POSITION PAPER

COVID PANDEMIC AND VACCINATION: CDWD CONCERNS FROM SOUTH ASIA

Executive Summary

The impact of the COVID-19 pandemic has been unprecedented with over 99 million cases reported including over 2 million deaths. The spread of coronavirus across the globe has not only created a health crisis but has particularly affected the socio-economic and human capacities of most marginalized groups across the globe. More importantly, this virus has led to disruption of the economies, resulting in uneven impacts among the population in the developing countries of Asia. In particular, the Dalit communities in Asia have faced gruesome after-effects on their human capacities and livelihood systems including their daily survival during this era of the pandemic.

Dalits are communities discriminated on Work and Descent (CDWD) they are one of the most marginalized communities, with approximately 220 million people situated in Bangladesh, India, Malaysia, Nepal, Pakistan and Sri Lanka. These communities are traditionally excluded communities based on their standing in the social hierarchy and their inherent nature of work dictated through principles of purity and pollution. These communities have been socially, economically and politically discriminated by the systemic structures and dominant communities in various forms and have sustained this discrimination through atrocities and violence. The position paper narrates the impact of COVID-19 on CDWD in South Asia and the need for free vaccination and universal health coverage. The position paper also monitors from point of view of human rights, non-discrimination and access to justice for life of dignity and peace of Dalit communities and the type and quality of response of the state and civil society institutions through their COVID-19 mitigation measures.

Background

In recent history, the world has never experienced a crisis as it has with the spread of COVID-19. The outbreak of this deadly virus put the whole world at standstill. Every person on the planet was affected directly or indirectly by the infection of the virus. The biomedical crisis soon became a human crisis. The stringent actions taken by governments like shutdowns, quarantines, curfews, etc. had and continue to have adverse social and economic impacts on poor, vulnerable and marginalized communities. It is outrageous that during the pandemic time some business groups flourished, but vaccination attempts became a race; the developed countries are successfully stepping up for full vaccination as well as booster doses of vaccines while the developing countries struggled to procure vaccines. Millions of workers have been rendered jobless, inequalities have been accentuated and the crisis is likely to reverse in a few years, if not decades, of gains in poverty reduction.

Communities Discriminated on Work and Descent (CDWD) were double discriminated against first with the multi-dimensional discrimination they already face and second the pandemic for them brought high infections, high morbidity, economic distress, and re-grounded social stigma. The paper argues that CDWD in South Asia got mostly impacted and many suffered death during COVID-19. The economic shock the region went through affected millions of CDWD severely. They were helpless against this disaster, because of their social position and the shutdowns pushed them into economic turmoil. Poverty, unemployment, job loss, physiological distress, etc. were high among them. The heterogeneity found among CDWD in terms of castes, occupation, gender, age, disability, location, etc. affected the disadvantaged even more severely. Children were left without education, they lost almost two years and income loss in families pushed many of them to child labour. South Asia is the region where more than 25 percent of the whole humanity lives. The most populous countries in the region are India, Pakistan, and Bangladesh. This region is quite important because it has pockets that are like Sub-Saharan Africa, over a third of the world's people live in extreme poverty and hunger. CDWD constitutes a large section of the total population of this region. India was the most affected country by the pandemic in this region with the third largest death numbers in the whole world registered here.

COVID-19 Pandemic in South Asia

The first case of "pneumonia with an unknown cause" was reported to the World Health Organization (WHO) by the Chinese authorities on December 31, 2019. This was labeled as a "public health emergency of international concern" on January 30, 2020 and three months later on March 11, 2020 COVID-19 was declared a global pandemic. In a very short span of time, it spread all over the world, and confirmed cases started rising alarmingly. In just three months on March 7 there were around 100,000 confirmed cases; in just 12 days March 19, 2020, it doubled;

and in just three more days it reached 300,000 (March 22) and in two months on May 21 there were 5 million confirmed cases and less than a month doubling to 10 million just 38 days later (on June 28), and doubling again to 20 million just 44 days after that (August 10). So, in 3-4 months the whole world was engulfed in COVID 19 pandemic. The countries which were severely affected were China, Italy, Spain, United Kingdom, USA, Brazil, India, Russia and others. All countries, even those that had well-developed health infrastructure and the advanced medical system failed to cope with this crisis. The situation in developing countries was devastating; they already had underdeveloped health systems which simply crumbled under this pressure. Even though there was time to prepare for this crisis, politicians and administration knew that this was coming, but they did not take decisive preventive actions and plans. They allowed COVID cases to turn into crises and then haphazardly declared lockdowns and took direct control of managing the pandemic. South Asia is a classic example of how states failed in an emergency. This also showcases the inability of countries to be equipped with contingencies during catastrophes and pandemics. The decades of the negligence of investment in the basic health care system, the nonseriousness of politicians and the incapacity of bureaucracy paved the way to turn an emergency situation into an epic disaster. COVID-19 pandemic was a deadly, uncontrollable disaster but could have been less severe if managed properly on time.

South Asia has reported 5,03,22,760 cases, a total of 6,25,665 deaths in the region, and 4,95,96,303 recovered cases till 10 October 2022. India shares the most cases of death in the whole region. The first cases of COVID-19 in South Asia were reported in India on January 30, 2020. The cases reported in high numbers from April 2020 it has been classified into first and second waves. These waves are periods when the number of new infections and deaths rose high. The first wave of the pandemic can be identified between May to December 2020 and after a brief pause (January and February 2021) the cases and deaths started raging from April 2021 to June 2021. The second wave spanned over a shorter period but the incidence of new infections and deaths per day was approximately four times as compared to the first wave. In other words, the second wave was much more devastating than the first wave. Relaxation on the travel ban, the reopening of the economy, and the flow of migrants (internal and external) fueled the second wave.

