Key Findings from UNICEF-led Rapid Assessments on COVID-19 in India

(from March 2020 to October 2020)

A Synthesis Report by the UNICEF India Country Office
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Final Draft

Contents

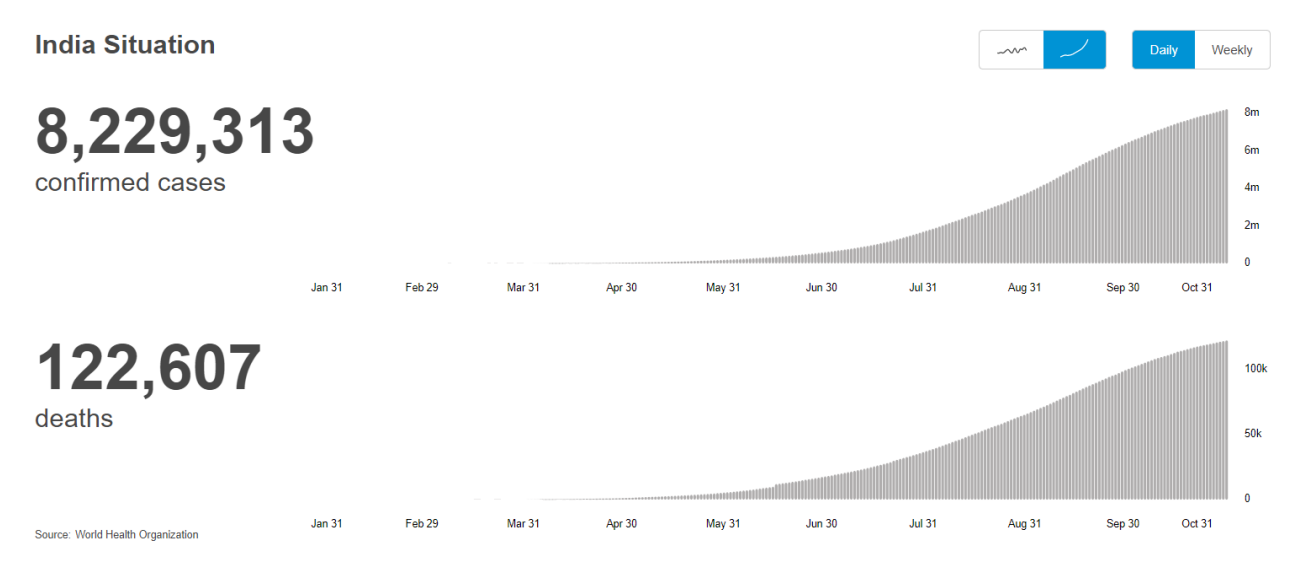
Chapter 1: Background/Context

The COVID-19 situation in India

The current COVID-19 crisis is posing an unprecedented threat to populations worldwide. In India too, vulnerable populations in particular are being adversely affected socio-economically by the pandemic in multiple ways.

India reported its first COVID-19 case on 30th January 2020, and numbers began to rise in late March 2020 (please see graph below). To contain the spread of the COVID-19 pandemic, the Government of India imposed a complete national lockdown from March 25th to May 31st, 2020. The first phase of reopening of activities was between June 1st-30th 2020 (termed Unlock 1.0), and the second phase was between July 1st-31st 2020. This process continues till date. During these phases, state governments had the authority to issue suitable restrictions depending on the local situation.

COVID-19 cases and deaths in India, January-November 2020
(as of 3rd November 2020)



Global data/evidence suggest that the COVID-19 pandemic has exacerbated many forms of inequalities among children, adolescents, and women. These groups are UNICEF's priority population groups, given the many disadvantages they already face related to access to health, nutrition, sanitation, education, and social protection. The most affected are likely to be children belonging to already disadvantaged groups including Scheduled Castes and Scheduled Tribes as well as the urban poor.

Policy context

The Government of India has announced several COVID-specific schemes and measures to stimulate the economy and strengthen the response for social protection. The first

announcement of a relief package of INR 1.7 trillion ($22 billion) was announced on March 27th, 2020 to support the poor under the Pradhan Mantri Garib Kalyan Yojana (PMGKY). This was followed by the Prime Minister's announcement of a second stimulus package of INR 20 trillion ($ 305 billion) on May 12th, 2020. The two key components of the relief package specifically targeted for the poor cover the following:

1. Ensuring **food and nutrition** security:
   - Under the Pradhan Mantri Garib Kalyan Yojana (Prime Minister's Welfare Scheme for the Poor) about two-thirds of the population (800 million) will be covered.
   - Provision of 5 kg of wheat or rice and 1 kg of preferred pulses every month for three months free of cost, in addition to the current 5 kg allocation. This has been extended to November 2020. Distribution will be done through the Public Distribution Scheme (PDS) and can be availed in two instalments.
   - Distribution of gas cylinders (free of cost) to 80 million families under the Pradhan Mantri Ujwala Yojana (PMUY).
   - Supplementary nutrition rations for children under six, pregnant and lactating women at home, or compensatory food security allowance for 800 million poor people.
   - Extension of the 'one nation, one ration card' scheme announced in January 2020, presently adopted by 20 states in India, to the remaining states by March 2021.
   - Recognizing how important mid-day meals (MDM) are to India's children, the Central Government requested continued provision of the MDM via home delivery or cash transfers to families of eligible children during COVID-19.

2. Ensuring **income security** through direct benefit transfers and payments under the following schemes:
   - Direct benefit transfer of INR 500 per month to the Jan Dhan accounts of 200 million women for three months.
   - Increasing wages under the Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) from INR 182 to INR 202 a day to benefit 50 million families. The wage increase will amount to an additional monthly income of INR 2,000 per worker.
   - Ex-gratia payment of INR 1,000 to 30 million poor senior citizens, poor widows and poor disabled in two instalments over 3 months.
   - INR 100 per homeless person to states to feed them three meals a day in night shelters
   - Farmers currently receive INR 6,000 every year through the PM-KISAN scheme (minimum income support scheme) in three equal instalments. The government released the first instalment of INR 2,000 upfront for the fiscal year starting April 2020. About 87 million farmers are expected to benefit from this.
   - For 630,000 self-help groups (SHGs), which assist 70 million households, the government is doubling collateral-free loans to INR 200,000.

State Governments have been directed to use the welfare fund for building and construction workers. The District Mineral Fund, worth about INR 310 billion, will be used help those facing economic disruption due to the lockdown. In addition, State Governments have announced specific relief measures such as:

- Special aid of INR 1,000 per family by the State Government of Uttar Pradesh
- National Social Assistance Programme (NSAP)

- Wage compensation scheme of INR 500 per month for three months to the bank accounts of tea garden workers in Assam under the Jan Dhan Yojana.
- Education scholarship schemes in Andhra Pradesh (Amma Vodi and Jaganna Vidya Deevena)
- Prime Minister Matritva Vandana Yojana (PMMVY)

UNICEF COVID-19 response

As UNICEF India responds to the COVID-19 crisis, our efforts in understanding its short-term and long-term socio-economic impacts have also intensified. As part of its COVID-19 response, UNICEF India is working across six pillars:

1. Risk communication and community engagement (RCCE)
2. Provision of critical medical and water, sanitation and hygiene (WASH) supplies and services and improving Infection, Prevention and Control (IPC)
3. Provision of adequate health care for women, children and vulnerable communities, including case management, provision of essential routine health and nutrition services
4. Access to continuous education, social protection, child protection, and gender-based violence (GBV) services
5. Data collection and social science research on the secondary impacts on children and women
6. National and State level coordination, technical support and operational costs

UNICEF COVID-19 Rapid Assessments

As the COVID-19 crisis is dynamic and fast-changing, quick assessments or situation analyses are urgently needed to understand the situation on the ground, especially with regard to vulnerable populations, including women and children. In this unprecedented situation, there is little existing information we can rely on, and it becomes even more important to design solutions and advocate for action that is evidence-based, meeting the needs of those who are most affected.

In order to gauge the impact of the COVID-19 pandemic in India (i.e., the direct effect of the disease and the effect of its response), UNICEF offices across the country are conducting several rapid assessments.

Rapid assessments:

- provide a very **quick, reliable and accurate analysis** of a situation or intervention;
- generally, involve collecting some form of primary data (qualitative or quantitative), although secondary data is often analysed as well and used to triangulate the findings;
- are usually iterative (i.e., can involve multiple rounds or phases), and often employ approaches and methods that are practical and convenient, due to time constraints;

- are a tool to provide a preliminary understanding of the situation.

The ultimate purpose of these rapid assessments is to inform UNICEF's adaptive programming and response, and subsequently advocate with the government on policy, programme and strategy adjustment. Other objectives include identifying information and data gaps and contributing to the general evidence base on effective COVID-19 response measures.

Note that rapid assessments should be one component in a larger evidence-building strategy, where they are complemented by longer-term and more robust research and evaluations.

Purpose of this synthesis report

With the quantum of evidence that UNICEF continues to gather through individual rapid assessments, there is a need to conduct a high-level synthesis of all the evidence found. This synthesis report provides a summary of evidence from all the rapid assessments completed from March to October 2020. This constitutes 24 assessments across 11 states, two seven-state studies,[1] one six state study[2], and three national-level efforts.

This synthesis report primarily aims to inform adaptations and improvements in UNICEF's evidence generating activities in the COVID context, both internally and externally, as well as to act as guidance for future pandemic emergencies of this scale and nature. The report will be updated periodically based on new evidence that emerges.

Structure of the report

Chapter 1 presents the Background/Context of the report and **Chapter 2**, the Methodology. **Chapter 3** presents the key findings. Evidence on knowledge, attitudes and practices around COVID-19 is presented first, followed by findings on the economic impact of the pandemic. Next, findings on the provision and access to services are presented by UNICEF programme areas, i.e., health, education, nutrition/food security, social protection, child protection and WASH. Given that access to services during the pandemic has been time-specific, where relevant the evidence is also presented temporally for the past five months; i.e., during the lockdown period and for the post-lockdown period. This is followed by a discussion on the psycho-social impact of COVID-19, including on gender dynamics, social cohesion, stigma, discrimination and violence, and coping strategies. Equity dimensions such as gender, urban populations, and migrants are explicitly highlighted throughout the report.

[1] One study covers Assam, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh, and one assessment covers Andhra Pradesh, Gujarat, Maharashtra, Rajasthan, Tamil Nadu, Telangana and Uttar Pradesh,

[2] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh, Uttar Pradesh,

Chapter 4 discusses the key takeaways from the synthesis and presents some hypotheses to consider. It further identifies challenges in the evidence, including gaps in the coverage of vulnerable populations and in the relevance or completeness of findings. Programmatic implications of the findings are briefly covered along with key recommendations in the final chapter in **Chapter 5**.

Please note that all gender-specific findings have been highlighted in blue in this report.

And all equity-based findings are highlighted in green. These include findings that specifically relate to, or can be disaggregated by urban vs rural, migrants, pregnant women, mothers and children, tribal populations.

Chapter 2: Methodology

Overview of the Rapid Assessments included in this report

Findings from 24 rapid assessments, completed between March 2020 and October 2020, are synthesized in this report. The rapid assessments cover three national-level efforts, one seven-state study and 15 state-level studies, covering eleven states – Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Jharkhand, Maharashtra, Rajasthan, Tamil Nadu, Telangana and Uttar Pradesh. This report includes five rapid assessments (from India's 'unlock' phases) – one six state study[3], one seven state study[4] and three state-level studies covering two states – Maharashtra and Gujarat. For easy reference, updated information from Round 2 covering five rapid assessments are presented in red font.

