

ASSESSING IMPACT OF THE COVID-19 PANDEMIC ON THE SOCIO-ECONOMIC SITUATION OF VULNERABLE POPULATIONS THROUGH COMMUNITY-BASED MONITORING



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HUMAN DEVELOPMENT

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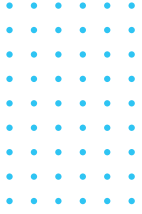
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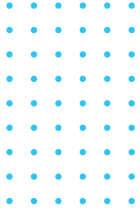
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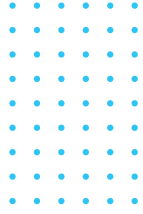
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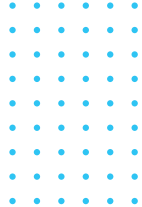
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Abbreviations

ASHAs	Accredited Social Health Activists
AWC	Anganwadi Centre
AWW	Anganwadi Workers
BBBP	Beti Bachao Beti Padhao
CSEI	Centre for Social Equity and Inclusion
CSOs	Civil Society Organizations
CBM	Community Based Monitoring
CVs	Community Volunteers
GDP	Gross Domestic Product
HMIS	Health Management Information System
IGNDPS	Indira Gandhi National Disability Pension Scheme
IGNOPS	Indira Gandhi National Old-age Pension Scheme
IGNWPS	Indira Gandhi National Widow Pension Scheme
IHD	Institute for Human Development
ICDS	Integrated Child Development Services
KSY	Kishori Shakti Yojana
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
NGOs	Non-Governmental Organizations
PMGKY	Pradhan Mantri Garib Kalyan Yojana

PMJAY	Pradhan Mantri Jan Arogya Yojana
PMJDY	Pradhan Mantri Jan-Dhan Yojana
PMJJBY	Pradhan Mantri Jeevan Jyoti Bima Yojana
PMMVY	Pradhan Mantri Matru Vandana Yojana
PMUY	Pradhan Mantri Ujjwala Yojana
PDS	Public Distribution System
SC	Scheduled Caste
ST	Scheduled Tribe
SAG	Scheme for Adolescent Girls
SHGs	Self Help Groups
THR	Take Home Ration
TOTs	Training of Trainers
WNTA	Wada Na Todo Abhiyan



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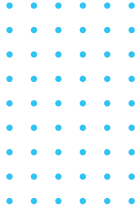
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Foreword

The COVID 19 pandemic continues to pose enormous challenges for humanity. The social and economic costs of pandemic containment and saving lives has been significant all across the globe. The vulnerabilities of marginalized families is exacerbated, pushing them further into poverty and deprivation, in a multidimensional way. As a joint UN strategy to address the evolving challenges, UNICEF undertook Community Based Monitoring (CBM) of the situation, partnering with thirteen Civil Society Organizations and their local network of three hundred community volunteers across India.

The cohort based longitudinal CBM study was conducted in 12 districts of seven states where UNICEF is operational. The real time results provided critical evidence in the effort for addressing this humanitarian crisis. Given the challenges of data paucity and collection in the existing data-ecosystem, results from CBM were important in planning effective interventions and in developing appropriate communications to address risks of the pandemic. Across the four rounds of the monitoring, the CBM covered several key themes and generated evidence for programming towards protecting the rights of children, young people and women.

This report presents the findings from the four rounds of data collection, starting from June to December 2020. There are some interesting time-trends indicating an evolving situation and gradual recovery. At a time when we are still battling the pandemic with its waning second wave, the findings can be used as a 'snap-shot' of the impact of the pandemic on multiple dimensions of the lives of the most vulnerable, across the country.

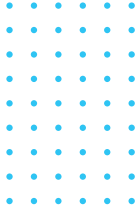
The study shows that COVID vaccine awareness is high amongst the marginalized families, even though the reach was low in many rural areas. Also, vaccine hesitancy was observed, with about 40 per cent of respondents, especially among the illiterate or those with low education levels. Families headed by a female, those with no fixed source of income, and home returnees are found to be more vulnerable, and possess lower levels of awareness on social protection schemes and services by the Government.

We hope that the findings highlighted by this study can serve as an informed resource for prioritization of mitigation measures of COVID-19 by Governments and support in designing appropriate long-term recovery plans for children and their families.

DR. YASMIN ALI HAQUE

Representative, UNICEF India





Preface

The year 2020 has witnessed unprecedented disruption and distress in people's lives as the COVID-19 pandemic spread throughout the world. Governments across the world have responded swiftly, and the Indian Government, in particular, declared an early nationwide lockdown with the onset of the virus in the month of March 2020. Concerted efforts from the government to contain the spread of the virus, along with tireless work by frontline workers, including doctors and nurses, sanitation workers, police personnel and others involved in maintaining the continuity of essential services have helped the common people to combat the disease and to negotiate the associated impact of the lockdown.

The adverse impacts of the pandemic on the marginalised segments of the population, who have already been battling poverty, unemployment, malnutrition, and many other challenges, are expected to be higher than for others in the society. The long and difficult journeys undertaken by millions of migrant workers back home to their villages have been recorded widely. Many families lost their earnings overnight, and hunger loomed as a major challenge. The voices of the vulnerable people needed to be heard by the policy-makers, which also posed a problem with people being confined to their homes, and restrictions being imposed on the movement of goods and services.

In this context, UNICEF took the lead in conducting a community-based monitoring mechanism to gather voices from the marginalised populations with the help of civil society organizations and its network of community volunteers. The ground level assessment, conducted over four phases during the period June-July till December 2020, uncovered the real situation that these families had faced during this period.

Given that government measures for combating the pandemic underwent changes during this time, and there were phases of unlocking the economy, it was found that these families suffered the loss of livelihood immediately after the lockdown, but subsequently there was a gradual recovery. There was a food shortage and many families went hungry, with grave implications for all, and the growth and development of children, in particular. Pregnant mothers also reported not being able to get three meals a day. The overall availability of food improved gradually, but gaps remained, particularly in urban centres. A similar adverse impact was witnessed in the health sector, with a disruption in government services for both pregnant and lactating mothers as well as for small children. The impact of the pandemic has been disastrous in the sphere of education, with school closures and the digital divide exposing the fault lines between the haves and the have-nots.

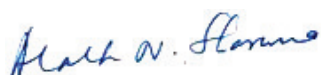
On the positive side, it is extremely encouraging to note that government institutions such as hospitals and *Anganwadi* centres have gradually become much more functional as compared to the situation prevailing immediately after the lockdown, though the outreach has been better in rural areas relative to the urban areas. Social protection instruments such as the Public Distribution System (PDS) and Mahatma Gandhi National Rural Employment Guarantee Scheme



(MGNREGS) have proved to be lifelines for vulnerable families though many other social protection schemes have not proved to be as effective. The Panchayati Raj institutions have, however, contributed enormously in these troubled times.

It has been an enriching experience for the Institute for Human Development (IHD) to partner with UNICEF for the preparation of this important report on “Assessing Impact of COVID-19 Pandemic on Socio-Economic Situation of Vulnerable Population—Through Community Based Monitoring”. I am very happy that IHD has been able to play a pivotal part in the preparation of this report—its responsibilities comprised data processing, analysis, and report preparation. It has been a great pleasure for my colleagues and me to work with the UNICEF Team, comprising Ms. Misaki Akasaka Ueda, Mr. K.D. Maiti, Ms. Antara Lahiri, Mr. Chayan Roy Chaudhary, and Ms. Urvashi Kaushik, for preparing this report and we express our sincere thanks to all of them for their cooperation and efforts. From IHD, Professor Tanuka Endow led the team, which was ably supported by Dr. Tanushree Kundu and Dr. Prashant Arya. Professor Ravi Srivastava provided his valuable inputs at every stage of the work and my sincere thanks are due to them.

This report has brought out the voices of the vulnerable populations, as they experienced the devastation caused by the disruptive COVID-19 pandemic. With the country having witnessed a severe second phase of the pandemic, we hope that the experiences and lessons from the first phase, as captured in this report, will aid policymakers in the formulation of targeted strategies for improved livelihoods, assuaging hunger and ensuring better access to education and health services.

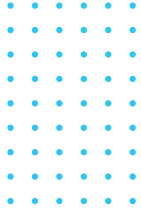


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We are grateful to the Institute for Human Development, New Delhi, under the leadership of Professor Alakh N. Sharma, Director, Professor Tanuka Endow and the team for agreeing to develop this report based on the evidence gathered in four rounds, in 7 states. The Community Based Monitoring (CBM) study would not have been possible without collaboration of 12 (twelve) civil society organizations and their network of 300 community volunteers, in meeting the very objective of gathering voices from the ground. I would like to express sincere thanks to Ms. Annie Namala, Executive Director, Centre for Social Equity and Inclusion (CSEI), Ms. Binish Nafees and the entire team for spearheading the CSO partnership and in facilitating inputs from the ground level.

I am grateful to Dr. Yasmin Ali Haque, UNICEF Country Representative for her leadership in appreciating the need for this study and the need to disseminate results quickly with all stakeholders, focusing on the 'leave no one behind' principle of the Sustainable Development Goals (SDGs) and Yasumasa Kimura, Deputy Representative, UNICEF, Jalpa Ratna, Chief Of Field Services, UNICEF and all UNICEF Programme Chiefs and their teams in supporting the study and providing valuable technical inputs and encouragement across all the 4 rounds of the longitudinal study. Special mention needs to be made for the constant support and valuable comments, of Ms. Antara Lahiri, Social Policy Specialist, Dr. Robert Johnstone, Nutrition Specialist, Dr. Ajay Trakroo, Health Specialist, Ms. Alka Malhotra, C4D Specialist, Ms. Tannistha Dutta, Child Protection Specialist, Mr. Padmanav, M&E Specialist, Mr. Chayan Roy Choudhury, M&E and Data Consultant, Ms. Sunisha Ahuja, Education Specialist, Ms Neelam Pol, T4D specialist, Dr. Sanjay Kumar, UNFPA, Ms. Anubha Dubey, IT Specialist and Mr. Devanik Saha, Data Consultant.

Last but not least, I would like to especially acknowledge and thank Mr. K D Maiti, PME Specialist for leading and contributing to the design and implementation of this near-real time data collection on a digital format, in a manner to be able to disseminate the data quickly.

As research of this nature need innovations at every step, this is a result of strong teamwork. I would like to thank all those colleagues that contributed to the report but whose names may not appear in this short note.

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EXECUTIVE SUMMARY



Background

The outbreak of the COVID-19 pandemic in India led to a nation-wide lockdown starting from March 25, 2020. The pandemic and the lockdown involved restricted mobility of people as well as goods and services. This created severe challenges for vulnerable families due to the closure of shops, factories, and offices, and restricted access to public services. One of the biggest impact of the lockdown was the loss of livelihoods, especially in urban locations, as a result of which millions of workers across India moved back to their villages. The post-lockdown challenges encompassed practically all sectors, including not only livelihoods, but also food availability, health and nutrition, education, and access to public facilities for people. The children were also severely impacted in terms of food shortage, healthcare, disruption in education, and increase in risk of child marriage and child labour.

In April 2020, the UN agencies in India considered ways to assess the socio-economic impact of COVID-19 on the marginalized population. UNICEF, took the lead in conceptualizing a Community Based Monitoring (CBM) mechanism to gather voices from the marginalized families with the help of the civil society organizations (CSOs) and their network of community volunteers (CVs).

THE PRIMARY OBJECTIVES OF THE CBM WERE TO:

- i) Generate evidence and a quick analysis of the impact of the COVID-19 pandemic on the vulnerable population about a broad range of issues, including the impact on livelihoods, access to essential goods and basic services, awareness about critical health and hygiene issues, and receipt of and access to direct benefit transfers and services allied to social protection measures; and
- ii) Provide evidence for policy making at the district and state levels to reduce the current and future risk of widened inequalities after the pandemic.

The CBM was carried out in 12 districts, including six rural and six urban ones, in seven states. The selection of states and districts was based on: (i) the high incidence of COVID-19 positive cases, as of April 2020, and (ii) the available CSO structure and network for facilitating data collection. The criterion for selecting rural districts was the presence of large numbers of home returnees and highly vulnerable population in the districts concerned. For urban districts, the selection criterion was the prevalence of large slum habitations with a high likelihood of transmission of infection and more out-migration. Data was gathered through 25 CVs from 25 habitations in each district, who were associated with the various partnering CSOs, and working with people in the sample habitations.

The CBM was conducted over four phases in 2020, starting with Phase 1 in June-July, followed by Phase 2 in August-September, Phase 3 in October-November, and Phase 4 in December. It covered approximately 5,000 households in the first phase and 6,000 households in each successive phase. The sample families, located in villages (rural) and slums (urban) comprised mainly casual workers, some regular salaried workers, and some unemployed persons. Around half the main earning members were either illiterate or had completed primary level education. More than half of the sampled families belonged to Scheduled Caste (SC) or Scheduled Tribe (ST) communities.



Key Results: Economic Condition

- The vulnerability of the sample families deepened in the COVID-19 pandemic-induced lockdown in March 2020, which increased the share of jobless persons. The percentage of the unemployed subsequently declined and by December (that is, in Phase 4) had fallen to below the pre-lockdown levels. But the situation was exacerbated by increased casualization of work and a decline in access to regular salaried work, resulting in poorer quality of the jobs available post-lockdown. As a result, most families experienced a decline in wages and persistence of lower incomes till December (Phase 4).
- Access to jobs under the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) provided some relief to rural communities. Those who were seeking MGNREGS jobs but were not working under this scheme, accounted for 27 per cent of the respondents during Phase 3 in October-November. The main reasons cited by them for not working were: they had not received a job card after application (cited by 37.3 per cent of the respondents); they were not registered due to the lack of documents (cited by 29.6 per cent) and that the Panchayat was not open (cited by 28.8 per cent). The respondents also mentioned delays in receipt of payments as one of the reasons for not working.
- Access to adequate food was a daunting challenge for the respondents. Rural communities fared better than their urban counterparts in this respect. The situation improved after June-July (Phase 1), but many people continued to grapple with hunger

right up to December (Phase 4), with 28 per cent of the urban respondents reporting food shortage.

- One-third of the respondents spent relatively less on essential food items such as vegetables, milk, fruits, and eggs, in December (Phase 4) as compared to the pre-lockdown levels. This decline, which likely led to curtailed consumption of these protein-rich food items, is expected to have adversely impacted children's development, in particular.
- There is good (but not universal) access to PDS ration cards in poor communities, with better access observed in the rural locations. However, there was higher non-availability of ration cards in urban areas (23.4 per cent) as compared to rural areas (12.1 per cent) during December (Phase 4). People reportedly received foodgrain staples from the community PDS shops, but there was lower distribution of pulses, sugar, and edible oils than rice and wheat.
- Home returnees and female-headed families were more vulnerable than the average households as far as the share of jobless persons and food availability were concerned. Moreover, in families with small children, a higher percentage of home returnees reported food scarcity vis-à-vis resident families. This indicated a higher adverse impact on children's growth in the families of home returnees.
- There is a lack of awareness and low access to some major social protection schemes among respondents, particularly in urban locations. Only 63 per cent of the urban respondents were aware of the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), and 26 per cent of urban respondents could access the same. Similarly, 72 per cent of the respondents in the urban areas were aware about the Pradhan Mantri Ujjwala Yojana (PMUY) and the benefits offered under the programme. Still, correspondingly only 38 per cent of the respondents could access the benefits being offered under this scheme.



Key Results: Health and Nutrition

- Urban communities were more affected by COVID-19 than rural communities. But people were largely able to receive treatment in health facilities and were aware of the COVID-19 testing centres. For many, the testing facilities were available far away from their habitations.
- Wearing a mask and maintaining social distance were major challenges for the respondents in protecting themselves from COVID-19. Only 52 per cent of the respondents reported wearing a mask throughout while going outside their homes and 46 per cent reported maintaining social distance in rural locations.

- The use of toilets was reported by 90 per cent of the urban respondents, but the corresponding figure was much lower among rural respondents.
- Respondents showed a high degree of awareness about the COVID-19 vaccine and opined that the elderly (those above 65 years of age) should receive the vaccine ahead of others. The next preferred category for receiving vaccines was that of children up to 18 years of age. Television, radio and newspapers were the most important and trusted sources of information about COVID-19, followed by government health workers, including Accredited Social Health Activists (ASHAs) and *Anganwadi* Workers (AWW). The study found that rural communities rely more on Government health workers as compared to urban communities. Social media, family, and friends are also trusted sources of information.
- Access to Government facilities for pregnant women was limited in June-July (Phase 1) but improved considerably over the subsequent assessment rounds. Access to prenatal services also increased between June-July (Phase 1) and August-September (Phase 2). A high proportion of rural pregnant women reported that the local *Anganwadi* Centre (AWC) provided services under the Integrated Child Development Services (ICDS) scheme. However, In the case of urban respondents, the percentage of pregnant women reporting that the local AWC was providing ICDS services declined between August-September (Phase 2) and December (Phase 4).
- Only around three-fifths of the pregnant women respondents could eat three main meals daily (October-November, Phase 3), reflecting the pressures on food availability among the vulnerable populace. The unavailability of food also has adverse implications for the nutrition of unborn children. The sample districts of Jalaun, Lalitpur, and Agra fared the worst in this respect.
- The supplementary source of nutrition, that is, the Take Home Ration (THR) intake, for pregnant women, lactating mothers, and mothers of 2-5-year-old children, was adversely affected in the wake of the lockdown. But subsequently there was improvement, with rural access to THR being higher than urban access.
- Although child immunization suffered a greater negative impact in urban areas because of the lockdown, access to immunization improved subsequently. In December (Phase 4), 72 per cent of the rural and 69 per cent of the urban mothers of a one-year-old child reported that their child had received immunization as of the previous month.



Key Results: Education

- School education of children from vulnerable families has suffered major disruption in the wake of the COVID-19 pandemic and lockdown. Nearly all the schools were closed for the major part of 2020, and online classes became the main avenue for learning. Consequently, the digital divide affected the respondent families adversely. Many of them could not afford devices such as smartphones and lacked digital literacy and access to adequate Internet connectivity. The children from such families were thus at risk of falling off the education grid altogether.
- Following the lockdown, an increasing number of schools offered online classes. For example, in June-July (Phase 1), 22 per cent of the rural and 31 per cent of the urban mothers of 6-19-year-old children reported that their children were attending online classes, but the corresponding figures during October-November (Phase 3) improved to 50 per cent (rural) and 74 per cent (urban), respectively.
- Access to online classes varied significantly between locations and was better in urban than in rural areas. Mobile phones were the primary means of attending online classes, followed by the sharing of Internet links and television.
- Some children were not attending classes even when their school was offering online classes. Again, lack of access to digital devices like smartphones and computers was the main reason behind the non-attendance.
- An encouraging finding was that despite the threat of the COVID-19 infection, most respondent mothers reported in December (Phase 4) that they were willing to send their children to school when the schools would re-open.



Key Results: Child Protection and Gender-based Protection

- There was limited reporting of the incidence of child marriage among the sample communities. Two-fifths of the CVs reported an increase in incidents of gender-based violence. Awareness regarding helplines to report such incidences of violence was much higher among urban mothers of 6-19-year-old children than among rural mothers.
- In December (Phase 4), one-fifth of the rural and 16 per cent of the main earners in the urban setting with 6-18 year-old children in their families said that their children were either doing paid work or were looking for such work. One-third of such children were in the age group of 6–14 years. There were also reports of considerable engagement of children in domestic chores, especially in rural localities.
- Access to the important child protection scheme, *Beti Bachao Beti Padhao*, was particularly low among the sample communities, as reported by the CVs.



Key Results: Local Governance

- Panchayats have been active in awareness-building regarding the use of masks and social distancing, sanitation, distribution of food and financial assistance, facilitating quarantines and access to MGNREGS work, immunization of children, and distribution of THR to pregnant women and lactating mothers.



Concluding Observations

- The COVID-19 pandemic caused enormous distress in the lives of the people, particularly among the vulnerable population. Yet the innate resilience of human beings, along with urgent responses from governments and institutions helped people get back on their feet. However, this task of restoring normalcy is still unfinished as problems associated with livelihoods, food shortage, health and nutrition deficits among both adults and children, and problems emanating from school closures persist to a large extent.
- It is thus crucial for social protection programmes to function effectively and Government institutions to continue to provide critical services for the poor. It is encouraging to note the high degree of access to ration cards and the very high shares of ration-cardholders who could get ration from shops under the Public Distribution System (PDS). However, the urban respondents in slums did not report as high an access to ration cards as the rural respondents. In contrast, a large part of the rural population sought access to MGNREGS job cards but not all could get it.
- Therefore, going forward, while the especially vulnerable segments such as the home returnees and female-headed families need to be provided targeted assistance, including cash transfers, other solutions are also needed in the medium term. Some such measures could entail creating livelihood options for the poor, with suitable skill development, strengthening the PDS network with an improvement in ration-card holding for slum populations in urban centres or introducing universal PDS distribution during the pandemic in vulnerable geographies. In this context, introducing across-state portability of ration cards can help overcome the problems of getting ration cards for workers who migrate from state to state. Accessibility of job cards under MGNREGS must be improved.
- In education, the lockdown served to show the importance of technology in the present age. Many children, especially in rural areas, could not attend online classes after the lockdown due to school closure and the digital divide in the dispensation of education. Therefore, longer-term solutions for educating first-generation learners must be identified to narrow the gap between them and the children from better-off families.

- The Panchayati Raj Institutions have contributed in a big way towards battling the devastating impact of the COVID-19 pandemic. They have contributed towards ensuring sanitation, spreading awareness about wearing of masks and maintaining social distance, managing food distribution, quarantine situations, and reaching THR to pregnant women and lactating mothers, among other things. Since they are in direct touch with the communities, they can be extremely effective on the ground and become a fundamental channel in managing the ramifications of the pandemic.
- The CBM findings have shown that people find wearing masks all the time and maintaining social distance at gatherings a challenge and are therefore not practising these adequately. Given that TV was one of the most effective mediums of dissemination, there is a greater need for effective campaigns to spread awareness regarding such coping mechanisms and implementation of COVID-appropriate behaviour.
- Along with awareness campaigns, stricter law enforcement is also needed to build public opinion against gender-based violence and to embolden women to contact helplines. The CBM has shown that many children are engaged in paid work and domestic chores. This is largely due to a drop in family income. Therefore, it would be advisable for the government to provide a certain fixed amount as compensation to poor families to mitigate the loss of wages for families and avert a situation wherein children may be pushed into doing paid or unpaid work for family sustenance.
- The CBM found that the impact of the lockdown was more severe in urban than in rural areas. Further, despite easier geographical access in urban locales, rural services were more resilient than urban services in most places. The finding indicates that over a period of time, the rural social protection and health delivery system has developed a stronger foothold. However, there are still large gaps in the delivery systems in the urban areas. Given that the lockdown and the pandemic exposed the precariousness of poor urban populations (including home returnees), more focus is needed to develop appropriate institutional structures and mechanisms to deal with deprived urban population, especially those living in slums and peri-urban areas.
- Finally, though the CBM reports an improvement over time in most indicators across geographical areas, the degree of improvement and the gaps that remain vary significantly across locations. Hence, states and local governments need to strengthen the delivery mechanisms and responses in such areas.

