COVID-19

IN MEMORY OF 2021
A YEAR OF HAVOC

ऑक्सफैम इंडिया
OXFAM
India

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The Research and Knowledge Management Team, Oxfam India

LIST OF ABBREVIATIONS

BPL	Below Poverty Line
CDOs	Community Development Organisations
CMIE	Centre for Monitoring Indian Economy
CSOs	Civil Society Organisations
DGHS	Directorate General of Health Services
DPCO	Drug Price Control Order
DV	Domestic Violence
EBC	Economically Backward Class
ePoS	Electronic Points of Sale
FGDs	Focus Group Discussions
FMES	Forum for Medical Ethics Society
GBV	Gender Based Violence
GFR	General Financing Rules
HCQ	Hydroxychloroquine
HRW	Human Rights Watch
ICMR	Indian Council of Medical Research
IP	Intellectual Property
ISWs	Informal Sector Workers
KIIs	Key Informant Interviews
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act

MoHFW	Ministry of Health and Family Welfare
NCW	National Commission for Women
NEP	National Education Policy
NHRC	National Human Rights Commission
NSS	National Sample Survey
OBC	Other Backward Class
ONORC	One Nation, One Ration Card
PDS	Public Distribution System
PLFS	Periodic Labour Force Survey
PLIs	Production Linked Incentives
PRC	Patients' Rights Charter
PTA	Parent Teacher Association
PwD	Persons with Disabilities
RTE	Right to Education Act
SC	Scheduled Caste
SII	Serum Institute of India
SMC	School Management Committees
ST	Scheduled Tribes
UIP	Universal Immunization Programme
UT	Union Territories
VAW	Violence Against Women
VHSNC	Village Health, Sanitation and Nutrition Committees

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PREFACE

By all accounts 2020 was a terrible year. The year 2021 was even worse for much of the world. For many Indians, 2021 brought with it the second wave of the COVID-19 pandemic and was the very worst period in their lives.

In January 2021, the Indian government declared publicly that India had beaten the pandemic and followed this declaration with a relaxation of COVID-19-related containment measures. In a now infamous statement in March, India's then Health Minister claimed that 'we are in the end game of the COVID-19 pandemic in India'. The scale of the tragedy of the second wave, as it is now popularly acknowledged, demonstrates that the Indian government was not only unprepared but also actively dismantled[i] India's already dwindling public health infrastructure after the first wave.

On 20 July, the Central government informed the Rajya Sabha that no deaths due to lack of oxygen were specifically reported by States and Union Territories (UTs) during the second COVID-19 wave, on 7th of August 2021 it also went on record stating that no panel had ever been formed to review oxygen availability.[ii] Not only was the first lockdown (in March 2020) implemented badly with no prior notice, it also caused mass migration and loss of lives. In the year that followed, the Indian government failed to ramp-up medical facilities despite this being placed

on record in Parliament and then catastrophically failed to arrange enough oxygen, regulate super spreader events, and even prioritised vaccine diplomacy versus vaccination *atma-nirbharata* when and where it mattered!

In this volume, Oxfam India takes a look at the many dimensions of the question 'could the pandemic have been managed better?' When one looks at some of the decisions made by the Indian government, one can tell that relatively better management could indeed have been possible. India's top virologist quit a scientific advisory panel after criticising the government's 'stubborn resistance to evidence-based policymaking', an opinion that rings true. India's COVID-19 mismanagement includes the government's complicity in actively allowing huge political rallies for election campaigns and mass religious gatherings, including the Kumbh Mela, where millions of people shunned the all-important mask[iii] while they jostled for space.

The second wave arrived because – in the year intervening between the first hasty lock-down that left hundreds upon hundreds of migrant workers without food and shelter and the subsequent drop in the number of cases – the government did next to nothing to prepare for another wave of infections. Indeed, so bad was the policy planning that oxygen supplies were not ramped up and field hospitals that were hastily assembled together after the first wave were actually actively dismantled.

Between January and May 2021, India bought roughly 350 million doses of the two approved vaccines – the Oxford-AstraZeneca, manufactured as Covishield by the Serum Institute of India (SII),

and Covaxin by the Indian firm Bharat Biotech. The vaccines were cheap at procurement (but pricy for those who needed to take the vaccines) and sufficient for barely 20 per cent of the population.

During the same time, the Prime Minister took to the television no less than three times to declare that India had defeated COVID-19. Then came 'vaccine diplomacy', exporting more vaccines than were administered in India by March and then the mass pyres. While India continues to celebrate vaccination success with absolute numbers (India has surpassed the number of vaccines administered by the US, for instance), in reality, it has only fully vaccinated 38 per cent of its population (at the time of this document going to press). The government likes to emphasise that it is currently vaccinating around four million people every day, but does not say that it should be administering double that number if we want to beat the pandemic this year (Dec '21-January '22).

The day India rolled out free (but not really free, it still costs money in private hospitals while government hospitals have long queues and shortage of vaccines) vaccinations to everyone aged 18+ years, the Prime Minister's heart was gladdened given the record administration of 8.5 million doses, but that feat was immediately followed by a sharp decline with average daily inoculation falling below 3 million. Madhya Pradesh, for instance, which recorded 1.7 million vaccinations on Monday (the first day of the vaccine drive), saw only 68,370 doses administered till 10 pm on Tuesday (the day after the launch day) – a drop of 96 per cent between the two days. In Haryana, there was a 75 per cent drop in daily vaccination numbers on the second day (128,979

doses administered till 10 pm), compared to 511,882 doses on the launch day, data showed.

While there has been a plethora of data documenting the migrant crisis in 2020 for instance, and the terrible lack of oxygen and basic medical infrastructure in India, far too little has made it into the public domain about the crisis our socio-economic fabric faced, one that allowed an estimated 4.67 lakh (numbers as on the date this narrative went to press)[iv] Indians to die in the pandemic. The insights of people with lived experience can be extremely valuable in preventive-planning, treatment and education, contributing to improved care, enhanced safety, reducing deaths and improving support for loss survivors.

How did the middle class suffer as a result of India's disastrous second wave? What aspects of the larger institutional arrangements and social protections that allowed for migrants to go hungry and lose their lives need reform? What have peoples' lived experiences of COVID-19 and accessing the vaccine been? What challenges have parents had to face with education in the face of mass school-closures (both private and government)? How have the unequal power relations in the household precipitated a documented rise in domestic violence (DV)[v] against women?

These and other questions form the centre of this layered collection of Rapid Research Studies conducted through the year 2021, focussing on the lived experience of India's informal sector workers (ISWs), women who faced intimate partner violence in the face of the pandemic, India's middle class and finally the lived experience of those who had to access

hospitals, medical facilities and vaccines during the pandemic. The studies together constitute an accurate assessment of the state's orientation, and this volume raises several questions, especially about lockdowns and the many facets of crises accompanying public health emergencies. For instance, the rapid surveys undertaken by Oxfam India show the following:

ON THE COVID-19 EXPERIENCE OF THE MIDDLE CLASS

Our rapid survey that looked at the impact of the second wave of the pandemic on the middle class found that the pandemic deepened the cracks in an already fissured society. For instance, 66 per cent of those surveyed who faced a job loss during the pandemic belonged to a Scheduled Caste (SC), Scheduled Tribe (ST) or Other Backward Class (OBC) category. A third were Muslims and adding other minority religions brought the total religious distribution of those who lost jobs to 60 per cent.

Similarly, the old and the very young faced the most reductions in salary during the pandemic with 20 per cent income reductions for those below twenty years of age and 40 per cent for those between 45 to 60 years of age. We also found that the least reduction in salary was in those who were in the highest income bracket and 30 per cent of the self-employed faced salary reductions of 40 per cent and above. With regard to increases in household expenditure, 57 per cent and 61 per cent of respondents from the lowest two income brackets witnessed an increase in expenditure while Muslim households bore a disproportionate burden at 60 per cent.

COVID-19 was terrible in terms of housework, particularly for

the lower middle class, our survey shows that 70 per cent of the respondents in the lowest income bracket felt that the burden of housework increased in the second wave, and this was true in 70 per cent of SC households and 50 per cent of ST households. It is possible that the spiralling cost of private healthcare at about one lakh rupees a day explains this response. The survey also found that nearly 45 per cent of all respondents across States rated the Central government's response to the pandemic as 'very poor'.

ON SOCIAL SECURITY FOR INFORMAL SECTOR WORKERS

Awareness of the Public Distribution System (PDS), one of the most important ways to ensure food security during the pandemic, among respondents surveyed was at 66 per cent, with nearly three-fourths of all casual-wage workers having a ration card. However, despite having a ration card, only 45.6 per cent of casual-wage workers were able to buy ration during the second wave of the pandemic. The vast majority reported that fair price shops were either closed altogether or open for a very limited duration of time. Disaggregated analysis of data showed that short-term circular migrants and the unemployed, two of the most vulnerable groups, ironically, are the most deprived when it comes to accessing PDS.

Only eight per cent of respondents, surveyed, had ever heard of Ayushman Bharat (health insurance) out of which only one per cent had health cards. As a proportion of respondents from all four cities, respondents who had heard of Ayushman Bharat was the highest (17.6 per cent) for those with an annual income above INR 75,000, but even there, less than a

tenth had a health card. The lowest level of awareness (3.7 per cent) was in the group which earns the least i.e. those with an annual income below INR 15,000 and of these, less than four per cent have a card. None of the short-term circular migrants surveyed had a card.

Eighty per cent respondents surveyed (of those employed) stated that they did not receive any social security benefits they are entitled to. Among short-term circular residents and those with an annual income below INR 15,000, none have a written contract of employment, effectively resulting in zero income and employment security. A mere 0.7 per cent of all workers with an employer, in our rapid survey, were found to be registered with a workers' welfare board.

A gender-disaggregated analysis revealed that the level of awareness for Ayushman Bharat and employee benefits are higher among males. The percentage of males who have an employer is more than females, indicating either a higher level of unemployment or greater self-employment among females. The provision of paid maternity leave is also very low for females with only 1.2 per cent of female respondents stating that they received maternity benefits.

ON PATIENTS' RIGHTS AND THEIR VACCINATION EXPERIENCE

Eight out of 10 people did not think that the government will be able to fully vaccinate all adults by December 2021, 80 per cent people believed that it is more difficult for a daily wage worker to get the vaccine as compared to a salaried, middle class person. Most did not think that the experience was equitable. A third of all people surveyed said that they either

had to make multiple visits to the vaccination centre or stand in long queues.

Ten per cent of people said they had to lose a day's wages to get themselves vaccinated, 43 per cent respondents stated that they could not get vaccinated because the vaccination center had run out of vaccines when they visited the center, and 12 per cent did not get vaccinated because they could not afford the high prices of the vaccine.

ON SCHOOLS AND EDUCATION

On the education front too, Oxfam found several issues; for instance, we found that 40 per cent of private schools had hiked their fees during the pandemic period. Unsurprisingly, 84 per cent of parents reported that the government has been unable to regulate private schools effectively, 51 per cent parents said they had no voice and agency around key decisions and less than 5 per cent of private school parents were satisfied by the action taken by any school on any complaint made. Only under 20 per cent parents reported that their child's school has a parent teacher association (PTA).

The Oxfam study also found that almost half of the private school students were not involved in any form of teacher-led learning activity over a two-month period and that 2 in every 3 children found it difficult to get doubts cleared in online classes. Only 33 per cent of those earning under INR 20,000 per month reported being able to keep up with teaching their children at home, when compared to 53 per cent of those earning above INR 80,000 per month. Worst of all, our study also found woefully inadequate attention being given in private schools to addressing learning deprivation, with only 14 per

cent parents reporting that their child's school assessed his/her current learning level as they returned to school.

The situation in government schools has also not been encouraging. While 80 per cent respondents stated that schools had finally re-opened, 12 per cent girls are not attending school after reopening as compared to 7 per cent of boys. Our study also showed that 41 per cent of Muslim children are not attending school and less than 50 per cent of children overall are actually attending school six days a week. Over 40 per cent of the parents whose children are not attending school said that they accessed learning through a physical class, led by a tuition teacher, leading to additional expenses for the household.

In government schools, two in five children shared that they had lost interest in studying and don't want to go back to school. Alarmingly, 29 per cent of the surveyed children said that they had been married off during this time, and therefore can't go to school. Child labour has made a comeback, 40 per cent and 38 per cent of the children who are not attending school have said that they needed to help with household chores and support their families financially. Mid-day meals, one of the de-facto success stories of government schools, have resumed only in approximately 40 per cent of the schools, hurting long-term nutritional outcomes for children.

The digital divide in education is real. Over half the children, who are not attending physical classes in school, face the challenge of not having the right device or having to share the phone with other family members. One-fifth of the students reportedly struggle to ask questions in online classes. Over

70 per cent of responding teachers said that children have forgotten what they learnt previously and 73 per cent said that attendance of children is irregular.

Our study also found that teachers felt under-equipped, two in five teachers reported not being trained/equipped to address a full year's learning loss of students. Over two in five teachers also faced challenges in ensuring adherence of children to COVID-19 protocols because of teacher shortage, only a little over half of the teachers surveyed felt that their school was equipped with adequate resources to ensure COVID-19 protocols were met. Finally, we also found that 70 per cent of the teachers' families who received compensation, for their deaths during compulsory pandemic services, were not satisfied with the compensations provided.

ON INCREASED INTIMATE PARTNER VIOLENCE (IPV) IN SLUMS

In Patna, our in-depth qualitative study with victims of DV during the pandemic showed that the COVID-19 pandemic caused significant disruptions to access to food, healthcare, nutrition programmes, education, and public transport. This was accompanied by direct forms of violence such as police brutality and increased violence against women (VAW). The impact on women's everyday lives as a result of the pandemic and the lockdowns has been multifaceted – economic, social, mental/psychological, physical, and personal. Loss of livelihood and dwindling of savings had a devastating and long-term effect on several aspects of women's everyday lives such as changes in food habits and quality of nutrition, increase in debts and harassment by money lenders, and increase in mental stress.

The restrictions imposed by the lockdown and presence of male members at home 24x7 also meant loss of mobility, personal space, leisure time, and opportunities for rest for women. Increased proximity with family members and increase in unpaid care-work and sexual and personal demands by husbands also increased instances and intensity of household discord and DV. At the same time, because the streets were desolated, instances of public harassment, snatching and petty thievery also increased in some areas.

With a slow vaccine rollout and overwhelmed health infrastructure, there is a critical need to examine India's response and recommend measures to further arrest the current spread of infection, especially as newer variants emerge, and to prevent and prepare against future waves.

This collection of excerpts from the six full-fledged rapid studies brings to bear on the pandemic peoples' own experience of the economics, sociology, law, architecture, psychology, public health, and gender studies aspects of the COVID-19 pandemic in India. Taken together, they present a rich tapestry of the multiple dimensions of India's COVID-19 story up to December 2021.

CHAPTER 1
CRACKS IN INDIA'S MIDDLE CLASS

In 2021, Oxfam India's Research and Knowledge Management Team undertook a rapid opinion survey to understand the experience of India's middle class in the context of the COVID-19 pandemic, especially the second wave, on job loss and wage reduction, hospitalisation and their experience of getting vaccinated.

In developing economies the distribution of socioeconomic classes can best be graphically represented by a skewed distribution to the left of a distribution curve (the majority is poor) as opposed to more of a bell curve for richer nations. Despite this clear economic and demographic 'location', the middle class is a somewhat amorphous entity as far as classifications go.[vi]

Being 'middle class' is something of a good thing in that it includes within it the idea of aspiration and growth, and yet is also something of a discomfort in that it appears to be that class of people, who work as hard as the poor belabouring class, and yet don't quite possess all the purchasing power that a member of the elite classes might have. Far from being just an income bracket, the middle class is those who are dependent upon their growth and achievements as defined by their purchasing power, educational levels, perceptions of who constitute 'the wealthy', and levels of social services among other factors.

The golden age for India's middle class arrived after India's economic liberalisation reforms of 1991-92 and has been

primarily attributed to the incentivisation of private capital investment and opening up of the economy to foreign investments. The total number of people in the middle class approximated thirty million in the 1990s, or less than 1 per cent of the population. The percentage of those in the middle class began rising steadily to about 5 per cent of the population in 2004.[vii] During the eight-year period between 2004 and 2012, the middle class doubled in size from 300 million to 600 million.

By 2015, the size of the middle class in India was between 300 and 600 million, in 2015, fewer than 19 per cent of Indians lived below the poverty line, nearly a 10 per cent reduction from 22 per cent in 2011. The Indian household savings rates also tripled between 2005 and 2015, with many more households having a significant disposable income.[viii] By 2016-2017, and in early 2018 approximately half of India's population of 1.3 billion was in the middle class, within this group the fastest growing incomes was those of the 'lower middle class' who earned between $4 to $6 a day according to international estimates. This group managed to save up to a third of their incomes to spend.[ix]

Despite this, there were concerns starting to show up in the later part 2018 about India's 'middle-class opportunity'. Whispers in the boardrooms of larger corporations such as Amazon and Apple, who were banking on the McKinsey-style 'Indian golden bird' to fly, were starting to suggest that the Indian middle class, while large, also masked large income inequalities. Piketty's graphs[x] were starting to become a persistent thorn in the side of 'India Growth Story' enthusiasts.[xi]

Ultimately, the great Indian middle class story was cut short

rudely by the pandemic. Before the pandemic, 99 million people in India were expected to belong to the global middle class in 2020.[xii] However, after one year of pandemic, that number has reduced by a third, to 66 million people.

The middle class also shrank catastrophically in the pandemic, according to a study by Pew research;[xiii] 59 million people were to be classified as 'poor' from an income perspective prior to the pandemic. However, the post-pandemic estimate now indicates 134 million people live in poverty in India – which is more than double the original estimate. The shrinking of India's economy as a whole by a whopping 7.3 per cent in 2020-21, with its falling employment, wages and the incomes, has catastrophically struck middle class households.[xiv] Current estimates of the size of India's middle class vary widely, from 200 million to 600 million,[xv] but all experts agree that its prosperity is crucial for reviving the economy. Smaller studies also estimate that household earnings and wealth almost halved[xvi] during the pandemic, however, nobody really knows what the real story is.

The Hurun Global Rich List[xvii] in 2020 adds 40 new Indian billionaires but there are few indications in any public datasets that indicate a recovery for India's middle class. Given this, Oxfam India decided to run an online survey that aimed to capture the lived reality of India's middle class during the second wave of the pandemic. The study shows that the aura of security and progress that previously defined the middle class fell apart as a result of COVID-19.

Methodology and Data Collection

This rapid survey adopted a quantitative methodology and was administered online via a Google form. The survey asked

respondents a range of questions about their hospitalisation and vaccine experiences as well as their opinion on the state of healthcare in the country. In addition, it asked questions about job-loss, wage-reduction and other social protection measures offered to, and taken up by middle class respondents.

Given that the survey was conducted online, respondents were from nearly all States and several union territories (UTs) but largely from urban areas and tier-II cities. The survey had a total of approximately 1,800 respondents and ran for a little over two months, starting mid-September of 2021.

Data Analysis

The survey was analysed using simple percentage and crosstabs in Microsoft Excel. Multiple choice question were analysed at response level, and not respondent levels. Where results reported as proportions or percentages, do note that, multiple-choice question responses have also been normalised.

Results

Nearly half of the respondents to the survey were aged between 21 to 35 years of age, 65 per cent were male respondents and close to 70 per cent of respondents were from the southern States of Karnataka, Kerala, Telangana and Tamil Nadu, only approximately three per cent of respondents each were from Uttar Pradesh and West Bengal.

In terms of employment, close to 60 per cent of the sample stated it was salaried and nearly 10 per cent self-employed and unemployed respectively. Forty per cent of the sample had an annual income of over ten lakh rupees a year, 20 per

cent earned between five to ten lakh a year, while 26 per cent earned less than Rs 250,000 annually.

Majority of the sample (70 per cent) stated their religion as Hindu while eight per cent preferred not to reveal their religion. The majority of the sample also consisted of 'general' category of castes, with only 17 per cent of the sample declaring itself to be OBC, 3.5 per cent to be SC and a mere 1 per cent identifying themselves as STs.

This background is important because the survey was an online survey and as such, open for anyone to participate and yet the inequities in respondent representation from those who self-selected themselves to respond, reflect the inequities of internet access and in agency, as present in Indian society.

JOB LOSS AND WAGE REDUCTION

In the study, 16 per cent of respondents stated that they lost jobs during the second wave of the pandemic. When disaggregated by gender, we see 15 per cent of these job losses were for women while 17 per cent of men in the sample lost jobs. Jobs were also lost disproportionately for those belonging to the clear lower middle-class category by income, one in every third person from this income category in our survey lost their jobs.

TABLE 1 RESPONDENTS FACING JOB LOSS BY HOUSEHOLD INCOME IN RUPEES

HOUSEHOLD INCOME	PERCENTAGE SHARE
<250,000	31
250,001-5,00,000	20
500,001-1,000,000	14
>1,000,000	7

Of those who reported losing jobs, 34 per cent were still unemployed (since the second wave of the pandemic in April 2021) and 27 per cent who reported having lost a 'job' actually lost hundred per cent of their income due to business losses as they were self-employed, ten per cent were regular salaried employees.

The caste differentials in job-loss were apparent with over a quarter of respondents who lost their jobs being from a SC, 24 per cent from a scheduled tribe (ST) and nearly twenty per cent being OBCs, in comparison to persons from the general category at only fifteen per cent.

TABLE 2 CHANGES IN WAGES BY AGE GROUP

AGE	100%	20%	20-40%	40% +	REDUCED DEARNESS ALLOWANCE
> 20	0	19	21	4	0
21-35	0	12	7	8	0
36-45	3	12	9	12	0
45-60	2	12	14	19	0
60+	4	10	8	9	1

Of those who did manage to retain jobs during the second wave of the pandemic, we found that the burden of wage loss was unequally distributed even within the middle class. As the table demonstrates, 4 per cent of those aged sixty or more faced a total loss of salary and some reductions in allowances, while 19 per cent in the 45-60 age bracket witnessed a salary reduction of more than 40 per cent and 19 per cent of those aged twenty or less faced a reduction of 1-20 per cent.

Gender disaggregated analysis shows that men and women were both at similar levels in terms of wage-loss across categories (12 and 8 per cent for a forty per cent reduction in wage respectively, for instance); however there was a difference between the relatively better-off and those living precariously.

TABLE 3 PERCENTAGE LOSS IN WAGES BY INCOME GROUP IN RUPEES

HOUSEHOLD INCOME	100%	1-100%	20-40%	40% +	REDUCED DEARNESS ALLOWANCE
<2.5 L	2.8	16.0	12.2	16.2	0.0
2.5 L – 5L	2.07	14.88	14.88	16.53	0.83
5.01 – 10L	2.16	11.08	8.11	10.54	0.00
>10L	1.06	9.18	6.65	6.65	0.13

As the table demonstrates, *total loss* in salary was faced by 2.8 per cent respondents in the lowest income bracket – highest among all income categories; while the least impact on reduction in salary was by the highest income bracket. The middle-income middle class saw the largest percentages of wage loss, 15 per cent and 17 per cent and a reduction of nearly one per cent in their dearness allowances as well.

CHANGES IN HOUSEHOLD EXPENDITURE

Another way in which the middle class experienced the pandemic at large, and the second wave in particular, was through a 'belt tightening' exercise. Anecdotally, we know that households reduced spending significantly in order to cope with medical expenses and in order to finance regular household expenditure in the face of job-loss and wage

reduction. Our survey showed that the burden of 'managing' within a new and restricted budget was mostly felt by the lower middle class.

TABLE 4 INCREASE IN EXPENSE BY INCOME CATEGORY IN RUPEES

HOUSEHOLD INCOME	INCREASE BY PERCENTAGE
<250,000	57
250,001-500,000	61
500,001-1,000,000	50
>1,000,000	46

Our data also demonstrates that the burden of changes in household expenditure was relatively less on the highest income bracket, while three out of every five persons (i.e. 57 per cent and 61 per cent of respondents from the lowest two income brackets) in the lower middle-class witnessed an increase in household expenditure. The vast majority of these households also belong to religious minorities, specifically Muslims.

TABLE 5 INCREASE IN EXPENSE BY HOUSEHOLD RELIGION

RELIGION	INCREASE BY PERCENTAGE
HINDUISM	52
ISLAM	60
SIKHISM	38
CHRISTIANITY	51
OTHER	49
PREFER NOT TO SAY	41

SOCIAL IMPACT

Studies, including one conducted by OXFAM's Gender Justice Team (see chapter 4), demonstrate that the pandemic as a whole and the second wave in particular, exacerbated household inequities in terms of the burden of care work sharply. As our survey shows, despite the existing burden of household work being disproportionately skewed towards women, an increase in household work for women was still the norm.

TABLE 6 PERCENTAGE INCREASE IN HOUSEHOLD WORK BY GENDER

SEX	INCREASED BY
MALE	63
FEMALE	66

In addition to the gender skew, the increases in housework were acutely felt by the lower middle-class (seven out of every ten people experienced an increase) but also by the upper middle-class who perhaps found that the pandemic affected their ability to hire labour for domestic work.

TABLE 7 PERCENTAGE INCREASE IN HOUSEHOLD WORK BY INCOME GROUP IN RUPEES

HOUSEHOLD INCOME	INCREASED BY
<250,000	72
250,001-500,000	70
500,001-1,000,000	61
>1,000,000	58

Our survey also found that there is a clear caste dimension to the increased household work burden, with 71 per cent of SC

and 53 per cent of SC respondents bearing the weight of the increase in in-home time.

TABLE 8 PERCENTAGE OF INCREASE IN HOUSEHOLD WORK BY CASTE

RELIGION	INCREASED BY
SC	71
ST	52
OBC	64
GENERAL	64
PREFER NOT TO SAY	65
OTHER	58

Thus, one can conclude that the burden of increased household work fell clearly on those who bear the cross of intersectionality, with lower-caste and low-income household and women shouldering the lion's share of the burden.

THE COVID-19 EXPERIENCE

Our survey asked respondents to respond to a range of questions on their experience with the second wave of the pandemic. One clear area of concern was around the costs of hospitalisation, data from our survey showed that the cheapest way to get medical care was the home-hospital setup. In our study only 1.15 per cent of respondents went this route and had to pay between Rs 50,000 to Rs 100,000 per day as cost of hospitalisation, this is perhaps a reflection of the availability of this service.

Alarmingly, 4 per cent of respondents spent between Rs 100,000 to Rs 150,000 in government hospitals and unsurprisingly, private hospitals were the most expensive with 9 per cent spending more than Rs 100, 000 per day.

TABLE 9 DAILY COST OF HOSPITALISATION BY HOSPITAL SERVICE

DAILY HOSP COST (INR) IN PERCENTAGE	GOVT HOSPITAL	HOME HOSP	PVT HOSP
0-50,000	96	99	77
50,000-100,000	0	1	14
100,000-150,000	4	0	6
150,000-450,000	0	0	3

Our survey shows that in the States of Assam, Bihar, Chhattisgarh, Kerala, Punjab, Rajasthan, Uttarakhand and all the UTs, per day cost for all respondents was less than INR 50,000; this was at two per cent in Telangana. Five per cent in UP (India's most populous State) spent between Rs 4-4.5 lakh as per day cost of hospitalisation. More than half of all respondents (53.6 per cent) spent between Rs 500-999 on a single dose of any vaccine, see Annexure A for State-level data tables.

To get a sense of where the middle class went to get medical treatment during the pandemic, we asked our respondents to share where they were treated. We found that an overwhelming percentage went to private hospitals, when compared to income we found that of those that went to private hospitals for treatment, 41 per cent belonged to the highest income category (INR 10 lakh and above).

Our data shows that 40 per cent of respondents that went to government hospitals were from the lowest income category of INR 250,000 or below. Of those that opted for home set-ups, 36 were in the highest income category and 34 per cent were in the lowest income category, indicating that the price for home hospital setups was variable and could be afforded by all.

TABLE 10 HOSPITAL TYPE BY PERCENTAGE OF RESPONDENTS

HOSPITAL TYPE	SHARED BY
GOVERNMENT HOSPITAL	5
PRIVATE HOSPITAL	16
HOME HOSPITAL SET-UP	6
NOT REQUIRED	3
OTHERS	1

We asked our respondents who they sought help from during the second wave of the pandemic and found that close to 40 per cent of all respondents relied on friends and family, while nearly a quarter of all respondents made arrangements themselves. The bottom two income categories had the highest reliance on social media (34 per cent and 39 per cent). As many as 26 per cent and 24 per cent of the respondents in the bottom two income categories made calls/arrangements themselves.

For the top two income categories, one-third made calls/ arrangements themselves, followed by 28 per cent and 32 per cent who relied on social media. A detailed tabulation by income categories is available in Annexure A.

We asked those respondents who home isolated (with mild COVID-19 that did not require hospitalisation), what issues they faced during their home-isolation experience and found that twenty per cent of respondents found oxygen cylinders too expensive to procure, 14 per cent tried to get admitted to a hospital but could not and a similar percentage was overcharged for medicines.

TABLE 11 HOME ISOLATION EXPERIENCE ISSUES

HOME-ISOLATION EXPERIENCE	SHARED BY PERCENTAGE
NO DOCTORS TO CONSULT	8
NO OXYGEN CYLINDERS	0
EXPENSIVE OXYGEN CYLINDERS	19
MEDICINES NOT AVAILABLE	10
EXPENSIVE MEDICINES	14
NO MEDICAL EQUIPMENT	11
NO HOSPITAL BEDS	14

When respondents were asked about their hospitalisation experiences, they stated that their main issues were overpriced oxygen cylinders, non-availability of hospital beds, expensive medication and a lack of response from hospitals.

TABLE 12 HOSPITALISATION EXPERIENCE BY PERCENTAGE OF RESPONDENTS

HOSPITALISATION EXPERIENCE	SHARED BY
HOSPITAL BEDS NOT AVAILABLE	16
HOSPITAL OVERCHARGING	13
OXYGEN CYLINDERS NOT AVAILABLE	10
OXYGEN CYLINDERS AT HIGH PRICES	17
MEDICINES NOT AVAILABLE	0
MEDICINES AT HIGH PRICES	13
NO PLASMA/BLOOD DONORS	3
NO RESPONSE FROM HOSPITAL	10
NO AMBULANCE SERVICE	4
AMBULANCE AT HIGH PRICE	8

We also asked respondents to document their issues with the vaccination drive and found that 40 per cent of respondents

struggled to find vaccination slots and 26 per cent struggled to get registered on the CoWin app while 26 per cent complained of long queues at the vaccination center.

TABLE 13 VACCINATION EXPERIENCE BY PERCENTAGE RESPONDENTS

HOME-ISOLATION EXPERIENCE	SHARED BY
NO VACCINATION SLOTS	40
CENTER DID NOT OBSERVE SDPS	21
APPOINTMENT WAS CANCELLED	5
CENTER WAS VERY FAR AWAY	11
LONG QUEUES	26
CENTER RAN OUT OF VACCINES	10
DIFFICULTY WITH COWIN	26

Based on their experience during the second wave, respondents rated the Central government's handling of the COVID-19 pandemic and results showed a general state of dissatisfaction across income categories with some State-level variations.

With the exception of Assam, Himachal Pradesh, Manipur, Meghalaya and Tripura, the perception of the performance of the Central government in response to the government is that it was very poor (44.5 per cent). It is to be noted that the majority of those surveyed in Assam, Gujarat, Manipur, and Tripura felt that the performance of the Central government was 'good', data tables for all States are available in Annexure A.

We also asked our respondents to rate the performance of their State governments, vis-à-vis COVID-19 management and response and found that Assam, Chhattisgarh, Goa, Gujarat, Jharkhand, Karnataka, Kerala, Maharashtra, Manipur, Odisha,

Punjab, Rajasthan, Tamil Nadu, Tripura, and the UTs were happy with their State government responses.

