

Original Research Article

Acceptability of a second lockdown in Western India: anniversary of lockdown one

Shibal Bhartiya¹, Nishant Kumar^{2,3*}

¹Fortis Memorial Research Institute, Gurugram, Haryana, India

²Eyebetes Foundation, Mumbai, Maharashtra, India

³PD Hinduja Hospital, Khar, Mumbai, Maharashtra, India

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*Correspondence:

Dr. Nishant Kumar,

E-mail: nishant6377@hotmail.com

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ABSTRACT

Background: The aim of the study was to evaluate the knowledge and attitude of the inhabitants of the urban slums in Mumbai, Maharashtra, regarding re-imposition of a lockdown.

Methods: This cross-sectional, voluntary, questionnaire-based study was conducted in an urban slum in October, 2020. Questions were designed to elicit responses about COVID-19 awareness, acceptability of lockdown, including travel restrictions, closure of schools, colleges, and places of worship. Median and range were calculated for continuous variables, while categorical variables were represented as frequency and percentages. P value < 0.05 was statistically significant.

Results: A total of 1342 adult respondents (710 females, 632 males), were included in this questionnaire-based analysis. Most respondents believed awareness about COVID-19 was adequate, the younger population more in agreement with statement. 77.4% of the respondents believed that authorities should restrict travel to and from COVID-19 hotspot areas, while 81% said colleges and schools should be closed. Interestingly, 80.5% of the respondents supported closure of temples and mosques, while 75.7% supported a citywide lockdown with cases rising, and 7.6% were against it. The significant positive associations for lockdown included younger age, higher education, higher and income. Retired people were least likely to agree with the restrictions of a lockdown.

Conclusions: While majority of urban slum inhabitants in Mumbai agree with the need for a lockdown in case of increase in COVID-19 cases, it is important to continue culturally targeted risk communication, along with implementation of social justice-oriented policies.

Keywords: Second wave COVID-19, Lockdown reimposition, KAP in urban slum

INTRODUCTION

While various political, economic and social factors have determined the differential timing and intensity of lockdowns in various parts of the world, there is no denying that it has been the single most effective measure in preventing the spread of COVID-19.¹⁻⁶ The second-wave of the COVID-19 pandemic, albeit delayed, is now a reality in most parts of India.⁵

The first lockdown in India was a year ago, and sparked off an unprecedented social and economic crisis. The resultant chaos brought into sharp focus the reverse migration: thousands of the urban poor working in the unorganised sector, walked home to their villages, thousands of kilometres away, and thousands were pushed into abject hunger and poverty.^{4,7,8} Even a year after the event, the social and economic ramifications of the stringent curbs of industry and other economic activities,

along with those on educational institutions, are yet to be understood fully.

As the social distancing measures were relaxed, and expansionary economic measures prioritised, there has been a spurt in the number of cases of COVID-19.⁶ Governments, therefore, must weigh the socioeconomic costs of imposing stringent social restrictions yet again, against the risk of yet another health crisis.

Our study is an exploratory survey in the urban slums of Mumbai, the capital of Maharashtra, which continues to be at the epicentre of the COVID-19 second wave. To the best of our knowledge, it's the only study which attempts to evaluate the attitude of the local populace about the re-imposition of a lockdown.

METHODS

This cross-sectional questionnaire-based study was conducted in an urban slum in Mumbai, Maharashtra. A questionnaire designed to assess knowledge, attitude and practices pertaining to COVID-19 was administered along with a diabetes and eye screening program, after approval from the Institutional Ethics Committee at Ashwini Rural Medical College, Hospital and Research Center, Sholapur, Maharashtra.

A validated questionnaire in English, Hindi or Marathi was administered by trained personnel to 300 adults each day from the 5th October 2020 to 10th October 2020, after an informed consent. The questions had been designed to elicit the following details: demographic information, knowledge, attitudes and perspectives regarding COVID-19 and diabetes. For the purpose of this report, we have analysed the answers related to the lockdown only.

