DEVELOPMENT SOLUTIONS INC
IDEAS to ACTION

EFFECT OF COVID-19
ON PROGRAMS AIMED AT

IMPROVING HEALTH & NUTRITION STATUS OF WOMEN & CHILDREN

IN RAJASTHAN

APRIL 2021

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Acknowledgements

The COVID-19 pandemic has led to an unprecedented crisis affecting the lives of millions globally. Evidence and research to understand the effect of the pandemic on various facets of life and socio-economic development are critical to guide Governments, policymakers, and program implementors. We hope that this report would provide valuable insights to the Government in Rajasthan and local organizations to respond to the pandemic effectively.

We wish to thank the Departments of Women & Child Development (DWCD) and Medical, Health & Family Welfare (DMH&FW), Government of Rajasthan, for their support in conducting this study.

We thank the Institute of Development Studies, Jaipur, for their technical inputs as the Knowledge Partner in this study. We also thank IPE Global Limited for commissioning this study.

We are grateful for the time and support of the study respondents, including officials from the district offices of the DWCD and DMH&FW, front line workers, and community members.

We also thank our research team without whose support ensured the completion of this study on schedule.

Abbreviations

ANC	Antenatal Checkup
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCMO	Block Chief Medical Officer
CAS	Common Application Software
CDPO	Child Development Project Officer
CMHO	Chief Medical Health Officer
COVID-19	Coronavirus Disease - 19
DWCD	Department of Women & Child Development
DMH&FW	Department of Medical, Health & Family Welfare
FAO	Food and Agricultural Organization
FLW	Frontline Worker
GO	Government Order
HCM	Hot Cooked Meal
HBNC	Home Based Nutrition Care
HMIS	Health Management Information System
HSC	Health Sub Centre
ICDS	Integrated Child Development Services
IFA	Iron and Folic Acid
IRB	Institutional Review Board
IGMPY	Indira Gandhi Matritva Poshan Yojana

JSY	Janani Suraksha Yojana
LS	Lady Supervisor
MAM	Moderate Acute Malnutrition
MCHN	Maternal & Child Health and Nutrition
MDM	Mid-Day Meal
MIS	Management Information System
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MoHFW	Ministry of Health and Family Welfare
MPR	Monthly Progress Report
NFHS	National Family Health Survey
NL	Non-Lactating
NP	Non-Pregnant
PDS	Public Distribution System
PHC	Primary Health Care
PCTS	Pregnancy Child tracking and Health Services Management System
PMMVY	Pradhan Mantri Matru Vandana Yojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PNC	Prenatal Check-up
POSHAN	Prime Minister's Overarching Scheme for Holistic Nutrition
SAM	Severe Acute Malnutrition
SHG	Self Help Group
SNP	Supplementary Nutrition Programme
THR	Take Home Ration
TT	Tetanus Toxoid
VHND	Village Health and Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committee

Executive Summary

The COVID-19 pandemic globally and in India has affected the health and social support systems. There were significant disruptions in delivery of essential services, particularly rural outreach services in India. Several studies and media articles reported the challenges faced by Frontline Workers (FLWs) in delivering healthcare and nutrition support services to women and children.

India, over the years, has made progress in addressing the health and nutrition status of women and children; however, it is likely that the disruption caused by the COVID-19 pandemic may adversely affect this progress. **This study, undertaken in Rajasthan, India, sought to understand women and children's health and nutritional challenges in the context of the COVID-19 pandemic** and derive recommendations.

The study, undertaken in four districts of Rajasthan - Baran, Jhunjhunu, Jodhpur and Udaipur, used mixed methods of data collection:

- Primary data was collected through qualitative interactions with – lactating women, heads of households, community members, frontline workers (FLWs), and officials from the district offices of the Departments of Women & Child Development (DWCD) and Medical, Health & Family Welfare (DMH&FW).
- Secondary data on key indicators were gathered from State Government data systems and Anganwadi Centre (AWC) registers.

Key Findings	
Effect of COVID-19 on health services	**Antenatal Checkup (ANC)** • The Maternal & Child Health and Nutrition (MCHN) days were suspended from March – July 2020. Instead, FLWs followed up with pregnant women over the phone or during home visits. In case of discomfort, women were referred to the health facility. No physical ANC examinations or weight monitoring was done. • In Jhunjhunu, ANC examinations were conducted on the 9th of each month at the Primary Health Centres (PHCs) under the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA). The PMSMA, launched by the Ministry of Health and Family Welfare (MoHFW), Government of India, aims to provide assured, comprehensive, and quality ANC, free of cost to all pregnant women.

Effect of COVID-19 on health services	**Provision of Iron-Folic Acid (IFA) and Calcium supplements to pregnant women** • Initially, a few supply concerns were reported. FLWs took additional stocks from PHCs. They also accessed stocks available at schools, which were closed due to the pandemic. • FLWs provided rationed the supplements and gave smaller quantities to the women and adolescent girls till stocks were replenished to ensure that no one was deprived. **Counselling for pregnant and lactating women** • In the absence of routine care, FLWs provided women advice and counselling on pregnancy, breastfeeding, nutrition and diet, childcare, consumption of IFA and calcium tablets during home visits or over the phone. **Institutional deliveries** • Institutional delivery services were available through the year. However, there was apprehension among communities regarding the safety of Government hospitals. **Post Natal Care (PNC) and Home-Based Newborn Care (HBNC)** • During the first lockdown (particularly in the initial months), many households did not permit the ASHAs to enter their homes or meet women and children, owing to the fear of contagion. • ASHAs continued to undertake PNC and HBNC visits, spoke to the older women of the house, enquired about the health and wellbeing of the woman and child and gave them context-specific advice. **Immunization** • Across districts, immunization services were not provided between March to May 2020. • Catch up rounds of immunization and MCHN days were conducted on resumption of services. **Growth monitoring and identification of malnourished children** • From April – June 2020, while MCHN days were suspended and AWCs were not functional, growth monitoring of children was hindered. • To the extent feasible, malnourished children were identified based on visual observation and enquiry during home visits.

Effect of COVID-19 on nutrition services	• Access to Take Home Ration (THR) for pregnant, lactating women and children was ensured throughout 2020 by the state. Anganwadi Workers (AWWs) undertook significant efforts to provide the same within their service areas. • Children (3-6 years of age) who were earlier partook of the Hot Cooked Meals (HCM) at the AWC were given THR instead. • Between April – June 2020, AWWs delivered THR at the beneficiaries' doorsteps. Since the end of the lockdown (in June 2020), beneficiaries are called in smaller batches to collect rations. • The change in THR form provided (from fortified dry mix to whole grains) was preferred by beneficiaries, leading to increased demand for THR at the AWCs. • Access to the Pradhan Mantri Matru Vandana Yojana (PMMVY) was not affected by the COVID-19. Systemic delays in receipt of payments by beneficiaries was a challenge.
Challenges in service delivery	• In addition to their recurring roles and responsibilities, FLWs were engaged in the community-based response to the COVID-19. • They faced several challenges in undertaking both roles – ▪ Resistance and hostility from the community ▪ Lack of safety and protective equipment ▪ Lack of adequate transportation services ▪ Workload and role management; management of household responsibilities ▪ Fear and stress • Supervisors and officials also faced challenges in the coordination and management of field-based and other activities. There was a heavy reliance and sudden pivot towards phone/ technology for remote monitoring and updates.
Effect of COVID-19 on households	**Other than affecting the provision of and access to health and nutrition services, COVID-19 also affected:** • Livelihoods and income; household expenses increased, with reduced or no income. • Restrictions on mobility and lack of public transport affected access to healthcare and other essential services.

Effect of COVID-19 on households	• In the absence of schools, the education and engagement of children were affected. • There was an additional burden on women to manage household responsibilities (look after children, cook and provide for all household members). • Access to some foods was affected; fruits and vegetables were expensive during and post lockdown. • In most households, efforts were made to ensure that pregnant and lactating women and children were given adequate food and nutrition, despite increasing expenses. • However, women from financially insecure households skipped meals or reduced the frequency of eating.
Cash distress owing to COVID-19	• Given the loss of livelihoods and income and increased expenses, many households faced cash distress. • They used their savings or resorted to borrowing from friends and relatives or purchasing on credit to make ends meet. • However, there was a concern that this stop-gap arrangement was temporary - that people would eventually stop lending and that borrowed money would have to be returned. There was need for employment.
Mitigating the effect of COVID-19	• Communities and households adapted to address the challenges of COVID-19. The government's support, both at the state and local levels, support from NGOs, and leveraging the local social capital enabled the adaptation. • Several forms of Government support, including THR from AWCs, double rations provided through the Public Distribution System (PDS) and relief as a part of the Jan Dhan Yojana, were accessed. • Affluent persons from the villages/ communities provided support in the form of food grains—Panchayats set up kitchens to provide food for those who could not afford it. • Many also borrowed from friends and relatives and purchased from stores in credit. • Apart from relying on external support, some started kitchen gardens; others cultivated vegetables in their farmlands. • NGOs also supported in access to food grains, food kits, vegetables, and other essential supplies, including masks, soaps, sanitizers, and even sanitary pads for women and girls.

Recommendations

In pandemic times, such as the COVID-19, the Government systems are invariably geared to address the immediate challenges. There is a tradeoff. It is likely that the attention shifts from the long-term program activities to focusing on immediate needs. With the pandemic continuing to spread in waves, the effort should be to strengthen Government systems such that they are robust and functional during critical times while not losing the long-term program focus. It is also essential to build community resilience so that they can manage without significant disruptions. More so, the poorer households that are more dependent on government support. It is from this perspective that nutrition-specific and nutrition-sensitive recommendations are suggested.

1. Maternity Entitlements: Put Cash in Women's Hands

Despite the rations and support provided by the Government and civil society organizations, many households still felt the need for cash for household, transportation, and medical expenses.

Maternity benefits amounting to at least Rs. 6,000 per child are a legal right of all Indian women under the National Food Security Act, 2013. The Government of India's Pradhan Mantri Matru Vandana Yojana (PMMVY), which provides financial relief to first-time pregnant women, is the right step in this direction. During difficult times, the need for a cash transfer scheme that gives money directly to the hands of the needy is even more pressing.

However, our research shows that delay in paperwork and lack of an automated system has created challenges for beneficiaries in receiving the benefits of such schemes, especially when they need it the most. In case of delayed payments, pregnant and nursing women might not be able to buy nutritious foods during the crucial 1,000 days of a child's life.

Sufficient and systematic cash transfers can play a significant role in plugging gaps in individuals' health and nutritional requirements, especially for vulnerable groups such as pregnant and lactating women. Thus, especially during crises, governments should ensure that cash transfers reach eligible beneficiaries on time.

2. Empower Women through Financial and Mobile Literacy

Cash transfers alone do not guarantee that women will use these for their essential needs – policies must also focus on women's financial and mobile literacy. According to NFHS-4, in rural Rajasthan, only 55% of women have a bank or savings account that they use, and only 34% of women have a mobile phone they use. Making Direct Benefit Transfers (DBT) paperless

and automated and women's financial and mobile literacy should go together. Platforms to educate women about financial and mobile literacy can also help spread awareness about maternity entitlements.

3. Family MUAC as a no-touch assessment protocol

The Family MUAC approach, also known as Mother MUAC, is an established strategy to increase screening coverage and promote early detection of wasting and/or deterioration by training caregivers to assess MUAC and check for oedema at home. In the context of COVID-19, caregivers should also conduct these assessments during home visits by ASHAs, thereby eliminating the need for FLW to touch a child.

The considerations for implementing no-touch assessment are:

- The caregiver/child should sit in a designated area that is 2 metres away from the ASHA.
- The ASHA should provide caregivers with their separate MUAC tape during home visits.
- Before coaching and observing, the ASHA should first demonstrate how to take MUAC, check for oedema, repeat as necessary, and use a doll or cylindrical object to display from a 2-metre distance.

ASHAs should work with caregivers to identify the color zone and read the numeric measurement during home visits.

4. Strengthen Maternal and Child Health Outreach Services

Given the current pandemic situation and anticipation of a third wave, governments need to explore alternatives for in-person outreach health services like growth monitoring, Home Based Newborn Care (HBNC), and services conducted in public gatherings like MCHN day Community Based Events (CBEs). The use of mHealth and telemedicine can prove to be helpful in such a scenario. More so in Rajasthan, where the population in different pockets is scattered owing to the state's topography. Tele counselling (using phones owned by women/ their families) can be adopted to continue giving nutrition-related education and information

to pregnant and lactating mothers. For HBNC, Kangaroo Mother Care (KMC) demonstration can be done using demonstration material and showcasing educational videos.

5. Improving distribution mechanism of THR during emergency

For AWW, it wasn't easy to arrange transportation to pick up bulk rations from a distribution centre. A public-private partnership with private transport service providers can be helpful in an emergency and lockdown scenario. A vehicle with three staff can be deployed to pick up the supply from storage/warehouse and distribute the ration from Anganwadi to Anganwadi till movement is restricted and lockdown is imposed. For elderly AWWs, it isn't easy to load the supply and bring the same to a common distribution point. The THR provided to AWWs should be pre-packed to avoid additional workload for them.

SECTION: 1

Introduction and Objectives

"We are facing a global health crisis unlike any in the 75-year history of the United Nations — one that is killing people, spreading human suffering, and upending people's lives" (Department of Economic and Social Affairs, United Nations). The COVID-19 pandemic has led to an unprecedented crisis, owing to its high morbidity and mortality burden globally and related economic, social, and political disruptions.

The increasing demand for health care is overstretching health and social support systems and limiting other essential healthcare services. Shut down in travel and trade have impacted supply chains and access to drugs, products, and protective equipment. Health and social support systems, both in developed and developing nations, have been affected and overwhelmed.

