

# IMPACT OF COVID-19 IN RURAL INDIA

A cross sectional study from 12 states



JESUIT COLLECTIVE INDIA



**Indian Social Institute, Delhi** established in 1951, is committed to social transformation through socially relevant research, training and action, publication and advocacy works aimed at integral development of marginalized communities, particularly Dalits, Adivasis/tribals, women, minorities, unorganized and landless labourers in partnership with academicians, people's movements, human rights organizations and ecological movements nationally and internationally.

**Conference Development Office (CDO)** is the development wing of the Jesuit Conference of India/South Asia. It promotes programmes and fosters linkages among Jesuit-led institutions and networks in the region. It enhances the thematic and developmental thrust areas of the Conference such as the Sankalp (informal education), JesuiTec, Ecology, Peace and Reconciliation, Migration, Lok Manch and Disaster Response.

**Lok Manch (People's Platform)** is an initiative of the Social Justice and Ecology Secretariat of the Society of Jesus. It is a platform of community leaders and civil society organizations for strengthening community leadership and community-based organizations in order to build a just, democratic and secular society.

**The Migrant Assistance and Information Network (MAIN)** reaches out to distress migrants both inter-state and intra-state in collaboration with individuals, NGOs / CSOs / CBOs, institutions, religious congregations, dioceses, and networks at various levels to develop a replicable and sustainable model of Accompanying, Serving and Advocating for the cause of distressed migrants.

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# CONTENTS

|  |           |
|--|-----------|
| <b>Foreword</b>  | <b>4</b>  |
| <b>Acknowledgments</b>                                   | <b>5</b>  |
| <b>Abbreviations</b>                                     | <b>6</b>  |
| <b>List of Tables</b>                                    | <b>7</b>  |
| <b>List of Figures</b>                                   | <b>8</b>  |
| <b>List of Boxes</b>                                     | <b>9</b>  |
| <b>Executive Summary</b>                                 | <b>10</b> |
| <b>Introduction</b>                                      | <b>13</b> |
| <b>Chapter 1: Methodology</b>                            | <b>20</b> |
| <b>Chapter 2: Impact on Livelihood</b>                   | <b>24</b> |
| <b>Chapter 3: Impact on Health</b>                       | <b>33</b> |
| <b>Chapter 4: Impact on Children and their Education</b> | <b>43</b> |
| <b>Chapter 5: Impact of Social Security Schemes</b>      | <b>49</b> |
| <b>Chapter 6: Major Findings of the Study</b>            | <b>54</b> |
| <b>Chapter 7: Recommendations and Conclusion</b>         | <b>57</b> |
| <b>References</b>  | <b>60</b> |

# Foreword

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The COVID-19 pandemic took the people of the country by surprise in the beginning of 2020. The Government tried to contain the spread of the pandemic by imposing lockdowns, which created further distress to the poor, especially the migrants, and the economy of the country as a whole. In April 2021, a devastating second wave of the COVID-19 pandemic brought a trail of death and immense suffering to millions of people throughout the country. The healthcare system of the country could not cope up with the rapid spread of the virus resulting in shortage of beds, ventilators, oxygen and medicines in hospitals and healthcare centres. Though new vaccines were produced and approved within a year to protect the people, the vaccination process faltered shortage of vaccines on one hand and vaccine hesitancy on the other.

At the peak of the second wave, of the pandemic, Indian Social Institute teamed up with the Jesuit Collective comprising of Jesuit Conference of India – Conference Development Office (JCI-CDO), Migrant Assistance and Information Network (MAIN) and the Lok Manch network of Social Justice and Ecology Secretariat of South Asia (SJES-SA) to engage in a massive COVID-19 relief work across twelve states in India. While engaging in the relief work, it was felt that since a lot of the reports of death and suffering of people was getting coverage in the media, not much was known about the impact of the COVID-19 pandemic in rural parts of India. Most of the studies undertaken by different institutions during the pandemic also focused on its impact on people in urban centres. Therefore, Indian Social Institute, in collaboration with JCI-CDO led by Dr. Siji Chacko, decided to undertake a study of the impact of the COVID-19 pandemic in rural India with the help of the Jesuit Collective network. Mr. Shinu Joseph from JCI-CDO and Dr. Alwyn D’Souza from ISI Delhi were deputed to undertake the study.

On the completion of the study in early 2022, a factsheet of the key findings of the study was published and released at a webinar on 21st June, 2022. I am glad that the final report of the research study on “Impact of COVID-19 in Rural India: A cross sectional study from 12 states” has been completed. I thank all members of the Jesuit Collective network who were involved in this research study. I hope the findings of the study will help academicians, social scientists, health professionals and policy makers to respond effectively to pandemic-like emergency situations keeping in mind its impact on most marginalized communities in rural India.

**Dr. Denzil Fernandes**

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I thank Mr Shinu Joseph from Conference Development Office (CDO) for his assistance in the preparation of research tools and for the technical assistance in the use of Kobo Toolbox app. I also thank Mr Julian Pascal Osta of IGSSS for providing the initial training on the use of Kobo Collect software.

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I extend my sincere thanks to all the interns (Anushka Rawat, Neha Aggarwal, Jenny Xalxo, Apphia Shohe and Sneha Mathew) who assisted in this research study at different times. Their assistance varied from translation of the responses, review of literature, standardization of responses, categorization of Case Studies and FGDs. I am grateful to all of them for making my task a lot easier.

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**Dr Alwyn D'Souza**

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# Abbreviations

|         |  |
|---------|--|
| ABBA    | Aadhar- based Biometric Authentication                 |
| ASER    | Annual Status Education Report                         |
| CDO     | Conference Development Office                          |
| CSs     | Case Studies   |
| FGDs    | Focus Group Discussions                                |
| IHD     | Institute for Human Development                        |
| IS      | Interview Schedule                                     |
| ISI_D   | Indian Social Institute, Delhi                         |
| LNOB    | Leaving No One Behind                                  |
| MDMS    | Mid-Day Meals Scheme                                   |
| MGNREGA | Mahatma Gandhi National Rural Employment Guarantee Act |
| MRD     | Ministry for Rural Development                         |
| NRLM    | National Rural Livelihood Mission                      |
| OBCs    | Other Backward Classes                                 |
| PDS     | Public Distribution System                             |
| POS     | Point of Sale  |
| SCs     | Scheduled Castes                                       |
| SDGs    | Sustainable Development Goals                          |
| SHGs    | Self Help Groups                                       |
| SPSS    | Statistical Package for Social Sciences                |
| SSSs    | Social Security Schemes                                |
| STs     | Scheduled Tribes                                       |
| UN      | United Nations   |
| UNICEF  | United Nations International Children’s Emergency Fund |
| WHO     | World Health Organization                              |

## List of Tables

| Sl. No. | Title   | Page No |
|---------|---|---------|
| 1       | State-wise distribution of the sample                                       | 14      |
| 2       | Gender distribution of the sample   | 15      |
| 3       | Social category of the respondents  | 16      |
| 4       | Income category of the respondents  | 17      |
| 5       | General profile of the stakeholders   | 18      |
| 6       | State-wise distribution of the stakeholders                                 | 19      |
| 7       | Sampling structure of the Interview Schedule for Households                 | 20      |
| 8       | Sampling structure of the In-Depth Interview with Stakeholders              | 21      |
| 9       | Sampling structure for Focus Group Discussions                              | 21      |
| 10      | Sampling structure for Case Studies   | 22      |
| 11      | State-wise distribution of people who lost their livelihood                 | 25      |
| 12      | State-wise distribution of impact on the livelihood options of women        | 26      |
| 13      | Experience of the loss of livelihood based on income category               | 28      |
| 14      | Experience of the loss of livelihood based on type of occupation            | 28      |
| 15      | Experience of the loss of livelihood based on social category               | 31      |
| 16      | Income and social category of those who frequented public health facilities | 34      |

# List of Figures

| Sl. No. | Title  | Page No |
|---------|--|---------|
| 1       | Educational Status of the Respondents  | 16      |
| 2       | Occupational Status of the Respondents   | 18      |
| 3       | Percentage of the people who lost their livelihood   | 24      |
| 4       | Impact on the livelihood of the marginalized communities   | 29      |
| 5       | Accessing public health facilities   | 33      |
| 6       | Percentage of people who accessed private health facilities due to inadequacies in the public health facilities              | 35      |
| 7       | State-wise distribution of people who accessed private health facilities due to inadequacies in the public health facilities | 36      |
| 8       | State-wise status of people's spending on COVID-related treatment  | 37      |
| 9       | Spending on COVID-related treatment by the marginalized communities  | 38      |
| 10      | Borrowing for COVID-19 related treatment   | 39      |
| 11      | Access to treatment for Non-Covid health issues  | 40      |
| 12      | Availing health insurance schemes during COVID-19  | 41      |
| 13      | Preferred type of medical treatment during COVID-19  | 41      |
| 14      | Children facing problems in their learning   | 43      |
| 15      | Type of problems faced by children in their learning   | 45      |
| 16      | Perception of the school staff on the impact of COVID-19 on children's education   | 47      |
| 17      | Functioning of MGNREGA during the Pandemic   | 49      |
| 18      | Importance of PDS during COVID-19  | 51      |
| 19      | Availability of Mid-Day Meals in the schools during COVID-19   | 52      |
| 20      | Perception of stakeholders on the importance of social security schemes during COVID-19                                      | 53      |



## List of Boxes

| Sl. No | Title  | Page No |
|--------|--|---------|
| 1      | How an auto driver lost his livelihood   | 25      |
| 2      | How COVID-19 affected a widow's livelihood   | 27      |
| 3      | A grave situation of a single mother with two sick children                          | 27      |
| 4      | Difficulties of domestic workers   | 28      |
| 5      | Lost livelihood for a daily-wage dependent family                                    | 29      |
| 6      | A migrant brick maker whose hopes soon turned into sorrows                           | 30      |
| 7      | A landless man and his family survived through tough times                           | 30      |
| 8      | COVID restrictions disrupted the livelihood of a tea garden worker                   | 32      |
| 9      | Broken public healthcare system  | 35      |
| 10     | Delayed treatment and high costs of medical treatment                                | 36      |
| 11     | Poor facilities and inadequate care in public health centers                         | 37      |
| 12     | First suspected of COVID, but report came negative after his death                   | 38      |
| 13     | Bad condition of quarantine centers  | 39      |
| 14     | Timely and effective interventions showed a positive trend                           | 42      |
| 15     | Education of my child is ruined due to the pandemic                                  | 44      |
| 16     | Discontinued studies due to lack of funds  | 44      |
| 17     | Self-study was the only option to learn during COVID-19                              | 45      |
| 18     | Struggle of school children in rural areas   | 46      |
| 19     | Lockdown put kids away from social and cultural activities                           | 46      |
| 20     | Students dropout of school in order to earn a living                                 | 47      |
| 21     | A teacher's perspective on how children's education was affected due to the pandemic | 48      |
| 22     | MGNREGA was a lifesaver but only got less than 25 days of work                       | 50      |
| 23     | COVID and its stigma affected the MGNREGA workers                                    | 50      |
| 24     | How PDS helped a family during the Pandemic  | 51      |
| 25     | Digital illiteracy caused problems in accessing PDS                                  | 52      |

# Executive Summary

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This research study was an initiative of Jesuit Collective India, consisting of Conference Development Office (CDO), Indian Social Institute, Delhi (ISI\_D) and Lok Manch (People's Entitlements) to understand and assess the impact of COVID 19 in rural India, especially from the perspective of marginalized sections of people like the Dalits, Adivasis, Women and Children.

## Understanding the general profile of the sample

With a large sample size comprising of the Dalits and Adivasis (75 per cent) the findings further demonstrate and expose the fault lines at India's rural landscape. A large section of people, 60 per cent, earns less than Rs 3000 a month and illiteracy is still high at 42 per cent and only 12 per cent having studied beyond the secondary level. Among the respondents 46 per cent were landless laborers and 34 per cent farmers.

Among the stakeholders 27 per cent were ASHA workers, 22 per cent were school staff and 18 per cent were Ward members. Other stakeholders included Anganwadi staff, NGO representatives, village heads and other government officials.

## Impact on livelihood

During the pandemic 71 per cent of the respondents lost their livelihood. This shows how severely the pandemic affected the rural population. It greatly affected states like Uttar Pradesh, Odisha and Bihar. In order to find out the gendered impact of COVID-19, a specific question was asked, 'whether the livelihood options of women were more affected during the pandemic', and 75 per cent said yes. This shows that women were more affected during the pandemic. The social impact of the COVID-19 shows that 54 per cent of the SC and ST households lost their livelihood.

Despite the loss of livelihoods, rural population had its own ways of coping with it. Among the coping mechanisms adopted by the rural households to tide over the loss of livelihood, 44 per cent said that they managed from their savings, 26 per cent of them said that they took monetary and non-monetary support from their relatives and 18 per cent said that they borrowed money from money lenders.

## Impact on Health

During the pandemic a large majority, 67 percent, had accessed the public health facilities. A majority of the respondents who visited public health facilities were from the states of Odisha, Kerala, West Bengal, Chhattisgarh, Gujarat and Uttar Pradesh. When the respondents were asked whether the inadequacies in the public health facilities had compelled them to visit private health facilities 34 per cent of them said yes. Most of them were from the states of Bihar, Uttar Pradesh and Karnataka.

Regarding the health expenditure, data showed that 32 per cent of the respondents spent more than Rs 5,000 on COVID-19 related treatment and 25 per cent of them spent above Rs 10,000 on COVID-19 related treatment. To meet the health expenditure, 45 per cent said that they had borrowed money for COVID-19 related treatment, most of them from the states of Uttar Pradesh, Bihar, Gujarat, Karnataka and Andhra Pradesh.

There were people who faced difficulties in getting treatment for non-COVID health issues. Most of the 46 per cent of the respondents who said that they faced difficulties in getting treatment for non-COVID related health issues were from the states of Uttar Pradesh, Bihar, Gujarat and Maharashtra. In these four states those who faced difficulties to access treatment for non-COVID related health issues outnumbered those who didn't face difficulties to access treatment for non-COVID related health issues.

Data also shows that only 11 per cent had availed health insurance. Many of them were from the states of Kerala and Chhattisgarh.

When the respondents were asked to reveal their preferred type of medical treatment 60 per cent opted for allopathic treatment and 23 per cent said that they preferred herbal treatment.

From the perspective of the stakeholders 62 per cent of them said that the public health facilities had desired facilities and 38 per cent said that the public health facilities don't have the desired facilities.

### **Impact on Children and their Education**

The impact of COVID-19 has been very severe on children's learning as documented by UNICEF, Save the Children, Indiaspend.com and so on. The data shows that 70 per cent of the respondents said that their children faced problems in their learning. Among the type of problems faced by children in their learning non-access to digital infrastructure dominated the results at 46 per cent. Another 24 per cent said that the network coverage issues hampered their children's learning. So close to 70 per cent of the problems relate to what can be called as 'digital divide'.

From the perspective of the stakeholders, 58 per cent of them said that the children in their areas couldn't attend the classes via online mode regularly.

### **Impact of Social Security Schemes**

What was the impact of SSSs during the COVID-19? We considered only the MGNREGA, PDS and MDMS to assess their importance and impact during the COVID-19. Our study findings reveal that 21 per cent of MGNREGA card holders did not get work and 14 per cent of them got less than 25 days of work. In another study done by Azim Premji foundation it was shown that 39 per cent of the card holders did not get a single day of work during 2020-21 in the four states of Bihar, Madhya Pradesh, Maharashtra and Karnataka.

Regarding the MDMS, 56 per cent of the respondents said that their children didn't receive

MDMs in the school. A significant number of them were from the states of Uttar Pradesh and Bihar.

PDS was also a life saver for many households and 58 per cent said that it was very important for their family during COVID-19.

The importance of social security schemes was emphasized by the stakeholders too, with 51 per cent of them saying that it was very important and 44 per cent of them saying it was important.

We hope the findings from this study would be used by the policy makers, civil society organizations, state and local governments and others in each of the 12 states to not only understand the impact of COVID 19 in rural areas but also to address some of the gaps in the delivery of government services.

# Introduction

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COVID 19 pandemic brought the entire world to a standstill, affecting everyone in various proportions. In the case of India, though the first wave was considered to have predominantly affected the cities, the second wave devastatingly affected the lives and livelihood of even the rural population. (CSE, 2021). Numerous studies and reports (Basole et al, 2021; Bhakla et al, 2021; Bauza et al, 2021; Hoop et al, 2020; Wakharde, 2021) have emerged in the past two years, from different perspectives highlighting the impact of COVID-19 in rural India, and how rural population has been affected in terms of loss of jobs, fall in incomes, increased poverty, inequality and distress. However, many of those studies were largely state-specific or at the most covering a small number of states.

Against this background, a research study was imagined and initiated by the Jesuit Collective India, consisting of Conference Development Office (CDO), Indian Social Institute, Delhi (ISI\_D) and Lok Manch (People's Entitlements) to understand and assess the impact of COVID 19 in rural India, from the perspective of marginalized communities like the Dalits, Adivasis, women and children. Some of the objectives of this study included the following.

- ❑ To understand how the pandemic has impacted the social and economic lives of rural population
- ❑ To assess the impact of the COVID-19 pandemic on the lives and livelihoods of the poor, tribals, and other marginalized communities, including rural women.
- ❑ To examine the relief provided by of 'Mahatma Gandhi National Rural Employment Guarantee Act' (MGNREGA) and social security benefits such as Public Distribution System (PDS) to those whose livelihoods have been severely impacted due to the lockdown triggered by the pandemic.
- ❑ To explore the accessibility and availability of health services in rural areas.
- ❑ To analyze the role of the support mechanism of government and non-government agencies in the turbulent time of the pandemic in rural areas.
- ❑ To suggest steps to be taken to mitigate the risks being faced by poor, tribals and other marginalized communities in rural areas
- ❑ To suggest measures to ensure that the deprived rural communities are included in the post-COVID social and economic recovery.

## General profile of the respondents (Households)

The sample size varied from the highest number of 511 in Jharkhand to the lowest size of 419 from Andhra Pradesh (212) and Telangana (207). The variation in the sample size was due to the differential in the selection of villages for this study. Another reason for this variation was due to the differential in the availability of people to conduct this study in these states.

**Table 1: State-wise distribution of the sample**

| State          | Frequency   | Percent    |
|----------------|-------------|------------|
| Andhra Pradesh | 212         | 4.1        |
| Bihar          | 478         | 9.2        |
| Chhattisgarh   | 460         | 8.8        |
| Gujarat        | 461         | 8.8        |
| Jharkhand      | 511         | 9.8        |
| Karnataka      | 481         | 9.2        |
| Kerala         | 493         | 9.5        |
| Maharashtra    | 472         | 9.1        |
| Odisha         | 510         | 9.8        |
| Telangana      | 207         | 4          |
| Uttar Pradesh  | 464         | 8.9        |
| West Bengal    | 461         | 8.8        |
| <b>Total</b>   | <b>5210</b> | <b>100</b> |

Among the 5210 respondents 52 per cent were male, 47 per cent were female. Though it was desired and expected of the field staff to reach out to the female population and the LGBTQI+ more, it wasn't possible for the field staff to realize this as the field staff recorded that the female population in the rural areas was more hesitant to respond.