The responses to the following questions were analysed: (a) Is awareness regarding COVID-19 in society adequate? (b) If COVID-19 cases rise should authorities restrict travel from hotspot areas? (c) If COVID-19 cases rise should authorities' schools and colleges be closed? (d) If COVID-19 cases rise should authorities' close places of worship (temples mosques etc)? (e) If COVID-19 cases rise should authorities lockdown the city?

Inclusion criteria

Age >18 years, voluntary participation for 300 subjects each of the five days on a first come, first served basis. Residents of the slum who did not consent to their involvement in the study were excluded from the evaluation.

Statistical analysis

Median and range were calculated for continuous variables, while categorical variables were represented as frequency and percentages. The χ^2 test with Yates' correction, if required, and Fishers' exact test were used to

evaluate the difference in proportions. P value of <0.05 was considered as statistically significant.

RESULTS

A total of 1342 respondents, 710 of whom were females and the rest male, were included in this questionnaire-based analysis. Their demographic profile, including age, education, occupation and annual income is depicted in Table 1.

Table 1: Demographics (n=1342).

Variables	N (%)
COVID-19 antibody	Positive
	605 (45.1.1)
	Negative
	201 (15)
	No blood test
	536 (39.9)
Age (years)	18-40
	524 (39)
	40-60
	647 (48.2)
	>60
	171 (12.8)
Sex	Female
	710 (52.9)
	Male
	632 (47.1)
Education	Illiterate
	405 (30.2)
	<10 th standard
	841 (62.6)
	Graduate
	83 (6.2)
	Post graduate
	13 (1)
Income	No Income
	756 (56.3)
	<50000
	472 (35.2)
	50000-200000
	93 (6.9)
	>200000
	21 (1.6)
Occupation	Unemployed
	97 (7.2)
	Housewife
	517 (38.5)
	Blue collar
	485 (36.1)
	White collar
	26 (1.9)
	Small business
	85 (6.3)
	Retired
	85 (6.3)
	Student
	47 (3.5)
Have you had COVID-19	Yes
	8 (0.6)
	No
	1303 (97.1)
	Don't want to answer this question
	31 (2.3)

Most respondents believed that the awareness about COVID-19 was adequate, with the younger population more in agreement with statement. Other positive associations included higher education, higher income and those with blue collar jobs/small businesses (Table 2).

As many as 77.4% of the respondents believed that authorities should restrict travel to and from COVID-19 hotspot areas, while only 6.2% were against the idea. 16.4% of the people questioned said they did not know. The significant associations included COVID-19 antibody positivity, older age, male gender, and was the least in retired individuals (Table 3).

Table 2: Is awareness regarding COVID-19 in society adequate.

Variables		Yes (%)	No (%)	Don't know	P value
COVID-19 antibody	Positive	436 (72.1)	49 (8.1)	120 (19.8)	0.058
	Negative	158 (78.6)	18 (9)	25 (12.4)	
	No blood test	415 (77.4)	44 (8.2)	77 (14.4)	
Age (years)	18-40	428 (81.7)	44 (8.4)	52 (9.9)	<0.001
	40-60	470 (72.6)	53 (8.2)	124 (19.2)	
	>60	111 (64.9)	14 (8.2)	46 (26.9)	
Sex	Female	516 (72.7)	62 (8.7)	132 (18.6)	0.065
	Male	493 (78)	49 (7.8)	90 (14.2)	
Education	Illiterate	244 (60.2)	32 (7.9)	129 (31.9)	<0.001
	<10 th standard	686 (81.6)	64 (7.6)	91 (10.8)	
	Graduate	66 (79.5)	15 (18.1)	2 (2.4)	
	Post graduate	13 (100)	0 (0)	0 (0)	
Income	No income	544 (72)	74 (9.8)	138 (18.3)	0.001
	<50000	361 (76.5)	31 (6.6)	80 (16.9)	
	50000-200000	85 (91.4)	4 (4.3)	4 (4.3)	
	>200000	19 (90.5)	2 (9.5)	0 (0)	
Occupation	Unemployed	68 (70.1)	18 (18.6)	11 (11.3)	<0.001
	Housewife	374 (72.3)	45 (8.7)	98 (19)	
	Blue collar	382 (78.8)	19 (3.9)	84 (17.3)	
	White collar	16 (61.5)	10 (38.5)	0 (0)	
	Small business	74 (87.1)	7 (8.2)	4 (4.7)	
	Retired	53 (62.4)	7 (8.2)	25 (29.4)	
	Student	42 (89.4)	50.6	0 (0)	
Have you had COVID-19	Yes	7 (87.5)	1 (12.5)	0 (0)	0.323
	No	982 (75.4)	105 (8.1)	216 (16.6)	
	Don't want to answer this question	20 (64.5)	5 (16.1)	6 (19.4)	

