FATIMA COLLEGE (AUTONOMOUS)

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Mary Land, Madurai – 625018, Tamil Nadu

Project
On

Awareness and Challenges Posed by Covid-19 in UBA Villages Adopted by Fatima College in Madurai District

Submitted
By

Reach Out to Society through Action
(ROSA)
Fatima College (Autonomous)
Madurai 625018
TamilNadu

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To

MHRD

Contents

INTIDUCTION **2**

CHAPTER I **7**

Parallel Study on Spanish Flu (1918) and its Impact

CHAPTER II **23**

Role of Fatima College in Creating Awareness on Covid-19 among UBA Villagers through Outreach Programs

CHAPTER III **31**

Analysis and findings

CHAPTER IV **57**

Summary and Conclusion
Suggestion and Recommendation

CHAPTER V **59**

Social Relevance of the Study

Appendix. **60**

REFERENCES **67**

INTRODUCTION

As we are all aware, Government of India is taking various measures to fight the COVID-19 pandemic and is leaving no stone unturned to ensure constant, consistent and credible communication to provide necessary public health guidance to all citizens. The current focus is to fight against the pandemic to contain the increasing number of cases and to avoid further escalation of the situation.

As we fight this pandemic, we require greater cooperation, adaptability and understanding to meet the new scenario. Importantly, there is a pressing need to sensitively analyze the impact of pandemic as well the role played by communities in agrarian part of the country. As per UGC guidelines, Fatima College is facilitating the study of 5 villages adopted by the institution. The study would focus on the awareness levels in the villages regarding COVID-19, various challenges posed by COVID-19 disrupting the normalcy of the livelihood and socio-economic life of the villagers and the best strategies or measures adopted by the village to combat the challenges posed by COVID-19.

Fatima College has identified and adopted five villages of Madurai district (Vadugapatti, Ambalathadi, Thirumalnatham, Nedukulam,_Kondaiyaanpatti) implementing the vision of Unnat Bharat Abhiyan. The Mission of Unnat Bharat Abhiyan is to enable higher educational institutions to work with the people of rural India in identifying development challenges and evolving appropriate solutions for accelerating sustainable growth. It also aims to create a virtuous cycle between society and an inclusive academic system by providing knowledge and practices for emerging professions and to upgrade the capabilities of both the public and the private sectors in responding to the development needs of rural India.

Human history is undergoing a very strange stage fighting an invisible enemy, the novel COVID-19 corona virus which is an infectious disease caused by a new virus. The disease causes respiratory illness (like the Flu), with symptoms such as cough, fever, dry throat, tiredness and in severe cases, difficulty in breathing, shortness of breath and loss of speech and movement. Older people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness.

The outbreak of corona virus disease (COVID-19) got reported first on December 31st 2019 from Wuhan, China. Covid-19 has been declared as a pandemic by WHO due to the alarming levels of spread and currently there is no effective medicine or treatment to combat or prevent Covid-19.

To address this outbreak, it requires immediate action to provide preventive measures and active solutions including diagnostics, medical devices, sanitizers, disinfectants, masks, ventilators, goggles other medical equipments. IT (Information Technology) based solutions for tracking, awareness, mental health will provide opportunity to hand holding by means of incubation, technical support, IP support connect to Industry Professional.

To support the preparedness, readiness and responses for COVID-19, project proposals are invited for developing and face challenges and giving awareness mental health or any other intervention for prevention and control of COVID 19 by individuals and villages belonging to all age groups in Madurai District.

1.1 Statement of Problem:

COVID-19 is not SARS and it is not Influenza. It is a new type of virus with its own specifications and characteristics. The COVID 19 virus is unique among human corona viruses which have greater capacity of high transmissibility, substantial fatal deaths in some high- risk groups and the ability to cause huge societal and economic disruption to Nations in the world.

The present study will identify and focus on a new virus (SARS-CoV-2) which has spread panic globally and consumed the lives of many people in a short span of time. The people are ignorant about the sources of infection, risk factors of infection, disease progression and effectiveness of prevention and control measures. Timely knowledge, individual awareness and to control with strategies adopted by policy makers.

1.2 Objectives Defined:

- To study the Parallel study on Spanish Flu (1918) and its impact.
- To identify the Demographic profile of the UBA villages in and around Madurai district.
- To analyze the awareness levels in the villages regarding COVID 19.
- To study the challenges faced by villagers due to COVID-19.

- To analyze the preventive measures followed by the people in the villages taken for study.

1.3 Review of Literature:

Mankind has witnessed various pandemic throughout history where some were more disastrous than the others to the human race. Human beings are undergoing a hard phase and a tough time fighting an invisible enemy, the novel COVID-19 corona virus. Initially, observed in the Wuhan provinces of China, it now spreads quickly and ubiquitous in the world.

Various journals have published free issues about corona virus. Here in this short review, we will discuss the E-Journals and Articles about corona virus that can be accessed free of cost.

As of today, 20th March 2020 there are 270069 corona cases with 11271 deaths while 90603 have recovered. The death toll is followed by China (3248), Iran (1433) and Spain (1044).

(http://www.worldometres.info/coronavirus)

(http://pages.semanticsscholar.org/coronavirus-research) In response to the COVID-19 pandemic, the data is intended to mobilize researchers to apply recent advances in natural language processing to generate new insights to support the fight against the infectious disease.

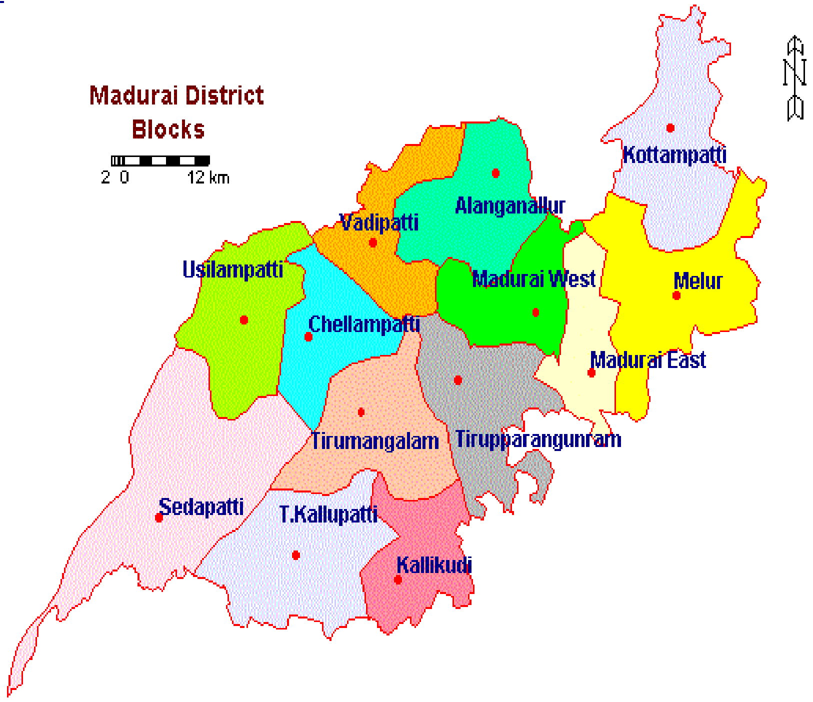
WHO (World Health Organization) is gathering the latest scientific findings and knowledge on corona virus disease (COVID-19) and compiling it in a database and relevant journals**. (http://www.who.int/emergencies/diseases/novel-coronavirus-2019/global-research-on-novel-coronavirus-2019-ncov.)**

JAMA network is providing information on the corona virus disease 2019 (COVID-19) Updates on treatments (**http://jamanetwork.com/journals/jama/pages/coronavirus-alert)**. There are various video tutorials on the page. This page is highly informative about COVID-19. For instance, Epidemiology, Public Health preparedness, Patient information and WHO Guidance.

1.4 Research Methodology:

Analytical and Descriptive, case study research design will be used to assess the awareness, challenges and protection of disease regarding COVID-19 villages belonging all age groups.

1.5 Area of the study:


Madurai District
Blocks
2 0 12 km
N
Kottampatti
Alanganallur
Vadipatti
Usilampatti
Madurai West
Melur
Chellampatti
Madurai East
Tirumangalam
Tirupparangunram
Sedapatti
T.Kallupatti
Kallikudi

The selected area will be five villages of Madurai District. (Vadugapatti, Ambalathadi, Thirumalnatham, Nedukulam,_Kondaiyaanpatti). The prominent reason for the selection of the villages is that a pilot study has been done on these villages on 2018-2019 by the extension program staff and students of Fatima College, Madurai and it is also feasible for researchers to reach the villages to conduct survey.

1.6 Sample Technique:

Samples have been drawn from five UBA villages. 100 respondents have been selected from UBA villages namely Vadugapatti, Ambalathadi, Thirumalnatham, Nedukulam,_Kondaiyaanpatti. Each 20 respondents have been selected from each village based on disproportionate stratified random sampling method. Respondents have been selected between below 18 years and above 60 years.

1.7 Data Collection:

Primary data and secondary data have been collected from different sources. Secondary data collected from journals, newspapers, books, magazines and etc. Questionnaire has been applied to collect primary data for the present study. Data have been collected from June 14th 2020 to June 30th 2020

1.8 Data Analysis:

Once the data is collected, the collected data have been interpreted and analyzed by make use of SPSS package and presented in chart.

1.9 Limitations of Study:

The research is confined within the selected village Panchayat of Madurai District. The study is only based on all the age groups. Due to time constraint and financial constraints the research is confined only to the selected villages of study.

CHAPTER I

Parallel study on impact of 1918 (H1N1 virus) in India

“India handled the 1918 Pandemic”

“India took to boost the Indian Economy after the Pandemic”

History of Spanish Flu (1918)

1918 – “Spanish” flu –The mother of all influenza pandemics

History repeats itself. It's an old cliché that we hear often. The Covid-19 pandemic has brought back conversations around past pandemics. Spanish Flu and Covid-19 have uncanny similarities in the lesson the two pandemics offer to human kind.

In 1918-1919 ‘Spanish influenza” was the most devastating pandemic in recent history, with estimates of global mortality ranging from 20 to 50 million. The focal point of the pandemic was India, with an estimate death toll of between 10 to 20 million. We will characterize the pattern of evolution, spread and mortality of the 1918 influenza across India. This study estimates deaths in 213 districts from nine Provinces in India. We compute statistical measures of the severity, spread and duration of the virulent autumn wave of the disease as it create a clear picture of the spread of pandemic across India.

Causes:

The main three types of influenza virus that cause illness in people are named A, B, and C. Influenza A and B viruses cause seasonal epidemics of disease almost every winter in the United States, while influenza C causes only mild respiratory symptoms and is not thought to cause epidemics. The influenza A virus is broken down into subtypes and both A and B are broken down into strains for classification. Also, avian influenza (bird flu, H5N1) is a flu virus that typically only affects birds. It is very rare for a human to contract it and only around 700 cases of this bird flu in humans have been reported from 15 countries since 2003, it is most often contracted directly from birds and is usually not spread from human to human like most types of influenza.

Another type of rare bird flu, called H7N9, first appeared in people in China in 2013. Since then, the virus has caused several hundred human infections per year in China, but there was spike in cases from 2016 to 2017, when 766 human cases in China were reported. The H7N9 virus also does not appear to spread easily between people.

In contrast to bird flues, influenza A and B viruses are very contagious, and can spread from person to person by droplets from the cough or sneeze of an infected person. In 2018, researchers also confirmed that the virus can spread just by breathing, through small particles called aerosols. Other research has found that such infectious particles can travel up to six feet after they are exhaled by a sick person.

SYMPTOMS OF THE FLU

- headache
- aching muscles, especially in your back, arms and legs
- fever
- chills and sweats
- sore throat
- dry, persistent cough
- weakness
- nasal congestion

In children, emergency symptoms include:

- Fast breathing or trouble breathing
- Bluish skin color
- Not drinking enough fluids
- Not waking up or not interacting
- Being so irritable that the child does not want to be held
- Flu-like symptoms that improve, but then return with a fever and worse cough
- Fever with a rash

Risk condition

Young children, people over age 65, pregnant women and people with certain medical conditions, such as asthma, diabetes or heart disease, face a higher risk of flu-related complications, including pneumonia, ear and sinus infections and bronchitis. A flu pandemic, such as the one in 1918, occurs when an especially virulent new influenza strain for which there’s little or no immunity appears and spreads quickly from person to person around the globe.

Prevention

Though washing your hands regularly and practicing good hygiene are good tactics for preventing the flu, the best course of action is to receive the flu vaccine every year. Each year, researchers determine what strain of the influenza virus will be most active and vaccines are produced to prevent infection.

The CDC (Centers For Disease Control and Prevention) recommends a yearly flu vaccine for everyone 6 months and older. "For the seasonal flu, those who are younger, those who are older, and those who are immune compromised are more likely to contract influenza; and if someone in that group is unable to get vaccinated, it is important for those who have close interaction with them or care for them to get vaccinated to reduce their exposure."

Fight against flu

The 1918 flu was first observed in Europe, the United States and parts of Asia before swiftly spreading around the world. At the time, there were no effective drugs or vaccines to treat this killer flu strain. Citizens were ordered to wear masks, schools, theaters and businesses were shuttered and bodies piled up in makeshift morgues before the virus ended its deadly global march.

Additionally, hospitals in some areas were so overloaded with flu patients that schools, private homes and other buildings had to be converted into makeshift hospitals, some of which were staffed by medical students. Officials in some communities imposed quarantines, ordered citizens to wear masks and shut down public places, including schools, churches and theaters. People were advised to avoid shaking hands and to stay indoors, libraries put a halt on lending books and regulations were passed banning spitting.

Treatment

Most people infected with influenza recover within one to two weeks without requiring medical treatment, according to the WHO. "It is very important for anyone diagnosed with influenza to take care of themselves, giving themselves enough time, enough fluids and enough rest to fully recover," said Dr. Susan Donelan, medical director of health care epidemiology at Stony Brook University in New York. Over-the-counter painkillers such as ibuprofen (Advil, Motrin) and aspirin may help reduce fevers and relieve aches and pains during the flu. Decongestant drops and cough syrups may also help ease symptoms, but always contact a medical professional before administering over-the-counter remedies to children.

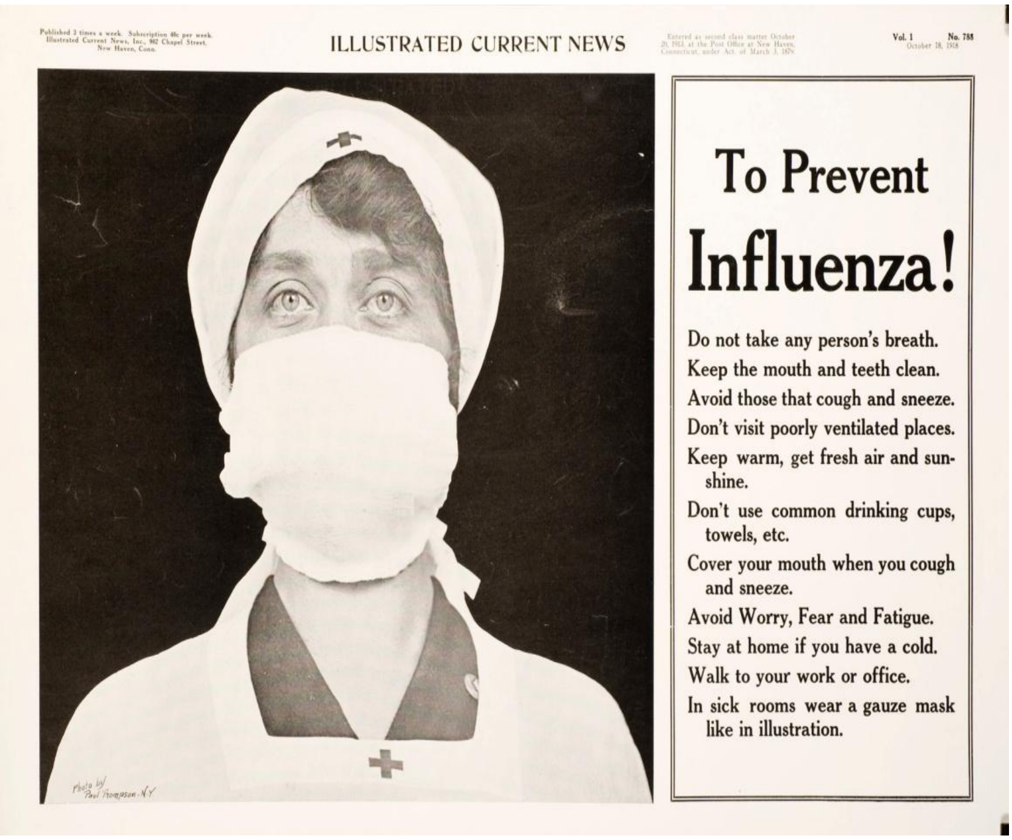
From Kansas to Mumbai

Although it is commonly called the Spanish flu, the 1918 pandemic likely began in Kansas and killed between 50 and 100 million people worldwide.

During the early months of 1918, the virus incubated throughout the American midwest, eventually making its way east, where it traveled across the Atlantic Ocean with soldiers deploying for WWI (World War I).

Soldiers from Fort Riley, Kansas, ill with Spanish flu at a hospital ward at Camp Funston

Nurses wearing mask during Spanish Flu pandemic



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20, 1913, at the Post Office at New Haven,
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Vol. 1 No. 788
October 18, 1918

Photo by
Paul Thompson N.Y.

To Prevent

Influenza!

Do not take any person's breath.
Keep the mouth and teeth clean.
Avoid those that cough and sneeze.
Don't visit poorly ventilated places.
Keep warm, get fresh air and sunshine.
Don't use common drinking cups, towels, etc.
Cover your mouth when you cough and sneeze.
Avoid Worry, Fear and Fatigue.
Stay at home if you have a cold.
Walk to your work or office.
In sick rooms wear a gauze mask like in illustration.

1918 Flu pandemic in India:

1918 flu pandemic in India was the outbreak of an unusually deadly influenza pandemic in India between 1918-1920 as a part of the worldwide Spanish flu pandemic. Also referred to as the *Bombay Influenza* or the *Bombay Fever* in India. The pandemic is believed to have killed up to 14 -17 million people in the country, the most among all countries. David Arnold (2019) estimates at least 12 million dead, about 5% of the population. The decade between 1911 and 1921 was the only census period in which India’s population fell, mostly due to devastation of the Spanish flu pandemic. The death toll in India's British-ruled districts was 13.88 million.

In India, the pandemic broke out in Bombay in June 1918, with one of the possible routes being via ships carrying troops returning from the First World War in Europe. The outbreak then spread across the country from west and south to east and north reaching the whole of the country by August. It hit different parts of the country in three waves with the second wave being the highest in mortality rate. The death rate peaked in the last week of September 1918 in Bombay, in the middle of October in Madras and in the middle of November in Calcutta.