In states like Kerala, Karnataka, Jharkhand, Bihar and Gujarat female respondents were more than the male respondents. In the states of Andhra Pradesh, Chhattisgarh, Maharashtra, Odisha, Telangana, Uttar Pradesh and West Bengal the male respondents outnumbered the female respondents. There was representation from the LGBTQ community only from the state of Andhra Pradesh. (Refer table 2)

**Table 2: Gender Distribution of the Respondents (in Percentage)**

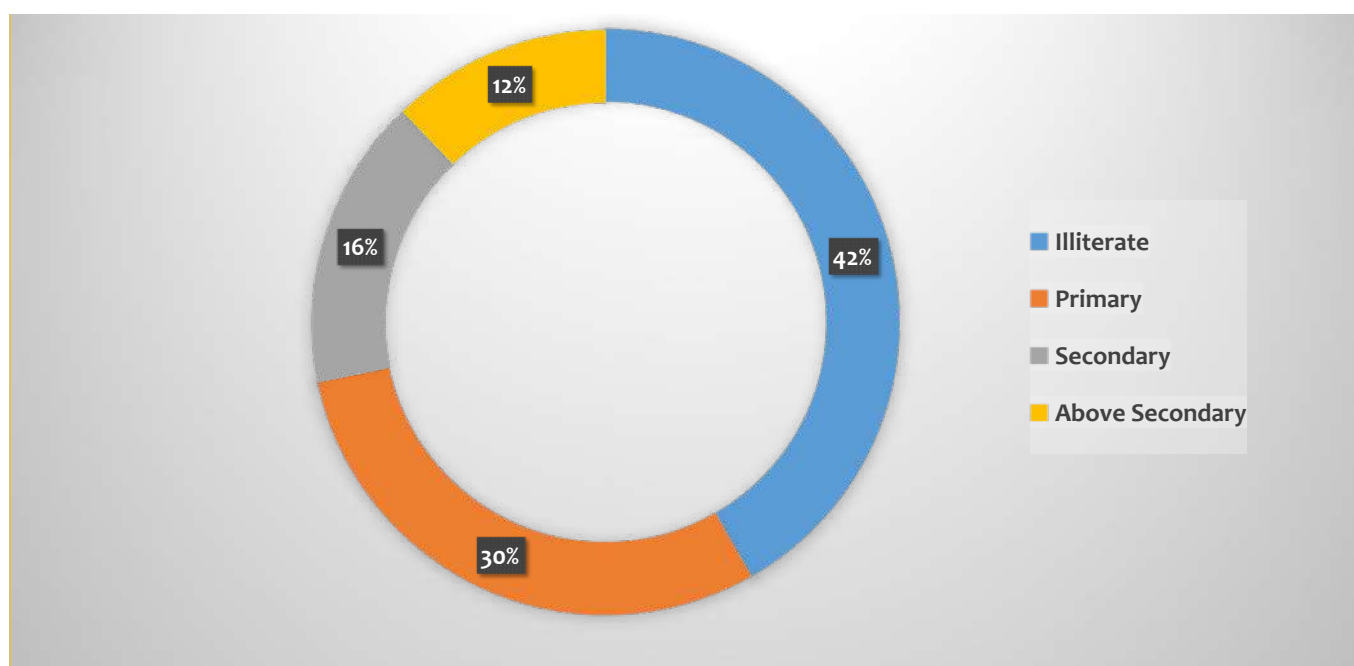
| State          | Gender of the Respondent |             |            | Total      |
|----------------|--------------------------|-------------|------------|------------|
|                | Female                   | Male        | Others     |            |
| Andhra Pradesh | 1.8                      | 2.1         | 0.1        | 4.1        |
| Bihar          | 6.3                      | 2.9         |            | 9.2        |
| Chhattisgarh   | 2.6                      | 6.2         |            | 8.8        |
| Gujarat        | 4.6                      | 4.2         |            | 8.8        |
| Jharkhand      | 5.8                      | 4           |            | 9.8        |
| Karnataka      | 5.7                      | 3.6         |            | 9.2        |
| Kerala         | 5.9                      | 3.6         |            | 9.5        |
| Maharashtra    | 3.8                      | 5.2         |            | 9.1        |
| Odisha         | 2.5                      | 7.3         |            | 9.8        |
| Telangana      | 1.5                      | 2.5         |            | 4          |
| Uttar Pradesh  | 3.1                      | 5.9         |            | 8.9        |
| West Bengal    | 4                        | 4.8         |            | 8.8        |
| <b>Total</b>   | <b>47.60</b>             | <b>52.3</b> | <b>0.1</b> | <b>100</b> |

A vast majority of the respondents belonged to the SC and ST categories (75 per cent). The respondents that belonged to ST category (45 per cent), were predominantly from the states of Maharashtra, West Bengal, Chhattisgarh, Jharkhand, Odisha and Kerala, amounting to 88 per cent of the total ST respondents. In the states of Bihar, Uttar Pradesh, Karnataka, Andhra Pradesh and Telangana the respondents were predominantly from the SC category, together constituting 74 per cent of the SC respondents. The respondents that belonged to the OBC category were primarily from the states of Gujarat, Karnataka Kerala and Odisha, constituting 66 per cent of the total OBC respondents. (Refer table 3)

**Table 3: The social category of the respondents (In Percentages)**

| State          | Type of Social Category |                              |                      |                      | Total      |
|----------------|-------------------------|------------------------------|----------------------|----------------------|------------|
|                | General                 | Other Backward Classes (OBC) | Scheduled Caste (SC) | Scheduled Tribe (ST) |            |
| Andhra Pradesh | 0.9                     | 0.4                          | 2.4                  | 0.3                  | 4.1        |
| Bihar          | -                       | 0.1                          | 8.6                  | 0.5                  | 9.2        |
| Chhattisgarh   | 0.1                     | 1.1                          | 0.8                  | 6.9                  | 8.8        |
| Gujarat        | 1.4                     | 3.5                          | 1.6                  | 2.3                  | 8.8        |
| Jharkhand      | -                       | 1.4                          | 2                    | 6.4                  | 9.8        |
| Karnataka      | 1.9                     | 3.2                          | 3.6                  | 0.6                  | 9.2        |
| Kerala         | 0.5                     | 3.2                          | 1                    | 4.8                  | 9.5        |
| Maharashtra    | 0.2                     | 0.3                          | 0.2                  | 8.4                  | 9.1        |
| Odisha         | 0.3                     | 2.3                          | 1.7                  | 5.5                  | 9.8        |
| Telangana      | 0.8                     | 1.2                          | 1.9                  | 0.2                  | 4          |
| Uttar Pradesh  | 0.3                     | 1.6                          | 5.7                  | 1.2                  | 8.9        |
| West Bengal    | 0.2                     | 0.2                          | 0.6                  | 7.9                  | 8.8        |
| <b>Total</b>   | <b>6.5</b>              | <b>18.4</b>                  | <b>30</b>            | <b>45.1</b>          | <b>100</b> |

**Figure 1: Educational status of the respondents**



Regarding the educational status of the respondents, 42 per cent were illiterate and 30 per



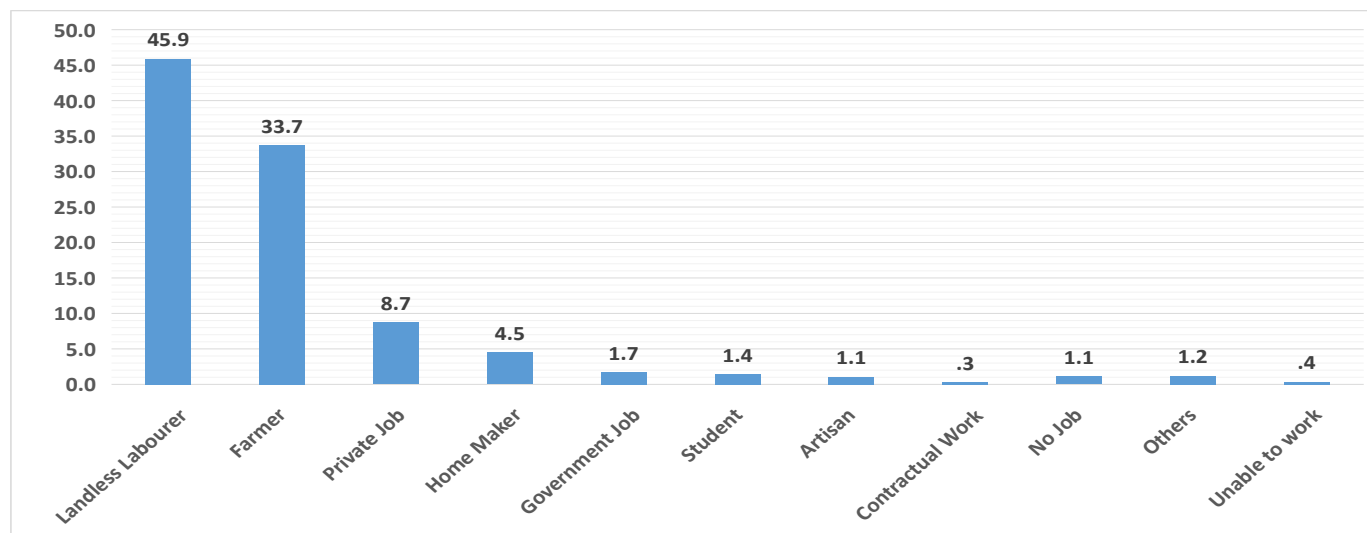
cent had studied only up to the primary level, till the 5th standard. In a way, it brings to focus that there is still a sizeable rural population that is illiterate and only 12 per cent of the respondents claimed to have studied beyond secondary level.

**Table 4: The Income category of the respondents (In percentages)**

| State          | Household Income (in thousands/month) |              |                | Total      |
|----------------|---------------------------------------|--------------|----------------|------------|
|                | Less than 3000                        | 3000-5000    | 5000 and above |            |
| Andhra Pradesh | 0.3                                   | 1.1          | 2.7            | 4.1        |
| Bihar          | 3.7                                   | 3.5          | 2              | 9.2        |
| Chhattisgarh   | 6.7                                   | 1.5          | 0.6            | 8.8        |
| Gujarat        | 3.6                                   | 2.6          | 2.7            | 8.8        |
| Jharkhand      | 6.9                                   | 1.7          | 1.2            | 9.8        |
| Karnataka      | 5.1                                   | 2.3          | 1.8            | 9.2        |
| Kerala         | 8.2                                   | 0.7          | 0.6            | 9.5        |
| Maharashtra    | 8.1                                   | 0.7          | 0.2            | 9.1        |
| Odisha         | 7.3                                   | 2.1          | 0.4            | 9.8        |
| Telangana      | 0.8                                   | 1.1          | 2.1            | 4          |
| Uttar Pradesh  | 6.6                                   | 1.5          | 0.9            | 8.9        |
| West Bengal    | 2.4                                   | 4.8          | 1.6            | 8.8        |
| <b>Total</b>   | <b>59.60</b>                          | <b>23.60</b> | <b>16.9</b>    | <b>100</b> |

The respondents were predominantly poor, earning less than Rs 3,000 a month, mostly from the states of Kerala, Maharashtra, Odisha, Jharkhand, Chhattisgarh, Uttar Pradesh and Karnataka. Those earning less than Rs 5000 a month constituted a huge 83 per cent of the respondents.

**Figure 2: Occupational status of the Respondents**



Many of the respondents were landless labourers (46 per cent), followed by farmers (34 per cent), doing private job (9 per cent) and home makers (5 per cent). The landless labourers were dominantly present in the states of Bihar, Uttar Pradesh, Maharashtra, West Bengal, Karnataka, Gujarat and Kerala, constituting 79 per cent of the total landless labourers. A vast majority of the farmers were from the states of Chhattisgarh, Jharkhand and Odisha, totaling 58 per cent of the total farmers.

**Table 5: General profile of the stakeholders**

| Type of stakeholder                                   | Frequency   | Percent    |
|---|-------------|------------|
| Anganwadi Staff                                       | 151         | 7.9        |
| ASHA Worker   | 513         | 26.8       |
| Block Development Officer (BDO)                       | 4           | 0.2        |
| Gram Rozgar Sahayak or Employment Guarantee Assistant | 35          | 1.8        |
| Head of the School/Teacher                            | 424         | 22.1       |
| Medical Officer (PHC/Govt. Hospitals)                 | 36          | 1.9        |
| Civil Society Representative                          | 36          | 1.9        |
| Others  | 77          | 4          |
| Panchayat Development Officer                         | 27          | 1.4        |
| Sarpanch/Pradhan                                      | 205         | 10.7       |
| The Village Health Committee Head                     | 51          | 2.7        |
| Village Extension Officer (VEO)                       | 19          | 1          |
| Ward Member   | 339         | 17.7       |
| <b>Total</b>  | <b>1917</b> | <b>100</b> |

**Table 6: State-wise distribution of the Stakeholders**

| State          | Anganwadi Staff | ASHA Worker | Head of the School/Teacher | NGO Head/Representative | Sarpanch/Pradhan | Ward Member | Others      | Total      |
|----------------|-----------------|-------------|----------------------------|-------------------------|------------------|-------------|-------------|------------|
| Andhra Pradesh | -               | 1.4         | 0.2                        | 0.1                     | 0.1              | 0.1         | 0.7         | 2.5        |
| Bihar          | 0.3             | 2.5         | 2.5                        | 0.3                     | 1.2              | 2.2         | 1.6         | 11         |
| Chhattisgarh   | 0.9             | 2.8         | 1.6                        | -                       | 1                | 2.1         | 0.7         | 9.3        |
| Gujarat        | 1               | 2.6         | 2                          | 0.2                     | 1                | 1.2         | 2.5         | 11.5       |
| Jharkhand      | 2.8             | 5.3         | 4.9                        | 0.3                     | 3.3              | 3.9         | 1.3         | 21.9       |
| Karnataka      | 2.1             | 5.7         | 5.6                        | 0.3                     | 0.9              | 3.7         | 1.4         | 20.2       |
| Kerala         | -               | 1.5         | 1.5                        | -                       | 0.7              | 1.1         | 0.5         | 5.4        |
| Maharashtra    | 0.7             | 1.5         | 1.1                        | 0.1                     | 0.6              | 1.4         | 0.6         | 5.9        |
| Odisha         | -               | 1.2         | 0.8                        | 0.3                     | 0.7              | 1           | 3           | 4.2        |
| Telangana      | -               | 0.8         | 0.3                        | 0.2                     | 0.1              | 0.3         | 0.5         | 2.1        |
| Uttar Pradesh  | -               | 0.4         | 0.3                        | 0.1                     | 0.2              | 0.3         | 0.6         | 1.8        |
| West Bengal    | 0.1             | 1           | 1.4                        | 0.2                     | 0.8              | 0.5         | 0.2         | 4.2        |
| <b>Total</b>   | <b>7.9</b>      | <b>26.8</b> | <b>22.1</b>                | <b>1.9</b>              | <b>10.7</b>      | <b>17.7</b> | <b>12.9</b> | <b>100</b> |

Among the stakeholders, the primary focus was on the health workers and school staff and they constitute nearly 60 per cent of the total stakeholders. Moreover, we also got some perspectives from the elected representatives and civil society representatives.

This study while relying on four tools of research (questionnaire for the households, In-depth interview with the stakeholders, FGDs and Case studies) spread across the 12 states focused on understanding the impact of COVID-19 in rural India and the data makes it very clear that the COVID-19 impacted the rural population significantly, particularly on the livelihood and health status of rural population and the education of rural children.

In the subsequent chapters the impact of COVID-19 on the livelihood of rural population, their health and the education of the children is highlighted. Moreover, the impact of social security schemes during the pandemic is illustrated and finally some policy recommendations are proposed.

# Chapter 1

## Methodology

The research study on the Impact of COVID 19 in rural India made use of both quantitative research method, (through questionnaire for households and in-depth interview for the stakeholders) and qualitative research method (through FGDs and Case Studies). A semi structured interview schedule was used to assess the socio-economic impact of COVID-19 among the reference communities. Data was collected using KoBo Toolbox from September 2021 to January 2022 and analyzed through Statistical Package for Social Sciences (SPSS).

A target sample size of 400 responses from different cross-sections of the target population from each state was selected in the intervention areas of Jesuit Conference of India (JCI) through a purposive sampling method. The informants for the study were the following:

- i) The vulnerable segments of the workforce such as daily wage earners, the rural landless poor, migrant workers, tribal communities etc.
- ii) Elected Representatives such as Sarpanch/Gram Pradhan.
- iii) Government and Non-Government Officials who closely worked in villages during the pandemic (ASHA Worker, Medical Officers of PHC/CHC/Taluk Hospitals etc.)

The study collected two sets of samples, one from the households and other from the stakeholders. For the sample size of households, we received 5210 samples against the targeted sample size of 4800 and for the sample size of in-depth interview, we received 1917 samples against the targeted sample size of 1796.

In addition, more information and data were gathered through FGDs and Case Studies. Each organization working in a particular state was asked to conduct 2 FGDs and 2 Case Studies and that explains the differential for each state in terms of FGDs and Case Studies.

The study covered 474 villages from 46 districts of 12 states.