However, residents of Bihar, Chhattisgarh, Delhi, Goa, Madhya Pradesh, Telangana, West Bengal, Andhra Pradesh, Haryana, Himachal Pradesh, Jharkhand, Meghalaya, Rajasthan, Uttar Pradesh and Uttarakhand rated their State government performance to be either 'poor' or 'very poor', data tables for each State are available in Annexure A.

Close to 40 per cent in all income brackets felt that the response of their State governments was good suggesting that people blamed the Central government more than their States for their pandemic troubles, tabulated data by income bracket is available in Annexure A.

Conclusions

Our rapid survey that looked at the impact of the second wave of the pandemic on the middle class found that the pandemic deepened the cracks in an already fissured society. For instance, 66 per cent of those surveyed who faced a job loss during the pandemic belonged to a SC, ST or OBC category. A third were Muslims and adding other minority religions brought the total religious distribution of those who lost jobs to 60 per cent.

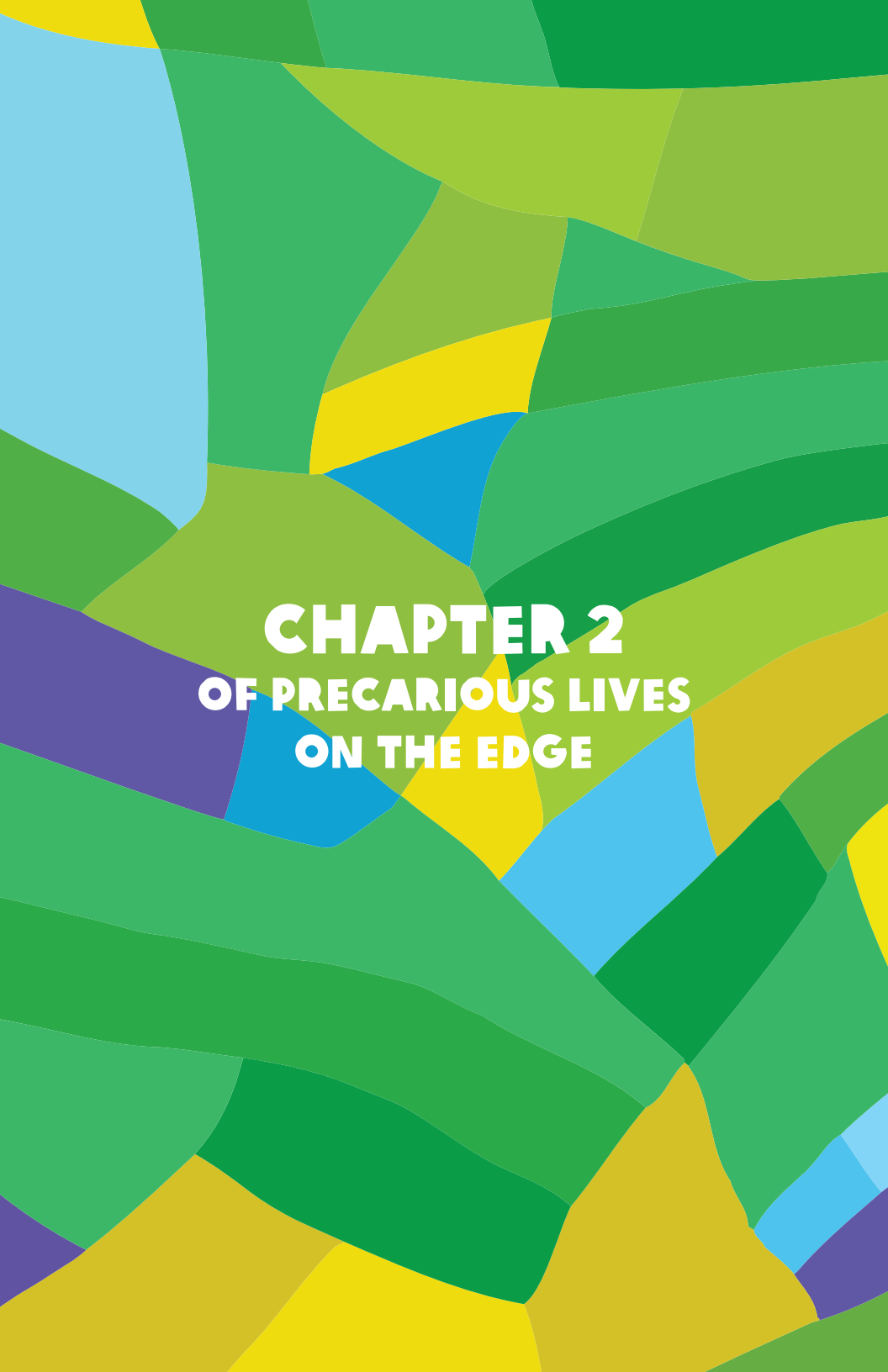
Similarly, *the old and the very young faced the most reductions in salary* during the pandemic with 20 per cent income reductions for those below twenty years of age and 40 per cent for those between 45 to 60 years of age. We also found that the least reduction in salary was in those who were in the highest income bracket and 30 per cent of the self-employed faced salary reductions of 40 per cent and above.

With regard to increases in household expenditure, 57 per cent and 61 per cent of respondents from the lowest two income brackets witnessed an increase in HOUSEHOLD expenditure while Muslim households bore a disproportionate burden of household expense increases at 60 per cent of households surveyed.

COVID-19 was terrible in terms of housework, particularly for the lower middle-class, our survey shows that 70 per cent of respondents in the lowest income bracket felt that the burden of HOUSEHOLD work increased in the second wave, and this was true in 70 per cent of SC households and 50 per cent of ST households, the spiralling cost of private healthcare at about one lakh rupees a day explains this response.

Nearly 45 per cent of all respondents across States rated the government's response to the pandemic as 'very poor'. Overall, we found that the middle class, especially the lower middle-class suffered from having to overly rely on personal networks to tide over a crisis, twice as much as normal, as indicated by a positive standard deviation of 2 on this parameter.

Similarly, the non-availability of medicines was particularly painful for a upwardly mobile middle class, as indicated by a negative standard deviation of 2 on this parameter and finally being forced to fall back on ostensibly expensive private hospitals also seems to have made the COVID-19 experience particularly bitter, as indicated by a positive standard deviation of 2 on this parameter.



CHAPTER 2
OF PRECARIOUS LIVES ON THE EDGE

In 2021, Oxfam India's Private Sector Engagement Team and Research and Knowledge Management Team undertook a rapid on-ground exploratory study on social security and Informal Sector Workers. This study was undertaken to develop an understanding of the lives and losses of ISWs during the pandemic. Designed in the midst of the second wave to guide Oxfam India's work for ISWs under its new strategy (2020-25), it focussed on understanding the status of rights, entitlements and dignity of ISWs in India during the COVID-19 pandemic.

A plethora of news reports focussing on the impact of India's lockdowns and documented loss of employment suggested that ISWs were the worst affected group, because as a class, they are workers who lack social security benefits.

While the government had moved to provision social security, for instance, in early May 2020 India's finance minister Sitharaman allocated an additional INR 40,000 crore as part of the economic stimulus package to The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), these measures have not been enough to cushion ISWs from food and health insecurity.

Further, the coverage of social security measures in the form of welfare schemes have been fragmented and employee

benefits to ISWs are practically non-existent. In fact, universal social security, the idea that every citizen has a safety net in terms of income, employment, health cum disability insurance and parental benefits, seems like a distant dream.

India, from the inequality perspective, often appears to be two distinct countries, one urban, another rural; one male, another female; and one rich and the other poor. This dual characteristic also extends to the economy.

The economy has the *formal* sector, governed by laws and recognition of rights and the informal sector which is largely ungoverned and unprotected by the state and the law. The informal sector forms a massive proportion of India's economy: it employs 86.8 per cent of the total work force which contributes almost 50 per cent to the total GDP of the country.[xviii]

The formal sector in some sense also contributes to the growth and rise of the informal sector through the use of contract and casual labour,[xix] without the safety and security that usually characterises the formal sector.[xx] Adding the contractual and casual labour force within the formal sector to the number of informal workers takes the total percentage of workers in the informal sector to almost 93 per cent of the total participating labour-force in India which is about 450 million workers.[xxi]

The multidimensionality of the employment problem,[xxii] attendant poverty and the precarious lives of informal workers is exacerbated by the diversity of what the 'informal economy' is – it comprises numerous economic activities, enterprises and jobs. In India, the agricultural sector has the highest level

of informal employment in the country. It employs 55 per cent of the nation's labour force, followed by manufacturing, trade and construction.[xxiii]

In terms of rural-urban differentials, informal employment constitutes 96 per cent of total jobs in rural areas, where female informal employment is at 98 per cent, compared to 95 per cent of male informal employment; 79 per cent of total jobs in urban India are of an informal nature, with 82 per cent of total female workers engaged in informal employment compared to 78 per cent among urban male workers.[xxiv]

The informality that characterises the informal sector makes it a breeding ground for discrimination – workers face high risks to their human and labour rights, dignity of livelihood, unsafe and unregulated working conditions and lower wages among many other vulnerabilities. The ISWs are devoid of any employment security, paid leaves, health benefits or social security. Discrimination, for the ISW, quickly becomes a norm, especially for women, children,[xxv] bonded and migrant workers.

As per the National Commission for Enterprises in the Informal Sector, employment in the urban informal sector happens in three ways: First is by 'standing at the factory gate', second is through a family, caste, and community-based network and third is through labour contractors or *jamadars*. The nature of these employment 'arrangements' is precarious.

When examined at the level of industry, we find that the causes of precariousness are wide and varied. In construction, an estimated 10.7 million construction workers, accounting for 83 per cent of all construction workers in India, were employed

through contractors and do not receive minimum employment protection and benefits from their jamadars. Contractors have played the middleman between the employee and the final employer in which the final employers are not accountable for advances, transport expenses and wages payable to workers. This has led to the exploitation of workers at the hands of contractors.

Industries such as underground mines, ship breaking, fireworks and match industry are dangerous and full of hazards. NCEUS noted that workers in underground mines are at the risk of losing limbs or lives due to fire, flooding and collapse of roof, emission of toxic gases and the failure of ventilation systems in the underground mines.

Loss of limbs and amputations due to accidents occur most often when workers operate unguarded or inadequately safeguarded machines. There is usually no official compensation for work-related injuries in the informal sector. Obtaining any form of support is purely based on the quality of relationship between the owner and worker and is mostly limited to the permanent employees.

Temporary workers do not receive any medical benefits, resulting in loss of pay and even the loss of job in the event of an accident or illness. There are usually no crèches, canteen, and shelter for rest in the informal sector. Worksites which provide these have exceptionally low-quality facilities.

The construction industry involves a large number of women workers, a number of them young mothers with infant children. Despite such high employment of women with young children,

crèche facilities are not available on the worksites (Report on Conditions of Work, 2007).

The vulnerability of the ISWs, worsened with the pandemic. Out of the total 122 million who lost their jobs in the first wave of the pandemic, 75 per cent of the jobs (92 million) were lost in the informal sector.[xxvi] These workers are usually employed in small businesses or as casual labour, with no employment benefits. They also have far less opportunities to work remotely, leading to more job losses than in the formal sector.

The plight of migrant workers on their journey back to their homes has been well-documented. Statistics from Centre for Monitoring Indian Economy (CMIE) report that India is now seeing a reverse migration of labour from factories to farms.

India's Periodic Labour Force Survey (PLFS) (Q1, 2020) shows a sharp increase in employment in agriculture from 42.5 per cent of the total employment in 2018-19 to 45.6 per cent in 2019-20. Such a large shift of labour in favour of agriculture is an indicator of labour market distress. Wage data from the PLFS demonstrates that salaried wages average at INR 558 per day and self-employment at INR 349 per day, agriculture is at the lowest at INR 291 per day – people work at that rate only if they have no other choice and indeed it is true that agriculture provides a low wage safety net for labour during times of distress in India.

PLFS also tells us that labour is leaving manufacturing, construction and transport, storage and communications. The second wave of the pandemic 2020-21 (July to June) which could have seen a return of the informal workforce

to manufacturing, instead appears to have gone back to agriculture.

Government efforts to boost manufacturing through Production-Linked Incentives (PLIs) and the many credit opportunities to borrow more and survive, are not being utilised by manufacturers. The slowdown of the economy and the manufacturing sector is also the result of a slowing down of consumer demand per se in the face of less of purchasing power parity per capita, if one has less money to buy, one also suffers as industry and that results in the existence of poorer quality jobs as also fewer jobs overall.

When manufacturing that has the capacity to employ the bulk of the Indian workforce (this is at seventy per cent of the whole labour force in India) is now creating the least number of jobs, something is wrong. India's exports data suggests that we don't export much and the reason we don't export much is because we don't create much worth exporting.

The manufacturing sector's share in India's GDP increased by a lowly 1 per cent from 2017 to 18.2 per cent of the whole GDP, in 2019.

Historically, in the current paradigm of accounting for capital and labour, a reasonable assumption to make is to look at a company's borrowings or investments into new projects. It stands to reason to surmise that if companies are expanding either infrastructure or buying new machinery or capacity then they probably are growing. People and firms and industries invest when they have excess or disposable capital that they want to generate returns on. So, when one looks at the ratio

of investment to GDP, we can see that this has been falling for a long while.

When industries aren't investing their money into anything, it seems unlikely that any new jobs are about to arrive.

The other way to understand if new jobs can come about is to assess the capacity of industry to absorb more labour, this is also called an 'utilisation rate', i.e. how well or efficiently labour is utilised.

In India, no manufacturing industry has been at 100 per cent capacity utilisation for years. Like with the unemployment rate, we've generally hovered at seventy per cent capacity. What could that mean? Of all the things it could mean, and there are several (for example, production is not efficient, regulatory barriers exist, maybe information asymmetry is an issue), the one thing that is most obvious is this: people just aren't buying as much, i.e. demand isn't there.

When is demand for products not there? When people aren't spending. There are two reasons, broadly, in economics for not spending a) people are saving and doing things like hoarding gold because they are not hopeful about income flow and are trying to smoothen risks in their lives or b) people aren't earning enough to spend.

Now, while there may be two reasons for why people aren't spending, there is usually just one reason to be negative about the future in any economy, people just don't see themselves in better times. Aspirations and hope effect markets and the economy of a country or even countries, in very real ways. This is more than what can be dismissed as a business cycle.

It has to do with aspiration traps that afflict a developing nation's 'poor' people. Development economists define aspiration traps as the phenomenon of poor self-belief, causing poor performance, which in turn causes a person to continue to be stuck at the very bottom of their lives. Aspiration traps are cyclic and a consistent feature of persistent poverty.

In imperfect markets, the poor often make, seemingly irrational choices such as choosing to practice a low-paid vocation as opposed to investing in long-term full education, because many of these choices are constrained by aspiration traps or a lack of imagination with regard to a 'better future' for themselves.

Why has this been the case? Could it be that the working class felt that there is very little by way of social security and benefits that they were able to access while working in the informal sector?

These statistics demonstrating a move away from employment at cities, showed that those employed in the informal sector, who already earn meagre wages, were in some sense 'voting with their feet' to leave working conditions that offer no social protection, leaving them vulnerable to all kinds of economic and health shocks. This is unlike the formal sector, with its employee benefits and medical insurance, that could cushion the blow of the pandemic. What is true of the pandemic is also an indicator of the economic and social security distress and deprivation for the informal sector as a whole.

The significance of social security has increased, given the ongoing global pandemic which has severely impacted ISWs. Managing one's health and securing food unquestionably,

became the core needs for sustenance of this group of people, who found themselves at the margins of life, due to the economic impact of the lockdown.

The informal sector, specifically, earns far too little and is able to invest or save next to nothing to ensure its survival the next day. As such, the ISW remains excluded generation after generation from formal banking, access to credit or basic social protection. Little to no social security has meant that they are still losing out on not just income but basic human necessities such as food and health care. The importance of policy initiatives such as the PDS and Ayushman Bharat cannot be overstated as immediate cover, and MGNREGA as long-term security, on the continuum of social protection, which is to provide the poor and the vulnerable with a safety net by averting food insecurity and ill-health plus livelihood.

Given this background, this study was commissioned to develop an understanding of the lives and losses of ISWs during the pandemic. Designed in the midst of the second wave to guide Oxfam India's work for ISW under its new strategy (2020-25). it focusses on understanding the status of rights, entitlements and dignity of ISWs in India during the COVID-19 pandemic.

The study examined the awareness and accessibility of two flagship welfare schemes which aim to provide food and health security – the PDS and Ayushman Bharat, to ISWs across four cities, income groups, occupations, resident status and gender. The study also looked at the availability of social security benefits to ISWs as mandated by law, both in terms of employer action and worker awareness.

The findings suggest that ISWs are far from securing social protection.

Methodology and Data Collection

The survey had a sample size of 1,461 respondents. The respondents were purposively sampled and met two eligibility criteria; a) respondents were engaged in informal sector work as on date of the data collection or had been in the past for any period of time; and b) respondents had to be chief wage earners of the family.

Our sample looked to cover a minimum of ten per cent of the total population of each selected slum. Of the total sample covered, 30 per cent was from Bangalore, 27 per cent from Mumbai, 22 per cent from Delhi and 21 per cent from Pune.

Data was collected via a primary survey with a structured questionnaire. The questionnaire was developed by Oxfam India and was circulated among the community development organisations (CDOs) who would facilitate the data collection for their feedback.

The heads of the organisations were oriented orally on the questionnaire and were provided with a guidance note which had definitions of the terms used in the questionnaire. Data was collected in the months of June and July, 2021 and was facilitated by four CDOs viz., Basti *Suraksha Mancha, Centre for Youth Development and Activities, Centre for Promoting Democracy,* and *The United Foundation* located in Delhi, Pune, Mumbai and Bangalore respectively.

Each organisation sent out a team of field enumerators to the slums who administered the questionnaire using an open-

source data collection application named Kobo-collect, all eligible households who consented were interviewed, in first eligible order from within the slums from entry point, till the specific sample size was reached.

Data Analysis

Two sets of analysis were undertaken to produce the report of this study. The first was an extensive review of India's existing labour laws and new labour codes along with an analysis of secondary data on India's consumption and production levels. The second piece of analysis had to do with the results of the on-ground survey and included simple percentage analysis and cross tabs computed from the quantitative dataset in Microsoft Excel. A list of the terms used in this study and a list of the government schemes included in the study are present in Annexure B.

Results

LABOUR CODES

The idea behind the concept of social security is simple – to provide a safety net to citizens, particularly to the economically vulnerable. Social security operates as a 'generalised policy paradigm' of social protection, i.e., it lays down the means through which social protection is to be delivered to people in the form of targeted policy-making.[xxvii]

Legislation in India relating to social security benefits for workers includes the Employee's State Insurance Act 1948, which provides medical, sickness, maternity and disability benefits. It also includes the Employee's Provident Fund & Miscellaneous Provisions Act 1952, which provides retirement benefits. However, none of these apply in any form to the ISW

principally because most industrial establishments do not employ more than ten workers 'formally', although many are employed via precarious, temporary contractual arrangements.

Given that the vast majority of India's labour force, by government estimates, falls under the informal sector, implementing a constitutional guarantee in a culturally divided set-up has been a long-standing challenge for successive governments.

Thus, policy planning and implementation of social security has suffered from a fragmentation of legislations and schemes, each designed according to geographic and demographic variables ultimately leading to the exclusion of many.

The informal sector is also characterised by a rapidly changing nature of work which denies income security and related benefits to an already vulnerable workforce which also lacks adequate representation and the power of collective bargaining.

Successive governments in India have sought to address the legislative deficit on the matter by operationalising schemes that address various components of social security. This approach has been piecemeal and has resulted in a highly disaggregated and fragmented framework whose administration depends on a number of variables such as 'nature of employment, income of worker, or income status of the worker's household'.[xxviii]

Consequently, the *National Commission on Labour* in 2002 stressed on the need to universalise coverage and aggregate the different segments of administering social security policy

ostensibly unifying all of these under a universal framework of human-labour rights.

The *Code of Social Security* which was introduced in 2020 subsumes nine previous laws related to social security. The code introduces new definitions for the informal workforce as gig and platform workers. This represents a recognition of the changing nature of the workplace and the increasingly ad hoc nature of employment that is seen across various sections of the society.

The 2020 Code also allows the Central government to apply social security provisions to any establishment irrespective of the class of employment, size of establishment or any other criteria (Section 1(6)).

This, at least in principle, has the potential to significantly expand the coverage of social security, especially when it comes to the unorganised labour force. The Code also mandates that both, the Centre and the State, will be required to set up a social security fund for the benefit of the unorganized workers, gig workers and platform workers.[xxix]

However, the Code suffers from a number of unknowns:

- The data of enforcement of the Code, if it is right at all, is unknown.
- The enforcement mechanism of the Code is unknown. As it currently stands, the responsibility for enforcement of the Code now lies, with the earlier mentioned contractors, who are themselves marginalised by larger corporations.

- Issues such as workplace safety and equal treatment of permanent and contractual workers are not mentioned, and their status is unknown.

- The status of the *Standard Committee on Labour of 2020* provision of minimum entitlement for all unorganised workers is unknown.

- It is unknown how the law and code will deal with the substantial overlap between different categories of workers.[xxx]

- It is not known how the C*ode on Occupational Safety, Health and Working Conditions, 2020* requirement of the establishment of a Social Security Fund for unorganised workers will take place.

- It is unknown how the *Code on Wages, 2019* will work in the absence of a regulatory mechanism that can actually monitor wage and bonus payments for ISW as a statutory obligation.

In our survey, we found that less than 1 per cent of respondents had ever heard of the Wage Code and none of them had heard of the Social Security Code at all. Of those who had heard of the wage Code, all knew that workers are entitled to a minimum wage, 0.5 per cent knew that employers had to pay their workers within 30 days and only 0.6 per cent were aware that men and women were to be paid equally as per the law.

FOOD SECURITY

The PDS under the *National Food Security Act, 2013* ensures food security and is jointly operated under the Central and

State/UT governments. Fair price shops operate under the PDS which sells commodities namely wheat, rice, sugar and kerosene at subsidised rates.

Some States/UTs also distribute additional items of mass consumption as pulses, edible oils, iodized salt, spices, etc. Under the Antyodaya Anna Yojana, 'poorest of the poor' among the Below Poverty Line (BPL) population are eligible for 35 kg of food-grain at a subsidised rate of Rs 2 per kg, for wheat and Rs 3 per kg for rice, providing coverage to 2.5 crore households (i.e. 38 per cent of BPL).

When the pandemic hit, the Central government announced an additional 5 kg per person ration for the urban poor countrywide, State governments also provided various amounts of food security benefits, for instance Maharashtra provided free ration to those families whose annual income is INR 59,000 or less while Delhi made ration free for a period of two months in 2020 for all ration card holders.[xxxi]

Migrant workers, especially the ISWs, fall prey to the sedentary bias of the PDS. Sedentary bias refers to the idea that the migrants primarily belong to their place of origin. Therefore, ration cards, which are required to buy goods from fair price shops, featuring addresses of the original location of the migrants cannot be used in the destination State, making the PDS inaccessible to the migrant. Errors of targeting are also quite common in the PDS; to be eligible for PDS, a household should not have an annual income above 1 lakh, should not possess more than 4 hectares of land and should not possess a four- wheeler.[xxxii]

However, errors in targeting have wrongfully included those who don't make the cut and excluded those who should have been included in the list of beneficiaries. Economists as Jean Dreze et al., compute that the system leaves more than a 100 million people out.[xxxiii]

The PDS loses 58 per cent of its supplies to a combination of ghost BPL cards, direct theft and mistargeting, as per a performance evaluation of the scheme by the government.[xxxiv] That is a high cost, a cost much higher than the self-selection of some non-poor households into a social welfare programme.[xxxv]

Then there is the fact that the government still uses data from Census 2011 (now over a decade old) to determine who the beneficiaries of the PDS should be. As such, the number of beneficiaries have remained frozen over time. For instance, a study[xxxvi] documents that the Jharkhand government has stopped issuing new ration cards and about 700,000 applications for ration cards are pending.[xxxvii]

One Nation, One Ration Card - A Step towards Universal Accessibility

The Central government launched the One Nation, One Ration Card (ONORC) initiative to enable nation-wide portability of ration cards in 2019. It will enable migrant workers and their families to buy subsidised ration from fair price shops located in any part of the country. As of August 2021, the scheme has been expanded to 34 States and UTs excluding Assam and Chattisgarh.[xxxviii]

The functioning of ONORC is based on technology that involves details of beneficiaries' ration card, Aadhaar number, and electronic Points of Sale (ePoS).

The system identifies a beneficiary through biometric authentication on ePoS devices at fair price shops. Therefore, ONORC implementation won't be complete until all fair price shops have ePos installed and 100 per cent Aadhaar seeding of ration cards is achieved. Currently, there are 4.74 lakh ePos devices installed whereas there are 5.27 lakh fair price shops operational across the country.

In addition to implementation challenges, ONORC risks being exclusionary due its dependence on Aadhar authentication. Beneficiaries of PDS who don't have an Aadhaar card would still fall prey to the sedentary bias of the PDS.

In our study, two-thirds (66.1 per cent) of survey respondents had a ration card and 15 per cent of them claimed to have not applied for a ration card at all. Eleven per cent of respondents stated that they faced a range of issues in accessing food via the PDS route, due to issues like their ration card being at their home State, difficulty in the registration process or an extremely long-wait to receive their card.

The remaining did not know about ration cards. Of those that had a ration card, one-third were unable to buy ration at a PDS outlet during the pandemic. Tabulated data featuring city-wise access to PDS and ration cards is available in Annexure B.

TABLE 14 ACCESS TO PDS BY ANNUAL INCOME IN RUPEES

ANNUAL INCOME	WITH RATION CARD	% ABLE TO BUY RATION
<15,000	64.8	88.5
15,001-30,000	63.8	95
30,001-45,000	68.5	59.8
45,001-60,000	69.6	48
60,001-75,000	54.6	83.6
>75,000	79.6	82.5
TOTAL	66.1	67.8

Our data shows that persons with an annual income above INR 75,000 have the highest percentage of ration cards, which is close to 80 per cent.

The income category of INR 60,001-75,000 (poorer) has the lowest percentage of ration cards (54.6 per cent), and 33 per cent of those without a ration card in this income group have not registered for the card of which 29 per cent simply did not know about them.

A further 25 per cent either faced a difficulty in the registration process or had applied for the card but had not received it yet, and 13 per cent had ration cards but based in their home State.

Of those with a ration card, the ability to buy ration at a PDS outlet was poor for those in the income category of 30,001-60,000. In this category, 92 per cent stated that the PDS shop (during the pandemic) was closed or open for a limited time and therefore inaccessible to them.

TABLE 15 ACCESS TO PDS BY OCCUPATION IN PERCENTAGE

OCCUPATION	RATION CARD	ABLE TO BUY RATION
CASUAL WAGE WORKERS	73.4	45.6
HOME-BASED WORKER	68.5	90.5
REGULAR WAGE WORKERS	62.4	79.9
SELF-EMPLOYED WORKERS	58.2	85
UNEMPLOYED	47.6	50
TOTAL	66.1	67.8

Worker types also demonstrated differential access with 73.4 per cent of casual-wage workers having a ration card, the highest among the occupation groups but only 45.6 per cent of them being able to buy ration citing closed shops as the issue. The unemployed have the lowest percentage of respondents (47.6 per cent) with a ration card, but also the highest requirement for subsidised ration.

This group is followed by the self-employed of whom 58.2 per cent have a ration card. Half of the respondents in these two categories report not being registered as their reason for not having a card.

It is of utmost importance to examine the accessibility of migrants to subsidised ration particularly because of the sedentary bias inherent in the scheme. Our survey findings show that 83.6 per cent of semi-permanent residents have ration cards, despite having such high access to ration cards, only 19.6 per cent of semi-permanent residents with a ration card could buy ration during the pandemic – the lowest of all types of residents.

TABLE 16 ACCESS TO PDS BY TYPE OF RESIDENTS IN PERCENTAGE

TYPE OF RESIDENTS	RATION CARD HOLDER	ABLE TO BUY RATION
LONG-TERM PERMANENT	61.4	81.5
LONG-TERM CIRCULAR (SEMI-PERMANENT)	83.6	19.6
NATIVE RESIDENT	66.5	93.2
SHORT-TERM CIRCULAR	35.5	81.8

Short-term circular migrants are one of the most vulnerable groups and ironically are also the most deprived when it comes to accessing PDS. Only 35.3 per cent of them have a ration card. Of those who have a ration card, 93.2 per cent of native residents, 81.5 per cent of long-term permanent residents and 81.8 per cent of short-term circular residents could buy ration from a PDS outlet during the pandemic.

HEALTH INSURANCE

Ayushman Bharat is the health insurance social security scheme that aims to cushion 500 million BPL households from health shocks and spiralling health expenditures. It provides a cover of 5 lakhs per family per year for treatment in public and private empanelled hospitals. The scheme also covers the cost of COVID-19 testing.

As of 6 October 2021, 10.66 crore Ayushman Bharat Cards have been issued. Scepticism over the ability of health insurance schemes to offer financial risk protection to the poor have always concerned policy enthusiasts. For instance, Ayushman Bharat alone cannot make healthcare accessible to the poor and the vulnerable, while the scheme covers hospitalisation expenses there are other costs which are levied on

consultations, diagnostic tests and medicines that are borne out-of-pocket.

Further, insurance schemes are notoriously hard to take advantage of and navigate for even educated consumers. Claiming anything for medical expenses is often a chess game between the patient and the medical triumvirate (the unholy nexus of hospitals, third-party administrators and insurers) trying to game the board in favour of reimbursement as opposed to cashless claims, in effect sacrificing the consumer's pocket anyway.

For insurance schemes to be effective, they have to go hand-in-hand with a robust government-sponsored primary health care system which makes health-care workers, infrastructure and long-term care free and easy to access for all. Moreover, despite the rolling out of health insurance schemes, Oxfam India's 2021 Inequality Report notes that less than one-third of households were under any form of health coverage in 2015-16.[xxxix]

Despite being publicised as the largest health insurance scheme across the globe, only 8.3 per cent of the respondents in our survey had ever heard about Ayushman Bharat. Accessing benefits under this scheme requires the beneficiary to have an Ayushman Bharat health card. In our survey, *a mere 1 per cent of respondents had the card, and none had ever used it in the last one year;* as to why this was the case respondents stated among other reasons that several hospitals did not accept the card.

Among the respondents, of those were aware of the scheme but did not have the health card, nearly half the per cent faced difficulty in the registration process and 46 per cent stated that while they did register for the card – the card had simply not arrived. Annexure B includes a tabulation of the awareness and access to PM-JAY by city, covered in the study.

TABLE 17 AWARENESS OF AND ACCESS TO PM-JAY BY ANNUAL INCOME

ANNUAL INCOME IN RUPEES	% WHO HAVE HEARD OF PM-JAY	% WITH AYUSHMAN BHARAT CARD
<15,000	3.7	3.7
15,001-30,000	5.3	1.1
30,001-45,000	9.2	0.7
45,001-60,000	8.3	1.5
60,001-75,000	6.2	0
>75,000	17.6	0.9
TOTAL	8.3	1

As with the PDS, access to Ayushman Bharat also differs with the income levels of respondents. Of the respondents who have heard of Ayushman Bharat (the highest is 17.6 per cent), less than 1 per cent have the card and these are individuals with an annual income above INR 75,000.

The lowest level of awareness (3.7 per cent) is in the group that earns below INR 15,000 annually of which only 3.7 per cent actually have the card.

TABLE 18 AWARENESS OF AND ACCESS TO PM-JAY BY OCCUPATION

OCCUPATION	% EVER HEARD OF PM-JAY	% WITH PM-JAY CARD
CASUAL WAGE WORKERS	3.6	1
HOME-BASED WORKER	3.7	0.9
REGULAR WAGE WORKERS	11.4	0.3
SELF-EMPLOYED WORKERS	14.5	5.8
UNEMPLOYED	0	0
TOTAL	8.3	1

Differentials by employment status also exist, none of the unemployed respondents had ever heard of Ayushman Bharat, 14.5 per cent of self-employed respondents and 11.4 per cent of regular-wage respondents had heard of the scheme while the level of awareness is less than four per cent for casual-wage and home-based workers.