The outbreak most severely affected younger people in the age group of 20 - 40, with women suffering disproportionately according to the Sanitary Commissioner's report for 1918, the maximum death toll in a week exceeded 200 deaths in both Bombay and Madras. The spread of the disease was exacerbated by a failed monsoon and the resultant famine-like conditions, that had left people underfed and weak and forced them to move into densely populated cities. As a result of the severity of the outbreak, the year 1919 saw a reduction of births by around 30 percent. The population growth of India during the decade from 1911-1921 was 1.2%, the lowest among all decades under the British Raj. In his memoirs the Hindi poet, Suryakant Tripathi, wrote "Ganga was swollen with dead bodies." The sanitary commissioner's report for 1918 also noted that all rivers across India were clogged up with bodies, because of a shortage of firewood for cremation. The highly infectious anis flu had swept through the ashram in Gujarat where 48-year-old Gandhi was living, four years after he had returned from South Africa. He rested, stuck to a liquid diet during "this protracted and first long illness" of his life. When news of his illness spread, a local newspaper wrote: "Gandhi's life does not belong to him - it belongs to India."

Outside, the deadly flu, which slunk in through a ship of returning soldiers that docked in Bombay (now Mumbai) in June 1918, ravaged India. The disease, according to health inspector JS Turner, came "like a thief in the night, its onset rapid and insidious." A second wave of the epidemic began in September in southern India and spread along the coastline.

Mahatma Gandhi, the leader of India's independence struggle, was also infected by the virus. The pandemic had a significant influence in the freedom movement in the country. The healthcare system in the country was unable to meet the sudden increase in demands for medical attention. The consequent toll of death and misery and economic fallout brought about by the pandemic led to an increase in emotion against colonial rule.

The 1918 pandemic and its impact

Contrary to its name, the ‘Spanish’ flu that swept the globe in 1918 seems to have originated in the United States. Some of the earliest recorded cases of the virus were among army recruits in Kansas in the US, in March 1918. The virus seems to have then spread eastward across Europe and then to the rest of the world from Northern France in April 1918, reaching India and China in June. Given that the pandemic swept the world during the First World War, troop movements, amply aided by transportation, via railways and steamships acted as an important conduit for its transmission.

The pandemic itself struck in two waves, broadly. The first was a mild wave that lasted until July, while the second, more virulent, wave began in late August and continued into 1919. The second wave of the disease was one of the most lethal pandemics to have swept the world, accounting for a global death tally running into tens of millions of people.

Complications to the respiratory tract and lungs were considered to be the key reason for a number of such deaths. British India (including modern day Pakistan, Bangladesh and Myanmar) was the region that saw the most number of causalities due to the pandemic, with the estimated number of deaths between 12.5 and 20 million people (close to half of all deaths due to the pandemic). British India was followed by China which was witness to between four to nine and a half million deaths and Sub-Saharan Africa, which saw between

1.7 and two million deaths. In this sense, the 1918 influenza pandemic affected the poorer countries and regions more severely than the richer ones.

“India took to boost the Indian Economy after the Pandemic”

Even within countries, it was the poor and the deprived that bore the brunt of the disease, as examples from British India will amply indicate. In 1918, vast parts of India faced famine-like conditions following the failure of the south-west monsoon. Famine was officially declared in two Indian provinces- Central Provinces (includes parts of today’s Maharashtra, Chhattisgarh and Madhya Pradesh) and the United Provinces (today’s Uttar Pradesh) while the lack of rains also seriously affected areas in Bombay presidency. These famine-stricken regions were also the most severely affected by the disease.

For instance, the Central Provinces registered the highest mortality per 1000 people due to the disease at 67.6, followed by the Bombay Presidency at 54.3 and the United Provinces at 47.2. The corresponding rates for Madras Presidency (15.8) and Lower Burma (16.2) were in the range of the global average rate of between 13.6 and 21.7 per 1000 people.

The economic strain due to war-time inflation and commodity shortages further exacerbated these difficulties by making essential commodities such as food and kerosene dearer and thus beyond the reach of the vast majority of the population. Although not directly related to the disease, parts of Madras Presidency witnessed food riots in September 1918, indicating the extent of economic deprivation that was rife among the Indian population of that period. The mortality statistics of Bombay city in late 1918 provide more clinching evidence of the differential impact of the disease on the country’s poor and deprived sections. The category ‘low-caste Hindus’ – which refers to the socially oppressed sections in India – registered the highest case specific mortality rate per 1000 people in the city at 61.6; a number much higher than the average rate for the remaining categories of people, which stood at 14.35. The numbers certainly indicate who the most likely victims of an epidemic disease will be. Therefore, any relief effort during such epidemics should be specially geared towards increasing access of food and essential commodities to these sections if a catastrophe of the magnitude of the 1918 flu is to be avoided.

Although there did not seem to be any economically disruptive ‘lockdowns’ in 1918 like the ones we are currently witness to in 2020, the period had its fair share of serious economic dislocations, as workers and professionals were incapacitated by the disease. Unlike COVID-19, which is known to attack relatively older people more severely, the ‘Spanish’ flu in India severely affected people in the working age group who were between 20 and 40 years of age. From mines to textile manufacturing units and agricultural fields to the docks, workers belonging to most sectors of the Indian economy were directly affected by the disease. In Bombay presidency, the aforementioned monsoon failure and the reduction in workforce that this illness lead to meant a 19% reduction in the area under food crop cultivation, thus contributing further to food shortage in the country. The pandemic left deep scars on an already battered war-time Indian economy.

A more important factor was the difference in the structure of the economy. A century ago, less than half of all workers were employed in service industries; About 86% are manufacturing and agriculture were less vulnerable to the pandemic than retail and other businesses that depended on lots of customer traffic.

The impact of the war economy was a related factor. As some economists have pointed out, WWI was still exerting a tremendous influence on production in 1918. The government simply mandated that factories stay open to meet war needs. This made epidemic worse but reduced the blow to economic output. By the time the economy started shifting back toward peacetime industries, the flu was gone.

Responses to the pandemic

The colonial government’s response was directed along two lines – relief and research. However, on both these counts, its efforts proved inadequate to handle the severe onslaught of the virus. In 1918, India possessed a fragile medical system urgently in need of expansion, concentrated as it was, chiefly, in its cities. War-time deployment meant that even this system was further depleted of its personnel. Private medical practitioners were available but they were known to charge exorbitant fees, using the pandemic as an opportunity to make money, thereby making medical care even more expensive to the general populace. A large section of medical practitioners were themselves struck down by the disease and were incapacitated at a time when they were needed the most, highlighting the importance of providing adequate protection to the health workers at the forefront of treating contagious diseases.

In Bombay city, as the incidence of the disease began to peak, hospitals were overflowing with patients and crude versions of dispensaries were raised on the roadsides to provide medical relief in an effort that roughly parallels the construction of makeshift hospitals in many parts of the world following the recent outbreak. The colonial government met the virus outbreak with a sense of resignation and helplessness and found isolating a large number of patients affected by the virus 'impracticable'. Facing a paucity of health workers, the Bombay city's municipal corporation gave a call for volunteers to help, even with its medical relief efforts. It also opened up cheap grain shops and attempted to provide foodstuff such as milk for free to the patients.

The government's scientific research work was geared towards developing a vaccine to treat the disease. This effort did not create a big impact, given the then prevalent lack of clarity in the medical knowledge of that period on disease causation. There was a lack of consensus on what the specific germ that was responsible for this outbreak was. It was then widely believed, albeit with doubts, that the disease was caused by a bacteria, *bacillus influenza,* and it was not until 1933 that the virus that caused this pandemic was isolated.

Fortunately for India, the pandemic rapidly lost its virulence from December 1918, although, not after claiming millions of lives. One contemporary estimate of the morbidity of the disease put the figure at between 50% and 80% of the population of India. As the epidemic receded in Bombay city, its health officer showered his thanks on the city's private individuals and non-official organizations for their voluntary services in carrying out relief work in the city. This effort during the 1918 pandemic was an early precedent to the impressive relief efforts undertaken by a huge number of volunteers in different places in India following the recent COVID-19 lockdown.

It has been more than 100 years since the devastating Spanish influenza outbreak happened in India. While there are important differences between it and the pandemic we face now, some of its lessons certainly continue to ring true for contemporary India, as well as for other developing countries, that in the short term, the virus cannot be effectively fought without fighting hunger and deprivation, if large scale human suffering and devastation is to be avoided. While at the same time, this examination of the past also emphasizes the importance of providing adequate protection to health workers. This examination also shows that a broad-based and inclusive co-operation of the state with non-governmental outfits such as civil society groups, trade unions, peasant organizations and the like can certainly be used as important vehicles to direct and deliver short term relief. In the longer term however, prioritizing liberal expenditure on the country’s public health infrastructure to vastly increase its capacity to effectively respond to epidemics, would be a useful starting point. In this regard, it seems that even supposedly richer countries seem to have forgotten this very important but basic lesson from the ‘Spanish’ flu.

Change ahead

Death tolls across India generally hit their peak in October, with a slow tapering into November and December. A high ranking British official wrote in December, “A good winter rain will put everything right and … things will gradually rectify themselves.”

Normalcy, however, did not quite return to India. The spring of 1919 would see the British atrocities at Amritsar and shortly thereafter the launch of Gandhi’s Non-Cooperation Movement. Influenza became one more example of British injustice that spurred Indian people on in their fight for independence. A nationalist periodical stated, “In no other civilized country could a government have left things so much undone as did the Government of India did during the prevalence of such a terrible and catastrophic epidemic.”

The Ministry of Human Resource Development (MHRD) of the Indian government asked its universities and research institutes to ‘delve into their archives’ to study how British India handled the 1918 H1N1 pandemic-commonly referred to as the ‘Spanish’ Flu. The suggestion was based on a legitimate belief that the research will help support the broader effort of the Government in its fight against the recent COVID-19 pandemic.

Just like in the case of Covid-19, there was no known medicine available to treat Spanish Flu. The world of medical science was in a nascent stage back then. Developing a vaccine against Spanish Flu was out of question. The first flu vaccine came on the scene only in 1940. The first antibiotic medicine came in 1928, years after Spanish Flu had ravaged the human population.

It was lockdown, social distancing and masks that saved the world, particularly the developed one, back then. Health professionals in America and Europe wore face masks to reduce chances of contracting Spanish Flu while treating patients, who were coming in huge numbers every day.

Spanish Flu, combined with the World War - I (1914-19), saw a sudden change in sex ratio in the world's population. More men had died in these two catastrophes. This pushed women for the first time towards the job market in large numbers. The economies bloomed before the Great Depression happened in 1929. The flu took a heavy human toll, wiping out entire families and leaving countless widows and orphans in its wake. Funeral parlors were overwhelmed and bodies piled up. Many people had to dig graves for their own family members. People are talking about a similar reorientation of workforce, not necessarily on gender lines but some fresh bottom lines may be drawn.

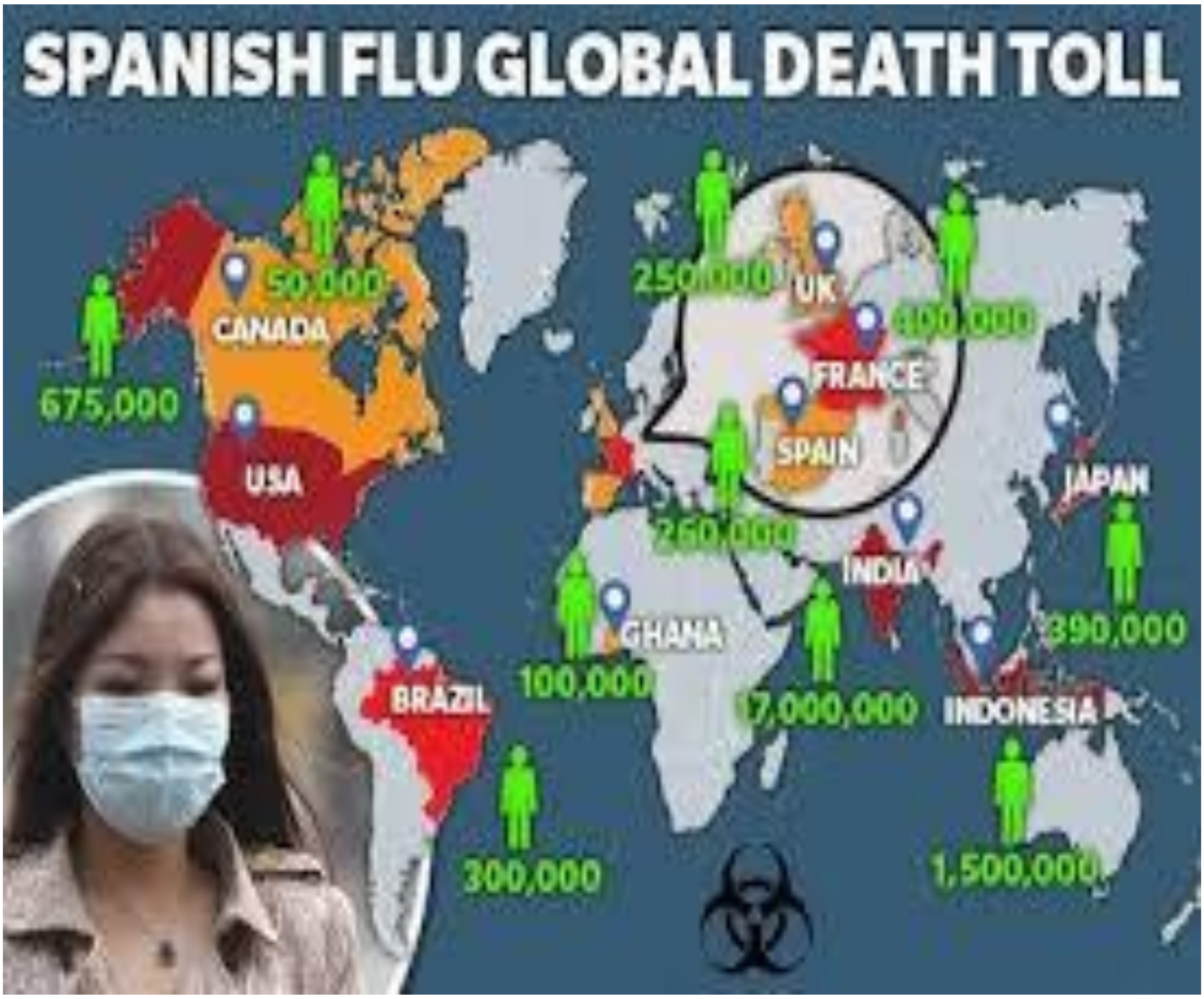
The flu was also detrimental to the economy. The businesses were forced to shut down because so many employees were sick. Basic services such as mail delivery and garbage collection were hindered due to flu-stricken workers.

In some places there weren't enough farm workers to harvest crops. Even state and local health departments closed for business, hampering efforts to chronicle the spread of the 1918 flu and provide the public with answers about it. Spanish Flu, interestingly, strengthened the idea of a welfare state under constitutional framework. At the global level, the League of Nations (a precursor to the United Nations) founded the Health Organization in 1923 which became the World Health Organization (WHO) in 1948. By the summer of 1919, the flu pandemic came to an end, as those that were infected either died or developed immunity.

Almost 90 years later, in 2008, researchers announced they'd discovered what made the 1918 flu so deadly: A group of three genes enabled the virus to weaken a victim's bronchial tubes and lungs and clear the way for bacterial pneumonia.

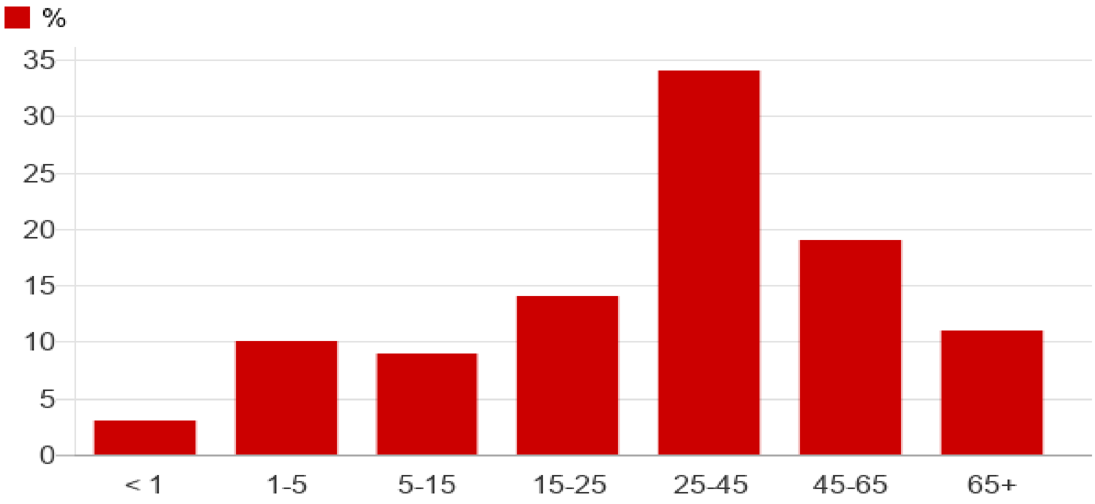
Spanish Flu of 1918 Compared to COVID-19

Although the world has faced several major pandemics over the last 100 years, one of the worst was the 1918 influenza pandemic, the so-called Spanish flu. It was caused by an H1N1 virus that originated in birds. It was first identified in the U.S. in military personnel in the spring of 1918. It was dubbed the Spanish flu because it was thought at the time to have originated in Spain. Research published in 2005 suggests it actually originated in New York. It was named Spanish flu because Spain was neutral in World War I (1914-1918), meaning it could report on the severity of the pandemic, but countries fighting the war were suppressing reports on how the disease affected their populations.