**Table 7: Sampling structure for Interview Schedule with the Households**

| Name of the state            | Target (expected) sample size | Received sample size | Number of districts covered | Number of Villages Covered |
|------------------------------|-------------------------------|----------------------|-----------------------------|----------------------------|
| Andhra Pradesh and Telangana | 400                           | 419                  | 5                           | 12                         |
| Bihar                        | 400                           | 478                  | 6                           | 50                         |
| Chhattisgarh                 | 400                           | 460                  | 3                           | 40                         |
| Gujarat                      | 400                           | 461                  | 6                           | 53                         |
| Jharkhand                    | 400                           | 511                  | 10                          | 90                         |

| Name of the state | Target (expected) sample size | Received sample size | Number of districts covered | Number of Villages Covered |
|-------------------|-------------------------------|----------------------|-----------------------------|----------------------------|
| Karnataka         | 400                           | 481                  | 5                           | 84                         |
| Kerala            | 400                           | 493                  | 3                           | 75                         |
| Maharashtra       | 400                           | 472                  | 3                           | 21                         |
| Odisha            | 400                           | 510                  | 1                           | 21                         |
| Uttar Pradesh     | 400                           | 464                  | 2                           | 8                          |
| West Bengal       | 400                           | 461                  | 2                           | 20                         |
| <b>Total</b>      | <b>4,400</b>                  | <b>5,210</b>         | <b>46</b>                   | <b>474</b>                 |

**Table 8: Sampling structure for In-Depth Interview with the Stakeholders**

| Name of the state            | Target (expected) sample size | Received sample size | Number of districts covered | Number of Villages Covered |
|------------------------------|-------------------------------|----------------------|-----------------------------|----------------------------|
| Andhra Pradesh and Telangana | 68                            | 88                   | 5                           | 12                         |
| Bihar                        | 204                           | 210                  | 6                           | 50                         |
| Chhattisgarh                 | 168                           | 178                  | 3                           | 40                         |
| Gujarat                      | 232                           | 220                  | 6                           | 53                         |
| Jharkhand                    | 408                           | 420                  | 10                          | 90                         |
| Karnataka                    | 340                           | 387                  | 5                           | 84                         |
| Kerala                       | 100                           | 104                  | 3                           | 75                         |
| Maharashtra                  | 84                            | 114                  | 3                           | 21                         |
| Odisha                       | 80                            | 81                   | 1                           | 21                         |
| Uttar Pradesh                | 32                            | 35                   | 2                           | 8                          |
| West Bengal                  | 80                            | 80                   | 2                           | 20                         |
| <b>Total</b>                 | <b>1796</b>                   | <b>1917</b>          | <b>46</b>                   | <b>474</b>                 |

**Table 9: Sampling structure for Focus Group Discussions (FGDs)**

| State                        | No of organizations | No of FGDs |
|------------------------------|---------------------|------------|
| Andhra Pradesh and Telangana | 2                   | 4          |
| Bihar                        | 8                   | 16         |
| Chhattisgarh                 | 8                   | 16         |
| Gujarat                      | 12                  | 24         |
| Jharkhand                    | 22                  | 44         |
| Karnataka                    | 12                  | 24         |

| State         | No of organizations | No of FGDs |
|---------------|---------------------|------------|
| Kerala        | 12                  | 24         |
| Maharashtra   | 4                   | 8          |
| Odisha        | 4                   | 8          |
| Uttar Pradesh | 1                   | 2          |
| West Bengal   | 5                   | 10         |
| <b>Total</b>  | <b>90</b>           | <b>180</b> |

**Table 10: Sampling structure for Case Studies**

| State                        | No of organizations | No of Case Studies |
|------------------------------|---------------------|--------------------|
| Andhra Pradesh and Telangana | 2                   | 4                  |
| Bihar                        | 8                   | 16                 |
| Chhattisgarh                 | 8                   | 16                 |
| Gujarat                      | 12                  | 24                 |
| Jharkhand                    | 22                  | 44                 |
| Karnataka                    | 12                  | 24                 |
| Kerala                       | 12                  | 24                 |
| Maharashtra                  | 4                   | 8                  |
| Odisha                       | 4                   | 8                  |
| Uttar Pradesh                | 1                   | 2                  |
| West Bengal                  | 5                   | 10                 |
| <b>Total</b>                 | <b>90</b>           | <b>180</b>         |

## Limitations of the Study

Despite its focus on 12 states, this study has limitations like a limited sample of 400 from each of the 12 states and the limitation of covering less than 50% of the states in India.

Though the study was mostly focused on the rural areas, it also covered a few slums from the semi-urban and urban areas especially from the states of Andhra Pradesh, Gujarat, Karnataka and Telangana.

In the case of Andhra Pradesh and Telangana the sample size was reduced to 200 per each state, due to non-availability of people to conduct the data collection on time.

The number of villages, districts and taluks is not uniform across the 12 states. It varies from one district (from Odisha) to 10 districts (from Jharkhand).

The percentage of SCs (30) and STs (45) in the sample is much higher than their national average, 20 per cent (SCs) and 9 per cent (STs) as per 2011 census. This is due to the fact

we used a purposive sampling in terms of limiting the study to the marginalized sections of rural population, who were mostly within the vicinity of Lok Manch partners engaged in data collection.

The data collection was carried out by the field partners through the use of mobile app, Kobo Collect and the researchers didn't visit the field. Despite the online trainings given to the enumerators, including the pilot study, on the usage of app for data collection, we cannot rule out the errors resulting from the use of app for data collection. The researchers were not able to visit the field areas due to the COVID restrictions.

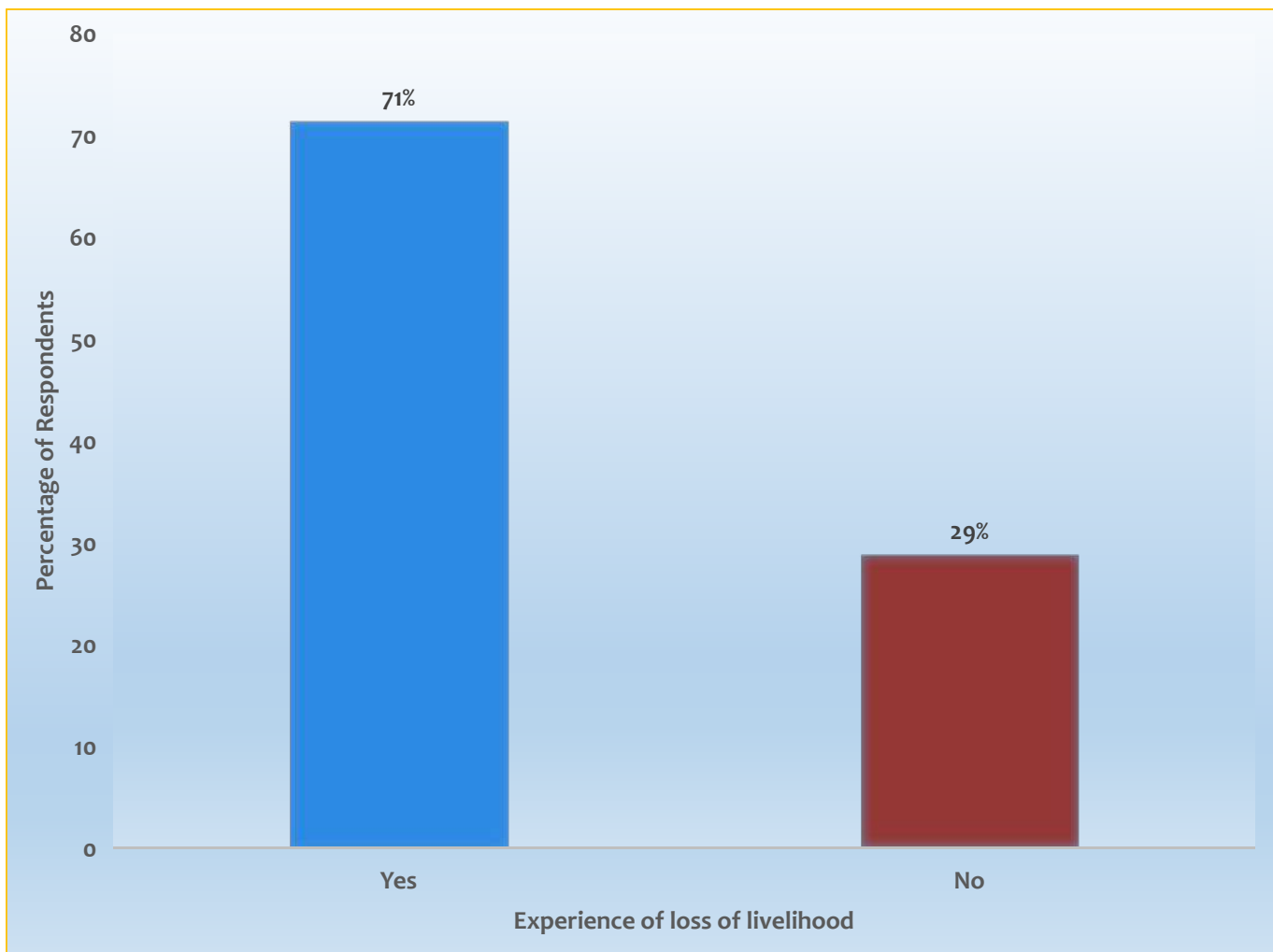
## Chapter 2

# Impact on Livelihood

One of the important objectives of this study was to assess the impact of pandemic on the livelihood of the rural population. In India, the pandemic resulted in increased unemployment, lower daily labour income, increased food insecurity, depletion of savings, and relief measures (Harris et al., 2020; Kesar et al., 2020).

Our data reveals that 71 per cent of the respondents lost their livelihood and some of the worst affected were the daily wage workers, landless laborers, domestic workers, auto/cab/truck drivers. As per the data findings, some of the states that were more affected were Uttar Pradesh, Odisha and Bihar.

**Figure 3: Percentage of people who lost their livelihood**





**Table 11: State-wise distribution of people who lost their livelihood**

| State          | State-wise distribution of people who lost their livelihood (In percentages) |             | Total      |
|----------------|--|-------------|------------|
|                | No   | Yes         |            |
| Andhra Pradesh | 0.6  | 3.4         | 4.1        |
| Bihar          | 0.5  | 8.7         | 9.2        |
| Chhattisgarh   | 3.2  | 5.7         | 8.8        |
| Gujarat        | 3.4  | 5.4         | 8.8        |
| Jharkhand      | 3.8  | 6           | 9.8        |
| Karnataka      | 3  | 6.3         | 9.2        |
| Kerala         | 2.8  | 6.6         | 9.5        |
| Maharashtra    | 3.9  | 5.1         | 9.1        |
| Odisha         | 1.2  | 8.6         | 9.8        |
| Telangana      | 2.6  | 1.4         | 4          |
| Uttar Pradesh  | 0.6  | 8.3         | 8.9        |
| West Bengal    | 3.1  | 5.7         | 8.8        |
| <b>Total</b>   | <b>28.7</b>  | <b>71.3</b> | <b>100</b> |

When we try to understand the situation in each states, it appears that the states like Bihar, Odisha and Uttar Pradesh had high concentration of people who lost their livelihood during the pandemic. As evident from Table 11, only in the state of Telangana the percentage of people who didn't lose their livelihood (2.6 per cent) was more than those who lost their livelihood (1.4 per cent), mostly those with private jobs and landless labourers.

### ***Box 1: How an auto driver lost his livelihood***

An elderly man from the village of Andhra Pradesh reported that during Covid, his auto rickshaw was left in the house for nine months and was not used at all as there was a nationwide lockdown. Earlier he used to earn 600-700 rupees in a day but now his earnings have been affected. He has also mentioned that the Government has announced Covid Relief to them but in order to receive it, they had to provide their driving license along with the vehicle details. But he did not have his vehicle registered in his name so he could not get the Covid Relief. There were 12 auto drivers in the village and only 3 drivers received the Covid Relief from the Government. He exclaimed sadly that even when the autos were permitted to run, many drivers had to travel without Passengers.

## Impact on the livelihood options of women

Did COVID-19 impact women more? Were the livelihood options of women impacted more? Some studies show that wage disparities and the burden of unpaid care have pushed more women out of the labour force and into poverty. Women's earned income in India was just one-fifth that of men's even before the pandemic. During COVID-19, more women lost their jobs globally and in India. (UN Women, 2021)

Women were more vulnerable to job loss than men due to market and social and demographic factors such as education, age, religion, experience, work arrangement or sector of employment, presence of children in household, marital status, and so on. (Azim Premji University, 2021).

When a specific question was asked 'whether the livelihood options of women were more affected during the pandemic', 75 per cent said yes. This shows that women were more affected during the pandemic, especially in the states like Bihar, Maharashtra, Odisha and Uttar Pradesh as evident from Table 12.

**Table 12: State wise distribution of Impact on the livelihood options of women**

| State          | Whether the livelihood options of women were affected more (In percentages) |             | Total      |
|----------------|---|-------------|------------|
|                | No  | Yes         |            |
| Andhra Pradesh | 0.6   | 3.4         | 4.1        |
| Bihar          | 0.6   | 8.5         | 9.2        |
| Chhattisgarh   | 2.7   | 6.1         | 8.8        |
| Gujarat        | 2.3   | 6.6         | 8.8        |
| Jharkhand      | 2.9   | 6.9         | 9.8        |
| Karnataka      | 3   | 6.2         | 9.2        |
| Kerala         | 3.4   | 6.1         | 9.5        |
| Maharashtra    | 1.4   | 7.7         | 9.1        |
| Odisha         | 2.5   | 7.3         | 9.8        |
| Telangana      | 2.6   | 1.4         | 4          |
| Uttar Pradesh  | 0.6   | 8.3         | 8.9        |
| West Bengal    | 2.9   | 6           | 8.8        |
| <b>Total</b>   | <b>25.5</b>   | <b>74.5</b> | <b>100</b> |

### ***Box 2: How COVID-19 affected a widow's livelihood***

A 55 year old widow, a resident of Jharkhand, narrated that during the time of Covid Pandemic, she faced a lot of problems. She was earning two to three thousand rupees in a month by selling vegetables. But things were not the same after the Pandemic. She had to survive with the vegetables that were grown in her land. She could not earn as she wasn't able to sell vegetables in the village market. Her whole livelihood depended on that. She was also infected with COVID-19. When her illness became more severe she had to be hospitalized. Her children had to borrow money from moneylenders. After almost 2 weeks, she was discharged and now she has to repay to the moneylenders around thirty-five thousand rupees. Though she had the Priority Ration Card, this was not enough. And apart from this ration, she stated that she did not get help from any government or non-government organizations. She did not even get processed for widow pension. For her, paying off her debt was the biggest problem.

The impact of COVID was very harsh on widows and domestic workers. As box 2 shows, the impact was severe on many fronts leading to huge loans and ending up in a debt trap. Such incidents were also reported from other states.

### ***Box 3: A grave situation of a single mother with two sick children***

Mrs. Vani (Name changed) and her family didn't have a specific work, so she would go for the daily wage. During the COVID-19 period, her livelihood was severely impacted. Both son and daughter were unable to do any physical labour and thus couldn't earn a living on their own. Though she is eligible for the old-age pension, but she was denied it. She was forced to borrow money from a variety of sources for both the hospital expenses and the survival of her family. During the pandemic, since there was no work available, she had to rely on begging and support from their neighborhood.

The situation of single mothers and widows was excruciatingly deplorable as evident from Box 3. Many such women depended on the generosity of their neighbors or strangers.

**Table 13: Experience of the Loss of livelihood based on the category of income**

| Household Income<br>(in thousands/month) | Did COVID-19 cause any loss of livelihood for you or your family? (In percentages) |             | Total      |
|--|--|-------------|------------|
|  | No   | Yes         |            |
| Less than 3000                           | 16.8   | 42.8        | 59.6       |
| 3000-5000                                | 5.3  | 18.3        | 23.6       |
| 5000 and above                           | 6.6  | 10.2        | 16.9       |
| <b>Total</b>                             | <b>28.7</b>  | <b>71.3</b> | <b>100</b> |

As evident from Table 13, those with income less than Rs 3000 constituted 43 per cent of the people who experienced loss of livelihood. Even the other studies (UNICEF and IHD, 2022) show how the vulnerable people were affected more during the pandemic.

#### *Box 4: Difficulties of domestic helpers*

A 58 year old woman from Uttara Kannada district in Karnataka said that most of the women in her village were engaged in domestic work in different houses. They cooked meals and cleaned houses but with the pandemic their employers did not accept them in their houses for work due to the fear of spreading COVID. There was no work for such women during this time. And they did face a lot of problems as their livelihood depended on working at houses.

**Table 14: Experience of the loss of livelihood based on the type of occupation**

| Type of Occupation | Did COVID-19 cause any loss of livelihood for you or your family? (In percentages) |             | Total      |
|--------------------|--|-------------|------------|
|                    | No   | Yes         |            |
| Artisan            | 0.3  | 0.8         | 1.1        |
| Contractual Work   | 0.2  | 0.1         | 0.3        |
| Farmer             | 11.7   | 22.1        | 33.7       |
| Government Job     | 0.9  | 0.8         | 1.7        |
| Home Maker         | 1.8  | 2.7         | 4.5        |
| Landless Labourer  | 8.6  | 37.3        | 45.9       |
| No Job             | 0.5  | 0.6         | 1.1        |
| Others             | 0.4  | 0.8         | 1.2        |
| Private Job        | 3.6  | 5.1         | 8.7        |
| Student            | 0.6  | 0.8         | 1.4        |
| Unable to work     | 0.1  | 0.2         | 0.4        |
| <b>Total</b>       | <b>28.7</b>  | <b>71.3</b> | <b>100</b> |

As shown in table 14, a greater number of landless labourers, 37 per cent, experienced loss of livelihood. Even the farmers (22 per cent) experienced the loss of livelihood. Some of the farmers responded that they were not able to sell what they produced, incurring huge losses and a debt burden as well.

One of the groups that was severely affected during the COVID-19 was the daily wagers. It is said that they were hit the hardest by the coronavirus pandemic. The COVID-19 scare has harmed the livelihoods of daily wage earners as the economy has slowed (Sengar, 2020).

**Box 5: Lost livelihood for a daily-wage dependent family**

A family of four, residing in a village in Vijayapura, Karnataka depends on daily wages for their livelihood. During off seasons, they usually migrated for work in the neighboring state of Maharashtra, usually for six months.

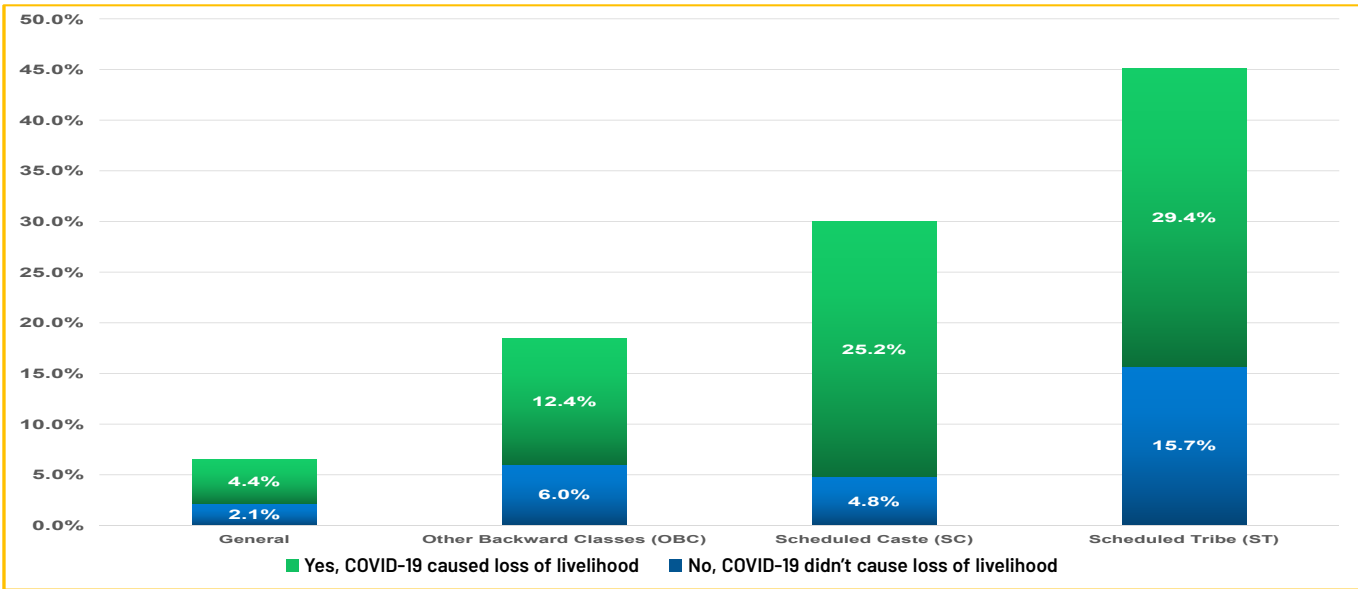
During COVID, though they were not much affected with sickness as compared to other villages around but they struggled financially due to lockdown.

