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Responding Today for Tomorrow: South Asia

Regional Report, 2023

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FOREWORD

The COVID-19 crisis has sent shock waves across the region, upending lives, plunging families into economic precarity, compounding the existing learning and nutrition crises and propelling anxiety disorders among children to an all-time high.

Food and energy prices have spiked, impacting the most vulnerable families first. A devastating new war and humanitarian crisis in Europe has threatened international stability. And record heatwaves and catastrophic floods have led to a scale of climate devastation in the region unlike anything we have seen before.

This Report is the first in a series that aims to collect evidence and draw lessons on how progress for children can be sustained in the face of multiple overlapping shocks.

Our analysis is resolutely optimistic, befitting a region where economic growth and social progress was strong before the pandemic. Indeed, South Asia has emerged from the economic downturn caused by COVID-19 relatively swiftly- thanks in part to a host of impressive achievements, such as immunizing over 1 billion people and expanding income, food and livelihood support to an additional 400 million.

Still today, South Asia is one of the few regions in the world where prospects for economic growth remain. Acting now to make cost-effective investments in children's health, nutrition, learning, safety and well-being is one of the most surefire ways to secure long-term social and economic growth for the region.

Such investments need not be costly, but they must be strategic, focusing particularly on safeguarding investment in human capital- especially the cognitive capital of children in the early years- and ensuring child-centred reforms in the health, education, social protection and child protection systems.

This will not only help address the upheaval of compounding crises on girls and boys in South Asia, but also build strong systems which help safeguard progress against future shocks.

By firmly placing children at the heart of economic and social policy, countries in South Asia will reap long-term economic and social benefits.

George Laryea-Adjei
Regional Director, UNICEF South Asia

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METHODOLOGY

The key research question of the "Responding Today for Tomorrow" project is how macro-level instability, caused by unfolding global challenges (i.e., the COVID-19 pandemic and subsequent economic crisis characterized by macroeconomic uncertainty, high prices and supply chain disruptions), impact on children and countries' long-term development opportunities in South Asia.

One of the key challenges in addressing this research question lied in finding adequate benchmarks from which data could be compared over time and across the region. In the case of the pandemic, the obvious reference year was 2019 i.e., the year before any official cases of COVID-19 had been recorded. For measuring the direct impact of the pandemic on the population, the report uses a combination of administrative data, which captures the officially recorded COVID-19 infection and death cases, as well as results of representative surveys that involved taking blood samples of survey participants (serosurveys).

Major representative surveys that provide a wealth of child-related data and use a coherent methodology across countries and over time (such as the World Bank-supported Income and expenditure surveys, the Demographic Health Surveys, DHS or the Multiple Indicators Cluster Survey, MICS) are normally conducted once or twice a decade rather than on an annual basis. It was, therefore, fortunate that in half of the eight countries – including some with the largest child populations –, these surveys were available for 2019 or 2018 (while the other found countries had child-outcome-related surveys between 2010 and 2016).

Measuring the indirect impact of the COVID-19 crisis the report uses a mix of sources: results of rapid surveys (e.g., child and family impact tracker surveys capturing what people think and do), administrative reports (e.g., on service continuity and dislocation), and model estimates. These latter include impact estimates and "nowcasts" by the UN system agencies (such as the World Bank, the IMF, WHO etc.) and/or by groups of internationally renowned experts (published in high profile, peer-reviewed journals such as the Lancet). Typically, these estimates are based on regression analyses, first identifying the general or country-specific relationship between independent variables (e.g., change in GDP, employment, prices, number of days missed in schools) and key dependent variables (e.g., household income, learning outcomes etc.) to model the net impact of change in the independent variables (determinants). In the case of "nowcasts" the calculation assesses not only the net impact (of a dislocation or dislocations) but also the counterfactual: how the trend would have continued without the impact.

When the results of such calculations were available only for the total population or all households, the authors of the report have made an effort to adapt those results (e.g., on poverty or mental health) for households with children or the 0–17-year-old population mirroring the core methodologies used in the original source. Likewise, efforts were made to highlight and bring into the debate results of impact evaluation of interventions, such as cash transfers or nutrition-specific interventions. Such modelled predictions and impact estimates are useful to alert decision makers on the need to adjust policies, scale up investment, and to consider a broader range of protective factors. However, there are important limitations to these estimates, and to modelling approaches in general. It is essential to deconstruct models, to challenge the underlying assumptions.

In this context, the report encourages developing a national practice whereas preliminary estimates are made available and regularly updated not only for economic but also for social statistics, and in general expand the availability and publication of child-sensitive evidence in more real-time. Readers of the report should therefore continue to reach out for the latest surveys, results and estimates and keep the dialogue alive on evidence-based policy interventions for young children, adolescent girls and boys as well as women and men. These efforts are encouraged and facilitated by the detailed methodological notes and ample references attached to data, statistical tables and graphs presented in the report.

Finally, it should be noted that the interpretation of the data was assisted by reaching out to practitioners, authors of national or global reports as well as by feedback from a Reference Group consisting of eminent researchers from leading thinktanks in the region. These people, however, bear no responsibility for the data and analyses presented in the report.

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ABBREVIATIONS

ADB	Asian Development Bank
ANC	Ante-natal check-up
AP	Aama/ Safe Mother Programme
ASPIRE	Atlas of Social Protection Indicators of Resilience and Equity
AWC	Anganwadi Center
BDT	Bangladeshi Taka
BISP	Benazir Income Support Programme
BLP	Below Poverty Line
COVID-19	Coronavirus disease (identified in 2019)
DEA	Department of Economic Affairs
DHS	Demographic and Health Surveys
ECA	Emergency Cash Assistance
ECD	Early Childhood Development
EIOS	Epidemic Intelligence from Open Sources
GDP	Gross Domestic Product
GNHC	Gross National Happiness Commission
ICCT	Afghanistan Inter-Cluster Coordination Team, United Nations
IGNOPS	Indira Gandhi National Old Age Pension Schemes
IGNWPS	Indira Gandhi National Widow Pension Schemes
IGNDPS	Indira Gandhi National Disability Pension Schemes
IIPS	International Institute for Population Sciences
ILM	International Learning Movement
ILO	International Labor Organization
INR	Indian Rupee
IPC-IG	International Policy Center for Inclusive Growth
IPCC	Intergovernmental Panel on Climate Change
IMF	International Monetary Fund
IIPHG	Indian Institute of Public Health Gandhinagar
JSY	Janani Suraksha Yojana
KWPF	Korea-World Bank Partnership Facility
LAYS	Learning Adjusted Years of Schooling
LKR	Sri Lankan Rupee
MCBP	Mother and Child Benefit Programme
MICS	Multi-Indicator Cluster Survey
MNRGES	Mahatma Gandhi National Rural Employment Guarantee Scheme
MVR	Maldivian Rufiyaa
NIPS	National Institute of Population Studies
NFHS	National Family Health Survey
NPR	Nepalese Rupee

NSER	National Socioeconomic Registry
Nu	Bhutan Ngultrum
OECD	Organisation for Economic Co-operation and Development
OxCGRT	Oxford Covid-19 Government Response Tracker
PM	Particulate Matter
PCP	Pakistan Center for Philanthropy
PHFI	Public Health Foundation of India
PKR	Pakistani Rupee
PMGKAY	Pradhan Mantri Garib Kalyan Anna Yojana
PMEP	Prime Minister's Employment Program (PMEP)
PMMVY	Pradhan Mantri Matru Vandhana Yojana
PPP	Purchasing Power Parity
PTI	Press Trust of India
PWLM	Pregnant Women and Lactating Mothers
SAARC	South-Asian Association for Regional Cooperation
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus-2
SDG	Sustainable Development Goals
SEARO	Regional Office of South-East Asia, World Health Organization
SPA	Single Parent Allowance
SRS	Sample Registration System
T-NSFP	National Supplementary Food Programme/ Thriposha
UHC	Universal Health Coverage
UNCTAD	United Nations Conference on Trade and Development
UNDESA	Population Division, Department of Economic and Social Affairs, United Nations
UNEP	United Nations Environment Programme
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UN IGME	United Nations Inter-Agency Group for Child Mortality Estimation
UN UHC	United Nations Universal Health Coverage
USAID	United States Agency for International Development
WCD	Ministry of Women and Child Development, India
WDI	World Development Indicators
WHO	World Health Organization

INTRODUCTION AND OVERVIEW

This report offers a summary of the situation of children in South Asia at a critical juncture: as countries are coping with the continuing impacts of the COVID-19 pandemic at the same time that the effects of new global political and economic tensions threaten their recovery. Home to one in four children globally, the region has an estimated 628 million children in 2022, 12 million more than in 2020. The future of these children and the economic security of the nations in which they live both depend on the degree to which leaders attend to the urgent needs of the current moment, and invest in responding accordingly.

The eight countries of the region had achieved important progress in child rights and well-being in the two decades before the pandemic. Between 2005 and 2019, under-five mortality rates were almost halved in South Asia, from 77 to 40 cases per 1,000 live births.[1] Reflecting much-needed progress in gender equity and child protection, early marriage has become less frequent: surveys before the pandemic showed one out of four to five young women were married before their eighteenth birthday,[2] while around the turn of the millennium this ratio was still one out of two.[3] The number of people living in extreme poverty was reduced from 500 to 156 million between 2007 and 2019, an impressive achievement given the growing population.[4]

In the aftermath of the global food, fuel and financial crisis of 2007-2009 that stymied growth elsewhere in the world, the rates of GDP growth and poverty reduction in South Asia have accelerated. While the region contains significant cultural diversity as well as a variety of demographic and socioeconomic indicators (see Table A), the eight countries undeniably shared in fast-paced economic and social progress over the last few years before the pandemic. In light of this, there had been few global regions which had as much to lose, in terms of opportunities for progress, as South Asia did when COVID-19 arrived. Still, the history of the region over the last three years contains not only setbacks, but also important victories.

[1] UNICEF Data: Monitoring the situation of children and women. See https://data.unicef.org/topic/child-survival/under-five-mortality/. Accessed November 2022.
[2] UNICEF Data: Monitoring the situation of children and women. See https://data.unicef.org/topic/child-protection/child-marriage/. Accessed November 2022.
[3] UNICEF. (2006). The State of World's Children 2007: Women and Children, The Double Dividend of Gender Equality. See https://www.unicef.org/media/84811/file/SOWC-2007.pdf.
[4] Poverty and Inequality Platform, The World Bank. See https://pip.worldbank.org/home.There is less data on changes over time in multidimensional poverty, but available data on the Multidimensional Poverty Index suggest India and Bangladesh suggest similarly large reductions. See: https://hdr.undp.org/content/2022-global-multidimensional-poverty-index-mpi#/indicies/MPI.

Table A: Key background statistics

Countries	2022 Population* (1,000s)		% of 0-17	Development Index (2021)		GNI per capita, 2021 (2017 PPP dollars)	Poverty headcount ratio (%) at national poverty line*	Multi-dimensional Poverty Index (MPI)**	Gini Coefficient ***
	Total	of which: aged 0-17		Human	Gender				
Afghanistan	41,129	20,687	50.3	0.478	0.681	1,824	54.5	0.272	31.0
Bangladesh	171,186	54,295	31.7	0.661	0.898	5,472	24.3	0.104	48.3
Bhutan	782	215	27.5	0.666	0.937	9,438	8.2	0.175	37.4
India	1,417,173	434,505	30.7	0.633	0.849	6,590	21.9	0.069	51.9
Maldives	524	132	25.3	0.747	0.925	15,448	5.4	0.003	31.3
Nepal	30,548	10,700	35.0	0.602	0.942	3,877	25.2	0.074	32.8
Pakistan	235,825	101,480	43.0	0.544	0.810	4,624	21.9	0.198	33.5
Sri Lanka	21,832	6,058	27.7	0.782	0.949	12,578	4.1	0.011	45.0

Source: Population, Gini coefficient: UNICEF Data Warehouse, accessed on 14 October 2022. https://data.unicef.org/dv_index/. HDI, GDI, GNI per capita: HDR 2021-22. https://hdr.undp.org/system/files/documents/global-report-document/hdr2021-22pdf_1.pdf. Poverty headcount: WB development indicators database, accessed on 14 October 2022. https://data.worldbank.org/indicator/SI.POV.NAHC MPI: https://hdr.undp.org/content/2022-global-multidimensional-poverty-index-mpi#/indicies/MPI

Notes: *Population data: Preliminary result of Nepal's 2021 population census shows the population at 29.2 million. **National poverty headcount ratio at national poverty lines (% of population), data refer to: Afghanistan (2016); Bangladesh (2016); Bhutan (2017); India (2011); Maldives (2019); Nepal (2010); Pakistan (2018); Sri Lanka (2016). The World Bank's 2022 report 'Poverty and Shared Prosperity, Correcting Course' quotes World Bank research, at https://openknowledge.worldbank.org/handle/10986/37273, which estimates that in India poverty headcount at the $1.90 poverty line has declined from 22.5 per cent to 10.2 per cent between 2011 and 2019. ***MPI: The data in the table refer to "MPI value", an index which reflects both the incidence of multidimensional deprivation (a headcount of those in multidimensional poverty) and its intensity (the average deprivation score experienced by those found multidimensionally poor according to this methodology). The MPI method is less suitable to measure short-term poverty impacts than the income-consumption based methods, but it eminently captures longer-term change in human deprivation. For example, in India between 2019/2021 and 2005/2006 the number of people exposed to multidimensional poverty were reduced by 415 million and both the MPI value and incidence of MPI poverty were more than halved. (Ibid.) Data refers to: Afghanistan (2015-16); Bangladesh (2019); Bhutan (2010); India (2019/21); Maldives (2016-17); Nepal (2019); Pakistan (2017-18); Sri Lanka (2016). ***Gini coefficient data refer to: Afghanistan 2017, Bangladesh 2016, Bhutan 2017, India 2012, Maldives 2016, Nepal 2011, Pakistan 2016, Sri Lanka 2016.

(a) The recent MPI value for Maldives Is 0.145 based on DHS 2016/17 HYPERLINK "http://statisticsmaldives.gov.mv/mpi-2020/" Maldives Bureau of Statistics > Multidimensional Poverty Index (statisticsmaldives.gov.mv); (b) The national MPI (NMPI) for Sri Lanka stands at 0.067 based on HYPERLINK "http://www.statistics.gov.lk/IncomeAndExpenditure/StaticalInformation/HouseholdIncomeandExpenditureSurvey-2019FinalReport" HIES survey (2019) data.

Chapter 1, 'The Pandemic and Its Economic Impact', shows how the pandemic has engulfed the region and how countries made substantial efforts to contain its spread and check its collateral effects. In 2020, when the world faced a formerly unknown virus and vaccines were still under development, governments in the region showed great determination to slow the spread of infections and save lives, even at the cost of strict lockdowns bringing whole sectors of the economy near standstill for considerable periods. High rates of immunizations achieved from mid-2021 and a rapid return of economic growth in most countries were clearly a success. Fiscal policy played a role in both, by softening the economic impact on households and businesses and increasing health spending. Agriculture has also played a stabilizing role. The analysis finds that COVID-19 infection spread more rapidly in urban areas, but that case fatality rates were higher in rural and less developed areas.

Chapter 2, 'COVID-19 Effects on Household Income, Child Poverty, and Social Protection', looks at labour market effects, household coping strategies and government support. Shoring up countries' social protection floors and enhancing systems that identify beneficiaries and deliver support has been a major policy success. Expanding social assistance was also a dire necessity given that the overwhelming majority of adults in the region do not have formal-sector jobs and the corresponding social insurance that could respond to the sudden and dramatic increase in poverty and joblessness during lockdowns. Expansion in social assistance coverage and benefit top-ups have strengthened further those cash and food aid interventions that were institutionalized at the time of the 2007-2009 food, fuel and financial crisis. Still, they rarely included child-sensitive social protection[5]: conditional and unconditional programmes focusing on maternal and early childhood well-being as well as children's education progress. As households with children, especially young children, were estimated to have a higher risk of monetary poverty before 2020, prioritizing preventive, life-cycle-oriented programmes over generic, means-tested poverty alleviation would

address this issue, as well as a number of other problems that families with children face in the post-lockdown context.

Chapter 3, 'The Multidimensional Impact of the Crisis on Children', identifies areas where inherited weaknesses in basic social services, in combination with pandemic-related disruptions, are expected to compromise the right of children to develop to their full potential. Four areas stand out in which the COVID-19 crisis has seriously undermined child rights: access to parental care, mental health, nutrition and learning.