Details of the 24 assessments are in the Tables below (click on the Rapid Assessment titles to access final reports)

Rapid Assessments included in the synthesis report				
	Rapid Assessment ID	**Title**	**Geography**	**Programme area**
1	205001b	(Round 2) Chhattisgarh: Rapid Assessment of the situation of children and women due to CoVID-19 Lockdown	Chhattisgarh, few districts	Health, Communication, Nutrition, Livelihoods and employment, Child protection, WASH, Social policy, Education, Cross-cutting DRR, Gender
2	205003	Key Observations and Recommendations on Relief Camps in Maharashtra	Maharashtra, few districts	Education, WASH, Communication, Health, Nutrition, Child protection
3	205004a	Rapid Assessment of humanitarian cash transfers and Gram Panchayat's capacity to support and monitor the relief measures at the grass root level in AP	Andhra Pradesh, few districts	Social policy, Nutrition, Education, Health, Livelihoods and employment
4	205004b	Rapid Assessment of humanitarian cash transfers and Gram Panchayat's capacity to support and monitor the relief measures at the grass root level in Telangana	Telangana, few districts	Social policy, Nutrition, Education, Health, Livelihoods and employment

[3] Gujarat, Kerala, Bihar, Assam, Uttar Pradesh, Madhya Pradesh
[4] Uttar Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Andhra Pradesh and Telangana

5	205009	Field Observations in Tea Estates in the context of COVID-19	Assam, 8 districts	Child protection, Education, Nutrition, Health, WASH, Communication, Social policy
6	205010	Rapid Assessment with representatives of CSOs	Rajasthan, few districts	Communication, Health, WASH, Nutrition, Livelihoods and employment, Cross-cutting Gender
7	205012	Dipstick analysis of effectiveness and efficiency of social protection measures in the state of Jharkhand: COVID-19	Jharkhand, few districts	Communication, Health, WASH, Child protection Education, Nutrition, Social policy
8	205013b	(Round 2) Assessing the immediate impact of COVID-19 among the most vulnerable in the state of Uttar Pradesh	Uttar Pradesh, few districts	Communication, Livelihoods and employment, Social policy, Nutrition, Health, Education, Cross-cutting Gender
9	205015a	COVID-19 UReport Rapid Assessment, round 1	National, All states and UTs	Communication, Health
10	205015b	COVID-19 UReport Rapid Assessment, round 2	National, All states and UTs	Communication, Child protection, Nutrition, Cross-cutting Gender,
11	205018	Response to the COVID-19 Crisis: Observations from Communities in Assam	Assam, few districts	Communication, Child protection, Social policy, Nutrition
12	205019	Rapid Assessment of Situation of Children and Women due to CoVID-19 in Bihar	Bihar, few districts	Communication, Social policy, Nutrition, Livelihoods and employment, Health, Education
13	205021	Rapid Assessment of Anganwadi Services (Take Home Ration)	Rajasthan, few districts	Communication, WASH, Health, Nutrition, Social policy
14	205023	Assessment of the Stigma and Discrimination Campaign during COVID-19	Seven states, Assam, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh	Communication, Health, Livelihoods and employment
15	205025a	Dipstick COVID 19 Situation Analysis of Maternal & Child Health Services provided by	Gujarat, Surat city	Health, Communication, Nutrition, Livelihoods

		ASHAs and AWWs in Surat City, Gujarat, India		and employment, Social policy
16	205025b	Dipstick COVID 19 Situation Analysis of Maternal & Child Health Services provided by ASHAs and AWWs in Surat City, Gujarat, India	Gujarat, Surat	Health, Communication, Education, Nutrition, Livelihoods and employment, Social policy
17	205032	COVID Adolescent Vulnerability Assessment	National, All states and UTs	Education, Child protection, Communication, Social policy
18	205033	Coverage of learning continuity during schools' closures in response to Covid 19	Gujarat, all districts	Education, Communication
19	205034	Teachers' views: Participatory review with school teachers in COVID-19 context	Tamil Nadu, all districts	Education, Health, Nutrition, WASH, Child protection

20	205002	Rapid assessment of learning during school closures in the context of COVID-19	6 states; Assam, Bihar, Gujarat, Kerala, Madhya Pradesh, Uttar Pradesh	Education, Communication, Social policy, Livelihoods and employment, Health, WASH, Cross cutting Gender, Cross cutting DRR
21	205005	Community- based monitoring to assess socio-economic impact of COVID-19 pandemic on vulnerable populations	7 states, Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh	Social policy, Livelihoods and employment, Cross cutting Gender, Cross cutting DRR, Health, Nutrition, Education, WASH, Communication
22	205016	Rapid survey in Maharashtra to understand the awareness of community and reach of relief packages announced by the government and general well-being of women and children	Maharashtra, all districts	Communication, Health, Nutrition, Education, Child protection, Cross cutting DRR, Social policy, Livelihoods and employment, Cross cutting Gender
23	205026	Situation analysis of private paediatrics and obstetric facilities in providing services during COVID-19 pandemic	Gujarat, four cities	Health, Communication
24	205035	Institutional response to Covid- 19 in rural areas: A study conducted to	Gujarat, 26 districts	Nutrition, Communication, Health, WASH, Livelihoods and

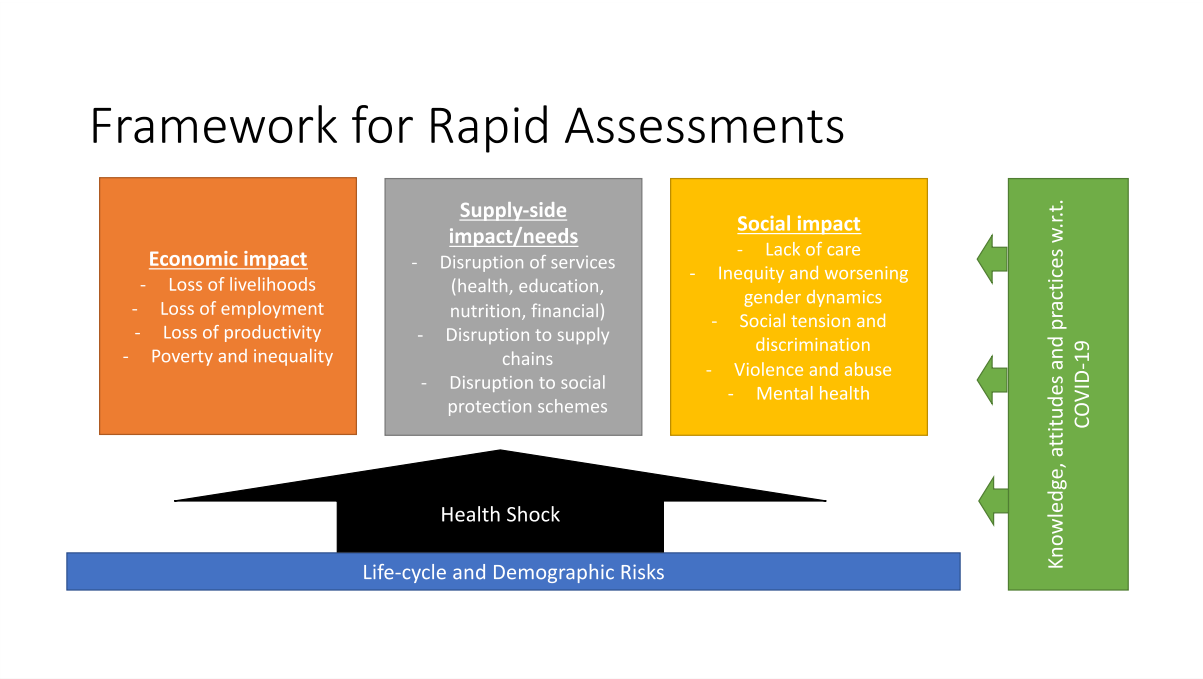
		understand the response of ASHA, AWW and GPs to COVID-19 in Gujarat		employment, Cross cutting Gender, Social policy, Cross cutting DRR

Key features of the 24 rapid assessments are presented below.

- **Wide geographical spread**: 11 field offices have led their own rapid assessments
- **Focus areas**: most assessments have examined services, but also covered multiple dimensions such as knowledge, attitudes and practices around COVID-19, the economic impact of the COVID-19 lockdown and the psycho-social impact of the lockdown.
- **Target population:** almost all assessments have looked at vulnerable/poor households, as well as sub-groups within these. Other populations include: adolescent girls, young married women, pregnant and lactating women, children, migrants and their families, tribal populations, elderly, persons and widows
- **Methodology:** all the assessments have used quantitative methods, some with additional qualitative data collection. Most assessments have used the household or the community as the unit of analysis. There are two general approaches adopted: directly reaching the households, or using community members as 'informants'
- **Questions:** the rapid assessments have typically asked questions around a range of sectors, most notably on social protection, health, nutrition, livelihoods and education. Fewer questions have been typically asked for WASH and child protection. Some of the assessments explicitly asked questions on gender, violence and social inclusion
- **Rounds:** three assessments conducted two rounds of data collection. In two cases, the same questions were repeated, and in one different questions were asked in the two rounds.

Framework for the analysis of Rapid Assessments

The analysis and synthesis of findings from the rapid assessments are guided by a basic framework (see Figure below) that seeks to capture the key aspects of the impact of COVID-19 on women and children. This covers the economic and psycho-social impact of the pandemic as well as the provision of and access to key services, which are influenced by knowledge, attitudes and behaviours around COVID-19. This framework was developed internally by UNICEF India, drawing on draft frameworks developed by the Economic Policy Research Institute for UNICEF Odisha, UNICEF DFAM, New York and UNICEF Lucknow.



Process of analysis and synthesis of findings

The following stepwise process has been adopted to analyse and synthesize the vast amount of data being generated across the rapid assessments.

Step 1 - Individual findings from each rapid assessment are extracted, filtered and catalogued into an online index. This index is a tool with a search and filter function.

Findings have been captured and organized from completed rapid assessments by:

- Sector (e.g., Health, Nutrition, Education, etc.)
- Sub-theme (e.g., Immunization, Take Home Rations (THR), Distant Learning etc.)
- Equity Marker (e.g., women, urban poor, migrant, etc.)
- Geography (national/state/district)
- Locality (urban/rural)
- UNICEF state typology (high burden, tribal, transition)
- Representativeness of the rapid assessment
- Focus Area (Knowledge, attitudes, and practices around COVID-19; Economic impact; Access to key services; Psycho-social impact)

Online index of key findings from Rapid Assessments (click here to access)

Sector	Sub-Theme	Key finding	COVID Response Are (Focus area)	Equity marker	Geography	State	State Typology	Locality (rural/Urb	Data collection perio	Representative	Rapid assessment ID nu
Nutrition	Food Intake/Diet/Nutrition Status	Food is being supplied by the local government in 7 out of 9 camps. A religious trust provides cooked food in one camp (Latur). A private company, with daily wage workers, is supplied inadequate dry rations in one camp (Nanded). The frequency of cooked food supplied in the camps is three times a day for 4 camps and twice a day for 5 camps. Additional food items are supplied for children like milk and biscuits by the communities on a voluntary basis. There was expressed need for tea/breakfast in the morning in camps where two meals were served.	Access to key services	Migrants	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003
WASH	Water Supply, Drinking Water	Water supply is mostly regular, with 7 camps getting water once a day, while two camps get water supply on alternate days. There is a common facility for storage of drinking water for residents. Camps mainly rely on overhead tanks for water storage in all but one camp where water purification is done at source. Stagnant water was observed in 5 of the 9 Relief Camps.	Access to key services	Migrants	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003
WASH	Toilet Access and Use, Solid Waste Management, Liquid Waste management	There are separate toilets and bathrooms for men and women; however, these are inadequate and not well kept. Separate toilets for men and women are available in residential school locations (6 Govt managed camps in Osmanabad and one in Solapur), but not in Nanded and Latur. Cleaning of toilets and urinals in camps is done once a day in 3 camps, on alternate days in 1 camp, and once in week in 3 camps. Solid & Liquid Waste Management is done as per the system in schools and hostels, though this aspect was not observed in detail	Access to key services	Migrant men and women	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003
WASH	Menstrual Hygiene Management	Sanitary pads are provided in one camp, while in the other, women were struggling to find cloth or pads. There is no menstrual waste disposal facility.	Access to key services	Migrant women	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003
Communication, WASH	Knowledge (COVID Awareness/Symptoms/Spread), Toilet Access and Use	Hygiene kits are not sufficient, with only a small all-purpose soap given at the start. There is no separate soap for toilet and bathing, as required by hygiene and cultural practices. While people are aware of the need for handwashing in the camps, monitoring and the supply of soap need to be increased. Hygiene awareness is also limited. Hygiene kits including masks were observed to be inadequate at the camps.	Access to key services	Migrants	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003
Health	Health Checkup, Mask Usage (Prevention), Drinking Water	Health checks are being conducted. Medical doctors have visited one camp; in the other camps frontline health workers are doing checkups. Masks are not adequately available in the camps. Health problems like vomiting and fever due to drinking untreated water were observed in one camp.	Access to key services	Migrants	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003
Health, Nutrition	Health Checkup, PDS, Food Security	No special health check-up or nutrition provisions are being done for pregnant and lactating women or children. In case any health service is required, the ASHA worker, Multi-Purpose Worker or ANM informs the Primary Health Centre to provide the service. In one camp, village communities were contributing milk and fruits for children.	Access to key services	Pregnant migrant women and children of migrants	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003
Health, Nutrition	IFA Tablet, Calcium Supplement, ANC	There were pregnant women in 2 out of the 9 camps; in one camp women received ANC services while in the other no service was received. IFA and calcium supplements were provided in one of the two camps that had pregnant women. Of these, only one pregnant woman received calcium supplements.	Access to key services	Pregnant migrant women	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003
Education	Pre-School Education (will include AWW), Schools, Home/Distance Learning	Education could not be observed in any of the camps. Nor were there any planned activities.	Access to key services	Children of migrants	Single state, few districts	Maharashtra	Good governance, Transition state	NA	16 - 18 April 2020	No	205003

Step 2 – Findings are compiled and synthesized around key thematic areas using the above framework.

The synthesis process involves qualitatively identifying and analysing patterns, synergies and differences in findings across the rapid assessments (where feasible/possible). A specific focus is on highlighting findings related to special populations (e.g., women, migrants, urban slum populations, adolescent girls, children, and tribal populations) that are high priority in UNICEF's COVID response.

What the report does not cover

The report does not attempt to cite all the findings of the rapid assessments, nor will it be possible to present or analyse findings by all the different parameters that audiences might be interested in. This level of disaggregation will make the report too long and complicated, and result in a less analytical product.

Methodological limitations

- The rapid assessments are a heterogenous mix of studies, with variance in geographical scope, target population, data collection methods, etc. Moreover, the data collected in most rapid assessments will not be statistically significant or even comparable across the assessments. As such, it is important to note that this is not a systematic review. There are no pre-defined inclusion criteria for rapid assessments, as all the assessments will be included in this synthesis.
- In some sub-sections of the chapter on findings (Chapter 3), a useful synthesis may be limited. This would depend on the volume and relevance of the findings.

Based on these limitations, care must be taken when making inferences and drawing conclusions based on this synthesis report. The indexing tool will usefully complement the synthesis report as it provides a comprehensive, up-to-date and definitive dataset, where colleagues can search for additional information. This will not only ensure that

discrepancies are identified by programme teams but also that users will not have to wait for the synthesis report updates before informing programming.