For the past two years, they have not migrated because of Covid.

**Impact on the livelihood options of the marginalized communities**

While assessing the impact of COVID-19 on the marginalized communities like SCs and STs, the data shows that 54 per cent of the STs and SCs admitted to the loss of livelihood, as shown in the figure 4. Many of the SC and ST households also spoke of their loss of income as they weren't able to migrate due to the restrictions. The situation of the tea estate workers and the landless workers was particularly dreadful.

**Figure 4: Impact on the livelihood of the marginalized communities**



***Box 6: A migrant brick maker whose hopes soon turned into sorrows***

Mr. X and his family are migrant brick makers who live in Sonachak and travel to Uttar Pradesh during the season, from November to May. Mr. X had his hope on his son to take up the responsibility as the bread earner but unfortunately COVID took a toll on his life. They had no other way of earning a living, so whatever money they had saved was spent on food and other necessities. They had to borrow money to treat their son. The family became even more helpless without the ration card. They were unable to repay the loan that they borrowed.

Each state has thrown up a lot of devastating stories of people who have lost their livelihood due to the lockdown and the pandemic, that has rendered many households helpless, hopeless, and penniless. Many households reported to being forced to go hungry with barely any financial resources. Case studies and FGDs also revealed to us of the existence of quite many households, though very poor and much deserving of a ration card, but without a ration card.

***Box 7: A landless man and his family survived through tough times***

Mr. G lives in the village of Banjamaha, Orissa. He works as a day labourer. The family lives in a small mud-walled thatched house. They do not have any agricultural land on which he could grow vegetables or cultivate paddy. The head of the family is a daily wage labourer who works in various agricultural fields. His wife collects leaves from the forest to make leaf plates. She can barely make Rs 400/500 per month from making leaf plates. However, making leaves is not a full-time job. During the rainy season, they work as agricultural labourers for 150 rupees per day. Mr. G's health had deteriorated following his release from the COVID Care Center. He is no longer able to perform physical labour as he once did. The circumstances forced them to borrow money. They obtained Rs 20,000 from the money lender in exchange for their gold and used the money to manage their family and pay for the health expenses. As a result of the high debt burden and his poor health, they decided to relocate in search of better employment. They travelled to Kerala soon after his release from Covid Care Center.

**Table 15: Experience of the loss of livelihood by marginal communities across states**

| State          | Did COVID-19 cause any loss of livelihood for you or your family? | Type of Social Category (In percentages) |                              |                      |                      | Total      |
|----------------|---|--|------------------------------|----------------------|----------------------|------------|
|                |   | General                                  | Other Backward Classes (OBC) | Scheduled Caste (SC) | Scheduled Tribe (ST) |            |
| Andhra Pradesh | No  | 0.5                                      | 0.5                          | 14.2                 | 0.5                  | 15.6       |
|                | Yes   | 22.2                                     | 9.9                          | 44.3                 | 8                    | 84.4       |
| Bihar          | No  | -  | -                            | 5                    | -                    | 5          |
|                | Yes   | -  | 0.8                          | 88.9                 | 5.2                  | 95         |
| Chhattisgarh   | No  | -  | 4.3                          | 0.2                  | 31.3                 | 35.9       |
|                | Yes   | 0.7                                      | 8                            | 8.7                  | 46.7                 | 64.1       |
| Gujarat        | No  | 9.5                                      | 15.2                         | 1.5                  | 12.4                 | 38.6       |
|                | Yes   | 6.3                                      | 24.3                         | 16.9                 | 13.9                 | 61.4       |
| Jharkhand      | No  | -  | 5.7                          | 4.7                  | 28                   | 38.4       |
|                | Yes   | -  | 8.6                          | 15.3                 | 37.8                 | 61.6       |
| Karnataka      | No  | 6  | 13.9                         | 10.4                 | 1.9                  | 32.2       |
|                | Yes   | 14.1                                     | 21.2                         | 28.3                 | 4.2                  | 67.8       |
| Kerala         | No  | 1  | 8.5                          | 2.8                  | 17.4                 | 29.8       |
|                | Yes   | 4.1                                      | 25.2                         | 7.5                  | 33.5                 | 70.2       |
| Maharashtra    | No  | 1.1                                      | 1.3                          | 0.4                  | 40.5                 | 43.2       |
|                | Yes   | 1.1                                      | 2.1                          | 1.5                  | 52.1                 | 56.8       |
| Odisha         | No  | 1  | 3.7                          | 1.4                  | 6.5                  | 12.5       |
|                | Yes   | 1.8                                      | 19.8                         | 15.9                 | 50                   | 87.5       |
| Telangana      | No  | 7.2                                      | 25.1                         | 31.4                 | 1.4                  | 65.2       |
|                | Yes   | 12.1                                     | 3.9                          | 16.4                 | 2.4                  | 34.8       |
| Uttar Pradesh  | No  | 0.6                                      | 1.5                          | 3.9                  | 1.1                  | 7.1        |
|                | Yes   | 3.2                                      | 16.6                         | 60.3                 | 12.7                 | 92.9       |
| West Bengal    | No  | 0.9                                      | 0.4                          | 2                    | 31.9                 | 35.1       |
|                | Yes   | 1.3                                      | 1.3                          | 4.6                  | 57.7                 | 64.9       |
| Total          | No  | 2.1                                      | 6                            | 4.8                  | 15.7                 | 28.7       |
|                | Yes   | 4.4                                      | 12.4                         | 25.2                 | 29.4                 | 71.3       |
|                | <b>Total</b>  | <b>6.5</b>                               | <b>18.4</b>                  | <b>30</b>            | <b>45.1</b>          | <b>100</b> |

Among the SCs who reported loss of livelihood most of them were from the states of Andhra

Pradesh, Bihar, and Uttar Pradesh. Among the STs who reported to the loss of livelihood many were from the states of West Bengal, Odisha, Chhattisgarh, Maharashtra and Jharkhand and more OBCs reported to loss of livelihood from the state of Gujarat. The maximum impact of the loss of livelihood was seen in Bihar (95 per cent), followed by Uttar Pradesh (93 per cent) and Odisha (87 per cent). Among the states that showed least impact the state of Telangana reported least impact at 35 per cent. One reason that contributed to the least impact was said to be the support of NGOs working around that area.

Other studies also shown how landless tribal populations faced a major threat to their livelihood during the COVID-19 outbreak and lockdown. (Soreng, 2021).

Among the 29 percent of the respondents who said that they didn't experience loss of livelihood, 16 per cent of them were STs, mostly from the states of Maharashtra, Jharkhand, Chhattisgarh and West Bengal, quite understandably as these states had more STs than other social categories of people.

### ***Box 8: Covid restrictions disrupted the livelihood of a tea garden worker***

Mr. S, 67, lives with his family at Katajhar labour line of Taipoo Tea Estate in Darjeeling district. The impact of the COVID-19 was huge on their livelihood options. During the second time, different tea estate managers followed all the government orders during working hours. Work orders were not filled to capacity as the government ordered 50%, 25%, 10%, and 15% of the total workforce from time to time. Two of the family members each received only three working days over the course of two months. During this period, his daughter in law was pregnant. Soon, their expenses increased and they were much more than their income. Though some relatives assisted them financially but the family was unable to repay the money to the relatives.

The data findings reveal the extent of COVID impact leading to the loss of livelihood options for many people, and its great damage experienced to a greater extent by the daily wagers, landless labourers, domestic workers, tea-garden workers, migrants etc. The qualitative data, collected through the FGDs and case studies from the sample states, provides greater evidence to its devastating impact on these sections of people.



## Chapter 3

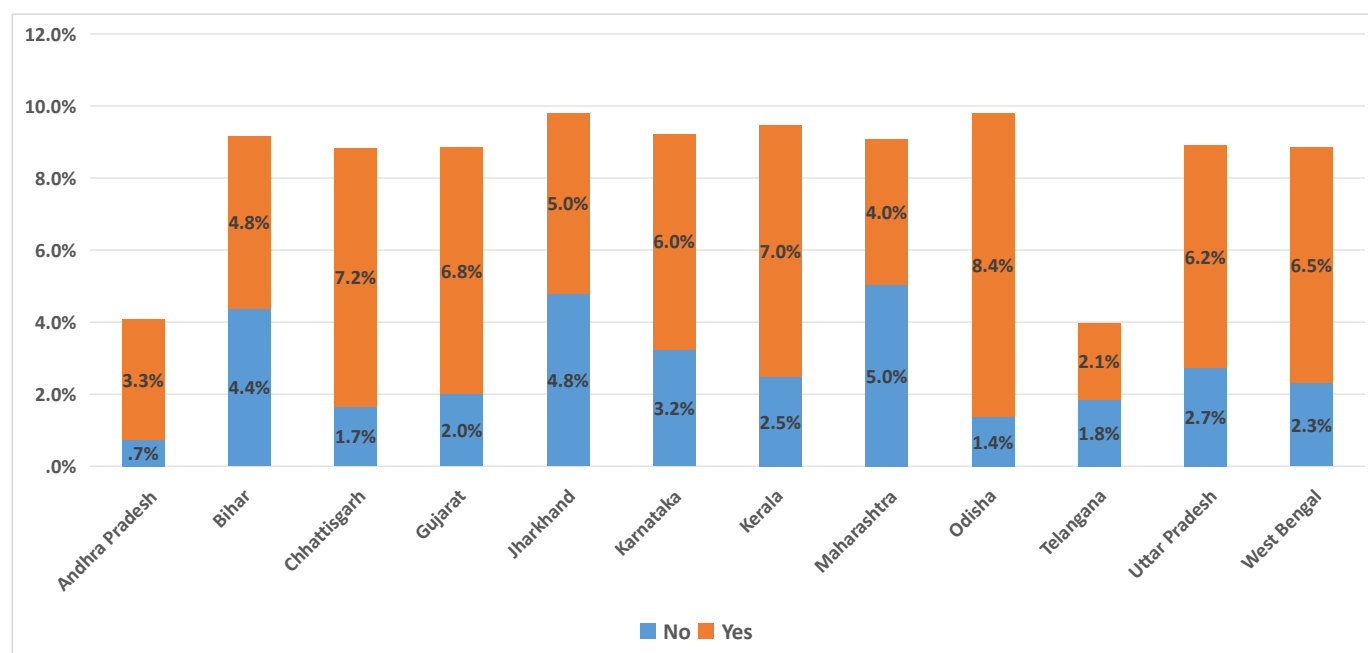
# Impact on Health

In order to understand the health impact of COVID 19 in rural India, we focused on such variables as a) access to and functioning of public health facilities, b) expenditure on COVID related health treatment, c) access to non-COVID related treatment, d) status of health insurance during COVID 19, and e) their preference for medical treatment during COVID 19.

It is known that the quality health care is dependent on the various components of the health system functioning properly, including a functional supply chain to ensure that goods, medications and supplies are available when needed; appropriate equipment is available such as ventilators in the case of COVID-19; the medical staff has the necessary training, skills, knowledge, and resources to perform their jobs effectively; the facilities are clean and well-maintained; otherwise, it does create barriers. (The Keough School of Global Affairs, 2021).

How did the different components of the health system function during the pandemic? Did people frequent the public health facilities more than the private health facilities? Were the people satisfied with the services and facilities available in the public health facilities? The answers to these and related questions are shown in the next few pages.

**Figure 5: Accessing public health facilities**



A large majority of people (67 per cent) had accessed the public health facilities in the last one year. Among the 67 per cent of the respondents who visited the public health facilities, many of them were from the states of Odisha, Kerala, West Bengal, Chhattisgarh, Gujarat

and Uttar Pradesh. The respondents from these states also expressed general happiness over the functioning of public health facilities in their respective states.

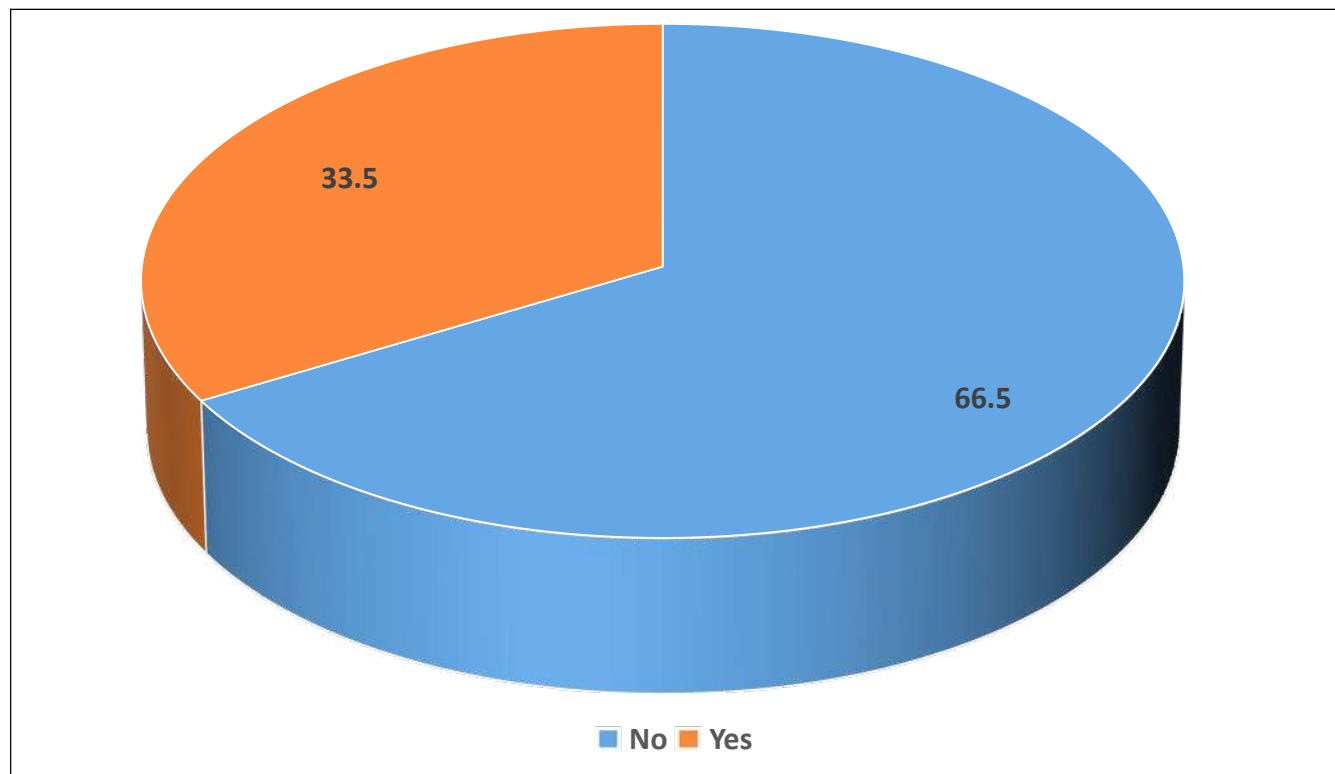
Those with household income less than Rs 3000 frequented the public health facilities more as evident from table 16. The data also reveals that people from all social categories had frequented the public health facilities.

**Table 16: Income and social category of the respondents who frequented the public health facilities**

| Household Income (in thousands/month) | Did you or your family visit any public health facilities in the last one year? (In percentages) |             | Total      |
|---------------------------------------|--|-------------|------------|
|                                       | No   | Yes         |            |
| Less than Rs 3000                     | 19   | 40.6        | 59.6       |
| Between Rs 3000-5000                  | 7.6  | 16          | 23.6       |
| Rs 5000 and above                     | 5.9  | 10.9        | 16.9       |
| <b>Total</b>                          | <b>32.6</b>  | <b>67.4</b> | <b>100</b> |
| Type of the Social Category           | Did you or your family visit any public health facilities in the last one year? (In percentages) |             | Total      |
|                                       | No   | Yes         |            |
| General                               | 1.6  | 4.9         | 6.5        |
| Other Backward Classes (OBC)          | 4.6  | 13.9        | 18.4       |
| Scheduled Caste (SC)                  | 11   | 19          | 30         |
| Scheduled Tribe (ST)                  | 15.4   | 29.7        | 45.1       |
| <b>Total</b>                          | <b>32.6</b>  | <b>67.4</b> | <b>100</b> |

When the respondents were asked if any inadequacies in the public health facilities compelled them to visit private health facilities only about 34 per cent said yes. Of these 34 per cent a significant number is from the states of Bihar, Uttar Pradesh and Karnataka, pointing to the poor status of their public health facilities in comparison to other states. From the qualitative data, we gather that many respondents had pointed out to the broken public healthcare system that caused heavy financial burden on them due to high health expenditure.

