IMPACT OF COVID–19 IN RURAL INDIA

A cross sectional study from 12 states

JESUIT COLLECTIVE INDIA

JCI-CDO

INDIAN SOCIAL INSTITUTE
NEW DELHI

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CONTENTS

Introduction

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. Numerous studies and reports 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-Delhi) 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. Another focus of this study was to understand whether or not the different social security schemes like Public Distribution System (PDS), Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) helped people during this pandemic to tide over these difficult times caused by the pandemic. The study also focused on access to health care in rural India and whether the rural population availed of any insurance schemes.

This fact-sheet is the result of a research study carried out in 12 states (covering 474 villages in 46 districts) from June 2021 - January 2022. Among the 5210 respondents, the study findings show that a lot of people are still illiterates (2172 respondents, 42%) in the rural areas, with 60 per cent of them earning less than Rs 3,000 per month and a large number of them being landless labourers (60%). The study also shows how COVID-19 has severely affected the women, children, Dalits and Adivasis. On the real impact of COVID-19, 51 per cent said that their families were infected with COVID-19 and 71 per cent of them said that COVID-19 caused loss of livelihood options for their families. The impact was such that 59 per cent said that they borrowed money for survival during this pandemic. Despite the great negative impact of COVID-19 on their families, only 11 per cent had availed some health insurance scheme during the pandemic.

The study shows that the rural population still relies on the public health facilities and also on the social security schemes like MGNREGA and PDS, with 55 per cent saying that they want the MGNREGA to continue. Improvements in the delivery of these services are sure to benefit the more disadvantaged sections of the rural population.

Despite its focus on 12 states, this study has limitations like a limited sample from each of the 12 states and also covered less than 50 per cent of the states in India. In some states, the study has not been limited to the rural areas but was also extended to the semi-urban and urban areas as well.

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.

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. The data collection was done between June 2021 - January 2022

Sampling:

A 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.

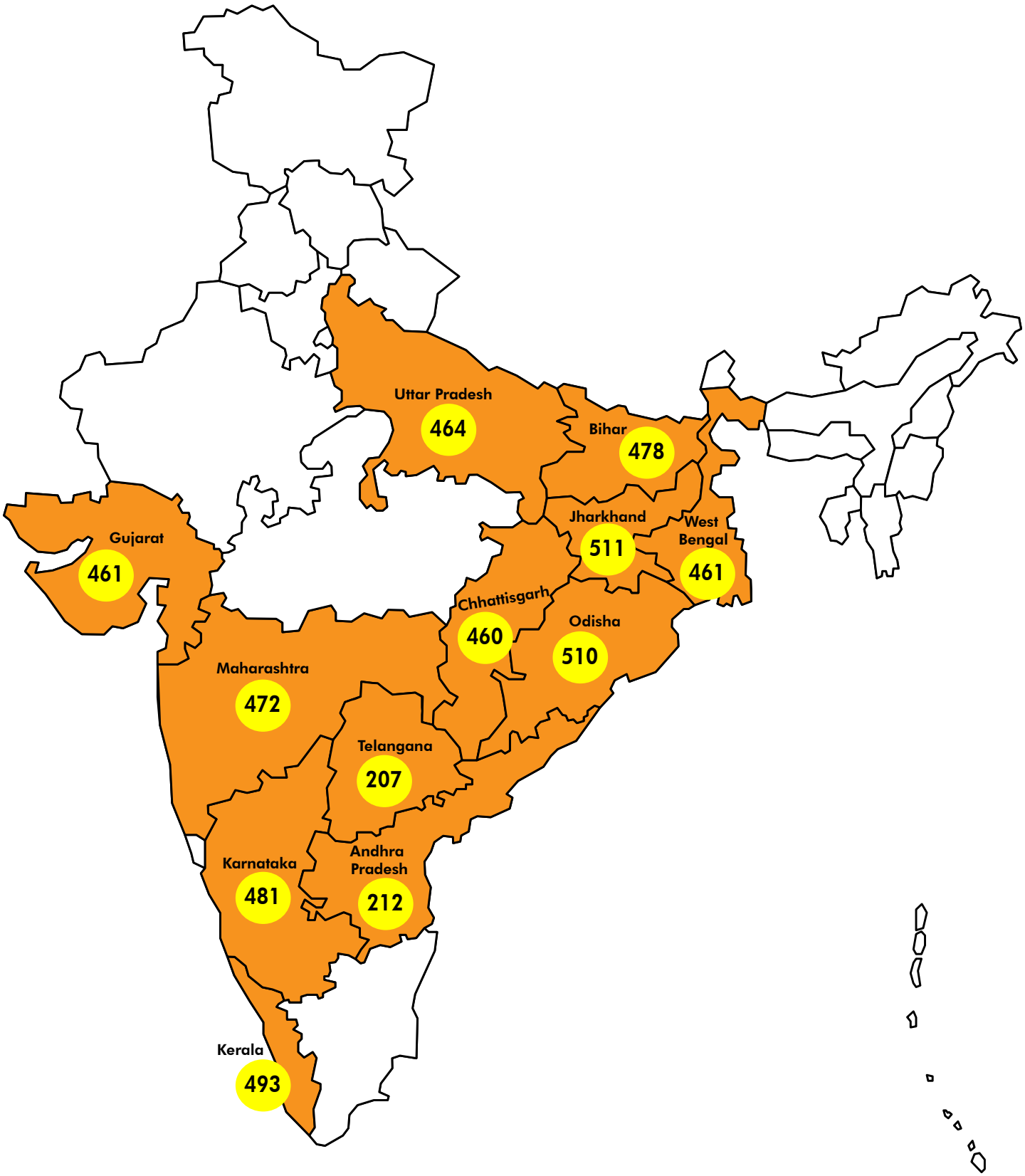
iii) Government and Non-Government Officials who closely worked in villages during the pandemic (ASHA Worker, Medical Officers of PHC/CHC/Taluk Hospitals etc.)

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 1924 samples against the targeted sample size of 1796.

Geographical Coverage/Assessment Area:

The study was carried out in the states of Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Kerala Maharashtra, Odisha, Telangana, Uttar Pradesh, and West Bengal.

Sample Distribution in 12 States



General Profile of the Respondents

The sample size varied from the highest number of 511 in Jharkhand to the lowest size of 207 from the state of Telangana. 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. In the case of Andhra Pradesh and Telangana, the sample size was reduced to 200 per state as they couldn't complete the data collection on time due to the resignation of some staff who were doing the data collection.

Figure 1: Gender Distribution of Respondents in 12 States

Among the 5210 respondents 52 per cent were male, 48 per cent were female. Though it was desired and expected of the field staff to reach out to the female population and the LGBTQ+ more, it wasn't possible for the field staff to realize this as in general the female population in the rural areas is more hesitant to respond. In states like Kerala, Karnataka, Jharkhand, Bihar and Gujarat female respondents were more than the male respondents.

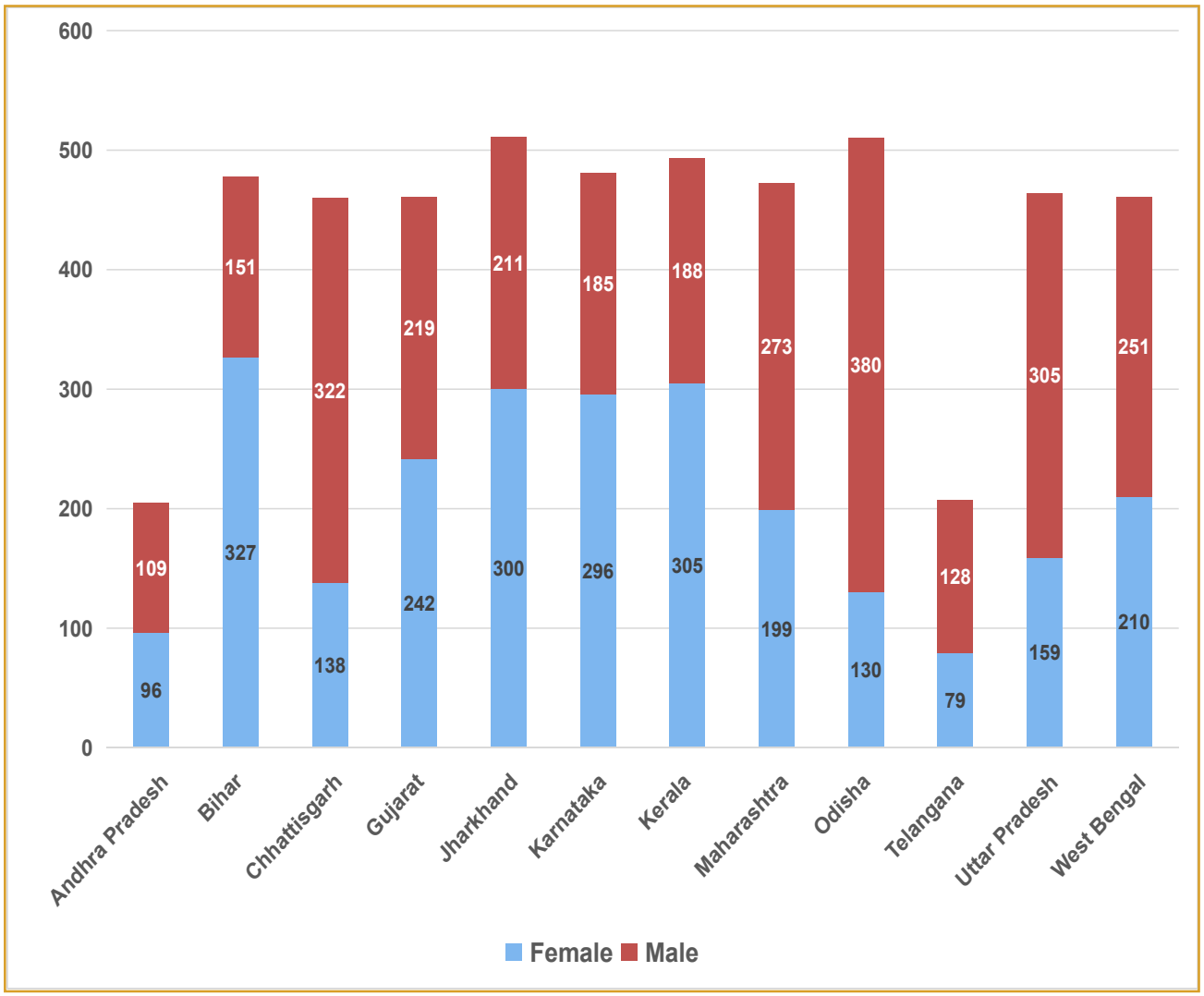
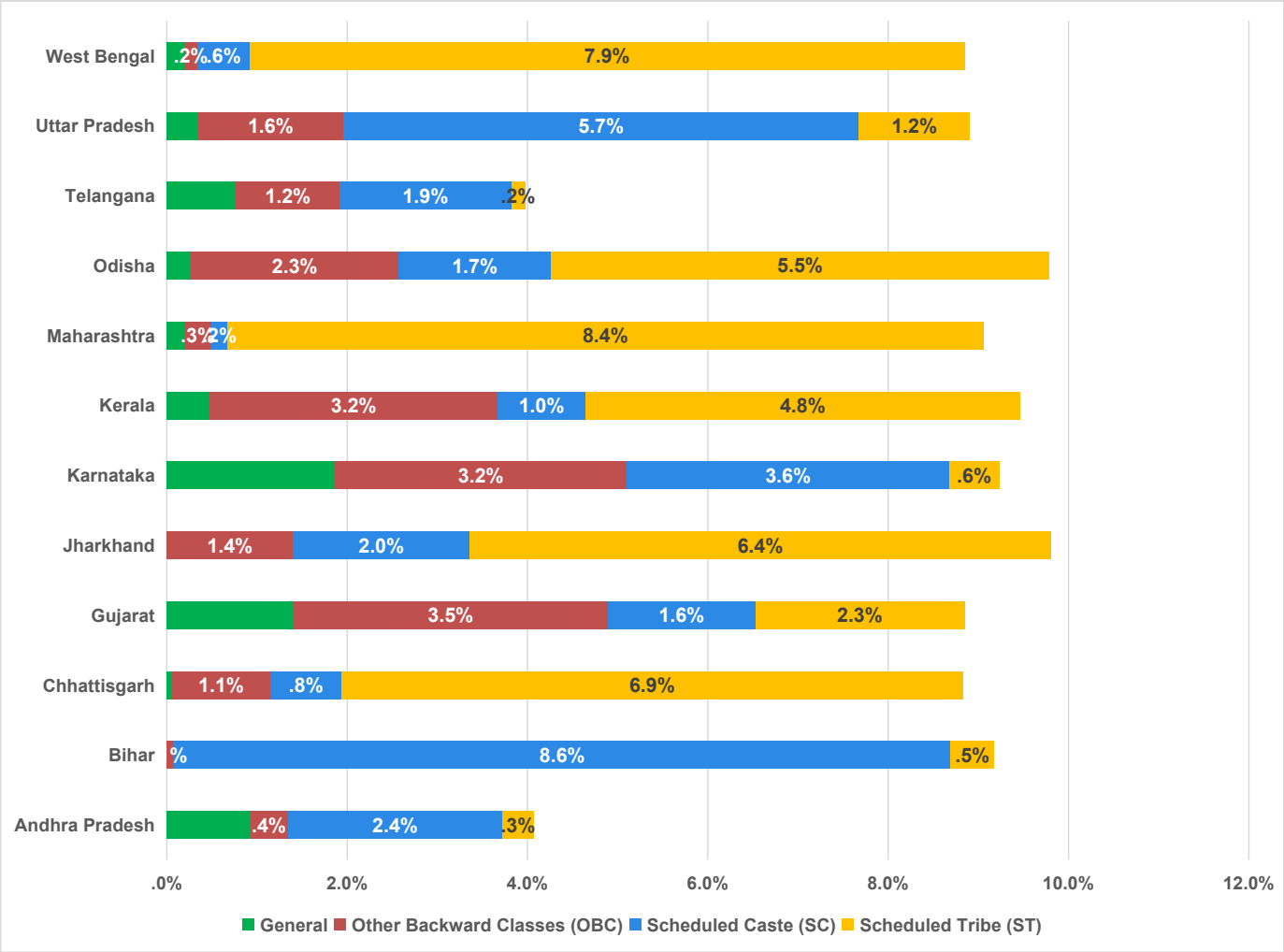