Chapter 3: Key findings

Knowledge, attitudes and practices around COVID-19

Fifteen of the 24 rapid assessments included in this report sought information on awareness of COVID-19. A variety of questions were posed to assess awareness of COVID-19 (symptoms, prevention measures, treatment, sources of information) and practices that people adopt to protect themselves from COVID-19. Studies in this summary include two large-scale national level assessments among U-Reporters, one covering 22,924 respondents from the general population across 28 states and four Union Territories (205015a) and the other covering 18,982 respondents, mainly adolescents across the country (205032); one seven-state study [5] covering 3,785 respondents (205023) and ten state-level studies. The state-level assessments cover communities in the tea estates of Assam (205009), panchayati raj institutions (PRIs) from six districts of Assam (205018), households in rural Bihar (205019), community volunteers in rural Chhattisgarh (205001b), ASHA workers and anganwadi workers (AWWs) in Gujarat (205025a; 205025b), ASHA workers, AWWs and gram panchayat members (GPs) in Gujarat (205035), vulnerable households in Jharkhand (205012), civil society organizations (CSOs) in Rajasthan (205010), AWWs in Rajasthan (205021), beneficiaries of social protection schemes in Uttar Pradesh (205013b) and GPs, AWWs and households across all districts in rural Maharashtra (205016).

Apart from the seven-state study, and two studies in Gujarat (205035) and Maharashtra (205016) which were conducted post-lockdown, all the assessments in this summary were conducted during the lockdown period. The rapid assessments well-represent the high-burden states, tribal states and transition states.

Across the studies, findings demonstrate a relatively high degree of access to information on COVID-19, and subsequently a high level of awareness about COVID-19 (205009; 205012; 205013b; 205018; 205015a; 205016; 205021; 205023; 205032). 88% of respondents in a national-level study covering 18,982 respondents, mainly adolescents, reported access to information on COVID-19, with a slightly higher proportion of urban than rural adolescents reporting so (205032). Even in Assam, 98% of tea estates surveyed reported access to information about COVID-19 (205009). The national-level U-Report study conducted during the lockdown, covering 22,924 respondents from the general population across 28 states and four Union Territories, reports that almost all (92%) the respondents had heard of COVID-19, 92% were correctly informed about COVID-19 prevention practices,[6] 68% were correctly aware of three social distancing measures[7] and 70% were correctly aware of three self-quarantine

[5] Assam, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh
[6] Handwashing with soap, social distancing and wearing a mask
[7] Stay 1 m/3 ft away from people around you; avoid all mass gatherings - social, religious, or political; avoid all public places

measures[8] (205015a). In rural Maharashtra, almost all the surveyed households and AWWs (94% and 96% respectively) were aware of the modes of transmission of COVID-19 (205016).

However, there are still important gaps in knowledge about COVID-19, especially in terms of behaviours to prevent and treat infection. In the national-level study covering 22,924 respondents cited above, notably, 39% of 10-19 year olds were not aware of all three social distancing measures (see footnote), 38% were not aware of all three self-quarantine measures (see footnote), and some respondents reported incorrect COVID-19 prevention measures such as soaking in the sun (4%), avoiding non-vegetarian food (1%) and doing nothing at all (1%). Similarly, while respondents were correctly aware of measures to be adopted in case of symptoms of COVID-19, 20% incorrectly reported visiting a hospital to get tested (since at the time it was mandated by the government to either contact a health worker/doctor call on the COVID helpline in case of symptoms), and a small proportion reported treatment with home remedies, practicing yoga or doing nothing at all (205015a). In the assessment across seven states[9] conducted post-lockdown, while 61% of respondents correctly reported they would contact a health care provider, 59% incorrectly reported they would visit a hospital for symptoms of COVID-19 (205023). In a study of beneficiaries of social protection schemes in Uttar Pradesh, conducted during lockdown, just 20% of surveyed respondents identified the use of masks as a protective measure against COVID-19, indicating incomplete knowledge around COVID-19 (205013b). Surveyed respondents in the seven-state study[10] and the Gujarat assessment, both conducted post-lockdown, noted the need for additional information on the symptoms, prevention measures and modes of transmission of COVID-19 (205035; 205023), and surveyed health workers and GPs in Gujarat also indicated that households were seeking information on COVID-19 from them (205035).

Some gender variations have been noted. In the seven-state assessment,[11] significantly more female than male respondents desired information on the modes of COVID transmission (205023).

Television clearly stands out as the <u>main source of information on COVID-19</u> (205012; 205015a; 205016; 205018; 205023; 205032). Almost all respondents (94%) in the seven-state assessment[12] (205023), two-thirds (67%) in the national-level U-Report study among the general population (205015a) and 50% in national survey covering mainly adolescents across the country (205032) cited television as their primary source of information. Other commonly reported information sources were social media, specifically Facebook and WhatsApp (205001b; 205012; 205015a; 205018; 205023; 205032), and newspapers (205012; 205023; 205032). In rural Maharashtra, TV/Radio were reported as sources of information on COVID-19 by the households surveyed (205016).

[8] Stay at home for 14 days, keep away from family members, avoid sharing household items

[9] Assam, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh

[10] Uttar Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Andhra Pradesh and Telangana

[11] Assam, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh

[12] Assam, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh

Social networks like family and friends, and community-level health care providers such as ASHAs, AWWs and ANMs were also cited as sources of information on COVID-19 (205012; 205023; 205016). Notably, 76% of respondents in the national survey covering mainly adolescents reported that they had taken action to inform their family /friends about prevention measures against COVID-19 during lockdown, including frequently reminding them about ways to keep themselves safe and sharing credible sources of information (205032). PRI members, CSO networks and voluntary groups (teachers and youth volunteers) were also cited as sources of information; in Assam, for example, PRI members reported sharing messages on COVID-19 prevention during awareness campaigns, public announcements and home visits (205018). Gender differences were noted; according to the seven-state assessment conducted post-lockdown, significantly more men than women had accessed information around COVID-19 from social media and newspapers, and more women than men depended on family members and frontline workers for such information (205023).

However, gaps in knowledge around COVID-19 were identified also by Community-level informants early during the lockdown phase. For example, around one-third or fewer of AWWs and ASHAs surveyed in the Gujarat study, and just over half the PRIs surveyed in the Assam study, could correctly recall the COVID emergency helpline numbers (205025a; 205025b; 205018). However, in a later study in rural Gujarat, it was found that almost all the sarpanches (97%) and ASHA workers (96%) knew the COVID-19 helpline number and the health department helpline number respectively (205035).

Notably, in the Gujarat study conducted during the lockdown, only 7% of AWWs had been provided study material on COVID-19 (205025b), and three-quarters of ASHAs articulated the need for refresher training on COVID-19 (205025a). In the Gujarat and Maharashtra studies conducted post-lockdown, higher proportions of AWWs and ASHA workers reported receiving COVID-19 related material and training; 62% vs 69% of surveyed AWWs had received training and material on identifying and referring potential COVID-19 positive cases in Gujarat (205035), and in Maharashtra, more than three-fourths of AWWs, 66% of ASHA workers and 38-42% of sarpanches in the GPs surveyed had received COVID-19-related material/training. Notably, 28% GPs had not received such training/material (205016).

Not all respondents were able to adopt prevention measures against COVID-19, including frontline workers and after lockdown was lifted. In the rural Bihar study conducted during lockdown, for example, less than two-fifths of male and one-quarter female respondents reported current practice of all four standard COVID preventive measures.[13] Those better educated, wealthier and belonging to higher castes were more likely to practice preventive measures, as were those who perceived moderate or high risk of COVID-19 in their neighbourhood (205019). In a study in Rajasthan conducted during lockdown, community volunteers reported that only 64% of the people in their area could adopt prevention behaviours (205010). In the Gujarat study conducted post-lockdown (205035), 60% of ASHA workers reported they were maintaining social distance during home visits; 52% were wearing masks, 30% were using sanitizers and 25% were practicing hand washing. Challenges were reported in adopting prevention behaviours; for example, reasons for not practicing social distancing, as reported in the national assessment covering the general population, included social and societal issues

[13] Staying at home, frequent handwashing, using masks, keeping social distance

(friends, family, neighbours), mental health concerns, limited access to essential services (due to jobs, businesses, and income), and logistical problems (space constraints, disruption of education) (205015a).

As the evidence in this summary indicates, high awareness around COVID-19 does not necessarily mean correct knowledge of the disease or the translation of knowledge into practice. Equity issues may explain the gap in the adoption of desired behaviours. As indicated in the one study conducted post-lockdown included in this summary, there is a need for further information and messaging on COVID-19. Mass messaging through the television and the use of existing community networks at the ground level may be the most effective means of translating knowledge into action.

Economic impact and coping strategies

Seven state-level rapid assessments elicited information on the economic impact of the COVID-19 pandemic, with a special focus on migrant workers. While there was no national level rapid assessment that explored the economic impact of COVID-19, the assessments covered in this summary represent the high burden states, transitions states, and tribal states. The seven assessments included in this summary cover gram panchayats (GPs) in Andhra Pradesh (205004a), households in rural Bihar (205019), community volunteers in Chhattisgarh (205001b), CSOs in Rajasthan (205010), beneficiaries of social protection schemes in Uttar Pradesh (205013b), gram panchayat members (GPs), anganwadi workers (AWWs) and households across all districts in rural Maharashtra (205016) and ASHA workers, AWWs and GPs in Gujarat (205035). Questions covered loss of income and livelihood, financial security and coping mechanisms. Five assessments included in this summary were conducted at the start of the lockdown (April-May 2020) and are lockdown-specific; the studies in Gujarat (205035) and Maharashtra (205016) were conducted post lockdown.

The COVID-19 lockdown adversely affected livelihoods and incomes in the immediate term (205004a; 205013b; 205019; 205016; 205035). In the Bihar assessment, for example, about four-fifths of surveyed respondents reported that their households had lost their source of income completely, had no employment and/or had experienced a major reduction in income, and two-thirds (64%) reported a family member had lost their job/income (205019). In the Uttar Pradesh assessment of beneficiaries of social protection schemes, far higher proportions (84%) reported that their income and employment had been adversely impacted (205013b). Two studies conducted post-lockdown also report a loss in household income; in rural Maharashtra, 51% of surveyed households had no income during the lockdown (205016), and in rural Gujarat (205035), 63% of surveyed GPs reported 'less than normal' monthly income among households in their area.

Daily wage workers (including artisans, unskilled labourers, and agricultural labourers) and those involved in private jobs, contractual jobs and their own small businesses were the most affected economically (205001b; 205019; 205035). In the rural Chhattisgarh assessment, conducted at the start of the lockdown, key informants reported that the lockdown had affected households engaged in agriculture and allied activities.

Households lacked financial resources/security due to the economic impact COVID-19. As reported in the assessment in rural Bihar, over half the respondents surveyed (57%) had the financial resources to survive for less than a month and 30% of self-help group families surveyed were in desperate need of cash (205019). Due to the lack of financial resources, 29% of surveyed respondents in poor households in Uttar Pradesh reported that it was difficult to buy daily necessities (205013b). As reported by community volunteers in Chhattisgarh, in the early stages of lockdown the poorest households had already exhausted their resources and had started taking loans from local moneylenders to cope with financial stress (205001b). In the rural Gujarat survey conducted post-lockdown, households had resorted to distress selling of their land and animals to cope with unemployment and debt (205035). These findings suggest that people have no savings, assets or safety nets they can fall back on in a crisis situation, that existing protection schemes may not be reaching them, and those that reach them may be insufficient/inadequate to meet their needs.

Migrant workers were particularly affected by the lockdown economically. As reported by gram panchayats in the rural Andhra Pradesh assessment, conducted from 24 April-8 May 2020, many migrants, especially those who commute daily to nearby areas for work, were without jobs due to the shutdown of public transport and lack of economic activity during the lockdown (205004a). Following the lockdown and the loss of work in destination areas, many migrants were not able to return to their native village due to containment measures; figures for migrants who returned to their native village range from 33% in rural Andhra Pradesh (205004a) to about half in rural Bihar (205019). As reported by CSOs in the Rajasthan assessment conducted during the lockdown, migrants who were unable to return to their villages were staying in transit camps or in concentrated clusters in destination areas (205010). In many villages in Chhattisgarh, key informants reported that sarpanches had provided migrants shelter in schools and panchayat houses, and given them food and water (205001b). Two studies also report that GPs had provided support to migrants; in Gujarat panchayats were providing food in migrant camps, and in Maharashtra GPs had arranged health check-ups, soap and masks, food grain and work under MGNREGS for returned migrants (205016; 205035).

Only half of daily wage workers (existing workers and home returnees) received work under MGNREGS. In Maharashtra, only 25% of the surveyed households with a MGNREGS job card holder had received work under MGNREGS during the lockdown (205016), while in Gujarat, 57% of GPs and 51% of AWWs surveyed reported that MGNREGS work was being done in the village; 59% of GPs reported women have been engaged in MGNREGA work in their area (205035). In the seven-state study,[14] volunteers reported that among almost half the habitations that received home returnees, families that wanted MGNREGA jobs had received MGNREGA job-cards; however, a large proportion of volunteers reported (36%) that returnees were not receiving job-cards and one-tenth said they did not know (205005).

[14] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

Evidence on the economic impact of COVID-19 covering the period during lockdown highlights the immediate effects of the lockdown. However, the situation has since evolved; the economy has restarted, and livelihood opportunities have emerged again. More recent studies have shown that the economic impact and the community's coping mechanisms have persisted ever since (i.e., after the lockdown was lifted). In this context, programmes need to look beyond issues related to migrants to cover additional aspects of equity.