**Figure 6: Percentage of people who accessed private health facilities due to inadequacies in the public health facilities**

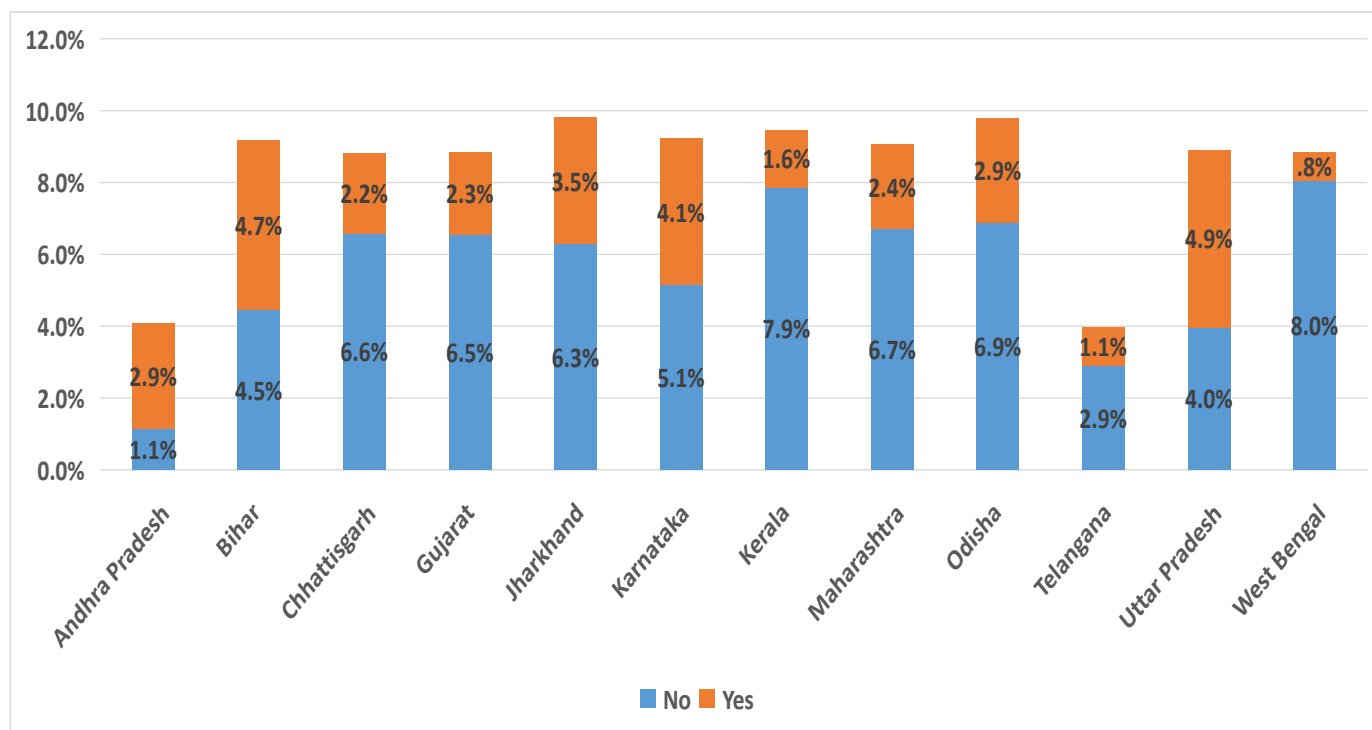


It is evident through the FGDs and case studies that among the 34 per cent of people who had to access private health facilities due to the inadequacies in the public health facilities reported to heavy expenditure on health leading to a huge debt burden. As some respondents said the ‘focus was on saving lives of our dear ones and we didn’t care about the money.’

### ***Box 9: Broken public healthcare System***

In 2020, when COVID hit Bihar, Rashmi’s father who was working in the Railways got infected with COVID. A sugar patient, his condition became very severe and he was rushed to the hospital. Rashmi recalls the night her father was rushed to the hospital as one of the scariest moments in her life as when they reached the government hospital, they were referred to other hospital due to lack of beds and facilities. She informs us about the lack of facilities during such hard times at the government hospitals. She feels that if the government hospital had better facilities her father would have survived.

**Figure 7: State-wise distribution of people who accessed private health facilities due to inadequacies in the public health facilities**



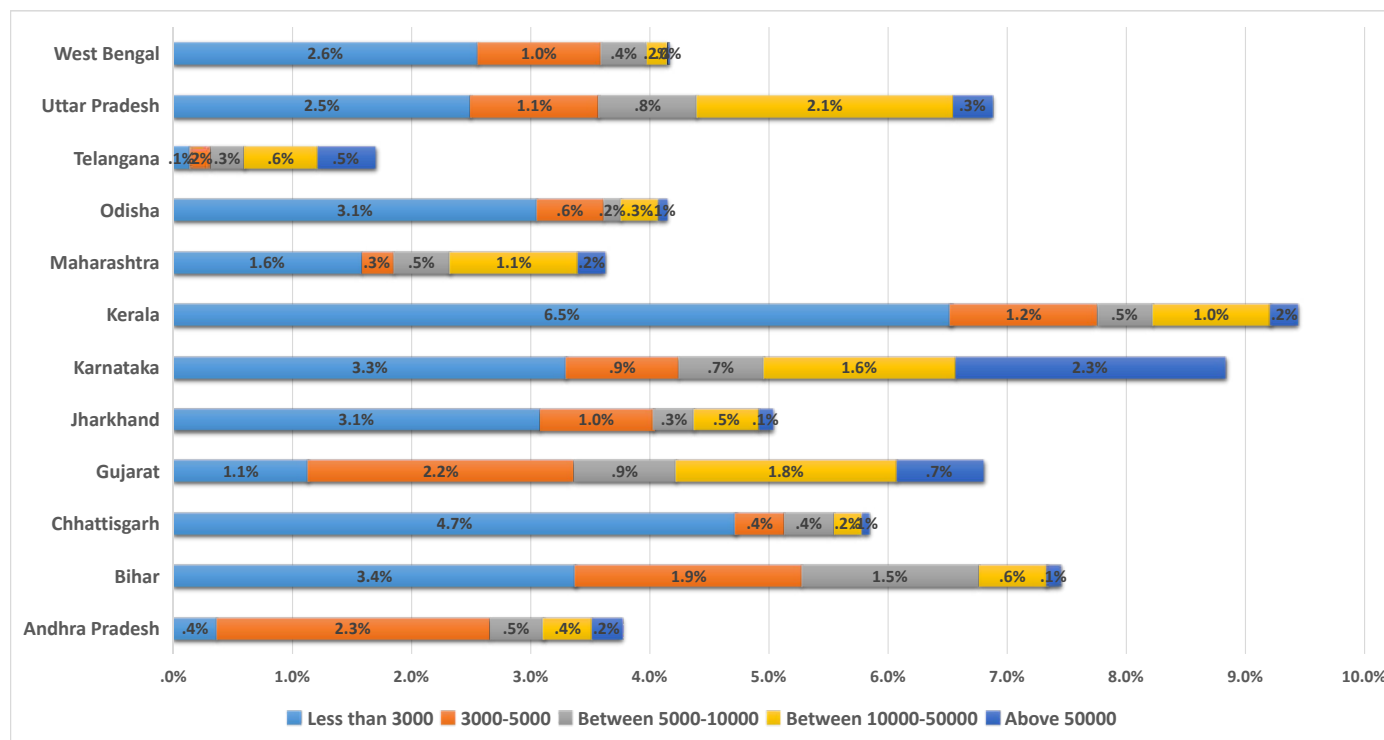
As evident from figure 7, the percentage of people who were forced to visit private health facilities was more in the states of Uttar Pradesh, Karnataka and Bihar.

### **Box 10: Delayed treatment and high costs of medical treatment**

During COVID, Mr. V experienced breathing difficulties and visited six hospitals in Ongole, Andhra Pradesh in search of a bed, including the district hospital, Ongole. He was later admitted and given a bed in one of the RIMS GOVT Hospitals in Ongole and was given oxygen for 30 days.

His total expenses were over Rs. 2 lakhs mainly due to oxygen and medicines. His son and daughter-in-law were skeptical of the public health system. They firmly believed that in order to save a person's life, people should go to private hospitals. They also mentioned that they have not been visited by an ASHA worker or anyone from the health department in the last two years.

**Figure 8: State-wise status of people spending on COVID related Treatment**



About the expenditure on COVID related treatment, most of the states, led by Kerala, spent less than Rs 3000. But this needs to be seen against the income status of the respondents, where 60 per cent of the respondents earned less than Rs 3000 per month. Even this amount, seemingly low, would have meant a lot of burden for the rural population, adding further burden into their meagre incomes.

Though predominantly the spending on COVID related treatment was less than Rs 3000, it is a big amount for the rural population and more so for the marginalized groups like SCs and STs. It is observed that the expenditure has gone beyond Rs 50,000 in some cases. Among those who spent between Rs 5000-10,000 and between Rs 10,000- 50,000 the SC respondents outnumber the others.

**Box 11: Poor facilities and inadequate care in public health centers**

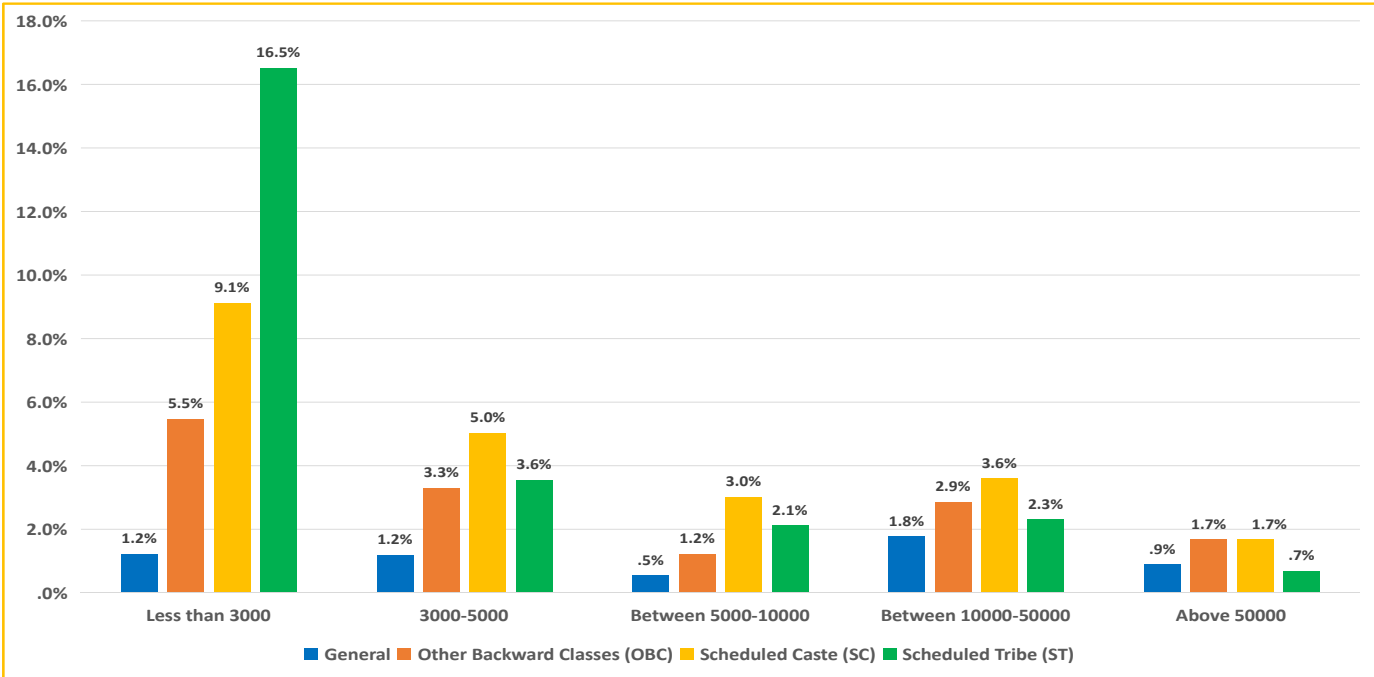
Mrs Rani (name changed) was eight months pregnant. She suffered from a cold and a cough for a few days and was having difficulty in breathing. So, her husband, Mr Chandu (name changed) took her to Balliguda, CHC first, accompanied by his in-laws. They referred her to Berhampur Medical College and Hospital, Odisha on October 6, 2020, where she was tested COVID positive. Her condition required intensive care at the time, so she was admitted to the ICU ward early in the morning. She died that night at 02:11 a.m. During the pandemic, Mr Chandu lost both his beloved wife and his unborn child. He had to spend Rs.30,000/- towards medical treatment and Rs.20,000/- for vehicle rental during his wife's funeral. He blamed the poor facilities and inadequate care in the public health facilities as the main reasons for the death of his pregnant wife.

It is observed that when the government invests more on the public health facilities, it ensures easy access for the poor and vulnerable sections of people. When better healthcare facilities are provided, it also paves the way for bringing down the expenditure on healthcare by the individuals and thus minimizing the financial burden of people, especially those belonging to the marginalized and the vulnerable communities.

**Box 12: First suspected of COVID, but report came negative after his death!**

Mrs. Renuka’s (Name changed) husband had a high fever and his blood pressure and sugar levels were fluctuating, so he was admitted to a private hospital in Mundgod town, Karnataka. When he showed no improvement in his health, he was referred to the Taluk Hospital in Mundgod. In the Taluk hospital he was given a COVID test, as he was suspected to have COVID. While in the hospital, he had trouble in breathing. As the Taluk hospital did not have enough oxygen at the time, the hospital requested that he be transferred to the district hospital. Since Mrs. Renuka was alone, she was unable to transport her husband to Karwar's district hospital. He died three days later on May 13, 2021. According to the law, the body was then taken to the crematory. The town panchayat officers arrived and sanitized the entire house. ASHA personnel paid a visit to Mrs. Renuka and her children and gave them a COVID medicine kit. Her husband's COVID test result came back negative after a few days. As a result, she was unable to seek compensation from the government. She had incurred over Rs 30,000 towards health expenses of her husband.

**Figure 9: Spending on COVID related Treatment by the Marginalized Communities**



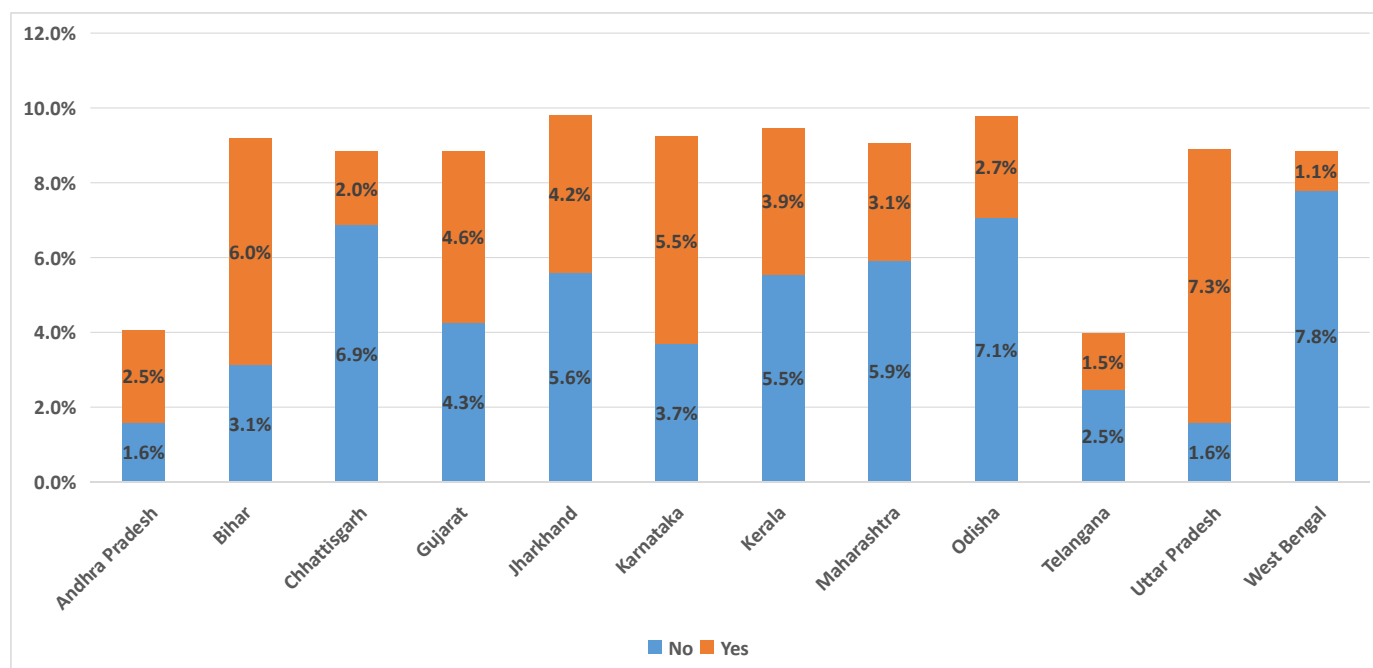
There were many complaints about the poor conditions and facilities at the quarantine centers. Moreover, the people from the ST and SC categories also reported to having had to spend huge amounts of money on COVID related treatment.

### Box 13: Bad condition of quarantine centers

A woman from Attappady taluk of Palakkad, Kerala quoted; “the situation at the quarantine center was quite pathetic. I experienced severe mental stress and loneliness. The quarantine center lacked adequate facilities. Even getting some hot water to drink proved difficult. The food was not tasty, and the same food was served both in the morning and at night. The child's condition was also difficult”. She could only stay for three days at the centre. Then they contacted the doctor, who said they could return home and continue quarantine there. She then returned to her mother's house. She mentioned health professionals such as ASHA worker, ward member, other staff from Agali CHC contacting her in between to know her condition.

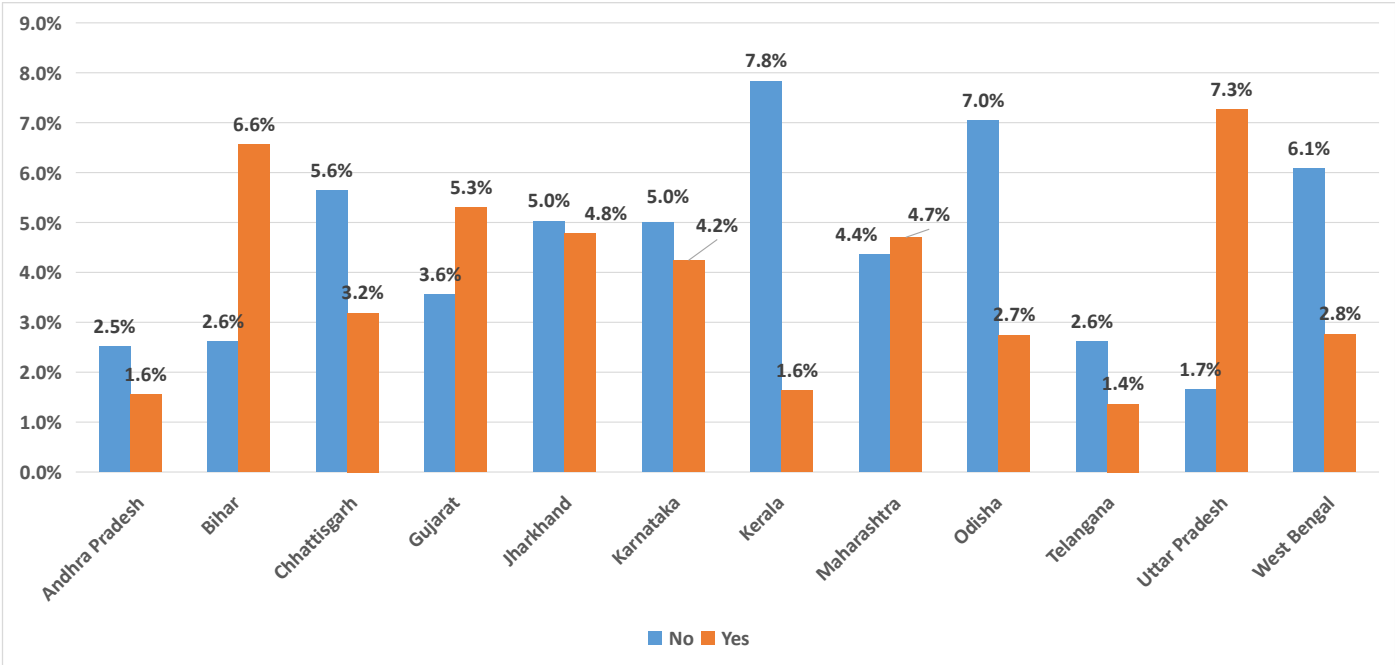
Studies show that Arunachal Pradesh, Goa, Kerala, Himachal Pradesh, Jammu and Kashmir, Mizoram, Sikkim, and the union territory of Puducherry are among the states that spend more than twice the national average, ranging from \$3,500 to \$10,000. As a result, these states have robust primary healthcare facilities, and their health outcomes are among the best in the country. (Duggal, 2020). It was evident from our findings as well that among the 12 states, Kerala presented a better picture in terms of people spending least on COVID related treatment and more percentage of people, over 90 per cent of those who visited them, were satisfied with the functioning of public health facilities.