01

CHAPTER



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INTRODUCTION



Following the outbreak of the COVID-19 pandemic worldwide, and within India, the nation went into a lockdown starting from March 25, 2020. After the lockdown, there were several restrictions on the mobility of people and on the movement of goods and services to contain the spread of the pandemic, which are now gradually being lifted. Thus, the COVID-19 pandemic posed a dual challenge—not only were the common people at risk of suffering from COVID-19, but the lockdown also created severe challenges for vulnerable families due to the closure of shops, factories, and offices, and restricted access of people to public services. One of the biggest impacts of the lockdown was the full or partial loss of livelihoods, especially in urban locations, as a result of which millions of workers across India moved back to their villages. The post-lockdown challenges encompassed practically all sectors, including not only livelihoods, but also food availability, health and nutrition, education, and access to public facilities for people. The situation at home too worsened, especially for women and adolescent girls due to a rise in gender-based violence, the incidence of children seeking paid jobs or being forced to work to improve the family's economic condition, and children getting married or being engaged for marriage.

The impact of the lockdown on the economy is evident from the significant decline of the Gross Domestic Product (GDP). The real GDP declined by a record 23.9 per cent on a year-on-year (y-o-y) basis in the first quarter in 2020-21 (April-June 2020), followed by a decline of 7.5 per cent in the second quarter.¹ “In the third quarter, a slight reversal of 0.4 per cent growth in GDP has been reported.”² Private consumption and investment slumped, and was only partly cushioned by government spending. The supply-side challenges included severe contractions in industry and services, and lack of resilience in most sectors, except agriculture. Supply bottlenecks were exacerbated by social distancing and higher taxes pushed up inflation, with pressures evident in the prices of both food and non-food items.³

The impact of COVID-19, the ensuing lockdown and the post-lockdown challenges are unlikely to have been uniform across the citizens of the country. Those who were disadvantaged before the lockdown due to various factors such as poverty, ill health, and malnourishment, would likely suffer a more adverse impact. In this background, sometime in April 2020, almost all UN agencies in India were trying to assess the

1. <https://pib.gov.in/PressReleasePage.aspx?PRID=1676486>

2. <https://indianexpress.com/article/business/economy/india-q3-october-december-gdp-updates-gross-domestic-product-data-7206108/>, RBI Monetary Policy Report, October 2020

3. RBI Monetary Policy Report, October 2020.

socio-economic impact of COVID-19 on the marginalised population. The main desirable characteristics of the assessment which evolved at that time, were that the assessment should be rapid, use innovative mechanisms, and should at the same time follow COVID-19 protocols laid down by the Government.

Considering that a traditional survey could not be taken up (in fact, all face-to-face interviews were banned or restricted), UNICEF, entrusted with the task of leading the study, conceptualised a Community Based Monitoring (CBM) mechanism to solicit voices from the marginalized families with the help of Civil Society Organizations (CSOs) and its network of community volunteers (CVs). The proposed mechanism used a mix of several digital tools for data collection and analysis.

The primary objectives of the CBM were to:

1. Generate evidence and provide a quick analysis of the impact of the COVID-19 pandemic on the vulnerable population with regard to a broad range of issues, including its impact on livelihoods, access to essential goods and basic services, awareness about critical health and hygiene issues, and receipt of and access to direct benefit transfers and services allied to social protection measures.
2. Provide evidence for policymaking at the district and state levels to reduce the current and future risk of widened inequalities in the aftermath of the pandemic.

Given that the pandemic situation was evolving rapidly, and that the COVID-19 pandemic hit the marginalized and vulnerable families the hardest in a multi-dimensional way, the study aimed to provide critical evidence quickly to policymakers to augment the implementation of social service programmes and schemes in a manner that would mitigate the current and future risks of widened inequalities. Since the challenges faced by the people were interconnected, the CBM focused on sectors that directly or indirectly exhibited deprivations such as livelihood, health and nutrition, education, social and child protection, and some governance issues.

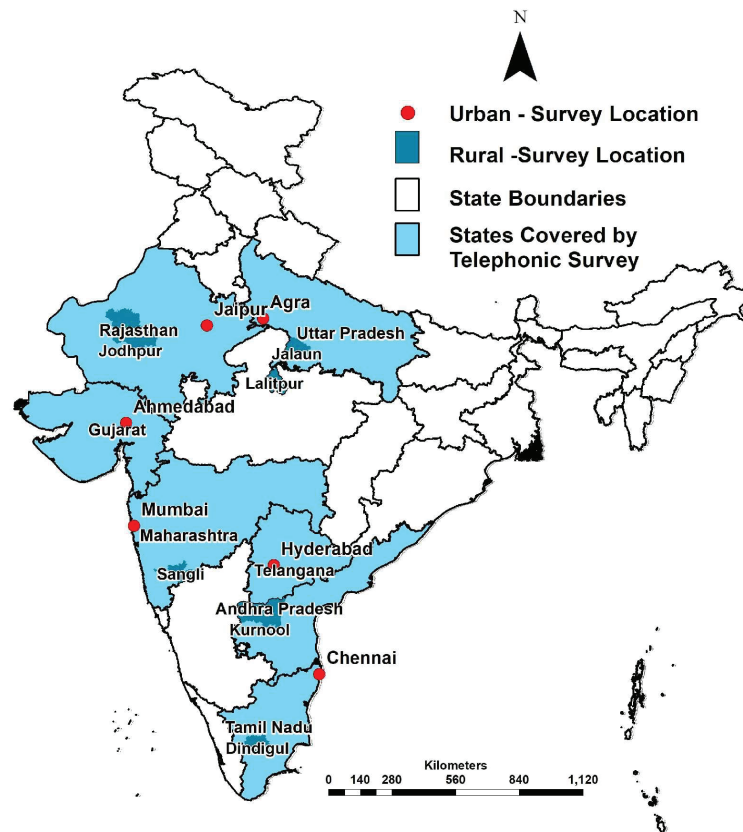
1.1 Background

Since the effect of COVID-19 on the marginal population across the country would be largely similar, irrespective of the geography, CBM was undertaken in 12 districts in seven states (see *Table 1.1*).

State	District	
	Rural	Urban
Uttar Pradesh	Jalaun and Lalitpur	Agra
Tamil Nadu	Dindigul	Chennai
Rajasthan	Jodhpur	Jaipur
Maharashtra	Sangli	Mumbai
Andhra Pradesh	Kurnool	-
Telangana	-	Hyderabad
Gujarat	-	Ahmedabad

The selection of states and districts was based on the (i) high incidence of COVID-19 positive cases as of April 2020, and (ii) available CSO structure and network for facilitating data collection. The criterion for the selection of rural districts was the presence of large numbers of home returnees and highly vulnerable populations. The criterion for the selection of urban districts was the existence of large slum habitations with a high likelihood of transmission of infection and higher incidence of out-migration.

Figure 1.1 Coverage of the CBM study



Source: Prepared by IHD team

Traditionally social groups such as Scheduled Castes (SCs) and Scheduled Tribes (STs) comprise the vulnerable segments of the population due to the socio-economic disadvantages faced by them. However, the COVID-19 pandemic created new dimensions of vulnerability in the form of people who suddenly lost jobs following the lockdown, including home returnees, as well as families lacking food security, and small children and school-going children who started being deprived of nutritious food due to the temporary suspension of Anganwadi and other government services. Such vulnerabilities formed the basis for identifying the vulnerable segments of the populations for the CBM.

02

CHAPTER



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DESIGN AND METHODOLOGY



2.1 Rapid Pro platform

The CBM adopted a longitudinal cohort design, to assess the evolving situation of deprivation and vulnerabilities, facilitating both a cross-sectional as well as a time-trend analysis. A key feature of the CBM mechanism for rapid assessment was about developing a panel of respondents at the habitation/community level for micro-assessment of the situation as well as macro-assessment based on the responses from the cohort of CVs.

The panel is so developed to consist of socio-economically marginalized and vulnerable families' main earning member, their other family members namely, the pregnant and lactating women, mothers of children of different vulnerable age-groups mainly, less than one year, 2 to 5 years and 6 to 19 years' school-going children. Given that the home returnees faced additional challenges due to displacement from their places of livelihood, purposively, the sample of families contains a significant proportion of home returnees (that is, families who had migrated back to their homes following the COVID-19 related national/state lockdown) and female-headed families, comprising around 15-17 per cent of the total families. For details on the stratification of families, see Section 2.1.3.

2.1.1 Respondent types

The following six different respondent types were targeted for interviews to be covered in each habitation:

- a. Main earning member of the selected family;
- b. Pregnant women;
- c. Lactating mothers;
- d. Women with a child aged below one year;
- e. Women with a child aged 2-5 years; and
- f. Women with a child aged 6-19 years.

The four phases of data collection were conducted between June-July and December 2020, with the first phase in June-July 2020, and the three subsequent phases in August-September, October-November, and December 2020, respectively.

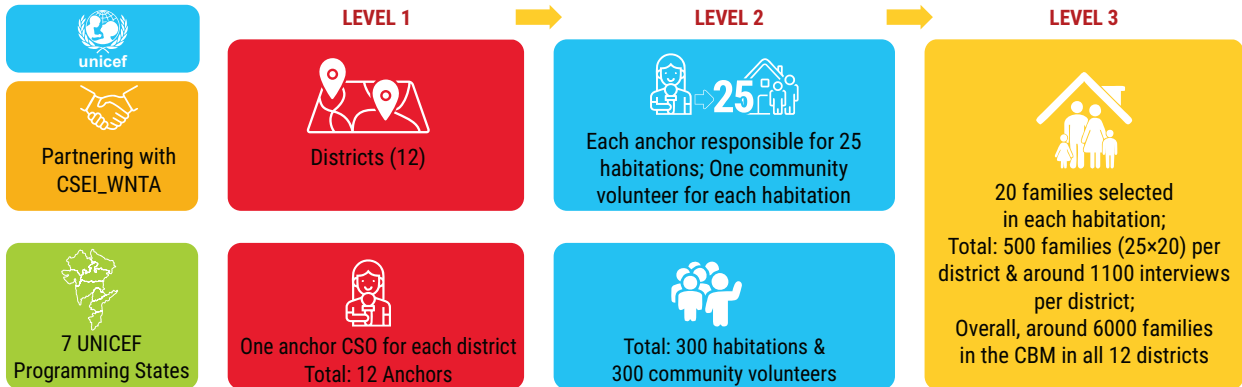
The network of 12 CSOs (one in each of the selected districts, named as anchor CSO) partnered for the CBM, coordinated under a single umbrella CSO (lead CSO), namely—the Centre for Social Equity and Inclusion (CSEI) and Wada Na Todo Abhiyan (WNTA). As regards the UNICEF-designed mechanism and implementation plan, evidence gathering was managed on the Rapid Pro platform,¹ a free open-source software. As stated above, the data collection was done by the CSO partners through their CVs, with field-level monitoring done by the UNICEF team and the anchor CSOs. Overall, around 300 CVs were engaged in the CBM, with each CV managing and collecting data from one habitation.

2.1.2 The overall implementation structure of the CBM

The implementation of CBM took place under the following three broad layers:

1. One lead CSO, networking with the 12 district-level CSOs, in seven states;
2. District level CSOs, including one in each of the selected 12 districts, and 25 habitations selected from each district; and
3. One CV supporting one habitation, resulting largely in 25 CVs in each district. Twenty families were selected purposively in each habitation, through a pre-determined grid decided by UNICEF, in such a manner that one CV was coordinating with 20 families in his/her habitation.

Figure 2.1 Implementation structure of the CBM

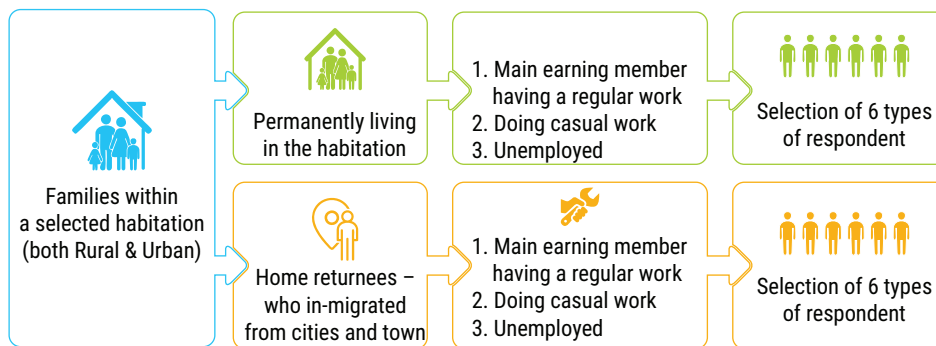


2.1.3 Stratification of selected habitations for selection of families and its members

Once the habitation was selected within the selected district, in order to capture vulnerabilities caused by the COVID-19 pandemic, families within the habitation were grouped under the following two broad categories: (1) those living permanently in the habitation, and (2) home returnees who had come back to the habitation post the March 2020 lockdown. Within each category, families were further stratified by the employment status of the main earning member of the families, as follows:

- Holding a regular job/having a monthly salary;
- Doing casual work with no fixed tenure of job and no contractual obligation with the employer; and
- Having no job.

Figure 2.2 Selection of sample for the CBM



Twenty families were selected from the above six sub-categories, including three each for the home returnees and the permanent residents, as per a fixed grid given in Figure 2.3.

Figure 2.3 Respondent types and interviews conducted per district

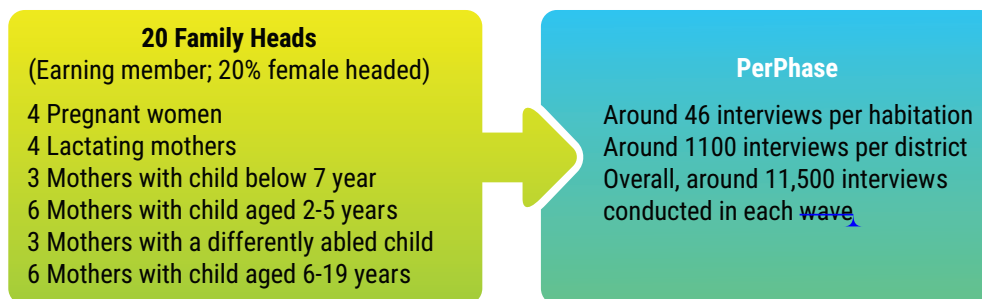


Table 2.1: Distribution of habitations by states and districts			
Village/Slum Areas	States	Districts	Habitations Covered
Villages	Tamil Nadu	Dindigul	25
	Andhra Pradesh	Kurnool	20
	Maharashtra	Sangli	25
	Rajasthan	Jodhpur	24
	Uttar Pradesh	Jalaun	25
	Uttar Pradesh	Lalitpur	25
Slum Areas	Maharashtra	Mumbai	25
	Telangana	Hyderabad	25
	Rajasthan	Jaipur	25
	Gujarat	Ahmedabad	25
	Tamil Nadu	Chennai	25
	Uttar Pradesh	Agra	25

The CBM used a mixed set of digital tools, namely, Google forms and UNICEF’s Rapid Pro survey tools (that work on a mobile platform) for the collection of data.

Seven types of question sets were developed for each type of respondent, with inputs from the various UNICEF sectors and the partner institution, viz., the Institute for Human Development (IHD).

The key areas of enquiry included livelihood and employment, education, access to a few identified social protection programmes, food security, WASH, COVID-19 related preventive practices and coping mechanisms, awareness and stigma/fear about COVID-19, and awareness and perceptions about the safety of the COVID-19 vaccine. The questionnaires were first designed in English and later translated into other Indian languages, keeping in view the geographical and demographic characteristics of the selected states (languages: Hindi, Gujarati, Marathi, Tamil and Telugu).

Parallel to the CBM in four phases in the 12 sample districts, IHD was engaged in a partnership with UNICEF, for processing the data collected from the CBM across four phases of assessment, carrying out a detailed analysis of the data, and for preparation of briefs for individual state UNICEF offices as well as a consolidated summary report spanning all the sample districts and all four phases of the CBM.

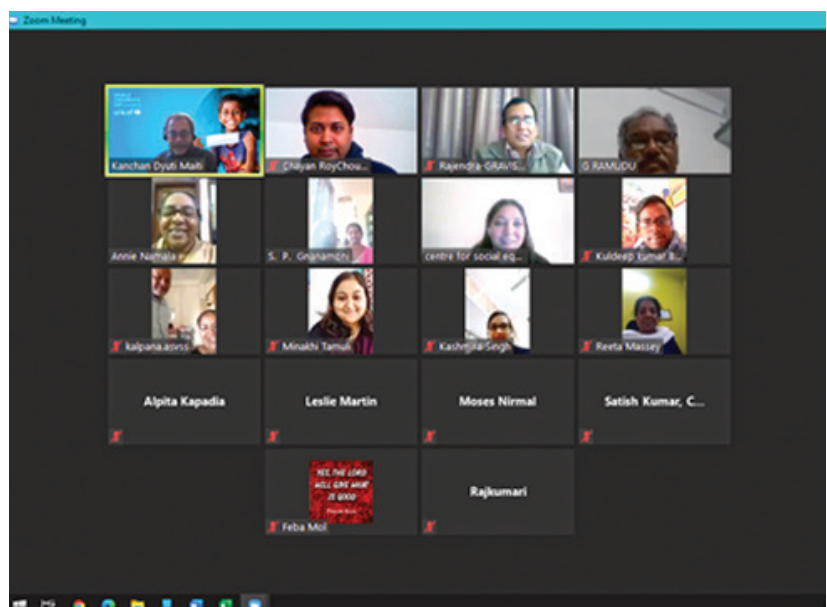
2.2 Role of the CSOs and its CVs

The main role of the CSOs anchor was aimed at: (1) identification of the CVs in all the selected states/districts, (2) conducting their training, (3) carrying out full coordination, and (4) ensuring their participation over the entire period of assessment and providing an appropriate replacement when needed. On the other hand, the CVs with support from the anchor CSO and the UNICEF team, facilitated the selection of the families and registering of each respondent with the contact details, some demographic information, and availability of mobile phones. The CVs ensured that the selected families did not drop out and also supported hand-holding/training, if needed, for the respondents.

2.2.1 Cascading training and capacity building

It was critical to build the capacity of the CVs and offer constant hand-holding support to the CSO network for ensuring collection of robust data, which required UNICEF to invest extensively in cascade training of the CSO network, including the CVs. A central team in Delhi, with representatives from UNICEF and the lead CSO, conducted extensive training of trainers (TOTs) for anchors. The training was imparted in the local language of the CVs. The training included both interacting with the participants, question by question, followed by self-administration of the questionnaires.

Figure 2.4 Online training and capacity building for the CBM



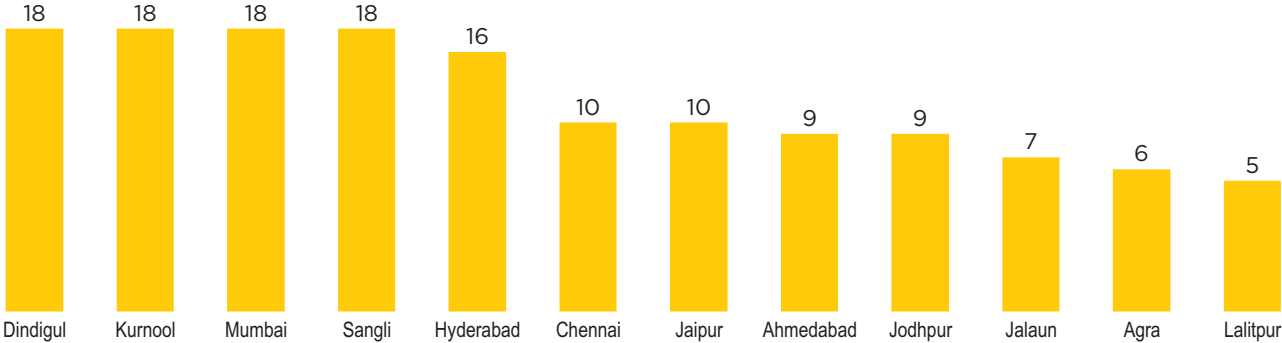
This was followed by training of anchors, along with a few central team members, and training of CVs in groups of 25-30 participants in their respective districts. The entire training was conducted virtually (see *Figure 2.4*).

A training component was included for all the phases, and it took time and constant handholding to orient the CVs and the anchors prior to each phase of data collection. Several WhatsApp groups were created to support the knowledge and respond to queries from the field. These WhatsApp groups were also used for monitoring and coordination of work at the district and state levels.² This process helped build a cadre of 300 CVs with the skills and confidence to monitor their work in their habitations. However, it was noticed that the time entailed in training and addressing queries got substantially reduced during the 3rd and the 4th phases.

The CBM had a component of data monitoring, including field monitoring on a real-time basis. As the data entered by the CVs were uploaded on the server in real time, a dashboard developed by UNICEF facilitated monitoring of the data collection status.

2.3 Sample size and sample characteristics

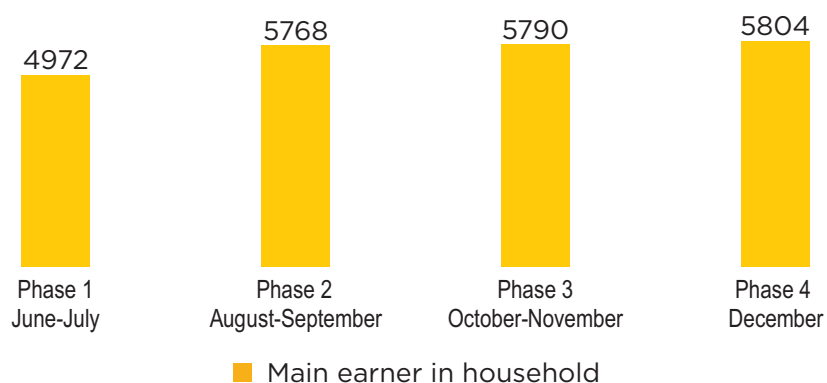
Figure 2.5 Distribution of habitations by postal pin codes



The states and districts were purposively selected in order to understand the vulnerabilities in the context of the COVID-19 pandemic. For the selection of the habitation, which consisted of villages, gram panchayats or a part of it, one of the selection criteria was that the habitations should not be in proximity to each other and should have robust coverage of the geographical spread of the district. The 298 selected habitations are distributed across 144 postal pin code areas (see *Figure 2.5*).

The number of households covered during each phase is delineated in *Figure 2.6*.