Figure 2: The Social Category of the Respondents

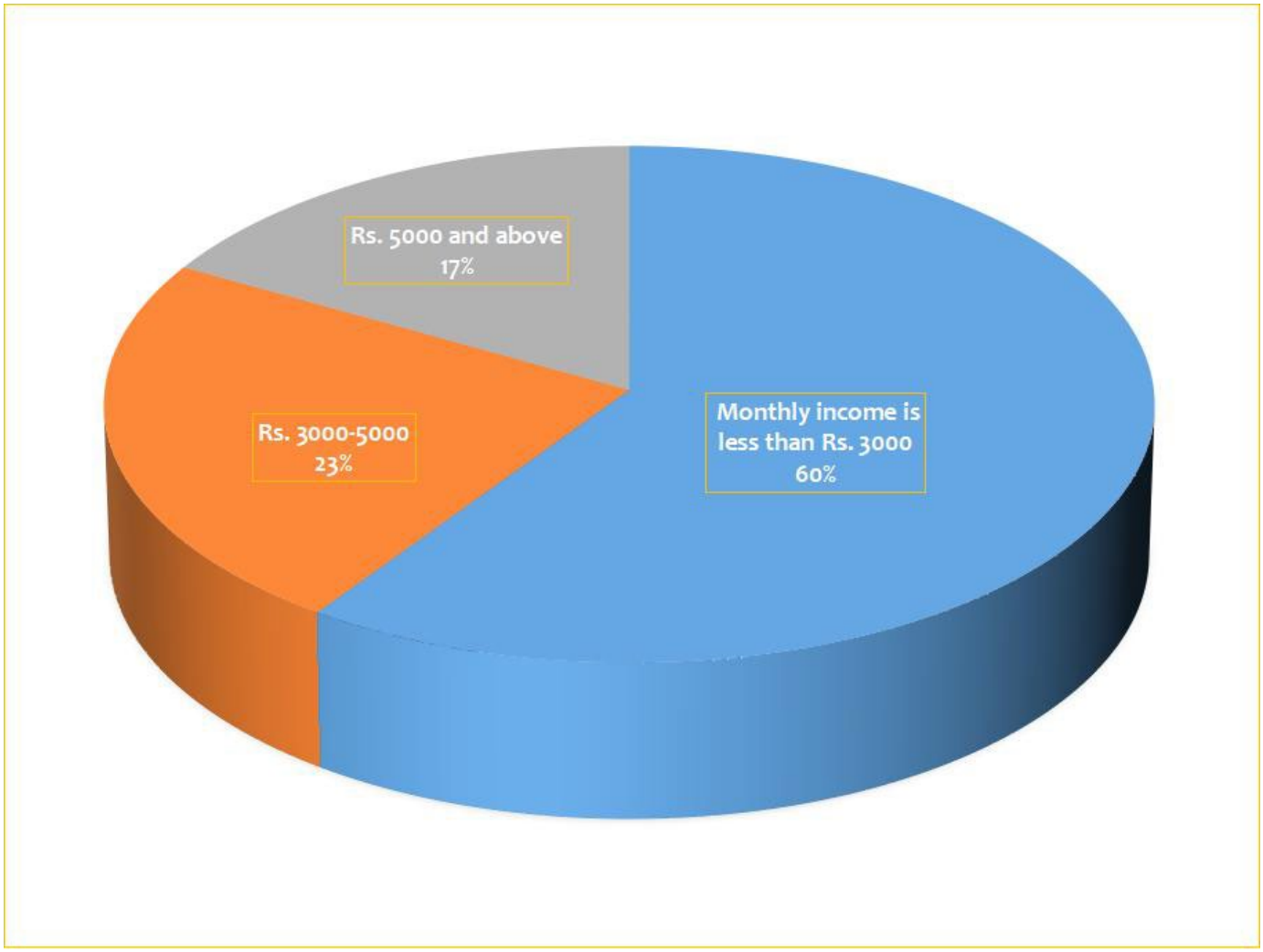
A vast majority of the respondents belonged to the SC and ST categories (75%). The respondents that belonged to ST category (45%), were predominantly from the states of Maharashtra, West Bengal, Chhattisgarh, Jharkhand, Odisha and Kerala, amounting to 88 per cent of the total ST respondents. In the states 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.



75 per cent of the respondents were from SC and ST categories.

Figure 3: Income Category of the Respondents

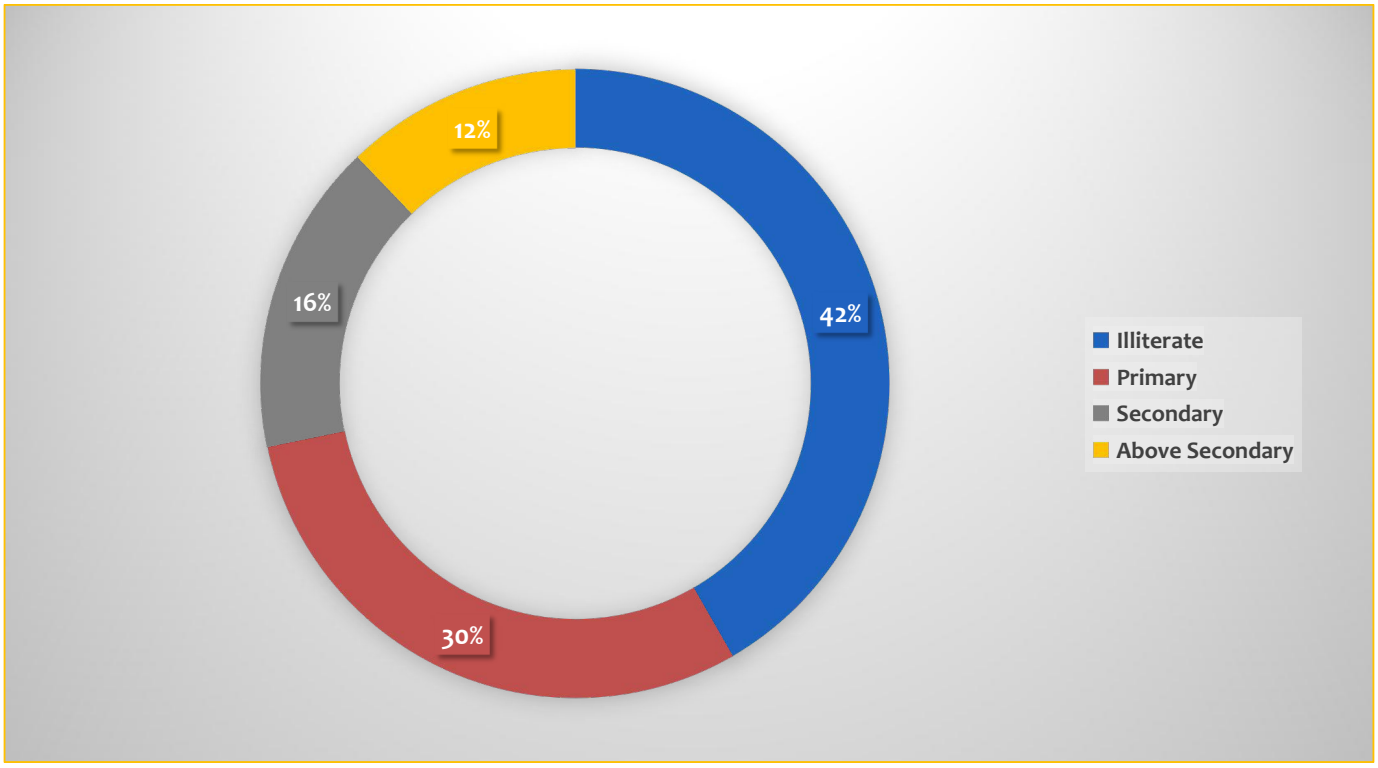
The respondents were predominantly poor, earning less than Rs 3,000 a month. Those earning less than Rs 5000 a month constituted a huge 83 per cent of the respondents. This throws light on the extent of rural poverty and how COVID-19 further impacted their lives and livelihood.



60 per cent of the respondents earned less than Rs. 3000 per month.

Figure 4: Educational Status of the Respondents

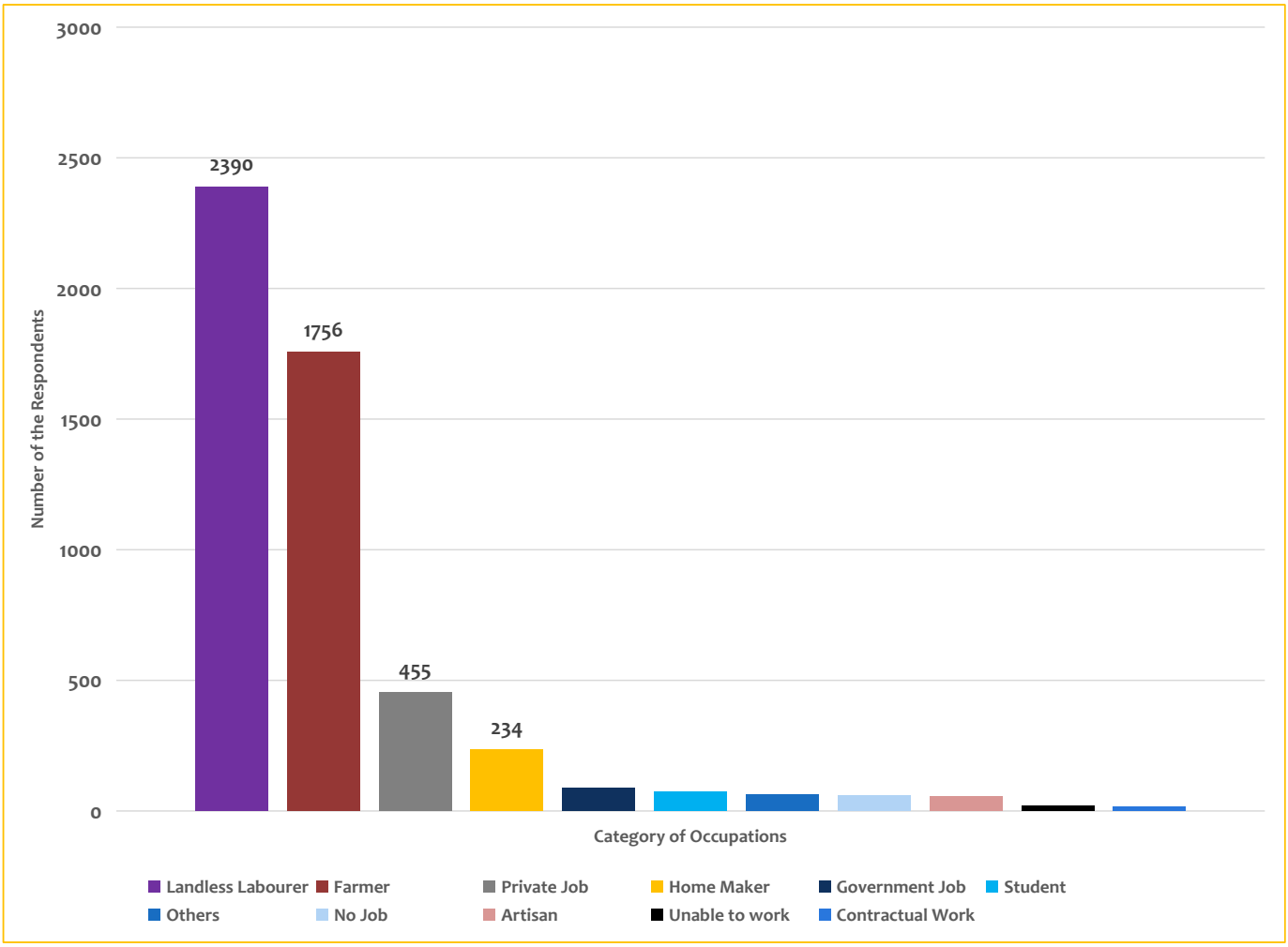
With regard to the educational status of the respondents, 42 per cent were illiterate and 30 per cent had studied only up to the primary level, (till the 5th standard). In a way, it brings to focus that there is still a sizeable rural population that is illiterate. With just about 12 per cent of the respondents having reached beyond secondary level, there is a greater need to improve the standard of the schools in rural areas.



42 per cent of the respondents were illiterate and only 12 per cent studied above secondary level.

Figure 5: Occupational Status of the Respondents

A majority of the respondents were landless labourers (46%), followed by farmers (34%), doing private job (9%) and home makers (5%). 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, totalling 58 per cent of the total farmers.



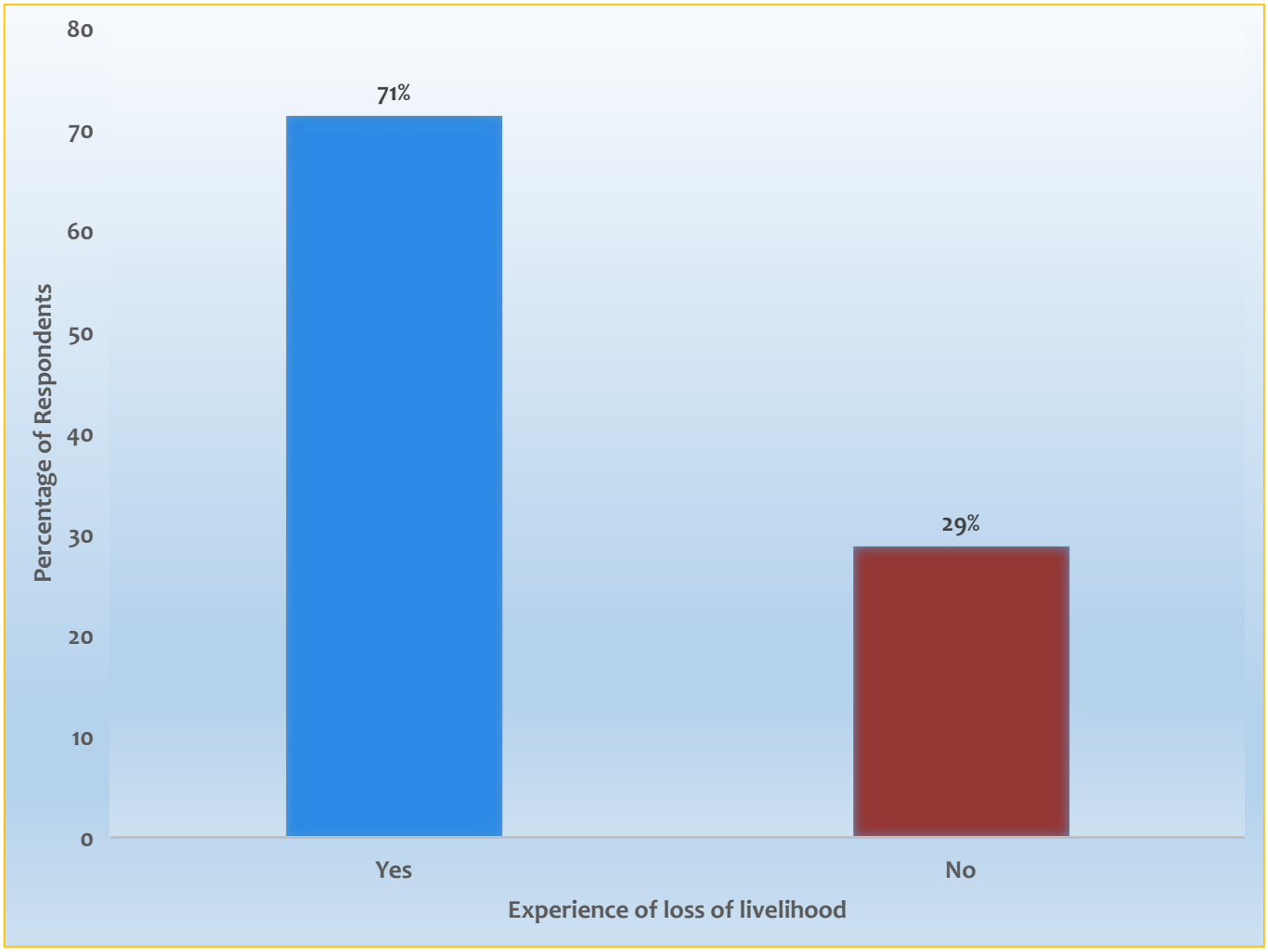
46 per cent of the respondents were landless labourers.