During the first wave, there was a lack of knowledge and preparedness. The calm between the two waves was assumed to be the end of the pandemic by many. Hence, the second wave was more shocking. It was devastating and damaging, placing the community and administration in unprecedented stress. The states of South Asia did not learn from the first wave, the new variant was more infectious; it affected lungs severely which demanded oxygen supply. Ventilators were not available in all hospitals and the oxygen supply chain was not pruned to the demand.[1]

[1] India was not prepared for the pandemic and it was unable to increase testing rapidly in the initial months. The Parliamentary Standing Committee on Health and Family Welfare, in its report submitted to the Parliament in November 2020, noted that poor contact tracing, low testing, and large-scale use of rapid antigen tests (RAT) instead

Pakistan confirmed its first 2 cases on February 26, 2020. The whole region of South Asia was engulfed in the pandemic. The close relation among South Asian countries, the return of international migrants and travelers from infected countries, the migration of people across countries and low preparedness paved way for the rapid spread of infections. South Asia registered higher death rates (2.22 percent) from the start of the pandemic up to January 9, 2022. The second wave was a disaster for India in particular; the number of deaths was unimaginably high. Almost 528754 people died as per the government reports. This is lower than the actual figure which experts believe and reported in media. Some mathematical modeling shows death numbers were more than doubled as reported by government agencies. The actual number of deaths is hard to document but one thing is certain the deaths were in excess. In South Asia, there were 37 percent excess deaths, the highest of all regions of the world.

Response by governments

On the outbreak of COVID-19 in South Asia, the governments took various steps like bringing back its citizens from COVID -19 infected countries and quarantining them for 14 days; restricting travel and entry in the country; suspending on-arrival visas and stopping all international flights and starting Coronavirus testing. When cases started to rise alarmingly like in other parts of the world, governments in South Asia too responded to this crisis by implementing the "Great COVID Shutdown''. Lockdown/shutdown meant a complete halt of all activities (except essential services) such as the closing of industries, schools, offices, shops, hotels, and commuting services and citizens were remanded to their homes. Only essential items like ration shops and vegetable shops were allowed to open for a limited duration. The leaders worldwide weighed the costs of saving lives over saving livelihoods. Through a combination of control measures that involve a restriction on mobility and closure of factories and workplaces, worldwide, countries were working to 'flatten the curve', that is, 'reducing the number of COVID -19 cases to prevent the clogging and collapse of the healthcare system.

Governments took measures to provide economic support to the poor in cash and kind. Cash transfers were done under existing schemes and services of food, and other benefits were

of the more reliable reverse transcriptase-polymerase chain reaction (RT-PCR) tests, could have impacted India's containment strategy adversely.

provided.[2] However, most of the measures were already present in the budget of governments, it only expanded it on a large scale. An assessment by the International Monetary Fund (IMF) shows that overall support by the central and state governments through various cash and kind transfers and other measures, such as healthcare infrastructure, testing facilities and tax relief, was only about 0.2 percent of India's GDP.[3]

For the economy, different measures were taken as stimulus packages. Bangladesh's government announced around $11.90 billion, which is 3.6 percent of the total GDP, stimulus packages. Pakistan's Ehsaas Emergency Cash program rolled out cash payments to millions of beneficiaries. Nepal combined in-kind food transfers with food-for-work or cash-for-work modalities for informal workers. Sri Lanka distributed weekly food stamps for essential food items. All countries provided cash or food items relief for poor citizens. However, a large number of CDWD were out of social protection schemes. To avail of any government schemes, identity card proofs are required which is not available to many of them. Besides they live in different and remote places of their origin for work, in the place of current stay they are akin to non-citizens. All countries in South Asia had implemented some employment protection interventions to protect workers from being laid off and/or compensate them for the loss of income; however, it was applied to higher ranks not to lower ranks and people on contracts. In the informal sector employment protections are not practiced normally. Given the small size and considerable revenue losses by firms, informal workers were among the first to lose their jobs and livelihoods. Hence, government attempts were futile and ended in only an emotional appeal.

International Aid to fight COVID 19

Poor countries in South Asia were given aid by international agencies to support their response to COVID -19 in the absence of fiscal space and growing macroeconomic difficulties.[4] The World Bank approved resources to support emergency response and health preparedness, including a USD104.4 million grant for Afghanistan, loans of USD100 million for Bangladesh, USD5 million for Bhutan, USD 11 billion for India, USD77.3 million for Maldives, USD29 million for Nepal, USD200 million for Pakistan, and USD128 million for Sri Lanka. The ADB

[2] Bangladesh rice at BDT 10 per kg was sold to the poor and low-income group citizens, free distribution of food materials was done. This was disbursed to 4.4 million beneficiaries, including poor elderly, widows, disabled persons, and informal sector workers. Indian government announced a relief package for the poor affected by COVID provided a one-off benefit of Rupees 1 000 (USD 13) to 480 000 daily wagers such as street vendors or rickshaw pullers as well as cash transfers of Rupees 500 (USD 6.50) for three months (April-June 2020) to 200 million women registered to its PMJDY financial inclusion account when the country-wide lockdown was relaxed,19. Amounting to US$22.6 billion, this would pay for free food grains, liquefied petroleum gas (LPG) for cooking, cash transfers for 3 months and insurance for frontline healthcare workers (The Economic Times, 2020). It also provided a one-off benefit of Rupees 1 000 to 480 000 daily wagers (street vendors, rickshaw pullers, etc.) (ILO, 2020

[3] IMF Policy Tracker

[4] Under IMF Afghanistan (USD33.8 million) and Nepal (USD33.9 million) had access to the Catastrophe Containment and Relief Trust (CCRT), which provides grants to poor countries to cover their IMF debt obligations for an initial phase over six months, to help them channel more of their scarce financial resources towards vital emergency medical services and other relief efforts.

approved loans for Bangladesh (USD500 million), Bhutan (USD20 million), India (USD11.5 billion) and Pakistan (50 million) together with grants for technical assistance to support countries' responses in the health sector and their provision of social protection for poor and vulnerable people. Many international NGOs too took the step to reach out to poor people.

Impact on Economy

The great COVID shutdown had a much more profound impact on low-and middle-income countries. Low-income countries were disproportionately affected as their jobs and businesses were immediately obliterated, which resulted in abrupt increases in poverty and hunger. On 14 April, according to an IMF statement, the quarantine and social distancing practices, the 'Great Lockdown', had led to a massive collapse in all economic activities, 'the worst economic downturn since the great depression.[5] This massive collapse led to a slowdown of GDP, a reduction in export and imports, a rise in inflation, an increase in external debt, less foreign investment and a weakening of the overall economic structure. They could not match the government stimulus programs in the developed world. The economic crisis has multiplier effects which ultimately hit the poor and marginalized hard. The rate of poverty and unemployment increased, the purchasing power of people decreased, and food insecurity increased all led to severe economic stress.