Figure 2.6 Number of main earning members covered in four phases of the assessment



The sample size of other types of respondents is shown in Table 2.2.

Table 2.2: Sample size for types of respondents covered in the CBM assessment				
Types of Respondents	Number of Interviews Undertaken in Each Phase			
	Phase 1 June-July	Phase 2 August-September	Phase 3 October-November	Phase 4 December
Main Earner in Household	4,972	5,768	5,790	5,804
Pregnant Women	737	850	738	563
Lactating Mother	751	974	1,157	1,407
Mother of Child (Less than 1 Years)	451	595	631	630
Mother of Child (2 to 5 Years)	1,010	1,258	1,302	1,342
Mother of Child (6 to 19 Years)	2,044	2,339	2,484	2,477
CVs (Community Volunteers)	298	296	294	290

Around half the main earning members were either illiterate or had completed only primary level education. More than half of the sampled families belonged to the SC and ST communities. The share of female-headed families in the total rural sample varied between 11 and 13 per cent while that for female-headed families in the urban sample varied between 20 and 25 per cent over the phases of assessment. The share of home returnees, that is, workers in urban locations who had returned home in their villages after the lockdown, was around 27-28 per cent of the total sample population in rural locations over the four phases of assessment.

Casual workers comprised the main segment of the main earner respondents in the sample habitations, with their shares varying between 67 and 78 per cent across the four phases in the rural sample locations, and with shares varying between 54 and 71 per cent in the urban sample locations. Casual workers usually work for daily wages and lack formal job contracts, fixed job tenures, and social security benefits, underlining the precariousness of their job situation. They comprise the lowest rung among workers. Thus, the large share of casual workers is expected in the purposive sampling among vulnerable families.

Workers who work with some contract and receive regular salaries are better placed than casual workers in the hierarchy of workers. Regular salaried workers comprise another segment of the main earner respondents, accounting for rural shares at 10-16 per cent over the four phases and urban shares at 20-26 per cent. The balance share of the unemployed varied between 9 and 20 per cent in the rural sample habitations and between 8 and 26 per cent in the urban sample habitations across the four phases of assessment.

2.4 Limitations and challenges

Estimations will not be statistically representative of the district or state, since the assessment is largely centred around assessing the situation of the marginalised in the pandemic situation. However, it may be noted that the effect of the pandemic, irrespective of the geography, would be more or less the same given their socio-economic and cultural profiles, and the selection of geographic entities has been purposively done as the pandemic was not random. The findings discussed in the following sections are based on the observations in the sample habitations covered in the study.



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MAJOR FINDINGS: ECONOMIC CONDITIONS



3.1 Introduction

The CBM assessment explored the impact of the COVID-19 pandemic on the sample population in the context of economic conditions. In Section 3.2, the impact of COVID-19 pandemic on the livelihoods of respondents in the sample habitations is examined. The impact of the pandemic on the wages is discussed in Section 3.3. The COVID-19 pandemic has had a severe impact on the food availability situation in the sample habitations and this issue is discussed in Section 3.4. Social protection is extremely important for the vulnerable communities, particularly in the context of the pandemic. Major social protection programmes such as PDS and MGNREGS are discussed in Section 3.5. The following section (Section 3.6) focuses on some more vulnerable segments of population. In Section 3.7 the access to Government social protection schemes and the status of awareness regarding these schemes among the respondents is examined. Finally, Section 3.8 presents the key observations and policy options based on evidence from the CBM assessment.

3.2 Lockdown leads to rise in joblessness in Phase 1 but recovery seen in Phase 2

The respondents in the study were mainly casual workers, followed by regular salaried workers. The main economic activities in the rural locations were agricultural work and construction work, while the main urban occupations were factory work, construction work, and government and private service, among others.¹

In December (Phase 4), the shares of the jobless were 8.9 per cent in rural and 8 per cent in urban locations, respectively. These shares were lower than the pre-lockdown situation (Phase 1) when the shares of the jobless were 10.9 per cent in rural and 10.8 per cent in urban locations, respectively.

Following the lockdown, larger shares of people lost their sources of livelihood and were rendered jobless. In both the rural and urban areas, joblessness showed a peak in the June-July (Phase 1) assessment, declined subsequently, and fell below the pre-

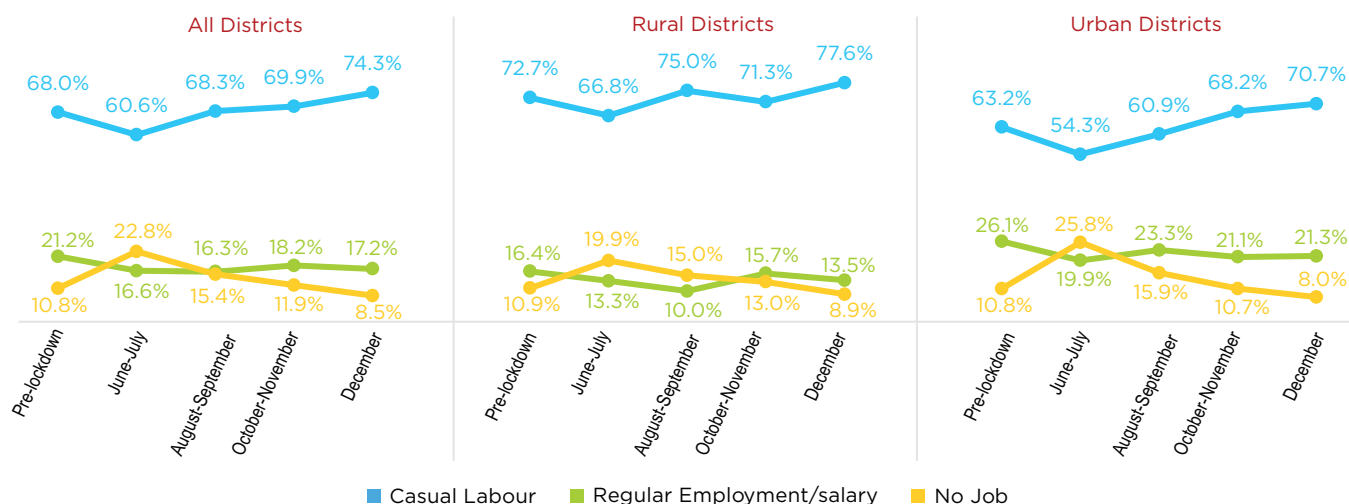


Unemployment was worst during June-July as the share of jobless reached 26 per cent in urban areas and 20 per cent in rural areas.

1. Based on the responses of 143 rural and 151 urban CVs for October-November (Phase 3).

lockdown levels in December (Phase 4). The highest degree of joblessness was witnessed in urban areas at around 26 per cent, affecting more than a quarter of the sample population, while in rural areas, joblessness was seen among one-fifth of the sample population. Figure 3.1 shows the main occupation shares of the respondents across the four phases of assessment.

Figure 3.1 Main occupation distribution of respondents (% of main earners)



The increased casualisation of work and diminished access to regular work implies that the jobs accessed currently are of poorer quality than during the pre-lockdown levels. However, the initial impact of the COVID-19 pandemic on the occupational structure in sample habitations, which was visible since the June-July (Phase 1) assessment, had ameliorated by December (Phase 4).

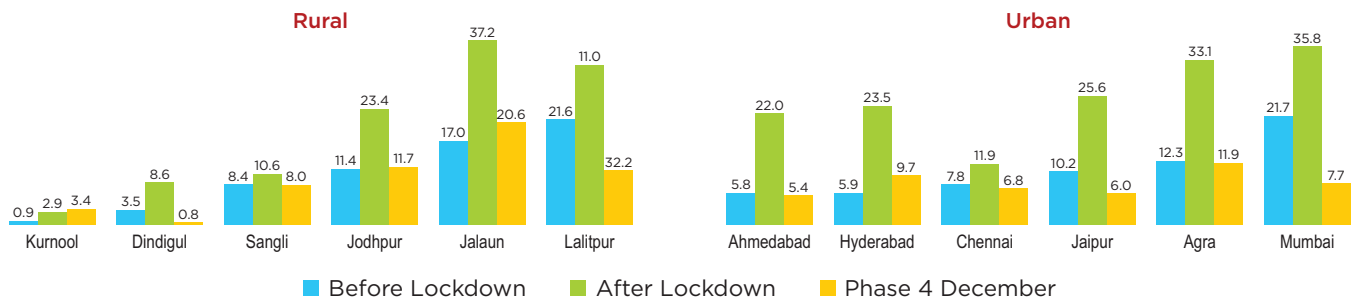
A study² conducted in April-May at the peak of the lockdown, among 5,000 self-employed, casual, and regular wage workers across 12 states of India, found higher job loss shares as two-thirds of the respondents were found to have lost work. The few informal workers who were still employed during the lockdown saw their earnings drop by more than half. By the time the CBM was conducted in June-July (Phase 1), some of the workers were likely to have found work, albeit possibly of lower quality than earlier. Loss of livelihoods and earnings was also reported by other studies for slum localities (NIUA-WVI, Ghosh et al 2020).³

During the pre-lockdown period, the proportion of the jobless population in the sample varied between 21.7 per cent in Mumbai to 0.9 per cent in Kurnool (see Figure 3.2). However, during June-July (Phase 1), the shares of the jobless population increased, and among the rural districts, Jalaun reported the highest level of unemployment, at around 37 per cent. During December (Phase 4), the employment situation showed a rapid improvement in the urban habitations and all the urban districts, except Hyderabad, reported lower proportions of unemployed main earning members as compared to the pre-lockdown levels.

2. 'Pandemic, informality, and vulnerability: Impact of COVID-19 on livelihoods in India', from Azim Premji University accessed at <https://cse.azimpremjiuniversity.edu.in/publications/pandemic-informality-and-vulnerability-impact-of-COVID-19-on-livelihoods-in-india/>

3. Ghosh, S., P. Seth and H. Tiwary, 2020, 'How does Covid-19 aggravate the multidimensional vulnerability of slums in India? A Commentary' in <https://doi.org/10.1016/j.ssaho.2020.100068>

Figure 3.2 Share of jobless respondents in the sample – by districts, before and after the lockdown (% of main earners)



3.3 Wages in December (Phase 4) and workers' perceived economic condition in Phase 4 lower than pre-lockdown levels

The daily wages in December (Phase 4) were less than during pre-lockdown levels, as reported by 75 per cent of the urban and 60 per cent of the rural respondents. These findings were recorded in tandem with the increased casualisation of work.

In December (Phase 4), nearly two-thirds of the respondents regarded their self-assessed incomes as being less than those at the pre-lockdown levels.⁴



The daily wages in December (Phase 4) were less than wages during pre-lockdown levels, as reported by 75 per cent of the urban and 60 per cent of the rural respondents. These findings were recorded in tandem with the increased casualisation of work.

Along with lower wages, the downward pressure on total income continued till December (Phase 4) for the respondents since the advent of the lockdown.

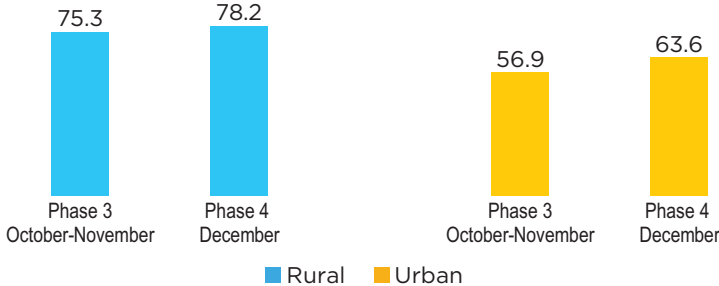
In June-July (Phase 1), two-thirds of the respondents had self-assessed their monthly incomes as being 'less than those of the pre-lockdown' levels.

3.4 Food insecurity persisting in the sample habitations

The reduced income with the vulnerable segments of the population translated into inadequate access to food. The respondents were asked whether, for the next one week, they had access to food items like wheat, rice, pulses, and oil, for meeting the requirement of at least two meals per day, for all members in the family (see Figure 3.3).⁵

4. The main earners were asked, 'In comparison to the pre-lockdown period, currently how is your monthly income?' and the options provided were 'Same as pre-lockdown', 'More than pre-lockdown', 'Less than pre-lockdown' and 'Can't say'. The options relevant for the 'Before Lockdown' situation was 'Same as normal', 'More than normal', 'Less than normal', and 'Can't say'.
 5. Based on the responses of main earners during October-November (Phase 3) (Rural N=3040, Urban N=2750), and December (Phase 4) (Rural N=3066, Urban N=2738).

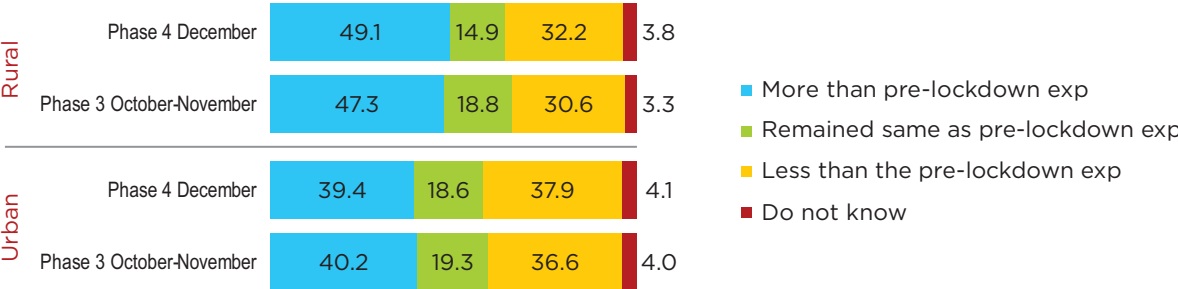
Figure 3.3 Percentage of main earning members reporting availability of food items for at least two meals per day for next week (Phases 3 and 4)



The food situation in the rural habitations was better than in the urban habitations. Three-quarters of the rural respondents reported having enough food for the next week in October-November (Phase 3), but only 57 per cent of the urban respondents reported having adequate food during this period.

The situation improved slightly in December (Phase 4) for both the urban and rural locations, but still less than two-thirds of the urban respondents reported having access to adequate food. The food crisis has been highlighted in several studies, including the Azim Premji University survey, which finds that almost 8 in 10 people covered in a survey across 12 states in April-May 2020 were consuming less food than before.⁶ The expenditure on fruits, vegetables, milk, and eggs, among other foods, was reported to be less than that incurred during the pre-lockdown levels by around one-third of the respondents in rural locations and around 37 per cent of the respondents in urban locations during October-November (Phase 3) and December (Phase 4). Nearly half the rural and two-fifths of the urban respondents reported that such expenses were higher than the pre-lockdown levels as of the previous month (see Figure 3.4).

Figure 3.4 Expenditure on fruits, vegetables, milk, eggs, etc. in last month (% of main earners)



It is likely that the prices of these nutritious food items had increased after the COVID-19 lockdown. Secondary sources indicate that food inflation, which was recorded at 7.8 per cent in March 2020, increased to 8.4 per cent by July-August, primarily reflecting the impact of adverse supply shocks.⁷ Food inflation

6. APU COVID-19 Livelihoods Survey.
 7. RBI Monetary Policy Report, October 2020.

surged to double digits in October across protein-rich items, including pulses, edible oils, vegetables, and spices on multiple supply shocks.⁸

Families which reported that the expenditure incurred by them on fruits, vegetables, milk, eggs and other food items was less than that of the pre-lockdown levels, might have curtailed their consumption of these items following the rise in prices. It has been observed that despite an economic upturn and improvement in the employment situation since around August-September (Phase 2), the respondent families faced downward pressure on their monthly incomes. This, coupled with the rise in prices of protein-rich foods such as milk, eggs, fruits, and vegetables, and the curtailment in consumption would very likely have impacted the development of children, along with the health of other family members. The absolute number of main earners who reported that the monthly expenditure on these protein-rich food items was less than that incurred during the pre-lockdown levels was 1060 in October-November (Phase 3) and 1308 in December (Phase 4). The likely reduction in the consumption of these food items would thus have adversely impacted the growth of children in many households in the sample habitations.

Among the rural jobless, a higher proportion of respondents (41 per cent) reported in October-November (Phase 3) that the expenditure incurred by them on these food items was less than that of the pre-lockdown levels, implying that they had to reduce consumption as a result of the rise in prices. Around 12 per cent of the jobless respondents also responded that they could not say whether the expenditure on these food items had increased or decreased, reflecting the uncertainty regarding their earnings.

3.5 Social protection with PDS and MGNREGS⁹

Social protection covers the range of policies and programmes needed to reduce the lifelong consequences of poverty and exclusion. It becomes particularly important when vulnerable families need to cope with crises and shocks. In the wake of the COVID-19 pandemic, the entire population of the world had to face a crisis, unlike anything seen before. In India, too, with the onslaught of the infection and the accompanying lockdown, people suddenly found themselves without jobs, workers walked long distances seeking their way back home to villages, families had to face food shortages, children could not attend school and the health infrastructure was over-burdened. Such a situation affects the poor and the vulnerable communities disproportionately and it becomes imperative to introduce social protection measures for those families to enable them to cope with such crises. Ensuring effective and well-functioning public policies and programmes, reduction of economic and social vulnerabilities among children, women, and families, and, providing them access to a decent standard of living as well as essential services can go a long way towards mitigating the adverse impact of a situation like the one caused by the COVID-19 pandemic and the associated lockdown.

Immediately following the lockdown, the Prime Minister announced a Rs 1.70 lakh crore relief package under the Pradhan Mantri Garib Kalyan Yojana (PMGKY) for the poor to help them fight the battle against

8. Monetary Policy Statement, 2020-21. Resolution of the Monetary Policy Committee (MPC), RBI, December 2-4, 2020.

9. Based on responses during December (Phase 4) by heads of households (Rural N=3006 and Urban N=2738) and based on responses by CVs (N=289).

COVID-19.¹⁰ This package included a provision of 5 kg of wheat or rice and 1 kg of preferred pulses for free for 80 crore poor people every month for the next three months (April-June 2020), relief for construction workers, monetary benefits for senior citizens, poor widows and poor disabled, farmers, and women Jan Dhan account-holders, as well as insurance cover for health workers. In June 2020, the Garib Kalyan Rozgar Abhiyan was launched with an initial funding of Rs 50,000 crore. This scheme aims to provide 125 days of employment to 670,000 migrant workers. Further, in June 2020 the Prime Minister announced the extension of the Ujjwala scheme and the Food scheme till November 2020.

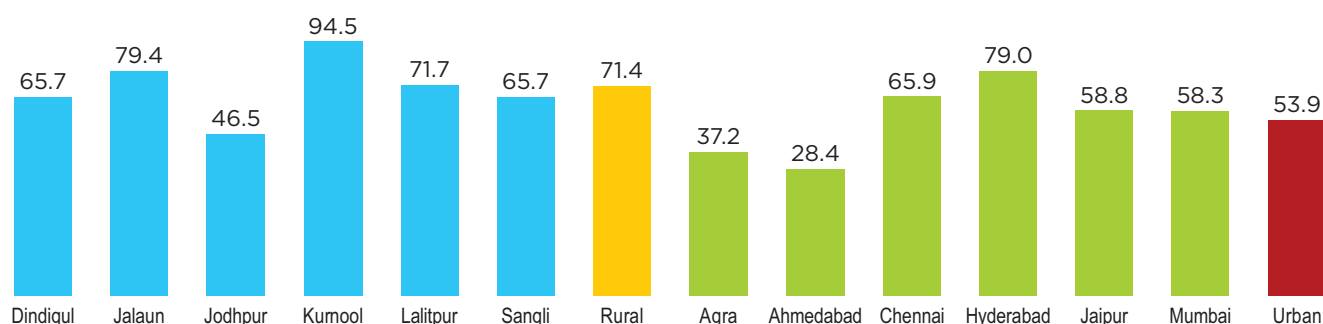
Two of the long-standing public programmes, which are the pillars for providing social protection to marginalised families, have been discussed in detail in the subsequent sections: the Public Distribution System (PDS) and the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA).

3.5.1 Half the PDS shops in the urban areas are outside the habitations

The PDS system had been introduced to manage food scarcity through the distribution of foodgrains at affordable prices and has become an important part of the Government's policy for the management of the food economy in the country. The CBM found good but not universal access to PDS ration cards among the respondents. About 88 per cent of the rural heads of households and 76 per cent of the urban heads of households in the sample locations reported having a PDS ration card. A similar share of ration-card holding in urban slums was reported by the NIUA-WVI primary survey conducted in May 2020.¹¹ The CBM found that among the ration card-holders, 93 per cent of the rural and 82 per cent of the urban respondents reported in December (Phase 4) that they had taken rations the previous month.

As regards access to ration shops, 71 per cent and 54 per cent of the main earners in the rural and urban locations respectively reported their PDS shops were located within their habitations (see Figure 3.5).

Figure 3.5 PDS shop located within the sample habitation (December, Phase 4) (% main earner respondents)



10. Accessed at <https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1608345>

11. The National Institute of Urban Affairs and World Vision India, "Impact on COVID-19 on Lives and Livelihoods: Rapid Study on Slum Dwellers in Indian Cities", presentation material (Dr Debolina Kundu).

Ahmedabad and Agra, among the urban districts, and Jodhpur, among the rural districts, showed very few households reporting PDS shops within sample habitations. It is possible that the sample habitations being located in slums is part of the reason for the low density of PDS shops.

Around 76 per cent of the rural and 70 per cent of the urban main earner respondents reported during the December (Phase 4) assessment they had received all food items as per their entitlement from the PDS shops as of the previous month.

This was largely corroborated by more than 80 per cent of the CVs reporting that in their community PDS shop wheat and rice were being distributed. However, the reporting for the distribution of pulses was lower, as reported by only 60 per cent of the CVs. Even lower shares of CVs reported the distribution of sugar (43 per cent), edible oil (27 per cent), and fortified salt (19 per cent). Among the CVs, around one-fifth reported that they have heard of food items being out of stock in ration shops in their respective localities.

Apart from staples such as rice, edible oil, pulse, wheat, and fortified salt, the CVs reported that people in the sample habitations had suggested that PDS shops could also be used for the distribution of other household items like sanitisers, masks, baby food, soaps, and fruits.



Around 76 per cent of the rural and 70 per cent of the urban main earners reported during December that they received all food items as per their entitlement from PDS shops

3.5.2 Majority of the respondents received work under MGNREGS but timely payment of wages remained an issue

The MGNREGS aims to enhance the livelihood security of people in rural areas by guaranteeing 100 days of wage employment in a financial year to a rural household whose adult members volunteer to do unskilled manual work.¹² In the post-lockdown period, when many poor families suddenly lost their livelihoods, food shortages became rampant, and many urban workers returned home to their villages after long and arduous journeys, access to MGNREGS jobs provided a much-needed lifeline to the poor communities.