- Translating official COVID-19 mortality figures into estimates on weaker parental and care capacities through a well-established methodology in the literature[6], at least 300,000 children may have lost one or both parents to COVID-19 related causes over the 24 months between March 2020 and February 2022 in the region. Men had significantly higher risk of COVID-19 mortality, which has particular economic implications in countries that still predominantly rely on a male-breadwinner structure, with relatively low female participation in paid jobs.[7] Given limited social insurance, surviving family members could face a highly precarious situation – as could the 2.8 million children who lose a parent due to all-cause adult mortality every year in the region. This latter includes maternal mortality, where COVID-19-related disruptions and stress are widely expected to have a negative impact.
- Social distancing, reduced mobility and heightened concerns about welfare and safety had detrimental impacts on the mental health of millions of people, according to a major global study.[8] Combining the study's estimates for the region on major depressive disorders and anxiety disorders, and considering possible overlaps, the analysis in the chapter estimates that an additional 7.5-8 million children may experience major mental disorders. An estimated 21-23 million children experienced such issues before COVID-19. Young girls and women are particularly vulnerable to mental health problems, increasing the risk of enduring, intergenerational impacts in the coming years and decades.
- The region-wide setback in real income in 2020 and the lingering effects of the lockdowns have undermined much-needed progress in addressing nutritional deficiencies among children. A 2021 modelling study[9] has projected that, due to delays in poverty reduction and COVID-19 related disruptions in health and nutrition services, between 4.4 and 6.3 million more young children will have experienced acute malnutrition, also known as wasting, in the three-year period following the first lockdowns. Considering that even before the pandemic 25 million children under five years of age – one child out of seven – had experienced wasting in South Asia, these projections are of serious concern.[10] Rising food inflation in 2021 and 2022 is increasing the risk of chronic food deprivation among children, with low height for age (also known as stunting) an issue still for nearly a third of young children in the region.[11]
- Most schools in the region were closed to in-person learning for most of the time over 2020-21, with far-reaching impacts on children. Despite great and often innovative efforts to replace school-based education with distance learning, the pandemic has led to a serious learning crisis. Learning poverty – defined as 10-year-olds who cannot read or understand a simple text – has increased from 58 per cent pre-COVID-19 to 78 per cent in the region, according to a World Bank modelled calculation.[12] Left unaddressed, the learning crisis could deprive families and economies in the region of trillions of dollars through forgone future wage earnings.

Considering all of these factors, combined with the fact that 35 million children aged 5-14 in South Asia were not in school before 2020, the development of the cognitive and non-cognitive skills of at least 200 million children under the age of 15 is likely to be showing serious gaps across the region. As COVID-19 has slowed or derailed statistical reporting, the full impacts of the COVID-19 crisis on children remain poorly understood and documented, yet they are almost certain to be profound.

The strong economic headwinds that reached the region in 2022, with regressions in global political stability, commodity price, exchange rate and lending rate stability and weakening global growth, have increased the cost of debt service, energy, fertilizer and food import. They make post-lockdown economic and social recovery an even more difficult task. Sri Lanka, an upper-middle income country with one of the highest ratios of sovereign debt in the region, defaulted on its debts in May 2022 amidst a serious cost-of-living crisis.

[5] UNICEF. (2019). UNICEF's Global social protection programme framework: A framework for child sensitive social protection. See https://www.unicef.org/reports/global-social-protection-programme-framework-2019
[6] Hillis, Susan D., et al. "Global minimum estimates of children affected by COVID-19-associated orphanhood and deaths of caregivers: a modelling study." The Lancet 398.10298 (2021): 391-402. See https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01253-8/fulltext.
[7] The World Bank Data. See https://data.worldbank.org/indicator/SL.TLF.CACT.FE.ZS?locations=NP). Accessed November 2022.
[8] Covid-19 Mental Disorders Collaborators. 2021. 'Global Prevalence and Burden of Depressive and Anxiety Disorders in 204 Countries and Territories in 2020 due to the Covid-19 Pandemic'. Lancet 398 (10312): 1700-1712. See https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2902143-7
[9] Osendarp, S., Akuoku, J.K., Black, R.E. et al. The Covid-19 crisis will exacerbate maternal and child undernutrition and child mortality in low-and-middle-income countries. Nat Food 2, 476-484 (2021). See https://doi.org/10.1038/s43016-021-00319-4.
[10] UNICEF, WHO and World Bank: Joint child malnutrition estimates- levels and trends- 2021 edition. See https://data.unicef.org/resources/jme-report-2021/
[11] Ibid.
[12] World Bank, 2022. The state of global learning poverty: 2022 Update: Conference Edition, June 23, 2022. See https://thedocs.worldbank.org/en/doc/e52f-55322528903b27f1b7e61238e416-0200022022/original/Learning-poverty-report-2022-06-21-final-V7-0-conferenceEdition.pdf.

This has triggered an even bigger fall in GDP and real incomes in the nation than did the advent of COVID-19 in 2020. Other South Asian countries are better positioned to weather the current storm. Still, risks associated with taking on more public debt, and/or low revenue ratios, limit what governments can do in term of proactive fiscal policy currently. This is a particular concern given the fact that all South Asian countries that submit data to the IMF were already experiencing negative trade and current account balances in 2021.[13]

Even though Bangladesh and India are expected to show some of the highest economic growth rates globally this year, they too had to make policy adjustments to weather the new macroeconomic volatilities.[14] Pakistan received a new IMF loan in August[15]; with Bangladesh starting negotiation for a pre-emptive loan from the IMF to bridge in October 2022. Therefore, three out of eight countries in the region are under IMF liquidity support – highlighting the need for policy reform.[16]

Chapter 4, 'Responding Today for Tomorrow', is forward-looking. It asks how countries can respond to compounding crisis impacts in ways that open new pathways to economic and social progress- while enhancing rather than constraining opportunities for the new generations. The analysis sees two major risks currently. The first risk lies in short-term solutions to macroeconomic tensions crowding out deeper economic policy reforms that would address the underlying causes of the region's vulnerability to shocks. The second risk is that current macroeconomic concerns will push aside proactive social sector reforms that could mitigate the detrimental impacts on children's lives and human capital that two hard years of COVID-19 have created. Because children's cognitive and noncognitive capital is the single most important economic resource for nations in the twenty-first century, addressing these needs and carrying out a coherent set of deeper economic and social policy reforms serve the same goal: child-friendly national progress.

The chapter argues that economic instability is linked to low productivity of labour, which in turns is linked to child poverty, insufficient investment in children's human capital, discrimination against women in the labour market as well as uneven regional development. Instability is also linked to low tax ratios over the value added, which pushes governments to lean on external resources for countercyclical economic policy and/or for emergency intervention (e.g., increasing liquidity support to enterprises and social assistance to poor and vulnerable populations, as was the case over 2020-2021). Because global shocks, disasters and climate change effects keep battering the region, there is a tendency for governments to accumulate external debt (which increases exposure to global volatility), and/or limit harm mitigation and put a low cap on investments in health, education and social protection. This, in turn, keeps labour productivity low.

The analysis suggests that the widescale informality of work – an emblematic issue in much of the region – is a major structural driver of these compounding problems. Informality implies job instability (as the huge return migration in 2020 has demonstrated), which goes against children's need for stability. It also implies lack of social insurance. Inadequate access to formal jobs and social insurance limits access to health care and reserves social protection coverage over the life cycle for the privileged few. As the compounding COVID-19 and cost-of-living crises over 2020-2022 have shown, this situation puts enormous political pressure on governments to secure social assistance (in form of food aid, cash transfers or price subsidies) to the majority of households lacking insurance.

Expanding formal employment would give a boost to countercyclical macroeconomic policy through automatic stabilizers (via unemployment benefits) and reduce social vulnerability through smoothing income over the lifecycle (via entitlements for children, the disabled and the elderly). The resources that this policy move could free up – for maternal and child nutrition, for social protection assisting early child development and education, for mental health, for universally accessible health interventions – could be invested at very high rates of return. The chapter argues that this shift is viable in the current macroeconomic and external context but would require careful planning and management to ensure that benefits outweigh costs in the short term, while countries will enjoy lasting benefits over the longer term.

Social sector reforms could augment and enhance the impact of these labour market reforms in nutrition and health, in social assistance and child protection, and in early childhood development and education. The post-lockdown social recovery requires planning and evaluation with a laser-sharp focus on efficiency and prevention; on effectiveness and quality; on equity and social justice. Digitalized social registries and upgraded information systems could strengthen multisectoral links and ensure that no child is left behind.

[13] IMF: World Economic Outlook Database. See: https://www.imf.org/en/Publications/SPROLLs/world-economic-outlook-databases#sort=%40imfdate%20descending
[14] 'India's economy faces significant external headwinds, IMF says', Bloomberg economics, 13 October 2022. See https://www.bloomberg.com/news/articles/2022-10-13/india-s-economy-faces-significant-external-headwinds-imf-says?leadSource=uverify%20wall
[15] 'IMF board releases over $1.1 Bln in Pakistan bailout funds', Reuters. 30 August 2022. See https://www.reuters.com/world/asia-pacific/pakistan-finance-minister-imf-board-approves-release-over-11-bln-bailout-funds-2022-08-29/
[16] 'Bangladesh has done well but has plenty to learn from India', Andy Mukherjee, Bloomberg. 2 August 2022. https://www.livemint.com/news/world/opinion-bangladesh-outshone-india-now-it-must-learn-from-its-neighbor-11659402078193.html

Responding Today for Tomorrow: UNICEF's recommendations

The recommendations of the report, presented in the last chapter, are organized into three groups.

The first series of recommendations are summarized under an over-arching theme: when responding to crises and aggregate shocks, build a coherent set of child sensitive economic and social policies that enhance stability, resilience and investment in human capital. The Report highlights ten priorities and policy opportunities which are listed below, but detailed in chapter 4. These are designed to strengthen child and gender rights and countries' human capital- especially children's cognitive capital, which holds the keys to productivity growth and sustained, long-term progress in the region. Moreover, observing these principles would provide relief to households and communities who are impacted by today's volatile international context, exacerbated by the increasingly felt effects of climate change.

The first of these policy priorities focus on key macro-level conditions of- and risks to- stability:

- pursue fiscal responsibility and prudent debt management
- combat climate change and environmental pollution
- ensure adequate levels of public revenues

The next three priorities consider institutional reform and recalibrated policy priorities for stronger resilience to aggregate shocks:

- implement countercyclical macroeconomic policy and build automatic stabilizers
- expand formal employment in the labour market i.e., jobs that offer income security, social and health insurance
- reallocate public revenues and keep engaging in multi-partner collaboration to address uneven development

The final four priorities set out opportunities for investment and mobilization of reserves to accelerate countries' economic and social sector performance in the rapidly changing world of the 21st Century:

- improve opportunities for women in the labour market by removing barriers associated with the unpaid care economy and expanding family support policies (i.e., cash and in-kind support to new parents, women and men, in their caring role).
- invest in human capital especially in the early years of life and adolescence when the rates of return– associated with stronger cognitive and non-cognitive capacities–- are particularly high
- build universal access to and adequate quality of basic social services by addressing gaps in in social protection floors and inequity in access to quality education, health, and child protection services
- harness digital innovation with focus on equity, disadvantaged youth and protection needs

The second set of recommendations of the report is centered around the urgency of recognizing the need for a child recovery from the compounding effects of the COVID-19 crisis while keeping the current cost-of-living threats under control. This requires a smart combination of special emergency-type measures with efforts to accelerate systemic reforms in the social sectors. This strategy entails establishing clear priorities in public budgets and national and sectoral plans so that health, education, social protection and child protection systems can respond to setbacks, such as losses of parents or carers, worsened mental health, disruptions in maternal and child nutrition, and in learning. An important precondition to action lies in evidence: without measuring and monitoring child outcomes at individual and group levels advocacy will miss power, policies will miss the compass needed, and interventions will not be able to find and help properly those in need.

The third set of recommendations focuses on data and evidence: what to learn from the COVID-19 crisis on evidence-based policymaking and how take advantage of today's digital revolution to enhance social registers and statistics. Improvements in digital capabilities can be used to continually enhance the coverage and accuracy of new social registers (the development of which has been accelerated by the COVID-19 crisis). They similarly offer a clear opportunity to upgrade the quality, breadth and speed with which social statistics and administrative data are collected. Data collection capabilities can be enhanced with fresh statistical surveys that monitor child outcomes in both existing and new areas, especially those where the COVID-19 crisis has left a strong mark. There is also an opportunity to adopt and align statistical models with official social statistics creating a new generation of preliminary estimates for improved decision-making ex-ante and/or in real-time. Sharing lessons learnt on the evidence and policy nexus and discussing related statistical methodologies in international fora could yield more useful, more resilient and more child-sensitive data systems.

As the report demonstrates, countries in South Asia have shown remarkable economic and social resilience in the face of the greatest disaster in recent human history. Even though countries are facing new macroeconomic challenges stemming from the unfavourable global context in 2022-2023, leadership and determination in acting for children and families today will secure a brighter tomorrow.

CHAPTER 1: THE PANDEMIC AND ITS ECONOMIC IMPACT

More than two years of repeated waves of the COVID-19 pandemic have had a wide-ranging and extensive impact on South Asia, home to 1.86 billion people, including 616 million children in 2020. By the end of August 2022, there were over 50 million confirmed cases of SARS-CoV-2 infections in the region, and more than 624 thousand people had died from the disease according to official data.[17] Impacts on the economy and public finance have been similarly profound. This chapter discusses the first two years of the pandemic and its economic fallout, highlighting features that increased vulnerability and factors that supported resilience. The analysis also reflects on the new threats such as the global surge of inflation and related pressures for economic adjustment policies. These threats weaken the ongoing economic recovery in the region in a time when families and children are still coping with the direct and indirect effects of the pandemic.

1.1. A region fighting with the pandemic

The first cases of COVID-19 were recorded in South Asia a few days before the WHO declared a public health emergency of international concern on 30 January 2020 (see Andrews et al. 2020, e.g.). Facing an uncertain amount of time until vaccines against COVID-19 could be made available, most countries in the region adopted a pre-emptive strategy that followed a socioeconomic containment model focused on flattening the epidemiological curve[18] through restrictions on mobility, economic and social activities, in addition to other measures.[19] Only Bhutan chose a zero-COVID-19 strategy initially (facilitated by its secluded geographic position).This section describes how the pandemic has engulfed the region. It relies on a combination of administrative and survey data on infections and mortality, while also citing model estimates on excess mortality by the World Health Organization (WHO) and recent data on progress with vaccination. Recorded infections have displayed high geographic concentration that reflects correlation with population density. And while infection numbers showed a positive correlation with per capita gross domestic product (GDP), the survival rates of COVID-19 exhibited a negative correlation with indicators of socioeconomic development. Thus, while COVID-19 spread more widely in urbanized areas, people in rural areas were at greater risk to succumbing to the disease once they became infected.

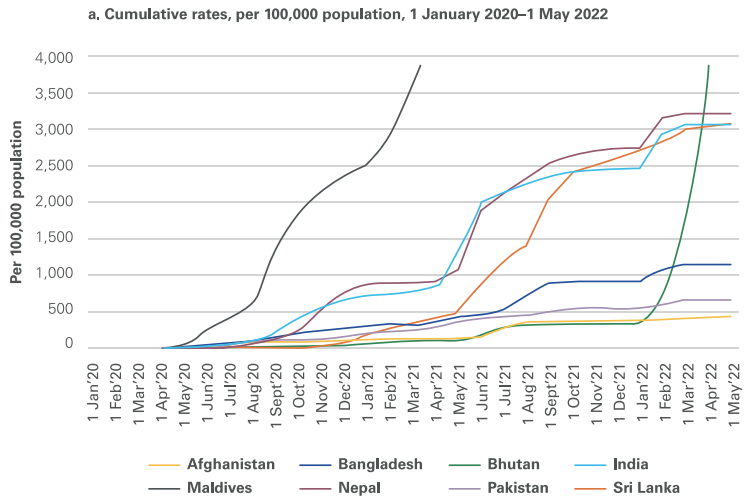
Infections and immunizations: COVID-19 in South Asia

Figure 1.1 shows how the registered cases appeared in various countries. In Panel A, the epidemiological curves climb to different magnitudes, but show largely similar patterns. In the case of Maldives, an upper middle-income country spread over hundreds of mostly tiny islands in the Indian Ocean and attracting substantial international high-end tourism, rates started soaring early. However, registered cases also attest that the small country's universal health and well-established vital registration systems could capture and report on the swelling number of COVID-19 infections better than most.[20]

[17] WHO Coronavirus (COVID-19) Dashboard, World Health Organization, Geneva, https://covid19.who.int/.
[18] Initially proposed by epidemiologists over a decade ago to manage the threat of severe acute respiratory syndrome (SARS), the model reflects a recognition that it will not be possible to avoid the community transmission of the virus. Instead of stopping infections altogether, the model endeavours to maintain the daily number of new cases at moderate levels to reduce the overall caseload and avoid large epidemiological waves overwhelming the health sector. See Boumans (2021).
[19] In the period preceding the vaccine rollout beginning in 2021, and also parallel with vaccine rollout, containment strategies included health and social measures such as screening, testing, enhancement of treatment, and socialization of broad preventive measures (including masks, distancing, and infection prevention and control in healthcare settings).
[20] After a lockdown of more than three months, Maldives resumed issuing on-arrival tourist visas on 15 July 2020, with no requirements that tourists quarantine. Maldives is the only South Asian country in which the completeness of death registration was considered 100 per cent in a pre-COVID-19 assessment by the WHO (2020, 29). While tourism targets chiefly the smaller islands, during 2020 first wave most cases were reported from Malé, the densely populated capital showing high infection rates due to large contact bubbles.

