13

# COMMITTEE ON EXTERNAL AFFAIRS
(2021-2022)

SEVENTEENTH LOK SABHA

**MINISTRY OF EXTERNAL AFFAIRS**

# COVID-19 PANDEMIC - GLOBAL RESPONSE, INDIA'S CONTRIBUTION AND THE WAY FORWARD

**THIRTEENTH REPORT**

सत्यमेव जयते

**LOK SABHA SECRETARIAT**
**NEW DELHI**

***MARCH 2022/CHAITRA, 1944 (Saka)***

**THIRTEENTH REPORT**

**COMMITTEE ON EXTERNAL AFFAIRS**
**(2021-2022)**

**(SEVENTEENTH LOK SABHA)**

**MINISTRY OF EXTERNAL AFFAIRS**

# COVID-19 PANDEMIC - GLOBAL RESPONSE, INDIA'S CONTRIBUTION AND THE WAY FORWARD

***Presented to Lok Sabha on 24 March, 2022***
***Laid on the Table of Rajya Sabha on 24 March, 2022***


**LOK SABHA SECRETARIAT**
**NEW DELHI**

***MARCH 2022/ CHAITRA, 1944 (Saka)***

COEA NO.

***Price :*** **Rs. .....**



Published under Rule 382 of the Rules of Procedure and Conduct of Business in Lok Sabha (Eleventh Edition) and Printed by

## CONTENTS



## REPORT



## APPENDICES

## COMPOSITION OF THE COMMITTEE ON EXTERNAL AFFAIRS (2019-20)

**1. Shri P.P. Chaudhary, Chairperson**

**Lok Sabha**

2. Shri Abhishek Banerjee
3. Shri Margani Bharat
4. Kunwar Pushpendra Singh Chandel
5. Shri Jayadev Galla
6. Shri Dileshwar Kamait
7. Smt. Preneet Kaur
8. Shri Pakauri Lal Kol
9. Smt. Meenakashi Lekhi
10. Smt. Poonam Mahajan
11. Shri P. C. Mohan
12. Shri Borlakunta Venkatesh Netha
13. Shri Ritesh Pandey
14. Dr. K. C. Patel
15. Shri Soyam Babu Rao
16. Shri Achyutananda Samanta
17. Shri Ram Swaroop Sharma
18. Shri Ravindra Shyamnarayan Shukla *alias* Ravi Kishan
19. Shri Manoj Tiwari
20. Shri Rebati Tripura
21. Shri N.K. Premachandran

**Rajya Sabha**

22. Shri K. J. Alphons
23. Smt. Jaya Bachchan
24. Smt. Misha Bharti
25. Shri P. Chidambaram
26. Shri Swapan Dasgupta
27. Shri Ranjan Gogoi*
28. Shri Shamsher Singh Manhas
29. Shri Kapil Sibal
30. Shri Abdul Wahab
31. Vacant**

**Secretariat**

| | | | |
|---|---|---|---|
| 1. | Shri P.C.Koul | - | Additional Secretary |
| 2. | Dr. Ram Raj Rai | - | Director |
| 3. | Shri Paolienlal Haokip | - | Additional Director |
| 4. | Mohd. Taimoor | - | Assistant Executive Officer |

*Shri Ranjan Gogoi, Member, Rajya Sabha nominated w.e.f. 23.07.2020, Parliamentary Bulletin Part II No. 59970 and

**Shri Chunibhai Kanjibhai Gohel and Shri Sharad Pawar, Members, Rajya Sabha ceased to be Members of the Committee w.e.f. 09.04.2020.

## COMPOSITION OF THE COMMITTEE ON EXTERNAL AFFAIRS (2020-21)

**1. Shri P.P. Chaudhary, Chairperson**

**Lok Sabha**

2. Smt. Harsimrat Kaur Badal
3. Shri Abhishek Banerjee
4. Shri Kalyan Banerjee
5. Kunwar Pushpendra Singh Chandel
6. Shri Dileshwar Kamait
7. Shri Suresh Kumar Kashyap
8. Smt. Preneet Kaur
9. Smt. Goddeti Madhavi
10. Smt. Poonam Mahajan
11. Shri P. C. Mohan
12. Ms. Chandrani Murmu
13. Shri Ritesh Pandey
14. Dr. K. C. Patel
15. Shri N.K. Premachandran
16. Shri Navneet Ravi Rana
17. Shri Soyam Babu Rao
18. Shri Manne Srinivas Reddy
19. Shri Rebati Tripura
20. Vacant[$]
21. Vacant[*]

**Rajya Sabha**

22. Shri K. J. Alphons
23. Smt. Jaya Bachchan
24. Smt. Misha Bharti
25. Shri P. Chidambaram
26. Shri Ranjan Gogoi
27. Shri Swapan Dasgupta[#]
28. Shri Kapil Sibal
29. Shri Abdul Wahab[@@]
30. Shri Brij Lal
31. Vacant[@]

**Secretariat**

| | | | |
|---|---|---|---|
| 1. | Shri P.C.Koul | - | Additional Secretary |
| 2. | Dr. Ram Raj Rai | - | Director |
| 3. | Shri Paolienlal Haokip | - | Additional Director |
| 4. | Mohd. Taimoor | - | Assistant Executive Officer |

[$] Shri Ram Swaroop Sharma passed away on 17 March, 2021.

[*] Smt. Meenakshi Lekhi ceased to Member of the Committee on her appointment as Minister w.e.f. 07.07.2021.

[#] Shri Swapan Dasgupta resigned on 17.03.2021 and has been re-nominated *w.e.f.* 11.06.2021.

[@@] Shri Abdul Wahab retired on 21.03.2021 and has been re-nominated *w.e.f.* 11.06.2021.

[@] Shri Jyotiraditya M. Scindia ceased to be Member of the Committee on his appointment as Cabinet Minister w.e.f. 07.07.2021.

## COMPOSITION OF THE COMMITTEE ON EXTERNAL AFFAIRS (2021-22)

**1. Shri P.P. Chaudhary, Chairperson**

**Lok Sabha**

2. Smt. Harsimrat Kaur Badal
3. Shri Abhishek Banerjee
4. Shri Kalyan Banerjee
5. Shri Dileshwar Kamait
6. Shri Suresh Kumar Kashyap
7. Smt. Preneet Kaur
8. Smt. Goddeti Madhavi
9. Smt. Poonam Mahajan
10. Shri P. C. Mohan
11. Smt. Queen Oja
12. Shri Ritesh Pandey
13. Dr. K. C. Patel
14. Shri N.K. Premachandran
15. Smt. Navneet Ravi Rana
16. Shri Soyam Babu Rao
17. Shri Manne Srinivas Reddy
18. Shri Rebati Tripura
19. Dr. Harsh Vardhan
20. Shri E.T. Mohammed Basheer*
21. Vacant

**Rajya Sabha**

22. Shri K. J. Alphons
23. Smt. Jaya Bachchan
24. Smt. Misha Bharti
25. Shri Brijlal
26. Shri P. Chidambaram
27. Shri Swapan Dasgupta
28. Shri Prakash Javadekar
29. Shri Sanjay Raut
30. Shri Kapil Sibal
31. Shri K. Somaprasad

**Secretariat**

| | | | |
|---|---|---|---|
| 1. | Shri P.C.Koul | - | Additional Secretary |
| 2. | Dr. Ram Raj Rai | - | Joint Secretary |
| 3. | Ms.K. Muanniang Tunglut | - | Deputy Secretary |
| 3. | Mohd. Taimoor | - | Executive Officer |

* Shri E.T. Mohammed Basheer, Member of Parliament, Lok Sabha nominated to the Committee *w.e.f.* 7.02.2022.

## INTRODUCTION

I, the Chairperson of the Committee on External Affairs, having been authorized by the Committee to present the Report on their behalf, present this Thirteenth Report of the Committee on External Affairs (2021-22) on the subject 'COVID-19 Pandemic-Global Response, India's contribution and the Way Forward'.

2. The Committee selected the subject 'COVID-19 Pandemic-Global Response, India's contribution and the Way Forward' for detailed examination during 2019-20 and continued the examination during 2020-21 and 2021-22. The Committee held briefing/took oral evidence of the representatives of the Ministries of External Affairs, Health and Family Welfare, Home Affairs, Civil Aviation, Finance (Department of Economic Affairs and Department of Revenue) Commerce and Industry, Education, Women and Child Development, Consumer Affairs, Food & Public Distribution, Skill Development and Entrepreneurship, Labour and Employment and Science and Technology (Department of Biotechnology) on 29 July, 2020; 11August 2020; 19 October, 2020; 10 March, 2021; 19 July, 2021 and 8 December, 2021.

3. The Report was considered and adopted by the Committee at their Sitting held on 21 March, 2022. The Minutes of the Sitting of the Committee are appended to the Report.

4. The Committee wish to express their gratitude to the Ministries of External Affairs, Health and Family Welfare, Home Affairs, Civil Aviation, Finance (Department of Economic Affairs and Department of Revenue), Commerce and Industry, Education, Women and Child Development, Consumer Affairs, Food & Public Distribution, Skill Development and Entrepreneurship, Labour and Employment and Science and Technology (Department of Biotechnology) for placing material information as well as tendering evidence and views before the Committee.

5. For facility of reference, the Observations/Recommendations of the Committee have been printed in bold letters in the Report.

**NEW DELHI**
**21 March, 2022**
**30 Phalguna, 1943 (Saka)**

**P.P. CHAUDHARY,**
**Chairperson,**
**Committee on External Affairs**

# CHAPTER I

## COVID-19 PANDEMIC - AN OVERVIEW

The world is witnessing an unprecedented health crisis since January 2020 due to the highly contagious COVID-19 Pandemic. Corona viruses are a large family of viruses which may cause illness in animals or humans. In humans, several corona viruses are known to cause respiratory infections ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).

1.2 The outbreak of Novel Coronavirus Disease (COVID-19) was initially noticed in a seafood market in Wuhan city in Hubei Province of China in mid-December, 2019, and has thereafter rapidly spread worldwide. On 30 January, 2020, WHO under International Health Regulations declared this outbreak as a "Public Health Emergency of International Concern" (PHEIC) and subsequently on 11 March, 2020, COVID-19 disease was declared a „pandemic". Covid -19 Pandemic has impacted societies, famiies, communities and individuals across the world in unimaginable ways.

1.3 Patients affected with this disease have fever, cough, breathing difficulty etc. with wide variation from mild to severe (including development of severe acute respiratory illness or SARI). Most people infected with COVID-19 have mild symptoms and recover. Approximately 85 % of laboratory confirmed patients have mild disease, 15% may require hospitalization of which 5% cases may be critical requiring intensive care.

1.4 When asked to present an analogy of COVID-19 disease in comparison with other viral diseases such as Avian Influenza, H1N1 influenza and Nipah, the Ministry of Health and Family Welfare in a written reply submitted, that COVID-19 is a new viral disease. Many crucial parameters like extent and role played by sub-clinical/asymptomatic infections, period of virus

shedding, modes of transmission, post COVID sequelae or long term consequences, etc. remain under investigation. However, being predominantly a viral respiratory disease, the presenting symptoms are similar to seasonal Influenza and other less known viral respiratory pathogens such as Respiratory Syncytial virus, Adenovirus, etc.

**Mutation of Virus/Multiple variants**

1.5 During the course of evidence on 28th December, 2020 regarding new mutation of virus reported in UK, the representative of Ministry of Health and Family Welfare informed the Committee:

> "SARS-CoV-2 is an RNA virus. An RNA virus mutating itself is not unusual. Mutation in virus is something that happens naturally. There are two concepts in the scientific community when they talk of these mutations. The first concept is of virus drift and the other concept is of virus shift. Virus drift happens when there are these minor mutations in virus. On an average, one to two mutations may take place in a virus every month in a pandemic situation. But that cannot be a cause for worry. The concept of virus drift basically means that mutations are such that human body has the resistance power and antibodies to fight with the virus. However, the second concept is of virus shift. This is when multiple mutations take place quickly in a virus and the virus becomes as good as a new virus. So, when virus shift takes place, the immune system of the body is challenged. What has happened in UK is a virus shift and not a virus drift. This new mutated virus is called VUI 202012/01. This VUI stands for Variant Under Investigation Virus. What has this done? This has impacted the spike protein of the virus and the S-gene, causing the S-gene to drop out which means that anything that is directed towards that spike protein or S-gene will not have any impact because that gene has dropped out from the virus".

1.6 In a written note Ministry of Health and Family Welfare further added that this variant is estimated by European Center for Disease Control (ECDC) to be more transmissible and affecting younger population. This variant is defined by a set of 17 changes or mutations. One of the most significant is an N501Y mutation in the spike protein that the virus uses to bind to the human ACE2 receptor. Changes in this part of the spike protein may result in the virus becoming

more infectious and spreading more easily between people. There is increasing evidence that the mutant variant of SARS-CoV-2 are in circulation in many countries and these mutant variants are driving the pandemic in their country of origin. So far, the three SARS-CoV-2 variants in circulation viz, (i) UK Variant [VOC 202012/01 (B.1.1.7)] (ii) South Africa variant [501Y.V2 (B.1.351)] and (iii) Brazil variant [P.1 (P.1)] - have been detected in 86, 44 and 15 countries respectively.

1.7 The World Health Organization has classified each emerging variant as either a Variant of Concern (VoC) or a Variant of Interest (VoI). The Alpha, Beta, Gamma and Delta variants fall under Variants of Concern where as ETA, Iota, Kappa and Lambala fall under Variants of Interest. A Variant of Concern translates to a rise in transmissibility, an increase in fatality and a significant decrease in effectiveness of vaccines, therapy and other health measures.

1.8 During the course of evidence when asked about the preventive measures undertaken to contain the spread of new mutation of virus in India, the representative of Ministry of Health and Family Welfare informed the Committee:

> "…We stopped all flights coming from UK. In fact, we stopped them from mid-night of 23rd December, 2020 onwards, but all the flights which came from 21st to 23rd December, 2020, 100 per cent RT-PCR tests were done at the airport and the people, who were found positive, were isolated and their samples were sent for genome sequencing because without doing that, you cannot determine whether the person is positive because of the mutated virus or the regular conventional virus which has already been reported in the country. To do genome sequencing, we have created a consortium of 10 labs which belong to the Ministry of Health and Family Welfare, CSIR, ICMR and Department of Biotechnology. These 10 labs are also geographically distributed and we have assigned States to these labs. These labs are National Institute of Biomedical Genomics in Kolkata, a DBT lab; Institute of Life Sciences lab, Bhubaneswar – a DBT lab; National Institute of Virology, Pune - a lab of ICMR; National Centre for Cell Science, Pune – a DBT lab; Centre for Cellular and Molecular Biology, a CSIR lab; Centre for DNA Fingerprinting and Diagnostics in Hyderabad, a DBT lab; InStem, Bengaluru - a DBT lab; NIMHANS, Bengaluru of Ministry of Health and Family Welfare; Institute of

Genomics and Integrative Biology, a CSIR lab; NCDC in Delhi, a lab of the Ministry of Health and Family Welfare. These samples have been sent to these 10 labs and by late evening today, we will start getting their results. This exercise would continue because we have also said that all people who have arrived in the country 28 days prior to 21st of December - 14 days is the incubation period of the virus and we have taken double the incubation period - from 23rd November to 23rd December will be subjected to their samples being taken and tested. Then, the genome sequencing would be done. Based on that, we will take further action. "

1.9 In the same context, the Ministry of Health and Family Welfare further informed that we had also convened a meeting of the National Task Force on COVID which is co-chaired by Dr. V.K. Paul, Member NITI Aayog and Dr. Balram Bhargava, DG, ICMR. They came up with three recommendations. The first one is that the mutant virus would require the same treatment protocol that is being given to the conventional positive patients. Second, the existing diagnostic kits will continue to function against the mutant virus also. The third recommendation was that people who test positive and in the genome sequencing are found to possess the mutant virus will have to be isolated for 14 days and their contacts will have to be traced and they will also have to be isolated for 14 days. We have already started that action even before the results have come because we cannot take the risk of letting them roam around in the society while their results are yet to come. This is as far as the mutant virus is concerned.

1.10 During the course of evidence on being enquired about symptoms of new mutation of coronavirus, the representative of Ministry of Health and Family Welfare *inter-alia* informed:

"Even before this mutation came into the picture, not every COVID-19 patient would have the same symptoms. As I told you, the infection is categorized into three categories, mild disease, moderate disease, and severe disease. If I have mild disease, I may have fever, I may have body ache, but I may have no breathing difficulty and I may recover".

1.11 Regarding Delta variants of virus, the representative of the Ministry of Health and Family Welfare during evidence on 19 July, 2021 submitted:

"It was in January that the Government of India decided that they will set a consortium of 10 Central Government labs which would do genome sequencing of various positive samples to see whether the virus is mutating in a significant manner. If yes, then where

this mutation is taking place and what the public health response to such mutation should be."

1.12 The witness further added:

"Sir, it started with 10 labs in January, 2021. Today, it has 28 labs and it is spread across the country. In course of genome sequencing, this consortium found the presence of Delta variant first in Maharashtra. Then, it found that it was reported from a large number of districts across the country. In some of the States, the consortium also found that the increased number of cases was also in part because of the presence of Delta virus in that geography. Therefore, Delta virus was termed as a virus of concern. Recently, the INSACOG has found that Delta has further mutated into Delta Plus. The consortium could find only 70-odd cases of Delta Plus across the country. Till date, the considered opinion of the consortium is that Delta Plus will not be, based on present evidence, in a position to drive infection in larger numbers across geographies."

1.13 Elaborating on virus behaviour, the witness from the Ministry of Health and Family Welfare during evidence on 19 July, 2021 deposed:

"What we are telling the States is that any future surge is largely governed by two parameters. One, the way we as a nation collectively behave and two, the way the virus behaves. Virus behaviour is basically relating to its mutation. Till date the virus in the last two-three months has not mutated significantly which would lead to greater transmissibility. This is as far as the virus behaviour is concerned."

1.14 Regarding the latest B.1.1.529 variant called the Omicron variant of Covid virus the Ministry of Health and Family Welfare, informed that it was reported to WHO from South Africa on 24th November, 2021 WHO on 26th November, 2021 declared Omicron, first detected in Gauteng Province, Southern Africa to be a variant of concern. As on 8th December, 53 countries have now reported a total confirmed 1092 cases of Omicron variant. Of these, 23 cases have been confirmed in India so far.

**Research on Virology**

1.15 When asked to chalk out plans to increase research and infrastructural support in virology in order to prevent such other pandemic in future, the Ministry of Health and Family Welfare in a written reply stated that Government of India, realizing the need for a comprehensive research ecosystem for facilitating research on virology and development of diagnostics, therapeutics and vaccines have factored in the requirements under the Atmanirbhar Bharat Abhiyaan of Ministry of Finance.

The health research related component before the Cabinet for approval includes:

i. Setting up of National Institute of Virology (NIV) Central Zone as Centre for "One Health" at Nagpur
ii. Establishment of regional NIVs (Dibrugarh, Chandigarh, and Bengaluru)
iii. Division for research on disease elimination sciences & health in ICMR-NARI, Pune
iv. Regional research platform of WHO-South East Asia Region countries
v. Strengthening of 80 Viral Research and Diagnostic Labs (VRDLs) and 19 new BSL-III labs

This in turn will facilitate -

i. Enhanced laboratory capacity for investigation of Zoonotic diseases
ii. Availability of trained viral research and diagnostic professionals
iii. IT enabled disease risk-maps and identification of hotspots for prioritized zoonotic diseases across the country
iv. Networking of multi-disciplinary institutions for early detection of emerging viral infections
v. Capacity and mechanisms for development of indigenous technology for diagnosis and treatment of virulent pathogens

**1.16 The Committee note that COVID-19 is an infectious viral disease caused by a newly discovered Corona Virus (SARS-CoV-2) which was first noticed in December, 2019 in Wuhan City, China. World Health Organization (WHO) declared the COVID-19 outbreak a Public Health Emergency of International Concern in January 2020, and a pandemic in March 2020. Initially the virus spread through droplets of saliva, cough particles or nasal**

**discharge from infected person. It quickly assumed global proportions. As on date it has affected 450 million people and has claimed more than 6 million**

**lives during a span of two years. „Variants of Concern" as classified are responsible for rise in transmissibility and an increase in fatality. The Delta variant that was first detected in India in October, 2020, was labeled a variant of concern by WHO. Delta was spreading 50 per cent faster than the Alpha variant which was 50 per cent more contagious than the original strain of SARS-CoV-2 more commonly known as Coronoa virus. The Delta strain had ravaged the country causing a record breaking number of daily cases and claiming lives during six months. By June 2021, it was responsible for a fresh surge in cases in UK, Israel, Russia, Australia and several other parts of the world. Omicron which was quickly tagged a variant of concern after being detected in South Africa in late November, 2021 has replaced Delta, almost globally, as a dominant strain in a very short span of time. Though milder, Omicron is at least two to four times more transmissible than the Delta variant. WHO has stressed that the Pandemic is far from over and future variants in some ways more virulent than Omicron may emerge in future. Due to such variants, India has already faced at least three waves of COVID-19 Pandemic and various countries have been faced/facing multiple waves. With the spread of Omicron Variant there is an unprecedented surge in COVID-19 cases in Japan, US, UK and to an extent in European Union countries during the last three months. China is in the middle of a new surge. In India in many States significant number of COVID-19 cases were reported both of Delta and Omicron. The daily cases peaked around 350000 during the third wave. Mercifully, hospitalization and deaths were quite low compared to the Second Wave due to the inherent nature of Omicron Variant. The Committee, therefore, can assume that in addition to the ongoing wave of Covid the country will remain vulnerable to future waves of other variants of virus. The Committee also find that after ebbing of second wave and**

**opening of lockdowns, people became unmindful of COVID-19 appropriate behavior and started attending social gatherings even without masks particularly in sub-urban and rural areas. Such carelessness could be responsible for spread of virus/infection of Omicron variant and this needs to be dealt with utmost seriousness. The Central Government has been issuing advisories from time to time pertaining to micro containment to prevent a wider spread in community. Moreover, the directions under National Disaster Management Act (NDMA) have been curtailed leaving the unlock process largely on states. The Committee, therefore, strongly recommend in the states/areas currently recording worrying level of infections, the Central Government should apply the National Disaster Management Act and issue strict directions to the states with high covid positivity rates for imposing restrictions particularly to prevent spurts and wide spread of infections and also to minimize the chances of mutation. Ministry of External Affairs should also proactively contribute in this endeavour by regular updation about mutations and spread of the disease in various parts of the world as well as regulation of the entry of persons with new mutants in the country.**

**(Recommendation No. 1)**

**1.17 The Committee are apprised that Corona Viruses may cause illness in animals or humans. The Committee are happy to learn that the proposals such as setting up of National Institute of Virology (NIV) as Centre for "One Health" at Nagpur, establishment of regional NIVs at Dibrugarh, Chandigarh and Bengaluru, Division for research on disease elimination sciences and health in ICMR-NARI, Pune, Regional research platform of WHO- South East Asia Region countries and strengthening of 80 Viral Research and Diagnostic Labs (VRDSs) and 19 new BSL-III labs are under consideration of the**

**Government and desire that the Government ought to clear the proposals with utmost promptitude so that the capacity** for **investigation of Zoonotic diseases in the country could be strengthened without any further delay. Given that many crucial parameters like extent and role played by sub-clinical/asymptomatic infections, period of virus shedding, modes of transmission, post COVID sequelae or long term consequences of coronaviruses are under investigation, the Committee feel the need for establishment of a comprehensive research ecosystem for strengthening research on virology and development of diagnostics, therapeutics and vaccines in each part of the country. The Committee, therefore, strongly recommend setting up a chain of research institutes/laboratories for the same purpose in each State/Union Territory to supplement the functions of National Institute of Virology (NIV) so that the country can become fully capable to deal with diseases like covid-19 timely and effectively in future. Ministry of External Affairs should take the responsibility of exploring international cooperation in establishing those laboratories with latest technology and equipment in consultation with the Ministry of Health and Family Welfare and the Department of Health Research.**

**(Recommendation No.2)**

**Global Status of Covid-19 Cases during two years**

1.18 The novel Coronavirus pandemic has been spreading all over the world since it was first reported in Wuhan, China in December 2019. Since then, it has affected all the countries in the world. Although the rate of increase of Covid positive cases has increased in India in recent times, the recovery rate has also improved significantly and death rate has remained very low.

1.19 When asked to provide the details of covid cases reported in India vis-a-vis countries affected severely worldwide, the Ministry of External Affairs in a written reply submitted the following details:

**(As on 22 March, 2021)**

| Sl No | Country | Total cases (new cases) | Deaths (new deaths) | Case Fatality Rate (in %) |
|---|---|---|---|---|
| 1 | US | 30,521,774 (39,505 ) | 555,314 (455) | 1.81 |
| 2 | Brazil | 11,998,233 (47,774) | 294,115 (1,259) | 2.45 |
| 3 | **India** | **11,645,719 (47,009)** | **160,003 (213)** | **1.37** |
| 4 | Russia | 4,456,869 (9,299 ) | 95,030 (371) | 2.13 |
| 5 | UK | 4,296,583 (5,312) | 126,155 (33) | 2.93 |
| 6 | France | **4,282,603** (30,581) | 92,305 (138) | 2.15 |
| 7 | Italy | 3,376,376 (20,159) | 104,942 (300) | 3.10 |
| 8 | Spain | 3,212,332 (NA) | 72,910 (NA) | 2.26 |
| 9 | Turkey | 3,013,122 (20,428) | 30,061 (102) | 0.99 |
| 10 | Germany | 2,670,000 (11,149) | 75,270 (74) | 2.82 |
| 11 | Colombia | 2,337,150 (5,963) | 62,028 (121) | 2.65 |
| 12 | Argentina | 2,245,771 (4,032) | 54,545 (28) | 2.43 |
| 13 | Mexico | 2,193,639 (5,729) | 197,827 (608) | 9.02 |
| 14 | Poland | 2,058,550 (21,849) | 49,300 (140) | 2.39 |

| | | | | |
|---|---|---|---|---|
| 15 | Iran | 1,801,065 (7,260) | 61,797 (73) | 3.43 |
| 16 | Ukraine | 1,546,363 (11,145) | 29,941 (166) | 1.94 |
| 17 | South Africa | 1,537,852 (1,051) | 52,111 (29) | 3.39 |
| 18 | Czechia | 1,469,547 (5,443) | 24,667 (71) | 1.68 |
| 19 | Indonesia | 1,460,184 (4,396) | 39,550 (103) | 2.71 |
| 20 | Canada | 933,785 (3,269) | 22,676 (33) | 2.43 |
| 21 | Israel | 827,772 (552) | 6,092 (10) | 0.74 |
| 22 | Iraq | 793,892 (4,502) | 14,007 (38) | 1.76 |
| 23 | Philippines | 663,794 (7,757) | 12,968 (39) | 1.95 |
| 24 | Japan | 455,638 (1,480) | 8,812 (22) | 1.93 |
| 25 | South Korea | 98,665 (456) | 1,696 (3) | 1.72 |
| 26 | China | 90,099 (12) | 4,636 (0) | 5.15 |
| | **Total Worldwide** | **123,855,882 (426,143)** | **2,727,462 (5,961)** | **2.20** |

1.20 When the Committee sought the updated number of covid cases reported in India and abroad, the Ministry of Health and Family Welfare in a written submission provided the following figure as on 2 August 2020:

| S. No. | Country | Total Cases | Total Deaths | Total Recovered | Active Cases | Tot Cases/ 1M pop | Deaths/ 1M pop |
|---|---|---|---|---|---|---|---|
| | **World** | **19,90,22,838** | **42,40,374** | **17,96,31,883** | **1,51,50,581** | **25,533** | **544** |
| 1 | USA | 3,57,68,924 | 6,29,380 | 2,96,73,290 | 54,66,254 | 1,07,381 | 1,889 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **2** | **India** | **3,16,95,958** | **4,24,808** | **3,08,57,467** | **4,13,683** | **22,726** | **305** |
| 3 | Brazil | 1,99,38,358 | 5,56,886 | 1,86,45,993 | 7,35,479 | 93,085 | 2,600 |
| 4 | Russia | 62,88,677 | 1,59,352 | 56,25,890 | 5,03,435 | 43,072 | 1,091 |
| 5 | France | 61,46,619 | 1,11,885 | *57,02,014* | 3,32,720 | 93,942 | 1,710 |
| 6 | UK | 58,80,667 | 1,29,719 | 45,20,199 | 12,30,749 | 86,136 | 1,900 |
| 7 | Turkey | 57,47,935 | 51,428 | 54,59,899 | 2,36,608 | 67,369 | 603 |
| 8 | Argentina | 49,35,847 | 1,05,772 | 45,81,132 | 2,48,943 | 1,08,137 | 2,317 |
| 9 | Colombia | 47,94,414 | 1,20,998 | 45,87,754 | 85,662 | 93,151 | 2,351 |
| 10 | Spain | 44,47,044 | 81,486 | 37,11,200 | 6,54,358 | 95,074 | 1,742 |
| 11 | Italy | 43,55,348 | 1,28,068 | 41,35,930 | 91,350 | 72,150 | 2,122 |
| 12 | Iran | 39,03,519 | 90,996 | 33,85,195 | 4,27,328 | 45,840 | 1,069 |
| 13 | Germany | 37,78,276 | 92,172 | 36,56,300 | 29,804 | 44,940 | 1,096 |
| 14 | Indonesia | 34,40,396 | 95,723 | 28,09,538 | 5,35,135 | 12,436 | 346 |
| 15 | Poland | 28,83,029 | 75,261 | 26,53,807 | 1,53,961 | 76,267 | 1,991 |
| 16 | Mexico | 28,54,992 | 2,41,034 | 22,15,884 | 3,98,074 | 21,894 | 1,848 |
| 17 | South Africa | 24,56,184 | 72,191 | 22,30,871 | 1,53,122 | 40,857 | 1,201 |
| 18 | Ukraine | 22,53,269 | 52,951 | 21,86,994 | 13,324 | 51,860 | 1,219 |
| 19 | Peru | 21,13,201 | 1,96,438 | N/A | N/A | 63,141 | 5,869 |
| 20 | Netherlands | 18,67,815 | 17,829 | *16,68,937* | 1,81,049 | 1,08,746 | 1,038 |

1.21 The number of Covid cases reported in India and abroad as on 22.11.2021

| S.No. | Country | Total Cases | Total Deaths | Total Recovered | Active Cases | Tot Cases/ 1M pop | Deaths/ 1M pop |
|---|---|---|---|---|---|---|---|
| | **World** | **25,53,24,963** | **51,27,696** | **23,27,56,554** | **1,99,08,576** | **32,757** | **658** |
| 1 | United States of America | 4,70,30,792 | 7,59,388 | 3,84,63,041 | 93,36,118 | 1,42,090 | 2,290 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **2** | **India** | **3,44,89,623** | **4,65,082** | **3,39,34,547** | **1,18,443** | **24,990** | **340** |
| 3 | Brazil | 2,19,77,661 | 6,11,851 | 2,12,22,032 | 1,82,522 | 1,03,400 | 2,880 |
| 4 | The United Kingdom | 97,21,920 | 1,43,559 | 80,87,993 | 16,13,572 | 1,43,210 | 2,110 |
| 5 | Russian Federation | 92,57,068 | 2,61,589 | 80,24,930 | 10,42,133 | 63,430 | 1,790 |
| 6 | Turkey | 85,03,220 | 74,428 | 80,91,947 | 4,04,565 | 1,00,820 | 880 |
| 7 | France | 71,22,737 | 1,15,920 | 70,50,282 | 2,46,228 | 1,09,510 | 1,780 |
| 8 | Iran (Islamic Republic of) | 60,57,893 | 1,28,531 | 57,83,425 | 1,65,057 | 72,120 | 1,530 |
| 9 | Argentina | 53,10,334 | 1,16,313 | 51,81,366 | 17,605 | 1,17,500 | 2,570 |
| 10 | Germany | 52,48,291 | 98,739 | 46,49,300 | 6,29,279 | 63,110 | 1,190 |
| 11 | Spain | 50,74,027 | 87,804 | 49,01,074 | 91,779 | 1,07,200 | 1,860 |
| 12 | Colombia | 50,38,544 | 1,27,912 | 48,88,278 | 31,690 | 99,020 | 2,510 |
| 13 | Italy | 48,93,887 | 1,33,034 | 46,43,751 | 1,48,760 | 82,060 | 2,230 |
| 14 | Indonesia | 42,52,705 | 1,43,714 | 41,01,547 | 8,126 | 15,550 | 530 |
| 15 | Mexico | 38,51,079 | 2,91,573 | 32,24,604 | 3,46,287 | 29,870 | 2,260 |
| 16 | Ukraine | 33,04,058 | 80,231 | 27,62,950 | 4,88,721 | 75,550 | 1,830 |
| 17 | Poland | 33,03,046 | 80,399 | 28,87,847 | 3,76,719 | 87,020 | 2,120 |
| 18 | South Africa | 29,27,499 | 89,555 | 28,21,141 | 19,147 | 49,360 | 1,510 |
| 19 | Philippines | 28,21,753 | 46,422 | 27,58,235 | 21,101 | 25,750 | 420 |
| 20 | Malaysia | 25,69,533 | 29,892 | 24,87,809 | 68,790 | 79,390 | 920 |

*** WHO Coronavirus (Covid-19) Dashboard**.

1.22 The following table shows the number of Covid cases reported during third wave in India and abroad as on 31 January, 2022:-

| S.No. | Country | Total Cases | Total Deaths | Total Recovered | Active Cases | Tot Cases/ 1M pop | Deaths/ 1M pop |
|---|---|---|---|---|---|---|---|
| | **World** | **36,41,91,494** | **56,10,291** | **29,11,35,726** | **7,30,55,768** | **46,724** | **723** |
| 1 | United States of America | 7,23,73,369 | 862,863 | 4,36,40,468 | 2,87,32,901 | 2,18,649 | 2628 |
| **2** | **India** | **4,06,22,709** | **4,91,127** | **3,87,91,441** | **18,31,268** | **29,437** | **357** |
| 3 | Brazil | 2,45,35,884 | 6,23,356 | 2,19,75,068 | 25,60,816 | 1,15,431 | 2938 |
| 4 | France | 1,76,43,246 | 1,26,729 | 1,07,90,287 | 68,52,959 | 2,71,270 | 1957 |
| 5 | The United Kingdom | 1,62,45,478 | 1,54,356 | 1,34,17,583 | 28,27,895 | 2,39,305 | 2284 |
| 6 | Russian Federation | 1,15,02,657 | 3,28,105 | 1,03,14,529 | 11,88,128 | 78,821 | 2258 |
| 7 | Turkey | 1,12,49,216 | 86,299 | 1,06,27,550 | 6,21,666 | 1,33,381 | 1028 |
| 8 | Italy | 1,05,39,601 | 1,44,343 | 78,95,784 | 26,43,817 | 1,76,716 | 2434 |
| 9 | Spain | 96,60,208 | 92,376 | 58,13,903 | 38,46,305 | 2,04,092 | 1960 |
| 10 | Germany | 94,29,079 | 1,17,126 | 73,93,211 | 20,35,868 | 1,13,376 | 1413 |
| 11 | Argentina | 81,30,023 | 1,19,444 | 75,20,587 | 6,09,436 | 1,79,885 | 2656 |
| 12 | Iran (Islamic Republic of) | 62,93,695 | 1,32,274 | 61,84,230 | 1,09,465 | 74,931 | 1576 |
| 13 | Colombia | 57,98,799 | 1,32,477 | 57,06,043 | 92,756 | 1,13,964 | 2614 |
| 14 | Mexico | 47,30,669 | 3,03,301 | 40,93,391 | 6,37,278 | 36,691 | 2356 |
| 15 | Poland | 47,52,700 | 1,04,373 | 39,78,153 | 7,74,547 | 1,25,209 | 2764 |
| 16 | Indonesia | 43,09,270 | 1,44,254 | 42,47,552 | 61,718 | 15,755 | 527 |
| 17 | Netherlands | 41,31,630 | 21,227 | 29,44,118 | 11,87,512 | 2,37,347 | 1221 |
| 18 | Ukraine | 39,80,610 | 99,584 | 36,39,063 | 3,41,547 | 91,019 | 2284 |
| 19 | South Africa | 35,94,499 | 94,397 | 35,29,200 | 65,299 | 60,607 | 1596 |
| 20 | Philippines | 34,93,447 | 53,598 | 33,02,629 | 1,90,818 | 31,880 | 490 |

1.23 From the available data, it was observed that India had a case fatality rate of 1.37 while the global case fatality rate was 2.20 during first wave. In this context, Foreign Secretary during evidence on 19.10.2020 justified these facts stating that I would refer to some of the proactive measures taken by the Government that have contributed to our high recovery and low fatality

outcomes. These include early commencement of COVID-19 screening and significant scaling up of COVID-related specific health infrastructure and testing capabilities.

1.24 The overall case fatality ratio (CRF) is 2.20% globally, which is considerably lower than that was reported during SARS (15%) and MERS-CoV outbreaks (37%). The CFR varies by location and intensity of transmission. The Mortality is high among elderly, particularly those with co-morbid conditions like coronary artery disease, diabetes, hypertension, chronic respiratory diseases, etc.