Table 3: If COVID-19 cases rise authorities should restrict travel from hotspot areas.

Variables		Yes (%)	No (%)	Don't know	P value
COVID-19 antibody	Positive	443 (73.2)	45 (7.4)	117 (19.3)	0.001
	Negative	156 (77.6)	19 (9.5)	26 (12.9)	
	No blood test	440 (82.1)	19 (3.5)	77 (14.4)	
Age (years)	18-40	443 (84.5)	28 (5.3)	53 (10.1)	<0.001
	40-60	488 (75.4)	41 (6.3)	118 (18.2)	
	>60	108 (63.2)	14 (8.2)	49 (28.7)	
Sex	Female	543 (76.5)	32 (4.5)	135 (19)	0.001
	Male	496 (78.5)	51 (8.1)	85 (13.4)	
Education	Illiterate	251 (62)	25 (6.2)	129 (31.9)	<0.001
	<10 th standard	700 (83.2)	51 (6.1)	90 (10.7)	
	Graduate	76 (91.6)	6 (7.2)	1 (1.2)	
	Post graduate	12 (92.3)	1 (7.7)	0 (0)	
Income	No income	575 (76.1)	42 (5.6)	139 (18.4)	0.014
	<50000	362 (76.7)	34 (7.2)	76 (16.1)	
	50000-200000	82 (88.2)	6 (6.5)	5 (5.4)	
	>200000	20 (95.2)	1 (4.8)	0 (0)	
Occupation	Unemployed	79 (81.4)	9 (9.3)	9 (9.3)	<0.001
	Housewife	391 (75.6)	23 (4.4)	103 (19.9)	
	Blue collar	380 (78.4)	29 (6)	76 (15.7)	
	White collar	20 (76.9)	6 (23.1)	0 (0)	
	Small business	74 (87.1)	6 (7.1)	5 (5.9)	
	Retired	50 (58.8)	9 (10.6)	26 (30.6)	
	Student	45 (95.7)	1 (2.1)	1 (2.1)	
	Yes	8 (100)	0 (0)	0 (0)	0.563

Continued.

Variables		Yes (%)	No (%)	Don't know	P value
Have you had COVID-19	No	1007 (77.3)	82 (6.3)	214 (16.4)	
	Don't want to answer this question	24 (77.4)	1 (3.2)	6 (19.4)	

Table 4: If COVID-19 cases rise authorities should schools and colleges be closed.