Figure 1.1: Registered COVID-19 infections: Cumulative and daily infections

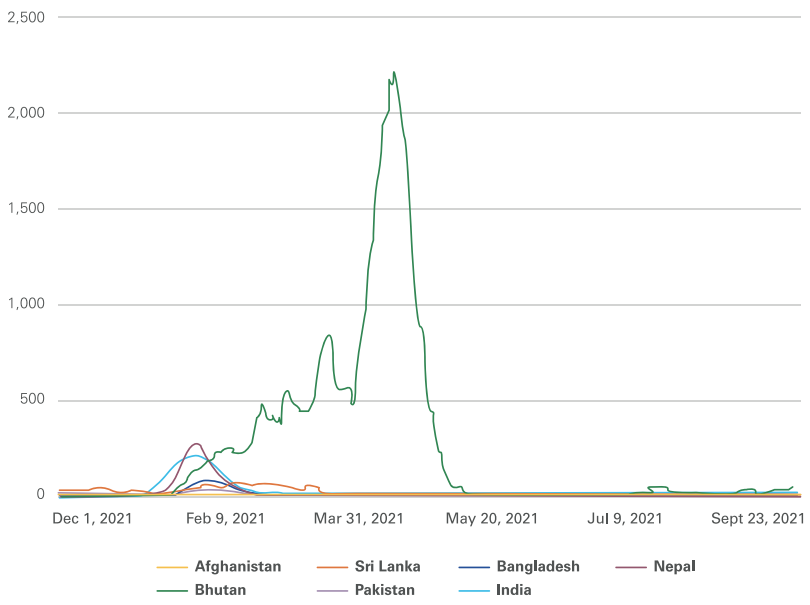
a. Cumulative rates, per 100,000 population, 1 January 2020–1 May 2022



Source: EIOS (Epidemic Intelligence from Open Sources) (dashboard), World Health Organization, Geneva, https://portal.who.int/report/eios-covid19-counts/; World Population Prospects 2019 (database), Population Division, Department of Economic and Social Affairs, United Nations, New York, https://population.un.org/wpp/.

Notes: Registers report cases within national territories. The infection rates in Maldives and Bhutan are out of the figure's range. As of 1 May 2022, the rate in Maldives was 33,806 and in Bhutan 7,543 per 100,000 population respectively (implying 3.4 per cent and 0.7 per cent of the population was registered with infection). For various reasons, an unknown number of COVID-19 cases, especially those associated with no symptoms or only mild symptoms, are not registered in any country. Hence, the figure is more informative on trends than on endpoint levels of cases of infection.

b. Omicron: new daily cases, 7-day rolling average per million, December 2021–September 2022



Source: COVID-19 Data Explorer (dashboard), Our World in Data, Global Change Data Lab, University of Oxford, Oxford, UK, https://ourworldindata.org/explorers/coronavirus-data-explorer.

India and neighbouring Nepal managed to flatten the curve for several months during the first part of 2020 (as seen in Figure 1.1a), but were hit by a large wave during the second part of 2020. After a few months of relative stability, an even more powerful second wave appeared in the second quarter of 2021. At this point, Sri Lanka reported climbing rates, after having recorded relatively few cases throughout 2020. Although the registered number of COVID-19 cases has also increased in Afghanistan, Bangladesh and Pakistan, altogether the official prevalence rates there have remained on the lower side.

Some caveats need to be added. Representative surveys that measure seropositivity using blood tests suggest that the information in Figure 1.1 is revealing about trends and the timing of the COVID-19 waves, but it does not show actual infection prevalence. By the end of 2020, a significant part of the population in South Asia showed seropositivity, implying prior exposure to the COVID-19 virus. In Bangladesh, a survey showed national seroprevalence at 30.4 per cent in October 2020 (Bhuiyan et al. 2022). In India, a survey[21] found 24.1 per cent population seropositivity around the end of 2020.[22] Nonetheless, large gaps between officially registered cases and the probable actual number of infections have also been noted in other countries and global regions.

The frighteningly large second wave of infection, associated with the more contagious Delta variant, extended the reach of the virus significantly. In March 2021, South Asia became the global epicentre of the COVID-19 pandemic for several weeks, with newly registered cases jumping to 1.2 million, then 7 million in April, and nearly 10 million in May.[23] Following the Delta wave, the number of new infections waned again, until the Omicron variant of the virus appeared toward the end of 2021.

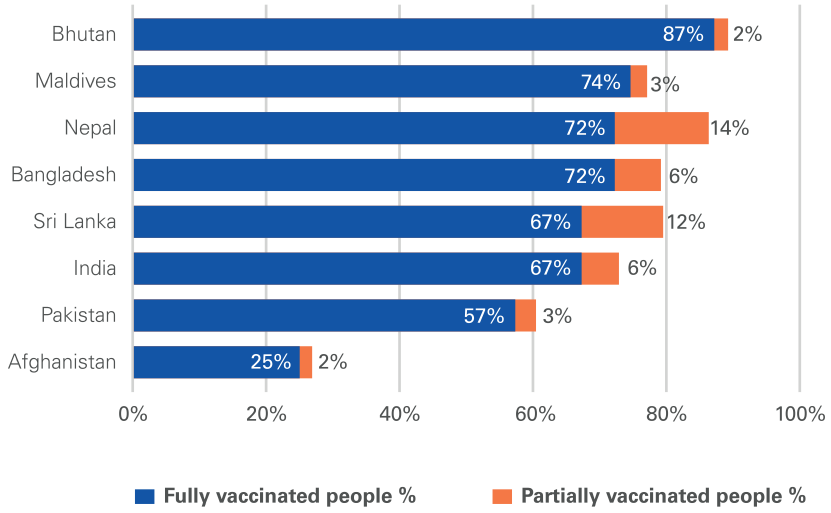
Figure 1.1, Panel B illustrates daily infection prevalence as reported to the WHO by countries during this late period, from early December 2021 until early March 2022. It is striking how quickly cases of the highly transmittable Omicron variant shot up and then started fading in most countries. Apart from Maldives (not shown in Panel B), Bhutan – which had had hardly any Alpha variant cases and few Delta cases – reported the highest Omicron rates per population (see Figure 1.1b). Indeed, by the end of the first quarter of 2022, Bhutan lost the comparative advantage in terms of the low cumulative infection rates that it had been enjoying for nearly two years in the pandemic. But, by that time, it also had the highest immunization rates.

Immunization against COVID-19 had a relatively slow start in some countries, but it soared in the wake of the huge Delta wave across the region.[24] By mid-May 2021, when the Delta variant was widespread, only Maldives had achieved a meaningful immunization level. By the time Omicron reached the region, all countries in South Asia with the exception of Afghanistan and Pakistan had reached more than 60 per cent of the population in the COVID-19 vaccination effort. Pakistan had reached 60 per cent of people with at least one dose as of September 2022 (see Figure 1.2). Bangladesh, Bhutan, Maldives and Sri Lanka post immunization rates similar to those in high-income countries.

This vaccine role out was made possible in India, through the use of technologies, such as COWIN app, which enabled people to do vaccination totally paperless, cashless and seamless.

[21] Between 18 August and 20 September 2020, researchers "enrolled and collected serum samples from 29,082 individuals from 15,613 households. The weighted and adjusted seroprevalence of SARS-CoV-2 IgG antibodies in individuals aged 10 years or older was 6.6% (95% CI 5.8–7.4). Among 15,084 randomly selected adults one per household), the weighted and adjusted seroprevalence was 7.1% (6.2–8.2). Seroprevalence was similar across age groups, sexes, and occupations. Seroprevalence was highest in urban slum areas followed by urban non-slum and rural areas" (Murhekar et al. 2021).
[22] Translating these rates to cases per 100,000 population (see Figure 1.1a) the graph should show 30,400 instead of 240 cases in Bangladesh in November and about 24,100 instead of 740 in India in December 2020.
[23] See COVID-19 Content Portal (dashboard), Center for Systems Science and Engineering, Johns Hopkins University, Baltimore, https://systems.jhu.edu/research/public-health/ncov/. Registration data follow the actual peak in new infections with about two weeks of lag.
[24] The fourth serosurvey, conducted in the last 10 days of June and the first week of July 2021, found neutralizing antibodies to COVID-19 in 67.6 per cent of people over 6 (Dyer 2021). About a fifth of the seropositivity in the survey may have reflected reaction to vaccination rather than infection. Immunization had been accelerating in 2021, and India had administered about 300 million doses before the survey. The 45–60 age group was the most seropositive; 77.6 per cent had antibodies. The least seropositive group was children aged 6–9, of whom 57.2 per cent had antibodies (Dyer 2021). This difference between adults and children reflected probably more the different levels of immunization rather than variations in infection prevalence (that is, an immune reaction acquired through infection).

Figure 1.2: Vaccination against COVID-19, South Asia, as of early September 2022



Source: Data accessed on 14 September 2022) from COVID-19 Data Explorer (dashboard), Our World in Data, Global Change Data Lab, University of Oxford, Oxford, UK, https://ourworldindata.org/explorers/coronavirus-data-explorer.

Notes: Full vaccination includes two shots and may include a third as a booster. The closest available data point is shown. Alternative definitions of a full vaccination, for example, previous infection with SARS-CoV-2 or one dose of a two-dose protocol, are ignored to maximize comparability across countries.

The experience with Omicron in South Asia in late 2021 and early 2022 seems to mirror what has been observed in Europe, Israel, and the United States: soaring infection rates in countries with high levels of vaccination. Yet, many South Asian countries – Bangladesh, India, Nepal, Pakistan and Sri Lanka – have experienced Omicron waves that were both less extensive than their experience with the Delta wave and shorter than the struggle in the well-immunized rich countries with the highly contagious Omicron variant. Certainly, this does not mean that vaccination is not useful: vaccination reduces the risk of infection, and unvaccinated people have a much poorer chance of surviving an infection.[25] But it does offer some hope that the frequent combination of naturally acquired COVID-19 immunity and vaccination in the region may make South Asian populations particularly resilient to additional infection waves.[26]

A high mortality toll despite mostly youthful populations

If hybrid immunization status – the combination of vaccination and infection – did help in the recent fight with the Omicron variant of COVID-19 in South Asia, it came at a cost. Table 1.1 shows the officially registered COVID-19 mortality data from the start of the pandemic to the beginning of September 2022. Reflecting the large second infection wave, COVID-19 mortality was significantly higher in 2021 than in 2020. By the end of 2020, the eight countries had reported a total of 171,500 COVID-19 deaths; by 31 December 2021, the number had risen to 572,300, by the end of March 2022, to 617,000 and by early September to 624,600 (see Table 1.1).

Figure 1.3 shows the official COVID-19 mortality per 100,000 population as well as the overall case fatality rate – COVID-19 deaths divided by confirmed cases – based on official country reports. Comparing the data in Table 1.1 and Figure 1.3 makes clear that, while India dominates in the absolute number of human losses to COVID-19, India's outcomes are average to low for the region if one considers population size or calculates case fatality. Bhutan and Maldives post the lowest case fatality rates for COVID-19.

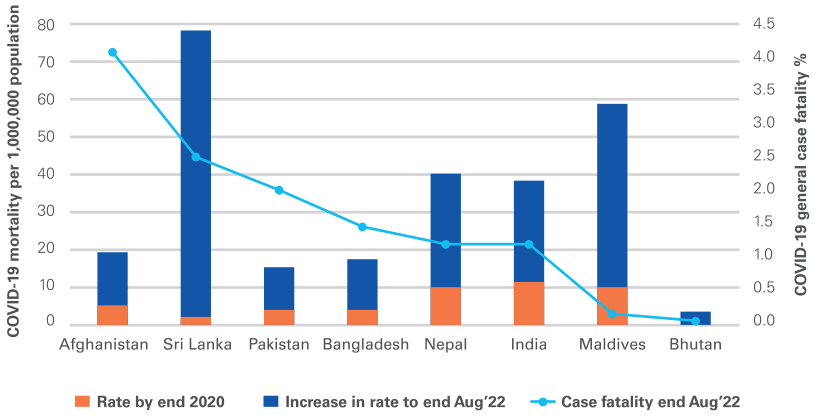
[25] Data on Switzerland show, for instance, that people with full vaccination exhibit 10 times better survival rates than unvaccinated people. Vaccinated people receiving booster shots have a better chance by a factor of 32. See Mathieu and Roser (2021).
[26] There is some clinical evidence that hybrid immunity – vaccination following prior infection – provide the highest quality antibodies, that is, the strongest protection (Abu-Raddad et al. 2021; ScienceDaily 2021).

Table 1.1: Official statistics on COVID-19 mortality, South Asia, 1 September 2022

Registered number of COVID-19 deaths, all ages									
	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka	Total
2020	2,189	7,559	0	148,738	48	2,758	10,047	204	171,543
2021	5,167	20,513	3	332,342	214	8,836	18,874	14,775	400,724
Jan-Aug 2022	421	1,251	18	46,794	46	407	1,654	1,719	52,310
Total	7,777	29,323	21	527,874	308	12,001	30,575	16,698	624,577

Source: Based on reported cumulative deaths; data accessed on 3 September 2022 from EIOS (Epidemic Intelligence from Open Sources) (dashboard), World Health Organization, Geneva, https://portal.who.int/report/eios-covid19-counts/.

Figure 1.3: Reported COVID-19 mortality and general case fatality rates, South Asia



Source: EIOS (Epidemic Intelligence from Open Sources) (dashboard), World Health Organization, Geneva, https://portal.who.int/report/eios-covid19-counts/; World Population Prospects 2019 (database), Population Division, Department of Economic and Social Affairs, United Nations, New York, https://population.un.org/wpp/.

Notes: Calculations based on country COVID-19 reporting to the WHO (total accumulated cases by end of August 2022) and United Nations population estimates. The case fatality rate is calculated by dividing confirmed COVID-19 deaths by the number of registered COVID-19 cases. While both this ratio and the infection fatality rate (used in the medical literature) refer to the share of the infections that led to death, the latter assumes that the measurement of all infections and related deaths is accurate, which is clearly not the case of the COVID-19 data from vital statistics registers. Thus, the former is a proxy for the latter.

Sri Lanka, meanwhile, appears to be an outlier. It posts the highest official mortality rate per population. (Almost all the deaths occurred during the second year of the pandemic, after a highly successful containment effort in 2020.) The outlier status largely reflects population effects. Unlike all the other South Asian countries, Sri Lanka has an ageing population, which makes it more vulnerable to COVID-19. The share of people over 65 is 11 per cent (or 2.2 people of every 20.0) in Sri Lanka, nearly four times the share in Afghanistan and about twice the share in Bangladesh, India, and Nepal (see Table 1.2).

Afghanistan posts the fourth lowest COVID-19 death rate per population (see Figure 1.3). However, because it reports relatively few cases of infection (possibly omitting even more milder cases than other countries), it has the highest overall case fatality ratio: 4.5 per cent of known cases have ended in death. The low overall case fatality ratio in Bhutan shows the high returns on the government's COVID-19 strategy; officials closed the country before vaccines were made available, and then the country quickly became a leader in vaccination only shortly before the Omicron variant broke across the borders.