1.25 After having been apprised of covid cases in USA and European countries when the Committee desired to know more about the neighbhouring countries like Pakistan, Bangladesh, Nepal, Bhutan and Sri Lanka to get a clear picture of successes and achievements of our country as covid conditions of these countries more or less are similar to that of India. The Ministry of External has provided the following statistical data of covid -19 cases of neighbouring countries data vis-a-vis India as on 22 March 2021:

| Sl. No. | Country | Total cases (new cases) | Deaths (new deaths) | Average Death (in %) |
|---|---|---|---|---|
| 1. | **India** | **11,645,719 (47,009)** | **160,003 (213)** | **1.37** |
| 2. | Pakistan | 626,802 (3,667) | 13,843 (44) | 2.20 |
| 3. | Bangladesh | 570,878 (2,172) | 8,690 (22) | 1.52 |
| 4. | Nepal | 275,906 (77) | 3,016 (0) | 1.09 |
| 5. | Myanmar | 142,212 (NA) | 3,204 (NA) | 2.25 |
| 6. | Sri Lanka | 90,200 (354) | 546 (1) | 0.60 |
| 7. | Afghanistan | 56,153 (50) | 2,464 (1) | 4.38 |

| | | | | |
|---|---|---|---|---|
| 8. | Maldives | 22,513(140) | 66 (1) | 0.29 |
| 9. | Bhutan | 869 (0) | 1 (0) | 0.11 |

1.26 When asked to provide the details of COVID-19 cases reported in neighbouring countries during second wave in India, the Ministry of External Affairs in a written reply submitted as under:

| S.No. | Country | No of cases (in Lakhs) | Daily cases (Weekly Average) |
|---|---|---|---|
| 1 | Pakistan | 10.2 | 2300 |
| 2 | Bangladesh | 12.1 | 8900 |
| 3 | Nepal | 6.88 | 1920 |
| 4 | Myanmar | 2.0 | 410 |
| 5 | Sri Lanka | 3.02 | 1700 |

Statistical data of Covid-19 cases of neighbouring countries vis-a-vis India as on 22.11.2021

1.27 Ministry of External Affairs submitted the similar details as on 31 January, 2022 as under:

| S.No. | Country | No of cases (in Lakhs) | Daily cases (Weekly Average) |
|---|---|---|---|
| 1 | Pakistan | 13.94 | 6869 |
| 2 | Bangladesh | 17.47 | 11816 |
| 3 | Nepal | 9.39 | 6098 |
| 4 | Myanmar | 5.35 | 122 |
| 5 | Sri Lanka | 6.07 | 986 |

| S.No. | Country | Total Cases (New cases) | Total Deaths (New Deaths) | Average Death (in %) |
|---|---|---|---|---|
| **1** | **India** | **3,44,89,623 (11,106)** | **4,65,082 (459)** | **1.35** |
| 2 | Pakistan | 12,80,822 (460) | 28,638 (10) | 2.24 |
| 3 | Bangladesh | 15,73,214 (0) | 27,934 (0) | 1.78 |

| | | | | |
|---|---|---|---|---|
| 4 | Nepal | 8,18,578 (271) | 11,494 (5) | 1.40 |
| 5 | Myanmar | 5,16,146 (0) | 18,989 (0) | 3.68 |
| 6 | Sri Lanka | 5,54,459 (0) | 14,072 (0) | 2.54 |
| 7 | Afghanistan | 1,56,786 (47) | 7,361 (64) | 4.69 |
| 8 | Maldives | 90,340 (0) | 248 (0) | 0.11 |
| 9 | Bhutan | 2,632 (3) | 3 (0) | 0.27 |

1.28 Covid-19 cases of neighbouring countries vis-a-vis India as on 31.01.2022 is as under:-

| S.No. | Country | Total Cases (New cases) | Total Deaths (New Deaths) | Average Death (in %) |
|---|---|---|---|---|
| **1** | **India** | **4,06,22,709 (2,93,812)** | **4,92,327 (562)** | **1.21** |
| 2 | Pakistan | 13,93,887 (6869) | 29,162 (17) | 2.09 |
| 3 | Bangladesh | 17,47,331 (11,816) | 28,288 (14) | 1.62 |
| 4 | Nepal | 9,39,267 (6,098) | 11,687 (7) | 1.24 |
| 5 | Myanmar | 5,34,671 (122) | 19,310 (0) | 3.61 |
| 6 | Sri Lanka | 6,07,104 (986) | 15,369 (14) | 2.53 |
| 7 | Afghanistan | 1,61,009 (244) | 7,403 (2) | 4.60 |
| 8 | Maldives | 1,28,089 (0) | 274 (1) | 0.21 |
| 9 | Bhutan | 4,225 (110) | 3 (0) | 0.07 |

1.29 The State/UT-wise corona cases reported in India during first wave in terms of number of cases, active cases, deaths, recovery rate, patients recovered/discharged due to COVID-19 as on 1 March 2021 are as under:

| S. No | States/UTs | Total cases | Total Active Cases | Total Cured/ Discharged/ Migrated | Recovery Rate | Deaths |
|---|---|---|---|---|---|---|
| 1 | Andaman and Nicobar Islands | 5020 | 6 | 4952 | 98.6% | 62 |
| 2 | Andhra Pradesh | 889916 | 718 | 882029 | 99.1% | 7169 |
| 3 | Arunachal Pradesh | 16836 | 0 | 16780 | 99.7% | 56 |
| 4 | Assam | 217537 | 1615 | 214830 | 98.8% | 1092 |
| 5 | Bihar | 262534 | 399 | 260594 | 99.3% | 1541 |
| 6 | Chandigarh | 21770 | 381 | 21037 | 96.6% | 352 |
| 7 | Chhattisgarh | 312560 | 2774 | 305951 | 97.9% | 3835 |
| 8 | Dadra & Nagar Haveli and Daman & Diu | 3406 | 4 | 3400 | 99.8% | 2 |
| 9 | Delhi | 639289 | 1335 | 627044 | 98.1% | 10910 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 10 | Goa | 54986 | 606 | 53585 | 97.5% | 795 |
| 11 | Gujarat | 269889 | 2363 | 263116 | 97.5% | 4410 |
| 12 | Haryana | 270784 | 1275 | 266461 | 98.4% | 3048 |
| 13 | Himachal Pradesh | 58645 | 318 | 57332 | 97.8% | 995 |
| 14 | Jammu and Kashmir | 126441 | 823 | 123661 | 97.8% | 1957 |
| 15 | Jharkhand | 119949 | 494 | 118365 | 98.7% | 1090 |
| 16 | Karnataka | 951251 | 5823 | 933097 | 98.1% | 12331 |
| 17 | Kerala | 1059403 | 49709 | 1005497 | 94.9% | 4197 |
| 18 | Ladakh | 9818 | 53 | 9635 | 98.1% | 130 |
| 19 | Lakshadweep | 382 | 120 | 261 | 68.3% | 1 |
| 20 | Madhya Pradesh | 261766 | 2785 | 255117 | 97.5% | 3864 |
| 21 | Maharashtra | 2155070 | 78212 | 2024704 | 94.0% | 52154 |
| 22 | Manipur | 29273 | 33 | 28867 | 98.6% | 373 |
| 23 | Meghalaya | 13962 | 17 | 13797 | 98.8% | 148 |
| 24 | Mizoram | 4423 | 20 | 4393 | 99.3% | 10 |
| 25 | Nagaland | 12200 | 7 | 12102 | 99.2% | 91 |
| 26 | Odisha | 337191 | 704 | 334571 | 99.2% | 1916 |
| 27 | Puducherry | 39725 | 185 | 38872 | 97.9% | 668 |
| 28 | Punjab | 182176 | 4632 | 171712 | 94.3% | 5832 |
| 29 | Rajasthan | 320336 | 1308 | 316241 | 98.7% | 2787 |
| 30 | Sikkim | 6145 | 46 | 5964 | 97.1% | 135 |
| 31 | Tamil Nadu | 851542 | 4022 | 835024 | 98.1% | 12496 |
| 32 | Telangana | 298923 | 1902 | 295387 | 98.8% | 1634 |
| 33 | Tripura | 33417 | 39 | 32987 | 98.7% | 391 |
| 34 | Uttar Pradesh | 603527 | 2103 | 592699 | 98.2% | 8725 |
| 35 | Uttarakhand | 97031 | 489 | 94850 | 97.8% | 1692 |
| 36 | West Bengal | 575118 | 3307 | 561543 | 97.6% | 10268 |
| **Total** | | **11112241** | **168627** | **10786457** | **97.1%** | **157157** |

1.30 When asked to provide State/UT-wise details of COVID-19 cases reported following the second wave of covid-19 infection in the country, the Ministry of Health and Family Welfare in a written response submitted the following figure as on 13 August 2021:

| S. No | Name of State / UT | Total cases | Active cases | Deaths | Recovery rate | Cured/ Discharged/ Migrated |
|---|---|---|---|---|---|---|
| 1 | Andaman & Nicobar Islands | 7,548 | 6 | 129 | 98.2% | 7,413 |
| 2 | Andhra Pradesh | 1,988,910 | 18,688 | 13,595 | 98.4% | 1,956,627 |
| 3 | Arunachal Pradesh | 50,973 | 2,395 | 251 | 94.8% | 48,327 |
| 4 | Assam | 577,970 | 10,427 | 5,451 | 97.3% | 562,092 |
| 5 | Bihar | 725,369 | 273 | 9,646 | 98.6% | 715,450 |
| 6 | Chandigarh | 62,009 | 37 | 811 | 98.6% | 61,161 |
| 7 | Chhattisgarh | 1,003,537 | 1,509 | 13,545 | 98.5% | 988,483 |
| 8 | Dadra & Nagar Haveli and Daman & Diu | 10,655 | 5 | 4 | 99.9% | 10,646 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 9 | Delhi | 1,436,938 | 502 | 25,068 | 98.2% | 1,411,368 |
| 10 | Goa | 172,276 | 993 | 3,166 | 97.6% | 168,117 |
| 11 | Gujarat | 825,118 | 182 | 10,078 | 98.8% | 814,858 |
| 12 | Haryana | 770,146 | 672 | 9,654 | 98.7% | 759,820 |
| 13 | Himachal Pradesh | 209,344 | 2,668 | 3,542 | 97.0% | 203,134 |
| 14 | Jammu and Kashmir | 323,061 | 1,307 | 4,395 | 98.2% | 317,359 |
| 15 | Jharkhand | 347,498 | 211 | 5,130 | 98.5% | 342,157 |
| 16 | Karnataka | 2,924,732 | 22,754 | 36,911 | 98.0% | 2,865,067 |
| 17 | Kerala | 3,631,638 | 177,040 | 18,280 | 94.6% | 3,436,318 |
| 18 | Ladakh | 20,430 | 87 | 207 | 98.6% | 20,136 |
| 19 | Lakshadweep | 10,274 | 40 | 51 | 99.1% | 10,183 |
| 20 | Madhya Pradesh | 791,998 | 131 | 10,514 | 98.7% | 781,353 |
| 21 | Maharashtra | 6,375,390 | 65,808 | 134,572 | 96.9% | 6,175,010 |
| 22 | Manipur | 106,707 | 6,835 | 1,683 | 92.0% | 98,189 |
| 23 | Meghalaya | 70,661 | 4,539 | 1,200 | 91.9% | 64,922 |
| 24 | Mizoram | 47,471 | 11,620 | 174 | 75.2% | 35,677 |
| 25 | Nagaland | 28,955 | 1,347 | 593 | 93.3% | 27,015 |
| 26 | Odisha | 991,182 | 9,729 | 6,697 | 98.3% | 974,756 |
| 27 | Puducherry | 121,989 | 914 | 1,803 | 97.8% | 119,272 |
| 28 | Punjab | 599,758 | 533 | 16,334 | 97.2% | 582,891 |
| 29 | Rajasthan | 953,887 | 194 | 8,954 | 99.0% | 944,739 |
| 30 | Sikkim | 28,275 | 2,398 | 360 | 90.2% | 25,517 |
| 31 | Tamil Nadu | 2,583,036 | 20,399 | 34,428 | 97.9% | 2,528,209 |
| 32 | Telangana | 651,288 | 7,996 | 3,836 | 98.2% | 639,456 |
| 33 | Tripura | 80,980 | 1,953 | 775 | 96.6% | 78,252 |
| 34 | Uttarakhand | 342,526 | 418 | 7,369 | 97.7% | 334,739 |
| 35 | Uttar Pradesh | 1,708,851 | 490 | 22,780 | 98.6% | 1,685,581 |
| 36 | West Bengal | 1,536,446 | 10,127 | 18,268 | 98.2% | 1,508,051 |
| **Total** | | **32,117,826** | **385,227** | **430,254** | **97.5%** | **31,302,345** |

1.31 About the active cases, recoveries and deaths due to Covid-19 as reported by the States/UTs, as on 7th February, 2022 the Ministry of Health and Family Welfare submitted the following details:-

| S. No. | Name of State / UT | Active Cases | Cured/ Discharged/ Migrated | Deaths | Total cases | Recovery (%) |
|---|---|---|---|---|---|---|
| 1 | Andaman and Nicobar Islands | 199 | 9587 | 129 | 9915 | 96.7% |
| 2 | Andhra Pradesh | 69572 | 2219219 | 14664 | 2303455 | 96.3% |
| 3 | Arunachal Pradesh | 1599 | 61589 | 291 | 63479 | 97.0% |
| 4 | Assam | 9701 | 705118 | 6561 | 721380 | 97.7% |
| 5 | Bihar | 2451 | 812625 | 12236 | 827312 | 98.2% |
| 6 | Chandigarh | 1571 | 88005 | 1139 | 90715 | 97.0% |
| 7 | Chhattisgarh | 16608 | 1108630 | 13937 | 1139175 | 97.3% |
| 8 | Dadra & Nagar Haveli and | 96 | 11298 | 4 | 11398 | 99.1% |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Daman & Diu | | | | | |
| 9 | Delhi | 8869 | 1809081 | 25983 | 1843933 | 98.1% |
| 10 | Goa | 4664 | 234034 | 3740 | 242438 | 96.5% |
| 11 | Gujarat | 44618 | 1144956 | 10667 | 1200241 | 95.4% |
| 12 | Haryana | 14136 | 940332 | 10395 | 964863 | 97.5% |
| 13 | Himachal Pradesh | 6280 | 266199 | 4043 | 276522 | 96.3% |
| 14 | Jammu and Kashmir | 17412 | 424521 | 4715 | 446648 | 95.0% |
| 15 | Jharkhand | 2616 | 423698 | 5311 | 431625 | 98.2% |
| 16 | Karnataka | 97814 | 3758997 | 39347 | 3896158 | 96.5% |
| 17 | Kerala | 330105 | 5883023 | 58255 | 6271383 | 93.8% |
| 18 | Ladakh | 987 | 25729 | 226 | 26942 | 95.5% |
| 19 | Lakshadweep | 152 | 11012 | 52 | 11216 | 98.2% |
| 20 | Madhya Pradesh | 44778 | 950313 | 10662 | 1005753 | 94.5% |
| 21 | Maharashtra | 122015 | 7538611 | 143074 | 7803700 | 96.6% |
| 22 | Manipur | 3786 | 129013 | 2063 | 134862 | 95.7% |
| 23 | Meghalaya | 1462 | 89293 | 1546 | 92301 | 96.7% |
| 24 | Mizoram | 14006 | 171256 | 623 | 185885 | 92.1% |
| 25 | Nagaland | 698 | 33415 | 743 | 34856 | 95.9% |
| 26 | Odisha | 20101 | 1237976 | 8734 | 1266811 | 97.7% |
| 27 | Puducherry | 4152 | 158086 | 1948 | 164186 | 96.3% |
| 28 | Punjab | 10351 | 724214 | 17436 | 752001 | 96.3% |
| 29 | Rajasthan | 45893 | 1189910 | 9379 | 1245182 | 95.6% |
| 30 | Sikkim | 613 | 37628 | 435 | 38676 | 97.3% |
| 31 | Tamil Nadu | 121828 | 3251295 | 37759 | 3410882 | 95.3% |
| 32 | Telangana | 26498 | 746932 | 4100 | 777530 | 96.1% |
| 33 | Tripura | 748 | 98997 | 918 | 100663 | 98.3% |
| 34 | Uttarakhand | 16409 | 405512 | 7618 | 429539 | 94.4% |
| 35 | Uttar Pradesh | 28156 | 1993043 | 23318 | 2044517 | 97.5% |
| 36 | West Bengal | 17994 | 1967055 | 20823 | 2005872 | 98.1% |
| **Total** | | **1108938** | **40660202** | **502874** | **42272014** | **96.2%** |

1.32 Elaborating on the status of Infection in India during first wave, Secretary, Ministry of Health and Family Welfare during evidence on 19 December, 2020 informed that the highest number of active cases was achieved on 16th of September, which was 10 lakh plus. After 16th of September till date there has been a rapidly declining trend.

1.33 Secretary, Ministry of Health and Family Welfare during the same evidence submitted:

"If we look at different States in the country, we will see that most of the States are showing a declining trend or a stabilizing trend in terms of new numbers. There are only five States which are a cause for worry for the Union Ministry of Health because they on a day-to-day basis are still showing an increasing trend. These States are, Kerala, Karnataka, Rajasthan, Chhattisgarh and West Bengal. So, the Union Ministry of Health has deputed central teams to these five States to hand hold them and to provide technical assistance to these States to ensure that the rapidly increasing numbers are brought within control.

We have cause to believe that in case of Kerala it was basically letting down of the guard during the Onam festival which led to non-maintenance of physical distance, non-wearing of masks and eventually contributed to these high numbers of cases that are being reported by the State.

In respect of the remaining four States, we have reason to believe that it is less than satisfactory performance in terms of containment and aggressive testing which has led to these high numbers. But we still believe that in active collaboration with the State Governments, we would be in a position to control these numbers."

1.34 When asked to explain covid deaths crossing over one lakh during unlock "0" and unlock"1" while it was below five hundred during pre-lockdown, and to comment about transparency in statistical data of COVID-19, the Ministry of Health and Family Welfare in a written reply, inter-alia, stated that it has been estimated that the decision of lockdown by slowing down the progress of pandemic in India, prevented 14–29 lakh cases and 37–78 thousand deaths. This estimation has been arrived at by independent evaluation studies. On transparency, they submitted that the Ministry of Health & Family Welfare collates data provided by States/UTs and districts and the same is made available on the Ministry of Health & Family Welfare website on a daily basis. Hence, there is no lack of transparency in data.

1.35 Comparing Covid cases in the country to cases in other countries of the world, Secretary, Ministry of Health and Family Welfare further submitted during the same evidence:

"..There are a few countries which have a population which is less than 1/3rd or 1/4th of our country but are reporting fresh cases, which are eight to ten times higher in number than ours on per day basis. For example, in the last week, there was a specific day when USA reported four lakh new cases in 24 hours, which is a stupendous figure. That number of cases would stretch any medical facility or any public health system to its collapsing point.

1.36 On being asked about possibility of second wave of corona infections in India and preventive measures in this regard, the Ministry of Health and Family Welfare in a written reply inter-alia stated that the scientific basis of why a pandemic virus (such as Influenza virus, SARS-CoV-2) affects the population in multiple waves is still not fully understood. However, Government of India is cognizant of the fact that there is enhanced survivability of viruses in colder environments and also propensity of viral infections to peak in winter months. Hence a second wave at National level cannot be ruled out and the Government of India continues to maintain vigil and monitor the situation on daily basis. The situation is being continuously reviewed with all the States and States have been conveyed to remain prepared to manage spurt in cases. Central teams have also been deployed to the States showing increasing trajectory. The crucial preventive interventions in view of lack of a specific pharmaceutical intervention remain focused on COVID appropriate behaviour. This cannot be achieved without people"s participation.

1.37 Regarding second wave of infections in China, Foreign Secretary, during evidence on 19 December, 2020 submitted:

"China reported a decline in pandemic in early May and has not reported a second wave of infections thereafter".

1.38 About status of covid pandemic in Africa, Foreign Secretary during the same evidence informed:

"In Africa, pandemic has started to show an accelerated rate of new increases from the month of June, 2020, possibly because of insufficient testing and reporting compared to other parts of the world".

1.39 Describing the success in controlling of covid cases in several countries, Foreign Secretary during evidence on 29 July 2020 submitted:

"Of course, in terms of successes, I think, New Zealand, Australia, and some of the Scandinavian countries have been able to control it. In the case of China, of course, because of the fact that they have had stringent measures taken in terms of contact-tracing and testing, they have been able to control the local outbreaks."

**Global Scenario**

1.40 Elaborating on global situation of COVID-19 cases, the Secretary, Ministry of Health and Family Welfare during evidence on 19 July 2021 stated:

"Globally, COVID cases are again increasing, and we are seeing a fourth wave in the countries like USA, UK, Indonesia, Iran, and Bangladesh. On an average, globally, we are seeing 5,50,000 cases a day. So, this is a matter of concern."

As I said, United Kingdom has already seen three waves, and the cases are increasing. Although, they have decided that from today, they will open up all their economic activities. In Brazil, there are more than four waves that have happened. In Indonesia, they are in the midst of the third wave. They are reporting 51,000 cases a day, and given their population, it becomes that much more critical. Russia is in the midst of the third wave. So, what the global experience has told us is this. Even in the countries where large scale immunization has taken place, the cases are still increasing. For example, United Kingdom. It does not have more than 6.5 crore people. They have inoculated two-third of their population, and still, they are seeing large number of cases. It is not resulting in commensurate mortality but the cases are increasing."

1.41 Apprising the Committee regarding latest updates on COVID-19 situation in India in the backdrop of second wave, the Secretary, Ministry of Health and Family Welfare during evidence on 19 July 2021 deposed:

> "India has so far seen two surges or two waves. The first one was in September, 2020 when on a single day, on an average, we saw roughly 90,000 to 97,000 odd cases getting reported. The second surge was in April-May 2021, when we saw an unprecedented level of 4,14,000 cases getting reported in a day. So, at that point in time, that is in mid-May, 2020, the total number of active cases, that is cases who are either hospitalized or who are in home isolation, were around 37 lakhs. This number has been progressively coming down and today this number is 4,22,000. So, there is a distinct trend of cases declining. However, Sir, we are seeing what is technically called a long and fat tail of the infection. So, the rate of decrease of new cases is not increasing at the pace that we would have hoped and this is largely being contributed by two states, Kerala and Maharashtra. Kerala, on an average, is reporting 15,000 to 16,000 cases a day whereas Maharashtra is still reporting 8,000 to 9,000 cases a day. That is what is making the decline that much more slower. Therefore, we cannot say that we have seen the conclusion of the second wave or surge. We are very well in the midst of the second surge."

1.42 The Committee were informed that after reaching over 37 lakh active cases during the second wave, India has 4.3 lakh active cases and a case fatality rate of 1.33 %, lowest among similarly affected countries and lower to the current global case fatality rate 2.15% as on 15 July 2021.

1.43 Updating the Indian scenario, the Ministry of Health and Family Welfare submitted that as on 6 December 2021, a total of 3,46,41,561positive cases and 4,73,537deaths have been reported in India so far. India has reported 25,070cases and 340 deaths per million population, which is considerably lower than similarly affected countries. As on 6 December 2021, a large majority of total cases (98.35%) have recovered. India"s case fatality rate of 1.37% is also lowest among similarly affected countries.

Five States (Kerala, Maharashtra, Tamil Nadu, West Bengal and Karnataka) are contributing to 79.03% of all active cases in the country. As on 6thDecember 2021, the trajectory of cases in the country has registered a sustained and considerable decline since second surge witnessed in April-May 2021. However, some of the States continue to report large number of cases.

**1.44 The Committee observe that globally, India stands second in terms of number of covid cases after US followed by Brazil. Also, the Committee find that per million covid cases and deaths in India are significantly low in comparison to that of UK, Spain and United States, although their population is less than 1/3rd and 1/4th of our country, As far as case fatality rate (CFR) of covid cases is concerned, globally it is 2.15% at present, which is comparatively far less than SARS (15%) and MERS-CoV (37%) diseases. Most importantly, India has only 1.37 CFR of covid cases and the credit for controlling CFR rate goes to timely proactive measures such as early commencement of COVID-19 screening and significant scaling up of COVID related specific health infrastructure and testing capabilities by the Government. The Committee note that many countries have witnessed two or more waves of infections while India has also witnessed three waves including the new Omicron variant. Therefore, there is an apprehension of consequent waves also. In the initial phase of second wave five States (Maharashtra, Kerala, Punjab, Karnataka, and Tamil Nadu) contributed to 83.98% of all active cases in the country and presently five States (Kerala, Maharashtra, Tamil Nadu, West Bengal and Karnataka) are contributing to 79.03 per cent of all active cases in the country. The Committee find that scientific basis of multiple waves is still unkown. In Committee‟s view, it is pertinent to investigate the exact nature of transmission and persistence of COVID-19 in urban / rural**

**areas and various regions of the country and guide the State Governments accordingly to take measures to control the spread of virus including the new Omicron variant.**

**The Committee consider covid appropriate behaviour as „social vaccine" and feel that it is crucial to break the chain of Corona Virus transmission to contain the spread of COVID-19 disease. In Committee"s view any carelessness and complacency in this regard may be fatal and result in further increase in cases any time. The Committee are also aware that people particularly in rural areas have become very reluctant and not following covid appropriate behaviour. The Committee, therefore, desire the Government ought to provide more focus on preventive intervention and ensure that COVID-19 appropriate behaviour such as wearing mask, social distancing and hand washing, etc. are followed in letter and spirit in all parts of the country till the Pandemic is controlled.**

**(Recommendation No. 3)**

## CHAPTER II
## MANAGEMENT OF COVID-19 PANDEMIC

### Containment Strategy for Past Viral Diseases in India

Prior to outbreak of COVID-19, India has witnessed a number of viral disease outbreaks, most notable amongst these were Avian influenza (2006-08), H1N1 Influenza pandemic (2009), Zika virus disease (2016-18) and Nipah virus disease (2018, 2019).

2.2 The Ministry of Health and Family in its background note has described lessons learnt/experiences gained in containing outbreak of various viral diseases in India prior to Covid-19 and their utilization during covid-19 pandemic as under:

| S. No. | Viral disease outbreak | Lessons learnt/experiences gained | Utilization during COVID-19 |
|---|---|---|---|
| 1 | Avian influenza outbreak | Containment strategy, One health approach | Containment strategy |
| 2 | Influenza pandemic | Whole of Government approach, System strengthening, development of core capacities, | Managing pandemic |
| 3 | Zika virus disease | Containment strategy | Containment strategy |
| 4 | Nipah virus disease | Containment strategy, One health approach | Containment strategy |

### Scenario Based Approach for Management of COVID-19

2.3 The Committee were apprised through a written note that taking cue from the past pandemics and outbreaks of major viral diseases, India followed a scenario based approach for the following possible scenarios:

(i) Travel related case reported in India

(ii) Local transmission of COVID-19

(iii) Large outbreaks of COVID-19 disease amenable to containment

(iv) Widespread community transmission requiring mitigation measures

(v) India becomes endemic for COVID-19

2.4 The Ministry of Health and Family Welfare further submitted the following details of the scenario, inference and approach to be adopted by Government of India for management of covid-19 in the country:

| Scenario | Inference | Approach |
|---|---|---|
| Only travel related cases | No community transmission in India | • Continued activities at Points of Entry Surveillance<br>• Concurrent review and strengthening of all core capacities |
| **Local cluster of indigenous cases (with no travel history)** | Signalling start of local transmission | • Cluster containment strategies<br>• listing of contacts,<br>• deciding on the containment zone,<br>• perimeter control (exit and entry controls) and<br>• focused actions in the containment zone for<br>  • isolation of cases,<br>  • home quarantine of contacts,<br>  • social distancing measures (school closure, office closure, ban on gatherings) and<br>  • communicating the risk to public. |
| Large outbreaks amenable to containment | Local community transmission within a specified large geographic area | • Cluster containment strategies as above with:<br>  • geographic community wide quarantine<br>  • strict perimeter control<br>  • strict implementation of social distancing measures<br>• Focused actions in the containment zone for<br>  • Surveillance and testing<br>  • Rapid operationalization of surge capacities for hospitals and laboratories<br>  • Resource mobilization: Logistic and manpower<br>  • Chemoprophylaxis for healthcare workers and close contacts |
| Large outbreaks | Widespread community transmission | • Abandon cluster containment strategy and Points of Entry surveillance<br>• Minimize mortality and morbidity while ensuring essential services and continuity of operations to minimize impact on health and non-health sectors<br>• Exit Screening (based on risk assessment to other countries)<br>• Mitigation measures :<br>  • triage of patients (through screening clinics),<br>  • surge capacity of hospitals for isolation and |

| | | |
|---|---|---|
| | | • ventilator management and<br>• large scale IEC activities. |
| COVID-19 becomes endemic | Pool of susceptible population will decrease – stabilization of incidence of new cases | • Programmatic approach shall be followed – akin to that being followed post Pandemic Influenza 2009 (H1N1 outbreak)<br>• Routine surveillance as an epidemic prone disease and sentinel surveillance to know public health burden of the disease. |

2.5 The Ministry of Home Affairs has informed the Committee that Covid-19 pandemic is a biological disaster and as per National Disaster Management Plan (NDMP) 2019, the Ministry of Health and Family Welfare is the nodal Ministry for handling and managing the biological disasters.

**Components of Covid Management**

2.6 The Committee were apprised that there are seven important interventions/elements for covid management:

(1) Entry Surveillance-airports, land ports and sea ports

(2) Community Surveillance

(3) Logistics Intervention

(4) Lab Testing

(5) Hospital Preparedness

(6) Risk Communication

(7) Capacity Building

**I. Entry Surveillance**

2.7 The Committee were informed by the Ministry of Health and Family welfare through a written note that thermal screening has been initiated with effect from 18 January, 2020 at the international airports of Delhi, Mumbai and Kolkata and multi-disciplinary Central teams were tasked with inspection of airports and hospitals attached to them to ensure proper screening and

end to end management of suspect cases detected on screening. During initial part of pandemic, hospitals were linked with point of entry surveillance at airports, ports and land border crossings.

2.8 About the entry surveillance at the airports, the, Secretary, Civil Aviation during briefing on 29 July 2020 submitted that as soon as it was decided by the High Level Group that steps have to be taken, the Ministry of Civil Aviation made the first arrangements at the airports for screening of passengers. The first screening started as early as 17th of January. So, we were the first to intervene and take action. Initially it started with few airports and then we gradually spread it to all the airports where screening of passengers coming from abroad was made mandatory.

2.9 About the overall status of surveillance at points of entry the Ministry of Health and Family welfare submitted that Universal Screening of passengers from all countries. Till 23rd March 2020 (till suspension of all commercial flights), a total of 14,154 flights with 15,24,266 passengers have been screened at these airports. In addition to airports, screening is also being done at 12 major, 65 minor seaports and at land border crossings. Activities pertaining to Points of Entry have been suspended till such time the Governments takes a decision to resume international travel.

With the aim to bring home stranded Indians in many countries due to Covid-19 pandemic Govt. of India initiated Vande Bharat Mission on May 7th, 2020. In addition, Transport Bubble scheme has been initiated on mutual bilateral agreement with many countries to resume limited resumption of air travel.

2.10 Latest status in this regard, the Ministry of Health and Family welfare informed that revised Advisory for International Travel last issued on 30thNovember which has been made applicable from 1stDecember 00:01 Hrs. Countries reporting Omicron variant of SARS-CoV-2 were added in the list of „at-risk" Countries" requiring additional follow up measures including post-arrival testing and mandatory home quarantine. States have also been advised to increase sampling and genome sequencing of positive samples from international travelers from „at-risk" Countries. As on 5th December 2021, total 130 international flights from "at- risk" Countries have landed in India, with 28,830 passengers, out of which 43 have tested positive. Also, 1,084

"non at- risk" international flights have landed in India, with 1,71,322 passengers, out of which 10 have tested positive.

## II. Community Surveillance

2.11 In a written note the Ministry of Health and Family welfare has informed the Committee that they released a containment plan that envisages a strategy of breaking the chain of transmission that included:

(i) Defining containment and buffer zones,

(ii) Applying strict perimeter control,

(iii) Intensive active house to house search for cases and contacts,

(iv) Isolation and testing of suspect cases and high risk contacts,

(v) Quarantine of high risk contacts,

(vi) Intensive risk communication to raise community awareness on simple preventive measures and need for prompt treatment seeking, and

(vii) Strengthening of passive ILI/SARI surveillance in containment and buffer zones.

2.12 Elaborating further on this issue the MoHFW submitted that all States/UTs on 17.01.2019 were advised for Severe Acute Respiratory Infection (SARI) surveillance to pick up any travel related case reported in the community and follow up contacts of suspect/confirmed cases. Community surveillance was initiated initially for travel related cases and subsequently for clusters of cases being reported. During house to house surveillance elderly and other high risk population (in particular those with co-morbidities) are identified and followed up. In high density populations like urban settlements, such high risk populations were moved out of such settlements into quarantine facilities.

2.13 Ministry of Health and Family Welfare submitted in a brief note that community based surveillance was initiated initially for travel related cases and subsequently for clusters of cases being reported.

Ministry of Health & Family Welfare released containment plans to contain cluster and large outbreaks on 2nd March and 4thApril, 2020 respectively and these plans were updated from time to time. The containment plans envisage a strategy of breaking the chain of transmission by (i) defining containment and buffer zones, (ii) applying strict perimeter control, (iii) intensive active house to house search for cases and contacts, (iv) isolation and testing of suspect cases and high-risk contacts, (v) quarantine of high-risk contacts, and (vi) intensive risk communication to raise community awareness on COVID appropriate behavior and need for prompt treatment seeking.

Taking note of spread of the disease to peri-urban and rural areas in many Districts, Ministry of Health and Family Welfare on 16thMay 2021 has issued an "SoP on Covid19 Containment and Management in Peri-Urban, Rural and Tribal Areas"

**Sero Survey**

2.14 In the same written note the Committee were apprised that the Indian Council for Medical Research (ICMR) conducted population sero-surveillance involving about 60 districts with a sample size of about 24,000. The first round was conducted in April – May 2020 and the second round in August - September 2020. The national sero-prevalence was 0.7% in the first round and 6.6% in the second round. Both these sero-prevalence studies highlighted that a substantive population is still susceptible to COVID infection. States are conducting sero-prevalence studies using antibody-based testing for identifying susceptible population.

2.15 During the evidence on 28.12.2020 the representative of Ministry of Health submitted the following details regarding the procedure followed during sero surveys and thereof :

"..Sero surveys are of two kinds. There are pan national sero surveys that are being conducted by the Indian Council for Medical Research. They have conducted two such national sero surveys. The third one is about to begin. Then, the second kind of sero surveys are those which are undertaken by the State Governments, Union Territories or Municipal Administrations. For example, we have had three sero surveys which were initiated by the Government of GNCT of Delhi. We had one sero surveys done by Brihan Mumbai Mahanagarpalika Parishad, so on and so forth.

The objective of sero survey is to find out the nature of the spread of the disease. Sero survey is done by taking a blood sample which is different from taking a virus sample which is a nasal swab or a nasopharyngeal swab. In sero prevalence, blood sample is taken. It is tested and it is tested for antibodies. It tells us as to how many people have generated antibodies in a given population. Based on that percentage, our public health and epidemiological policies are shaped. As I submitted to you, the third sero survey to be taken by ICMR will begin shortly and would finish by mid-January and we will have the results in mid-January. The only difference that this third sero survey has from the earlier two sero prevalence surveys that ICMR did is that ICMR would be covering a population beginning from ten years. This sero prevalence will also tell us about the prevalence of disease among children; those children who had COVID, who recovered from COVID and built antibodies inside their bodies. So, this is about sero prevalence."

2.16 Regarding the third national sero-surveillance, the Ministry of Health and Family Welfare in a written reply stated that the third national sero-surveillance was conducted by ICMR from 17$^{th}$December, 2020 to 8$^{th}$January 2021. The study was conducted in the same 700 villages/wards; 70 districts from 21 States selected during 1$^{st}$ and 2$^{nd}$sero-surveillance studies. The survey involved over 28,589 persons general population (≥10 yr) and 7,171 healthcare workers (HCW). Prevalence among adults (age >18 years) was estimated as 21.4%, with sero prevalence rates higher among those residing in Urban slum (31.7%) as compared to the urban population not residing in slums (26.2%). The sero prevalence rate was estimated to be 19.1% in rural population. Among healthcare workers the sero prevalence rate was estimated to be 25.7%,

with highest rates seen among doctors and nurses (26.6%).The sero prevalence study has demonstrated that a large section of population still remains susceptible even after a year of pandemic.

**2.17 The Committee are of the opinion that an efficient surveillance system plays an important role in promoting awareness of potential health hazards and supporting effective exchange of information during outbreaks of zoonotic diseases. The Committee are happy to learn that at the very initial stage of the Pandemic, proper arrangements were made at airports, ports and land border crossings to ensure proper screening of passengers and end to end management of suspect cases. Recently for controlling the spread of Omicron variant very stringent measures have been taken. The Committee are informed that Severe Respiratory Infection (SARI) Surveillance are conducted in all States/UTs to pick up travel related cases reported in the community and follow up contacts of suspect/confirmed cases. This included identifying potential outbreaks or clusters of disease during house to house surveillance, public health investigation, active case finding and contact tracing. Apart from SARI surveillance, three sero surveillance surveys have been conducted by the Indian Council for Medical Research (ICMR) to find out the nature of the spread of the disease which is done by taking a blood sample to ensure the presence of antibodies among population segments which is different from taking a virus sample which is a nasal swab or a nasopharyngeal swab. The Committee note that the national sero prevalence was found to be 0.7 % , 6.6% and 21.5 in the first, second and third rounds of survey respectively and the sero prevalence rates are higher among those residing in urban slums (31.7%) as compared to the urban population not residing in slums (26.2%) and 19.1% in rural population. Among healthcare workers the sero prevalence rate was estimated to be 25.7%, with highest rates seen among doctors and nurses (26.6%). The findings of these**

**surveys demonstrate that a large section of population still remains susceptible even after two years of the pandemic. Given that a significant percentage of population of the country is still susceptible to COVID-19 Pandemic and public health and epidemiological policies at state level and national level are to be shaped based on the findings of these surveys, the Committee, desire that sero surveys should continue on regular basis, state wise with increased sample size, as in the Committee‟s view, the sample size of earlier surveys appear to be small and inadequate. The Committee also desire that sero survey results ought to be brought into the public domain for the people‟s awareness about the prevalence of disease in various age groups and modification in behaviors to prevent community transmission of virus. Ministry of External Affairs and Ministry of Civil Aviation should also appropriately use these results while making negotiations as well as to regulate the movements of Indian citizens in other countries.**

**(Recommendation No. 4)**

**III. Logistic Intervention**

2.18 Highlighting the importance of logistic intervention in the fight against corona pandemic, Secretary, health and Family Welfare during the briefing on 29 July 2020 submitted that we did not manufacture PPEs, N-95 masks and ventilators in our country and suddenly we found that we cannot import them anymore. I think when history will be written, it will be recorded that how India became not only self-reliant in these three essential Covid commodities, but now we are in a position to actually export.

2.19 Underscoring the significant role played by MEA in addressing domestic shortage of essential medical equipment related to Covid 19, Foreign Secretary during briefing on 29 July 2020 submitted:

> "..In the beginning we had a shortage of many of the items that were required on an emergency basis at home such as PPEs, N 95 masks, goggles, ventilators, etc. Our

Missions and the Ministry worked closely with the Inter-Ministerial Groups set up for this purpose under the oversight of the Ministry of Health. Many of these items were procured on a fast-track basis. We have now been increasingly achieving self-reliance in this area. We now manufacture over five lakh PPE kits and over three lakh N 95 masks every day. We have developed capacity to produce over three lakh ventilators every year. This has also enabled exports of these items to several countries that we identified and which have reached out to us for assistance in this regard."

2.20 On the Committee"s apprehensions regarding quality and efficiency of Indian manufactured Kits and masks, standard medical parameters for their quality and institutional mechanism to ensure quality of PPE kits, the Ministry of Health and Family Welfare in a written reply stated that PPE manufacturing in India is an entirely indigenous development. The quality parameters and test standards at par with world standard has evolved over a short period of time and the Government (both at the level of Ministry of Health and Family Welfare and Ministry of Textiles) have ensured quality in respect of procurement by MoHFW. Several interim advisories have been issued from time to time over the period of development to the State Governments and Users, including newspaper and media publications. In June 2020, BIS has come up with an Indian Standards IS:17423:2020 on PPE for COVID-19. The quality control mechanism is now being monitored through BIS mechanism.

2.21 Describing the overall self-reliance and maintenance of standard and quality of logistics in this regard Ministry of Health and Family Welfare submitted that at the onset of COVID pandemic, there were no indigenous manufacturers of PPEs with requisite standards. Now, more than 1100 domestic manufacturers of PPE coveralls have cleared quality test and India is now not only self-reliant to meet local requirements but also in a position to export the same. Similar self-reliance has been achieved for ventilators too.

States are supported in terms of supply of logistics which includes PPE Kits, N-95 masks, ventilators and drugs like Hydroxychloroquine, Remdesivir etc.

States have been supported with supply of oxygen cylinders and oxygen concentrators. States are also being supported in terms of installation of Oxygen concentrator plants/ PSA (Pressure Swing Adsorption plants) plants. All the States have been advised rational use of oxygen and to prohibit the wasteful usage by strict monitoring. States have also been advised to undertake oxygen consumption audit in hospitals including private hospitals and to undertake facility-wise/hospital-wise oxygen inventory mapping and advance planning for timely replenishment so that there is no stock out.