Impact on the Livelihood and Social Security

This section shows how the COVID-19 affected the families, how their livelihood options were impacted and what coping mechanisms they adopted to tide over the impact of COVID-19.

Figure 6: Experience of the Loss of Livelihood

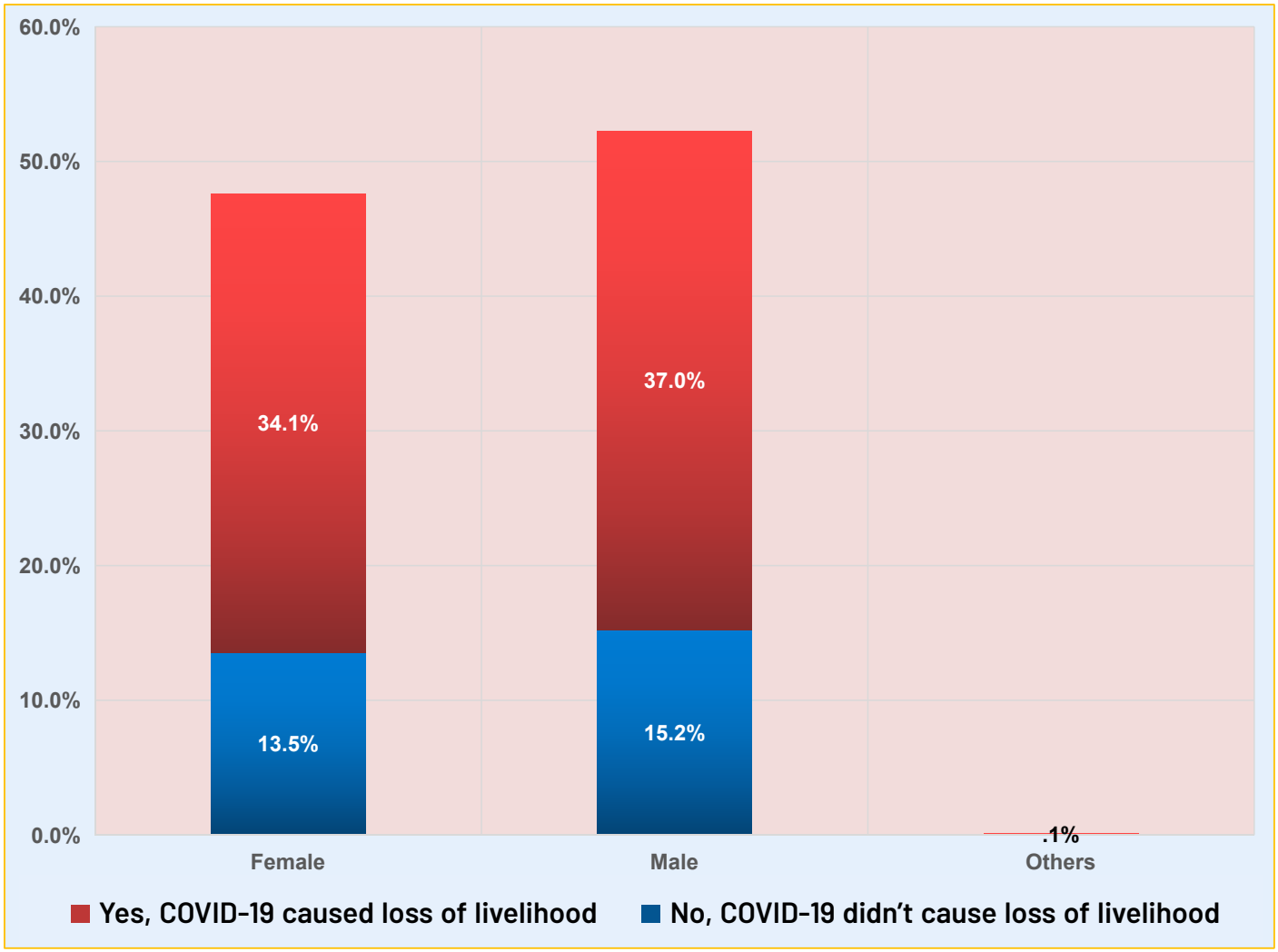
During the pandemic 71 per cent of the respondents lost their livelihood. This shows how severely the pandemic affected the rural population.



71 per cent said that they experienced loss of livelihood due to COVID-19. It greatly affected states like Uttar Pradesh, Odisha and Bihar.

Figure 7: Impact on Livelihood Options of Women

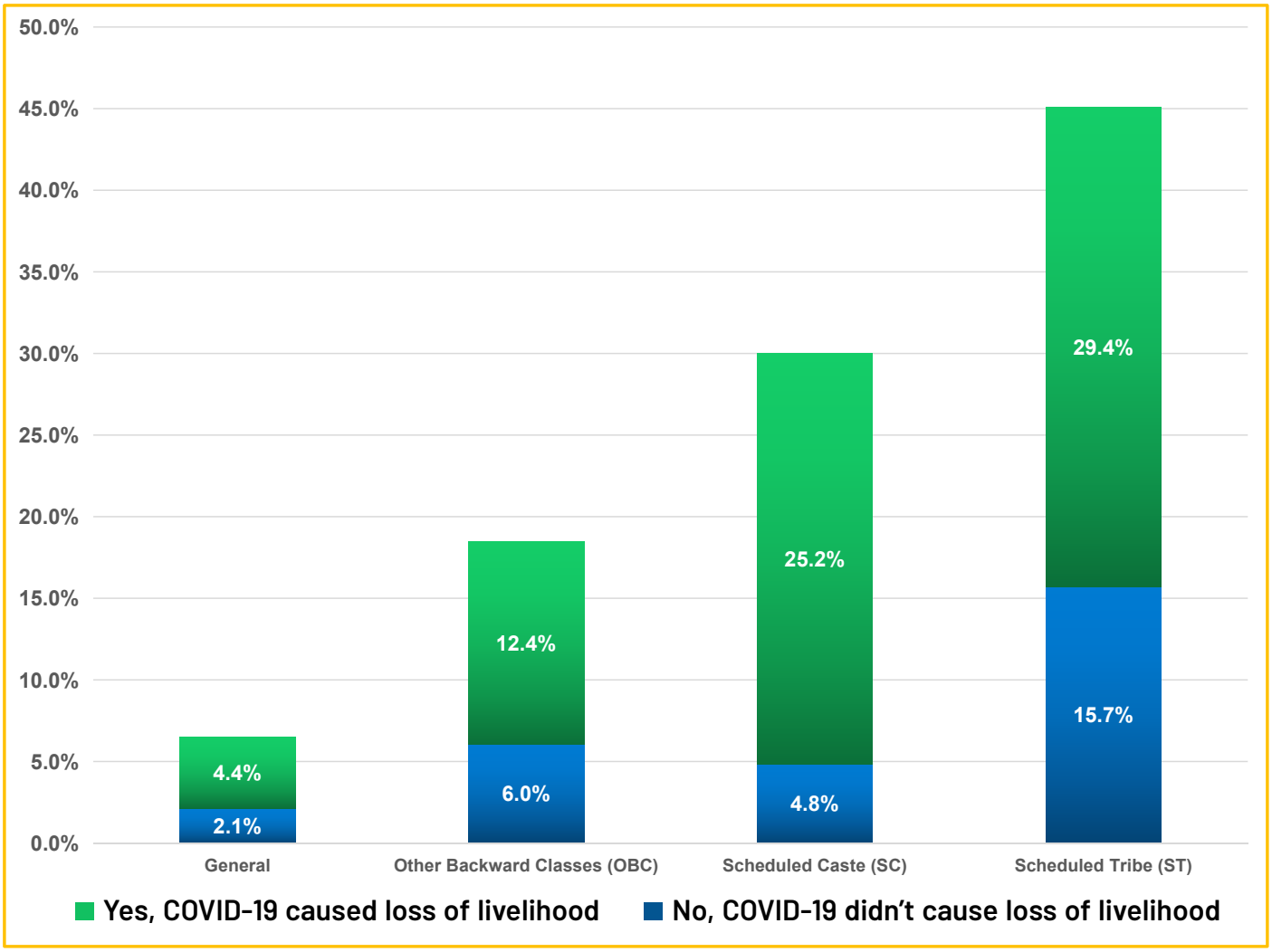
Among the 71 per cent who said that the COVID-19 caused loss of livelihood, 34 per cent of them were women. When a specific question was asked 'whether the livelihood options of women were more affected during the pandemic', 75 per cent said yes. This shows that women were more affected during the pandemic.



Among the 71 per cent who lost livelihood during the pandemic, 34 per cent of them were women.

Figure 8: Impact on the Livelihood of the Marginalized Communities

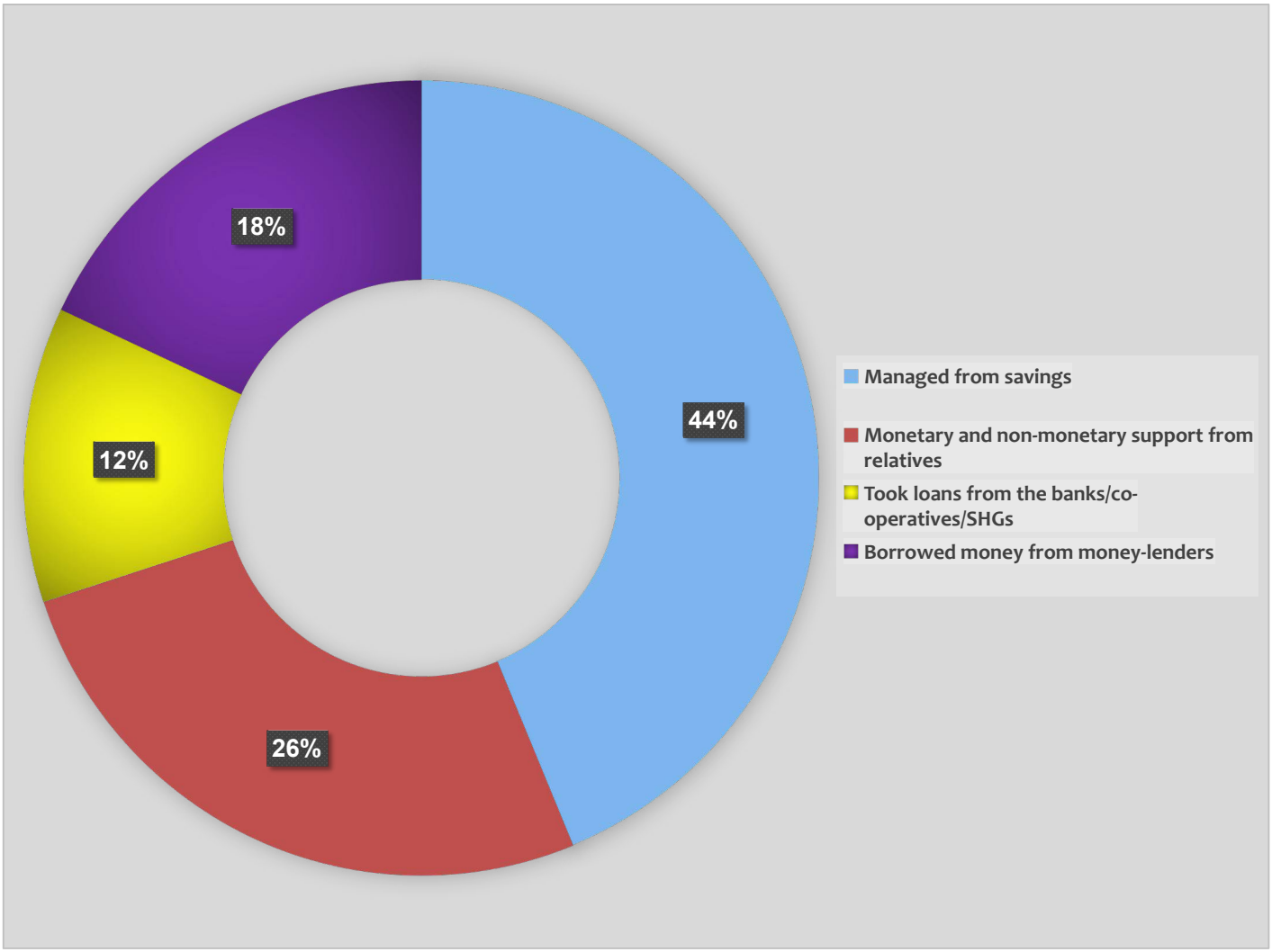
Data analysis shows that among the 71 per cent of the respondents who said that the COVID-19 caused loss of livelihood, a majority of them belonged to either SC or ST categories, with 54 per cent of them claiming loss of livelihood during the pandemic.



54 per cent of the SC and ST households lost their livelihoods.