Nearly half the sample population in rural areas reported seeking MGNREGS work in December (Phase 4), with the corresponding share for the October-November (Phase 3) assessment being 60 per cent. The receipt of timely wage payments was reported by 62 per cent of those working under MGNREGS in December (Phase 4).¹³

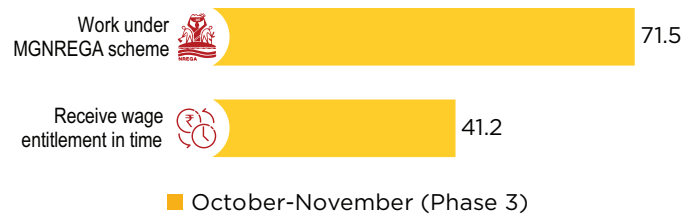
During October-November (Phase 3), 71 per cent of those seeking MGNREGS work were working. Among those (27% respondents) who sought MGNREGS work during October-November (Phase 3), but were not working, the reasons mentioned were that they had applied for a job card but had not received it, that the respondent was not registered due to lack of documents, and that the Panchayat was not working.

12. <https://nrega.nic.in/netnrega/home.aspx>

13. The numbers of head of households who reported that they were seeking work were similar during October-November (Phase 3) and December (Phase 4) at 1533 and 1499, respectively. However, the total sample sizes differed, at 2,563 and 3,066 for October-November (Phase 3) and December (Phase 4), respectively.

While 41 per cent of the respondents reported receiving wage payments on time during October-November (Phase 3), 62 per cent of the respondents reported during December (Phase 4), that they or their family members had received wages on time.

Figure 3.6 Coverage and timely payment under MGNREGS (% main earner)



During the Phase 1 pre-lockdown period, around 42 per cent of the CVs reported that those (male and female) who were willing to work under MGNREGS and wanted a job card, were able to get it while a similar percentage of CVs reported that ‘Some’ were able to get a job card. The share of CVs reporting that the households could not obtain a job card at all was very low, at around 10 per cent. The situation did not change according to the CV responses for the June-July (Phase 1) period.

During August-September (Phase 2), there was an improvement in the situation, as 67 per cent of the CVs reported that the men and women in the community who were seeking MGNREGS work were able to get a job card but 27 per cent reported that they were unable to do so.

As regards wage payment, 39 per cent of the CVs reported that during the pre-lockdown period, ‘Most’ MGNREGS workers had received wage payment in time, while 35 per cent reported that ‘Some’ had received payment in time. However, 20 per cent of the CVs said that ‘None’ had received payment in time. In June-July (Phase 1), this situation improved very slightly, with a lower share of CVs, at about 17 per cent, reporting that ‘None’ had received payment on time. However, during the August-September (Phase 2) assessment, the share of CVs who reported that ‘None’ had received payment on time, rose to 40 per cent.

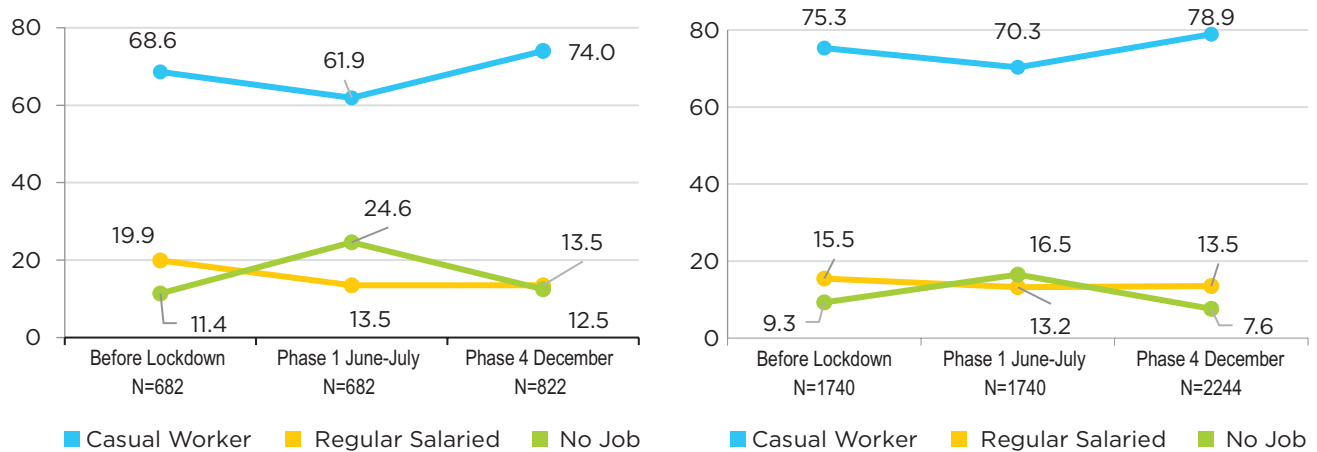
3.6 More vulnerable households

The CBM findings indicated that the home returnees and female-headed families were relatively more vulnerable than others, even compared to members of the average households in the sample habitations.

3.6.1 Home returnees were more vulnerable in terms of jobless share and inadequate food availability

During the periodic assessments, the share of home returnees was around 27-28 per cent of the total rural sample. Figure 3.7 shows that the share of the jobless peaked for both home returnees and residents in June-July (Phase 1), but the peak was higher for home returnees. The share of the jobless among the home returnees (12.5 per cent) in December (Phase 4) was 5 percentage points higher than for residents (7.6 per cent).

Figure 3.7 Main occupation of home returnees and residents (rural) (% of main earners)



Before the lockdown, home returnees had a higher share of regular salaried workers and a lower share of casual workers vis-à-vis residents. The share of regular salaried workers among the home returnees declined over the assessment rounds till August-September (Phase 2), recovered subsequently, but in December (Phase 4), it was more than 6 percentage points lower than that witnessed during the pre-lockdown levels. Home returnees were more vulnerable than residents in terms of having enough food items like wheat, rice, pulses, and oil for meeting the requirement of at least two meals per day for the family for the following week (see Figure 3.8).

Figure 3.8 Food item availability for at least two meals for family per day for the following week (% of main earners) rural



Food scarcity has adversely affected the children in the families of home returnees. There is a stark difference in food availability between the home returnee households and residents' households for families having less than one-year-old children, those having 2-5-year-old children, and those with 6-19-year-old children (see Table 3.1). Among all the families with children in various age groups, the home returnees faced relatively more food scarcity vis-à-vis the residents. This reflects the adverse impact on children's development, as they were not receiving adequate food and nutrition.

Table 3.1 Percentage share of families reporting enough availability of food items such as wheat, rice, pulses, oil to meet the requirement of daily two meals for all family members for the next week

Families with	Home Returnees (%)	Residents (%)
	(1)	(2)
Less than one-year-old child	69.3 (61)	78.8 (212)
2–5-years-old children	75.6 (149)	80.2 (433)
6–19-years-old children	67.7 (258)	79.4 (769)

Note: Numbers in brackets denote the sample size.

During December (Phase 4), 60 per cent of the CVs in rural habitations reported that a few home returnees had gone back and 23 per cent said that most home returnees had gone back to their place of work. While 76 per cent of the CVs reported that among the home returnees who stayed back, the work status as of October–November (Phase 3) was ‘casual worker’, 37 per cent said that their status was ‘unemployed’.

3.6.2 Female-headed families

The share of female-headed families in the total rural sample varied between 11 and 13 per cent and that for female-headed families in the urban sample varied between 20 and 25 per cent over the phases of assessment.

The vulnerability of the female-headed families is evident from the relatively higher share of jobless families among them vis-à-vis the male-headed families. Higher shares of female-headed families also reported inadequate food availability as compared to male-headed families. The relative vulnerability for female-headed families continued over all the assessment rounds and was higher in urban than in rural habitations (see Figure 3.9 and Table 3.2).

Figure 3.9 Jobless female-headed and male-headed households (% of main earners)

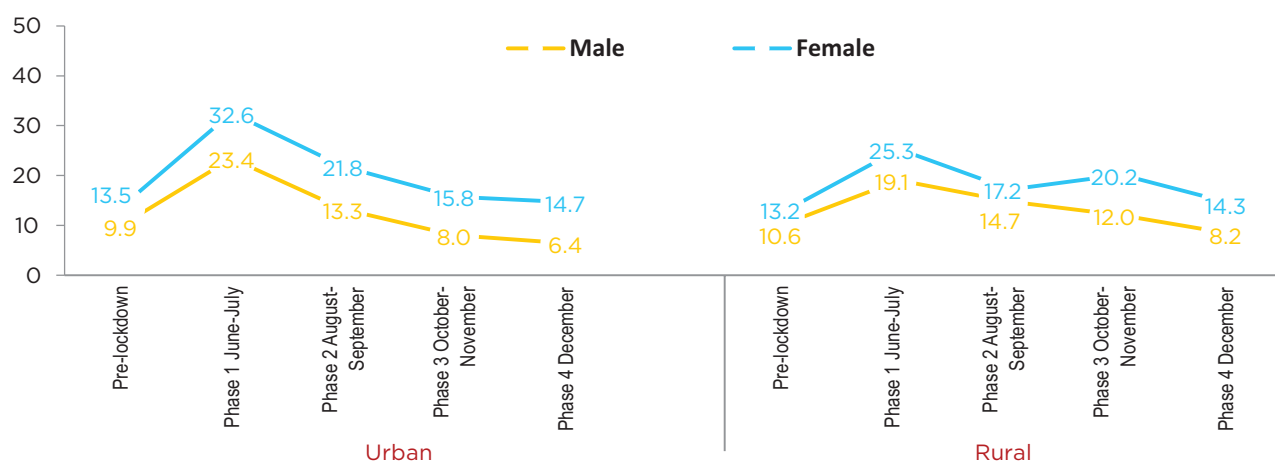


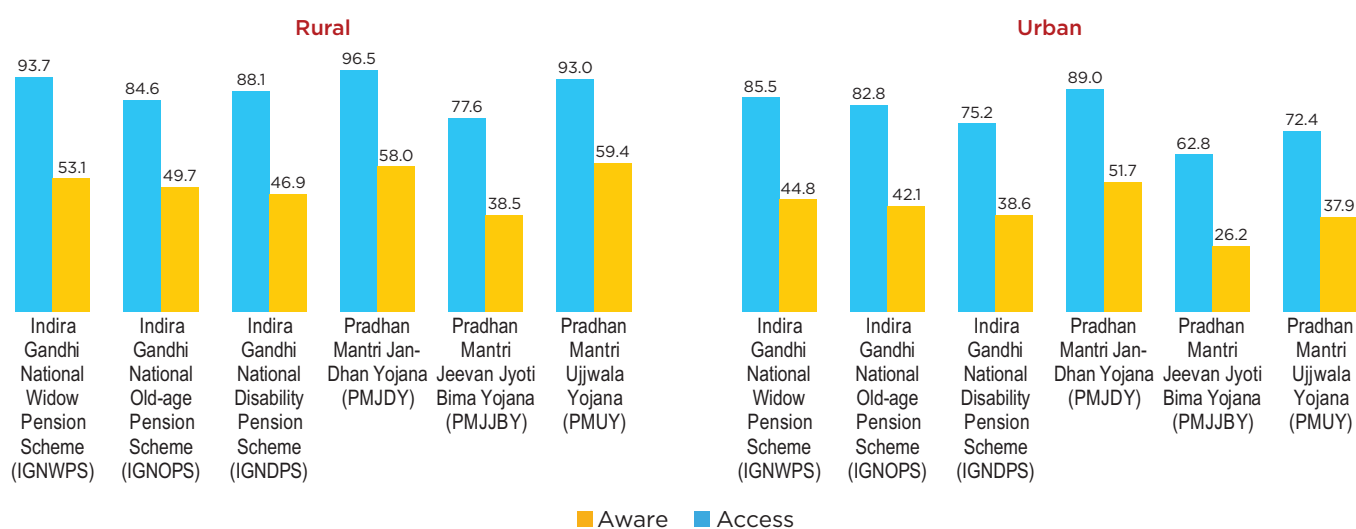
Table 3.2: Food item availability for at least two meals daily for next week for female-headed and male-headed families (% of main earners)

	Female-headed Families	Male-headed Families
October-November (Phase 3)	71.3	75.9
December (Phase 4)	73.6	78.8

3.7 Low access to government social protection schemes and gaps in awareness regarding schemes

There are many government schemes that provide social protection to the vulnerable populations in the country. As the findings from the CBM assessment for selected schemes show,¹⁴ there is a high degree of awareness regarding the pension-related schemes among the rural sample populace. In rural habitations, the level of awareness is highest for the Pradhan Mantri Jan Dhan Yojana (PMJDY), Indira Gandhi National Widow Pension Scheme (IGNWPS), and the Pradhan Mantri Ujjwala Yojana (PMUY). The awareness is relatively low for the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY). Despite awareness about some schemes, the access to the schemes is not adequate (see Figure 3.10). Only a little over half the CVs in the sample habitations reported access to PMUY at 59 per cent, to PMJDY at 58 per cent, and to IGNWPS at 53 per cent, respectively. As regards the other schemes, lower shares of CVs reported access to these.

Figure 3.10 Awareness among people in the sample habitations regarding government schemes and access to schemes (% of CVs)



14. Based on the responses of CVs December (Phase 4) (Rural N=143, Urban N=145).

A lower level of awareness regarding the selected schemes was recorded in the urban areas under study. The corresponding awareness was relatively high for PMJDY, IGWPS, and IGOPS, and the lowest for PMJBY. The access situation was much poorer in urban than in rural locations. More than half the CVs reported access to only the PMJDY, at 52 per cent. Access for all other selected schemes was reported by less than half the CVs. Even for the pension schemes such as IGWPS, IGOPS and IGNDPS, only 45 per cent, 42 per cent, and 39 per cent of the CVs, respectively, reported access to the schemes. The lowest access was reported for PMJBY, at 26 per cent.

3.8 Key observations and policy options

The vulnerability of families deepened with an increase in the share of the jobless after the onset of the COVID-19 pandemic-related lockdown in March 2020. Although the shares of the jobless declined subsequently, and by December (Phase 4) had fallen below the pre-lockdown levels, the situation was exacerbated by increased casualization of work and decline in regular work access, resulting in poorer quality of jobs post-lockdown. Most families faced a decline in wages and lower incomes.

Access to MGNREGS jobs provided relief to rural respondents. Among those who were seeking MGNREGS jobs but were not working under this scheme, the main reasons were that they had not received job cards after application, they were not registered due to lack of documents, and that the Panchayat was not open.

Provision of improved livelihood options for vulnerable families, especially in urban slum areas, to enhance their income, along with the provision of skill training linked to employment is important. In the rural areas, while MGNREGS provides an avenue for earning work for the poor and vulnerable households, bottlenecks in the process for accessing MGNREGS job cards and for getting timely MGNREGS wage payment need to be investigated and addressed to enable an improvement in livelihoods.

Food adequacy has been a daunting challenge for respondents though rural habitations fared better than urban habitations in this respect. While the situation improved after June-July (Phase 1), many people continued to grapple with hunger as even in December (Phase 4), 28 per cent of the urban respondents reported food shortage.

One-third of the respondents reported spending relatively less on essential food items such as vegetables, milk, fruits, and eggs, as compared to the pre-lockdown levels, which would have had adverse implications for the development of children, in particular.

There is good (but not universal) access to PDS ration cards in poor communities, more so in the rural locations. A low proportion of respondents in Ahmedabad, Agra, and Jodhpur reported having PDS shops within their habitations. People reportedly received foodgrain staples from the community PDS shops, but the distribution of pulses, sugar, and edible oils was lower than that of rice and wheat.

There is an urgent need to increase provision of ration cards to households in slum communities. For this, universal PDS distribution during the pandemic in vulnerable geographies may be considered. Diversification

of PDS items can also be considered to include select items of household use such as sanitisers, masks, baby food, and soaps, as suggested by the people themselves during the December (Phase 4) assessment.

Home returnees and female-headed families were found to be relatively more vulnerable to loss of jobs and lack of access to adequate food for the family. In families with small children, a relatively higher percentage of home returnees reported food scarcity vis-à-vis the resident families, indicating an adverse impact on children's growth.

Targeted assistance in both cash and kind for female-headed families and home returnees for augmenting their food availability and funds available to them would be an appropriate measure.

Lack of adequate awareness and low access to some major social protection schemes among respondents, were reported, particularly in urban locations. Access to social protection schemes was particularly low, as reported by the CVs.

The bottlenecks in getting the benefits across to the vulnerable population must be addressed and removed urgently as the social protection schemes are meant to serve such marginalised segments of the populace. It is also important to increase awareness about these social protection schemes among the marginalized families, particularly in the urban areas.



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MAJOR FINDINGS: HEALTH AND NUTRITION



4.1 Introduction

The CBM assessment explored in detail the impact of the COVID-19 pandemic on the sample population in the context of health and nutrition. The unprecedented devastation caused by the hitherto unknown virus also prompted the inclusion of questions pertaining to COVID-19-appropriate behaviour practised by people as a coping mechanism. In Section 4.2, the incidence of COVID-19 in the sample habitations and access to Government facilities for tackling the same are the main issues under discussion. In Section 4.3, the behaviour of the respondents in the sample habitations in response to the COVID-19 pandemic and the associated lockdown is discussed. This includes a discussion of issues such as COVID-appropriate behaviour, attitude towards the protection measures adopted and social stigma. In Section 4.4, respondents' access to the information about COVID-19 and their perception about the COVID-19 Vaccine have been discussed based on evidence from the CBM assessment.

Section 4.5 contains a discussion on nutrition for the women respondents with a focus on pregnant women and lactating mothers, as well as the nutritional intake for small children, along with access to Government facilities in this context. Under-nourishment is a persistent challenge for a quarter of women of reproductive age in India.¹ The major reason for stagnant levels of under-nutrition among Indian children is the failure to provide for nutrition and to adequately prevent under-nutrition when it is most likely to happen—that is, before and during pregnancy. In keeping with the focus area of women's nutrition, before, during and after pregnancy, the impact of the COVID-19 pandemic, and particularly, access to adequate nutrition, has been assessed for pregnant women, lactating mothers, mothers of less than one-year-old children and 2-5-year-old children, based on evidence from the CBM exercise. The awareness of and access to Government social protection schemes are discussed in Section 4.6 and Section 4.7 presents some key observations and policy options.

4.2 Availability of treatment for COVID-19

4.2.1 Reported incidence of COVID-19

It is well-known that urban locales have been affected far more by the spread of the COVID-19 infection as compared to the rural areas. The CBM shows similar findings. The CVs were asked if there were any COVID-

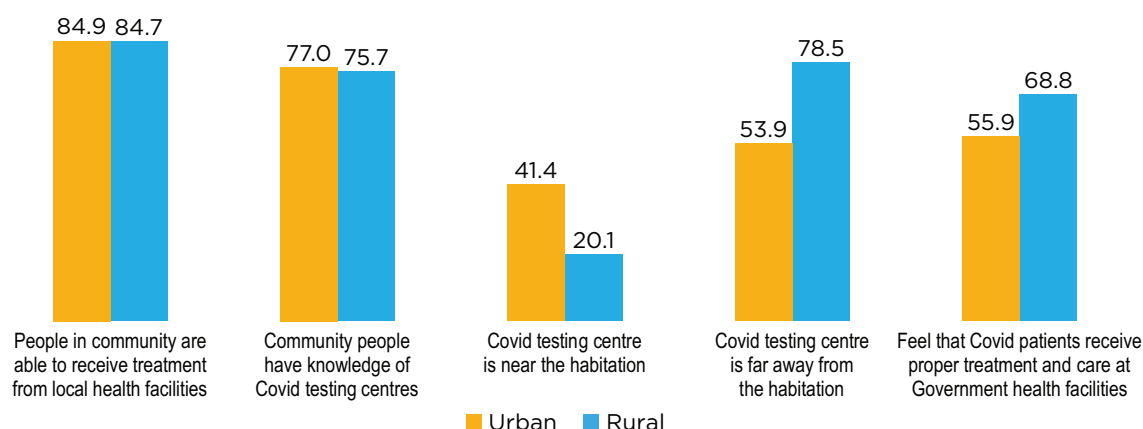
1. Accessed at <https://www.unicef.org/india/what-we-do/womens-nutrition>

positive cases in the habitation in the last month. In response, two-fifths of the CVs in urban habitations and a quarter of the CVs in rural habitations reported an incidence involving COVID-19 during August-September (Phase 2). The household heads, however, reported a very low COVID-19 incidence during the August-September (Phase 2) and October-November (Phase 3) assessments. Around 2-3 per cent among rural and 3-6 per cent among urban households reported COVID-positive cases during these two phases of assessment. It is also possible that there was under-reporting among the households, given the social stigma attached to the disease.

4.2.2 Good access to COVID-19 treatment at local government facilities but some testing centres located far from habitation, especially in rural locations

While 85 per cent of the CVs reported during August-September (Phase 2) that people were able to receive treatment in health facilities, more than three-fourths of the CVs reported that the community was aware about the COVID-19 testing centres (see Figure 4.1). However, for many of the respondents, the COVID-19 testing centres were located far away from the habitations, more so in the rural habitations. A comparatively higher share of CVs in rural habitations (69 per cent) as compared to urban habitations (56 per cent), however, also reported that patients receive proper care and treatment at Government health facilities.

Figure 4.1 COVID-19 testing facilities in the sample habitations (% CVs)



Source: Responses by CVs (Rural N= 143, Urban N=151) during August-September (Phase 2).

4.3 COVID-19 pandemic related behaviour

4.3.1 Wearing a mask constantly and maintaining social distance are main challenges in protecting oneself from COVID-19

Wearing a mask constantly and maintaining social distance in gatherings were perceived to be the major challenges among the respondents (see Table 4.1). The non-availability of soap for washing hands was cited as a challenge by one-third of the rural and a quarter of the urban respondents in December (Phase 4).



The non-availability of soap for washing hands was cited as a challenge by one-third of the rural and a quarter of the urban respondents in December (Phase 4).

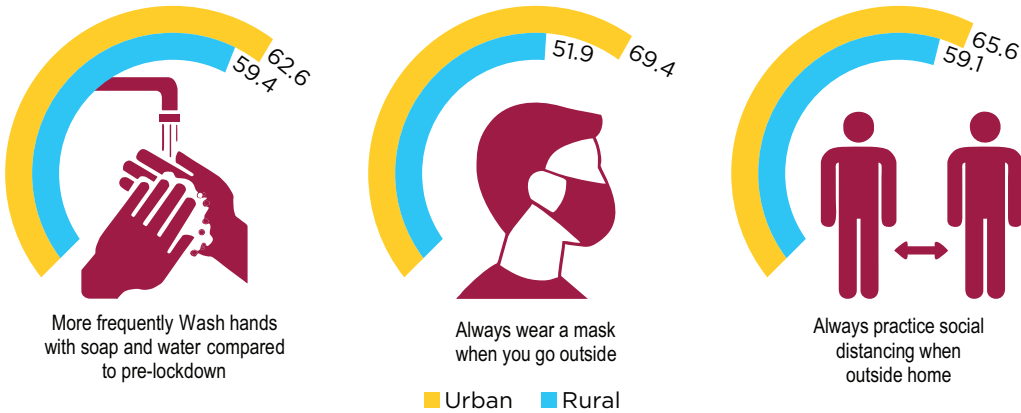
Table 4.1: Challenges of protecting oneself from COVID-19 (% of main earners) (December, Phase 4)					
	We don't have soap and water to frequently wash our hands with soap and water	It is difficult to wear a mask all the time	It is difficult to maintain social distancing in a gathering	Others	I do not have any Challenge
Rural (N=3066)	32.9	66.3	64.1	9.8	12.4
Urban (N=2738)	26.5	61.0	60.0	13.9	15.5
Total (N=5804)	29.9	63.8	62.2	11.8	13.9

Note: The percentage of responses are with reference to multiple responses and do not add up to 100.