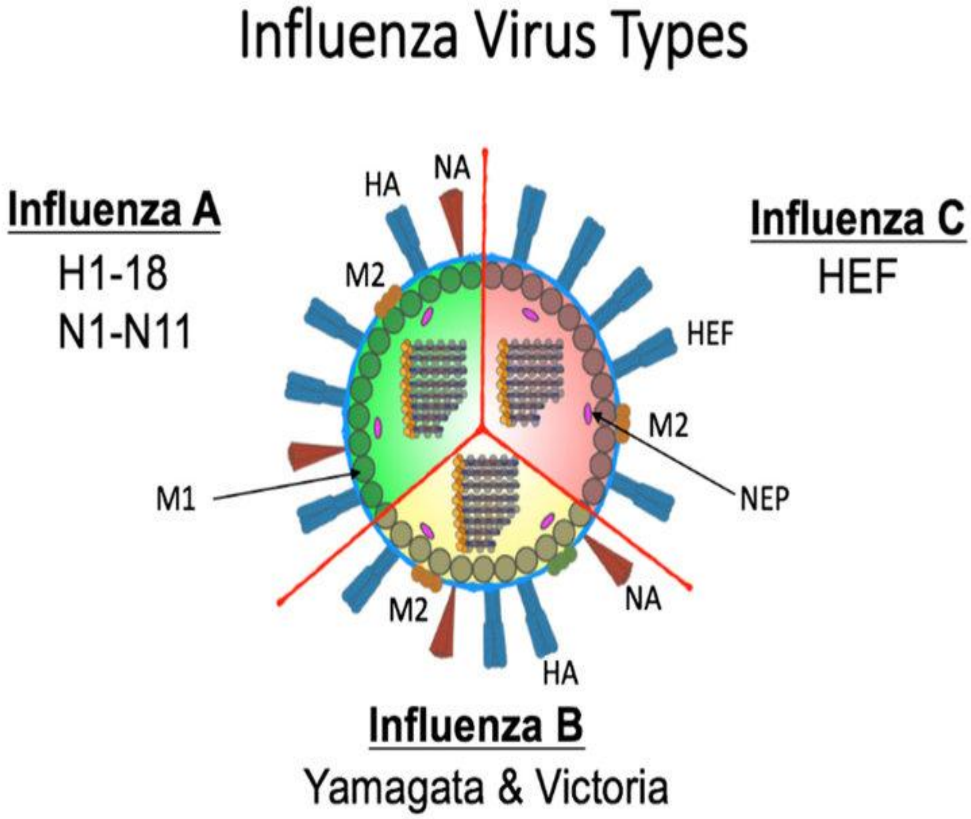

SPANISH FLU GLOBAL DEATH TOLL
675,000
CANADA
50,000
USA
250,000
UK
400,000
FRANCE
SPAIN
JAPAN
260,000
INDIA
GHANA
100,000
390,000
BRAZIL
7,000,000
INDONESIA
300,000
1,500,000

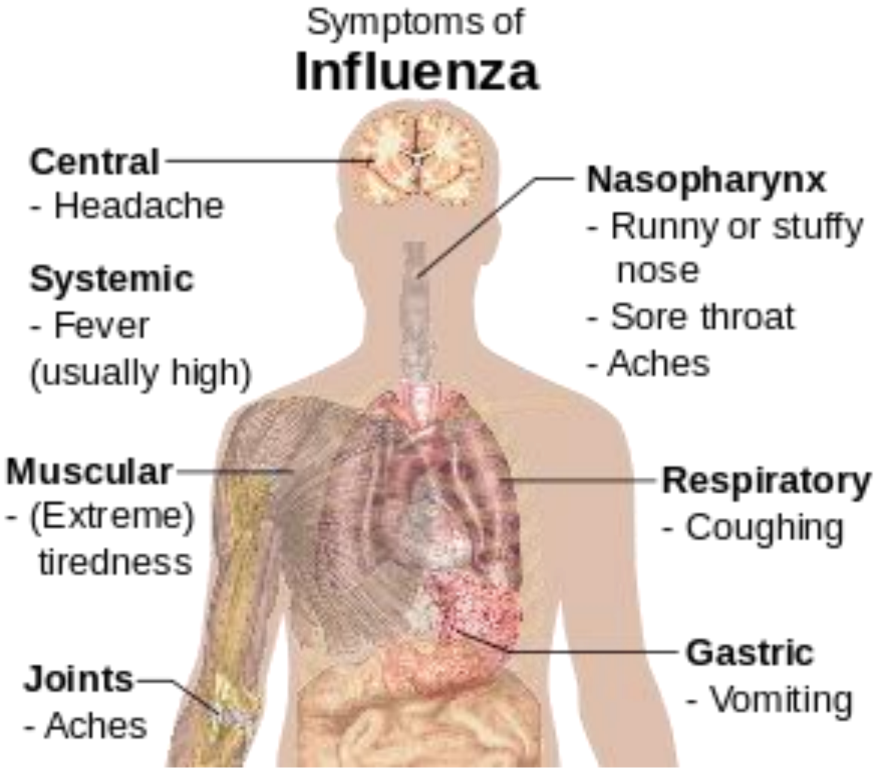
Ages of people dying of influenza in 1918 and 1919

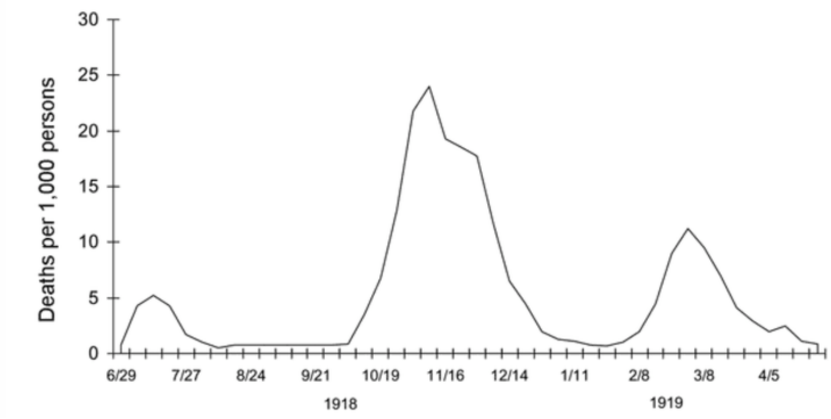
Sample of 14,120 deaths recorded in local health reports

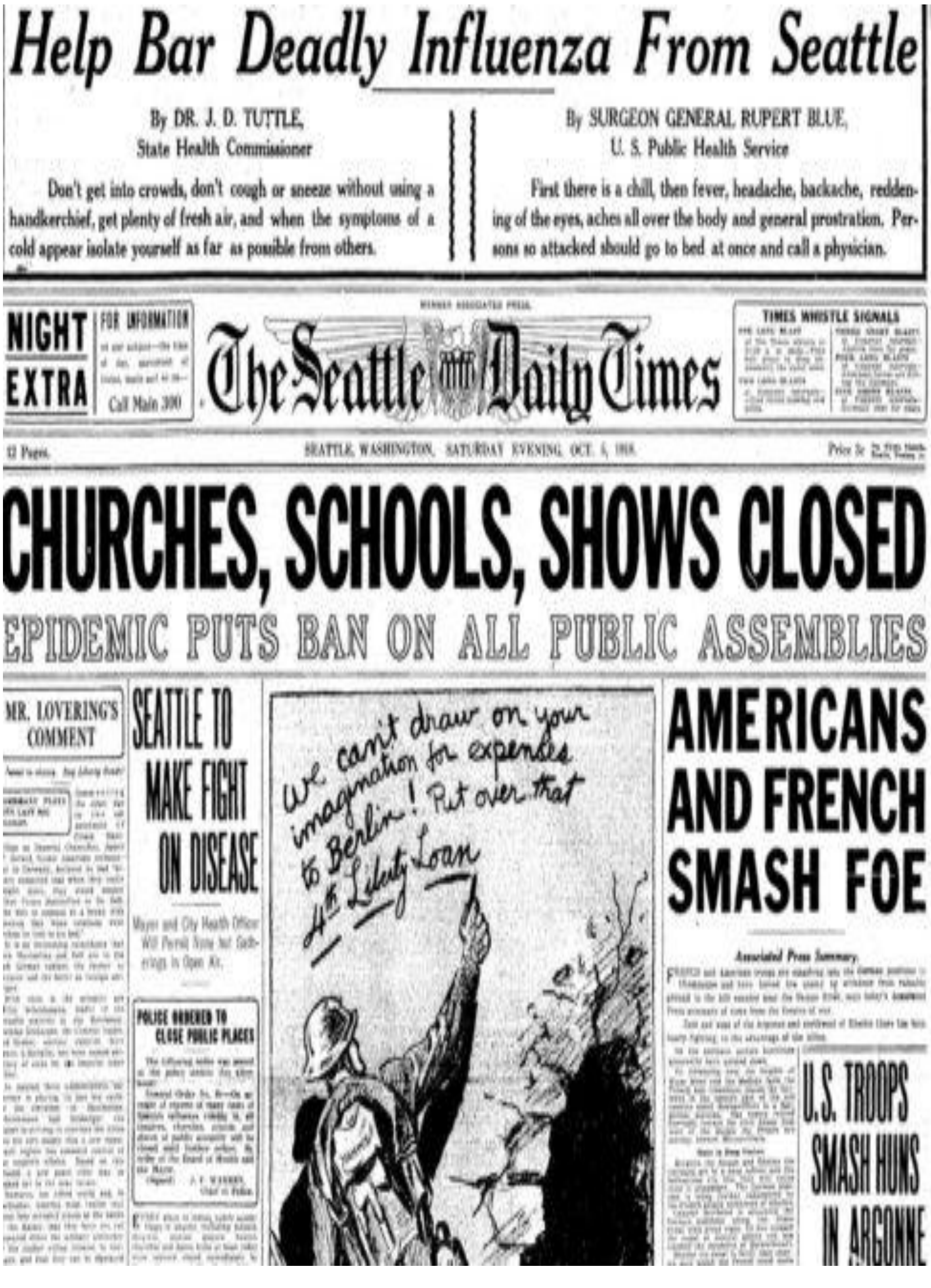


Source: Wellcome Library


Influenza Virus Types
Influenza A
H1-18
N1-N11
Influenza C
HEF
Influenza B
Yamagata & Victoria
HA
NA
M2
HEF
M2
NEP
M1
M2
NA
HA


Symptoms of
Influenza
Central
- Headache
Systemic
- Fever
(usually high)
Muscular
- (Extreme)
tiredness
Joints
- Aches
Nasopharynx
- Runny or stuffy
nose
- Sore throat
- Aches
Respiratory
- Coughing
Gastric
- Vomiting





Help Bar Deadly Influenza From Seattle

By DR. J. D. TUTTLE,
State Health Commissioner

Don't get into crowds, don't cough or sneeze without using a handkerchief, get plenty of fresh air, and when the symptoms of a cold appear isolate yourself as far as possible from others.

By SURGEON GENERAL RUPERT BLUE,
U. S. Public Health Service

First there is a chill, then fever, headache, backache, reddening of the eyes, aches all over the body and general prostration. Persons so attacked should go to bed at once and call a physician.

NIGHT EXTRA

FOR INFORMATION

Call Main 300

The Seattle Daily Times

TIMES WHISTLE SIGNALS

12 Pages. SEATTLE, WASHINGTON, SATURDAY EVENING, OCT. 5, 1918. Price 5c

CHURCHES, SCHOOLS, SHOWS CLOSED

EPIDEMIC PUTS BAN ON ALL PUBLIC ASSEMBLIES

MR. LOVERING'S COMMENT

SEATTLE TO MAKE FIGHT ON DISEASE

Mayor and City Health Officer Will Permit None but Gatherings In Open Air.

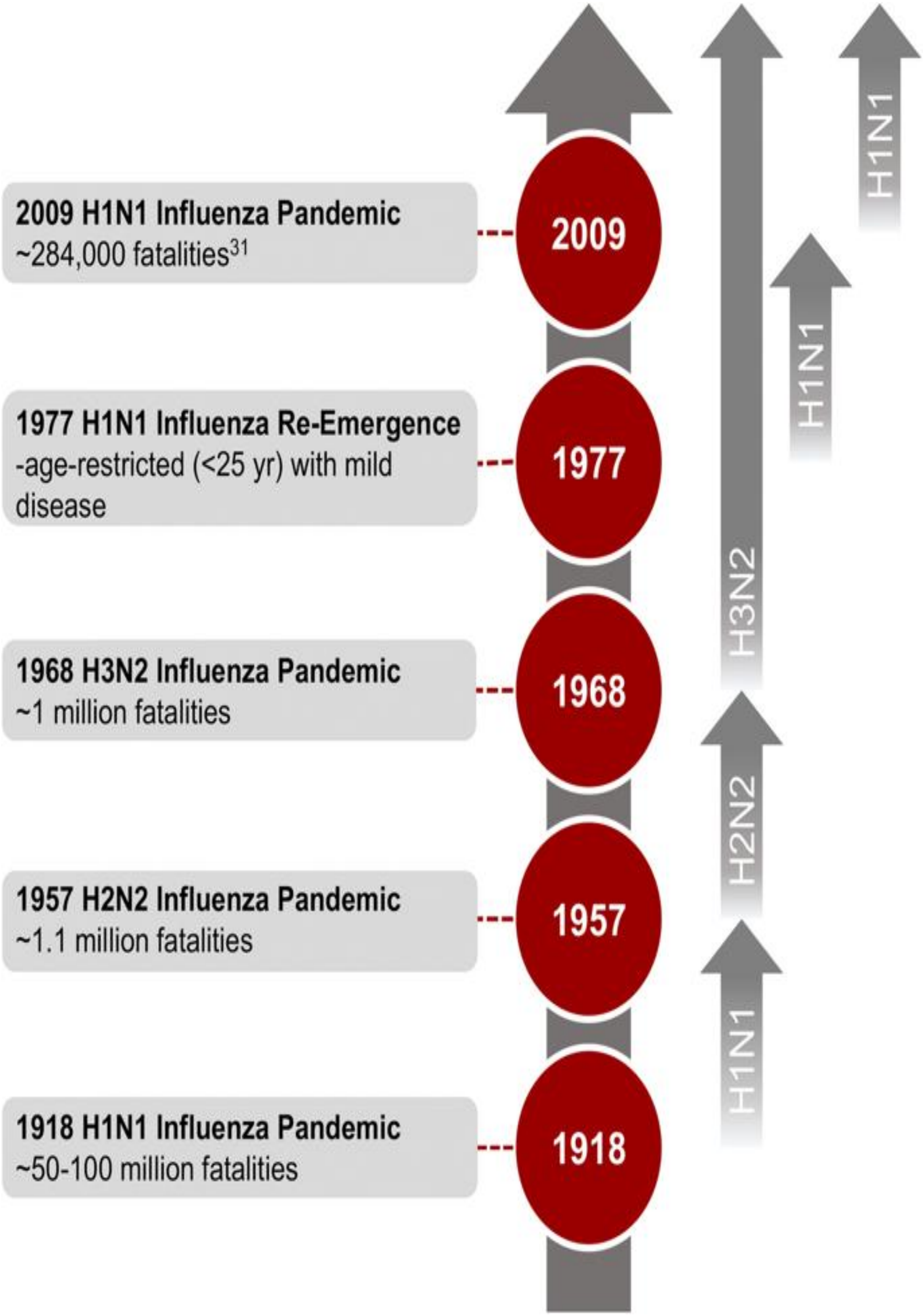
POLICE ORDERED TO CLOSE PUBLIC PLACES

We can't draw on your imagination for expenses to Berlin! Put over that 4th Liberty Loan

AMERICANS AND FRENCH SMASH FOE

Associated Press Summary.

U.S. TROOPS SMASH HUNS IN ARGONNE



2009 H1N1 Influenza Pandemic
~284,000 fatalities[31]

1977 H1N1 Influenza Re-Emergence
-age-restricted (<25 yr) with mild disease

1968 H3N2 Influenza Pandemic
~1 million fatalities

1957 H2N2 Influenza Pandemic
~1.1 million fatalities

1918 H1N1 Influenza Pandemic
~50-100 million fatalities

2009
1977
1968
1957
1918
H1N1
H1N1
H3N2
H2N2
H1N1

CHAPTER II

Role of Fatima College in creating awareness on Covid-19 among UBA Villagers through Outreach Programs

Socio-Demographic Profile of UBA Villages in Madurai District

Unnat Bharat Abiyan 2.0

Unnat Bharat Abiyan is a flagship program of the Ministry of Human Resource Development with the intention to enrich Rural India. We are happy that Fatima College is one of the Participating Institution selected in a challenge mode based on our past contribution to societal development. Indeed we are happy to become a Participating Institution under UBA- 2.0.

As per requirement, our institution has identified 5 villages namely, Thirumal Natham, Nedungulam, Vadugapatti, Ambalathadi and Kondayampatti in consultation with the District Collector and have built good rapport with people. So far we have conducted Participatory Rural Appraisal and formed stake holders committee in each villages. Village survey and house hold survey has been carried out. The students have actively participated in identifying natural and human resources available in each village with the view to match those resources with the actual needs of the local people. Summer intern programme was organized in Kondaympatti village and addressed to the education, health and environmental issues of the village. The faculty and students participated in Gram Sabha meeting on August 15th in all the UBA villages and identified key problems to be addressed. The following are the key problems identified in each village.

Thirumal Natham

1. Open defecation
2. Health and hygiene problem

3. Stagnated open drainage
4. Alcoholic problem
5. Lack of Street lights

Nedungulam

- Lack Of Bus Facilities
- Lack of Proper Infrastructure for the School
- Alcoholic problem

Vadugapatti

- In Need of PHC
- Open Defecation in spite of common toilet available in the village.

Ambalathadi

- Drinking Water
- Stagnated Open Drainage
- Garbage in the Streets
- Alcoholic Problem
- Street Lights
- Unemployment

Kondayampatti

- Drainage problem
- Lack of water facilities
- Lack of toilet facilities
- Garbage Disposal problem
- Lack of street light

Activities carried out:

For the past five months our faculty and students were actively engaged in ….

- Imparting awareness on open defecation and cleanliness drive (Rally, Street Play).
- Preparation and Distribution of Seed Ball was done in all the UBA villages.

- Identifying slow learners and started tutoring.
- Signature Campaign on Plastic Free Village
- Medical Camps organized
- World literacy day organized
- Awareness on Disposal of waste and cleanliness drive
- Exhibition of Herbal Medicines, Encouraging each household to start Herbal Garden
- Children’s day was organized to ensure rights of children and stressed the importance of health and hygiene.

Faculty and Student Community of Fatima College is committed in carving out a generation who would take active role in social activities. The extension committee is reaching out to the underprivileged people and thereby works towards the nation building. We assure that in close collaboration with district administration we strive to work for the development of the UBA villages believing that the future of India lies in its villages.

Profile of Thirumalnatham:

Thirumalnatham is a small Village in Vadipatti Block in Madurai District of Tamil Nadu State, India. It comes under Thirumalnatham Panchayath. It is located 20 KM towards west from District head quarters Madurai. 5 KM from Vadipatti. 489 KM from State capital Chennai. Thirumalnatham postal head office is Tiruvedagam .

Ayyankottai (3 KM) , Kattakulam (3 KM) , Thenkarai (3 KM) , Thanichiyam (4 KM) , Melakkal (4 KM) are the nearby Villages to Thirumalnatham. Thirumalnatham is surrounded by Alanganallur Block towards East ,Chellampatti Block towards west , Madurai West Block towards east, Tirupparangunram Block towards South . Sholavandan, Vadipatti, Madurai, Usilampatti are the nearby Cities to Thirumalnatham. This Place is in the border of the Madurai District and Dindigul District. Dindigul District Nilakottai is North towards this place.