Table 1.2: Population distribution by age, 2019
% of total

Age	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
0–19	54	37	35	36	25	41	45	32
20–64	43	58	59	58	71	53	51	57
65+	3	5	6	6	4	6	4	11
Total	100	100	100	100	100	100	100	100

Source: 'World 2019', Population Pyramids of the World from 1950 to 2100 (database), PopulationPyramid.net, Saint-Gillis, Belgium, https://www.populationpyramid.net/; World Population Prospects 2019 (database), Population Division, Department of Economic and Social Affairs, United Nations, New York, https://population.un.org/wpp/.

Notes: The population is much younger in the countries of South Asia than in the countries of the Organisation for Economic Co-operation and Development (OECD). In the United Kingdom, for example, one person in five is age more than 65, nearly double the 11 per cent in Sri Lanka and more than six times the share of 3 per cent in Afghanistan.

In recent decades, overall mortality rates had fallen rapidly in South Asia, reflecting reductions in child and maternal mortality and a rise in adult life expectancy – related to underlying causes such as rising literacy and falling poverty. Although the ageing of the population had already been advancing several countries, the impact of ageing on overall mortality figures were countered by reductions in young child mortality and falling fertility rates – further distinctive marks of the demographic transition (see Appendix C). Large swaths of youth moving into young adulthood (characterized by generally lower mortality risks) also played a role.

At this juncture, it is difficult to tell to what extent the COVID-19 crisis has impacted these trends. Existing demographic surveys either have not yet covered 2021, the year when COVID-19 mortality spiked in the region, or they do not survey the impact of COVID-19 and publish no data on crude mortality rates.[27] Moreover, experience suggests that it takes a significant time publish the results.[28] While administrative data on vital events can be made available at a much faster rate, these data were considered less reliable in most countries even before the widescale disruption COVID-19 had created (see Box 1.1).

The most relevant and authoritative source on the topic – India's annual Sample Registration System (SRS) survey – has published results only up to 2020 as of this writing. These suggested that the crude death rate in the country was 6.0 per 1,000 people in 2019 (0.2 and 0.3 per 1,000 lower than in 2018 and 2017, respectively).[29] For India's population of 1.4 billion people, this translates into 8.3 million deaths from all causes in the year preceding COVID-19. The 332,342 COVID-19 deaths recorded in the country for 2021 (see Table 1.1) represent approximately 0.24 deaths per 1,000. Thus, official deaths from SARS-CoV-2 infection may have pushed the crude mortality rate in 2021 back to its level in 2018 (assuming that registered COVID-19 deaths represent if excess mortality associated with the pandemic).[30]

Results from India's 2020 SRS survey, published in early 2022, suggest an uptick in death rates in urban areas (possibly in association with COVID-19). However, because mortality continued to fall in rural areas, the nation-wide crude death rate has been estimated at 6.0 per 1,000 population in 2020, which is the same as in 2019. This suggests that the impact of COVID-19 infections on the crude death rate may have been counterbalanced by other effects – at least in

[27] See, for example, https://dhsprogram.com/publications/publication-FR375-DHS-Final-Reports.cfm.
[28] Pakistan, for example, published its demographic and health survey for 2019 in early 2022 (see https://www.pbs.gov.pk/content/demographic-and-research).
[29] The SRS survey is probably the largest representative survey in the world. It collects demographic information annually from 8.2 million people. It was created in the 1970s when it became clear that the civil registration system exhibited serious reporting gaps and delays with paperwork. See SRS STAT (Sample Registration System Statistical Report) (document archive), Office of the Registrar General and Census Commissioner of India, Ministry of Home Affairs, New Delhi, https://censusindia.gov.in/census.website/data/SRSSTAT#.
[30] The WHO defines excess death as "the mortality above what would be expected based on the non-crisis mortality rate in the population of interest." This includes not only those who died of the crisis-causing event or pathogen directly, but also those who died due to indirect effects of the crisis, such as lack of access to health care. (See 'Global Excess Deaths Associated with COVID-19 (Modelled Estimates)', World Health Organization, Geneva, https://www.who.int/data/sets/global-excess-deaths-associated-with-covid-19-modelled-estimates.) There are several reasons why countries, health ministries, statistical offices, doctors, and researchers struggle to identify the number of fatalities among people infected with the SARS-CoV-2 virus. First, identifying COVID-19 as the underlying cause of the immediate disease or condition (for example, acute respiratory distress syndrome or pneumonia) that killed victims is often constrained by lack of testing pre- or post-mortem. In rural areas, where there is less access to hospital care, at-home deaths are common, and people are likely to die without ever being tested. Moreover, it has been difficult to estimate general mortality that is, the total number of deaths over the last two years, because of COVID-19–related upheavals that have disrupted data collection and created uncertainty in vital statistics, especially in those developing countries in which administrative reporting of vital events exhibited gaps pre-COVID. Indeed, over the last two years, both COVID-19 case mortality and all-case (general) mortality showed data gaps even in several middle- and high-income countries with strong administrative reporting of vital events.

2020, when there were far fewer COVID-19 deaths in the country than in 2021. Other South Asian countries may have seen similar trends. In Bangladesh, for instance, official COVID-19 mortality amounted to less than 1 per cent of the annual overall death cases in 2020.[31] Hence, the effect may have been overwhelmed by other impacts during the first year of the pandemic.

These results and calculations assume that the vital statistics of countries did indeed capture all COVID-19 deaths, and that the large socioeconomic impact of the COVID-19 crisis did not add more early deaths the way it did in the majority of countries in the OECD.[32] Several researchers in India and elsewhere have questioned these assumptions.[33] Moreover, there is evidence from Nepal, the only country in South Asia which makes age-specific COVID-19 mortality figures public, that SARS-CoV-2 infection killed comparatively more people in active age brackets than it did in high-income countries (see Appendix D).[34]

Arguments could be made that, as result of contrasting trends, COVID-19 may have ended up with more moderate effect than that on overall mortality. First, some of those who died of COVID-19 with comorbidities may have died anyway during the two years in question because of old age and/or poor health. These deaths would not be counted as "excess mortality" associated with the pandemic. Second, a significant number of deaths from other causes (for instance, associated with influenza and other infectious diseases) may have been prevented by social distancing, mask-wearing and emphasis on handwashing. Likewise, death by accidents or injuries (which tend to be a major killer of children and younger adults) were likely reduced by lockdowns and greater health awareness as it did in a few Organisation for Economic Co-operation and Development (OECD) countries.[35]

Statistics on births and deaths, adult and child mortality bring literally vital information to the table of national decisionmakers. These data are important on their own right – survival and longevity are core indicators of population health and wellbeing. They are also important as social indicators reflecting the aggregate effect of underlying trends in nations' progress.

During the pandemic, in addition to monitoring SARS-CoV-2 infections, the number of deaths related to confirmed infections were used for designing better targeted, more nuanced policy responses. However, experience suggests that aggregate crises tend to impact mortality and other vital outcomes through channels other than virus transmission: poverty, unemployment, inflation, disruption in social services and increases in social stress are all well-established social determinants of health (see Appendix A). Therefore, monitoring vital outcomes in the current post-lockdown situation remains important, especially in countries and among population groups affected by high inflation, economic adjustment, social dislocations and/or climate-related aggregate shocks.[36] Box 1.1 discusses how vital statistics could be strengthened to better serve recurrent policy needs.

[31] See Barnwal et al. (2021). The ratio was only slightly higher in India.
[32] See excess death figures in OECD statistics, at Mortality (by Week): Excess Deaths by Week, 2020–2022 (database), OECD. Stat, Organisation for Economic Co-operation and Development, Paris, https://stats.oecd.org/index.aspx?queryid=104676.
[33] For example, see Jha et al. (2022); Malani and Ramachandran (2021).
[34] Age-specific COVID-19 data are helpful as they can remove the effect of the demographic structure, and hence reflect better the risk people face due to factors other than age in given contexts. As the discussion around Figure 1.3 and Table 1.2, general case fatality rates among countries could significantly differ because one possesses a higher share of older people (a sub-population particularly vulnerable to COVID-19).
[35] Some OECD countries that have strong health systems or that were less affected by COVID-19 in 2020, such as New Zealand and Norway, reported indeed falling mortality figures during that year due to such effects. See Mortality (by Week): Excess Deaths by Week, 2020–2022 (database), OECD.Stat, Organisation for Economic Co-operation and Development, Paris, https://stats.oecd.org/index.aspx?queryid=104676.
[36] See later chapters. Climate-change-related extreme weather events are becoming more frequent and less predictable across the region, as the extreme heatwave in early 2022 and the extreme floods later in the year demonstrate.

Box 1.1: COVID-19 highlights the need to incentivize and digitize civil registration and vital statistics

The term 'civil registration and vital statistics' references the dual data sources on key vital events. Registers are part of administrative statistics, where either service providers must report information, or the law compels individual residents to record an event and/or change in status with legal implications. *Representative statistical surveys* interview a sample of the population or carry out full-scale censuses. In these latter cases, individual-level data are protected by confidentiality laws and only aggregate (population-level) data is meaningful. South Asian countries possess both type of statistics, but before COVID-19 registers had received less attention, chiefly because registration by individuals of vital household events was a challenge in much of the region. In India, for example, the 2019-2021 National Family Health Survey found that only 71 per cent of deaths were registered with the civil authorities and 75 per cent of young children had a birth certificate.[37] Where there are large gaps in reporting of vital events, the information is less useful for policymakers and local officials because it is difficult to ascertain whether a rising trend indicates increased social stress or improved reporting.

The COVID-19 crisis has, in general, shown the usefulness of registries, as Chapter 2 discusses, and of having real-time information on impact. It also accelerated the digitalization of services. Strengthening the civil registration system through digitalization and monetary or non-monetary incentives for the timely reporting of events, such as birth and death, marriages and divorces, would bring multiple benefits. Digitalization could add speed and efficiency; financial incentives to report vital events could enhance completeness and links to services.[38] Concerted efforts could build on achievements in COVID registration and immunization reporting, and they could also feed into the next population census.[39] This universalist approach to vital and social registries would eventually enable a near real-time feedback as well as a more granular picture of the impact of crises across locations and population groups than even the large Sample (Vital) Registration System surveys could produce (Rao and Gupta 2020).[40] Attaching cash or in-kind incentives to registration – e.g., lifecycle social insurance and assistance such as birth grants, maternity assistance, or burial allowances– will have the biggest impact in the rural and informal settlements. These are the same localities where inflation and a new standard of living crisis could hit families particularly hard.

[37] The rate was below 76 per cent in Bihar, 74 per cent in Jharkhand, and 73 per cent in Nagaland. The good news is that birth registration was improving and found universal in the small states of Lakshadweep and Goa, and around 95 per cent or more in 21 States/UTs; and that female and male children were equally likely to have their birth registered. See International Institute for Population Sciences (IIPS) and ICF. 2021

[38] Experience suggests that when birth grants, maternity benefits, disability allowances, burial supports, etc. are being offered, registration of related events improves significantly.

[39] In India and Bangladesh, respectively, the 2023 and 2022 population censuses were conceived as a digital data collection using mobile phones and tablets even before 2020, reflecting accelerated use of digital tools.

[40] Censuses and large representative surveys will remain important for structural analyses, benchmarking and controlling results, while digitized civil registration systems should capture ongoing trend changes more accurately. Indeed, the 2019-21 National Family Health Survey (NFHS-5) of India published in March 2022 focuses on the relationship between variables and detailed breakdown while publishes no results on trends in crude death rate or deaths associated with COVID-19. As of mid-2022 no Sample (Vital) registration Survey has been published for 2021, but given the large number of unregistered deaths in the more real-time administrative system (civil registries), these type of surveys are likely the most authoritative source of data on changes in mortality rates.

Infections and deaths: Higher rates of infection in urban areas; higher case fatality rates in less developed areas

In South Asia, the dynamics of the pandemic have exhibited an urban-rural divide. Urban areas with high population density and better economic development, which translate into high contact density, were more highly affected by COVID-19 than rural areas with smaller populations and weaker economies. For example, the National Capital Territory of Delhi, with a GDP per capita nearly six times higher than that of Uttar Pradesh, recorded five times as many COVID-19 cases per population by January 2022.[41] Among the top states by economic development, Kerala has registered extremely high COVID-19 incidence over the last two years, exceeding 15,000 cases per 100,000 population, around five times the Indian national average.[42] In Pakistan, the cumulative COVID-19 case incidence by the end of 2021 was 5,416 per 100,000 population in Islamabad, compared with only 272 per 100,000 in Balochistan, the largest but least populated state in Pakistan, and one in which economic development lags.[43] Likewise, across other South Asian countries, infections have been highly concentrated in urbanized areas.

Representative surveys that estimate COVID-19 infection rates using seropositivity tests have confirmed the general pattern according to which urban areas post higher infection rates, especially in the early stages of the epidemic. In Bangladesh, for example, a serosurvey estimated 28.7 per cent positivity in rural areas, 35.4 per cent in non-slum areas of Dhaka, 37.5 per cent in urban areas outside Dhaka, and 63.5 per cent positivity in slum areas of Dhaka in November 2020.[44] Serosurveys in India showed a similar pattern in infection prevalence.[45] These findings are consistent with suggestions that population density, poor housing and sanitary practices, and limited capacity for infection control are factors in high transmission rates. They also confirm that findings elsewhere[46] that local economies producing higher value added also tend to show higher COVID-19 infection rates (because they thrive on personal mobility and the breadth and intensity of human contacts) may also be valid in the context of South Asia. On the other end of the spectrum, lower COVID-19 infection rates in rural areas tend to coincide with the poorer integration of the localities into the most dynamic parts of the national and world economy.

In terms of differences by age and gender, active-age adults, especially men, have posted the highest COVID-19 positivity. This suggests that COVID-19 may have spread mostly through work contacts given the significantly lower employment rates among women in the region. Men also experienced higher case fatality rates. This calls attention to the impoverishing effect of COVID-19 in households affected by mortality as well as morbidity (including long-COVID as well as the repeated infections), given the prevailing gender patterns in access to paid employment – as the next section highlights.

Moreover, while more industrialized or population-dense areas in general faced higher infection risk, the case fatality rate (the mortality risk with COVID-19 infection) was 22 per cent higher in Balochistan than in Islamabad.[47] Uttar Pradesh, one of the poorest states, reported the lowest cumulative COVID-19 incidence per capita (860 per 100,000 people) in India, but posted a case fatality ratio that exceeded the ratio in Kerala by 43 per cent by January 2022.[48]

People's overall health status is influenced and shaped by lifecycle effects such as the availability of good nutrition and quality care, especially during early childhood when the foundations of adult capacities are

[41] See COVID19 Statewise Status, Corona Data (dashboard), MyGov, National Informatics Centre, Ministry of Electronics and Information Technology, New Delhi, https://www.mygov.in/corona-data/covid19-statewise-status/; India GDP (dashboard), Trading Economics, New York, https://tradingeconomics.com/india/gdp#:~:text=GDP%20in%20India%20averaged%20699.64,3703%20USD%20Billion%20in%201960.

[42] COVID19 Statewise Status, Corona Data (dashboard), MyGov, National Informatics Centre, Ministry of Electronics and Information Technology, New Delhi, https://www.mygov.in/corona-data/covid19-statewise-status.

[43] COVID cases: COVID-19 Dashboard, Pakistan Cases Details, Ministry of National Health Services, Regulation and Coordination, Islamabad, https://covid.gov.pk/stats/pakistan. Population: Provinces of Pakistan (dashboard), World Atlas, Reunion Technology, St. Laurent, Quebec, Canada, https://www.worldatlas.com/articles/provinces-of-pakistan.html#:~:text=Provinces%20of%20Pakistan/.

[44] Immunoglobulin M rates showed 40 per cent on average. See Bhuiyan et al. (2022).

[45] Murhekar et al (2021) found that "seroprevalence was highest in urban slum areas followed by urban non-slum and rural areas" according to the second nationwide household serosurvey of ICMR National Institute of Epidemiology in India. The authors estimated a cumulative 74.3 million infections in the country by August 18, 2020, based on the weighted average of SARS-CoV-2 antibody seroprevalence of 7.1 per cent in the population over the age of 10 years.

[46] Pardhan and Drydakis (2021) conclude that "in the first wave of the pandemic in Europe, a country's GDP per capita might be associated with a lower rate of new COVID-19 cases". See also Gangemi, Billeci, and Tonacci (2020).