**Lifeline UDAN Initiative for Supply of Logistics to States/UTs**

2.22 Underlining the role of Civil Aviation in supply of essential logistics to various parts of the country, Secretary, Civil Aviation during briefing on 29 July submitted:

> "When the lockdown was imposed on 25th of March, our immediate crisis was that all modes of transportation had stopped. Trains had stopped, flights had stopped and truck movement had become difficult. So, the biggest challenge was, how do we ensure supply of essential medicines, the testing kits and the testing arrangements of Covid-19, the re-agents, the chemicals and sometimes even the samples had to be carried. So, for that purpose, we launched Lifeline UDAAN. Lifeline UDAAN is a system in which Air India and its subsidiary Alliance Air would make a network of operations everyday and they would take demands from all the States, what all States wanted, what the Health Ministry wanted and what ICMR wanted. So, they used to club all the demands using an electronic platform and this demand was converted into airplane movements and in this airplane movements, we were carrying only the essential kits, that is, the medicines, the equipment, the testing kits, the samples and the re-agents. So, that was Lifeline UDAAN and this continued very effectively in the lockdown period and there absolutely no problem of any supply hindrance of any health facility. We carried almost 1,000 tonnes of all these things which are very small. A packet will go to Agartala which would weigh

only 50 kgs. The ICMR Testing Kit would weight only 25 kilos. So, these small things were taken to their destinations and all put together we carried about 1,000 tonnes. This worked very well. Now with the opening of domestic air service operations, Lifeline UDAAN was not required because the domestic aircraft are carrying the medicines and the essential supplies."

2.23 When asked to outline the mechanism established for lifeline UDAN operations to ensure proper supply of medical kits to deal with covid-19 in the remotest parts of the country, the Ministry of Civil Aviation in a written reply stated that a core team of officers was constituted in MoCA which met twice a day to map the requirements of the States/UTs with route planning of airlines to ensure proper supply of medical kits to deal with COVID-19 with special focus on North Eastern States, Islands, UTs of J&K and Ladakh. The Core team held regular discussions with ground handling agencies, airlines, airport operators and State Govts/UTs to ensure smooth operations of the Lifeline Udan flights.

2.24 On being enquired about role of private air operators and incentives for their services under Lifeline UDAN, the Ministry of Civil Aviation submitted that Private operators viz. Indigo and Vistara and cargo operator Blue Dart mounted cargo flights carrying essential supplies/COVID cargo under the Lifeline UDAN on free of cost basis.

2.25 As on 1st March 2021, the State/UT-wise details of logistic support provided to States/UTs and Central Government Institutions submitted by the Ministry of Health and Family Welfare in written reply are as under:

| S. No. | State / UT / Central Government Institutions | N95 masks distributed (in lakh) | PPE kits distributed (in lakh) | HCQ tablets distributed (in lakh) | Ventilators Delivered |
|---|---|---|---|---|---|
| 1 | Andaman and Nicobar Islands | 2.71 | 0.84 | 1.8 | 34 |
| 2 | Andhra Pradesh | 15.63 | 3.19 | 31.5 | 4960 |
| 3 | Arunachal Pradesh | 2.76 | 1.36 | 6.5 | 63 |
| 4 | Assam | 11.96 | 4.11 | 21.7 | 1000 |

| | | | | | |
|---|---|---|---|---|---|
| 5 | Bihar | 14.32 | 6.04 | 64 | 500 |
| 6 | Chandigarh | 3.28 | 1.31 | 3 | 65 |
| 7 | Chhattisgarh | 5.72 | 2.32 | 51.2 | 230 |
| 8 | Dadra and Nagar Haveli and Daman & Diu | 1.84 | 0.70 | 4.75 | 20 |
| 9 | Delhi | 20.42 | 9.11 | 64.8 | 763 |
| 10 | Goa | 3.22 | 1.06 | 8.8 | 200 |
| 11 | Gujarat | 25.42 | 13.08 | 28.5 | 3400 |
| 12 | Haryana | 9.20 | 2.86 | 26.3 | 423 |
| 13 | Himachal Pradesh | 5.50 | 2.82 | 11 | 500 |
| 14 | Jammu and Kashmir | 11.14 | 6.04 | 27.8 | 908 |
| 15 | Jharkhand | 6.11 | 3.16 | 28.2 | 460 |
| 16 | Karnataka | 18.31 | 6.54 | 49.7 | 2025 |
| 17 | Kerala | 8.00 | 1.89 | 39.5 | 480 |
| 18 | Ladakh | 1.90 | 0.79 | 6 | 130 |
| 19 | Madhya Pradesh | 15.54 | 9.02 | 54 | 841 |
| 20 | Maharashtra | 32.01 | 14.83 | 97.2 | 4434 |
| 21 | Manipur | 2.67 | 0.84 | 5.7 | 97 |
| 22 | Meghalaya | 2.10 | 0.57 | 4.75 | 54 |
| 23 | Mizoram | 1.96 | 0.36 | 4.2 | 115 |
| 24 | Nagaland | 1.95 | 0.30 | 3.75 | 120 |
| 25 | Odisha | 9.55 | 2.98 | 13.5 | 567 |
| 26 | Puducherry | 3.89 | 1.71 | 4.7 | 107 |
| 27 | Punjab | 7.02 | 3.73 | 20.7 | 810 |
| 28 | Rajasthan | 18.65 | 9.13 | 63 | 1900 |
| 29 | Sikkim | 2.10 | 0.57 | 3.25 | 0 |
| 30 | Tamil Nadu | 18.66 | 5.39 | 72.3 | 1450 |
| 31 | Telangana | 14.85 | 2.81 | 42.5 | 1400 |
| 32 | Tripura | 3.66 | 1.53 | 5.5 | 92 |
| 33 | Uttarakhand | 4.26 | 2.39 | 8 | 700 |
| 34 | Uttar Pradesh | 23.56 | 14.72 | 89.4 | 4016 |
| 35 | West Bengal | 18.38 | 4.85 | 43.5 | 1120 |
| 36 | Lakshadweep | 0.42 | 0.20 | 2.25 | 57 |
| 37 | Central Institutions | 59.79 | 26.41 | 102.516 | 2907 |
| **Total** | | **408.49** | **169.52** | **1115.77** | **36,948** |

2.26 Further, when asked to provided updated figure on logistic support provided to States/UTs and Central Government Institutions in the aftermath of second wave in India, the Ministry of Health and Family Welfare in a written submission furnished the following details as on 13 August , 2021:

| **S.No** | **State / UT / Central** | **N95 masks** | **PPE kits** | **Remdesivir** | **Ventilators** |
|---|---|---|---|---|---|

| | Government Institutions | distributed (in lakh) | distributed (in lakh) | Supplied (in Thousands) | Delivered |
|---|---|---|---|---|---|
| 1 | Andaman and Nicobar Islands | 4.71 | 1.84 | 0.500 | 34 |
| 2 | Andhra Pradesh | 15.63 | 3.19 | 793.534 | 5478 |
| 3 | Arunachal Pradesh | 2.76 | 1.36 | 10.922 | 63 |
| 4 | Assam | 11.96 | 4.11 | 135.628 | 1000 |
| 5 | Bihar | 14.32 | 6.04 | 162.657 | 500 |
| 6 | Chandigarh | 4.03 | 1.66 | 54.982 | 109 |
| 7 | Chhattisgarh | 5.72 | 2.32 | 242.194 | 405 |
| 8 | Dadra & Nagar Haveli and Daman & Diu | 1.84 | 0.70 | 3.368 | 80 |
| 9 | Delhi | 21.17 | 9.36 | 348.741 | 1013 |
| 10 | Goa | 3.22 | 1.06 | 38.960 | 200 |
| 11 | Gujarat | 28.42 | 16.08 | 858.365 | 5700 |
| 12 | Haryana | 12.50 | 3.16 | 296.156 | 673 |
| 13 | Himachal Pradesh | 5.50 | 2.82 | 32.472 | 750 |
| 14 | Jammu and Kashmir | 13.64 | 6.54 | 74.857 | 908 |
| 15 | Jharkhand | 6.11 | 3.16 | 179.049 | 1553 |
| 16 | Karnataka | 20.31 | 8.54 | 996.517 | 2725 |
| 17 | Kerala | 8.00 | 1.89 | 340.381 | 480 |
| 18 | Ladakh | 1.90 | 0.79 | 2.000 | 130 |
| 19 | Madhya Pradesh | 15.54 | 9.02 | 393.252 | 1611 |
| 20 | Maharashtra | 32.01 | 14.83 | 1928.052 | 5554 |
| 21 | Manipur | 2.67 | 0.84 | 45.628 | 247 |
| 22 | Meghalaya | 2.10 | 0.57 | 19.990 | 86 |
| 23 | Mizoram | 1.96 | 0.36 | 8.494 | 115 |
| 24 | Nagaland | 1.95 | 0.30 | 1.950 | 320 |
| 25 | Odisha | 9.55 | 2.98 | 178.803 | 617 |
| 26 | Puducherry | 3.89 | 1.71 | 25.052 | 107 |
| 27 | Punjab | 7.02 | 3.73 | 214.730 | 809 |
| 28 | Rajasthan | 18.65 | 9.13 | 415.786 | 1900 |
| 29 | Sikkim | 2.10 | 0.57 | 3.930 | 0 |
| 30 | Tamil Nadu | 18.66 | 5.39 | 1223.418 | 2465 |
| 31 | Telangana | 14.85 | 2.81 | 485.212 | 1400 |
| 32 | Tripura | 3.66 | 1.53 | 6.385 | 92 |
| 33 | Uttarakhand | 4.26 | 2.39 | 104.184 | 800 |
| 34 | Uttar Pradesh | 23.56 | 14.72 | 580.755 | 5416 |
| 35 | West Bengal | 18.38 | 4.85 | 246.787 | 1445 |
| 36 | Lakshadweep | 0.42 | 0.20 | 0.000 | 57 |
| 37 | Central Institutions | 59.79 | 26.41 | 343.824 | 4613 |

2.27 Logistic support provided to all States/UTs and Central Institutions (as on 7 February, 2022)

| S. No. | State / UT / Central Government Institutions | N95 masks distributed (in lakh) | PPE kits distributed (in lakh) | Remdesivir supplied ( in Thousands) | Ventilators Delivered |
|---|---|---|---|---|---|
| 1 | Andaman and Nicobar Islands | 4.71 | 1.84 | 0.500 | 34 |
| 2 | Andhra Pradesh | 15.63 | 3.19 | 834.380 | 6216 |
| 3 | Arunachal Pradesh | 2.76 | 1.36 | 10.922 | 63 |
| 4 | Assam | 11.96 | 4.11 | 144.394 | 1000 |
| 5 | Bihar | 14.32 | 6.04 | 164.157 | 500 |
| 6 | Chandigarh | 4.03 | 1.66 | 59.496 | 109 |
| 7 | Chhattisgarh | 5.72 | 2.32 | 242.544 | 515 |
| 8 | Dadra & Nagar Haveli and Daman & Diu | 1.84 | 0.70 | 3.404 | 20 |
| 9 | Delhi | 21.17 | 9.36 | 353.961 | 1330 |
| 10 | Goa | 3.22 | 1.06 | 39.835 | 200 |
| 11 | Gujarat | 28.42 | 16.08 | 991.703 | 5705 |
| 12 | Haryana | 12.50 | 3.16 | 296.562 | 673 |
| 13 | Himachal Pradesh | 5.50 | 2.82 | 32.580 | 500 |
| 14 | Jammu and Kashmir | 13.64 | 6.54 | 74.867 | 908 |
| 15 | Jharkhand | 6.11 | 3.16 | 179.179 | 1410 |
| 16 | Karnataka | 20.31 | 8.54 | 1025.424 | 2871 |
| 17 | Kerala | 8.00 | 1.89 | 428.986 | 480 |
| 18 | Ladakh | 1.90 | 0.79 | 2.000 | 130 |
| 19 | Madhya Pradesh | 15.54 | 9.02 | 456.345 | 1725 |
| 20 | Maharashtra | 32.01 | 14.83 | 2199.439 | 5554 |
| 21 | Manipur | 2.67 | 0.84 | 50.619 | 247 |
| 22 | Meghalaya | 2.10 | 0.57 | 20.144 | 86 |
| 23 | Mizoram | 1.96 | 0.36 | 8.494 | 115 |
| 24 | Nagaland | 1.95 | 0.30 | 2.122 | 320 |
| 25 | Odisha | 9.55 | 2.98 | 289.982 | 735 |
| 26 | Puducherry | 3.89 | 1.71 | 25.244 | 107 |
| 27 | Punjab | 7.02 | 3.73 | 215.320 | 809 |
| 28 | Rajasthan | 18.65 | 9.13 | 824.847 | 1900 |
| 29 | Sikkim | 2.10 | 0.57 | 4.287 | 25 |
| 30 | Tamil Nadu | 18.66 | 5.39 | 1668.328 | 2775 |
| 31 | Telangana | 14.85 | 2.81 | 535.598 | 2346 |
| 32 | Tripura | 3.66 | 1.53 | 6.645 | 92 |
| 33 | Uttarakhand | 4.26 | 2.39 | 108.030 | 800 |
| 34 | Uttar Pradesh | 23.56 | 14.72 | 582.481 | 5216 |
| 35 | West Bengal | 18.38 | 4.85 | 265.416 | 1530 |

| | | | | | |
|---|---|---|---|---|---|
| 36 | Lakshadweep | 0.42 | 0.20 | 0.000 | 57 |
| 37 | Central Institutions | 59.79 | 26.41 | 343.824 | 4893 |
| 38 | Central allocation not under DoP | | | 1.682 | |
| **Total** | | **422.79** | **176.91** | **12493.741** | **51,996** |

2.28 In the same context, about the logistic support provided to States/UTs and Central Government Institution in the aftermath of Covid outbreak in India as on 24th November, 2021, the Ministry of Health and Family submitted the following details:

> "To share our experiences, we have organised a number of online training programmes for COVID-19 testing, clinical practices, case management, vaccine development and delivery etc. in which nearly 1000 participants from Asian, South East Asian and African countries have participated. We have also organised a training programme covering administrative and operational aspects, which was conducted on 19-20 January 2021 for immunization managers, cold chain officers, communication officers and data managers of the partner countries, both at national and provincial levels. More than 150 experts from the neighbouring countries participated in this training programme.
>
> A workshop on „Covid-19 management: Experience, Good practices and way forward" with 10 neighbouring was organized on 18 February 2021, in which Health secretaries and technical experts shared their experiences in tackling covid19 pandemic. While addressing the workshop Hon'ble Prime Minister suggested to create a special visa scheme for our doctors and nurses, coordinate an air ambulance agreement for medical contingencies, create a regional platform for collating, compiling and studying data on vaccines and create a regional network for promoting technology-assisted epidemiology for preventing future pandemics."

2.29 Asked about action plans to stimulate and to help increase the production of different kinds of ventilators India, the Ministry of Health and Family Welfare in a written reply submitted, that as part of Make in India initiative, local manufacturers of the ventilators have been identified and given guidance to meet the specifications and the requisite benchmarks (both essential and desirable), finalizing the training and other protocols, creating new supply chains, helping them in logistics issues with suppliers and State Governments and deciding about

arrangement of consumables etc. The demand and supply for ventilators is being regularly monitored.

**2.30 The Committee note that in the initial phase of the pandemic, there was a significant shortage of many equipment such as PPE kits, N95 masks, goggles, ventilators which were essential to fight against COVID-19 and these items were imported with the swift intervention of Ministry of External Affairs. Even during the peak of second wave the scarcity of ventilators was felt. The Committee appreciate the commendable job done by the Cetral Government in providing significant regular logistic support to the States, UTs and Central Government Institutions in the aftermath of COVID-19 outbreak in the Country as per requirement. The Committee with satisfaction note that within a very short span of time, country"s manufacturing capability has been scaled up and India after achieving self-reliance in this area has now become an exporter from a importer of most of these equipment items. The Committee, therefore, desire that a national action plan should be prepared to ensure sustainability and self reliance in the indigenous production of medical items such as lab testing kits and ventilators so that even under extreme conditions in future, no shortage of these equipment is felt.**

**The Committee also acknowledge the remarkable efforts made by the civil aviation sector in terms of supply of medicines and testing kits, other equipment, samples and the reagents to deal with COVID-19 in all the States and UTs through their special initiative „Lifeline UDAN" at a time when all modes of transportation such as trains, trucks and flights were stopped due to imposition of unprecedented lockdown across the country. There is no gainsaying the fact that private air operators chipped in service to the nation at the time of need and participated as a part of „Lifeline UDAN" operations at nil costs to**

**the exchequer. The Committee desire that a suitable recognition be accorded all operators in Civil Aviation Sector for their commendable good Samaritan efforts. The Committee also desire that the lessons learnt by the civil aviation sector while fulfilling the essential needs of the nation during the hardest of times caused by the worst pandemic the world witnessed, should be appropriately utilized in preparing a ready to act plan so that in any such national emergencies in future no shortage of medicines, equipment or reagents is felt in any situation.**

**(Recommendation No. 5)**

## IV. Lab Testing

2.31 Referring to facilities for testing, Secretary, Health and Family Welfare during evidence on 19 October, 2020 submitted that when the pandemic hit us in India in January, we had only one lab, National Institute of Virology in Pune and we could do very low number of tests per day. But today we have 1962 labs across the country and all States and all Union Territories have adequate number of labs. In addition to these 1962 labs, we also have indigenous capacity of Rapid Antigen Tests which are point of care test for which you do not require a lab. They can be done at designated spots, booths or even through mobile vans.

2.32 The Committee were apprised that adequate laboratory reagents are available with ICMR. The number of samples being tested for detection of COVID-19 is substantially growing every day with enhanced focus on "Test, Trace, Treat" strategy in coordination with the States/UTs.

2.33 On being asked to provided State-wise figure of tests conducted per million population, the Ministry of Health and Family Welfare in written reply submitted the details as on 13 August 2021 as under:

| S. No. | States/UTs | COVID-19 tests conducted per million population |
|---|---|---|
| 1 | Andaman & Nicobar Islands | 6,57,355 |
| 2 | Andhra Pradesh | 4,35,070 |
| 3 | Arunachal Pradesh | 77,777 |
| 4 | Assam | 3,35,461 |
| 5 | Bihar | 3,26,643 |
| 6 | Chandigarh | 5,49,342 |
| 7 | Chhattisgarh | 3,06,462 |
| 8 | Dadra & Nagar Haveli and Daman & Diu | 6,55,290 |
| 9 | Delhi | 11,93,299 |
| 10 | Goa | 7,13,382 |
| 11 | Gujarat | 2,91,002 |
| 12 | Haryana | 3,86,349 |
| 13 | Himachal Pradesh | 3,23,363 |
| 14 | Jammu And Kashmir | 4,09,860 |
| 15 | Jharkhand | 2,98,580 |
| 16 | Karnataka | 6,10,754 |
| 17 | Kerala | 7,64,031 |
| 18 | Ladakh | 8,24,589 |
| 19 | Lakshadweep | 3,44,829 |
| 20 | Madhya Pradesh | 1,68,508 |
| 21 | Maharashtra | 3,71,908 |
| 22 | Manipur | 2,95,897 |
| 23 | Meghalaya | 1,98,602 |
| 24 | Mizoram | 5,66,381 |
| 25 | Nagaland | 83,163 |
| 26 | Odisha | 3,58,043 |
| 27 | Puducherry | 6,25,453 |
| 28 | Punjab | 3,69,619 |
| 29 | Rajasthan | 1,55,093 |
| 30 | Sikkim | 1,56,493 |
| 31 | Tamil Nadu | 4,28,371 |
| 32 | Telangana | 4,09,158 |
| 33 | Tripura | 2,36,155 |
| 34 | Uttar Pradesh | 3,16,302 |
| 35 | Uttarakhand | 5,95,751 |
| 36 | West Bengal | 1,53,489 |
| **Total** | | **3,54,688** |

2.34 The Ministry of Health and Family Welfare submitted State-wise figures for cumulative tests conducted per million population as on 24th November, 2021 as under:

| State/UTs | COVID-19 tests conducted per million population |
|---|---|
| **Andaman and Nicobar Islands** | 997,325 |
| **Andhra Pradesh** | 559,716 |
| **Arunachal Pradesh** | 458,472 |
| **Assam** | 431,827 |
| **Bihar** | 423,843 |
| **Chandigarh** | 680,911 |
| **Chhattisgarh** | 453,618 |
| **Dadra &Nagar Haveli and Daman & Diu** | 445,192 |
| **Delhi** | 1,492,734 |
| **Goa** | 994,940 |
| **Gujarat** | 361,532 |
| **Haryana** | 437,931 |
| **Himachal Pradesh** | 449,117 |
| **Jammu and Kashmir** | 796,669 |
| **Jharkhand** | 373,303 |
| **Karnataka** | 795,023 |
| **Kerala** | 1,077,591 |
| **Ladakh** | 1,052,660 |
| **Lakshadweep** | 922,235 |
| **Madhya Pradesh** | 215,028 |
| **Maharashtra** | 510,445 |
| **Manipur** | 430,451 |
| **Meghalaya** | 335,992 |
| **Mizoram** | 1,100,673 |
| **Nagaland** | 115,012 |
| **Odisha** | 504,884 |
| **Puducherry** | 710,128 |
| **Punjab** | 506,727 |
| **Rajasthan** | 169,816 |
| **Sikkim** | 193,137 |
| **Tamil Nadu** | 675,820 |
| **Telangana** | 526,808 |
| **Tripura** | 475,920 |
| **Uttar Pradesh** | 391,113 |
| **Uttarakhand** | 702,917 |
| **West Bengal** | 200,414 |
| **Total** | 464,776 |

2.35 State/UT wise figures for cumulative tests conducted per million population (as reported by States/UTs on 7th February, 2022)

| S. No. | State / UT | Cumulative COVID-19 tests conducted per million population |
|---|---|---|
| 1 | Andaman and Nicobar Islands | 763682 |
| 2 | Andhra Pradesh | 472540 |
| 3 | Arunachal Pradesh | 82,086 |
| 4 | Assam | 367623 |
| 5 | Bihar | 390378 |
| 6 | Chandigarh | 617703 |
| 7 | Chhattisgarh | 321245 |
| 8 | Dadra & Nagar Haveli and Daman & Diu | 687350 |
| 9 | Delhi | 1316541 |
| 10 | Goa | 824312 |
| 11 | Gujarat | 304938 |
| 12 | Haryana | 419793 |
| 13 | Himachal Pradesh | 353307 |
| 14 | Jammu and Kashmir | 584537 |
| 15 | Jharkhand | 337059 |
| 16 | Karnataka | 689506 |
| 17 | Kerala | 939248 |
| 18 | Ladakh | 908986 |
| 19 | Lakshadweep | 2096890 |
| 20 | Madhya Pradesh | 189538 |
| 21 | Maharashtra | 434763 |
| 22 | Manipur | 324433 |
| 23 | Meghalaya | 234371 |
| 24 | Mizoram | 141320 |
| 25 | Nagaland | 100609 |
| 26 | Odisha | 407051 |
| 27 | Puducherry | 706331 |
| 28 | Punjab | 415763 |
| 29 | Rajasthan | 162638 |
| 30 | Sikkim | 170394 |
| 31 | Tamil Nadu | 494729 |
| 32 | Telangana | 453445 |
| 33 | Tripura | 295765 |
| 34 | Uttarakhand | 639963 |
| 35 | Uttar Pradesh | 352355 |
| 36 | West Bengal | 167434 |

2.36 When asked whether corona treatment and testing protocol followed by India are similar and in line with worldwide practices, the Ministry of Health and Family Welfare in a written reply submitted that globally, RT-PCR testing is considered as gold standard for diagnosis of

COVID-19. The same is being used in India also. COVID-19 is a novel disease with no proven anti-viral treatment. The clinical management protocol evolved by Government of India is based on clinical evidence and has been updated from time to time based on emerging scientific evidence and after examination by experts in the Joint Monitoring Group under DGHS. The treatment protocol by and large is almost same as those used globally by many countries.

2.37 In a written note the Committee were also informed by the Ministry of health and Family Welfare that rapid antigen test has been introduced for testing in containment zones and in hospital settings. Those found positive by this test are considered as „true positives". Those symptomatic but found negative patients should be sequentially tested by RT-PCR. Besides the Gold Standard RT-PCR (in 1015 labs), TrueNat (in 800 labs) and CBNAAT (in 129 labs) techniques are also being used for testing. In addition, Rapid Antigen testing is being utilized for point of care testing.

2.38 When asked about similarities and differences between PT-PCR and RAT and their accuracy, the Ministry of Health and Family Welfare in a written reply stated that RT-PCR remains the gold standard for COVID 19 while antigen test is point of care detection method. RT-PCR requires a BSL-2 facility and the process takes about 7-8 hours, but specificity and sensitivity is above 95%. Rapid Antigen Test (RAT) does not require any lab facility and results are provided within 15-30 minutes but sensitivity is only 50-80%.

2.39 Elaborating on the course of evidence on 19 December, 2020 Secretary, Ministry of Health and Family Welfare categorically submitted that 60 per cent of these tests are RT-PCR tests and the remaining are rapid antigen tests.

2.40 On the observation of the Committee that the results of rapid tests are correct only in 20 percent cases, Secretary, Health, during evidence on 19 December 2020, submitted:

"there is a protocol which we have shared with all the States where we say that all the symptomatic negative people of rapid antigen tests have to be mandatorily subjected to RT-PCR. But if some States do not follow this, we make it a point on a weekly basis to engage with those States and tell them that last week, „x" number of people tested negative in rapid antigen test but they did have symptoms. So, out of this „x" number, they subjected only „y" number to RT-PCR, and this was the number they missed. Those people who were missed are spreading infection in the community. Therefore, they are requested to track them and get them tested. That is the protocol."

2.41 On the Committee"s observations about timing of result of coronavirus tests, Secretary, Health, during the evidence on 19 December, 2020 submitted:

"..It takes anywhere from four to eight hours. RT-PCR is the technology of the test. If the RT-PCR test is done using A TrueNAT or CBNAAT machine, then it takes only four hours. If it is done using a conventional RT-PCR machine, then it takes anywhere from six to eight hours. But, however, I entirely appreciate what you are saying. If you look at mufassil areas, say, in Bihar or in Odisha or in West Bengal or in Assam, there the Swabs are collected, taken to the lab. Then, the lab also takes time. Then, the results are given to the Chief Medical Officer or the Civil Surgeon of the District; and from there, it is communicated to the person whose swab has been taken. Therefore, at times, it does take 24 hours."

2.42 On being enquired by the Committee regarding arrangements made at airports to ascertain whether people who are landing at airports are positive or negative, given the result of their test could not be known within two hours of journey or three to four days after the journey so as to check the chance of spread, Secretary, Civil Aviation, during the course of evidence on 19 December 2020 submitted:

"The Hon. Member has pointed out a very critical problem which exists, that if infected with this virus, it takes four to five days to come up to a detectable level. Now, at the airport, when they are travelling, what we have ensured is that within the aircraft or at the airport, the chances of transmissions have been minimized. I cannot say that it is zero. They have been minimized. Now, there are practical difficulties. What happens is that in these two hours, we have taken a series of precautions, a series of protections so as to minimize it. To give an example, all aircraft have got something called HEPA filters.

These are high efficiency filters; and the air which is circulating, is filtered through that filter; it removes the virus. That is point number one. The second thing, which we are doing is that we are telling the airlines that the air inside the aircraft should be changed as frequently as possible. Thirdly, we are saying to have the mask and sanitizers. Fourthly, in addition to mask, we have put a face shield. If mask fails, the face shield will protect. Then, in order to ensure that transmission by occasional contact is minimized, we are saying that if the load is less, the next seat should be kept vacant. If load is there, the person sitting in between has to put a protective cover."

2.43 On the types of infection, and the transmission of virus through the people infected but undetected, Secretary, Health and Family Welfare, during evidence on 19 December 2020 submitted "Sir, when we refer to the load of the virus, we were referring to a positive result being detected in RT-PCR test. What we are now discussing is the ability of a positive person to infect others. There are contradictory studies on this. There is a recent study, which has been done by an Institute based in USA. It comprises study of 70,000 subjects spread across Tamil Nadu and Andhra Pradesh. It is being quoted in all international journals.

This study is being quoted in all international journals. This study says that out of those 70,000 odd positive people, they found that 25 to 30 per cent people were spreading infection to 80 per cent people. That means, that irrespective of viral load, there were 70 per cent people who were not spreading infection in the same proportion in which these 25 to 30 per cent people were spreading infection. This is one side of the inference of scientific studies.

There is another scientific study, much smaller, done by a US university which says that even if you are asymptomatic positive, you have the potential of spreading the virus from day one. Then, there is a third study which says that for the first three days, even if you are asymptomatic positive, you are not spreading the virus and it is only from day four onwards that you are spreading the virus.

Sir, you would appreciate that our exposure to the virus is hardly ten months old globally, therefore, this evidence is still emerging. As we go ahead, we would have better

studies and we would be in a position to say, with some amount of certainty, what is happening? "

2.44 Further, regarding chances of transmission on detection of virus, Secretary, Ministry of Health and Family welfare also added:

"That detection of the positive person does not mean that it is, now, in our control to stop the infection. If this positive person, we are not doing his contact tracing."

2.45 On being enquired about availability of test kits-RAT and RT-PCR in the country including rural areas, the Ministry of Health and Family Welfare in written reply stated that the Department of Health Research has undertaken a detailed exercise to upgrade diagnostic capacity development in the country. As on 20$^{th}$July 2021, 374 RT-PCR kits (incl. those from indigenous manufacturers) have been evaluated by ICMR, of which 168 have been validated for use. Similarly, for antigen testing, as on 5$^{th}$August 2021, 126 antigen based Rapid Tests Kits (including 26 revalidated kits) have been validated, and 48 have been found to be satisfactory. Further, as on 5$^{th}$August 2021, 3 kits for COVID-19 Home Test have been approved by ICMR. As per estimates conveyed by ICMR, the total domestic manufacturing capacity for RTPCR Kits and RAT has been assessed to be 80.65 lakh and 53.14 lakh kits per day. Owing to large scale indigenous production of testing kits the price of these tests has come down considerably. Testing kits are also made available in Government-e-marketplace (GeM) for facilitating procurement for Stats/UTs. There are 725 RT-PCR kits, 109 Rapid antigen kits, 1016 VTMs and 745 RNA extraction kits from various brands available in GeM portal.

**2.46 The Committee observe that since COVID-19 hit the country, there has been a significant increase in the number of laboratories and their testing capacity of this virus in the country. It is praiseworthy that the the number of labs has been enhanced from a single laboratory, the National Institute of Virology in Pune, to 1962 across the country during**

**this period. The Committee believe that the country has been able to identify active cases, quickly isolate and treat them and bring absolute numbers of cases under control because of sustained levels of tests done on daily basis. India today stands second in terms of number of diagnostic tests in the world after USA. The Committee note that the detection of COVID-19 cases is being done through Reverse Transcription Polymerase Chain Reaction (RTPCR) and Rapid Antigen Test (RAT) and the number of samples being tested has substantially increased with enhanced focus on "Test, Trace, Treat" strategy to minimize the chance of transmission of virus among the population in the country. The focus on increasing RT-PCR testing is based on the fact that it is considered as the gold standard for diagnosis of COVID-19 globally, its sensitivity being greater than RAT. The Committee feel that the states which have followed this strategy with due seriousness have contributed significantly in controlling the transmission of virus. The Committee, however, find that cumulative Covid-19 tests conducted has decreased during the third wave when there was a need to increase this number in view of very fast spread of Omicron variant. The Committee, therefore, desire that the Central Government should ensure that all the States/UTs strictly follow the issued protocol that all the symptomatic negative people of Rapid Antigen Test have to be mandatorily subjected to RT-PCR and they should not reduce the number of tests from time to time without any justified reasons.**

**(Recommendation No. 6)**

**2.47 The Committee are highly impressed with the efforts made by the Department of Health Research in the direction of upgrading diagnostic capacity development in the country as a result of which a large number of RT-PCR kits and Rapid Test Kits have been developed indigenously and ICMR has validated 178 RT-PCR kits and 126 antigen based RAT kits and 3 kits for COVID-19 tests have also been approved. Manufacturing capacity**

**for total 80.65 lakh RT-PCR kits and 53.14 lakh RAT kits per day has been achieved. Due to enhancement in indigenous production of testing kits, the price of these tests has also come down significantly. The Committee, now, desire that the Government should continue to make all possible efforts to bring the prices of testing kits to more affordable levels and make people aware about the availability of various validated approved options of kits particularly the Home Test kits so that with maximum testing, the transmission of virus is controlled. MEA should disseminate such achievements at world level so that India contributes further to the global efforts in this matter in these testing times.**

**(Recommendation No. 7)**

## V. Preparedness of Hospital

2.48 The Committee were informed, that for appropriate management of suspect/confirmed COVID-19 cases, a three tier arrangement of health facilities had been implemented in consultation with the State Governments:

(a) COVID Care Centre (CC) that shall care for mild cases. These were being set up in hostels, hotels, schools, stadiums, lodges etc., both public and private.

(b) Dedicated COVID Health Centre (DCHC) that shall offer care for all cases that have been clinically assigned as moderate. These should either be a full hospital or a separate block in a hospital with preferably separate entry/exit/zoning. These hospitals would have beds with assured Oxygen support.

(c) Dedicated COVID Hospital (DCH) that shall offer comprehensive care primarily for those who have been clinically assigned as severe. These Hospitals should either be a full hospital or a separate block in a hospital with preferably separate entry/exit. These hospitals would have fully equipped ICUs, Ventilators and beds with assured Oxygen support.

2.49 As on 7 March 2021, the following details regarding treatment facilities with dedicated isolation bed capacity without oxygen support, oxygen supported isolation beds, ICU beds and ventilators were furnished by the Ministry of Health and Family Welfare a written background note:

| India facility category | No of Facilities | Total Isolation beds (Excl. ICU beds) | O2 Supported beds | Total ICU beds | No of Ventilators |
|---|---|---|---|---|---|
| Cat. I - Dedicated COVID Hospitals / DCH | 2213 | 287651 | 160719 | 52244 | 28537 |
| Cat. II - Dedicated COVID Health Center / DCHC | 4251 | 243562 | 105548 | 26109 | 11044 |
| Cat. III - Dedicated COVID Center / DCCC | 8721 | 990113 | NA | NA | NA |
| Total | 15185 | 1521326 | 266267 | 78353 | 38581 |

2.50 In this context, when asked to provide the updated figures regarding treatment facilities, the Ministry of Health and Family Welfare furnished the following details as on 13 August, 2021:

| **Category** | **No of Facilities** | **Total Isolation beds** | **O2 Supported beds** | **Total ICU beds** | **No of Ventilators** |
|---|---|---|---|---|---|
| Cat. I - Dedicated COVID Hospitals / DCH | 4416 | 409359 | 237493 | 80223 | 39938 |
| Cat. II - Dedicated COVID Health Center / DCHC | 8478 | 389013 | 191164 | 44375 | 18721 |
| Cat. III - Dedicated COVID Center / DCCC | 10056 | 1004894 | 5559 | NA | NA |
| **Grand Total** | 22950 | 1803266 | 434216 | 124598 | 58659 |

2.51 While further updating the dedicated Covid-19 treatment facilities as on 24 November, 2021, the Ministry of Health and Family Welfare informed as under:

| Category | No. of Facilities | Total Isolation Beds | O2 Supported Beds | Total ICU Beds | No of Ventilators |
|---|---|---|---|---|---|
| **Cat. I - Dedicated COVID Hospitals / DCH** | 4503 | 425555 | 259052 | 89758 | 44422 |
| **Cat. II - Dedicated COVID Health Center / DCHC** | 9344 | 420285 | 218955 | 48313 | 20143 |
| **Total** | 13847 | 845840 | 478007 | 138071 | 64565 |
| **Cat. III - Dedicated COVID Center / DCCC** | 9815 | 969679 | 14415 | NA | NA |
| **Grand Total** | 23662 | 1815519 | 492422 | 138071 | 64565 |

2.52 Regarding dedicated COVID-19 treatment facilities as reported by States/UTs (as on 7th February 2022):

| Category | No. of facilities | Total isolation beds | Oxygen supported beds | Total ICU beds | No. of ventilators |
|---|---|---|---|---|---|
| Cat. I - Dedicated COVID Hospitals / DCH | 4423 | 404631 | 251650 | 90210 | 43504 |
| Cat. II - Dedicated COVID Health Center / DCHC | 9841 | 448652 | 247366 | 55812 | 21232 |
| **Total** | **14264** | **853283** | **499016** | **146022** | **64736** |
| Cat. III - Dedicated COVID Center / DCCC | 9762 | 957406 | 19028 | 0 | 0 |
| **Grand Total** | **24026** | **1810689** | **518044** | **146022** | **64736** |

2.53 Regarding availability of medical oxygen for management of COVID-19 effectively, the Secretary, Ministry of Health and Family Welfare stated during the evidence on 19.07.2021 as under:

> "Sir, on oxygen, during the first wave in September, 2020, the peak medical oxygen that this country needed was 2200 metric ton a day. This is the position of first wave.
>
> During the second wave, we provided a highest level of 10500 metric ton of liquid medical oxygen a day. So, in six months, from almost 2200 to 10500 metric ton a day is a significant increase and this was made possible because there was a planning. As you said Sir, there was a Committee which went into how oxygen production can be increased and it restricted supply of oxygen to other industries and diverted all oxygen for medical purposes. It also said oxygen which is produced as a bi-product in petroleum refineries and in iron foundries, that should also be diverted to medical oxygen. That is what enabled us to ramp up the production from 2200 metric ton to 10500 metric ton. In addition, as hon. Chairperson has said, 1220 PSA plants were sanctioned. These are plants that capture air from the atmosphere, convert it into oxygen and then pump it into the medical gas pipeline system of the hospital and then it comes through pipeline to each and every bed on which patients were there. So, 1220 PSA plants are sanctioned."

2.54 The witness during the same evidence also added:

Sir, you will be surprised to learn that in the Capital, private hospitals which made front page news, hospitals like Ganga Ram, Fortis, etc. also did not have any PSA plant. In the last 30 to 40 years, hospitals in the private sector never thought of having PSA plants. So, for the first time, the Government provided Government hospitals with PSA 1220 plants. In addition, one lakh oxygen concentrators have been provided to the States. That supply is still going on. It will conclude in end August. We also provided ventilators and we provided more than two lakhs oxygen cylinders. During this crisis, in April and May, the hon. Supreme Court constituted an independent Committee of expert doctors from across the country. Some of them were from Mumbai, some were from Kolkata, some from Delhi and this was called the National Task Force and the hon. Cabinet Secretary to the Government of India was made the convenor of this Task Force. Hon. Supreme Court gave them 12 Terms of References. Out of those 12 TORs, first five were only review of oxygen and whether Government of India was able to deliver on the medical

oxygen front to the States and to participating hospitals. So, they have reviewed this and they have submitted their report to the hon. Supreme Court and we have shared all information with them.

2.55 When enquired whether any assessment has been made regarding additional requirements in view of third wave in the country and steps being taken to upgrade all the facilities in a time bound manner, the Ministry of Health and Family Welfare in written submission stated that States/UTs have been communicated recommendations by Empowered Group-I on Health System Preparedness, Needs on Emergency Management Plan and Strategy, wherein need for (i) further strengthening of health infrastructure especially in rural regions, (ii) planning for pediatric COVID-19 care, (iii) augmenting availability of trained human resource, (iv) enhancing logistic management with respect to crucial supplies and (v) engagement with private sector/NGOs has been communicated to all States/UTs. To further strengthen the health infrastructure in the country to meet exigencies arising out of any surge in cases, Union Cabinet has approved a new scheme „India COVID-19 Emergency Response & Health System Preparedness Package: Phase-II" amounting to Rs. 23,123 crore for FY 2021-22. This scheme aims to accelerate health system preparedness for immediate responsiveness for early prevention, detection, and management, with the focus on health infrastructure development including for Paediatric Care and with measurable outcomes.