4.3.2 WASH practices, sanitation and observing COVID-19 protective behaviour better in urban locations

About 59 per cent of the rural and 63 per cent of the urban respondents reported in December (Phase 4) that they were washing hands with soap and water more frequently as compared to the pre-lockdown period. Urban respondents reported wearing a mask when going outside the house relatively more frequently.

Figure 4.2 Protective behaviour from COVID-19 (% of main earners) December (Phase 4)



Around 69 per cent of the urban respondents said in December (Phase 4) that they 'Always' wore a mask and 21 per cent said they 'Often' wore a mask. The corresponding shares for rural respondents were less, at around 50 per cent and 23 per cent, respectively. Social distancing when outside home was practised 'Always' by around 50 per cent of the urban and 46 per cent of the rural respondents.

The use of toilets was higher among urban as compared to rural communities as of December (Phase 4); 90 per cent of the urban main earner respondents and 61 per cent of the rural respondents said that they 'Always' used a toilet/latrine.

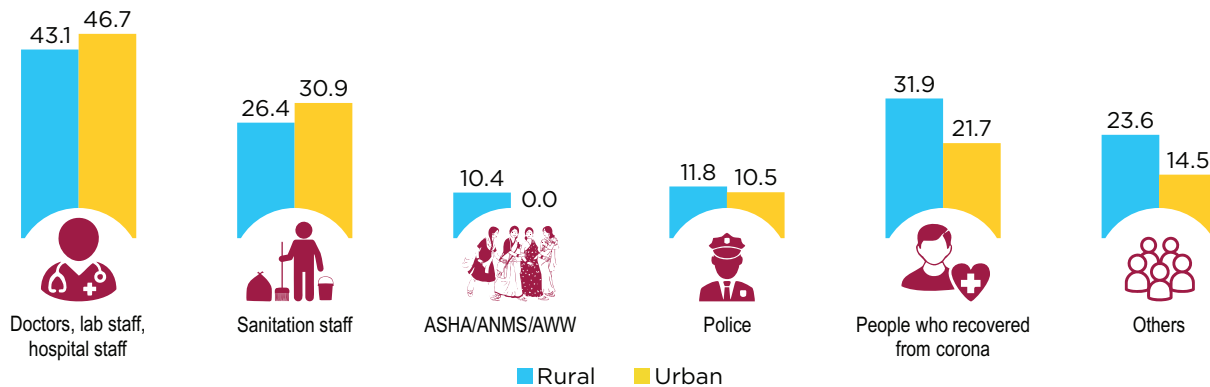
Among the 290 CVs in the sample habitations, 61 per cent reported that they observed hand washing facilities set up in public places in or around their habitations following the COVID-19 pandemic. Such hand

washing facilities were set up in healthcare facilities/hospitals, *Anganwadis*, offices, bus stands, schools, markets, and other public places.

4.3.3 Some social stigma associated with COVID-19 infection

Since COVID-19 is a very contagious disease, people’s outlook about it reflected some stigma associated with it (see *Figure 4.3*). Findings show that among people likely to be viewed poorly by the community are the doctors and hospital staff, followed by sanitation staff, and people who recovered from COVID-19.

Figure 4.3 Groups of people likely to be seen negatively within the community due to COVID-19 pandemic (% of CVs)



Source: Responses by CVs (rural N= 143, urban N=151) during August-September (Phase 2).

Note: The percentages of responses are with reference to multiple responses and do not add up to 100.

4.4 Information about COVID-19 and perception about the COVID-19 vaccine

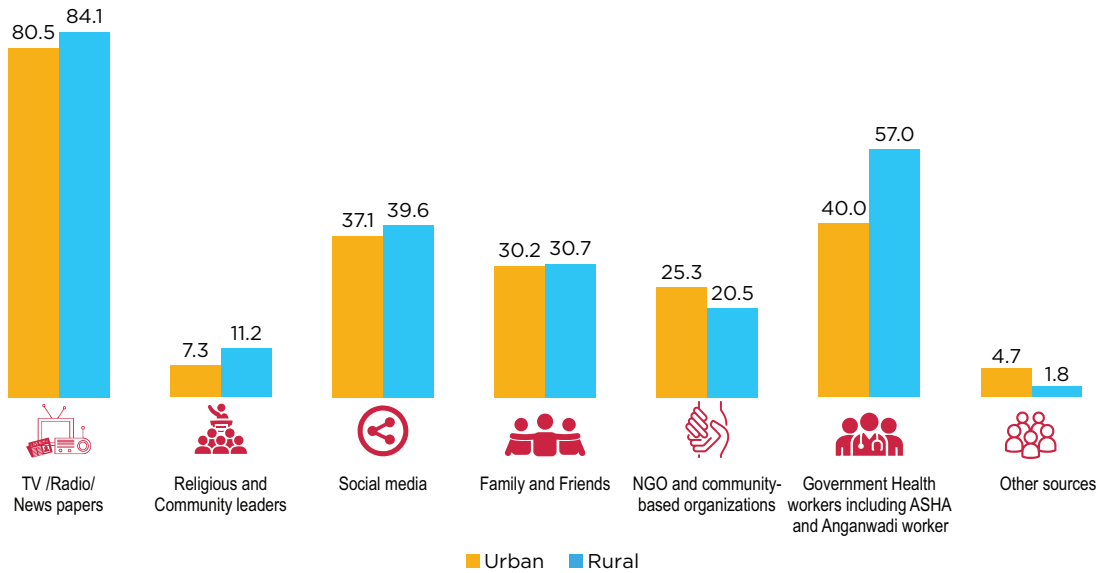
4.4.1 Media and government health workers are trusted sources of information about the COVID-19 pandemic

Media such as TV/radio/newspaper, followed by government health workers, were the most important and most trusted sources of information for COVID-19 in both rural and urban locations, as of December (Phase 4) (see *Figure 4.4*). Social media, family, and friends were also major sources of information for COVID-19, but social media was less trusted in urban than in rural areas.²

Findings from June-July (Phase 1) corroborate the fact that respondents in the sample habitations trusted health workers regarding the information on COVID-19. Local Non-Governmental Organizations (NGOs), Self Help Groups (SHGs) and friends/relatives were also mentioned as trusted sources in both locations, while Panchayats were regarded as a trusted source of information in rural sample habitations.

2. The information pertaining to the sources that were most ‘Trusted’ has not been presented here.

Figure 4.4 Source of information for COVID-19 (% of main earners)



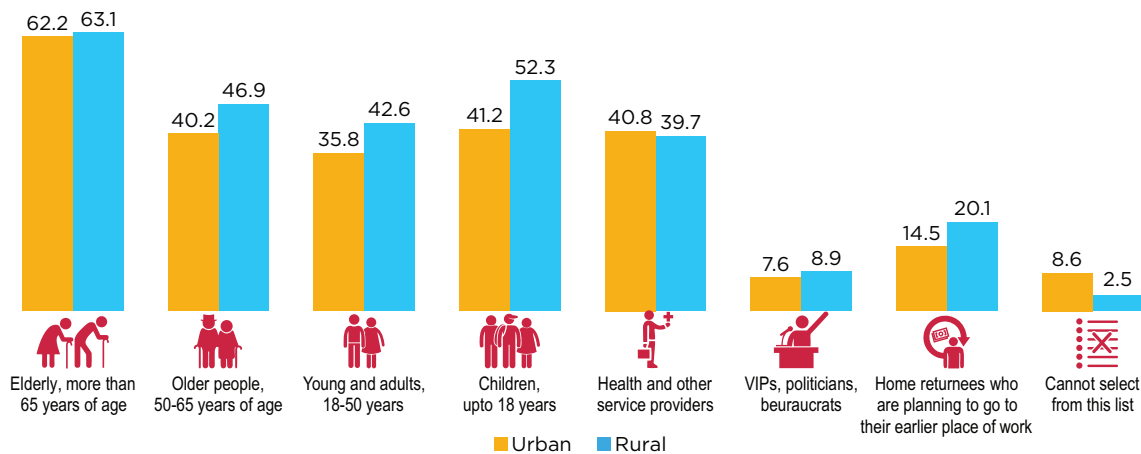
Note: Based on responses by main earners for December (Phase 4). The percentages of responses are with reference to multiple responses and do not add up to 100.

Among the various types of TV channels, the respondents in the sample habitations expressed a preference for the option ‘Doordarshan and private TV channels’, followed by only ‘Private TV channels’, according to findings from October-November (Phase 3).

4.4.2 High awareness about COVID-19 vaccine among respondents and elderly preferred recipients for vaccine

A high level of awareness regarding COVID-19 vaccines was found among the respondents during the December (Phase 4) assessment, with 80 per cent of the urban and 76 per cent of the rural respondents in the sample habitations showing awareness about the COVID-19 vaccine.³ The highest preference was expressed for the elderly to receive the COVID-19 vaccine ahead of others (see Figure 4.5).

Figure 4.5 Responses about who should take COVID-19 vaccine first (% of main earners)



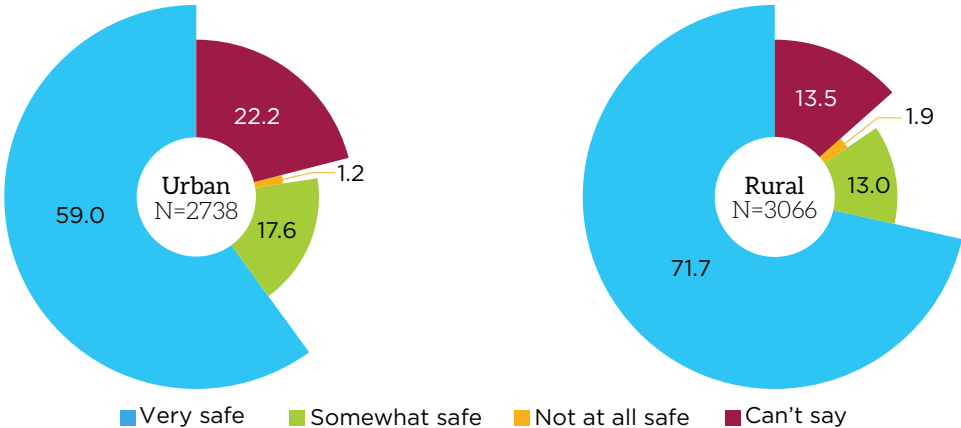
Note: Based on responses by the main earners for December (Phase 4). The percentages of responses are with reference to multiple responses and do not add up to 100.

3. The question posed to the respondents was ‘Have you heard about COVID vaccine to protect against Corona virus?’

Among both rural and urban communities, the elderly above 65 years of age were the most preferred category for the COVID-19 vaccine. The next preferred category was that of children up to 18 years of age, but this preference for children was higher in rural (52 per cent) than in urban (41 per cent) communities. The other preferred categories were older people (50-65 years), health workers, and young and adults.

Urban respondents were less inclined to believe in the necessity of the COVID-19 vaccine. Around 79 per cent of the rural and 72 per cent of the urban respondents felt that the vaccine was 'Very necessary'. Urban respondents were also less inclined to believe in the safety of the vaccine for use against the COVID-19 pandemic (see Figure 4.6). The share of responses for the option, 'Cannot say' was also much higher for the urban sample habitations vis-à-vis the rural habitations.

Figure 4.6 Respondents' opinions regarding the safety of the COVID-19 vaccine (% of main earners)



Note: Based on responses by main earners for December (Phase 4).

4.5 Impact of the COVID-19 lockdown on women

4.5.1 Pregnancy-related services in government facilities

The access of pregnant women to Government facilities was limited immediately after the lockdown. Even where Government facilities were open, pregnancy-related services were not always available. While two-thirds of the respondents reported that government facilities were providing treatment to pregnant women, a quarter of them reported that these were open but were not providing services (see Table 4.2).

Table 4.2: Government health facilities open and providing treatment (rural + urban) (% pregnant women respondents)				
	Yes, available but not providing services	Yes, available and providing services	Not available	Do not know
August -September (Phase 2)	25.3	62.2	6.7	5.8
October-November (Phase 3)	22.2	68.7	4.5	4.6
December (Phase 4)	24.2	66.1	5.3	4.4

The access to Government facilities for pregnancy-related services improved during August-September (Phase 2) and December (Phase 4), as reported by the respondents who could access such services from local Government health facilities. Among the pregnant women who reported that local Government facilities were open and were providing services, the access to Government facilities was reported to be limited in June-July (Phase 1) following the lockdown, but it improved over successive phases to reach very high levels in December (Phase 4) (see Figure 4.7).⁴

It is observed that between June-July (Phase 1) and December (Phase 4), there was an improvement of a 20 percentage points in access to pregnancy-related services available from local government health facilities in rural areas and around a 28-percentage point increase in urban areas. However, quite clearly, pregnant women in rural areas (72 per cent) were better off in June-July (Phase 1) than women in urban areas (60 per cent).

However, in June-July (Phase 1), the access in rural areas was not uniformly good. Some sample districts indicated better availability, such as Sangli, Kurnool, and Dindigul, where more than 90 per cent of the respondents said that Government facilities were providing pregnancy-related services. In Jalaun, only 39 per cent and in Lalitpur, 53 per cent of the respondents said that pregnancy-related services were available at Government facilities. Among the urban districts, Mumbai (27 per cent), Agra (53 per cent), and Jaipur (54 per cent) showed low reporting for the availability of pregnancy-related services at the Government facilities in June-July (Phase 1).

Figure 4.7 Pregnancy-related services available from local government health facilities (% pregnant women)

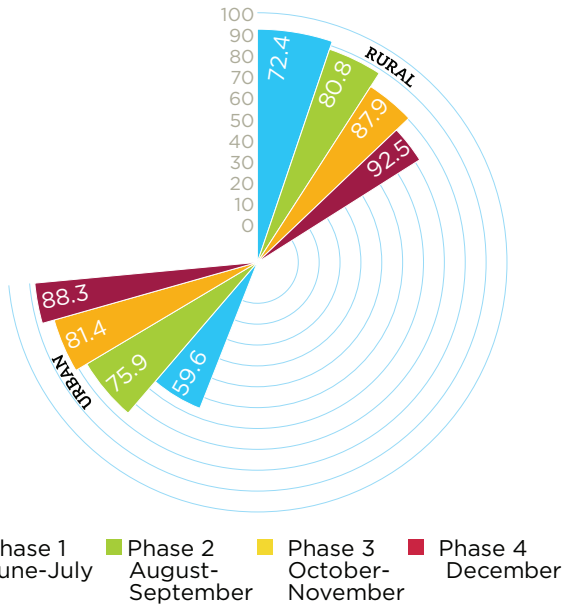
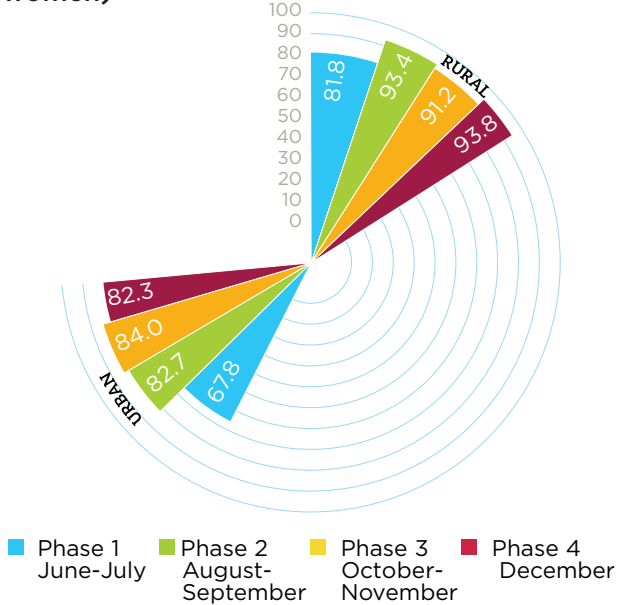


Figure 4.8 Pregnant women who have Mother-Child Protection (MCP) card or Jachcha Bachcha card or Mamta card (% pregnant women)



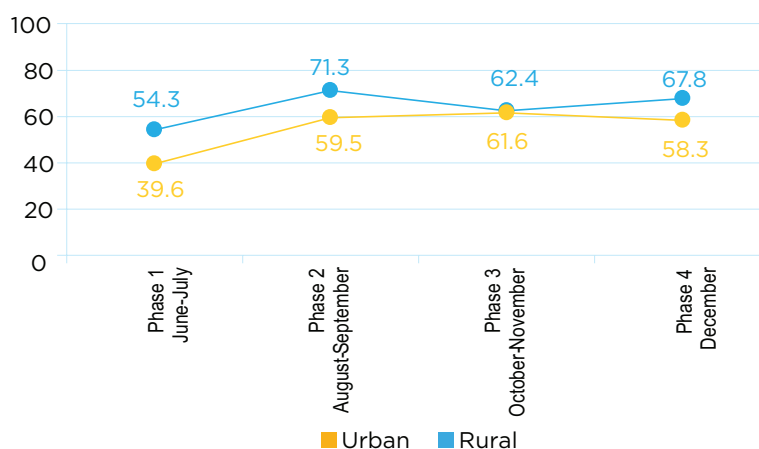
4. Based on responses by pregnant women in rural areas (June-July (Phase 1) N=293; August-September (Phase 2) N=416, October-November (Phase 3) N=281, December (Phase 4) N=201) and Urban (Phase 1 June-July N=314; August-September (Phase 2) N=328, October-November (Phase 3) N=226, December (Phase 4) N=171) sample habitations.

The access to Mother-Child Protection Card/Jachcha Bachcha Card/Mamta Card was higher in rural areas in December (Phase 4), as reported by 94 per cent of the pregnant women respondents vis-à-vis 82 per cent urban respondents (see Figure 4.8). However, the access in urban locations improved by 15 percentage points between June-July (Phase 1) and August-September (Phase 2), while in rural locations, the access improved by 12 percentage points during the same period.

4.5.2 Sharp improvement in access to prenatal services between June-July (Phase 1) and August-September (Phase 2)

As regards responses to the question about accessing prenatal services during the preceding month which was posed to pregnant women, it is observed that such access increased between June-July (Phase 1) and December (Phase 4) in both rural and urban areas (see Figure 4.9). A sharp improvement was seen between June-July (Phase 1) and August-September (Phase 2), after which, it seems to have stabilised.

Figure 4.9 Access to prenatal care (% pregnant women)



The percentage of urban respondents who reported that they accessed prenatal care was low, at around 40 per cent post-lockdown (June-July, Phase 1), whereas the corresponding figure in rural areas was 54 per cent. In December (Phase 4), access to prenatal care (last month) was 10 percentage points higher in rural (68 per cent) vis-à-vis urban (58 per cent) areas.

4.5.3 High share of rural pregnant women reported that local AWC is providing ICDS services

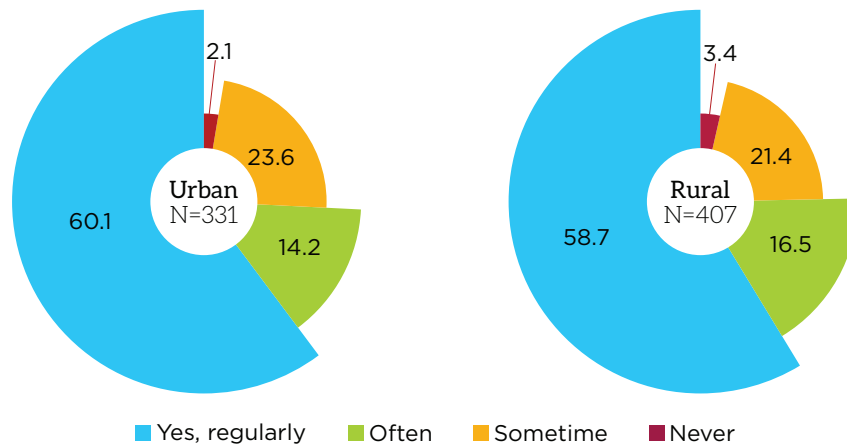
On an average, around 90 per cent of the pregnant women respondents in rural habitations reported that their local Anganwadi Centres (AWCs) were providing ICDS services to women and children between August-September (Phase 2) and December (Phase 4). During the same period, in the urban sample, the corresponding share declined by 20 percentage points from 88 per cent (August-September, Phase 2) to 68 per cent (December, Phase 4).

4.5.4 Food insecurity for pregnant women in October-November (Phase 3)


Hunger stalked poor and vulnerable families in the aftermath of the COVID-19 pandemic-related lockdown, as has been discussed in Section 3.3. As per the findings of a large survey conducted by 'The Right to Food Campaign' and other networks, which covered around 4,000 vulnerable and marginalised populations across 11 states, two-thirds of the respondents stated that the quantity of food they consumed either 'decreased somewhat' or 'decreased a lot' as compared to before the lockdown.⁵

The CBM findings too indicate that just around three-fifths (60 per cent) of the pregnant women respondents were able to eat three main meals daily in October-November (Phase 3).⁶ Close to a quarter of the pregnant women in urban and one-fifth in the rural sample locations could eat three main meals only 'Sometime' while 2-3 per cent of the respondents never had access to the three major meals in a day (see Figure 4.10).

Figure 4.10 Able to eat three main meals in the last month (October-November) (% pregnant women respondents)



The district-wise difference in access to three daily meals by pregnant women is evident from Figure 4.11.⁷ In Jalaun, and Lalitpur among the rural districts, and Agra among the urban districts, more than half the pregnant women respondents did not have access to three daily meals. Access to meals was also found to be very low for the Jodhpur sample.