In India, the initial phase of the pandemic led to a significant disruption in the provision of healthcare and other essential services. Several studies and media articles reported the challenges of FLWs in delivering healthcare and nutrition support services to women and children. A study undertaken by Development Solutions in five states, including Rajasthan, in May-June 2020, indicated the suspension of outreach health and nutrition care services for women and children. FLWs were engaged in COVID-19 related responsibilities, affecting their ability to simultaneously provide care to women and children. While services were available at the facility level, fear of COVID-19 kept communities from accessing Government facilities[1].

India, over the years, has made progress in addressing the health and nutrition status of women and children; however, it is likely that the disruption caused by the COVID-19 pandemic may adversely affect this progress. This study, undertaken in Rajasthan, India, sought to understand the health and nutritional challenges of women and children in the context of the COVID-19 pandemic and enable recommendations to safeguard access to nutritious diets and essential services for women and children.

[1]*Rapid assessment to understand the impact of COVID-19 on availability and access to health and nutrition services for children, women and adolescents; Development Solutions; supported by Population Foundation of India and Children's Investment Fund Foundation*

Health and nutrition status of women and children in India and Rajasthan

Nutrition is one of the significant determinants of health. According to Food and Agricultural Organization (FAO), 16% of the population in India is malnourished despite various government interventions[2]. Just over half of all women, 15-49 years of age in India, are anaemic (NFHS 4). Though there is a marginal decrease in the prevalence of anaemia among women in India, from 58% in the National Family Health Survey 3 (NFHS 3)[3] to 50% in NFHS 4[4], the pace of improvement has been gradual and falls short of the national and Sustainable Development Goals[5].

The nutritional and health status of children in the country is a concern too. Nearly 60 per cent of children 6-59 months of age are anaemic. 38% of under 5-year children are stunted, and 21% are wasted (NFHS-4). Despite various interventions, under-nutrition among children persists. The reasons range from insufficient access to food, inadequate access to health-related services, and inadequate maternal/childcare practices at the household level [6 7].

Rajasthan, the largest state in India in geographical terms, bears a significant burden of anaemia and malnutrition. According to the NFHS- 4, Rajasthan falls short on most national average health and nutrition indicators, except for prevalence of anaemia among women aged 15-49 years. (see Table 1.1).

Table 1.1: Indicators of health and nutrition among women and children by NFHS-4 (2015-2016)

Indicator	NFHS-4 (2015-2016) Statistics[8]	
	India	Rajasthan
All women aged 15-49 years who are anaemic (%)	50.4	46.8
Non-breastfeeding children age 6-23 months receiving an adequate diet (%)	14.3	3.7
Children under 5 years who are stunted (height-for-age) (%)	38.4	39.1
Children under 5 years who are wasted (weight-for-height) (%)	21.0	23

[2] *Ghai, K., Rana, Y., Ahmad, N., & Clift, J. (2016). Nutrition Financing in Rajasthan: Trends and Gaps in 2016-17*

[3] *Conducted in 2005-06*

[4] *conducted in 2015-16*

[5] *Paul, V. K., Sachdev, H. S., Mavalankar, D., Ramachandran, P., Sankar, M. J., Bhandari, N., ... & Kirkwood, B. (2011). Reproductive health, and child health and nutrition in India: meeting the challenge. The Lancet, 377(9762), 332-349.*

[6] *UNICEF, S. (1998). The state of the world's children 1998.*

[7] *Martorell, R. (1999). The nature of child malnutrition and its long-term implications. Food and nutrition Bulletin, 20(3), 288-292*

[8] *National Family Health Survey (NFHS-4), 2015-16: India. (2017). Retrieved from http://rchiips.org/nfhs/NFHS-4; Reports/India.pdf. (25February 2021)*

Rajasthan had among the highest rates of maternal and neonatal deaths (Census 2011)[9]. 47% of women aged 15-49 years in Rajasthan are anaemic. Rajasthan is ranked 10th worst out of 29 states for stunting and 15th for wasting among children[10]. 39% of children under 5 years are stunted, 23% are wasted, and 37% are underweight. Only 39% of women in the state had at least four antenatal care visits, and only 17% consumed IFA for 100 days or more when they were pregnant (NFHS-4).

To address the poor nutritional status of women and children, the Government of India and the Government of Rajasthan have taken immense strides and instituted various programs and initiatives. These programs seek to provide financial and nutrition supplementation, in addition to information to key beneficiary groups. They also seek to mobilize communities to change behaviours and act on issues of nutrition.

1.1 Objectives of the study

The objectives of the study were to:

- To understand the effect of the COVID-19 pandemic on the functioning of health and nutrition programs for women and children.
- To understand and assess the enhanced risk factors at a household level, owing to COVID-19.

Given the objectives, the study understood how the COVID-19 impacted (A) delivery and access to Government programs and (B) domestic food security, nutrition, and health behaviours:

Program delivery and access

- Gaps and challenges in delivery of health and nutrition programs and services
- COVID-19 induced challenges in access to programs
- Role of schemes in mitigating the nutritional distress induced by COVID-19

Food security & nutrition behaviors

- Factors affecting food security at a household level
- Impact on nutrition and health behaviors and practices
- Impact of the shift in provision of supplementary nutrition (from hot cooked meals to THR) on children

[9] *Census of India: Rajasthan profile. (2011). Retrieved from https://censusindia.gov.in/2011census/dchb/Rajastan.html. (25 February 2021)*

[10] *Rapid Survey on Children 2013-2014. (2014). Retrieved from https://wcd.nic.in/acts/rapid-survey-children-rsoc-2013-14. (25 February 2021)*

1.2 Study locations

The study was undertaken in four districts in Rajasthan – Baran, Jhunjhunu, Jodhpur and Udaipur. The districts' selection was purposive based on nutritional indicators, population groups, geography, topography, and agro-ecology. Two blocks were selected for data collection in each of the districts – one district headquarters (HQ) block and one far from the district headquarters. A profile of the study districts is provided in Table 1.2.

Figure 1.1: Rajasthan district map with study districts

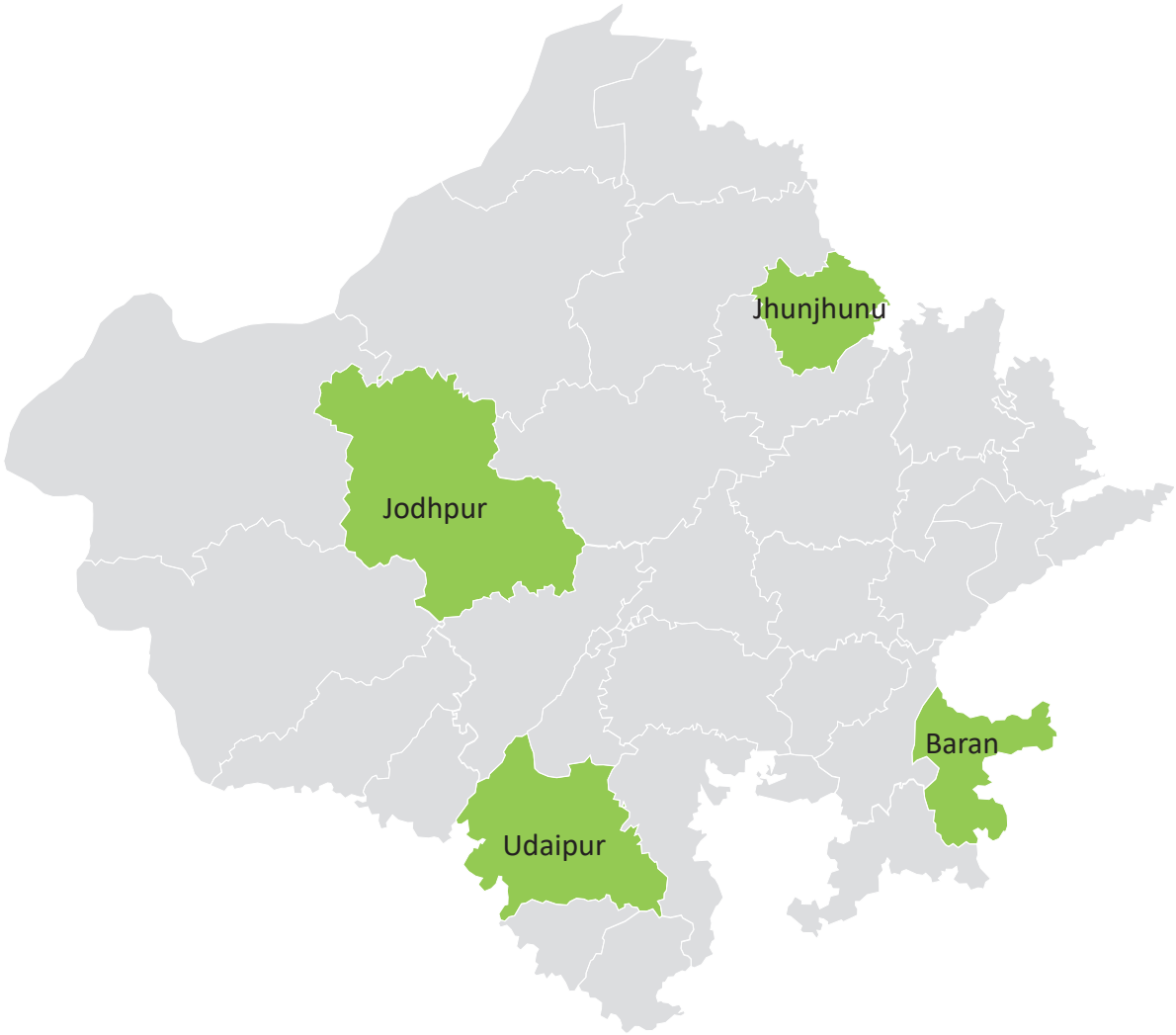


Table 1.2: Profile of study districts

	Baran	Jhunjhunu	Jodhpur	Udaipur	Rajasthan
Profile	South-East Rajasthan	North Rajasthan	West Rajasthan	South Rajasthan	
	Tribal Population Group; Poor Performing District	Best performing district in Rajasthan in terms of health and nutritional indicators (except stunting)	Arid Zone- distinct agro-ecology Average performing district in terms of nutritional indicators.	Tribal population; poor-performing district	
Study blocks	• Baran – District HQ block • Shahbad – Inhabited by Saharia tribe; block known for malnutrition-related deaths, poor service access	• Jhunjhunu – District HQ block • Alisisar - High Muslim and SC population. Block known to have limited access	• Jodhpur - District HQ block • Osian – Desert/ arid region	• Girwa - District HQ block • Rishabdeo - High ST population, hilly region	
Sex ratio	959	1020	952	1043	973
Women's literacy	52.9%	68.7%	55.7%	50.5%	56.5%
Child Stunting	40.2 %	32.5%	40.3%	47.5%	40.8%
Child Wasting	28.5%	13.6%	23.8%	29.9%	23.8%
Child Underweight	41.1 %	19.5%	38.6%	52%	38.4%
Women with low BMI	30.7%	19.3%	20.8%	37.7%	29.9%
PW with anemia	69.5%	27.7%	40.8%	73.5%	48%

1.3 Study methodology

The study used mixed methods of data collection:

- Primary data was collected through qualitative interactions with – lactating women, heads of households, community members, front line workers, and officials of the health and women and child development departments.
- Secondary data on key indicators gathered from State Government data systems such as the Pregnancy Child tracking and Health Services Management System (PCTS), Management Information systems (MIS) and Monthly Progress reports (MPR) disaggregated at the district level. Data was also gathered from registers at the AWCs.

The secondary data was triangulated with primary insights wherever possible to enable a comprehensive understanding of the study objectives.

Primary – Qualitative data collection

In each of the study blocks, two AWCs were selected from nearby Gram Panchayats. The first AWC was chosen randomly, and the second AWC was at least 10 kilometres away from the first. Respondents were selected from each AWC area, and interactions were undertaken, as outlined in Table 1.3. Interactions with officials were undertaken at block and district levels.

Table 1.3: The respondents and methods of primary data collection

Respondents	Method of data collection	Sample
Community members		
Lactating Mothers	Semi structured in-depth interview	32 (8 per district)
Lactating mothers	Semi-structured in-depth interview	32 (8 per district)
Head of the household	Semi-structured in-depth interview	32 (8 per district)
Community members	Mini Group Discussions (MGDs)	8 (2 per district)
Service providers		
AWW	Key Informant Interviews	16 (4 per district)
ASHA	Key Informant Interviews	16 (4 per district)
ANM	Key Informant Interviews	8 (2 per district)
Supervisors and officials		
Lady Supervisor (LS)	Key Informant Interviews	4 (1 per district)
Child Development Project Officer (CDPO)	Key Informant Interviews	4 (1 per district)
Block Chief Medical Officer (BCMO)	Key Informant Interviews	8 (2 per district)
Chief Medical Health Officer (CMHO)	Key Informant Interviews	2 (1 each in Baran and Jhunjhunu districts)

1.4 Challenges and limitations

- This study captures only the experiences from the 2020 lockdown period; the experiences from 2021 are outside the scope of this assignment.
- Pregnant women were initially proposed as a respondent group for the study. However, given that pregnant women fall in the high-risk category for COVID-19, women who had 'recently delivered/ lactating' were included instead as respondents for the study.
- In certain districts, owing to the COVID-19 vaccination drive, it was challenging to secure appointments with health officials (BCMO, CHMO).
- Secondary data gathered from CDPOs, BCMOs and CMHOs, was variegated, with data for specific indicators and time periods missing. In some locations, only annual data (not monthly) was made available. In others, while data on reach was available, the data on several eligible beneficiaries was not available. In the data made available from the PCTS and HMIS, proportions for some indicators exceeded 100%. In this report, the authors have used PCTS data for secondary reference. Any data anomalies are as recorded on PCTS and used under bona fide assumptions.
- Given limited time, primary data collection and secondary data analysis were done simultaneously; and hence, trends emerging from the quantitative data could not be understood wholistically through qualitative enquiry. Studies can be undertaken later to understand the contexts and trends for the quantitative data and understand the longer-term impact of the pandemic if any.