Figure 10: Borrowing for COVID-19 related Treatment expenses (In percentage)



As evident from the figure 10, a lot of people were forced to borrow money to cover their COVID related treatment expenses. These were predominantly from the states of Uttar Pradesh, Bihar, Karnataka, Gujarat and Andhra Pradesh and it can be observed that the percentage of respondents who said yes outnumbered those who said no in these states.

**Figure 11: Access to Treatment for Non- COVID related health issues**



When the respondents were asked if they faced any difficulties in getting treatment for non-COVID related treatment, 46 per cent said yes and among the 46 per cent, the respondents were primarily from the states of Bihar, Uttar Pradesh, Gujarat and Maharashtra.

There have been reports of people with non-COVID related health issues turned away from hospitals. There have also been reports of an increase in the cases of some of the other diseases like TB, Measles (WHO, 2022) and others due to the exclusive focus on the COVID and neglect of other health issues. According to Dr Tedros Adhanom Ghebreyesus, the WHO Director-General, “The paradox of the pandemic is that while vaccines against COVID-19 were developed in record time and deployed in the largest vaccination campaign in history, routine immunization programs were badly disrupted, and millions of kids missed out on life-saving vaccinations against deadly diseases like measles. (WHO, 2022).

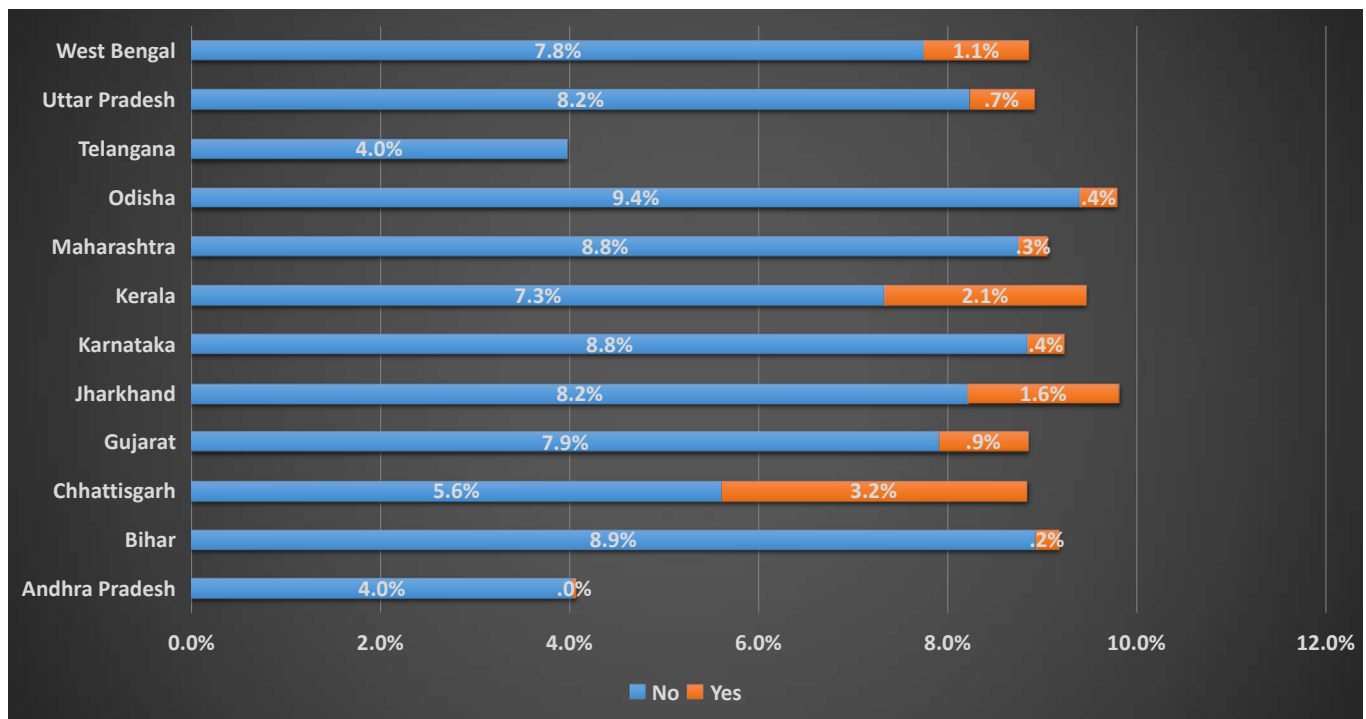
In other words, a disproportionate focus on COVID-19 led to neglect in the diagnosis and treatment of other diseases such as cancer, TB, kidney failure and other rare diseases. (The Telegraph Online, 2021).

Non-COVID illnesses served by health services halted, resulting in unprecedented hardships and sufferings for chronic patients and those in need pregnant women, for example, require immediate medical attention. Access to non-Covid medical services were worse for patients



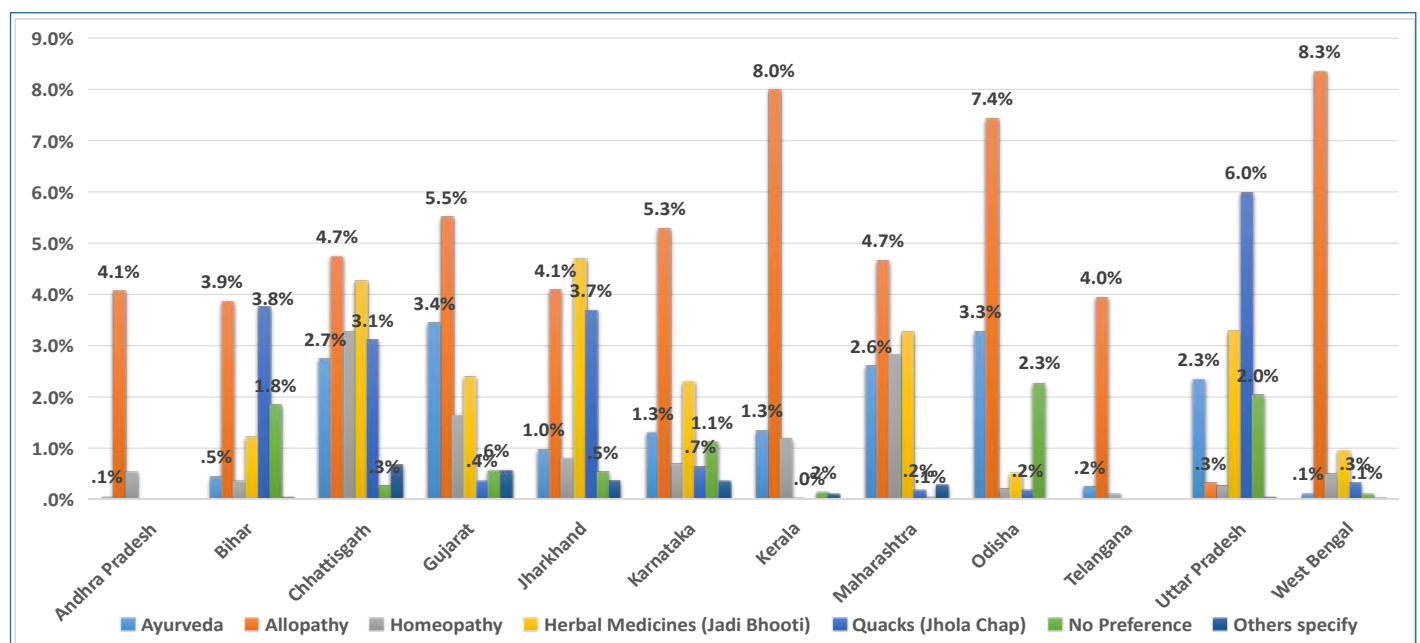
in rural and hard-to-reach areas than in urban areas due to the lack of nearby health care facilities and a lack of transportation options. (Oxfam, 2021)

**Figure 12: Availing of Health Insurance Scheme during COVID-19**



As evident from figure 12, many respondents couldn't avail any health insurance. If only the health insurance was available and easily accessible to these rural people, their burden on health would have been much lower. Only in the states of Chhattisgarh and Kerala the coverage was marginally better.

**Figure 13: Preferred type of Medical Treatment during COVID-19**



In general, there was a preference for allopathy treatment in most of the states, though most significantly in West Bengal, Kerala and Odisha. However, in states like Uttar Pradesh, Bihar, Jharkhand and Chhattisgarh there was a significant preference for quacks (Jhola Chap). Preference for herbal medicines (Jadi Bhooti) was high in states like Jharkhand, Chhattisgarh, Uttar Pradesh and Maharashtra. Just about 9 per cent said that they had no preference for any type of medical treatment.

Among those who preferred allopathy, there was no significant difference with respect to gender, except in Kerala where a greater number of women preferred allopathy treatment than men.

Data shows that there wasn't any significant difference with respect to other variables like social category, education and occupation.

#### ***Box 14: Timely and effective interventions showed a positive trend***

Ambareli village is approximately 8 kilometers from Dholka, Gujarat. The population is approximately 6500 people. The people have a sub-center in their village, so ASHA workers would visit homes and distribute tablets, sanitizers, and provide information about social distancing and the use of masks and sanitizers. If they discovered any symptomatic cases, they would refer them to Ganol PHC for testing. The PHC team used to go around and perform RT-PCR/antigen tests/any other tests. The health center team administered the vaccine to everyone in their village. It was all given away for free.

As evident from Box 14, the health workers, especially the ASHA workers have contributed immensely to keep the rural population free from COVID infection. They put their lives to great risks to ensure the greater good of the rural population. There were many such stories from all the 12 sample states of how the ASHA workers greatly risked their health by visiting every house in their area and providing all the required information and also medical assistance in case of any need.

What is evident is that COVID-19 has impacted and negatively altered the health status of rural population. Right to Food Campaign, through the Hunger watch surveys, has documented a lot of instances of women's health being severely impacted due to lack of access to nutrition. (Right to Food Campaign, 2021). It remains to be seen how the poor nutritional intake during the testing times of COVID would further deteriorate the health conditions of many women, especially the rural women.

## Chapter 4

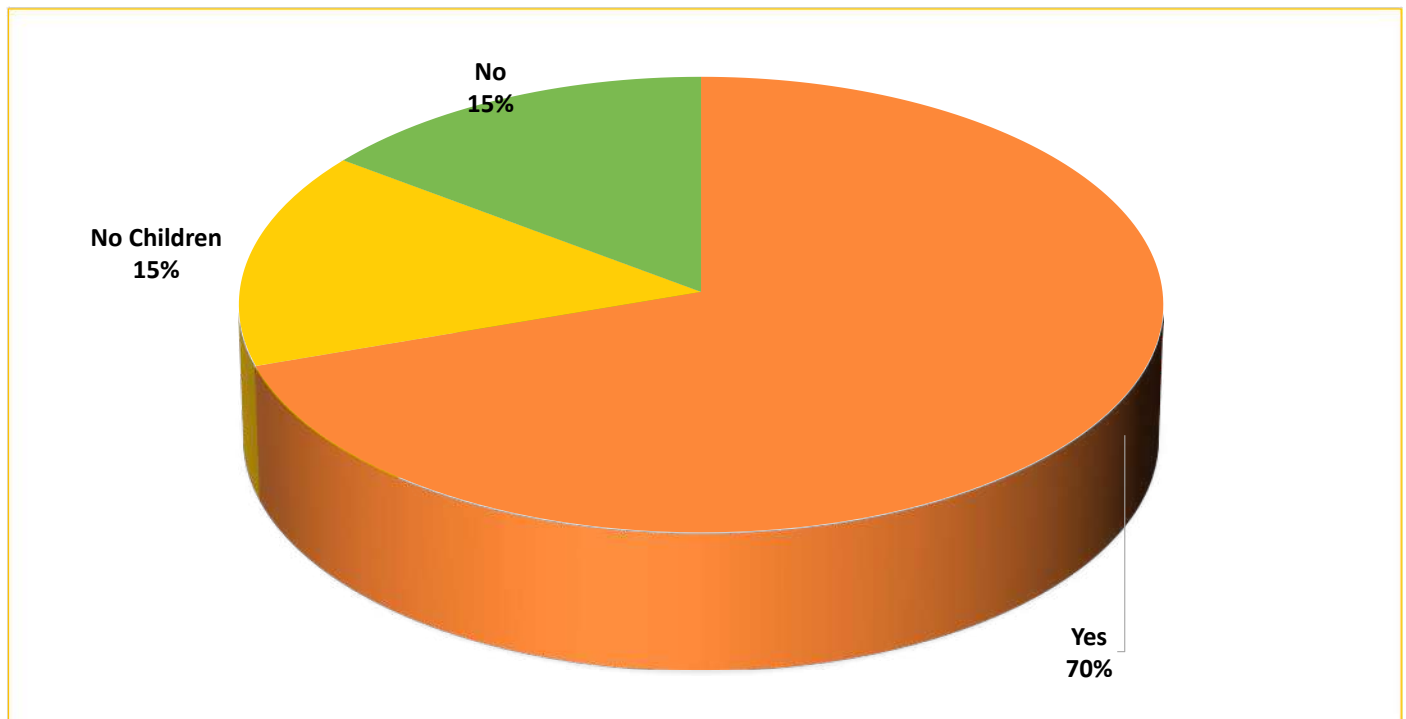
# Impact on Children and their Education

A lot of studies (UNICEF 2020, UNICEF and IHD 2021, Save the Children 2020, Indiaspend.com) have documented how the children were impacted heavily during the pandemic, with increase in child abuse, child labour and child marriages. The data from this study brings to light the digital divide that has greatly impacted children's learning in rural areas. This section shows how COVID-19 impacted children's learning in rural India during the pandemic, what major problems the children faced in their learning including the perceptions of the school staff.

Some studies have shown that the school closure has increased the likelihood of being driven out of the educational system due to a lack of resources, a poor home environment in terms of access to print material other than school textbooks, and parental despondency (Meo & Chanchal, 2021).

As shown in Figure 14, overall 70 percent of the respondents revealed that their children faced problems in learning during the pandemic. It shows how disproportionately the COVID 19 affected the children's learning in rural India.

**Figure 14: Children facing problems in their learning**



### ***Box 15: Education of my child is ruined due to the Pandemic***

Shreyasi, (name changed) a resident of a village in Jharkhand, said that her 11 year old daughter faced many problems during the Pandemic. With schools being shut down, syllabus was not completed. Attending the online classes was not an easy task. Most of the times, online classes were not even held. She said that education is completely ruined and the children in her village have forgotten all their studies by staying at home.

Among the different problems faced by the children in their learning, 46 percent of the families cited non-access to digital infrastructure (Smart phones/PCs/laptops etc.) as the major problem. Another related problem was the network coverage issues faced by 24 per cent of the people.

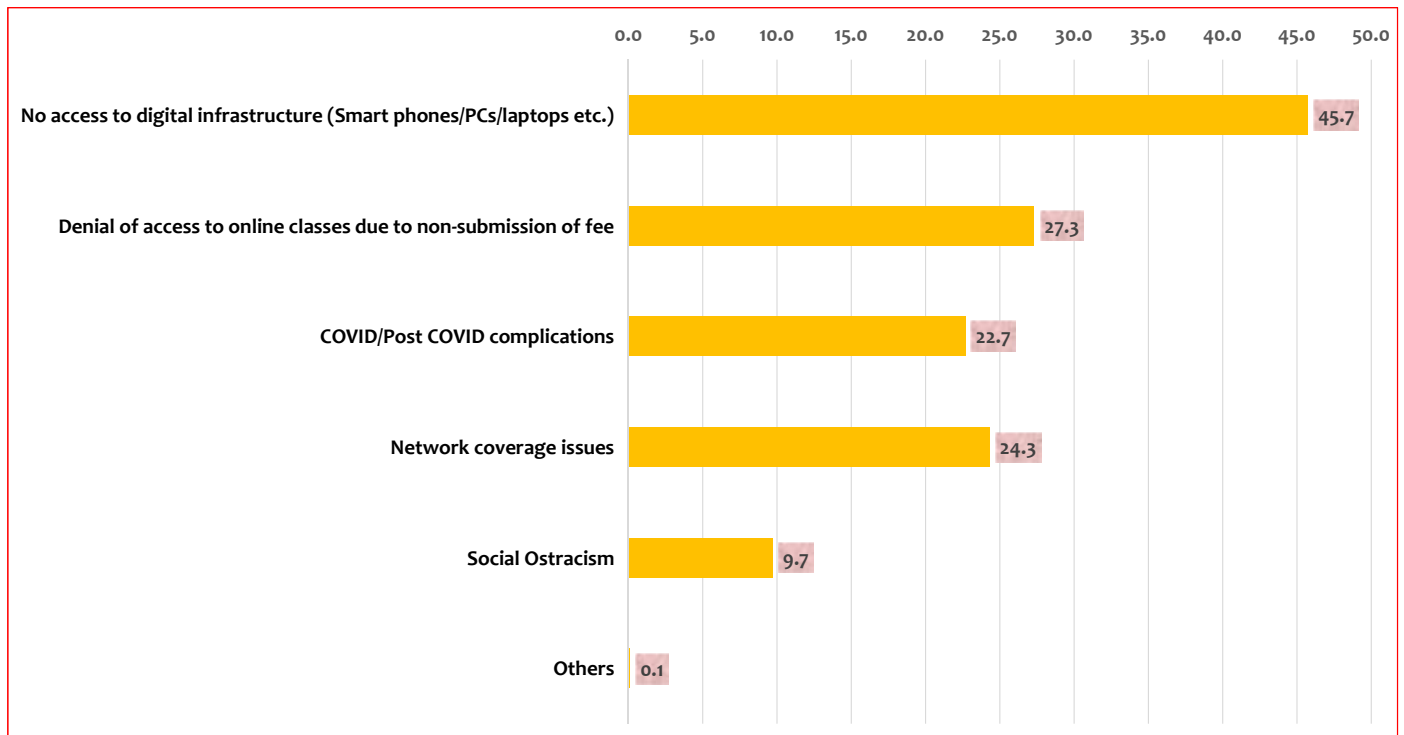
### ***Box 16: Discontinued studies due to lack of funds***

Mrs. L's grandson attended a local government school and graduated in the 10th grade last year. He dropped out of school due to lack of funds. Even her granddaughter who's in the seventh grade at a government school has been at home for the past two years. Mrs. L's grandchildren were unable to attend the online classes because they had no smartphones. During the pandemic, children did self-study and they received no assistance from the school. The school provided no scholarships or dry rations.