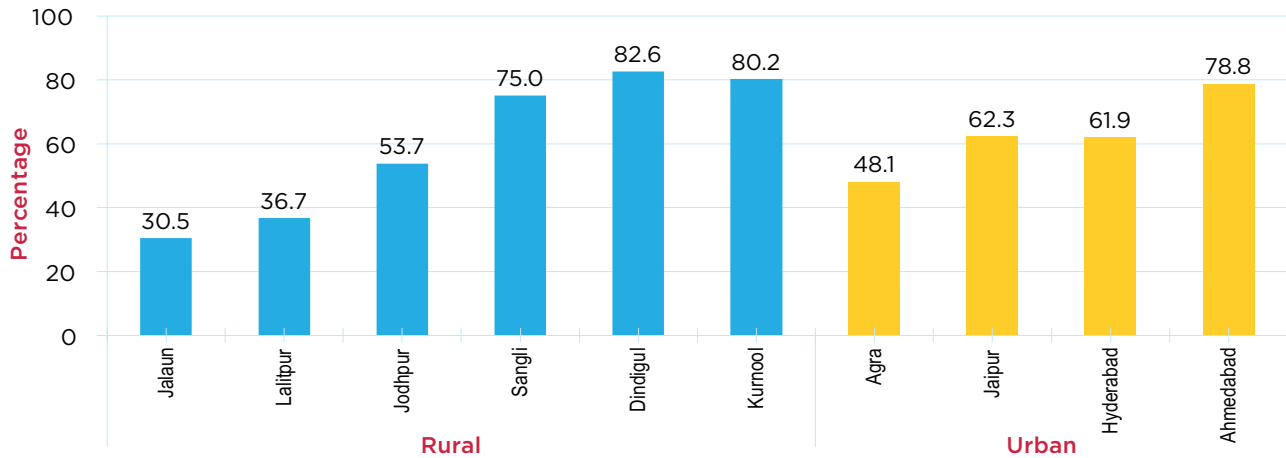
 Only 60% of pregnant women respondents were able to eat 3 main meals daily in October-November

5. The survey was conducted by 'The Right to Food Campaign', along with a number of other networks, which launched the 'Hunger Watch' in September 2020 to track the situation of hunger among the vulnerable and marginalised communities in different parts of the country, particularly in the backdrop of the COVID-19 pandemic. Accessed at <https://www.downtoearth.org.in/news/food/COVID-19-lockdowns-may-be-over-but-poor-still-go-hungry-74574>

6. The pregnant women respondents were asked the question, "In the last month, were you able to eat 3 main meals?", for which the response options were as follows: 'Yes, regularly', 'Often', 'Sometime', and 'Never'.

7. The districts with low sample size have not been presented in the figure.

Figure 4.11 District-wise, percentage of pregnant women regularly able to eat three daily meals (% of pregnant women respondents), October-November (Phase 3)



Note: The information for districts with low sample size has not been presented in the figure.

4.5.5 Access to take home ration for women from ICDS centres improved over time, though it was at a low level initially

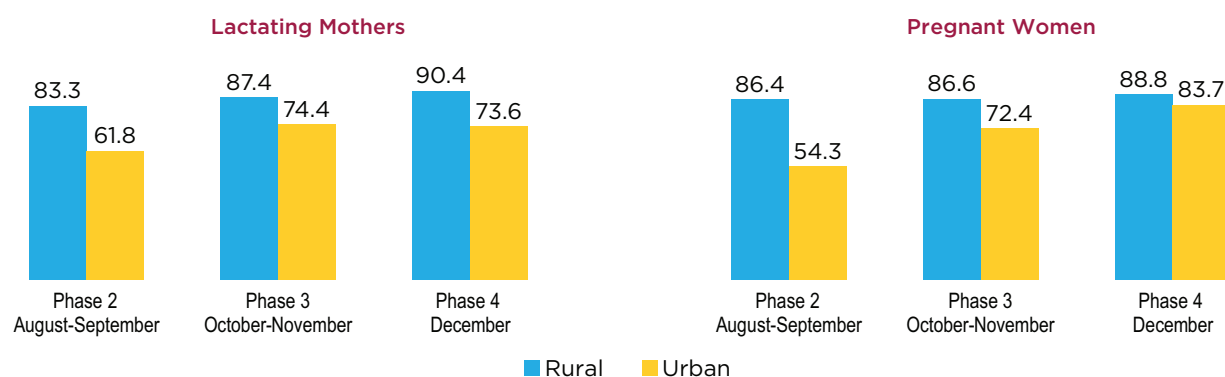
Take-Home Ration (THR) is an important supplementary nutritional component of the Integrated Child Development Services (ICDS) scheme for the women and children. The THR of micronutrient fortified blended food and/or energy-dense food are distributed to children aged 6-36 months and to pregnant/lactating women for consumption at home through the ICDS scheme.

The lockdown had a direct adverse impact on THR access. During the June-July (Phase 1) assessment, 55 per cent of the pregnant women in rural and 32 per cent in urban areas reported that they got THR before the lockdown. After the lockdown, 48 per cent of the rural and 26 per cent of the urban respondents reported that they got THR.⁸ Subsequently, the access to THR improved during August till December (Phases 2, 3, and 4) (see Figure 4.12).

For lactating mothers, THR-related questions were asked for June-July (Phase 1) at rural locations only. About 68 per cent of the lactating mother respondents reported that before the lockdown, they took THR, but this share declined by 20 percentage points to 48 per cent after the lockdown. The access to THR improved for rural respondents during August till December (Phases 2, 3, and 4) to reach 90 per cent by December (Phase 4) (see Figure 4.12). For urban respondents, there was a sharp improvement of 13 percentage points in access to THR reported during August till November (Phases 2 and 3), after which it stabilised at around 74 per cent in December (Phase 4).

8. The questions asked during the June-July (Phase 1) assessment were not comparable with the other phases and have, therefore, been discussed separately.

Figure 4.12 Access to THR among respondents who reported local AWCs are functional (% of women respondents)



The district-wise disaggregated situation for access of lactating mothers to THR for December (Phase 4) is shown in Table 4.3. It shows relatively lower access to THR in Jalaun among the rural districts, and in Jaipur and Agra among the urban districts.

Table 4.3: District-wise access to THR among respondents who reported local AWCs to be functional (% of lactating mother respondents) (December, Phase 4)						
RURAL						
	Jalaun	Jodhpur	Lalitpur	Sangli	Dindigul	Kurnool
Reported access to THR (%)	75.6	81.3	83.0	96.5	96.8	99.3
URBAN						
	Jaipur	Agra	Mumbai	Hyderabad	Chennai	Ahmedabad
Reported access to THR (%)	65.2	70.7	75.0	78.5	78.8	81.6

4.5.6 Increased access to THR in rural compared to urban habitations (respondent: mothers of less than one-year-old child and mothers of 2-5-year-old children)

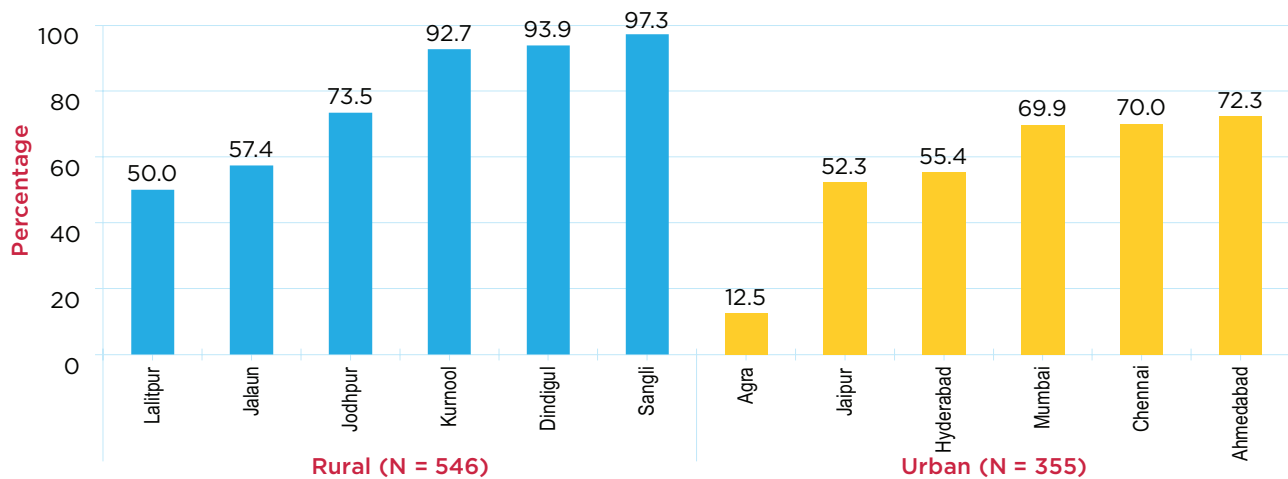
In December (Phase 4), 83 per cent of the mothers of a less than one-year-old child in rural locations said that they had got THR from the AWC during the preceding month and the corresponding share for urban respondents was much lower, at 60 per cent.

Mothers of 2-5-year-old children, too, reported higher access to food or THR for their children (from the local AWC) in rural vis-à-vis urban locations. During August-September (Phase 2), among mothers of 2-5-year-olds, who said that they take services from the local AWC, 77 per cent of the rural and 51 per cent of the urban respondents reported taking food/THR from the AWC. The situation was similar during October-November (Phase 3).

The disparity in reporting access to food/THR by mothers of 2-5-year-old children across the sample districts is shown in Figure 4.13. Among the rural districts, the reported access to THR was above 90 per cent in Sangli, Kurnool, and Dindigul, but was much lower in Lalitpur and Jalaun. Among the urban districts, only

13 per cent of respondents reported access to THR/food in Agra. The access was also relatively low in Jaipur and Hyderabad.

Figure 4.13 Access to food/THR from the local AWC for 2-5 year-old children (% mothers of 2-5-years-old children among those who reported that they take services from local AWC), (October-November, Phase 3)



4.5.7 Only about half of the mothers reported visits by AWWs or ANMs/ASHAs for doorstep delivery of THR

Around 53 per cent of the lactating mother respondents during October-November (Phase 3) and 51 per cent of the respondents during December (Phase 4) reported that an AWW or ANM/ASHA worker made a home visit for doorstep delivery. Among mothers of 2-5-year-olds, 53 per cent of the respondents in October-November (Phase 3) and 51 per cent of the respondents in December (Phase 4) mentioned home visits as of the previous month by AWWs or ANMs/ASHA workers for doorstep delivery.

4.5.8 Growth monitoring of children was impacted adversely by the lockdown⁹

Growth monitoring of children was impacted as a result of the lockdown, with the lowest shares of respondents reporting in August-September (Phase 2) that the child's growth was being monitored. Monitoring was comparatively less in the urban as compared to the rural habitations (see Figure 4.14).

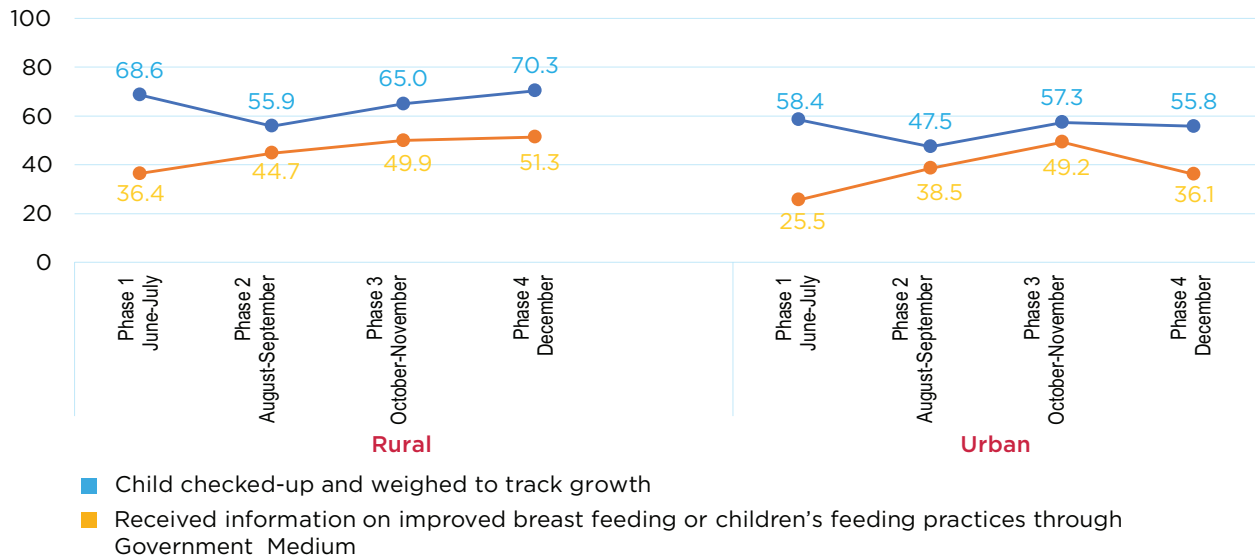
4.5.9 Inadequate dissemination of government messages regarding improved breastfeeding practices as reported by lactating mothers in sample habitations

The lactating mothers were asked whether they had received any information on improved breast-feeding or on children's feeding practices through any government medium. Their responses indicated that the

9. Based on responses of lactating mothers (Rural and Urban) (N=752 for June-July (Phase 1); N=974 for August-September (Phase 2); N=1156 for October-November (Phase 3) and N=1407 for December (Phase 4).

dissemination of government messages for improved breastfeeding practices was low across both urban and rural locations (see Figure 4.14).

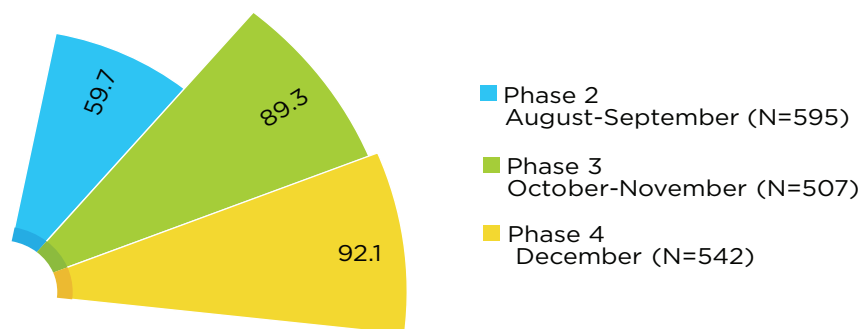
Figure 4.14 Access to breast feeding information for lactating mothers and growth monitoring for new-borns, (% lactating mother respondents)



4.5.10 Access to local health facilities and AWCs improved for mothers of less than one-year-old child

Access to local health facilities and AWCs improved between August-September (Phase 2) and December (Phase 4), as reported by mothers of children who were than one year-old (see Figure 4.15).¹⁰

Figure 4.15 Access to health facilities and AWCs (% mothers of less than one-year-old child)



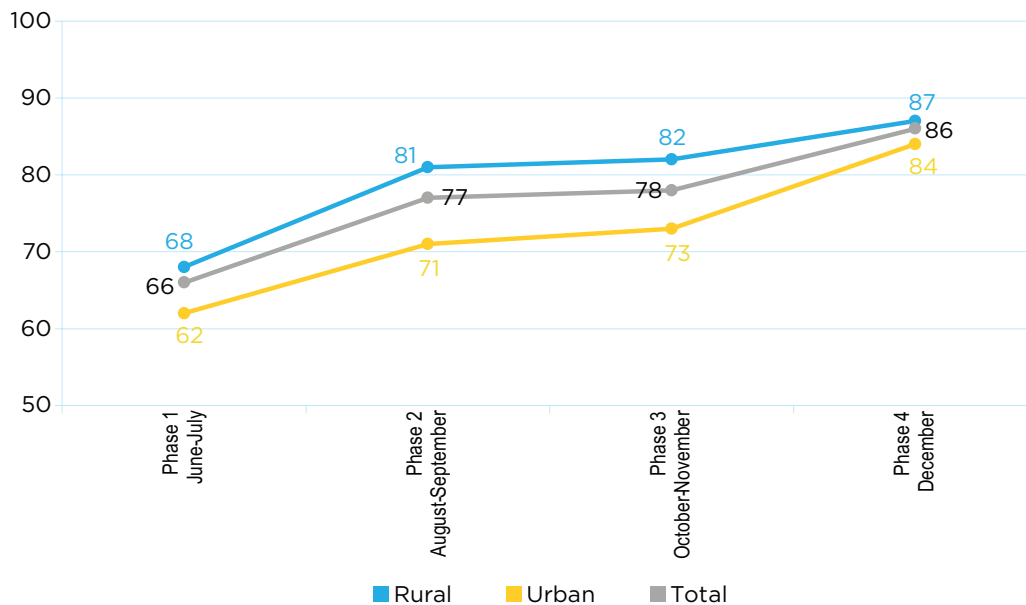
After the initial impact of the lockdown, around 60 per cent of the mothers reported that local health facilities and AWCs were open. Subsequently, the access improved and around 92 per cent of the mothers in December (Phase 4) reported that local health facilities were open.

10. This question was not asked for June-July (Phase 1).

4.5.11 Child immunization was adversely impacted more in urban than in rural areas

Child immunization was adversely impacted more in urban areas because of the lockdown (see Figure 4.16). During August-September (Phase 2), 71 per cent of the urban mothers reported immunization of their children (those who were due for immunization) as compared to 81 per cent of the rural mothers. However, the share of urban mothers reporting that their child had been immunized the preceding month improved by 13 percentage points between August-September (Phase 2) and December (Phase 4).

Figure 4.16 Child received immunization last month (% mothers of less than one-year-old child)



The immunization had been done mostly in Government health facilities. The adverse impact of the COVID-19 lockdown on immunization has been reflected in data from the Health Management Information System (HMIS), showing that far fewer children received immunization in March and April as compared to the same period the preceding year.¹¹

4.6 Awareness about and access to government social protection schemes

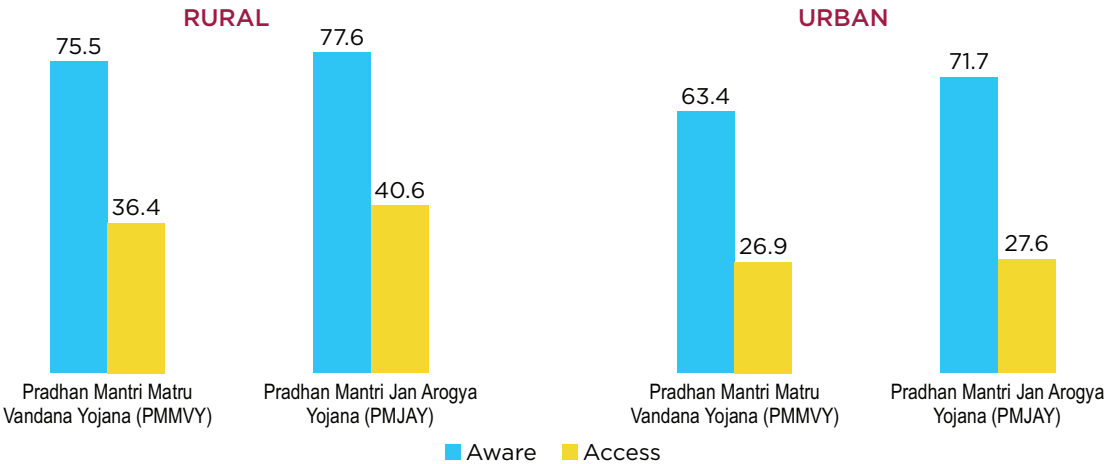
Social protection programmes are crucially important for vulnerable families. Such families tend to live hand to mouth and usually lack the financial savings needed to tide them over when they face a crisis such as the COVID-19 pandemic. Intending to explore the awareness of relevant government programmes among the sample communities, as well as the access they have to such programmes, the CBM, with the help of CVs, canvassed related questions for many programmes such as the Pradhan Mantri Jan Dhan Yojana, Indira Gandhi National Widow Pension Scheme, and Pradhan Mantri Ujjwala Yojana, among others.

11. Rukmini (2020), cited in 'Impact of COVID-19 on Child Nutrition in India: What are the Budgetary Implications? A Policy Brief', CRY and CBGA, accessed at <https://www.cbgaindia.org/wp-content/uploads/2021/01/Impact-of-COVID-19-on-Child-Nutrition-in-India-What-are-the-Budgetary-Implications.pdf>

In the health sector, the two social protection schemes considered were the Pradhan Mantri Matru Vandana Yojana (PMMVY) and Pradhan Mantri Jan Arogya Yojana (PMJAY). Under PMMVY, a cash incentive of Rs. 5,000 is provided directly into the accounts of pregnant women and lactating mothers for the first living child of the family, subject to some conditions. The other scheme, PMJAY, provides a health cover of Rs. 5,00,000 for families and individuals living below the poverty line across India.

Despite the importance of these schemes which provide direct healthcare-related benefits for poor families, and for pregnant and lactating mothers, in particular, the awareness regarding the two schemes is low among the respondents¹²(see Figure 4.17). The level of access to the schemes, as reported by the CVs, is only around 27 per cent in the urban location. The level of access in rural locations is slightly higher, at 36 per cent for PMMVY and 41 per cent for PMJAY.

Figure 4.17 Awareness about and access to selected government schemes (% of CVs)



4.7 Key observations and policy options

Urban communities were relatively more affected by COVID-19 but people were mostly able to receive treatment in health facilities and had knowledge of COVID-19 testing centres. For many people, however, testing facilities were far away from their habitations.

The density of COVID-testing centres may be increased in the areas where testing facilities are distant from the community.

Wearing a mask constantly and maintaining social distance all the time were found to be major challenges for the respondents in protecting themselves from COVID-19. The use of toilets in urban sample localities was reported by around 90 per cent of the respondents, but the corresponding figure was much lower in rural sample habitations. Post-lockdown, hand washing facilities were made available at public places such as offices, healthcare facilities/hospitals, Anganwadis, offices, bus stands, schools, and markets.

12. Based on the responses of CVs during December (Phase 4).

There is a continuous need for people to practice measures such as the use of masks and social distancing, and not all are practising such COVID-appropriate behaviour. The media needs to be used in a targeted manner in the sample habitations among the vulnerable population to increase awareness regarding these measures. Given that it is very difficult to maintain social distancing within slums, the emphasis should be on using masks. There is need for a similar awareness campaign to highlight the importance of using toilets/latrines for better hygiene, especially in the rural areas.

The CBM found a high degree of awareness about the COVID-19 vaccine among the respondents from both rural and urban areas, who opined that the elderly (those above 65 years) should receive the vaccine ahead of others. The next preferred category was children up to 18 years of age. Television, radio, and newspapers were found to be the most important and most trusted sources of information for COVID-19, followed by government health workers including ASHAs and AWWs. Rural communities rely more on Government health workers relative to urban communities. Social media, family, and friends are also trusted sources of information.

Among the local government health facilities which are open, not all were providing services for pregnant women. Access to Government facilities was found to be limited in June-July (Phase 1) among pregnant women, but it improved considerably over the subsequent assessment rounds. Access to prenatal services also increased between June-July (Phase 1) and August-September (Phase 2). A large share of rural pregnant women reported that local AWCs were providing ICDS services. Urban respondents, on the other hand, reported that the percentage of pregnant women reporting that local AWCs were providing ICDS services declined between August-September (Phase 2) and December (Phase 4).