COVID 19 hit the informal sector particularly hard. In South Asian economies, the informal sector contributes, on average, over a quarter of GDP, with values ranging from 18.5 percent in India to 35.5 percent in Sri Lanka.[6] Furthermore, informal jobs constitute 88 percent of the total employment in the region.[7] In Bangladesh, over $6 billion in export orders were canceled in the initial month of the shutdown. The president of the Bangladesh Garment Manufacturers and Exporters Association called the situation "apocalyptic." In April, over a million workers in the country's garment sector were laid off as export orders plummeted by over 80 percent. India, Bangladesh, Pakistan and Sri Lanka have large manufacturing industries related to garments, and small merchandise goods and they are exported. Millions of people are involved in this sector, most of them are internal migrants who leave their villages and stay put in industrial areas.

GDP growth rates

In 2019, South Asia remained one of the fastest-growing regions in the world. Compared to global growth rates of, on average, 2.4 percent and 3.5 percent among emerging markets and developing economies (EMDEs), 2019 saw the region grow markedly faster than other parts of the world, spurred by rapid growth in Bangladesh, India and Nepal. Conversely, Afghanistan,

[5] Gopinath, 2020, IMF blog Accessed on 21 Sep 2022
[6] Leandro Medina, and Friedrich Schneider. "Shedding light on the shadow economy: A global database and the interaction with the official one." *Available at SSRN 3502028* (2019).)
[7] ILO (2020. ILO Monitor: COVID-19 and the world of work. Fifth edition Updated estimates and analysis. Available at: https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_749399.pdf

Pakistan, and Sri Lanka noted rather subdued growth, below the EMDE average.
South Asia was forecast to register increased growth of 5.5 percent in 2020 and a slightly more homogenous picture across the countries, with 2021 continuing the trend of accelerated economic growth.[8] GDP loss was uneven across countries with South Asia registering a 6 percent reduction, except Bangladesh which performed relatively better with low (3.30 percent) but positive growth in 2020. Other countries like Pakistan had negative growth of -1.33 percent, Sri Lanka witnessed -3.62 prevent growth, Nepal went down from 6.66 percent of growth to -2.37 percent growth and lastly, India slumped down -6.60 percent of annual GDP growth.

Much of the loss in GDP was due to reduced working hours. Most of the medium and large firms and SMEs switched to slow work mode, with under-utilization of labour and capital because of lockdowns and travel restrictions. Differences between the sub-regions reflect structural differences in labour markets (formal versus informal) across the economies. The Asia Pacific Region suffered an average 7 percent loss in labour use. South Asia has the largest loss (11.5 percent), followed by Southeast Asia (7.3 percent), East Asia (4 percent), the SIDS (5.5 percent) and the Pacific (2.8 percent). In South Asia, Nepal and India had the largest losses.[9]

Inflation

Inflation (Consumer price annual growth percent) rose in all parts of South Asia. In Pakistan, it was highest. It rose from 6.8 percent in 2019 to 10.7 percent in 2020. In Nepal it rose to 6.1, Sri Lanka 4.6 percent, Bangladesh 5.6 percent and in India 6.2 percent. The rise of inflation led to a decrease in private consumption growth (annual %). In Bangladesh, it reduced from 4.9 to 3.0 percent, in other countries it went to negative. Like in India -6.0 percent, Sri Lanka -3 percent, Nepal 3.6 percent and Pakistan -3.1percent were registered in 2020. This brought immense economic distress to the vulnerable population, including the CDWD, in South Asia.

Debt

In the year prior to the onset of the pandemic, the region was already seeing rising levels of public debt. Exports and investments were already weak or in decline in 2019 (except for investments in Nepal and Bangladesh). India and Bangladesh in particular were seeing a decrease in loanable funds. With the outbreak of COVID-19 and the resulting economic recession, remittances—a major source of external income and foreign exchange in the region—are expected to decline. The General Government Debt (% of GDP) of Bangladesh, India, Sri Lanka, Nepal and Pakistan in 2020 has increased from the average growth of debt. They had debt of 31.7 percent, 88.6 percent, 109.7 percent, 36.3 percent and 81.1percent respectively. All of this implies that governments will be limited in terms of fiscal space, which

[8] Data bank, World Bank. Accessed on 22 Sep 2022.
[9] UNESCAP (2020). The impact of COVID-19 on South East Asia. Policy Brief. United Nations Economic and Social Commission for Asia. Available at: https://www.unescap.org/sites/default/d8files/2020-07/SG-Policy-brief-COVID-19-andSouth-East-Asia Accessed on 14 Sep 2022.

may constrain their responses to the pandemic and the recession (World Bank 2020). Sri Lanka had 69.8 percent external debt of its GDP in 2020. The situation in Sri Lanka deteriorated rapidly in 2022 and the whole country has fallen into turmoil.

Impact on CDWD

South Asian countries except a few have not been able to progress in Human Development Indicators. Education and health, the two most important sectors have not been developed, these countries are highly populated, and have a high density of people per sq km, and poverty and inequality are also high. Poverty, housing condition, literacy, health condition of individuals and groups determine how vulnerable they can be to any epidemic, disaster or emergency. The lower you are in a hierarchy the more vulnerable you are to disaster. This has been proven right in the case of CDWD.

Literacy

Literacy in South Asia is very low. It is lower than the low and middle-income group of countries they belong. India and Bangladesh have around 74 percent of people who are literate. Pakistan and Nepal are the lowest with 57.9 percent and 67.9 percent respectively. Sri Lanka is ahead in the region with 92.3 percent of people who are literate. Middle-income countries and low and middle-income countries have 84.5 percent and 86.6 percent of literacy. There is big gender and caste/group-wise disparity. CDWD have very low literacy, women among them in rural parts are mostly illiterate. In India, their literacy level is only 66.1 percent as compared to the all-India literacy level of 73 percent. Due to low literacy, they are involved in manual and menial jobs which gives them low income. Their representation in professional, high and middle-income jobs, corporate jobs, and government jobs is dismally low. Lack of literacy also makes them vulnerable to misinformation, low awareness, less access to government benefits and getting involved in superstitions. COVID-19-related health awareness bulletins and information, government relief attempts, medicine and hospital-related information, and health and vaccination camps were advertised through newspapers, television, radio and the internet. Those who were literate and had those appliances and knew how to use them were more informed and alert. CDWD relied on information coming only through the community. Many did not understand the severity of the pandemic, some believed that it was divine intervention; some started to worship COVID-19 as a goddess and relied on traditional curing methods. Some devotees with nowhere else to turned seeking divine intervention at temples dedicated to coronavirus goddesses in India and some other South Asian nations.[10]

Health System

The availability of doctors, nurses, and other health staff was critical during the COVID-19 period. The limited number of health professionals in unequipped hospitals, and the limited number of beds and equipment (ventilators, oxygen supply and other machines) aggravated the