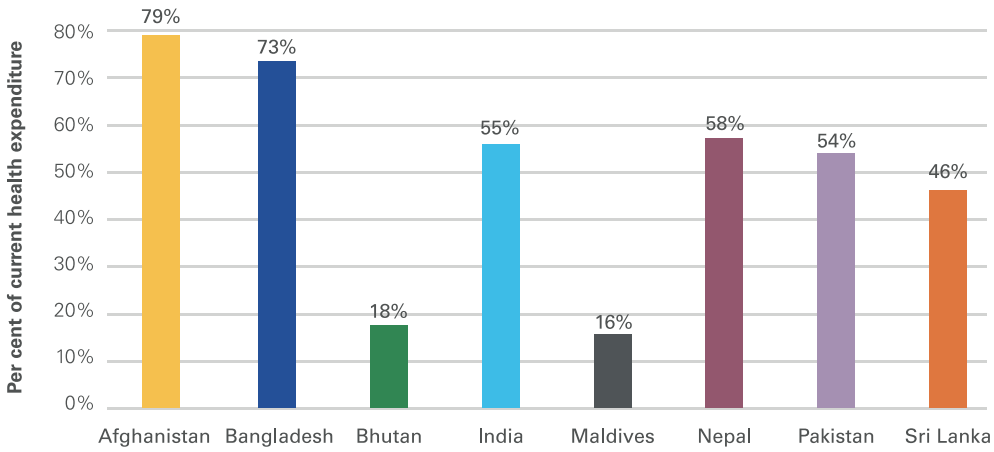
[47] Based on data of COVID-19 Dashboard, Pakistan Cases Details, Ministry of National Health Services, Regulation and Coordination, Islamabad, https://covid.gov.pk/stats/pakistan.

[48] See COVID19 Statewise Status, Corona Data (dashboard), MyGov, National Informatics Centre, Ministry of Electronics and Information Technology, New Delhi, https://www.mygov.in/corona-data/covid19-statewise-status. There is a caveat in interpreting these statistics. Because COVID-19 mortality is not only health condition–sensitive, but also age-sensitive, it is possible that the difference is explained by age differences rather than socioeconomic gradients in health (that is, social determinants) or in access to emergency medical care across these territories. Uneven quality of reporting may offer a further explanation. It is often assumed that COVID-19 mortality is more accurately reported than COVID-19 infection, and the reporting propensity for one or the other may differ systematically between asset rich and asset poor areas. Official statistics in South Asia rarely report COVID-19 mortality by age or by an urban-rural breakdown, which hinders analysis.

established. These, in turn, are influenced by broader social determinants of health,[49] including economic development, the prevalence of poverty, air pollution, water and sanitation, cultural traditions, equity, governance, and the strength of the social fabric. Most of these factors – although not all – tend to be more favourable in areas with higher economic development, which tends to correlate closely with urbanization and population density (Vlahov et al. 2007).

In the case of COVID-19–related mortality, the importance of timely access to life-saving intensive care, including oxygen and ventilators, which are available in most cases only in hospitals or special health centres, adds a marked disadvantage to the survival chances of rural populations. So does the fact that private hospitals, clinics, and health-related facilities are situated mostly in urban centres and may charge considerable fees. Apart from Sri Lanka, the private sector accounts for a large share of hospital beds and modern diagnostic facilities in the region. For example, in Pakistan, over a third of hospitals are owned privately.[50] In India, nearly two thirds of hospital beds were in private facilities in 2020 (Kanwal 2021).

Figure 1.4: Out-of-pocket expenditure as a percentage of current health expenditure, 2019



Source: WHO: Global health expenditure database, https://apps.who.int/nha/database/Select/Indicators/en

The dominance of private health provision is also reflected in the large share of out-of-pocket spending, which represents over half of health expenditures in all South Asian countries except in Bhutan, Maldives, and Sri Lanka (see Figure 1.4 and Bloch 2020). Recent efforts in India, where only a third of people had access to some health insurance pre-COVID, to expand health insurance using public funds to give a boost to service uptake in the private health facilities may have helped families in urban areas where such facilities are easier to find, but were unable to change the situation in rural areas (Economist 2018).

Government efforts to contain the pandemic: The lives versus livelihoods predicament

The pandemic containment strategy of flattening the curve to refers to a managed response whereby lockdowns are used periodically to choke off sharp rises in infection. Governments in South Asia were quick to respond to the threat of the pandemic and, for most of 2020–2021, maintained stringent policies to reduce the spread of the virus.[51]

The Oxford COVID-19 Government Response Tracker Project, a composite index based on nine response

[49] See https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
[50] https://2016.export.gov/industry/health/healthcareresourceguide/eg_main_108609.asp
[51] The strictest measures aimed at sharply reducing the intensity of human contacts were adopted during the first few months when the total number of cases was low. See Estupinan et al. (2020). The strategies that were adopted more well articulated beyond a focus on the limitation of movement. They included screening, testing, enhancement of treatment, and risk communication on broad preventive measures, such as masks, social distancing, and infection prevention and control.

indicators, such as school closures, workplace closures, and travel bans, has consistently shown that the region had some of the highest scores globally during the last two years.[52] From 25 March to 3 May 2020, India had the highest stringency measures in the world (Sharma and Mahendru 2020). During April 2020, the stringency index showed scores between 80 per cent and 100 per cent in all South Asian countries, and, in seven countries, workplace closures among all but the most essential workers were in effect for several weeks (Hale et al. 2021). These policies certainly contributed to flattening the initial curve of infections during the first half of 2020, even if implementation met with great challenges and generated heated debates (Wasdania and Prasada 2020).

Once the steady rise in the daily number of registered COVID-19 cases started to reverse during 2020 (for example, in Pakistan by mid-June, in Bangladesh in late June and in India in mid-September), the choice either to save lives or to protect livelihoods appeared less conflicted. Hence, hard lockdowns were eased in several phases to reduce the cascading impacts on livelihoods, and governments tried to deploy selective measures and targeted lockdowns instead of blanket national bans on movement, in some cases (e.g., in Pakistan, easing lockdown impact with additional cash transfers for those below the poverty line). Still, strict measures had to be reimposed at larger scales for a few weeks or even a few months beginning in March 2021 to dampen the frightening momentum of the second large COVID-19 wave in the region. Towards the end of 2021, Omicron created a similar effect before stringency measures were finally significantly eased in 2022 (but did not altogether disappear: see Figure 1.5).

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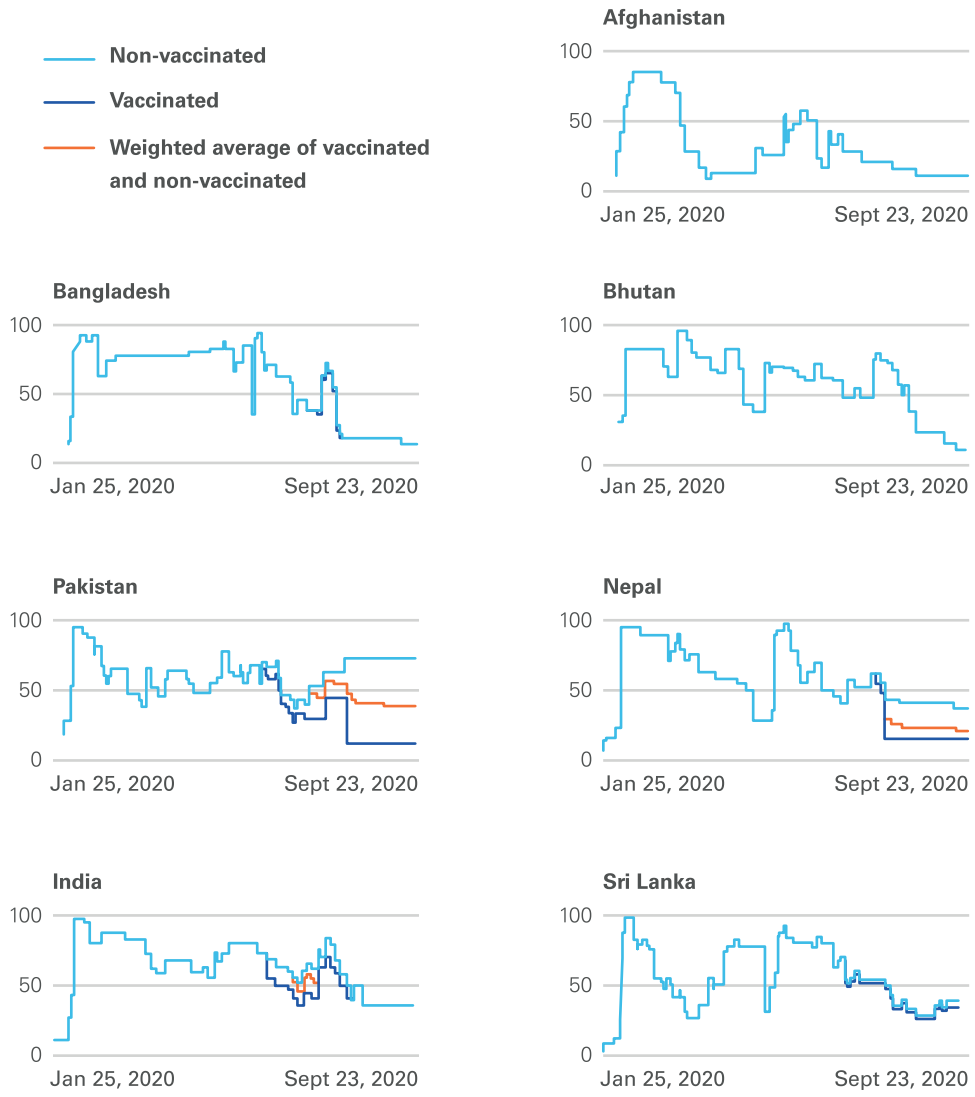
[52] University of Oxford, Oxford, UK, https://www.bsg.ox.ac.uk/research/research-projects/covid-19-government-response-tracker.

Figure 1.5: Easing lockdowns were often followed by reimposing stricter measures

COVID-19: Stringency Index

The stirngency index is a composite measure based on nine response indicators including school clousers, workplace clousers, and travel bans, rescaled to a value from 0 to 100 (100 = stricted).

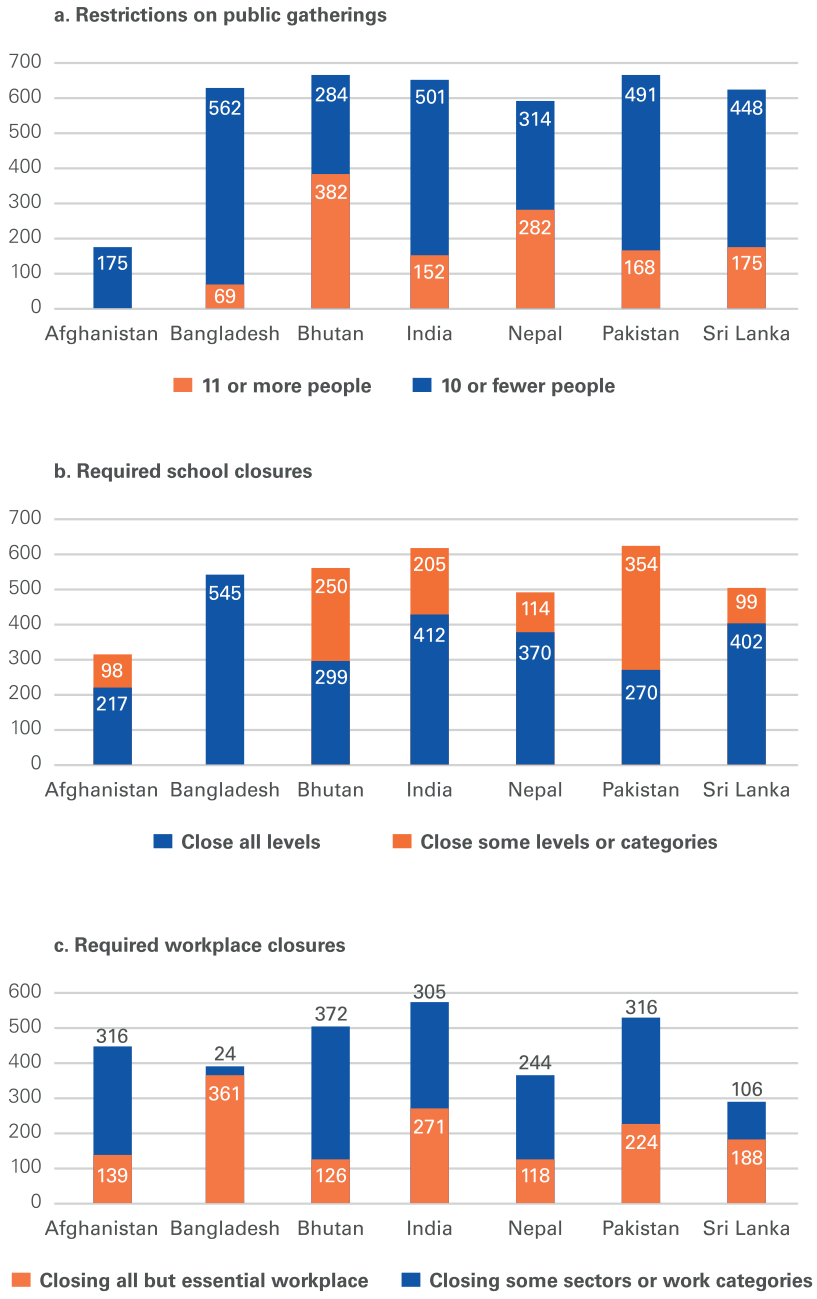


Source: COVID-19 Data Explorer (dashboard), Our World in Data, Global Change Data Lab, University of Oxford, Oxford, UK, https://ourworldindata.org/explorers/coronavirus-data-explorer; OxCGRT (Oxford COVID-19 Government Response Tracker) (dashboard), Blavatnik School of Government, University of Oxford, Oxford, UK, https://www.bsg.ox.ac.uk/research/research-projects/covid-19-government-response-tracker.
Notes: OxCGRT codes the most stringent government policy in place in a country or territory, which is represented by the highest ordinal value. At times, the most stringent policy in a country or territory may only apply to a small part of the population. The composite measure of the stringency index is a simple score of nine indicators measured on an ordinal scale, that is, rescaled to vary from 0 to 100. The nine response indicators are as follows: (a) school closures, (b) workplace closures, (c) cancel public events, (d) restrictions on gatherings, (e) close public transport, (f) public information campaigns, (g) stay at home, (h) restrictions on internal movement, and (i) international travel controls. It also includes a COVID-19 containment and health response index that is based on the metrics used in the stringency index that includes testing policy, contact tracing, face coverings and vaccination policy. Since government policies may differ by vaccination status, a stringency index is calculated for three categories: those who are vaccinated; those who are non-vaccinated; and a national average which is weighted based on the share of people that are vaccinated.

Using three major components of the COVID-19 stringency index, Figure 1.6 details how governments have attempted to find ways to enforce social distancing while protecting people and the economy. The total number of days between March 2020 and December 2021 when public gatherings were banned either at the national level or at some subnational level, such as district, province, or state, was 572 on average in the region.[53] Schools and skills training institutions were closed for an average of 519 days.

Figure 1.6: Three dimensions of COVID-19 restrictions in South Asia, 2020-2021

Total days with restriction in effect over 2020-2021, nationally or for some sectors or regions of the country



Source: OxCGRT (Oxford COVID-19 Government Response Tracker) (dashboard), Blavatnik School of Government, University of Oxford, Oxford, UK, https://www.bsg.ox.ac.uk/research/research-projects/covid-19-government-response-tracker.

Notes: There may be subnational or regional differences in policies. The policy categories shown may not apply at all subnational levels. A country is coded as required closures if at least some subnational regions have required closures. The numbers shown do not include government recommendations; they only include policy orders that could legally be enforced. The definition of essential workplace varies from country to country, but, most often, relates to production, transport and retail related to keeping shops open and functional that supply daily necessities, such as groceries. No data are available on Maldives.

[53] Calculations do not cover Maldives, which is not included in the data source.

The closure of certain sectors or workplace categories or all but essential sectors lasted 128 days less on average than the 572 days for public gatherings. Strict orders to close all but essential workplaces were in force for an average of 238 days in the seven countries with data available, nearly 334 days less than the length of the bans on public gatherings, indicating efforts to prioritize and phase in the opening of the economy.[54] Still, the lockdown of nearly seven months in all but essential workplaces at least in parts of the region is astonishing and raises questions about how businesses and livelihoods could survive such a blow.