SECTION: 2

The effect of the COVID-19 pandemic

This section outlines the effect of the COVID-19 on the delivery and access to health and nutrition programs, the challenges faced by frontline workers in enabling services, and how the pandemic affected households.

2.1 Health services

- Provision and access to health services were affected between April – June 2020, more so in April and May 2020. Community-based services, including MCHN day, ANC, Immunization, and growth monitoring for children, were affected.
- During this period, FLWs enabled home and phone-based support. The scope was limited to general enquiry and advice. No physical examinations and tests were done.
- PNC, HBNC services and counselling/ advice to pregnant and lactating women were provided by FLWs during home visits, to the extent feasible.
- Despite initial supply issues, IFA and calcium supplementation was provided to pregnant women.
- In the April – June 2020 period, the identification of SAM cases was primarily based on observations, with adequate social distancing. Overall, a lower number of SAM cases were reported in 2020, as compared to 2019, as families did not permit close contact measurement by FLWs for the latter to gauge malnutrition.
- Community-based care was resumed post-July 2020, ensuring safety and COVID-19 precautions. Several adaptations in service delivery were undertaken, including – catch up rounds of missed services and staggered hours for footfall control.

The central and state governments issued several notifications and orders on providing health and nutrition services during and post the first lockdown in 2020. In Rajasthan, on 27 March 2020, all social mobilization for immunization was cancelled. It was recommended that in institutions where deliveries are undertaken and are cold chain points, newborns be given birth doses of immunization before discharge. On 23 April 2020, in line with the Ministry of Health

& Family Welfare (MoHFW) guidelines for providing essential services during the COVID-19 outbreak, the Government of Rajasthan recognized reproductive, maternal, newborn, child and adolescent health services as essential. The order issued to districts directed them to ensure the availability of these services 24x7 at health facilities[11].

Qualitative interactions with service providers and officials in the four study districts indicate that outreach health services were affected between April – June 2020. This insight is corroborated by the secondary data analysis and reflects in the Government orders for suspension of outreach services. At the facility level, while services were available, there was a pervasive fear of contagion that discouraged people from availing routine services.

Maternal Health services

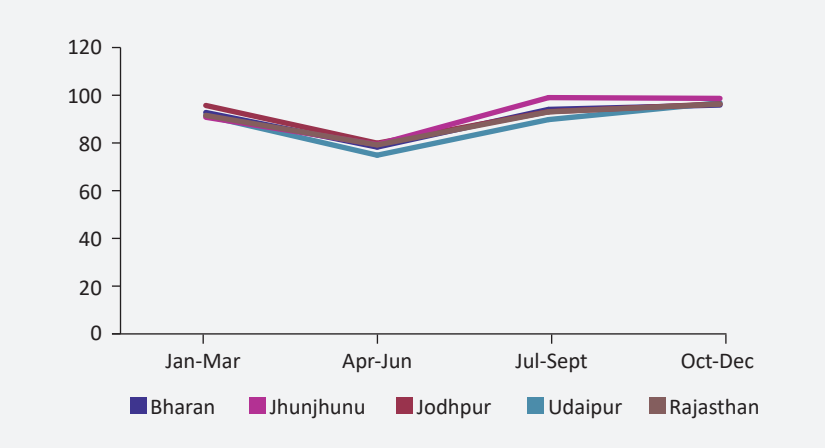
Across districts, MCHN day was suspended between March/April and June/July 2020. As reported by service providers, the periods of suspension varied across districts (March-May 2020 in Baran; April – July in Jhunjhunu; and April – May 2020 in Jodhpur and Udaipur). This is reflected in the secondary data, where a decline in the conduct of MCHN days against the plan is noted in April – June 2020, at the state level and in the study districts (Figure 2.1).

MCHN Day

During the lockdown, services like ANC, MCHN day have been compromised. We could not provide vaccinations for children, or ANC services, or any other outreach services. Post that, we have increased the number of MCHN days from 2 to 3 days or even 4 days in a month; we put in extra efforts to make up for the time and services lost in the initial phase.

– Health Official, Baran

Figure 2.1: % MCHN day held (vs. planned) (Jan – Dec 2020)



Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

[11] *PRS Legislative research; https://prsindia.org/covid-19/notifications; accessed on May 12, 2020.*

With the suspension of outreach services, FLWs were expected to follow up with beneficiaries at the village level to ensure access to services – at the doorstep wherever feasible, or else direct them to the nearest Government health facility. FLWs were also allocated various COVID-19 related tasks and responsibilities, limiting the time available for regular MCHN activities.

Antenatal care and weight monitoring

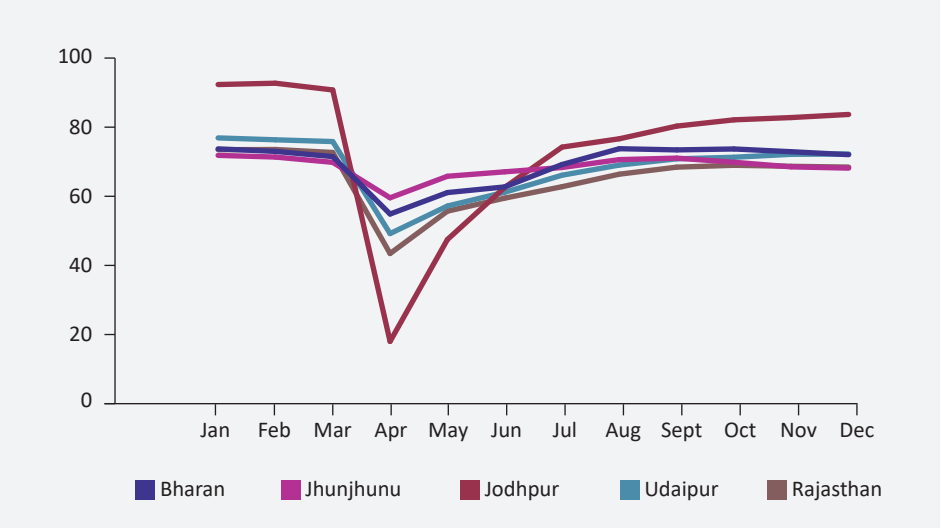
In the absence of the MCHN day, in Baran, Jodhpur and Udaipur, FLWs followed up with pregnant women during home visits (undertaken for the COVID-19 surveillance) or over the phone. In case of any discomfort, they advised the women to go to the health facility. No physical ANC examinations or weight monitoring could be done.

In Jhunjhunu, ANC examinations were done on the 9th of each month by doctors at the Public Health Centres (PHCs), under the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA). The PMSMA, launched by the MoHFW Government of India, aims to provide assured, comprehensive, and quality ANC, free of cost to all pregnant women on the 9th of every month. Women reported accessing ANC at the local Government hospital before the COVID-19 lockdown as well. They preferred this since they were examined by a doctor (than ANM at the MCHN day).

Across districts, women who had private transport or could afford to hire transport services accessed ANC at Government or private hospitals. Others relied on the home visits and phone-based support provided by the FLWs and accessed ANC once MCHN day and outreach services were resumed.

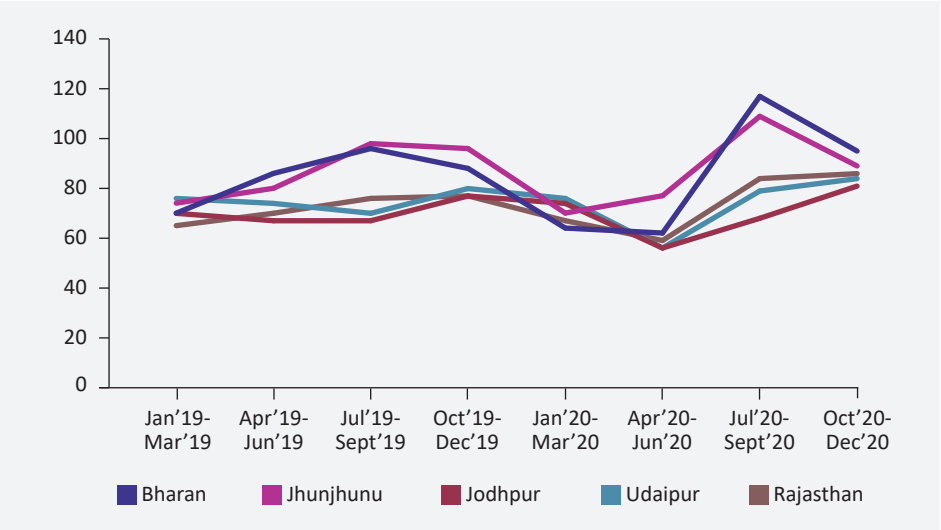
Secondary data analysis indicates that while pregnant women were consistently registered, ANC delivery was affected between March – June 2020. A sharp decline in the provision of 3 ANC against targets was noted in April 2020; the sharpest drop was in Jodhpur (from 92% in January to 18% in April 2020). A revival in ANC services was seen from May-July 2020 (Figure 2.2). Similarly, pregnant women, having received 3 ANCs, declined in April – June 2020 across the study districts and the state (Figures 2.3 and 2.3.1). A sharp rise was seen in the next quarter (July – Sept 2020). In Baran and Jhunjhunu, 117% and 109% pregnant women (against those registered for ANC in the quarter) received 3 ANC checks, respectively, indicative of catch-up rounds of ANC that were undertaken to cover up for the services not provided in the April-June quarter.

Figure 2.2: % Achievement of 3 ANC against targets (Jan – Dec 2020)



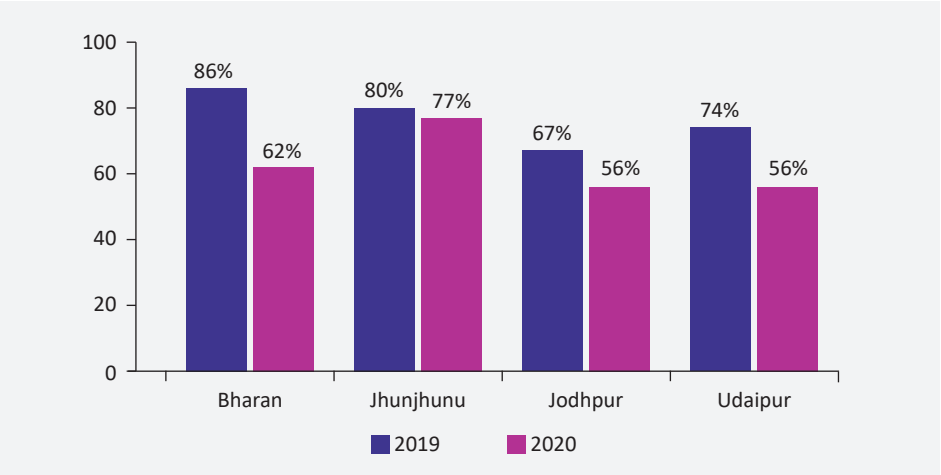
Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

Figure 2.3: % PW received received 3 ANC check ups (Jan 19-Dec20)



Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

Figure 2.3.1: % PW given received 3 ANC check ups (Apr-June 2020)

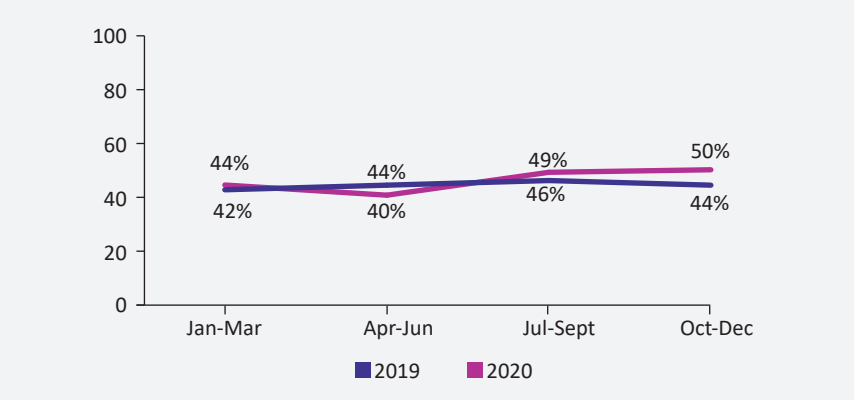


Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

Provision of IFA and calcium supplementation

FLWs provided IFA, Calcium, and zinc supplementation to women (and IFA to adolescents) throughout the lockdown during home visits. In the early days of the lockdown, supplies were a concern. In districts such as Jhunjhunu, FLWs took additional stocks from the PHC. They also accessed stocks available (for adolescent girls) at schools closed due to the pandemic. Across districts, FLWs provided smaller quantities to each beneficiary till supplies arrived to ensure that no one was deprived of the supplements. Women across districts also reported receiving IFA and Calcium supplements from the FLWs. This is reflected in the secondary data (Figures 2.4), where a near consistent provision of IFA tablets is noted. A marginal decline in April-June 2020 is indicated. This could be owing to the initial supply challenges.