The highest percentage of respondents with an Ayushman Bharat card, in our study, were from the self-employed (5.8 per cent) category whereas none of the unemployed respondents had the health card. In spite of 11.4 per cent of regular wage workers having heard of the scheme, only 0.3 per cent had the card. More than half of the respondents in this category faced difficulty in the registration process and 40 per cent of them stated that had not registered for the card.

Awareness of PM-JAY is exceptionally low. Only 10.1 per cent and 8.2 per cent of long-term permanent residents and natives, respectively, have heard of Ayushman Bharat. Awareness among migrants is even lower – only 3.4 per cent of semi-permanent and 3.2 per cent of short-term circular have heard of the scheme.

TABLE 19 ACCESS TO PM-JAY BY TYPE OF RESIDENTS

TYPE OF RESIDENTS IN %	AWARENESS OF PM-JAY	WITH CARD
LONG-TERM PERMANENT	10.1	1.0
LONG-TERM CIRCULAR (SEMI-PERMANENT)	3.4	0.7
NATIVE RESIDENT	8.2	1.2
SHORT-TERM CIRCULAR	3.2	0
TOTAL	8.3	1.0

There are notable differences by sex too. Male respondents who have heard of Ayushman Bharat were at least double of female respondents in all occupation categories.

The only exception is among native residents among whom 12.6 per cent female respondents have heard of Ayushman Bharat whereas only 1.1 per cent males have heard of this scheme. The highest percentage of respondents with an Ayushman Bharat card are native residents at 1.2 per cent, followed by long-term permanent at 1 per cent. None of the short-term circular residents, surveyed, had a card.

Differentials were also evident when the results of the survey were disaggregated by gender:

TABLE 20 AWARENESS OF PM-JAY BY GENDER

GENDER	AWARENESS OF PM-JAY
FEMALE	7.4
MALE	10.4
TOTAL	8.3

Overall, the poorest and most insecure groups even among the

ISW lacked access to PM-JAY both in terms of knowledge and awareness and actual benefits.

EMPLOYMENT ENTITLEMENTS

Our survey also looked at social security benefits as employment entitlements and examined the availability of and access to paid leave, pension contribution, paid maternity leave and health insurance or any other medical benefit.

Our survey found that only 9.3 per cent of those that are employed had a written contract of employment. Of the total respondents who were employed, only 16.4 per cent received paid leaves, 3.6 per cent receive a pension contribution, 1.1 per cent receive paid maternity leave and 0.64 per cent have a health insurance. Eighty per cent of those who were employed did not receive any social security benefits at all. Tabulated data city-wise is available in Annexure B.

Clear differentials by income levels also exist as also differences of gender and the provision of benefits for women such as maternity leave in particular:

TABLE 21 WRITTEN CONTRACT OF EMPLOYMENT BY ANNUAL INCOME

INCOME IN RUPEES	% EMPLOYED RESPONDENTS WITH WRITTEN CONTRACT
<15,000	0
15,001-30,000	8.05
30,001-45,000	8.70
45,001-60,000	8.25
60,001-75,000	2.50
>75,000	5.66
TOTAL	6.81

The percentage of men who had an employer is higher than those for women indicating either a higher level of unemployment or self-employment among females. Of the total employed, while the provision of paid leaves and pension was better for females, health insurance privileged male respondents. Detailed tables of differences by gender are available in Annexure B.

TABLE 22 PERCENTAGE RESPONDENTS WITH SS BENEFITS BY INCOME

INCOME IN RUPEES	PAID LEAVE	PENSION	MATERNITY LEAVE	HEALTH INSURANCE
<15,000	20	0	0	0
15,001-30,000	12.64	4.6	1.15	0
30,001-45,000	15.94	7.97	2.17	1.45
45,001-60,000	9.28	1.03	0	0
60,001-75,000	26.25	0	1.25	0
>75,000	20.75	1.89	0	1.89
TOTAL	16.38	3.62	1.06	0.64

As we can see the highest percentage of employed respondents (8.7 per cent) with a written contract of employment is in the income group of INR 30,001-45,000 and the lowest (0) is in the income group of less than Rs 15,000.

Of those that had an employer, the provision of paid leaves is highest in the income category of INR 60,001-75,000 at 26.2 per cent, followed by the above RS 75,000 income category at 20.7. The under Rs 15,000 income category had 20 per cent of respondents who received paid leaves but did not receive any other social security benefit. The Rs 30,001-45,000 income category has the highest percentage of respondents receiving

pension and paid maternity leave at 7.8 per cent and 2.17 per cent, respectively.

The highest percentage of employed respondents getting health insurance by their employer was in the above Rs 75,000 income category (1.9 per cent). Differentials are also visible depending on employment type:

TABLE 23 WRITTEN CONTRACT OF EMPLOYMENT BY OCCUPATION CATEGORY

OCCUPATION	WRITTEN CONTRACT
CASUAL WAGE	2.31
HOME-BASED	0
REGULAR WAGE	10.36
TOTAL	6.81

Only 10.3 per cent regular wage workers and 2.3 per cent casual-wage workers had a written contract of employment. In terms of provision of social security benefits, the percentage receiving paid leaves was highest for regular wage employees at 24.6 per cent, followed by casual wage workers at 6.1 per cent. The other benefits were only received by regular-wage workers.

TABLE 24 SOCIAL SECURITY BENEFITS BY EMPLOYMENT TYPE IN %

OCCUPATION	PAID LEAVE	PENSION	MATERNITY LEAVE	HEALTH INSURANCE
CASUAL WAGE	6.15	0	0	0
HOME-BASED	0	0	0	0
REGULAR WAGE	24.64	6.07	1.79	1.07
TOTAL	16.38	3.62	1.06	0.64

The findings suggest that the provisioning of social security benefits by employers is extremely low. The provisioning of medical insurance has been the lowest among the benefits. Such low provisioning of a safety net by employers makes it even more pertinent for the government to provide the already vulnerable ISWs with food and health security.

The survey also examined the level of awareness of the ISWs about informal sector schemes, particularly rolled out for them, including provisions relevant to social security and wages included in two of the labour codes.

Close to 90 per cent of respondents had not heard of any of the nine schemes we asked about in the survey mentioned. Of the 11.7 per cent of the respondents who have heard about the schemes, 8.8 per cent of them were aware of ONORC or PDS, implying that this scheme had been heard of the most. A tabulation of awareness by city is available in Annexure B.

Differentials in awareness by income levels was evident in the survey, a full tabulation is available in Annexure B.

The highest level of awareness for most schemes was found in the above Rs 75,000 income group, as stated previously this group was most aware of PDS followed by PMSBY (20.4 per cent) and PM-JAY (16.7 per cent). None in the lowest two income groups had ever heard of PMSBY and only 1.1 per cent and 5.6 per cent of the Rs 15,001- Rs 30,000 and below Rs 15,000 income groups had ever heard of PM-JAY.

Regular wage workers were more aware of informal sector schemes than other workers. The percentage of respondents that were aware of the nine schemes in all other occupation

categories was at least half of regular wage workers. The only exception to this was of home-based workers, 6.5 pe rcent of whom were aware of APY. A full tabulated list is available in Annexure B.

Awareness about social security schemes is lowest in the self-employed and unemployed workers category. Migrant workers, despite their vulnerability often face administrative obstacles in accessing social security. One of the most obvious reasons for their exclusion was the insufficient duration of their periods of employment and residence.[xl] Furthermore, the informal nature of work that migrants are involved in gives employers the leeway to exclude them from social security benefits which are otherwise available for formal employees.

TABLE 25 EMPLOYED RESIDENT TYPES WITH WRITTEN CONTRACTS

TYPE OF RESIDENTS	IN % SHARE WITH WRITTEN CONTRACT
LONG-TERM PERMANENT	7
LONG-TERM CIRCULAR (SEMI-PERMANENT)	5
NATIVE RESIDENT	10
SHORT-TERM CIRCULAR	0
TOTAL	6.8

Only 6.8 per cent of respondents who had an employer had a written contract of employment. Natives had the highest percentage of respondents (10 per cent) with a written contract, followed by long-term permanent residents (7 per cent) and semi-permanent residents (5 per cent). Short-term circular residents had no written contract of employment. A full tabulation of benefits to respondents provided by employer is available in Annexure B.

Out of the total respondents with an employer, the highest percentage of respondents getting paid leaves was for long-term permanent migrants at 19.5 per cent, followed by semi-permanent at 15 per cent and native residents at 9.5 per cent. Semi-permanent migrants did not receive any other benefit. Health insurance has been provided only to long-term permanent residents. Nearly six per cent of short-term circular migrants received paid maternity leave while 0.9 per cent of long-term permanent and native residents each received the same.

Awareness of informal sector schemes is highest for long-term permanent migrants, followed by semi-permanent migrants. Native residents were unaware of four out of five schemes, while short-term circular migrants were only aware of PDS, a detailed tabulation is available in Annexure B. Yet another important aspect of social security is that of continuous work availability and secure working conditions for the ISW. Welfare boards are statutory bodies that engage in matters concerning policy and legislation related to ISWs and are supposed to overlook the safety, health and overall welfare of workers. Welfare worker boards not only improve industrial relations and efficiency, but also contribute to high worker morale, creation of permanent labour force and provision of social benefits. It is, therefore, important that workers are registered with such boards.

Our findings show that a mere 0.7 per cent of all workers with an employer were registered with a workers' welfare board; 3.2 per cent of the short-term circular migrants were registered with a welfare worker board; of whom none were female ISWs.

TABLE 26 RESIDENT TYPES REGISTERED WITH A WELFARE WORKER BOARD IN PERCENTAGE

RESIDENT TYPE	FEMALE	MALE	TOTAL
LONG-TERM PERMANENT	0.8	1.5	1.1
LONG-TERM CIRCULAR (SEMI-PERMANENT)	0.4	0	0.3
NATIVE RESIDENT	0	0	0
SHORT-TERM CIRCULAR	0	6.6	3.2

Only 1.1 per cent long-term permanent and 0.3 per cent semi-permanent are registered. None of the native residents were registered with a welfare board.

Conclusions

Our study demonstrated that the state of social security in the surveyed population leaves much to be desired. Awareness and accessibility to flagship schemes and employee benefits is highly fragmented across cities, occupations and income groups. Accessibility to government welfare schemes, especially the PDS and Ayushman Bharat, have also been poor and while PDS is more accessible than the Ayushman Bharat scheme, the difficulties in accessing the two are both unsurprising and unfortunate.

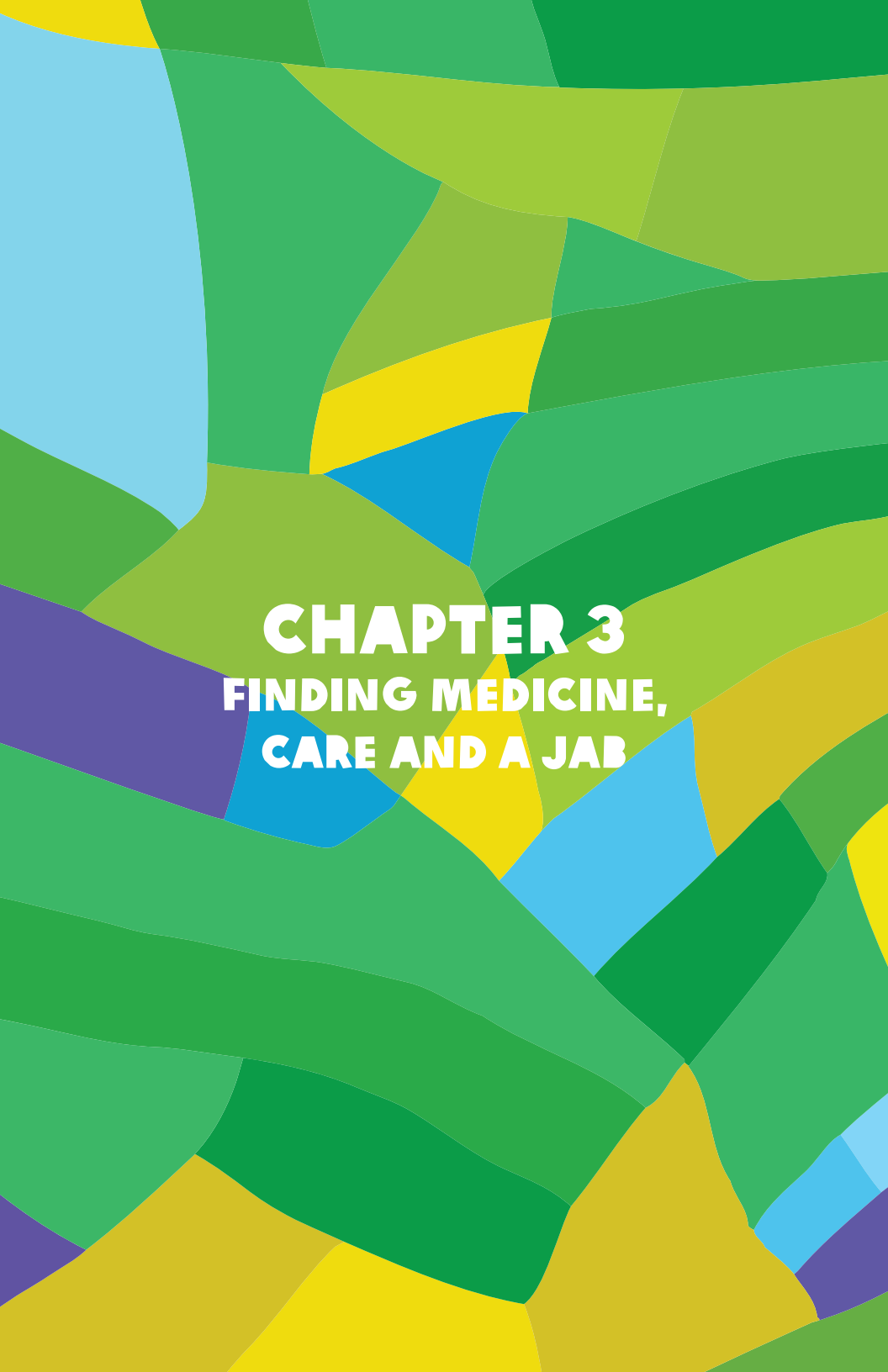
As far as the provision of social security benefits by employers is concerned, this also remains so low that one could assume there is actually none at all. This is particularly true for health insurance which had been completely denied to casual and home-based workers.

Awareness of government schemes, employee benefits and rights guaranteed by law ought to be the first step towards

access to social protection; however our findings from this study indicated exceptionally low levels of awareness of available social security benefits and legal provisions.

Sadly, the poorest groups also exhibited the least awareness and consequently had the least access as well. Of all the respondents, migrant workers happen to be the least protected group.

Short-term circular migrants have no employment guarantee, have no access to employer-provided benefits, and access to PDS and health insurance is the lowest. Similarly, female ISWs are much more vulnerable than their male counterparts. Female workers also have lesser accessibility to and awareness of their entitlements and social security benefits. The need to advocate for increased awareness of ISWs about their legal rights and entitlements and to make social security accessible to them is both urgent and fundamental.



CHAPTER 3
FINDING MEDICINE, CARE AND A JAB

The COVID-19 pandemic has devastated families and communities and disrupted societies and economies. Patients had to endure various indignities in both public and private hospitals without protections or recourse to adequate preventive and redressal mechanisms. While the COVID-19 vaccine is seen as a solution to the pandemic, its roll-out has also been rife with inequalities. However, many of the problems we have seen at this time stem from the deep-rooted problems in the public health system. This two-part chapter covers two studies undertaken by Oxfam India's Advocacy Team and focuses on India's Patients' Rights Charter (PRC) and COVID-19 vaccinations from this perspective.

The COVID-19 pandemic has brought into sharp relief the extent to which rights of patients are violated across India. The pandemic has stretched beyond breaking an already abysmal state of patient rights in India's healthcare system.

In this period, patients had to endure various indignities including denial of essential healthcare services, being forced to pay inflated hospital bills in the private sector and being refused admission for emergency services without a COVID-19 test. Additionally, marginalised communities like Dalits, Adivasis and

religious minorities like Muslims faced new forms of violence, and discrimination in both public and private hospitals.

However, these issues might have come to the fore during the pandemic but have always been around. In most States, there are no well-defined preventive and redressal mechanisms against such violations.

The National Human Rights Commission (NHRC) has long taken up the patients' rights issue as a human rights issue. In August 2018, the Ministry of Health and Family Welfare (MoHFW) released India's first PRC[xli] with 13 patients' rights incorporating the recommendations from NHRC.

Health is a State subject. In June 2019, the MoHFW issued a letter requesting State governments to adopt the Charter. Two years have now passed since the States were directed to adopt the Charter but they are yet to be adopted by States and UTs in India.

This is not the only instance of how citizen voice goes unheard in the healthcare system. India's vaccination drive has been dogged by a range of problems arising from the limited extent to which India's citizens were consulted in the initial stages of the COVID-19 vaccination roll out. All this is particularly critical to understand in the context of India's increased reliance on private healthcare providers. Formal mechanisms for citizen participation and redressal, to an extent, exist in the public health system but not in private hospitals.

The 75th National Sample Survey[xlii] (NSS) found that out of the total hospitalisations in rural areas 54 per cent were in the private sector; the corresponding figure was 66 per cent in

urban areas. While the poorest two income quintile groups tend to rely on public sector providers for inpatient hospitalisation in rural areas, for outpatient care, both rural and urban population across all income quintile groups depend more on the private sector[xliii] (72 per cent in rural and 79 per cent in urban sector). This makes it necessary to critically examine the track record of the private healthcare sector.

Methodology and Data Collection

This pair of studies consisted of self-administered questionnaires (designed by Oxfam India), covering 32 States and 5 UTs administered between February - April 2021 and Aug-September 2021 and received approximately 15,000 responses in total.

The PRC study received a total of 3,890 responses from 28 States and 5 UTs in India through a self-administered questionnaire. The questionnaire was designed to understand respondent experiences on parameters pertaining to rights of patients in line with the PRC. Respondents were asked for their experiences or experience of their close relatives. Data was collected online via Google forms.

The vaccination study consists of 10,955 responses of individuals from 28 States and 5 UTs in India. The study was conducted through a combination of on-ground data collection and collection of online data through a self-administered Google form. The period of data collection for this online survey was from March to May 2021. A second round of offline data collection was undertaken to include the perspectives of those who lacked easy online access.

Data Analysis

Analysis of the data has been done on the basis of perceptions/ opinions shared by the respondents on some of the key patients' rights given in the Charter. An attempt was made to see the trend/linkages between violations of patients' rights in the context of gender, income status, rural-urban and religion/caste front.

Results

PATIENTS' RIGHTS CHARTER

In India, there are various legal provisions related to Patient's Rights which are scattered across different legal documents including the Constitution of India, Article 21;[xliv] the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002;[xlv] The Consumer Protection[xlvi] Act 1986; Drugs and Cosmetic Act[xlvii] 1940; Clinical Establishment Act 2010[xlviii] and rules and standards framed therein; various judgments given by Supreme Court of India and decisions of the National Consumer Disputes Redressal Commission[xlix] also cover specific dimensions of patient's rights. While having this range of legislative provisions is welcome, India has missed a comprehensive, and legally binding framework.

In 2018, MoHFW adopted and released its PRC drawing on the first draft charter[l] prepared by the NHRC. This provides a consolidation of various rights which enables the assurance of protection and promotion of Human Rights of patients and works as a guidance document for the Union and State governments to formulate concrete mechanisms so that patient rights are given adequate protection.

Nearly six months after the peak of the first wave of COVID-19 in India, NHRC released a Human Rights advisory on Health for All[li] in the context of COVID-19 (NHRC, 2020). The advisory dated 28 September 2020, advised State governments to display PRC as per the order issued by MoHFW to all the States/UTs dated 2 June 2019. Later, during the second wave of COVID-19 pandemic, a second advisory on Right to Health[lii] was issued by NHRC, dated 4 May 2021.

While these provisions are made, it is not always clear to what extent they are realised in practice. Limited research has been undertaken on this topic. Most research[liii] available in the public domain focusses on the extent of awareness of patients' rights[liv] among patients and doctors. Most are, fairly localised, looking at individual cities.

Existing research on awareness of patients' rights suggests that women are more aware of their rights than men; younger adults are more aware than older age groups and patients admitted to more expensive wards had higher awareness.[lv] Those who are financially better off presumably had a higher degree of awareness of their rights. However, no large-scale research exists that looks at the realisation of patients' rights, especially across multiple States.

Out of 3,890 respondents, 3,242 respondents were men; only 643 were women and only 5 were transgender. This is possibly reflective of the prevalence of the digital divide which has left women with limited access to a digital device and internet. This skewed sample may also impact the overall trends, given the preliminary evidence that awareness of patients' rights may be unequal across the population.

Citizens between 18-24 years (48 per cent) formed the biggest category of respondents, followed by 25-40 years (43 per cent). Involvement of youth was maximum as this demography may have had more access to smart phones and internet, 72 per cent respondents were from urban areas whereas 28 per cent were from rural areas. The monthly income of 41 per cent (maximum) of the respondents was between INR 10,001 to INR 50,000 whereas 19 per cent of respondents were earning less than INR 10,000 per month.

Disaggregating by religion, the maximum number of respondents i.e. 68 per cent were Hindu, followed by 19 per cent Muslim. With respect to respondents' caste profile, 50 per cent were from the general category, 27 per cent were OBC, 11 per cent Dalits and 9 per cent Adivasis.

PRIVACY AND FEMALE MEDICAL EXAMINERS

Our study finds that of the women surveyed, over one-third (36 per cent) reported that they had to undergo a physical examination by a male practitioner without any other female present in the room. This is not just an issue of privacy and dignity, but women's health and safety. Studies have demonstrated time and again that most women are not comfortable with being treated by male doctors without the presence of another woman in the room (Yanikkerem, 2010).

Districts with higher women physician availability in rural primary care report higher reproductive and maternal health care utilisation (e.g. modern contraceptive use, antenatal care, skilled birth attendance and maternal postnatal care) (Bhan, 2020).

Incidents of mistreatment have been reported against male doctors for alleged molestation in the guise of physical examination. In most cases, especially in the private sector, there is no accountability mechanism in place to ensure justice for victims. In fact, often private hospitals protect their staff despite such acts being in direct violation of MCI's code of ethics under the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002.

While over 40 per cent of the women whose monthly income ranges from INR 10,000 to INR 200,000 per month said that they had to undergo a physical examination by a male practitioner without any other female present in the room, only 21 per cent women who reported earning less than INR 10,000 per month had the same experience.

Similarly, on the caste front, in comparison with 39 per cent women from general caste, 29 per cent women from marginalised communities (30% from OBC, 28% Adivasis and 29% Dalits) said that they too had to undergo physical examination in the absence of a female in the room. It is possible that this could be a result of the poorer communities (marginalised communities such as Dalits and Adivasis) to be dependent on the public health system with a substantially feminised workforce.

NO EXPLANATION OF ILLNESS

Nearly three of every four people (74–75 per cent) people said that when they went to the doctor and explained their condition to them, the doctor simply wrote a prescription, prescribed treatment or asked them to get tests/investigations done without explaining their disease, nature and/or cause of

illness. This violation of patients' right to information is rampant in both rural and urban areas.

Rates of violations were high across the board for all groups; indeed, they were reported to be higher for those who were richer (74 per cent for those earning between INR 1-2 lakhs, compared to 68 per cent for those under INR 10,000 per month), came from a higher caste (80 per cent for the general category, compared to 75 per cent for Adivasis) or were better educated (75 per cent for postgraduates, compared with 54 per cent who were uneducated).

This is probably a reflection of different expectations that social status brings into the engagement with medical professionals. It also mirrors the anticipated higher levels of awareness of patients' rights in these groups. Reporting is presumably higher among the more aware, educated patients who are better aware of their rights and can pinpoint violations.

Studies have shown that access to information about patients' illness and treatment is linked to patient satisfaction.[lvi] According to one such study, two aspects of care which rank most highly in terms of importance by patients were 'the information and explanation given' and the 'doctor's attitude'.[lvii]

In rural India, cases of 'forced sterilisation' and 'hysterectomy' among women were a result of patients being provided incomplete information by the providers, often to meet targets in public sector and for profits in private sector.

FAILURE TO SEEK INFORMED CONSENT

In India, one of the major barriers to implementation of medical

ethics is the information asymmetry between patients and healthcare providers which is more likely to be unequal for the poor and marginalised. The failure to seek informed consent while providing care is rampant in India. Women, transgender people, minority religious groups and marginalised caste groups are denied complete information about treatment. This leads to clear-cut breach in right to informed consent and bodily autonomy.

Evidence shows that physicians in India have always held disproportionate power over their patients, mostly by virtue of their class, caste and gender as a majority of physicians in India belong to general castes and are predominantly males. This leads to skewed power dynamics among patients and doctors, both in the public and the private sector. This translates into widespread violation of patients' right to information.

Article 21[lviii] of India's constitution covers the right to live with human dignity. Any act which damages, injures, or interferes with the use of any limb or faculty of a person, either permanently or temporarily is deemed to be inhibitory of Article 21 (Francis Coralie Mullin v. The Administrator, UT Delhi).[lix] Drugs and Cosmetic Act (1940), Rules (2016)[lx] on Informed Consent also make it an obligation for healthcare professionals to seek informed consent from patients.

More than half of the respondents (57 per cent) reported not receiving any information about investigations and tests done. More than half (55 per cent) also reported that they were not informed about probable complications that can occur during the course of treatment for a serious illness for themselves or a close relative. Nearly half of the sample (48 per cent) of

respondents said that they were denied information about alternative treatment options or modality, apart from the treatment that was being provided to them or their close relatives. This has been seen across social classes and was prevalent in both rural and urban areas.

When it comes to education, 17-18 per cent of those who completed 10th standard experienced absence of informed consent, compared to 28 per cent of those who were educated below the 10th standard or 25 per cent who classified themselves as uneducated. This is in line with existing research where doctors appear to have more meaningful discussions on treatment options with those who are more educated.

This violates the principle of personal liberty and principle of autonomy which is enshrined in the Article 21 of the Indian Constitution. Doctors are expected to seek informed consent and provide proper information under the Section 13 of the Indian Contract Act (1872).[lxi]

However, in India, in most cases, 'implied consent' and 'proxy consent' is taken and hence, denying the right to comprehensible information about diagnosis, investigations, treatment and probable complications or informed consent. Expectations may vary with educational and class status. Instances of inadequate informed consent were frequently reported in the media during the pandemic. One report[lxii] from March 2020 is of Srinivas (name changed), a 30-year-old nurse, who heard that the Mumbai government hospital where he worked was giving resident doctors a course of the anti-malarial drug hydroxychloroquine (HCQ).

The hospital said it was following a one-page advisory[lxiii] from India's apex medical research agency — the Indian Council of Medical Research (ICMR) to administer the drug as prophylaxis for COVID-19. By then, the number of people confirmed to have COVID-19 in India had begun to grow fast in Mumbai. Major shortages of HCQ were declared by hospitals, so several nurses purchased HCQ from medical stores instead of waiting for the hospital to replenish its stock.

After all, ICMR had recommended the drug: that must mean HCQ worked, Srinivas said. However, no one from the hospital's administration had said anything about the drug being experimental – that it could be useless in preventing the disease. The hospital also didn't talk about the drug's side-effects[lxiv] either, from milder ones like nausea and stomach-ache to severe ones like Hypoglycemia and heart-rhythm abnormalities. He added that his experience was no different from that of thousands of healthcare workers across India, who were told by their hospitals to take HCQ.

The push to take HCQ may have been in line with the ICMR's advisory, which says a doctor must prescribe the drug, but did not negate the need for a discussion to ensure informed consent. Everyone consuming a drug must do so only after fully understanding its benefits and harm.

GETTING A SECOND OPINION

The right to second opinion is strengthened by The Consumer Protection Act, 2019.[lxv] As well as in the Annexure 8 of standards for Hospital level 1 by National Clinical Establishments Council set up as per Clinical Establishment Act 2010;[lxvi] also given in The Consumer Protection Act, 1986.[lxvii]

One-third of study respondents who were either themselves or had their relatives hospitalised in the past ten years, stated that their doctor did not allow them to seek a second opinion. Of these, 30 per cent of those earning INR 100,001 to INR 200,000 per month reported facing denial of the right to take a second opinion regarding their test/treatment, as contrasted with 42 per cent of those earning less than INR 10,000 per month.

More of those who are poor found themselves denied the right to have a second opinion. Being denied the right to seeking a second opinion was broadly consistent across different genders and locations (urban vs rural). Many studies[lxviii] have shown that a large number of patients believe that physicians suggest unnecessary diagnostic and treatment procedures, particularly in the private sector. A number of studies[lxix] have reported that misdiagnosis of various health conditions remains a major challenge in India. This could lead to delay in receiving appropriate treatment. In conditions like cancer, hypertension, and diabetes delay in diagnosis and hence receiving treatment can heavily jeopardise patient's health outcome.[lxx]

DISCRIMINATION IN HOSPITAL

Hospital managements have a duty to ensure that no form of discriminatory behaviour or treatment takes place with any person under the hospital's care. The right to non-discrimination is highlighted in the Annexure-8 of Standards for Hospital level 1 by National Clinical Establishments Council[lxxi] set up as per Clinical Establishment Act 2010.

In our survey, a third of the Muslim respondents reported that they felt being discriminated against on the grounds of their

religion in a hospital or by a healthcare professional. At the same time, a significant share of Dalits and Adivasis respondents have experienced caste-based discrimination. As many as 22 per cent people belonging to the ST and 21 per cent belonging to the SC said that they have been discriminated by healthcare providers or in a hospital setting due to their tribal identity/caste.

The study also found that 15 per cent people belonging to OBC said they felt discriminated because of their caste. The survey also showed that 28 per cent people from Karnataka, 24 per cent from Gujarat, 21 per cent people in Maharashtra, and 20 per cent people in Uttar Pradesh, Bihar, Jharkhand and Rajasthan reported facing discrimination by healthcare professionals due to their language, which reflects on anti-migration sentiments of healthcare professionals. These findings are consistent with studies looking at the experiences of Dalits, Adivasis and religious minorities in the health system. Health outcomes are consistently lower for Dalits,[lxxii] Adivasis and Muslim minority communities.

A study[lxiii] exploring religion-based discrimination in health facilities in Mumbai showed that many Muslim women felt that there was a difference in the way the staff at the public health facilities spoke to them when compared to how they spoke to people belonging to their caste or religion. The pandemic has further deepened the systemic Islamophobia within the country's health system.

A series of events that took place in Nizamuddin with the gathering of people from the Muslim organisation Tablighi Jamaat, was given a communal turn. This further fuelled the

Islamophobia which has become rampant in the country. Reports[lxxiv] of hospitals refusing to admit Muslim patients became common. This was noted[lxxv] by the Supreme Court later in the pandemic. In response to the inquiry[lxxvi] made to the Centre by the apex Court in April 2021, the MoHFW formulated[lxxvii] and later revised the 'national policy for admission of COVID-19 patients to various categories of COVID-19 facilities'.

HOSPITAL ADMISSION DENIED

In a directive[lxviii] to all the States, MoHFW on 8 May 2021 mandated certain guidelines to be adhered to by all hospitals under the Central govt, State government and UT administrations, which included private hospitals handling COVID-19 cases. This included the provision that 'hospitals cannot refuse service, including oxygen or essential drugs, to any patient on "any count" including religion, caste, and ability to pay or migrant status'.

The findings of the survey are similar to those reported by the Human Rights Watch (HRW) published in 2001. The report said that people belonging to the SCs are frequently denied admission in hospitals. Similarly, Untouchability in Rural India[lxxix] survey found that Dalit communities were denied entry into private health centres or clinics in 21 per cent of villages. A study[lxxx] conducted in Attapadi, Kerala showed that Adivasi communities experienced discrimination at the hand of healthcare professionals. They believed that non-tribal healthcare professionals spoke to them in a condescending manner and looked down upon them (George, 2020).