Provision and access to key services

Health

Fourteen rapid assessments gathered information on the impact of the pandemic on health-related services. Studies include assessments of migrant relief camps in Maharashtra (205003), gram panchayat members (GPs) in Andhra Pradesh (205004a) and Telangana (205004b), communities in tea estates in Assam (205009), households in rural Bihar (205019), community volunteers in Chhattisgarh (205001b), beneficiaries of social protection schemes in Uttar Pradesh (205013b), CSOs in Rajasthan (205010), ASHA workers and anganwadi workers (AWWs) in Gujarat (205025a; 205025b), ASHA workers, AWWs and GPs in Gujarat (205035), GPs, AWWs and households across all districts in rural Maharashtra (205016), providers in private paediatric and obstetric facilities in four cities in Gujarat (205026), and a seven state longitudinal study[15] covering 4972 families and 298 habitations (205005).

Twelve studies cover the period of lockdown (March-May 2020). Two studies (205016; 205035) cover the post-lockdown period. Information was elicited on reproductive, maternal, neonatal, child and adolescent health, health facilities and patient services. The assessments cover the high-burden states, tribal states and transition states.

In the initial stages of lockdown, various supply-side issues obviously hindered access to maternal and child health (MCH) services. As reported in assessments in different states, during the lockdown government health facilities and private clinics were closed, medical staff were not available at health facilities, long queues and overcrowding at facilities, transport and ambulance services were not readily available and maternal and child health activities had been discontinued at some government health facilities, resulting in compromised care (205001b; 205025a; 205016). ASHAs in Gujarat, for example, reported that families had delayed child immunization during the lockdown because the regular MAMATA day had not been organized at the health centre and private clinics were closed (205025a), and in both Rajasthan and in Chhattisgarh key informants reported poor functioning of MCH services during lockdown (205010; 205001b).

Findings clearly indicate that the provision of and access to maternal and child health services were disrupted during the lockdown period, although to a different extent across States and for specific services (205001b; 205003; 205004a; 205009;

[15] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh.

205010; 205013b; 205019; 205025a; 205025b; 205035). In Bihar, just about one-quarter of women who had planned for ANC services reported receiving the service, and nearly three out of four women had received services from private healthcare providers (205019). Home deliveries were taking place due to the lockdown as reported by ASHAs and GPs in the Gujarat assessments, and by GPs in Andhra Pradesh (205004a; 204025a; 205035).

Notably, in Bihar about 10% of mothers with a young child reported not receiving the scheduled child immunization (205019), and in Andhra Pradesh less than half the GPs (48%) reported continued routine immunization in their area (205004a). In Gujarat 11% of surveyed obstetricians and pediatricians in private health facilities had suspended immunization services during lockdown (205026). Access to family planning services was low; just 14% of young married women in rural Bihar reported current use of modern contraceptive methods, with lower access to family planning services reported by marginalized communities (205019). However, in Maharashtra and Gujarat (205016; 205035), higher access to health services was reported during lockdown. Almost all (98%) the surveyed AWWs in Maharashtra reported that children and pregnant women had received routine immunization, and 97% reported that pregnant women had received ANC services during the lockdown (205016). In Gujarat 69% of surveyed ASHA workers reported immunization for pregnant women was being done at Mamta Divas/health camps and 72% reported child immunization was being done at health camps during lockdown; 54% of ASHAs indicated that attendance for these sessions has remained the same while 49% ASHA workers reported an increase during lockdown (205035).

Observations from migrant camps in Maharashtra indicate that no special check-ups were being conducted for pregnant and lactating women and children, and pregnant women in only one of the two camps had received ANC services during the lockdown (205003). Notably, one assessment highlighted poor quality of care during the lockdown; in Andhra Pradesh, 24% of GPs indicated that pregnant women had faced difficulty accessing delivery services during the lockdown (205004a). As reported by community volunteers in the seven-state study[16], access to health treatment[17] in rural habitations declined from 82% pre-lockdown to 75% at the time of survey (end May 2020); moreover, the proportion of people not receiving treatment from government health facilities increased over the same period (17% pre-lockdown to 25% during lockdown) (205005).

Even where MCH services were available during lockdown, a decline in uptake of services was observed during the lockdown period. In an assessment conducted in Chhattisgarh, for example, community volunteers reported that while ANC services were available, the number of women seeking these services had declined over the lockdown period (205001b). Similarly, as reported in both the Andhra Pradesh and Chhattisgarh assessments, admissions to SNCUs for newborn care had declined during the lockdown (205004a; 205001b). Several assessments underscore a reduction in immunization coverage over the lockdown period: in Gujarat, for example, 98% of ASHAs reported a decline in the number of pregnant women and children accessing immunization services during the lockdown (205025a), and in Telangana, one-fourth of GPs surveyed reported

[16] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh
[17] A functional health facility dispensing treatment and medicines

that routine immunization was not taking place (205004b). As indicated by community volunteers in Chhattisgarh, immunization services were available in most places during lockdown; however, the second-round assessment suggests that the number of women and children seeking these services had declined due to the extended lockdown (205001b). Provider level challenges, such as fear of providers/staff getting COVID-19, reduced patient load, non-availability of supplies (e.g. PPE), getting permissions for COVID testing, affordability of the COVID test, and accessibility of designated COVID testing facilities, compromised provision of care, as reported by obstetricians and paediatricians in Gujarat (205026).

Where MCH services were available (or became available again), they were not being accessed during lockdown due to demand-side issues. According to assessments from Bihar and Gujarat, key reasons for families not availing available MCH services were the fear of getting COVID infection, private clinic services not being affordable and families having migrated to their native village and therefore could not access the required services (205019; 205025a). At the same time, community outreach by health providers was limited during the lockdown. As reported in the Gujarat assessment, ASHAs and AWWs had been given additional COVID-related responsibilities and additional areas to cover during the lockdown; however, most ASHAs reported that they could not complete all the required home visits due to the lockdown and follow-up was often done over the phone; AWWs also reported that home visits during lockdown were managed mostly telephonically except in emergencies (205025a; 205025b)

While many of these issues may be resolved post-lockdown, and services may go back to normal, several concerns remain. First, in some cases, temporary disruption of health services may mean knock-on effects for women and children (e.g., child illness due to no vaccination, issues in delivery due to no ANC, family planning, etc). Second, the demand side issues show that uptake is likely be remain lower than before, especially given the fact that the COVID crisis is still ongoing. Fear of COVID and lack of money to pay for medical care will likely persist. Indeed, many community health workers, often relied on to stimulate demand, are still overworked and they may not be doing the job they are required to do.

WASH

Nine rapid assessments gathered WASH-related information, including on current awareness and practice of hygiene behaviours, COVID-prevention services in institutions/facilities, and WASH-related measures required when schools reopen. Studies cover a national-level U-Report study covering 22,924 respondents from the general population across 28 states and 4 Union Territories (205015a), a seven-state longitudinal study[18] covering 4972 families, 298 habitations (205005), relief camps in Maharashtra (205003), tea estates in rural Assam (205009), poor households in Jharkhand (205012), anganwadi workers (AWWs) in Rajasthan (205021), 1,956 government and private school teachers across all districts in Tamil Nadu (205034), ASHA workers, AWWs and gram panchayat members (GPs) in Gujarat (205035), and community volunteers in Chhattisgarh (205001b). All the assessments, except one in

[18] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

Gujarat, cover the lockdown period (March to May 2020). The assessments well-represent the high-burden states, tribal states and transition states.

Findings on awareness and practice of WASH-related COVID-19 prevention measures were mixed. The national-level rapid assessment, covering 22,924 respondents, reports that when asked, just 37% of respondents stated washing hands with soap as one of the ways to prevent COVID-19 (205015a). Similarly, in migrant relief camps in Maharashtra, observations indicate limited hygiene awareness among the camp residents (205003). In the seven-state study[19], community volunteers in 37% of rural habitations and 56% of urban habitations reported handwashing had increased to 'more than normal' after the lockdown while in 48% of rural habitations and 40% of urban habitations, volunteers said that handwashing is 'same as normal' as before the lockdown (205005). In contrast, key informants in rural Chhattisgarh reported that most people were aware of the need for regular handwashing with soap and were practising it daily, and most villages had adopted protection measures at water collection points such as physical distancing and washing hands before use (205001b). A study of AWWs in Rajasthan indicates that most (95%) respondents practised handwashing with soap at regular intervals (205021), and 82% of respondents in Jharkhand reported handwashing with soap (205012).

Findings from specific groups/areas suggest that WASH services were limited during lockdown. In rural Assam, for example, 53% of tea estates with quarantine centres reported inadequate WASH facilities although, in the majority (75%) of these centres disinfection was being done (205009). Just 45% of GPs surveyed in Gujarat reported facilities to wash or sanitize hands in common areas (shops, ATMs, banks) and 26% reported that there were no such facilities in their areas (205035). In migrant relief camps in Maharashtra, observations indicate that while water supply was fairly regular and separate toilets and bathrooms were available for men and women in some camps, the toilets were not well maintained, and while hygiene kits were being provided at the camps, supplies such as of soap, were not adequate. Sanitary pads were provided in only one camp, and there was no menstrual waste disposal facility (205003).

On WASH in schools, a study from Tamil Nadu conducted during lockdown, enquired about school teachers' perspectives on COVID-prevention measures needed when schools reopen; suggestions included the need for full-time cleaning staff (73%), frequent cleaning/maintenance of toilets (70%), and students bringing their own drinking water as schools may not be able to ensure a safe supply (85%) (205034).

While it might be expected that, since May, awareness and information around hand-washing practices might have increased and WASH services may have improved, the findings still highlight issues to be addressed. In particular, the mixed results around handwashing suggest that realities might be very different even from one community to the next, but also that monitoring handwashing through self-reported methods might not be accurate or systematic. The findings around WASH services suggest that even when they exist, there needs to be a core focus on quality/maintenance.

[19] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

Nutrition/food security

Fifteen rapid assessments elicited information from households, service providers and gram panchayat representatives (GPs) on the impact of the pandemic on nutrition-related services. Studies cover a seven-state longitudinal study[20] covering 4972 families, 298 habitations (205005), and 11 states: relief camps for migrants in Maharashtra (205003), gram panchayat members (GPs), anganwadi workers (AWWs) and households across all districts in rural Maharashtra (205016), GPs in Andhra Pradesh (205004a) and Telangana (205004b), communities in tea estates in Assam (205009), CSOs in Rajasthan (205010), households in rural Bihar (205019), community volunteers in Chhattisgarh (205001b), beneficiaries of social protection schemes in Uttar Pradesh (205013b), AWWs in Rajasthan (205021), PRIs in Assam (205018), ASHA workers, AWWs and GPs in Gujarat (205035), and ASHA workers and AWWS in Gujarat (205025a; 205025b). Two studies (205016; 205035) were conducted post-lockdown; the rest cover the lockdown period (March-May 2020). The assessments in this summary cover the high-burden states, tribal states and transition states.

Across all the studies, it is clear that households lacked food security and resorted to different coping mechanisms during the lockdown (205001b, 205019, 205010, 205013b; 205035). In the Gujarat assessment, for example, 41% ASHAs reported families in their area had not enough food to eat in May 2020 (205025a), and in rural Bihar, 48% of households reported shortage of food in the month preceding the survey (15 April-15 May 2020) (205019). In many locations in Chhattisgarh, food stocks had depleted raising concerns about food security (205001b). In another study in Gujarat 32% of GPs surveyed reported difficulty in accessing essential supplies such as food and 35% reported households in their GPs were facing food insecurity (205035).

To cope with food insecurity, households in Uttar Pradesh had reduced their frequency of food consumption and quantity of food items consumed during the lockdown (205013b). In Bihar, 59% of respondents reported reduced food intake and 58% reported reduced food intake among children under five during the lockdown (205019). Food shortage and reduced food intake during the lockdown were more commonly reported by marginalized populations and those reporting loss of income (205019). Findings from Uttar Pradesh among beneficiaries of social protection schemes indicate pervasive disparity in intra-household food distribution; only 3% said that children and pregnant women were given preference in consuming available food items (205013b).

Overall, the lockdown has disrupted the continuation of nutrition services, particularly among women and children. Fortunately, some nutrition services such as Take-Home Rations (THR) were operational and reaching vulnerable populations during the lockdown. For example, the distribution of THR is reported to have continued during the lockdown in some areas. In the Rajasthan study of anganwadi services, 92% of AWWs reported they were able to carry out door-to-door distribution of THR in their respective areas (205021). Almost all (98%) the AWWs surveyed in Maharashtra reported that THR was being supplied to all the beneficiary

[20] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

groups (205016). Similarly, in Gujarat, AWWs reported distributing THR to beneficiaries during the lockdown (205025b), and in Chhattisgarh, community volunteers reported that in addition to regular beneficiaries, children of returnee migrant families had also been registered for AWC services and provided THR (205001b). In Telangana, almost all GPs (94%) reported that THR was being distributed to pregnant women and children during the lockdown (205004b). However, coverage of THR was lower in some studies. As reported by volunteers in the seven-state study,[21] in rural habitations, the provision of THR services to pregnant women and lactating mothers declined from 86% pre-lockdown to 69% at the time of the survey (May 2020), and from 85% to 66% among children over the same period. Notably, pregnant women and lactating mothers and children in around one-third of rural habitations were not receiving THR at the time of the survey (May 2020) (205005). In the tea estates of Assam, 54% of tea estates reporting that AWWs had provided THR to children aged 3-6 years (205009). In Assam, Andhra Pradesh and Telangana, community-based networks such as PRIs and voluntary groups have supported the distribution of dry rations to vulnerable groups (205004a; 205004b; 205018).