2.56 On the protocol for patients who land up in the hospitals, the Ministry of Health and Family Welfare in their written reply stated that a suspected case of COVID-19 is isolated in the earmarked facility for suspected cases. On confirmation of diagnosis, the patient is shifted to isolation beds earmarked for confirmed cases. If the suspected patient does not test positive, then he/she is treated for other possible ailments in non-COVID block of the same hospital or a non-COVID hospital. There is a standard treatment protocol for suspect/confirmed cases of COVID-19, which is updated from time to time based on the evolving clinical evidence.

2.57 The Committee were apprised that „eSanjeevani", a web based comprehensive telemedicine solution is being utilized (in 19 States) to extend the reach of specialized healthcare services to masses in both rural and isolated communities.

2.58 When asked which medicines are being used by physicians to treat those infected with the virus in the absence of a vaccine, the Ministry of Health and Family Welfare stated that the COVID-19 clinical management protocol issued by Ministry of Health & Family Welfare prescribes use of supportive therapy and drugs as per clinical severity of disease in the patient. While mild cases are to be treated symptomatically with monitoring of clinical status, moderate to severe cases have been advised use of oxygen therapy, corticosteroids (like Dexamethasone, Methyl Prednisolone), Low Molecular Weight Heparin, Hydroxycholoroquine and supportive therapy under direct medical supervision. The protocol also has provision for use of investigational therapy (including Remdesivir, Convalescent plasma therapy and Tocilizumab).

2.59 Regarding the Ministry of Health and Family Welfare"s assessment about WHO"s report on inefficacy of Remdesivir, HCQ and some more drugs commonly flaunted as the cure for COVID-19, they in a written reply submitted that WHO report was based on a randomized control trial (SOLIDARITY) which had its own limitations. On the other end, there have been a number of observational studies which suggest that Hydroxychloroquine has positive impact on patient outcomes, especially when given early in the disease. There is also some evidence to support that it has usefulness when used for pre- and post-exposure prophylaxis. Under the COVID-19 treatment protocol issued by MoHFW, Remdesivir has been recommended only as an investigational drug and not as mainline therapy.

2.60 On being enquired about the chances of damages to vital organs of even asymptomatic patients, and the management protocols to address such threats, the Ministry of Health and Family Welfare in a written reply submitted that there is no scientific evidence that establishes

that asymptomatic patient can suffer from damages to vital organs. However, MoHFW has issued Post COVID management protocol. Also Expert group consultations are ongoing to review emerging evidence on organ system specific (respiratory system, renal system, cardiovascular and gastro-intestinal) sequelae of COVID. All AIIMS like institutions have been requested to undertake research to study long term impact of COVID. ICMR has established a National Clinical Registry on COVID that will provide insights into clinical course of COVID-19 disease, its spectrum and outcome on patients.

2.61 Addressing queries about the efficacy of plasma therapy being used for COVID treatment, the Secretary, Ministry of Health and Family Welfare during evidence on 28 December, 2020, inter-alia, submitted:

"Plasma therapy means fractionation of blood so that plasma is separated, particularly in case of those people who have recovered from the disease. The assumption is that such separated plasma from recovered people would have antibodies and then that plasma is given as in blood transfusion to a COVID patient. Again, the assumption is that injection of these antibodies would enable the patient to fight COVID. Based on this, plasma therapy was categorised as an investigational therapy by the Ministry of Health & Family Welfare in the National Treatment Protocol."

2.62 Secretary, Ministry of Health and Family Welfare further added:

"ICMR did a study on 400 patients across the country. They were given plasma therapy. Based on that study, ICMR concluded that plasma therapy neither reduces the time of hospitalization, that is, the number of days a person is hospitalized, nor does it reduce mortality. In effect, that study was saying that plasma therapy has not demonstrated any efficacious use. Based on that, the whole issue was debated in a task force on COVID-19 where some of the hospitals, including some hospitals of Delhi, presented evidence to the contrary. So, that matter is still under examination and plasma therapy is being shown as an investigational therapy in the National Treatment Protocol. It has not been removed."

**2.63 Due to its global spread even the developed countries claiming the best health care infrastructure faced immense difficulties in handling the severity of the COVID-19 pandemic. So far as India is concerned, health is a State subject and most of the states did not have adequate health care infrastructure to handle such Pandemic. It was the toughest time before the country, therefore, the Central Government appropriately took the command and managed the situation in high challenging times. The Committee are apprised that for appropriate management of suspect/confirmed COVID-19 cases, a three tier arrangement of health facilities such as Covid Care Centre, Dedicated Covid Health Centre and Dedicated Covid Hospital with different set ups and specific facilities ranging from hotels, schools, hospitals with assured oxygen support and hospitals with ICUs and Ventilators were made across the country during the both waves of Pandemic and are continuing regular till date. All the concerned Ministries of the Government of India, agencies and healthcare workers served timelessly and the State Government machineries were activated accordingly to face this national calamity. The Committee observe that most of the States have enhanced the number of facilities, isolation beds, ICU beds and number of ventilators between the period of first wave and second wave but assessing the exact requirement of oxygen during the worst case scenario was not factored in thus adequate facilities for production and storage of oxygen were lacking in several states. No one could imagine such huge increase in serious cases resulting in peak demand of oxygen from 2200 metric ton a day during first wave reaching up to 10,500 metric ton per day, during second wave and most of the States faced the scarcity of oxygen and a situation of panic. Under such extraordinary situation, scarcity of oxygen was exceptionally handled by the Central Government which enabled to ramp up the production to that level by restricting the supply of oxygen to other industries and diverting all oxygen for medical purposes. Oxygen which is produced as a bi-product in Petroleum refineries and in iron foundries was also**

**diverted in medical oxygen. 1220 Pressure Swing Absorption (PSA) plants were also sanctioned for Government Hospitals which capture air from the atmosphere, convert into oxygen and then pump it into the medical gas pipeline system of the hospital and then it comes through pipeline to each and every bed on which patients were there. In addition, one lakh concentrators were provided to States alongwith two lakh oxygen cylinders. Several countries also provided oxygen, cylinders, concentrators in significant quantities. Oxygen was delivered to States as per requirement through all possible means like air, road, rail, sea and even from external resources. Such exemplary handling of that situation saved the lives of lakhs of seriously affected people during the Second wave. In view of the foregoing the Committee desire that the Government should ensure that all the States assess the exact maximum requirement of oxygen during such exigencies in scientific manner and set up all necessary infrastructure for production, storage and supply of oxygen without any delay so that the country is able to handle any such situation in future. Ministry of External Affairs may also prepare an emergency plan by identifying the countries / resources from where oxygen may be obtained if the national production and availability is inadequate. The Committee may be apprised about the outcome of all the initiatives taken in that regard.**

**(Recommendation No. 8)**

**2.64 The Committee appreciate the Government of India for the steps and measures taken to enhance the health care infrastructure country-wide to combat COVID-19 Pandemic. The Committee observe that certain drugs and therapy such as oxygen therapy, corticosteroids (like Dexamethasone, Methyl Prednisolone), Low Molecular Weight Heparin, Hydroxycholoroquine (HCQ) and supportive therapy under direct medical**

**supervision as per clinical severity of disease in the patients are advised for COVID-19 treatment. Further, the drug Remdesivir and Plasma therapy are categorized as an investigational therapy by the Ministry of Health and Family Welfare in the National Treatment Protocol, based on some evidence in support of their usefulness for pre and post exposure prophylaxis. Given that there are no proven drugs for COVID-19 treatment and lack of scientific evidence about the impact of COVID on specific organ systems (respiratory system, renal system, cardiovascular and gastro-intestinal), the Committee would like to recommend the Government to organize planned study research in various parts of the country on long term impact of COVID-19 on human organs and increase the awareness in people based on such studies. The Committee also note that „eSanjeevani", a web based comprehensive telemedicine solution is being utilized in the country to extend the reach of specialized healthcare services to masses in both rural and isolated communities. They desire the Government to further expand the scope of telemedicine to reduce the crowd and pressure on the Government hospitals in the country.**

**(Recommendation No. 9)**

## VI. Risk Communication

2.65 Highlighting the risk communication efforts of the Government, Secretary, Ministry of Health and Family Welfare during the course of briefing on 29 July, 2020 submitted:

> "..With the clarion call that hon. Prime Minister gave for *Janta Curfew* and that is when the whole of India got alerted, came together, to observe voluntary lock down is

unprecedented with a population that we have in our country! So, that was risk communication at the highest level and since then we have uploaded various videos on our website; we have sent messages on social media."

2.66 The Committee were apprised that communication material and toolkits such as pamphlets, poster, audio and AV films had been developed and provided to the States. Apart from this, a dedicated call centre/helpline (1075) has been started to guide community at large which are being used by the citizens very effectively and on a regular basis.

2.67 When the Committee enquired about efforts towards publicity of SoP, the best way evolved to deal with corona infection by an individual and the family as a whole, the Ministry of Health and Family Welare in a written reply submitted that communicating the risk to the individuals, families and communities and enabling them to adapt to COVID appropriate behavior is a major non-pharmaceutical intervention to suppress/contain the transmission of COVID. Ministry of Health & Family Welfare has issued a range of guidelines, and information, education communication (IEC) materials on use of masks, physical distancing, respiratory hygiene, hand hygiene, home isolation, home quarantine, addressing stigma and myths, timely reporting of signs and symptoms to call centers and early treatment, including guidelines for various settings (office, markets, malls, hotels, places of religious worship, entertainment parks, schools, colleges, gymnasiums etc.). These have been widely disseminated to States and made available on the website of Ministry of Health & Family Welfare.

2.68 The Committee were also informed that taking note of spread of the disease to peri-urban and rural areas in many District, Ministry of Health and Family Welfare on 16th May 2021 has issued an "SoP on Covid19 Containment and Management in Peri-Urban, Rural and Tribal Areas"

2.69 Emphasizing the importance of community behaviour, the representative from the Ministry of Health and Family Welfare during evidence on 19 July 2021 submitted:

> "The community behaviour or the national behaviour is also important. You would have seen in the recent past, various States have announced their intention in respect of the *KanvarYatra* where large crowds of devotees take water from the river Ganga and then take it to places of religious worship, particularly Shiva temples and offer it there. So, this *yatra* has been suspended this year in Uttar Pradesh, Uttarakhand and Delhi. The State Government of UP has also requested the Union Government that neighbouring States like Punjab, Haryana, Rajasthan, etc. be requested that they should also stop *kanwarias* from travelling from their States to Haridwar, that is the popular spot from where the water is taken. This is one example where the community or the nation collectively has decided to behave in a particular manner to restrict spread of infection. Similarly, the way people gather in marriages, in parties, in other social and religious functions does have an impact on how the virus spreads."

**Jan Andolan**

2.70 The Ministry of Health and Family Welfare informed the Committee that Prime Minister on 8$^{th}$October, 2020 launched the "Jan Andolan for COVID-19 Appropriate Behavior" campaign in view of the upcoming festivals and winter season as well as the opening up of the economy. The campaign aims to encourage People"s Participation (Jan Andolan). It endeavors to be a low cost high intensity campaign with the key messages of 'Wear Mask, Follow Physical Distancing, Maintain Hand Hygiene'.

**Aarogya Setu App**

2.71 Aarogya Setu App is an Indian open-source COVID-19 contact tracing, syndromic mapping and self-assessment digital service. On being asked about much stress being given on the Aarogya Setu App, the Ministry of Health and Family Welfare in a written reply stated that the corona virus spreads by contact and proximity. The Arogya Setu App based contact tracing complements the manual methods and it also reduces the time taken to trace the contacts who

may be at a potential risk. Through the mobile numbers of affected persons, their area of infection can be mapped facilitating identification, delineation of containment zones. These are crucial interventions in the containment strategy for breaking the chain of transmission. The App also augments the COVID-19 initiatives of the Government in proactively reaching out to and informing the users of the app regarding risks, best practices and relevant advisories pertaining to the containment of COVID-19.

2.72 On Committee‟s query, whether the Arogya Setu App is proper and serving the purpose as such it generally asked whether we have come across any positive case or not instead of giving answer itself about covid positive to App users, Secretary, Ministry of Health and Family Welfare, during evidence on 19 December, 2020 submitted that first the factual information, the Aarogya Setu is an App which was designed by the Ministry of Electronics and Information Technology. We are using it. There is absolutely no doubt about it.

2.73 Secretary, Ministry of Health and Family Welfare also added:

> "Sir. I also have Aarogya Setu. If I press it, it tells me: "We have captured 124 Aarogya Setu users contacts with you through Bluetooth proximity. One is at moderate risk. Four are healthy or low risk. It is telling us."

2.74 In this context, the Ministry of Health and Family Welfare in a written reply further submitted that as a part of the Self-Assessment Questionnaire, the App asks whether the User has interacted or lived with someone who has tested positive for COVID-19 or if the User is a healthcare worker, who has examined COVID-19 confirmed cases without protective gear. The self-assessment Questionnaire has been created in consultation with ICMR. The App records the responses given by the User for the Self-Assessment questions and evaluates the likelihood of COVID-19 infection based on the User's self-reported symptoms and other relevant information like diseases declared, age and gender. This evaluation takes place on the App and the results are

communicated to the User immediately in terms of colour-coded risk stratification. This helps as an educative tool for the Users and guide them if they need to go for testing, etc.

2.75 When the Committee desire a review of Aarogya Setu as it apparently alerts only within a radius of one kilometer of the affected person, the Ministry of Health and Family Welfare submitted that the same is not correct. The Aarogya Setu Home Screen shows four statistics (500m, 1 Km, 2 Km, 5 Km and 10 Km) as per the User's location (note: this is the live location of the User's phone and is based on User‟s consent). If the User moves from point A to point B, the numbers will change in accordance with their live location. The following statistics are shown as per the distance radius selected by the User:

- Number of users within X distance from your location who have taken the self-assessment test
- Number of Aarogya Setu Users within X distance from your location
- Number of users within X distance from your location who have indicated one or more of the three symptoms for COVID-19
- Number of users within X distance from your location who have been tested COVID-19 positive
- Number of users within X distance from your location who have come in direct contact with someone has been tested COVID-19 positive

  Where X can be any one of the following values depending upon the User‟s choice of selection: 500m, 1km, 2km, 5km, 10km.

**2.76 The Committee feel that communicating the risk to the individuals, families and communities and enabling them to adapt to COVID appropriate behavior is a major non-pharmaceutical intervention to suppress/contain the transmission and note with appreciation that before imposition of complete lockdown "Janta Curfew" was observed as a voluntary lock down to alert whole of India against the unprecedented once in a century Pandemic. During unlock period „Jan Andolan" campaign was launched on 8 October, 2020 to encourage peoples participation to follow COVID-19 appropriate behavour with**

**the key messages of „Wear Mask, Follow Physical Distancing, Maintain Hand Hygiene in view of the upcoming festivals and winter seasons alongside the opening of the economy. Given that Corona virus spreads by contact and proximity, Aarogya Setu App was launched to trace the contacts who may be at a potential risk. The App records the responses given by the User for the Self-Assessment questions and evaluates the likelihood of COVID-19 infection based on the User"s self-reported symptoms and other relevant information. It informs the users of the app regarding risks, best practices and relevant advisories pertaining to the containment of COVID-19. The Committee believe that the Aarogya Setu App, call centres and designated helplines, communication material and toolkits such as pamphlets, posters, audio and AV Films have played a vital role against corona virus transmission but have not been used widely as expected. Given huge dependence on Aarogya Setu App in the containment strategy for breaking the chain of transmission, the Committee, would like to recommend the Government to conduct an assessment about the contribution and the effectiveness of the Aarogya Setu App in breaking the chain of transmission, with a view to enhance its utility in any future COVID-19 waves and also in possible future outbreaks of other communicable diseases.**

**(Recommendation No. 10)**

## CHAPTER III

## COVID LOCKDOWN AND IMPACT REDRESSAL MEASURES

The main purpose of implementing the lockdown measures was to contain/ slow down the spread of Coronavirus by breaking the chain of transmission and to provide additional time to ramp up capacities at all levels.

3.2 COVID-19 pandemic has brought up many challenges. In the process of effectively responding and continuously adapting to improve response to these challenges, many useful lessons have been learnt along the way like need for Systematic Preparedness and SoPs for Emergent Risky/Disruptive Situations; need to work closely with all relevant stakeholders, to create domestic capacity in order to make economy resilient to global disruptions and use of digitized/electronic office technology etc..

**India‟s Preparedness Prior to First Covid Case**

3.3 Regarding pre-emptive actions, the Committee are apprised:

> "Even before the crisis actually hit India in full measure, the pre-emptive actions which needed to be taken had already been started in the Ministry of Home Affairs. Right in the beginning of January, travel advisories had started being issued, thermal screening had been started in all international airports with focus on flights and passengers coming from the most sensitive countries and gradually international flights coming to India were stopped. Subsequently rail and metro services, and finally all kinds of domestic flights were also banned."

3.4 Elaborating on the Government‟s approach towards a preventive, proactive and graded approach prior to the first case reported in Kerala on 30th of January 2020, Secretary, Ministry of Health and Family Welfare during the briefing on 29.7. 2020 submitted:

> "..It was on 7th January that China identified a new Corona virus in Wuhan. We have Joint Monitoring Group under our Director, Health Services. On 8th January itself they

met. This is the technical group which has representatives from AIIMS, has public health experts, has representatives from ICMR, so they just met to find out actually what is China trying to report. On 17th of January itself we issued our first advisory which said, `avoid travel to China‟. …So, as I said on 17th itself the first advisory was issued. We had our first case in Kerala on the 30th of January. I would like to emphasise that much before we had our first case we were alert and pro-active..”

3.5 Elaborating the details of proactive steps taken by the Central Government prior to the first case reported in the country Ministry of Home Affairs submitted in a written note as under:

(1) The Government proactively started in regulating, restricting and even prohibiting in-coming international passengers‟ traffic through immigration check to contain the spread of COVID1-19 in India.

(2) The Government also managed and controlled the visa issuance process and effective screening of passengers tested and traced for COVID-19 and had taken quick and timely measures in anticipation of the potential crises reaching our country even before India had the first confirmed case and geared up all its Ministries much before WHO declared COVID-19 to be a “Public Health Emergency of International Concern”.

(3) On 17 January 2020, Union Health Secretary advised all State/UT Authorities to examine and take necessary actions for adequate hospital preparedness to meet with any potential emergency.

(4) First Travel Advisory was issued on 17 January and additional advisories related to international travel were issued periodically. Travel restrictions were imposed and existing visas were suspended periodically commensurate with the severity and spread of the disease from the countries which reported high number of cases and deaths. Progressively, flights in India were restricted.

(5) On 18 January 2020, thermal screening was started for all passengers coming from

China and Hong Kong at three international airports. From 4th March, thermal screening was initiated for all international flights, and an advisory to follow standard health protocol for COVID-19 was issued by Ministry of Health and Family Welfare (MoHFW) and it was progressively extended to seaports and land borders.

(6) On 22 March, 2020, with a view to contain the spread of Covid-19 in the community all International flights coming to India and, mass transportation services i.e. metro and rail traffic were suspended till 31 March, 2020 and On 24 March, domestic air traffic was also suspended.

**Role of Central Ministries in Management of Pandemic**

3.6 The Committee were apprised that the Government was following a "whole of Government" approach to manage COVID-19. Apart from the COVID Pandemic being reviewed and monitored by the Ministry of Health, Ministries of External Affairs, Civil Aviation, Home Affairs, Shipping, Pharma, Tourism, Textiles, Defence, National Disaster Management Authority (NDMA) are reviewing and coordinating actions beyond health sector.

**Inter-Ministerial and Centre-State Coordination**

3.7 When asked to spell out the inter-ministerial coordination mechanism established to deal with the challenges arising out of covid pandemic in the country, the Ministry of External Affairs stated that the Government of India established a three tier framework for decision making, namely:

(i) Group of Ministers;

(ii) Committee of Secretaries; and

(iii) Empowered Group of Ministers.

The decision taken in these meetings were put up to the Hon"ble Prime Minister for

guidance and approval. These decisions have been issued *vide* various SOPs and guidelines of the Ministries of Home Affairs, Health and Family Welfare and Civil Aviation.

3.8 Regarding monitoring the COVID-19 situation, the Ministry of Health and Family Welfare apprised the Committee that Hon'ble Prime Minister and his office are monitoring the situation. Under the directions of the Hon'ble Prime Minister, a High-level Group of Ministers (GoM) has been constituted on 3rd February 2020 to review, monitor and evaluate the preparedness and response measures being taken regarding management of COVID-19 in the country. The GoM convened under the Chairmanship of Dr. Harsh Vardhan, Hon'ble Union Minister of Health & Family Welfare has since then met 29 times. The Ministry of Home Affairs, Govt. of India, under extant provisions of Disaster Management Act, 2005 had constituted 11 Empowered Groups on 29th March 2020 for informed decisions for COVID-19 management. Based on the evolving needs and scenario in the country, on 11th September 2020, these groups were condensed into six larger empowered groups (EGs). On 8th January 2021, another Empowered Group on Vaccine Administration has been constituted to take all necessary measures for effective implementation of CO-WIN platform created for inventory management and delivery of COVID-19 vaccine. On 29th May 2021, these were reconstituted in 10 Empowered Groups. These 10 Empowered Groups are tasked with (i) Emergency Management Plan and Strategy, (ii) Emergency Response Capabilities, (iii) Augmenting Human Resources and Capacity Building, (iv) Oxygen, (v) Vaccination, (vi) Testing, (vii) Partnership, (viii) Information, Communication and Public Engagement, (ix) Economic and Welfare Measures and (x) Pandemic Response and Coordination. A Committee of Secretaries under Cabinet Secretary is reviewing the situation regularly. He has also held regular video conferences with States/UTs. Union Health Minister and Senior officers in the Ministry of Health & Family Welfare are constantly reviewing the evolving scenario and have held 113 video conferences so far with State Health functionaries. The Joint Monitoring Group (JMG) under the Chairmanship of DGHS

which advises MoHFW on technical matters has met 55times till now to assess the risk, review the preparedness & response mechanisms and finalize technical guidelines.

3.9 When asked to underline Centre-State Cooperation and coordination with regard to management of COVID-19, the Ministry of Health and Family Welfare stated that the Hon"ble Prime Minister, Hon"ble Union Health Minister, Cabinet Secretary, Union Home and Health Secretaries are regularly interacting with the States/UTs to review preparedness measures and public health response to COVID-19. These interactions have provided avenues for furthering cooperation and coordination with regard to management of COVID-19. Many of the good practices being followed by some of the States have been advised for replication in others. Plans, procedures and guidelines (some of them as per the request of the State Government) have been provided. In addition, logistic and financial assistance to the States have been provided based on the feedback received from States. In addition, Central multi-disciplinary teams have been deployed to States/UTs (some of them as per the request of the State Government) to provide supportive supervision to States for on-ground implementation of strategies/plans.

**Measures Taken before Imposition of Lockdown**

3.10 The Committee were informed that **on** 11 March 2020, Home Secretary, the Chairperson of National Executive Committee (NEC) delegated power under Section 10(2)[(i) & (i)] of Disaster Management Act, 2005 to Secretary, MoHFW to enhance preparedness and containment of Covid-19 and other ancillary matters connected thereto. This enables MoHFW to issue advisories on COVID-19 management.

3.11 The Committee were also apprised that with a view to augment the availability of funds with the State Governments, COVID-19 was declared as notified disaster by Central Govt. on 14.03.2020 for the purpose of providing assistance under State Disaster Response Fund (SDRF) placed at the disposal of respective State Governments. This allowed SDRF to be used for

setting up quarantine facilities**;** sample collection and screening; setting up additional testing laboratories within the Government; cost of consumables; purchase of personal protection equipments (PPE) for healthcare, municipal, police and fire authorities; purchase of thermal scanners; ventilators, air purifiers, and consumables for Government hospitals; to supplement the State resources for the above purposes.

**Janta Curfew and Imposition of Lockdown**

3.12 The Committee were apprised that on an appeal made by the Prime Minister on 19 March in his address to the Nation, a "Janta" curfew was observed whole-heartedly throughout the Country on 22nd March, 2020. MHA advised States and UTs to observe Janta Curfew across the country on 22nd March, 2020 to promote voluntary social distancing as a measure to control Covid-19. All the citizens of the country voluntarily observed the Janta Curfew and conveyed their strong determination to deal with this global crisis by rising to the occasion in a mature and determined manner.

3.13 Further regarding imposition of lockdown and lockdown measures, the representative from the Ministry of Home Affairs during the briefing on 29 July submitted:

> "..Hon. Prime Minister addressing the nation on the 24th of March and announced imposition of lockdown for 21 days with effect from March 25th. In pursuance of these announcements by the hon. Prime Minister, the Ministry of Home Affairs invoked the Disaster Management Act for which it is administratively responsible and imposed certain measures for social distancing also called lockdown measures. So, the order and the guidelines were issued on the 24th of March and they came into effect from the 25th of March. Under these guidelines, except for the most essential activities, all other activities were prohibited across the country. Gradually, with the increasing fortification of our capabilities to address the pandemic, particularly in view of the increased infrastructure on the medical side, these guidelines, with a view to allowing the most important economic activities, were progressively relaxed in a graduated manner. We

issued guidelines again on the 15th of April with certain other relaxations. Thereafter, guidelines were issued on the 1st of May, on the 17th of May and then beginning from the 30th of May, we entered a new phase of regulating activities which we called the Unlock Phase and under the Unlock Phase two sets of guidelines have been issued. Along with these guidelines, the point that we would like to emphasise is that we have also issued what are known as national directives for Covid Management which are, in a sense, the SOP for Covid safe practices both in public spaces as well as in work spaces. These are very important parts of our guidelines and these can be legally enforced by the administrative and police authorities across the country."

3.14 While elaborating about early start of restrictions, Foreign Secretary during briefing on 29 July, 2020 submitted:

"We were there early in the curve and we moved to bring in full lockdown on the 55th day of the outbreak in India with only around 600 confirmed cases. Other countries undertook full lockdown only after cases rose beyond several thousands. The WHO also acknowledged that our public health responses were pro-active and pre-emptive. So, in that sense, one of the positive aspects of our handling the crisis was that we stayed ahead of the curve. We started screening COVID-19 cases even before Phase-I of the infection was detected in India. I am just giving a comparative analysis. Italy started its screening 25 days after the first case and Spain did so only 39 days after the first case was discovered."

**Inter-State Movement of Goods and Persons during lockdown**

3.15 In a written note the Committee were informed that transportation for the following was allowed during lockdown:

- Inter-state movement of goods/ cargo for inland and exports.
- Fire, law and order and emergency services.
- Operations of Railways, Airports and Seaports for cargo movement, relief and evacuation and their related operational organisations.
- Cross land border movement of essential goods including petroleum products and LPG, food products, medical supplies.
- Intra and inter-state movement of harvesting and sowing related machines like combined harvester and other agriculture/horticulture implements.

3.16 It was also informed that the movement of individuals was prohibited except those which were allowed under the guidelines. However, there was no restriction on movement of health personnel and those in supply of essential goods and services. In subsequent guidelines, movement of persons was gradually opened up on assessment of the situation.

**Impact of Lockdown and Redressal Measures**

3.17 In a written note the Committee were apprised that due to lockdown migrant workers, pilgrims, tourists, students and other persons were stranded in different part of the country. Highlighting the response of MHA for the migrant worker community, the representative from the Ministry of Home Affairs during briefing on 29 July 2020 submitted as under:

> "Starting from the end of March we allowed the States to use the State Disaster Response Fund for providing benefits to migrant workers and under this relief camps could be set up and various kinds of facilities could be established in these relief camps and the money which were available with the State Governments, or which were due to the State Governments were released in advance on the 3rd of April to enable them to undertake all these activities. Thereafter, a series of advisories had been issued on 27th March, 28th March, thereafter on 29th March, 30th March, 14th April, 19th April, 29th April, 1st of May and so on with focus on the facilities to be provided to migrant workers, with focus on their transportation arrangements and with focus on how they could be provided employment *in-situ* wherever they had gone or in neighbouring areas. So, all these have essentially resulted due to large scale movement of migrant labourers across the country which was a major issue which had arisen right in the beginning of the lockdown measures and in such a manner that it has not led to any disorderly arrangements anywhere and all these migrant labourers have been tested; they have been quarantined and they have been comfortably settled in their respective places of work."

**Advisories for Assistance to Stranded Migrant Workers**

3.18 Ministry of Home Affairs submitted in a written note that with a view to make adequate funds available to the State Governments for effective response against COVID 19, as a special dispensation, the 1st installment of Rs. 11,092 crore as Central Share of State Disaster Risk Mitigation Fund (SDRMF) for financial year 2020-21 was released in advance to all States on 03.04.2020.

3.19 MHA further informed that advisories were issued by the Ministry of Labour and Employment to all States/UTs on 24.3.2020 and 27.3.2020 for extending financial assistance to construction workers during the outbreak of covid-19. In response, 31 State/UT Governments have provided cash benefits (ranging from Rs. 1000/- to 6000/- per worker) by DBT from cess fund, to 1.82 crore workers across the country involving an amount of approx. Rs.4970.00 crores.

3.20 Through same written note the Committee were informed that on 27 March, 2020, an advisory was issued on the issue of migrant agricultural labourers, industrial workers and other unorganized sector workers etc. who were trying to return to their domicile States/UTs. Considering the overall scenario including prevention of spread of COVID 19 and lack of transportation facilities and States and UT Governments were advised to:

- Ensure that such incidents are avoided, through strict measures by handling the situation urgently and sensitively to stem their exodus from their existing locations, as also to prevent any disruption to law and order.
- To immediately explore options for providing shelters rigorously through existing infrastructure etc., keeping in mind the requirements for drinking water, sanitation, common kitchen, storage etc.
- Provision of food packets to the vulnerable groups can be explored through various means including spare capacities in prison kitchens, NGOs (including large scale meal providers such as mid-day meal scheme vendors), IRCTC facilities, religious organizations, CSR efforts etc. after examining their suitability.

- To take measures for including provision of free food grains and other essential items through the public distribution system and should be brought to their notice and its distribution should be streamlined.

- Take steps to ensure that other categories such as students, working women hostel inmates etc. are also allowed to continue in their existing facilities with all precautions. It is necessary that hotels, rented accommodation etc. continue to remain open and functional and delivery of essential services be streamlined.

3.21 The Committee were further apprised through a written note that to deal with the situation and for effective implementation of the lockdown measures, and to mitigate the economic hardship of the migrant workers, in exercise of the powers conferred under Section 10(2)(l) of the Disaster Management Act 2005, Union Home Secretary, in the capacity as Chairperson, NEC issued an Order on 29th March 2020, with the directions to the State/Union Territory Governments and State/ Union Territory Authorities to take necessary action and to issue necessary orders to their District Magistrate/ Deputy Commissioner and Senior Superintendent of Police/ Superintendent of Police/ Deputy Commissioner of Police, to take following additional measures:

- State/Union Territory Governments shall ensure adequate arrangements of temporary shelters, and provision of food etc. for the poor and needy people, including migrant labourers, stranded due to lockdown measures in their respective areas;

- The migrant people, who have moved out to reach their home states/ home towns, must be kept in the nearest shelter by the respective State/Union Territory Government quarantine facilities after proper screening for a minimum period of 14 days as per standard health protocol;

- All the employers, be it in the Industry or in the shops and commercial establishments, shall make payment of wages of their workers, at their work places, on the due date, without any deduction, for the period their establishments are under closure during the lockdown;

- Where ever the workers, including the migrants, are living in rented accommodation, the landlords of those properties shall not demand payment of rent for a period of one month.

- If any landlord is forcing labourers and students to vacate their premises, they will

be liable for action under the Act.

3.22 They also submitted that on 28 March 2020, NDMA also issued an advisory detailing the role of State and District Disaster Management Authorities (SDMA/DDMA) in handling COVID19 pandemic. A number of measures were suggested such as functioning of State and District Emergency Operation Centers for flow of information; inter agency coordination; community awareness; proactive planning; coordination with NGOs; coordination with industry; coordination with neighboring States; to deal with issues relating to migrant workers and stranded tourists and recommendations for police and administration to adopt humane approach in dealing with public particularly those who are left adrift by the lockdown, and to interpret the lockdown restrictions with compassion and a sense of duty of care for the citizens.

**Exemptions during Lockdown**

3.23 The Ministry of Home Affairs in a written note informed the Committee that based on the suggestions received from Central Ministries/ State Governments/various quarters and keeping in view the difficulties faced by different sections of society, the following exemptions were allowed from time to time during the lockdown period:

- Farming operation by farmers and farm workers. Tea Industry including plantation with maximum 50% workers.
- Mandies operated by Agriculture Produce Market Committee or as notified by State Governments.
- Shops and manufacturing unit of fertilizers, pesticides and seeds. Shops for agriculture machinery and spare parts.
- Inter and Intra State movement of harvesting and sowing related machines.
- Operations of fishing (marine)/ aquaculture industry and workers for related activities.
- Operation of IT Vendors for banking operations; Banking correspondence and ATM operations and cash management agencies.

- Manufacturing units of essential goods including good, pharmaceutical, medical devices, their raw materials and intermediates.
- Inter-state movement of goods/ cargo for inland and exports.
- Shops for truck repair on highways.
- Collection, harvesting and processing of Minor Forest Produce (MFP)/ Non Timber Forest Produce (NTFP) by Scheduled Tribes and other forest dwellers in forest areas.
- Bamboo, coconut, Arecanut, Cocoa, Spices plantation and their harvesting, processing, packaging, sale and marketing.
- Non Banking Financial Institutions (NBFCs) including Housing Finance Companies (HFCs) and Micro Finances Institution (NBFC-MFIs) with bare minimum staff.
- Cooperative Credit Societies.
- Water supply and sanitation, laying/ erection of power transmission lines and laying of telecom optical fiber and cable along with related activities.
- Facility for export/ import such as Pack houses, inspection and treatment facility for seeds and horticulture produce.
- Research establishment dealing with agriculture and horticulture activities.
- Inter and intra State movement of planting materials and honey bee colonies, honey and other beehive products.
- Sign-on and sign-off of India Seafarers at Indian ports and their movement for the aforesaid purpose as per SOP.
- Activities for forest plantation including Silviculture operations.
- Shops of educational books for students.
- Shops of electric fans.

**Arrangement for Movement of Stranded Persons by Bus and Train**

3.24 On the issue of arrangements made for movement of stranded persons during lock down the Committee were informed through a written note that all States/UTs were advised on 29 April 2020 to facilitate the movement of people stranded at different places by buses to their

native places following adequate health safe guard during their movement and subsequently the movement of these stranded persons was allowed by Special „Shramik" trains started on 1 May 2020.

**Economic Stimulus Plan**

3.25 Ministry of Finance informed the Committee through a written note that within few days of the nationwide lockdown was announced, the Government announced an INR 1.7 trillion economic stimulus plan that provided direct cash transfer and food security measures, offering relief to millions of poor people hit by a nationwide lockdown triggered by the corona virus pandemic.

**Relief Package under PMGKY**

3.26 About the relief Package for poor people, MHA informed the Committee through a written note that Central Government announced a Rs 1.70 Lakh Crore relief package under Pradhan Mantri Garib KalyanYojana (PMGKY) for the poor people to help them fight the battle against Corona Virus. The package includes:

i. Insurance cover of Rs 50 Lakh per health worker fighting COVID-19 will be provided.

ii 80 crore poor people will be provided 5 kg wheat or rice and 1 kg of preferred pulses (per family), free of cost, every month for the next three months.

iii 20 crore women Jan Dhan account holders will be given cash assistance of Rs 500 per month per person for next three months.

iv 8 crore poor families registered under the scheme of Ujjwala will get 1 Gas cylinder, per family, per month free of cost for the next three months.

v MNREGA wage to be increased Rs 202 a day from Rs 182, which will benefit 13.62 crore families.

vi An ex-gratia financial assistance of Rs 1,000 per person will be given to 3 crore poor senior citizen, poor widows and poor disabled.

vii Government will front-load Rs 2,000 to farmers in first week of April under the existing PM Kisan Yojana to benefit 8.7 crore farmers.

viii Wage-earners earning below Rs 15,000 per month in businesses having less than 100 workers, would be given 24 percent of their monthly wages into their PF accounts, per person, per month for next three months.

Ix Central Government has given orders to State Governments to use Building and Construction Workers Welfare Fund to provide relief to Construction Workers and support to 3.5 Crore registered workers.

3.27 Elaborating on the measures taken for workers under the Pradhan Mantri Garib Kalyan Yojana, Secretary, Ministry of Labour and Employment during evidence on 11 August 2020 stated:

> "We have around 47 crore workers as per the 2017-18 census. During the COVID-19 times, under the Pradhan Mantri Garib Kalyan Yojana, many measures were taken up. One was from the EPFO. We deferred even the payment for EPFO for the month of March and for the ESIC also we have deferred the payment for two months, for March and April. It means both the employer and the employees need not pay. Under the Pradhan Mantri Garib Kalyan Yojana, 24 per cent, that is 12 per cent for the employees and 12 per cent for the employers, particularly for the companies whose strength is 100 and where 90 per cent of the employees earn Rs. 15,000, for them the amount was paid by the Government. It is for six months from March. So, it will be there up to August. The Government will be paying the full amount. In addition to that, the employees were allowed to withdraw it. We made a special provision, COVID provision, and till now around Rs. 18,500 crore have been withdrawn by the employees as a special measure. In addition to that, they can withdraw from their regular accounts, like housing, marriages, sickness, etc. This is for COVID only because they may be facing problems and the employers may not be paying the amount. So, we have allowed them to withdraw from their EPF accounts. In addition to that we have reduced the EPF contribution from 12 per cent to 10 per cent so that employees can get more amounts and take more amounts to their homes. The employers are also allowed to pay two per cent less so that it becomes more viable for him to run his establishment."

3.28 The Witness further added:

> "During the COVID time, 2.58 crore workers of the building and other construction works, were given assistance through the Rs. 35,000 crore Fund that we have. It is Building and other Construction Workers Cess Fund. It is with the State Welfare Boards. They have distributed around Rs. 4,985 crore. The directions were given by the Government of India and accordingly they have distributed it. In addition to that, many States have distributed food packets, etc."

**Definition of Inter-State Migrant Worker**

3.29 The Committee were informed that definition of Inter State Migrant Worker is proposed to be expanded in the Draft Labour Code on Occupational Safety and Health to cover all workers, including organized, unorganized and self-employed workers.

3.30 On this issue, Secretary, Ministry of Labour and Employment during evidence on 11 August, 2020 informed:

> "After seeing the huge migration, particularly many people were moving from working place to their native places, we are now increasing the scope of definition of inter-State migrant worker. Earlier, they were supposed to come only through a contract worker, but now he can come through employer or through contractor or he can come on his own. He can declare himself as an inter-State migrant worker. "

**National Database on Workers**

3.31 The Committee were apprised that a National Database on Workers to facilitate the registration of the workers including migrant workers will be launched soon by the M/o Labour & Employment. This database will help the State Government, migrant labourers, other workers and other stakeholders including Government authorities to know the movement of workers from their native states to the destination states and back. Moreover it will help the authorities to plan welfare schemes and measures for them. Their occupations, skill profiles and income levels will

be captured to help in delivery of various social security schemes.

3.32 Over a national data base on migrant workers, Secretary, Ministry of Labour and Employment during evidence on 11 August 2020 illustrated:

> "..We are going for a big national data base on these workers, particularly for the unorganised workers and inter-State migrant worker will be a sub-sect of that national data base. Yesterday also we had a discussion in the Finance Ministry and we are getting it approved. What we are doing is that the details are captured in Aadhar. In Aadhar we have name, gender and their residential address. In addition to that, now we want to have the occupation, his State profile and the place where he is working currently. So, we are working as to how to make use of the UIDAI, and the payment banking system. Through that we can ask them to update the unorganised workers so that we can get this data base. We can prepare a national data base. We are working on that. It will be launched very shortly because we have gone for the EFC and we hope that in a week"s time the EFC will also be over. The inter-State migrant worker will be the sub-sect of this data base and it will be Aadhar seeded."