Several reports[lxxxi] have shown that during the time of the first lockdown in the country, migrant workers (mainly those

belonging to SC, ST, OBC groups) returning to their home States, faced discrimination at the hand of the community and healthcare providers alike. In recent months, several reports have emerged on discrimination against transgender patients by the medical community. While revealing the findings of the study,[lxxxii] a transgender narrated her story of discrimination. Three years ago, an HIV-positive transwoman from Kolkata, visited a government hospital for an HIV test.

She said the doctor and her assistant laughed at her, saying, *'Agar yeh sab bimari tumko nahin hoga toh aur kisko hoga?* (If you people are not infected with such diseases, then who is?)'. Discrimination against transgender people gets worse if they are HIV-positive. 'If you are a transgender with HIV, then you face double the discrimination'. 'In medical wards of hospitals, male patients are uncomfortable with our presence or pass sexual comments, and females do not want us around them either.' Most doctors, knowingly or unknowingly, do not ask them which ward, male or female, they might prefer.

COMMISSION FEE FROM DIAGNOSTCS

The Consumer Protection Act, 2019[lxxxiii] The MCI's code of ethics regulations[lxxxiv] says in clause 6.4.2 under 'unethical acts' that a physician shall not offer or receive any 'commission' or 'bonus' or 'split' any fee for referring a patient or recommending a diagnostic test. However, the code is hardly enforceable in the private sector. Apart from a matter of ethics, the issue is also a matter of patients' rights to choose, which can be covered under the Clinical Establishment Act.

States like Chattisgarh have a provision to effectively deal with it in terms of PRC ('Obligation to Secure Patients' Convenience')

under State's CEA.[lxxxv] It must be noted that only 10 States and 6 UTs have adopted the Clinical Establishments Act as per latest (2020) information[lxxxvi] from the website of Directorate General of Health Services (DGHS).

Our study found that over 70 per cent women, men, Dalits, Adivasis, and even respondents across different income groups, all reported that they were asked to get tests done from a particular place only. This points to the ubiquitous nature of the 'referral fee' in India. Referral fee practice and commissioning[lxxxvii] is the norm rather than the exception and applies to all healthcare providers, radiology centres, pathology laboratories and hospitals.

The practice is in violation of patients' rights to referral and transfer without perverse commercial influences. It leads to excessive expenditure by patients as they are denied the choice of a more affordable option. While referrals are also done to cross-check the accuracy of investigations/tests, in most instances they come with a referral fee.

We note that this practice of 'referral fees' can take many forms.[lxxxviii] Dr Akash Rajpal of Ekohealth said in a media interview, 'a doctor may be ''rewarded'' for referring a patient to another doctor, diagnostic facility, nursing home or hospital. Cash, cheques (in the guise of professional fee), expensive gifts and dinners, sponsorship to attend conferences, etc., are some of the common rewards. Sometimes, this gratitude is expressed differently. Reciprocal referral amongst doctors is commonplace.

'For example, a general surgeon and a cardiologist could agree

to send each other patients from their respective specialties. It would, of course, be justified if each of them felt that the other was the best in that field, but not if they were simply scratching each other's backs'. Commissions paid to doctors add significantly to the cost of treatment when catastrophic health expenses make a significant contribution to the fact that 39 million are pushed into poverty each year. Estimates of cost mark-up vary from 20 per cent, based on the estimate published in the *Indian Journal of Medical Ethics*[lxxxix] or higher.

LACK OF COST BREAK-UP

Failure to provide information about the rates of each type of service provided by a hospital is against the MCI Code of Ethics section 1.8 regarding Payment of Professional Services,[xc] Section 9(i) and 9(ii) of the Clinical establishments (Central Government) Rules, 2012,[xci] Drug Price Control Order (DPCO) Act, 2013[xcii] and the Consumer Protection Act, 2019.[xciii]

In our study, 58 per cent respondents said that they were not provided with an estimated cost of treatment/procedure before the start of treatment/procedure when they or their close relatives were hospitalised in the past 10 years. A sizeable proportion (31 per cent) respondents reported being denied case papers, patient records, investigation reports for treatment/procedure by the hospital even after requesting for the same.

The failure to provide detailed cost of treatment was fairly uniform across the board, holding for rural (58 per cent) and urban areas (59 per cent) and irrespective of the family income, although the rates were somewhat higher for those who were poorer and more disadvantaged. More than half

(53 per cent) of the respondents earning less than INR 50,000 per month said that they didn't receive case papers/ investigation reports by the hospital. Over 59 per cent Dalit respondents reported the same.

While such practices[xciv] existed even prior to the pandemic, however, the situation has become particularly grave during the COVID-19 pandemic. This forced many States to take steps to curb malpractices by the private sector. Thus, in October 2020, Telangana used their Clinical Establishments Act to punish hospitals that failed to provide detailed bill to the patients and showcause notices were issued to 105 hospitals guilty of overcharging. In Andhra Pradesh, 16 hospitals were fined[xcv] amounts ranging INR 200,000 to 600,000 for overcharging COVID-19 patients; 46 hospitals were booked for violating government rules and regulations, while another 50 hospitals were issued show cause notices in May 2021. In Maharashtra, Municipal Corporations in many cities like Pune and Pimpri Chinchwad established committees[xcvi] to audit bills issued by private hospitals; most of these were not itemised. In the audits conducted for 75 cases, the committee found that the bills were inflated by INR 50 lakh.

States like Chattisgarh appointed[xcvii] Nodal Officers for private hospitals (including hospitals empaneled with PM-JAY and the State insurance scheme, the *Khubchand Baghel Swasthya Sahayata Yojana*, in each district. These officers were responsible for coordination, facilitation and overseeing of compliance to government order related to price-capping. In Karnataka, the High Court had to intervene[xcviii] as despite capping of treatment charges, unlike the first wave, enforcement of the guidelines were weak in the

second wave. The High Court ordered the State to expeditiously create a mechanism for grievance redressal over allegations of some private hospitals overcharging hapless patients for COVID-19 treatment.

The second advisory on Right to Health,[xcix] issued by NHRC, dated 4 May 2021 advocated for the capping of treatment charges including charges of oxygen cylinders and essential medicines, as well as following Standard Treatment Guidelines to avoid unnecessary use of COVID-19-related medications, irrational prescription of expensive medicines, especially by the private sector (NHRC, 2021).

OVERCHARGING AND EXCESS BILLING

Media reports have long appeared regarding inadequate transparency in billing and overcharging in big corporate hospitals. Dinesh was one of many people[c] overcharged at an hospital. He was admitted to Max Hospital, Saket in May 2020. Dinesh was slapped with a bill of INR 410,000 at the time of his discharge. The hospital charged INR 80,000 for PPE kits for nine days. It is alleged that for the first two days they charged INR 4,300 and then for the remaining seven days, they charged INR 8,900 for each kit which was being used. The hospital also reported to have charged INR 55,000 for doctors' visits; the summary of the bill listed 22 doctors' visits.

However, according to the patient, the doctor only visited him five to seven times. As per the patient's relatives, the patient tested negative on day six, but he was kept in the hospital for four more days. In its defense, the hospital management had responded saying that they charged the overall consumption of PPEs during a 24-hour cycle, which is approximately nine

PPEs per day per person in the ICU. The PPEs are charged at approximately INR 1,200 per PPE per day and 'are in line with the costs incurred by the hospital in sourcing the PPEs'; they did not furnish any proof for the same.

NO RELEASE OF DEAD BODIES

The act of denying to release the dead bodies is in violation of the prohibition of wrongful confinement under Section 340-342[ci] of the Indian Penal Code, and many other statements of the Mumbai High Court.

Despite this, in our study *19 per cent of respondents said they were denied release of dead body by the hospital*. However, in practical terms, this figure is likely to be much higher because not all respondents experienced the death of a close relative after hospitalisation. Nearly equal numbers of people in rural (19 per cent) and urban (18 per cent) areas experienced the denial of release of dead body.

While this inhuman practice was experienced by people from all strata of the society, the heaviest brunt was borne by the poorest — 23 per cent of those earning less than INR 10,000 had faced the issue of denial of release of dead body, unlike 15 per cent of those earning over a lakh per month. Nearly every third (29 per cent) respondent in Jharkhand and 21 per cent in Odisha, Uttar Pradesh and West Bengal, 20 per cent from Maharashtra and 16 per cent people Gujarat were denied release of the dead body of the deceased by the hospital.

The media reported many incidents of hospitals refusing to release dead body of those who died during the pandemic. Thus, a private hospital[cii] in rural part of Pune district of

Maharashtra, refused to release the body of a 50-year-old patient who died due to COVID-19, as his family was unable to pay the medical bill of INR 70,000. The body was released after the intervention by a Member of Parliament who took the issue to the Chief Minister's office; as a result of the intervention by the district administration the bill was waived and the dead body was released.

In Vapi, Gujarat[ciii] the private hospital management asked the family to keep their car as a guarantee to get the body of the patient who died due to COVID-19. The family filed a case against the private hospital; following a police investigation, the dead body and the car were handed over to the family.

VACCINATION EXPERIENCE

Vaccines[civ] offer the possibility of returning to the pre-pandemic ways of living and working. This, however, is thwarted by a slow and unequal roll out of COVID-19 vaccination. Only 3 per cent of lower-income countries[cv] have fully vaccinated their citizens, compared to 24 per cent for lower middle-income countries and 66 per cent for high-income countries.

After a slow and delayed start, India is now starting to catch up, even though its immunisation rate remains below the global average. Only 26.77 per cent of Indians were fully immunised (as on 17 Nov 2021).[cvi] In April 2021, the government announced a 'liberalised and accelerated'[cvii] phase-3 strategy of COVID-19 vaccination in which the government stepped away from its commitment to free universal vaccination with distribution, based on need and risk and announced that everyone over the age of 18 was eligible for vaccination.

On 7 June 2021, Prime Minister Narendra Modi announced several changes in India's vaccination policy, once again committing to centralised procurement of the vaccines, a price cap on sale of vaccines in private hospitals and their free distribution in the public sector to all above 18 years of age from 21 June 2021.

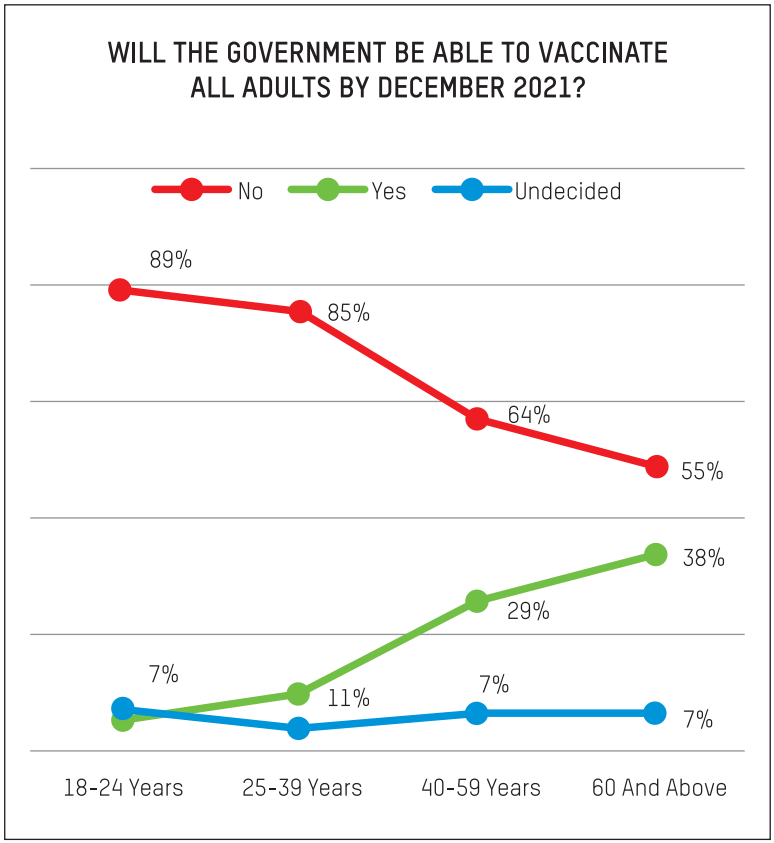
In the subsequent weeks, as vaccine production was ramped up, at the end of September 2021,[cviii] the average number of operational vaccination centres increased from 32,552 to 65,780 including allowing door to door vaccination;[cix] this helped vaccination rates to pick up. India reached the 100 crore vaccine dose milestone on 21 October 2021.

It is critical to remember that the government had committed to the 31 December deadline to get all Indians fully vaccinated, i.e. with two doses. However, the latest prediction from the International Monetary Fund is that only 40 per cent of Indians[cx] would be immunised by this deadline. Which means there is time to ensure universal immunisation. Eight of every ten people surveyed said that they did not think that the government will be able to vaccinate all adults by 31 December 2021. This was the sentiment from the relatively under-vaccinated younger population. The vast majority (87 per cent) respondents in the age group of 18-24 years and 85 per cent of those in age group of 25-39 years said that it is unlikely that government would be able to vaccinate all adults by December 2021.

Objectively, at present, India is vaccinating an average of 3.6 million people per day, compared to an estimated coverage of around 21 million people[cxi] per day needed for achieving the target of vaccination of all adults by the end of 2021. At

the same time, one has to recognise the reality of a 12-week waiting period between vaccine shots. Hundred per cent of the population would have to have been vaccinated with at least the first shot by early October to ensure that they received the second shot ahead of 31 December. But this did not happen.

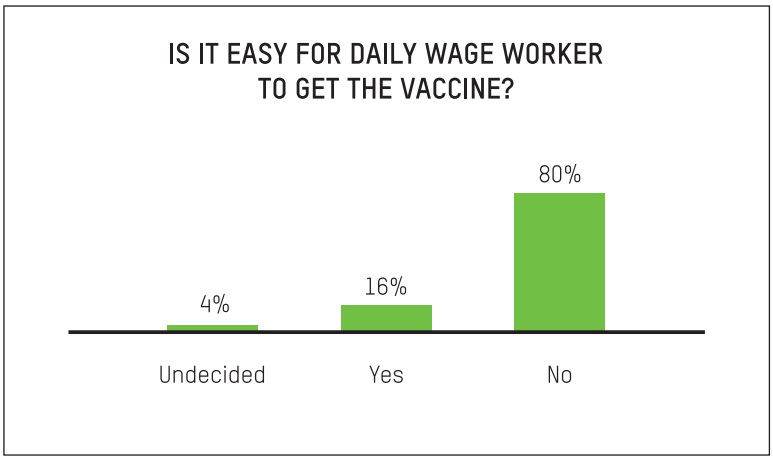
FIGURE 1 LIKELIHOOD OF 100 PERCENT VACCINATIONS



Despite the Prime Minister's stated intention to not discriminate during the vaccination drive, most respondents did report that the drive was unequal. The experience of the drive shows that *vaccine availability*[cxii] *has not been equal for Indians living in*

various States and UTs. India does not maintain records of people vaccinated disaggregated by income or social group[cxiii] which would have been critical to tailor strategies to the specific population needs. Any commitment to equity on the vaccination drive accordingly needed to be rooted in an effort to track the relative progress of vaccination for India's rich and poor in the various social groups.

FIGURE 2 EASE OF GETTING VACCINATED



The majority of respondents (83 per cent) believed that all vaccination should be completely free of cost through the government, like with the Polio vaccination drive. Vaccines are global public goods, and it is the constitutional responsibility of the Government of India to provide them for free to everyone. Right to Health, in turn, flows directly from Article 21 (Right to Life)[cxiv] of the Indian Constitution.

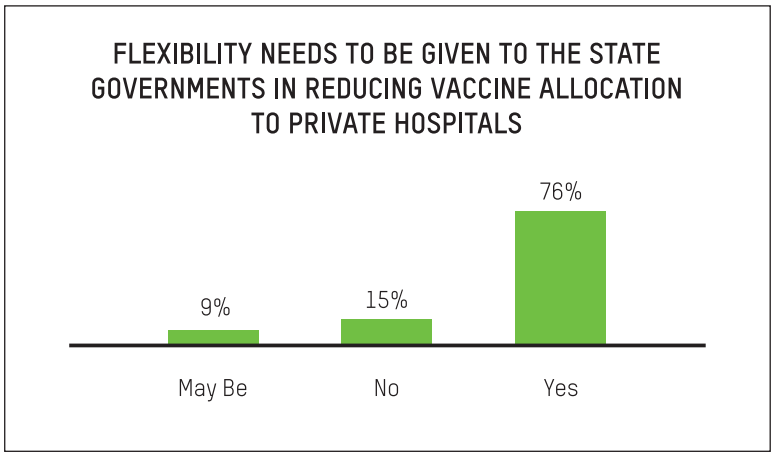
India's National Vaccine Policy enables access to free vaccination through its Universal Immunisation Programme (UIP).[cxv] For all other national vaccination efforts, the funds

have come from the Centre and have been largely free for India's citizens. India's National Vaccination Policy (2011) requires vaccines to meet UIP goals and follow centrally-procured General Financing Rules (GFR).[cxvi]

Three out of every four people (76 per cent) surveyed, believed that in order to advance equity in vaccination, State governments should be given the flexibility to reduce vaccine allocation to private hospitals to avoid possible shortages of free vaccines. This was a major task for several States in the beginning of the current phase of vaccination; several States asked for a relaxation of the 25 per cent cap.

This was subsequently revised with India's health secretary stating in a press briefing that this is an 'indicative percentage of what the government would procure and what would be available for the private sector to procure, not an earmarked[cxvii] quota'.

FIGURE 3 REDUCING VACCINE ALLOTMENT TO PRIVATE HOSPITALS



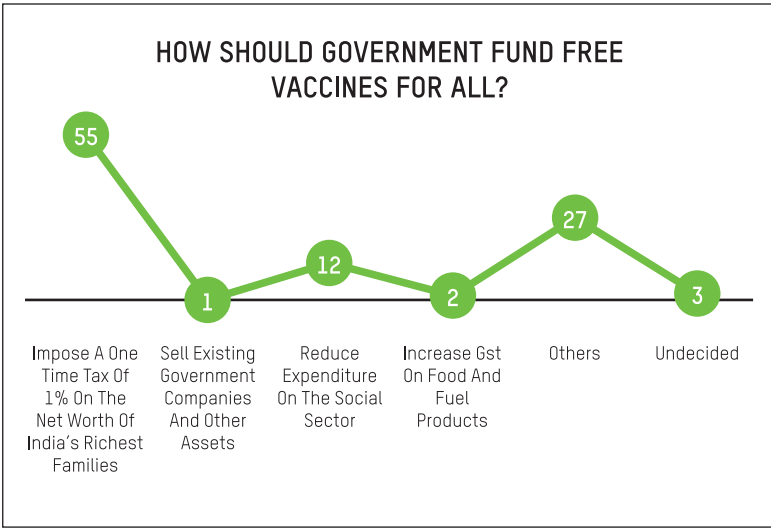
Only 6 per cent of the total vaccination in the country has been carried out in the private sector.[cxviii] The cost of vaccines in private hospitals remains prohibitively expensive. An Indian family with three adults will have to pay INR 3,600[cxix] in a private hospital for a full course of the Covishield vaccine or INR 7,200 for Covaxin. This amounts to 24 per cent of their monthly income in case of Covishield and 48 per cent in case of Covaxin. For the bottom 20 per cent of households, this burden will be 43 per cent and 86 per cent of their monthly income, respectively.

Thus, only the rich can really afford these rates. As an earlier analysis from Oxfam India had shown, these prices out a significant share of India's population and contributes to artificial vaccine shortages.

Equity issues also prevailed in States with a high share of private hospitals. One analysis of data for Delhi showed[cxx] that it had more sites and slots of free vaccines but most of these lacked doses. In contrast, 74 per cent of the doses available on CoWIN were for paid doses which were also available days in advance, given their high price.

Given the prohibitive costs, private hospitals had been struggling to deliver[cxxi] their existing stock of vaccines and fears have been expressed about unopened vials expiring.[cxxii] The wealth and digital divide continues being a vaccine divide, despite the opening up of the option for walk-in registration. Our survey asked respondents how they would like the government to finance free vaccines for all.

FIGURE 4 HOW SHOULD FREE VACCINES BE FUNDED



Only 2 per cent of the survey's respondents were in favour of taxes on fuel and food being used to fund the vaccination drive. In contrast, 55 per cent individuals believed that imposing a one-time tax of 1 per cent on the net-worth of India's richest 1,000 families will be helpful. Only 12 per cent felt that the government should reduce other social expenditure and 1 per cent felt that the government should sell existing government companies to fund the vaccination drive. A sizeable 28 per cent felt that other source of funding should be explored. Similar trends were found across all demographies of respondents.

Targeted taxation of India's richest 1,000 families emerged as the most popular source for funding India's vaccination drive. Economists like S Subramanian estimated that the total wealth of just 953 of India's richest families on the Hurun Rich list must be approximately INR 50.3 trillion (around $684.6 billion).[cxxiii] Health economist Indranil Mukhopadhyay has estimated[cxxiv] that the cost of vaccinating the 1.3 billion population of India

ranges between INR 500 billion to INR 800 billion. By taxing just 1 per cent of the wealth of these super rich families India could fund its entire vaccination programme cost of INR 500 billion ($6.8 billion).

In recent times, many researchers and economists have been touting progressive wealth tax[cxxv] as the best solution to fund COVID-19 response. Latin American countries like Argentina adopted a one-off special levy, known as the 'millionaire's tax' that has brought in around $2.4 billion to pay for pandemic recovery. Policymakers, leading economists, Civil Society Organizations (CSOs), the United Nations, IMF and the World Bank are calling for one-time 'solidarity tax' and longer-term wealth tax to mitigate the economic impacts of the pandemic and reduce inequalities by funding vaccination too.

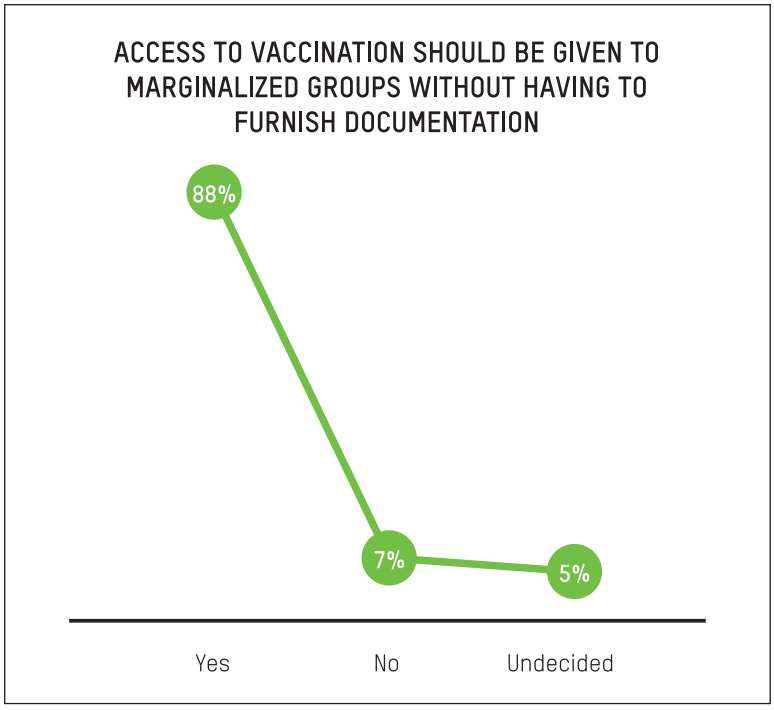
The vast majority of respondents said (89 per cent) that the government must ensure that vaccination centres are kept open beyond 9 am-5 pm to enable those in full-time employment and informal workers to get vaccinated without having to take leave. Keeping centers open for longer hours will prevent loss of wages suffered by informal workers. It will also prevent crowding in the vaccination centers, allowing the recipient to have a hassle-free experience at government vaccination centers.

This could be particularly useful for the poorest who are more likely to be working in the informal sector; 83 per cent of respondents earning less than Rs 10,000 per month said that the government should extend the timings of vaccination centers beyond 9 am-5 pm.

Around 95 per cent respondents from all age categories (18 to 60 and above) felt that vaccination must be brought closer to the elderly, persons with disabilities (PwDs) and ISWs by making use of mobile vans, vaccination camps and home-based vaccination.

A large majority (88 per cent) believed that the government must ensure that marginalised groups such as street dwellers, migrant workers, immigrants, refugees and asylum-seekers are given access to vaccination without having to furnish documentation. Nearly all respondents (90 per cent) said that the government must make teachers, domestic workers and those working in medical and grocery stores eligible for priority vaccination by adding them to the list of frontline workers.

FIGURE 5 NO-IDENTIFICATION VACCINATION



These findings echo the lack of prioritisation/consideration and planning of the government on vaccine administration, based on real field-level facts. For instance, in the initial period of COVID-19 pandemic, the policy of the union government was to cover frontline health workers and medical staff but in reality, apart from those in the medical field, there were other professionals too who were involved in providing COVID-19 related care in the communities.

It is clear that the presence and contribution of workers and professionals (other than medical staff) had not been recognised and addressed by the government. There is much to be learned from how different States' vaccination drives evolved to address local challenges.

Well over half the study's respondents (61 per cent) felt that the government failed at informing them about how and when to get vaccinated. There were significant differences across income groups — 74 per cent of those earning less than INR 10,000 per month reported they were inadequately informed, as compared to 27 per cent of those earning over INR 100,000 per month. The government communication around vaccination appears to have failed to reach the poorest and most marginalised people of the country. Furthermore, 8 in 10 people felt that the government changed its COVID-19 vaccine policy too frequently, especially at the early stages of the vaccination drive. The government failed to maintain transparency in development and implementation of the vaccine policy.

In April 2021, Oxfam India and the Forum for Medical Ethics Society (FMES)[cxxvi] released a policy brief[cxxvii] highlighting

the importance of transparency in COVID-19 vaccine policy and demanding the need to consult the State governments and involve the people of India (Taneja, 2021). The COVID-19 pandemic has highlighted how lack of clear information, frequent change in vaccine policy without effective communication of the rationale behind it, and failure to engage with people can foster mistrust among the citizens of the country. Improving transparency can enhance public trust in vaccination policy of the country.

Nearly all (89 per cent) respondents said that the government must use all available domestic manufacturing capacity, especially through public sector companies. India has almost two dozen vaccine production units[cxxviii] and both the public and private sector have units that can potentially contribute to the expansion of local vaccine production. In the beginning of 2000s, 80 per cent of India's vaccines[cxxix] for the UIP were sourced from the public sector.

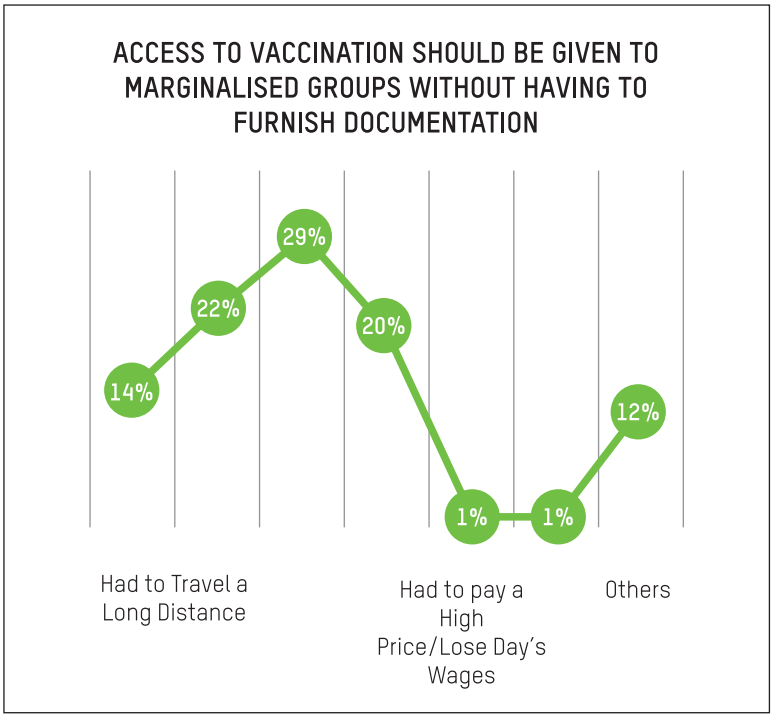
Today, 90 per cent are sourced from the private sector at a higher cost. The pandemic could, therefore, serve as an opportunity to strengthen India's public sector manufacturing capacity. This would entail sharing the intellectual property (IP) of the existing set of vaccine manufacturers, thus augmenting supplies and reducing prices. Brazil's senate[cxxx] recently voted to approve a temporary breach of patents for COVID-19 vaccines, tests, and medicines for the duration of the pandemic.

India has been at the forefront of the global fight for lifting intellectual property rights on the COVID-19 vaccine. It could show the way for other vaccine manufacturers by sharing

the recipe for Covaxin for which ICMR claims royalty.[cxxxi] The experience of the COVID-19 vaccination drive has been largely rigged in favour of the rich[cxxxii] and the relatively more tech-savvy. In the survey, 12 per cent people who earned less than INR 10,000 per month had not received even a single dose of vaccine, while only 5 per cent of people who earned between INR 60,000 and above did not receive a single dose.

Challenges faced in vaccination were fairly similar, irrespective of the socio-economic profile of respondents or the site of vaccination. These included the need to make multiple visits to vaccination centers, economic consequences of doing so (either in terms of loss of wages or high cost of vaccination) and the need to travel long distances to obtain the vaccine.

FIGURE 6 VACCINATION CHALLENGES



Around 29 per cent of respondents said that they either had to make multiple visits to the vaccination centres, or stand in long queues at public vaccination camps (31 per cent) or public vaccination centres (29 per cent). Long queues outside vaccination centres have been reported[cxxxiii] across India in the early months of the vaccination drive.

Four out of every ten (36 per cent) respondents belonging to Economically Backward Class (EBC), followed by 30 per cent of people from OBC and general categories reported that they had to make multiple visits to the vaccination centre/stand in a long queue at the centre. However, long waiting time was the biggest challenge reported for private vaccinations as well.

Over 22 per cent people reported facing issues in booking the slot online and having to try for multiple days to get a slot in all vaccination camps/centres. This challenge was particularly prevalent in the initial days of vaccination when booking through the CoWIN portal was compulsory to get a slot.

A fair number of respondents (16 per cent) said that they had to travel long distances to reach private vaccination centres, contrasted with 10 per cent who had to travel to access a public vaccination camp. According to public health experts,[cxxxiv] the long distance is a deterrent for women to get vaccinated, particularly if there is no male member to accompany them.

A fair number of respondents (9%) who visited vaccination centres or camps reported losing a day's wage to get themselves vaccinated or had to pay a high price for the vaccine. There are multiple reports[cxxxv] showing that the risk of wage loss is a huge deterrent for daily wage workers such

as domestic workers, agricultural workers, and construction workers from getting vaccinated. Of those who lost wages due to days of trying to get vaccinated – 18 per cent of OBCs and 16 per cent of Dalits – reported having lost a day's wage to get the vaccine, compared with 12 per cent of respondents from the general category.

The experiences were fairly similar for people across income groups. The group of highest earners were slightly more likely to have travelled long distances (16 per cent vs 12 per cent) and have persevered to obtain a vaccine slot online. In contrast, the economic barriers were higher for those who are poorest (high price/lost wage).

Post the second wave in India, there were multiple reports of vaccine centres shutting down[cxxxvi] due to a lack of vaccines. Consistent with these reports, this study found that of those respondents who couldn't get a single dose of the vaccine, 40 per cent could not get vaccinated because the vaccination center had run out of vaccines when they visited the center. While the country celebrates reaching the 1 billion dosage mark, it must remember that the vaccination drive has been plagued with supply issues that have prevented people from taking the vaccine when they wanted to.