1.2 Economic vulnerability and resilience

The large, densely populated urban centres of South Asia have proven particularly vulnerable to the pandemic. At the same time, youthful populations, a geography of oceans and mountains that promote isolation, and good access to health services, testing and surveillance have been important protective factors in the region. Still, during the first 18 months of the pandemic, until the new vaccines had reached most places, lockdowns and restriction on businesses and on people's movements were the only effective (if imperfect) macro-level policy tools available to fight off COVID-19 and reduce excess mortality. Economic policy thus acquired an important role in reducing the harm that stringent, public health-oriented administrative measures kept inflicting on productive assets, businesses and workers.

This section explores the vulnerability and resilience of nations to the COVID-19 crisis by focusing on macroeconomic stability, fiscal packages and public debt, the labour market and poverty. These dimensions are important underlying factors in family and child well-being. Policy responses during the pandemic have had significant impacts on these dimensions, with implications for the years ahead. The discussion starts with the impacts on labour productivity, a major determinant of economic progress in which much of the region has not yet overcome a historical disadvantage.

The pandemic's impact on economic growth and labour productivity

The human capital possessed by the labour force is a decisive factor in national income. Countries in which human capital investment is not prioritized often become caught up in a vicious circle. Low human capital breeds poverty and low incomes, which in turn keep human capital investment low. It is the job of macroeconomic and social policy to eliminate such traps through fiscal, labour market, and social sector – health, education and social protection – interventions. The pandemic is expected to affect productivity in two principal ways: a short-term effect involving the disruption of demand and supply, leading to stifled economic growth, and a longer-term effect that reduces growth through weakened human capital, partly through shortened healthy life expectancy among the current generation and partly through less investment in the health and skills of the next generation.

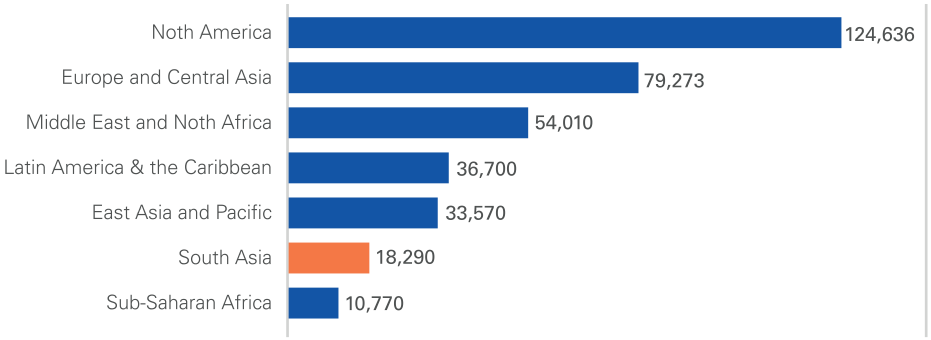
Figure 1.7 illustrates labour productivity across global regions expressed as GDP per person employed. The average shown for South Asia – the second-lowest average globally – reflects the region's large economies, especially India, Pakistan, and Bangladesh, although with significant subnational variation. Afghanistan and Nepal posted lower productivity, while Maldives and Sri Lanka showed significantly higher GDP per worker in 2019, thanks to their stronger human capital investments as well as their lucrative tourist industries. Hydroelectricity generation helped boost GDP per person employed in Bhutan, but around half the workforce in Bhutan is still employed in low-productivity agriculture (Choden 2021).

While South Asia's labour productivity is still low in international comparisons, it was improving in most of the countries over the two decades previous to the COVID-19 crisis.[55] To a large extent, this progress was caused by steadily expanding access to primary and secondary education, rapid (although unplanned) urbanization and the region's increasing participation in global trade.

The economic growth rates shown in Figure 1.8 have, moreover, been boosted by another factor: the growing size of the workforce thanks to previously high fertility rates and reductions in child mortality.

[54] See details at OxCGRT (Oxford COVID-19 Government Response Tracker) (dashboard), Blavatnik School of Government, University of Oxford, Oxford, UK, https://www.bsg.ox.ac.uk/research/research-projects/covid-19-government-response-tracker.
[55] GDP growth in Maldives and Sri Lanka were temporarily set back by the 2007–2009 global financial crisis.

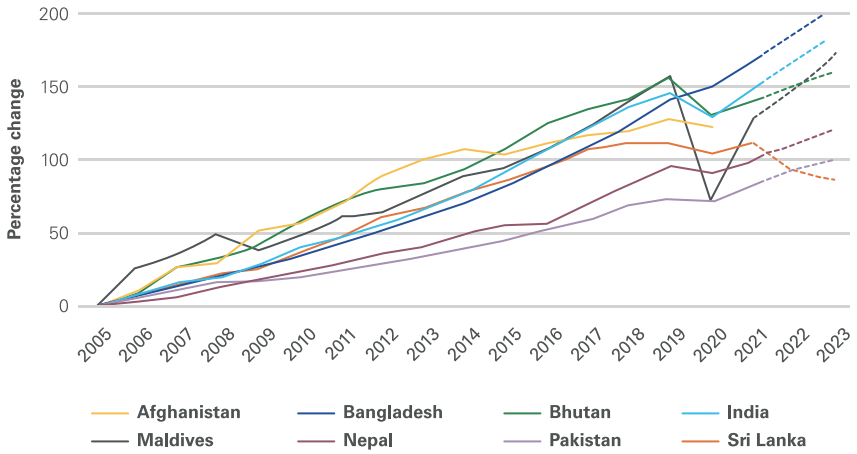
Figure 1.7: Labour productivity: GDP per person employed, 2019 (Constant 2017 PPPUSD)



Source: Data of 'GDP per Person Employed (Constant 2017 PPP $)', World Bank, Washington, DC, https://data.worldbank.org/indicator/SL.GDP.PCAP.EM.KD?msclkid=6a02dc34cec111ecb753503c788929cd.

Notes: GDP per person employed is gross domestic product, divided by total employment in the economy. The data represent purchasing power parity (PPP) GDP, that is, GDP converted to 2017 constant international US dollars using PPP rates. An international dollar has the same purchasing power relative to GDP that a US dollar has in the United States.

Figure 1.8: GDP trends and projections, South Asia, 2005–2023



Source: Asian Development Bank (ADB) Key Indicators Database https://kidb.adb.org; 2021-2023: Asian Development Outlook (ADO) 2022 Update: Country Outlook. September 2022, https://kidb.adb.org/economies

Notes: GDP per person employed is gross domestic product, divided by total employment in the economy. The data represent purchasing power parity (PPP) GDP, that is, GDP converted to 2017 constant international US dollars using PPP rates. An international dollar has the same purchasing power relative to GDP that a US dollar has in the United States.

In sharp contrast with pre-COVID economic growth projections, all economies in the region posted negative growth rates in 2020, except for Bangladesh, where growth slowed sharply, but did not take a downturn. Analyses show that, in terms of forgone growth opportunities, the emerging markets of Asia lost the most after 2020 (Gopinath 2021). Unlike the situation after 2008, when South Asian export markets showed resilience thanks to the coordination of strong monetary and fiscal policy interventions by the G20, demand plummeted in many sectors in 2020 – in tourism, in garments, in steel – because of the exposure of these sectors and industries to COVID-19–related changes in global demand and lockdowns in industrialized countries.[56] Across the region, tourism, air travel and catering went into an economic tailspin beginning in March and April 2020 (UNCTAD 2021). Construction firms and workers were also greatly affected initially (UNCTAD 2021).

However, the graph also shows that following the general contraction in 2020 all economies posted growth in 2021. Moreover, in some – including two large economies, India and Bangladesh – the pace of economic growth is expected to accelerate in 2022 and 2023 despite strong headwinds from the global economy manifested in the

[56] For example, because of sustained global demand, the demand for steel (important for India) or ready-made–garment industry products (in which Bangladesh has a major stake) did not plunge during the Great Recession. See Waldorf (2012). For the Indian example of the more recent situation, see DEA (2022).

higher prices of food, fuel and fertilizers, supply chain bottlenecks in trade, a strong dollar, and interest rates hikes in international lending.

Key components of South Asia's economic resilience and post-lockdown recovery

Despite the monumental challenges posed by the pandemic, economic growth returned in 2021, as Figure 1.8 shows. In a forward-looking perspective, most South Asian economies are expected to remain dynamic at least up to the second part of the 2020s. What factors have mitigated the losses and fostered economic resilience?

The analysis has so far identified one important factor: effort. After the first shocks and lockdowns in the second quarter of 2020, economies were reopened and kept running. These efforts were advanced by encouraging work from home. The COVID-19–related mobility restrictions boosted the use of digital technologies, thereby promoting labour productivity – although the sectors and firms that chiefly benefited from this digital revolution had already been producing high-value goods or services (for example, see Borowiecki et al. 2021).

Favourable population structure was another important factor. The demographic window of opportunity has started to close in parts of the region over the last decade, but the region as a whole still enjoyed low dependency rates per worker, which fostered economic resilience and growth.

Contrary to expectations, total remittances received through official channels edged upwards, despite some job losses among South Asian nationals who had been sending remittances (Ernst 2021). Remittances add about 4 per cent on average to GDP in South Asia, reaching as much as a quarter of national income in Nepal.[57] In early 2022, remittances were still above 2019 levels, except in Sri Lanka, in which fixed exchange rates up to early March 2022 created parallel foreign exchange markets that reduced official flows (World Bank 2022).

Donations, loans and other voluntary transfers between wealthier and less well-off households also had a role in reducing the impact of the economic shock on families, and in stimulating market demand because low-income households exhibit a greater need to spend and less opportunity to save. Data on Pakistan show that philanthropy in 2014 amounted to almost 1 per cent of GDP and that people who can afford to do so are more willing to give money or food, time, or other in-kind contributions in times of hardship (PCP 2017). In Nepal, the Child and Family Tracker survey found that, in May 2020, 55 per cent of households in the lowest income quintile had no more savings and were borrowing from others (UNICEF 2022).

Agriculture also played an important role during the pandemic in South Asia (ADB 2021a). Because agriculture was much less exposed to COVID-19 restrictions and because weather was mostly favourable, output continued to expand even while other sectors of the economy suffered.[58] In Pakistan, wheat harvesting increased in 2020 despite the reduced availability of labour and transport because many drivers in local transportation systems, including buses, taxis, and rickshaws, had been sent home (Demaree-Saddler 2020). In Bangladesh, agriculture had a role in avoiding negative growth in 2020 (Kabir 2021). The agricultural sector has thus generally acted as a stabilizing factor in the economy, much like it did during the 2007–2009 financial crisis.[59] It has also helped feed and employ young job-seekers and the millions of migrant labourers who have been forced to return from cities to their rural homelands (ADB 2021b; Sharma 2021).

However, the sector offers a weak platform for resilience-oriented development in the region. Production is largely rain-fed, holdings are fragmented, and agriculture is laborious, inefficient, and often polluting (World Bank 2020). The yields are highly exposed to the weather, which introduces a destabilizing factor in poverty reduction, especially if one considers the negative and increasing influence of climate change.[60] In Pakistan, the employment of 88 per cent of agricultural workers is considered vulnerable (Shafi, Liu, and Ren 2020). While agriculture absorbs around two fifths of the workforce on average, it contributes less than a fifth of the GDP in the region, implying that there are large overlaps among low productivity, structural poverty, and agricultural labour.[61]

[57] See 'Personal Remittances, Received (% of GDP): South Asia, Afghanistan, Bangladesh, Bhutan, India, Maldives, Pakistan, Sri Lanka, Nepal' (dashboard), World Bank, Washington, DC, https://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?locations=8S-AF-BD-BT-IN-MV-PK-LK-NP.
[58] Timely and proactive exemptions from COVID-induced lockdowns to the sector facilitated uninterrupted harvesting of rabi crops and sowing of kharif crops," notes the Economic Survey 2020–21 of India (DEA 2021, 12). "However, supply chain disruptions impacted the flow of agricultural goods leading to food price inflation and adverse initial impact on some major agricultural exports."
[59] Agriculture in other regions was also found to be a stabilizing factor during the COVID-19 crisis. For example, an analysis of the sectoral impact of restrictions in the euro area concluded that "agriculture exhibits a negative elasticity and actually seems to have benefited from the restrictions, on average, possibly due to agricultural production processes requiring limited social interaction and being supported by sustained demand" (Battistini and Stoevsky 2021).
[60] The extreme heat wave in India and Pakistan beginning in March 2022 is threatening wheat and rice production after five consecutive record harvests (Nandy 2022). In 2021, Afghanistan and Bangladesh suffered substantial weather-related losses. The former experienced an abysmal drought, while the latter, together with Nepal, Sri Lanka, and West Bengal, had major floods that took lives and destroyed livelihoods. See BDRCS (2020); ESCAP (2021).

The record heatwave in India and Pakistan in March–May 2022 underlined the fragility of the sector to climate change effects (UNEP 2022). Drought in Afghanistan was a major reason for double-digit inflation on a year-over-year basis in July 2022.[62]

Agriculture is also a weak area for child rights and gender equity. A significant share of women labourers in the region are active as self-employed agricultural workers. While the sector is an important source of income among women, it contributes to earnings gaps by sex (Najeeb, Morales, and Lopez-Acevedo 2020). Many children are also working in the sector. A 2014 investigation by the International Labour Organization found that South Asia had at least 16.7 million child labourers and that agriculture absorbed the largest share of children in employment in every country on which data are available, ranging from 46 per cent in Bangladesh to around 90 per cent in Nepal.[63] Considering the extended school closures, a major COVID-19 policy effect in the region, there is a risk that agricultural work has become built even more deeply into the daily schedules of children and that families have become more dependent on these inputs.

Macroeconomic policy softened the impacts of the COVID-19 crisis, but at a cost

Macroeconomic policy has had several closely related objectives across the globe during the pandemic: preventing otherwise profitable enterprises from going bust, containing job losses and unemployment, and boosting household income and aggregate demand. Between January 2020 and September 2021, governments globally spent US$10.4 trillion on pandemic-related fiscal measures and US$6.1 trillion on liquidity support for businesses.[64]

Relative to national GDPs across Asia in 2020, the additional fiscal measures announced in March 2020–May 2021 were substantial in South Asia – generally larger than those adopted during the global financial crisis of 2007–2009. Table 1.3 shows the most recent data available on five South Asian countries in the International Monetary Fund (IMF) Fiscal Monitor Database.

[61] For agricultural value added, see Agriculture, Forestry, and Fishing, Value Added (Current US$) (dashboard), World Bank, Washington, DC, https://data.worldbank.org/indicator/NV.AGR.TOTL.CD; for agricultural employment, see Employment in Agriculture (% of Total Employment) (Modeled ILO Estimate): South Asia (dashboard), World Bank, Washington, DC, https://data.worldbank.org/indicator/SL.AGR.EMPL.ZS?locations=8S.
[62] https://reliefweb.int/report/afghanistan/afghanistan-economic-monitor-august-23-2022
[63] One child labourer in five was under 12 years old. See Khan (2015); Khan and Lyon (2015).
[64] See Fiscal Monitor Database of Country Fiscal Measures in Response to the COVID-19 Pandemic, Fiscal Affairs Department, International Monetary Fund, Washington, DC, https://www.imf.org/en/Topics/imf-and-covid19/Fiscal-Policies-Database-in-Response-to-COVID-19.

Table 1.3: Country fiscal measures in response to the pandemic, since January 2020

Percentage of 2020 GDP

	Additional public budget spending or forgone revenues			Liquidity support to enterprises
	Subtotal	of which:		
		Health	Non-health	
Afghanistan	2.1	0.7	1.4	-
Bangladesh	2.3	0.9	1.4	0.1
India	4.1	0.5	3.6	5.3
Pakistan	2.0	0.4	1.6	-
Sri Lanka	1.1	0.3	0.8	-

Source: Fiscal Monitor Database of Country Fiscal Measures in Response to the COVID-19 Pandemic, Fiscal Affairs Department, International Monetary Fund, Washington, DC, https://www.imf.org/en/Topics/imf-and-covid19/Fiscal-Policies-Database-in-Response-to-COVID-19.
Notes: Estimates as of 27 September 2021, based on October 2021 World Economic Outlook. The fiscal measures include resources allocated or planned in response to the COVID-19 pandemic since January 2020, which will cover implementation in 2020, 2021, and beyond. Liquidity support includes below the line measures, such as equity injections, loans, asset purchases, debt assumptions and credit guarantees. Typically, these do not have an immediate impact on the balance of the public budget, but may contribute to future budget deficits, debt, or inflation if firms receiving support fail or underperform.