Demographics of Thirumalnatham

Locality Name : Thirumalnatham
Block Name : Vadipatti
District : Madurai
State : Tamil Nadu
Language : Tamil and Telegu, Sourashtra, English, Hindi
Elevation / Altitude : 185 meters above Seal level
Telephone Code
/ Std Code : 04552
Population : 640
House hold number: 162

Kondayampatti

According to Census 2011 information the location code or village code of Kondayampatti village is 640747. Kondayampatti village is located in Vadipatti Tehsil of Madurai district in Tamil Nadu, India. It is situated 7km away from sub-district headquarter Vadipatti and 26km away from district headquarter Madurai. As per 2011 stats, Melachinnampatti is the gram panchayat of Kondayampatti village.

Profile of Kondayampatti

Particulars	Total	Male	Female
Total No. of Houses	**839**	-	-
Population	**2,999**	1,497	1,502
Child (0-6)	**323**	168	155
Schedule Caste	**526**	263	263
Schedule Tribe	**1**	0	1
Literacy	**78.66 %**	86.46 %	70.97 %
Total Workers	**1,485**	910	575
Main Worker	**1,138**	-	-
Marginal Worker	**347**	163	184

AMBALATHADI VILLAGE

Ambalathadi is a village panchayat located in the Madurai district of Tamil-Nadu state, India. The latitude 10.0156188 and longitude 78.0676541 are the geocoordinate of the Ambalathadi. Chennai is the state capital for Ambalathadi village. It is located around 419.4 kilometer away from

Ambalathadi. The other nearest state capital from Ambalathadi is Thiruvananthapuram and its distance is 198.8 KM. The other surrouning state capitals are Thiruvananthapuram 198.8 KM., 287.7 KM., Bangalore 333.8 KM. Ambalathadi is a medium size village located in Madurai North Taluka of Madurai district, Tamil Nadu. Ambalathadi village has lower literacy rate compared to Tamil Nadu. In 2011, literacy rate of Ambalathadi village was 78.79 % compared to 80.09 % of Tamil Nadu.

Profile of Ambalathadi:

Particulars	Total	Male	Female
Total No. of Houses	**367**	-	-
Population	**1,497**	753	744
Child (0-6)	**172**	87	85
Schedule Caste	**1,078**	548	530
Schedule Tribe	**0**	0	0
Literacy	**78.79 %**	84.53 %	72.99 %
Total Workers	**580**	401	179
Main Worker	**221**	-	-
Marginal Worker	**359**	219	140

VADUGAPATTI VILLAGE

The village Vadugapatti is situated in Madurai North. It is situated between Kulamangalam and Kumaram. The nearest town is Anaiyur. The village comes under Kulamangalm Panchayat. The geographical area of this village is approximately two square kilometres.

Vadugapatti is a small village comprising of nearly 80 houses. It houses three hundred and twenty people of which 158 are male and 162 are female. There are around 35 children of various age groups. Nearly seventy percent of the village people belong to general category while others belong to schedule community. The staff and the students of Fatima College visited the village in the months of July and August, and established a good rapport with the people there. Interactions and discussions with them revealed their current living status and their expectations.

There is an elementary school with minimum number of students with two staff. There is an Anganwadi. Their day to day life is very difficult because there is no proper drainage and basic facilities. They do not have hospital, health care unit or medical shop in their village. Students have to go outside the village for higher education to faraway places. The village is also surrounded by green fields. One of their main occupations is agriculture. There are peoples who are engaged in other odd works and part time works also. There is no rain water harvesting in village, the road is in a very bad condition. The people in the village demand basic facilities like bus, road, and drainage.

Many impacts of COVID-19 are reflected in socio-economic and epidemiologic data (e.g. unemployment statistics, infection rates, and mobility and transportation data). However, combining socio-economic) data can enhance our understanding of and generate new insights regarding the effects of COVID-19.

Role of Fatima College in Creating Awareness on Covid-19 among Villagers through Outreach Programs

Response of ROSA to Covid-19

Hundreds of countries are affected by Covid-19 and it started spreading slowly in India too from the beginning of January 30th onwards. The first case was reported in Kerala and slowing it was identified in other states too. Tamil Nadu being one of the affected states due to this virus, ROSA felt the urgency to spread the awareness among the villagers where the village development activities are organized by the college for final year under graduate students of Fatima College, Madurai. Prevention is better than cure, so the linking staff for outreach program in each of the department were motivated to spread this awareness among villagers and school children. From the mid of February onwards each department planned their activity to impart awareness on Corona virus through drama, speech, poster making, rally and awareness film. People were taught to protect themselves and to boost their immune system by taking lot of vitamin C and to avoid cold food and processed food items. They were also taught to maintain social distancing and avoid touching face unnecessarily. Demonstration was done on how to clean hands. Pamphlets were also prepared to impart awareness about this deadly virus. Totally 12 villages are reached out to impart this awareness. People have benefitted lot of awareness about this virus and how to protect themselves. They were taught both preventive and curative methods.

During the lockdown period along with staff and few volunteers of Non-teaching staff, five students who reside within the campus were motivated to prepare mask to distribute to Madurai Corporation commissioner. Due to the unavailability of cloth material only 500 mask was prepared and handed.

COVID-19: BIGGER CHALLENGE TO INDIA

Covid-19 has reached the community spread phase. Developed or underdeveloped, rich or poor, all countries are affected by this today. However, they are facing these challenges – shortages in medical supplies and difficulty stopping its spread – in different magnitudes. In an attempt to stop the spread to save lives, Prime Minister Narendra Modi announced a 21-day lockdown, starting from 25th of March. Developing countries across the globe are looking down quickly, after witnessing the helplessness of the US, UK and the rest of Europe – though these are the countries with much stronger healthcare systems and much better availability of doctors. In Italy, doctors are forced to prioritize whom to save and whom to leave untreated.

India's healthcare infrastructure is incapable of dealing with this crisis today. Shortages in medical supplies and an inability to provide adequate testing are the major issues. However, the Prime Minister's announcement to allocate 15,000 core rupees (USD 2 billion) for building infrastructure can strengthen the fight against corona virus. Also, state governments are trying to expand facilities to deal with this situation.

The majority of Indians finance their healthcare themselves. About 62 percent of households' expenditure on healthcare in 2017 was made through out-of-pocket payments. In comparison, the equivalent figures for the European Union (excluding UK) is 22.29 percent and for the USA and UK it is 11 percent and 16 percent, respectively (Table 1). While many patients diagnosed with Covid-19 will need Intensive Care Unit (ICU), there is no clarity from the government regarding who will pay these expenses.

STRATEGIES ADOPTED BY INDIA:

Many impacts of COVID-19 are reflected in socio-economic and epidemiologic data (e.g. unemployment statistics, infection rates, and mobility and transportation data). However, combining socio-economic) data can enhance our understanding and generate new insights regarding the effects of COVID-19. As the corona virus disease (Covid-19) continues to spread, India's most populated states have adopted both common and distinct, strategies to deal with the pandemic

Maharashtra, Uttar Pradesh, Bihar, Madhya Pradesh and West Bengal, Tamilnadu account for one-third of total 10,444 Covid-19 cases in India and about 40% of the country's 1.21 billion population in 2011. Being densely populated, the probability of rapid spread of Covid-19 in these states was and remains higher than in less populated southern and Himalayan states. They are also more vulnerable because they house about 60% of 1.3 million migrant laborers in shelters across India.

While providing food to all, including about 20 million poor citizens in these states, was a challenge, the state governments adhered to health ministry's guideline of testing and strong Covid-19 cluster management. They also launched apps to track hundreds of patients and put thousands of people in quarantine.

But they also opted for state specific models that helped in containing the spread. Maharashtra opted for aggressive testing (42,000 so far) and created the most number of containment zones in cities; Uttar Pradesh ensured that the virus is restricted to 41 of the 75 districts; Bihar focused more on isolating migrant workers and screening of all foreigners; Madhya Pradesh came across as lax initially before ramping up screening and testing efforts; and West Bengal termed its plan as containment with "humane face."

CHAPTER III

Findings and analysis

INTRODUCTION

The study analyses the attributes of the status of Covid-19 among villagers in Madurai District of Tamil Nadu. Data had been collected through a well administered questionnaire following telephone interview from 100 respondents chosen at random from 5 UBA villages based on simple random sampling. Such data had been statistically analyzed using SPSS (version20). This chapter presents the data analyzed.

SOCIO DEMOGRAPHIC ANALYSIS

The social demographic factors play a vital role in understanding the tenants of the population in an area. They contribute to the realistic expression of the status of the population in the study area.

Among the many factors, age determines the level of awareness, strategies and effects of COVID 19 pandemic. Table 1 presents the age wise classification of the respondents.

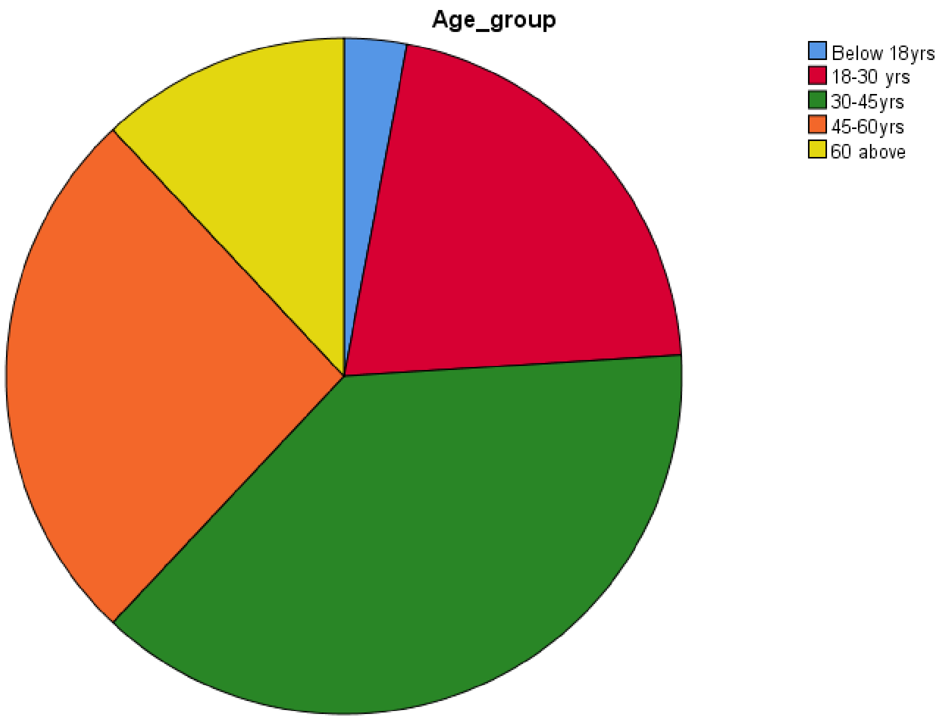
Table 1

Age wise Classification of the Respondents

S. No.	Age classification	No. of Respondents	Percent	Cumulative Percent
1.	Below 18yrs	3	3.0	3.0
2.	18-30 yrs	21	21.0	24.0
3.	30-45yrs	38	38.0	62.0
4.	45-60yrs	26	26.0	88.0
5.	60 above	12	12.0	100.0
	Total	100	100.0	

Source: Primary data

Table 1 depicts that among 100 respondents, 3 percent are below 18 years of age, 21% are between 18 and 30 years, 38 percent are from 30 to 45 years, 26 percent are from 45 to 60 years and 12 percent are above 60 years of age. It is inferred that majority of the respondents are between 30 and 45 years of age. The diagrammatic expression of Table 1 is presented in chart 1



The awareness, strategies adopted to cope up with the pandemic and its effects on the population varies individually and on the basis of gender. Hence gender has been taken for the purpose of the study.

TABLE 2

Gender wise Classification of the Respondents

S.No.	Gender Classification	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Male	51	51.0	51.0	51.0
2.	Female	49	49.0	49.0	100.0
	Total	100	100.0	100.0	

Source : Primary Data

Table 2 clearly pictures that 51 percent of the total respondents are male and 49 percent are female. The population of the UBA villages reveals men outnumbering women population which has been true to the study. Majority of the respondents (51 per cent) are male.

Table 3

Religion wise Classification

Religion	Frequency	Percent	Valid Percent	Cumulative Percent
Hindu	100	100.0	100.0	100.0

Faith in God also determines the extent of coping strategies and the impact of COVID 19 on individual's lives. Hence religion is taken as a variable for the purpose of the study. Table 3 shows that all the respondents belong to Hindu religion. Chart 3 shows religion wise classification.

Table 4

Community wise Classification					
S. No.	Community	No. of respondents	Percent	Valid Percent	Cumulative Percent
1.	BC	41	41.0	41.0	41.0
2.	MBC	12	12.0	12.0	53.0
3.	DNC	1	1.0	1.0	54.0
4.	SC	43	43.0	43.0	97.0
5.	ST	3	3.0	3.0	100.0
	Total	100	100.0	100.0	

Table 4 depicts that among 100 respondents, Majority of the respondents (43 percent) belongs to the category of SC, 41% are BC, 12 percent are MBC, 3 percent are ST and 1 percent is DNC.

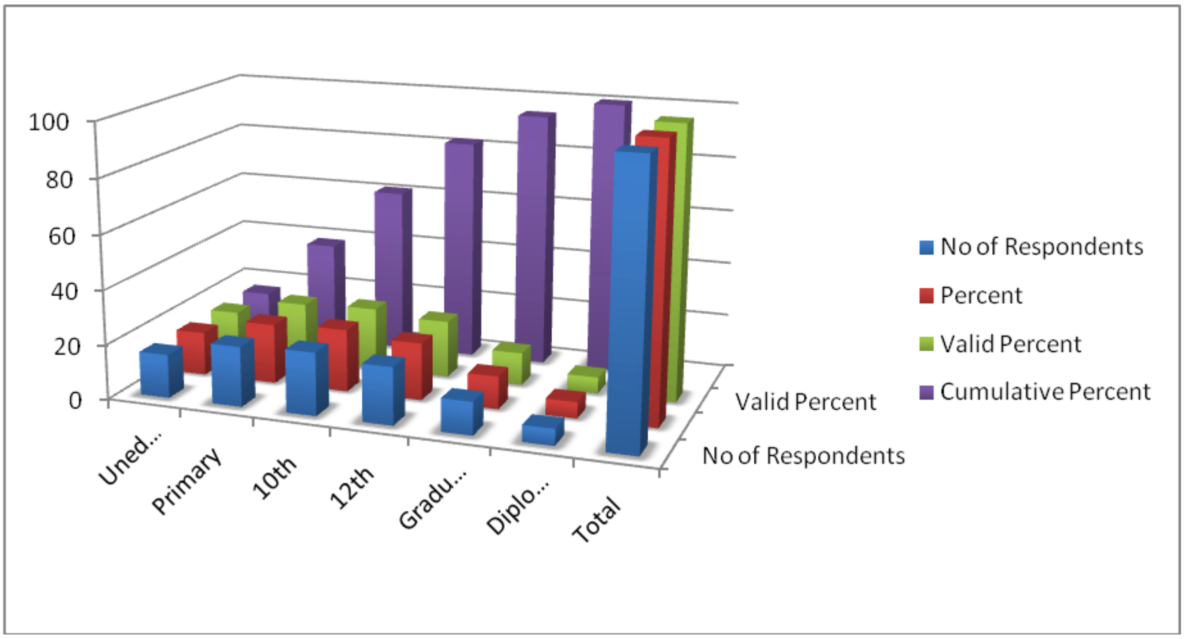
Classification on the basis of Educational Qualification

UBA villages have an elementary/ primary school and middle school in some cases. Villagers work for labor intensive jobs and have meager educational qualification in most cases. The pandemic coping strategies and awareness is equally influenced by the educational level of the villagers and hence an attempt has been made to classify the respondents on the basis of educational qualification.

Table 5

Educational qualification wise classification					
S. No.	Educational qualification	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Uneducated	16	16.0	16.0	16.0
2.	Primary	22	22.0	22.0	38.0
3.	10th	23	23.0	23.0	61.0
4.	12th	21	21.0	21.0	82.0
5.	Graduate	12	12.0	12.0	94.0
6.	Diploma	6	6.0	6.0	100.0
	Total	100	100.0	100.0	

Table 5 depicts that 16 percent of the respondents are uneducated 22 percent have done primary schooling due to influence of many social factors such as poverty, ignorance, not interested, not habituated, improper socialization, discrimination and so on. 23 per cent are qualified with 10thclass, 21 percent have finished 12th 12 percent are graduates and 6 percent are diploma holders. It is hence inferred that majority (23 percent) of the respondents have passed their 10th class. This is diagrammatically expressed in chart 5



Occupation wise Classification

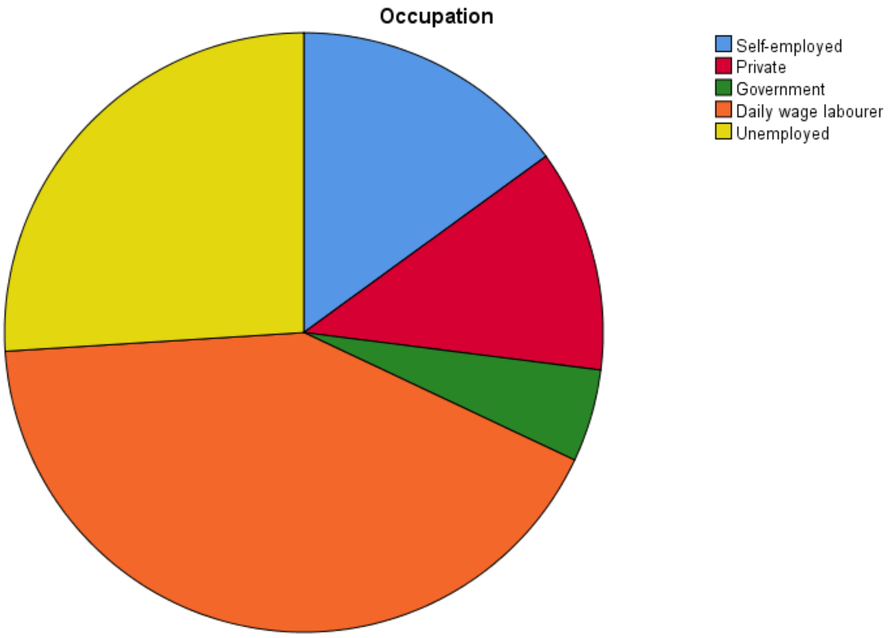
In the UBA Villages, the mainstay of occupation is either self-employment or daily wage-earning method. This potentially influences the extent of awareness and strategies adopted to cope up with COVID-19. Hence occupation of the villagers have been taken into consideration for the purpose of the study.

Table 6

Occupation wise Classification

S. No.	Occupation	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Self-employed	15	15.0	15.0	15.0
2.	Private	12	12.0	12.0	27.0
3.	Government	5	5.0	5.0	32.0
4.	Daily wage labourer	42	42.0	42.0	74.0
5.	Unemployed	26	26.0	26.0	100.0
	Total	100	100.0	100.0	

Among the 100 respondents, 42 percent are daily wage labourers including labourers in building construction, agriculture, 100 days' work and etc… 26 percent are umemployed, 15 percent are self-employed, 12 percent are employed with private organizations and 5 per cent are government servants. It is clear from Table 6 that the main stay of occupation in villages is daily wage earning method, followed by self-employment though unemployment is widely prevalent among the villagers. Chart 6 shows the same.