Traveling independently to get vaccinated was a huge barrier; 1 in 5 respondents reported that they couldn't get vaccinated because of this barrier. The biggest challenge faced by the elderly has been their inability to travel on their own; 33 per cent people above the age of 60 years said that it was not possible for them to travel to the vaccination centre compared with 11 per cent of the rest of the sample. This suggests that

India is missing out on vaccination of the most vulnerable sections of the society including persons with disabilities and the elderly.

The current government at the Centre has historically been opposed to doorstep vaccination[cxxxvii] until November when the PM finally endorsed it during a call with the group of CMs.[cxxxviii] Oxfam hopes that this policy move will play a significant role in increasing vaccination rates.

One of the key differences between the COVID-19 vaccination drive and previous vaccination drives, such as that of Polio, is that the current vaccination drive is being delivered by government and private health providers. Thus, 12 per cent of those who couldn't get vaccinated, reported that they could not afford the high prices of the vaccine, presumably in the private sector. This could be a combination of two challenges – the perceived unavailability of vaccines in public health facilities and the lack of clear communication from the government on how to access free vaccines.

Furthermore, the experience of vaccination has varied, based on place of residence. Rural respondents found it harder to obtain vaccines either in terms of booking a slot or going to the vaccination centre or going to the vaccine centre without obtaining the vaccine. In contrast, expensive private vaccines and failing to have necessary documentation was a greater challenge for urban areas.

Conclusions

The PRC study shows that the basic rights of patients in India are being routinely denied in healthcare facilities. Skewed

power dynamics with respect to class, caste, religion, and gender between the healthcare providers and patients, have deepened existing structural inequalities in the health system. However, as this survey shows, India's middle class is also not exempt from extreme violations. The COVID-19 pandemic has only further thrown into sharp relief the extent of vulnerability of Indian patients to the violation of their rights, especially, for the private sector.

The vaccine survey showed that people from all income groups and all strata of society faced common challenges and barriers in both public and private health facilities while availing the COVID-19 vaccines. In the event that India opts for booster doses or doses against new variants, it will be critical to have a well thought-out policy to ensure vaccines are available free of cost and accessible through the public health system. At the same time, it would be important to learn from this experience for subsequent vaccination drives.

In the long run, India needs to further strengthen the Public Health System and establish social control over Private Health Sector. It is time for the Government of India to enact a justiciable right to health to ensure that every citizen has recourse when their rights are violated. It is possible for the government to do so. As our Prime Minister said two years back:

"Health does not simply mean freedom from diseases. A healthy life is every person's right. The onus for this is on our government to make every possible effort to ensure this"— Narendra Modi, 2019.[cxxxix]

CHAPTER 4
PUBLIC FAILURES IN PRIVATISED SCHOOLS

In 2021 Oxfam India's Advocacy and Education Team commissioned a rapid survey to understand parents' experience with private schooling during the pandemic. The study was conducted in the context of the National Education Policy (NEP) 2020 that recognises that the current regulatory regime has failed to prevent profiteering and commercialisation by private schools and calls for more effective regulation.

The last few decades have seen a significant rise of the private sector in education. Children enrolled in private schools (aided and unaided) now constitute nearly 50 per of all school-going children.[cxl]

Despite this, there remains limited critical research looking at the experience of parents in private schools. Existing research has largely looked at the relative performance of students in private and government schools, triggering a somewhat sterile debate. This study instead objectively looked at the experience of private schools; and it did so in the context of the pandemic.

The study explored the experiences of private school parents with accessing learning during the period of school lockdown in addition to looking at experiences of children with reopening. It captured the overall experiences of parents including their experiences with the admission process, responsiveness of the school and administration to complaints and other issues

which are of critical interest to parents, but which are often omitted from private school research in India.

This is particularly significant, given the focus of the NEP[cxli] which saw its first year during this period. The NEP recognises commercialisation of education as an issue and notes that the current regulatory regime has been unsuccessful in protecting parents from exploitation by private schools. It seeks to do so through putting in place transparent public self-disclosure of all the basic regulatory information for public oversight and accountability.

This would be expected to operate by parents exercising their voice and agency in their interaction with schools. In the months since the NEP was finalised, calls have been made by lobby groups[cxlii] to ease regulatory frameworks as they apply to private schools and even end the legal mandate of keeping education as a not-for-profit domain.

As such the results of this study are critical inasmuch as they examine the extent to which parents' voices can effectively be exercised in school settings at present.

Methodology and Data Collection

A total of 3,440 respondents across 36 States and UTs of India constitute the sample for this study. The study was conducted between the months of September to November, the questionnaire was created in-house by Oxfam India.

This sample is neither representative nor evenly distributed across States. Further, a large section of the data was collected through a self-administered online questionnaire, thereby

limiting the representativeness of the sample given that these were people with a digital device, internet, motivation, and the technical know-how to fill an online questionnaire.

Data Analysis

The survey was analysed using simple percentage and cross-tabs in Microsoft Excel. Multiple choice question have been analysed at response level and not respondent levels.

Results

The sample consists of 30 per cent responses from households with an annual income of less than Rs 20,000 per month indicating that the data does not reflect the opinions and experiences of only the elite and the rich. The sample consists of 28 per cent of responses from parents of girl children, a critical sub-group from an educational point of view. The representation of marginalized groups in the sample is – 3% STs, 10% SCs, 18% Muslims and 25% Other Backward Castes.

A large percentage of parents (58 per cent) who responded to the survey, send their children to CBSE schools, while a quarter (27 per cent) send their children to State board schools. The rest of the sample is made up of those in ICSE (11 per cent) and other schools. In terms of the break-up across grades, roughly a quarter of the respondents have children studying in grades 1-2 and 3-5 respectively while around half the respondents have children enrolled in grades 10-12.

MOVING SCHOOLS DURING THE PANDEMIC

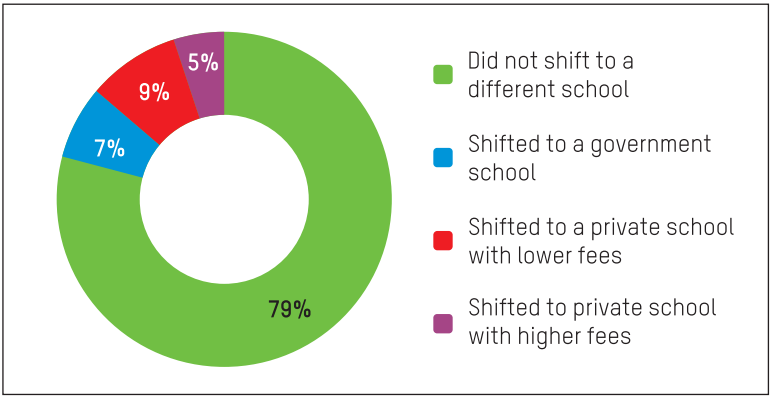
News reports have documented a move away from private schools to government schools during the pandemic. In Andhra Pradesh, 2 lakh[cxliii] children moved from private to

government schools while Karnataka saw a similar shift of 1.5 lakh children[cxliv] moving to government schools. Our survey found 7 per cent of private school parents shifted their child/ children to a government school, which is in line with findings in ASER[cxlv] which shows that private school enrolment reduced by 8 per cent over the past year.

This shift also took place across private schools, those with lower fees and those with higher fees. Given the financial repercussions of the pandemic (at the peak of the pandemic, 84 per cent households suffered a loss in income), it is understandable that 9 per cent private school parents moved their children to a private school with lower fees.

However, somewhat counterintuitively, 5 per cent private school parents moved their children to a school with higher fees. Interestingly, this is broadly consistent across different income, wherein 7.5 per cent parents earning more than RS 80,000 per month shifted their child to a more expensive private school, as compared to 4.5 per cent parents earning less than Rs 20,000 per month.

FIGURE 7 SHIFT IN SCHOOL TYPE BY PERCENTAGE OF OCCURANCES



One potential explanation for this finding could be parents' disappointment with education delivery by their child's private school during the pandemic, and the assumption that paying a premium might mean a better quality of education.

VIOLATION OF RTE NORMS DURING SCHOOL ADMISSIONS

Our survey found that 13 per cent children were denied admission on the grounds of their gender/social identity. Further, close to 60 per cent parents had to pay capitation fees at the time of admission despite the existence of norms preventing this.

The Right to Education Act (RTE) clearly lays out that private schools can't deny admission to children on grounds of gender, caste, religion, language, background etc. Despite this, 13 per cent private school parents surveyed in our study, reported that a private school denied admission to their child on one or a combination of these grounds.

For Muslims, the rate of denial is higher than for Hindus when combined with a non-religion related factor, at 19 per cent. This finding is consistent with a study of nursery admissions in Delhi, which found that only 3 per cent Muslim students got admission in a private school. Of the schools that denied admission to students, 70 per cent were neither co-ed, nor minority institutions, meaning that they had no grounds on which to deny admission.

State RTE rules clearly prohibit schools from demanding donation/capitation fees at the time of admission. Despite this, the practice of charging capitation fees by private

schools appears to be rampant, with close to two in five parents reporting that they were asked to pay capitation fees. While regulation exists, this finding indicated that its enforcement has been poor and ineffective, allowing private schools to continue this exploitative tactic.

Although this violation is a widespread phenomenon across the country, there is some variation – for instance, in economically better off States, a much greater percentage of parents reported having to pay capitation fees as compared to parents from poorer States, which could be due to the relatively higher ability of parents to pay in States such as Karnataka, Maharashtra and Delhi.

TABLE 27 STATE-WISE BREAKUP OF PARENTS PAYING CAPITATION FEES

STATE	SHARE
KARNATAKA	57
MAHARASHTRA	48
DELHI	46
BIHAR	35
ODISHA	34
JHARKHAND	34
UTTAR PRADESH	28

While RTE rules explicitly prohibit any form of screening including tests and interviews of parents and children, private schools continue to blatantly violate these norms. Over half the parents reported that their child had to appear for a test/ interview prior to seeking admission in the school. While there have been multiple media reports[cxlvi] highlighting this issue across various States the pattern consistently occurs across

States, regardless of their economic status and governance ability, from 58 per cent in Karnataka and Haryana to over 60 per cent in Bihar and Uttar Pradesh.

SCHOOLING COSTS

Two of the biggest concerns that private school parents have, are to do with the rising commercialisation of education promoted by private schools. Around two in three parents reported that they were forced to buy books/uniform/ stationery from a specific vendor despite this being a punishable offence in multiple States, including Uttar Pradesh, Bihar and Karnataka. Unfortunately, a large percentage of parents in these States continue to be pressurised into buying school supplies from a specific vendor, indicating that poor enforcement of existing private school regulation is at the heart of the issue of rising commercialisation. This issue exists across the country, regardless of the existence of private school regulation, governance ability and economic status of the State.

TABLE 28 PARENTS FORCED TO BUY FROM SPECIFIC VENDOR, STATE-WISE IN PERCENTAGES

STATE	SHARE
KARNATAKA	65
BIHAR	65
DELHI	64
UTTAR PRADESH	59
MAHARASHTRA	56
JHARKHAND	55
ODISHA	53

Our study shows that 57 per cent parents had to pay many additional charges throughout the year, which were not part of the break-up of fees shared by the school at the beginning of the year.

Various State private school legislations, such as in Bihar, Punjab and Chandigarh clearly lay out that the school is required to display details of all types of fees on its notice board and on its official website.

The UP Fee Regulation Act clearly states that private schools need to disclose the fees and their break-up at the time of admission. Nationally, the NEP 2020 stresses the importance of transparency and disclosure by private schools.

Despite this, close to 60 per cent parents in our survey stated that they were asked to pay additional charges throughout the year, which were not disclosed by the school at the beginning of the year. As a result of these hidden charges, private schools are increasingly becoming an unaffordable burden for parents. Two in three parents in the survey stated that private school fees (including all charges) constitute over 15 per cent of their household income, which is consistent with data from the NSS 75th round.

There is a need for State governments to regulate private schools such that they comply with these basic norms of transparency and disclosure as part of their functioning, rather than institutions that focus on exploiting parents and making profits through hidden charges.

A State-wise analysis shows that existence of a private school fee regulation doesn't necessarily help in preventing private

schools from exploiting parents and taking additional/hidden charges throughout the year. For instance, in Bihar and Uttar Pradesh, both of which have private school fee legislations, a higher percentage of parents (66 per cent and 59 per cent respectively) reported having to pay additional fees throughout the year as compared to 55 per cent in Odisha which does not have a private school legislation in place.

This does not mean that having a private school legislation is meaningless, but it does indicate that without enforcement of regulation, private schools will continue to exploit parents with/without a legislation.

TABLE 29 PARENTS WHO PAID HIDDEN CHARGES FOR EDU, STATE-WISE

STATE	SHARE IN PERCENTAGE
BIHAR	66
DELHI	64
JHARKHAND	60
UTTAR PRADESH	59
ODISHA	55
MAHARASHTRA	53
KARNATAKA	51

QUALITY OF EDUCATION

The NEP 2020[cxlvii] clearly states that pedagogy must move away from being inequity-driven and education itself must be more holistic in nature. However, private schools don't appear to believe in the concept of holistic education. Over half the parents believed that there is an excessive focus on marks in private schools, and not on the overall needs and development of their child. In addition, over a third of the parents are

concerned that there are too many children in one class, as a result of which, their child does not get enough individual attention and support from the teacher.

In our study 51 per cent parents said they had no voice and agency around key decisions. Various State legislations explicitly mention that parents must be consulted by the management before key decisions are taken. For instance, the Chhattisgarh fee regulation mandates the school management to make a presentation to parents before hiking/changing the fee structure.

According to the Jammu & Kashmir legislation, schools must consult and appraise parents on matters pertaining to academics and co-curricular activities. Despite the ethical and legal obligations of schools involving parents in key decisions, over half the parents reported that they had no voice and agency in important decisions that are taken in the school.

Once again, having explicit norms in place does not appear to help in increasing parental voice. In Maharashtra for instance, there is a specific private school fee regulation that requires private schools to seek approval from a school-level fee committee consisting of parents. Despite this, 46 per cent parents in Maharashtra said that they had no voice and agency around key decisions as compared to 44 per cent parents in Odisha, which does not have a comparable norm in place related to parental participation.

Our study also shows that 41 per cent parents said quality of infrastructure was inadequate compared to fees paid. On

average, expenses on private schooling cost 10 times that of public education. The current survey shows that parents spent a substantial part of their household income (15 per cent and above) on private school fees. Despite paying such large sums, two in five parents felt that the quality of infrastructure in their school was inadequate compared to the fees paid. This is borne out by UDISE data[cxlviii] as well, which shows that a mere 8.1 per cent of private unaided schools meet all the 10 RTE infrastructural norms, as compared to 14.6 per cent government schools.

Further, we found that children did not receive enough individual attention, faced corporal punishment and bullying. In line with parents' concerns that there were too many children in one class, they were also concerned that their children did not receive enough individual attention, with around half the parents reporting this. There were also issues of corporal punishment and bullying, with over a fifth of the parents reporting that their child faced corporal punishment by a school staff or teacher, a similar number reporting that their child was bullied by other children in the school.

COMPLAINT RESOULUTION

We found that less than 5 per cent parents were satisfied by actions taken by the school on complaint in addition, over 36 per cent of parents reported that their children were harassed over complaints. These findings indicate a skewed power dynamic between the school and parents, where parents have little choice to defer to the school's decision in case of complaints and issues, even if they are dissatisfied with the action taken, a trend that is prevalent across the country,

TABLE 30 PARENTS SATISFIED WITH COMPLAINT RESOLUTION

STATE	SHARE IN PERCENTAGE
BIHAR	2
DELHI	3
JHARKHAND	2
UTTAR PRADESH	3
ODISHA	5
MAHARASHTRA	3
KARNATAKA	1

An unfortunate pitfall of parents complaining to the school is harassment of children – of the parents who complained, over a third reported that their children were insulted and harassed over the complaints. Existing media reports[cxlix] also show that, that is one of the main reasons parents are reluctant to complain in the first place, a finding that is in line with existing media reports as well as a rapid survey by Oxfam India of private school parents in Delhi.[cl]

The other key reason behind the low level of complaints to the education department, relates to the lack of faith in the grievance redress mechanism, where over half the parents are not confident of their complaint getting resolved.

Lastly, there are issues with the design of the education department's complaint mechanism itself, wherein around half the parents believe the process of complaining is too complex and a similar number don't even know where to complain. These findings indicate the need for State governments to simplify existing complaint mechanisms and make them parent-friendly, such that a larger percentage of parents

feel confident that their issues will be heard and thus, come forward to file complaints against their child's school.

Of those parents who were not satisfied by complaint resolution, around 60 per cent said that they tried complaining but got no response, and a similar number reported that no action was taken against the school. Around a third of the parents said that the education department ruled in favour of the school over the complaint.

The actual experiences and challenges of parents who have tried to engage with the education department are quite aligned with the perceptions of those parents who haven't ever complained to the education department, indicating that unless the government takes concrete measures to simplify and strengthen the grievance redressal process, parents will lose faith in the process altogether.

Multiple State legislations make it compulsory for all schools to have a PTA. Having such a body would be the first step in ensuring that decisions in the school are taken in a consultative and participative manner with parents, teachers and school management, thereby reducing possibilities of conflict.

Unfortunately, less than 20 per cent parents report that their school has a PTA. In Uttar Pradesh, law mandates that all private schools to setup a PTA. Despite this, a mere 11 per cent parents reported that their school has a PTA setup. Even in cases where a PTA exists, four in five parents are *not consulted* over decisions taken by the school, signifying that many PTAs exist on paper but not in practice.

TABLE 31 SCHOOLS WITH PTA, STATE-WISE

STATE	SHARE IN PERCENTAGE
BIHAR	9
DELHI	16
JHARKHAND	7
UTTAR PRADESH	11
ODISHA	18
MAHARASHTRA	36
KARNATAKA	17

Parents and children are amongst the most important stakeholders in the school but their role in school management and decision-making remains limited. An overwhelming 95 per cent of the parents surveyed were of the opinion that every school should have a parents' group that is empowered to review all key decisions by the school that concern parents and children.

In States such as Chattisgarh, Maharashtra and Rajasthan, there already exist legislations which require schools to consult and seek approval from parents prior to hiking/ changing the fee structure of the school. However, there is a need to go beyond fee fixation and involve parents in all key decisions concerning children, including issues of child safety, academics, and co-curricular activities.

COVID-19 EXPERIENCES

With specific regard to the delivery and management of education and learning in private schools – our study asked parents how many actually received any form of education in the last two months (pertaining to September and November

2021), we found that almost 50 per cent parents reported that their child was not involved in any form of teacher-led learning activity at all.

In instances where parents reported that their child was involved in some form of teacher-led learning, live online classes were the main mode of delivery with over 80 per cent parents reporting this. The second main form of education delivery was through resources shared on WhatsApp (47 per cent). Of the parents who reported that their child was involved in some sort of teacher-led learning activity over the past two months, only one in five parents reported that their child accessed learning through physical classes in school.

Further, there were significant differences across grade levels.

While around 30 per cent children in grades 10-12 accessed learning through physical classes in school, the figure for children in the primary section (1-5) was a mere 7 per cent. This is because reopening of schools in most States has remained restricted to secondary and senior secondary sections, while school closure for children in grades 1-5 has now completed over 600 days in multiple States.

According to norms,[cli] children in India are supposed to spend slightly more than 4 hours per day in school on average. However, our study found that only a fifth of the children accessed teacher-led learning for over 4 hours a day on average. Over 50 per cent children accessed education for even less than 3 hours a day.

According to a study by Azim Premji University, over 90 per cent children have lost at least one major language competency

during the pandemic. As this study shows, this isn't just because of the lack of access to education, it is also of reduced teaching time for those who could access teacher-led instruction during the pandemic.

The reduced time of teacher-led instruction has also meant an increased burden on parents to follow up and support children's learning. While parental involvement was also expected in the pre-pandemic era, a separate survey showed that 80 per cent parents[cliii] are spending more time with children since schools were closed.

The same survey[cliii] also showed that 2 in 3 parents were not comfortable with teaching mathematics. The increased dependence on parents for providing instruction to children will lead to an increase in educational inequality since not all parents are equally equipped/qualified to support their child's learning. The burden for supporting children is also likely to fall disproportionately on mothers who are already primary caregivers for older people in the family.

TABLE 32 HOURS PER DAY INVOLVED IN TEACHER-LED LEARNING ACTIVITY

TIME SPENT IN THE LAST 2 MONTHS	SHARE IN %
< 1 HOUR	7
1-2 HOURS	21
2-3 HOURS	25
3-4 HOURS	26
> 4 HOURS	21

Two in three parents supported their children's learning by purchasing a digital device, which is in line with multiple media reports[cliv] of parents investing in digital devices during the pandemic.

This figure was consistent across income groups, indicating that the pandemic forced even the poor to spend their meagre earnings on digital devices. According to ASER 2021, 28 per cent of rural households reported buying a mobile phone for their child. However, our survey was not restricted to rural households, which could explain a higher proportion of parents reporting that they purchased a digital device to support their child's learning.

While 40 per cent parents said that they tried to ensure their child was involved in some form of learning activity every day, there was a difference across income groups – while 33 per cent earning less than Rs 20,000 per month reported this, the figure for those earning over Rs 80,000 was 53 per cent.

The gap should be seen not in terms of intent to support children's learning, but the capacity of the poor to do so. This is demonstrated by the fact that over 20 per cent of low-income parents have said that they were not in a position to support their children as compared to only 4 per cent of the high income parents.

Only 37 per cent parents reported that they had setup a special place in the house for the child to learn. While 50 per cent parents earning more than Rs 80,000 per month reported this, the figure was 25 per cent for those earning less than Rs 20,000, highlighting constraints faced by poor children in learning from home, which were not restricted to digital access alone, which much of the media coverage has focused on.

Similarly, only 31 per cent parents said they tried to engage with their child by asking them questions. For parents from ST households, the figure was much lower, at 17 per cent while for parents earning over Rs 80,000 per month, the corresponding

figure was 38 per cent. This must not be interpreted as ST parents being less concerned about their children's learning. Rather, it highlights the challenge faced by parents from marginalised groups to support children's learning due to constraints of time and their own educational disadvantages.

TABLE 33 FAMILY SUPPORT TO CHILD'S LEARNING DURING THE PANDEMIC

WAYS OF SUPPORT	<RS 20,0000	>RS 80,000	OVERALL %
BOUGHT DIGITAL DEVICE	66	69	67
HIRED TUITION TEACHER	20	31	29
SET UP STUDY LOCATION	26	50	37
ASKED QUESTIONS	27	38	31
DAILY LEARNING ACTIVITY	33	53	40
COULD NOT SUPPORT	22	4	13

This serves to show the need for teachers and schools to take the lead in supporting children's education, and providing additional support to children from marginalised groups, particularly Adivasis.

Our study found that the biggest challenge faced by children in online classes, was the lack of opportunities for deeper engagement, with two in three parents reporting that their children found it difficult to get their doubts cleared in online classes. This finding is backed up by other surveys as well. In an Azim Premji University survey,[clv] more than 90 per cent teachers reported that meaningful assessment of children's learning was not possible in online classes.

In the same study, over 80 per cent teachers said that establishing an emotional connect with children was impossible through this mode. It is, therefore, important to understand that the primary issue with digital learning is not simply of access to devices, but of pedagogical effectiveness.

Over one in three parents reported three types of challenges with accessing education, that pertain to issues of digital access and the internet. These include, expensive data, issues with internet speed and more importantly, the challenge of not having the right device or having to share a phone with family members. This was borne out by other studies as well, with one study[clvi] finding that smartphones were often used by working adults and not available for school children. Similarly, the ASER survey[clvii] found that of children who had smartphones at home, less than one-third were able to access it all times.

Over 35 per cent parents also reported that children lacked a conducive space in the house to study. Interestingly, this challenge was faced across parents from different income groups, with some variation – while 41 per cent parents earning less than Rs 20,000 reported this, the figure for those earning over Rs 80,0000 was 26 per cent.

Research from across the world[clviii] indicates that for children, the lack of conducive learning environment at home is one of the major deterrents for effective digital learning. Digital access is only one part of the enabling environment needed; the more crucial bits are teacher preparedness, participative pedagogy that allows children to ask questions and teachers to assess learning, and the availability of a dedicated space in the household for the child to learn digitally.

Our report clearly shows that none of these pre-conditions are being met, and even for children who are attending online classes, it remains a medium of passively receiving instruction, and not one of co-creation of knowledge based on children's lived experiences.

TABLE 34 CHALLENGES IN ACCESSING EDUCATION DURING THE PANDEMIC

ISSUES OCCURING IN THE LAST 2 MONTHS	SHARE IN %
COULD NOT CLEAR DOUBTS	65
DEVICE ACCESS ISSUES/SHARING	44
NO SPACE IN HOUSE TO STUDY	35
DATA PACK WAS TOO EXPENSIVE	35
NO/SLOW INTERNET	34
DID NOT GET TIME DUE TO HOUSEHOLD CHORES	15

It wasn't just children's access to learning that was impacted, it was also their physical and mental health. For many children, the school was a space that provided them space for playing sports and getting focused physical education. However, during the pandemic, as schools closed physically, private schools failed to support children's health needs during this time, with over 50 per cent parents reporting that no alternative was provided by schools for physical education and sports.

In addition to children's physical health, various studies have shown that that pandemic and prolonged school closure has had a detrimental impact on children's mental health. Over a fifth of the parents have reported that their child's school failed to provide any form of support for her/his/their psychosocial needs.

More than half of the parents surveyed in this study (52 per

cent) reported having to pay hiked fees during the pandemic despite 14 State governments releasing notifications asking private schools to not hike fees during the pandemic. A State-wise analysis of fee hikes reported by parents is presented in Annexure C. While lack of enforcement is certainly an issue, many States have issued conflicting orders and notifications during the pandemic, leading to litigation between the government, private schools and parents. This is why a clear law regulating private school fee hikes is required, along with an effective grievance redress mechanism in place for parents to report violations by private schools.

Despite guidelines by NCPCR that *the best interests of the child* should be kept in mind while dealing with any conflict between the school and parents, 35 per cent parents reported that access to online classes were blocked in their child's school for those children who were unable to pay fees. In addition, 22 per cent stated that their child was insulted over non-payment of fees. These findings are indicative not only of poor enforcement of regulation but also of the regressive attitude of schools towards the very children they are supposed to nurture and support.

While only 40 per cent parents of children in primary grades (1-5) reported that their child's school had reopened, the figure for children in grades 6-9 wass 62 per cent while for grades 10-12, it was 70 per cent. This finding is consistent with school reopening in most States which have prioritised reopening for older children.

For instance, Odisha[clix] has allowed reopening for classes 6-7 but not for junior classes. In West Bengal,[clx] physical classes

have only started for secondary and senior secondary students while remaining closed for middle and junior sections. A State-wise analysis of reopening is available in Annexure C.

Broadly 15-30 per cent private schools are still reluctant to reopen, despite government guidelines around the same. This could be a combination of the school's own lack of preparedness as well as anxiety amongst parents about sending children back to school, as evidenced by media reports.[clxi]

Our survey also found that there was *little attention being given to children with regard to helping recover the learning deprivation of children that has come about during the lockdown.* A focus on assessing their current learning levels and leading remedial programmes is missing. The study also found that while children are enjoying interacting with their classmates after resumption of physical classes, they are also struggling to follow what is being taught in class, an outcome of prolonged school closure.

Around half the parents in this study reported that COVID-19 protocols were being followed in their school which includes the school being sanitised prior to reopening and teachers and staff have been vaccinated. However, only a third of the parents reported that schools are conducting thermal screening of students at the time of entry and only 30 per cent reported that classes are operating with reduced capacities.

In schools that have reopened, the emphasis on following COVID-19 protocols (while not very high), appears to be much stronger than addressing the learning deprivation that children have experienced due to prolonged school closure.

UNICEF guidelines[clxii] on effective reopening stress the need to conduct rapid assessments of children's learning levels as they return to school, in order to design effective remedial programmes. Unfortunately, only 14 per cent parents reported that their child's school assessed their child's current learning level as they returned to school.

Multiple studies[clxiii] have shown that children have suffered a learning deprivation due to the prolonged school closure, making it difficult for them to follow the current year's syllabus. Therefore, it would have been crucial for schools to help children catch-up through revising last year's syllabus. However, fewer than 10 per cent parents shared that their child's school was doing such a revision, to help them catch up.

It should have been imperative for schools to understand the current learning level of students and adapt the curriculum and teaching to help them get back on track. Given that fewer than 10 per cent private schools are doing this, children are likely to struggle with following what is being taught in class, which will further increase the burden on parents to provide/pay for additional learning support. This will widen the already existing learning disparities between children from high income and low-income groups.

According to a survey by CRY,[clxiv] released after a year of the pandemic, two in five children reported experiencing trauma and missing interactions with their friends in school. Given the mental health needs of children, particularly vulnerable children, it is heartening to see that around half the parents in this survey report that their children are enjoying interacting with their classmates in school.

At the same time, around half the parents reported that their child had a reduced attention span to sit for long hours. With the pandemic-led shift to online modes of learning, there are concerns over the attention span of students.[clxv]

Furthermore, given the challenges that children faced in accessing digital learning and the lack of revision of last year's curriculum by the school, around two in five parents reported that their children were finding it hard to follow what was being taught in class.

On the positive side though, parents also reported that their children were finding it easier to get their doubts cleared better than during online classes. At the same time, over 20 per cent parents reported that their child was getting learning support from peers and finding it easier to get access to new learning materials. We also found that 19 per cent of the respondents said that it is easier to get access to new learning materials in physical schools then it was during online learning. This offers some hope for catch-up learning.

The fear of the virus remains prevalent with close to 40 per cent of parents reporting that their children were anxious about being infected. In cases where schools have reopened, 27 per cent parents are still not sending their child to school. Of the parents not sending their children to school, the dominant concerns pertain to children getting infected and the fact that children haven't been vaccinated yet.

Around one in three parents were concerned that social distancing norms were not being followed in school, and there were no safe transportation options. An additional concern of

parents regarding COVID-19 preparedness is that their child's school hasn't been sanitised yet. This is in line with multiple media reports that have highlighted that post-pandemic, parental anxiety is keeping a rising number of children away from physical classes.[clxvi]

However, all concerns don't pertain only to the preparedness of the school in following COVID-19 protocols. The prolonged school closure, which was the 4th longest in the world, has had an impact on children's own interest and engagement with learning. *Around one in five parents reported that their child was not going to school because s/he had lost interest in studying.* There was some variation across income and social groups, while this figure is 9 per cent for parents whose income is greater than Rs 80,000 per month, it is over 20 per cent for parents from STs, Other Backward Castes and those earning less than Rs 20,0000 per month.

The lack of interest could be due to a greater gap in learning for children from economically and socially marginalised groups, due to learning moving online during the pandemic. Various reports have highlighted that prolonged school closure, along with the economic impact of the pandemic, is likely to lead to an increase in dropouts and a rise in child labour. This is borne out by the Oxfam survey as well. Over one in five parents earning less than Rs 20,000 per month reported that they were not sending their children to school because the children had to help their family financially.