Variables		Yes (%)	No (%)	Don't know	P value
COVID-19 antibody	Positive	473 (78.2)	16 (2.6)	116 (19.2)	0.084
	Negative	169 (84.1)	16 (3)	26 (12.9)	
	No blood test	447 (83.4)	16 (3)	73 (13.6)	
Age (years)	18-40	461 (88)	9 (1.7)	54 (10.3)	<0.001
	40-60	508 (78.5)	23 (3.6)	116 (17.9)	
	>60	120 (70.2)	6 (3.5)	45 (26.3)	
Sex	Female	558 (78.6)	22 (3.1)	130 (18.3)	0.038
	Male	531 (84)	16 (2.5)	85 (13.4)	
Education	Illiterate	265 (65.4)	13 (3.2)	127 (31.4)	<0.001
	<10 th standard	734 (87.3)	22 (2.6)	85 (10.1)	
	Graduate	78 (94)	3 (3.6)	2 (2.4)	
	Post graduate	12 (92.3)	0 (0)	1 (7.7)	
Income	No income	598 (79.1)	18 (2.4)	140 (18.5)	0.005
	<50000	387 (82)	15 (3.2)	70 (14.8)	
	50000-200000	85 (91.4)	5 (5.4)	3 (3.2)	
	>200000	19 (90.5)	0 (0)	2 (9.5)	
Occupation	Unemployed	81 (83.5)	1 (1)	15 (15.5)	<0.001
	Housewife	405 (78.3)	14 (2.7)	98 (19)	
	Blue collar	397 (81.9)	15 (3.1)	73 (15.1)	
	White collar	25 (96.2)	1 (3.8)	0 (0)	
	Small business	80 (94.1)	2 (2.4)	3 (3.5)	
	Retired	57 (67.1)	4 (4.7)	24 (28.2)	
	Student	44 (93.6)	1 (2.1)	2 (4.3)	
Have you had COVID-19	Yes	7 (87.5)	0 (0)	1 (12.5)	0.701
	No	1059 (81.3)	36 (2.8)	208 (16)	
	Don't want to answer this question	23 (74.2)	2 (6.5)	6 (19.4)	

Table 5: If COVID-19 cases rise authorities should close places of worship (temples mosques etc).

Variables		Yes (%)	No (%)	Don't know	P value
COVID antibody	Positive	467 (77.2)	20 (3.3)	118 (19.5)	0.039
	Negative	166 (82.6)	9 (4.5)	26 (12.9)	
	No blood test	447 (83.4)	16 (3)	73 (13.6)	
Age (years)	18-40	455 (86.8)	12 (2.3)	57 (10.9)	<0.001
	40-60	507 (78.4)	26 (4)	114 (17.6)	
	>60	118 (69)	7 (4.1)	46 (26.9)	
Sex	Female	558 (78.6)	21 (3)	131 (18.5)	0.045
	Male	522 (82.6)	24 (3.8)	86 (13.6)	
Education	Illiterate	263 (64.9)	15 (3.7)	127 (31.4)	<0.001
	<10 th standard	727 (86.4)	28 (3.3)	86 (10.2)	
	Graduate	78 (94)	2 (2.4)	3 (3.6)	
	Post graduate	12 (92.3)	0 (0)	1 (7.7)	
Income	No income	594 (78.6)	22 (2.9)	140 (18.5)	0.02
	<50000	384 (81.4)	17 (3.6)	71 (15)	
	50000-200000	84 (90.3)	5 (5.4)	4 (4.3)	
	>200000	18 (85.7)	1 (4.8)	2 (9.5)	
Occupation	Unemployed	80 (82.5)	3 (3.1)	14 (14.4)	<0.001
	Housewife	404 (78.1)	13 (2.5)	100 (19.3)	
	Blue collar	393 (81)	19 (3.9)	73 (15.1)	

Continued.

Variables	Yes (%)	No (%)	Don't know	P value
White collar	24 (92.3)	1 (3.8)	1 (3.8)	0.854
Small business	81 (95.3)	1 (1.2)	3 (3.5)	
Retired	54 (63.5)	7 (8.2)	24 (28.2)	
Student	44 (93.6)	1 (2.1)	2 (4.3)	
Yes	7 (87.5)	0 (0)	1 (12.5)	
No	1050 (80.6)	44 (3.4)	209 (16)	
Don't want to answer this question	23 (74.2)	1 (3.2)	7 (22.6)	

Table 6: If COVID-19 cases rise authorities should lockdown the city.