**One Nation One Ration Card**

3.33 On being enquired about mechanism under which a migrant labour who do not have a ration card can get ration from a ration shop, a representative of Department of Consumer Affairs during evidence on 11 August informed:

> "Sir, we have the „One Nation One Ration Card" system where anybody who has a ration card back home, if he is travelling or wherever he is living for his work, he need not prepare another ration card."

3.34 When asked, whether it has been implemented, he submitted:

> "It is basically the States who have to get on board."

**3.35 The Committee are happy to learn that before the COVID-19 could enter India, several pre-emptive actions such as travel restrictions were imposed and thermal screening**

**was started at all international flights focusing on passengers coming from the most sensitive countries. Further, the Committee note that a robust Inter-ministerial and Centre-State Coordination mechanism was established to deal with various issue pertaining to Pandemic and to review, monitor and evaluate the preparedness and measures being taken regarding management of COVID-19 in the country. The Committee are happy to learn that WHO also acknowledged our public health responses positively. The Committee also observe that the main purpose of imposition of nationwide lockdown was to contain and slow down the spread of Corona Virus by breaking the chain of transmission and to provide additional time to ramp up capacities at all levels. In pursuance of imposition of lockdown, National Disaster Management Act was invoked and except for the most essential activities, especially movement of health personnel and those in supply chain of essential goods and services, all other activities were prohibited across the country. But gradually, with our increasing capabilities to address the pandemic, particularly in view of the improved medical infrastructure, the most important economic activities were progressively relaxed in a graduated manner. The Committee observe that one of the positive aspects of our handling the crisis was in the country staying ahead of the curve. However, the Committee are also constrained to note that, migrant workers, pilgrims, tourists, students and other persons were stranded in different parts of the country. The Committee further note that to address the hardships faced by the migrant workers during return to their respective States/UTs, a series of advisories were issued with focus on facilities such as shelters, free foodgrains and payments of wages, etc. as well as regarding their transportation arrangements and provision of employment *in-situ* or in neighbouring areas. Most importantly, authorities of all levels were advised to adopt a proactive humane approach in dealing with the public, particularly those who were left adrift by the lockdown to bring succour to them. Based on the suggestions received from**

**Central Ministries/State Governments/various other quarters and keeping in view the difficulties faced by the stranded people, their movement with health safeguards was allowed by buses and „Shramik Special" trains. In view of difficulties faced by the people during national lockdown, the Government appropriately modified the policy and during the second wave and third wave the decision of lockdown or relaxation etc. was appropriately left on the State Governments and it was done on the basis of local conditions of disease spread and need. The Committee find this modification as the core one and recommend for the continuation of the same in future also. However, the Central Government should keep a vigil on situation in each State and strictly apply the National Disaster Management Act in the States having high positivity rates to prevent wide spread of infections.**

**(Recommendation 11)**

**3.36 The Committee note that under the Pradhan Mantri Grib Kalyan Yojana, the Government paid the mandated 24 per cent contribution in PF accounts, i.e 12 per cent for the employees and 12 per cent for the employers, particularly for the companies whose strength is upto 100 and where 90 per cent of the employees earn Rs. 15,000. While appreciating this initiative, the Committee are of the opinion that it should have been made applicable to those establishments having more than 100 employees also. The Committee also feel that the welfare measures during Pandemic faced difficulties due to lack of definition of Inter-State Migrant Worker in the Draft Labour Code on Occupational Safety and Health, a National Database on Workers for the registration of workers and implementation „One Nation One Ration Card" addressing the issues of exodus of migrant workers. Hence, the Committee desire that the Government must ensure the implementation of these important interventions in the country so that the affected**

**population may not face any difficulty in getting the help of Government in case of any such eventuality in future.**

**(Recommendation No. 12)**

**Relaxation for MSME**

3.37 Regarding the relaxation provided for ease of doing business looking at compelling situation on account of COVID pandemic, a representative of Department of Consumer Affairs during evidence on 11th August, 2020 submitted:

> "For ease of doing business, we have carried out certain relaxations under Legal Metrology Act and there were relaxations for MSME also. The extension of six months period in two phases for verification and stamping of weights and measures was undertaken. The manufacturers and packers were allowed to utilize the packaging material and wrapper with pre-printed date of manufacturing up to 30th September.
>
> For MSMEs, the relaxations include providing special benefits of approximately 54.38 crore for the licensees of BIS in the manufacturing sector with an additional rebate of 20 per cent which has been given on minimum marking. A rebate of 20 per cent on inspection fee has also been given. The application fee, which is to be submitted along the license for management system certification has been reduced from Rs. 7,000 to Rs. 1,000. They have been allowed for advanced marking fee at the time of grant of renewal of BIS license."

**Relaxations to Industry**

3.38 While elaborating on relaxation to industries during lockdown, he added:

> **"**There is also relaxation to industries by renewal of licence after validity date without charging late fee during lockdown, renewal of licence on the basis of self-declared production statement instead of certified statement from the chartered accountant during

lockdown, extension of time limit for deferred licence beyond 90 days during lockdown and 30 days after lifting of lockdown and relaxation in time limit for deposition of samples for grant of licence in the third party lab by the applicant up to 30 days after the lifting of lockdown. BIS has developed Indian standards for Personal Protection Equipment (PPE) to be manufactured for use of doctors, health professionals. This has enhanced domestic production of the equipment which was substantially low during COVID months. It has many new units now in position to even export their produce."

**3.39 The Committee are of the view that the Micro, Small, and Medium Enterprises(MSMEs) and other Industries have faced the maximum brunt mainly due to liquidity crunch, interrupted supply chain, inter-state lockdown provisions, laying off their workers because of inability to pay them salaries during lockdown. The Committee note with satisfaction that the Government proactively came up with an economic stimulus plan and relaxation for ease of doing business, offering relief to the MSMEs and industries that were adversely hit by a nationwide lockdown in the wake of COVID-19 Pandemic. The Committee further note that the relaxations include special financial benefits for the licencees of Bureau of Indian Standards (BIS), rebate in inspection, application and marking fees, renewal of licence without charging fee, extension of time limit for renewal of licence and relaxation in time limit for deposition of samples for grant of licence. The Committee also observe that despite facing disruptions on account of pandemic, MSMEs shifted focus from producing traditional essential goods and made exemplary efforts to produce items such as hand sanitizer, PPE kits and face mask and even in such tough times of Pandemic have not only fulfilled the country"s need of these products but also enabled India to help other nations in distress. In view of the MSME sector being one of the largest employment generator, its catalyst role for the development of the country and the goal of Atmanirbhar Bharat, the Committee strongly recommend that the Government should make all possible efforts with the collaboration of the external and internal investors to**

**create more conducive environment in order to boost MSMEs and reduce dependency upon imports. The Committee may be apprised about the steps undertaken in this regard and the outcome thereof.**

**(Recommendation No. 13)**

**Effect of Pandemic on Education Sector**

3.40 Highlighting the impact of the pandemic on education sector, Secretary, Ministry of Education during the course of evidence on 11 August, 2020 submitted that Education sector has been affected very seriously and very adversely because of the pandemic. For the last almost five months, since 25th March, 2020, educational institutions, right from the school to the higher education level, have been closed. But I would like to point out that during this challenge, we have tried to convert our education system into an online system.

3.41 Elaborating on online courses, Secretary, Ministry of Education during evidence 11 August 2020 deposed:

> "The massive open online courses, which have been named as SWAYAM in our country. These SWAYAM courses were permitted 20 per cent so far, but because of the pandemic we have taken a decision that any Degree Programme can have up to 40 per cent online courses, which means that if there are 10 credits in that particular course, then four can be through online and six will be offline blended mode.

3.42 Further, regarding educational channels, Secretary, Ministry of Education submitted that we have 34 educational channels. We are using educational channels where we are not able to provide online content so that through TV, the same content can be provided by Doordarshan.

3.43 Underlining the challenge of transformation of traditional classroom system to the online system in the education sector, he added:

> "There are many challenges – challenge of the digital divide, challenge of availability of devices and in much case, challenge of connectivity itself. For example, in Andaman, the connectivity has been provided through cable only."

3.44 Regarding use of technology for teaching and training of teachers, he stated:

"During this period we have been using technology for teaching and training of teachers because while we may provide online resources, actually the teachers must also be trained in using these online resources. This programme by the name of NISHTHA is going on for school education, and for higher education NITT is being conducted where 20,000 teachers have already been trained. Hackathons have been organised by the All India Council of Teachers Education (AICTE).

3.45 Elaborating on collaboration with MEA for welfare of Indian and Foreign Students, he submitted:

"Nearly, 7.5 lakh Indian students go and study abroad. So, one is their welfare. Secondly, 40,000 students are coming to India to study. So, we have to be cautious about the welfare of foreign students also and for both of them we have worked together with MEA that issue which had come about the visa problem in USA. The MEA has informed that there is no such issue as of now. Even online courses where universities have shifted to online they will continue to have the visa. So, as of now, those problems are not there, but we are using this opportunity and we are treating this period as an opportunity where we can attract more foreign students to India. We have already informed through MEA to all the Missions that the first semester of our country will be totally online. So, students coming from other countries need not be afraid of the Covid situation here because the first semester will be provided online wherever they are situated.

Secondly, with the help MEA and particularly DG, ICCR we have worked out to bring more awareness about our educational initiatives in other countries because it is possible that many of them may like to come to India as they have to do an online study in US and online study in India, the courses are almost same. Many people go to US because they have a different ambience, but now that both are offering online courses, we can attract more foreign students to India given the good education system that we have."

**3.46 The Committee observe that due to prolonged closure of schools and higher educational institutions to contain the spread of virus in the country, the education sector has been seriously impacted and has witnessed unprecedented transformation in classroom**

**system. The Committee are happy to learn that during such difficult times, the Government has enhanced the scope of open online courses under the Study Webs of Active-Learning for Young Aspiring Minds (SWAYAM) courses from 20 per cent to 40 per cent and providing the content through educational channels of DD wherever the access of online content was difficult, Through the National Initiative for School Heads' and Teachers' Holistic Advancements (NISHTHA), thousands of teachers were trained to use technology to get acquainted with online resources and to provide these resources to students. The Classroom activities and Board exams have been avoided keeping the safety of students in mind. However, on the other hand, the Committee observe that the education sector has been facing several challenges like digital divide, availability of devices and connectivity due to which a significant number of students could not continue their studies. Now, the gradual opening of schools in most of the States has taken place with strict precautions. The Committee, however, would like to suggest that schools / colleges should be opened in phases and at least for six months a hybrid system of online as well as offline classes should be organized so that students/parents have an option to attend in either mode. Moreover, directions should be issued that due to exposure of children, if the number of cases rise then they should immediately shift to the online system. The Committee, also, strongly recommend that the Government should initiate a comprehensive survey on impact of digital divide and chalk out an institutional mechanism to address the issue of digital divide with a view to ensure that those without online learning devices also get access of free and compulsory education which is a fundamental right enshrined in the Constitution. For this purpose only DD should not remain, the mode of dissemination but all private channels should also be roped in this national effort. The Committee further note that lakhs of students go abroad to study and in many countries the universities / colleges have opened. The Committee, therefore, desire that**

**MEA/Department of Education should facilitate the students to enable to join their institutions abroad in an appropriate way. Thousands of foreigners also come to India for education every year. The Committee desire that the Government should bring more awareness in other countries about our digital educational initiatives so that in this period of pandemic, foreign students are attracted to India"s online courses in more number.**

**(Recommendation No. 14)**

## CHAPTER IV

## SUPPORT TO STRANDED INDIAN AND FOREIGN NATIONALS

Indian Nationals who had travelled to different countries before the lockdown, on various purposes such as employment, studies/ internships, tourism, business, etc., are stranded abroad due to lockdown. Due to their prolonged stay abroad, they are facing distress and are desirous of returning to India urgently. Apart from the above cases, there are other Indians who need to visit India in medical emergencies or death of a family member. Also, many persons are stranded in India who are desirous to travel abroad urgently for various purposes.

4.2 In the evolving pandemic situation, travel visas of citizens of Covid-19 affected countries were suspended and w.e.f 22 March 2020, commercial operation by International airlines were stopped by India. Further, from 25 March 2020 domestic schedule operations were also suspended. Consequently, the pandemic which had spread all over the world had left many Indians stranded in foreign countries and vice versa.

**Measures Taken to Facilitate Movement of Stranded Persons**

4.3 In a written note the Committee were apprised that with an aim to better coordinate requests of stranded Indians abroad and also of those foreign nationals in India, MEA had set up a COVID Cell on 12 March 2020. Subsequently, on 16 March, a COVID Control Room was set up to respond and address concerns of stranded Indians abroad and also of those foreigners stranded in India.

4.4 Regarding modus operandi of the Covid Cell, in MEA the Foreign Secretary during the briefing on 29 July, 2020 stated:

> "This Cell is headed by an Additional Secretary level officer and at its peak, had over hundreds of our officers working on this particular Cell. It was set-up 24X7 to address the concerns of Indians wherever they were".

4.5 During the same briefing, Foreign Secretary also added:

> "To date, the Ministry of External Affairs Control Room has responded to about 31,000 emails, more than 21,000 telephone calls, and more than 12,000 grievances on the Centralized Public Grievance Redress and Monitoring Systems (CPGRAMS), and sixty Right to Information queries. I am also happy to inform the Committee that much of the 24X7 shifts undertaken by the MEA Control Room was handled by our youngest officers who insisted on performing these duties personally."

4.6 Elaborating on the role of Missions and Posts abroad in assisting stranded Indians due to spread of coronavirus disease worldwide, the Foreign Secretary during the briefing on 29 July, 2020 submitted:

> "..Our diplomatic Missions abroad also set-up their own helpline and extended full support to the stranded Indian citizens with material resources in countries that had imposed lockdowns. The hon. Prime Minister himself addressed all our Heads of Missions on 30th March, 2020 instructing them to reach out to Indians seeking help with all possible assistance during the crisis. Our Missions have reached out to stranded Indians by providing them guidance, counselling, and in certain cases, funding under the Indian Community Welfare Fund. The Local Indian Community Resources, in other words, the Mobilised Local Community Associations also assisted in making arrangements of food and shelter for stranded Indians in some cases as long as to even two and a half months during the lockdown period."

4.7 Highlighting the Repatriation Portal (REPAT PORTAL), he added:

> "In order to ensure that information of the returnees was available on a real-time basis, the MEA set-up a dynamic online platform, that is, Repatriation Portal, on which details of Indian nationals were regularly uploaded. Even today, if you see the portal, it has the details of all of the people who have come back and also of people who have themselves expressed a desire to return to India."

4.8 Foreign Secretary during the same briefing also submitted that our Missions have been working closely with the Air India and the other airlines in preparing passenger manifest and uploading this on portal. The portal shows country-wise, state-wise, category-wise, and lots of flight-wise details of the passengers returning to India. This has helped facilitate coordination

between agencies, including Airlines, Immigration, State Health Ministries, District Administrations, and Airport Authorities.

4.9 Explaining the manner in which the Indian Welfare Community Fund (ICWF) operates in times of distress and emergency in the most deserving cases on a means tested basis, Foreign Secretary during the course of evidence on 11 August, submitted:

> "The fund was initially set up in 17 countries in 2009 after due approval of the Cabinet to assist overseas Indian Nationals operates in times of distress and emergency in the most deserving cases on a means tested basis. It was gradually extended to all Missions and Posts abroad. The ICWF guidelines were last revised in 2017 with a view to make them more broad based and to expand the scope of welfare measures that can be extended through the fund. The revised guidelines cover the following three key areas - assisting overseas Indian Nationals in distress situations, support for community welfare activities, improvement in consular services. ICWF"s key source of funding is the service charges that we levy for those who take both visa and consular service. For example, all Indian Nationals who come for consular service, we levy a two dollar charge. For foreigners, PIOs, OCI card holders, we levy a three dollar charge. Every person who comes for a service, he is charged this amount. This amount straightaway goes into the ICWF account. So, it is an account which is maintained on the contribution by those of avail of our services. So, Government has not spent directly anything on the Indian Community Welfare Fund and there is no budgetary support. It is self-sustaining. Missions and Posts have these funds based on their abilities to collect these charges. Government does not give anything further in this. I also want to clarify that if an Indian National has a financial means of support for himself or herself, they cannot qualify for financial assistance under the ICWF. Our heads of Missions and Posts have been delegated powers to deicide the eligibility of an individual for ICWF assistance on the basis of clearly defined guidelines.

4.10 Elaborating further he added:

> "Our Missions and Posts use the ICWF effectively to help deserving Indian nationals who got stranded abroad in this Covid period. Around 62,000 Indian nationals as of end of

July,2020 have been provided assistance involving a total expenditure of Rs. 22.5 crore from the Indian Community Welfare Fund.

4.11 When specifically asked about the expenditure incurred by the Ministry for bringing back the stranded Indian nationals in the country the Ministry of External Affairs submitted in a written reply that our Missions and posts have used the ICWF effectively to help deserving Indian nationals (as of 30th September, 2020) have been provided assistance involving a total expenditure of Rs. 29.44 Crore from ICWF. After September, 2020 all the returnees have travelled paying for their expenses and tickets.

**4.12 The Committee observe that many Indians who had travelled to different countries before the lockdown for purposes such as employment, studies/internships, tourism, business, etc., were stranded abroad due to imposed lockdown. The Committee are pleased to note that with aim to better coordinate the requests of stranded Indians abroad and also of those foreign nationals in India, MEA had set up Covid Cell, Covid Control Room, Helpline and Repatriation Portal. In addition, the diplomatic Missions abroad reached out to the stranded Indians and made arrangements for food and shelter for them by mobilising Local Community Associations as well as guidance, counselling and financial support under the Indian Community Welfare Fund (ICWF). The Committee are thankful especially to Indian Missions and Indian diaspora organisations for the exemplary work done by them for their fellow citizens during the unprecedented human crisis. The Committee note that the ICWF was set up in 2009 to assist overseas Indian nationals and operates in times of distress and emergency in the most deserving cases on a means tested basis. The key source of ICWF"s funding is the service charges levied, a three dollar charge for those who take both visa and consular services, and the Government does not contribute in this Fund. The Committee note that several crores were spent from the ICWF to help stranded Indian nationals in Pandemic period. However, the Committee are of the**

**view the responsibility of providing assistance to stranded Indians should not have been left only on a small fund like ICWF rather the Government could have managed the problem in a better way by providing more funds to missions. Further, given the fact that a significant role is being played by the ICWF in addressing all types of problems of Indians living abroad, the Committee strongly recommend the Government to expand the scope of eligibility for assistance under ICWF and contribute in it as well particularly in such crisis involving large number of citizens.**

**(Recommendation No. 15)**

**Vande Bharat Mission**

4.13 Vande Bharat Mission was basically evacuating Indian citizens who were in distress all over the world elaborating on Vande Bharat Mission, Foreign Secretary during briefing on 29 July 2020 submitted:

> "This has been done very successfully. Air India has been in the forefront of this operation; its subsidiary Air India Express is there and so far, roughly we have been able to evacuate people from 53 different destinations all over the world".

4.14 Foreign Secretary inter-alia further added:

> "There are some specialties of the Vande Bharat Mission. Firstly, this is by far the biggest evacuation ever conducted. The nearest we saw was that during the Kuwait Crisis, Air India had evacuated about 1.1 lakh people only... At that time, Kuwait was one destination and now we are flying from all over the world.
>
> The second special feature is that this time even the private carriers were involved to participate in the Vande Bharat Mission and they have also participated under the leadership of Air India.
>
> The third feature was that these flights were carrying people and initially only the standard Indians were brought in. But with the passage of time, when the plane was going, we started carrying stranded foreigners in India to their destinations. So, it virtually became a two-way movement."

4.15 The Vande Bharat Mission was planned in close coordination involving Ministry of External Affairs and Ministries of Civil Aviation, Home Affairs, Health & Family Welfare as well as the concerned State governments. These operations were carried out through non-scheduled commercial flights arranged by Air India, chartered flights, Air Bubble flights and ships of the Indian Navy as well as by land from the neighboring countries.

4.16 On being asked to illustrate the coordination mechanism of civil aviation sector with other stakeholders for safe return of stranded Indian nationals abroad, the Ministry of Civil Aviation in a written submission stated that Indian nationals stranded abroad were asked to register at the nearest Indian Embassy/Mission. The mission intimated the number of passengers registered for repatriation to the MEA based on which Indian carriers were requested to operate repatriation flights. The airlines after obtaining necessary clearances from the respective foreign country and NoC from the State/UT government concerned in India, operated the flights in accordance with the relevant SoPs of MoCA,MHA and MoH&FW.

4.17 The complete covid lockdown was imposed in the country on 24 March and Vande Bharat Mission (VBM) was started on 7 May 2020. On being enquired about delay in bringing back stranded Indians from foreign countries, the Ministry of Civil Aviation in a written reply stated that the VBM is a repatriation exercise of unprecedented proportions. The planning of such exercise and preparation for the same requires a considerable amount of time. A lot of effort was put in by the MEA and Indian embassies/missions abroad to compile details of stranded Indians who wanted to return to India before the mission could be planned. The quarantine centres and airports had to be prepared to handle the incoming passengers while adhering to the various health related norms put in place by the MoHFW. The arrangements put in place as part of lock-down viz. restrictions on plying of public vehicles, interstate movement of people etc had

also to be accounted for before initiating the VBM. As such, there has been no delay in commencing the VBM.

4.18 In this regard, Secretary, Ministry of Civil Aviation, during briefing on 29 July 2020 submitted:

> "..We also took up evacuation of stranded Indians, especially from Wuhan, China who were in great distress. So, we had to operate special flights and get these people back and gradually we also had to evacuate people from Iran. So, all this happened during the pre-lockdown period when the severity of the virus spread was not very high."

4.19 The Committee were informed that Initially, passengers were chosen on the basis of compelling grounds cited by them for travel including those facing deportation by foreign governments, Migrant Workers/Labourers who have been laid off, Non-Permanent Residents/Short-Term Visa holders faced with expiry of visas, those faced with medical emergency/seeking treatment for terminal illness, Pregnant Women/Elderly, Those required to return to India due to death of a family member, Tourists/visitors stranded abroad, Students if their educational institutions/hostels are closed, etc.

4.20 Regarding setting up of criteria for returnee, Foreign Secretary submitted during briefing on 29 July, 2020:

> "The criteria were set-up through a process of inter-Ministerial consultations and approved by the Group of Ministers".

4.21 Elaborating on the movement of stranded persons, Foreign Secretary during the briefing on 29 July deposed:

> "..These movements were not normal movements because we had to follow very strict health protocols; we had to have all safety measures inside the aircraft; and special discipline was maintained. Upon coming here, we had to coordinate with the State

Governments because they had to make arrangements for their testing and the quarantine facilities. So, that is how, Vande Bharat Mission went on."

4.22 When the Committee desired to know about the arrangements made by MEA for difficulties faced by stranded Indian nationals on return, the Ministry of External Affairs in a written reply, inter-alia, stated that to better coordinate with the concerned state governments, Ministry of External Affairs designated its senior officials of the rank of Additional Secretary/Joint Secretary to liaise with state governments for coordinating arrival of flights directly with the state, as per the domicile the incoming passengers and also coordinate logistics including quarantine issues. This ensured a framework for coordination among various agencies and facilitation of the incoming passengers. After arrival, the passengers are entrusted in the care of the respective State Governments, who would ensure quarantine or testing, as per the existing guidelines of the Ministry of Home and Ministry of Health & Family Welfare in this regard.

4.23 On being enquired about inconvenience faced by returnees as quarantine facilities were available only in Delhi, the Ministry of External Affairs in a written submission inter-alia stated that before commencing with the Vande Bharat Mission, State Governments ensured that all receiving airports in India have adequate quarantine facilities for incoming passengers.

4.24 The Committee observed that several people who were stranded in London and willing to leave for their country had to wait seven to eight days for the covid report and only those who have a negative report were allowed to fly. In this regard, when Committee desired to know the steps taken by the Indian Embassy to redress the same, the Ministry of External Affairs in a written reply submitted that at the beginning of the Vande Bharat Mission repatriation flights from May 2020, as per the SOPs issued by Ministry of Home Affairs, it was to be ensured that only "asymptomatic" passengers are allowed to board the flights. Accordingly, HCI, London had arranged thermal screening of passengers at London Airport by Mission's panel doctor. The National Health Service (NHS) of the UK Government was then only testing for COVID-19

when people had symptoms or had come in contact with the COVID positive people. COVID test for the purpose of taking flights was not being done then. Later, some private hospitals started COVID-19 test on payment basis. In all such cases appointments for testing had to be booked in advance. There may have been cases when people had to wait for the test due to a large number of applicants for the tests at private clinics. However, test reports in such cases had been made available within 24-48 hours. The complaints of delays by passengers initially should be seen in the context and, of late, the High Commission of India in London did not receive any such complaint.

4.25 In several countries including Canada, anybody coming from another country has to pass through one COVID-19 test and he/she is provided two Kits with guidelines on how to conduct the test/take sample personally. The traveller has to remain in isolation for 14 days and to conduct two tests on their own and put the sample outside the home to be collected by the Government Agency. Report is sent on the mobile number of the person. If all the three Reports are negative only then he/she is permitted to move outside. When the Committee desired to know the reasons for not introducing the same system in India, the Ministry of External Affairs in a written reply submitted that the primary sample for RTPCR for COVID-19 is oropharyngeal (throat) swab or nasopharyngeal swab. Collection of these samples requires some amount of expertise and self-collection of these samples may lead to injury or inappropriate collection. Besides, the RTPCR test even detects the dead virus. Therefore, anybody who is non-infective and shedding dead virus will be unnecessarily kept in isolation due to positive tests results. We have, however, issued guidelines for managing international travellers visiting India, wherein they are either asked to get negative RT-PCR test report (72 hours prior to boarding) or get themselves tested on arrival at the airport (wherever such facilities exist). Apart from this, there are certain exemption criteria for institutional quarantine. In absence of negatives test report or applicability of exemption criteria, the international travellers are required to undergo

institutional quarantine for a period of 7 days followed by self-monitoring of health by another 7 days.

4.26 In this context, Secretary, Civil Aviation during the course of evidence on 19 December, 2020 deposed:

> "..The places like UK were not doing this test. They say, „we have got our own priorities; we will not test Indian citizens going back to India." So, now, for that, we have started a new system. At Delhi Airport, we have installed RT-PCR testing facility. Passengers coming from outside, have to book online. They come to the airport and do the test at the airport. The result is coming between four and half to five hours. For this, we have created a special lounge. In the lounge, social distancing is maintained. They are given food; they can take rest; they can sleep also. So, this is being done at Delhi Airport. It has been extended to Mumbai. We are talking to the Government of West Bengal. We have got the letter from the Chief Secretary. We will be setting up such facilities at Kolkata also."

4.27 Regarding exemption to passengers from institutional quarantine, Secretary, Ministry of Civil Aviation during evidence on 19 December, 2020 clarified as under:

> "..What was happening was that a large number of people from other countries were come to India; and at the airport, they would put pressure to seek exemption from quarantine. We have said that very vulnerable people can be exempted from institutional quarantine; say for example, pregnant ladies, elderly people, minor children or some emergency in the family like death and all is there. This was creating a huge ruckus at the airport; passengers were taking as much as eight hours to get clearance from the airport because of this. What we did was, we simplified the process and said that „anyone who wants exemption shall apply online before boarding a plane." So, we created a website. All the applications were taken online. These applications were given to the State Government; they would process it; and the permission of exemption was given online. ..We said that if the passenger has an RT-PCR negative certificate, he will be given an exemption from institutional quarantine."

4.28 There were provisions of undertaking chartered flights during lockdown. It was realized that chartered flights have no cargo and return facility. However, the fares were five to six times

higher than that of the usual seasonal fares. In this regard, when justification was sought about higher fare imposed by Air India as many labourers and poor people were unable to afford the higher amount and therefore could not come back, the Ministry of Civil Aviation in a written reply submitted that there were initially some complaints regarding high airfares in VBM flights in some sectors. The aircraft were traveling empty (ferry) on the outbound leg and fares were high as the cost of operations had to be recovered from the one-way load. Also, the COVID situation has added to the cost of operations towards PPE kits, new guidelines for ground handling, sanitizers, etc. However, these fares were substantially lower than fares charged by some of the competitor airlines. Air India had charged around Rs. 13000/- for tickets from UAE to India which is quite reasonable. The private carriers operating flights under VBM were asked to maintain parity with the fares of Air India on similar routes. However, the Government does not interfere in the prices of charter operations.

4.29 When the Committee desired details on the issues of refund of air ticket and imposition of cancellation charges and Supreme Court‟s judgment thereon, the Ministry of Civil Aviation in a written reply stated that the matter with regard to refund of air fare by airlines was brought before Hon‟ble Supreme court through Writ Petitions. The Hon'ble Supreme Court of India has passed a judgment dated 01.10.2020 in this regard. Directorate General of Civil Aviation (DGCA) vide Circular dated 7th October, 2020 has issued detailed instructions to all scheduled domestic and international airlines for strict compliance of directions issued by Hon‟ble Supreme Court of India.

**Air Bubble Arrangement**

4.30 Elaborating on opening up of Travel Bubbles or Air Bubble for international movement, Foreign Secretary during the briefing on 29 July 2020 submitted:

" ..We have opened up what we call the travel bubbles. Say, for example, between India and America, American carrier said that when Air India is flying there, we should allow them to fly their careers also because that is the law of the International Convention of Civil Aviation. So, we have to allow them also. So, in the bubble, what is happening now is that Air India also flies to US and even American carriers are also flying to India. But this movement is regulated and all passengers cannot travel. Only those people, who are permitted by the Government of India to enter India can travel. That is a restricted category. In the same way, the US Government also -- whatever they permit, will be carried in the carriers. That is how, gradually the Vande Bharat is converting into the air bubbles."

4.31 Foreign Secretary during the course of evidence on 19 December, 2020 deposed:

"On the international side, there are a lot of restrictions which different countries have imposed on travel of Indian citizens. So, what we have done is that we have entered into Air Bubble Arrangement. Under this Air Bubble Arrangement, citizens of two countries are allowed to travel between those two countries and airlines of both countries can participate".

4.32 Elucidating on air bubble concept, Foreign Secretary, during evidence on 11August, 2020 added:

"The air bubble really means that if there is a direct flight between India and the US, you do not touch a third country. So, you bring citizens of your two countries to each other and it is a regular scheduled flight depending on the airlines. Similarly, with France, we have this facility with Air France and Germany with Lufthansa".

4.33 On being enquired regarding severe restrictive practice under the air bubble principle, Foreign Secretary during evidence on 11 August, 2020 responded:

"..We have been increasingly liberalizing the regime for people to come back. Initially it was only for Indian nationals who were to be repatriated, then it was OCI card holders who had certain reasons for coming, now we have also this arrangement where we have air bubbles, we have come down to that. We have also allowed any OCI card holder to

come back without any reason. We are also liberal in allowing foreign nationals of Indian origin to come back in air bubbles. We are also allowing people who have to come here for business; foreign nationals who have business interests, those who are having plants in India or who are having investments in India, we are allowing them also to come. A lot of people have also come by chartered flights. I think the number of people returning by chartered flights is actually greater than the number of people who have come back under Vande Bharat flights."

4.34 During the evidence on 28th December, 2020 the representative of Ministry of External Affairs apprised the Committee;

"The following countries, namely, Afghanistan, Bahrain, Bangladesh, Bhutan, Canada, Ethiopia, France, Germany, Iraq, Japan, Kenya, Maldives, Nepal, Nigeria, Oman, Qatar, Rwanda, Tanzania, Ukraine, UAE, UK and USA, were permitting flights from both Air India and foreign carriers from their countries. Flights operated by Air India under this Air Bubble arrangement form part of the Vande Bharat Mission. As part of the revised guidelines of the Ministry of Home Affairs, passengers and flights under the Air Bubble are not required to register with the Mission. Their details are provided to the Mission by the concerned airlines to be uploaded on the MEA"s online portal for Vande Bharat Mission."

4.35 When enquired about current status of Air Bubble, Foreign Secretary during evidence on 10 March 2021 submitted:

..This system continues as of now. This decision has to be taken by the Ministry of Civil Aviation as to whether we have to change it. For normalization, obviously, we would have to consult the Ministry of Health. International travel has not yet resumed even otherwise globally and restrictions are still there all around the world. We would be guided by reciprocity conditions in the countries concerned and in our own country when we make decisions in that regard.

As you are aware, we also do not give tourist visas to any country. We are issuing all other visas, but we are not issuing tourist visa. This decision again has to be a considered decision based on the situation."

4.36 When asked about impact of lockdown imposed by several countries in the backdrop of the new wave of infection caused by new variant of coronavirus on air travel and air bubble agreements, the representative of Ministry of Civil Aviation stated as under:

> "..Many countries have imposed internal lockdown. That is true for European countries like France, Germany, UK etc. In UK, it has directly impacted because we took a decision because of this new COVID-19 variant that will stop international movement. So, international movement between UK and India has totally stopped. As far as other countries like France or Germany are concerned, we have not put restrictions on the movement of people from France to India or Germany to India, mainly because the traffic is very limited and some minimum amount of contact is always required. There are some essential people; there may be diplomats or professionals who want to travel between these two countries. The number of people travelling has come down, but we have not imposed restrictions and the bubble arrangements continue as they were, but with limited capacity."

**Samudra Setu Mission**

4.37 The Committee were informed that Indian Navy has launched Operation *"Samudra Setu*", as a part of the national effort to bring back Indian citizens from overseas. Indian Naval Ships *Jalashwa* and *Magar* commenced evacuation operations from 8 May 2020 as part of the first Phase. The Indian Mission in Republic of Maldives, prepared a list of Indians to be evacuated by Naval ships and facilitated their embarkation after requisite medical screening and after making provision of basic amenities and medical facilities during the sea-passage. Operation *Samudra Setu*, has culminated after successfully bringing 3,992 Indian citizens back to their homeland by sea.

4.38 The Ministry of External Affairs informed the Committee that Kerala has received the maximum number of returnees followed by Delhi, Maharashtra and Uttar Pradesh. UAE is the country from which maximum number of stranded Indians have returned, followed by Saudi Arabia, USA, Qatar and Oman. As per the registration data on MEA"s online portal, of the total

arrived passengers, 39.2 per cent are workers, 39.1 per cent are professionals, 5.9 per cent are students, 7.8 per cent visitors and 4.8 per cent Indian tourists stranded in foreign countries.

4.39 When asked to provide country-wise details of returnees under the Vande Bharat Mission, the Ministry of External Affairs in a written reply stated that the Vande Bharat Mission commenced on 07.05.2020 and has continued ever since. Till 24 July 2021, more than 88,000 inbound flights have been operated and over 71 lakh passengers have returned to India from more than 100 countries. In the same period, more than 87,600 outbound flights have been operated and over 57 lakh passengers have travelled from India to foreign countries. Out of 71 lakh returnees, 5 lakh have entered India by land from Nepal, Bhutan, Bangladesh and Myanmar. The country-wise details of returnees are given below:

**Country-wise Stranded Indians Repatriated till 30 April, 2021**

| **Name of Country** | **No. of Indians Repatriated** |
|---|---|
| Afghanistan | 35869 |
| Algeria | 1338 |
| Angola | 770 |
| Armenia | 722 |
| Australia | 12903 |
| Austria | 4 |
| Azerbaijan | 186 |
| Bahrain | 78128 |
| Bangladesh | 62499 |
| Barbados | 115 |
| Belarus | 232 |
| Belgium | 296 |
| Bhutan | 3186 |
| Brazil | 510 |

| | |
|---|---|
| Brunei | 693 |
| Bulgaria | 689 |
| Cambodia | 596 |
| Canada | 96900 |
| China | 1367 |
| Croatia | 3 |
| Denmark | 55 |
| Egypt | 1892 |
| Estonia | 6 |
| Ethiopia | 17908 |
| Fiji | 5 |
| Finland | 238 |
| France | 72492 |
| Georgia | 4293 |
| Germany | 99926 |
| Ghana | 302 |
| Greece | 164 |
| Hong Kong | 3306 |
| Hungary | 9 |
| Indonesia | 5384 |
| Iran | 6935 |
| Iraq | 15072 |
| Ireland | 486 |
| Italy | 14892 |
| Japan | 14575 |
| Jordan | 838 |
| Kazakhstan | 3965 |
| Kenya | 15281 |

| | |
|---|---|
| Kuwait | 226777 |
| Kyrgyzstan | 10303 |
| Laos | 427 |
| Latvia | 5 |
| Lebanon | 1122 |
| Madagascar | 84 |
| Malaysia | 52767 |
| Maldives | 122161 |
| Mali | 237 |
| Malta | 256 |
| Mauritius | 2647 |
| Mexico | 228 |
| Moldova | 243 |
| Mongolia | 80 |
| Morocco | 99 |
| Myanmar | 3265 |
| Nepal | 26900 |
| Netherlands | 28341 |
| New Zealand | 1897 |
| Nigeria | 6501 |
| Norway | 267 |
| Oman | 329139 |
| Others | 21611 |
| Pakistan | 683 |
| Philippines | 8484 |
| Poland | 342 |
| Portugal | 54 |
| Qatar | 367078 |

| | |
|---|---|
| Romania | 8 |
| Russia | 15115 |
| Rwanda | 4697 |
| Saudi Arabia | 479103 |
| Scotland | 38 |
| Seychelles | 2826 |
| Singapore | 89687 |
| South Africa | 1161 |
| South Korea | 5248 |
| Spain | 1117 |
| Sri Lanka | 23350 |
| Sudan | 125 |
| Sweden | 1270 |
| Switzerland | 33 |
| Syria | 157 |
| Taiwan | 14 |
| Tajikistan | 2814 |
| Tanzania | 9436 |
| Thailand | 7603 |
| Tunisia | 25 |
| Turkey | 3081 |
| Turkmenistan | 234 |
| Ukraine | 9062 |
| United Arab Emirates | 2544288 |
| United Kingdom | 197730 |
| United States of America | 397542 |
| Uzbekistan | 4777 |
| Vietnam | 1966 |

| | |
|---|---|
| Yemen | 1311 |
| Zimbabwe | 5 |
| **Total** | **5593351** |

4.40 Further, the Ministry of External Affairs furnished the State-wise details of stranded Indians repatriated as under:

**State-wise Stranded Indians Repatriated ill 30 April, 2021**

| **Name of State** | **No. of Stranded Indians Repatriated** |
|---|---|
| A & N Islands | 45 |
| Andhra Pradesh | 43758 |
| Assam | 1005 |
| Bihar | 34660 |
| Chandigarh | 5937 |
| Chhattisgarh | 878 |
| D & N Haveli | 40 |
| Daman and Diu | 132 |
| Delhi | 1335919 |
| Goa | 27627 |
| Gujarat | 139937 |
| Haryana | 6423 |
| Himachal Pradesh | 1570 |
| Jammu and Kashmir | 5162 |
| Jharkhand | 2249 |
| Karnataka | 366451 |
| Kerala | 1410275 |
| Ladakh | 486 |
| Lakshadweep | 866 |
| Madhya Pradesh | 3329 |

| | |
|---|---|
| Maharashtra | 589222 |
| Manipur | 393 |
| Mizoram | 126 |
| Nagaland | 81 |
| Odisha | 10717 |
| Puducherry | 1085 |
| Punjab | 116222 |
| Rajasthan | 98691 |
| Sikkim | 90 |
| Tamil Nadu | 564015 |
| Telangana | 365249 |
| Tripura | 545 |
| Uttar Pradesh | 367286 |
| Uttaranchal | 2877 |
| West Bengal | 89955 |
| **Total** | **5593431** |

4.41 Regarding evacuation of foreign nationals stranded in India during lockdown, Foreign Secretary during the briefing on 29 July, 20 submitted:

> "In addition to getting our own nationals back, the Ministry of External Affairs has also assisted over 120 nations to safely evacuate their nationals stranded in India during the lockdown. The total number of evacuations has crossed 110 thousand which means 110 thousand people have returned which involved massive coordination of logistical operations from different parts of India because these people were stranded in different parts of India during the lockdown and we had to work closely with the Ministry of Home Affairs and the State Administrations in getting these people back to airports where they could catch their flights.
>
> This also involved repatriation of Third country nationals stranded in Nepal, Bhutan and Bangladesh. They had to enter India and subsequently board special flights

back to their countries. As a special gesture, India has also facilitated the return of nationals of Bhutan and Nepal stranded in Third countries on Vande Bharat flights to enter India for their onward journey back to their home countries."