This finding contrasts with the ASER survey which shows no change in the proportion of children enrolled in schools.[clxvii] While children's names may potentially have remained enrolled

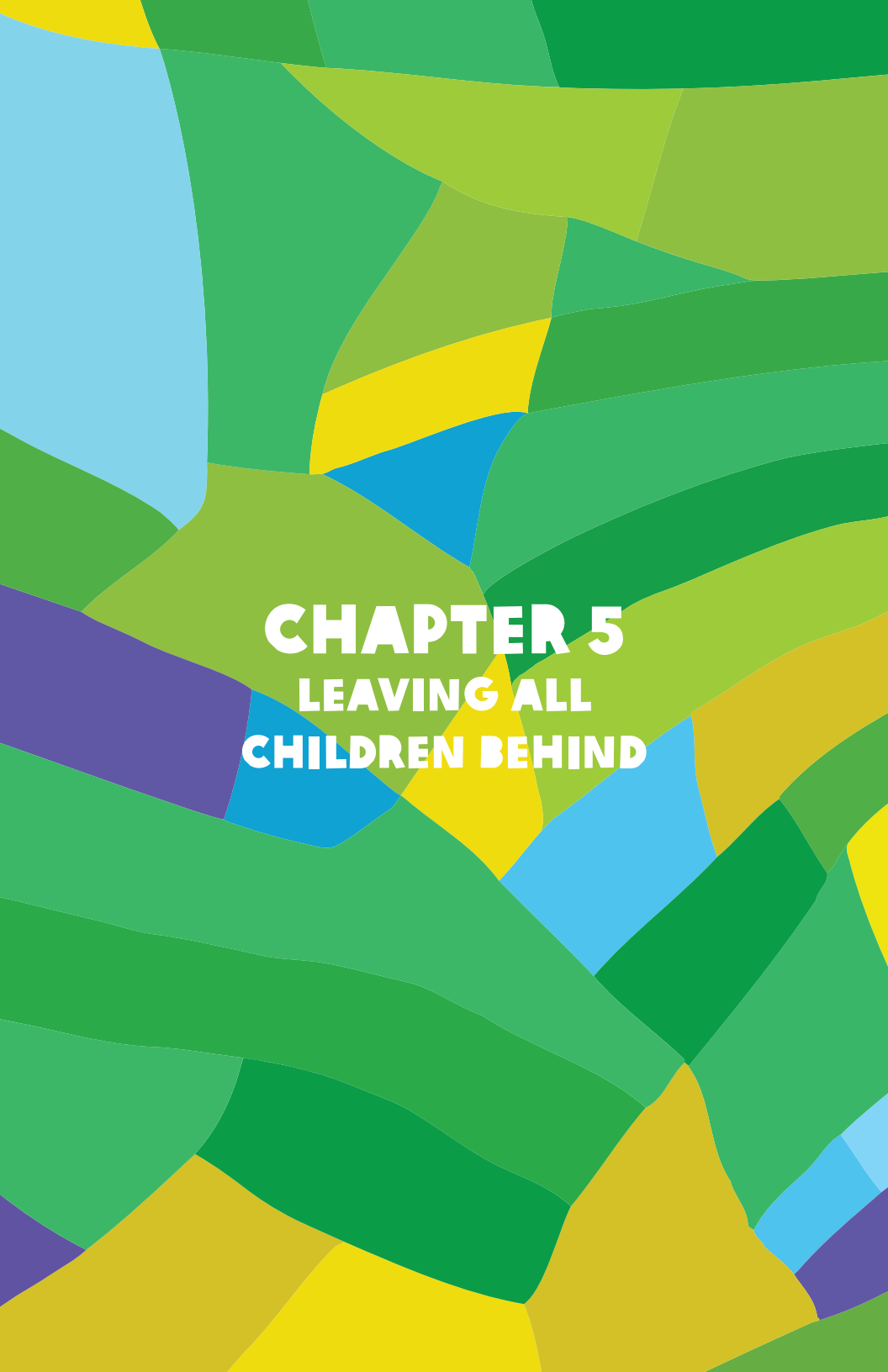
in school, many appear to have, for all effects and purposes, dropped out.

Of those parents whose children's schools haven't reopened yet, an overwhelming majority (80 per cent) wanted schools to reopen. While multiple States have reopened schools, reopening has been partial in nature wherein schools have opened only for specific classes and online classes have remained an option, for those who want to avail of them. The Omicron scare has also contributed to speculation about schools being closed again.

It is time for India to have a well thought-through policy for disaster preparedness and have mechanisms in place to ensure uninterrupted education for its children. This is especially the case given the evidence that children and teachers have all struggled with learning and teaching virtually during the pandemic.

Conclusions

The pandemic has served to highlight that private schools, if left unregulated, will continue to profiteer and exploit parents. There are issues of parental voice not being respected in decision-making, harassment of children, poor quality of education and a lack of transparency in functioning, all of which need urgent attention.



CHAPTER 5
LEAVING ALL CHILDREN BEHIND

In 2021, Oxfam India's Advocacy and Education Team undertook its second school survey of government schools which looked to the future focussing on the experience of teachers, parents and children at the moment of reopening of schools post-Pandemic. It particularly focussed on the perspectives of teachers who have been silent COVID-19 warriors – teaching students, serving as frontline workers to combat the pandemic and facing their own challenges on the home front as well as being involved in non-teaching work like elections during the pandemic.

The COVID-19 pandemic has been the worst shock to India's education systems in a century. India's 32 crore students in the world's second largest education system have faced the world's fourth longest school lockdown.[clxviii]

Last year, at the peak of the pandemic, 64 per cent of children in rural India feared they will drop out without additional support.[clxvix] Those absolutely worst fears may not have been borne out, but the educational scenario has been grim. Schooling moved online despite the fact that barely 15 per cent of rural households had an internet connection at the start of the pandemic; 96 per cent of SC and ST households lacked a computer.[clxx]

The result was psychological trauma, loss of psychosocial support for those already vulnerable and unaddressed

classroom hunger and learning loss. The vast majority of children (92 per cent) lost at least one specific language ability from the previous year.[clxxi] It is estimated that school lockdowns would cost India in future earnings.[clxxii] The likelihood of dropout increased with decreasing wealth quintile and hit Dalits, Adivasis and Muslims worst.

Studies have estimated that 52 per cent of girls felt that their time for studies decreased and 42 per cent experienced an increase in domestic workload.[clxxiii] During the pandemic, several surveys have reported higher levels of perceived learning decrease by about 20 per cent for every additional hour of time spent by children on domestic chores.[clxxiv] However, schools are reopening now. As such, it is important to focus on the experience of teachers, parents and children at the moment of reopening of schools, to learn from them and to plan for the future.

Methodology and Data Collection

A total of 3,876 respondents participated in the survey, including 1,406 parents, 1,557 children and 913 teachers, from across 11 States. Boys and girls are equally represented in the survey. Data from parents and children was collected offline in six States – Bihar, Chattisgarh, Delhi, Jharkhand, Odisha and Uttar Pradesh.

Different sets of parents and children participated in the survey. That is, if a child was interviewed, then their parents were not interviewed and vice-versa. The questionnaire was designed by the Oxfam India Education Team.

An effort was made to include the most marginalised groups in

the survey. Government teachers participated in the survey by filling the form online, which affected the representativeness of the sample, given that only teachers with the technical know-how and motivation to fill the form, participated in the survey.

Responses from teachers were received across 11 States including Assam, Bihar, Chattisgarh, Delhi, Haryana, Jharkhand, Madhya Pradesh, Odisha, Punjab, Uttarakhand and Uttar Pradesh.

Data Analysis

As with other studies, the data for this study too consisted of simple percentage analysis performed in Microsoft Excel.

Results

Analysis shows that 89 per cent of our sample belonged to rural areas, and 71 per cent earned less than Rs 10,000 per month. As such, the data has not been disaggregated, based on rural-urban and family income. The break-up by social groups is 30% STs, 30% SCs, 27% Other Backward Castes, 8% Muslim and 4% General.

ATTENDING SCHOOL

Most (80 per cent) of the teachers, children, and parents across 11 States said that their school had reopened. Of the 6 States where parents and children were interviewed, only 9 per cent children were not going to school even after reopening. Fewer girls were returning back to schools after reopening as compared to boys. Combining the responses of parents and children, 12 per cent girls were not attending school after reopening as compared to 7 per cent boys. We

also found that 41 per cent Muslim children were not attending school after reopening.

The Oxfam stydy reiterates that marginalized communities are lagging in terms of their participation in education. Furthermore, there are continued concerns about attendance of children. Less than 50 per cent children are attending school six days a week. Majority of the teachers have reported that average attendance on any given day is less than 75 per cent. This appears to be below the average pre-pandemic rates (68.5 per cent and 75.7 per cent in primary and upper primary levels respectively).[clxxv]

DIGITAL LEARNING

In cases where schools have reopened, physical class in school is the main mode through which children are accessing learning, as reported by around 75 per cent of the parents. Close to 50 per cent children whose schools have not reopened, are still dependent on learning through digital means, as compared to 11 per cent for whom schools have reopened. For children in Jharkhand whose schools have not reopened, learning through digital means was relatively lower than the average, at 23 per cent.

Given the prolonged school closure, parents appear to have hired tuition teachers to ensure learning continuity for their children. Over 40 per cent parents, whose children were not attending school, said that they accessed learning through a physical class led by a tuition teacher. However, the figure is less than half (17 per cent) for SC children, indicating that while more privileged social groups were able to purchase additional learning support during the pandemic, much fewer

marginalised children could access the same support, which is likely to increase educational inequalities.

The percentage of children who get tutored fell to 25 per cent overall, for those who attend school physically; the figure for girls is marginally lower at 23 per cent. This is close to the figure reported in NSS 2017-18 which pegged the number at 21 per cent. One can, therefore, see the reliance on tuition teachers as a temporary coping mechanism on the part of parents to address the absence of teacher-led learning opportunities. A detailed breakdown of modes of accessing learning is available in Annexure D.

The single biggest reason for both parents and children, for not going to school is the fear and anxiety of getting infected, with 59 per cent children and 71 per cent parents reporting this. However, beyond the fear of the infection, lie issues that have emerged due to prolonged school closure. *Over two in five children have shared that they had lost interest in studying and don't want to go back to school, a concern that various surveys during the pandemic have raised.*

Around 40 per cent children who were not attending school said that they needed to help with household chores and support the family financially. Interestingly, less than 10 per cent of the parents admitted that their children were not going to school because they were working, as opposed to 38 per cent children saying this; this figure is 47 per cent for children from SC, ST and Other Backward groups.

The lack of COVID-19 preparedness (no sanitisation of school), non-vaccination of all teachers and staff, and social

distancing not being followed in school was listed as a reason for not attending school by over a third of the children.

A third of the children not attending school said that their school was far away and they lacked access to safe transportation to go to school *while 29 per cent parents said that their children were married off during this time, and therefore can't go to school.* The latter is an alarmingly high share, especially given that this only includes children in grades 1-8.

COVID-19 PROTOCOLS AT SCHOOL

Roughly half parents and children report that everyone is wearing masks and being asked to sanitize their hands before entering school. Two in five parents and children report that children/teachers with symptoms were asked to go back, teachers provided orientation on COVID-19 protocols and classes are operating with reduced capacities. Less than 20 per cent parents and children reported that temperature check is being done of everyone entering school, which could possibly be due to a lack of equipment to measure temperature.

EDUCATION DEPRIVATION

Over two in five parents and children reported that regular curriculum was being followed in the school. This is problematic given that multiple studies[clxxvi] have pointed out the large-scale learning deprivation of students due to prolonged school closure. Various experts and the Ministry of Education's own guidelines have pointed out the need to assess children's learning levels after resumption of school, and to adapt the curriculum accordingly. However, in less than a third of the schools, were children's current learning levels assessed after reopening.

Further, fewer than 30 per cent parents and children reported that last year's revision was being done to help children catch up. Just 27 per cent and 23 per cent of parents respectively said that assessment and revision were being done.

Mid-day meals have resumed in only 39 per cent schools, despite the Centre's guidelines to States asking them to resume provision of hot cooked meals for children attending schools.[clxxvii] Physical games and outdoor activities have also resumed in only 33 per cent schools, a detailed tabulation of activities inside schools is available in Annexure D.

Given that schools have resumed after over 500 days of closure, it would have been crucial to implement an accelerated learning programme to help recover the learning deprivation suffered by children. However, the previous section shows that a catch-up programme/ revision is happening in less than a third of the schools. As a result, two in three children report that they are struggling to follow what is being taught in class. Failure to capture learning levels and needs and revise the curriculum accordingly would be contributing towards this trend.

According to a survey by CRY,[clxxviii] released after a year of the pandemic, two in five children reported experiencing trauma and missing interactions with their friends in school. The fear of being infected is still prevalent with over a third of the children saying that they are anxious about being infected. This could be one of the reasons behind the irregularity of attendance reported by teachers, parents and children alike.

In addition to interacting with classmates, there are three

clear positives related to learning that have emerged due to reopening – children are getting learning support from peers, they are able to get doubts cleared much easier now and they are also finding it easier to get access to new learning materials.

The biggest challenge being faced by children who are attending school as well as those who are not, is that they are struggling to follow what is being taught in class, an implication of the prolonged school closure during which children's access to learning has been interrupted; three-fourth of children whose schools are closed/not attending physical classes are struggling to follow what is being taught.

Over half the children who were not attending physical classes in school, faced the challenge of not having the right device or having to share the phone with other family members, a finding that various other studies such as SCHOOL and ASER have highlighted.

A related challenge is that of not having internet access or having internet that is too slow to learn online, which was faced by over a third of the students who were not attending school physically. One-fifth of the students struggled to ask questions in online classes, indicating that the issues with digital learning are not restricted to access alone but also with pedagogy.

Given the limitations of the digital medium, children were forced to receive information passively, with little opportunity to get doubts cleared. This could be one of the key reasons as to why children were struggling to follow what was being

taught. Around half of the students not attending school were not getting time to access education because they had to help with household chores. For students who were attending physical classes in school, this figure was much lower, at 25 per cent. This highlights the importance of the school as a dedicated space for children where they can learn and interact with teachers and friends without being interrupted to help with household chores and care work.

TEACHERS' COVID-19 EXPERIENCE

Over 70 per cent teachers said that children hade forgotten what they had learnt previously; in Bihar and Jharkhand this figure is 77 per cent. This is consistent with various surveys during the pandemic. In addition, *prolonged school closure had also reduced the attention span of children,* an issue flagged by 73 per cent teachers.

A related finding is the challenge flagged by two in five teachers of not being trained/equipped in addressing a full year's learning loss of students. Almost a third of teachers (73 per cent) said that attendance of children was not regular, a finding that is consistent with parents and children's own responses and requires attention from the government to bring all children back to school and ensure that they attend regularly.

Over two in five teachers claimd that they had to do twice the work – teach online as well as offline; in Haryana, this figure was substantially higher at 68 per cent. Since various States have made physical classes only optional, this means that teachers have to continue delivering classes online for those not attending school physically. Over two in five teachers

were facing challenges in ensuring adherence of children to COVID-19 protocols because of teacher shortage. Further, 36 per cent teachers argued that the government/s had not sanctioned adequate budgets to ensure that the school adheres with COVID-19 guidelines.

Only 54 per cent said that their school was equipped with adequate resources to ensure COVID-19 protocols were met. Less than half of the teachers said that they received adequate monitoring and support to ensure compliance with COVID-19 protocols. In addition, only 48 per cent teachers said that they hade access to doctors/medical facilities to provide emergency care.

GETTING CHILDREN BACK TO SCHOOL

Close to half the teachers did not receive any training on supporting emotional needs of children and getting children back to school. Both these areas would be crucial to ensure educational recovery and help children attend school regularly. Less than half the teachers believed they were adequately prepared to address concerns of School Management Committees (SMCs) and communities about reopening of schools.

While crucial, over 50 per cent teachers believed they had not been trained adequately to address the learning deprivation of students; in Madhya Pradesh, 66 per cent teachers reported this as compared to 24 per cent in Jharkhand. In this survey, children as well as teachers had flagged that the biggest challenge after reopening was that children hade forgotten what they had learnt previously and were struggling to follow what was being taught in class.

Over 60 per cent teachers had not received training on maintaining hybrid teaching – with some classes being taken offline and others online. Further, over 70 per cent had not been provided the necessary equipment and data to conduct online classes.

Teachers were in the frontline of the COVID-19 response and were also involved in non-teaching work like elections during the pandemic. In the present study, 9 per cent teachers reported that their colleague/s passed away while on special government duty, such as election duty, during the pandemic. This figure comes amidst media report of over 1,621 teachers dying in UP[clxxix] during the Panchayat elections. Karnataka lost 268 teachers to COVID-19 in 2020.[clxxx] Clearly defined measures are needed to protect teachers in emergency settings.

It is doubly unfortunate that with regard to compensation, a mere 10 per cent said that compensation had been sanctioned and received by the family while 23 per cent said that it was still in process, 23 per cent were not aware and the remaining (43 per cent) said that no compensation had been received. Close to three out of every four (70 per cent) teachers were not satisfied with the compensation provided to families.

Conclusions

As the process of school reopening continues across different States, the government must take this opportunity to mitigate the risks of dropout, learning deprivation and mental health issues that will arise due to the world's fourth longest school lockdown. As this study shows, while children are coming back to school, they are facing anxiety and struggling to follow what is being taught. At the same time, a large percentage of

children from marginalised communities including girls and Muslims are not coming back to school.

Multiple studies have warned that this prolonged school closure will lead to large-scale dropout, affect future earnings and erode the educational gains made in the past decade.

CHAPTER 6
A VIOLENT PANDEMIC WITHIN WALLS

In 2021, Oxfam India's Gender Justice Team undertook an exploratory study to understand the experience of violence faced by women in the context of the COVID-19 pandemic in Patna. The study was undertaken as a response to the new emphasis on Gender Based Violence (GBV) faced by women in the context of lockdowns and the COVID-19 pandemic.

Background

WHO has long acknowledged that all forms of VAW including sexual violence, human trafficking, coerced sex work, child labour under duress, girls dropping out of school and destitution increase in the aftermath of all humanitarian crises. Studies suggest that natural disasters disproportionately affect women and girls as they are at greater risk of violence and exploitation than men and boys in the face of destruction of housing, breakdown of traditional support structures, and disruption in access to services, food, relief, supplies, and toilets.[clxxxi] Women's experience of violence during crises is further exacerbated by existing structural and systemic inequalities.

In this context, the COVID-19 pandemic and associated public health lockdowns have had a familiar yet unprecedented impact on women around the world because of disruption of social and physical environments. Several media reports highlighted an increase in DV in various countries in the months following the global outbreak of the pandemic.[clxxxii]

Chinese and European activists, for example, have raised alerts that Domestic Violence (DV) has increased almost threefold since the coronavirus outbreak.[clxxxiii] In US, multiple States reported an increase of 21-35 per cent in DV in March 2020.[clxxxiv] A report in *The Guardian* similarly drew attention to increase in DV by 20-40 per cent across the world – from China to Brazil – because of lockdowns imposed to curb spread of the virus.[clxxxv] In view of this, WHO released a document in April 2020, titled 'COVID-19 and VAW: What the health sector/system can do', taking cognisance of increase in VAW during the pandemic. It underlined the pandemic's impact on women's health, ranging from physical and mental health problems to unplanned pregnancies.

The document also discussed the various reasons which might have increased the risk of violence for women including mental stress due to potential/actual loss of livelihoods, punctured access to basic services, disruption of formal and informal support mechanisms and networks, lockdowns which pushed women inside homes along with their abusive partners and increased proximity between family members, social isolation, increased care work, closure of schools, and misuse of COVID-19 restrictions by perpetrators of abuse to exert control over women and curtail them from accessing help or psychosocial support.

This, the document stated, might be further exacerbated by scaling back of services like helplines, crisis centers, shelters, legal aid, and protection services, and reduced mobility options for women, severely curtailing women's access to formal and informal help.[clxxxvi] The United Nations also recognised the rising VAW during the time of COVID-19 lockdown as a 'shadow

pandemic'. This kind of acknowledgement brought attention towards the issue of violence faced by women, especially DV, which was already at epidemic proportions prior to the onset of the COVID-19 pandemic.

In India, the strict and sudden nationwide lockdown in March 2020 led to a significant increase in the incidence of DV, harassment, and dowry abuse as many women were trapped at home with their abusers, without access to support services.[clxxxvii] The National Commission for Women (NCW) reported a surge in complaints by women facing violence in the period immediately after the lockdown, according to official data.[clxxxviii] Between March 25 and May 31, the NCW received 1,477 complaints of DV, half of which were received on NCW's WhatsApp helpline which was set up in April for women who could not access emails or make complaints by post.

The total complaints during the 68-day lockdown period were 1.5 times the total complaints received between March and May in the previous year, 2019. The NCW and women's rights activists also found that several women who were facing violence at home were unable to receive help due to increased proximity with abusers and limited access to support services. Services are especially poor at the sub-district level, and most had closed down.[clxxxix]

The shift of GBV services to online and phone-based systems[cxc] also raise critical questions of access and confidentiality of survivors of GBV.[cxci] As a result, as NCW noted, although DV increased, majority of survivors could not officially report it (Gupte and Zahan 2021).[cxcii] However, no systematic study has been conducted on this so far.

The data captured by NCRB is an unreliable indicator because it depends on women's access to the police stations. Civil society and women's organisations and the National and State Commissions of Women have documented the challenges women faced in accessing support services due to limited mobility of women as well as of staff, during the lockdown period. The social, economic and psychological impact of the pandemic on poor and marginalised women, girls, and gender and sexual minorities (LGBTQI), especially the transgender community and sex workers has been substantial.

The COVID-19 crisis and the subsequent lockdowns also led to immense loss of livelihood and, in turn, mass hunger and starvation amongst vulnerable communities, hardship, and consequently rising interpersonal tensions. Data is meagre when it comes to issues of livelihoods but there is much lesser reliable information when it comes to VAW, the factors which may protect or increase women's risk of violence, women's coping mechanisms and help-seeking behaviours, *functioning of redressal services for victims of violence,* and women's expectations for preventing and addressing the violence during a crisis.

In fact, there is not much research available in India regarding the experience of women following any crisis situation with a few exceptions such as Madhuri's study on impact of 2013 Bihar floods[cxciii] and more recently, qualitative studies on impact of COVID-19 on women such as Roy, Sen and Bagchi (2021)[cxciv] and Chakravarthy (2020).[cxcv] Currently, the dominant policy response tends to overlook the gendered aspects of crises, leaving women more vulnerable to harm. VAW response and prevention is considered as long-term

development work and not viewed as important to respond to any crisis.[cxcvi]

Given this background and as part of OXFAM's humanitarian response work to the Bihar floods of the Kosi river in 2019, it was observed that the context of Bihar's urban spaces in Patna, particularly slums, are significantly different from its rural spaces.

For instance, one of the main issues that women shared with volunteers in OXFAM's urban settlements programme, during the floods was that they did not have access to toilets. Community toilets had become dysfunctional due to waterlogging and women were forced to go towards railway tracks to relieve themselves, which they did not wish to for reasons of safety.

Women also shared experiences of DV with the volunteers during the time of floods and they attributed the violence they faced to the scarcity of resources at home. Unlike rural areas, where there is some open land, urban informal settlements have acute space crunch and therefore, maintaining norms of physical distancing during COVID-19 period has been an issue of grave concern for these women.

OXFAM's Gender Justice Team undertook this study to understand Patna slum-dwelling women's lived experience of violence and its multi-dimensional nature, with the objective of guiding future programmatic interventions in the area.

Methodology and Data Collection

Informed by feminist principles of social justice and equality and an intersectional approach, this exploratory study

adopted a qualitative research methodology to capture in-depth data on women's experience of violence during the COVID-19 pandemic.

Qualitative data was collected from six purposively selected informal settlements in urban Patna – Kaushal Nagar, Yarpur Band Gumpti, Mestarpara, Bahadurpur, Saidpur and Gausnagar. These settlements were selected based on them being identified as 'intensively affected' by the 2019 floods by the OXFAM programme team and share similar demographic and geographical characteristics. An extensive literature review was also conducted, and all research instruments underwent an ethical review from domain experts.

Focus Group Discussions (FGDs) were conducted in Patna in-person by trained facilitators in July 2021. Key Informant Interviews (KIIs) were conducted in August and September 2021, using a mix of telephonic and in-person methods.

Informed and voluntary oral consent was obtained from participants at the start of every discussion and interview. Participants were informed about the research, its process, design, information storage and use, anonymity and confidentiality, along with referrals for helpline numbers and support. All recorded data was treated as confidential and anonymous.

Facilitators who had previously worked in these communities and spoke the local language were engaged to establish greater trust among participants. A total of 12 FGDs (each lasting between 30 to 50 minutes), six each with groups of 6-7 young women (18-30 years) and 6-7 older women (30 years

and above), from the 6 settlements were conducted in order to understand the different forms and impact of violence faced by women in 'normal' times as well as in the aftermath of the COVID-19 pandemic.

The discussion guide for FGDs was simple and easy to understand, facilitators shared contextualised vignettes with the participants at the beginning of each discussion, to set the context of the discussion to the first lockdown and the hardships it entailed.

These vignettes helped respondents open up about real cases they had experienced or heard of, aided in recalling the experience of the first lockdown, and sparked a discussion on challenges they faced. The broad information areas covered by the FGDs included the following:

- The social context of lockdowns, loss of work, increased unpaid care work, space constraints for physical distancing or isolation, and overall impact of COVID-19 restrictions on women's lives
- Impact of COVID-19 pandemic on direct forms of violence (DV, public harassment, sexual abuse) and its reasons
- Challenges in accessing basic services – ration and nutrition facilities, childcare facilities, sanitation facilities, health care and SRH services
- Women's coping mechanisms and help-seeking behaviours (formal and informal)

- Relief received during lockdown (from government and non-government sources)

- Expectations during a crisis – what would have helped; what facilities were expected

The study aimed to recognise how research itself can be a site where power plays out between researchers and participants and as such made attempts to keep discussions as participatory as possible – enabling women to voice their emotions and apprehensions as openly as possible.

KIIs sought to gather information on VAW during 'normal' as well as crisis situations, its impact, help-seeking behaviour of the victim-survivors, presence and efficacy of support/ redressal mechanisms, and factors which increase risks of violence.

In addition to the FGDs, a total of 16 KIIs were conducted with the following stakeholders:

TABLE 35 KII RESPONDENTS

STAKEHOLDER	KIIS	MODE
WOMEN'S RIGHTS ACTIVISTS/NGO LEADERS IN PATNA	2	TELEPHONIC
WOMEN COUNSELLORS AT POLICE STATIONS	2	IN-PERSON
PWDVA PROTECTION OFFICER/ WOMEN'S HELPLINE IN-CHARGE	1	IN-PERSON
WARD COUNCILLORS', PATNA MUNICIPAL CORPORATION	2	TELEPHONIC
ANGANWADI SEVIKAS/WORKERS	3	IN-PERSON + TELEPHONIC

STAKEHOLDER	KIIS	MODE
ASHA WORKERS	1	IN-PERSON
HEALTH PRACTITIONERS (FLWS OTHER THAN ASHAS)	2	TELEPHONIC
OXFAM PROGRAMME STAFF MEMBERS/ GENDER EXPERTS	3	TELEPHONIC
TOTAL	16	

Local and community leaders like the Ward councillors and Anganwadi workers provided an acute understanding of local context and the hardships that women in the slums faced during the COVID-19 pandemic. These interviews also validated the data collected through FGDs.

Women's rights activists/NGO leaders who supported women during crisis situations and Oxfam staff members who have been involved in these communities since the 2019 floods helped in nuancing these findings and understanding how the violence that women face during crisis interacts with other factors such as food security, unpaid care work, job losses, and public infrastructure.

Interviews with police counsellors and PWDVA Protection Officers further helped in triangulating and validating information regarding reporting and incidence of VAW and the support structures available to aggrieved women, their efficacy, and the challenges therein. Finally, interviews with healthcare practitioners including a health rights activist, a district hospital OB-GYN, and an ASHA worker threw light on specific problems with respect to healthcare delivery, SRH and family planning services during the pandemic.

Data Analysis

Qualitative data collected from the field was transcribed and translated for data analysis. The FGD data was first categorised and coded into different themes to identify overall trends. While the broad mandate of the project was to explore VAW, narratives of a wide-ranging experience of violence in the form of denial of entitlements, lack of access to civic infrastructure, and lack of support systems also emerged starkly on the field. As a result, an inductive coding method was adopted at this stage to capture the various themes and nuances in women's experience of violence during the pandemic.

The preliminary findings at this stage were used to inform and adapt the KII questionnaires for each category of respondent to validate findings, plug data gaps, and gather more information. Subsequently, the KII data was categorised and coded thematically, using a deductive coding method and the categories that emerged through FGD data. FGD and KII data under each theme was then further categorised into emergent sub-themes.

The analysis was informed by established frameworks such as Lori Heise's ecological model.[cxcvii] An ecological framework aids in understanding the interplay of personal, situational and socio-cultural factors that cause or contribute to VAW. Conceptualised as four concentric circles, it focuses on different levels of the social environment–personal/individual; family/household; community/institutions (formal and informal); and the macrosystem (laws, policies, and cultural norms).

Although the ecological framework has gained broad acceptance for conceptualising VAW and has influenced research and programming for more than a decade, it is important to think about how the risk factors from different levels relate to each other and influence women's vulnerability to violence. Keeping this in mind, care was taken to ensure that the ecological framework did not limit our analytical categories and strategies, but only served as a starting point to organise and unpack the data.

Following this, the data was interpreted to identify trends and outliers and to establish meaningful relationships between different categories such as loss of jobs, experience of DV, increase in care work, loss of mobility, access to healthcare, access to recourse systems, coping mechanisms and so on. The analysis also drew from literature on 'vulnerability mapping' to identify the risk factors that disempower women in crisis situations. A careful reading and re-reading of the transcripts and the coded data enabled us to capture women's lived experiences. The narratives from the transcripts are anonymised and incorporated throughout this chapter.

Findings

Across all the FGDs and KIIs conducted for this study, economic hardships and loss of livelihood emerged as the biggest challenge of the COVID-19 pandemic for women living in Patna's slums. This loss of livelihood and income had a cascading effect on women's lives ranging from food security and deepening of debt cycles to increase in DV, loss of decision-making power, and change in food habits.

The experience of India's two lockdowns for both men and women living in slums have been different. As one of the experts interviewed for this study succinctly put it, 'while during the second wave people died and suffered because of the disease, in the first lockdown people suffered because of the lockdown itself'. The first lockdown saw a complete closure of services which caused extreme loss of livelihoods and incomes. During the second lockdown, the restrictions were partial, several industries were open, and transport facilities were functional even though the disease was more widespread and severe this time.

However, as we will see in this section, the economic setbacks that people experienced because of the first lockdown were **long-term** in many ways. Though a large-scale systematic study on this is missing, qualitative data from this exploratory study suggests that the decline in quantum of work and wages particularly for informal workers has persisted even a year-and-a-half after lifting of the first lockdown.

IMPACT ON DOMESTIC WORKERS

Reeta Devi* from Yarpur Mestarpara, for example, was working as a domestic worker when COVID-19 started spreading in India. After the imposition of the first lockdown, her employers told her not to come to work until the lockdown was completely lifted. Her husband also lost his job. In her case, her employers paid her partially through the lockdown period so that she could manage buying food for the family.

However, not everyone was treated as fairly as Reeta. Across all the slums, women who worked as domestic workers were dismissed without pay because of lockdown restrictions, and

because the employers feared that they would catch COVID-19 from the women.

Sanjana Devi* from Yarpur Band Gumpti, for example shared that the place where she used to work as a domestic worker accused her of having COVID-19 infection and fired her summarily.

It's been more than a year since then and she hasn't found another job yet. Her husband and her son also lost their jobs because of the pandemic. Similarly, Sarita Devi* in Bahadurpur (30 – 50 years age group) lost her job during the lockdown as a domestic worker. Even households where she had been working for 20+ years refused to pay her until she started coming to work again. As a result, she used up all her savings to arrange food. Eventually, she returned to work when restrictions eased but she had to take an advance on her salary because she didn't have any ration at home.

Domestic workers are often paid in cash at the end of the month. What was also unfortunate was that the lockdown was announced towards the end of March, as a result of which, they were denied salary even for the work they had already done. Consequently, they had to dip in their limited savings to get by. Preeti Devi * for example shared:

> *It was 4-5 days before month-end (first lockdown). Mahamari fael gayi (the pandemic spread). They used to pay me Rs 3200 per month. They deducted Rs 1600. They said I didn't come in to work. But I told them you told me to not come. Then how is it my mistake. And yet they deducted money. Another place was paying me Rs 2500. I didn't*

work there for an entire month during lockdown but they paid me in full nonetheless. (Bahadurpur FGD)

Several reports and small-scale studies in the past year have revealed that domestic workers were among the worst affected during the lockdowns.[cxcviii]

Surviving on little to no wages for months with meagre government support, many domestic workers fell down the economic ladder during the pandemic. According to a survey conducted by IWWAGE, 60 per cent of the 797 domestic workers interviewed did not receive wages during the lockdown periods and 12 per cent were fired.[cxcix] Further, even after more than a year since the first lockdown, studies have documented that wages earned by domestic workers have sharply declined either because they are being employed in fewer households and for fewer hours (ibid).