[10] https://www.scmp.com/week-asia/health-environment/article/3135370/shes-angry-goddess-indias-coronavirus-deities-disease

situation. CDWD had to bear the brunt because it limited their access to medical care. They live on the outskirts of villages and slums and underdeveloped areas of cities where there are no hospitals and healthcare services. Hence, they had to rely on quacks or do self-medication.[11] There were only 0.63 doctors per 1000 people in Bangladesh in 2019 and in India there were 0.92 doctors only for the same number. India had the lowest number of doctors among the low and middle-income countries which had 1.38 doctors per 1000 people in 2017 whereas in high-income countries and middle-income countries the numbers were 3.72 and 1.49 respectively. The whole of South Asia had only 0.91 doctors per 1000 people. Similarly, nurses and midwives in South Asian countries are very low per 1000 people.[12] The unavailability of hospital beds was the most serious factor during the medical care of patients.[13] Private hospitals with all facilities were affordable to the rich and upper middle class/castes. During COVID time, CDWD and poor people had nowhere to go and they suffered the most and many lost their lives waiting for their numbers in government hospitals or helplessly at their homes.

Health Expenditure

Health expenditure by the government in South Asia has been neglected for a very long time. The total health expenditure of all South Asian countries put together in proportion to total GDP is significantly low at 3.03 percent. Whereas, in high-income countries and middle-income countries, it is high around 12-8 percent. Bangladesh, Nepal, Sri Lanka, India, and Pakistan expends 2.48 percent, 4.44 percent, 4.07 percent, 3.01 percent and 3.37 percent respectively. Similarly, **c**urrent health expenditure per capita (current US$) in the region is very low Bangladesh had US$ 45.85 Nepal had US$ 53.24 Pakistan had US$39.49 Sri Lanka had US$ 160.69 and India had US$63.74 per capita expenditure. These figures are very low for the high-income countries and low-income countries group which is US$268.88 and US$5638.68 respectively. This implies how the health system simply betrayed the poor and CDWD and let them die during the pandemic time.

Out-of-pocket expenditure (percentage of current health expenditure) is high among South Asian countries. It has the highest share percentage around 56.03 percent whereas other regions and

[11] Covid-19 infection was unpredictable, minor symptoms drastically changed into a critical stage in day or two leading to death. Hence from beginning to full recovery patients were needed to be in direct monitoring of health professionals. This did not happen as cases were magnanimously high in numbers and health professionals and supporting system were very low and unprepared, so the health system just collapsed.

[12] The number of nurses and mid wives in Bangladesh and Pakistan it is only 0.39 and 0.48 respectively. The situation is little better in Bhutan, Nepal, Sri Lanka, and India who have 1.82, 3.3, 2.26 and 2.38 nurses and midwives respectively. Community health workers in South Asia are only 0.51 per 1,000 people. In 2015 Pakistan had 0.087 community health workers per 1000 people. The situation is similar in all states; India has 0.58 community health workers per 1000 people.

[13] In Nepal there were 0.3 beds per 1000 people. Pakistan, Bangladesh, Sri lanka and India have 0.63, 0.79, 4.15 and 0.53 beds respectively. Only Sri Lanka had better condition to admit Covid patients. India with 0.53 beds had the lowest bed availability in the region. In high income countries the bed availability per 1000 people stands for 5.28.

economic groups have lower than 35 percent, in the higher economy it is below 13 percent.[14] The number of people who fall below the poverty line because of out-of-pocket health expenditure is high in the region. Hence, CDWD has not been availed of treatment on time and remained unattended for many illnesses. One of the main reasons for high fatality in patients was due to comorbidity. They also fell into the debt trap.

Water and sanitation

To stay safe, hand washing at regular intervals was important for people who went outside. Besides that, the use of a common toilet system, water facility, and any items where the virus could be alive was crucial in curtailing the chances of getting infected. So, the unavailability of safe water and sanitation facility played a significant role in the spread of the virus. Some studies found that viruses were detected in stools, and open sewage systems had the potential of spreading them. South Asia has a very low status in these aspects. In cities, people live in congested areas with unsafe water system, use a common toilet system, and sewerage is uncovered. In other parts, these facilities are not available to a large section of people, mostly CDWD.[15] People with basic hand washing facilities including soap and water in Bangladesh, Nepal, Pakistan and India were 58.40 percent, 62.14 percent, 80.06 percent and 67.72 percent respectively. The average in the whole region stands at 67.78 percent only. Hence a large section of society did not have the facility to hand wash with shops daily.

Housing Conditions

Housing conditions like its location, space, number of rooms, ventilation, water and sanitation are determinants in the spread of communicable diseases. In Indian cities, millions of people are homeless and live on the streets, and multigenerational families stay together in crowded homes, all of which made social distancing impossible. South Asian cities have enormous slums,[16] about 25–30 percent of the population of India's largest cities live in slums. Around two-thirds of Karachi's population and 4 million people in Dhaka are slum dwellers.[17] These slums were hot spots during the pandemic. Dharavi (Mumbai) was the worst hit, it is the largest slum where low castes/class, migrants and CDWD live.

[14] In Bangladesh the share was 72.67 percent, in Nepal it was 57.91 percent , in Pakistan it was 53.80 percent, in Sri Lanka it was 45.63 percent and in India it was 54.78 percent in 2019.

[15] The percentage of population using safely managed drinking water services in Bangladesh, Nepal, and Pakistan were 58.51percent, 17.57 percent and 35.83 percent respectively in 2019. The percentage of population using safely managed sanitation services in Bangladesh, Nepal and India were 38.66 percent, 48.64 percent and 45.90 percent respectively. Only 44.7 percent of population in South Asia has safe sanitation system.

[16] The Ebola epidemic in West Africa from 2014–16 was driven by transmission in slums. Overcrowding, lack of clean water and sanitation, indoor pollution, the prevalence of chronic medical conditions and malnutrition all make slum residents susceptible to disease.

[17] The world's largest slums are in South Asia and many of these are home to huge numbers of people, for example the Orangi area in Karachi, Pakistan (2.5 million), Dharavi in Mumbai, India (1 million), and the Rohingya camps in Cox's Bazaar, Bangladesh (about one million)

South Asian countries have a high rate of morbidity due to household air pollution and unsafe water and sanitation facilities. Hence, in the situation where people already getting sick and reported to have high chances of morbidity due to household conditions, this added fuel to the growing COVID 19 infection. The mortality rate attributed to household and ambient air pollution per 100,000 populations in Bangladesh was 149, in Nepal was 193.8, in Pakistan was 173.6, in Sri Lanka was 79.8 and in India was 184.3. Mortality rates attributed to unsafe water, unsafe sanitation and lack of hygiene per 100,000 populations 11.9, 19.8, 19.6, 1.2 and 18.6 for the same countries respectively.