Other nutrition services, such as the provision of dry ration or provision of iron and folic acid (IFA) and calcium supplements, were more varied and it appears specific vulnerable groups might be left out. In Assam, while most (81%) tea estates reported the availability of dry ration for school-going children, fewer (49%) reported AWWs were providing dry ration to pregnant and lactating women, and just 14% reported AWWs providing additional dry ration to severely underweight children (205009). In contrast, higher proportions (80%) of GPs in Andhra Pradesh reported distribution of dry rations to pregnant women and children at home (205004a). In Rajasthan, 30% of CSO representatives reported the provision of dry ration to non-NFSA beneficiaries (205010).

A similar varied picture emerges for the provision of IFA and calcium supplements to pregnant and lactating women and adolescents. In rural Chhattisgarh, community volunteers reported that AWWs were distributing IFA supplements regularly to pregnant and lactating women at home (205001b), and most GPs in rural Andhra Pradesh reported that pregnant women had been receiving IFA and calcium supplements (88% and 84% respectively) during the lockdown (205004a). Coverage of adolescent girls was less; fewer GPs in rural Andhra Pradesh reported that adolescent girls were receiving IFA tablets (72%) and calcium supplements (24%) (205004a). Similarly in Telangana, 75% of GPs surveyed reported pregnant women continued to receive IFA and calcium during lockdown, while fewer (49%) reported adolescent girls were provided IFA and calcium during this period (205004b).In the Gujarat assessment, 83% ASHAs reported they had provided adequate supplies of IFA tablets to pregnant and lactating women and 55% reported providing IFA tablets to adolescent girls during the lockdown (205025a). However, facility-level provision of IFA tablets had been discontinued during the lockdown, as reported by ASHAs in Surat, Gujarat (205025a), and in Maharashtra, IFA and calcium supplements had been provided in only one of the two migrant camps with pregnant women (205003).

[21] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

Severe malnutrition and anaemia continue to be a major issue, as provision of services and monitoring were disrupted. In Chhattisgarh the number of severely anaemic pregnant women receiving treatment declined from 824 (40%) in February 2020 to just one pregnant woman in March 2020. Moreover, most Nutrition Rehabilitation Centres (NRCs) in the state were not functional during the lockdown and, as a result, admissions to NRCs declined (205001b). In Andhra Pradesh, only 40% of GPs reported that they had made provision for ASHA workers or anganwadi teachers to identify underweight or undernourished children during the lockdown (205004a). However, in some districts of Chhattisgarh key informants reported that growth monitoring of pre-school children (6 months-5 years) was being conducted during the distribution of supplementary nutrition at home (205001b).

Several challenges were identified in the provision of nutrition services during the lockdown period. Reported challenges in the distribution of THR during lockdown included providing rations to beneficiary families who have migrated to their village, the time-consuming process of distribution due to social distancing, lack of community acceptance of THR, refusal to accept THR packets for fear of COVID transmission, demand for THR from non-beneficiary community members due to food scarcity, shortage of supplies and the inability of AWWs to monitor THR consumption (205025b; 205016). Food and ration scarcity were the major concerns of the community in the lockdown period, as reported by ASHAs in Gujarat (205025a), and AWWs perceived nutrition followed by tracking vulnerable children to be the biggest challenges (205025b). In Chhattisgarh, the discontinuation of on-site feeding of hot cooked meals led to concerns about the nutritional status of children (205001b). While the Village Health and Nutrition Day was organized in almost all (97%) surveyed AWCs in Maharashtra in April and May 2020 (during lockdown), attendance was very poor (205016).

Despite the continuation of some nutritional services such as THR during the lockdown, there were instances of food shortage and lowered consumption levels. While nutritional services may have largely resumed after the lockdown ended, it is likely that even the temporal disruption will have longer-term consequences for the nutritional status of vulnerable populations, like women, adolescents and children. Furthermore, it is likely that food security issues will persist, with the economic impact that was witnessed from the lockdown, and so coping strategies such as reduced food intake may continue for a longer time.

Education

Findings from ten rapid assessments gathered information on the impact of the lockdown and the closure of schools/colleges, on children's education, including continuity of learning. Assessments include one national U-report study covering 18,982 respondents, mainly adolescents, across all states and 5 UTs (205032), a seven-state longitudinal study[22] covering 298 habitations (205005), an assessment across six states[23] covering 6400 respondents (parents of children aged 5-13, adolescents, government school

[22] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh
[23] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

teachers and U-reporters) (205002), and seven state-level assessments: migrants in relief camps in Maharashtra (205003), tea estates in Assam (205009), households in rural Bihar (205019), community volunteers in Chhattisgarh (205001b), 11,216 primary school principals from all districts of Gujarat (205033), relief camps for migrants in Maharashtra (205003), 1,956 government and private school teachers across all districts in Tamil Nadu (205034), and beneficiaries of social protections schemes in Uttar Pradesh (205013b). Apart from the six-state study which was conducted in August 2020, all the surveys were conducted during the lockdown. The assessments well-represent the UNICEF state typology of high-burden states, tribal states and transition states.

A number of children were not able to study/learn while schools were shut during the lockdown. Proportions range from 34% in rural Bihar (among households who have at least one child aged 6–14 years attending school prior to the lockdown) (205019) to 72% in Uttar Pradesh among beneficiaries of social protection schemes with children in elementary school (205013b). Pre-school education also declined during lockdown; community volunteers in the seven-state study[24] reported that children were not going to the AWC for pre-school education in 46% of rural habitations at the time of survey (end May 2020) compared to 10% pre-lockdown (205005). Educational services were not available in any of the migrant relief camps in Maharashtra during the lockdown (205003).

Some children continued their studies on their own (self-study), without remote learning materials during the lockdown; parents and siblings also provided learning support. In the Uttar Pradesh assessment (April 2020), for example, 19% of respondents said their child was self-studying at home with the help of siblings or other family members (205013b), and in rural Bihar, most children continued their studies on their own (self-study) during the lockdown although one in eight participants reported that children accessed digital modes to continue their studies (205019). Parental/ sibling engagement in remote learning was reported during school closure in the six-state study,[25] with ~57-75% of children between ages 5-13 and adolescents learning under the supervision of their siblings and parents respectively. Among parents of children aged 5-13, 41% were spending more time vs. 19% who were spending less time on learning; among adolescents corresponding percentages were 26% and 21% (205002).

Reported access to distance/remote learning materials varied widely. Only a minority of children were able to access digital/online learning platforms. In a study conducted post-lockdown, it was found that only ~60% of students had accessed remote learning while schools were closed, as reported in the six-state survey[26] (205002). Secondary and urban students reported higher access. While secondary level access (among students 14-18 years) ranged from 58% to 94% in Madhya Pradesh and Gujarat, primary level access (among children aged 5-13) ranged from 33-35% in Madhya Pradesh to 86-91% in Gujarat. In urban areas, 62% of primary students and 77% of secondary students had accessed learning materials vs 57% and 62% respectively in rural areas. Access to remote learning in government schools exceeded, or was comparable with, private schools across the states. Across all six states fewer children in

[24] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

[25] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

[26] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

BPL households than in vulnerable families had accessed remote learning tools (52% of vs 58%). The U-Report survey indicates that a slightly higher proportion of respondents (~68%) had access to remote learning tools, with lower access in rural (vs urban) areas (57% vs 77%) and government (vs private schools) (59% vs 76%).

A study of government primary school principals from all 33 districts of Gujarat during lockdown estimated that only around 60% of registered students were being reached with home learning materials; around 47% of students were learning through smartphones, 18% learning only through TV and 2% learning only through radio (205033). In the Uttar Pradesh study, online classes, and WhatsApp and phone-based course materials reached only 4-5% of households and TV classes and radio classes were not reported in the early stages of lockdown (205013b). An assessment of tea estates in Assam (March-April 2020) indicates that in only 12% of tea estates children had access to online digital learning platforms (205009). In rural Bihar, 20% of respondents reported that children accessed digital modes for continuing their studies; notably, children from vulnerable households were less likely to have access to digital learning (205019). In Chhattisgarh, school-based learning activities had come to a halt following school closure at the start of the lockdown (Round 1 assessment); however, following the availability of online material, children had started accessing online portals for learning (Round 2 assessment) (205001b).

A variety of learning tools are being used; across specific tools, WhatsApp is the most common tech-enabled tool, and home visits the most common traditional tools used by students and teachers. The majority of students in the six-state survey [27]who had used at least one learning tool in the last 3 months (since May 2020) had accessed multiple tools, including traditional tools (e.g. textbooks), tech-enabled tools (WhatsApp and YouTube) and mass communication channels (TV, radio); around half (46-47%) had accessed interactive learning channels (e.g. calls by teachers and tutors, private tuitions, home visits by teachers, WhatsApp, live video classes, community learning) and ~65% had accessed high tech channels (e.g. WhatsApp, YouTube, learning apps, live video classes). Just 30-32% had accessed low tech channels e.g., radio, TV, SMS). Rural primary students and children in government schools had lower access to tech-enabled tools than their counterparts (205002).

Of those who had accessed at least one remote learning tool since May 2020 in the six surveyed states,[28] the main tools used were WhatsApp (30%) or YouTube (~20%). Textbooks and WhatsApp were the most common combination of learning tools used by both primary and secondary students (22% vs 27%). Adolescent girls were less likely to use WhatsApp and YouTube (~8% point gender gap). Parents and teachers reported a higher frequency of home visits for students with no device access, and students with disabilities as compared to others. Notably, students were not using the radio for learning as the content is not tailored to meet their needs.

Among U-Reporters in the six surveyed states,[29] (conducted in August 2020), schools are the major source for learning tools in both municipalities and village areas (31% vs 15%),

[27] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh
[28] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh
[29] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

followed by private tuitions (6% vs 7%). A larger proportion of girls had accessed learning through schools compared to boys (~43% vs ~30%). Overall access by government schools was low; higher access was reported in villages vs. municipalities. 42% of students preferred video classes, 8% WhatsApp, 7% YouTube and 7% textbooks (205002).

The inability to access online learning tools to ensure continuity of learning was cited as a key challenge. In a national-level assessment of respondents mostly below the age of 25 years, the main challenges cited during the COVID-19 crisis and the lockdown were the closure of schools/colleges and the inability to access online classrooms being run by schools/colleges (205032). In the six-state survey[30] challenges in accessing remote learning and ensuring continuity of education included, for example, lack of awareness of remote learning resources, followed by lack of access to government/ school programmes, and lack of access to devices cited students; low student access and engagement with online classes cited by teachers, and data and device affordability cited by parents. Notably, parents were finding it difficult to support children's learning due to lack of time, tools and training needed for proper facilitation, and ensuring that children, especially younger children, sit through digital classes. Uneducated and working parents found it more difficult to support their children's learning and perceived that their guidance/instruction was less effective than the teachers'. Loss of relevant documents and lack of information about local learning resources prevents parents in migrant families from ensuring continued learning for their children, while children with disabilities face unique challenges due to lack of peer support, lower concentration levels, and increased parental burden, as well as supply side issues (limited policy prioritization, lack of private sector solutions, and special educator shortage) (205002). Reasons cited by primary school principals in Gujarat for children not accessing online learning materials during the lockdown were children not having access to smartphones, no network/internet, financial crisis in the family, parent not having time/enthusiasm to support the child and phone number not being registered with the school (205033).

At the same time, rural youth and community members are helping to address access gaps. Teachers are using offline resources like anganwadi centres and loudspeakers (in Madhya Pradesh, Jharkhand, Haryana, Maharashtra), and parents/ community members are pooling digital devices to bridge the digital divide; AWWs are nudging fathers to support children's education (e.g., Odisha and Chhattisgarh); and older children are playing the role of educators (e.g., Telangana Social Welfare Residential School Students) (205002).

The quality of learning, student progress and student engagement are perceived to be less through remote learning as compared to in-person learning. Overall, across the six surveyed states,[31] 76% of parents of children aged 5-13 years who had accessed remote learning and 80% of adolescents perceived that the quality of learning through remote learning was less/significantly less than if children were in school, and 67% of parents of children aged 5-13 years and 71% of adolescents perceived progress in

[30] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

[31] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

learning was less/ less with current learning tools compared to in-person classroom learning.

While teachers are engaged in teaching remotely, the majority spent less time teaching and preparing learning materials post-lockdown, which could lead to adverse learning outcomes. Most teachers (80%) in the six-state survey[32] were teaching remotely and felt somewhat prepared to teach remotely; at the same time, teachers were spending less time teaching and preparing materials during lockdown/school closure as compared to pre-lockdown, were unable to engage with all their students as frequently as before, and perceived no advantages in remote teaching over in-person teaching. Moreover, most (72%) teachers reported that schools had started providing learning resources only in the last 4 months (205002).

Rural-urban and gender differences are noted; 75% vs. 60% of teachers in urban vs rural areas perceived that student engagement had reduced and 25% vs. 20% of teachers perceived higher female than male student engagement with online learning (205002).

There will likely be serious knock-on effects from school closures and the lack of continuation of education. In the Chhattisgarh study, concerns were raised about the possibility of drop-out even when schools reopen; households were concerned about their livelihoods and may engage children in work (205001b). Findings from the six-state survey[33] (205002) underscore these concerns; ~8% of students are not expected to return to school in the next three months or after, and ~4% students are not expected to return even after three months. Differences by socio-economic strata, rural-urban and type of school are noted. More BPL children than those in vulnerable households (11% vs 9%), more in urban than rural areas (7-13% vs 5-8%), and more students in private schools than government schools are not expected to return to school in the next three months.