CLASSIFICATION BASED ON ANNUAL INCOME

Income an important factor in throwing light on the economic conditions of the villagers also quite significantly influences the coping strategies and awareness of COVID 19 pandemic. Hence an analysis has been made on the annual income of the respondents, which is presented in Table 7.

Table 7

Income wise classification

S .No.	Income	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	less than 1 lakh	94	94.0	94.0	94.0
2.	Greater than 1 lakh	6	6.0	6.0	100.0
3.	Total	100	100.0	100.0	

Table 7 shows that 94 per cent of the respondents earn an annual income of less than one lakh and 6 per cent earn greater than one lakh per annum. Majority of the respondents earn less than 1 lakh per annum which stands confirmed by 2011 census.

AREA OF RESIDENCE

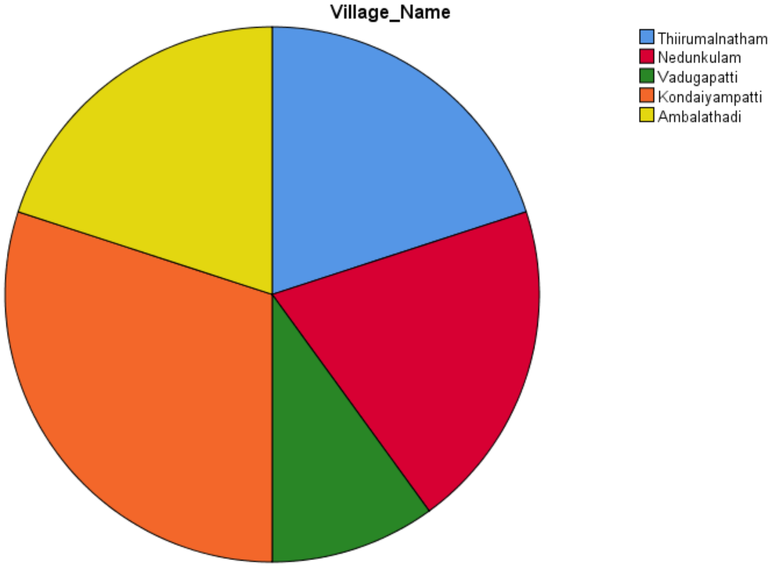
Table 8 shows the area of residence of the respondents. Respondents have been chosen at random based on the size of the population of the villages, following simple random sampling. Area of residence has significant impact on the awareness, effects and coping strategies adopted by villagers in tackling the pandemic and hence area of residence is considered to be one among the variables.

Table 8

Classification of Respondents based on Area of Residence

S. No.	Area of Residence	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Thiirumalnatham	20	20.0	20.0	20.0
2.	Nedunkulam	20	20.0	20.0	40.0
3.	Vadugapatti	10	10.0	10.0	50.0
4.	Kondaiyampatti	30	30.0	30.0	80.0
5.	Ambalathadi	20	20.0	20.0	100.0
	Total	100	100.0	100.0	

Table 8 shows that 20 percent of the respondents are from Thirumalnatham, Nedunkulam and Ambalathadieach , 30 per cent is from kondayampatti and 10 per cent is from Vadugapatti village. The distribution of the sample size is in accordance with the density of the population of the villages. Chart 8 shows the same.



COVID-19AWARENESS AMONG VILLAGERS

COVID-19 a type of virus of the corona family is a novel virus which is less than a nano in measure, but spreads through simple touch or from the spittle of human beings. Its primary nature is to mutate in the respiratory system of the human beings causing no symptoms until 14 days of the first contact with individuals. To know its cause and effect and to take protection from the pandemic one requires to be aware of the symptoms it causes. An attempt has been made among the villagers to understand their knowledge on the symptoms of COVID-19.

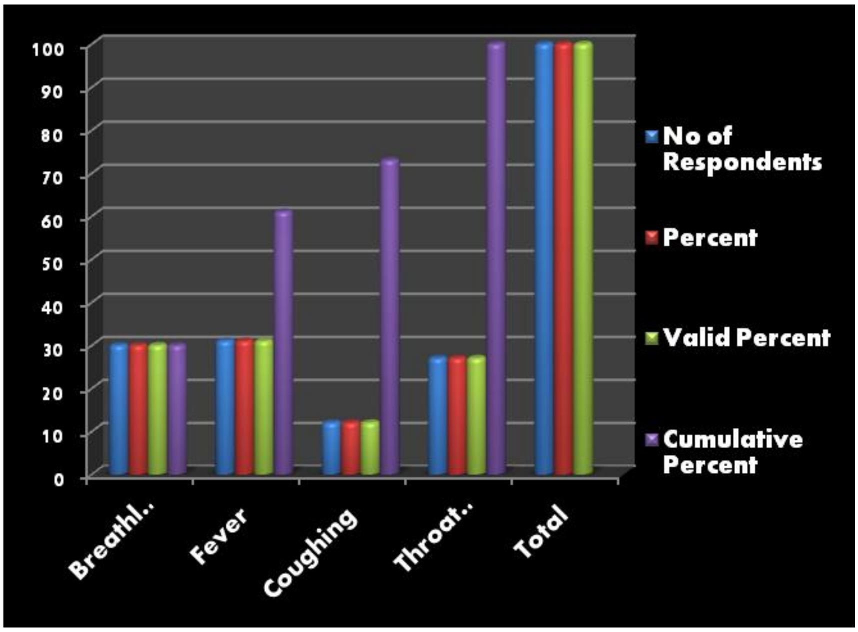
Table 4.1

Symptoms of COVID-19 Pandemic

S. No.	Symptoms of COVID-19	No of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Breathlessness	30	30.0	30.0	30.0
2.	Fever	31	31.0	31.0	61.0
3.	Coughing	12	12.0	12.0	73.0
4.	Throat pain	27	27.0	27.0	100.0
	Total	100	100.0	100.0	

Table 4.1 shows that 30 per cent of the population recognizes breathlessness as an indicator, 31 percent recognize fever as an indicator, 27 per cent say it is throat pain and 12 per cent include coughing as an indicator of Covid-19 pandemic. Fever as a symptom of Covid-19 is agreed among 31 per cent of the total respondents. Diagrammatical expression is given in chart4.1

Symptoms of COVID-19 Pandemic



COVID 19 is a communicable disease, which gets transmitted through droplets arising out of coughing or sneezing, or being in touch with the infected persons or touching the surface and or clothes of the infectious. The villagers' awareness on the same is tested in asking this question and the results are summarized in Table 4.2.

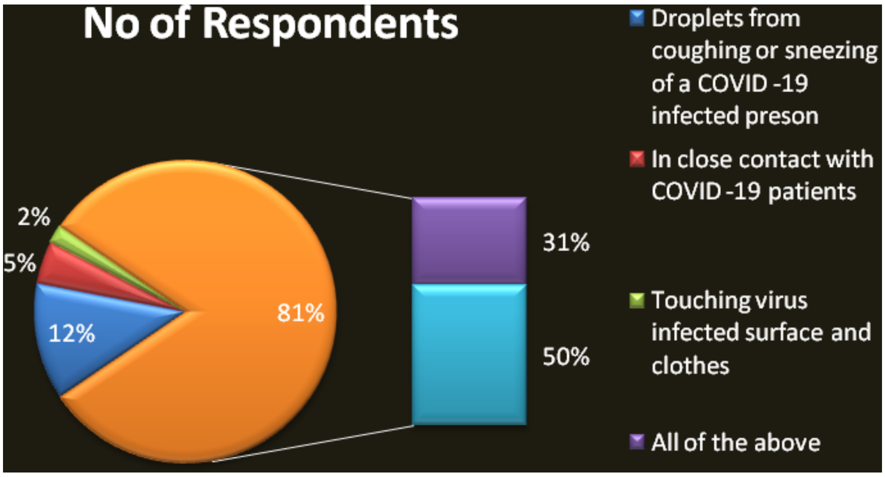
Table 4.2

Means of COVID-19 Transmission

S. No.	Means of COVID-19 Transmission	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Droplets from coughing or sneezing of a COVID -19 infected person	25	25.0	25.0	25.0
2.	In close contact with COVID - 19 patients	9	9.0	9.0	34.0
3.	Touching virus infected surface and clothes	4	4.0	4.0	38.0
4.	All of the above	62	62.0	62.0	100.0
	Total	100	100.0	100.0	

Table 4.2 shows that 25 per cent of the respondents believe the cause of Covid-19 transmission as droplets of sneezing or coughing, 9 per cent as being in close contact with the infected persons, 4 per cent in touching the surface and clothes carrying Covid-19 and 62 per cent from all the above. The villagers are quite aware of the mode of transmission of the disease as majority (62 per cent) know the mode of transmission of the disease. Pictorially is this given representation in chart 4.2

Means of COVID-19 Transmission



COVID -19 INFLUENCERS

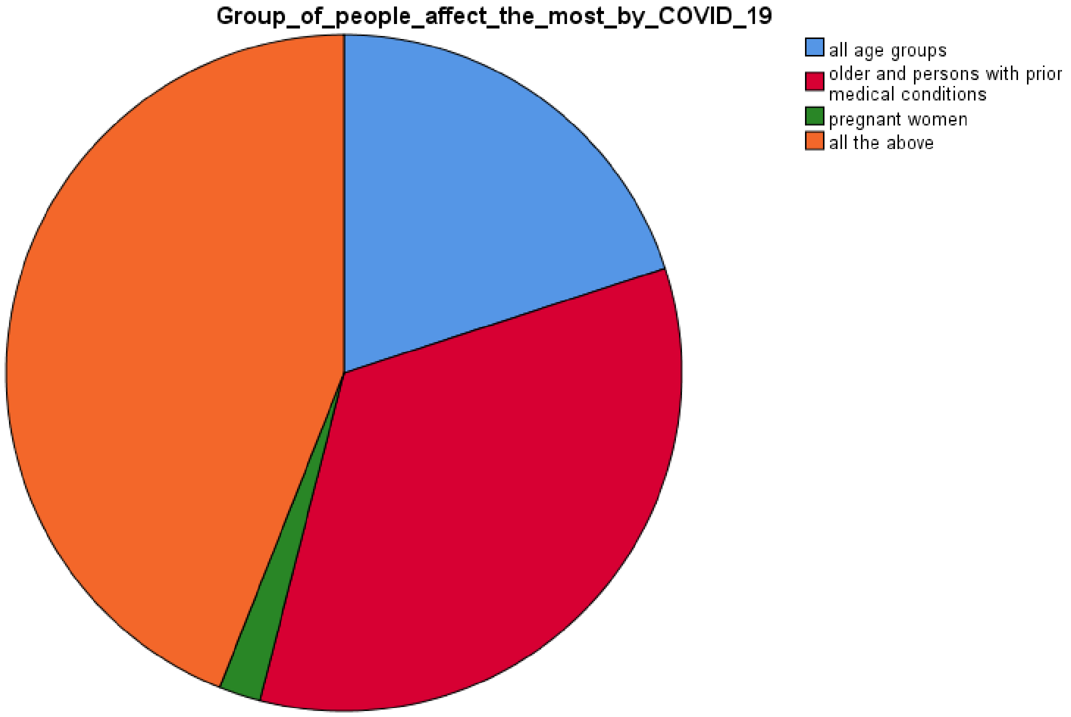
The pandemic affects all people irrespective of any type of disparity in them. This aspect is tested in the questionnaire. The anlaysed results are tabulated and presented in Table 4.3.

Table 4.3

Influencers of Covid-19 pandemic

S. No.	Influencers	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	All age groups	20	20.0	20.0	20.0
2.	Older and persons with prior medical conditions	34	34.0	34.0	54.0
3.	Pregnant women	2	2.0	2.0	56.0
4.	All the above	44	44.0	44.0	100.0
5.	Total	100	100.0	100.0	

Table 4.3 portrays the target group of the pandemic virus and 44 per cent of the respondents agree that it affects all people, whereas, 20 per cent believe that all age groups fall in its fold, 34 per cent believe that older persons and persons with prior medical conditions are at risk and 2 per cent say it is the pregnant women who are at high risk. Majority of the respondents believe that Covid-19 pandemic affects all people. This is reflected in chart 4.3



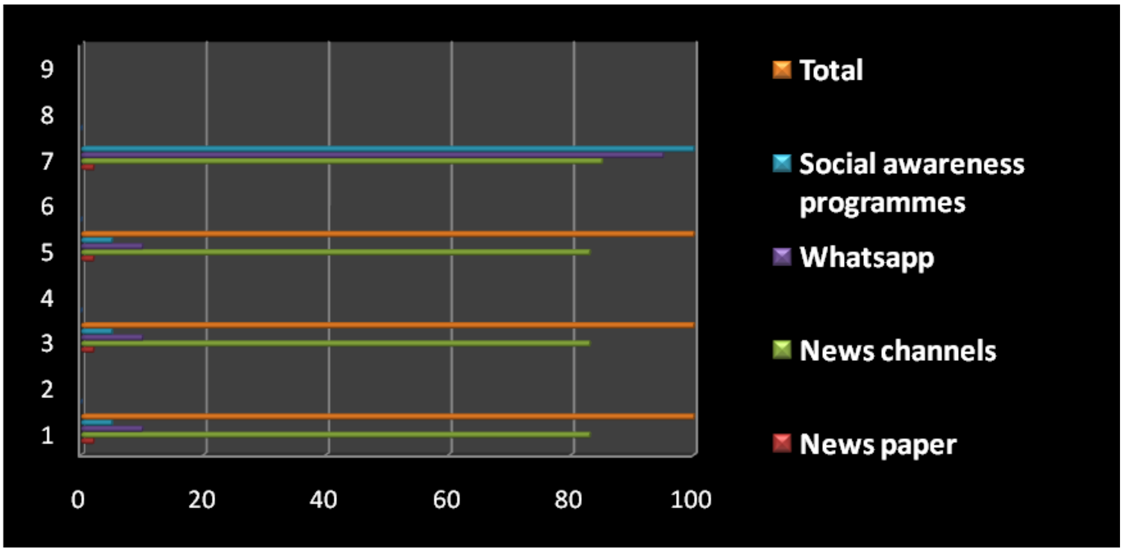
The villagers' source of awareness of Covid-19 has been identified and summarized in Table 4.4

Table 4.4

Medium of awareness of Covid-19					
S.No.	Medium of awareness	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	News paper	2	2.0	2.0	2.0
2.	News channels	83	83.0	83.0	85.0
3.	Whatsapp	10	10.0	10.0	95.0
4.	Social awareness programmes	5	5.0	5.0	100.0
	Total	100	100.0	100.0	

Table 4.4 shows that 83 per cent of the respondents came to know about Covid19 through news channel, 10 percent knew through whatsapp message 5 percent through social awareness programmes and 2 percent through newspaper. Majority of the respondents came to know about Covid 19 through news channels. Chart 4.4 reflects the same.

Medium of awareness of Covid 19



Means of Awareness Created by Fatima college students

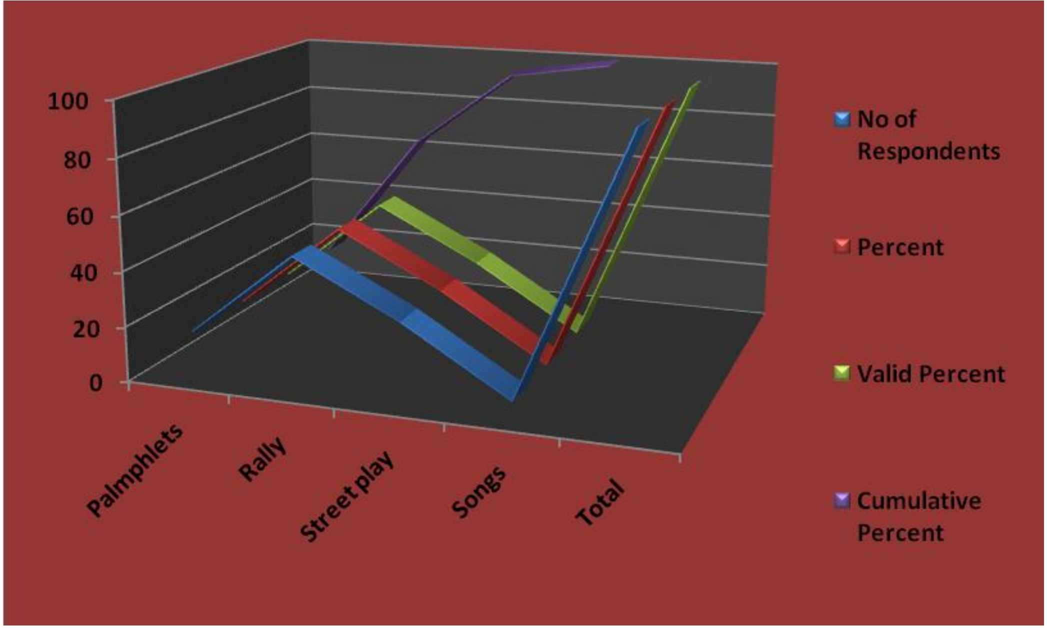
UBA villages are visited by Fatima college students twice a month, to facilitate the development of village. In the last visit in the month of February and March, Fatima college students created awareness about Covid-19 pandemic among the villagers. The same is presented in Table 4.5

Table 4.5

Means of awareness created by Fatima college students					
S. No.	Means of awareness	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Palmphlets	17	17.0	17.0	17.0
2.	Rally	48	48.0	48.0	65.0
3.	Street play	29	29.0	29.0	94.0
4.	Songs	6	6.0	6.0	100.0
	Total	100	100.0	100.0	

Table 4.5 portrays that awareness on Covid19 pandemic was created by Fatima college students. 48 percent say that students went on a rally, 29 per cent say students performed street play, 17 per cent through pamphlets, and 6 per cent through songs. The is also presented in chart 4.5

Means of awareness created by Fatima college students



CHALLENGES OF COVID-19FACED BY VILLAGERS

EFFECTS OF THE SPREAD OF COVID-19 PANDEMIC ON NORMAL LIFE

The effects of Covid-19 on normal life are assessed among the villagers and presented in the following pages.

Table 5.1

Mobility restricted due to Covid-19					
		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	18	18.0	18.0	18.0
2.	Agree	40	40.0	40.0	58.0
3.	Moderate	24	24.0	24.0	82.0
4.	Disagree	10	10.0	10.0	92.0
5.	Strongly Disagree	8	8.0	8.0	100.0
	Total	100	100.0	100.0	

Table 5.1show that 40 percent of the respondents agree that mobility is affected and 24 percent agree that mobility is moderately affected. Mobility restriction due to Covid 19 has affected people in all aspects such physically, psychologically, financially and socially. Many people were physically by not taking regular treatment. Health condition of sick people became worst due to mobility restriction. When people were not let to attend to imperative events like marriage, birth and death of loved one they affected emotionally which also caused them to develop physical problem. Covide 19 brought unemployment and social isolation among people. 18 percent say that their mobility is strongly affected.