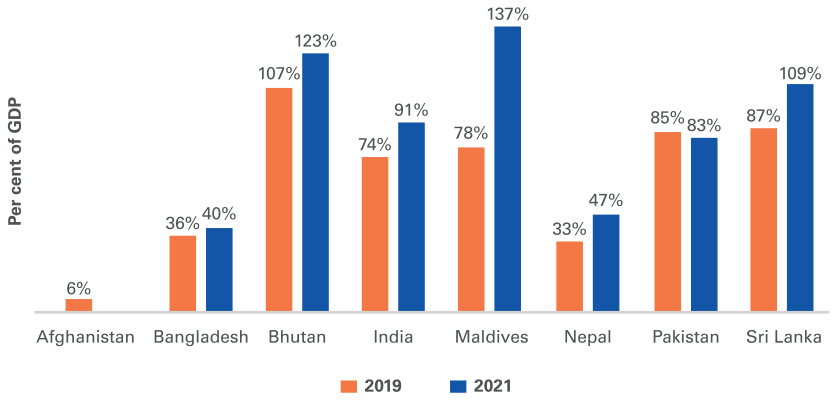
Most extra spending was aimed at supporting businesses, jobs and local government. New subsidies (e.g., on fertilizers), tax cuts and deferrals were financed through the public budget. Even more significant support went to businesses off the budget through credit guarantees, loans and other liquidity support.[65] A significant part of this support targeted small and medium enterprises, which were considered more vulnerable than larger firms.[66] In Pakistan, a survey found that over 83 per cent of micro, small and medium enterprises were unprepared and had no contingency plan to manage the situation. More than two thirds of the enterprises reported that they could not survive if the lockdown lasted more than eight weeks (Shafi, Liu, and Ren 2020).

A smaller, but still substantial, share of the fiscal packages were aimed at strengthening health and social protection. In India, for example, the health sector received over 10 per cent of the extra budget package (amounting to 0.4 per cent of GDP); an even bigger part – about 1 per cent of GDP – served to expand social protection programs, including free grain to individuals.[67] Together with extra resources for COVID-19 testing facilities, personal protective equipment, isolation beds, intensive care unit beds, ventilators and medical screening and increasingly also for vaccination, nearly half of the additional public budget spending supported social sectors. In Pakistan, health and social protection measures were even more strongly prioritized, although within an overall smaller package (McKinsey 2021).

Figure 1.9 shows one reason why some countries had difficulty supporting the business and household sector even more: sovereign debt. At least half the countries in South Asia entered 2020 in a vulnerable financial position, with public external debt at elevated levels. Over the ensuing two years, debt mostly increased. This is largely due to the greater spending associated with pandemic response, but low or falling public revenue has had a role, too. In Sri Lanka, tax cuts reduced revenue, while annual debt repayments were already absorbing almost 5 per cent of GDP, or around 40 per cent of government revenue before COVID-19 (Kidd et al. 2020). A large share of public expenditures in Afghanistan was financed through foreign aid, which plummeted after August 2021. Pakistan also received aid and concessional loans over 2020–2021 that helped consolidate external debt, as well as technical assistance from IMF. [68]

[65] See also Policy Measures, ADB COVID-19 Policy Database, Asian Development Bank, Manilla, https://covid19policy.adb.org/policy-measures.
[66] "One group of recipients which seems to already be receiving more attention in the current crisis is small and medium enterprises (SMEs)," notes a recent report (UNCTAD 2020, 18). "Partly this could be due to increased awareness on the importance of supporting firms which are the backbone of many countries' economies and provide a majority of jobs. It could also be due to the nature of the COVID-19 crisis and the resulting lockdowns, which tend to disproportionately affect smaller firms which depend more on face-to-face business and are less likely to have access to large amounts of savings and/or alternative sources of credit to smooth over their costs."
[67] Fiscal Monitor Database of Country Fiscal Measures in Response to the COVID-19 Pandemic, Fiscal Affairs Department, International Monetary Fund, Washington, DC, https://www.imf.org/en/Topics/imf-and-covid19/Fiscal-Policies-Database-in-Response-to-COVID-19.
[68] See USAID (2021). However, here, more than in other South Asian countries, budget deficits have also been financed customarily through domestic debt. This may fuel inflation, especially if the central bank is involved. Evidence shows, for example, that domestic debt and domestic debt servicing (chiefly through treasury bills) boosted consumer price inflation in Pakistan prior to the global financial crisis (Ahmad, Sheikh, and Tariq 2012). Since 2018, the involvement of the central bank in deficit financing has been discontinued in Pakistan. In advanced economies, central banks generally do not finance government expenditure due to inflationary risks (Jácome et al. 2012).

Figure 1.9: Gross general government debt, South Asia, 2019 and 2021



Source: IMF 2021.
Notes: Gross government debt denotes all accrued external financial obligations of a country. Data for 2021 are not available for Afghanistan.

In Bangladesh and Nepal, the ratio of external debt to GDP is low by international standards despite recent expansion. Low public revenue and GDP ratio in Bangladesh is increasingly acting as a barrier to countercyclical economic policy and taking more government debt, as only 1 taka in 10 reaches public coffers.

Table 1.4 illustrates public expenditures, revenues and budget deficits over 2019–2021. On the revenue side, taxes normally closely follow changes in GDP. However, the COVID-19 crisis particularly disrupted the modern urban sectors of the economy with links to external trade and global supply chains, which play an important role in tax collection in South Asia. Meanwhile, the support needed by enterprises struggling under the pandemic meant that the state suspended tax collection and lowered taxes to reduce financial burdens and liquidity pressures on businesses. As a result of these trends and actions, public revenues fell even more quickly in 2020 relative to GDP in all countries except Bhutan, Maldives and Pakistan. In the first two, natural endowments played a role, while, in the last, fiscal reform explains the resilience in revenue streams. In India and especially in Sri Lanka, the ratio of revenue to GDP was still less in 2021 than in 2019.

Table 1.4: Public budget revenues, expenditures and budget deficits, 2019–2021

Percentage of GDP

Country	General government revenue			General government expenditure			General government balance		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
Afghanistan	26.9	25.7	n/a	28.0	27.9	n/a	−1.1	−2.2	n/a
Bangladesh	10.0	9.8	10.1	15.4	15.3	16.1	−5.4	−5.5	−6.0
Bhutan	24.3	29.5	24.9	25.5	32.3	34.5	−1.2	−2.8	−9.6
India	19.7	18.3	19.2	27.1	31.1	30.4	−7.4	−12.8	−11.2
Maldives	26.8	27.2	27.9	33.4	50.0	46.0	−6.6	−22.8	−18.1
Nepal	22.4	22.1	24.2	27.3	27.4	28.8	−4.9	−5.3	−4.6
Pakistan	13.0	15.2	14.5	21.9	23.2	21.6	−8.9	−8.0	−7.1
Sri Lanka	12.6	9.2	9.5	20.6	21.9	20.0	−8.0	−12.7	−10.5

Source: IMF 2021.
Notes: General government revenue consists of taxes, social contributions, grants, receivables, and other revenue. Part of this revenue is raised by the central government; another part is raised by local government. Intergovernmental transfers (between different levels of government) do not change the total (i.e., the general government revenue).

Expenditures mostly increased in 2020 or 2021 relative to 2019, reflecting the stabilizing effect of the wage bill of public sector employees and discretionary fiscal measures. Maldives, where GDP and public revenues plummeted, could only pay public sector employees by incurring more debt and could afford few discretionary measures. The fact that fiscal deficits rose or remained significant during 2020 and 2021 (see Table 1.4) had a role in the rising debt.

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New macroeconomic risks: Inflation and pressure for economic adjustment policies

All countries avoided runaway inflation during the COVID-19 crisis, which was helped by the falling consumer demand for many products and services. Maldives saw deflation, but, in general, prices edged upward in the region often even before 2020. These tendencies have gained momentum in 2022 (see Table 1.5). In a World Bank (2022) key informant group survey of economists, policymakers, consultants and researchers, the vast majority ranked inflation as the greatest short-term risk for growth in the region: three times as many as those who ranked a new COVID-19 wave the greatest risk.

Table 1.5: Consumer prices have been moving upward in most countries in South Asia

Inflation, average consumer prices (per cent change)

Country	2018	2019	2021	2022*
Afghanistan	0.6	2.3	—	—
Bangladesh	5.8	5.5	5.6	6.0
Bhutan	3.7	2.8	8.1	7.9
India	3.4	4.8	5.5	6.1
Maldives	1.4	1.3	0.2	2.3
Nepal	4.1	4.6	3.6	5.8
Pakistan	3.9	6.7	8.9	11.2
Sri Lanka	4.3	4.3	6.0	**

Source: IMF: World Economic Outlook Database, April 2022 https://www.imf.org/en/Publications/WEO/weo-database/2022/April

Notes: The data show annual average inflation. Consumer price indices measure changes in the prices of goods and services purchased or otherwise acquired by households.

* IMF April 2022 projections based on data of IMF (2022).

** The IMF projections which were prepared at the end of first quarter in 2022 expected 17.6 per cent annual inflation. Following the country defaulting on all of its external debt in May 2022 inflation soared. The Central Bank reported 58.9 per cent consumer price inflation on a year-on-year basis in June 2022. See https://www.cbsl.gov.lk/en/news/inflation-in-june-2022-ncpi

Political, social and economic pressures could intensify further with new global supply chain disruptions, rising interest rates, and further inflation threats. External shocks, such as the global fallout from Russia's war on Ukraine and Omicron-related disruptions in China, continue to slow further global recovery with spillover effects in the region and push up commodity price inflation. Households with children are particularly vulnerable to higher food prices, as a very high share of their expenditures goes to basic necessities, especially food (see Table 1.6).

Inflation always increases inequality because it affects poorer households more than richer ones. If it is met with shortages because of balance of payment problems due to the stifling costs of external debt financing, political stability becomes fragile, as events in Sri Lanka attest (see Box 1.2 below).

Table 1.6: Proportion of expenditures on food in total expenditures of households with children, by wealth deciles

Per cent and percentage point difference

Decile	Bangladesh	India	Maldives	Nepal	Pakistan	Sri Lanka
Lowest wealth decile	61	60	35	70	55	67
2nd	60	59	35	70	54	63
3rd	58	57	35	67	53	59
4th	57	55	33	68	52	57
5th	55	53	33	66	50	54
6th	54	51	28	66	49	51
7th	52	47	27	62	48	47
8th	50	44	25	59	46	44
9th	46	39	24	54	43	37
Highest wealth decile	37	28	20	40	35	24
Percentage point difference between lowest and highest deciles	**24**	**32**	**15**	**30**	**20**	**43**

Source: Kidd, S., Athias, D., & Tran, A. (2021). Universal Child Benefits: transforming the lives of children across South Asia. Working Paper], based on Bangladesh HIES 2016, India IHDS-II, Maldives HIES 2016, Nepal AHS 2014/15, Pakistan HIICS 2015/16 and Sri Lanka HIES 2016. UNICEF Regional Office for South Asia.

Notes: The value of self-consumption of agricultural products are included in the consumption expenditures. A decile refers to each tenth of the population within a ranking, in this case by wealth.

Box 1.2: Sri Lanka's insolvency has added shocks to the shock

In May 2022, for the first time in its history, Sri Lanka defaulted on all of its debt. With its lucrative tourist industry just starting to recover from the impact of COVID-19, the country was running out of foreign currency needed for servicing its rapidly maturing external debt and paying for its fertilizer, energy and food imports. The dramatic increase in global energy prices following the invasion of Ukraine in February 2022 added to its economic woes. Unable to pay its international creditors, the country became insolvent, which led to further shortages and accelerating inflation.[69] First its government, then its president resigned amidst public unrest. The Governor of the Central Bank suggested in August 2022 that the economy will shrink by 8 per cent on an annual basis, implying an even more dramatic drop in incomes than what was recorded in 2020.[70] ADB projections (see Figure 1.8 in the main text earlier) suggest the economy will shrink further in 2023. The impact of the balance of payment crisis and default on sovereign debt on the economy appears therefore both longer and deeper than that of the terrible COVID-19 crisis. This underlines the importance of prevention and early action as underlying determinants of social stability, which overlap with child sensitive policies and principled actions, as the last chapter of this report argues.

[69] Some experts claim by delaying action on the restructuring of accumulated debt has greatly contributed to the default. See https://www.bbc.com/news/business-61505842.
[70] See https://www.telegraphindia.com/world/sri-lankas-forex-situation-has-improved-says-central-bank-governor-nandalal-weerasinghe/cid/1880925.

Sri Lanka's sovereign debt and balance of payment crisis raises the question of the extent of economic risk for other countries in South Asia. Sri Lanka is one of six South Asian countries that accumulated higher sovereign debt between 2019 and 2021. The two exceptions were Afghanistan, where reporting debt to the IMF stopped after the Taliban-led government took over in August 2021 and the country lost access to large aid flows and the international financial system; and Pakistan, where the debt to GDP ratio in 2021 stood very nearly as high as in 2019. Moreover, most countries posted a negative current account balance in 2020, and all of them did so in 2021 according to the IMF calculations,[71] which in the given context means that remittances sent home did not compensate for a negative trade balance with the rest of the world.[72]

Prudent macroeconomic policy is therefore due everywhere to prevent the debt situation from getting out of hand elsewhere in the region. Countries' balance of payment and terms of trade need to be monitored. If higher bills of imported food, fuel, fertilizer and other commodities are not in equilibrium with higher revenues from export and remittances sent home, reserves may dry up and further debts could occur.[73] The fact that the cost of servicing sovereign debt is rising globally, crowding out countries' import capacity and making fresh financing more expensive, adds a further threat.

However, there is reason for hope that other South Asian countries will fare better, as the high exposure of Sri Lanka to higher debt service as well as fuel and grain prices is not necessarily representative of the region. Nepal and Bhutan are net food importers, like Sri Lanka, but their sovereign debt is still relatively moderate.[74] Due to extreme weather, 2022 does not appear to be as good a year for agriculture in South Asia as 2020 and 2021 had been (when the sector played an important stabilizing role, considering that it still employs over half of the labour force). Still, that fact that the region's three largest economies – India, Pakistan and Bangladesh – are net exporters of cereals offers not only protection against commodity price inflation, but also revenue opportunities. Indeed, the economies of India and Bangladesh are expected to grow by approximately 7 per cent over 2022, which is the fastest economic growth of any large economy in the world currently.[75]

Key takeaways

Despite energetic and widescale government responses, the COVID-19 crisis has caused **much greater devastation in South Asia than the global financial crisis did a decade earlier.** While the direct impacts of the pandemic increased mortality and morbidity, especially among older men and women,

[71] IMF estimates start after the 2020-21 fiscal year (2021) for Bhutan, Nepal and Pakistan, and 2019-20 fiscal year (2020) in the rest of the South Asian countries using the GFS methodology. See International Monetary Fund, World Economic Outlook Database, April 2022.
[72] According to the IMF definition, the "Current Account shows flows of goods, services, primary income, and secondary income between residents and nonresidents."
[73] The Balance of Payment also includes the Capital Account, which could be positive (e.g., due to more foreign direct investment and/or portfolio investment arriving than leaving the country). Hence a negative current account does not necessarily mean that the country must use its foreign currency reserves to avoid getting more indebted or facing an immediate risk of insolvency. However, the capital account can also bring instability ("capital flight").
74] In February 2021, the Minister of Finance announced an ambitious program to privatize about $24 billion in state-owned enterprises as part of the FY 2021-22 (March 31-April 1) budget of India. See https://www.state.gov/reports/2022-investment-climate-statements/india/.
[75] https://www.imf.org/external/datamapper/NGDP_RPCH@WEO/OEMDC/ADVEC/WEOWORLD

the indirect impacts dealt a substantial blow to economic and social progress, destroying livelihoods, disrupting services and undermining human capital development. Both types of effects will have far-reaching impacts on children and on the region more broadly, as the next chapters explore.

Protective measures and fiscal packages have aimed at slowing infections and reducing economic scarring effects by delivering liquidity support to enterprises, expanding health sector capacity and enhancing social protection. Vulnerable families have also benefitted from increased charity activity, as well as transfers between households and within extended families.