Figure 9: Coping Mechanisms Adopted by Rural Population with the Loss of Livelihoods

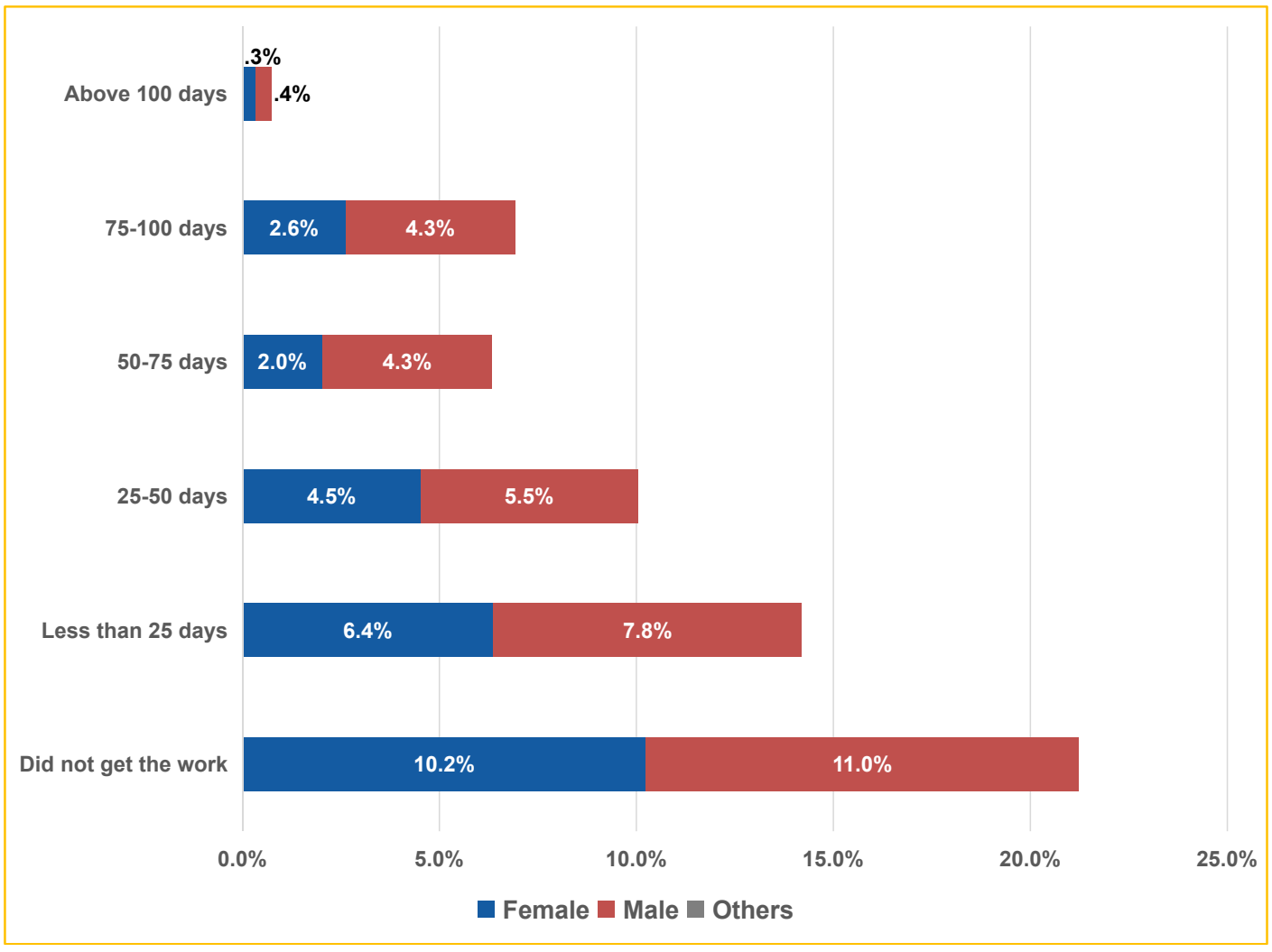
The study shows that the people in rural area adopted divergent strategies to cope with the loss of livelihoods. Some managed from their own savings (44%), others though monetary and non-monetary support from relatives (26%), a few others borrowed money from money-lenders (18%) and some others took loans from the banks/co-operatives/SHGs (12%).



44 per cent of the households could cope with the loss of livelihood through their own savings

Figure 10: Functioning of MGNREGA during the Pandemic

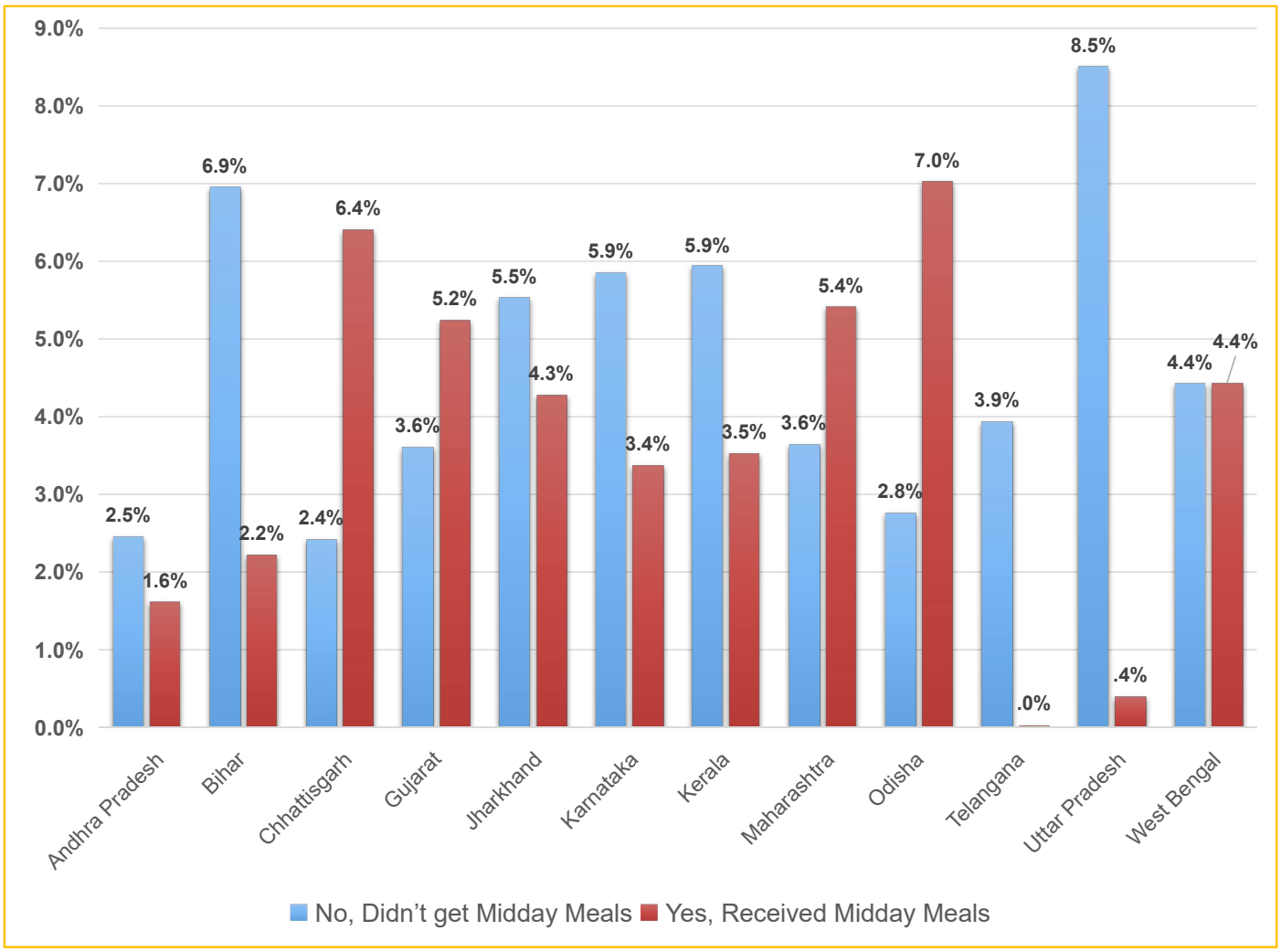
Though 59 per cent of the people claimed to possess the MGNREGA card, a large majority of them either didn't get work or got less than 25 days of work. When MGNREGA was hailed as the 'life line' during the pandemic especially with reverse migration, the data shows that the benefits were minimal for a large majority in the case study villages. 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.



21 per cent of MGNREGA card holders did not get work, 14 per cent got less than 25 days of work.

Figure 11: Availability of Mid-day meals in the schools during COVID-19

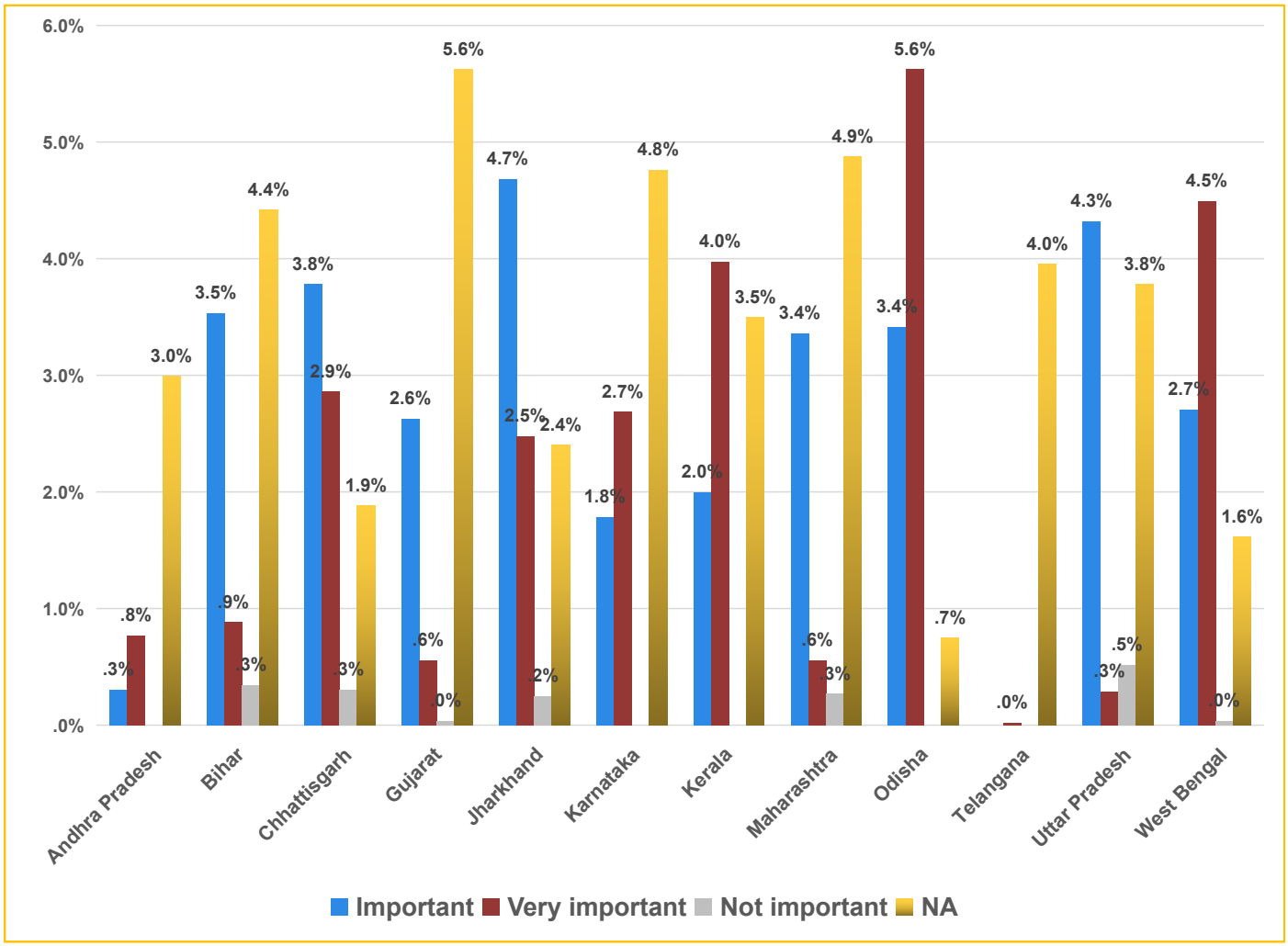
With regards to the availability of midday meals in the schools, 56 per cent of the respondents said that their children didn't receive midday meals through the school during COVID-19. As the figure shows, the percentage of those who didn't get midday meals through the schools was more in the states of Uttar Pradesh and Bihar.



56 per cent of the respondents said that their children didn't receive midday meals in the school during COVID-19.