Figure 2.4: % Pregnant women given 180 IFA tablets - Rajasthan (Jan19-Dec20)



Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

Figure 2.4.1: % PW given 180 IFA tablets in Baran (2019-2020)

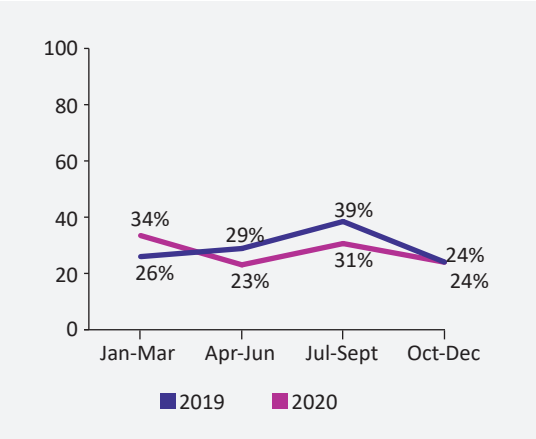
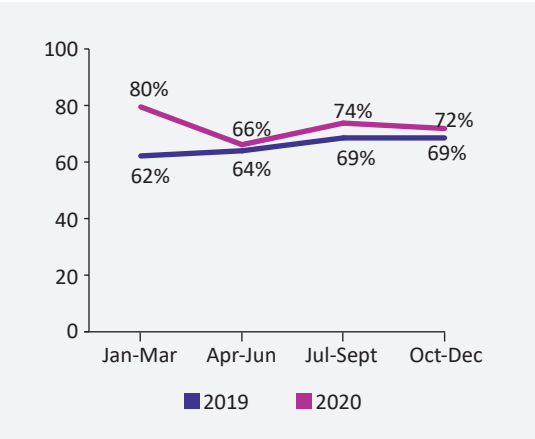


Figure 2.4.2: % PW given 180 IFA tablets in Jhunjhunu (2019-2020)



Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

Comparing across districts, in Jhunjhunu and Udaipur, the proportion of pregnant women who received 180 IFA tables was nearly the same or marginally higher across quarters in 2020 than in 2019 (Figures 2.4.2 and 2.4.4). In Baran and Jodhpur, a lower proportion of women received 180 IFA tablets between April – September 2020 than the same period in 2019 (Figures 2.4.1 and 2.4.3).

Figure 2.4.3: % PW given 180 IFA tablets in Jodhpur (2019-2020)

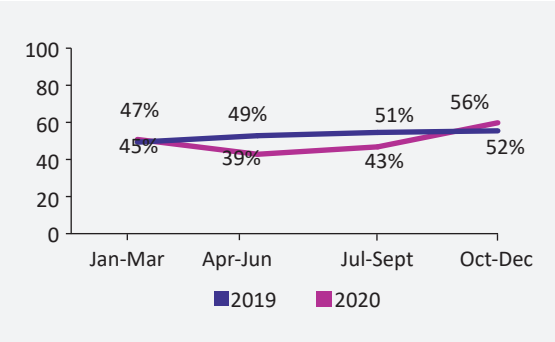
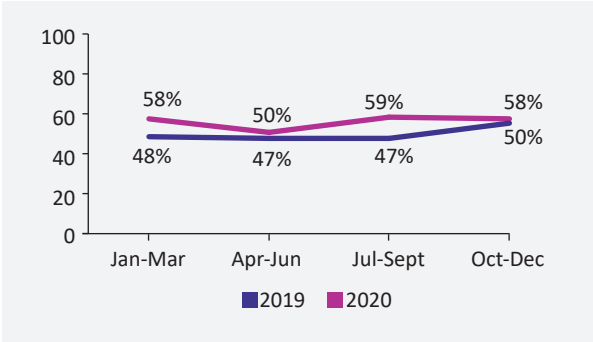


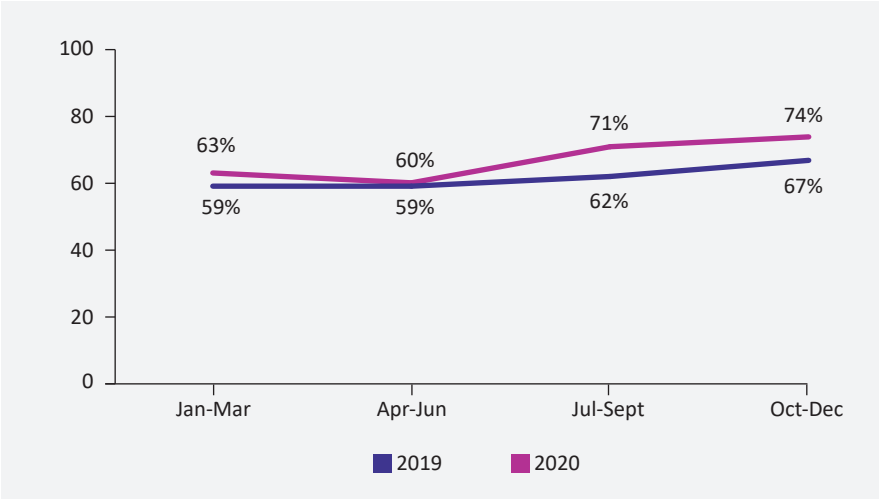
Figure 2.4.4: % PW given 180 IFA tablets in Udaipur (2019-2020)



Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

A similar trend is seen in the case of calcium tablets as well; where a similar proportion of pregnant women were given 360 calcium tablets in 2020, as compared to 2019 (Figure 2.5)

Figure 2.5: % Pregnant women given 360 calcium tablets - Rajasthan (Jan19 - Dec20)



Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

As was the case for IFA tablets, the proportion of pregnant women in Jhunjhunu and Udaipur who received 360 calcium tables was nearly the same or marginally higher across quarters in 2020, as compared to 2019. Whereas in Baran and Jodhpur, a decline in April-June 2020 and April – September 2020, respectively, was seen, as compared to the same periods in 2019 (Graphs 2.5.1 to 2.5.4, Annexure).

ASHAs and ANMs in Jhunjhunu reported increased demand for contraceptives – condoms and pills during the lockdown period.

Counselling

Counselling/ advice on pregnancy, breastfeeding, nutrition and diet, childcare, consumption of IFA and calcium tablets was provided by the ASHAs and AWWs during home visits or over the phone. Across districts, however, while some women reported having received advice/ counselling, others did not. Women also reported varied issues on which advice and information were provided. This is indicative of inconsistent provision of counselling/ advice and information.

FLWs usually provided pregnant women advice on accessing care during pregnancy, institutional deliveries, nutrition and diet, consumption of THR, consumption of IFA and calcium tablets, breastfeeding, and childcare during the MCHN day. However, during the initial phase of the pandemic, between April and June 2020, FLWs were saddled with additional responsibilities and faced challenges in accessing women and households (community members were apprehensive of the FLWs and did not, in several cases, allow them to enter their homes). However, on resumption of the MCHN days and with lesser apprehension in the community, they reported being able to interact with women and provide needed advice.

Institutional deliveries

Institutional delivery services were available at Government health facilities throughout the year, despite the pandemic. At all facilities, safety protocols were established to ensure uninterrupted provision of delivery services.

However, there was a fear among women and families to access the Government facilities. There was a perception that all COVID-19 cases were being treated at these facilities, making them unsafe. There was also a perception that the quality of care was inadequate, given that health personnel were overburdened by COVID-19 care. Those who could afford to, chose to access private care for deliveries. A few home deliveries with assistance from private doctors and *Dais* were reported in Baran and Udaipur.

> **My friend who went to the Government hospital for delivery was put alongside other COVID-19 patients. I felt very uncomfortable, so I decided to go to a private hospital. I spoke to the AWW; she supported my decision.**
>
> – Lactating woman, Udaipur.

> **We had decided to go to a Government hospital. We went there, but no doctor saw us properly, and there was a complication, so we went to a private hospital.**
>
> – Lactating woman, Jhunjhunu.

FLWs reiterated the fear of accessing Government facilities among communities. Some also said that the quality-of-service provision at the facilities had suffered due to the COVID-19 caseload.

> **Ambulance services were hampered, and patients were not being checked properly by the doctors. Hence several women preferred private facilities.**
>
> – ASHA, Udaipur.

> **Due to several COVID-19 cases, Government hospitals were unable to ensure proper care for institutional deliveries, and hence many women went to private hospitals.**
>
> – ASHA, Baran

FLWs also reported that those who could not afford private care or had fewer apprehensions about COVID-19 continued to access Government hospitals for deliveries. Some said that an increased number of deliveries took place at PHCs and Health Sub-centres (HSCs), as women and families preferred smaller and less crowded venues (as against a large government hospital). ANMs undertook significant efforts to ensure that there are no home deliveries.

The secondary data indicates a nearly similar proportion of institutional deliveries in public institutions across the four districts in 2020, as compared to 2019. However, in 2020, a marginal decline in deliveries is noted between April -June, with a sharp increase in the next quarter (Figures 2.6 and 2.6.1).

Figure 2.6: % Institutional deliveries- Public institutions (2019-2020)

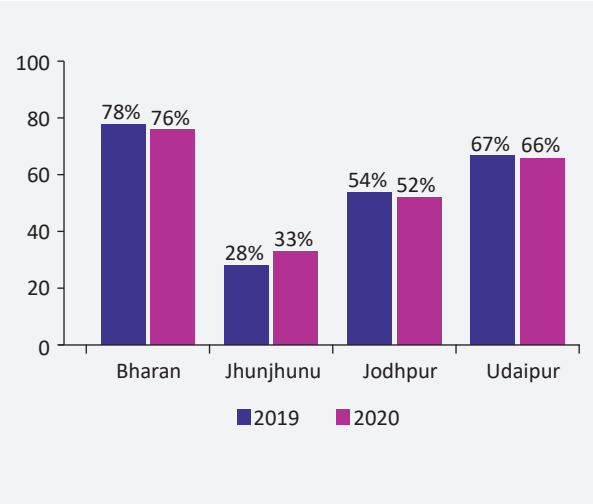
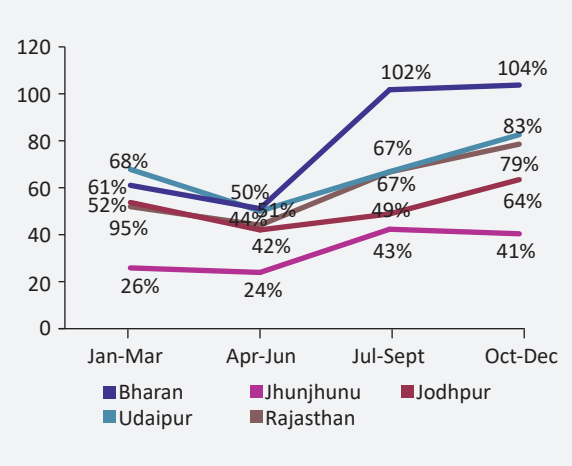


Figure 2.6.1: % Institutional deliveries - Public institutions (of those registered for ANC) (Jan – Dec 2020)



Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

Postnatal and home-based newborn care

ASHAs reported having provided PNC and HBNC services throughout the year, even during the April-June 2020 period, when other services were suspended. ASHAs provided the services during home visits undertaken for COVID-19 surveys to the extent families were comfortable. In several cases where families were uneasy with them entering the homes or meeting the lactating women, advice was provided to the older women in the household. Many respondents, however, were not aware of these visits. They reported that the ASHAs visited them post their delivery; however, they could not recall any specifics on the visits and their services.

A comparative summary of the key maternal health indicators for 2019 and 2020 for the four study districts and the state is provided in table 2.1. Overall, the state and the districts performed nearly the same in 2020, as against 2019, indicating catch-up rounds of service provision after the lockdown. Jhunjhunu and Baran appear to have performed better on maternal health

indicators than Udaipur, Jodhpur, and the state average. In Jhunjhunu, performance on key maternal health indicators improved in 2020, as compared to 2019. The inadequate provision of IFA tablets is a cause of concern in Baran. In Jodhpur, except for the provision of IFA tablets, most other indicators fare below the state average.

Table 2.1: Comparative analysis of key maternal health indicators for 2019 and 2020

Districts	% Pregnant women registered before 12 weeks		% Pregnant women given received 3 ANC		% of Pregnant women given IFA tablets		% Pregnant Women given 360 Calcium tablets		Maternal health score (Out of 40)[12]	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
Baran	82%	82%	85%	84%	29%	28%	70%	75%	26.7	26.9
Jhunjhunu	81%	87%	87%	86%	66%	73%	89%	98%	32.2	34.5
Jodhpur	61%	53%	70%	70%	49%	46%	44%	43%	22.4	21.2
Udaipur	65%	64%	75%	74%	49%	56%	97%	74%	28.7	26.8
Rajasthan	68%	71%	72%	74%	44%	46%	62%	67%	24.7	25.7

Child health services

Immunization

Across districts, community level immunization services were suspended between March to May 2020, following which they were resumed. In Baran, FLWs reported an increased frequency of MCHN days once resumed to catch up on loss of service provision. In other districts, catch up rounds of immunization were conducted during successive MCHN days. This reaffirmed by lactating women, who reported immunization services to have resumed from June-July 2020.

> **Workers compiled a list of pregnant women and did more campaigns for ANC. Efforts were made to make up for the loss of service delivery during the lockdown.**
>
> – BCMO, Baran.