Just around three-fifths of the pregnant women respondents were able to eat three main meals daily (October-November, Phase 3), reflecting the pressures on availability of food among the vulnerable respondents, with additional implications for under-nourished children. The sample districts of Jalaun, Lalitpur, and Agra fared the worst in this respect. The supplementary source of nutrition, that is, the THR intake, was also adversely affected in the wake of the lockdown but improved subsequently for pregnant women, lactating mothers, and mothers of 2-5-year-old children, with access to it being higher in rural than in urban areas.

The gaps in access of pregnant women respondents to three major meals a day must be addressed urgently by the targeted PDS, and THR schemes. Universal coverage of THR for lactating women and immunization for mothers of less than one-year-old child are also required.

The CBM shows that women-headed households, pregnant women, lactating mothers, and young children need special focus in the implementation of social protection schemes, and they also need unconditional and easy access to critical services.

The very low levels of awareness and outreach regarding health sector government schemes among the marginalised populace in the sample should be addressed. This is of crucial importance since the vulnerable groups of women and children can benefit from such protection schemes, especially during the pandemic. The reasons for the relatively low level of outreach in urban vis-à-vis rural habitations must also be explored.

05

CHAPTER



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MAJOR FINDINGS: EDUCATION



5.1 Introduction

Education has been one of the worst-affected sectors in the COVID pandemic situation. After schools closed down, the most widely prevailing technological solutions used for classroom instructions have been the use of digital platforms that offer video-conferencing facilities. However, this technology-driven dispensation of education has adverse implications for social equity in the area of classroom instructions. Findings by UNESCO and 'Save the Children' indicate that school closures entail high social and economic costs for people across communities all over the world, and this impact is severe for the most vulnerable and marginalised children.¹ Reportedly up to 9.7 million children are at risk of dropping out of school due to the rising levels of child poverty.² The UNESCO report highlights how school closures exacerbate the already existing disparities within the education system.

In Section 5.2, the findings regarding expansion of online schooling, the major means with which children attend online classes and the impact of a deepening digital divide among the children in sample habitations are discussed. In Section 5.3, the attitude of mothers towards reopening of schools is under discussion. The final section (Section 5.4) presents the key observations in this section based on findings from the CBM.

5.2 Continued school closure led to an expansion of online education

The adverse impact on education and evidence of the deepening digital divide and social inequity is observed in the findings from the CBM. After the March lockdown, schools were closed, and during the August-September (Phase 2) assessment, nearly all the respondent mothers of 6-19-year-old children in both the locations reported that their children's schools were closed. Even in October-November (Phase 3), 69 per cent of the rural mother respondents, and 88 per cent of the urban mother respondents said that their children's schools were closed. Consequently, after the lockdown, online education became the standard practice in the sphere of children's education.

1. Accessed at <https://en.unesco.org/covid19/educationresponse/consequences> and 'Save our Education', 2020, report by Save the Children accessed at https://resourcecentre.savethechildren.net/node/17871/pdf/save_our_education_0.pdf

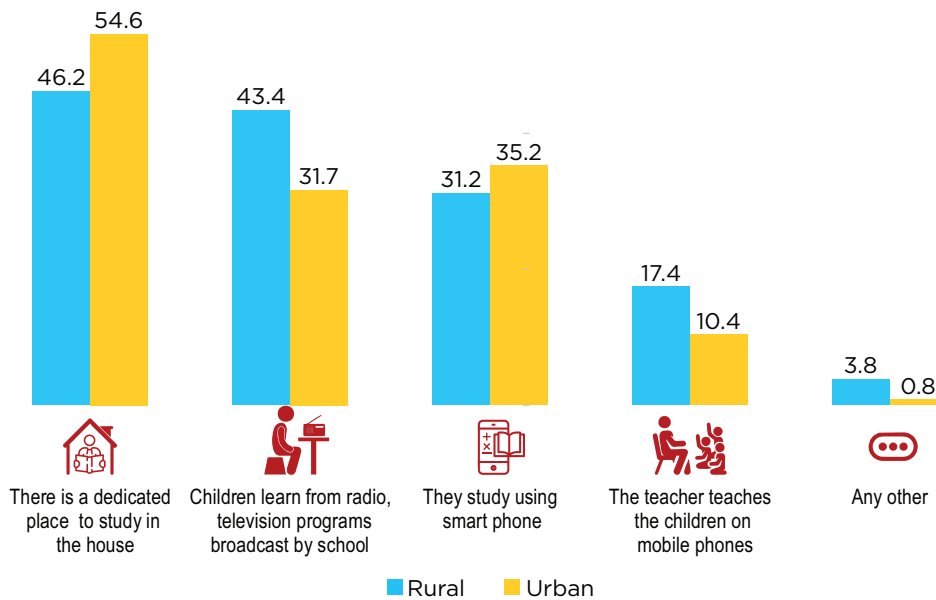
2. 'Save our Education', 2020, report by Save the Children accessed at https://resourcecentre.savethechildren.net/node/17871/pdf/save_our_education_0.pdf

5.2.1 Use of smartphones in education post-lockdown has aggravated the digital divide for marginalised children

Among the main earner respondents, around 71 per cent reported having school-going children, with the majority of them having one or two school-going children. About 88 per cent of the earning members reported that their children were enrolled in a school, with the figure ranging between 81 and 97 per cent across the districts.³

The main earners in the household were asked how their children studied at home and were presented with a set of options. A higher share of urban respondents mentioned a dedicated place in the house for their study, indicating that the children were studying on their own. The other important options mentioned in this regard were studying with the help of a smartphone and learning from radio, and TV programmes broadcast by the school (see Figure 5.1).

Figure 5.1 How do children (6-19 years) in the household study at home (% of yes responses), October-November (Phase 3)



Note: The percentages of 'Yes' responses of the Heads of Households are with reference to multiple responses and do not add up to 100.

5.2.2 Improvement in attendance of online classes over successive phases of assessment⁴

During the assessment in June-July (Phase 1) post the lockdown, very low shares of mothers of 6-19-year-olds reported that their children were attending online classes. These shares were 22 per cent in rural and 31 per cent in urban habitations.

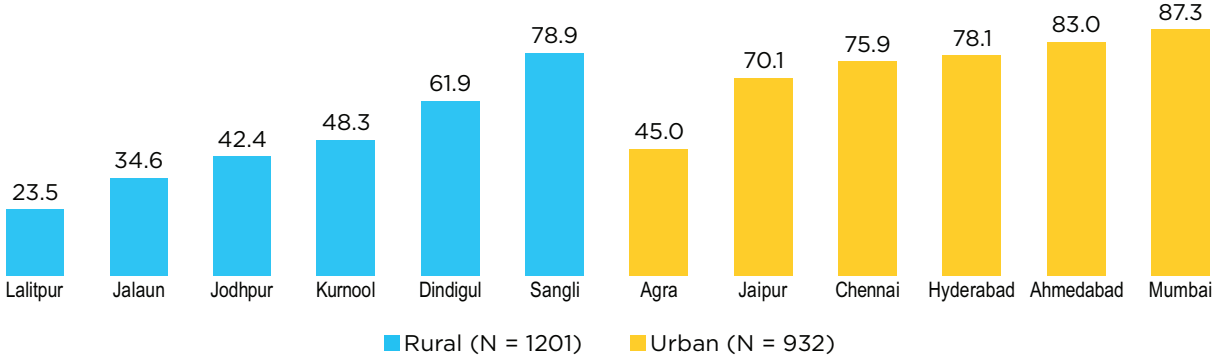
3. Based on 3667 observations.

4. Based on responses of mothers of 6-19 years old June-July (Phase 1) (Rural N=1079, Urban N=965), August-September (Phase 2) (Rural N=1288, Urban N=1051), and October-November (Phase 3) (Rural N=1201, Urban N=932).

Subsequently, during the August-September (Phase 2) assessment, 41 per cent of the rural and 54 per cent of the urban mothers of 6-19-year-olds said that their schools were providing online classes. The corresponding shares improved further during the October-November (Phase 3) assessment to touch 50 per cent in the rural and 74 per cent in the urban habitations as more and more schools moved towards providing online classes.

The variation across sample districts for the online provision of learning facilities by schools is presented in Figure 5.2 for October-November (Phase 3).


Figure 5.2 Is the school providing online facilities (% mothers of 6-19-year-olds) October-November (Phase 3)




A large proportion of urban mothers reported the provision of online facilities in their children’s schools in all the districts except Agra. Among the rural districts, Sangli and Dindigul showed relatively higher proportions of mothers reporting online classes in their children’s schools, while Lalitpur and Jalaun recorded the lowest percentages of mothers reporting online classes.

5.2.3 Mobile phones, internet links and TV are the primary means for attending online classes

The mode of online facilities for classes is primarily mobile phones, according to information available from the August-September (Phase 2) and October-November (Phase 3) assessments. Internet links and TV are some other important options. During October-November (Phase 3), 28 per cent of the parents in rural and 11 per cent of the parents in urban locations said that their children do not attend online classes despite the provision of these classes by the school (see Figure 5.3).

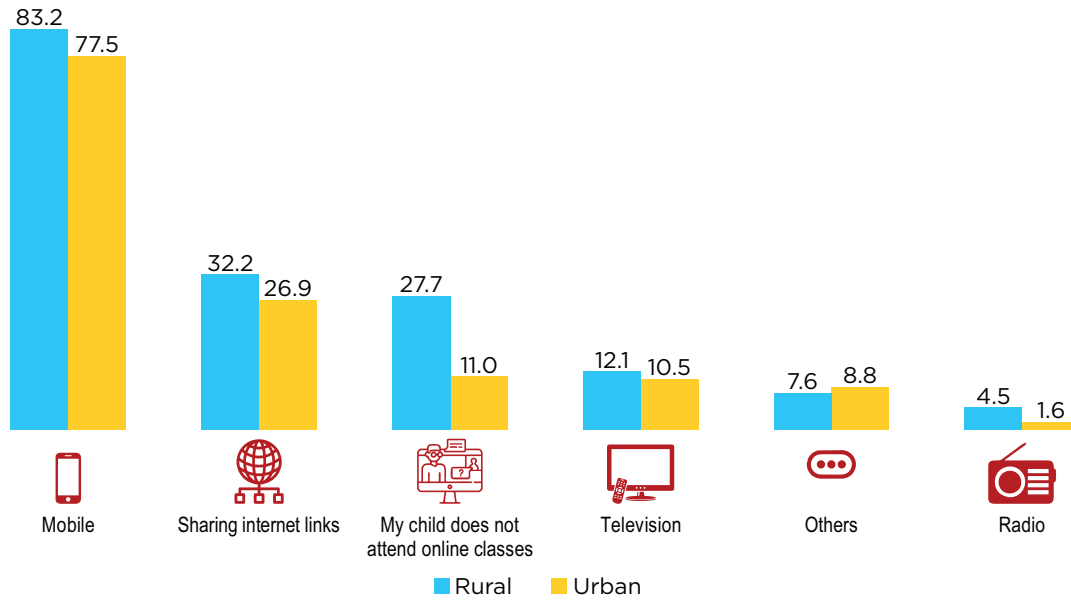


83.2 per cent rural and 77.5 percent urban mothers of 6-19-year-olds reported during October-November that mobiles was the mode of online facilities provided by schools to hold classes.



28 per cent rural and 11 per cent urban parents said that their children do not attend online classes despite the provision of classes by school (October-November).

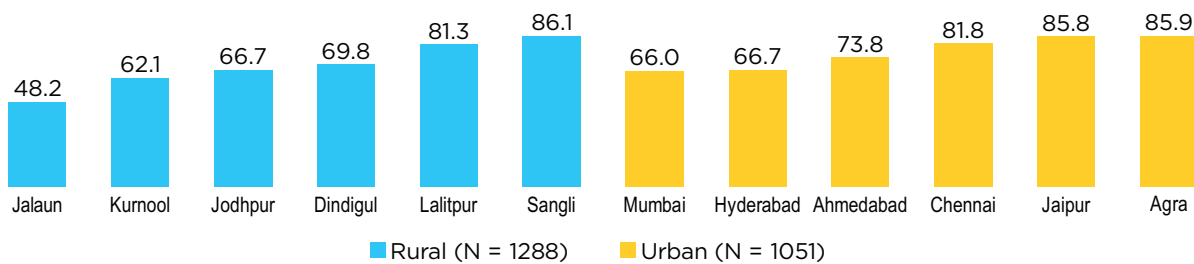
Figure 5.3 Mode of online facilities provided by schools (% mothers of 6-19-year-olds), October-November (Phase 3)



Note: The percentages of 'Yes' responses in the bar chart are with reference to multiple responses and do not add up to 100.

When asked whether the families had Internet connections in their areas, 69 per cent of the rural respondent mothers of 6-19-years-old children and 76 per cent of the urban respondents reported during August-September (Phase 2) that they did have an Internet connection. The variation in Internet access across the sample districts is presented in Figure 5.4. Within the same state, less than half the respondents in Jalaun district reported having Internet connections in the area, while 81 per cent of the respondents in Lalitpur district did so. Among the urban districts, a relatively lower percentage of respondents in Mumbai and Hyderabad reported having Internet connections in the area as compared to the other cities.

Figure 5.4 Respondents having internet connections in their areas (% mothers of 6-19-year-old children) (August-September, Phase 2)



5.2.4 Lack of access to smartphones and computers are main reasons that prevent students from attending online classes

During October-November (Phase 3), several respondent mothers said that their children were not attending online classes, even though such classes were being offered by the schools. When asked about the

reasons for the non-attendance of online classes by their children, a majority of the mothers cited the lack of smartphones in the family, followed by the lack of computers/laptops and lack of or poor Internet connectivity (see Table 5.1). Another reason cited for this non-attendance was that the child did not have digital skills. This brings into sharp focus the digital divide in the country as some children can fall off the education grid due to lack of access to the necessary devices. The other reasons cited for non-attendance of online classes were that the children were engaged in household chores/unpaid work or were supporting their families, and the relative share of such families was much higher in the rural than in the urban sample habitations.

Table 5.1: Reasons for not participating in online learning (% mother of 6-19-year-olds) (October-November, Phase 3)

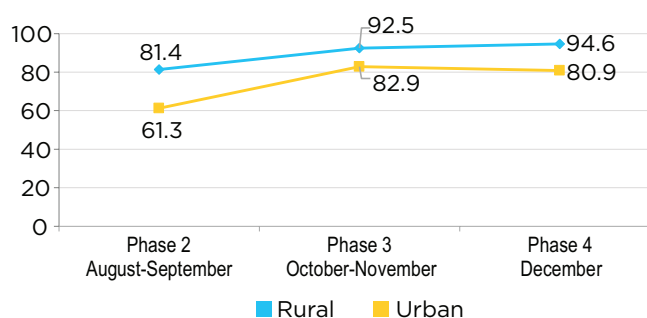
	Do not have access to smartphone in the family	Do not have a computer/laptop	Do not have access to Internet at home or connectivity is weak	Child does not have digital skills	Child engaged in household chores/unpaid work/supporting family	Do not have TV/radio in the family
Rural (N=181)	65.7	44.2	35.4	23.2	19.3	12.2
Urban (N=122)	54.1	22.1	22.1	19.7	9.0	7.4

Note: The percentages of responses are with reference to multiple responses and do not add up to 100.

5.3 More mothers ready to send their children to school after their re-opening in Phase 4

The mothers of 6-19-year-old children were asked the question, “Will you send your child back to school when these re-open?” It is heartening to note that though lower shares of respondents were willing to send their children back to school in August-September (Phase 2), the confidence among people had bounced back by December (Phase 4). Around 95 per cent of the rural and 81 per cent of the urban respondents reported in December (Phase 4) that they would send their children back to school once it re-opened (see Figure 5.5).

Figure 5.5 Mothers who want to send their children back to school after it reopens (% mothers of 6-19-year-olds)



5.4 Key observations

The school education of children from vulnerable families has suffered major disruptions since the advent of the COVID-19 pandemic and lockdown. Nearly all schools remained closed for the major part of 2020, and online classes became the main avenue for learning. Consequently, the digital divide adversely affected the respondent families from the marginalised communities as many of them could not afford devices such as smartphones and they also lacked digital literacy. Some children from such families either fell off the education grid altogether or faced the risk of doing so in future.

Following the lockdown, an increasing number of schools started offering online classes to ensure that learning did not come to a halt altogether. In June-July (Phase 1) 22 per cent of the rural and 31 per cent of the urban mothers of 6-19 years old children reported that their children were attending online classes. The corresponding shares during the October-November (Phase 3) assessment improved to 50 per cent in the rural and 74 per cent in the urban sample habitations as more schools moved towards holding online classes. Mobile phones were the primary means of attending online classes organised by schools, followed by the sharing of Internet links and the use of television.

Some children were not attending classes even when their schools were offering online classes. The main reason for this non-attendance was reported to be the lack of access to devices such as smartphones and computers for the children.

The CBM assessment shows that access to online means of education and online education varied significantly between locations and was marginally better in urban than in rural areas. Overall, learning and school education became a major casualty among children in the poor localities.

It is encouraging to note that despite the threat of the COVID-19 infection, most of the respondent mothers reported in December (Phase 4) that they were willing to send their children to school once the schools re-opened.



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MAJOR FINDINGS: CHILD PROTECTION AND GENDER-BASED PROTECTION



6.1 Introduction

Child protection and social protection offer necessary safety nets for vulnerable children and communities who suffer from poverty, joblessness, and associated vulnerabilities such as hunger, malnutrition, diseases, indebtedness, and social evils like child marriage, child labour, and violence against women and children. The CBM assessment included questions on related issues such as child marriage and engagement of children in paid work, which might have arisen or been aggravated as an impact of the COVID-19 pandemic. In Section 6.2, the issue of child marriage and/or engagement is discussed, followed by a discussion on the impact on violence against women and children as a result of the lockdown in Section 6.3. Findings regarding engagement of children in paid work and domestic chores are presented in Section 6.4. Next in Section 6.5, the findings related to awareness of child protection schemes among sample respondents as well as access to the related benefits are discussed. Section 6.6 presents key observations and policy options based on evidence from the CBM assessment.

6.2 Limited evidence of child marriage but increase in its incidence between October-November (Phase 3) and December (Phase 4)¹

Child marriage in India signifies a marriage in which either of the contracting parties is a child, that is, marriage before the legal age of 18 years for girls and 21 years for boys. Following the spread of the COVID-19 pandemic and the associated lockdown and need for social distancing, many people lost their jobs, and income streams became uncertain, especially for people of the marginalized communities. There have been reports that in such a situation, child marriage is being seen as an option for parents for reducing their future household expenditure and meeting parental responsibilities, as schools remained closed after the lockdown.²

Around 65 per cent of the mothers of 6-19-year-old children said in October-November (Phase 3) that they had a daughter below 18 years of age. About 95 per cent of the respondents with daughters below 18 years of age said that since the start of the lockdown, their daughters had not got married or engaged for

1. Child marriage information based on the responses of mothers of children aged 6-19 years in October-November (Phase 3) (Rural N=862, Urban N=741) and December (Phase 4) (Rural N=821 and Urban N=680).

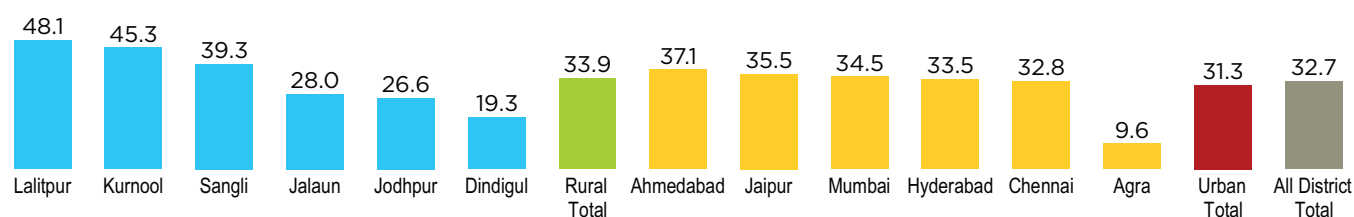
2. Accessed at <https://thefederal.com/news/centre-intervened-to-stop-5584-child-marriages-amid-lockdown/>

marriage. Among the urban respondents, 4.6 per cent reported that their daughters got married/engaged, as compared to a slightly lower share of 3.7 per cent among the rural respondents. In December (Phase 4) the corresponding shares for reporting child marriage/engagement were higher at 6.8 per cent in the urban and 5.4 per cent in the rural locations, respectively.

6.3 Rise in violence against women and children reported in the sample habitations

Around one-third of the respondent mothers of 6-19-years-old children reported in December (Phase 4)³ that they had heard or seen cases of violence against women and children during the lockdown period. There was considerable variation in reporting across districts in the rural sample habitations, as seen in Figure 6.1.

Figure 6.1 Respondent has heard or seen cases of violence against women and children during the lockdown period (December, Phase 4) (% mothers of 6-19-year-old children)



Among the rural districts, the number of reports of violence against women and children was relatively higher in Lalitpur, Kurnool, and Sangli. Among the urban districts, the reporting of such incidents was largely similar across the cities, that is, in the range of 33-37 per cent, but in Agra, the reporting was exceptionally low, at around 10 per cent.



Limited evidence of child marriage but rise in violence against women and children reported.

The CVs reported a rise in violence against women and girls (both at home and outside), more so in the rural than the urban sample habitations.⁴ This reporting was done by 44 per cent of the CVs in August-September (Phase 2) and by 40 per cent in October-November (Phase 3). In urban locations, the corresponding shares were 25 per cent and 29 per cent, respectively. But the rural-urban differential narrowed from 19 percentage points to 11 percentage points from August-September (Phase 2) to October-November (Phase 3).

Awareness regarding helpline/services for reporting violence against women and children was reported by around 70 per cent of the mothers of 6-19 years old children in both locations as of August-September (Phase 2). A much higher proportion of 78 per cent of the urban respondents reported such awareness during the assessment in October-November (Phase 3), but there was little corresponding change among the rural respondents.

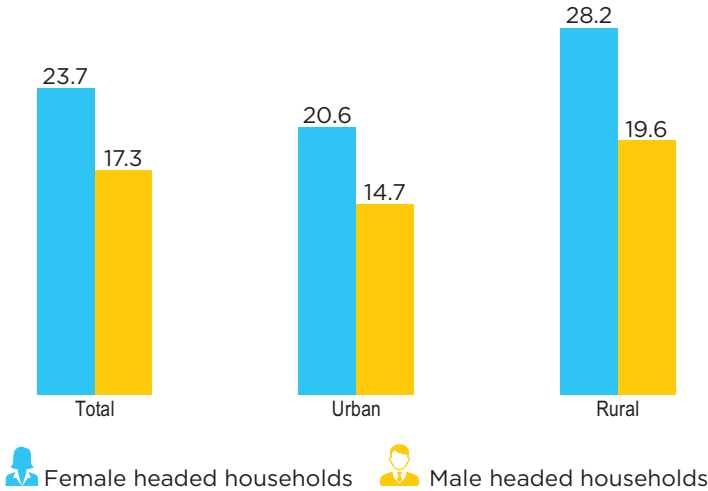
3. Based on the responses of mothers of 6-19 year old children, December (Phase 4) (Rural N=1350, Urban N=1127).