Figure 12: Importance of PDS for your family during COVID-19

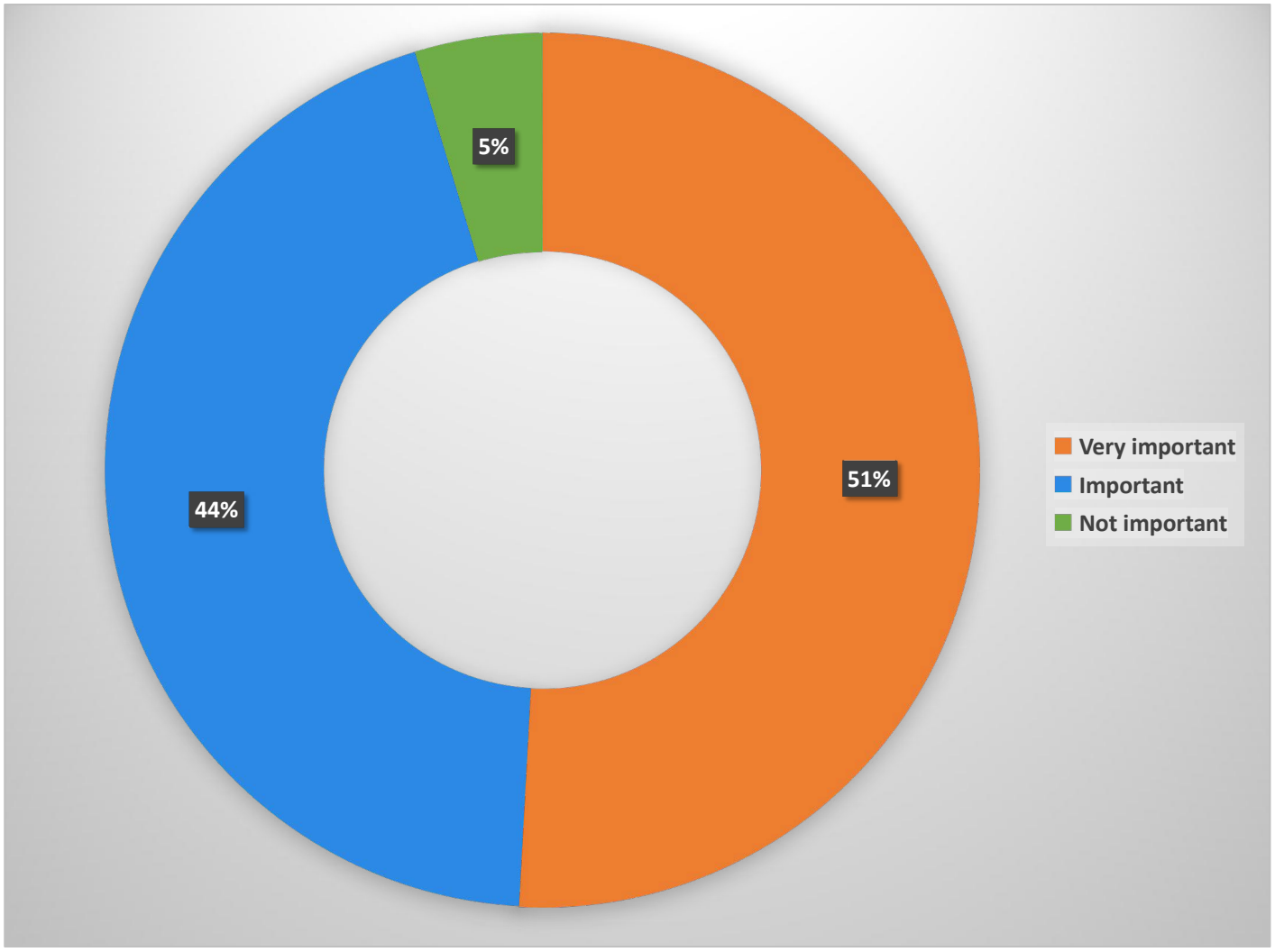
When the respondents were asked about the importance of PDS during the COVID-19, 33 per cent said that it was important for their family and 25 per cent said it was very important for their family during the COVID-19.



58 per cent of said that PDS was important for their family during COVID-19.

Figure 13: Perception of Stakeholders on the Importance of Social Security Schemes During COVID-19

51 per cent of the stakeholders confirmed that social security schemes such as Job Guarantee Schemes (MGNREGA/Public Distribution System (PDS)/ any other schemes) were very important for peoples' welfare during COVID-19, 44 per cent of the respondents also accentuated that these schemes were important to minimize the impact of COVID-19 among the rural population.



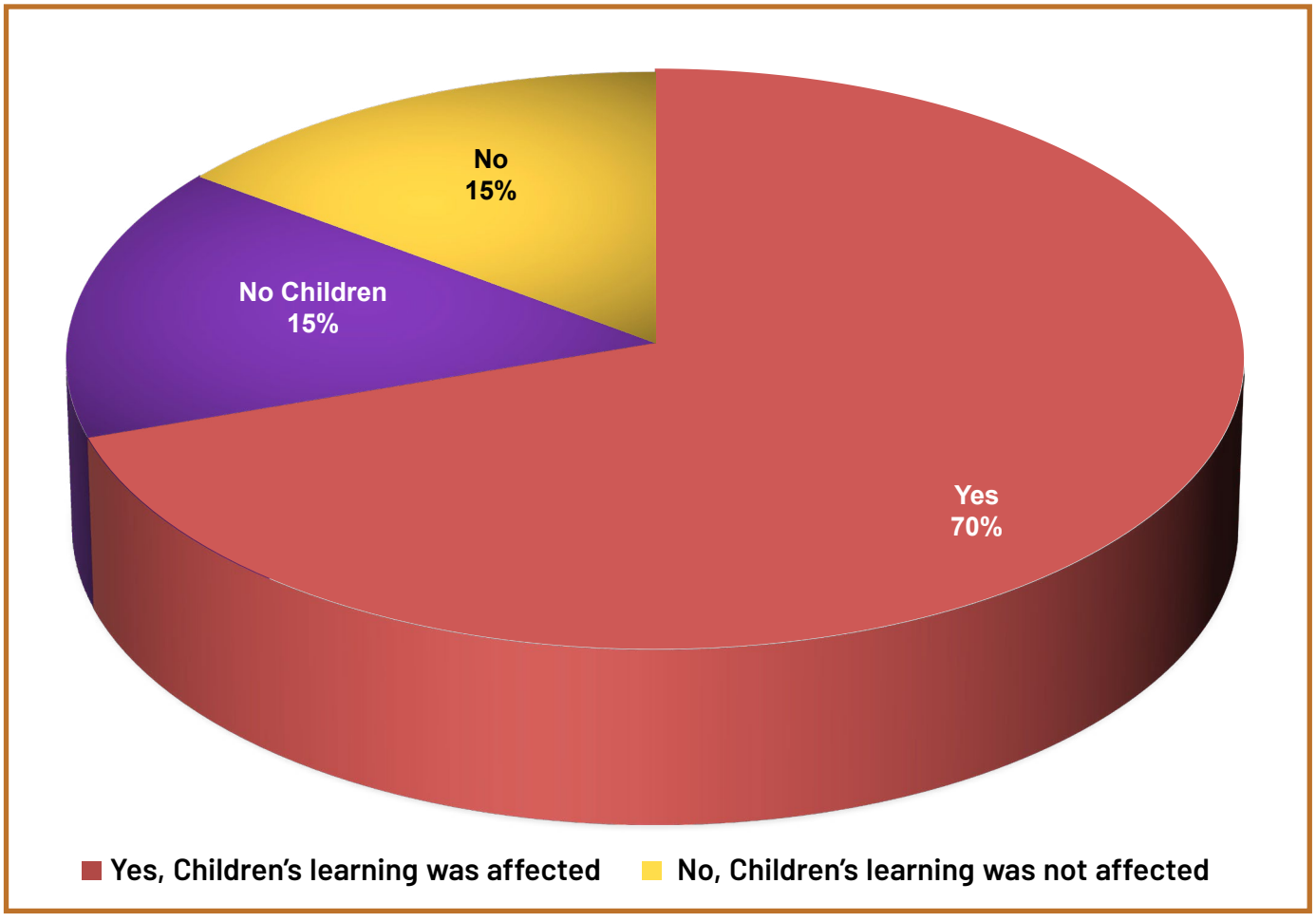
95 per cent of the stakeholders said that social security schemes were either important or very important.

Impact on the Children

A lot of studies (UNICEF, Save the Children, Indiaspend.com to name a few) 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.

Figure 14: Children facing Problems in their Learning

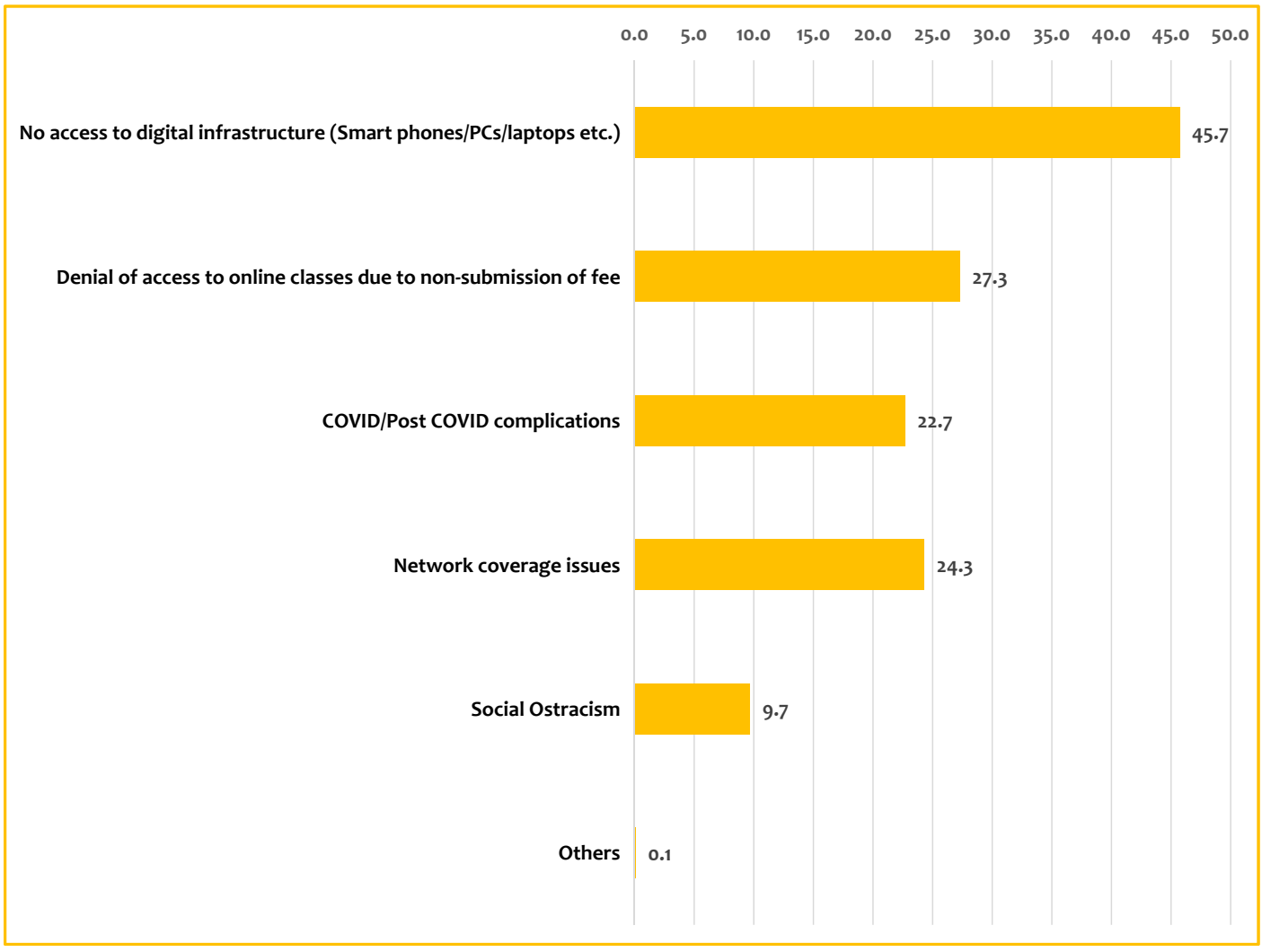
Overall, 70 per cent of the respondents revealed that their children faced problems in learning during the pandemic. It shows how disproportionately the COVID-19 affected the children's learning in rural India.



70 per cent of the households said that their children faced problems in their learning during the pandemic.

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

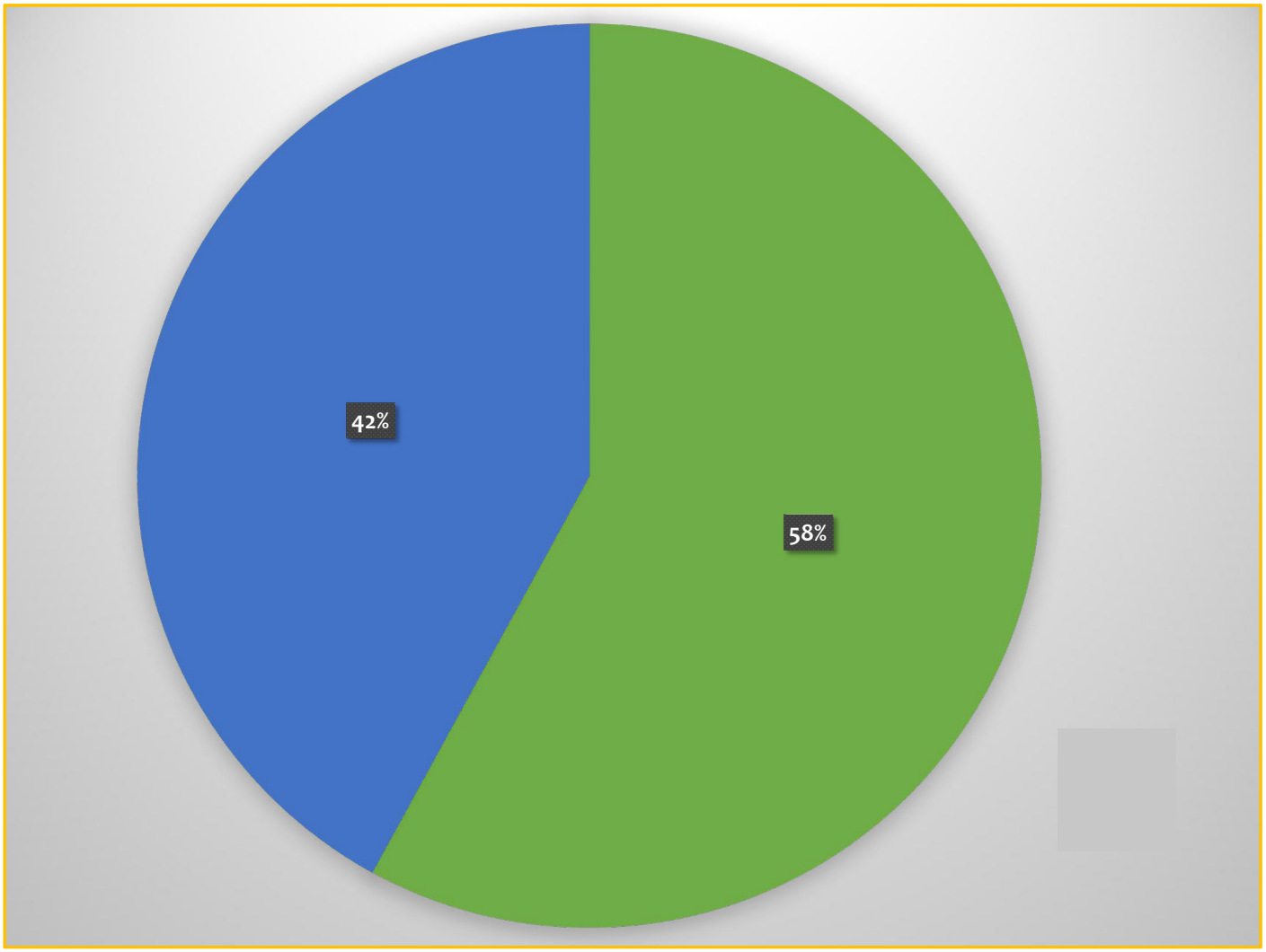
70 per cent of the respondents indicated that their children faced problems in their learning. Among the responded families, 46 per cent of the families revealed that they could not learn/ attend the classes due to no access to digital infrastructure (Smart phones/PCs/laptops etc.). It was seen from the data that 27 per cent of the families reported that their children could not access online classes due to non-submission of fees.