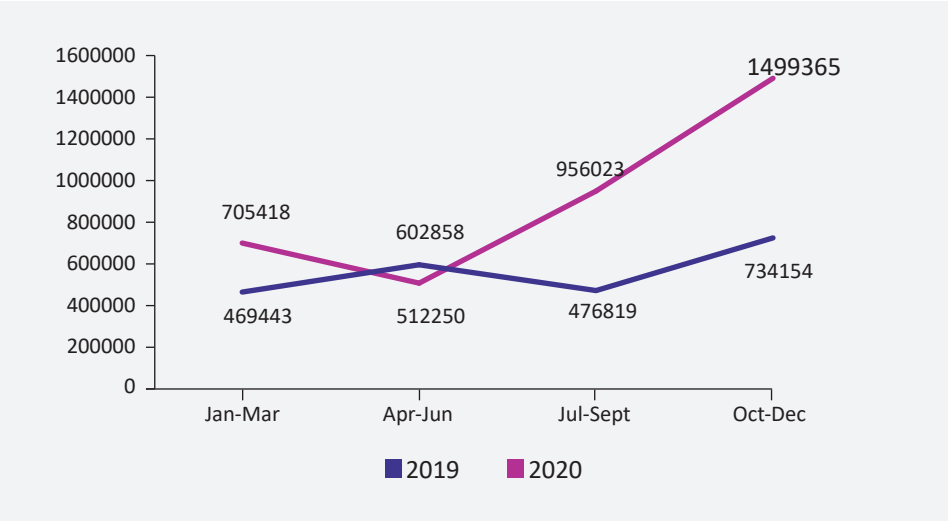
[12] *The percentages for each of the indicators are an average across quarters. To arrive at the overall score, percentage for each indicator was converted to a decimal score, out of 10 and then added.*

Vitamin A supplementation and deworming

Across most AWCs, it was reported that Vitamin A supplementation was provided twice a year (every six months). Interactions with FLWs indicate that in about half the AWCs, the supplementation was provided to more than 80% eligible children at two time points in 2020. In others, it was provided only once in 2020, owing to the COVID-19.

However, quarterly data available from the Directorate of Medical Health and Family Welfare indicates a decline in the provision of Vitamin A in the state between April-June 2020, with a steep rise following that, far exceeding the performance in the previous year (2019) (Figure 2.7).

Figure 2.7: Number of children age 6-59 months given 8-10 doses of Vit. A syrup (weekly) - districts



Data source: Government of Rajasthan, Directorate of Medical Health and Family Welfare, accessed on 25/01/2021.

At the AWC and CDPO level, data for vitamin A supplementation was available only at one or two time points (for most AWCs). However, data from the Directorate of Medical Health is available throughout the year at the state level.

Similarly, in the case of deworming, FLWs reported providing the same twice a year. Nearly half of the AWCs visited reported providing the deworming tablets to eligible children, only once in 2020.

Growth monitoring and Identification of malnourished children[13]

During the initial phase of the lockdown (April – June 2020), when the AWCs were not functional and MCHN days were not conducted, no growth monitoring of children was feasible. During home visits made for the COVID-19 monitoring and surveys, AWWs reported observing children and enquiring about their health. ASHAs did the same during HBNC and other home visits. However, FLWs said that observing children was also not always feasible. Sometimes parents did not let them come inside the house or near the child, owing to the

fear of COVID-19. In such instances, they only spoke to the mother and family and enquired about the wellbeing of the child and asked if the child looked weak or unhealthy. They also highlighted that they were given no special orders, guidelines, or safety protective equipment – sanitizers, gloves, masks etc. to undertake growth monitoring at a household level. Thus, identifying malnourished children was based on visual observation and enquiry to the extent feasible.

CDPOs felt that fewer malnourished children were identified and referred, more so during the April – June 2020 period. Only those who looked visibly malnourished or unwell were referred. This is reflected in the secondary data. Overall, a lower number of SAM children were reported in 2020 in Rajasthan than in 2019.

Even though children were not weighed, some AWWs reported consistently filling up the registers with the previous weight of the child. Similarly, few AWWs reported filling up data on SAM, MAM children identified, based on previous data, or any known case of a malnourished child.

Table 2.2 presents a comparative view of key child health indicators in the four study districts and Rajasthan in 2019 and 2020. While Udaipur has the highest proportion of newborns with weight less than 2.5 kg, the highest proportion of SAM cases in 2019 and 2020 were reported in Baran. As seen earlier, there is an overall decline in reported SAM cases in 2020, as compared to 2019. Performance on key child health indicators in the state and study districts is nearly the same in 2020 and 2019.

Table 2.2: Comparative analysis of key child health indicators for 2019 and 2020

Districts	% of New-born having weight less than 2.5 kg.		% of Severe Acute Malnutrition (SAM) Cases[14]		Child Health score (Out of 20)*[15]	
	2019	2020	2019	2020	2019	2020
Baran	16%	17%	7%	4%	2.3	2.1
Jhunjhunu	6%	7%	0%	0%	0.6	0.7
Jodhpur	14%	11%	0%	0%	1.4	1.2
Udaipur	20%	21%	1%	2%	2.1	2.2
Rajasthan	14%	14%	1%	1%	1.5	1.4

** Lower score denotes better performance*

[13] *While AWWs are expected to conduct regular growth monitoring for children at the AWCs or during MHCN days; all three FLWs (ASHA, ANM and AWW) are expected to use available opportunities – home visits, facility consultations etc. to identify malnourished children.*

[14] *Proportion calculated of 'number of new born weighed at birth'.*

[15] *The percentages for each of the indicators are an average across quarters. To arrive at the overall score, percentage for each indicator was converted to a decimal score, out of 10 and then added.*

On resumption of MCHN days, growth monitoring was resumed too. AWWs reported actively following up to ensure that children came to the AWCs for growth monitoring.

Most services, thus, were disrupted in the first phase of the pandemic between April – June 2020. Officials, service providers and women alike reported services resumed between July-August 2020 across locations and districts. This is also reflected in the secondary data, where an increased service provision is seen in the – July-Sept 2020 period.

Service provision, while resumed, was reported to be undertaken, keeping in mind safety precautions and protocols for COVID-19.

- Women were called in smaller batches and in different time slots during MCHN days to avoid crowding.
- Services were provided maintaining COIVD protocols - social distancing, FLWs use mask, sanitizers.

These protocols continued to be followed in Jan – Feb 2021 as well.

> **With safety protocols, fewer vaccinations and ANC done at a time. It is combined with nutrition also. A woman is called, given all services, including nutrition support/ THR .**
>
> – ANM, Jhunjhunu

2.2 Effect of the COVID-19 on supplementary nutrition services

- Access to THR for pregnant, lactating women and children was ensured through the year 2020 by the DWCD. At the state and district levels, efforts were made by the AWWs to provide access to rations to all eligible beneficiaries.
- The change in THR form provided from fortified dry mix to whole grains was preferred by beneficiaries, leading to a greater number of them demanding THR at the AWCs.
- Access to PMMVY was not affected by the COVID-19. Systemic delays in receipt of payments by beneficiaries were a continued challenge.

In Rajasthan, the state issued an order on 15 March 2020 to shut all AWCs till 31 March 2020. On 1 April 2020, this was extended indefinitely till further notice. However, the guidelines on 1 April 2020 directed AWWs to ensure THR provision for children 3 – 6 years of age at their doorsteps.

During the pandemic, the focus of the supplementary nutrition services was to ensure adequate nutrition support and that no one was left hungry. Pregnant and lactating women were provided THR uninterrupted through 2020. Children, 3-6 years of age, who received hot cooked meals at the AWCs, were provided THR instead. However, with the closure of the AWCs, preschool learning, provision of hot meals and community events such as Godhbharai and Annaprashan were affected. These services are yet to be wholly resumed.

Provision and access to THR – for women and children

Between April to June 2020, THR was distributed to beneficiaries at their doorstep by the AWWs. In April 2020, just after the lockdown announcement, there were initial supply-related challenges, during which period AWWs made local arrangements to procure and distribute food. Available supplies at the AWCs and schools were also used.

On resumption of the AWCs and MCHN days, in July 2020, beneficiaries were notified a day in advance (on the arrival of food supplies) and called in batches to collect the rations. AWWs created WhatsApp groups of beneficiaries or their family members (if women did not have phones, their husbands or other family members were included in the group).

While the initial challenges in the supply of food grains were addressed in the months following April 2020, several AWWs reported that they would often receive two months' supply together; or, in some months, receive less than the requested supply of food grains. In such instances, AWWs adjusted the provision of food grains to beneficiaries by distributing in smaller quantities twice a month or provision once in two months. This was, however, recorded in the registers to have been provided each month.

> **In March-April 2020, to ensure food supplies, Matra samitis were told to buy and distribute the dry rations; it was said that they would be reimbursed the payment. However, there was a delay in supplies from the food department, so in April, we distributed the ration by taking it from school; we also told workers to buy rations and distribute it because there was no supply.**
>
> **Then supply started, but it was not consistent. Some panchayats got rations; some did not. Some panchayat got less, and others more. Then we told workers to take rations from the panchayats, which got more and redistribute where there was none. This is how we made sure that every area got rations. Of course, they would have got double rations next month, even if they did not get it this month, but we tried to ensure monthly supplies.**
>
> – CDPO, Udaipur

Women and community members across districts received THR from AWCs, nearly every month during 2020. Some said that while there may have been delays, they received their complete due. Women and families across districts reported varying amounts of THR received. During the pandemic, families received nutrition support from AWCs, PDS, Panchayats, NGOs, and more affluent persons in the communities. Further, at the AWCs, sometimes they received two months' rations at a time. Hence, a lack of clarity among women on quantity obtained from different sources was noted.

> **From PDS, we got 10 kgs wheat.**
>
> – Community member, Jhunjhunu.

> **We received double ration for free during the lockdown.**
>
> – Woman, Jhunjhunu.

> **Got wheat, rice, daal for two months during the lockdown, was delivered at home. Then I get THR every month from AWC. We got two months rations at once in May. Children got wheat, rice, daal, masalas, a whole kit distributed at the school; 3-4 times after corona.**
>
> – Woman, Baran.

> **I got 3kg dal, 1/2 kg rice and wheat from Anganwadi. Panchayat distributed roti, gave dal, wheat and tea leaves.**
>
> – Woman Udaipur.

Change in the form of THR

An order dated 12 May 2020, issued by the Department of Women and Child Development, Government of Rajasthan, directed officials and service providers to ensure the provision of wheat and chana dal to beneficiaries at the AWCs, for 25 days in a month (300 days in a year)[16] instead of the repackaged dry mix rations (that were prepared by SHGs).

[16] *https://wcd.rajasthan.gov.in/content/dam/wcd-cms/icds/order/2020/43618%201352020.pdf; accessed on February 23, 2021*

Table 2.3: Food entitlement at AWCs, GO dated 12 May 2020.

	Pregnant and Lactating women; School going girls 11-14 years of age	Children 6 months – 6 years of age	Malnourished/ underweight children – 6 months to 6 years of age
Wheat	3000 gms/ 3kgs	2000 gms/ 2kgs	3000 gms/ 3kgs
Chana Dal (Grade A)	1000 gms/ 1kg	1000 gms/ 1kg	2000 gms/ 2kg

A revised order on the same, issued on 21 July 2020[17], enabled a provision of a higher amount of food grains/ ration to beneficiaries at the AWC.

Table 2.4: Food entitlement at AWCs, GO dated 27 July 2020.

	Pregnant and Lactating women; School going girls 11-14 years of age	Children 6 months – 6 years of age	Malnourished/ underweight children – 6 months to 6 years of age
Wheat	3000 gms/ 3kgs	2500 gms/ 2.5 kgs	3500 gms/ 3.5 kgs
Chana Dal (Grade A)	3000 gms/ 3kg	3000 gms/ 3kg	3000 gms/ 3kg

This change in THR provision was preferred by nearly all women and communities (across districts) compared to the dry mix provided earlier. The food grains could be prepared as desired and shared and eaten with all family members. Several women reported not liking the taste of the earlier dry mix provided and perceived it to be stale; it was often fed to the cattle.

> **The dal and wheat provided now are good. We can bring it and mix it up with the other food grains in the house. We can cook it as we like and eat it.**
>
> – Woman, Jhunjhunu.

> **Everybody shares and eats the food grains that are provided. This is more helpful to us.**
>
> – Head of the household. Udaipur

[17] *https://wcd.rajasthan.gov.in/content/dam/wcd-cms/icds/order/2020/78195%202172020.pdf; accessed on February 23, 2021*

Owing to the provision of food grains, AWWs reported an increased number of beneficiaries who were now coming to collect the rations.

An AWW in Jhunjhunu explained that even though she had 125 women and children registered, only 50 would come to collect the food regularly before the change in THR. And so, she would raise the demand only for 50. Now, however, nearly 100 were coming to gather the food grains. So, she had suddenly increased her demand but was not getting as much supply. She was getting food grains for only about 80 persons.

Similarly, an AWW reported that 37 new beneficiaries had registered in Udaipur because food grains were provided.

Officials such as CDPOs and LS also highlighted the community preference for food grains. One of the LS from Jhunjhunu explained that supplies were procured for the dry ration mix and then ground and roasted and supplements added, which took time. Further, that the taste of it was not much liked. Significant time was also spent in explaining the benefits of consuming the mix. She felt that now, with the provision of food grains, people were consuming the same (rather than throwing it away or feeding it to the cattle).

> **The food grains provided now are more liked and acceptable to the community. There is better uptake of this.**
>
> – Lady Supervisor, Baran

Only two Lady Supervisors highlighted that the earlier dry mix provided to pregnant women was more nutritious since supplements were added. However, it was said that most women did not like the taste of the mixture and often threw it away or fed it to the cattle. Hence, they felt that the provision of food grains had higher acceptance and consumption.

While the THR is provided primarily for pregnant, lactating women and children, it was shared and eaten by all family members and proved to be helpful in enabling families to tide the challenges posed by the pandemic. However, some households felt that children, when provided HCM at the AWCs, were assured of at least one good meal, which may not always be the case at home, given that the food grains were distributed and eaten.