Another study shows that only 27 per cent of Indian households have internet access, and only 47 per cent of households with internet access own a computing device (including a smartphone) (Learning Spiral, 2021).

It was seen from the data that 27 percent of the families reported that their children could not access online classes due to non-submission of fees.

**Figure 15: Type of Problems faced by Children in their Learning**



Many households reported that they didn't have smartphones and therefore their children's education was hampered. There were some others who observed that the erratic power supply also affected their children's learning. Therefore, many households recorded that self-study was the only option for their children.

***Box 17: Self-study was the only option to learn during COVID-19***

In a rural household from Orissa, Prem (name changed) revealed that his children, and likewise many other children in his village, had no access to smartphones. So, the children were unable to attend online classes. During the pandemic, the kids did self-study and received no assistance from the school. Only dry rations were provided by the school. Although there is a primary school in the village, there were no classes during COVID-19 as all gatherings were banned. Even though the government has begun to provide online education, no parents in this village could afford to purchase a smartphone for their children. Thus, their studies were hampered.

The experience was not uniform across all the sample states. Many households from northern states attributed their children's poor learning to non-affordability and non-access to smartphones. In comparison, there were less households from the southern states that attributed their children's poor learning to non-affordability and non-access to smart phones.

Even there was variation in the provision of dry rations instead of midday meals across the 12 sample states. This variation was also seen within the states, as some schools in rural areas distributed dry ration and others did not distribute dry ration, further impacting the nutritional status of children.

### ***Box 18: Struggle of school children in rural areas***

Devi, (name changed) a laborer from a village in Uttar Pradesh said that her work was completely stopped and her children were not able to go to school as Schools were shut down. Government announced the online mode of education which was a difficult task for the children. Online classes never happened in rural areas. Moreover, they could not afford smartphones. During the pandemic, her children did self-study as they did not receive any help from the schools.

Lockdown put children behind the closed doors without any interaction with the outer world making them incapacitated culturally and socially. There have also been some studies about the impact of COVID-19 on the mental health and wellbeing of children and young people (UNICEF, 2021).

Another issue that has been reported is the negative effects from the use of smartphones, somewhat captured in Box 19. The excessive use of smartphones has resulted in children getting addicted to them. This addiction has limited their outward activities and has also affected their creativity.

### ***Box 19: Lockdown put kids away from social and cultural activities***

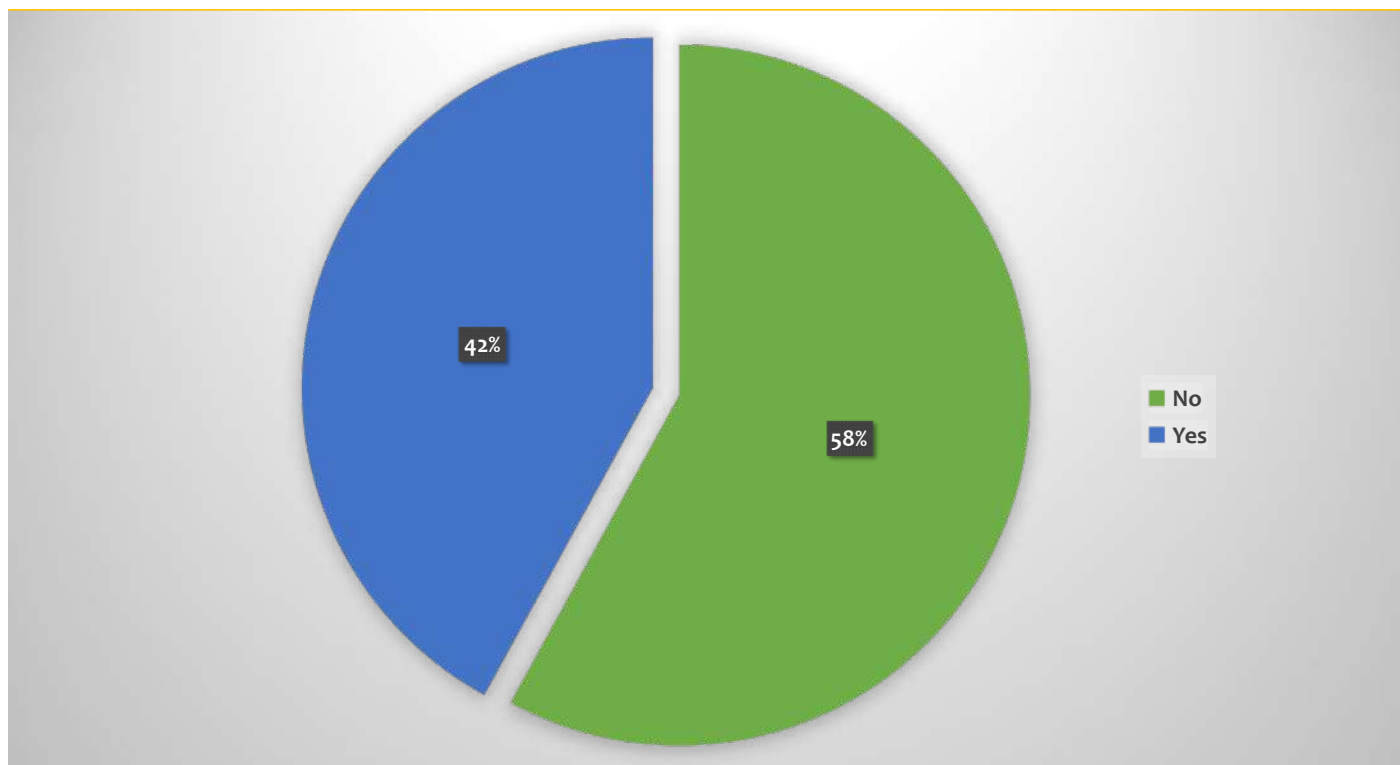
A parent from Gujarat revealed that children were kept occupied with mobile phones in the name of social distancing, but it had a negative impact on the lives of children. Simply sitting at home and watching TV has taken away their resourcefulness, and now they don't even like to play out. It has now become an addiction for them. During the pandemic, her children did not attend online classes due to outstanding fees and a lack of a smartphone.

A study done by Vidhi Centre for Legal Policy, mapping 'Out of School Children (OOSC)' states that at least 43 per cent students in India did not have access to any online education for up to 19 months during the Covid-19 pandemic. (Vernekar et al, 2022). Although many states attempted to provide learning materials to children through alternative means, such as television, radio, WhatsApp groups, and even some group tutoring, efforts were sporadic, with uncertain results (Kazmin, 2021).

### ***Box 20: Student dropout of school in order to earn a living***

In major parts of West Bengal students find it difficult to get there because there are no transportation options. Students did not take any online classes due to inaccessibility. Schools have been closed since the first phase and during the pandemic, there are no learning levels or achievements in the classrooms as everything was shut and there existed no bonding or close relationship with anyone. One of the instances showed how when the schools were shut and there existed economic hardships during the Covid phase, one of the students who took up jobs never returned to books once he had money in his hand and he still says he never would want to go back to the learning phase.

**Figure 16: Perceptions of school staff on the Impact of COVID-19 on children's Education**



Data illustrates that only about 42 percent of the children in the rural areas were able to attend the classes via online mode regularly.

Similar issues and problems were reported by the stakeholders as well. The digital divide in terms of non-access to digital devices and erratic online learning was explicit from the states of Chhattisgarh, Bihar, Uttar Pradesh, Jharkhand and West Bengal. Better situation in terms of access to digital devices and regularity of online learning was reported from the states of Kerala and Karnataka.

According to a study conducted among the Paliyan tribes in Kerala, teachers at Kumily tribal school believe that dropout rates among Paliyans are higher than in the Mannan tribal community. After completing their basic school, youngsters are obliged to work in order to alleviate poverty in their family. While boys are required to work to support the family income, girls are responsible for their siblings while their parents go to work. (Pushpam & Nair, 2021).

***Box 21: A teacher's perspective on how children's education was affected due to the pandemic***

A 27 year old school teacher residing in a village of Kerala said that the Pandemic has largely affected children's learning. Children in this village did not go to school for almost two years. Moreover, they could barely attend any online classes due to network issues. Many of these children are now suffering from eyesight problems. It was only after an initiative of the community study room that the children began studying again.

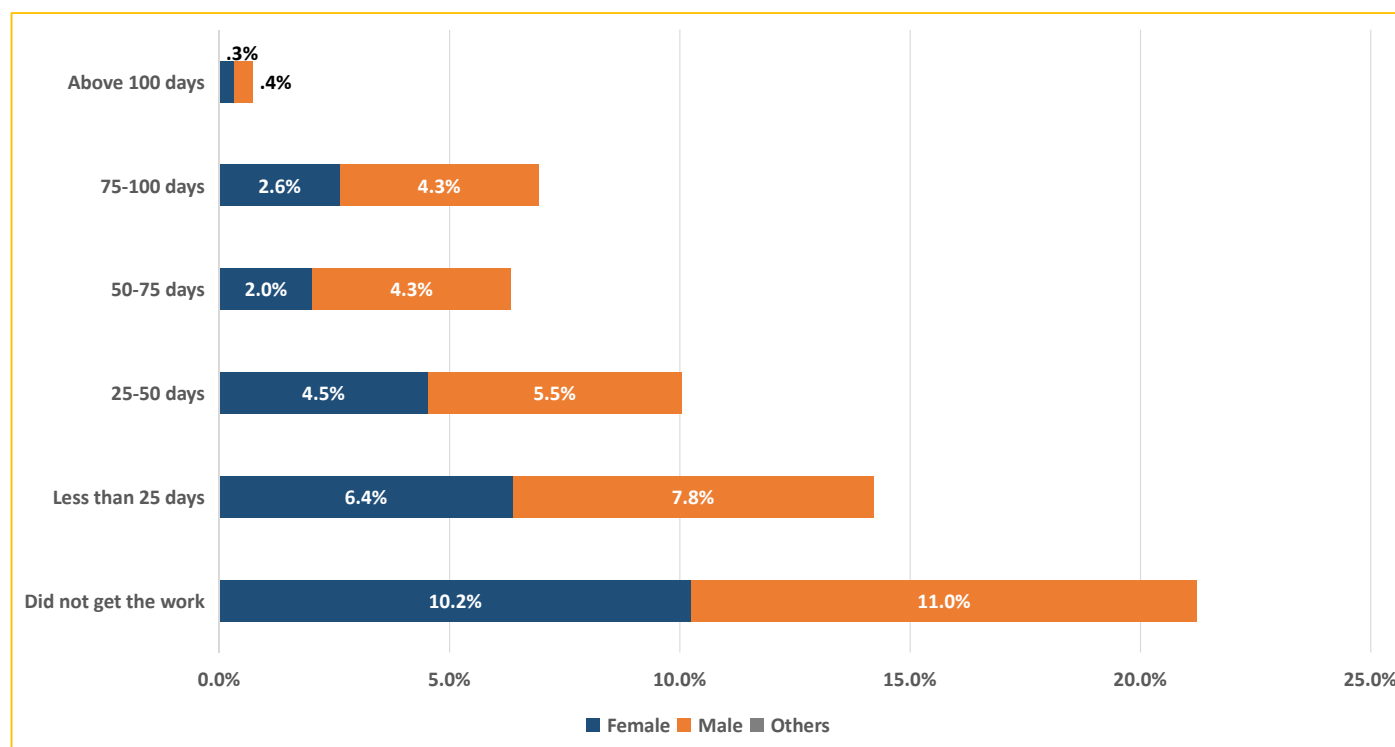


## Chapter 5

# Impact of Social Security Schemes

This chapter reviews the importance and impact of the Social Security Schemes (SSSs) during the COVID-19, focusing mainly around the MGNREGA, PDS and MDMS. How did the social security schemes like MGNREGA, PDS, MDMS and others function during the pandemic? What was their importance for the rural population? Were any of these SSSs accessible to the rural population? Our study results are shown below.

**Figure 17: Functioning of MGNREGA during the Pandemic**



From the figure 17, we also gather that 21 per cent of MGNREGA card holders did not get work and 14 per cent got less than 25 days of work. Though 60 per cent of the people claimed to possess the MGNREGA card, a large majority of them either didn't get work or got less than 25 days of work. A large number of those who didn't get work were predominantly from the states of Jharkhand, Bihar and Maharashtra.

When MGNREGA was hailed as the 'life line' during the pandemic especially with reverse migration, the data shows that the benefits were minimal for a large majority in the sample states.

In relation to the total number of women respondents, a significant number of them either

didn't get work or got less than 25 days of work. Our findings show that almost half the SC households didn't have job cards and about one-third of the ST population didn't have job cards. Less than 1 per cent of the respondents said that they got more than 100 days of work days.

Among those who didn't get even a single days work a significant percentage of them were from the states of Jharkhand, Maharashtra and Bihar.

A study done by the Azim Premji foundation titled 'Employment guarantee during Covid-19: Role of MGNREGA in the year after the 2020 lockdown' shows that 39 per cent of the card holders did not get a single day of work during 2020-21 in the four states of Bihar, Madhya Pradesh, Maharashtra and Karnataka. (Azim Premji University, 2022)

Another study by Dalberg Advisors titled 'The state of rural employment: A look at MGNREGS across 5 states in India' shows that 58 per cent of the job card holders reported delay in the payment of wages. (Dalberg, 2022)

### ***Box 22: MGNREGA was a lifesaver but got less than 25 days of work***

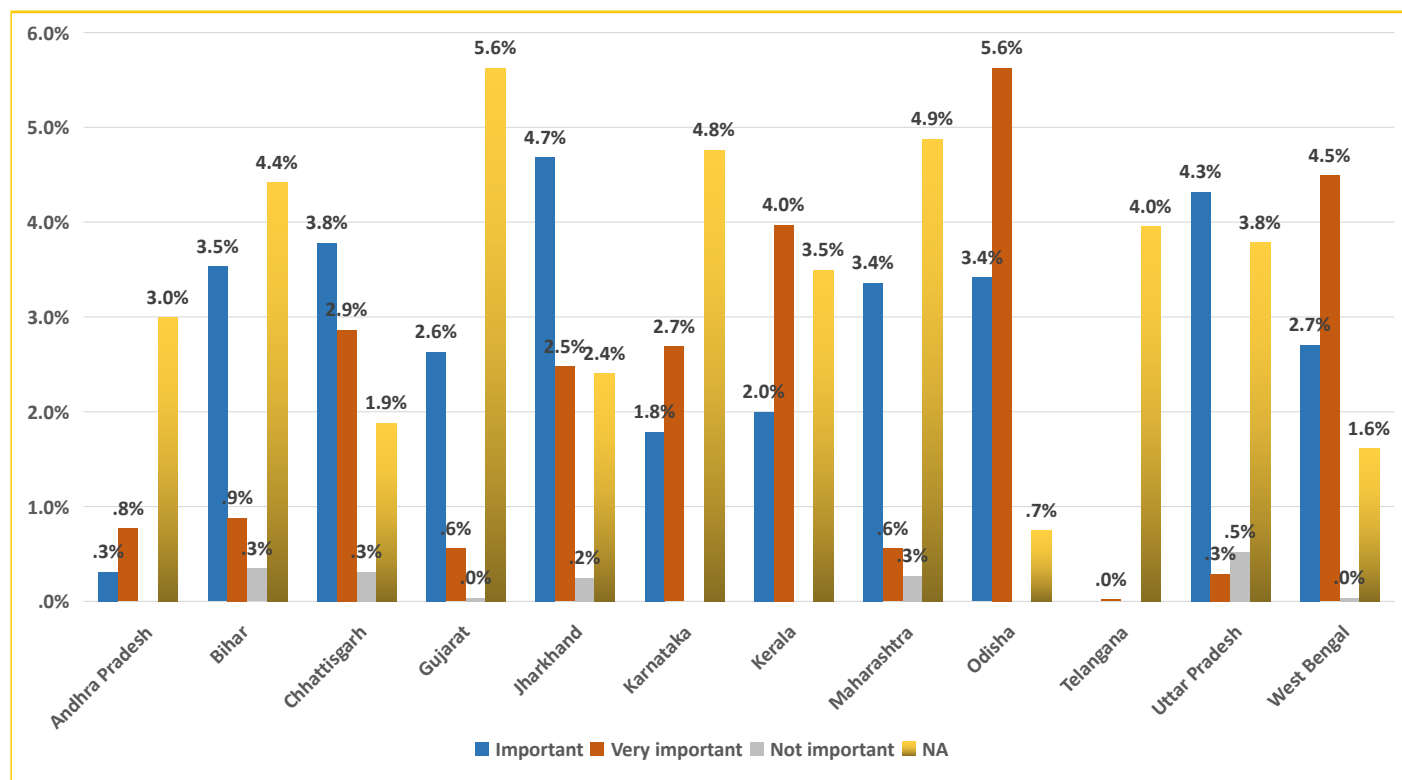
A 32 year old woman, hailing from the Raichur district of Karnataka, was infected with Covid-19 during the second wave. However, her condition was not severe and she was cured. She recalls that she had experienced ostracization in the village. No one came to her house. She worked on her family's land. But during covid, when there was no work, MGNREGA was a lifesaver for her as she and her family had a job card under MGNREGA. But She does mention that during lockdown, they got work less than 25 days and could not get the proper payment too. She narrates how COVID has had a huge impact on her family and how it has put them in difficulties as they could not work.

The MGNREGA was a life saver for many households. It benefited a lot of households during the pandemic. Yet the respondents show that its impact could have been more and better if they were able to get more number of work-days. There were some others who lamented that despite having job cards they didn't get any work under MGNREGA.

### ***Box 23: COVID and its stigma affected the MGNREGA workers***

A household from Angally, Kerala shared that the pandemic's impact on women's livelihoods was primarily felt by MGNREGA workers. If someone was quarantined at home, no family members could go to work; the rules were strict. Even after we were cured, people seemed to be frightened and used to run even when a cured person walked in.

**Figure 18: Importance of PDS during COVID-19**



When the respondents were asked about the importance of PDS during the COVID-19, 33 per cent said that it was important for their family and 25 per cent said it was very important for their family during the COVID-19. This further confirms how PDS turned out to be a life saver for a large section of people, especially the rural population. Among the respondents who stressed on the importance of PDS, a large percentage was from the states of Uttar Pradesh, Bihar, Chhattisgarh and West Bengal.

When asked about the functioning of PDS a significant percentage of them considered it to be either good (63 per cent) or very good (21 per cent). Mostly all the sample states were satisfied with the functioning of PDS, except Bihar and Uttar Pradesh who appeared to be least satisfied with the functioning of PDS.