A Ward Councillor, interviewed for this study, explained this rather presciently:

Women were very troubled by the pandemic. They lost their source of income. Kyunki ye chua-choot ka beemari hai. And so, the women who used to work in big houses for sweeping, mopping, washing utensils, cooking food – they were made to leave that work. People said you can't come to work because we will get corona through you. But it was the opposite… As per the information I received, when women from slum areas resumed going to work in the kothis, the people who lived in those houses were (COVID-19) positive and through them, women in slums tested positive. And once they tested positive, their children and all their family members tested positive. (Ward Councillor, Patna, KII)

The pandemic thus re-enforced practices of untouchability in an already divisive society and exacerbated social and economic violence faced by domestic workers. Domestic workers were being caricatured as carriers of disease and were removed from their jobs without notice, even as national leaders continued to urge people to pay their domestic workers during the lockdown.

Narrative evidence from this study suggests that domestic workers are now employed for half the time that they were employed for, prior to the pandemic, resulting in a significant drop in wages, even though inflation has increased considerably in the last one year. This has meant that the economic hardships spurred by the first lockdown have continued even 18 months later for women from marginalised backgrounds.

IMPACT ON SMALL INDUSTRY INFORMAL WORKERS

Women living in Patna's slums also lost their livelihood because of lack of public transport facilities to go to work and due to sanctions imposed by police on any physical movement. As one woman from Bahadurpur put it, 'we couldn't step out even on the road because the police would beat us, then how could we earn?' another woman explained her circumstances thus:

> *Agar koi taash khel raha, toh police unko maar rahi hai ki lockdown hai. Bahar jayenge tabhi toh kamayenge na (if someone was playing cards, the police would hit them that there is a lockdown. We will earn only when we will step out). (Bahadurpur FGD)*

Nivedita Jha (Bihar Mahila Samaj) also shared how *the police harassed even those informal women workers who had permission to go to work and would instead punish them publicly, displaying state-sanctioned violence.* In her narrative, women who were going to their workplace were made to perform 'sit-ups' while holding their ears at an intersection. Since March 2020, instances of police brutality to enforce the lockdown have come to light from all parts of the country,[cc] such violence only serves to further marginalise those already employed in unfair labour conditions such as waste pickers or those working in garbage management and as sanitation labour.

Women in the study who worked as sanitation workers and support-staff in schools, hostels, and hospitals lost their livelihoods after the lockdown was announced. Chintu Devi* from Yarpur Band Gumpti used to work in a girl's hostel until March 2020, the lockdown caused all workers at the hostel to go back their hometown, and the hostel owner refused to pay the support staff, citing the non-functioning status of the hostel. With schools and colleges continuing to deliver education online hostels have not reopened, which means that for women like Chintu, there has been no source of income for over a year.

Similarly, Priya Devi* from Mestarpara used to work as a sanitation worker in a hospital until March 2020. When lockdown was imposed, she was told to stay at home. Over the course of 15 months, she exhausted all her savings and at the time of field work for this study (July-August 2021), was still waiting to be called back to her job so that her family could 'eat properly again'.

Women who worked as vendors and home-based workers also suffered a severe setback. In Saidpur for example, many women who ran small shops or businesses had to permanently shut shop because of lockdown restrictions.

Similarly, women who worked as small vendors, ran small snack or tea stalls, or sold fish had to shut shop because of government restrictions and because people stopped (or significantly reduced) eating street food. Even with the lifting of lockdown, the situation hasn't improved. Many women lost all their savings, setting them back several years economically.

Aside from losing their own jobs, women were also confronted with the challenge of their spouses and in some cases their grown children losing jobs.

During the first lockdown, all business and commercial activity stopped – from construction work to restaurants, hostels and transport industry. As a result, men who worked as daily wagers in the construction industry, or those who plied autorickshaws, rickshaws, and vegetable carts lost their livelihoods. An increase in economic hardships pushed households into extreme poverty and marginalisation.[cci]

> *Mera ghar toh barbaad ho gaya (my home was ruined). My husband lost his job. And then he drowned in alcohol, and he hasn't come out yet. So, lockdown ruined my life. He used to work, go to office, eat well. He wasn't a cleaner. He used to handle files. But ever since lockdown, he lost his job, and started drinking a lot. (Female participant, 18-30 years Mestarpara FGD)*

What has become clear is that the economic losses had a spiraling effect on multiple aspects of women's lives – from food insecurity and poor nutrition to a loss of access to private healthcare and private tuitions for their children and an increase in mental stress.

IMPACT ON NUTRITION AND FOOD HABITS

The biggest impact of the pandemic for women in the study was a change in food habits, a loss of nutrition levels, and difficulty in basic sustenance. Women across age-groups and slums shared how it became difficult to even arrange three meals a day, since they were already living hand to mouth when the pandemic hit. While many of them received food grains from the PDS system, families no longer had adequate money to purchase vegetables, oil, spices, or basic dairy products.

> *Sabse bada dikkat khaane peene ka hua. (multiple women, FGD Mestarpara)*

> *Biggest problem was in terms of sustenance. Ration was a problem. There was no money. (FGD, Kaushal Nagar)*

> *We live in a rented house. I had to sell my anklet to buy ration for the house. These women are my neighbours. So, when they cook something, they give a little to my children also. (FGD Yarpur Band Gumpti, 18-30 years)*

> *When lockdown was imposed, we lost our work…. We didn't have enough food to eat. We ate less. Ab hum do biscuit bhi nahi kha sakte (we can't even eat two biscuits now). (FGD Saidpur, 30-50 years)*

Humko khane-peene ka bahut dikkat hua. We used up whatever savings we had to arrange food. Our business also got shut down during lockdown. (Bahadurpur FGD)

Vo jo kamate hai, vahi khate hain (They eat what they earn). So, when they couldn't earn, they faced problems. They used to cook food in other people's houses, but people refused to get food cooked because of this (COVID-19). (Anganwadi 1, KII)

The situation was very pitiable. I had tears in my eyes. One woman was pretending to make food in front of her children…She put a little rice in a wok and told her children she is giving them food. That time, I felt, if the centre had kept running, we would have been able to help somehow. (Anganwadi 2 KII)

Shital Devi* (Bahadurpur), for example, shared that she had problems in arranging vegetables and dairy because she didn't have enough money. As a result, she stopped buying milk for her young son. Another woman shared that for several months during and after lockdown, she could cook food only once a day and somehow managed in that.

Basic sustenance was such a big problem that some women sold their jewellery to sustain, relied on their neighbours to feed their children, took loans from micro-credit banks as well as from informal moneylenders at high interest rates, and at times, only ate once a day.

Often, women would use whatever food they could arrange to feed their children and their husbands and sleep empty-stomach themselves. According to a study documented by

People's Archive of Rural India, 50 per cent of the households in rural India had to reduce the number of meals since the lockdown and 68 per cent reduced the number of items in their meals to adjust to the shock.[ccii]

Studies and data sets (like the IHDS 2011 survey) have documented how women are often the last to eat in Indian families, which in resource-poor households often means that they eat less food and less nutritious food, for instance women rarely get to eat pieces of meat, just the gravy which affects protein levels.

This trend seems to have exacerbated even further during the pandemic, with an adverse effect on women's overall health and well-being. Several key informants in the study stated that during and after the first lockdown, some women even died of starvation.

One Anganwadi worker for example exclaimed:

> *Bhook se marr rahe hain log. Every 15 days or every month, some one or the other is dying. Why is that happening? Because there is no food to eat. There are no medicines. There is no one to look after them. So, people are dying frequently here.*

Studies[cciii] have shown that women, who live in households where they eat last, are more likely to be underweight than their counterparts in households where they don't eat last, across all levels of per capita household consumption. The latest round of NHFS also demonstrates that women's nutrition particularly around iron is a key area of concern.[cciv]

Undernutrition amongst women has negative consequences for their energy levels, immunity, and for maternal and new-born health. Recent research also suggests that women who eat last have poorer mental health, even after accounting for socioeconomic differences. While earlier, women would eat fish and meat once a week, eat biscuits with their tea, and give milk to their children every day, with loss of incomes many couldn't even afford pulses and vegetables. Often times, they survived on rice, water, and potatoes (KII Women's rights activist), and depended on the PDS for basic ration.

IMPACT ON INTER-PERSONAL RELATIONSHIPS (IPV)

Along with the national lockdowns, States also imposed their own-imposed intermittent lockdowns, the main outcome of these various lockdowns for women, was a locking-in of women with perpetrators of violence.

The NCW reported a significant surge in DV complaints according to official data.[ccv] The total complaints during the 68-day lockdown period in 2020 were 1.5 times the total complaints received between March and May in the previous year.[ccvi] This upward trend continued through the Unlock period. According to Roy et al (2021),[ccvii] DV increased during lockdown because of lack of freedom, curbed mobility and scarcity of resources for women.

According to NCRB data, while total crimes against women dropped by 8 percentage points in 2020, the *proportion* of DV cases recorded under 'cruelty by husband or his relatives' and cases registered under the PWDVA Act remained largely the same. This, is in spite the fact that there was a strict lockdown

and as experts across the board acknowledge, access to police stations/justice system was poor during the pandemic (see table below).

The fact that a significant proportion of complaints that reached the police stations under VAW were about DV itself, speaks volumes about its prevalence and intensity.

TABLE 36 CHANGES IN DV CASES - NCRB DATA

	2020	2019	% CHANGE
TOTAL CRIMES AGAINST WOMEN	371,503	405326	-8.3
A. CRUELTY BY HUSBAND OR HIS RELATIVES (SEC. 498 A IPC)	112,292	126575	-11.3
B. PROTECTION OF WOMEN FROM DV ACT	446	554	-19.5
TOTAL CASES RELATED TO DV (A+B)	112,738	127,129	-11.3
PROPORTION OF DV VIS-À-VIS TOTAL CRIMES AGAINST WOMEN	30.35	31.36	

According to a Ward Councillor (Patna Municipal Corporation), DV and fights in homes increased during the lockdown because 'people were struggling to even arrange two meals a day, there was no money', and 'women wanted their husbands to earn money to run the household, but everything was shut, so men were also frustrated' (KII). In this situation, 'household discord was bound to increase' because 'people tend to take out their frustration on their family members' (sic).

While he didn't have a record of official numbers, in his experience, the number of women who approached him for help to solve domestic matters were more during COVID-19 pandemic than in pre-COVID-19 times. According to a PWDVA Protection Officer/Helpline-in-charge in Patna, while the total number of cases that the Women's Helpline Centre received were largely the same during the pandemic as before, the proportion of DV cases in comparison to other cases actually increased. This trend, she added, has continued till date (as of September 2021).

FGDs conducted for this study suggest that more than the number of DV cases, it was the intensity of DV that increased during the pandemic because men felt that the women are now helpless. This impunity arose from the fact that women could not access women's organisations, police stations, their neighbours, or their natal homes because of lockdown rules, lack of transport facilities, social isolation and the temporary closure of facilities.

> *We received a lot of DV cases in this period…. Because men thought that there is a lockdown and the woman can't go anywhere, so I can hit her, beat her, and do whatever I want with her. Normally, what would happen is that the woman would gather some courage and go to her natal home for a few days. Or she'd go to a neighbour's house for a while for relief. And the man would think that I'd lose respect in the society, so he'd calm down after a while, or four people from the neighbourhood would calm him down. But during lockdown, all these things were not there. Because of that also, violence increased. (Women's Rights Activist, Sahyogi)*

When asked about prevalence of DV, many women in the FGDs simply stated:

> *'Ghar mei maar-peet toh hoti hi hai'*
> *'Ye toh aam baat hai, ye hota rehta hai'*
> *'Maar-peet, gaali-galoch toh hamesha hota hai'*
> *'Ye toh roz ka hai, ab aapko kya kya batayein, kabhi yahan, kabhi wahan'*
> *'Daaru peeke ye sab toh hota hi hai'*

DV and discord (including verbal, physical, and sexual violence) is thus normalised, it is 'everyday', 'it happens'. Across FGDs, women categorically denied or trivialised the existence of DV in their own homes. Women in the older age-groups particularly were more reluctant to open up about experiences of DV, especially in Bahadurpur, Mestarpara, Gausnagar, and Saidpur. They simply stated that they endure (*'seh lete hain'*) the fights (phrased as *'maar-peet, ladai-jhagda*) because 'this is how it is'.

As one woman explained: 'See, after a husband puts vermillion on us, from marriage till death, we have to spend our life with him, no matter what.... *Hum nibha rahe hain* (we will maintain the relationship), even if we get beaten up, or kicked. If we go to our parents, they'd be humiliated. So, we maintain the relationship, howsoever it is.

'We have to come back to him ultimately' (Saidpur FGD, 18-30 years). Dominant social norms dictate that (i) disobedience by wife or failure to adequately perform care-work, (ii) alcohol abuse, (iii) increased mental stress and interpersonal tensions because of economic hardships, and (iv) suspicion and distrust

by the husband were all considered as 'valid' reasons for DV in the household.

One woman in Kaushal Nagar for example, shared what she witnessed in her neighbourhood:

> *…the other day, at 11 pm at night, her husband beat her up badly. He hit her so much that her entire body was black and blue. Her in-laws also don't stay with her…. The husband asked her to massage (press) his legs for an hour and she didn't. So, they started fighting, he hit her and verbally abused her. (FGD Kaushal Nagar, 18 – 30 years)*

Another narrative put it thus,

> *Aadmi log bahut shaukeen hote hain, unko jo karna hai vo karenge (men are very fanciful, they do what they want)…. We have to do everything ourselves. Prepare food, other household chores – and everything must happen on time. And even then, we have to face beatings. They won't help us, but demand that they must get food at the right time. If they don't, they hit us. (FGD Kaushal Nagar, 18 – 30 years)*

During the pandemic, increase in unpaid care-work and increased demands by husband sparked disagreements and disputes leading to DV.

Mental stress because of economic hardships and food insecurity also fuelled discord. If women would ask their husbands to find work so that they can buy ration, men would get irritated and take it out on their wives

(Women's rights activist, KII):

> *There'd be a lot of fights at home. A fight would break out over preparation of food for example. The husband would dictate what should be done when, and if there would be a slight delay in that, fights would break out. If we tell them to go work and earn a living, fights break out. If they do not go to work, then how will they get money, if there'd be no money, then how'd we get ration, if there's no ration, how will we cook? Then there'd be fights…. The problem is that there is no work. So, there is no money, no ration, and then there are fights. The stomach gets hungry after all. (Kaushal Nagar FGD, 18 -30 years)*

> *When there would be no earning, fights are bound to increase. If there is no earning, then how will we eat?... We'd fight. On small issues. (Bahadurpur FGD, 18 – 30 years)*

Anganwadi workers interviewed in the slums corroborated these accounts. They also gave examples of fights between women and their mother-in-law and between different family members because of increased proximity during the lockdown.

> *Fights increased. Because when all family members will stay together at one place, fights are bound to happen... if the daughter-in-law will not give food at the right time to the mother-in-law, and then the mother-in-law will say something, then, of course, there'd be a fight, it will escalate…. See when men won't go out to earn, and wives are also sitting at home, children will get hungry, they will ask for food…. Then fights are bound to happen. (Anganwadi worker, KII)*

Fights, thus, also increased because of loss of personal space. The PWDVA Protection Officer also corroborated these observations and added that these kind of disputes came from all kinds of households. She gave an example of a case where the woman is a teacher and her husband is a salaried employee. Since the lockdown, both of them have been working from home.

Their small children are also studying online. In that scenario, the husband expected the wife to take her online classes, monitor her children during their online classes, and then cook food and manage the household, while he only focused on his remote work, this caused tensions between the two, the fight escalated, and the Women Helpline Centre received a complaint from the woman.

> *My friend used to work as a nurse in a hospital. On that income, she used to run her household. Her husband didn't work anywhere. But she had late night shifts. She would come back late. Or sometimes she had to work all night. So, her husband started getting suspicious. Shakk karne laga… So then she left her job. Because she left the job, she had no income. When there was no income, there was no food. Then how will she eat. So, she fell sick…Then she died. (FGD Yarpur Band Gumpti, 30 – 50 years)*

For some women, the pandemic brought shame and disrespect, for instance – a woman from Band Gumpti (30-50 years) shared that ever since she lost her job because of the lockdown, her husband and her grown-up son fight with her even more and taunt her not doing any paid work:

My husband fights a lot with me. He says I don't do any work, I sit idle all day. Ever since I lost my job, this is what he says. My son sometimes says some things which makes me feel I should run away somewhere.

Another reason attributed to DV in these discussions was suspicion and mistrust by husbands. This came up across all FGD groups. In Mestarpara, for example, one woman shared that her sister's husband beats her up even if she goes to urinate after having sex, because he suspects her of having illicit relations:

My sister's husband beats her a lot. He would sleep with her and then go off to sleep, and if she would go downstairs to relieve herself, he would say, 'why did you go downstairs? To have illicit relations?' He is the one who does all that. He drinks. And hits my sister a lot, breaks his head, tears her clothes…. Our parents are no longer there. If we complain and the husband leaves her then who will look after her? … She has to live and die in her married home (sasural). So, she bears it. Majboori hai. (FGD Yarpur Band Gumpti, 18 – 30 years)

The PWDVA Protection Officer in Patna noted that DV increased during the pandemic because of 'mobile phones' and ensuing suspicions:

Another reason why cases of DV and discord increased was because of mobile phones. If husband or wife is working, then they'd be away from each other for 8 hours. Because of COVID-19, proximity increased, they are staying in the same room all the time. If any one person's phone rings and

they decide to take the call from the balcony or from outside, the other person gets suspicious – even if it's a very normal call, work call, family call. And because of this shakk, DV cases increased. (KII, paraphrased)

According to one of the police counsellors interviewed for this study, DV cases, especially in slum areas in Patna, increased substantially during the pandemic because people lost their work, started staying at home all the time, and money was tight. Another reason for DV, which is well-documented in existing studies and came up tangentially in almost all FGDs is alcohol abuse.

Even though alcohol is banned in Bihar, it is widely available locally, often in the form of home-made and spurious alcohol. Instances of men beating up their children and wives after drinking are commonplace:

This is a daily grind. During the day, it's okay. But in the evenings, men come back drunk and beat their wives…. They fight at 12 or 1 at night and wake us all up…. Every night there is a fight…. Women get injured, they bleed…. Ye toh roz ka hai. (FGD Kaushal Nagar, multiple voices, 30 – 50 years)

When he (my husband) drinks, he abuses me a little, says abusive words. But since he is drunk, I don't answer back…. It keeps happening. (Saidpur FGD, 18 – 30 years)

As per interviews with police counsellors and women's rights activists, alcohol abuse increased during the pandemic despite the economic hardships and as a result, DV also increased.

> *Women endure the violence unless their life is endangered, or its beyond their tolerance…. Because the society also teaches them that tolerate until you can. And where can they go (for recourse)? Who will support them? There is no support system from the government…. Parents also don't support them when they are facing violence. Women think that even if they somehow get out of that situation and ask for some help, they will have to eventually return to the same violence again and get beaten up twice as much. If she goes to the police thana, and let's assume that the police detain the husband. But when he returns from the jail, he'd beat her again even more. The cycle of violence doesn't end. (Nivedita Jha, Bihar Mahila Samaj, Personal Interview, August 2021)*

When asked about the formal and informal recourse and redressal systems available to women when faced with violence, a women's rights activist (quoted above) highlighted the absence of such recourse systems, how women are encouraged and taught to endure violence and harassment till they can, and how even if women do gather some courage and file a complaint, they run the risk of facing even more violence as a repercussion.

As a result, women, especially from marginalised sections, tend to not use any redressal system at all. It is also important to underline here that not complaining or reaching out for support is also a strategy that women use to maximise their safety.

When faced with DV, while some women resist or flee, others stay put to keep peace and protect herself and her children.

As Ellsberg and Heise (2005) point out, these decisions are driven by multiple factors including fear of retaliation, lack of economic support, concern for children, inadequate support from family and community, lack of options available for support and complain, social unacceptability of divorce or a breakdown of marriage, and a hope that the husband 'will change' or mend his ways.

Conclusions

Findings from the slums, in this study demonstrate that when women faced violence during the lockdowns their first reaction was to ensure their own and their children's safety and with reduced access to their natal homes, social conditioning and ecological environment, women only reached out for support when the violence became intolerable. In these cases, the most common recourse was often the local representatives (ward councillors) and the police (especially the *Mahila Thana*), however, the level of trust in both these avenues is perfunctory at best.

As Ellsberg and Heise write, a woman's response to abuse is limited by the options that are available to her.[ccviii] These formal and informal channels of help, with all their shortcomings and challenges, became even more difficult to access during the lockdowns and the pandemic. Service providers as well as women's organisations found it difficult to reach women in distress. The NCW and women's rights activists also found that several women who were facing violence at home were unable to receive help. Services were especially poor at the sub-district level as many centres had closed down.

Anticipating rising incidents of violence, on 25 March 2020, the Ministry of Women and Child Development issued a circular for all state-run 'One Stop Centres' and helplines to be made operational despite the lockdown. According to Oxfam's submission to the UN Special Rapporteur for Violence Against Women, during lockdown, only women who faced the most serious cases of physical violence sought some form of support.

The women's helpline centre/OSC was functional during the lockdown but with limited staff. Further, most cases were being tackled telephonically or online. Women were not able to go to the centre physically because of lack of transport, increased control of their mobility by their husbands/family members, lockdown rules, and inadequate staff at the centres itself. Instead, women could reach out for help only through Whatsapp or telephone, which for many marginalised women, is additional barrier to accessing support systems. At the start of the lockdown, such centres and even NGOs were entirely shut as staff members were also staying at home. On the flip side, when the centres did re-open, the staff was overburdened with complaints:

> *Our throat started hurting, talking to women because most of the problems we resolved was done telephonically – counselling, sorting out. Because there was a lot of problem. People couldn't come here. (PWDVA/Helpline-in-charge, paraphrased)*

The crisis of the pandemic clearly aggravated the existing challenges and gaps in the system which was not tailored to prioritise women's needs to begin with. Findings from this

study suggest that the structural and interpersonal violence experienced by marginalised women during the pandemic was not exceptional but was consistent with a larger trajectory of everyday, structural, and gender-based violence that they are routinely subject to as urban subalterns.

It is important to note here that the COVID-19 pandemic followed closely on the heels of the 2019 Patna floods which had already left the urban slums in a vulnerable state. During the 2019 floods in several districts of north Bihar, Oxfam's need-assessment survey found that flood victims were facing lack of safe drinking water, sanitation and hygiene issues, and the threat of water-borne diseases.

Women were the most vulnerable, with no access to safe toilets or privacy and susceptible to ill-health and disease. Women, in 2019 too attributed the violence they faced to the scarcity of resources at home. With no food to eat, men took out their frustration on women within the households, and sometimes even children. As we saw in this study, these patterns repeated itself during the COVID-19 pandemic as well.

Infrastructural failures reduce the capability of urban subalterns to cope with shocks. The burden of fixing infrastructural deficiencies at the household such as collecting water from a communal tap or collecting ration invariably fall on women. Further, densely packed houses in urban slums have also meant that COVID-19 prevention measures like maintaining hygiene and sanitation, social distancing, and practicing frequent hand washing, are extremely difficult in these slums.

Moreover, given their limited resources and poorly serviced living quarters, women do not have access to good quality healthcare and education which further increases their vulnerability to environmental and economic shocks. Structural and infrastructural violence is thus built into the fabric of lives of urban subalterns.[ccix]

Violence of the pandemic is thus not spatially or temporally limited to the pandemic. Instead, the pandemic contributed to, reshaped, or amplified the already-existing experience of violence for subaltern groups due to 'unequal infrastructural, labour, caste, class' (Gupte and Zahan 2021: 148) and gender relationships in Patna's slums.

What this means is that women's experience of the violence of the pandemic is not an exception but falls in the continuum of their everyday negotiations, with structural and interpersonal violence within the city. Understood this way, the findings of the study demonstrated that women's experience of violence of the pandemic is both *longue durée* and structural, which needs long-term and systemic interventions to reduce their vulnerabilities to future shocks.

Thus, while the biggest obvious impact of the pandemic was loss of livelihood, its biggest fallout seems to be increase in household discord, disputes and DV. In fact, the burden of this loss of livelihood seems to have fallen unduly on women – be it in terms of enduring DV or ensuring there is food on the table by collecting ration from wherever possible as the onus of cooking food for the family and ensuring everyone's nutrition falls on women. The COVID-19 pandemic shifted the responsibility of care from governments to families,

particularly women at great cost to their health, economic security and wellbeing.

This loss of personal space and time, increased proximity, increase in care work and increase in household disputes also worsened women's mental health. Further, when faced with DV, women's already tenuous access to formal and informal recourses was further truncated during the pandemic. For the urban subaltern women, the lockdown and the pandemic were thus another experience of violence which worked to further disadvantage them.


CHAPTER 7
WAS A BETTER
YEAR POSSIBLE?

The main question the country's citizens at the end of 2021 have been grappling with is this: was a better year possible? Could our country have planned better and saved lives, ensured food security and livelihood, constrained spiralling health costs for all, paid attention to the security and wellbeing of our women, delivered healthcare and vaccines in a just and equitable manner and supported our children so we needn't have been standing at the brink of losing an entire generation's future to a pandemic? Based on the many rapid assessments undertaken this year, this final section of the volume attempts to put together a coherent policy response based on Oxfam India's learnings this year across the many domains of crisis that 2021 brought with it.

In 2021, COVID-19, as we have seen, severely impacted Indian society not only in terms of health but also economically, making the survival of individuals difficult. It has been a year of unhinged grief for many. The writing on the wall at the end of this long and difficult year for most Indians is clear – unless adequate support is provided, the pandemic will have long-lasting effects, especially on the lives of the most vulnerable and this impact will be intergenerational, not just long-term in our lifetimes.

The pandemic, of course, is a global problem and dealing with it, especially in policy-terms, is far from easy or simple. Despite this, now is as good an opportunity as ever to look at the evidence coming ground-up and to try and develop a coherent policy response. By coherent, we mean that the overall policy response – of our government and all the parties it regulates such as the non-profit sector, the voluntary sector, individuals and service providers – is so designed that actions in each sphere reinforces the other.

To understand this fully means, to acknowledge that there are concerns and fallouts of the pandemic that are beyond just 'temporary' and managing that will require systemic changes in policy delivery – that is currently situated in the domain of efficiency – to one that sits squarely in the domain of justice for all.

We provide policy lessons focussing on particular actors and institutions, suggesting that knowledge-sharing and listing to people is probably the best way to effectively respond to crises. These suggestions are guided by the principles of public policy viz. a) minimising hysteresis or supporting easy reversibility, b) subsidiarity or supporting local action by both official and civil society and c) sustainability that is retaining the ability to provide a graded response to win back the lost confidence of people in government.[ccx]

HELPING ALONG THE MIDDLE CLASS

One of the main ways in which the middle class can be helped is with actually creating some measures to stimulate demand, such as reduction in fuel prices, a fairer distribution of tax and lower prices on essential consumer goods. Much of this

prescription is common sense. Data shows that unemployment levels have risen to a 45-year high even as consumption expenditures have fallen sharply. Health and nutrition data has also demonstrated a significant decline even as educational outcomes continue to lag. National accounts data shows that middle class Indians are only getting into more and more debt since 2017. Instead of offering cheaper credit and moratoriums on credit loans, which affect long-term creditworthiness of the middle class, policies should focus on rewarding consumption and the old middle class values of saving and investing on *longue durée* items with social returns such as education and good health.

The middle class must also be protected by labour laws, and the issuance of temporary contracts and arbitrary reduction of wages and job-loss must be dealt with comprehensively. In addition, effort must be made to provide for the middle-class adequate health and educational infrastructure as entitlements, effectively pushing up disposable income by reducing costs on basic necessities.

Indeed, policies that factor in the welfare of the middle class and nurture their growth are likely to be a more effective long-term strategy for alleviating poverty, compared to policies focusing solely on the poor because such policies are likely to tick the sustainability box. Not only would such policy be more inclusive of class, caste and economic minorities (all members of a broad middle class) but could also safeguard democracy by holding government accountable to the rule of law.

Doing this could be relatively simple, government needs to make taxation a lot more progressive (let the rich pay more

tax), lower the cost of living for the middle class by making housing, for example, affordable. And finally, it must urgently address the lack of jobs and falling labour force participation rate particularly for women – both of which will require urgent attention to be paid to upskilling and education.

EXPANDING SOCIAL PROTECTION FOR ISWs

The heterogeneous nature of the informal sector, temporary working arrangements and precariousness of work, taken together, is a powerful argument for employers and governments, together, to join hands and take on the responsibility of securing the lives of ISWs. Awareness and accessibility to flagship schemes and employee benefits is highly fragmented across cities, occupations and income groups. Accessibility to government welfare schemes, especially PDS and Ayushman Bharat, is also poor and while PDS is more accessible than the Ayushman Bharat scheme, the difficulties in accessing both are unsurprising and unfortunate. As far as the provision of social security benefits by employers is concerned, this also remains so low that one could assume there is actually none at all. This is particularly true for health insurance which has been completely denied to casual and home-based workers.

Awareness of government schemes, employee benefits and rights guaranteed by law ought to be the first step towards access to social protection; sadly, the poorest groups also exhibit the least awareness and consequently have the least access as well.

The need to advocate for increased awareness among ISWs about their legal rights and entitlements and to make social

security accessible to them is both urgent and fundamental. Based on our study, we recommend that a coherent strategy be developed for ISWs, based on the following key recommendations:

- **Increase awareness of social security schemes:** ISWs' knowledge about social security schemes is exceptionally low, and as a result they risk missing out on benefits that they are entitled to. Therefore, local governments and workers' welfare boards should inform and educate workers in their jurisdictions about available social welfare schemes, employee benefits and legal rights. Local CSOs should also be made partners in the regular dissemination of such awareness programmes.

- **Reduce administrative and registration barriers:** The registration of potential beneficiary in a social security scheme is difficult to navigate and a long-drawn process. As we pointed out earlier, there is a need to make all social security schemes self-selectable, instead of going down the tedious route of identification of the poor. Making the process of registration easy will also increase the uptake of these schemes. Innovative approaches as mobile registration vans, walk-in counters with available assistance etc. can be adopted to ease the registration process, the launch of India's e-shram portal is one such idea.

- **Create and enforce mechanisms to protect casual and migrant workers:** Casual workers and migrants, particularly, short-term circular migrants are two of the most vulnerable groups among the ISW. It is absolutely

essential to ensure that they can access social security benefits. This can be done by ensuring that casual and migrant workers across all occupations are registered with worker's welfare boards or with the e-shram portal right before they pick up casual-wage labour, perhaps on-site as well. Workers' Welfare Funds provide workers with an old-age pension, employment injury protection, health insurance and maternity cash benefits for women. While the success of *Worker Welfare Boards and Welfare Funds*[ccxi] has not been evaluated, it's potential to protect vulnerable workers should be taken seriously.

- **Ensure legal compliance:** The Code on Social Security, 2020 explicitly identifies ISWs as a target group needing access to health care and income security, particularly in cases of old age, unemployment, sickness, invalidity, work injury, maternity or loss of a breadwinner. However, the heterogeneous nature of the informal sector makes it hard to oversee if employers are, in fact, practicing the legal dictum. Health insurance and maternity benefits are two of the least accessible provisions. Lack of maternity benefits make women very vulnerable – she loses her job due to lack of maternity benefit and is left with no income to take care of herself and her child. Therefore, State governments should set up monitoring and evaluation groups at the local level to ensure legal compliance by employers.