Variables	Yes (%)	No (%)	Don't know	P value
COVID-19 antibody	Positive 441 (77.9)	43 (7.1)	121 (20)	0.068
	Negative 157 (78.1)	16 (8)	28 (13.9)	
	No blood test 418 (78)	43 (8)	75 (14)	
Age (years)	18-40 431 (82.3)	34 (6.5)	59 (11.3)	<0.001
	40-60 477 (73.7)	52 (8)	118 (18.2)	
	>60 108 (63.2)	16 (9.4)	47 (27.5)	
Sex	Female 521 (73.4)	53 (7.5)	136 (19.2)	0.037
	Male 495 (78.3)	49 (7.8)	88 (13.9)	
Education	Illiterate 239 (59)	37 (9.1)	129 (31.9)	<0.001
	<10 th standard 692 (82.3)	58 (6.9)	91 (10.8)	
	Graduate 74 (89.2)	7 (8.4)	2 (2.4)	
	Post graduate 11 (84.6)	0 (0)	2 (15.4)	
Income	No income 554 (73.3)	57 (7.5)	145 (19.2)	0.006
	<50000 360 (76.3)	39 (8.3)	73 (15.5)	
	50000-200000 85 (91.4)	5 (5.4)	3 (3.2)	
	>200000 17 (81)	1 (4.8)	3 (14.3)	
Occupation	Unemployed 75 (77.3)	8 (8.2)	14 (14.4)	<0.001
	Housewife 376 (72.7)	38 (7.4)	103 (19.9)	
	Blue collar 376 (77.5)	33 (6.8)	76 (15.7)	
	White collar 18 (69.2)	8 (30.8)	0 (0)	
	Small business 77 (90.6)	5 (5.9)	3 (3.5)	
	Retired 51 (60)	9 (10.6)	25 (29.4)	
	Student 43 (91.5)	1 (2.1)	3 (6.4)	
Have you had COVID-19	Yes 7 (87.5)	0 (0)	1 (12.5)	0.677
	No 986 (75.7)	101 (7.8)	216 (16.6)	
	Don't want to answer this question 23 (74.2)	1 (3.2)	7 (22.6)	

Similarly, 81% of the respondents said it is correct to close colleges and schools, and only 2.8% believed it was not right to do so. 16% said they did not know. The significant associations included younger age, higher education, higher income and the retired people were least likely to agree with the statement (Table 4).

Interestingly, 80.5% of the inhabitants of the urban Mumbai slum believed that it is correct to close temples and mosques. Only 3.5% were against the idea, the others responding with a I don't know. The significant associations included younger age, higher education, higher income and the retired people were least likely to agree with the statement (Table 5).

75.7% supported the idea that if the number of COVID-19 cases increases, authorities should lock down the city, while 7.6% was against it. 16.7% of the respondents said they did not know. The significant associations included younger age, higher education, higher income (maximum for the 50,000-200,000-income group) and the retired people were least likely to agree with the statement (Table 6).

Similarly, of those agreeing to isolation of patients in specialised COVID-19 facilities for in patient care, significant associations included younger age, higher education, higher income and also profession. Those in white collar jobs and small business owners were most likely to agree, and the retired least likely to agree with the statement (Table 6).

DISCUSSION

As the country rides the second wave of COVID-19 infections, there seems to be a general consensus among policy makers that a second lockdown may well be inevitable. While there is no consensus at present on the timing of the lockdown in Western India, its imposition seems to be a foregone conclusion since an on-time enforcement of lockdown may control the spread of infection. Verma et al compared the pattern of transmission rates in six countries at posterior estimated change points, and reported that in India, like Italy, even though the lockdown was announced on time, or even ahead of schedule, its inadequate implementation was responsible to the spread of infections.¹ In case of the USA, the partial implementation of lockdown lead to the spread, while the delayed implementation of the lockdown Russia, United Kingdom and France was responsible for the same.

Even though the reimposition of the lockdown transfers the responsibility back for epidemic control from individual to state, it is the individual whose cooperation is essential for its successful implementation. It must, also be kept in mind that the poorest and the most marginalised are impacted the most, by both, the disease and the socioeconomic ramifications of the lockdown. The inhabitants of the urban slums in Indian metros were affected the most during lockdown one. They live in squalor, overcrowded spaces where social distancing is almost impossible. Add to it the poor access to health and sanitation facilities, and the fact that they are already more prone to infections due to poor general health and malnutrition. The reverse migration during lockdown one is also fresh in the minds of the local populace and the policy makers alike. However, despite this, the urban slums have managed to fight the pandemic with great resilience, with death rates no more than the national average. It is therefore imperative to understand the mindset of all stakeholders, especially those it will affect the most: the urban poor and the marginalised, who are already grappling with the aftermath of the year-long COVID-19 pandemic.