4. Based on the responses of CVs for August-September (Phase 2) (Rural N=144, Urban N=152) and October-November (Phase 3) (Rural N=143, Urban N=151).

6.4 Child engagement in paid work and domestic chores

Among the main earner respondents who reported having 6-18 year-old children in their families in December (Phase 4), one-fifth of the rural and 16 per cent of the urban respondents said that they had a child/children (6-18 year-old) who were either doing paid work or were looking for such work. One-third of such children who were workers or prospective workers were 6-14 years old and two-thirds were 15-18 years old. Proportionately a higher number of child workers was found in the female-headed households as compared to the male-headed ones (see Figure 6.2).

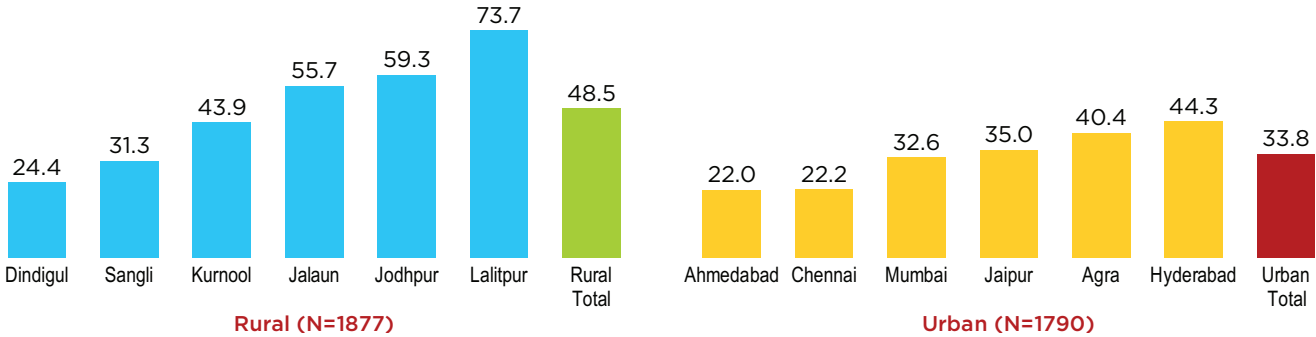
Figure 6.2 Children engaged in any type of paid work or looking for paid work by sex of the main earning member of the households (% of main earners) (December, Phase 4)



In December (Phase 4), among the main earner respondents who reported having 6-18 years-old children in their families, around 50 per cent of the respondents in rural and 34 per cent of the respondents in urban sample locations said that these children were doing household chores. The variation across sample districts is shown in Figure 6.3.

Share of children engaged in paid work or looking for paid work more in female headed households than male headed households.

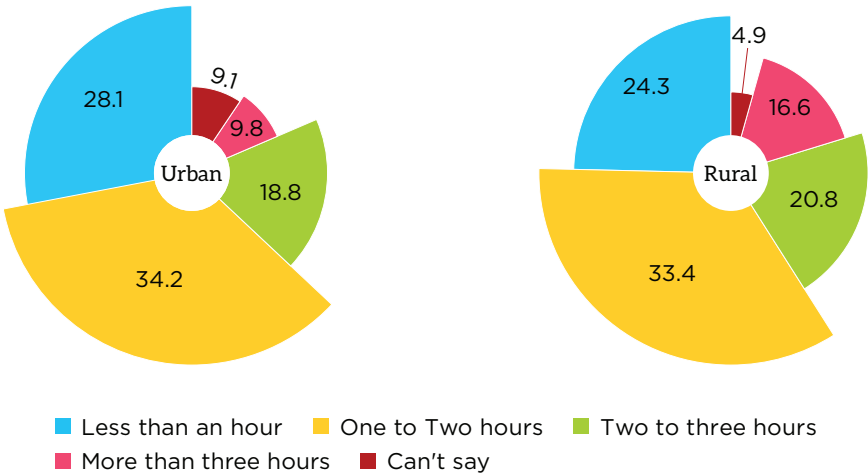
Figure 6.3 Children engaged in household chores (% of main earners) (yes %) December (Phase 4)



Nearly half the rural main earners reported that their children were engaged in household chores as compared to a much lower share of 34 per cent among the urban main earners. Among the rural districts, the Lalitpur, Jodhpur, and Jalaun districts reported relatively higher child engagement in household chores, while among the urban districts, Hyderabad and Agra reported relatively higher child engagement in household chores.

The main earners were asked the following question regarding the 6-18 years-old children living in their families: ‘In your opinion, currently, on average, daily, how many hours are spent on domestic chores by these children?’ Around one-third of the main earners in both locations reported that their children spent two to three hours a day on domestic chores, but 16.6 per cent of the rural respondents said that their children worked for more than three hours daily, vis-à-vis a much lower corresponding share of 9.8 per cent of urban respondents who reported this (see Figure 6.4).

Figure 6.4 Number of hours spent daily on domestic chores by children (% of main earners) in December (Phase 4)

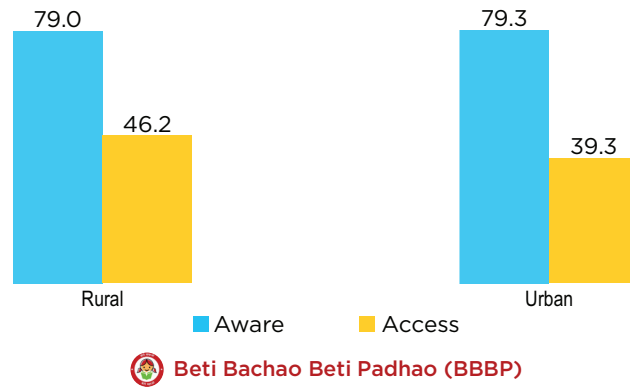


6.5 Moderate awareness about child protection scheme and limited access to benefits⁵

The flagship government scheme of ‘*Beti Bachao Beti Padhao*’, launched in 2015, has the main objectives of arresting the declining child sex ratio by prevention of gender-biased sex-selection practices, protection of the girl child, and promoting the girl child/women’s education. The awareness about this major scheme was reported by around 79 per cent of the CVs in the sample habitations. With overall access reported by only 43 per cent of the CVs, the access among the urban communities was reported to be far lower at 39 per cent vis-à-vis the rural communities (46 per cent) (see Figure 6.5).

5. Based on the responses of CVs in December (Phase 4) (Rural N=143, Urban N=145).

Figure 6.5 People's awareness about and access to the Beti Bachao Beti Padhao scheme (% of CVs)



6.6 Key observations and policy options

The reporting of the incidence of child marriage was found to be limited in the sample habitations, but the reporting was slightly higher in December (Phase 4) vis-à-vis October-November (Phase 3). Two-fifths of the CVs reported an increase in incidents of gender-based violence. The level of awareness regarding helplines for reporting such incidents of violence was much higher among urban mothers of 6-19 years-old children than among the rural respondents.

The level of awareness must be raised among women about the need for reporting incidents of violence, as gender-based violence tends to be under-reported. Awareness campaigns regarding the availability of helplines may be carried out among the vulnerable communities, especially in rural locations.

With schools closed, and incomes depressed, there was a risk of children being pushed into paid work to supplement household earnings. According to the CBM findings, one-fifth of the rural and 16 per cent of the urban main earners with 6-18 years-old children in their families in December (Phase 4), said that they had children who were either doing paid work or were looking for such work. One-third of such children were 6-14 years old. Many children were also found to be engaged in domestic chores, more so in the rural locations. The number of daily hours spent on domestic chores was also higher in rural than urban areas.

The re-opening of schools is likely to act as a preventive factor for child workers. But effective government oversight for tackling the issue of children being engaged in paid work is a necessity to enable children from poorer families to reach their full potential in life. In this regard, the focus should be more on rural areas for the prevention of paid work and domestic chores by children.

Access to the important child protection scheme, *Beti Bachao Beti Padhao*, was particularly low among the sample habitations, as reported by the CVs.

The bottlenecks in getting the benefits across to the vulnerable population must be addressed and removed urgently since the social protection schemes are meant to serve such marginalised segments of the populace.



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MAJOR FINDINGS: LOCAL GOVERNANCE



7.1 Introduction

The critical role of local governance in coordinating the COVID-19 pandemic response has been mentioned by secondary evidence. The very nature of a pandemic demands a decentralised response and in this context, the Panchayati Raj Institutions are ideally suited to respond to the challenge.¹ A study based on evidence from the states of Rajasthan, Odisha, and Kerala has highlighted how state authorities are attempting to bridge the gap between the need for a rapid, vigorous response to the pandemic and local realities (Dutta and Fischer 2020²). Local governments have reportedly assumed central responsibility in the implementation of disease control and social security mechanisms, especially in states such as Kerala. Similar encouraging findings have been reported from the CBM, which are discussed in Section 7.2. Section 7.3 presents the key observations and policy options based on evidence from the CBM assessment.

7.2 Active role played by panchayats in promoting COVID-appropriate behaviour and distribution of THR³

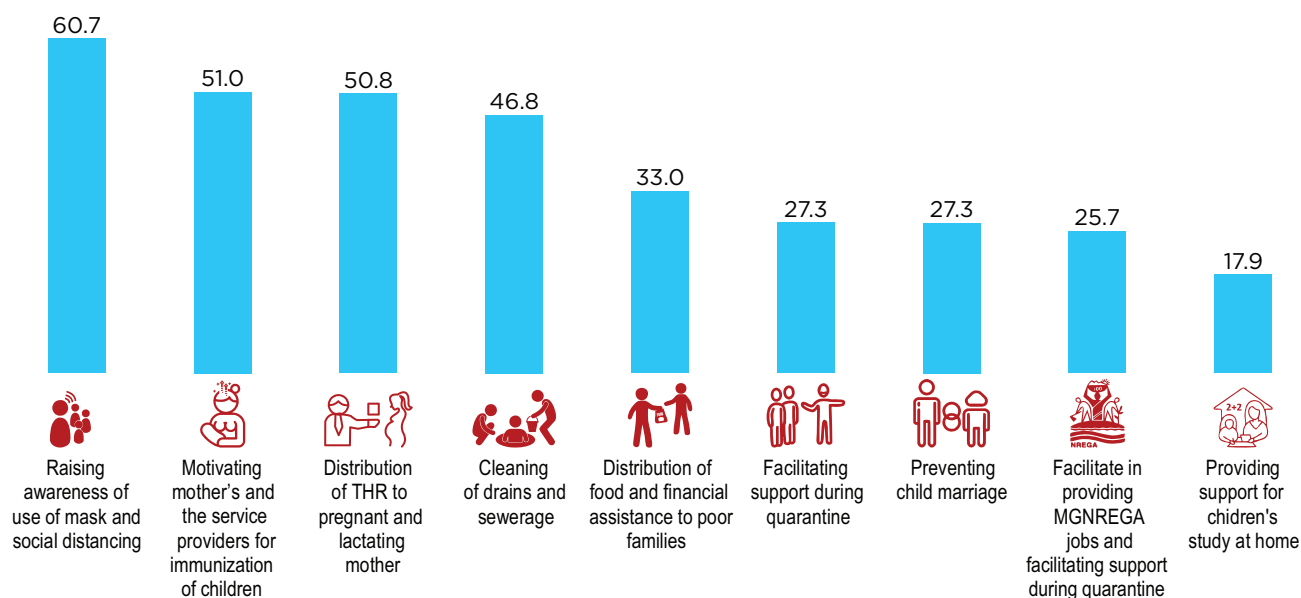
About 83 per cent of the main earners in the rural habitations reported in December (Phase 4) that they were within the jurisdiction of a Gram Panchayat. Among those respondents, 77 per cent said that they were aware of Gram Sabha meetings in the Gram Panchayat.

According to respondents in the sample habitations, during the COVID-19 pandemic, the Panchayat has been active in promoting awareness about COVID-appropriate behaviour, including the use of masks and social distancing, improving sanitation via the cleaning of drains and sewerage, in the facilitation of MGNREGA job provision and wage payment as well as in the distribution of food and financial assistance to poor families (see *Figure 7.1*). In Odisha, the Gram Panchayats have reportedly played a key role in ensuring food security for people in times of emergency, ensuring observations of quarantine, and providing food for the quarantined people, among other

1. Chibber and Verma 2020, cited in Ananthpur 2020: Kripa Ananthpur "Role of Panchayati Raj Institutions in Dealing with Covid-19 Crisis", *MIDS Occasional Policy Paper 10*.
2. Dutta, Anwasha and Harry W. Fischer 2020, 'The local governance of COVID-19: Disease prevention and social security in rural India' in <https://doi.org/10.1016/j.worlddev.2020.105234>
3. Based on responses of main earners in December (Phase 4) (N=3066).

things.⁴ In Tamil Nadu, a preliminary telephonic survey in some rural districts showed that local governments had been actively involved in creating awareness about the pandemic, disinfecting and sanitising of the Gram Panchayats, ensuring lockdown protocols and delivery of essential services, tracking and tracing of cases, and enforcing quarantine measures.⁵ The Rural Development and Panchayati Raj department had instructed the panchayats in Thanjavur and Thiruvavur to act as employment exchanges by registering agricultural labourers requiring work and providing such labour for farmers requiring wage labour.

Figure 7.1 What has been the role of the panchayat in your locality during the COVID-19 pandemic (% of main earners) (N=2538)



Note: The percentages of responses are with reference to multiple responses and do not add up to 100.

Other responses indicate that the Panchayat has also been active during the COVID-19 pandemic in the areas of organising the immunization of children and in the distribution of THR to pregnant women and lactating mothers. Their role in preventing child marriage and, to an extent, in providing study support for children was also cited. The district-wise variation in the reporting of the Panchayat activity for MGNREGA and THR distribution are shown in Figures 7.2 and 7.3.

Figure 7.2 Facilitating providing of MGNREGA jobs and facilitating timely payment of wages (% of main earners) December (Phase 4)

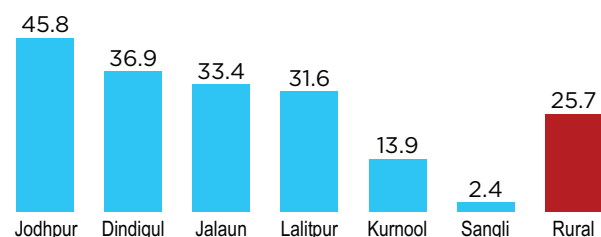
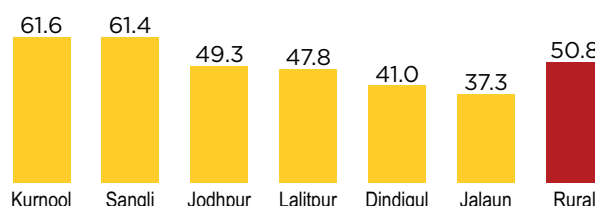


Figure 7.3 Distribution of THR to pregnant and lactating mothers (% of main earners) December (Phase 4)



4. Material from a webinar on "Role of Panchayati Raj Institutions (PRIs) in Disaster Preparedness and Management - Lessons from COVID-19 Pandemic" on 24 April 2020, jointly organised by PRIA International Academy (PIA) and National Institute of Rural Development and Panchayat Raj (NIRDPR), accessed at <https://www.pria.org/featuredstory-role-of-panchayati-raj-institutions-pris-in-disaster-preparedness-and-management-lessons-from-covid-19-pandemic-44-242>

5. Ananthapur 2020.

Thus, the Gram Panchayats in the sample habitations played an active role in the battle against COVID-19, and their efforts were seen in almost all aspects of a villager's life, including prevention of the spread of the infection, augmenting livelihoods, assuaging hunger, providing nutrition to children and women, and maintaining cleanliness. They thus made important contributions towards mitigating some of the adverse impact of the COVID-19 pandemic on the lives of the common people. However, the local government functions and capacity of the panchayats varied a lot across sample locations and districts and state governments would do well to focus on the long-term institutional capacity of the Panchayati Raj system.

According to the CV response, though people in 77 per cent of the habitations were aware of the Gram Panchayat Development Plans, only 29 per cent of those who were aware were involved in preparing such Plans. The awareness regarding Gram Sabha meetings was even lower and very few CVs reported that people in their habitations attended the Gram Sabha meetings. A majority (three-quarters) of the CVs said that people in the sample habitations had not faced disruption in drinking water supply following the advent of COVID-19 and had witnessed disinfection drives being carried out in the habitation following COVID-19.

7.3 Key observations and policy options

The CBM findings show that the Panchayats had been active in awareness-building regarding the use of masks and social distancing, sanitation, distribution of food and financial assistance, facilitating quarantine and MGNREGA work, immunization of children and distribution of THR to pregnant women and lactating mothers.

Their efforts were seen in almost all aspects of a villager's life, and had helped towards mitigating some of the adverse impacts of the COVID-19 pandemic.

The engagement of the locals in Panchayat functioning such as attending Gram Sabha meetings and participating in village level planning needs to be increased further. In order to strengthen the role of the Panchayats to augment decentralised development as well as to strengthen coping mechanism during situations such as the one caused by the COVID-19 pandemic, there is a need for capacity development, including providing access to more resources at the local level. As has been done in Tamil Nadu, panchayats can be utilised to act as employment exchanges by registering agricultural labourers requiring work and providing such labour for farmers who need wage labour. At the same time, the villagers need to be more involved in the decision-making process so that their aspirations and needs get reflected in the local planning process.



CONCLUSIONS



The COVID-19 pandemic caused enormous distress and upheavals in the lives of the people. Yet the innate resilience of human beings, along with the responses from governments and institutions helped people get back on their feet. In India, the poor and the vulnerable were particularly impacted by the pandemic. The CBM aided in getting quick feedback from the ground regarding the constantly evolving situation that the vulnerable communities faced during the months after the pandemic and how they coped.

Immediately after the lockdown, the vulnerable segments of the population, comprising mainly casual workers and some regular salaried workers, along with some unemployed, suffered from loss of livelihoods, lower wages, and food shortage. However, with gradual unlocking, as the decline in the economy reversed, so did the economic fortunes of these workers. The share of the jobless fell and people accessed jobs, albeit of poorer quality than earlier, and by December (Phase 4), the joblessness in the sample locations was less than the pre-lockdown levels. However, income had not gone back to the pre-lockdown levels.

Hunger and food shortage persisted in the sample families till December (Phase 4), which impacted the entire family, including the children. The development of children was adversely affected as they had reduced access to nutritious food. There was also an adverse impact on unborn children, as many pregnant mothers were reportedly not getting three square meals a day. Lactating mothers and other women respondents also suffered on account of poor access to services from local health facilities and AWCs.

It was of utmost importance for the sample respondents for the social protection programmes currently in place to function effectively and for the Government institutions to work to continue to provide services on which the poor are crucially dependent. It is extremely encouraging that the CBM reported good ration-card access in the sample habitations and that very high shares of ration-cardholders could get ration from the PDS shops. However, the urban respondents living in slum habitations did not report as high an access to ration card possession as the rural respondents. The rural population sought but not all of them could get MGNREGS job cards, though many of them reported receiving timely wage payments for MGNREGS work.

Therefore, going forward, while the especially vulnerable segments such as the home returnees and the female-headed families need to be provided targeted assistance such as in the form of cash transfers, other solutions are needed in the medium term. Livelihood options need to be created for the poor, with arrangements for suitable skill development. The PDS network needs to be further strengthened with improvement in ration-card holding for the slum population in urban centres. Another important measure is the introduction of universal PDS distribution during the pandemic in vulnerable geographies. In this context, the across-state portability of ration cards is suggested as a measure to overcome the problems of getting ration cards for workers who migrate

from state to state. The bottlenecks in the issuance of job cards under MGNREGS must also be addressed.

The CBM showed that proper functioning of local health facilities and AWCs is important for mother and child health in the sample habitations. With gradual unlocking, as the AWCs started functioning, pregnant women, lactating mothers, and mothers of small children could access THR and other services such as growth monitoring of the child. These institutions too need to be strengthened along with augmentation of the general health infrastructure such as local hospitals. The AWWs/ANMs have performed crucially important roles during the lockdown and later in reaching services to families as well as in spreading hygiene-related awareness.

Education is an area where poor children have suffered the most, as they lack the necessary devices to switch to the online mode of education. The children in rural habitations were even more at a disadvantage than their urban counterparts. Many children, especially in rural areas, did not attend classes, even though their schools were offering online classes, in the aftermath of the lockdown, school closure and the digital divide. While schools are slowly re-opening, the lockdown served to show the importance of access to technology in the present age. Even if children from vulnerable families acquire smartphones or computers, they and their parents usually lack the digital literacy to make optimum use of such devices. Therefore, longer-term solutions of educating first-generation learners need to be implemented to narrow the gap between them and children from better-off families.

Panchayati Raj Institutions (PRIs) have contributed in a big way towards battling the devastating impact of the COVID-19 pandemic, particularly in some states. They have contributed towards improving sanitation, spreading awareness about the wearing of masks and maintaining social distance, managing food distribution, offering quarantine situations, and reaching THR to pregnant women and lactating mothers. Since the PRIs are in direct touch with the communities and have been effective on the ground in managing the ramifications of the pandemic, there is a need to further strengthen these institutions for the future. However, the findings of the CBM have shown that people find wearing masks constantly as well as maintaining social distance at gatherings a challenge and are thus not practising these measures adequately. Given that TV was found to be a most effective medium of dissemination, awareness campaigns regarding such coping mechanisms which can protect people from the pandemic need to be carried out with greater efficacy.

Similar awareness campaigns are required along with stricter law enforcement to build public opinion against gender-based violence and to embolden women to contact helplines. The CBM has shown that quite a high percentage of children are engaged in paid work and domestic chores. This is largely due to a drop in family incomes. It would be good if the government can provide certain fixed compensation to poor families to mitigate the extent of loss of wages to prevent children being pushed into doing paid or unpaid work.

A major finding flagged by the CBM assessment is that the impact of the lockdown was more severe in urban than in rural areas. Further, despite easier geographical access in urban locales, rural services were more resilient than urban services in most places. This shows that over a period of time, the rural social protection and health delivery system has developed a stronger foothold, but there are larger gaps in the delivery systems in the urban areas. Given that the lockdown and the pandemic exposed the precariousness of the poor urban populations (including home returnees), more focus needs to be accorded to developing appropriate institutional structures and mechanisms for dealing with the deprived urban population, especially those living in slums and peri-urban areas. There is also an urgent need to provide social protection and a steady stream of important services to female-headed households, pregnant women, lactating mothers, and young children.