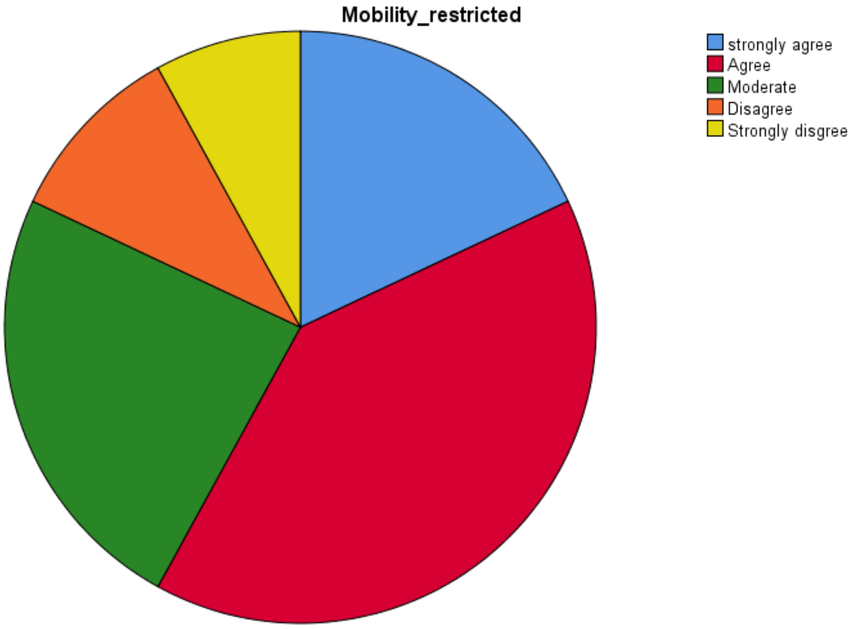


Table 5.2

Engulfed by Fear Anger Helplessness					
		No of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	20	20.0	20.0	20.0
2.	Agree	38	38.0	38.0	58.0
3.	Moderate	7	7.0	7.0	65.0
4.	Disagree	12	12.0	12.0	77.0
5.	Strongly Disagree	23	23.0	23.0	100.0
	Total	100	100.0	100.0	

Table 5.2depicts the fear, anger and helplessness engulfing the respondents, due to Covid-19 pandemic. 38 per cent agree that they are engulfed with fear, anger and helplessness and 20 percent strongly agree to the same. 7 per cent are moderate, 12 per cent are disagreeing and 23 per cent are strongly disagree about engulfed with fear, anger and helplessness. Covid-19 brought fear, anger and helplessness among large portion of the respondents because of feeling of insecurity, social isolation, no entertainment, lack of means to ventilate their emotions, Boardman of life and so on. This situation also may create many personal and social problems in the society. Chart 5.2 shows the same.

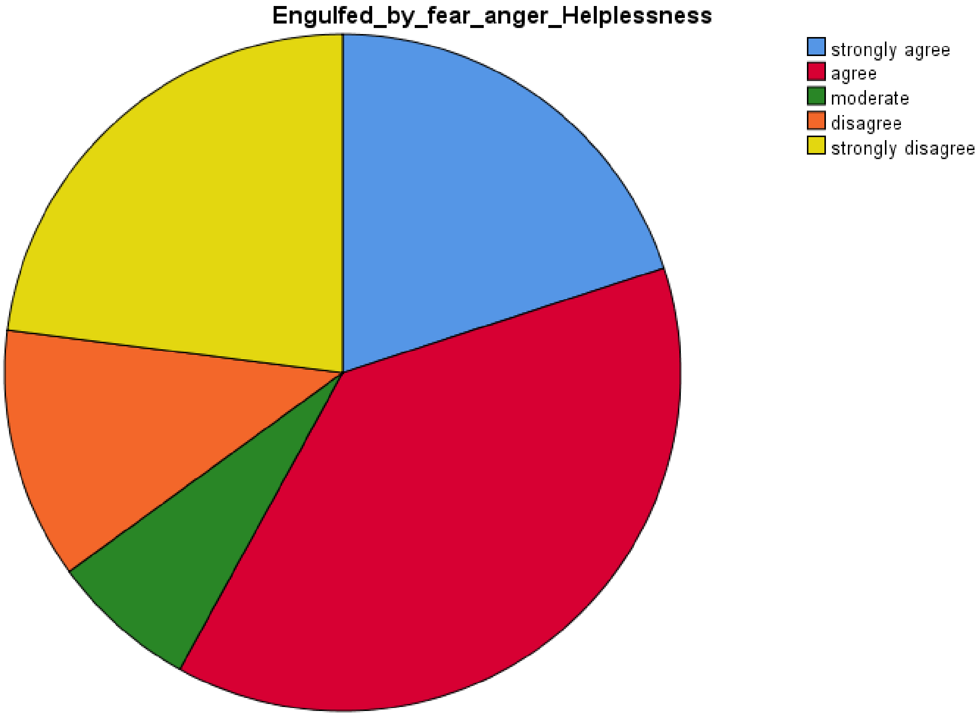


Table 5.3

Increase in family and relationship conflicts

		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	12	12.0	12.0	12.0
2.	Agree	18	18.0	18.0	30.0
3.	Moderate	21	21.0	21.0	51.0
4.	Disagree	14	14.0	14.0	65.0
5.	Strongly Disagree	35	35.0	35.0	100.0
	Total	100	100.0	100.0	

Table 5.3 shows that 21 per cent say that there is moderate increase in family and relationship conflicts whereas 35 per cent strongly disagree that there is increase in family and relationship conflicts. Unemployment, poverty, social distance, loneliness Covid-19 Lockdown resulted in quarrel among spouses, family detachment, conflict in relationship and etc…Chart 5.3 pictures the same.

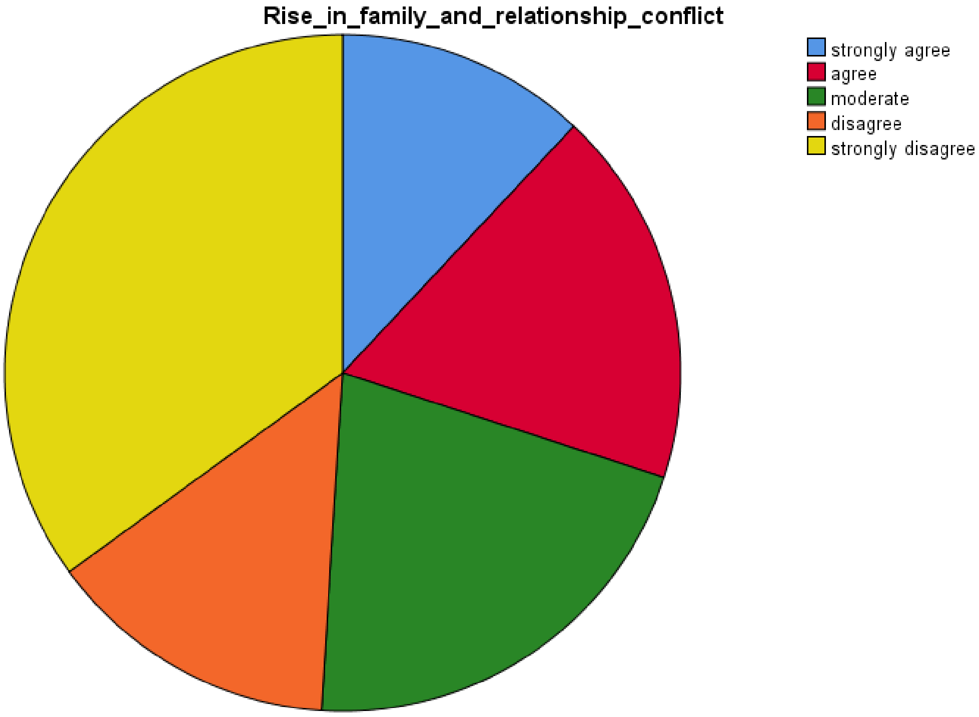


Table 5.4

Able_to_get_Aid_through_Government_Help_Lines					
		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	27	27.0	27.0	27.0
2.	Agree	25	25.0	25.0	52.0
3.	Moderate	22	22.0	22.0	74.0
4.	Disagree	17	17.0	17.0	91.0
5.	Strongly Disagree	9	9.0	9.0	100.0
	Total	100	100.0	100.0	

Table 5.4 reveals that 27 per cent strongly agree that they received aid through government help lines because of mobile facility, transport and ambulance and medical advancement, 25 per cent agree and 22 per cent moderately agree to the same. Chart 5.4 reveals the same in pictorial form

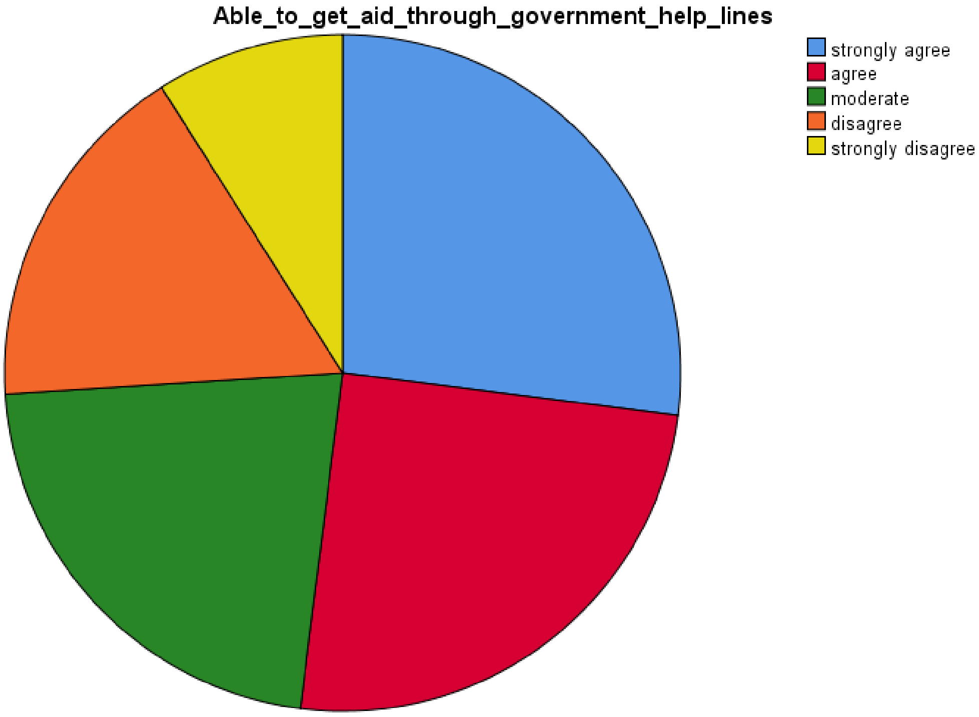


Table 5.5

Limited_Access_to_Doorstep_Delivery_Essential_Resources					
		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	11	11.0	11.0	11.0
2.	Agree	29	29.0	29.0	40.0
3.	Moderate	22	22.0	22.0	62.0
4.	Disagree	26	26.0	26.0	88.0
5.	Strongly Disagree	12	12.0	12.0	100.0
	Total	100	100.0	100.0	

Table 5.5 reveals that 29 per cent agree that they had limited access to doorstep delivery of essential resources due to internal politics, social discrimination, unavailability, ignorance and etc… 22 percent moderately agree and 26 percent disagree to the limited access to doorstep delivery of essential resources because of social status, position, social influence, economic and political power and etc...

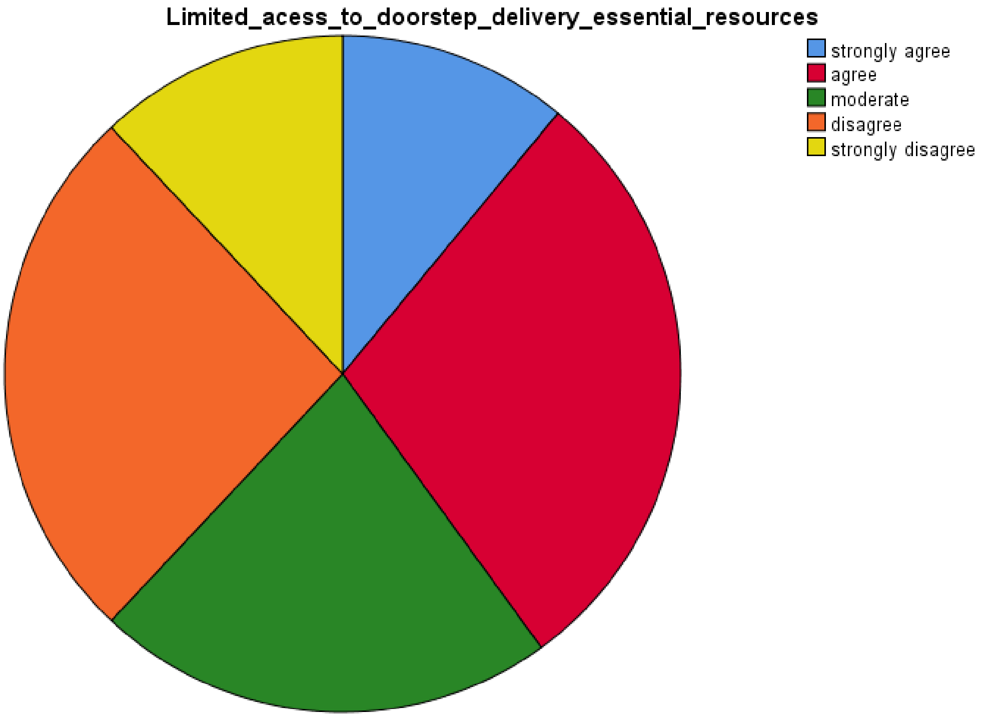


Table 5.6

Liberty_and_freedom_curtailed					
		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	9	9.0	9.0	9.0
2.	Agree	16	16.0	16.0	25.0
3.	Moderate	28	28.0	28.0	53.0
4.	Disagree	13	13.0	13.0	66.0
5.	Strongly Disagree	34	34.0	34.0	100.0
	Total	100	100.0	100.0	

Table 5.6 shows that 34 per cent strongly disagree to the curtailment of liberty and freedom because they lead a simple life everything they can access necessary sources in their village itself, 28 per cent moderately agree that liberty and freedom has been curtailed they need to move to outside their village to meet their basic needs like employment, education, health care, buy essential goods and etc...

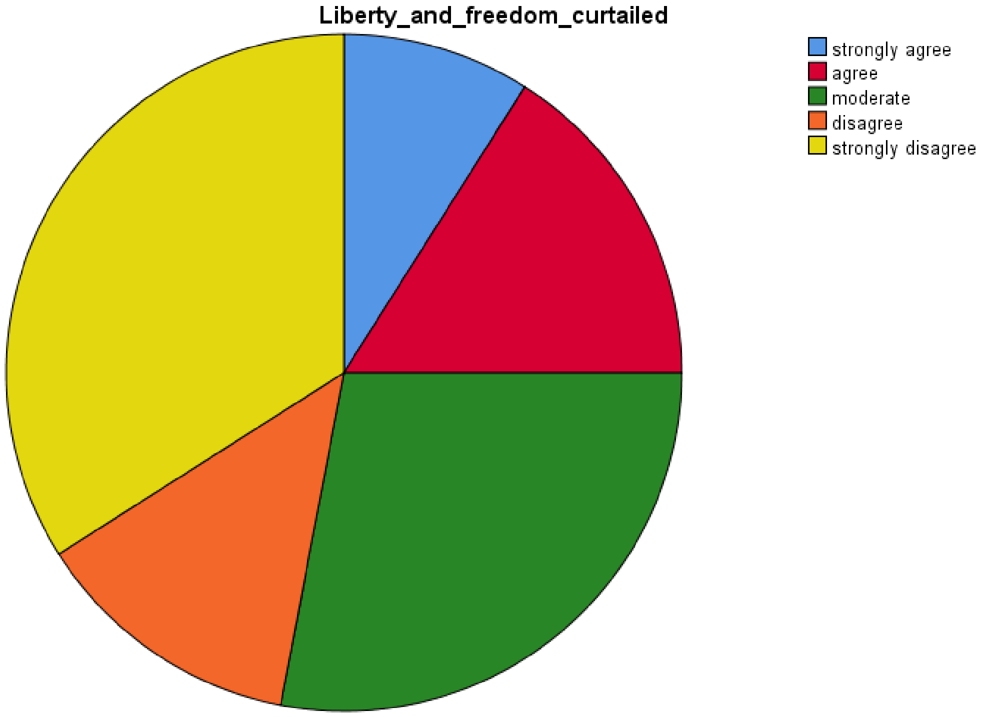


Table 5.7

Pushed_to_a_state_of_stress_and_depression					
		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	18	18.0	18.0	18.0
2.	Agree	32	32.0	32.0	50.0
3.	Moderate	12	12.0	12.0	62.0
4.	Disagree	14	14.0	14.0	76.0
5.	Strongly Disagree	24	24.0	24.0	100.0
	Total	100	100.0	100.0	

Table 5.7 reflects that 32 per cent agree that they are pushed to a state of stress and depression due to social isolation, Not being with family, feeling of insecurity, worried about loved ones, community spreading of Covid 19, social ambiguity, life uncertainty and etc… 24 per cent strongly disagree to the state of being pushed to stress and depression because they stay safe with their family.