Access to PMMVY

Nearly all the women respondents were aware of PMMVY and had registered for it. While cash transfers were received, delays were reported to be routine. One of the recently delivered women in Jhunjhunu said she was yet to receive any instalment for PMMVY, even though the documents were submitted nearly 8 months ago.

> **It has been more than 8 months since I submitted my documents. I have even had my child but am yet to get even the first PMMVY payment. Once I get it, then I will see what to do with it.**
>
> – Woman, Jhunjhunu.

Among those who had received payments, the majority reported having received the first instalment INR 1000. Some have also reported receiving INR 2000[18].

The available secondary data corroborates the delays and backlogs in payment receipt. Only an average of 27% beneficiaries, among those registered, received all three payment instalments, across quarters, in the year 2020. A marginal decline in the proportion of beneficiaries who received all three instalments were noted in quarters 2 (April – June 2020) and 3 (July – September 2020) (Table 2.5).

Table 2.5: Proportion beneficiaries who received all three PMMVY instalments.

% who received all three instalments - of No. of PMMVY applications registered (across all instalments)	Jan – March 2020	Apr- Jun 2020	Jul – Sept 2020	Oct – Dec 2020
Baran – Baran	118%	6%	21%	27%
Baran – Shahbad	39%	9%	14%	27%
Jhunjhunu – Jhunjhunu	34%	0%	9%	7%
Jhunjunu - Alsisar	17%	1%	3%	11%
Jodhpur – Jodhpur	8%	485%	150%	37%
Jodhpur – Osian	14%	8%	16%	50%
Udaipur – Rishabdev	47%	9%	22%	37%
Udaipur – Girwa	40%	54%	54%	64%

A review of the PMMVY data for the year 2020 for the study blocks indicates that there are significant delay and backlog in the receipt of instalments to beneficiaries. For instance, in the quarter of January – March 2020, across the eight blocks, more than 100% of those registered were paid the first instalment (Table 2.5.1, Annexure). While 55 beneficiaries were registered in Rishabdev, Udaipur, nearly 184 were provided with the 1st instalment payment. Similarly, in Baran block, Baran, while 38 beneficiaries were registered, 306 received the 1st instalment (Tables 2.5.2 and 2.5.3 Annexure).

[18] *Some respondents reported that they had got INR 2000 in total thus far. This could be indicative of lack of awareness on the instalments, or on the amount received in the bank.*

This is because payments are processed in bulk and at a later period; women who receive payments in the current period have mostly been registered in the preceding periods. Thus, while payments are assured under the scheme, the processing time of applications (from submission of hard copy at AWC to digitization at the block and payment at the state) is high. Restricted mobility has hindered digitization at block offices early in the lockdown as gathered through interactions with CDPOs.

No significant disruptions in the PMMVY payments due to the COVID-19 was reported. However, fresh registrations and successive instalment requests in the scheme were affected; CDPOs across districts mentioned that there were delays in the digitizing PMMVY forms in the initial few weeks of the lockdown. Due to lack of transportation, documents from beneficiaries were not able to reach district offices. Further at district offices, staff were unavailable to undertake data entry. However, after the first month, routine processes were functional.

While the PMMVY cash transfers are expected to provide partial compensation for wage loss and incentivize improved health and nutrition behaviours among women, no clear purpose or use of the PMMVY money was reported by women. Some women said that the payments were delayed, so by the time they received the same, most of the pregnancy was over and that they had already spent money on needed expenses. The majority said that the money is kept in bank accounts and used as required – on food or other costs.

2.3 Challenges faced by Frontline workers in enabling health and nutrition services

FLWs (ASHAs, ANMs and AWWs) spearheaded the community-based response to the COVID-19 pandemic. In addition to their regular roles and responsibilities, they were expected to undertake COVID-19 related surveys and screening, enable information and awareness on the pandemic and preventive measures, monitor those coming back from cities, report and refer those with symptoms and monitor those in home quarantine. In undertaking their routine and COVID-19 related responsibilities, FLWs faced several challenges. Additionally, interactions with FLWs indicate attempts at delivering services; however, hesitation and informational asymmetry led to sputtering uptake of their services by their local communities.

Figure 2.10: Challenges faced by FLWs; more in the April – June 2020 period

» **Resistance and hostility from communities –** FLWs reported fear and distrust from the communities, leading to non-cooperation and hostile behaviour. Community members felt that the FLWs might infect them with COVID-19. It was also thought that they were visiting households because they were being given additional money. Households were hesitant to report any migrants/ family members who may have returned from the cities and avoided the FLWs to avoid reporting. In several cases, FLWs were not allowed to enter homes and provide services.

> **People would say, these women have gone to 10 places and come and have unnecessarily come here to bother us. Even if we wanted to follow up or provide services, they would not let us come into their homes.**
>
> – ASHA, Udaipur.

- **Lack of safety and protective equipment -** Nearly all FLWs reported not having adequate protective equipment, including face masks, sanitizers in the initial days of the lockdown. Many resorted to using homemade masks.

- **Lack of transportation services –** Travel for ANMs, lady supervisors, and those living far away from their field locations/ health facilities was challenging. ANMs who owned transport reported visiting the villages and assisting the ASHAs in the surveys and other services. Others followed up over the phone. Some said that they requested their family members to drop and pick them up. Even after the lockdown, transportation (such as autos) was expensive, given limited supply.

- **Workload and role management –** FLWs reported to be overworked, trying to manage their COVID-19 and routine roles and tasks. AWWs, in the first month following the lockdown, had to procure and locally arrange for food grains to be given to the communities in the absence of supplies. They had to deliver food grains at home without any transportation support. Several AWWs reported taking the help of their husbands or other family members to support THR delivery.

Even at present, when the AWCs are functional, AWWs continue to face challenges in procuring and transporting the food grains to the AWCs. Lady Supervisors said that the AWWs often have to carry large quantities of food grains on their back and transport them to the vehicle (from the supplier) and then from the vehicle to the AWC.

> **At each centre, 300 kilos of dal, rice, wheat, for each month comes. The AWWs are not able to lift, so this is a big problem for them. They take the help of someone or the other. The money they are paid is insufficient for transport, packing etc.**
>
> – Lady Supervisor, Jhunjhunu

- **Management of household responsibilities –** In addition to their workload, FLWs also had to manage household responsibilities. Their households were also affected by the pandemic, with family members having lost jobs, migrant workers coming back home, and children being at home due to school closures.

- **Fear and stress -** FLWs feared that their work was putting them and their families at risk; they were working when everyone else was inside their homes. They also feared that they were working without adequate safety measures.

> **We were doing surveys; we could have got COVID-19. We had to keep washing hands and sanitizing, which was difficult.**
>
> – ASHA, Udaipur.

Challenges faced by officials in the management of health and nutrition services

- Coordination and management were challenging for stakeholders such as Lady Supervisors, CDPOs and ANMs, especially during the first three months of the lockdown (April – June 2020).
- With travel being limited, they could not call for meetings or undertake routine monitoring as was done earlier.
- There was a heavy reliance and sudden pivot to phones/ technology for remote monitoring and updates.
  - Updates on service provision, supply needs etc., were sought over WhatsApp.
  - Any guidance to be provided was also done through phone calls/ WhatsApp messages.
  - FLWs were provided training and guidance on COVID-19 through the use of technology and phone.
- In the months following the lockdown (after June – July 2020), the physical monitoring and review meetings had resumed. However, it was said that some of the mechanisms, such as WhatsApp updates, phone follow-ups and provision of training and support remotely through phones, would likely continue to be used going forward.

> **Physically Anganwadis were closed, due to COVID-19, and our dependence on technology increased. The only mode to contact workers was WhatsApp; one message posted would reach all the workers. If they are facing any problems, they also contact us on WhatsApp.**
>
> – CDPO, Jodhpur

2.4 Effect of COVID-19 on households

Besides affecting access to health and nutrition services, the COVID-19 also had a variegated effect on households through reduced livelihoods and income, school closures, and uncertain access to food.

Figure 2.11: Impact of COVID-19 on households

Livelihoods and income | Restrictions on mobility | Children and education | Fear of COVID-19 | Access to food

Livelihoods and income: The critical impact of COIVID-19 was on livelihood and income. This was more so for daily wage earners and those in informal occupations. It had affected the agricultural operations including those dependent on agriculture. The salaried persons did not receive their salaries or did not receive them entirely. Also, many who had migrated to other locations for work had returned19.

The distress was nearly the same across the four districts. Due to the pandemic, the Mahatma Gandhi National Rural Employment Guarantee Act 2005 (MGNREGA) was also not operational in the initial months. The community had no alternate means of earning wages or income due to the lockdown. Many also mentioned that household expenses had increased while they had reduced or no income. Hence, many had to use their savings, borrow from relatives and friends, or purchase on credit to make ends meet.

> **My husband is a LIC agent; his earning stopped for a while. Offices would not open, so his LIC commission would not be processed. We were in standby mode.**
>
> – Lactating woman, Udaipur

> **Daily wage work (Mazdoori) came to a standstill; we could not go out of the house; everyone was at home. Our daily expenses were affected.**
>
> – Community member, Jodhpur

[19] *The media, had highlighted the return of the migrant labor and the challenges they faced. A survey by the Azim Premji University indicated these aspects in Rajasthan See https://cse.azimpremjiuniversity.edu.in/wp-content/uploads/2020/06/State-Pamphlet-Rajasthan-English-final.pdf*

> **My husband is a LIC agent; his earning stopped for a while. Offices would not open, so his LIC commission would not be processed. We were in standby mode.**
>
> – Lactating woman, Udaipur

> **Daily wage work (Mazdoori) came to a standstill; we could not go out of the house; everyone was at home. Our daily expenses were affected.**
>
> – Community member, Jodhpur

Restrictions on mobility: The mobility restrictions in the lockdown's initial phases were challenging for communities and service providers. The lack of public transport meant that they could not step out even if needed or for an emergency. Due to limited transportation facilities, the cost of transportation had gone up. This challenge affected access to health services, more so for pregnant women. Those who had personal transport were not affected much. For frontline workers, the lack of public transportation was a challenge. In June 2020, when they had to access field locations for service provision, they found it challenging. An increased police presence also restricted mobility as the police only allowed access to health facilities in an emergency.

> **Transport was a challenge for us. In June, things had not opened as yet, but we had to start going to the field. Few autos were available, they charged much more than usual, but we had no other choice.**
>
> – Lady Supervisor, Jhunjhunu

> **My daughter has come to our house from her in-laws, and she is pregnant, so taking her to the hospital is very expensive for us-for Rs 1500-1600, we rent a car and then go.**
>
> – Head of the Household, Jodhpur

Fear of COVID-19: There was also the fear of catching COVID-19, which prevented people from meeting others or accessing services. Many preferred to stay home than go out. The fear of transmission through vegetables and fruits was another concern. Several households reported not consuming fruits and vegetables and relying on food grains or home-grown vegetables if any.

> **I live on the first floor, and my husband's family lives downstairs. I was few months pregnant during the lockdown. But even after the lockdown ended, we were scared. I used to be alone at home all day but could not meet my family which lives downstairs.**
>
> – Lactating woman, Jhunjhunu

Children and education: The COVID-19 was a challenge for children too. With schools shut, they were unable to interact with their friends. The online classes were not accessible to many students, and even those who could access them did not seem keen on online classes. Parents feared that the children would forget what was taught to them earlier. Communities shared a common concern over the digital divide, both for children and others. They reported that those with access to mobile phones and the internet were at an advantage during the pandemic.

> **Not all children have access to mobile phones for online classes. Only the ones who have it are studying. Children often lose interest after half the class; they cannot follow what is taught online.**
>
> – Lactating woman, Baran

The additional burden on women: The presence of children and non-working adults added to women's responsibility. They had to manage the children, cook, and provide for all household members. Some women respondents reported feeling depressed/sad due to loss of household income or loss of family members' jobs.

Access to food: Fruits and vegetables had become expensive during and post lockdown. There was also a supply shortage of vegetables and fruits as most shops were either closed or did not have adequate supplies. While vegetables and fruits had become expensive, pregnant and lactating women were assured these foods in many households. Efforts were

also made to ensure food for children. Many took loans, borrowed food, or bought on credit and accessed PDS to ensure adequate food. The young pregnant and lactating mothers in several households had limited agency and decision-making roles. Most were unaware of the households' challenges in providing their needs.

> **When corona started, green vegetables and fruits were not available; whatever things used to get from shops were getting half of them.**
>
> – Community member, Jodhpur

> **We have been getting a double ration from PDS, which has helped so far. As soon as my son gets a job, that will also stop. The person running the local dairy is known to me, so I have been getting milk on credit for the last few months. We have some savings, and we have this land so that we can manage food. However, we have cut down on other expenses. It is up to us to ensure that food and other expenses are provided for – whether we borrow or sell our clothes or other assets, but we ensure that it does not affect the household.**
>
> – Head of Household, Jhunjhunu

However, women from financially insecure households skipped meals or reduced the frequency of eating. FLWs and officials reported that, following the initial one week of lockdown when supplies were affected, food grains were provided to most households; and that no one starved, though the frequency of meals for some may have gone down. The children from financially insecure households who ate at the Anganwadi earlier were deprived of the food, as available THR and food supplies were shared and consumed. The households relied on support from Government and NGOs for food grains.

In the unlock phase, the challenges eased a bit. However, many were yet to find employment and regular income in all four districts.