4.42 On being enquired whether stranded Indians who were coming from abroad spread the disease in the country, the Ministry of External Affairs in a written reply submitted that as per the data compiled by the Ministry of Health & Family Welfare, of the 23 lakh Indians who have returned to India under the Vande Bharat Mission, a total of around 3,625 people have tested positive on arrival. All incoming passengers, not carrying a negative Covid test certificate, are required to undergo mandatory institutional quarantine, as per the existing guidelines issued by Ministry of Home Affairs and Ministry of Health & Family Welfare.

4.43 Regarding precautions and public health measures at airports, Secretary, Ministry of Civil Aviation during evidence on 19 December, 2020 submitted:

" ..We have taken precautions and public health measures at the airports as well as in the airlines. So, the biggest change at airports has been that the entire check-in has been made electronic. It is 100 per cent web check-in. The entire process of check-in and baggage drop has been made totally contact-free and paperless… In addition to this, all the airports and airlines are taking additional measures. All the passengers in the airlines have been provided with masks and not even masks, an additional layer called the face-shield is being provided. The person sitting on the middle seat is being provided with the protective cover."

4.44 He further clarified:

"there have been no reported case of infection at the airlines or the airport because of all these measures".

**4.45 The Committee note that, before imposition of lockdown in India, special flights were operated to evacuate stranded Indians in China and Iran and post lockdown Vande Bharat Mission was started on 7th May, 2020 to evacuate Indians distressed and stranded due to lockdowns/restrictions all over the world. These operations were to be carried out through non scheduled commercial flights arranged by Air India, chartered flights, „Air Bubble flights" and „Samundra Setu" operations of Indian Navy to bring back Indians from overseas. Under the Air Bubble arrangement the citizens of two countries are allowed to travel without touching a third country. The Committee are apprised that firstly those passengers who wanted to return had to register on MEA's REPAT PORTAL and thereafter, they were chosen logically on the basis of compelling grounds. The Committee appreciate the way the biggest evacuation was successfully conducted by Ministry of External Affairs and Ministry of Civil Aviation to bring back more than 55 lakh Indian workers, professionals, students and tourists stranded abroad due to imposition of lockdowns. In addition to getting our own nationals back, 120 nations were assisted to safely evacuate their nationals stranded in India during lockdown. The Committee, however, are constrained to note that higher airfares were charged in VBM flights on the ground that aircraft were travelling empty (ferry) on the outbound leg and the cost of operations had to be recovered from the one-way load. They also note that people also faced problems in refunds and high cancellation charges. They are pleased to note that the Hon'ble Supreme Court had intervened on the issue. The Committee hope that the Government will stick to strict compliance of the orders of the Apex Court in this regard. Moreover, the Committee also desire the Government to review the existing institutional mechanism for evacuation in view of experiences gained during this historic evacuation exercise so that any such emergent situations in future might be dealt with more effectively.**

**(Recommendation No.16)**

**Skill Mapping of Returning Indians**

4.46 With the spread of the COVID-19 pandemic in various countries, especially, the Gulf and the European countries, the economic activities in these countries reduced drastically on account of closure of factories, business establishments etc. leading to job loss of a large number of Indian migrant workers.

4.47 The Committee were apprised that the Government of India has launched the Skilled Workers Arrival Database for Employment Support (SWADES) initiative with the aim of consolidating a database of the skilled workforce returning to the country under *Vande Bharat* Mission (VBM) due to the on-going pandemic. SWADES has been integrated with the online comprehensive data base of skills portal Atmanirbhar Skilled Employee-Employer Mapping (ASEEM) that was launched by hon. Prime Minister on 10 July, 2020, the Youth Skills Day."

4.48 Elaborating on skill mapping of returning Indians under VBM, Foreign Secretary during evidence on 19 December, 2020 submitted:

> "The SWADES initiative or skilled workers arrival database for employment support launched jointly by the Ministry of Skill Development and Entrepreneurship, MEA and Ministry of Civil Aviation to map the skills of Indian nationals returning under the Vande Bharat Mission. More than 29,700 citizens have registered for Swadesh Skill Card as on 30th September 2020. To ensure holistic skill mapping of Vande Bharat returnees, SMS/Call centres outreach is planned for all citizens who have arrived in India and have not yet registered for SWADES. Further details of SWADES registration have been integrated with Skill India"s Atmanirbhar Skilled Employee-Employer Mapping portal. Currently, over 700 employers are registered on this ASEEM portal and have posted a combined demand of more than three lakh employees in India. Through ASEEM, employer-specific reach out is also being conducted for providing job opportunities to candidates."

4.49 Elaborating on the top countries from where people are coming back and top sectors in which they are registering for job, he added:

> "The top countries from which people are coming back and registering are UAE, Oman, Saudi Arabia, Qatar and Kuwait. It is mainly the Gulf countries that are relevant. The top sectors in which people are registering themselves are construction, oil and gas, tourism, hospitality, automotive, IT and IT e-services. Top receiving Indian States are Kerala, Tamil Nadu, Maharashtra, Uttar Pradesh and Karnataka. To ensure holistic skill mapping of Vande Bharat returnees, SMS, call centres outreach is planned for all citizens who arrive in India and those who have not yet registered with SWADES. The Ministry of Shipping through DG, Shipping has already agreed to make the database for seafarers available for SWADES mapping. For facilitating employment opportunities, details of SWADES registrations have been integrated with Skill India"s ASEEM."

4.50 Asked about the steps being taken to help the returning migrants from abroad, Secretary, Ministry of Skill Development and Entrepreneurship during evidence on 11 August, 2020 submitted:

> "ASEEM portal is playing a very significant role. We are having a massive outreach programme with all the employers in the country. Through Sector Skill Councils we are approaching all the industries to use the ASEEM portal for all kinds of hiring."

4.51 He further added:

> "On the ASEEM portal, we have now about 2.3 lakh job offers and about 64,000 people have been offered jobs. About 6000 have already accepted and joined. On the SWADES system, about 314 people have joined so far.

4.52 On being enquired about number of people sent abroad for jobs based on this data base, he stated:

> "We send about 40,000 people abroad every year through India International Skill Centres. We have about 513 centres which train people as per the skills required in the

international market. So, we send around 40,000 people every year. Most of them go to Gulf countries. Then, they also go to Canada and Italy in oil and gas sector."

4.53 In this context, he also added:

"So far no one has been sent out because there is no job opportunity out there. The system that we have developed is still under trial. But one information that I want to share with the hon. Committee is that about 60 per cent, that is, 19,000 people, who are registered themselves, are employed and only about 40 per cent are unemployed."

4.54 On the Committee‟s observation that a very small number of companies registered on the ASEEM Portal, he clarified:

"No doubt, the number right now is small. But now, as I said, through Sector Skill Councils, which are 37 in number, we have contacted all the industries in private sector to come on the portal for their requirement of manpower. So, the NSDC is going to schedule a meeting of these Sector Skill Councils with their member industries.

4.55 On queries regarding involvement of private sector, he informed the Committee:

"Sir, our National Skill Development Council is basically a public private partnership body with 49 per cent Government‟s share and 51 per cent share partnership is held by the private sector. It is basically a private sector driven council. All the Sector Skill Councils are hundred percent private.

4.56 Elaborating on international opportunities for jobs, it was submitted:

"COVID will have its massive impact on certain sectors internationally. I think that is an opportunity for the country and we should use it in our favour. The first one is health sector where we can play a major role. There are seven roles that health personnel have to perform like nurse, general duty assistant, etc.. What we have done is that we have identified 12 countries and mapped the requirement of different roles in health sector. We have also worked out where the gap is. We are trying to contact the regulators in these countries through the Ministry of External Affairs. If the regulators agree to accept our courses which we have designed as per their requirements, the negotiation process in this

regard can start. Thus, anyone who has got a training through these courses and got the certificate can get employment in these countries.

So, this effort is going on. Matching of these 12 countries have been done. We have been able to identify 32 roles in these 12 countries and through the bridge courses and certification in health sector these people can join employment in these countries."

4.57 The Committee were informed that the findings of the Global Skill Gap Study were analysed to determine the global demand for healthcare workers. The results show that there is a potential for mobilizing skilled Indian healthcare workers to fulfill the global demand that stands at approximately 2,00,000 up to 2022 in 12 countries which include: Australia, Canada, Germany, Japan, Sweden, United Kingdom, United States of America, Switzerland, New Zealand, Qatar, Kingdom of Saudi Arabia and Singapore.

4.58 On being enquired about hurdles to return of Indian nationals to their country of employment on valid visiting visas, Foreign Secretary, during evidence on 11 August, 2011 responded:

"With regard to returning back to countries, I think, the current SOP says that as long as you have a valid visa, you can return back to the country. But of course, the country has to be willing and accept you also. I gave the example of UAE where now, we are not restricting anyone, who wants to go back. As long as he has a visa, he can go back to the UAE."

4.59 On the issue of expatriates visit to UAE or Saudi Arabia via other countries after staying 14 days there, the representative from the Ministry of External Affairs during the evidence on 19 July 2021 stated:

"..We have taken it up not with just UAE but there are a lot of restrictions in Gulf countries, Australia, Europe and USA. The fact of the matter is we have gone through a crisis and the world is aware of the crisis. In the last two months, there have been four lakh cases and 4000 deaths. This is the official number.

The world has come to believe that India is still not very safe to receive people from there. But, Sir, we are constantly in touch with them. We have been able to be successful with EU countries to accept our Covishield. But there is a particular problem with gulf countries. They are saying that, yes, you could come via third country, which is still not the best arrangement.

They are asking them to do 14-days" quarantine and then come into that country. But I believe that will also go away because now we are getting some kind of signals that they will open airlines with India. The moment Emirates will start flying into India, then other countries will start to accept the Indians directly travelling into their country.

In the meanwhile, I think, Sir, we also need to develop our own travel protocol. The mechanism is still not in place. We need to work with health as well as civil aviation to develop our own protocol and then bilaterally we can accept the protocol. Once we get into that arrangement, it will become much easier. I think it is a matter of time. Things will start improving."

**4.60 The Committee observe that with the spread of the COVID-19 Pandemic in various countries, especially, the Gulf and the European countries, the economic activities in these countries were reduced drastically on account of closure of factories, business establishments etc. leading to job loss of a large number of Indian migrant workers. To this effect, the skilled Workers Arrival Database for Employment Support (SWADES) and the Atmanirbhar Skilled Employee-Employer Mapping (ASEEM) were launched jointly by the Ministries of Skill Development and Entrepreneurship, External Affairs and Civil Aviation with the aim of consolidating a database of the skilled workforce returning to the country under the Vande Bharat Mission (VBM) and facilitating employment opportunities for those registering on ASEEM portal. The Committee note that through ASEEM, a massive outreach programme with all the employers including private sector in the country was conducted to encourage them to use ASEEM portal for hiring all kinds of candidates for job in their establishments. The top sectors in which people are registering themselves are**

**construction, oil and gas, tourism, hospitality, automotive, IT and IT e-services. The Committee observe that so far, a very small number of returnees could get jobs under the ASSEM system and hence feel the need of a review and more comprehensive intervention in the outreach programme of ASEEM. The Committee further note that India International Skill Centres facilitate thousands of trained citizens under its ambit to get job in Gulf countries as well as Canada and Italy every year. Although there have been massive impact on certain sectors internationally, yet the Committee think that there is an opportunity before the country to use it in its favour. For example, as per the Global Skill Gap Study, there is a potential for mobilizing skilled Indian healthcare workers to fulfill the global demand that stands approximately, 2,00,000 up to 2022 in 12 countries which include: Australia, Canada, Germany, Japan, Sweden, United Kingdom, United States of America, Switzerland, New Zealand, Qatar, Kingdom of Saudi Arabia and Singapore. The Committee, therefore, strongly recommend the Ministry of External Affairs in coordination with the Ministry of Skill Development and Entrepreneurship should make sincere efforts to mobilize and train the Indian healthcare workers to improve their skills as per global demand of healthcare workers so that they can get employment in these 12 countries. Similar initiatives are also required to be taken urgently in similar other areas requiring human resources.**

**(Recommendation No. 17)**

**4.61 The Committee are of the view that remittances received as foreign exchange are a vital source of income and means of survival for a chunk of Indian communities and families. The Committee observe that there has been significant decline in the remittances because of loss of employment due to the economic disruption induced by the COVID-19 pandemic and lockdown in the various host countries, particularly those in Gulf countries.**

**The Committee are apprised that those returnees who have valid visa are allowed to return back to their destination of employment. The Committee, therefore, desire that the Government should suitably facilitate those people who want to go back to their jobs so that they are enabled to fulfill the needs of their families and also restore foreign exchange remittances in the country. Given the significant role of remittances received as foreign exchange in Indian economy, the Committee would like to suggest the Government to take steps for encouraging remittances and for its easy flow into the country. Albeit, the health scenario ought not to be lost sight of.**

**(Recommendation No. 18)**

# CHAPTER V

# INTERNATIONAL COOPERATION IN FIGHT AGAINST COVID PANDEMIC

The Covid-19 pandemic delivered a major shock to the international system in 2020-21. Society as a whole and governments across the world were forced to cope with unprecedented disruption. The spreading virus caused different parts of the world to lock down and impose restrictions on movement. This in turn led to major economic trauma including loss of livelihoods and the most severe contraction of output in decades.

5.2 In terms of our global outreach, India has taken the lead in engaging the global community for evolving a coordinated response to the Covid 19 pandemic. India has been part of several important conversations globally on dealing with the pandemic. .

**Role of Global Fora/Institutions in Response to COVID-19**

5.3 Elaborating on global response to pandemic, Secretary, Ministry of Finance during briefing on 29 July, 2020 stated:

> "India, being a key member of global fora like G-20, BRICS, G-24, has been participating in all the discussions to evolve a global response to the pandemic. India, in its capacity as the Co-Chair of the G-20 Framework Working Group, played a prominent role in drafting the G-20 Action Plan specially on commitments related to economic response and recovery to strong, sustainable, balanced and inclusive growth. The G-20 Finance Ministers have endorsed this G-20 Action Plan on 15th April, 2020. One of the major highlights of this Action Plan is the Debt Service Suspension Initiative being implemented by G-20 Official Bilateral Creditors for the poorer countries, which are 73 in number, through suspension of their Debt Service Payments falling due from 1st of May to end of 2020. India has strongly responded to this initiative and it has already received requests for debt suspension from 17 friendly nations from Africa out of the total 49 debtors so far."

5.4 When the Committee desired to know the role of multilateral cooperation fora to deal with the outbreak of coronavirus pandemic, the Ministry of Health and Family Welfare in a written reply stated that Multilateral Cooperation fora like UN (and its agencies WHO, UNICEF, UNDP), G7, G20, BRICS, World Bank, Asian Development Bank, SCO, SAARC, etc. have been playing crucial role in global / regional advocacy and oversight for managing Covid pandemic. India is actively coordinating the related activities with all these organisations.

5.5 Elaborating on G-20 Summit, Foreign Secretary during briefing on 29 July, 2020 submitted:

> "It is an extraordinary virtual Summit under the Saudi Arabian Presidency to discuss challenges posed by the Covid 19 pandemic and forge a coordinated global response. At the Summit, the Prime Minister underlined the need for putting human beings at the centre for vision of prosperity and cooperation and presented the vision of a more people centric globalisation.
>
> It would also be recalled that G-20 Summit was the first, I would say, a consensual arrangement whereby it was decided that loans and credit offered to various developing countries would be allowed to be paid later which means this year it was agreed that no country would be asked to repay their loans and many other financial measures that would help countries, particularly developing countries deal with the Covid pandemic were taken."

5.6 While elaborating on the impact of Covid-19 pandemic on world economies, a representative of the Ministry of Finance during briefing on 29 July 2020 submitted the following details:

> "Sir, the severity of the Covid-19 pandemic has challenged the health system worldwide while preventive measures have disrupted normal life and business activities. IMF projects World output to contract by 4.9 per cent in 2020 before recovering to 5.4 per cent in 2021. Advanced economies are likely to be impacted more and they are likely to shrink by eight per cent in 2020 and emerging market economies are likely to face

contraction by three per cent. As per IMF, India‟s GDP is likely to contract by 4.5 per cent in 2020 and recovering to 6 per cent next year.

5.7 Regarding liquidity support provided by the multilateral financial institutions to its member states to address issues arising out of covid-19 pandemic, he submitted:

> "IMF has temporarily doubled the annual access limits for its various credit facilities to address balance of payment issues arising out of Covid-19 crisis. IMF has also introduced a new short-term liquidity line to provide swap-like liquidity support to very strong members for special balance of payment needs. The NDB has also announced financial packages specific to Covid-19. The global World Bank group package amounts to US $ 14 billion, the ADB package amounts to US $ 20 billion and AIIB and NDB packages amount to US $ 10 billion."

5.8 The Committee were also informed that the IMF is responding to the corona virus crisis with unprecedented speed and magnitude of financial assistance to help countries protect the lives and livelihoods of people, especially the most vulnerable. For financing through various IMF arrangements, including precautionary lines, the IMF stands ready to fully deploy its US$1 trillion lending capacity to help member countries weather the crisis. The IMF is providing real-time policy advice and capacity development support to over 160 countries to address urgent issues such as cash management, financial supervision, cyber security and economic governance. In particular, the Fund has been working with tax administrations and budget offices in many countries to help them restore operations and strengthen support to businesses and individuals, without compromising safeguards and accountability. IMF technical experts are also working with countries to revise and update their debt management strategies.

5.9 Regarding policy measures to limit the impact of Covid-19, Finance Secretary, during the course of evidence on 19 December, 2020 deposed as under:

> "Almost all countries internationally have undertaken fiscal, monetary and other policy measures to limit the impact of Covid-19 on their economies besides addressing the health system challenge. In India, despite the strain on revenue collection in challenging economic environment, we had announced measures for spending on health and other sectors, social security, economic stimulus and liquidity support together comprise above six per cent of our GDP. India, as an important shareholder has been involved in detailed deliberations in multilateral institutions like IMF, World Bank, Asian Development Bank, Asian Infrastructure Investment Bank and New Development Bank on their response to Covid-19."

5.10 Elaborating on the support extended by the World Bank, Asian Development Bank (ADB), Asian Infrastructure Investment Bank (AIIB) and New Development Bank (NDB) to India‟s efforts in addressing the health system challenge and social support measures, he submitted:

> "India‟s efforts at addressing the health system challenge and social support measures have been appreciated by multilateral and bilateral agencies. To support spending on Covid-19 Emergency Response and Health Preparedness, India has been provided loan by the World Bank to the extent of US $ 1 billion, by ADB, AIIB and NDB to the extent of 500 USD each. Even for our social security measures and the Prime Minister Garib Kalyan Yojana, India has been provided assistance by these multilateral development banks. ADB has provided assistance of US $ 1 billion, World Bank and AIIB each US $ 750 million and NDB an amount of US $ 500 million."

5.11 The details of loans received by India from multilateral institutions for limiting Covid-19 impact on health and economic fronts are as under:

| Name of Multilateral Institution | Purpose of loan | Loan Amt. ($ million) | Disbursement as of 24.7.2020 ($ million) |
|---|---|---|---|
| | | | |
| **World Bank** | Health | 1,000 | 503 |
| | Social Security | 750 | 750 |
| | MSME Finance | 750 | - |
| **WB Total** | | **2,500** | **1,253** |
| | | | |
| **Asian Development Bank(ADB)** | Health | 500 | 500 |
| | Social Security | 1,000 | 1,000 |
| **ADB Total** | | **1,500** | **1,500** |
| | | | |
| ***Asian Infrastructure Investment Bank* (*AIIB*)** | Health | 500 | 250 |
| | Social Security | 750 | 750 |
| **AIIB Total** | | **1,250** | **1,000** |
| | | | |
| ***New Development Bank* (*NDB*)** | Health | 500 | 500 |
| | Social Security | 500 | 500 |
| **NDB Total** | | **1,000** | **1,000** |
| | | | |
| **Grand Total** | | **6,250** | **4,753** |

5.12 When the Committee asked the details regarding assistance received from foreign countries in the form of medical equipment and grants-in-aid, the Ministry of External Affairs furnished the following details:

| Country | Assistance |
|---|---|
| JAPAN | (i) ODA Grants-in-aid in the Health Sector for COVID 19 combat for an amount of JPY 1 billion (Rs 70 Crores approx)<br>(ii) ODA loan of JPY 50 billion (Rs 3500 crores approx) for COVID 19 Crisis Response Emergency Support |
| GERMANY | 5000 test kits |
| USA | 200 ventilators to Indian Red Cross |

| | |
|---|---|
| | Society through the US Agency for International Development |
| FRANCE | (i) 50 Osiris 3 transport ventilators<br>(ii) 70 Yuwell 830 bipap ventilators<br>(iii) 50,000 serological tests<br>(iv) Military medicine expertise |
| ISRAEL | (i) 125 ventilators<br>(ii) Medical Equipment and sanitizing systems worth USD 22000 |

5.13 Further, the Committee were apprised that during the second wave of pandemic in India in April-June 2021, the world came forward to reciprocate India's generosity. India received medical assistance from 52 countries**.** Indian Missions abroad also diligently assisted in the coordination of foreign donations as well as procurement of essential medical supplies under the guidance of Minister of External Affairs. During EAM's interaction at multilateral, regional and bilateral level, he reiterated the importance of global cooperation in tackling the Covid pandemic by keeping medical supply chains open. The details of global assistance to India during second wave are given below:

| **Item Name** | **Supplies Received** | | | | **Supplies Expected** | | | | **Grand Total** |
|---|---|---|---|---|---|---|---|---|---|
| | **Govt. To Govt.** | **Pvt. To Govt.** | **GoI Procurement** | **Total** | **Govt. To Govt.** | **Pvt. To Govt.** | **GoI Procurement** | **Total** | |
| Oxygen | | | | | | | | | |
| O2 cylinders(10L) | 630 | 100 | | 730 | 0 | 0 | 0 | 0 | 730 |
| O2 cylinders(45L) | 1960 | 1200 | | 3160 | 0 | 0 | 0 | 0 | 3160 |
| Oxygen Cylinders | 15736 | 15250 | | 30986 | 0 | 0 | 0 | 0 | 30986 |
| Oxygen concentrators | 13826 | 16051 | | 29877 | 0 | 0 | 0 | 0 | 29877 |
| Oxygen PSA Plant | 47 | 1 | | 48 | 0 | 0 | 0 | 0 | 48 |
| Ventilators/BIPAP/Cpap | 17120 | 2440 | | 19560 | 0 | 0 | 0 | 0 | 19560 |
| Metric Tonnes of LMO | 635 | 210 | 0 | 845 | 0 | 0 | 0 | 0 | 845 |

| Item Name | Supplies Received | | | | Supplies Expected | | | | Grand Total |
|---|---|---|---|---|---|---|---|---|---|
| | Govt. To Govt. | Pvt. To Govt. | GoI Procurement | Total | Govt. To Govt. | Pvt. To Govt. | GoI Procurement | Total | |
| Drugs | | | | | | | | | |
| Amphotericin B | | | 10687 | 10687 | 0 | 0 | 0 | 0 | 10687 |
| Favipiravir | 1330107 | 2000080 | | 3330187 | 0 | 0 | 0 | 0 | 3330187 |
| Remdesivir | 701578 | 405362 | 300000 | 1406940 | 0 | 0 | 0 | 0 | 1406940 |
| Tocilizumab | 1000 | 50024 | | 51024 | 0 | 0 | 0 | 0 | 51024 |
| Others | | | | | | | | | |
| Mask | 8493000 | 1339274 | | 9832274 | 0 | 0 | 0 | 0 | 9832274 |
| Rapid Diagnostic Kit | 1978800 | 10185 | | 1988985 | 0 | 0 | 0 | 0 | 1988985 |

5.14 On being asked to underline the commitment made and role played by WHO to strengthen the collective global fight against coronavirus pandemic and resolve the challenges caused by it worldwide, the Ministry of Health and Family Welfare in a written submission stated that WHO is helping member states to coordinate the global response through its 150 country offices, 6 regional offices and the headquarters and providing advice to countries on critical preparedness, readiness and response actions for COVID-19, surveillance and case investigation, among others. WHO is informing the public through situation reports and dashboards displaying real-time data and coordinating with the scientific networks on surveillance, epidemiology, forecasting, diagnostics, clinical care and treatment, and other ways to identify, manage the disease and limit onward transmission. In addition, WHO works with Health Cluster partners to support implementation of the Global Humanitarian Response Plan for COVID-19 in 29 countries experiencing humanitarian crises, affecting 63 million people. The R&D Blueprint was activated to accelerate diagnostics, vaccines and therapeutics for this novel

coronavirus. A Solidarity trial was launched by WHO and partners to generate data on most effective treatments.

**India‟s Contribution in Combating Covid-19**

5.15 Highlighting the proactive approach of India in engaging the global community for evolving a coordinated response to the COVID-19 pandemic, Foreign Secretary during the course of evidence on 19 December, 2020 informed the Committee:

> "….Several bilateral and multilateral meetings have been held at the level of the Prime Minister and the External Affairs Minister. Hon. Prime Minister addressed the 75th Session of the United Nations General Assembly on 26th September, 2020 where he highlighted India‟s contribution to the world during the fight against the COVID-19 pandemic and put forward the need for reforms in the organisation of the United Nations. We have extensively used the virtual mode to sustain communication with our friends and partners from all over the world."

5.16 On the supply of essential medicines to various countries all over the world, Foreign Secretary during briefing on 29 July 2020 added:

> "India provided medical assistance in the form of essential drugs, test kits and protection gear to over 150 countries. In addition, Medical assistance worth Rs.80 crore has also been extended to 80 countries under Grants-in-Aid. These are our neighbouring countries and other partners which extended beyond our immediate region to include Africa, Latin America and other developing countries."

5.17 Regarding role of „Operation Sanjeevani‟ in fight against pandemic in partner countries, he clarified:

> "We undertook a number of medical and early response mission across the world. A number of our partner countries requested assistance and we were quick to respond. Operation Sanjeevani conducted by the Indian Air force delivered 6.2 tonnes of essential medicines and hospital consumables for Maldives. We overcame daunting logistical challenges to supply medicines and medical supplies to Sri Lanka, Mauritius, Seychelles

and the Dominican Republic. India also deployed Rapid Response Medical Teams. These were military teams both from the Army and the Navy to help Maldives, Kuwait, Mauritius and Comoros to deal with the pandemic. "

5.18 Elaborating on India"s role as a first COVID-19 responder in the region, Foreign Secretary during the same briefing submitted:

"In line with the Prime Minister"s vision of security and growth for all in the region (SAGAR) and India"s time-tested role as a first responder in the region, India launched Mission SAGAR under which an Indian Naval ship Kesari was deployed to Maldives, Mauritius, Madagascar, Comoros and Seychelles to deliver Coronavirus related assistance. This is the first time when a single operation covered all countries in the region".

5.19 While briefing the Committee on the shared resolution of SAARC countries in fighting the unprecedented challenge of pandemic, Foreign Secretary on 29 July, 2020 stated:

"..Early in the crisis, the Prime Minister took the initiative of hosting a video conference of SAARC leaders. The Conference demonstrated the shared resolve of countries in the SAARC region to come together to fight the unprecedented challenge of the pandemic. At the Conference, the Prime Minister announced a series of measures to deal with the pandemic including the creation of Covid 19 Emergency Fund and a commitment of ten million dollars from India to the Fund. Under this Fund, India has extended humanitarian relief to countries in the SAARC region including supply of essential drugs, antibiotics, medical consumables for Covid protection, testing kits, other laboratory and hospital equipment.

India has also been sharing experience and expertise with the SAARC countries through video conference of health and trade officials. India has developed a SAARC Covid 19 Information Exchange Platform called COINEX to facilitate exchange of specialized information and tools on Covid 19. Training of health care personnel from neighbouring countries with the involvement of Super Speciality Medical Institutes like AIIMS, and PGI, Chandigarh has been conducted. They have also undertaken workshops under the MEA"s e-ITEC network. "

5.20 When asked about the developments for creation of SAARC COVID-19 Emergency Fund with India"s offer of 10 million US dollars to the fund, the Ministry of External Affairs in a written submission stated that in the spirit of collaboration, voluntary contributions have also been committed by other member states: Sri Lanka (USD 5 million), Bangladesh (1.5 million), Nepal (USD 1 million), Afghanistan (USD 1 million), Maldives (USD 200,000) and Bhutan (USD 100,000). Pakistan has pledged USD 3 million subject to the condition that it be administered by SAARC Secretariat in accordance with SAARC Charter.

5.21 Further, the Ministry of External Affairs also informed the Committee that corresponding requests from member states in need of assistance under the Fund has been coordinated by the respective Indian Missions. Assistance in the form of supply of medicines, medical equipment and Rapid Response Teams has been provided through India"s bilateral aid arrangements. Aid worth Rs. 17.1 crores (approximately USD 2.3 million) was provided to countries in the region under the Fund as given below:

| **S. No.** | **Country** | **Aid provided under Covid-19 Emergency Response Fund** | | **Total Aid provided in INR** |
|---|---|---|---|---|
| | | **Item** | **Amount** | |
| **1.** | **Afghanistan** | Medical supplies consisting of essential medicines and equipment (including transportation) | 29.3 lacs | **29.3 lacs** |
| **2.** | **Nepal** | Medical supplies consisting of test kits and essential medicines | 6.04 crores | **6.12 crores** |
| | | Transportation | 8 lacs | |
| **3.** | **Bhutan** | Medical supplies consisting of test kits and essential medicines | 1.64 crores | **1.69 crores** |
| | | Transportation | 5 lacs | |
| **4.** | **Bangladesh** | Medical supplies consisting of test kits and essential medical equipment | 3.56 crores | **3.64 crores** |
| | | Transportation | 8 lacs | |
| **5.** | **Sri Lanka** | Medical supplies consisting of test kits and essential medicines and | 53.55 lacs | **1.55 crores** |

| | | | | |
|---|---|---|---|---|
| | | equipment | | |
| | | Transportation | 47 lacs | |
| **6.** | **Maldives** | Medical supplies consisting of essential medicines | 14.5 lacs | **60.14 lacs** |
| | | Transportation | 46.09 lacs | |

5.22 Ministry of External Affairs submitted details about global assistance by India for tackling Covid Pandemic as on 31 January, 2022:

**COMMERCIAL SUPPLY OF HYDROXYCHLOROQUINE FROM INDIA TO OTHER COUNTRIES**

| S.No | Country | Tablets (lakh units) | API MT) |
|---|---|---|---|
| 1 | Algeria | 20 | 2.4 MT |
| 2 | Argentina | | 1.3 MT |
| 3 | Australia | 60 | |
| 4 | Bahamas | 0.3 | |
| 5 | Bahrain | 15 | |
| 6 | Bangladesh | | 0.5 MT |
| 7 | Belarus | 11.9 | |
| 8 | Belgium | 2.28 | |
| 9 | Benin | WA | |
| 10 | Bolivia | 4 | |
| 11 | Brazil | | 5.9 MT |
| 12 | Bulgaria | 4.5 | |
| 13 | Burkina Faso | WA | |
| 14 | Cameroon | WA | |
| 15 | Canada | 160 | 3.5 MT |
| 16 | Chad | 22.5<br>WA | |
| 17 | Colombia | 9 | 1 MT |
| 18 | Democratic Republic of Congo | 3 | |
| 19 | Ecuador | 15 | |
| 20 | Egypt | 1.5 | 1.6 MT |
| 21 | France | 17.75 | |
| 22 | Gabon | WA | |
| 23 | Germany | 184 | 1.5 MT |
| 24 | Ghana | 5 | |
| 25 | Guinea | 3.4<br>WA | |
| 26 | Guyana | 0.09 | |
| 27 | Hong Kong | 28 | |
| 28 | Indonesia | | 1.203 MT |
| 29 | Israel | 28.5 | 9 MT |

| | | | |
|---|---|---|---|
| 30 | Italy | 54.23 | |
| 31 | Ivory Coast | WA | |
| 32 | Jamaica | 0.19 | |
| 33 | Jordan | | 0.5 MT |
| 34 | Kazakhstan | 4.65 | |
| 35 | Kenya | 3.79 | |
| 36 | Liberia | 0.5 | |
| 37 | Madagascar | 0.6 | |
| 38 | Malaysia | 12 | 0.1 MT |
| 39 | Malawi | 0.5 | |
| 40 | Mali | WA | |
| 41 | Mauritius | 1.92 | |
| 42 | Mexico | | 2.5 MT |
| 43 | Morocco | 60 | |
| 44 | Myanmar | 26.9 | |
| 45 | Netherlands | 210.9 | |
| 46 | Niger | 0.36 | |
| 47 | Nigeria | 0.75 | |
| 48 | Oman | 15 | 0.13 MT |
| 49 | Peru | 3.91 | |
| 50 | Poland | 25 | |
| 51 | Portugal | 0.5 | |
| 52 | Philippines | 20.26 | 0.21 MT |
| 53 | Qatar | 0.8 | |
| 54 | Republic of Congo | 11.75<br>WA | |
| 55 | Romania | 25 | |
| 56 | Russia | 1090 | 0.55 MT |
| 57 | Saudi Arabia | | 0.25 MT |
| 58 | Senegal | WA | |
| 59 | Singapore | 25 | |
| 60 | Slovenia | 5 | |
| 61 | South Africa | 10.53 | |
| 62 | South Korea | | 2 MT |
| 63 | Spain | 9 | |
| 64 | Sri Lanka | 1.2 | |
| 65 | Tajikistan | 5.93 | |
| 66 | Tanzania | 0.87 | |
| 67 | Thailand | 13.8 | |
| 68 | Togo | WA | |
| 69 | Trinidad and Tobago | 1.35 | |
| 70 | Uganda | 3 | 0.75 MT |
| 71 | Ukraine | 7.8 | |
| 72 | UAE | 428.5 | 10 MT |
| 73 | UK | 147 | 4 MT |
| 74 | USA | 3100 | 2 MT |
| 75 | Uruguay | 0.77 | |
| 76 | Uzbekistan | 0.24 | |

| | | | |
|---|---|---|---|
| 77 | Vietnam | 35 | |
| 78 | Zambia | 4.2 | |
| 79 | Zimbabwe | 4.59 | |
| | WA = West Africa | 9.43 | |
| 80 | Maldives | | |
| 81 | Comoros | | |
| 82 | Tchad (Ndjamena) | | |
| | **Total** | **5600.2 lakh tablets** | **53.13 MT** |

## COMMERICAL SUPPLY OF PARACETAMOL FROM INDIA TO OTHER COUNTRIES

| S.No | Country | Quantity (lakh units; various formulations including tablets, injections, suspensions) | API (MT) |
|---|---|---|---|
| 1 | Afghanistan | 0.9 | |
| 2 | Angola | 2.9 | 0.64 MT |
| 3 | Australia | 136.02 | 15 MT |
| 4 | Belgium | 180 | |
| 5 | Benin | 243 kg | |
| 6 | Bhutan | 4.95 | 0.2 MT |
| 7 | Bolivia | 0.17 | |
| 8 | Botswana | 10 | |
| 9 | Bulgaria | 925 | |
| 10 | Burkina Faso | 99 | |
| 11 | Burundi | 2.12 | |
| 12 | Cambodia | 19.77 | |
| 13 | Cameroon | 174 | |
| 14 | Canada | | 24 MT |
| 15 | Chile | | 165 MT |
| 16 | Colombia | | 67.2 MT |
| 17 | Cote d'Ivoire | 2 | |
| 18 | Curacao | 10 | |
| 19 | Democratic Republic of Congo | 27.2 | |
| 20 | Denmark | 3685 | |
| 21 | Dominican Republic | 0.35 | 1.2 MT |
| 22 | Ecuador | 7.5 | 0.1 MT |
| 23 | Egypt | | 28 MT |
| 24 | El Salvador | | 48 MT |
| 25 | Eswatini | 1352 kg | |
| 26 | Ethiopia | 356 | |
| 27 | Finland | | 2 MT |
| 28 | France | 12.1 | |
| 29 | Gambia | 56 | |
| 30 | Georgia | 10 | |

| | | | |
|---|---|---|---|
| 31 | Germany | | 240 MT |
| 32 | Ghana | 3.3 | 3.5 MT |
| 33 | Greece | | 45 MT |
| 34 | Greenland | 24 | |
| 35 | Guinea | 75000 bottles | |
| 36 | Haiti | 70 | |
| 37 | Honduras | 48 | |
| 38 | Iceland | 450 | |
| 39 | Iraq | 17 | |
| 40 | Italy | 32 | |
| 41 | Japan | 188.1 | 158 MT |
| 42 | Kenya | 4.27 | |
| 43 | Kuwait | 7.69 | |
| 44 | Kyrgyzstan | 7.5 | |
| 45 | Latvia | 9.4 | |
| 46 | Lesotho | 8000 bottles | |
| 47 | Liberia | 45000 bottles | |
| 48 | Malawi | 6000 cartons | |
| 49 | Malaysia | | 24 MT |
| 50 | Maldives | 5 | |
| 51 | Mali | 126 | |
| 52 | Malta | 800 | |
| 53 | Mauritania | 0.09 | |
| 54 | Mexico | | 96 MT |
| 55 | Mongolia | 28 | |
| 56 | Morocco | | 24 MT |
| 57 | Mozambique | 30 | |
| 58 | Myanmar | 57 | |
| 59 | Nepal | | 1.1 MT |
| 60 | Netherlands | 71.3 | |
| 61 | New Zealand | 500 | |
| 62 | Niger | 0.09 | |
| 63 | Nigeria | 0.55 | |
| 64 | Norway | 140 | |
| 65 | Panama | | 60 MT |
| 66 | Papua New Guinea | 130 | |
| 67 | Paraguay | | 41 MT |
| 68 | Philippines | 110 | |
| 69 | Republic of Congo | 1.6 | |
| 70 | Romania | | 31.2 MT |
| 71 | Russia | 190 | 6.8 MT |
| 72 | Rwanda | | 21000 ltrs |
| 73 | Singapore | 9.6 | 2 MT |
| 74 | Sierra Leone | 208 | |
| 75 | Slovenia | | 49 MT |
| 76 | Somalia | 65 | |
| 77 | South Africa | 2640 | 180 MT |
| 78 | South Sudan | 20000 bottles | |

| | | | |
|---|---|---|---|
| 79 | Sri Lanka | 189 | |
| 80 | Sudan | 72000 bottles | |
| 81 | Sweden | 220 | |
| 82 | Switzerland | N/A | |
| 83 | Tajikistan | 0.5 | |
| 84 | Tanzania | 10 | |
| 85 | Trinidad & Tobago | 1667 kg | |
| 86 | Tunisia | | 72 MT |
| 87 | Turkey | | 130 MT |
| 88 | Turkmenistan | 15 | |
| 89 | Uganda | 1.82 | |
| 90 | UK | 1400 | |
| 91 | Ukraine | 22 | |
| 92 | UAE | 220.2 | |
| 93 | Vietnam | | 90 MT |
| 94 | Yemen | 5000 bottles | |
| 95 | Zambia | 0.56 | |
| 96 | Spain | | |
| | **Total** | **15441.28 lakh** | **1605 MT** |

**5.23 The Committee observe that the severity of the COVID-19 Pandemic has challenged the health systems worldwide while preventive measures have disrupted normal life and business activities. Both advanced economies and emerging market economies including India have faced severe contraction in their GDP. The Committee are happy to learn that multilateral institutions such as UN and its agencies WHO, UNICEF, UNDP and G 7, G 20, BRICS, World Bank, Asian Devleopment Bank, SCO, SAARC, etc. have played crucial role in responding to the Pandemic with unprecedented speed and magnitude of financial assistance to help countries protect the lives and livelihoods of people, especially the most vulnerable. India as an important shareholder has been involved in detailed deliberations in these multilateral institutions. The Committee are pleased to note that India played a prominent role in drafting the G-20 Action Plan specially on commitments related to economic response and recovery to strong, sustainable, balanced and inclusive growth, underlining the need for putting human beings at the centre for vision of prosperity and cooperation, and presenting the vision of a more people centric globalization. The**

**Committee admire the strategy of the Government under which India provided medical assistance in the form of essential drugs, test kits and protection gear to over 150 countries during the first wave. In addition, on request of partner countries, Operation Sanjeevani and Mission SAGAR were initiated to overcome daunting logistical challenges to supply of medicines and medical supplies to Maldives, Mauritius, Madagascar, Sri Lanka, Seychelles, Comoros and the Dominican Republic. Under SAARC COVID-19 Emergency Fund, assistance in the form of supply of medicines, medical equipment and Rapid Response Teams was provided to SAARC countries through India"s bilateral aid arrangements. India"s efforts at addressing the health system challenge and social support measures have been appreciated by multilateral and bilateral agencies and during second wave of Pandemic in India in April – June, 2021 the world came forward to reciprocate India"s generosity and India received medical assistance in various form from 52 countries.**

**Given the crucial role played by multilateral fora in fight against the pandemic, the Committee feel that we can overcome this threat to humanity only by building a more sustainable and resilient world through enhanced international cooperation. Hence the Committee strongly desire that efforts by the Government should continue to fight with Covid-19 Pandemic through international cooperation and also to strengthen as well as bring the necessary reforms in the UN and other international organizations for a more sustainable and resilient world to ensure swifter post Pandemic recovery and rehabilitation.**

**(Recommendation No. 19)**

**Development of COVID Vaccines**

5.24 India, the world‟s foremost producer of vaccines, contributes to immunization of about 60% of the world‟s children and further committed to global efforts by producing quality and affordable medicines in a spirit of sharing and caring.