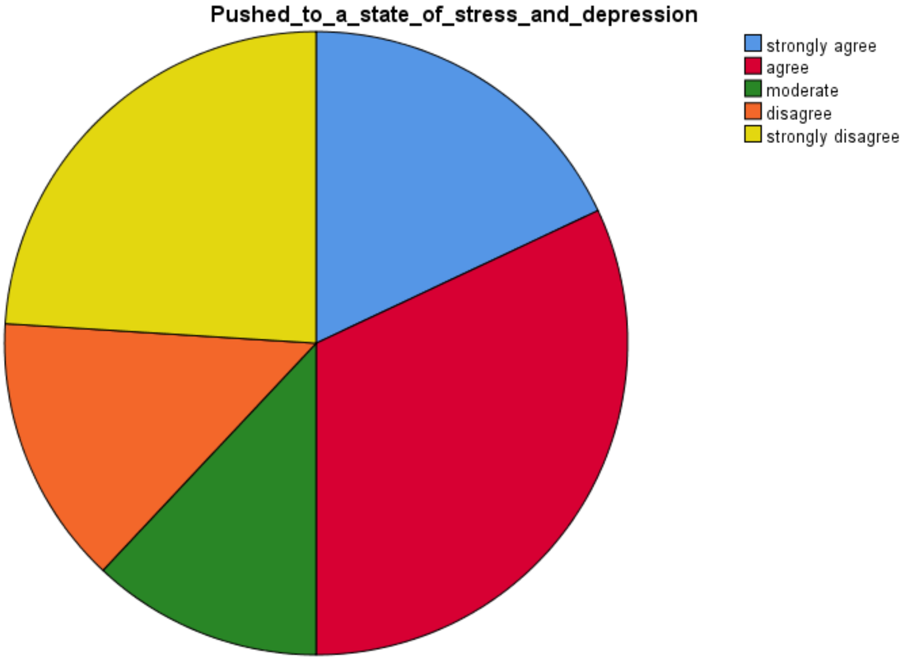


Table 5.8

Feel_Insecure_and_Frustrated					
		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	14	14.0	14.0	14.0
2.	Agree	10	10.0	10.0	24.0
3.	Moderate	14	14.0	14.0	38.0
4.	Disagree	30	30.0	30.0	68.0
5.	Strongly Disagree	32	32.0	32.0	100.0
	Total	100	100.0	100.0	

Table 5.8 shows that 32 per cent strongly disagree that they feel insecured and frustrated because they stay safe at home, got time to spend with their family, adapting strategies of Covid-19, got time to relax from work pressure. 30 per cent disagree to the idea that they feel insecure and frustrated as a result of Covid-19

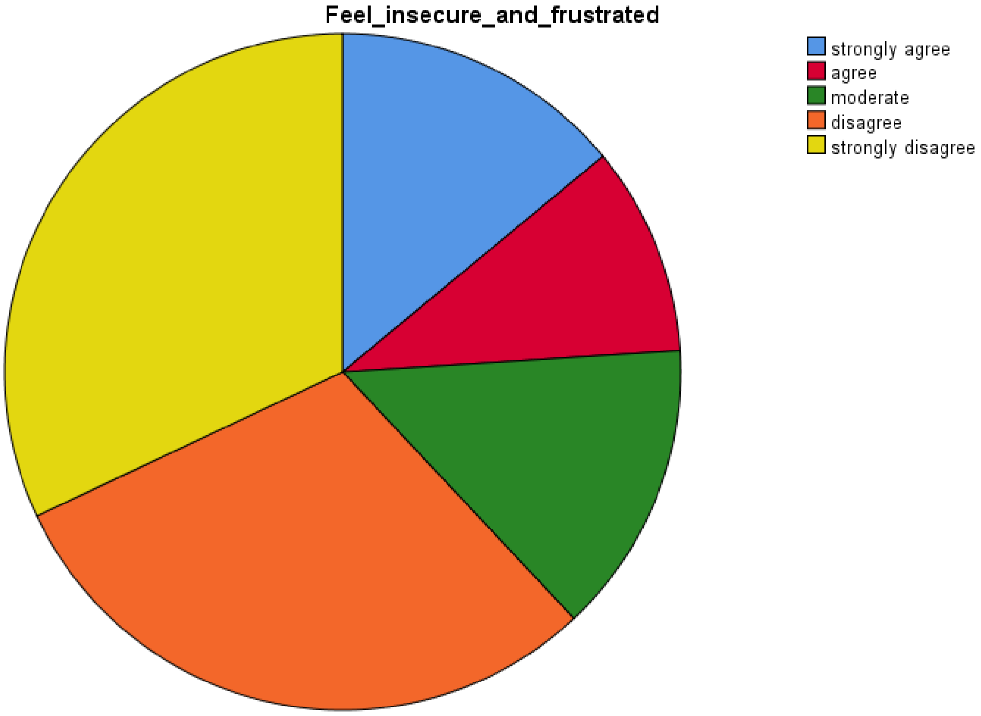


Table 5.9

Financial_Crisis Faced by the Respondents					
		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	17	17.0	17.0	17.0
2.	Agree	42	42.0	42.0	59.0
3.	Moderate	12	12.0	12.0	71.0
4.	Disagree	10	10.0	10.0	81.0
5.	Strongly Disagree	19	19.0	19.0	100.0
	Total	100	100.0	100.0	

Table 5.9 portrays that 42 per cent agree that they are in financial crisis and 17 per cent strongly agree to it, 12 per cent moderately agree whereas 19 per cent strongly disagree to it. Major portion of the part of the respondents are financially affected due to Covid 19. Stoppage of Many services like transport, production, distribution and marketing of goods, limited time of functions of government and private sectors resulted unemployment. Consequently, people could not meet their basic needs. This situation creates social disorder such as unemployment, poverty, theft, robbery, murder, suicide and etc...

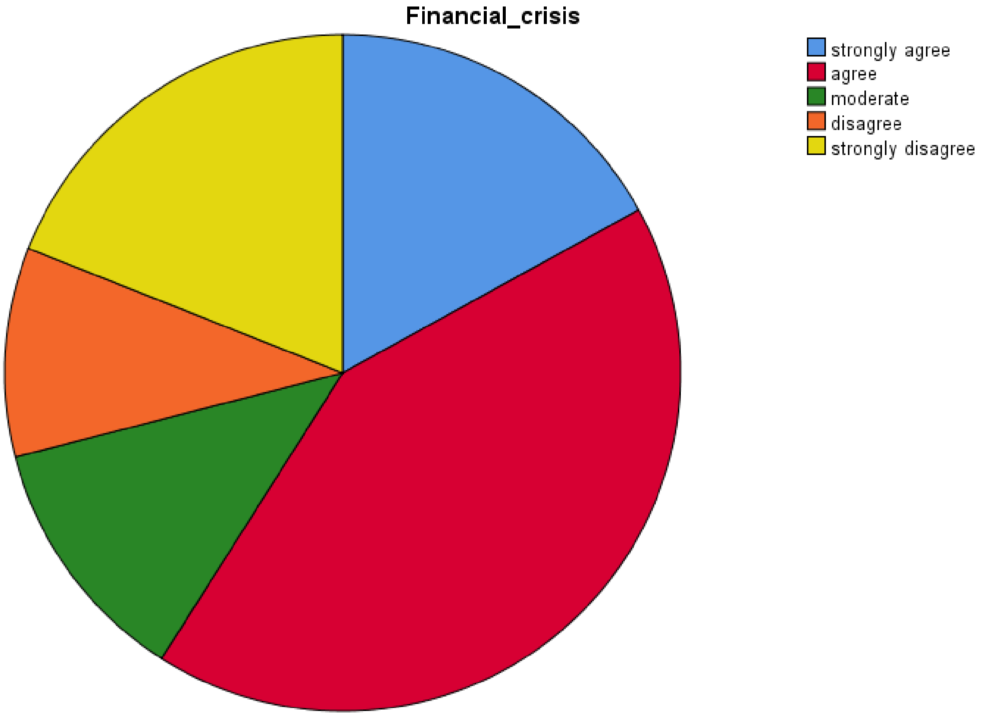
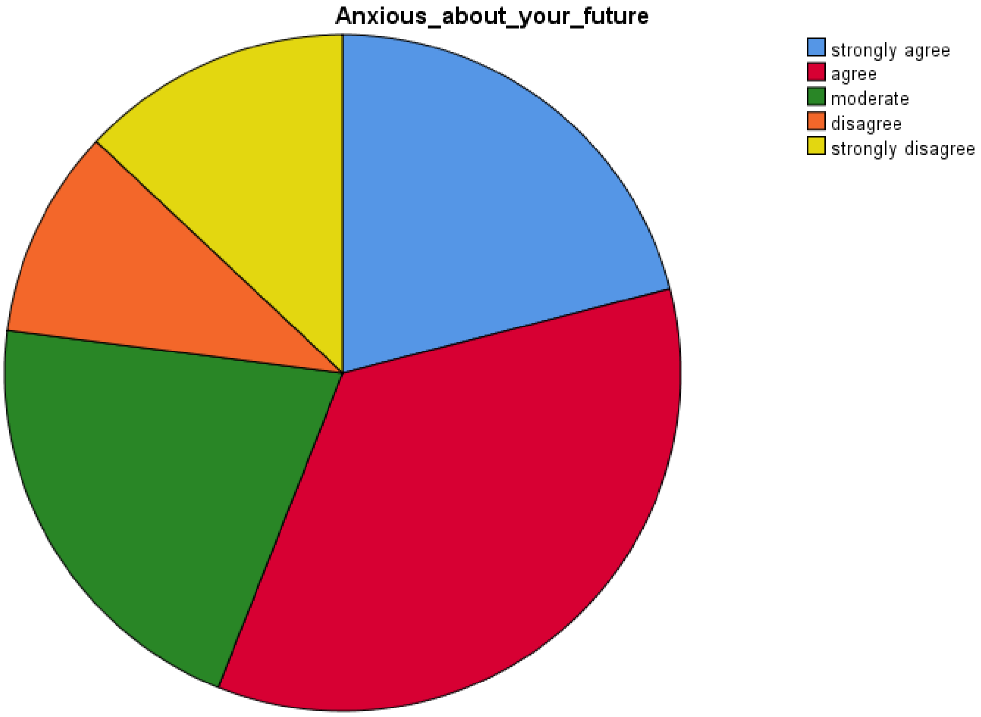


Table 5.10

Anxious_about_your_future					
		No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Strongly Agree	21	21.0	21.0	21.0
2.	Agree	35	35.0	35.0	56.0
3.	Moderate	21	21.0	21.0	77.0
4.	Disagree	10	10.0	10.0	87.0
5.	Strongly Disagree	13	13.0	13.0	100.0
	Total	100	100.0	100.0	

Table 5.10 describes that 35 per cent agree that they are anxious about the future 21 per cent strongly agree that they are anxious about your future and 21 per cent moderately agree. Huge size of the population is worried about their future due to the lack of medical advancement to cure the deadly disease like Covid-19, emergence of various strange viruses and its impact on human life. This anxiety about future causes psycho-physical problems among individuals.



PREVENTIVE MEASURES AGAINST COVID-19

“The best strategies or measures adopted by the village to combat the challenges posed by COVID-19”

Table 6.1

Strategies Against Financial Crisis					
S. No	Strategies Against Financial Crisis	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Personal saving scheme	22	22.0	22.0	22.0
2.	Jewel loan	11	11.0	11.0	33.0
3.	Personal loan from bank/individuals	21	21.0	21.0	54.0
4.	Any other employment	46	46.0	46.0	100.0
	Total	100	100.0	100.0	

Table 6.1 reveals that 46 percent of the respondents find alternative employment to overcome financial crisis 21 per cent avail loans, 22 percent rely on personal savings and 11 per cent took jewel loan.

Strategies against Financial Crisis

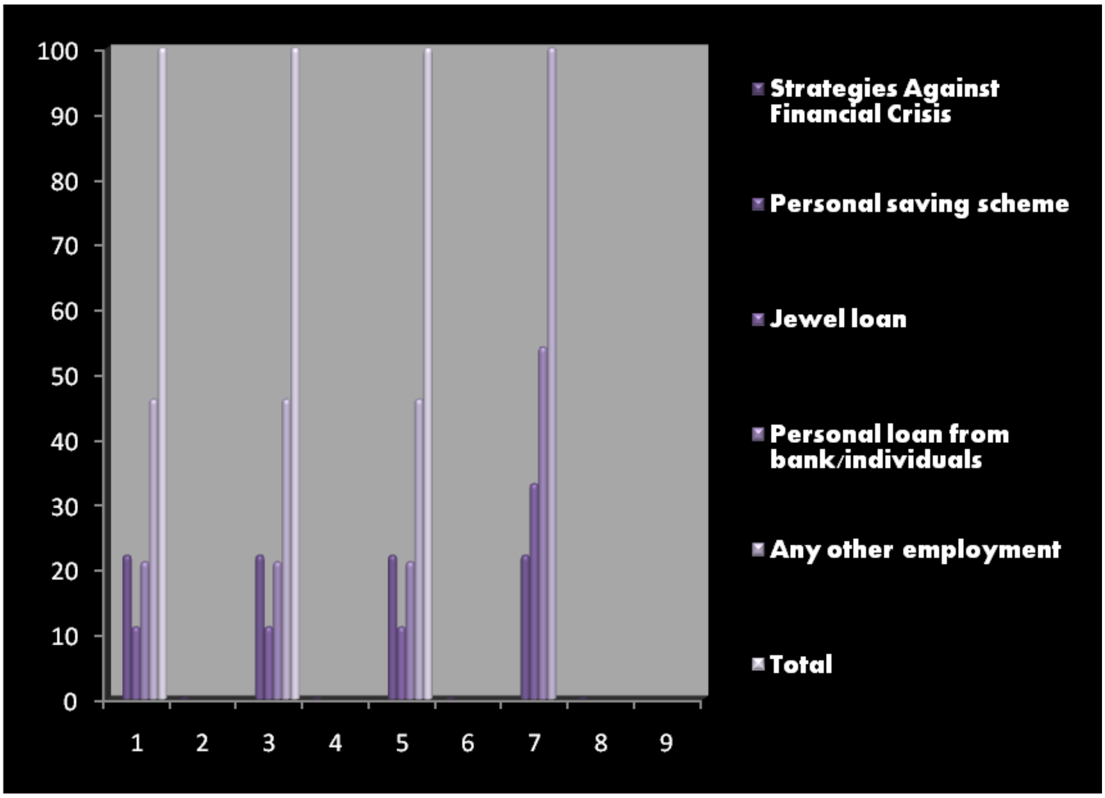


Table 6.2

Strategies to Personal Measures to Battle COVID -19 Pandemic					
S. No.	Strategies to Personal Measures to Battle COVID -19 pandemic	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Wearing face mask	68	68.0	68.0	68.0
2.	Washing hands regularly	11	11.0	11.0	79.0
3.	Drinking KabasuraKudineer	14	14.0	14.0	93.0
4.	Taking Vitamin D & Zinc tablets	7	7.0	7.0	100.0
	Total	100	100.0	100.0	

Table 6.2 shows that 68 per cent wear face mask, 11 per cent wash hands regularly. 14 percent drink kabasuraudineer and 7 per cent take vitamin D and zinc tablets. Wearing face mask is the most commonly adopted individual measure to combat Covid19 pandemic. People use face mask to protect themselves, low-priced, accessible.

Strategies to Personal Measures to Battle COVID _19_Pandemic

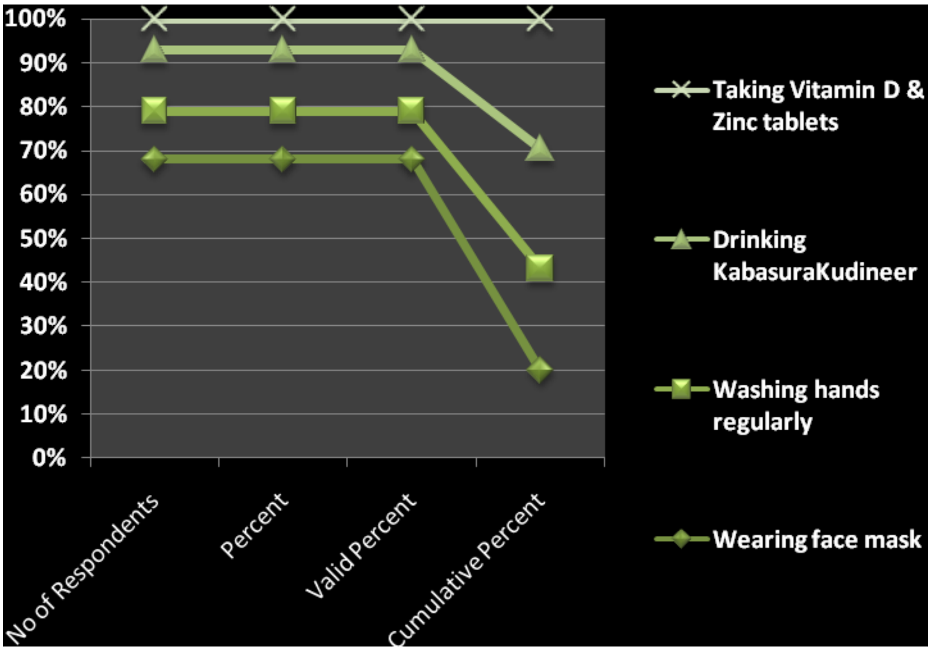


Table 6.3

Strategies to Building Immune System					
S. No.	Strategies to Building Immune System	No of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Healthy & Nutritious diet	61	61.0	61.0	61.0
2.	Avoiding smoking & drinking	14	14.0	14.0	75.0
3.	Traditional foods	16	16.0	16.0	91.0
4.	Exercise and good sleep	9	9.0	9.0	100.0
	Total	100	100.0	100.0	

Table 6.3 shows the strategies adopted to build immune system. 61 per cent take healthy and nutritious food since they are aware about the significance of food to fight against Covid-19, high economy, accessibility of food grain, fruits, vegetables and etc.. 14 percent avoid smoking and drinking, 16 percent take traditional foods and 9 per cent go for exercise and good sleep.

Strategies to Building Immune System

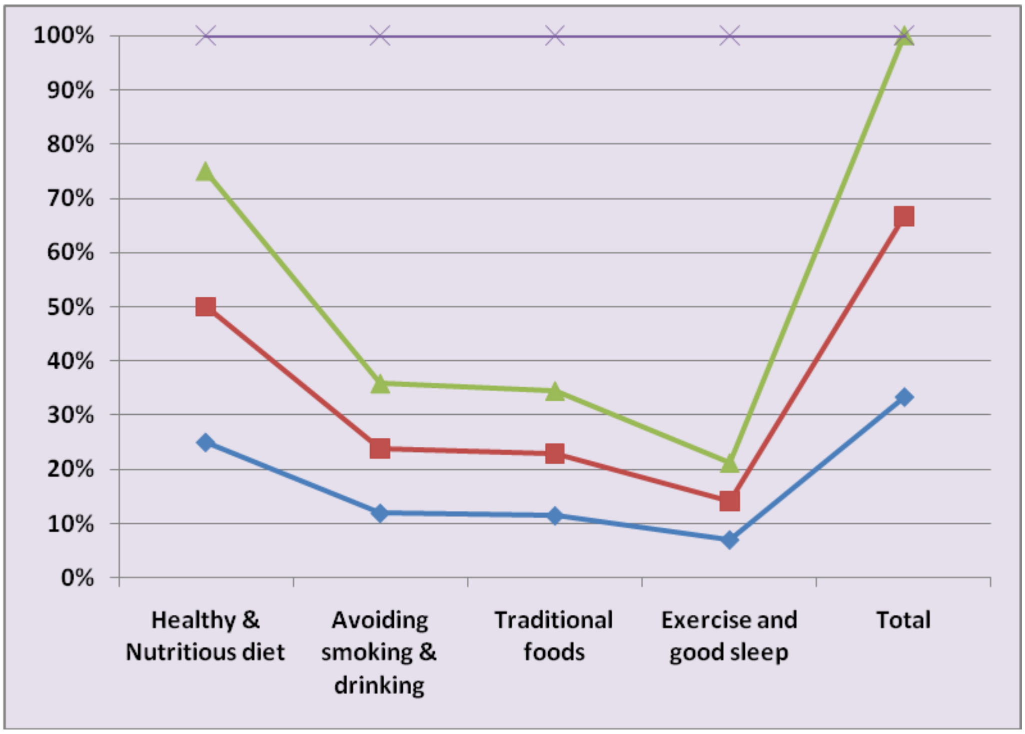


Table 6.4

Strategies to Tackle Emotions					
S.No.	Strategies to Tackle Emotions	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Spending time with family	76	76.0	76.0	76.0
2.	Playing indoor games	5	5.0	5.0	81.0
3.	Individual entertainment	19	19.0	19.0	100.0
	Total	100	100.0	100.0	

Table 6.4 portrays the strategies adopted to tackle emotions. Spending quality time with family is followed by 76 per cent of the respondents, For some people, spending time with family helps individuals to share their love and happiness with their life partners and children, to build healthy relationship in the family.19 per cent have individual entertainment and 5 per cent play indoor games to keep up their emotions.