Informal sector

The share of informal labour in total employment ranges from 70 percent in Sri Lanka, to almost 95 percent in Bangladesh. Due to the shutdown, the relative poverty rates among informal workers increased to 40 percent in Bangladesh and 91 percent in Sri Lanka. In Nepal, more than a million informal sector workers have lost their jobs temporarily or permanently and are in need of relief materials from the state.[18] CDWD mostly works in informal sectors. In India, 84 percent of CDWD are in this sector in comparison to 54 percent of high castes. The share of regular salaried non-farm workers, who were most affected, was 63 percent for the CDWD. This sector has no job security, contracts and, or social security.[19]

CDWD are involved in unhygienic and hazardous occupations. The leather industry, mines and quarries, mica industries, garments[20] industries, brick- kiln, etc. have a high percentage of CDWD workers even children and women are involved in great numbers.[21] The unhygienic conditions, working in cramped areas, and laborious and long periods of time made CDWD more vulnerable to the pandemic. Manual scavengers (*Safai karamcharis*) mostly belong to the Valmiki community and other Dalits, similarly, a hundred percent of cremators belong to Dom/Chandal caste, and both were involved directly during the pandemic. While the former was involved in the cleaning of beds, hospitals, streets, sewage, etc., the latter handled dead bodies and did cremation. The health workers mainly nurses, attendants, janitors, *safai karamcharis*, and cremators were the ones who were in direct contact with COVID patients. The study titled

[18] Awasthi, G., (2020). Gokarna reviving the world after covid-19 crisis. Kathamdu Post. April, 24

[19] In 2018-19, nearly 89 per cent of the CDWD were without any contracts or with contracts that were for the less-than-a-year period.

[20] In Bangladesh RMG products alone cover 83 percent of the country's export. Nearly USD 3 billion worth of work orders were canceled during Covid-19 that affected about 4 million people directly involved in this industry (Paul, 2020). Many RMG workers lost their jobs and did not get their previous months' salary.

[21] In 2017, extensive field research into the Indian leather industry found unacceptable health risks in production hubs supplying hides, leather, and footwear for export. The report uncovered that Dalits and Muslims made up most of the 2.5 million leather workers. Low caste, Dalit and Adivasi workers make up most of the workforce mining stones and minerals in India. Low castes, predominantly Dalits, form the majority of the workers in the carpet-weaving industries in India and Pakistan. About 20% of the workers are children and about half of the workers are found to be subject to forced labour. In 2018 a report by Anti-Slavery International documented widespread slavery in India's brick-making industry and found that the majority of workers are Dalits. Whole families, including small children, work 9-12 hours a day in debt bondage. 80%Of those working in bonded labour in India, Pakistan and Nepal are Dalits or indigenous.

"*Risk stratification as a tool to rationalize quarantine among health care workers exposed to COVID-19 cases – Evidence from a tertiary healthcare centre in India*" shows that a total of 321 positive cases were reported to the Central Contact Tracing Team from April 11 to June 8. Of these, 238 (74.1 percent) were healthcare workers and other employees, while 83 (25.9 percent) were patients admitted in non-COVID areas due to other medical conditions. Among the COVID positive HCWs, the largest proportion was contributed by hospital attendants and sanitation workers (35.3 percent), followed by nurses (17.2 percent), and security personnel (13.3 percent). Doctors and laboratory staff contributed about 12 percent while others included administrative staff (5.5 percent), and other workers.[22]

Unemployment

The International Labour Organization (ILO) estimates the loss of 25 million jobs and the United Nations Development Programme (UNDP) foresees USD 220 billion in loss of income for developing countries (UNDP, 2020, ILO, 2020). South Asia led with 315 million jobs lost because of the pandemic. The unemployment rate was high from the 2019 figure in 2020. Almost all countries experienced a rise in the unemployment rate. In Bangladesh, Nepal, Pakistan, Sri Lanka and India, the unemployment rate of the total labour force was 4.43 percent, 3.09 percent, 3.54 percent, 4.35 percent and 5.27 percent respectively. The pre-pandemic picture of India shows that in 2018-19, a higher percentage of CDWD workers (6.4) were unemployed, compared to the national average of 5.8 percent (5.9 percent for high castes, 5.8 for OBCs and 4.3 for STs).[23] Hence unemployment rate among CDWD in South Asia was already high, during shut down unemployment among them grew more. Among them, rickshaw pullers, cobblers, daily wage earners and all involved in informal sectors lost their jobs.

Poverty

In general, the poverty impacts of the COVID-19 crisis were estimated to range between 1.8 to 2.3 percentage points in poverty headcount ratios, with between 32 and 42 million previously non-poor people falling into poverty (ADB, 2021). The impact of COVID-19 on poverty in South Asian countries ranged from around less than a percentage point (10 percent) increase in Nepal and a 13 percent increase in India to a staggering 62 percent in Sri Lanka. However, given the already high rates of poverty in Nepal and India before the crisis, these increases mean that a considerable number of non-poor people are projected to fall into poverty. The same goes for Bangladesh, where both pre-crisis levels of poverty and the impact of the crisis are significant. At a regional level, the crisis is projected to increase extreme poverty so that it will reach 316 million people, or 17 percent of the South Asian population, with the highest absolute numbers in India (266 million), Bangladesh (28 million), and Pakistan (17 million) (Laborde, Martin, and Vos 2020).

[22] Sanitation workers, attendants most vulnerable to Covid-19 among hospital staff: AIIMS study- The New Indian Express
[23]NSS-PLF survey for 2018-19 on employment

The international poverty rate ($1.9 in 2011 PPP) rose from 4.4 percent to 5.4 percent in Pakistan in 2020. The lower-middle-income poverty rate ($3.2 in 2011 PPP) rose from 35.7 percent to 38.7 percent. The upper middle-income poverty rate ($5.5 in 2011 PPP) increased from 39.3 percent to 42.3 percent in Sri Lanka.[24]

Food security

Access to food for many vulnerable urban residents was also compromised during the pandemic lockdown. High urban population density subjected to movement restrictions, physical distancing and closure of many market outlets, made accessing food particularly difficult during the pandemic. The poor and slum dwellers were unable to stockpile food and the closure of street markets during quarantine further exacerbated the food insecurity status of the urban poor.