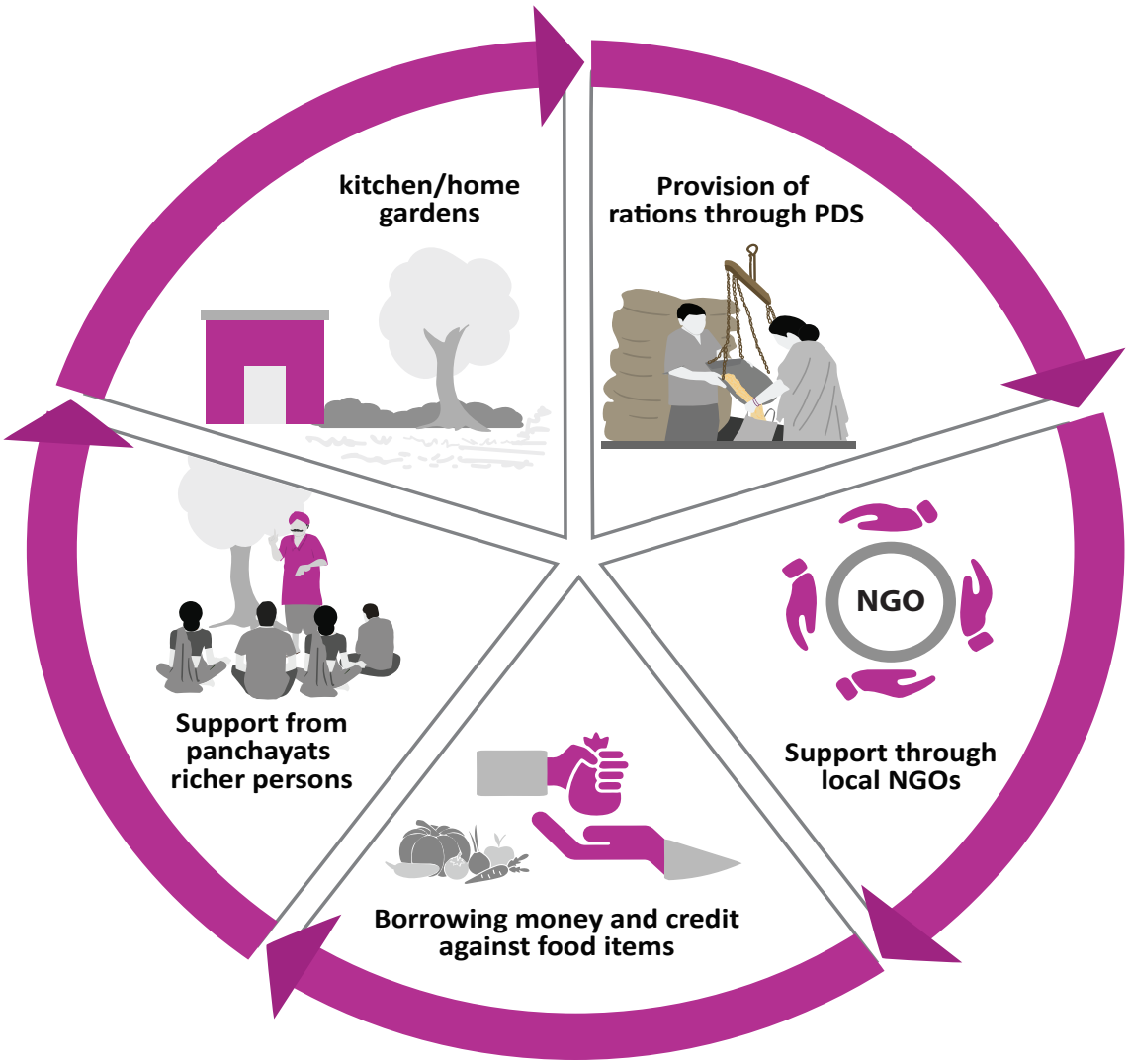
Overall, the impact of the pandemic was primarily on employment and household income. The access to health services had improved after June 2020. The support from the government, Panchayats, NGOs, and local community stakeholders ensured that no one starved. According to officials, there was an impact on children's education, and the community's mental health issues were also a concern.

SECTION: 3

Mitigating the effect of the COVID-19

Evident from the earlier sections of this report, the health and nutrition systems in the state adapted to enable service provision during the pandemic. Communities and households too adapted to address the challenges due to COVID-19 at the localized level. They tried to ensure that the nutritional needs of pregnant and lactating women and children were met. The government's support, state level and local level, support from NGOs, and leveraging the social capital (see figure 3.1) enabled the adaptation.

Figure 3.1: Adaptations to ensure nutritional needs during the pandemic.



Government support – Communities and households accessed several forms of Government support. This included THR provided through the AWCs, both for those accessing earlier and those who registered during COVID-19. The PDS provided double rations for 3 to 6 months. However, the quantity of rations reported to have been received varied across districts. A household in Jhunjhunu reported that their seven-member household used to get 35 kgs of wheat from ration before COVID-19; however, for the last six months, they were getting 70 kgs through multiple sources. Besides, families accessed COVID-19 relief as a part of the Pradhan Mantri Jan Dhan Yojana. However, while some received INR 500, others complained of non-receipt. The money was used for household expenses by those who received it.

> **Several children who used to attend private preschool earlier now have registered at the AWC. We have not denied food grains to anyone. Support has been provided to all.**
>
> – AWW, Udaipur

> **We are seven people in the house; we used to get 35 kgs of wheat from ration; for the last six months, we have got 70 kgs.**
>
> – Head of the household, Jhunjhunu

Some in Baran and Jhunjhunu reportedly traded/exchanged PDS rations for other supplies/ ingredients at stores, selling the same for money. A household in Baran said that that they cultivate wheat and hence sold the wheat they received from the PDS.

Accessing local support - The strength of the social capital helped during the pandemic. The community members helped others in need. The affluent persons from the villages/ communities provided food grains and ensured no one goes hungry. Moreover, Panchayats set up kitchens to enable food for those who could not afford it. Local shops, relatives, and others in the village helped by lending food items on credit.

NGOs' support ensured access to food grains, food kits, vegetables, and other essential supplies, including masks, soaps, sanitizers, and even sanitary pads for women and girls.

Borrowing and credit - Several households borrowed and accessed food items on credit. Those who borrowed preferred to do so from relatives or persons known to them. They also said that most people understood that this was a time of distress and those who could, lent money or enabled credit. However, households were also concerned that this may not be the case for long and that they would soon have to find work.

> **My relatives own a dairy, so I have been borrowing milk from them. We have not had a shortage, we have been consuming food as before, but I have lost my job and will have to pay the persons after some time.**
>
> – Head of the household, Baran

Kitchen gardens - Apart from relying on external support, some started kitchen gardens. Several households reported growing vegetables on their farmlands, plots near the house, to meet the household's food needs. They reported growing vegetables such as Palak, Methi, Mooli, Gobhi, Potatoes, Lauki, and Kaddu. Some started farming, with the additional hands available at home.

> **Many people in the village started farming or planting vegetables. They were free, so they planted vegetables. This helped them reduce their tension also. Some people also used their regular farmland to plant some vegetables for household use.**
>
> – ASHA, Udaipur

The households' adaptations and support from the government, state and local, NGOs, and the community partially mitigated challenges due to COVID-19.

SECTION: 4

Conclusion and recommendations

The present study reveals that the health and nutrition systems in the state adapted to enable service provision during the pandemic. Communities and households also coped and adjusted to the new challenges arising due to COVID-19. They tried to ensure that the nutritional needs, especially of pregnant and lactating women and children, were met. The government's support, both at the state and local level, support from NGOs, and leveraging the social capital enabled the adaptation.

It is evident that while communities do leverage social capital or other support, there is a significant reliance on government support. In pandemic times, such as the COVID-19, while the Government systems are invariably geared to address the immediate challenges, there is a tradeoff. It is likely that the attention shifts from the long-term program activities. With the pandemic continuing to spread in waves, the effort should be to strengthen Government systems that are robust and functional during critical times while not losing the long-term program focus. It is also essential to build community resilience so that they can manage without significant disruptions. This is especially important for the financially insecure households, which are more dependent on government support.

Strengthening Maternal and Child Health Services

Given the current pandemic situation and anticipation of a third wave, the government need to explore alternatives for in-person outreach health services like ANC, growth monitoring of children, Home Based Newborn Care (HBNC), identification of SAM children. Resistance and hostility towards the FLWs from the families was reported. There was a perception that FLWs may be the carriers of COVID-19. The use of mHealth, tele-counselling and telemedicine can prove to be helpful in such a scenario. More so, in Rajasthan, where several villages are difficult to reach, the population is scattered owing to the state's topography. Tele counselling can be adopted to continue giving nutrition-related education and information to pregnant and lactating mothers. Telemedicine approaches like E-Sanjeevani under Aayushman Bharat can be expanded, information and capacity building of the beneficiaries and FLWs should be increased to utilize these services. These services may especially prove helpful in the case of High-Risk Pregnant (HRP) women.

In case a need arises in future to suspend MHCN days, ANC services under PMSMA can present a viable alternative, with adequate COVID-19 mitigation strategies in place. It can be expanded to private hospitals as well.

Under HBNC services, Kangaroo Mother Care (KMC) demonstration can be shown through videos on mobile phones or using demonstration material like dummy dolls. The appropriate method of optimal feeding of low-birth-weight infants can also be demonstrated through videos on mobile/tablets. Use of phone or demonstration material will ensure physical distancing is maintained while services are being delivered.

1. Use of Mother Mid Upper Arm Circumference (MUAC) approach to identify Severely Acute Malnutrition in Children.

The Family MUAC approach, also known as Mother MUAC, is an established strategy to increase screening coverage and promote early detection of wasting and/or deterioration. Training of caregivers can be organized to assess MUAC and check for oedema at home. In the context of COVID-19, caregivers, especially ASHAs, should also conduct these assessments during home visits, thereby eliminating the need for FLW to touch a child.

2. Meeting health and nutrition needs of Mothers and Children during distress through Conditional Cash Transfer (CCT) schemes

Despite the rations and support provided by the Government and civil society organizations, many households still felt the need for cash for domestic needs, transportation, and medical expenses. Since outreach services like MCHN days were suspended in such scenarios, those who could afford accessed government or private hospital services, but there was an increased transport cost.

There was also fear among pregnant women in delivering at a government facility due to the spread of COVID-19. Hence, those who could afford preferred private health facilities. In such a scenario, Conditional cash transfer (CCT) schemes are an option for protecting maternal health from distress. Maternity benefits of at least Rs. 6,000 per child are a legal right of all Indian women under the National Food Security Act, 2013. The Government of India's PMMVY, which provides financial relief to first-time pregnant women, is also a step in this direction.

However, this research shows that delay in paperwork/ digitization and lack of an automated system has created challenges for beneficiaries in receiving the benefits of such schemes, especially when they need it the most. In case of delayed payments, pregnant and nursing women might not be able to buy nutritious foods during the crucial 1,000 days of a child's life. Schemes like the Jan Dhan Yojana and PMMVY could be made paperless and seamless to ensure easy access. It is also recommended that pending dues be cleared. Households

could use cash made available through the schemes for the nutritional and health needs of pregnant women, lactating mothers and children or any other related expenses.

3. Addressing challenges faced by Front Line Workers.

Support and guidance to FLWs are required to ensure the continuum of care. Tele-counseling during health emergencies can be facilitated by training FLWs and giving them hand-holding support. This will equip them to continue offering maternal health services through tele-counselling even during the pandemic. An adequate supply of protective equipment and materials to FLWs must be ensured. In addition, ongoing information and guidance to FLWs on the COVID-19, its symptoms and management, and ensuring safety protocols during care provision is necessary. There is a need to support and provide guidance to FLWs to ensure effective role and workload management. The timely release of payments and incentives for FLWs must be guaranteed.

AWWs also face the challenge of arranging transportation to pick up rations from distribution centres. Hence, transport facilities can be arranged for picking up supplies from storage/ warehouses. Distribution of ration from Anganwadi to Anganwadi can be organized till there is restricted movement during lockdowns. Pre-packed rations can be given to the AWW instead of them packaging the rations.

4. Ensuring food availability

To ensure food availability, during the pandemic, communities accessed Government support programs, food support provided by panchayats, NGOs, and influential persons from the community. Some started kitchen gardens: others cultivated vegetables in their farmlands. Local food security could be enabled by encouraging local kitchen gardens, local cultivation of vegetables, and local foods for cooking. The feasibility of promoting home-based ownership of livestock or poultry for meat should also be considered. Increased support and guidance to AWWs to establish and manage Poshan Vatikas should be provided.