46 per cent felt that non-access to digital infrastructure affected their children's learning.

Figure 16: Perceptions of School Staff on the Impact of COVID-19 on Children's Education

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



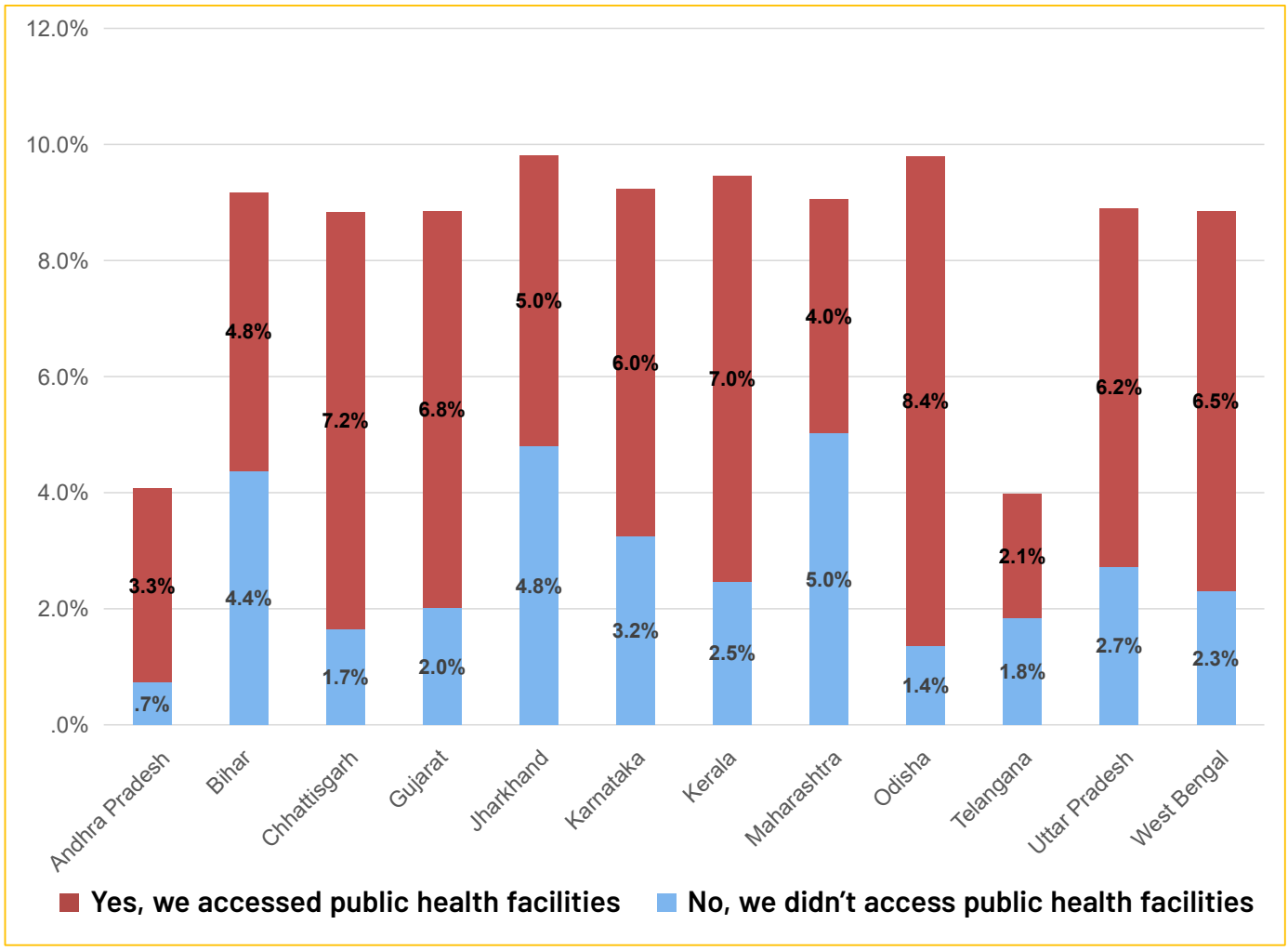
58 per cent of the school staff said that the children in rural areas couldn't attend the classes via online mode regularly

Health Impact of COVID-19 in Rural India

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.

Figure 17: Accessing Public Health Facilities

A large majority of people (67%) had accessed the public health facilities in the last one year. This shows how the rural population still relies on the public health institutions. As per the NFHS 5 data, the all-India average of the proportion of households who generally go to public sector when someone gets sick is 50 per cent. Among the 67 per cent of the respondents who visited the public health facilities, a majority 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.

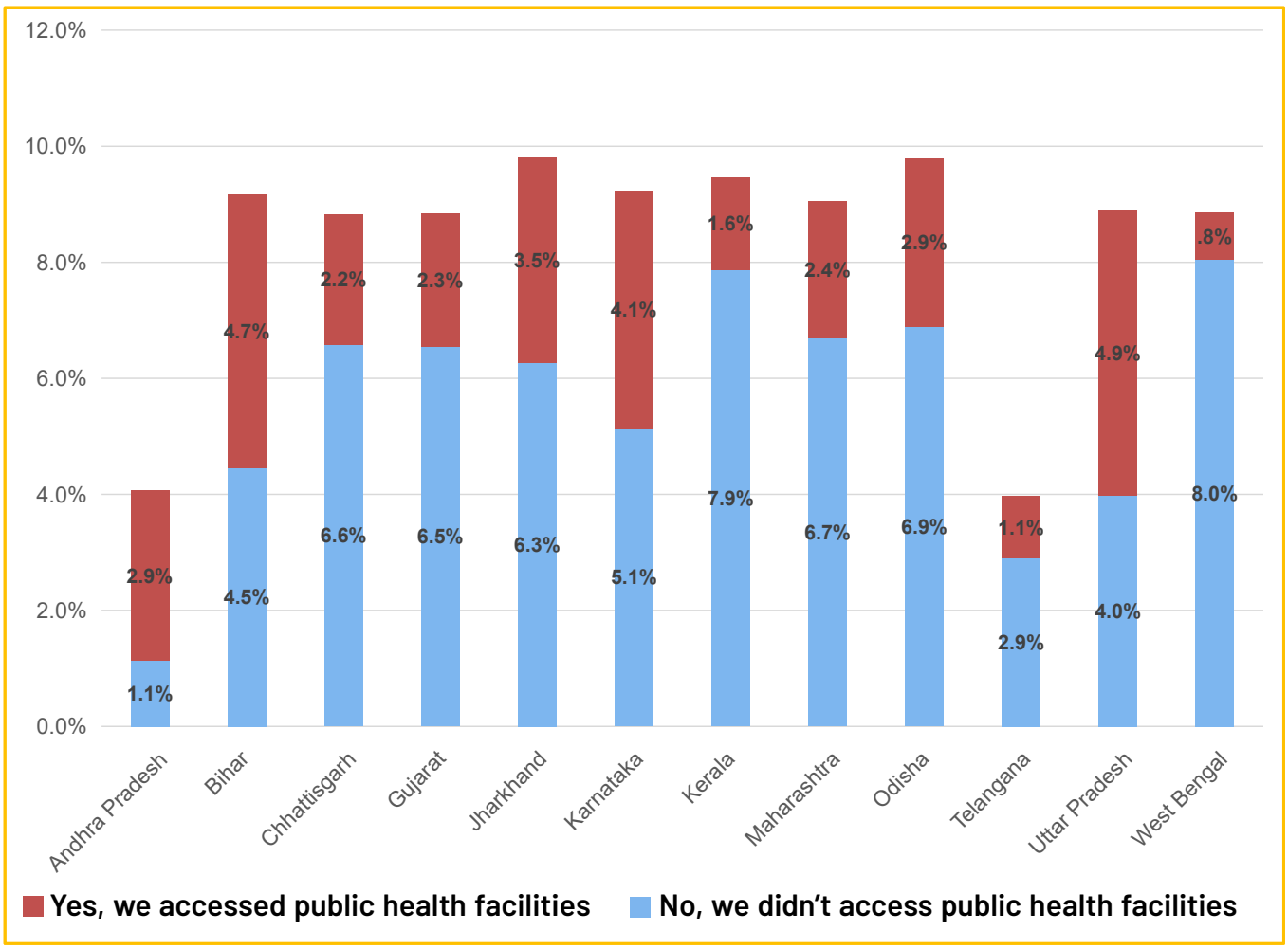


67 per cent of the respondents had accessed public health facilities.

Figure 18: Percentage of people who accessed private health facilities due to inadequacies in the public health facilities

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.

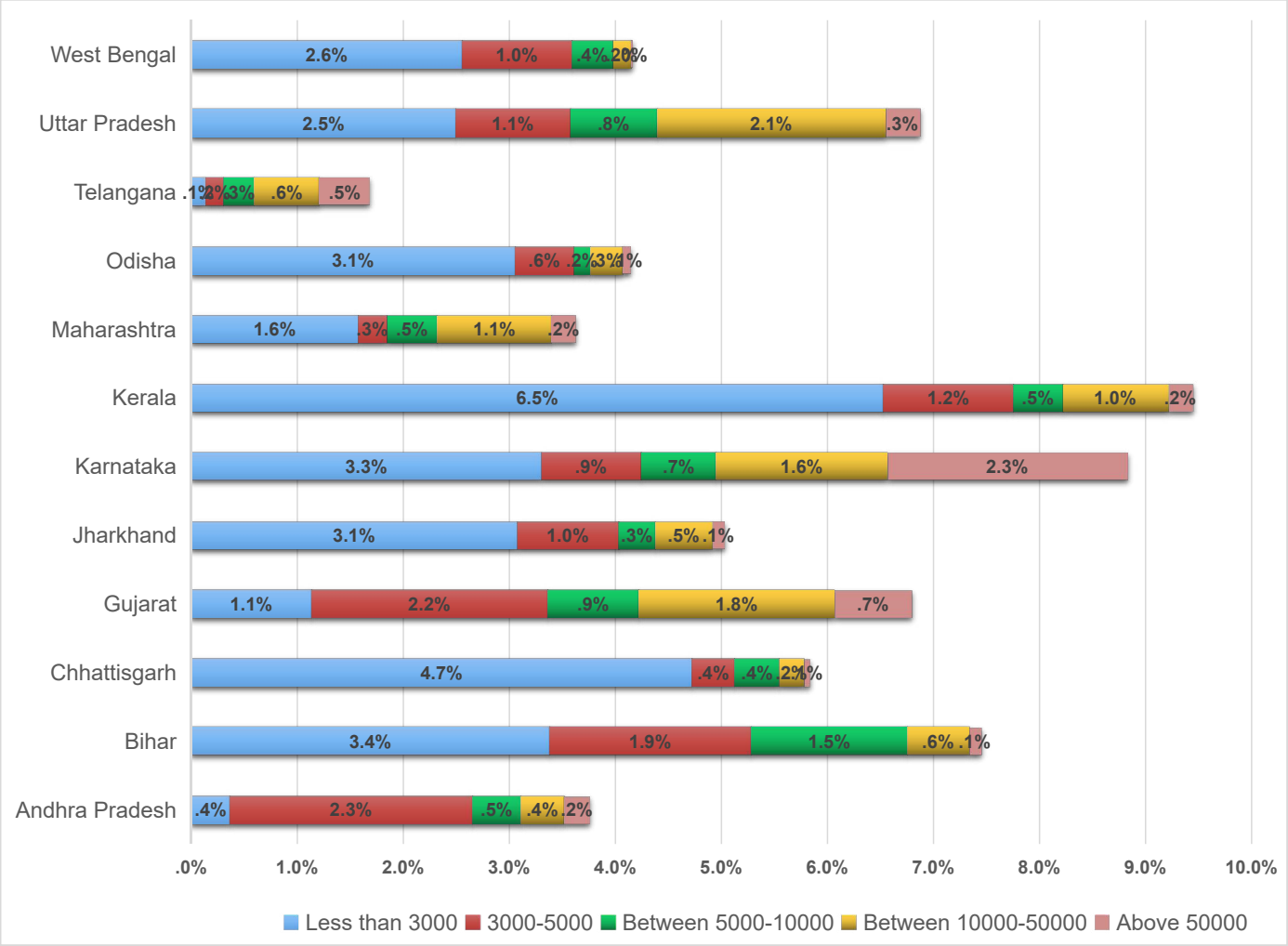
As evident from the following figure, the percentage of people who were forced to visit private health facilities was more in the states of Uttar Pradesh and Bihar.



34 per cent said that the inadequacies in the public health facilities forced them to visit private health facilities, mostly from state of UP and Bihar.