Globally, there were nearly one in three people in the world did not have access to adequate food in 2020 – an increase of 320 million people in just one year.[25] The global average of 30.4 percent, remains particularly high in South Asia at 43.8 percent in 2020. South Asia has the highest percentage of undernourished people in the world. In Bangladesh, Nepal Pakistan Sri Lanka and India 9.7 percent, 4.8 percent, 12.9 percent 6.8 percent and 15.3 percent of people are undernourished[26]. Income loss and rising prices for essential foods reduced people's access to food, resulting in lower consumption of nutritious foods such as vegetables, fish, eggs and broiler meat. The FAO data reveal that 2020 was a year of food inflation which increased significantly compared to 2019.[27] The average daily wage earnings of CDWD are low, so job loss and inflation both affected their food consumption and dietary habits. In India, salaried

[24] According to a survey of Bangladesh Bureau of Statistics: (i) the average monthly income of each household was BDT 19,425 in March 2020 that came down to BDT 15,492 in August 2020 (ii) the average expenditures of a family were Tk 15,403 in March 2020 that came down to Tk 14,119 in August 2020 i.e. household expenditure came down by 6.14 percent during the period; (iii) some 68.39 percent of the families went through financial crisis among which 21.33 percent with monthly income BDT 20,000 or less received government reliefs and assistance during April -July 2020; (iv) the country had 08 percent day labourers in March 2020 that came down to 4 percent in July 2020 but, again raised to 7.5 percent in September 2020; (v) there were 17 percent businessmen in the country in March 2020 that came down to 10 percent in July 2020 but, again raised to 17 percent in September 2020 in the new normal situation; (vi) the agriculture sector of the country had not been much affected in between March-July 2020, due to the outbreak.

[25] Data bank, WHO, Accessed on 17 Sep 2022

[26] In Sri Lanka, a study using FIES found that nearly half the food-secure households from pre-COVID-19 times had moved into the food insecurity category. In Bangladesh, the food security situation was tracked through the pandemic stages using FIES. Three weeks into lockdown around 90 percent of households experienced a negative income shock, affecting daily casual labourers most of all. The proportion of food-secure and mildly insecure households declined by 10 percentage points and the number of severely insecure households increased drastically by 30 percentage points. Food insecurity increased during the pandemic in 2020, more during wave 1 (with 67 percent of survey participants were moderately food insecure) then wave 2 (\56 percent of participants were food insecure) (FAO, 2022)

[27] FAO, 2022, Pakistan and Bhutan emerged as vulnerable countries, Pakistan had the highest shares of food spent from household budgets 42%, India 30%, 2016(Our World in Data.org/food-prices, share of consumer expenditure spent on food, accessed 17 Sep 2022)

CDWD informal workers earned only Rs 269 a day (upper castes, Rs 357) the average earnings of casual CDWD wage labourers was Rs 311 (upper castes Rs 331).[28]

Children

Unemployment, job uncertainty, and poverty affected children eating and emotional habits. Many immunizations and nutritious programmes run by different agencies were postponed/ stopped. This have had an impact on the health of poor children. A study covering 118 LMICs estimated a 14.3 percent increase in moderate or severe wasting among children under five years due to COVID-19.[29] It means, disruption in the food supply, like (mid-day meal, ICDS in India and other countries), immunization, and medicine supply, whose beneficiaries are mostly CDWD children, suffered during the pandemic. As these children have a high percentage of undernourishment, undergrowth, diseases and exposure to the pandemic may have caused or contributed to an increase in child mortality. Eighty-five percent of children involved in child labour in South Asia belong to CDWD and 100 percent bonded child labourers are CDWD. The economic distress on the family would lead to more involvement of them in labour and trafficking.

Children were forced to remain at home, their schools were closed. In India *anganwadis* were shut. They had to face mental stress during the last two years. Online classes were started but they were only within reach of the rich and upper middle class of society. As 51 percent of Scheduled Caste households have adult women who have zero years of education, i.e., are illiterate, and 27 percent have an illiterate adult male member were much less equipped to assist their children with any form of home learning, compared to parents of upper caste children. These proportions are in stark contrast to upper caste households, where the corresponding proportions are 11 percent and 24 percent respectively. Their economic conditions and know-how of technology affected CDWD children's education. The proportion of households with access to the Internet is 20 percent and 10 percent for upper caste and SC households, respectively. Only 49 percent of SCs have bank savings, as compared to 62 percent of upper-caste households. Thus, differential accesses to information technology, as well as disparities in the ability to invest in technology were critical in access to online education.[30]

Health impact

[28] NSS-PLF survey for 2018-19 on employment

[29] Derek Headey, Rebecca Heidkamp, Saskia Osendarp, Marie Ruel, Nick Scott, Robert Black, Meera Shekar et al. "Impacts of COVID-19 on childhood malnutrition and nutrition-related mortality." *The Lancet* 396, no. 10250 (2020): 519-521.

[30] Deshpande and Ramachandran,2021

The novel coronavirus compounds and complicates the disease burden among the poor who are major victims of Tuberculosis.[31] Pre-existing morbidities, communicable (e.g., TB, HIV) and non-communicable (e.g., cancer, health ailments, kidney problems, hypertension and diabetes), worsened the condition of COVID patients. The causes of death by communicable diseases, and maternal, prenatal and nutritious conditions and mortality from CVD, cancer, diabetes, or CRD are both high South Asian regions. During COVID 19 people who were ill from some other diseases had more chances to get into critical conditions. The incidence of tuberculosis (per 100,000 people in India was 188, in Bangladesh, it was 218, in Nepal, it was 235 and in Pakistan, it was 259 in 2020. The mortality rate from TB is also the highest in the region. It is mostly the poor who suffer from TB. It makes clear that COVID-19 affected CDWD and the poor severely as they were weak and had other illnesses which led to high tolls in their death. The NFHS data for 2018-19 in India clearly shows that CDWD has a high percentage of TB, anemia, malnutrition, and other non-communicable diseases. Women from the CDWD were underweight, anemic and suffered from hypertension. The mortality rate of them before reaching the 60s is also high, in fact, both men and women of CDWD die in higher numbers before reaching their 18th year and before reaching their 45th year. The effect of COVID-19 will be felt in other ailments too. Late vaccination and immunization for different diseases, not being treated for a long period of time, treatment by quacks, poor nutrition intake, hypertension, diabetes, mental stress, etc. will lead to more illness among CDWD people.