- **Clear set of guidelines for employers:** It is pertinent that employers are provided with a clear set of guidelines on the compliances required under law. This includes the issuing of mandatory written contract of employment, payment of

wages within 30 days of work and guaranteed basic pay in the face of any crisis.

HEALTHCARE FOR ALL

With regard to ensuring that patients are treated with care and justice, we recommend the formal adoption of PRC by Indian States and believe that this will be a critical step in ensuring enforcement of these rights and proving Indian citizens with mechanisms for redress, when their rights are violated. Specifically we recommend that:

- **MOHFW should:**
  - Set up a mechanism to review the present status of adoption of the PRC in all the States and UTs and order those who have not adopted the PRC yet, to do so;
  - Include the PRC in the Clinical Establishment Act, given that it offers the most robust existing mechanism for regulation of private healthcare systems; doing so would make the existing Act more comprehensive and inclusive in terms of rights and responsibilities of patients;
  - Issue a letter to the States and UTs for displaying the Charter in all private and public hospitals, in view of the unprecedented crisis induced by the COVID-19 pandemic and particularly, for hospitals empaneled in PM-Jay.

- **National Medical Commission should:**
  - Introduce mandatory modules of patients' rights in healthcare (MBBS study) curriculums, including sensitisation in delivering health equity and social justice.

- **State and UT governments should:**
  - Issue orders to display the PRC in all private and public hospitals, irrespective of adoption of CEA. The Health Department in each State/UT should issue guidelines/ orders to start displaying the Charter in government hospitals and private hospitals that receive state subsidies in any form or charitable hospitals even in States that do not have the Clinical Establishments Act;
  - Ensure grievance redressal mechanisms for patients. The first step is to appoint an internal grievance officer within every clinical establishment, i.e. in each public and private hospital. If this officer fails to resolve the problem, it can be escalated to the district registering authority, failing which a patient can approach the State councils and expect resolution within 30 days.

- **District Administrations should:**
  - Initiate awareness activities for the communities on the PRC in the form of campaigns, where various innovative methods like poster exhibition, *kala jathas*, street plays, competitions among the youth and school children around the issue are organised;
  - The role of CSOs will be crucial to facilitate the communities around the PRC, especially in the context of denial of patients' rights in public and private hospitals. Hence, the State government can engage CSOs in capacity building activities and awareness programmes, whereas the CSOs can initiate some activities independently in the form of documentation of denial of cases; facilitating dialogue between decision-makers and communities/patients.

A BETTER VACCINATION EXPERIENCE

In order to return to prior levels of productivity and socio-economic progress in the country, it will be critical to vaccinate on a war-footing. To do this we recommend:

- Government should ensure that vaccination policies are open to public scrutiny.
- All vaccination should be done completely free of cost through the government, like previous vaccination drives. Ensure delivery of free vaccines through government centres, avoiding the use of private hospitals to deliver vaccination.
- This should be funded through progressive taxation including a one-time tax of 1 per cent on the net-worth of India's richest 1,000 families.
- Existing practice of funding GST on essentials like petrol should be avoided.
- Proactively releasing timely information on vaccination strategies, modalities and accomplishments in disaggregated, user-friendly and open source formats.
- Prioritising the allocation, distribution and administration of vaccines for marginalised, poor, vulnerable, excluded communities first, of course, along with for those who are at risk.
- Extend operational hours of vaccination centres beyond 9 am-5 pm, to allow for vaccination without loss of wages.

- Maintain record and release disaggregated data on vaccination coverage, based on social and economic groups including Dalits, Adivasis, Muslims, and PwDs.
- Bring vaccination closer to the vulnerable. For covering all populations, mainly people from the informal sector, the elderly and PwD, 'door to door' vaccination is very effective.
- For COVID-19 vaccination, there was major delay in taking a decision regarding door-to-door vaccination drive and its execution and this should be avoided in future.
- Improve information about vaccination. Existing technology-based mechanisms (Arogya Setu and CoWin app) for getting information about vaccination centre locations and availability of vaccines is not sufficient.
- At local level, youth, local elected representatives, SHG members, elected local bodies such as Village Health, Sanitation and Nutrition Committees (VHSNCs) and SMCs must be involved in mobilising communities to address the challenges faced during the vaccination drive and will contribute to reducing the burden of work faced by frontline health workers.
- It is important to build a robust and functional grievance redressal mechanism from national to local level, to address emerging challenges.
- Adequate flexibility must be given to local health administrations to adapt to local circumstances.
- Further ramp-up vaccine production, especially through public sector companies.

EDUCATING ALL CHILDREN BETTER

The pandemic has served to highlight that private schools, if left unregulated, will continue to profiteer and exploit parents. However, this survey has shown that issues with private schools extend beyond commercialisation alone. There are issues of parental voice not being respected in decision-making, harassment of children, poor quality of education and a lack of transparency in functioning.

There were some positive measures around regulation of private schools that emerged from the pandemic. Himachal Pradesh introduced a draft bill[ccxii] for regulation of private school fees, which mandates the setting up of a district-level committee to regulate private school fees and the Chhattisgarh government passed the Chhattisgarh Private School Fee regulation Act which requires private schools to take parents' consent before hiking fees.

These measures illustrate that effective State regulation of private schools is possible, if a critical mass of people hold the government accountable and demand regulation. Other States like Himachal Pradesh and Maharashtra are in the process of revising their legal framework related to private schools.

Now, as States begin planning implementation of the NEP, they must use this as an opportunity to put in places measures for effective regulation of private schools.

With regard to functioning of private schools both before and after/during the pandemic, we recommend the following:

- Designing a consultative process involving parents, CSOs,

academicians to develop an effective grievance and response mechanism at district and State levels, related to regulation and malpractices of any school imparting school education

- Preparing a comprehensive regulatory framework for private school regulation, building on the existing legislations and the progressive orders issued during the pandemic.

The government must take this opportunity to mitigate the risks of dropout, learning deprivation and mental health issues that will arise due to the world's fourth longest school lockdown. As this study shows, while children are coming back to school, they are facing anxiety and struggling to follow what is being taught. At the same time, a large percentage of children from marginalised communities including girls and Muslims are not coming back to school.

It would also be important to consider improving the functioning of government schools, some recommendations in this sphere are as follows:

- Reopening be practiced across all States and UTs to minimise incidence of learning deprivation, and create opportunities for States to learn from each other on processes of effective reopening.

- Provide additional resources to State governments to support effective reopening, including enhancement of WASH facilities in schools and preparing teachers and enabling them to support children returning to school after such a long period of absence.

- Allocate additional funds to State governments for hiring requisite teachers, government officials and strengthen the infrastructure in government schools, given the rise in enrolment.

At the State level, the government must:

- Implement large-scale re-enrolment campaigns in collaboration with SMCs and Panchayat Samitis.
- Develop a restructured curriculum to address learning deprivation, and take steps to support the socio-emotional needs of children and orient teachers on its delivery.
- Assess extent of learning loss and implement a structured, accelerated learning curriculum, to recover the lost instructional time.
- Ensure availability of textbooks and additional learning materials for children to take home
- Ensure resumption of all entitlements such as Mid-day meals, textbooks, uniforms and scholarships.
- Ensure all schools are sanitised and equipped with necessary equipment for thermal screening, teachers and staff are vaccinated and schools are equipped for longer periods of staying open.
- Ensure that all instruction is physical in nature, rather than a reliance on hybrid modes, given access issues with digital modes for most children.

- Reopen small government schools that have closed down, to improve educational access, and make it easier for social distancing norms to be followed.

SECURING LIVES AND WELL BEING FOR WOMEN

The COVID-19 pandemic shifted the responsibility of care from governments to families, particularly women at great cost to their health, economic security and wellbeing. This loss of personal space and time, increased proximity, increase in care work and increase in household disputes also worsened women's mental health. Further, when faced with DV, women's already tenuous access to formal and informal recourses was further truncated during the pandemic.

For the urban subaltern women, the lockdown and the pandemic was, thus, another experience of violence which worked to their further disadvantage. This situation is not just unfortunate but also inhuman and needs urgent redressal. To that end we recommend the following:

- Frontline workers such as ASHAs and Anganwadi workers should be paid on time and should be provided with safety kits, psychosocial support, non-performance-based incentives, and additional transport allowance whenever required.

- Sexual and reproductive health, family planning and abortion services, and early child care services should be included in 'essential services' in times of any crisis.

- Information about health facilities and services, counselling centres, crisis centres, helplines, including

timings, types of assistance available, and modality should be disseminated.

- Infrastructure in urban slums in Patna need to be upgraded in-situ urgently; with enhancement of basic services to build resilience to external shocks.
- Immediate measures should be taken to fix gaps in the PDS
- Formal support systems/recourses for women who face violence should be strengthened (in terms of personnel, power, resources and rights); information about them should be disseminated, and they should remain active during any crisis.
- Anti-violence Services should be strengthened, women-centered and accessible. Measures should be taken to improve trust in government recourse systems.
- Collaborate with grassroots organisations and NGOs to strengthen access to services.
- Conduct participatory infrastructure mapping of key services in slums along the axis of availability, access, quality and sustainability to identify areas of improvement.
- Establish reliable work opportunities for women residing in slums.
- Work towards improving and securing women's working conditions.
- Raise awareness about recourses available to women when faced with violence (such as *Mahila* helpline).

- Sensitise ward councillors, police counsellors, and frontline workers on how to respond to cases of VAW and DV.

- Include men as well in programmess geared towards eliminating VAW and include work on masculinities in gender-based work, to achieve long-term and sustainable changes

Overall, Oxfam India believes there were many policy actions that could have been taken to have made 2021 a much less violent and difficult year for the average Indian. Yet, as the year draws to a close what we can do is try and imagine a better 2022 and to that end it is still not too late to create and implement policy to better our collective lives.

ANNEXURES

ANNEXURE A

TABLE 37 AVERAGE PER DAY COST OF HOSPITALISATION BY STATE

AVERAGE PER DAY COST OF HOSPITALISATION (INR)	0 - 50K	50K - 100K	100K - 150K	150K - 200K	200K - 250K	400K - 450K
ANDHRA PRADESH	95	-	-	4.6	-	-
ASSAM	100	-	-	-	-	-
BIHAR	100	-	-	-	-	-
CHATTISGARH	100	-	-	-	-	-
DELHI	92	4	4	-	-	-
GUJARAT	82	9	9	-	-	-
HARYANA	83	17	-	-	-	-
KARNATAKA	90	8	2	-	-	-
KERALA	100	-	-	-	-	-
MADHYA PRADESH	50	50	-	-	-	-
MAHARASHTRA	92	8	-	-	-	-
ODISHA	67	33	-	-	-	-
OTHERS	89	11	-	-	-	-
PUNJAB	100	-	-	-	-	-
RAJASTHAN	100	-	-	-	-	-
TAMIL NADU	84	11	3	1	-	-
TELANGANA	60	18	12	4	4	2
UNION TERRITORIES (MIXED)	100	-	-	-	-	-
UTTAR PRADESH	79	5	10	-	-	5
UTTARAKHAND	100	-	-	-	-	-
WEST BENGAL	80	10	10	-	-	-

Table 38 SEEKING SUPPORT IN THE SECOND WAVE BY ANNUAL HOUSEHOLD INCOME

INCOME IN RUPEES	> 250,000	250,000 - 500,000	500,000 - 1,000,000	> 1,000,000
COULD NOT FIND SUPPORT	0	0	0	0
DID NOT NEED ANY HELP OR SUPPORT	3	3	2	2
DOCTOR	0	0	0	0
FRIENDS AND FAMILY	13	14	13	11
GOVT OFFICIAL/ DISTRICT OFFICIAL	21	20	20	18
MADE CALLS/ ARRANGEMENTS YOURSELF	26	24	33	35
NEWS	0	0	0	0
SOCIAL MEDIA	34	39	28	32
OTHERS	2	0	3	2

Table 39 COST OF ONE DOSE OF VACCINE IN RUPEES

	<499	500-999	1000-1499	1500-1999	2000-2499	2500-2999	3000-3499	3500-3999	4500-4999
ANDHRA PRD.	27	41	27.3	4.5	0.0	0.0	0.0	0.0	0.0
ASSAM	100	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
BIHAR	50	0	50.0	0.0	0.0	0.0	0.0	0.0	0.0
CHATTISGARH	50	50	0.0	0.0	0.0	0.0	0.0	0.0	0.0
DELHI	20	59.6	17.0	2.1	0.0	1.1	0.0	0.0	0.0
GOA	33	66.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
GUJARAT	13	50.0	25.0	0.0	12.5	0.0	0.0	0.0	0.0
HARYANA	17	60.9	21.7	0.0	0.0	0.0	0.0	0.0	0.0
JHARKHAND	0	50.0	50.0	0.0	0.0	0.0	0.0	0.0	0.0
KARNATAKA	16	50.3	25.3	6.5	1.0	0.0	0.3	0.3	0.0
KERALA	12	71	7.8	6.7	0.0	0.0	1.1	0.0	0.0
MADHYA PRD.	33	50.0	0.0	0.0	0.0	16.7	0.0	0.0	0.0
MAHARASHTRA	14	66.7	15.7	2.9	0.0	1.0	0.0	0.0	0.0
MANIPUR	100	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

	<499	500-999	1000-1499	1500-1999	2000-2499	2500-2999	3000-3499	3500-3999	4500-4999
ODISHA	50	25.0	25.0	0.0	0.0	0.0	0.0	0.0	0.0
PUNJAB	33	33.3	33.3	0.0	0.0	0.0	0.0	0.0	0.0
RAJASTHAN	33	66.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TAMIL NADU	25	49.7	15.0	9.8	0.0	0.0	0.0	0.6	0.0
TELANGANA	15	38.0	35.9	5.4	1.1	2.2	1.1	0.0	1.1
UNION TERRITORIES	0	100	0.0	0.0	0.0	0.0	0.0	0.0	0.0
UTTAR PRADESH	28	37.9	31.0	0.0	0.0	3.4	0.0	0.0	0.0
UTTARAKHAND	0	100	0.0	0.0	0.0	0.0	0.0	0.0	0.0
WEST BENGAL	10	64.5	16.1	3.2	3.2	3.2	0.0	0.0	0.0

Table 40 RATING OF CENTRAL GOVERNMENT'S PANDEMIC RESPONSE

	AVERAGE	GOOD	POOR	VERY GOOD	VERY POOR
ANDHRA PRADESH	0.0	21.7	21.7	6.7	40.0
ASSAM	0.0	45.5	27.3	18.2	0.0
BIHAR	0.0	0.0	14.3	14.3	57.1
CHATTISGARH	0.0	0.0	40.0	20.0	40.0
DELHI	0.0	17.4	24.5	7.7	42.6
GOA	0.0	16.7	16.7	0.0	50.0
GUJARAT	0.0	34.6	19.2	7.7	34.6
HARYANA	0.0	13.5	29.7	2.7	37.8
HIMACHAL PRADESH	0.0	33.3	33.3	0.0	33.3
JHARKHAND	0.0	0.0	11.1	22.2	66.7
KARNATAKA	0.9	17.3	20.0	9.7	47.2
KERALA	0.0	11.0	19.9	9.6	50.0
MADHYA PRADESH	0.0	27.3	9.1	0.0	54.5
MAHARASHTRA	1.2	17.2	26.0	14.2	37.3
MANIPUR	0.0	50.0	0.0	50.0	0.0
MEGHALAYA	0.0	0.0	0.0	0.0	0.0
ODISHA	0.0	24.2	24.2	9.1	36.4
PUNJAB	0.0	22.2	33.3	0.0	33.3
RAJASTHAN	0.0	16.7	16.7	0.0	50.0
TAMIL NADU	0.0	18.9	20.5	10.1	45.6
TELANGANA	0.7	18.1	16.1	12.1	45.0
TRIPURA	0.0	100.0	0.0	0.0	0.0
UNION TERRITORIES	0.0	22.2	16.7	5.6	50.0
UTTAR PRADESH	0.0	17.2	19.0	13.8	44.8
UTTARAKHAND	0.0	0.0	28.6	0.0	71.4
WEST BENGAL	0.0	13.0	23.9	6.5	52.2

Table 41 RATING OF CENTRAL GOVERNMENT'S PANDEMIC RESPONSE BY INCOME IN RUPEES

	> 250,000	>1,000,000	250,001-500,000	500,001-1,000,000
AVERAGE	0	0	0	0
CAN'T SAY	3	3	2	2
GOOD	0	0	0	0
POOR	13	14	13	11
VERY GOOD	21	20	20	18
VERY POOR	26	24	33	35

TABLE 42 RATING OF STATE GOVERNMENT'S PANDEMIC RESPONSE

	AVERAGE	GOOD	POOR	VERY GOOD	VERY POOR
ANDHRA PRADESH	0.0	30.0	23.3	11.7	33.3
ASSAM	0.0	45.5	9.1	45.5	0.0
BIHAR	14.3	14.3	42.9	14.3	14.3
CHATTISGARH	0.0	40.0	40.0	20.0	0.0
DELHI	0.0	27.5	37.3	2.6	25.5
GOA	0.0	40.0	40.0	20.0	0.0
GUJARAT	0.0	34.6	15.4	15.4	30.8
HARYANA	0.0	18.9	27.0	0.0	37.8
HIMACHAL PRADESH	0.0	33.3	0.0	0.0	66.7
JHARKHAND	0.0	33.3	22.2	11.1	33.3
KARNATAKA	0.9	31.0	30.6	9.0	24.7
KERALA	0.7	54.1	12.3	23.3	4.8
MADHYA PRADESH	0.0	27.3	36.4	0.0	27.3
MAHARASHTRA	1.2	56.2	12.4	20.1	5.9
MANIPUR	0.0	50.0	0.0	50.0	0.0
MEGHALAYA	0.0	0.0	0.0	0.0	100.0
ODISHA	0.0	42.4	33.3	12.1	9.1

	AVERAGE	GOOD	POOR	VERY GOOD	VERY POOR
PUNJAB	0.0	66.7	22.2	0.0	11.1
RAJASTHAN	0.0	33.3	16.7	0.0	33.3
TAMIL NADU	0.5	50.5	11.3	29.6	4.9
TELANGANA	0.0	26.2	33.6	4.0	31.5
TRIPURA	0.0	100.0	0.0	0.0	0.0
UT	0.0	38.9	16.7	16.7	27.8
UTTAR PRADESH	1.7	12.1	19.0	17.2	44.8
UTTARAKHAND	0.0	14.3	14.3	14.3	57.1
WEST BENGAL	0.0	26.1	43.5	8.7	17.4

Table 43 RATING OF STATE GOVERNMENT'S PANDEMIC RESPONSE BY INCOME IN RUPEES

	> 250,000	>1,000,000	250,001-500,000	500,001-1,000,000
AVERAGE	0.42%	0.66%	0.00%	1.07%
CAN'T SAY	5.23%	4.09%	3.72%	4.28%
GOOD	35.36%	36.81%	42.56%	41.44%
POOR	21.34%	26.65%	20.25%	20.32%
VERY GOOD	14.64%	14.78%	15.70%	17.11%
VERY POOR	23.01%	17.02%	17.77%	15.78%

ANNEXURE B

Table 44 ACCESS TO PDS BY CITY

CITY	% WITH A RATION CARD	% WITH A RATION CARD WHO WERE ABLE TO BUY RATION
BANGALORE	64.3	94.6
DELHI	32.4	79.6
MUMBAI	71.9	90.3
PUNE	96.1	16.2
TOTAL	66.1	67.8

Table 45 AWARENESS OF AND ACCESS TO PM-JAY BY CITY

CITY	% EVER HEARD OF PM-JAY	% WITH A PM-JAY CARD
BANGALORE	7.4	2.3
DELHI	0	0
MUMBAI	19.2	1
PUNE	3.9	0
TOTAL	8.3	1

Table 46: PERCENTAGE OF RESPONDENTS WITH WRITTEN CONTRACT OF EMPLOYMENT BY CITY

CITY	RESPONDENTS WITH A WRITTEN CONTRACT (%)
BANGALORE	8.48
DELHI	0.00
MUMBAI	5.08
PUNE	10.0
TOTAL	6.81

Table 47 PROVISION OF SOCIAL SECURITY BENEFITS BY EMPLOYER (PER CENT) BY CITY

CITY	PAID LEAVE	PENSION	MATERNITY LEAVE	HEALTH INSURANCE
BANGALORE	6.22	6.7	1.79	0.89
DELHI	0	0	0	0
MUMBAI	19.92	0.85	0.42	0.42
PUNE	30	0	0	0
TOTAL	16.38	3.62	1.06	0.64

Table 48 PERCENTAGE OF RESPONDENTS WITH WRITTEN CONTRACT OF EMPLOYMENT BY GENDER

GENDER	RESPONDENTS WITH AN EMPLOYER (%)	RESPONDENTS WITH A WRITTEN CONTRACT (%)
FEMALE	30.6	10.7
MALE	35.5	6.8
TOTAL	32.2	9.3

Table 49 PROVISION OF SOCIAL SECURITY BENEFITS BY EMPLOYER (PER CENT) (OUT OF TOTAL RESPONDENTS WITH AN EMPLOYER)

GENDER	PAID LEAVE	PENSION	MATERNITY LEAVE	HEALTH INSURANCE
FEMALE	20.5	5.53	1.32	0.53
MALE	8.1	3.05	-	1.02
TOTAL	16.2	4.67	1.21	0.69

Table 50 AWARENESS OF INFORMAL SECTOR SCHEMES BY CITY

CITY	NFBS	IGNOAPS	AABY	PM-SYM	NPS TRADERS	APY	PMJJBY	PMSBY	ONORC
BANGALORE	0.23	1.84	0.46	0	0	3.2	1.1	0.46	0
DELHI	0	0	0	0	0	0	0	0	0
MUMBAI	2.99	19.65	5.72	4.2	3.9	7.2	20.8	21.89	31.8
PUNE	0	0	0	0	0	0	0	0	0
TOTAL	0.9	5.95	2.8	1.2	1.1	2.9	6.1	6.2	8.8

Table 51 AWARENESS OF INFORMAL SECTOR SCHEMES BY ANNUAL INCOME IN RUPEES

INCOME	NFBS	IGNOAPS	AABY	PM-SYM	NPS TRADERS	APY	PMJJBY	PMSBY	ONORC
<15,000	0	0	0	0	0	5.6	5.6	0	1.9
15,001-30,000	0	1.6	1.1	4.6	0	3.7	1.1	0	0.5
30,001-45,000	0.5	6.4	1.2	0	0.2	1.2	5.2	5.7	7.8
45,001-60,000	1.5	7.3	2.5	0.7	1.8	2.5	7	7	12.1
60,001-75,000	0.7	5.2	1.7	1.5	1	3.1	5.5	5.5	8.6
>75,000	2.8	12	1.7	1	4.6	8.3	16.7	20.4	18.5
TOTAL	0.9	6	2.8	1.2	1.1	2.9	6.1	6.2	8.8

Table 52 AWARENESS OF INFORMAL SECTOR SCHEMES BY OCCUPATION CATEGORY

OCCUPATION	NFBS	IGNOAPS	AABY	PM-SYM	NPS TRADERS	APY	PMJJBY	PMSBY	ONORC
CASUAL WAGE	0.2	0.6	0.2	0.6	0.2	1.6	1.2	0.8	1.4
HOME-BASED	0	1.9	0.9	0	0.9	6.5	1.9	0.9	0.9
REGULAR WAGE	1.6	10.4	3	1.8	1.9	3.8	10.6	11.3	16.1
SELF-EMPLOYED	0	5.8	1	1	0	0	1.9	1.9	1.9
UNEMPLOYED	0	0	0	0	0	0	4.8	0	0
TOTAL	0.9	6	1.7	1.2	1.1	2.9	6.1	6.2	8.8

Table 53 RESPONDENTS WITH AN EMPLOYER BY TYPE OF RESIDENTS

TYPE OF RESIDENTS	RESPONDENTS WITH A WRITTEN CONTRACT (%)
LONG-TERM PERMANENT	7
LONG-TERM CIRCULAR (SEMI-PERMANENT)	5
NATIVE RESIDENT	10
SHORT-TERM CIRCULAR	0
TOTAL	6.8

Table 54 PROVISION OF SOCIAL SECURITY BENEFITS BY EMPLOYER (%) (OUT OF TOTAL RESPONDENTS WITH AN EMPLOYER- CURRENTLY OR IN THE LAST 12 MONTHS) BY TYPE OF RESIDENTS

TYPE OF RESIDENTS	PAID LEAVE	PENSION	MATERNITY LEAVE	HEALTH INSURANCE
LONG-TERM PERMANENT	19.5	5	0.9	0.9
LONG-TERM CIRCULAR (SEMI-PERMANENT)	15	0	0	0
NATIVE RESIDENT	9.57	0	0.9	0
SHORT-TERM CIRCULAR	5.8	5.8	5.8	0
TOTAL	16.38	3.62	1.06	0.64

Table 55 AWARENESS OF INFORMAL SECTOR SCHEMES BY TYPE OF RESIDENTS

TYPE OF RESIDENTS	NFBS	IGNOAPS	AABY	PM-SYM	NPS TRADERS	APY	PMJJBY	PMSBY	ONORC
LONG-TERM PERMANENT	1	8.8	2.7	1.6	1.6	4.2	8.9	9.1	12.7
LONG-TERM CIRCULAR (SEMI-PERMANENT)	1.4	1	0.3	0.7	0.7	1.4	2.4	2.4	3.4
NATIVE RESIDENT	0	2.4	0	0	0	0.8	1.2	0.8	1.6
SHORT-TERM CIRCULAR	0	0	0	0	0	0	0	0	3.2
TOTAL	0.9	6	1.7	1.1	1.1	2.9	6.1	6.2	8.8

Note 1 DEFINITIONS

This note includes definitions of a few terms for clarity on the subject matter.

- **Informal Sector and Informal Sector Workers**

  Economic activities not authorized or regulated by the State is the informal sector;

  The workers employed in this sector are usually devoid of social security benefits as paid leave, maternity benefits, pension etc.;

- **Types of residents**

  Native resident: Born in the place where he is currently residing

  Long term permanent migrant: They have been residing in the place of employment for more than a year.

  Long-Term Circular/Semi Permanent: This group is also called semi-circular. They always have a connection with their native place and usually goes back home in the case of unemployment, end of work or any adverse circumstance.

  Seasonal Migrant: They move from one location to the other combining employment opportunities at several places according to seasonal labour requirements.

  Short Term-Circular: They follow a circular path and maintain continuous but temporary absences from their place of origin for more than one day.

- **Types of occupations**

  Regular wage workers: receive wages on a regular basis

Casual wage workers: whose employment is of casual nature, gets wages.

Self-employed worker: any person who operates a non-farm enterprise or engages in a non-agricultural profession, trade or business, either on own account individually or with one or more persons.

Home-based worker: involved in the production of goods or services as specified by an employer, in his / her own home or other premises of his / her choice (other than the work place of the employer) for remuneration

- **PDS and Ayushman Bharat**

  Antyodaya Anna Yojana (AAY): given to impoverished families identified by the State governments. Persons who do not have stable income are issued this card. Unemployed people, women and old aged people fall under this category. 35 Kg. of food grains per household per month.

  Below Poverty Line (BPL): Families that have BPL cards are the ones who are living below the poverty line specified by the State government. 10kg to 20kg food grains per family.

  Above Poverty Line (APL): Families that have this card are the ones who are living above the poverty line as specified by the State government. 10kg to 20kg food grains per family.

  Annapoorna Yojana (AY): Given to older people who are poor and above 65 years. 10 kgs of foodgrains per month under this card.

  Ayushman Bharat: A national health insurance scheme of the State that aims to provide free access to healthcare for low income earners in the country.

Atma-nirbharata: Self-sufficiency

Rajya Sabha: Upper House of the Indian Parliament

Shram: Labour

Note 2 SCHEMES COVERED

- National Family Benefit Scheme (NFBS) provides a lump sum family benefit of Rs 10,000/- to the bereaved households in case of the death of the primary breadwinner irrespective of the cause of death.

- Indira Gandhi National Old Age Pension Scheme (IGNOAPS) provides a monthly income in the range of INR 600-1000 to citizens or refugees above 60 years, who have no other source of income.

- Aam Admi Bima Yojana (AABY)/Janashree covers a range of workers as brick-kiln workers, carpenters, fisherman, and safai karmacharis among others. The scheme offers insurance coverage of INR 30,000 which can be availed upon the death of the insured or disability.

- Pradhan Mantri Shram Yogi Maan-dhan (PM-SYM) is a voluntary contributory scheme for unorganised workers' economic surety during old-age not covered under the New Pension Scheme (NPS); Employees' State Insurance Corporation (ESIC) scheme; or Employees' Provident Fund Organisation (EPFO).

- National Pension Scheme for Traders and Self-Employed Persons (NPS-Traders) provides old age social security to retail traders, shopkeepers or self-employed persons with an annual turnover of less than Rs. 1.5 crore.

- Atal Pension Yojna (APY) is a contributory pension scheme for unorganised workers who don't pay income tax.
- Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) provides life insurance cover of INR 2 lakhs to unorganised workers on payment of a yearly premium of Rs. 330.
- Pradhan Mantri Suraksha Bima Yojana (PMSBY) provides INR 2 lakhs upon the accidental death or full disability, of the insured and Rs. 1 lakh on partial disability on payment of a yearly premium of Rs. 12.

ANNEXURE C

Table 56 PERCENTAGE OF PARENTS REPORTING FEE HIKES BY STATE

NAME OF STATE	EXISTENCE OF NOTIFICATION PREVENTING FEE HIKES DURING THE PANDEMIC	PERCENTAGE OF PARENTS REPORTING FEE HIKES IN AY 2021-22
BIHAR	Yes	65
DELHI	Yes	65
GUJARAT	Yes	45
HARYANA	Yes	66
JHARKHAND	Yes	59
KARNATAKA	Yes	50
MAHARASHTRA	Yes	51
ODISHA	Yes	61
PUNJAB	No	61
UTTAR PRADESH	Yes	57

Table 57 STATE-WISE REOPENING STATUS OF SCHOOLS

NAME OF STATE	GRADES CONSIDERED FOR ANALYSIS	PERCENTAGE OF PRIVATE SCHOOLS THAT HAVE REOPENED
UTTAR PRADESH	ALL GRADES[ccxiii]	86
BIHAR	GRADES 1-9[ccxiv]	84
DELHI	GRADES 10-12[ccxv]	70
JHARKHAND	GRADES 6-12[ccxvi]	78
KARNATAKA	GRADES 10-12[ccxvii]	78

ANNEXURE D

TABLE 58 MODES OF ACCESSING LEARNING

FORM OF LEARNING	IN ALL SCHOOLS	SCHOOL OPEN AND ATTENDING	SCHOOL NOT OPEN/ NOT ATTENDING
PHYSICAL CLASS IN SCHOOL	-	74	-
LIVE ONLINE CLASS/ RESOURCES SENT ON WHATSAPP	23	11	49
SMALL GROUP PHYSICAL CLASS BY TUITION TEACHER	30	25	42
LESSON DELIVERED THROUGH RADIO/TV	12	9	18
GOVT RUN MOHALLA CLASS	12	12	11
NGO RUN MOHALLA CLASS	12	12	11
PHYSICAL WORKSHEET GIVEN BY GOVERNMENT	7	6	10
PHYSICAL WORKSHEET GIVEN BY NGO	8	8	9
DID NOT ACCESS LEARNING IN ANY FORM	7	5	10

TABLE 59 ACTIVITIES INSIDE SCHOOL

WHAT IS HAPPENING IN SCHOOL AFTER REOPENING?	% OF PARENTS AND CHILDREN REPORTING THIS
RELATED TO LEARNING	
REGULAR CURRICULUM BEING FOLLOWED	44
SERVING MID-DAY MEAL HAS RESUMED	39
REVISION OF PREVIOUS YEAR BEING DONE	28
ASSESSMENT OF CHILDREN'S LEARNING LEVELS DONE WHEN SCHOOLS FIRST STARTED	31
PHYSICAL GAMES AND OUTDOOR ACTIVITIES ARE TAKING PLACE	33

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