As reported in the six state survey[34] (205002), the key reasons for students not returning to school in the next three months are fear of health, not being able to afford it/lack of funds, don't find learning in school important, limited learning right now (for boys), need to help with household chores (for girls), and need to earn money for the family. OOSC efforts should focus on ensuring this group of students is not left out of the education system as schools start to reopen.

Longer-term effects were also noted at an institutional level (on curriculum, syllabus, exams etc.) by school teachers. For schools to be ready to respond to such needs, additional support in terms of workforce (technical as well as non-technical support staff) was requested. In the Tamil Nadu assessment conducted during lockdown, most school teachers perceived that the syllabus for the current academic year would need to be reviewed (87%) and exams should be based on minimal syllabus (95%) due to the prolonged closure of schools and colleges during the lockdown and post-lockdown periods (205034). They also suggested involving community stakeholders

[32] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

[33] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

[34] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

such as retired teachers, teacher-trainees, social workers and other community volunteers, to assist teachers when schools reopen, including in non-teaching work (205034).

Social protection

One national U-report study covering 18,982 respondents, mainly adolescents, across all states and 5 Union Territories (205032), a seven-state[35] longitudinal study covering 4972 families, 298 habitations (205005), and nine state-level studies –selected districts in Assam (205018), households in Jharkhand (205012) and rural Bihar (205019), community volunteers in Chhattisgarh (205001b), gram panchayat members (GPs) in Andhra Pradesh (205004a) and Telangana (205004b), GPs, anganwadi workers (AWWs) and households across all districts in rural Maharashtra (205016), ASHA workers, AWWs and GPs in Gujarat (205035) and beneficiaries of social protection schemes in Uttar Pradesh (205013b) – that is, a total of eleven rapid assessments – are included in this summary. Two assessments (Gujarat and Maharashtra, 205016; 205035) were conducted post-lockdown; the other assessments cover the period of the lockdown. The assessments well-represent the UNICEF state typology of high-burden states, tribal states and transition states. Findings are presented on access and coverage of special government benefits and schemes for marginalized populations, including women and children, aimed to strengthen the response to social protection during the COVID pandemic.

Access to social protection schemes (both existing and COVID-specific) during the lockdown was disparate/varied and mixed across states and across schemes. In some assessments, there were reports of just over a majority of beneficiaries being able to access and receive benefits.

Reach of Cash Benefits/Cash Transfers (PMJDY, PMMVY, Pension Schemes, Disability Benefits)

In the Bihar survey, half of households surveyed reported having received cash benefits during the lockdown from various social protection schemes (205019). Similarly around 60% of respondents surveyed in Assam were aware of cash transfers to their bank account under the Jan Dhan Yojana, and 52% had received the benefit. In Jharkhand, 59% of respondents surveyed had received cash benefits from social protection schemes in the month preceding the survey (205012). And in Maharashtra, among the surveyed households eligible for benefits, nearly half had received financial assistance under PMMVY during the lock-down, 59% had received assistance under the PM Kisan Yojana, 59% had received assistance under the Jan Dhan Yojana and 57% had received their additional entitlement of foodgrain during the period of lockdown (205016). When GPs were questions, they reported higher figures. In Telangana, 87% of GPs surveyed reported that BPL households had availed financial assistance of INR 1,500 per family per month (205004b). In Gujarat, most GPs (85%), ASHA workers (73%) and AWWs (72%) indicated that social security pensioners were regularly

[35] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

receiving their pension (205035). Over half the GPs in rural Andhra Pradesh reported having beneficiaries who had availed the benefits of various schemes such as the Pradhan Mantri Matru Vandana Yojana (PMMVY), Old Age Pension Scheme, Widow Pension Scheme and Disability Benefits Scheme, and 64% reported having households that had availed benefits from education scholarship schemes during lockdown (205004a).

However, coverage of schemes was poor in some areas. In Jharkhand, for example, just 23% of respondents surveyed had received dry ration benefits (under the MDM scheme) through schools in the month preceding the survey (205012), and in Bihar only 29% of eligible households reported having received cash assistance in lieu of the midday meal during the lockdown (205019).

Reach of Food Rations (PMGKY, MDM)

Among households with ration cards in Bihar (68%), most households (95%) reported having received rations in the month preceding the survey (15 April-15 May 2020) (205019). In Assam, most respondents surveyed had ration cards and 69% had received food rations during lockdown (205018). In Maharashtra 60% of surveyed respondents reported that students had received dry ration under the MDM scheme for the entire period of the lockdown (205016). GPs and community representatives/volunteers reported relatively higher figures across studies. In rural Andhra Pradesh, GPs reported that 73% of BPL households had availed the additional ration and 46% had received essential items like pulses and oil under the Prime Minister's Garib Kalyan Yojana (PMGKY) during lockdown (205004a). In Telangana, GPs reported that almost all BPL households with ration cards had availed free ration of rice under the PMGKY (205004b). Community volunteers in Chhattisgarh reported that almost all households were being covered by the MDM scheme (dry ration) during the lockdown (205001b). Almost all the sarpanches surveyed in Gujarat reported that during lockdown, School Management Committee members had provided cash assistance in lieu of the mid-day meal to households with children enrolled in school (205035).

However, coverage of schemes was poor in some areas. In Andhra Pradesh, GPs reported that financial assistance under PMGKY had reached just 34% of BPL households during lockdown (205004a) and in Telangana GPs surveyed reported that just 26% of BPL households had received the assistance under PMGKY and only 11% of GPs reported beneficiaries had availed benefits under the PMMVY (205004b). In Maharashtra 35% had received assistance under the Pradhan Mantri Ujwala Yojana (PMUY) (205016). In addition, as reported by community volunteers in the seven-state study,[36] more habitations got food ration as per their entitlement in the pre-lockdown period than at the time of lockdown; in rural areas three-fourths of the habitations surveyed pre-lockdown vs two-thirds at the time of survey (end May 2020) had got ration either as per their entitlement. In urban areas, between pre-lockdown and the time of the survey, the percentage of habitations receiving ration as per their entitlement reduced by around 10 percentage points (65% to 54%) (205005).

[36] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

Some assessments suggest an improvement in access to social protection schemes over time, during the lockdown period. In Chhattisgarh, for example, during the first round of the assessment, informants reported that the advance transfer of social security pensions and other cash benefits had reached only a few beneficiaries' accounts; in the second round, most of the targeted households had received the cash benefit in their accounts or it had been distributed at home (205001b). Among beneficiaries of social protection schemes in Uttar Pradesh, there was an improvement in the proportion of respondents reporting they had received the cash benefit of INR 1,000, from 27% in Round 1 (April 11-14, 2020) to 41% in Round 2 (April 23-27, 2020) (205013b).

Access to social protection schemes was highly inequitable for specific population groups such as migrants, women and daily wage workers; those who need them the most. In Bihar, for example, just half the migrant households surveyed had received government assistance and 10% reported having received the migrant cash assistance during lockdown (205019). In the Assam tea estates, pregnant women surveyed had not received wage compensation benefits during the lockdown; moreover, households surveyed in areas with minority and tribal populations in Assam had limited or no access to rations (205018). Coverage of schemes that benefit women, like the PMUY, was also low, as reported in four states—Assam, Andhra Pradesh, Telangana and Jharkhand (205018; 205004a; 205004b; 205012). In Assam, while 84% of respondents were aware of PMUY, only 50% had received its benefits (205018); in Andhra Pradesh, just 36% of GPs reported women beneficiaries for this scheme (205004a) and in Jharkhand, a similar proportion of those surveyed (36%) had benefited from the scheme (205012). In Telangana only 32% of GPs surveyed reported PMUY women beneficiaries (205004b).

Wage workers who participated in employment schemes also could not access their benefits; in Uttar Pradesh, for example, 33% of beneficiaries of Mahatma Gandhi Rural Employment Guarantee Act (MNREGA) surveyed had not received their pending wages and just 41% of respondents surveyed had received the Government's special aid of INR 1,000 per family (205013b). In Chhattisgarh, community volunteers reported that activities under MNREGA had begun in most rural panchayats; however, wages had not been transferred to workers' accounts (205001b). In the seven-state study,[37] volunteers reported that only around 2 out of 5 rural workers had got their MGNREGA wage payments on time while the rest reported delays in wage payments (205005).

An underlying challenge is limited access to bank accounts during lockdown (205001b; 205004a; 205004b; 205013b; 205012; 205018). Notably, as reported in the Andhra Pradesh and Telangana studies, while beneficiaries had bank accounts, many could not withdraw the cash benefit transferred to their account (205004a; 205004b). Reasons for not being able to withdraw the cash benefit were because banks were located at a distance, non-availability of transport during the lockdown, the fear of COVID-19 transmission, did not own an ATM card or did not use one to withdraw money, the local ATMs were not being serviced regularly, overcrowding in banks resulting in multiple trips, lack of supportive bank staff and inactive bank accounts, the need for documentation, which delayed cash withdrawal, and incorrect bank account numbers

[37] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

provided by government departments (205012; 205004a; 205004b; 205018; 205001b; 205013b).

Another challenge is the lack of awareness of schemes. As indicated in a national study covering 18,982 respondents from all states and Union Territories, just half (48%) the respondents reported awareness of special government benefits and schemes available during the COVID crisis, and 50% of those aware had accessed the benefits. More urban respondents and females were aware of these schemes, and more rural and females respondents reported accessing the benefits of these schemes. Notably 50% or more of respondents 15 years and older were not aware of these schemes, and more than half of those 20 years and above were not able to access the benefits (205032). In Assam, among eligible respondents, just 29% were aware of the benefits of National Social Assistance Programmes, and only 8% had accessed them, mostly in the form of old-age pension and widows' pension benefits (205018). Awareness of special benefits was higher in Bihar; 88% of respondents were aware of at least one COVID-19 specific social protection benefit; television and social media were the major sources of information on social protection (205019).

Another bottleneck to access is the lack of proper paperwork/documentation (i.e. PDS or ration cards). Ownership of PDS/ration cards was variable, compromising access to benefits; in the seven-state study, among rural habitations, 13% of community volunteers reported that some families in their locality did not have a PDS/ration card and 85% of the families in their locality had a PDS card; in urban habitations, only 46% of volunteers from habitations where people had moved out (n=54) reported that families had a PDS/ration card and 29% reported that families did not have a PDS card (205005).

Local community-based institutions such as GPs/PRIs can play an important role in supporting the social protection response to the COVID-19 pandemic. In Andhra Pradesh, for example, GPs reported distributing rations to beneficiary families during the lockdown (205004a), and in Jharkhand, households surveyed without ration cards had been provided ration through the Mukhiya/Ward Councillor (205012). In Assam, PRI networks have supported the distribution of rations and provision of cash transfers to vulnerable groups, coordinated with ration shops in their area to ensure they are functioning and contingency funds have been used to support marginalized households and identified households without ration cards and provided them with cash and food benefits (205018). In Gujarat, GPs supported the provision of services during lockdown by coordinating the work of AWWs, ASHA workers and PDS dealers, assisting health functionaries in monitoring during household visits, and providing financial support and safety kits to AWWs and ASHA workers (205035).

In terms of access to social protection, the findings show there is a clear 'last mile' gap. While this may have been the case in 'normal times' this very likely has been further heightened in 'COVID times'. More people may be reliant on social protection, given the impact on income and livelihoods. Despite lockdown being over, this is likely to persist, as bottlenecks continue. Improving awareness of schemes and access to bank accounts becomes even more critical. There is a key opportunity, however, to empower local institutions to take on the role of connecting people to social protection benefits.

Child protection

Three state-level rapid assessments conducted among community volunteers in Chhattisgarh (205001b), relief camps for migrants in Maharashtra (205003) and tea estates of Assam (205009) elicited information on the functioning of social and legal protection services for vulnerable children, including child protection units, childcare institutions and the Juvenile Justice Board, during the lockdown. The assessments cover the tribal states and transition states.

Awareness of protection measures against COVID-19 for children was high among Child Protection Committees members, as reported in the assessment during the lockdown covering women and children in tea estates across 8 districts of rural Assam (205009). However, while 93% of surveyed respondents reported that Child Protection Committees had received messages on prevention and protection of children from COVID-19, just 18% noted that Child Protection Committees had received training online on the COVID-19 response.

In rural Chhattisgarh community volunteers reported that **child protection services, such as District Child Protection Units (DCPUs) and child-care institutions, were functioning during the lockdown** (205001b). It was reported that DCPUs in most districts of Chhattisgarh were supporting vulnerable children in need of care and protection, particularly children of return migrant families, and the Juvenile Justice Board was conducting proceedings for most of the cases. However, child protection protocols could not be observed in any of the migrant relief camps in Maharashtra during the lockdown (205003).

Little can be summarized about the functioning of social and legal protection services for children and adolescents, as the findings available only pertain to three small-scale studies, and the situation may have changed since the end of the lockdown, i.e. with trainings actually being completed. Nevertheless, ensuring the protection of children will be even more important moving forward, with the likely knock-off effects of loss in income and livelihoods, leading to increases in child marriage, child labour and other violations.