Figure 19: Expenditure on COVID related Treatment across the 12 states

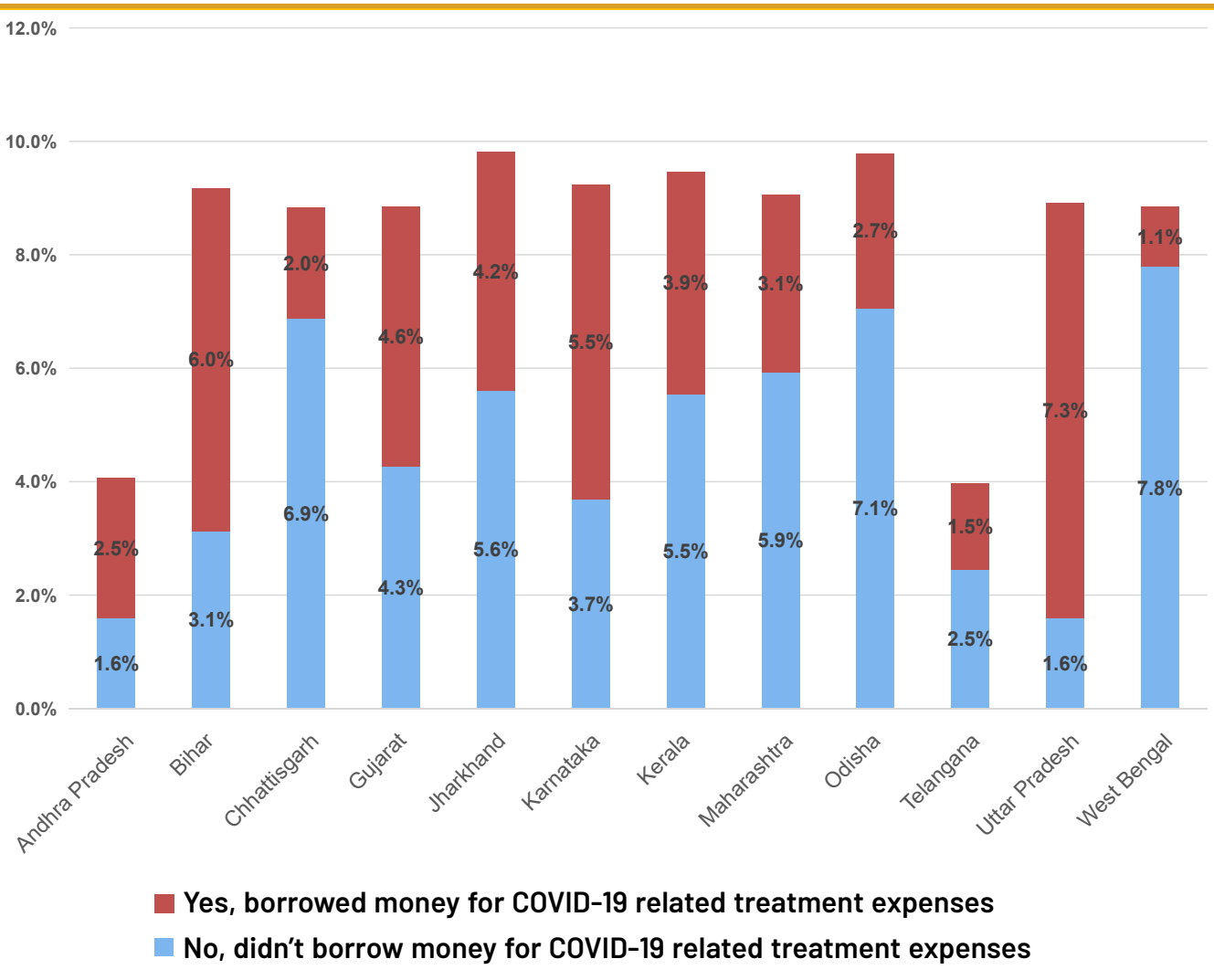
With regard to the expenditure on COVID related treatment, most of the states, led by Kerala, spent less than Rs 3000. But this needs to be seen against the income status of the respondents, where 60 per cent of the respondents earned less than Rs 3000 per month. Even this amount, seemingly low, would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



32 per cent of the respondents spent above Rs 5,000 on COVID-19 related treatment, 25 per cent spent above Rs 10,000 on COVID-19 related treatment.

Figure 20: Borrowing for COVID-19 related treatment expenses

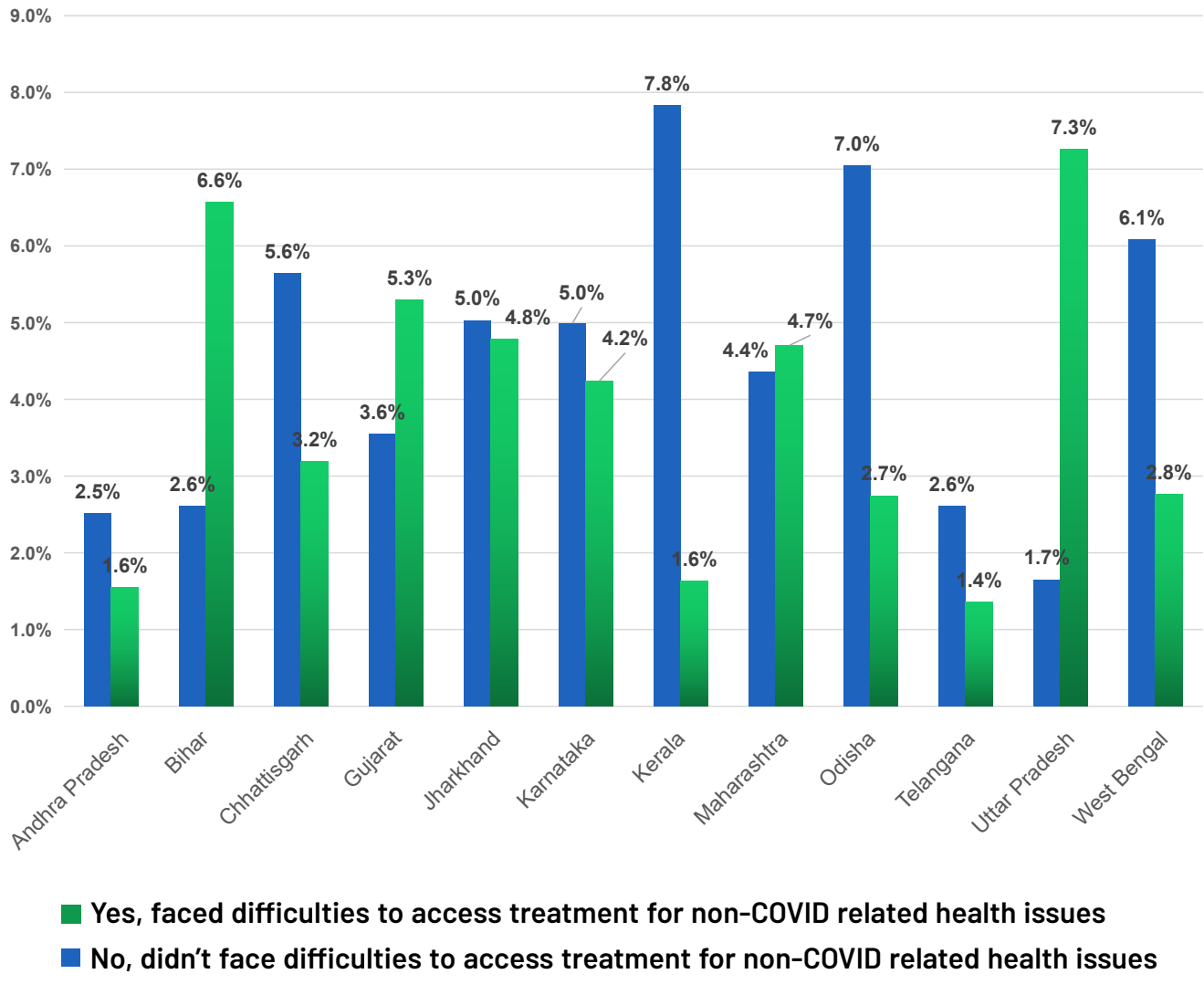
As evident from the following table, a lot of people were forced to borrow money to cover their COVID related treatment expenses. These were predominantly from the states of Uttar Pradesh, Bihar, Karnataka, Gujarat and Andhra Pradesh.



45 per cent said that they had borrowed money for COVID-19 related treatment.

Figure 21: Access to Treatment for Non- COVID Health issues

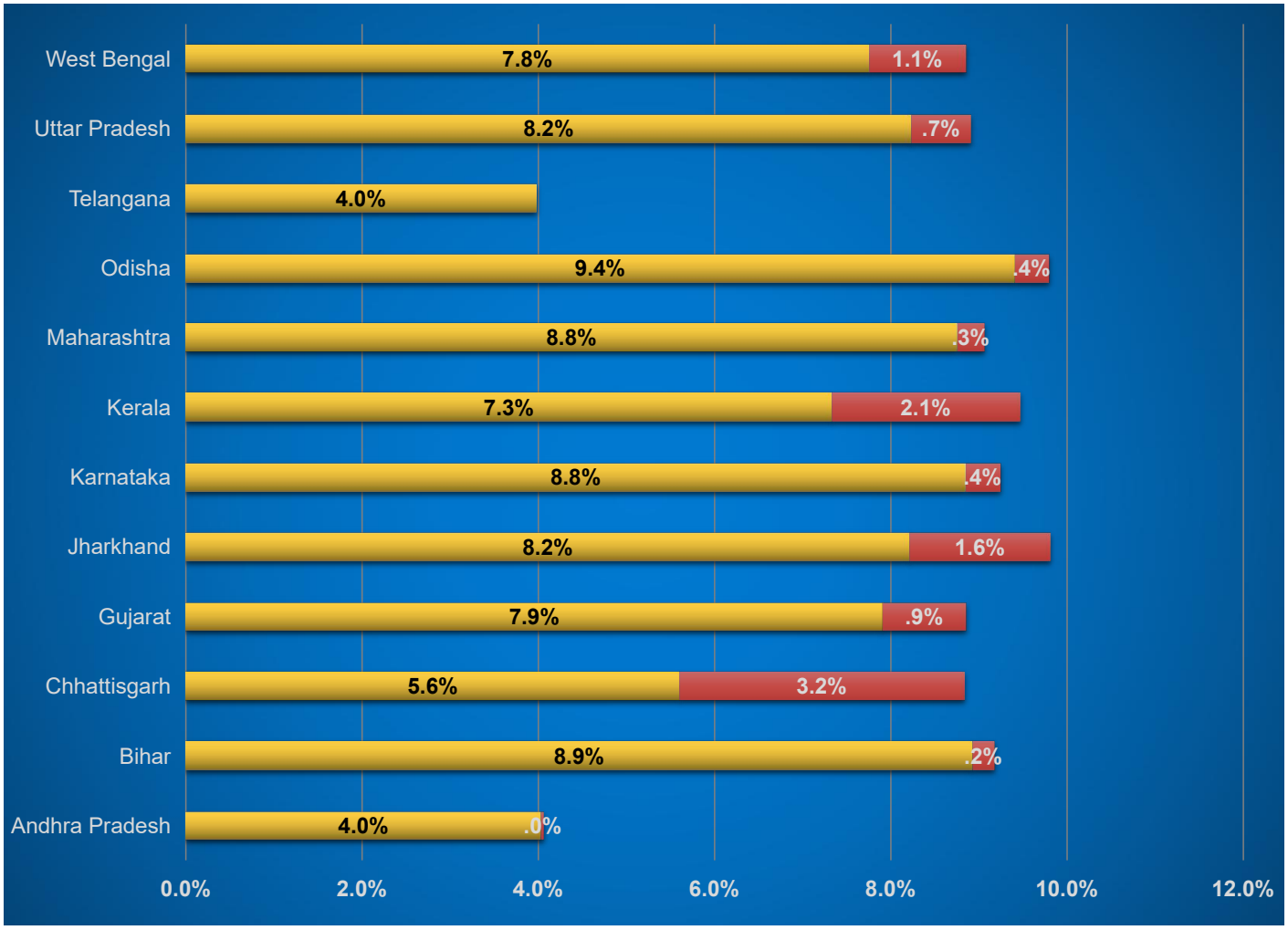
46 per cent of the respondents faced difficulties in getting treatment for non-COVID related treatment, who were primarily from the states of Bihar, Uttar Pradesh, Gujarat and Maharashtra.



46 per cent of the respondents faced difficulties in getting treatment for non-COVID related treatment

Figure 22: Availing of Health Insurance Scheme during COVID-19

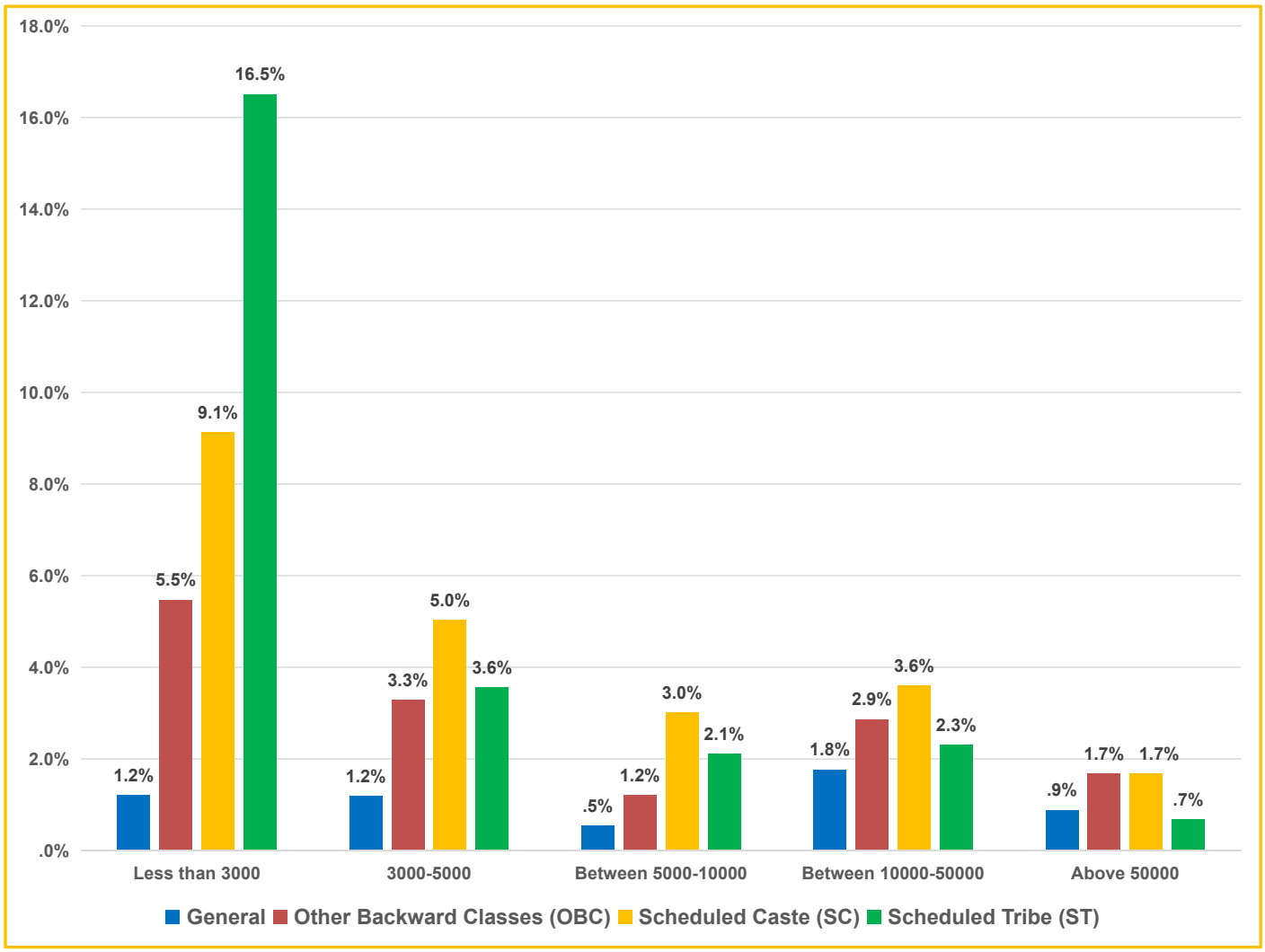
As evident from the following figure, a large number of respondents weren't able to avail any health insurance. If only the health insurance was available and easily accessible to these rural people, their burden on health would have been much lower. Only in the states of Chhattisgarh and Kerala the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



Only 11 per cent of the respondents had availed health insurance, predominantly from states like Chhattisgarh and Kerala.