**Box 24: How PDS helped a family during difficult times**

In a village in Chhattisgarh, Rekha (name changed) narrated that when she, her husband and her son had been infected with COVID during the second wave they were helpless. It was a difficult time that they had faced as nobody was there to look after them. During this time, the PDS proved to be helpful as they got 35 kg of rice for 2 months. This helped them survive during the tough times of COVID-19.

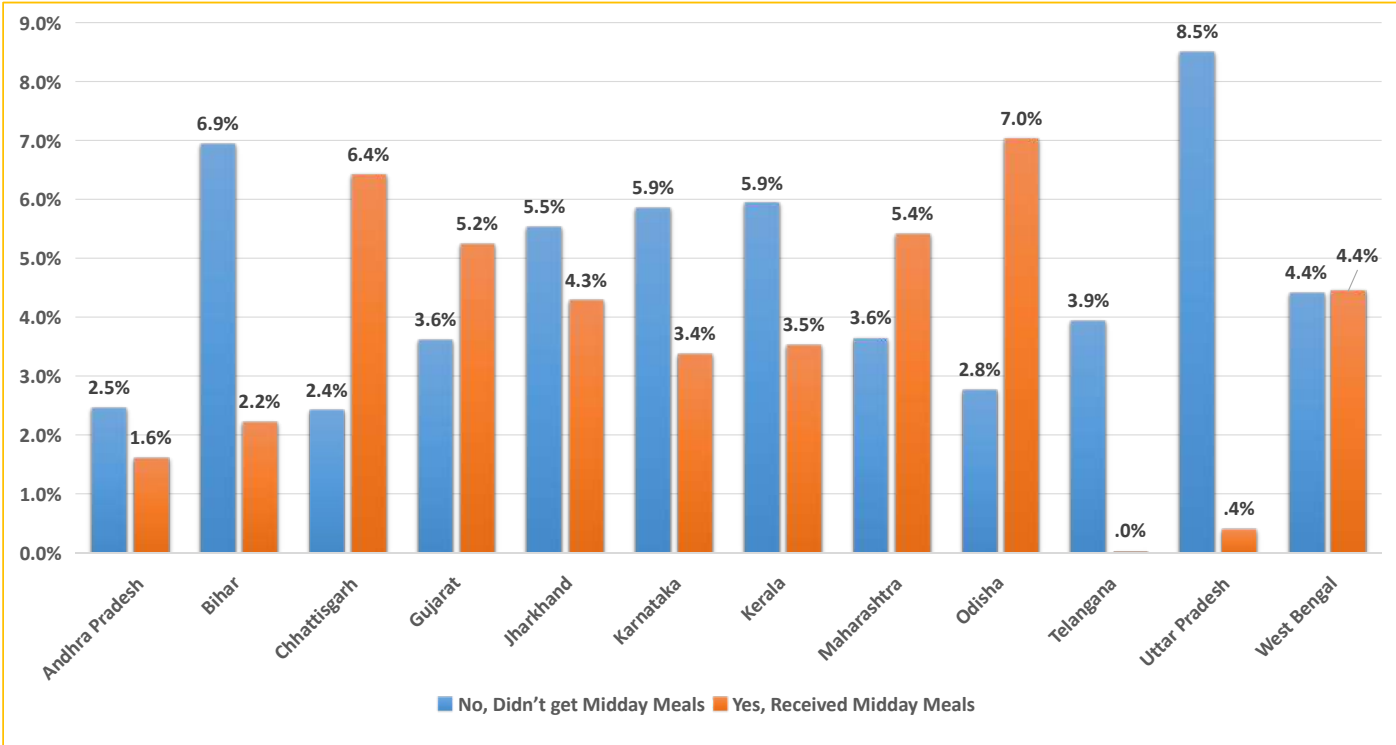
The findings show that the PDS functioned well during the pandemic and by and large there was positive feedback to its functioning and its importance. However, there were also some instances of people having faced problems in accessing PDS either due to their digital illiteracy or biometric issues.

Some respondents from Telangana reported that though the government promised an additional 5 kg of rice to those who have suffered as a result of COVID-19, many people were not aware of the timings of ration distribution. Moreover, there was no one to deliver rations to those who were quarantined.

**Box 25: Digital illiteracy caused problems in accessing PDS**

A household from a village in Telangana said that they did not receive ration as it was linked to their mobile phone and due to their digital illiteracy, they encountered problems with OTP. Many women had difficulty in getting PDS as they faced repeated problems with the OTP.

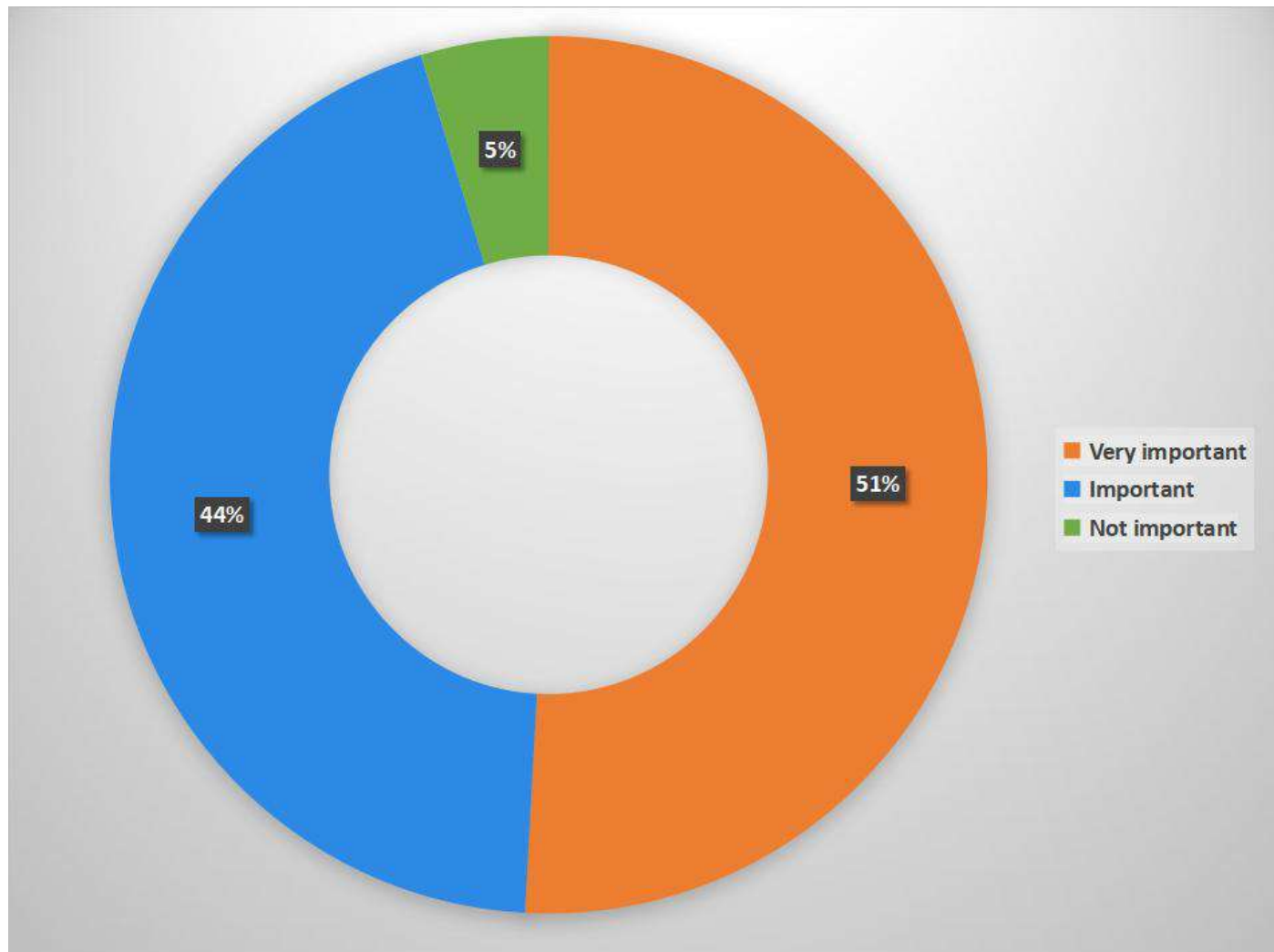
**Figure 19: Availability of Mid-day meals in the schools during COVID-19**



Regarding the MDMS, 56 per cent of the respondents said that their children didn't receive MDMs in the school. A significant number of them were from the states of Uttar Pradesh and Bihar. It must be noted that when the schools were closed and MDMs were not served,

dry rations were distributed. However, the findings varied across the states and within the states as well with some receiving the dry ration and others not receiving it.

**Figure 20: Perception of Stakeholders on the Importance of Social Security Schemes During COVID-19**



The importance of social security schemes was emphasized by the stakeholders too, with 51 per cent of them saying that it was very important and 44 per cent of them saying it was important.

The stakeholders confirmed that social security schemes like MGNREGA, PDS and MDMS were very important for peoples' welfare during COVID-19 and were very important to minimize the negative impact of COVID-19 among the rural population.

## Chapter 6

# Major Findings of the Study

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From the four research tools that were used for this research study we gather the following findings.

### Findings from the general profile of the respondents

The sample size largely consisted of the Dalits and Adivasis 75 per cent. It may indicate the social structure of the rural population with large sections of SCs and STs residing in rural areas.

Among the respondents 46 per cent were landless laborers.

A large section of people, 60 per cent, earns less than Rs 3000 a month.

The illiteracy is still high at 42 per cent and only 12 per cent studied beyond the secondary level.

### Findings based on the Impact on livelihood

During the pandemic 71 per cent of the respondents lost their livelihood. This shows how severely the pandemic affected the rural population. It greatly affected states like Uttar Pradesh, Odisha and Bihar. In order to find out the gendered impact of COVID-19, a specific question was asked, ‘whether the livelihood options of women were more affected during the pandemic’, and 75 per cent said yes. This shows that women were more affected during the pandemic. The social impact of the COVID-19 shows that 54 per cent of the SC and ST households lost their livelihood.

Despite the loss of livelihoods, rural population had its own ways of coping with it. Among the coping mechanisms adopted by the rural households to tide over the loss of livelihood, 44 per cent said that they managed from their savings, 26 per cent of them said that they took monetary and non-monetary support from their relatives and 18 per cent said that they borrowed money from money lenders.

### Findings based on the Impact on Health

During the pandemic a large majority, 67 percent, had accessed the public health facilities. A majority of the respondents who visited public health facilities were from the states of Odisha, Kerala, West Bengal, Chhattisgarh, Gujarat and Uttar Pradesh. When the respondents were asked whether the inadequacies in the public health facilities had compelled them to visit private health facilities 34 per cent of them said yes. Most of them were from the states of Bihar, Uttar Pradesh and Karnataka.

Regarding the health expenditure, data showed that 32 per cent of the respondents spent above Rs 5,000 on COVID-19 related treatment and 25 per cent of them spent above Rs 10,000 on COVID related treatment. To meet the health expenditure, 45 per cent said that they had borrowed money for COVID-19 related treatment, most of them from the states of Uttar Pradesh, Bihar, Gujarat, Karnataka and Andhra Pradesh.

There were people who faced difficulties in getting treatment for non-COVID health issues. Most of the 46 per cent of the respondents who said that they faced difficulties in getting treatment for non-COVID related health issues were from the states of Uttar Pradesh, Bihar, Gujarat and Maharashtra. In these four states those who faced difficulties to access treatment for non-COVID related health issues outnumbered those who didn't face difficulties to access treatment for non-COVID related health issues.

Data also shows that only 11 per cent had availed health insurance. Many of them were from the states of Kerala and Chhattisgarh.

When the respondents were asked to reveal their preferred type of medical treatment 60 per cent opted for allopathic treatment and 23 per cent said that they preferred herbal treatment. From the perspective of the stakeholders 62 per cent of them said that the public health facilities had desired facilities and 38 per cent said that the public health facilities don't have the desired facilities.

### **Findings based on the Impact on Children and their Education**

The impact of COVID-19 has been very severe on children's learning as documented by UNICEF, Save the Children, Indiaspend.com and so on. The data shows that 70 per cent of the respondents said that their children faced problems in their learning. Among the type of problems faced by children in their learning non-access to digital infrastructure dominated the results at 46 per cent. Another 24 per cent said that the network coverage issues hampered their children's learning. So close to 70 per cent of the problems relate to what can be called as 'digital divide'.

From the perspective of the stakeholders, 58 per cent of them said that the children in their areas couldn't attend the classes via online mode regularly.

### **Findings based on the Impact of Social Security Schemes**

What was the impact of SSSs during the COVID-19? We considered only the MGNREGA, PDS and MDMS to assess their importance and impact during the COVID-19.

Our study findings reveal that 21 per cent of MGNREGA card holders did not get work and 14 per cent of them got less than 25 days of work. In another study done by Azim Premji foundation it was shown that 39 per cent of the card holders did not get a single day of work during 2020-21 in the four states of Bihar, Madhya Pradesh, Maharashtra and Karnataka.

Regarding the MDMS, 56 per cent of the respondents said that their children didn't receive MDMS in the school. A significant number of them were from the states of Uttar Pradesh and Bihar.

PDS was also a life saver for many households and 58 per cent said that it was very important for their family during COVID-19.

The importance of social security schemes was emphasized by the stakeholders too, with 51 per cent of them saying that it was very important and 44 per cent of them saying it was important.



## Chapter 7

# Recommendations and Conclusion

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This research study has helped us assess and understand the impact of COVID-19 in rural India. Based on the findings of the study we propose the following recommendations.

- 1. Address low educational levels in the rural areas.** With 42 per cent of the respondents being illiterate, it demands concerted attention from the government and non-government agencies to work towards the achievement of 100 percent literacy in all the states. When only about 12 per cent of the respondents had studied beyond the secondary level, there is an urgent need to focus on quality education in rural areas, with better monitoring and transparency mechanisms.

Another barrier to making learning entirely digital in such areas is a teacher shortage or a low teacher to student ratio in villages. This ratio must be improved in order to complete the digitization of education in rural areas, and a large number of skilled and well-trained teachers are required to ensure that each and every student receives complete attention even during an online class.

- 2. Extend more support to the school-going children** to ensure that they don't drop out of school. The pandemic seriously affected children's learning (70 per cent said that their children's learning was affected). The pandemic while exposing the digital divide among the school children, also forced many children out of school. Children need to be brought back to schools through many incentives and incentives in the form of improved quality of mid-day meals, waiver of school fees etc can work wonders especially in rural areas.
- 3. Eliminate the digital divide** that has affected the rural children during the pandemic. The huge digital divide is exposed with close to 70 per cent of the problems the children faced in their learning being attributed to non-access to digital infrastructure and network issues.
- 4. More attention towards the better functioning of public health facilities** to provide better care to the rural population that still depends on them heavily, as the data shows that 67 per cent had accessed public health institutions during the pandemic. While the respondents were largely happy about the functioning of public health facilities, yet it was also true that the inadequacies in the public health facilities had forced 34 per cent of the respondents to the private health facilities. With more public funding, better public health infrastructure and better monitoring mechanisms, the public health facilities can address the existing anomalies and make them function better.

**5. Further strengthen and expand the reach of MGNREGA to benefit the most disadvantaged sections of people in rural India.** Though these schemes played an important role during this pandemic to provide a ‘safety net’ to the rural poor, owing to more demand caused by the increased unemployment, there is a need to expand it to at least 200 days for all the states but also to the urban areas. It is painful to note that despite its importance and a heavy reliance upon it by the rural population, MGNREGA funds have been reduced by 25 per cent in the 2022-23 budget. As rightly demanded by the Right to Food campaign group, the MGNREGA needs to be extended to the urban areas as well in order to provide basic income to the urban poor and this can ensure better indicators for India in the world map, especially on indices like the world hunger index and world food security index.

Our respondents have also given some other suggestions like a) addressing the delays in payments (both wages and material components), b) increasing the wages and c) increasing the number of work days.

Addressing the above concerns would further support the livelihoods of the population that is dependent on MGNREGA.

**6. Universalize PDS** to ensure that no one, especially those who migrate, faces any difficulty in accessing the basic food grains anywhere in the country. During the pandemic many migrants struggled to access PDS and some others couldn’t access PDS because of the biometric issues. Though a large number of respondents said that the PDS functioned well in the case study villages, there still exist some irregularities like not getting the full quota of the ration, biometric issues etc and only when such irregularities are eliminated, the rural population will benefit enormously.

**7. Ensure protection and empowerment of rural women** to prevent worsening of their situation especially in hard times. The data shows that the livelihood options of women were more affected during COVID-19 and it’s also true that the women were adversely impacted in many other ways as well. More number of women weren’t satisfied with the functioning of PDS in their villages. Better functioning of PDS and MDMS will have more positive impact on the women especially in rural areas. Timely and adequate state support would guarantee these rural women decent and dignified lives.

**8. Prioritize the issues and concerns of the marginalized groups like the Scheduled Castes (SCs) and Scheduled Tribes (STs)** to avert further exploitation, marginalization and exclusion. With data exposing their poor educational status (35 per cent illiterates) and a large number of them working as landless labourers (38 per cent), the linkages seem too obvious. Therefore, stepping up efforts to educate them are necessary and this is sure to reap great dividends.

The COVID-19 has had a ravaging impact on the rural population and our findings only confirm it further. People have lost their livelihood, something that they depended on to

make their ends meet. Among the things that worked wonders were the PDS and MGNREGA as expressed and confirmed by a sizeable number of rural population. It is a welcome step that the Ministry for Rural Development (MRD) has recommended 'greater diversification of permissible works instead of listing the types of permissible works.' It also recommends that 'broad categories of works may be listed out and flexibility should be given at the ground level to select the types of works as per broad categories.' These recommendations have emerged after the sixth Common Review Mission of the eight states, Andhra Pradesh, Arunachal Pradesh, Karnataka, Nagaland, Gujarat, Jharkhand, Himachal Pradesh and Jammu Kashmir. (MRD, 2022)

Ration distribution by NGOs has also been acknowledged to have helped the rural population greatly and it gives an indication and lends credence to the presence and reach of NGOs in the rural areas. The NGO sector was at the forefront during the pandemic, reaching out to the unreached and catering to their basic needs. One hopes that the government takes this aspect into greater consideration and gives greater credit to the activities and achievements of the NGO sector.

As we know that the rural population is largely dependent on the public health facilities. It was evident with a lot of rural population accessing them and finding them useful by and large. It is our hope that much more focus and investment go into the public health facilities in the rural areas to provide quality care to the rural population that depends on them.

What significantly hampered the rural population was the digital divide in terms non-access to the digital infrastructure and network issues making the online learning very difficult for the children in rural areas.

We hope that the findings from this study would be utilized to further uplift and empower the rural population and thus make them more resilient towards any such disasters or calamities in future.

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