Psycho-social impact and coping strategies

Nine rapid assessments elicited information on the psycho-social impact of the COVID-19 pandemic, including psycho-social well-being, stigma and discrimination related to COVID-19, violence, gendered psycho-social issues and gender relations. The assessments include a national-level U-Report study covering 20,284 respondents in all states and 7 Union Territories (205015b), a seven-state study [38] covering 3,785 respondents (205023); an assessment across six states[39] covering 6400 respondents (parents of children aged 5-13, adolescents, government school teachers and U-reporters) (205002), and six state-level studies covering civil society organizations (CSOs) in Rajasthan (205010), community volunteers in Chhattisgarh (205001b), poor

[38] Assam, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh
[39] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

households in Jharkhand (205012), beneficiaries of social protection schemes in Uttar Pradesh (205013b), ASHA workers, anganwadi workers (AWWs) and gram panchayat members (GPs) in Gujarat (205035) and 1,956 government and private school teachers across all the districts of Tamil Nadu (205034). The assessments cover the high-burden states and tribal states; transition states are not covered in this assessment. Three studies were conducted after the lockdown (205015b; 205023; 205035) and six were conducted during the lockdown.

Despite the challenges posed by COVID-19, including the lockdown, a substantial number of respondents still reported positive aspects of wellbeing; however, the impact or experience may be drastically different for different geographical regions and populations. According to the national-level U-Report study covering 20,284 respondents, conducted after the lockdown (21 June-16 July 2020), the majority of respondents reported positive aspects of wellbeing, such as currently feeling good (76%), sleeping well (68%), eating well (69%), and enjoying spending more time with the family at home (73%) (205015b). Differences by residence and age were observed; more urban respondents and those in the younger (aged 0-14 years) age group reported eating well. Overall, 81% and 45% of respondents respectively, reported feeling currently connected with family and friends; respondents mainly connected with family and friends via phone calls, social media and video chats, or met socially. More rural and male respondents reported meeting family members, and more urban respondents reported connecting with family and friends through video chats. At the same time, assessments conducted in Chhattisgarh and Uttar Pradesh during lockdown highlight the negative psycho-social impact of the pandemic (205001b; 205013b). Community volunteers in the Chhattisgarh study report, for example, increased fear and anxiety among children regarding COVID-19 and the related lockdowns (205001b), and according to the Uttar Pradesh assessment among beneficiaries of social protection schemes, married women perceived that their husbands got irritated more frequently due to the lockdown (205013b).

Mental health is an issue among many students following school closure. For example, the study across six states[40] indicates that for over one-third of primary students (as perceived by their parents) and nearly half of secondary students mental health is a challenge. Notably, more parents perceive their children's mental health to be better than children do themselves (63% vs 50%). Children expressed increased emotional and psychological stress due to lack ofsocialization, disruption of learning and family's financial insecurity. More children in vulnerable families and girls have very poor/ poor mental health; 55-61% of children in migrant and Scheduled Tribe households compared to 32% overall rated their mental and socio-emotional well-being as poor or very poor, and 30-49% of girls compared to 34-51% of boys considered their mental health to be poor or very poor (205002).

The COVID-19 pandemic and lockdown have adversely affected household-level gender relations. According to a national-level U-Report study conducted after the lockdown, while 63% respondents reported doing housework, more females than males reported being engaged in such activities (205015b). The national level assessment and

[40] Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh

the studies from Chhattisgarh and Uttar Pradesh report an increase in women's domestic workload during lockdown (205001b; 205013b; 205015b).

Evidence from several states indicates women and children's increased vulnerability to violence as a result of the pandemic and lockdown. The Rajasthan assessment conducted during lockdown, 19% of CSOs in Rajasthan reported hearing of incidents of violence against women and 17% reported heading of incidents of violence against children in migrant camps (205010), and in Chhattisgarh, community volunteers reported an increase in domestic violence during the lockdown (205001b). In Maharashtra, 15% of self-help groups/ members of voluntary organizations had heard of cases of domestic violence/abuse in their neighbourhood during lockdown; of these 29% perceived that domestic violence had increased substantially during the lockdown period (205016). In Gujarat, 77% of sarpanches reported seeing people being harassed or beaten by the police when leaving home during lockdown (205035).

Results are mixed on whether conflicts have escalated or decreased after the lockdown. In the Gujarat study conducted after lockdown, 32% of ASHA workers perceived there were conflicts in households before lockdown while 48% indicated there were conflicts in households after lockdown; 18% of surveyed GPs perceived that conflicts had increased after the lockdown while 11% were of the view that there were more conflicts before the lockdown (205035). In the seven-state study[41] (205005), in both rural and urban areas, the percentage of volunteers reporting that cases of violence against women and girls in the community during the lockdown period were 'same as normal or less than normal' was 65% and 64% respectively. Gender based violence was reported more in rural than urban areas (15% vs 7%).

According to the assessment among vulnerable households in Jharkhand conducted during lockdown, respondents perceived that children were more likely to experience physical/emotional/sexual abuse, be forced into child labour, child marriage, experience neglect by parents or other family members, and be subjected to migration and child trafficking (205012). Generally, incidents of violence by left wing extremists (LWEs) had increased during lockdown as reported by key informants in Chhattisgarh (205001b).

Specific coping strategies were adopted or suggested to help mitigate the psycho-social impact of the COVID-19 pandemic and the lockdown. To stay safe online, for example, almost half the respondents in a national-level U-Report study conducted after the lockdown reported they had adopted four safety measures (205015b).[42] Slightly more urban than rural respondents reported adopting these safety measures to say safe online. However, one-fifth did not follow any of these safety measures and only 4% reported that they would inform someone about objectionable content; 22% of rural and 16% urban respondents reported not following any security measures to stay safe online. In the Tamil Nadu assessment among school teachers conducted during lockdown, over 90% of respondents suggested the need for psycho-social counselling for school children and psycho-social training for school teachers before schools reopen to address the psycho-social impact of the pandemic and lockdown on students and teachers (205034).

[41] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

[42] Ensured that privacy settings on their devices were active, did not accept friend requests from strangers, did not share passwords and informed a responsible person about objectionable content.

While psycho-social support services are available, awareness of these services is limited. The national-level U-Report study conducted after the lockdown indicates that just 44% of respondents had heard of the COVID toll free psycho-social helpline number, and only 53% had heard of the psycho-social support service, Childline. Slightly more urban respondents and respondents over 35 years had heard of Childline (205015b).

Findings suggest that COVID-19 related stigma and discrimination against groups perceived to be at risk of transmitting COVID-19 exists. For example, the seven-state study[43] conducted after the lockdown (17-24 June 2020), reports that over half (55%) the respondents perceived some level of risk from exposure to individuals who have recovered from COVID-19 and individuals who have completed quarantine, and 75% of respondents believed the safest measure for migrants in the pandemic situation is to stay where they are rather than return home (205023). In Gujarat, the biggest challenge for ASHA workers during their work was facing stigma (205035); and around three-fourth of volunteers in the seven-state study[44] reported that in rural habitations, people were afraid to allow home returnees into the community for fear of spread of COVID-19 (62%) or looked down on them (14%). Just one in five volunteers (19%) reported home returnees were welcome to the community (205005). In Gujarat, community networks are addressing the impact of stigma; approximately 70% of sarpanches surveyed had taken the initiative to address COVID-19 related trauma/panic and stigma by providing counselling, creating linkages with CSOs that provide counselling services and providing correct information on COVID-19 to stop panic and rumours (205035).

For certain populations (e.g., the 'corona workforce'), stigma appears to be covert rather than overt. As reported in the aforementioned study, the role of doctors and the police in addressing the pandemic was widely acknowledged. Almost all (91%) respondents believed doctors, nurses and health workers should not to be blamed if they got infected with COVID-19. While 77% of respondents reported being comfortable with someone from the 'coronavirus workforce' (such as hospital and lab staff, police, frontline workers) living in the vicinity, just 57% of respondents were comfortable with the coronavirus workforce using the same essential services. Notably, over half (56%) the respondents reported exposure to messages against COVID-19 related stigma and discrimination (205023).

It can be assumed that the COVID-19 pandemic and the resulting lockdown in particular, have had a disruptive impact of psycho-social well-being, including of women and children. While some of these issues might have been resolved (e.g., access to family/friends) post lockdown, many of these issues are likely to persist as they relate to cultural and normative behaviour, which is difficult to reverse. These are also difficult to measure, with the evidence of these studies showing clear instances of social desirability bias, and difficulties in ethically measuring dimensions of vulnerability and violence.

[43] Assam, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh
[44] Andhra Pradesh, Maharashtra, Rajasthan, Gujarat, Tamil Nadu, Telangana, Uttar Pradesh

Chapter 4: Discussion

Key takeaways

Findings from the UNICEF-led rapid assessments presented in this report reveal an emerging picture of the awareness and knowledge around COVID-19, as well as the impact of the COVID-19 pandemic and the lockdowns, in terms of economic impact, provision and access to basic services and psycho-social impact. Some of the key takeaways are discussed below.

Knowledge, attitudes and practices around COVID-19

- Awareness of COVID-19 at a broad level seems to be fairly high, with messages seemingly reaching even more marginalized populations. Television is by far the most cited source of information (despite the high access to mobile phones), although some of the evidence suggests that especially women might depend more on information from family members and frontline workers.
- There are some gaps in information (or wrong information), especially on specific infection prevention practices – including with people that might be relied on for information (e.g., frontline workers, PRIs). Moreover, actually adopting the right practices seems to be difficult (even based on self-reported surveys), especially for more marginalized populations, which suggests an equity gap. The evidence so far is not able to explain this; the only assessment that probed why (on social distancing specifically) was conducted through U-Report, likely with wealthier and more (digitally) literate respondents.
- While significant efforts have been made to improve access and reach of accurate information about COVID-19 over the last couple of months, including by UNICEF, these findings demonstrate that the information-to-behaviour pathway is complicated. Based on existing psychological theory, other behaviour change techniques might be required to supplement an information-based strategy.

Economic Impact and Coping Strategies

- The COVID-19 lockdown from March-May 2020 had a clear and immediate negative impact on livelihoods and income. Furthermore, because of limited savings, for many marginalized households there was no financial safety-net to fall back on. This has likely led to an overreliance on borrowing and therefore further financial stress and insecurity.
- Migrant workers were particularly hard-hit by the COVID-19 lockdown economically, with many losing their jobs overnight and moving back to their native villages where there were limited opportunities for income.

- With the economy having restarted again after lockdown ended, livelihood opportunities have emerged again, and some migrants have returned to destination areas. However, the temporary loss of livelihoods has likely had significant negative effect on the vulnerability of families, with possible longer-term knock-on effects in terms of women and child health, nutrition, education and protection.

Provision and Access to Key Services

- It is evident that there were severe disruptions in health, nutrition and WASH services in communities during the lockdown. The extent of disruption seems to have varied geographically as well as per service. Some services such as Take-Home Rations were reported to be available and distributed in many places. Nevertheless, there was clear evidence of food insecurity and reduced food intake, especially among the most marginalized populations. This suggests that THR may not be sufficient and/or reaching the right people.
- The evidence around health services shows that even where services might be available (again), demand or uptake of these services might have significantly dropped (e.g. immunization). The limited evidence from WASH services highlights that beyond availability of services, it is important to ensure quality and sufficiency of services.
- Schools remain closed across the country, and access to remote learning opportunities varied, with only a minority of children able to access online/digital learning platforms. Reasons are not just linked to technological barriers, but importantly also issues in the child's immediate environment such as parental support and the financial crisis.
- Most importantly, the evidence around access to services during the lockdown period, across all the sectors, suggests that the most vulnerable groups were particularly left out, and likely continue to be so. The evidence related to access of social protection services - which are meant to be the safety-net of families affected particularly hard by the economic impact and the lack of continuation of basic services -, shows a clear 'last mile' gap. While this was true in 'normal' times, with COVID the gap has widened and become more critical.
- While many services have resumed since the lockdown ended, there are likely going to be lasting knock-on effects. For example, temporary disruption in ANC and immunization services are likely to adversely affect maternal and child health in the medium-term. Temporary disruption in nutrition services, coupled with greater food insecurity, are likely going to have longer-term effects on malnutrition of children, adolescents and women. The ongoing disruption to education services is likely going to adversely affect enrolment rates and learning outcomes in the longer-term.

- Moreover, even where services are available, particularly vulnerable households may not know about it or may not be convinced to use it. Frontline workers, who families often rely on, continue to be constrained in their capacity to mobilize demand. Thus, it will take time to get to a level of access before COVID, and the knock-on effects will persist.

Education

- A number of children were not able to study/learn while schools were shut during the lockdown. It was found that some children continued their studies on their own (self-study), without remote learning materials during the lockdown; parents and siblings also provided learning support.
- Reported access to distance/remote learning materials varied widely. Only a minority of children were able to access digital/online learning platforms.
- A variety of learning tools are being used; across specific tools, WhatsApp is the most common tech-enabled tool, and home visits the most common traditional tools used by students and teachers. The inability to access online learning tools to ensure continuity of learning was cited as a key challenge.
- The quality of learning, student progress and student engagement are perceived to be less through remote learning as compared to in-person learning.
- While teachers are engaged in teaching remotely, the majority spent less time teaching and preparing learning materials post-lockdown, which could lead to adverse learning outcomes.
- There will likely be serious knock-on effects from school closures and the lack of continuation of education.
- Longer-term effects were also noted at an institutional level (on curriculum, syllabus, exams etc.) by school teachers. For schools to be ready to respond to such needs, additional support in terms of workforce (technical as well as non-technical support staff) was requested.