An on-site, interviewer-administered questionnaire, performed within an urban slum limits selection bias, as these are the people least prone to participate in internet surveys. These surveys also eliminate another selection bias, where only the educated are included. Therefore, even though interviewer-administered surveys have a higher level of social-desirability response bias, as compared to online surveys, they are extremely important in an urban slum community where many respondents may not be able to read and write.⁹

Our study, therefore, not only attempts understand the acceptability of the lockdown in the most vulnerable populations, it also attempts to elucidate their knowledge about COVID-19 transmission, which may be critical in the successful enforcement of the proposed lockdown.

Most authors agree that, during a pandemic, people are likely to comply with control measures, but may not be able to do so if their livelihood is threatened. The psychological impact of quarantine means frequent reminders of its benefits are essential for its enforcement.¹⁰⁻¹²

Even though previous evaluations in different sociocultural contexts have reported an overall public support for lockdown measures, despite its economic and social consequences, there is scant data about the public acceptance of a second lockdown.¹³⁻²³

Peretti et al reported that the low-income and low-education respondents were more likely to display critical or limited support of the lockdown in France.¹⁶ They correlated it to the higher acceptance of the vaccine during the 2009 A/H1N1 flu pandemic by the higher socioeconomic class, both higher education and income, as well as professional and managerial occupations, which is usually associated with a higher trust in public health authorities.¹⁷ They also correlated the current response to the fact that the living conditions, financial adversities, and pre-existent social inequalities were exacerbated by the lockdown for those of a lower socioeconomic status far more than for others.

In our study also, those who were less educated and from a lower socioeconomic background are less supportive of the lockdown measures: be it closing of schools and colleges, or places of worship. As expected, those who are retired from an active professional life, and therefore perhaps older and less well informed are the most resistant to the lockdown measures. It is interesting to note that antibody positivity (which implies a recent infection) as well a history of actually having had COVID-19 has little significance on the responses to the lockdown. One possible cause could be that the number of COVID-19 patients in the study was small, and consequently unable to assume statistical significance. Another plausible cause is the fact that those who have had a recent infection, or have recovered from the disease in the past, are not as scared of the disease as the general population.

It is therefore important to tailor all communication strategies to the possible devastating effects of COVID-19, its infectivity, and methods of prevention.

Limitations

One major limitation was that our study was an interviewer-administered survey, which has a higher level of social-desirability response bias. However, since many inhabitants of the slum are illiterate, it includes a demographic that is usually underrepresented in KAP studies. Additionally, the results of this urban slum may not be representative of other similar slum clusters in the city, and elsewhere in the county. Also, since the survey was voluntary, the KAP of those who did not choose to participate in the survey remains unrepresented in this analysis.

CONCLUSION

While a majority of the population of urban slums in Mumbai agrees with the need for a lockdown in case of an increase in the number of COVID-19 cases, along with its attendant closures of educational institutions and places of worship, it is critical to remember that this is the demographic that is affected the most by its economic ramifications. It is, therefore, important that the core of the national agenda be two pronged: there must be a culturally targeted risk communication, and the implementation of social justice-oriented policies to deal with health and social inequalities must be an explicit priority.