Migration

Migration in South Asia is extremely high, according to the Indian census records of 2011, over 450 million internally displaced migrant workers exist of which 30 percent fall below the age of 30. Among them, over 100 million belong to the poorest category, and they largely work as footloose laborers. They are often the main breadwinners in their families, and they transfer part of their salaries to support relatives. A similar scenario is in other parts of the region. CDWD migrate to large cities in search of livelihood and escape the caste system. Many of them also migrate to outside countries. Remittances play a significant role in supporting their families back home. They are forced to live in slums, construction areas, and makeshift homes. The announcement of the lockdown in India with a notice of fewer than 4 hours spread panic and anxiety. They suddenly lost their jobs and without money, they could not stay hence they started to reach their villages by any means. Public transportation was overwhelmed, and migrant families had to walk or hitch truck rides for hundreds of miles. Job loss among them was very high, and a survey in Bihar and UP in India reported that 73 percent of the respondent migrant households have lost their jobs or main income source.[32]

[31] Stop TB Partnership (2020), published in May 2020, estimated that cases of TB in 2020–2025 could increase by more than 600,000 for every month of lockdown and more than 400,000 for every month of restoration. This translates to excess deaths from TB during the same period of more than 125,000 for every month of lockdown and more than 80,000 for every month of restoration.

[32] Population Council, India, 2020.

Caste discrimination and crimes

The customs of purity and pollution were reflected during the pandemic. Social distancing measures reminded us of the caste system. Poor, people involved in unclean work, caste involved in low-status work, hamlets of poor, etc. all appeared virus carriers for the middle and upper middle class. Instead of thanking *safai karamcharis* in similar ways, people were thanking and praising doctors, they were called to be a spreading virus. Some migrant workers were also crushed by trains.[33] Two men in a quarantine center of an Uttar Pradesh district refused to eat food cooked by a Dalit panchayat chief.[34] When the Prime Minister appealed to the masses to turn off the lights in homes across the nation on 5 April 2020 evening, a Dalit family of eight was attacked by armed upper-caste assailants for not following up with the leader's call to put off their house lights that led to serious injuries.[35] Furthermore, a child died in Bihar due to hunger since the parents lost their jobs and were left with no money.[36] Some victims were also pushed toward suicide due to extreme physical and mental agony. A Dalit youth from Uttar Pradesh, for example, was a contract worker in Delhi. He had no money after he lost his job, so started to walk home. After reaching his village, he was put in quarantine by officials. In an audio message shared with his friends, he said that he was beaten badly by a policeman who belonged to the upper caste.[37] These are some of the incidences CDWD had to go through during COVID-19. According to NCCRB data, crimes against CDWD increased to more than 9 percent in 2020. Crimes against CDWD women also increased.[38] Similarly, reports of Dalit organizations in Nepal, Bangladesh and Pakistan show high crime rates against Dalits during the pandemic.

Vaccination

Vaccination started in high-income countries; slowly it peaked in South Asia and other parts of the world. The first dose of vaccination is given to most people above 18 years. However, in the second dose, the vaccination momentum diminished. It was reported that in India, till September only 68.75 percent, in Bangladesh 75.04 percent, in Nepal 77.8 percent, in Sri Lanka 68.61

[33] On 8 May 2020, a group of workers belonged to the tribal communities were walking home, and along the way, they sat on the railway tracks to rest. They were not expecting trains to run as the government had already stopped them. When they were asleep on the tracks, 16 of them were crushed by a moving cargo train that came in early hours.

[34] Srivastava, Piyush. 2020. "Untouchability, even in Quarantine" The Telegraph, April 12, 2020.

[35] Scroll.in. Covid-19: Dalit family in Haryana attacked for allegedly not following PM's call to turn off lights. 2020. [online] Available at: https://scroll.in/latest/958665/covid-19-dalit-family-in-haryanaallegedly-attacked-for-not-following-pms-call-to-turn-off-lights. Accessed 15 Sep 2020.

[36] Thewire.in. COVID-19 lockdown: 8 year old dies of hunger as family struggles to make ends meet. 2020. [online] Available at: https://thewire.in/rights/bihar-starvation-deaths-lockdown. Accessed 15 Sep 2022.

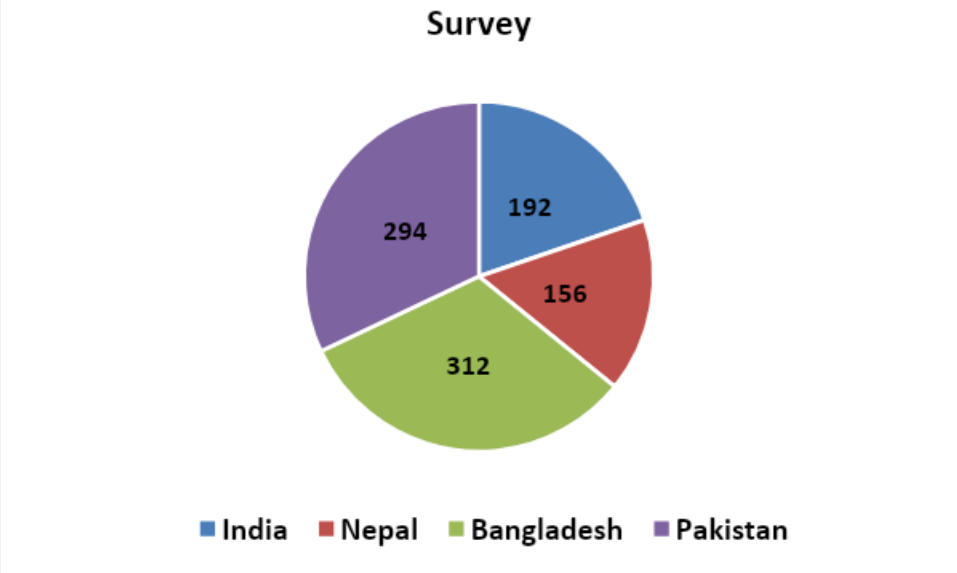
[37] He wrote, "Friends, if someone doesn't believe, then take off my clothes and see. You will not find anything but bloodclot all over my back. I'm going to commit suicide after this as I do not want to live. My hand has been broken. What will I do now in my life? Despite this, nobody came forward to help, that is why I'm taking this extreme step" Newsclick.in. UP: Dalit youth found hanging from tree after allegedly being beaten up by cops. [online] Available at: https://www. newsclick.in/UP-Dalit-Youth-Found-Hanging-Tree-AllegedlyBeaten-Cops. Accessed 15 Sep 2022.