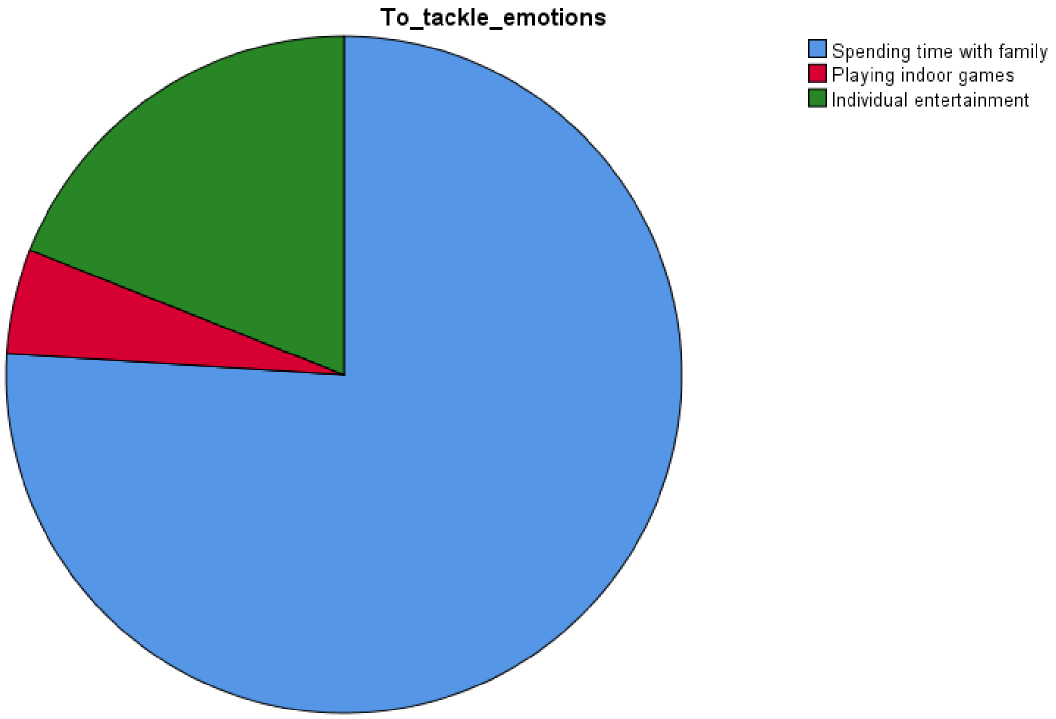
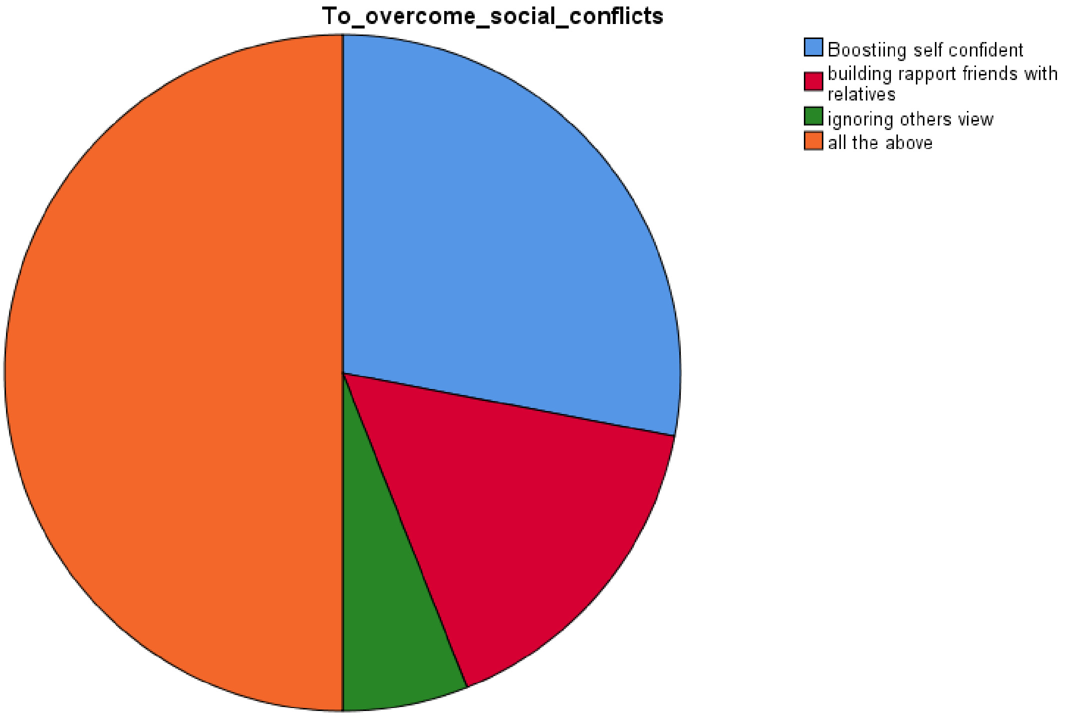


Table 6.5

To Overcome Social Conflicts

S. No.	Means to Overcome Social Conflict	No. of Respondents	Percent	Valid Percent	Cumulative Percent
1.	Boosting Self Confident	28	28.0	28.0	28.0
2.	Building Rapport Friends with Relatives	16	16.0	16.0	44.0
3.	Ignoring Others View	6	6.0	6.0	50.0
4.	All the Above	50	50.0	50.0	100.0
	Total	100	100.0	100.0	

Table 6.5 exhibits that 50 per cent of the respondents boost their self-confidence, build rapport with friends and relatives and ignore other point of view to overcome social conflicts. 28 per cent focus on boosting self-confidence. 16 per cent rely on building rapport with friends and relatives and 6 percent depend on ignoring other’s view point to overcome social conflicts.



CHAPTER IV

SUMMARY AND CONCLUSION:

- People are forced to live in inadequate housing.
- Many people are left jobless and without reserves of cash and food.
- People face difficulties in accessing government assistance.
- Access to healthcare is disrupted to a greater extent.
- Children could not access educational opportunities.
- Historically marginalized group are not able to work remotely.
- Lives of people are endangered and protection and livelihood needs to be guaranteed.
- Economic reconstruction is the need of the hour.
- Shops and grocery stores that do not go digital find it hard to survive.
- Cultural life of the people is disrupted.
- People are very much aware about Covid-19 through various agencies like Government, Students, Mobile Technology and Social Media.
- Respondents boost their self-confidence, build rapport with friends and relatives and ignore other point of view to overcome social conflicts.
- For some people, spending time with family helps individuals to share their love and happiness with their life partners and children, to build healthy relationship in the family.
- People are aware to build their immune system.
- Covid-19 brought impact in the life style of people.
- People are facing emotional problems such as isolation, frustration, stress, fear, anger, anxiety and depression, conflict in relationships both inside and outside family.
- People are aware of symptoms of Covid-19 such as coughing, sneezing, throat pain, fever, body pain and lack of tongue sensation.
- People are facing economic problems such as unemployment, poverty, theft, robbery, Debt and fetching loan.

- People are facing social problems such as social isolation, prejudice, stigma, social exclusion, difficulties in social gathering and geographical mobility.
- People unable to meet their basic needs like food, shelter and water.
- Life threatening situation due to Covid-19 brought social disorder in society.
- Some people are having the problem of limited access to doorstep delivery of essential resources due to internal politics, social discrimination, unavailability, ignorance and etc..
- People are adapting preventive measures to protect themselves from Covid-19 like wearing face mask, using hand sanitizer, taking medicines, maintaining social distance.

SUGGESTION AND RECOMMENDATION:

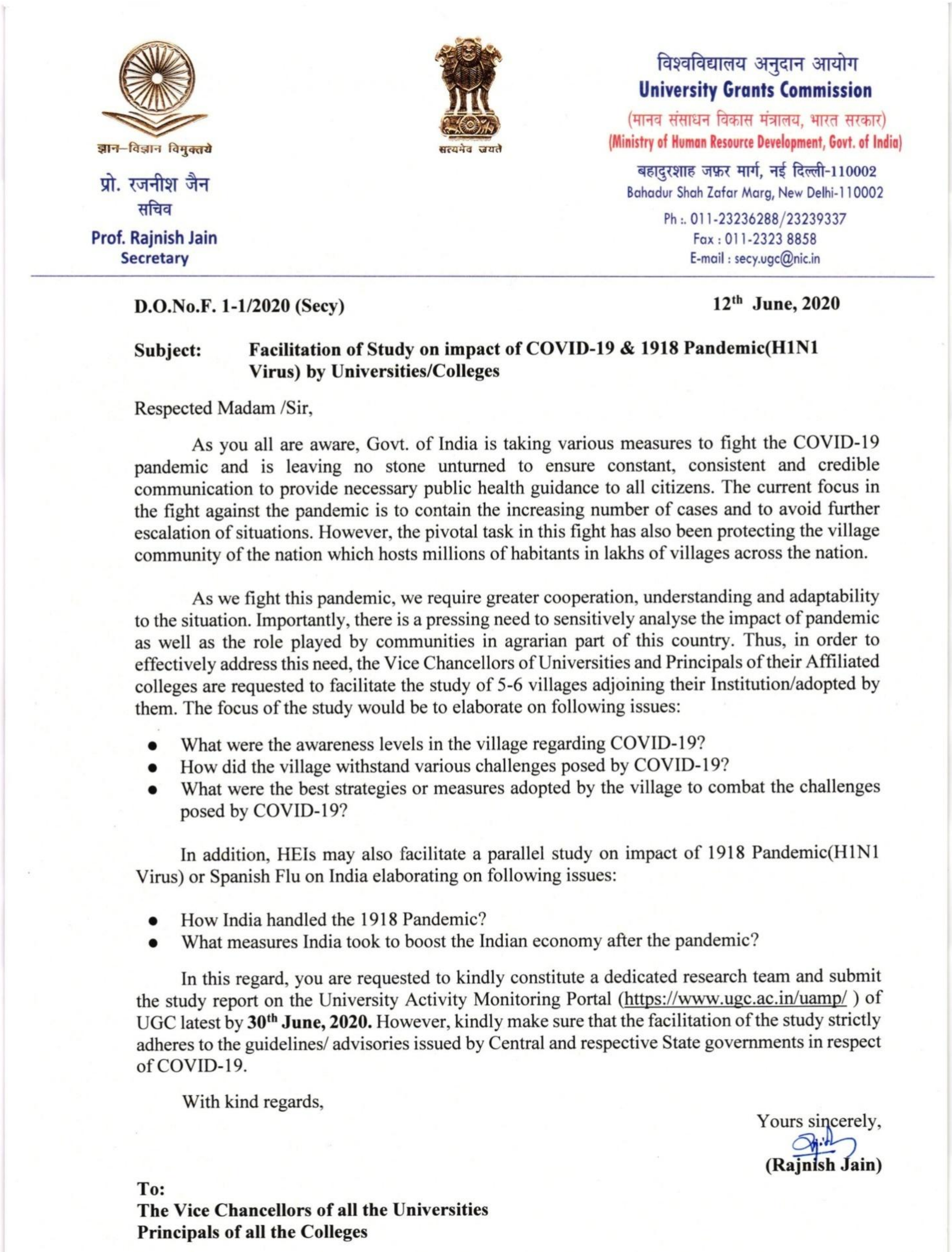
- People can strictly obey the rules and regulations given by government.
- People can stop going to crowded places like Market, Stores, Banks and Bus Stop and so on.
- The government can reach the unreached areas in delivering many services.
- Many institutions can take effort to find out medicines to control Covid-19.

CHAPTER V

SOCIAL RELEVANCE OF THE STUDY:

- This study would be useful for many institutions to undertake research study.
- The government can consider this research work in social planning, framing new schemes and welfare programmes for the marginalized group.
- This study shall create more awareness on Covid-19 and strategies that are adapted by the villagers in Tamil Nadu
- This study brings great change in one's personal and social life in the society.
- This study can influence to student community and people of other organizations to contribute something to needy people in a life-threatening situation.
- This study would aid in eliminating social stigma, prejudice, social exclusion and social discrimination about a family in which any of the family members is affected by Covid-19 or gone for Covid-19 test.

APPENDIX – I



ज्ञान–विज्ञान विमुक्तये

प्रो. रजनीश जैन
सचिव
Prof. Rajnish Jain
Secretary

सत्यमेव जयते

विश्वविद्यालय अनुदान आयोग
University Grants Commission
(मानव संसाधन विकास मंत्रालय, भारत सरकार)
(Ministry of Human Resource Development, Govt. of India)
बहादुरशाह जफ़र मार्ग, नई दिल्ली-110002
Bahadur Shah Zafar Marg, New Delhi-110002
Ph :. 011-23236288/23239337
Fax : 011-2323 8858
E-mail : secy.ugc@nic.in

D.O.No.F. 1-1/2020 (Secy) **12th June, 2020**

Subject: **Facilitation of Study on impact of COVID-19 & 1918 Pandemic(H1N1 Virus) by Universities/Colleges**

Respected Madam /Sir,

As you all are aware, Govt. of India is taking various measures to fight the COVID-19 pandemic and is leaving no stone unturned to ensure constant, consistent and credible communication to provide necessary public health guidance to all citizens. The current focus in the fight against the pandemic is to contain the increasing number of cases and to avoid further escalation of situations. However, the pivotal task in this fight has also been protecting the village community of the nation which hosts millions of habitants in lakhs of villages across the nation.

As we fight this pandemic, we require greater cooperation, understanding and adaptability to the situation. Importantly, there is a pressing need to sensitively analyse the impact of pandemic as well as the role played by communities in agrarian part of this country. Thus, in order to effectively address this need, the Vice Chancellors of Universities and Principals of their Affiliated colleges are requested to facilitate the study of 5-6 villages adjoining their Institution/adopted by them. The focus of the study would be to elaborate on following issues:

- What were the awareness levels in the village regarding COVID-19?
- How did the village withstand various challenges posed by COVID-19?
- What were the best strategies or measures adopted by the village to combat the challenges posed by COVID-19?

In addition, HEIs may also facilitate a parallel study on impact of 1918 Pandemic(H1N1 Virus) or Spanish Flu on India elaborating on following issues:

- How India handled the 1918 Pandemic?
- What measures India took to boost the Indian economy after the pandemic?

In this regard, you are requested to kindly constitute a dedicated research team and submit the study report on the University Activity Monitoring Portal (https://www.ugc.ac.in/uamp/) of UGC latest by **30th June, 2020.** However, kindly make sure that the facilitation of the study strictly adheres to the guidelines/ advisories issued by Central and respective State governments in respect of COVID-19.

With kind regards,

Yours sincerely,

(Rajnish Jain)

To:
The Vice Chancellors of all the Universities
Principals of all the Colleges

APPENDIX – II

FATIMA COLLEGE (AUTONOMOUS)

Re- Accredited With ‘A’ Grade By NAAC College with Potential for Excellence (2004-2019)

74th Rank in India Ranking 2020 (NIRF) by MHRD

Mary Land, Madurai -625018

JUNE 2020

Dear Brother/Sister, You have been rendering great help and support so far to our esteemed institution. Human beings are facing a tough situation right now, with the spread of COVID-19. As per the UGC guidelines, we are taking a survey on COVID-19. Please do answer the questions below and let us connect ourselves with bonds of togetherness and affection. **Thank You!**

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RELIGION : Muslim/Christian/Hindu
(Any Other) Specify :
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COMMUNITY : OC/BC/MBC/DNC/SC/ST
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EDUCATIONAL QUALIFICATION :

(Specify) : Uneducated/Primary/10 TH/12TH/Graduate/Diploma

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OCCUPATION : Self-employed/Private/Government/Daily wage labourer/

Unemployed

(Any Other) Specify :

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ANNUAL INCOME : Less than 1 lakh/ Greater than 1 lakh

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NAME OF THE VILLAGE :

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Section-A- Awareness

1. Symptoms of COVID-19 Pandemic?

a) Breathlessness b) Fever c) Coughing d) Throat pain

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2. Means of COVID-19transmission?

a) Droplets from coughing or sneezing of a COVID-19 infected person

b) In close contact with COVID-19patients

c) Touching virus infected surfaces and clothes

d) All the above

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3. Group of people affect the most by Covid 19

a) all age groups b) older and persons with prior medical conditions

c) Pregnant women d) All the above

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4.Got to know about COVID-19 through

a) Newspaper b) News channels c) Whatsapp d) Social awareness programmes

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5. Fatima College students created awareness among you on COVID-19 through

a) Palmphlets b) Rally c) Street play d) Songs

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Section-B- Challenges

S. No	**CHALLENGES FACED DUE TO COVID-19-PANDEMIC**	**Strongly agree**	**Agree**	**Moderate**	**Disagree**	**Strongly disagree**
1.	Is your mobility restricted?					
2.	Are you engulfed by feelings of fear, anger and helplessness?					
3.	Is there any rise in family and relationship conflicts?					
4.	Are you able to get aid through Government help lines?					
5.	Are you having limited access to doorstep delivery of essential resources?					
6.	Is your liberty and freedom curtailed?					
7.	Are you pushed to a state of stress and depression?					
8.	Do you feel insecure and frustrated?					`
9.	Do you face any financial crisis?					
10.	Are you anxious about your					

	future?					

Answer the following questions inside the boxes provided:

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Section-C-Strategies

Strategies Adopted - □□□□□□□□□ □□□□□□□□□

6. To fight financial crisis

a) Personal Saving Scheme b) Jewel loan

c) Personal loan from bank / individuals d) any other employment

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7. To battle COVID-19 Pandemic?

a) Wearing Face Masks b) Washing hands regularly

c) Drinking *Kabasura Kudineer* d) Taking Vitamin D & Zinc tablets

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8. To build Immune system

a) Healthy & Nutritious Diet b) Avoiding Smoking & Drinking

c) Traditional Foods d) Exercise and Good Sleep

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9. To tackle emotions

a) Spending time with family b) Playing Indoor games

c) Individual Entertainment d) Explore newthings

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10. To Overcome social conflicts.

a) Boosting self confident b) building rapport friends with relatives

c) Ignoring others view d) all the above

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Thanks for answering the questionnaire. Let us stay healthy & positive and fight COVID-19.

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