Social Protection Measures

- Reach of cash transfer schemes as well as food rations was recorded across states and state-typologies. About 50% of respondents (across states) recorded availing benefits of schemes such as PMJDY, PMMVY and pension schemes. Food rations were reported to have reached 60% to 70% of respondents. However, current data focuses only on reach and coverage. Data on the relevance and sufficiency of social protection measures is missing.
- Household respondents versus community representatives: It was found that reports of coverage of schemes by community representatives (GP sarpanch, FLW, community volunteers) were higher (i.e. more favourable) than when reported directly by households. There was no clear way of triangulating this by comparing

figures of one against the other in any study. However, future rapid assessments may need to reach directly to households (and more so, specific members of the household) to gain a complete understanding of the situation.

- Bottlenecks identified from various rapid assessments include: limited access to bank accounts, lack of awareness of schemes, lack of paperwork (PDS cards), and inequitable access w.r.t. vulnerable population groups (such as SC, ST groups, daily wage workers, pregnant women etc.)

Psycho-Social Impact and Coping Strategies

- From the available evidence so far, we can infer that there has been a negative psycho-social impact of the COVID-19 crisis and the lockdown. While one study shows that many respondents still reported positive aspects of well-being, this may have been because this was after lockdown and covered a wealthier, urban and (digitally) literate population (accessed through U-Report).
- Indeed, the evidence from some of the State studies shows a different picture, with households reporting increased gender inequality and informants reporting issues in domestic violence, violence against women and children, child labour, child marriage, child neglect, child trafficking, etc. linked to the lockdown and the economic crisis.
- While limited studies suggest that psycho-social support services and child protection services are/were available, awareness of these services was limited including awareness of the ChildLine number.
- Importantly, findings from one multi-state study found that COVID-19 related stigma and discrimination exists against groups perceived to be at risk of transmitting COVID-19 (especially migrants), which includes covert stigma directed at the so called 'corona workforce' (hospital and lab staff, police, frontline workers). This is not just likely to reinforce adverse psycho-social effects on those specific groups, it is also likely to engender further marginalization of vulnerable groups in terms of access to support.
- Worryingly, even after the COVID-19 crises eventually passes, many of the psycho-social issues identified are likely to persist as they relate to cultural and normative behaviour, which is difficult to reverse.

Challenges and gaps in the evidence

While a lot of evidence has been generated over the past six months, it has been a challenge to synthesize the data from all the rapid assessments in this report. As the previous section indicates, there were a lot of 'varied' findings; however, it is difficult to discern whether these truly reflect variations in geography and specific population groups, or if this is a consequence of the different approaches RAs used to undertake data collection (e.g., different modalities, different indicators, etc). Information across the RAs

was not gathered in a standardized manner, which makes it difficult to compare and synthesize. In future, it is recommended that standardized tools are developed and used to allow for comparisons across the studies.

Furthermore, the findings from the RAs themselves need to be interpreted with caution, as we find that:

- Very few of the findings from rapid assessments are representative, as they are drawn from single state studies covering a few districts and have sampled their respondents purposively rather than randomly. This means that findings cannot be generalized; at best they can indicate that instances or issues have occurred, rather than the extent of them and trends. There is a need to invest in larger, multi-state and representatively sampled studies to be able to establish this.
- Some studies have revealed the possible existence of social desirability bias (e.g. responses on issues around COVID-related stigma) and other issues in self-reported measurement (e.g. handwashing behaviour), which means we may not be measuring the 'truth'. There is a need to find different ways of measurement to try and circumvent any biases or issues, to obtain an accurate understanding.
- Most of the findings cited in this version of the synthesis report pertain to data collected during lockdown, and so they may be outdated; the situation and needs of populations likely changed substantially since June. It is therefore important to continue collecting evidence of the situation now, and to synthesize these findings quickly to influence programming and policy-making.

When examining thematic gaps, we find that there is still limited evidence available in sectors such as WASH and Child Protection. Especially sensitive issues such as violence against women and children have not be captured, likely because it is difficult to accurately and ethically measure these, including telephonically in a time when support services are still potentially not fully accessible. There is therefore a real need to identify more acceptable proxy-indicators, or sources of secondary data, to obtain critical information on serious protection issues for children during this time.

While most rapid assessments have been successful in obtaining information about the situation of vulnerable populations, it has been difficult to directly reach them and obtain information from these groups. Restrictions in sampling persist due to the need to undertake data collection telephonically, which - even in a country like India, with high degree of mobile phone ownership - means that the views and experiences of certain populations are missed out, such as women, adolescents, and children. It is important to devise ethically responsible mechanisms to be able to reach these more vulnerable populations, and ensure that their voices are heard.

The vast majority of rapid assessments undertaken by UNICEF were one-off efforts, with the intention to only obtain a high-level snapshot of the situation at that particular time. While this was useful in the immediate emergency response phase, we see that those assessments that investment time up front to set up multiple rounds of data collection are able to generate more useful information, especially as the lockdown was lifted. This is an important lesson for any future emergency response situation: think about ways to capture the longer-term effects, before the assessment starts.

A critical gap that is emerging from the attempted analysis in this report is the need to undertake qualitative data collection to answer questions of 'why' and 'how'. For example, why is it that there is high recall of COVID-19 messages on prevention but relatively low compliance of the same preventive measures? Why is it that while THR services are being reported to be functioning at the village-level, there are instances of food insecurity being reported? How are children belonging to the economically vulnerable households (who may not have access to a telephone) coping with their educational needs?

Finally, this review only considers UNICEF-led rapid assessments. While this chapter has tried to make some attempt at triangulating or validating the findings with research and studies undertaken by others, the synthesis picture is likely to be incomplete without including those assessments and their findings. A key recommendation moving forward therefore, is to expand the scope of this report to include a desk review and synthesis of all assessments and studies undertaken in India that focus on the socio-economic impact of COVID-19 on vulnerable populations, especially women and children.

Chapter 5: Programmatic Reflections and Recommendations

As indicated in the RAs, the COVID-19 pandemic and the lockdowns have had both short and long-term impacts on the population, particularly disadvantaged groups. The crisis is now compounded by financial challenges at the household level, which has the potential to derail previously made progress in areas of health, nutrition, education, protection etc. While many of service provision problems may have been resolved post-lockdown, several concerns remain. First, in some cases, temporary disruption of health services may mean knock-on effects for women and children (e.g., increased child illness due to no vaccination, issues in delivery due to no ANC, family planning, etc). Second, demand side issues show that access is likely be lower than before, especially given the fact that the COVID crisis is still ongoing means that the community health workers, often relied on to stimulate demand, are still overworked and they may not be doing the job they are required to do. The lack of food security and the disruption in nutrition services, even in some cases only temporarily, during the lockdown, and the lower intake of food, suggests that there will be consequences for the nutritional status of vulnerable populations, even post lockdown. Moreover, there could be considerable knock-on effects from school closures and lack of continuation of education (e.g., school drop-out, increase in child labour and child marriage). The psycho-social consequence could be immediate and far-reaching (e.g., adverse mental health outcomes and violence against women and children).

Evidence from the RAs indicates that a) there is still a need to correct misunderstandings around COVID; b) that, as is classic in behaviour change, knowledge/information does not necessarily translate to behaviour; c) despite the high degree of smartphone use and access to internet, TV remains the main source(which would be important to leverage and to explore further); d) while the media is a main source, community-level communication through local institutions or networks remains important; presumably to reach those who are most marginalized (although this would need to be validated)

Across the states, while a range of socio-economic and psycho-social support services and schemes and benefits are available (both existing and post-COVID-19), coverage is far from universal. Notably, access to these schemes and services was highly inequitable for specific population groups such as migrants, women and daily wage workers who need them the most. Programmes need to focus on bridging this 'last mile' gap. Lack of awareness of programmes and schemes is an underlying a barrier to access, identified for most sectors in most states, which would need to be addressed. Frontline workers can support the response by providing information around COVID-19 and ensuring prevention practices are adopted. Community groups could play an important role in supporting the COVID-19 response. PRIs could be capacitated and empowered to build awareness around COVID-19, including issues of stigma and discriminating attitudes, ensuring that COVID-prevention measures are in place and being adopted, ensuring food security to marginalised populations, linking marginalised groups to benefits and schemes and supporting them to access bank accounts, and ensuring support for continuing education.

As UNICEF continues to respond to the COVID-19 crises, we need to urgently respond to these challenges and recommendations arising from this synthesis report. While we ask ourselves the following questions, we do need to investigate further in some areas. The following recommendations, therefore, act as guiding questions for both – programmatic planning and implementation as well we further research and evidence generation. The questions below have been grouped according to the framework adopted in this report:

- Do we know enough about what the ongoing key issues are, and what the reasons behind them are? Do we need to undertake further research to understand the 'what', 'why' and 'how'?
- Is our programming responding to each of these issues sufficiently? Are we adopting a pre-emptive stance to ensure that further possible knock-on effects are minimized?
- Are we able to determine what works in our response and that of the government? How adaptive is our programming so that changes can be made quickly in response to new emerging evidence?

Knowledge, Attitudes and Practices

- Is our behaviour change communication theory of change any different in an emergency? What have we learnt so far?
- Are we leveraging television, as a key source?
- Given the gendered access to mobile phones and television, what have been some of our responses to reaching directly to women with critical information on COVID-19? DO we have any evidence to know if this has worked?
- Through our capacity building of frontline workers to spread information, are we being gender-responsive?
- Are we exploring other means of behavior change, beyond just providing information?

Economic Impact

- What has been the immediate, short-term impact of the COVID-19 crisis within the most marginalized communities? What have been some of their coping mechanisms?
- What is the longer-term impact of the COVID-19 crisis on income, livelihoods and employment?
- Can we more directly and robustly demonstrate the impact of the likely increase in poverty as a result of this crisis on the vulnerability of women and children?

Health, WASH, Nutrition Services

- What are we doing to ensure that services are of high quality, where they have resumed?
- What are we doing to ensure that services are adequate to meet a changed need (e.g. nutritional services)?
- What are we doing to encourage uptake for services such as immunization?
- Are we responding well to the demands of FLWs with respect to refresher trainings? Do we need to conduct more and often?
- Inquire why despite reports of THR services resuming, instances of food shortage and reduced food intake are being reported.
- Is it possible for us to conduct compliance surveys (especially w.r.t. critical WASH behaviours and mask usage)?
- Has our response to COVID resulted in a more equitable access to WASH services (i.e., access by the most vulnerable equity groups)?
- Have our definitions of 'marginalized populations' changed during COVID-19? How are we focusing on the 'medically vulnerable'?
- How well are we adapting to a change in focus from largely rural programming to a clear urban focus (e.g., urban slums)?

Education

- What does the schooling/education system look like for the most marginalized during times of closure/social distancing?
- What are some of the longer-term effects of school closure/children being out-of-school? Are there any knock-on effects such as an increase in instances of child marriage, child labour, instances of violence, unfulfillment of basic nutritious needs etc.?
- What are some of the most effective mechanisms to reach out to the most marginalized while at home? Is our programming prioritizing such mechanisms?
- Are there mechanisms through which we could inquire about the quality of learning during school closure and after services are resumed?

Social Protection

- More needs to be captured on what community members (especially the most marginalized) feel about the social protection support/interventions being sufficient/enough? At the moment assessments largely inquire about reach and access and not on the quality of interventions/schemes.
- What do we know about the gendered and equitable access to social protection scheme? Are women being able to access (and utilize) these interventions/schemes? Are the schemes being utilized by the most marginalized?

- How can we support local community-based institutions such as GPs/PRIs to play an important role in supporting the social protection response to the COVID-19 pandemic?
- How can we advocate with the government regarding the challenges faced by communities in accessing social protections schemes (e.g., access to cash, credit, banking services)?
- Much like 'migrants', have we identified the most critical or vulnerable groups of people/communities that need special social protection support? Who are these communities and how are we addressing their needs?

Child Protection

- While there is data available on systemic challenges around child protection services, how best can we inquire on issues of child protection – that is, keeping in mind challenges around ethics of data collections w.r.t. sensitive questions, ensure safety of respondents, etc.
- Could secondary sources be leveraged? Can anecdotal evidence from key informants be used (for example, qualitative reporting from CSO partners, community representatives/volunteers)?
- How effectively have we responded to the increased threat of violence that children may be facing in their households/communities?
- How well did we respond to protecting migrating children and children in relief camps? Can lessons be learnt from this experience – challenges as well as best practices?

Psycho-Social Support

Along the social ecological model, questions on psycho-social impact and coping strategies can be divided into three segments: individual-level, household-level, community-level.

Individual level

- Inquire what have been the effects on children during this period? As a result of school closure, restricted physical movement, limited outdoor play and socializing, increased screen time etc.
- Inquire what have been the effects on the most marginalized/vulnerable during this period?

Household/Interpersonal level

- Can we show the impact of COVID-19 within the household? Gender relations within the household: Increased workload on female members of the house? Limited exposure to direct sources of information? Limited facetime with existing

support structures (such as SHGs, other CSOs and NGOs working on gender issues).

- If collecting primary data is not possible, can we use existing global knowledge (from recent studies) to understand better household relationships and respond through programming? Can we use modelling techniques (with strong assumptions) on previously known data in India to better understand the situation?

Community level

- How effectively have we managed to address issues of stigma and discrimination at the community-level? How have we responded to challenges of discrimination against some of the new groups (i.e., health workers, medical staff, doctors etc.) and older marginalized groups (i.e., Religious groups, castes etc.).
- What has been our response to the reported metal health crisis (such as, emotional and psychological stress) How has our programming responded to addressing the mental health concerns of individuals as well as communities?