[38] AIDMAM and other Dalit organisations has documented increased crimes against Dalits in India.

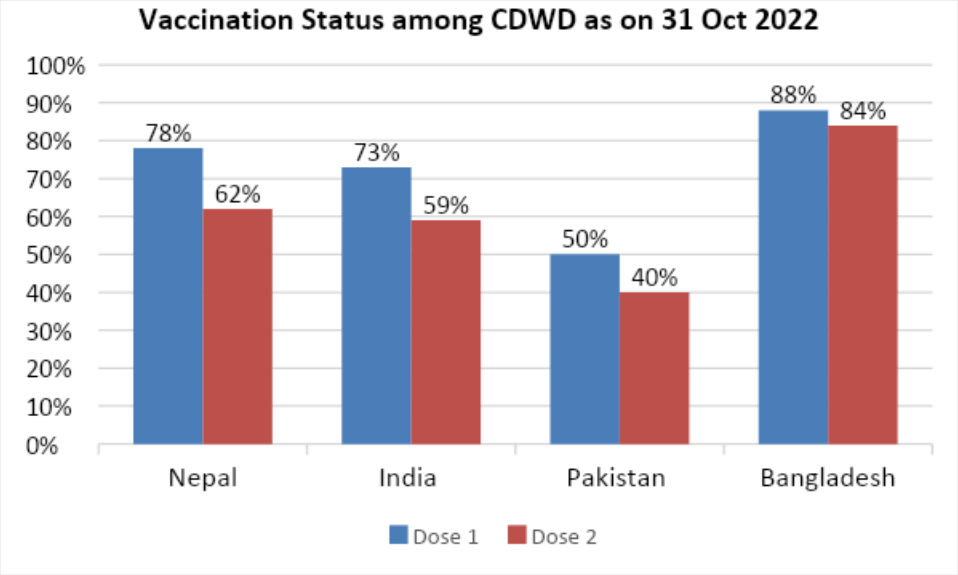
percent and in Pakistan 59.41percent has been administered. The condition for a booster dose has also diminished all over the world.

Survey and analysis

A survey was conducted in four South Asian countries to assess the status of vaccination and related concerns among Communities Discriminated on Work and Descent as on 31 October 2022. 954 CDWD respondents, including 156, 192, 294 and 312 were surveyed from Nepal, India, Pakistan and Bangladesh respectively.



While a total of 685 (72%) out of 954 respondents including 503 males and 451 females received the dose 1 COVID vaccine, 592 (62%) respondents said they have received the dose 2 COVID vaccine. The percentage of respondents who received the first and the second dose of vaccine in the respective countries include Nepal Dose 1 - 78% (122 respondents), Dose 2 – 62% (97 respondents), India Dose 1 – 73% (140 respondents), Dose 2 – 59% (114 respondents), Pakistan Dose 1 – 50% (147 respondents), Dose 2 – 40% (119 respondents), and Bangladesh Dose 1 – 88% (276 respondents), Dose 2 – 84% (262 respondents) respectively.



The survey also found that 57% of respondents in India had COVID, while it is 81% in Pakistan and 16% in Nepal respectively. It is interesting to note that none of the respondents in Bangladesh claimed that they had COVID. Even the number is less in Nepal. This states the lack of awareness among the CDWD in Bangladesh and Nepal when it comes to COVID.

This is when country information on COVID vaccination status states that 68.4% of the world population has received at least one dose of a COVID-19 vaccine.[39] Whereas 12.97 billion doses have been administered globally, and 2.07 million are now administered each day, and 24.5% of people in low-income countries have received at least one dose. The overall numbers in vaccine administration in these South Asian official records also differ. While India claims that 74.5% of the total population received the first dose and the second dose 67.5%, it is 83% (Dose 1) and 71.3% (Dose 2) in Nepal, 63.6% (Dose 1) and 59.1% (Dose 2) in Pakistan, and 79.6% (Dose 1) and 73.5% (Dose 2) in Bangladesh.[40]

Country response on TRIPS waiver on COVID Vaccine

In late 2020, India joined South Africa in an attempt to convince the World Trade Organization (WTO) to waive intellectual property rights on effective COVID-19 vaccines to enable greater production levels. The two countries jointly proposed to relax the Trade-Related Aspects of Intellectual Property (TRIPS) Agreement (1995) to facilitate swifter and more affordable access to vaccines. Pakistan supported the request seeking a waiver from certain provisions of the TRIPS Agreement for the prevention, containment and treatment of COVID-19. A group of powerful signatories, including the European Union, United Kingdom, Switzerland, and Norway, opposed this proposal, and, despite the support of over 100 countries, negotiations stalled.

[39] https://ourworldindata.org/covid-vaccinations
[40] https://graphics.reuters.com/world-coronavirus-tracker-and-maps/vaccination-rollout-and-access/

Recommendations

- Demand for allocation resources for Disaster Risk Reduction and capacity building for Dalit and other DWD communities through dedicated funds like Sub-Plans at country levels
- Inclusive, universal coverage of all Dalits and other DWD communities under existing national security schemes particularly those for livelihood and income support, preventive and curative healthcare, and food and nutrition security, on an urgent and priority basis.
- Economic packages (cash and in-kind assistance) oriented towards Dalit and other DWD communities which allow for flexibility in access to these packages (in terms of documentation required, ability to access the packages, etc.) must be rolled out
- Introduce social security measures, especially for the livelihood and income security of informal/unorganized sector workers.
- Access to healthcare support and insurance, such as having a government health card with sufficient credit to access healthcare facilities. Access to subsidized sanitation, hygiene, and health facilities for Dalit and other DWD communities.
- Ensure CDWD living in remote areas have valid ID proofs
- Promote employment opportunities for CDWD, rather than having caste-based occupations
- Awareness, free and universal vaccination should be provided to the poor and CDWD
- States must create a database or disaggregated data of individuals to enhance identification of those who have not secured relief entitlements and to ensure that efforts can be made in the future for more pointed relief for the most marginalized within the DWD communities, such as women, people with disabilities, LGBTQ+ individuals and the elderly. Subsequently, ensure that those left behind are prioritized.
- COVID-19 is not gone, and new variants can spread, so emergency measures should be decentralized