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REFERENCES

1. Yadav AK. Impact of lockdown to control over Novel Coronavirus and COVID-19 in India. J Family Med Prim Care. 2020;9(10):5142-7.
2. Hargreaves JR, Logie CH. Lifting lockdown policies: A critical moment for COVID-19 stigma. Glob Public Health. 2020;15(12):1917-23.
3. Ferraresi M, Kotsogiannis C, Rizzo L, Secomandi R. The 'Great Lockdown' and its determinants. Econ Lett. 2020;197:109628.
4. Verma BK, Verma M, Verma VK, Abdullah RB, Nath DC, Khan HTA, et al. Global lockdown: An effective safeguard in responding to the threat of COVID-19. J Eval Clin Pract. 2020;26(6):1592-8.
5. Atalan A. Is the lockdown important to prevent the COVID-19 pandemic? Effects on psychology, environment and economy-perspective. Ann Med Surg (Lond). 2021:102232.
6. WHO. Coronavirus disease (COVID-19) pandemic, 2020. Available at: <https://www.who.int/emergencies/diseases/novel-coronavirus>. Accessed on 20 March 2021.
7. Alfano V, Ercolano S. The Efficacy of Lockdown Against COVID-19: A Cross-Country Panel Analysis. Appl Health Econ Health Policy. 2020;18(4):509-17.
8. Lau H, Khosrawipour V, Kocbach P, Mikolajczyk A, Schubert J, Bania J, et al. The positive impact of lockdown in Wuhan on containing the COVID-19 outbreak in China. J Travel Med. 2020;27(3):37.
9. Krishan K, Kanchan T. Lockdown is an effective 'vaccine' against COVID-19: A message from India. J Infect Dev Ctries. 2020;14(6):545-6.
10. Khanna RC, Cicinelli MV, Gilbert SS, Honavar SG, Murthy GSV. COVID-19 pandemic: Lessons learned and future directions. Indian J Ophthalmol. 2020;68(5):703-10.
11. WHO. Rolling updates on coronavirus disease (COVID-19): WHO characterizes COVID-19 as a pandemic, 2020. Available at: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>. Accessed on 20 March 2021.
12. Suresh R, James J. Migrant Workers at Crossroads- The Covid-19 Pandemic and the Migrant Experience in India. Soc Work Public Health. 2020;35(7):633-43.
13. Mohan M, Mishra S. India's Response to the COVID-19 Pandemic: A Frontal Assault on the "Historically Dispossessed". Int J Health Serv. 2021;51(1):107-14.
14. Irudaya RS, Sivakumar P, Srinivasan A. The COVID-19 Pandemic and Internal Labour Migration in India: A 'Crisis of Mobility'. Indian J Labour Econ. 2020;1-19.
15. Galesic M, Tourangeau R, Couper MP, Conrad FG. Eye-Tracking Data: New Insights on Response Order Effects and Other Cognitive Shortcuts in Survey Responding. Public Opin Q. 2008;72(5):892-913.
16. Blendon RJ, Koonin LM, Benson JM, Cetron MS, Pollard WE, et al. Public response to community mitigation measures for pandemic influenza. Emerg Infect Dis. 2008;14(5):778-86.
17. Brooks SK, Webster RK, Smith LE, Woodland L, Wessely S, Greenberg N, et al. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. Lancet. 2020;395(10227):912-20.
18. Qiu J, Shen B, Zhao M, Wang Z, Xie B, Xu Y. A nationwide survey of psychological distress among Chinese people in the COVID-19 epidemic: implications and policy recommendations. Gen Psychiatr. 2020;33(2):100213.
19. Azlan AA, Hamzah MR, Sern TJ, Ayub SH, Mohamad E. Public knowledge, attitudes and practices towards COVID-19: A cross-sectional study in Malaysia. PLoS One. 2020;15(5):233668.
20. Sibley CG, Greaves LM, Satherley N, Wilson MS, Overall NC, Lee CHJ, et al. Effects of the COVID-19 pandemic and nationwide lockdown on trust, attitudes toward government, and well-being. Am Psychol. 2020;75(5):618-30.
21. Sabat I, Neuman BS, Varghese NE, Barros PP, Brouwer W, Exel J, et al. United but divided: Policy responses and people's perceptions in the EU during the COVID-19 outbreak. Health Policy. 2020;124(9):909-18.
22. Peretti WP, Verger P, Launay O, COCONEL Study Group. The French general population's attitudes toward lockdown against COVID-19: a fragile consensus. BMC Public Health. 2020;20(1):1920.
23. Raude J, Caille BAL, Setbon M. The 2009 pandemic H1N1 influenza vaccination in France: who accepted to receive the vaccine and why? PLoS Curr. 2010;2:1188.

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