Figure 23: Spending on COVID related Treatment by the Marginalized Communities

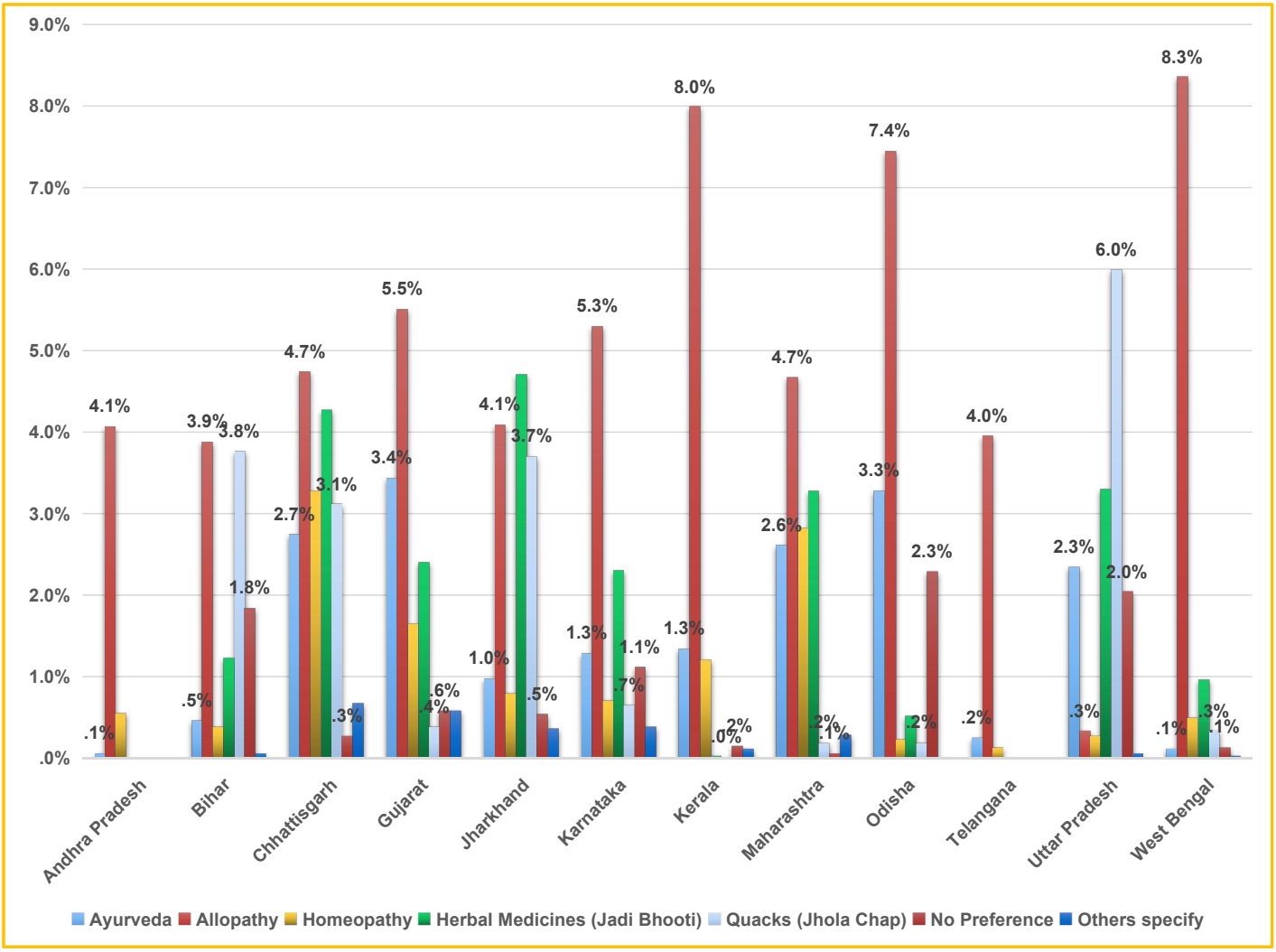
Though predominantly the spending on COVID related treatment was less than Rs 3000, it is a big amount for the rural population and more so for the marginalized groups like SCs and STs. It is observed that the expenditure has gone beyond Rs 50,000 in some cases. Among those who spent between Rs 5000-10,000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



15 per cent of the SC and ST population spent over Rs. 5000 for COVID related treatment.

Figure 24: Preferred type of Medical Treatment during COVID-19

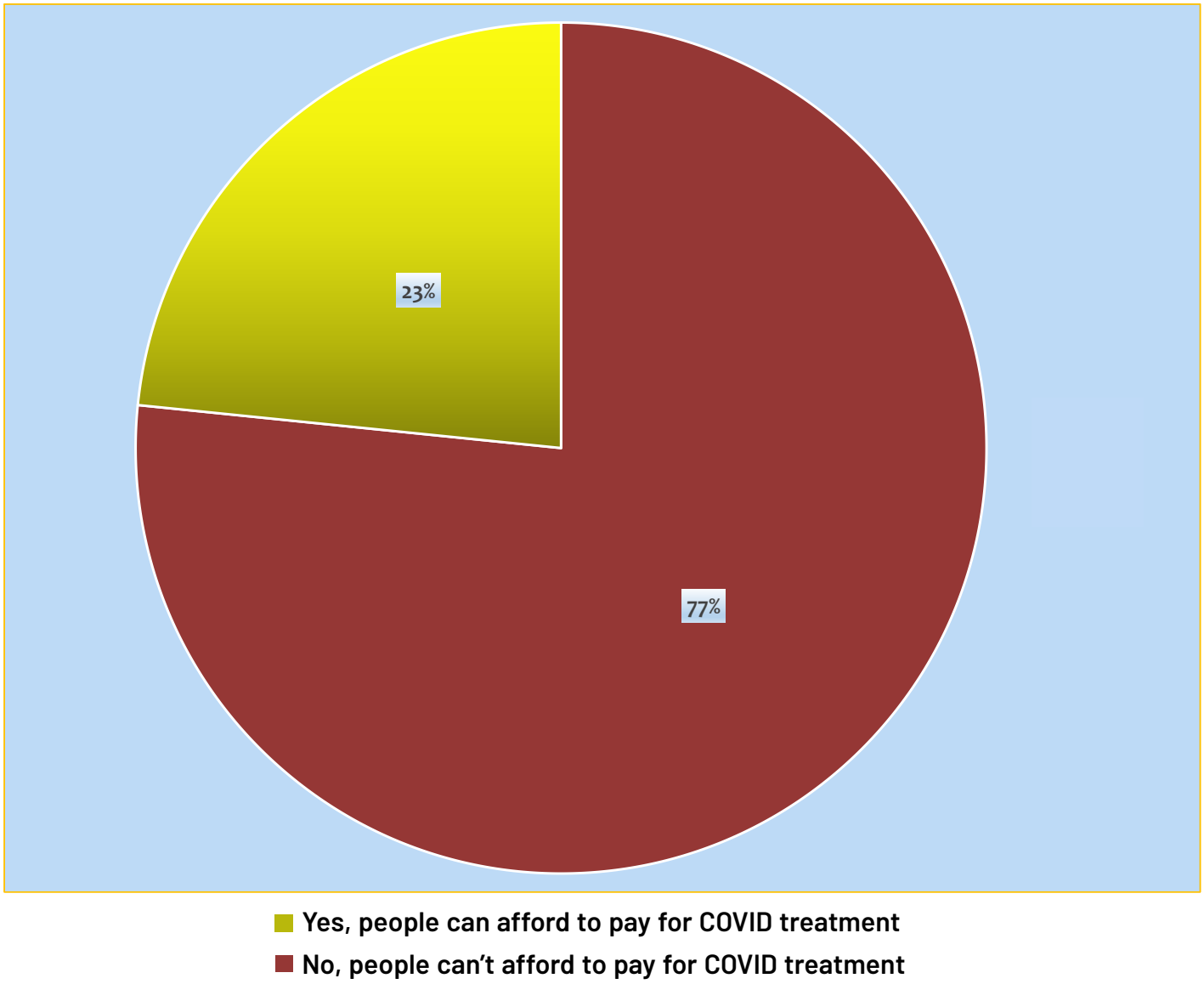
In general, there was a preference for allopathy treatment in most of the states, significantly in West Bengal, Kerala and Odisha. However, in states like Uttar Pradesh, Bihar, Jharkhand and Chhattisgarh there was a significant preference for quacks (Jhola Chap). Preference for herbal medicines (Jadi Bhooti) was high in states like Jharkhand, Chhattisgarh, Uttar Pradesh and Maharashtra.



60 per cent of the respondents opted for Allopathic treatment and 23 per cent for herbal treatment.

Figure 25: Perceptions of ASHA Workers on People's affordability to bear the Expenses for the COVID-19 Treatment

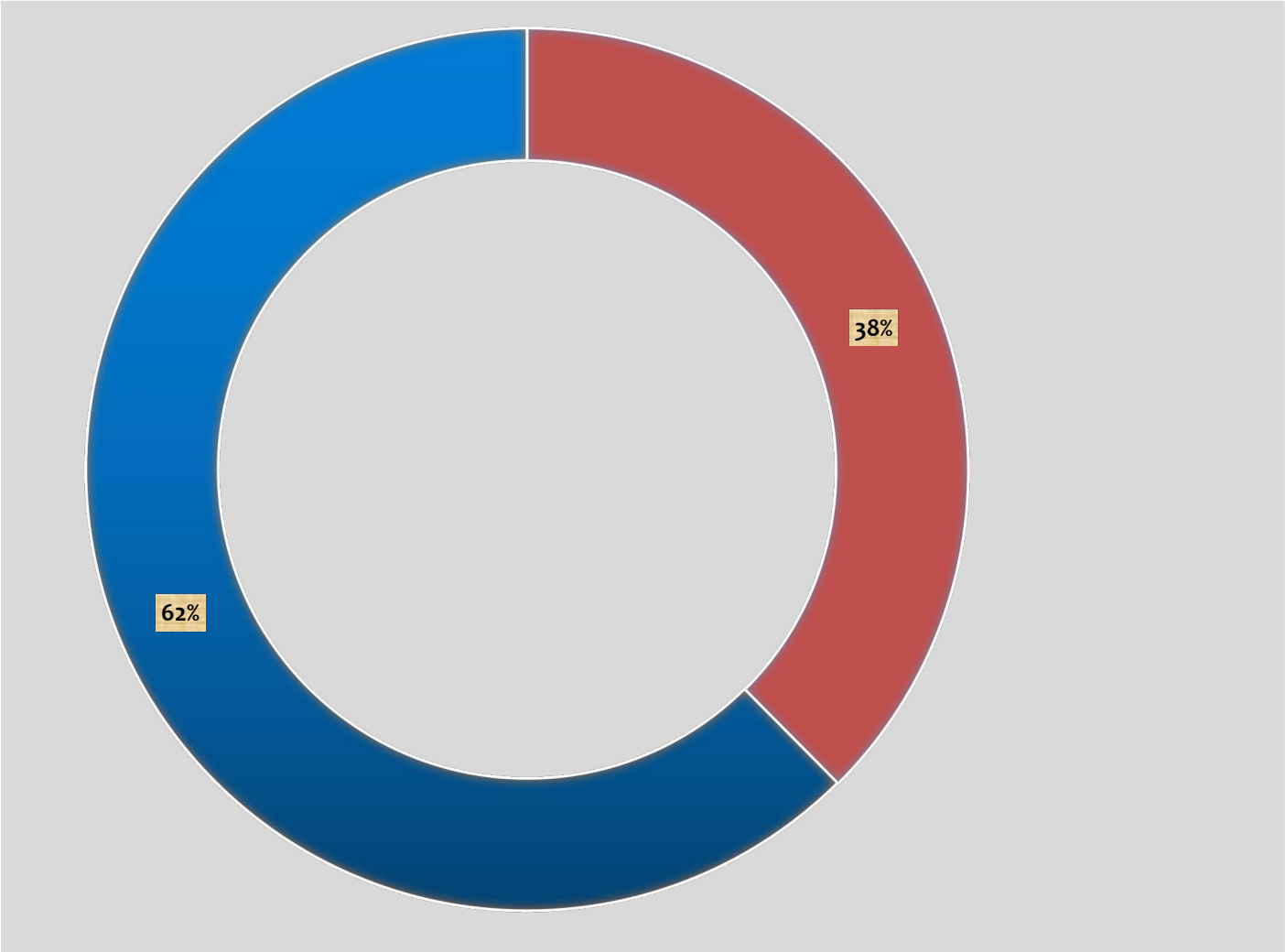
Using the data collated from the study, this fact sheet estimates that 77 per cent of the ASHA workers testified that the rural population were not able to bear the expenses for the treatment of COVID-19.



77 per cent of the ASHA workers felt that people in their area can not afford to pay for COVID related expenses.

Figure 26: Perceptions of ASHA workers on desired Facilities in Public Health Centre (PHC)/CHCs/Hospitals to treat the COVID-19 Patients

62 per cent of the ASHA workers participated in the study revealed that the Public Health Centre (PHC)/CHCs/Hospitals had desired facilities to treat the COVID-19 patients. The remaining 38 percent were not satisfied with the facilities in the respective medical care centers.



62 per cent of the ASHA workers felt that the public health institutions like PHCs/CHCs/hospitals had desired facilities.

Call for Action

- **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.
- **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.
- **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.
- **Further strengthen social security schemes like MGNREGA and PDS** 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 180 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. 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.
- **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. Timely and adequate state support would guarantee these rural women decent and dignified lives.
- **Attend to 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% illiterates) and a large number of them working as landless labourers (38 %), the linkages seem too obvious. Therefore, stepping up efforts to educate them are necessary and this is sure to reap great dividends.

Annexure

Description of the Stakeholders

Stakeholders	Frequency	Percent
Angawadi 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
NGO Head/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
Total	**1917**	**100**

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