest per capita consumption in the country, the state can never close its borders. Kerala imports most of the food commodities from its neighbouring states, which enhances its possibility of infection. Given the fact that coronavirus is likely to be with us for some time, I can say that Kerala is ready to face the monsoon rains and the floods that may follow, along with an inflow of around 300 thousand returnees till December 2020.

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ORCID iD

M Rashmi https://orcid.org/0000-0001-5389-3242

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