5.25 While describing the development process of Covid-19 vaccine in India, the Ministry of External Affairs elaborated in a written note that "Task Force for Focused Research on Corona Vaccine constituted in April 2020 to set up the process for coronavirus vaccine development and provided the necessary impetus in this direction. India started COVID-19 vaccination in the country from 16$^{th}$January 2021 with Health Care Workers (HCWs) of both government & private sector. From 2$^{nd}$February 2021, Front Line Workers were made eligible for vaccination. From 1$^{st}$March 2021, vaccination was expanded to persons above 60 years of age and persons above 45 years with associated specified 20 comorbidities. This was further expanded to all people above 45 years of age from 1$^{st}$April 2021 and later to all persons aged 18 years and above from 1$^{st}$May 2021. A National Expert Group on Vaccine Administration for COVID -19 Vaccine (NEGVAC) has been constituted in August 2020 to guide the Government on prioritization of population group for vaccination. As decided by NEGVAC, the population prioritized for vaccination currently include:

1. Healthcare providers and workers in healthcare settings both government & private
2. Personnel from State and Central Police department, Armed Forces, Home Guard and Civil Defense Organization including disaster management volunteers and Municipal Workers
3. Person above age of 45 years
4. Persons above 18 years of age

On the recommendation of NEGVAC, COVID-19 vaccination has been extended to include lactating mothers as well as pregnant women. Till now COVID-19 vaccines (Covishield,Covaxin, Sputnik V, Moderna, Johnson & Johnson and ZyCoV-D) have received approval of Drug Controller General for Restricted Emergency Use. Of these Covishield, Covaxin and Sputnik V are currently being used for COVID-19 vaccination in the country. All

these vaccines have established safety & immunogenicity. Both Covishield and Covaxin have now been approved under WHO EUL. ZyCoV-D, is World‟s first DNA based COVID-19 vaccine that is being manufactured by M/s Zydus Cadilla Ltd. It has been licensed to use in individuals aged 12 years and above. On the recommendation of National Expert Group on Vaccine Administration for COVID-19 (NEGVAC), Drug Controller General of India on 15th April 2021 has made provisions for issuance of Restricted Use in Emergency Situation for vaccines which are listed in WHO Emergency Use Listing as well as foreign produced COVID-19 vaccines which have been granted emergency approval for restricted use by US FDA, EMA, UK MHRA, PMDA Japan.

5.26 Elaborating on India‟s support to the international vaccine alliance at Global Vaccine Summit, Foreign Secretary, during briefing on 29 July 2020 submitted:

> "One of the important virtual Summits that took place was the Global Vaccine Summit hosted by the United Kingdom and attended by over 50 countries encompassing heads of States and country leaders, Government Ministers, representatives of the UN, civil society and business leaders. The Prime Minister pledged 15 million dollars to GAVI, the international vaccine alliance. In his intervention, the Prime Minister affirmed that India stood in solidarity with the world pointing to our capacity to produce quality medicines and vaccines at affordable prices, our experience of rapidly expanding immunization and our scientific talent pool.

5.27 Elaborating on the status of vaccine candidates globally, Secretary, Ministry of Health and Family Welfare during evidence on 19 December, 2020 underlined:

> "Presently there are 193 vaccine candidates globally, which are at different stages of clinical testing. While 151 candidate vaccines are in pre-clinical evaluation, which is basically testing on animals to establish toxicity and stability of the vaccine, 42 vaccines are in clinical evaluation stage, which is done on healthy human volunteers. When we say clinical evaluation, it involves Phase I, Phase II and Phase III of clinical evaluation".

5.28 The Committee were informed that till now 4 COVID-19 vaccines (Covishield, Covaxin, Sputnik V and Moderna) have received approval of Drug Controller General for Restricted Emergency Use. Of these Covishield, Covaxin are currently being used for COVID-19

vaccination in the country since 16th January 2021. Both the vaccines have established safety & immunogenicity. India has also approved Johnson and Johnson"s single dose vaccine for single dose use.

5.29 Highlighting the difference between „Covishield" and „Covaxin", Secretary, Ministry of Health and Family Welfare during the evidence on 10 March, 2021 deposed:

> "The difference between the two vaccines is that while Covishield is based on an adenovirus vector and the Covaxin is based on an inactivated virus. So, in broad terms, it means that while Covaxin is based on a dead virus or a killed virus, the Covishield is based on a weakened virus.
>
> Sir, ..virus is basically protein, which is covered with fat. So, all the vaccines that used human adenovirus like sputnik or chimpanzee adenovirus like Covishield, they remove the layer of fat. Therefore, the virus is weakened where the protein remains, and the fat goes. That is the only difference otherwise, both are safe, both are immunogenic, both are efficacious."

5.30 The Ministry of External Affairs also informed the Committee that the following vaccine candidates are under various stages of development as on 31 January, 2022:

| S. No. | Product platform/ Technology & supporting funding agency | Organization and Collaborator | Current stage |
|---|---|---|---|
| 1. | Covishield (Non-Replicating Viral Vector) - formulation | Serum Institute of India and AstraZeneca | Approved in India |
| 2. | Covaxin (Inactivated) | Bharat Biotech | Approved in India |
| 3. | ZyCov-D (DNA-based vaccine) | Cadilla Healthcare Ltd. | Approved in India |
| 4. | Corbevax (Protein Subunit) | Biological E Limited and Texas Children"s Hospital Centre Covaxin Development and Baylor College of Medicine, Houston | Approved in India |

| | | | |
|---|---|---|---|
| 5. | Covovax (Protein-based Subunit) | Serum Institute of India and Novavax Inc., USA | Approved in India |
| 6. | Vaxzevria (Non-Replicating Viral Vector) | Oxford/AstraZeneca | Approved in India |
| 7. | Sputnik V (Non-Replicating Viral Vector) | Gamaleya Research Institute | Approved in India |
| 8. | Janssen (Non-Replicating Viral Vector) | Johnson&Johnson | Approved in India |
| 9. | Spikevax (RNA) | Moderna | Approved in India |
| 10. | Nuvaxovid (Protein Subunit) | Novavax Inc., USA | Approved in India |
| 11. | BECOV2B (Protein Subunit) | Biological E Limited | Phase II |
| 12. | BECOV2C (Protein Subunit) | Biological E Limited | Phase II |
| 13. | BECOV2D (Protein Subunit) | Biological E Limited | Phase II |
| 14. | HGCO19 (RNA) | Gennova Biopharmaceuticals Ltd. | Phase II |
| 15. | BBV154 (Non-Replicating Viral Vector) | Bharat Biotech | Phase I |
| 16. | AKS – 452 (Protein Subunit) | University Medical Center Groningen | Phase III |

5.31 With regard to production capacity of vaccines, the Ministry of External Affairs apprised the Committee that the two companies which have already received authorizations, namely COVISHIELD by the Serum Institute and COVAXIN by Bharat Biotech, have current monthly capacities of around 100 to 110 million doses and 20 to 25 million doses respectively. COVAXIN production is being ramped up with new facilities in Bangalore and Pune as well as technology transfer to public sector units like Indian Immunological Limited. Manufacturing capacities of other companies as on 31 January, 2022 are given below:

| **Company** | **Estimated production capacity (million doses per month)** |
|---|---|
| Serum Institute of India – **Covovax (Novavax)** | 50 |

| | |
|---|---|
| Serum Institute of India – **Covishield** | 250 |
| Bharat Biotech – **Covaxin** | 50 |
| Bharat Biotech – **Intranasal vacccine** | 15 |
| Biological E – **Corbevax** | 110-120 |
| Biological E – **Janssen (J&J)** | 50 |
| Zydus Cadila – **ZyCov-D** | 10 |
| Gennova – **mRNA** | 10 |

5.32 On being enquired about scaling down supply of vaccines from 216 crore to 135 crore and production capacity of Covaxin and Covishied, Secretary, Ministry of Health and Family Welfare clarified:

> "This whole concern about 135 crore doses, and 216 crore doses has emerged because at different points the same facts were put differently. Although, at a subsequent date, the Union of India in a sworn affidavit has put up these numbers before the hon. Supreme Court, but I would not go into that affidavit. What was said at one point in time was that from January to 31st of July, 51.60 crore doses were ordered and from 1st of August till 31st of December, 135 odd crore doses will be available. So, 135 plus 51.60, which had already been ordered from January to July, was the overall resource basket of doses. Since different people at different points in time projected different numbers, that is why this confusion has arisen."

**Mission COVID Suraksha**

5.33 The Committee were informed that in 2020, the Government of India (GOI) launched „Mission COVID Suraksha- the Indian COVID-19 Vaccine Development Mission", as part of the third stimulus package, for research and development of Indian COVID-19 vaccines. The Mission is being implemented by Biotechnology Industrial Research Assistance Council (BIRAC), a Public Sector Undertaking of the Department of Biotechnology (DBT) at a total cost of Rs. 900 Crore (nearly **US$ 125 million**) for one year. The goal of the Mission is to accelerate the development of at least 5-6 vaccine candidates and to ensure that some of these are brought

closer to licensure and introduction in the market for consideration of regulatory authorities and for introduction in public health systems.

5.34 On the common global norms laid down for assessment of effectiveness of vaccine being developed, the Ministry of Health and Family Welfare in a written reply stated that the clinical trial data of various vaccines in terms of safety, immunogenicity and efficacy will be assessed by the Central Drugs Standard Control Organisation (CDSCO)/Drug Controller General of India (DCGI) before according marketing permission/Emergency Use Authorization for the use of vaccines. Besides, long term follow-up will also reveal valuable data in terms of long-term safety, duration of protection and effectiveness of vaccines in reducing severity of disease and mortality.

5.35 When the Committee desired information about coordination amongst Indian researchers and developer of vaccine, the Ministry of Health and Family Welfare in a written reply stated that ICMR-NIV, Pune and BBIL have worked in very close coordination for developing the indigenous candidate vaccine – COVAXIN. The partnership has worked well at all steps right from development of the candidate vaccine to various clinical trials. Proactive approach, hand-holding at all steps, much needed laboratory diagnostic assistance and technical as well as financial support is being ensured at all steps to expedite vaccine development. Researchers at ICMR-NIV, Pune have successfully conducted preclinical toxicity studies in Non-Human Primates (NHPs) for vaccines developed by BBIL, Zydus Cadila and Biological E.

5.36 On the involvement of female candidates or volunteers in vaccine development, the Ministry of Health and Family Welfare in a written reply submitted that Several female scientists, volunteers as well as field workers are involved in the development of vaccine, planning, conceptualizing and implementing preclinical studies and clinical trials, undertaking

field implementation of clinical trials as well as volunteering to receive the vaccines during clinical trials.

**Supply of Vaccine to Foreign Countries under Vaccine Maitri Initiative**

5.37 The Committee were apprised that under *Vaccine Maitri*, an initiative of Government of India, Supplies of Made-in-India COVID 19 vaccines to various countries across the world were started on 20 January 2021. India‟s initiative of supplying COVID19 vaccines to the world despite its huge domestic requirements has been widely appreciated, including by UN Secretary General, WHO, Heads of state/ heads of Government of several countries, foreign ministers and even by public at large around the world. Overall, *Vaccine Maitri* initiative has been a big diplomatic success for India and has helped raise our stature in the comity of nations, including establishing India as the *„Pharmacy of the World'*.

5.38 About India‟s contribution to world regarding supply of vaccines, the Ministry of External Affairs submitted the following report:

a) India in proactively engaged with the global community for evolving a coordinated response to the COVID-19 pandemic. In keeping with India‟s principle of Vasudaiva Kutumbakam, the Government commenced supplies of Made-in-India vaccines under Vaccine Maitri, to various countries across the world were started on 20 January 2021, while keeping in view the domestic production capacity and the requirement of the national vaccination programme. The conditionality of domestic requirement was publicly articulated in a press release of Ministry of External Affairs on 19 January 2021.

b) The initiative was in line with the commitment made by our Prime Minister during his speech at the United Nations General Assembly in September 2021, when he said "as the largest vaccine producing country of the world, I want to give one more assurance to the global community today. India‟s vaccine production and delivery capacity will be used to help all humanity in fighting this crisis."

c) In line with our Neighbourhood First policy, the supplies were first undertaken to our neighbouring countries as India‟s gift. Subsequently, supplies to other countries were undertaken, both as gifts and under commercial contracts. Till now, India has supplied 127.15 lakh doses as grant, 387.92 lakh doses as commercial sales and 198.63 lakh doses under the COVAX facility. Total

supplies amount to 707.7 lakh doses to 93 countries and two UN entities (UN peacekeepers and health workers). Supplies include 21.6 lakh doses of COVAXIN of Bharat Biotech.

d) Due to increased domestic demands in the wake of the second wave, external supplies of vaccines were paused in end-April. Since then India has successfully worked on improving vaccine equity by adding more vaccines to the basket, including the world‟s first DNA based vaccine. Vaccine manufacturing capacity has also been ramped up.

e) Given these developments, we have once again resumed external supplies of Covid-19 vaccines. Once again priority was given to neighborhood. In the last month, 10 lakh doses each were commercially supplied to Nepal and Bangladesh while 10 lakh doses were given as grant to Myanmar. Similarly, 10 lakh doses of COVAXIN was granted to Iran. Currently, more than 50 lakh doses have been approved to be supplied to COVAX.

5.39 About India‟s contribution to the world regarding supply of Covid-19 Related Medical Assistance, Ministry of External Affairs submitted that India has earned for ensuring supply of essential medicines even while meeting our own domestic requirements, and how this has cemented our reputation as the "Pharmacy of the World" and as a responsible stakeholder in global health supply chains. India provided medical assistance, in the form of essential drugs, test kits, protection gear, etc., to over 150 countries in the aftermath of Covid-19 pandemic. In recent months, India has supplied syringes, LMO (Liquid Medical Oxygen), Remdesivir and other critical items to the countries in neighborhood, Indo-Pacific and beyond. In July 2021, 200 MT of Liquid Medical Oxygen (**LMO**) was sent to Bangladesh through Indian Railways. Similarly, between July-Aug 2021, 300 Oxygen concentrators, 110 MT LMO and other items were supplied to Indonesia through Indian Naval ships under „Mission Sagar‟.

The following table provided by Ministry of External Affairs provides India‟s contribution to the world regarding supply of Covid-19 vaccines as on 28 January, 2022:

| Sl. No. | Country | Grant | Commercial | COVAX | Total Supplies |
|---|---|---|---|---|---|
| | | Quantity | Quantity | Quantity | |
| 1 | Bangladesh | 33.000 | 150.008 | 42.920 | 225.928 |
| 2 | Myanmar | 37.000 | 174.000 | | 211.000 |
| 3 | Nepal | 11.120 | 20.000 | 63.870 | 94.990 |
| 4 | Bhutan | 5.500 | | | 5.500 |
| 5 | Maldives | 2.000 | 1.000 | 0.120 | 3.120 |
| 6 | Mauritius | 1.000 | 3.000 | | 4.000 |
| 7 | Seychelles | 0.500 | | | 0.500 |
| 8 | Sri Lanka | 5.000 | 5.000 | 2.640 | 12.640 |
| 9 | Bahrain | 1.000 | | | 1.000 |
| 10 | Brazil | | 40.000 | | 40.000 |
| 11 | Morocoo | | 70.000 | | 70.000 |
| 12 | Oman | 1.000 | | | 1.000 |
| 13 | Egypt | | 0.500 | | 0.500 |
| 14 | Algeria | | 0.500 | | 0.500 |
| 15 | South Africa | | 10.000 | | 10.000 |
| 16 | Kuwait | | 2.000 | | 2.000 |
| 17 | UAE | | 2.000 | | 2.000 |
| 18 | Afghanistan | 10.000 | | 4.680 | 14.680 |
| 19 | Barbados | 1.000 | | | 1.000 |
| 20 | Dominica | 0.700 | | | 0.700 |
| 21 | Mexico | | 8.700 | | 8.700 |
| 22 | Dominican Republic | 0.300 | 1.100 | | 1.400 |
| 23 | Saudi Arabia | | 45.000 | | 45.000 |
| 24 | El Salvador | | 1.100 | | 1.100 |
| 25 | Argentina | | 5.800 | | 5.800 |
| 26 | Serbia | | 1.500 | | 1.500 |
| 27 | UN Health workers | | 1.250 | | 1.250 |
| 28 | Mongolia | 1.500 | | | 1.500 |
| 29 | Ukraine | | 5.000 | | 5.000 |

| | | | | | |
|---|---|---|---|---|---|
| **30** | Ghana | 0.500 | 0.020 | 16.620 | 17.140 |
| **31** | Ivory Coast | 0.500 | | 5.040 | 5.540 |
| **32** | St. Lucia | 0.250 | | | 0.250 |
| **33** | St. Kitts & Nevis | 0.200 | | | 0.200 |
| **34** | St. Vincent & Grenadines | 0.400 | | | 0.400 |
| **35** | Suriname | 0.500 | | | 0.500 |
| **36** | Antigua & Barbuda | 0.400 | | | 0.400 |
| **37** | DR Congo | 0.500 | | 17.160 | 17.660 |
| **38** | Angola | | | 6.240 | 6.240 |
| **39** | Gambia | | | 0.360 | 0.360 |
| **40** | Nigeria | 1.000 | | 96.660 | 97.660 |
| **41** | Cambodia | | 0.100 | 3.240 | 3.340 |
| **42** | Kenya | 1.000 | | 10.200 | 11.200 |
| **43** | Lesotho | | | 0.360 | 0.360 |
| **44** | Rwanda | 0.500 | 5.000 | 2.400 | 7.900 |
| **45** | Sao Tome & Principe | | | 0.240 | 0.240 |
| **46** | Senegal | 0.250 | | 3.240 | 3.490 |
| **47** | Guatemala | 2.000 | | | 2.000 |
| **48** | Canada | | 5.000 | | 5.000 |
| **49** | Mali | | | 3.960 | 3.960 |
| **50** | Sudan | | | 8.280 | 8.280 |
| **51** | Liberia | | | 0.960 | 0.960 |
| **52** | Malawi | 0.500 | | 3.600 | 4.100 |
| **53** | Uganda | 1.000 | | 8.640 | 9.640 |
| **54** | Nicaragua | 2.000 | | 1.350 | 3.350 |
| **55** | Guyana | 0.800 | | | 0.800 |
| **56** | Jamaica | 0.500 | | | 0.500 |
| **57** | UK | | 50.000 | | 50.000 |
| **58** | Togo | | | 1.560 | 1.560 |
| **59** | Djibouti | | | 0.240 | 0.240 |
| **60** | Somalia | | | 8.400 | 8.400 |

| | | | | | |
|---|---|---|---|---|---|
| **61** | Seirra Leone | | | 0.960 | 0.960 |
| **62** | Belize | 0.250 | | | 0.250 |
| **63** | Botswana | 0.300 | 1.000 | | 1.300 |
| **64** | Mozambique | 1.000 | | 11.040 | 12.040 |
| **65** | Ethiopia | | | 21.840 | 21.840 |
| **66** | Tajikistan | | | 8.905 | 8.905 |
| **67** | Benin | | | 1.440 | 1.440 |
| **68** | Eswatini | 0.200 | | 0.120 | 0.320 |
| **69** | Bahamas | 0.200 | | | 0.200 |
| **70** | Cape Verde | | | 0.240 | 0.240 |
| **71** | Iran | 10.000 | 1.250 | | 11.250 |
| **72** | Uzbekistan | | | 6.600 | 6.600 |
| **73** | Solomon Islands | | | 0.240 | 0.240 |
| **74** | Laos | | | 1.320 | 1.320 |
| **75** | Namibia | 0.300 | | | 0.300 |
| **76** | Bolivia | | | 2.280 | 2.280 |
| **77** | South Sudan | | | 1.320 | 1.320 |
| **78** | Paraguay | 2.000 | 4.000 | | 6.000 |
| **79** | Fiji | 1.000 | | | 1.000 |
| **80** | UN Peacekeepers | 2.000 | | | 2.000 |
| **81** | Zimbabwe | 0.750 | | | 0.750 |
| **82** | Niger | 0.250 | | 3.552 | 3.802 |
| **83** | Palestine | | 0.250 | | 0.250 |
| **84** | Yemen | | | 3.600 | 3.600 |
| **85** | Nauru | 0.100 | | | 0.100 |
| **86** | Trinidad & Tobago | 0.400 | | | 0.400 |
| **87** | Guinea | | | 1.944 | 1.944 |
| **88** | Papua New Guinea | | | 1.320 | 1.320 |
| **89** | Guinea Bissau | | | 0.288 | 0.288 |

| | | | | | |
|---|---|---|---|---|---|
| **90** | Zambia | | | 2.280 | 2.280 |
| **91** | Comoros | | | 0.120 | 0.120 |
| **92** | Cameroon | | | 3.912 | 3.912 |
| **93** | Mauritania | | | 0.696 | 0.696 |
| **94** | Albania | 0.500 | | | 0.500 |
| **95** | Syria | | | 2.568 | 2.568 |
| **96** | Indonesia | | 90.080 | | 90.080 |
| **97** | Vietnam | | 2.000 | | 2.000 |
| **98** | Netherlands | | 225.091 | | 225.091 |
| **Total** | **142.670** | **931.249** | **389.565** | | **1463.484** |

5.40 On the issue of returning of covid vaccine of the Serum Institute of India by South Africa, Foreign Secretary during the course of evidence on 10 March, 2021 stated:

> "The South African Government, due to some technical evaluation, feels that the mutant strain that is there is not covered by the normal generic vaccine supplied by the Serum Institute of India. So, it has decided to give those vaccines to other African Union countries because the mutant strain in Africa is quite strong and they feel that some other vaccines are more suitable. But having spoken to Serum Institute, they say that is not correct and their vaccine is also able to take into account these mutant strains. Even if you have COVID, you will have a mild form of that strain.
>
> It will not be a very serious form. Deaths will not be there. Serious illness will not be there. It will be a very controlled form. So, in a certain sense, they feel that our vaccines are actually suitable for even these countries. But South Africa obviously has taken its own decisions. Of course, that choice is left to them."

5.41 On being asked whether it is compulsory for India under the COVAX facility to supply a certain quantity of vaccine to other countries, Foreign Secretary during the evidence on 10 March, 2021 submitted:

> "With regard to supplies under COVAX, I think that the arrangement is COVAX asks the manufacturer -- in this case Serum Institute -- to supply the country with a certain

quantity. They will then work out the most convenient form of supply. Normally, it is by air because it is a perishable commodity and then they send it to the country concerned as fast as possible. In case of Pakistan, it could go by the land route also across the Wagah Border or it could also go by Dubai, etc. This is being worked out between the manufacturer and the recipient Government."

5.42 On being asked whether we have received any demand and request from Pakistan for supply of vaccine, Foreign Secretary, during the same evidence informed:

"In fact, as part of Covax, we were asked by Covax to supply it to Pakistan. We have given our green signal for that supply. That means we have agreed that we will supply it to Pakistan. But the Government of Pakistan has not requested us for any vaccine. But since they are part of Covax, that supply directly from us to Pakistan under the Covax facility has been requested and we have agreed to that".

5.43 Elaborating on the modules of training and trial of Indian vaccines in other countries, Secretary, Ministry of Health and Family Welfare submitted during the oral evidence on 19 October, 2020:

"We have conducted two modules of training, by the Department of Biotechnology, of experts in the neighbouring and gulf countries on vaccine trials, cold chain development and maintenance, and related issues. We plan to conduct more such training modules. There have been requests from several countries for conduct of Phase III trial of Indian vaccines in those countries. A composite team of the Department of Biotechnology, Indian Council of Medical Research and the Biotechnology Industry Research Assistance Council is currently in Bangladesh to discuss with the authorities there, issues relating to clinical trials, infrastructure requirements, cold chain development, etc. Based on these discussions, it is proposed to develop an SOP for extending support to other interested countries. Recently, Russia entered into a confidentiality agreement with India for collaboration, clinical trials and research. The World Bank has also shown interest in cooperation with us and other regional countries which would request funding support for procurement and distribution of vaccines."

5.44 While describing the Covid-19 related experience sharing with other countries the Ministry of External Affairs stated that to share our experiences, we have organised a number of online training programmes for COVID-19 testing, clinical practices, case management, vaccine development and delivery etc. in which nearly 1000 participants from Asian, South East Asian and African countries have participated. We have also organised a training programme covering administrative and operational aspects, which was conducted on 19-20 January 2021 for immunization managers, cold chain officers, communication officers and data managers of the partner countries, both at national and provincial levels. More than 150 experts from the neighbouring countries participated in this training programme.

A workshop on „Covid-19 management: Experience, Good practices and way forward" with 10 neighbouring was organized on 18 February 2021, in which Health secretaries and technical experts shared their experiences in tackling covid19 pandemic. While addressing the workshop Hon'ble Prime Minister suggested to create a special visa scheme for our doctors and nurses, coordinate an air ambulance agreement for medical contingencies, create a regional platform for collating, compiling and studying data on vaccines and create a regional network for promoting technology-assisted epidemiology for preventing future pandemics.

**Covid Vaccination in India**

5.45 Regarding Covid-19 Vaccination drive in the country, Secretary, Ministry of Health and Family Welfare during evidence on 10 March, 2021 submitted:

> "The vaccination started on 16th of January when the hon. Prime Minister started the first phase of vaccination which is the world's largest vaccination exercise. On 16th January, we started vaccinating health care workers. When we say health care workers, it means those workers who are working in health care facilities, both in private and public sector. It includes doctors, nurses, ward boys, everyone who is working in a hospital setting. Incidentally, it does not include doctors who are posted in the Ministry of Health. That is

the subtle difference. The priority focus was people who are more vulnerable, and who are more vulnerable among health care workers are workers who are exposed to Covid positive people. So, people who are in the hospital settings are included. This started on 16th January. On 2nd February, we started vaccination of frontline workers. The frontline workers are people who are in the frontline of dealing with the pandemic. For example, it includes all revenue workers like the circle officers and so on and so forth who were doing containment and surveillance exercise. Then all Panchayati workers who were doing house to house search of active cases, all municipal workers who were responsible for sanitation and other activities in and around hospitals, all police forces and all armed forces are included. This is the second category known as the frontline workers. They started vaccination on 2nd February.

On 1st of March, we started with age-appropriate priority groups that is, everyone who is more than 60 years of age and everyone who is 45 years to 59 years with specified co-morbidities. A set of 20 co-morbidities was specified. If one is more than 45 years up to 59 years and suffers from these co-morbidities, then they were all to be inoculated. "

5.46 Further, the Committee were informed that a National Expert Group on Vaccine Administration for COVID -19 Vaccine (NEGVAC) has been constituted to guide the Government on prioritization of population group for vaccination. As decided by NEGVAC, the population prioritized for vaccination currently include:

5. Healthcare providers and workers in healthcare settings both government & private
6. Personnel from State and Central Police department, Armed Forces, Home Guard and Civil Defense Organization including disaster management volunteers and Municipal Workers
7. Person above age of 45 years
8. Persons above 18 years of age

5.47 The Committee are also apprised that on the recommendation of NEGVAC, COVID-19 vaccination has been extended to include lactating mothers as well as pregnant women.

5.48 On timelines for vaccination, Secretary, Ministry of Health and Family Welfare during evidence on 19 July, 2021 submitted:

"The Government of India has already indicated a reasonable timeline for vaccinating all adult Indians and that is by the end of December, 2021. When I say

„all", that means that those who want to be vaccinated must be vaccinated. We are working towards it."

5.49 Ministry of Health and Family Welfare submitted the following details, about the operationalization of National Covid-19 vaccination programme:

- "The programme entailed multiple challenges, which were steadily overcome with the visionary leadership, immaculate & inclusive planning androbust efforts by the Government of India.
- The knowledge and experience of Universal Immunization Programme (UIP) coupled with the experience of elections (Booth-strategy) laid the basis for augmenting our healthcare infrastructure and undertaking the humungous task of inoculating the eligible population of the country.
- Capacity building of Health Care Workers and Vaccinatorshas been continuously undertaken in a cascading manner in consideration with the expanding programme. More than 2.6 lakh vaccinators and 4.7 lakh vaccination team members have been oriented on COVID-19 vaccination & it"s activities.
- Government of India has been providing free supply of Covid vaccines in enough quantity to States/UTs for free of cost administration to all eligible citizens.
- Involvement of Private Sector has also been done to facilitate access to vaccination to those who want to utilize the services of Private Hospitals. The demand of COVID-19 vaccines from private hospitals is aggregated on Co-WIN portal. The private hospitals can charge up to a maximum of Rupees 150 per dose as service charges.
- The CoWIN portal, which has incorporated various features & flexibilities based on previous experience, has enabled real time monitoring of status of vaccination drive, vaccine availability and utilization. It helps in registration, tracking of every beneficiary for second dose, generation of digital certificates etc. The registration and vaccination of people without access to digital technology can be done through walk-in registration and vaccination of either single individual or groups of individuals at COVID-19 Vaccination Centre (CVC), Facilitated cohort on–site registration and vaccination, Assisted registration through Common Service Centers (CSCs) or 1075 helpline/State"s Call Center, Special sessions for people who don"t have any of the specified identity cards, [migrants, seers, nomads etc.].
- In areas without internet connectivity, the vaccination sessions can still be organized using manual records which are to be entered into the Co-WIN system for generation of vaccination certificates, up to 5:00 pm on the day after the date of such session.
- During the course of time, strategic interventions were instituted to make the vaccination program and its process more people centric, convenient and more pragmatic. These include the following guidance and interventions issued to the States/UTs:
    - Vaccination of people at workplace for employees above 18 years & their dependents

- Vaccination of beneficiaries without prescribed identity cards
- Revision in dosage interval of Covishield based on growing evidence
- Vaccination recommendations for lactating mothers and pregnant women
- Near to Home COVID vaccination centres (NHCVCs) for elderly & differently abled citizens
- Vaccination at the place of residence for persons who are bed-ridden or have extremely restricted mobility or disability and/or special needs that may hamper their accessibility even to NHCVCs.
- „HarGharDastak" Campaign to identify and vaccinate missed beneficiaries for 1st dose and due beneficiaries for 2nd dose through house-to-house activity from 3rd November 2021.
- Vaccination of the beneficiaries aged 15-18 years.
- Administration of precaution dose to Health Care Workers, Front Line Workers and persons aged 60 years and above with comorbidities, upon completion of 9 months after administration of 2nd dose.
- CoWIN portal is updated regularly to reflect the key policy decisions and guidelines

- A targeted communication strategy has been put in place to address prevalent reasons for vaccine hesitancy thereby aiding vaccine demand.
- Monitoring of the programme has been conducted using top-down strategy, following consultative approach for deliberation on it"s progress involving all relevant stakeholders, from National level till the District/Sub-District level. All States/UTs are provided guidance on establishing governance and monitoring mechanism through State Steering Committee, State Task Force, District Task Force, Block/Urban Task Force. The performance of the States and Districts have been regularly analyzed in accordance of which **District-specific plans** have been prepared and implemented to ensure the pace of vaccination especially in the low-performing areas."

5.50 While stating the performance of vaccination drive, the Ministry of Health and Family Welfare submitted the following details:

- "Unparalleled milestones have been achieved by administration of **more than 1 crore vaccine doses** on multiple singular days, the highest being administration of **2.51 crore** vaccine doses on 17th September 2021.
- In a time-span of one year, more than **156.76 crore doses**were administered across the country, which is amongst the **highest in the world**, surpassing many developed nations.
- The daily rate of vaccination in the country during January"22 was 69.42 lakh doses/day which is more than the combined daily doses administered in the entire European Union, United Kingdom & USA.

- As on 01st February 2022, more than 166.68 crore doses of COVID-19 vaccine have been administered which include the following:
    - 1st dose to 18+ population:89,53,67,264 (95% coverage against eligible population)
    - 2nd dose to 18+ population: 71,19,66,993 (76% coverage against eligible population)
    - 1st dose to 15-18 year aged population:4,66,52,398 (63% coverage against eligible population)
    - Precaution dose to Health Care Workers, Front Line Workers and 60+ population with comorbidities: 1,25,02,003"

State/UT – wise details of COVID-19 vaccine administered in corona various categories of eligible population as on 1 February, 2022 is as under:

| S. No. | State/UT | 18+ 1st dose | 18+ 2nd dose | 15-18 yrs 1st dose | Precaution dose | Total |
|---|---|---|---|---|---|---|
| 1 | A & N Islands | 3,08,865 | 3,00,580 | 17,914 | 6,32,939 | 6,32,939 |
| 2 | Andhra Pradesh | 4,04,03,437 | 3,67,63,103 | 24,55,266 | 8,05,78,382 | 8,05,78,382 |
| 3 | Arunachal Pradesh | 8,38,923 | 6,80,388 | 36,097 | 15,72,268 | 15,72,268 |
| 4 | Assam | 2,22,93,253 | 1,80,41,436 | 8,76,878 | 4,13,74,590 | 4,13,74,590 |
| 5 | Bihar | 6,04,21,419 | 4,75,11,058 | 40,98,714 | 11,25,50,318 | 11,25,50,318 |
| 6 | Chandigarh | 10,73,982 | 8,47,670 | 37,128 | 19,75,068 | 19,75,068 |
| 7 | Chhattisgarh | 1,83,25,222 | 1,42,88,976 | 9,91,073 | 3,38,56,474 | 3,38,56,474 |
| 8 | Dadra & Nagar Haveli | 4,23,068 | 3,12,863 | 18,156 | 7,56,387 | 7,56,387 |
| 9 | Daman & Diu | 2,97,749 | 2,50,222 | 11,267 | 5,62,392 | 5,62,392 |
| 10 | Delhi | 1,61,89,076 | 1,23,44,977 | 8,15,338 | 2,96,36,960 | 2,96,36,960 |
| 11 | Goa | 13,37,439 | 11,57,451 | 43,441 | 25,61,324 | 25,61,324 |
| 12 | Gujarat | 4,85,22,008 | 4,53,24,065 | 27,09,433 | 9,80,07,793 | 9,80,07,793 |
| 13 | Haryana | 2,15,46,462 | 1,66,51,565 | 9,35,909 | 3,92,81,991 | 3,92,81,991 |
| 14 | Himachal Pradesh | 59,82,158 | 55,52,962 | 2,97,392 | 1,19,31,988 | 1,19,31,988 |
| 15 | Jammu & Kashmir | 98,50,565 | 98,20,210 | 6,28,056 | 2,04,80,446 | 2,04,80,446 |
| 16 | Jharkhand | 2,05,46,550 | 1,29,90,912 | 10,29,537 | 3,47,14,517 | 3,47,14,517 |
| 17 | Karnataka | 4,93,94,558 | 4,30,78,336 | 22,67,667 | 9,55,13,345 | 9,55,13,345 |
| 18 | Kerala | 2,68,18,708 | 2,25,05,145 | 10,75,727 | 5,09,68,136 | 5,09,68,136 |
| 19 | Ladakh | 2,17,538 | 1,77,524 | 8,095 | 4,20,378 | 4,20,378 |
| 20 | Lakshadweep | 56,576 | 53,659 | 2,802 | 1,14,909 | 1,14,909 |
| 21 | Madhya Pradesh | 5,36,40,458 | 5,13,63,505 | 37,62,313 | 10,95,71,852 | 10,95,71,852 |
| 22 | Maharashtra | 8,30,82,567 | 6,10,98,522 | 31,63,783 | 14,82,59,747 | 14,82,59,747 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 23 | Manipur | 13,73,666 | 10,49,538 | 57,005 | 25,10,192 | 25,10,192 |
| 24 | Meghalaya | 12,99,509 | 9,32,409 | 37,857 | 22,88,906 | 22,88,906 |
| 25 | Mizoram | 7,67,428 | 6,12,007 | 42,654 | 14,40,715 | 14,40,715 |
| 26 | Nagaland | 8,10,160 | 6,11,150 | 34,628 | 14,68,324 | 14,68,324 |
| 27 | Odisha | 3,05,52,086 | 2,45,95,043 | 14,95,382 | 5,71,15,320 | 5,71,15,320 |
| 28 | Puducherry | 8,81,350 | 6,06,152 | 40,405 | 15,35,671 | 15,35,671 |
| 29 | Punjab | 1,95,12,973 | 1,34,80,418 | 4,41,522 | 3,36,32,698 | 3,36,32,698 |
| 30 | Rajasthan | 4,96,16,334 | 3,99,49,226 | 29,41,407 | 9,34,04,928 | 9,34,04,928 |
| 31 | Sikkim | 5,35,912 | 4,90,187 | 23,560 | 10,67,115 | 10,67,115 |
| 32 | Tamil Nadu | 5,25,69,757 | 3,88,97,058 | 20,27,743 | 9,38,47,386 | 9,38,47,386 |
| 33 | Telangana | 2,90,12,501 | 2,36,68,625 | 12,39,248 | 5,42,08,134 | 5,42,08,134 |
| 34 | Tripura | 26,27,585 | 21,65,586 | 1,14,549 | 49,51,975 | 49,51,975 |
| 35 | Uttar Pradesh | 14,75,31,814 | 10,32,04,912 | 95,19,396 | 26,16,51,238 | 26,16,51,238 |
| 36 | Uttarakhand | 80,54,965 | 72,97,537 | 4,05,019 | 1,60,04,858 | 1,60,04,858 |
| 37 | West Bengal | 6,64,11,794 | 5,17,18,593 | 29,50,037 | 12,20,22,523 | 12,20,22,523 |
| | Miscellaneous | 22,38,849 | 15,73,423 | 0 | 43,76,017 | 43,76,017 |
| **Total** | | **89,53,67,264** | **71,19,66,993** | **4,66,52,398** | **1,25,02,003** | **1,66,68,48,204** |

5.51 With regard to vaccines for children of age group of 12 to 18, Secretary, Department of Biotechnology during evidence on 19 July 2021 informed the Committee:

> "..Globally as well the trials for vaccines for children are still continuing. There has been no vaccine currently which has been given any emergency use authorisation for children. As I said, we are in the late stages of our trials that we are doing. The ZydusCadila Vaccine, as I mentioned, the ZyCoV-D which is a DNA vaccine has now submitted their data on children from 12 to 18 which is what they are waiting to see. This is a rolling review which the regulator takes. But it will take a couple of months before this data can be looked at to see what the response is before this vaccine can be considered. We will have to wait for the regulator to assess the data.
>
> The Bharat Biotech Covaxin also has been given permission by the regulator now to start the trial which they have already initiated and that trial has again begun on children. While other vaccine manufacturers like Biological E are also considering, but that is very much in the early stage when we do not have information on that. But as we move forward, they will be taking it ahead. But as on date today, they have not been able to start that trial. So, this is where we stand in terms of vaccines for children."