Annexure

Figure 2.5.1: % PW given 360 calcium tablets in Baran (2019-2020)

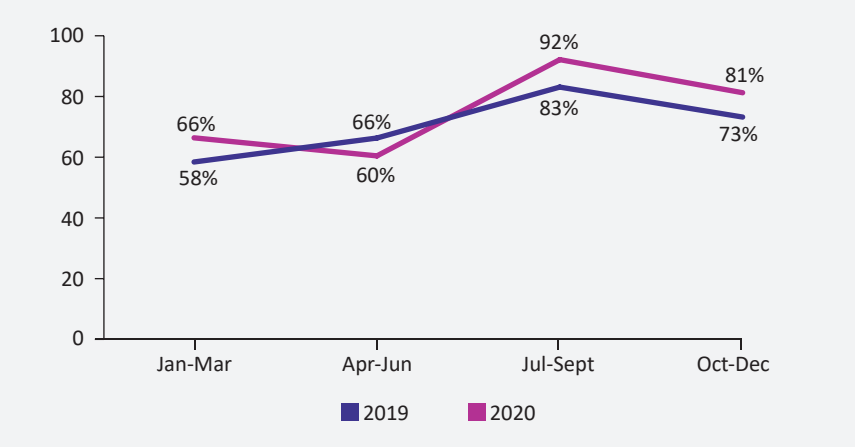
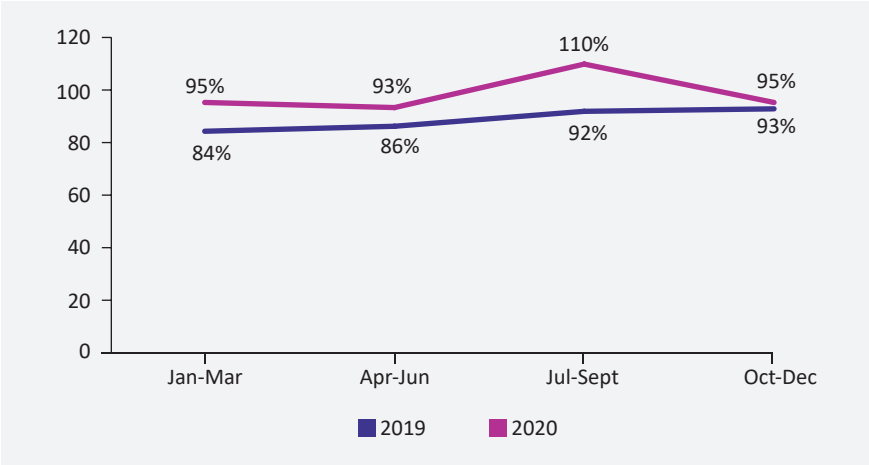
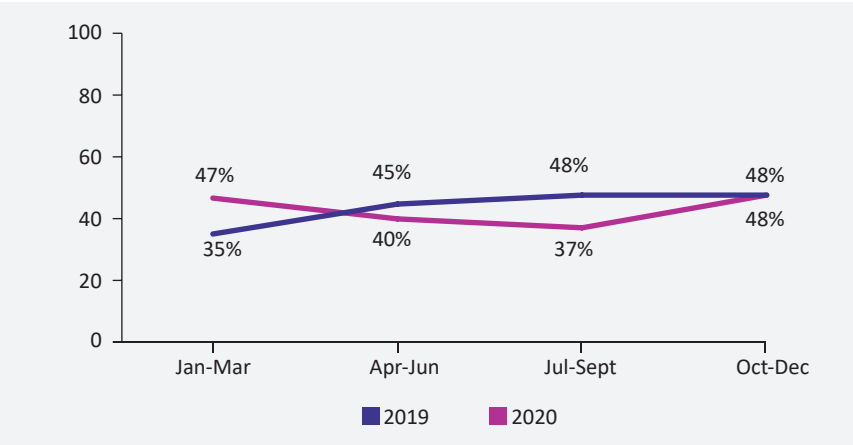


Figure 2.5.2 :% PW women given 360 calcium tablets in Jhunjhunu (2019-2020)



2.5.3 % PW given 360 calcium tablets in Jodhpur (2019-2020)



2.5.4 % PW given 360 calcium tablets in Udaipur (2019-2020)

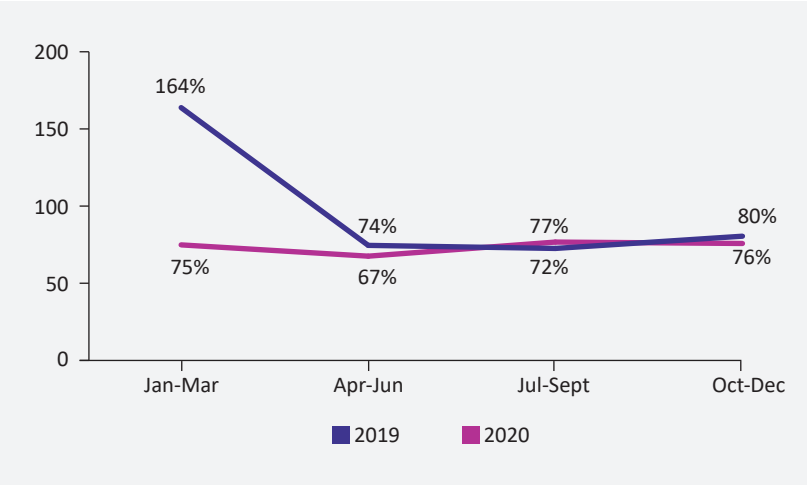


Figure 2.7.1: Number of children age 6-59 months given 8-10 doses of Vit.A syrup weekly in Baran (2019-2020)

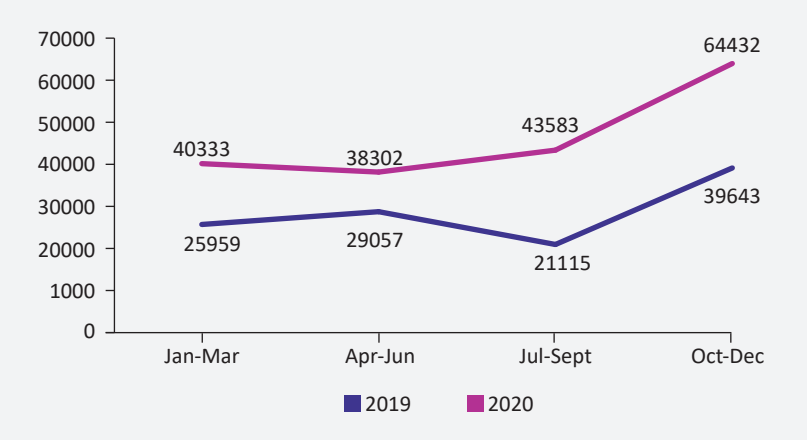


Figure 2.7.2: Number of children age 6-59 months given 8-10 doses of Vit.A syrup weekly in Jhunjhunu (2019-2020)

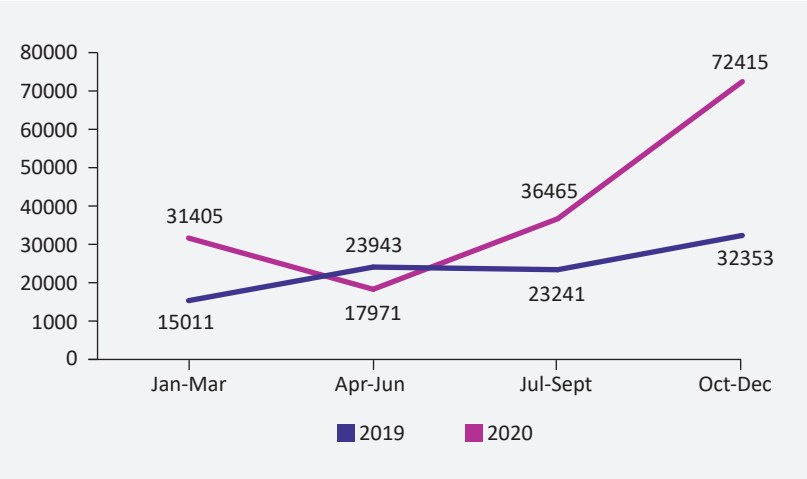


Figure 2.7.3: Number of children age 6-59 months given 8-10 doses of Vit.A syrup weekly in Jodhpur (2019-2020)

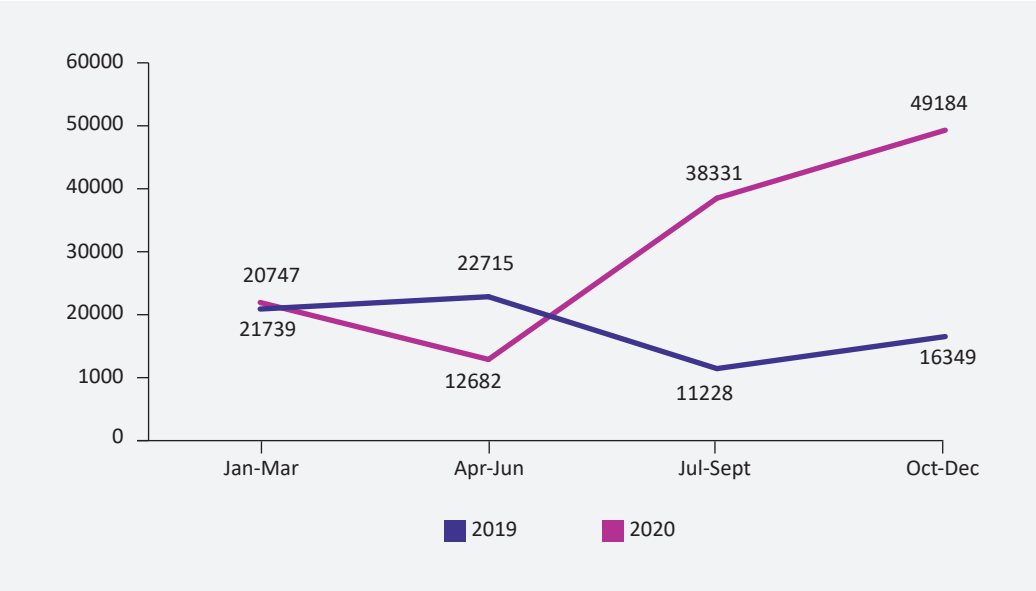


Figure 2.7.4: Number of children age 6-59 months given 8-10 doses of Vit.A syrup weekly in Udaipur (2019-2020)

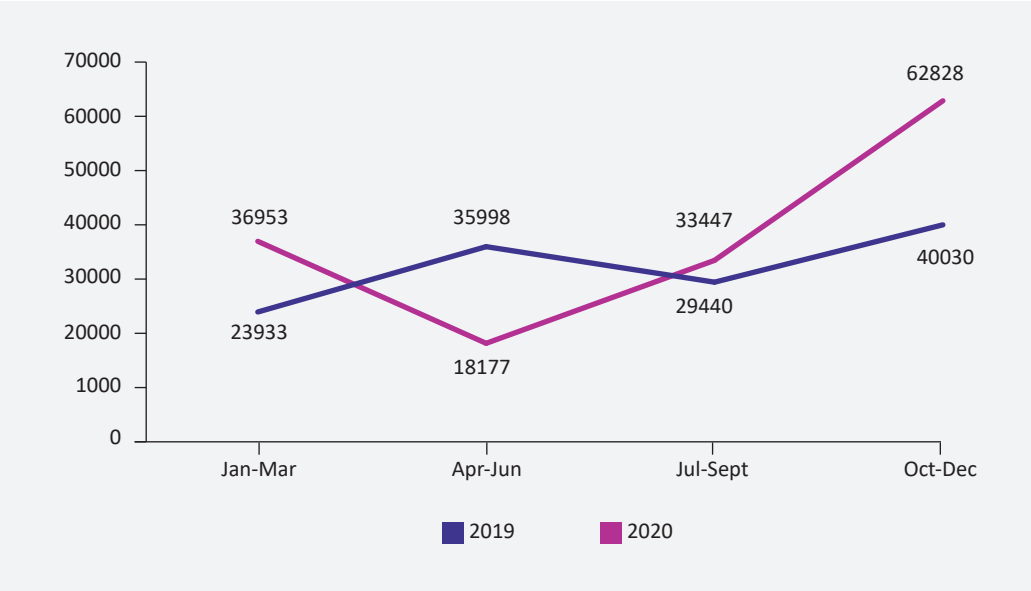


Table 2.5.1: % Beneficiaries who received 1st instalment for PMMVY (state-level data)

% who received 1st instalment – of No. of PMMVY applications registered (across all instalments)	Q1	Q2	Q3	Q4
Baran – Baran	805%	39%	211%	70%
Baran – Shahbad	199%	70%	72%	119%
Jhunjhunu – Jhunjhunu	166%	1%	80%	65%
Jhunjunu - Alsisar	179%	50%	49%	133%
Jodhpur – Jodhpur	186%	846%	226%	68%
Jodhpur – Osian	173%	152%	98%	240%
Udaipur – Rishabdev	335%	46%	110%	91%
Udaipur – Girwa	69%	82%	97%	109%

Table 2.5.2: % Beneficiaries who received 2nd instalment for PMMVY (state-level data)

% who received 2nd instalment – of No. of PMMVY applications registered (across all instalments)	Q1	Q2	Q3	Q4
Baran – Baran	771%	38%	205%	90%
Baran – Shahbad	209%	76%	78%	119%
Jhunjhunu – Jhunjhunu	177%	3%	80%	68%
Jhunjunu - Alsisar	189%	44%	49%	122%
Jodhpur – Jodhpur	170%	2285%	254%	83%
Jodhpur – Osian	177%	161%	99%	254%
Udaipur – Rishabdev	349%	47%	101%	102%
Udaipur – Girwa	67%	92%	97%	109%

Table 2.5.3: % Beneficiaries who received 3rd instalment for PMMVY (state-level data)

% who received 3rd instalment – of No. of PMMVY applications registered (across all instalments)	Q1	Q2	Q3	Q4
Baran – Baran	403%	17%	120%	88%
Baran – Shahbad	154%	74%	81%	82%
Jhunjhunu – Jhunjhunu	183%	0.19%	63%	57%
Jhunjunu - Alsisar	179%	41%	78%	55%
Jodhpur – Jodhpur	12%	2462%	445%	89%
Jodhpur – Osian	85%	81%	66%	172%
Udaipur – Rishabdev	211%	47%	75%	88%
Udaipur – Girwa	67%	72%	73%	85%

Principal investigator

Development Solutions is a research and consultancy firm that provides advisory, M&E services, research, and strategic support to Development Partners to maximize social impact.

Knowledge partner

Institute of Development Studies Jaipur

The Institute of Development Studies Jaipur was established in 1981 and is supported by theIndian Council of Social Science Research (ICSSR) and the Government of Rajasthan. It is a multi-disciplinary research organisation with a focus on understanding development processes and problems and contributing to policy discourse through theoretical and empirical research.

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