5.52 Elaborating on the adverse event after immunization, Secretary, Ministry of Health and Family Welfare during the evidence on 10 March, 2021 stated:

> "Sir, presently, our experience is that the adverse event following immunization, because now we have been doing it from 16th of January, is extremely low as compared to other countries. The percentage of adverse events so far is 0.0013 per cent, which is almost a surrogate for zero. That is the adverse event percentage. So, vaccines are very, very safe."

5.53 Regarding Vaccine hesitancy, Secretary, Ministry of Health and Family Welfare during the same evidence clarified:

> "There was an initial phase of vaccine hesitancy where people were not willing to go and get themselves vaccinated. So, we utilised some of the prominent Government and private sector doctors who had received their vaccine shots to dispel this vaccine hesitancy. Thereafter, once it was opened for 60 plus people, the sight of the hon. Prime Minister taking the vaccine, all hon. Chief Ministers taking the vaccines and all prominent political personalities taking the vaccine, has contributed in a great way to reducing the vaccine hesitancy. In fact, there are certain geographies in the country where now we are witnessing vaccine eagerness, where people are coming forward and saying: "why am I not getting vaccinated?" They are not part of the priority groups but those demands have also started coming."

5.54 On being asked on the development of antibodies and period of protection after vaccination, the representative of the Ministry of Health during the evidence on 10 March, 2021 stated:

> "You must appreciate one fact that COVID-19 is a new phenomenon. It will be too early to say how long the protection lasts because the vaccination process and everything is a new phenomenon".

5.55 With regard to support for vaccination activity, the Ministry of Health and Family Welfare informed the Committee that a unique digital platform- **Co-WIN** (Winning over COVID) supports the vaccination activity, helping the programme managers in registration and

tracking of every beneficiary for COVID-19 vaccination along with real time information on the available stocks of vaccine, their storage temperature, actual vaccination process, generation of digital certificates etc.

5.56 On being enquired about technical glitches in Co-WIN platform, the Ministry of Health and Family Welfare in a written reply stated that the servers on which the CoWIN digital portal is hosted continue to work smoothly and are able handle unprecedented workloads. This is evident from the fact that, registration for the beneficiaries in the age-group of 18-44 years which opened on 28th April 2021, witnessed 383 million API hits, initially as high as 2.7 million hits per minute in the first three hours (4-7 pm) on 28th April 2021. As many as 1.45 crore SMSs successfully delivered in the period of three hours.These Statistics indicate that the system has performed without any glitches. It has recorded 55,000 hits per second and is completely stable.

5.57 On being enquired about delivery system of vaccine across the country, the Ministry of Health and Family Welfare in a written submission stated that under Universal Immunization Programme (UIP), a network consisting of 85,634 equipments for storage of vaccine at about 28,947 cold chain points across the country in a temperature-controlled environment already exist.

5.58 The Committee were further informed that Stakeholders across Ministries/Departments, professional bodies, medical colleges, NGOs, CSOs, media houses, private sector, youth & women network have been involved in this drive which is being coordinated as a Jan Bhagidari Andolan. The country is utilizing the experience of immunization programme and of conducting large-scale immunization campaigns, along with the experience of elections (booth strategy) to effectively cover large numbers and varied geographies. Comprehensive review of activities was done regularly to ensure seamless last mile delivery of vaccine to the intended beneficiary. It encompassed dry run rounds across the country, covering all districts, to test end-to-end operations of the planned activities.

**5.59 The Committee appreciate the scientists in the country for their tireless efforts to develop the COVID-19 Vaccines in a very short span of time. The Committee are informed that India is the world"s foremost producer of vaccines and contributes to immunization of about 60 per cent of the world"s children, and as per data provided by the Ministry of Health and Family Welfare, as of now nine vaccines namely Covishield, Covaxin, Sputnik V, Spikevax(RNA) by Moderna, Janssen by Johnson and Johnson (single dose vaccine), ZyCoV-D, Cobevax, Covovax and Vaxzeric have been granted permission for restricted emergency use and four-five of them are being used for Covid-19 vaccination in the country. Further, 6 more vaccine candidates are under various stages of development. The Committee understand that the primary protection against covid is vaccination and feel privileged to note that India not only started the world"s largest and fastest COVID -19 vaccination drive on 16 January 2021 by utilizing the country"s vast experience of immunization programmes and of conducting large-scale immunization campaigns, employing its experience of elections (booth strategy) to effectively cover large numbers and varied geographies. The Committee appreciate the decision of the Government under which with its avowed commitment to help the world fight the pandemic, India shipped millions of „Made-in-India" COVID -19 vaccine doses to various countries under its „Vaccine Maitri" programme in the modes of grant, commercial sales and through the COVID-19 Vaccines Global Access (COVAX) facility despite its huge domestic requirements in the country. This was stopped in April 2021 by giving top priority to national demand and has been restarted recently in view of sufficient availability of doses. Apart from this, India has conducted modules of training of experts in the neighbouring and gulf countries on vaccine trials, cold chain development and maintenance, and related issues. This humanitarian approach of India has been widely appreciated by the world"s leadership. The Committee would like to praise both the Ministry of External Affairs and**

**the Ministry of Health and Family Welfare for the work they have done to deliver the made in India vaccine globally despite huge domestic demand. The Committee are convinced that such diplomatic initiative has helped raise our stature in comity of nations including establishing India as the Pharmacy of world and due to such initiative a large number of countries reciprocated this generosity by providing significant medical and other assistance during second wave in India and desire that the same policy should continue with the sufficient enhancement in production of vaccines as the COVID-19 being a global Pandemic cannot be overcome ignoring international cooperation.**

**(Recommendation No.20)**

**5.60 On analysing the facts placed by the Ministry of Health and Family Welfare regarding vaccine hesitancy and side effect of vaccine, the Committee observe that in the initial phase of vaccination, the vaccine hesitancy was one of the reasons for slow speed of vaccination. People hesitated to get vaccinated for many reasons from personal views and fears, logistical problems. Many of the prominent doctors and distinguished personalities have received vaccine shots to dispel vaccine hesitancy amongst the masses. As far as the adverse events are concerned it is almost a surrogate for zero. The Committee are of the opinion that since the COVID-19 vaccines are new and developed at short notice, the surveillance of short and long term adverse effects, duration of protection and effectiveness of vaccines in reducing severity of disease and mortality is crucial and a failure to report adverse effects transparently could easily create fear among beneficiaries and discourage them from taking vaccine. Hence, the Committee strongly desire that people should be made aware about the facts through print and electronic media that Covid-19 vaccines are carefully tested for safety, the vaccine side effects are temporary and getting the vaccine can protect a person from getting seriously sick, getting a vaccine will add extra protection**

**to those who already had Covid-19, vaccination help to save others particularly vulnerable people in society and maximum vaccination only can help us to move closer to normal life. Moreover, the Government should ensure proper follow up of vaccinated people in order to get empirical evidence of benefits as well as that side effects if any, of Covid-19 vaccination to convince the hesitant people.**

**(Recommendation No.21)**

**5.61 The Committee find it a big challenge before the Government to vaccinate the estimated adult population of 94 Crores (0.94 billion) in the country. The current level of vaccination may leave the country susceptible to another wave of COVID-19. The Committee, however find that the efforts made in this direction has enhanced the indigenous production and availability of vaccines significantly and the requisite target of vaccination everyday has been achieved with such planned and concrete efforts and the Government has been able to vaccinate more than eighty percent of eligible adult population and have achieved the target necessary for development of herd immunity of full vaccination of adult population more or less as per the target by using all means. The Committee, are also happy to note that with the same zeal and in a planned way the Government has approved and started the vaccination of 15-18 years aged children and more than 70 percent of eligible population of children of the age group has got first dose of vaccine. The Committee also find that the vaccine for children below 15-18 years of age has also been approved and therefore, desire that these children are also vaccinated in the similar manner. The Committee have been informed that the priming effect of two shots is likely to wane in six months to a year in a significant number of persons that is why the booster shots/precaution doses for the health workers, frontline workers, immune**

**compromised and elderly persons has also started and this vulnerable population has been protected.**

**Before concluding the Committee would like to advise the Government that COVID-19 Pandemic is a once in a century calamity but it does not mean that this is the last one to visit us. It is also not necessary that such calamities may befall at similar intervals. It is, therefore, imperative that a National Policy on combating viral and other such diseases which have the potential of spiraling into global Pandemics is worked out with utmost care, seriousness and speed and acted upon with due promptitude.**

**(Recommendation No.22)**

**NEW DELHI**
**21 March, 2022**
**30 Phalguna, 1943 (Saka)**

**P.P. CHAUDHARY,**
**Chairperson,**
**Committee on External Affairs**

**Annexure-I**

## MINUTES OF THE TWENTIETH SITTING OF THE STANDING COMMITTEE ON EXTERNAL AFFAIRS HELD ON 29 JULY, 2020

The Committee sat from 1230 hrs. to 1435 hrs. in Main Committee Room, Parliament House Annexe, New Delhi.

**Present**

**Shri P.P. Chaudhary – Chairperson**

**Members**

**Lok Sabha**

2. Smt. Meenakashi Lekhi
3. Shri P.C. Mohan
4. Shri Ritesh Pandey
5. Shri Manoj Tiwari
6. Shri N.K. Premchandran

**Rajya Sabha**

7. Shri K. J. Alphons
8. Shri Swapan Dasgupta
9. Shri Ranjan Gogoi
10. Shri Shamsher Singh Manhas

**Sl. No. Name & Designation**

**MINISTRY OF EXTERNAL AFFAIRS**

| S.No. | Name | Designation |
|---|---|---|
| 1. | Shri Harsh Vardhan Shringla | Foreign Secretary |
| 2. | Shri Dammu Ravi | Additional Secretary (Covid-19) |
| 3. | Shri P. Harish | Additional Secretary (ER) |
| 4. | Shri Vikram Doraiswami | Additional Secretary (IO & Summits) |
| 5. | Shri G. Balasubramanian | Joint Secretary (AD) |
| 5. | Dr. Devyani Khobragade | Joint Secretary (DPA-II) |
| 6. | Shri Robert Shetkingtong | Joint Secretary (Parl & Coord) |

## MINISTRY OF HOME AFFAIRS

| S.No. | Name | Designation |
|---|---|---|
| 1. | Shri Govind Mohan | Additional Secretary (UT) |
| 2. | Sh. Sanjeev Kumar Jindal | Joint Secretary (DM) |

## MINISTRY OF FINANCE

| S.No. | Name | Designation |
|---|---|---|
| **Department of Economic Affairs** | | |
| 1. | Shri Sameer Kumar Khare | Additional Secretary (FB & ADB) |
| 2. | Shri Anand Mohan Bajaj | Additional Secretary (Financial Markets) |
| 3. | Shri Shashank Saxena | Adviser (FSRL) |
| 4. | Shri Rajiv Mishra | Adviser (Economic Division |
| **Department of Revenue** | | |
| 1. | Shri Kamlesh Chandra Varshney | Joint Secretary (TPL-1) |

## MINISTRY OF HEALTH AND FAMILY WELFARE

| S.No. | Name | Designation |
|---|---|---|
| 1. | Smt. Preeti Sudan | Secretary |
| 2. | Shri Lav Agarwal | Joint Secretary |
| 3. | Dr. P. Ravindran | Additional DDG |

## MINISTRY OF CIVIL AVIATION

| S.No. | Name | Designation |
|---|---|---|
| 1. | Shri Pradeep Singh Kharola, | Secretary |

| | | |
|---|---|---|
| 2. | Shri Arun Kumar, | DG, DGCA |
| 3. | Shri Rakesh Asthana | DG, BCAS |
| 4. | Shri Rajiv Bansal | CMD,AAI |
| 5. | Shri Arvind Singh | Chairman, AAI |

**MINISTRY OF COMMERCE AND INDUSTRY**

| S.No. | Name | Designation |
|---|---|---|
| 1, | Dr. Anup Wadhawan | Secretary Commerce |
| 1. | Shri Sanjay Chadha | Additional Secretary |
| 2. | Shri Vijay kumar | Additional DGFT |
| 3. | Shri Surendra Kumar Ahirwar | Joint Secretary |

**Secretariat**

1. Shri P.C. Koul - Joint Secretary
2. Dr. Ram Raj Rai - Director

2. At the outset, the Chairperson welcomed the Members of the Committee and the representatives of the Ministries of External Affairs, Home Affairs, Health and Family Welfare, Commerce and Industry, Finance and Civil Aviation to the Sitting of the Committee convened to have briefing on the 'COVID 19 Pandemic - Global Response, India's Contribution and the Way Forward". After giving cue of the discussion, the Chairperson drew the attention of all the representatives to Direction 55 (1) of Directions by the Speaker, Lok Sabha in order to maintain the confidentiality of the proceedings. The Chairperson also apprised the witnesses about the provision of Direction 58 of Directions by the Speaker, Lok Sabha. In view of the importance of the subject in prevailing conditions, the Committee decided to select the subject for detailed examination and Report.

3. After introductions, the Foreign Secretary briefed the Committee on the subject in detail. Thereafter, representatives from Ministries of Home Affairs, Health and Family Welfare,

Commerce and Industry, Finance and Civil Aviation also briefed the Committee extensively on the issue.

4. During the deliberation, Members of the Committee raised certain queries such as number of cases, fatality and recovery rate, MEA‟s analysis about covid-19, reason for rapid increase in Covid cases worldwide, role of Missions/Post abroad, implication of nationwide lockdown on upgradation capacity and availability of dedicated COVID hospitals, isolation and ICU beds in various states and support of the Central Government provided to states, Pradhan Mantri Garib Kalyan package (PMGKP), Aatma Nirbhar Bharat Abhiyan, reforms in Agriculture, power, coal, Civil Aviation and Defence, Covid Cell, Covid Control room, operation under Vande Bharat Mission (VBM) etc.

*The Committee then adjourned*

**Annexure-II**

## MINUTES OF THE TWENTY SECOND SITTING OF THE STANDING COMMITTEE ON EXTERNAL AFFAIRS HELD ON 11 AUGUST, 2020

The Committee sat from 1150 hrs. to 1350 hrs. in Committee Room „D', Parliament House Annexe, New Delhi.

**Present**

**Shri P.P. Chaudhary – Chairperson**

**Members**

**Lok Sabha**

2. Smt. Meenakshi Lekhi
3. Shri P.C. Mohan
4. Shri Ritesh Pandey
5. Shri Ravindra Shyamnarayan Shukla *alias* Ravi Kishan
6. Shri Manoj Tiwari
7. Shri N. K. Premchandran,

**Rajya Sabha**

8. Shri K.J. Alphons
9. Shri Swapan Dasgupta
10 Shri Ranjan Gogoi

**MINISTRY OF EXTERNAL AFFAIRS**

| S.No. | Name | Designation |
|---|---|---|
| 1. | Shri Harsh Vardhan Shringla | Foreign Secretary |
| 2. | Shri Dammu Ravi | Additional Secretary (Covid-19) |
| 3. | Shri Vipul | Joint Secretary (Gulf) |
| 4. | Shri Abbaganj Ramu | Joint Secretary (OIA-I) |
| 5. | Shri Robert Shetkintong | Joint Secretary (Parl & Coord) |

## MINISTRY OF EDUCATION

| S.No. | Name | Designation |
|---|---|---|
| 1. | Amit Khare | Secretary |
| 2. | Rakesh Ranjan | Additional Secretary |
| 3. | Neeta Prasad | Joint Secretary |
| 4. | Madhu Ranjan Kumar | Joint Secretary |

## MINISTRY OF WOMEN &CHILD DEVELOPMENT

| S.No. | Name | Designation |
|---|---|---|
| 1. | Shri Ram Mohan Mishra | Secretary |
| 2. | Astha Saxena Khatwani | Joint Secretary |
| 3. | Ashish Srivastava | Joint Secretary |
| 4. | Anuradha S. Chagti | Joint Secretary |

## MINISTRY OF CONSUMER AFFAIRS, FOOD & PUBLIC DISTRIBUTION

| S.No. | Name | Designation |
|---|---|---|
| 1. | Ms Nidhi Khare | Additional Secretary |
| 2. | Shri Vineet Mathur | Joint Secretary |

## MINISTRY OF SKILL DEVELOPMENT & ENTREPRENEURSHIP

| S.No. | Name | Designation |
|---|---|---|
| 1. | Praveen Kumar | Secretary (MSDE) |
| 2. | Juthika Patankar | Additional Secretary (MSDE) |
| 3. | K.C. Gupta | Joint Secretary (MSDE) |
| 4. | Manish Kumar | MD & CEO (NSDC) |

## MINISTRY OF LABOUR & EMPLOYMENT

| S.No. | Name | Designation |
|---|---|---|
| 1. | Shri Heeralal Samariya | Secretary |
| 2. | Shri Ajay Tewari | Joint Secretary |
| 3. | Shri Hemant Jain | F.A & C.A.O |

**Secretariat**

1. Shri P. C. Koul - Joint Secretary
2. Shri Paolienlal Hoakip - Additional Director

2. At the outset, the Chairperson welcomed the members of the Committee and the representatives of the Ministries of External Affairs, Education, Women and Child Development, Consumer Affairs, Food & Public Distribution, Skill Development & Entrepreneurship and Labour & Employment to the Sitting of the Committee convened to have a briefing on „COVID 19 Pandemic-Global Response, India"s Contribution and the Way Forward". The Chairperson in his opening remarks apprised the stakeholders about the objectives of the Sitting and underlined the pinpoint issues relating to COVID 19 pandemic on which the Committee desire to be briefed. The Chairperson then drew the attention of all the witnesses about the provisions of Direction 55 (1) and Direction 58 of Directions by the Speaker, Lok Sabha in order to maintain confidentiality of the proceedings.

3. Thereafter, Foreign Secretary delved upon the issues underlined in opening remarks such as multitude of problems being faced by the Indian migrant workers who lost the job abroad due to COVID 19 pandemic and have returned to India, mapping and registration of skilled workers for SWADES SKILL CARDS, public-private partnership cooperation in managing and monitoring the database of skilled workers, allocation of funds under Indian Community Welfare Fund (ICWF) and eligibility of financial assistance thereunder and worldwide research for COVID 19 and the issues that were raised on subject during the last Sitting of the Committee

held on 29.07.2020. During the course of the discussion, Foreign Secretary also responded to the queries impinging upon the issues such as assistance for criminal cases framed against Indian nationals abroad under ICWF, facilities to Indian national for hiring lawyer framed in criminal cases, details of Indian national stranded abroad and those who returned to India including those waiting to return, arrangement of air bubble facilities for repatriation of Indian nationals, facilities of Covid Test at airports under Vande Bharat Mission, quarantine facilities in Delhi, arrangement of quarantine flights in other destinations, stringent quarantine laws in many States, details of consolidated amount under ICWF, database of returnees through Vande Bharat Mission, issue of losing visa validity and permission for ravel on valid visiting visas for returnees,

4. Subsequently, the representatives of the Ministry of Women and Child Development briefed the Committee about its role and initiatives taken to deal with the issues arising out of corona pandemic in the country. Thereafter, Secretary, WCD responded the query related to awareness campaign amongst the illiterate women living in villages about online service launched for cognizance of grievances and complaints received thereunder.

5. Thereafter, the representative of the Ministry of Consumer Affairs, Food & Public Distribution (Department of Consumer Affairs) briefed the Committee about the measures it has taken to address the problem of migrant and stranded labour and to boost the economy affected by corona pandemic situation. The queries raised on issues such as distribution of cereals to migrant workers, Survey to identify people who do not have rations cards and mechanism for providing ration for migrant workers who do not have ration card and status of „One Nation One Ration Card" system were also responded by its representative.

6. Afterwards, the representative of the Skill Development & Entrepreneurship elaborated upon facets of SWADES AND ASEEM portal and SWADES SKILL CARD. The Members raised a variety of quaries on the issues like special scheme for returnees who have lost their jobs

abroad due to corona pandemic, registration of companies on the ASEEM portal, international opportunities for jobs, involvement of private sector for imparting skill training to workers/professionals required in the international market and payment to agents/middlemen by nurses from Kerala to get a job abroad, etc. The representative of the Ministry responded to the queries.

7. The representative of Ministry of Labour & Employment threw light mainly on initiatives taken up and relief provided to companies and workers under the Pradhan Mantri Garib Kalyan Yojana which inter-alia included deferment of payment for EPFP and ESIC, permission for withdrawal from EPF accounts, preparing a national data base on inter-state migrant workers, financial assistance to building and construction workers. The Members raised queries related to PF pensioners, conversion of Government hospitals into Covid hospitals and super specialty treatment to poor workers, etc.

8. Finally, Secretary, Ministry of Education highlighted the challenges faced in the education sector because of corona pandemic which inter-alia included change in traditional class room to the online system, challenges of digital discrimination, availability of devices and connectivity, use of educational TV channels to provide online content, SWAYAM online degree courses, training of teachers under MISHTA AND NISHTHA programmers, facility of online study to foreign students in Indian universities, etc. Thereupon, the Members raised the issue of admissions in MBA, problems related to online education and issues of digital divide and learning devices, etc.

9. Before the Sitting concluded, the Chairperson directed the witnesses to furnish written replies to the points raised by the Members of the Committee at the earliest.

*The Committee then adjourned.*

**Annexure-III**

## MINUTES OF THE SECOND SITTING OF THE COMMITTEE ON EXTERNAL AFFAIRS HELD ON 19 OCTOBER, 2020

The Committee sat from 1600 hrs. to 1820 hrs. in Main Committee Room, Parliament House Annexe, New Delhi.

**Present**

**Shri P.P. Chaudhary – Chairperson**

**Members**

**Lok Sabha**

1. Smt. Harsimrat Kaur Badal
2. Shri Kalyan Banerjee
3. Smt. Preneet Kaur
4. Smt. Meenakashi Lekhi
5. Smt. Goddeti Madhavi
6. Smt. Poonam Mahajan
7. Shri N.K. Premchandran
8. Shri Manne Srinivas Reddy

**Rajya Sabha**

9. Shri Swapan Dasgupta
10. Shri Ranjan Gogoi

**MINISTRY OF EXTERNAL AFFAIRS**

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Harsh Vardhan Shringla | Foreign Secretary |
| 2. | Shri Dammu Ravi | Additional Secretary (Covid-19) |
| 3. | Shri Vinay Kumar | Additional Secretary (IO & Summits) |
| 4. | Shri Anil Kumar Rai | Joint Secretary (Parl & Coord) |
| 5. | Shri Abbagani Ramu | Joint Secretary (OIA – I) |

**MINISTRY OF HEALTH & FAMILY WELFARE**

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Rajesh Bhushan | Secretary |
| 2. | Shri Lav Agarwal | Joint Secretary |

## MINISTRY OF CIVIL AVIATION

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Pradeep Singh Kharola | Secretary |
| 2. | Shri Arun Kumar | DG, DGCA |
| 3. | Shri M.A. Ganapathy | DG, BCAS |
| 4. | Shri Aurobindo Handa | DG, AAIB |
| 5. | Shri Rajiv Bansal | CMD, AI |
| 6. | Shri Arvind Singh | Chairman, AAI |

**Secretariat**

1. Shri P.C. Koul - Additional Secretary
2. Dr. Ram Raj Rai - Director

2. At the outset, the Chairperson welcomed the Members of the Committee and the representatives of the Ministries of External Affairs, Health and Family Welfare and Civil Aviation to the Sitting of the Committee convened to have oral evidence on „COVID-19 Pandemic-Global Response, India‟s Contribution and the way forward‟. After underling the issues to be discussed during the course of oral evidence on the subject, the Chairperson drew the attention of all the witnesses about the provisions of Direction 55(1) and Direction 58 of Directions by the Speaker, Lok Sabha in order to maintain confidentiality of the proceedings. He, thereafter, welcomed Shrimati Harsimrat Kaur Badal and Shri Manne Srinivas Reddy being nominated as new member to the Committee for 2020-21. Thereafter, he directed witnesses to brief the Committee on the Subject.

3. The witnesses briefed the Committee on the subject, mainly dwelling on current status of covid cases in US, Brazil, European countries, neighbouring countries and India, onset of second and third wave of infections in various countries, status of development of vaccine in India and abroad, evacuation missions for stranded Indian nationals abroad and their testing protocol at airports.

4. The Members of the Committee then raised queries such as time by which the pandemic are likely to be controlled, reasons for different stages for clinical trials of covid vaccine, procedures for home quarantine, study on stranded Indians coming from foreign countries, study on impact of returnees on spread of corona disease, filling up of declaration form at airports for travel, clearance for air travel for persons not having negative report, non-maintenance of data relating to Indian Diaspora, fare of chartered flights, critical evaluation of lockdown, health infrastructure facilities, critical evaluation of cases in neighbouring countries, transparency in

country‟s statistical data on COVID-19, ratification of death due to COVID-19, SOPs for testing and discharge of patient, quality of isolation centres, protocol for patients in ICU/hospitals, kinds of testing and its protocol, allocation of ventilators to States, Impact of Tablighi Jamaat on covid disease, system of COVID-19 test in Canada, timing of report under RAT and RT-PCR test, time of infection and detection of virus and function and use of Aarogya Setu App etc. Meantime, the witnesses responded to queries of Members.

5. Before, the Sitting concluded, the Chairperson directed the witnesses to furnish written replies to the points raised by the Members of the Committee to the Secretariat on priority to ensure completion of examination of the subject.

*The Committee then adjourned*

**Annexure-IV**

**MINUTES OF THE NINETEENTH SITTING OF THE COMMITTEE ON EXTERNAL AFFAIRS HELD ON 10 MARCH, 2021**

The Committee sat from 1500 hrs. to 1540 hrs. in Committee Room „D', Parliament House Annexe, New Delhi.

**Present**

**Shri P.P. Chaudhary – Chairperson**

**Members**

**Lok Sabha**

2. Smt. Harsimrat Kaur Badal
3. Shri Dileshwar Kamait
4. Smt. Meenakashi Lekhi
5. Smt. Poonam mahajan
6. Shri Ritesh Pandey
7. Shri P.C. Mohan
8. Dr. K.C. Patel
9. Smt. Navneet Ravi Rana

**Rajya Sabha**

10. Shri Brijlal

**MINISTRY OF EXTERNAL AFFAIRS**

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Harsh Vardhan Shringla | Foreign Secretary |
| 2. | Shri Dammu Ravi | Additional Secretary (Covid-19) |
| 3. | Shri Vinay Kumar | Additional Secretary (IO & Summits) |

| | | |
|---|---|---|
| 4. | Shri G. Balasubramanian | Joint Secretary (AD) |
| 5. | Shri Anil Kumar Rai | Joint Secretary (Parl & Coord) |

**MINISTRY OF HEALTH & FAMILY WELFARE**

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Rajesh Bhushan | Secretary |
| 2. | Shri Manohar Agnani | Additional Secretary |
| 3. | Shri Mandeep Kr. Bhandari | Joint Secretary |

**Secretariat**

1. Dr. Ram Raj Rai - Director

2. At the outset, the Chairperson welcomed the Members of the Committee and the representatives of the Ministries of External Affairs and Health and Family Welfare to the Sitting of the Committee convened to take oral evidence with particular reference to COVID Vaccination and International Cooperation in connection with the examination of the subject „COVID-19 Pandemic-Global Response, India‟s Contribution and the Way Forward‟. After flagging the issues on which the discussion would start, the Chairperson drew the attention of the witnesses to the provisions of Direction 55(1) and Direction 58 of Directions by the Speaker, Lok Sabha regarding confidentiality of the proceedings. He asked Secretary, Ministry of Health and Family Welfare to brief the Committee.

3. The Witness presented a brief overview of the covid vaccination process and status thereof in the country. Subsequently, Foreign Secretary briefed the Committee about operation „Vaccine Maitri‟ which has been launched by the Government to send vaccines to foreign countries.

4. The Members of the Committee then raised several queries on issues such as demand or request of vaccines from Pakistan, interest of people towards vaccination including healthcare

and frontline workers, demand and supply of vaccine within the country, supply of vaccines under COVAX Facility, status of Vande Bharat Mission and Air Bubble flights, vaccine passport to travel abroad, preparedness against new strains, effectiveness of vaccine against new strains, maintenance of cold chain in rural areas, study for long term side effects of vaccine, follow up mechanism to find out covid infection after first and second dose of covid vaccination, development of antibodies after vaccination, duration of protection after vaccination and involvement of Indian Diaspora in immunization in foreign countries and vaccine diplomacy, etc. The witnesses responded to the queries of the Members.

5. Before the Sitting concluded, the Chairperson thanked the witnesses for their valuable inputs on the subject and directed them to furnish the written replies to the points that remained answered to the Secretariat at the earliest.

*The Committee then adjourned*

**Annexure-V**

## MINUTES OF THE TWENTY FIFTH SITTING OF THE COMMITTEE ON EXTERNAL AFFAIRS HELD ON 19 JULY, 2021

The Committee sat from 1500 hrs. to 1645 hrs. in Main Committee Room, Parliament House Annexe, New Delhi.

**Present**

**Shri P.P. Chaudhary – Chairperson**

**Members**

**Lok Sabha**

2. Shri Dileshwar Kamait
3. Smt. Goddeti Madhavi
4. Smt. Poonam mahajan
5. Shri P.C. Mohan
6. Dr. K.C. Patel
7. Shri N.K. Premchandran
8. Smt. Navneet Ravi Rana
9. Shri Manne Srinivas Reddy

**Rajya Sabha**

10. Shri K. J. Alphons
11. Smt. Jaya Bachchan
12. Shri Ranjan Gogoi
13. Shri Swapan Dasgupta
14. Shri Abdul Wahab
15. Shri Brijlal

## MINISTRY OF EXTERNAL AFFAIRS

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Dammu Ravi | OSD (Secretary Level |
| 2. | Shri Vinay Kumar | Additional Secretary (IO & Summits) |
| 3. | Shri G. Balasubramanian | Joint Secretary (DPA-III) |
| 4. | Shri Anil Kumar Rai | Joint Secretary (Parl & Coord) |

## MINISTRY OF HEALTH & FAMILY WELFARE

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Rajesh Bhushan | Secretary |
| 2. | Shri Lav Agarwal | Joint Secretary |

## MINISTRY OF CIVIL AVIATION

| S. No. | Name | Designation |
|---|---|---|
| 1. | Ms. Usha Padhee | Joint Secretary |
| 2. | Shri Angshumali Raastogi | Joint Secretary |
| 3. | Shri Arun Kumar | DG, DGCA |
| 4. | Shri Jaideep Prasad | DG, BCAS |
| 5. | Shri Rajiv Bansal | CMD, Air India |
| 6. | Shri Sanjeev Kumar | Chairman, AAI |

## MINISTRY OF SCIENCE AND TECHNOLOGY (D/o BIOTECHNOLOGY)

| S. No. | Name | Designation |
|---|---|---|
| 1. | Dr. (Ms.) Renu Swarup | Secretary |
| 2. | Shri Vishvajit Sahay | Additional Secretary & Financial Advisor |
| 3. | Shri Chandra Prakash Goyal | Joint Secretary |

## Secretariat

1. Shri P.C. Koul - Additional Secretary
2. Dr. Ram Raj Rai - Director

2. At the outset, the Chairperson welcomed the Members of the Committee and the representatives of the Ministries of External Affairs, Health and Family Welfare, Civil Aviation and Science and Technology (Department of Biotechnology) to the Sitting of the Committee convened to take oral evidence on the subject „COVID-19 Pandemic-Global Response, India‟s Contribution and the Way Forward‟. Having underscored the issues to be discussed, the Chairperson drew the attention of the witnesses to the provisions of Direction 55(1) and Direction 58 of Directions by the Speaker, Lok Sabha regarding confidentiality of the proceedings. After a brief introduction of witness from the Ministry of External Affairs, the Chairperson asked the Secretary, Ministry of Health and Family Welfare to brief the Committee.

3. Thereafter, the witness briefed the Committee about the latest updates in the COVID management as well as vaccination in the backdrop of second wave of covid infections. Subsequently, witness from the Ministries of Civil Aviation and Science and Technology (Department of Biotechnology) also briefed the Committee on respective issues.

4. The Members of the Committee then raised a range of queries on issues which inter-alia included, availability of medical infrastructure and equipment, capacity augmentation, upgradation regarding dedicated Covid hospitals, isolation beds and ICU beds during the second wave, vaccine development and rearch findings on emerging strains of corona virus, returning of stranded Indian nationals abroad and livelihood opportunities to them, international cooperation and international practices in tackling the Covid-19 pandemic, production, availability of vaccines and vaccination of population, approval of WHO vaccines being manufacture in India and other countries, ‚global stands on travel, submission of Covaxin to WHO, issuance of Green Pass‟ in European countries, availability of oxygen, preparedness for third wave, study on effectiveness of wearing/not wearing mask, travelling of people to gulf countries via other countries etc. The witnesses responded to the queries of the Members.

5. Before the Sitting concluded, the Chairperson directed the witnesses to furnish the written replies to the points by the Members of the Committee to the Secretariat on priority to ensure completion of Report on the subject.

*The Committee then adjourned*

**Annexure-VI**

**MINUTES OF SECOND SITTING OF THE COMMITTEE ON EXTERNAL AFFAIRS (2021-22) HELD ON 08 DECEMBER, 2021**

The Committee sat from 1600 hrs. to 1730 hrs. in Committee Room „D', Parliament House Annexe, New Delhi.

**Present**

**Shri P.P. Chaudhary – Chairperson**

**Members**

**Lok Sabha**

2. Smt. Harsimrat Kaur Badal
3. Shri Dileshwar Kamait
4. Smt. Preneet Kaur
5. Smt. Goddeti Madhavi
6. Smt. Poonam Mahajan
7. Dr. K.C. Patel
8. Shri N.K. Premchandran
9. Smt. Navneet Ravi Rana
10. Dr. Harshvardhan

**Rajya Sabha**

11. Shri K. J. Alphons
12. Smt. Jaya Bachchan
13. Shri Brijlal
14. Shri Swapan Dasgupta
15. Shri Prakash Javadekar

**MINISTRY OF EXTERNAL AFFAIRS**

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Dammu Ravi | Secretary(ER), Leader of Delegation |
| 2. | Shri Vinay Kumar | Additional Secretary (IO & Summits) |
| 3. | Shri Anil Kumar Rai | Joint Secretary (Parl & Coord) |

**MINISTRY OF HEALTH & FAMILY WELFARE**

| S. No. | Name | Designation |
|---|---|---|
| 1. | Shri Rajesh Bhushan | Secretary |

**Secretariat**

1. Dr. Ram Raj Rai - Joint Secretary
2. K. Muanniang Tunglut - Deputy Secretary

2. At the outset, the Chairperson welcomed the Members of the Committee and the representatives of the Ministries of External Affairs and Health and Family Welfare to the Sitting of the Committee convened to take oral evidence on the aspect of „The current global/domestic status of Covid-19 Pandemic and impact of control measures including vaccination" in connection with examination of the subject „COVID-19 Pandemic-Global Response, India"s Contribution and the Way Forward". Having underscored the issues to be discussed, the Chairperson drew the attention of the witnesses to the provisions of Direction 55(1) and Direction 58 of Directions by the Speaker, Lok Sabha regarding confidentiality of the proceedings.

3. Thereafter, Secretary, M/o Health and Family Welfare briefed the Committee about the latest global and Indian picture of the Pandemic.

4. The Members of the Committee then raised a range of queries on issues which inter-alia included active covid-19 cases of new and old variants in India and abroad; impact of omicron variant; guidelines/protocol of international flights coming from „at risk" countries, testing of samples of passengers including children; genome sequencing of samples of people from „at risk" countries; anti-bodies developed due to vaccines; research on memory cell; supply of vaccines to neighbouring countries; pending orders of vaccines; opening up of international travel; vaccine diplomacy with neighbouring countries; surveillance for omicron variant, consideration of booster dose; universal recognition of Covaxin and approval of vaccine for children; etc. The witnesses responded to the queries of the Members.

5. Before the Sitting concluded, the Chairperson directed the witnesses to furnish the written replies to the points raised by the Members of the Committee to the Secretariat on priority to ensure expeditions completion of Report on the subject.

*The Committee then adjourned*

**Annexure-VII**

**MINUTES OF THE SEVENTH SITTING OF THE COMMITTEE ON EXTERNAL AFFAIRS (2021-22) HELD ON 21 MARCH, 2022**

The Committee sat on Monday, 21 March, 2022 from 1500 hrs. to 1540 hrs. in Committee Room D, Parliament House Annexe, New Delhi.

**1. Shri P.P. Chaudhary, Chairperson**

**Lok Sabha**

2. Shri Dileshwar Kamait
3. Smt. Preneet Kaur
4. Smt. Goddeti Madhavi
5. Smt. Poonam Mahajan
6. Shri P. C. Mohan
7. Shri Ritesh Pandey
8. Shri N.K. Premachandran
9. Smt. Navneet Ravi Rana
10. Dr. Harsh Vardhan
11. Shri E.T. Mohammed Basheer

**Rajya Sabha**

12. Shri K. J. Alphons
13. Smt. Jaya Bachchan
14. Shri Brijlal
15. Shri Prakash Javadekar
16. Shri K. Somaprasad

**Secretariat**

| | | | |
|---|---|---|---|
| 1. | Dr. Ram Raj Rai | - | Joint Secretary |
| 2. | Smt Maya Lingi | - | Director |
| 3. | K. Muanniang Tunglut | - | Deputy Secretary |

2. At the outset, the Chairperson welcomed the members to the Sitting of the Committee.

3. The Committee took up for consideration the following two draft Reports:-

(i) XXXX XXXX XXXXX XXXX

(ii) Draft Report on the subject „COVID-19 Pandemic-Global Response, India‟s Contribution and the way forward.‟

4. The Chairperson invited the Members to offer their suggestions, if any, for incorporation in the draft Reports. The Members suggested some minor modifications. After deliberations the Committee adopted the two draft Reports with minor modifications.

5. The Committee then authorized the Chairperson to finalize the Reports incorporating the suggestions made by the members and present the same to Parliament.

*The Committee then adjourned.*