In the early stage of the pandemic, when immunization was not yet available, **infections soared in urban and economically developed areas** more than in rural and less developed areas. In this stage preventative policies focused on hygiene, mask wearing, social distancing, and **economic and social lockdowns.** The efficiency of the latter was greatly helped by geographic aptness for isolation as well as and by administrative capacity for enforcement, monitoring and reporting. In the second stage of the pandemic, most countries have achieved **high vaccination rates.** In some cases, this success arrived too late to prevent a large second wave in infection and mortality caused by the Delta variant of the virus, but it did save many lives from the Omicron variant across the region.

By early 2022 the combination of natural immunity and high rates of vaccination allowed a significant **easing of lockdowns.** This is good news for children, who were impacted by the sharp fall in household's economic opportunities in 2020, family coping strategies, and the continued service disruptions and lockdowns during the repeated waves.

Return to normalcy is hindered, however, by a **less favourable international political climate** and a new global **standard of living crisis** fuelled by high food, fuel and fertilizers prices in international markets. These are driven or exacerbated by Russia's war in Ukraine, supply chain bottlenecks largely due to continued Omicron-related lockdowns in China, aggressive hikes in international lending rates in OECD countries and a sharply appreciating dollar. These factors weaken the post-lockdown recovery in South Asia and retroactively raise the effective cost government efforts over the last two years to shield livelihoods and productive capacity during the pandemic at the cost of **higher public debt.** It is yet to be seen to what degree **extreme weather events in 2022** and the higher prices of fertilizer and fuel have undermined income from agriculture, the main employer of low-income families in much of the region, which remains vulnerable to climate change.

Prior to COVID-19, all eight countries of South Asia were experiencing rapid economic growth. Over two years later, Sri Lanka and Afghanistan – the richest and the poorest country in the region, respectively – are now outliers in continuing to see negative or weak growth respectively. The other six countries are back to prior growth trajectories, with Bangladesh, India and Maldives posting particularly strong growth economic despite current global headwinds. This is clearly a success. However, to continue with robust and sustainable economic growth and intensify **labour productivity**, countries will increasingly need a workforce that is not just abundant but also healthy, resilient and well trained. In this aspect, the last two years have added new concerns as well as highlighted important weakness in the initial conditions pre-COVID.

The next two chapters of this report explore how children's well-being and development have been impacted by the COVID-19 crisis and related shifts in public policies. Given that the cognitive and human capital of the workforce is established in childhood, these issues are highly relevant for long-term economic growth in South Asia. Annex A of the report offers a unifying framework for understanding the human development impact of the COVID-19 crisis. The last chapter focuses on how countries could use the complex post-lockdown situation as an opportunity for accelerating human development and further promoting child rights in the region.

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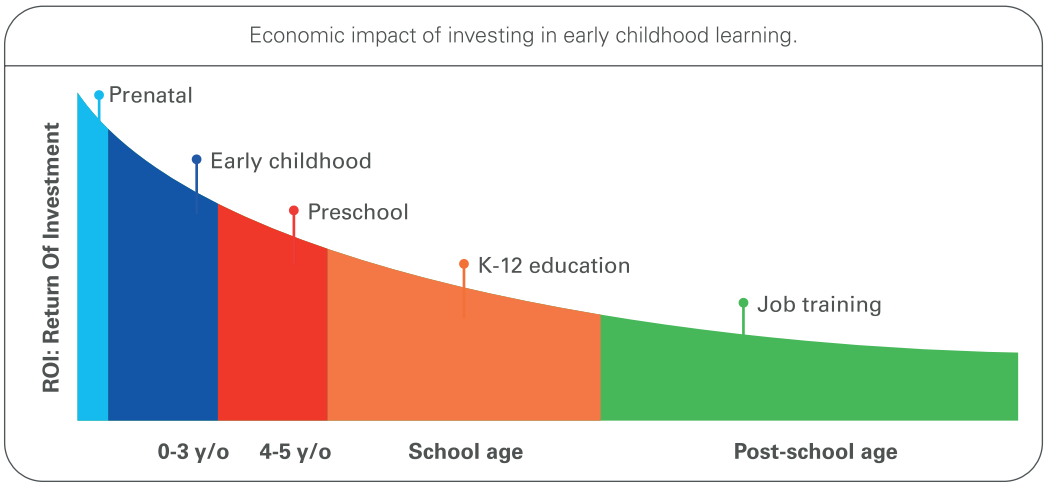
CHAPTER 2: HOUSEHOLD INCOME, CHILD POVERTY, AND SOCIAL PROTECTION

Children experience poverty as damaging to their mental, physical, emotional, and spiritual development.[76] It is clear that the impact of the pandemic has exacerbated this damage profoundly over the last two years. Household monetary poverty is only one measure of the deprivations that girls and boys experience, and it is an imperfect one. Still, it is a powerful explanatory factor in many child outcomes. Policies focusing on employment, wages and social transfers could produce windfalls in a range of social outcomes, including nutrition, health, education, and child protection.

This chapter looks at household monetary poverty and its key determinants: employment and social protection (including benefits in cash and in kind).[77] Stability in household income and access to services in childhood, particularly during the early years, is important for every individual in South Asia, and reaps benefits on a national scale. Figure 2.1 illustrates a prominent theory regarding the greater economic returns on investment realized when investments in learning are made early in life. Appendices A and B elaborate further on this concept, particularly with reference to the key relationship between on the cognitive capital of workforces and the future productivity of nations.

Figure 2.1: Age and the rate of return on human capital investment show an inverse relationship



Source: Reprinted from https://heckmanequation.org/, copyright 2022, under the Creative Commons license viewable at https://creativecommons.org/licenses/by-nc-nd/3.0/. Based on the work of James J. Heckman, PhD.

Notes: This image does not graph data of actual intervention outcomes, but expresses a noted theory about patterns of return on investment when interventions are ideally designed and executed. Further clarifications on this from Prof. Heckman and colleagues are available at https://statmodeling.stat.columbia.edu/2020/08/12/heckman-curve-update-update/.

[76] Child poverty is rarely differentiated from poverty in general, and its special dimensions are seldom recognized" (UNICEF 2004, 16; see also Minujin et al. 2006). This is true for all household poverty indicators, including monetary and multidimensional conceptualizations.

[77] The terms monetary poverty, income poverty and consumption poverty are used here interchangeably for practical reasons: people tend to be better at reporting consumption expenditures than income, so household surveys focus on the former. However, it should be noted that households experiencing income shocks or sudden large expenditure needs (for example, catastrophic health expenditures) may use savings or borrow to smooth consumption. For this reason, consumption-based measurements always understate income poverty. Consumption refers to purchased goods and services as well as to income in kind from the self-consumption of agricultural products.

2.1. Crisis impacts on household income and employment in South Asia

Prior to 2019, monetary poverty had been declining rapidly in South Asia. However, many households had only barely escaped poverty, and thus remained in a precarious situation. In the first year of the COVID-19 pandemic, due to the shrinking size of the economy and continued population growth, per capita income was reduced in all eight countries in South Asia, and the number of people living in poverty increased. In 2021, economic growth returned, but poverty levels were still higher than two years earlier (see Box 2.1). As Chapter 1 highlights, economic growth is expected to continue in the region in 2022 and 2023, with the exception of crisis-hit Sri Lanka; therefore, the real income of households should surpass 2019 levels despite a surge in consumer prices.

However, it remains to be seen whether employment and wage-earning opportunities for low-skilled people and disadvantaged groups will increase faster than the prices of food and other basic necessities – especially for the urban poor. In Nepal, for example, the share of households reporting monetary poverty was greater in the April 2022 edition of the UNICEF-supported child and family tracker survey than in the baseline survey in May 2020 (UNICEF 2022a). In Afghanistan, real wages are still significantly below their pre-August 2021 level due to high inflation.[78]

Box 2.1: World Bank estimates on changes in extreme poverty in recent years

The World Bank (2021b) has estimated that despite a declining trend before COVID-19, extreme poverty, which they associate with consumption below US$1.90 a day per capita at purchasing power parity[79], still affected between 116 and 156 million people in 2019 in South Asia. (The large range is applied because of difficulties stemming from the lack of recent household income and expenditure data in India.)[80] Due to the COVID-19 shock, poverty increased by at least 17 million people in 2020. However, the Bank points out that without COVID-19, poverty headcount numbers would have declined to 54-85 million in 2020. Hence, according to these calculations, the lockdowns reduced the ability of the economy to lift people out of poverty. In 2021, after economic recovery began, the World Bank put the headcount poverty figures between 119 and 162 million people in 2021, which were still higher than the numbers in 2019.

In April 2022, the World Bank extended its "nowcast" poverty projections to 2022 for all major regions except South Asia using the GDP projections available at that time. According to these projections, global poverty will be still somewhat higher in 2022 than it was three years earlier.[81] Because the IMF projected economic growth for South Asia at 7.5 per cent, significantly higher than for the total of emerging and developing economies (3.8 per cent), it may be realistic to assume that extreme poverty continued to decline in the region as a whole and most countries in the region will see lower poverty headcount numbers than before the COVID-19 crisis. These assumptions and estimates allow significant changes in the composition of households and individuals under the international poverty line, due partly to employment and partly to inflation effects: some households, for example, could benefit from higher food prices while others could not, as experience from the 2007-2008 crisis would suggest (Jacoby, 2013).

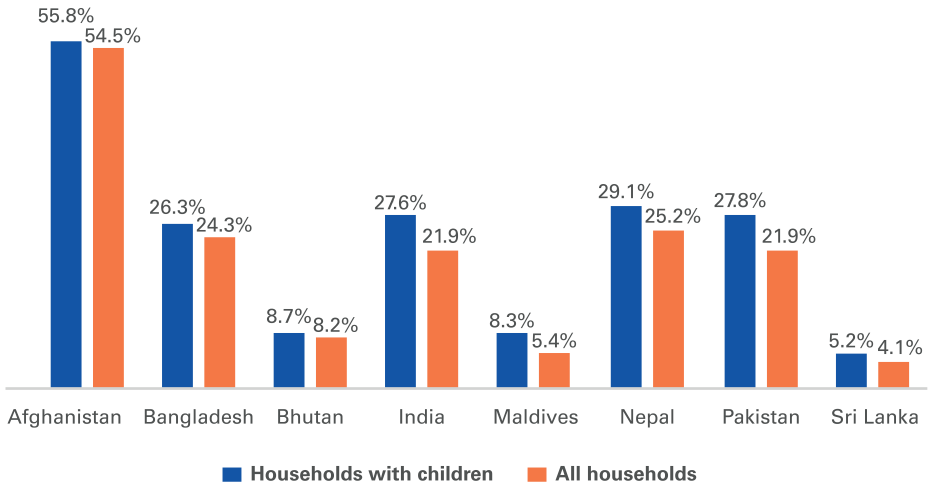
[78] Data published by National Statistics and Information Authority of Afghanistan quoted in the World Bank's Afghanistan Economic Monitor (August 23, 2022) shows headline consumer price index inflation at 17.5 percent in June 2022, driven chiefly by 26 per cent year-on-year food inflation. Increasing global energy and food prices (about half of the country's imports) and the impact of the drought on agriculture continue to undermine the purchasing power of the afghani. See https://reliefweb.int/report/afghanistan/afghanistan-economic-monitor-august-23-2022

[79] These estimates are calculated using the US$1.90 per person per day poverty line, which was updated by the World Bank in September 2022 to US$2.15 per person per day. Poverty data are now expressed in 2017 Purchasing Power Parity (PPP) prices, versus 2011 PPP in previous editions. The new global poverty lines of $2.15, $3.65, and $6.85 reflect the typical national poverty lines of low-income, lower-middle-income, and upper-middle-income countries in 2017 prices. While this was largely a technical change which should not significantly alter the global poverty data, the Bank will soon make the revised set of nowcast estimates available.

[80] In 2013, India's Planning Commission estimated that 269.8 million people or 21.9 per cent of the population had been living on less than Rs 816 per capita per month in rural areas and Rs 1,000 per capita per month in urban areas in 2011–2012. Since then, no official poverty estimates in India have been released. See Poverty Measurement in India: a status update See Gaur and Rao (2020).

[81] https://www.worldbank.org/en/topic/poverty

Figure 2.2: Households with children are more likely to live in poverty, across nations



Source: UNICEF calculations based on poverty headcount ratio at national poverty lines (% of population) (dashboard), World Bank, Washington, DC, https://data.worldbank.org/indicator/SI.POV.NAHC; Save the Children and UNICEF 2021.

Notes: The data refer to poverty prevalence (%). The 'all households' category includes those with children and those without. Accordingly, the gap between the two groups must be higher than the gap shown in the figure. The years of the latest available data are as follows: Afghanistan, 2016; Bangladesh, 2016; Bhutan, 2017; India, 2011; Maldives, 2019; Nepal, 2010; Pakistan, 2018; Sri Lanka, 2016. Edochie et al. (2022) suggest that the headcount poverty ratio was 10.4 per cent in 2017–2018, but they do not give an estimate on child poverty. The methodology of these estimates of child poverty is based on the work of Fiala et al. (2021). It should be noted that poverty conceptualizations using multidimensional poverty indices have also found that children face a higher-than-average risk of poverty in countries of the region (see UNDP and OPHI 2022).

Households with children are at greater risk of monetary poverty

All the large economies of South Asia showed significant monetary poverty and child poverty pre-COVID (see Figure 2.2). Despite progress, an estimated 177 million children were living in households with income-consumption under the national poverty lines pre-COVID-19. According to the latest available data, the prevalence of monetary child poverty in Bangladesh, India, Nepal and Pakistan was almost identical, hovering around the 28 per cent regional average, despite different survey years, populations with non-identical age composition and different per capita national incomes.[82] Low-income Afghanistan had much higher poverty rates, while Bhutan and upper middle-income Maldives and Sri Lanka posted substantially lower rates.

Moreover, children tend to be overrepresented among those living in monetary poverty. As Figure 2.2 shows, households raising children were estimated to face a higher-than-average risk of living under the national poverty line pre-COVID. This income-consumption penalty applied in all eight countries in South Asia. Partly this was due to demographic factors: children tend to arrive early to families in South Asia, when parents are young. Indeed, poverty risk is rampant among families with young children: in Bangladesh, for example, nearly half of all households with children under five live under the national poverty line (World Bank and KWPF 2019). And accelerating inflation, especially of food prices – as experienced in 2022 across the region – tends to hit families with children harder than households without children.

This should be of particular concern in South Asia because childhood deprivations, especially at an early age, undermine human capital development.[83] It is the cognitive capital of the new generations that could help South Asia – not only cities, but entire countries – leapfrog into the digitally connected world and take a leading role in the twenty-first century industrial revolutions.[84] It is important to develop the

[82] Because the poverty data on India are a decade old and because, during this decade, per capita income rose by over 40 per cent in the country, on average, there is reason to assume – but no firm evidence – that India's poverty headcount ratios shown in Figure 2.1 would be substantially lower today despite an upward spike in 2020. However, there is no reason to assume that the relative disadvantage of children and households with children has changed. Moreover, even though the methodologies the countries use to determine national poverty lines are not identical, they share some features, such as basing calculations on insufficient caloric intake.

[83] This is true even in high-income countries, because not only absolute but also relative poverty and inequality matters for child development. See, for example, https://www.healthscotland.scot/media/2186/child-poverty-impact-inequalities-2018.pdf.

[84] The first industrial revolution used the power of water and steam to mechanize production. The second used electric power to drive mass production. The third used electronics and information technology to automate production. A fourth industrial revolution is now building on the third, the digital revolution that has been occurring since the middle of the last century. It is characterized by a fusion of technologies that is blurring the lines among the physical, digital, and biological spheres. See Schwab (2016).

physical infrastructure, including machines, objects, and devices, for the networks that are connecting new industries. However, in order for these to be optimally useful, the cognitive development of the population cannot be overlooked (see Appendix B). The harm done even by temporary increases in poverty, by delays in poverty reduction, and by losses in education, peer contacts and optimal care conditions since early 2020 will have a long-lasting impact on tomorrow's economic and social development.

Yet, living in a household with income above the national poverty line is no guarantee that the children will grow to their full potential. For example, data from Pakistan show that 63 per cent of children living in households with incomes above the monetary poverty line in 2017–2019 were suffering from at least one material deprivation, such as young children showing low height for age, school-age children not attending school, children living in households with access only to surface sources of water or adolescents lacking access to digital communication tools when this is needed for distance education.[85] One reason for this is that national poverty lines are often set too low to support deprivation-free childhood conditions. A second important reason is that many conditions needed for optimal child development – clean water, good sanitation, clean air, proper schools – are public goods that depend on community development rather than the wealth of individual households.

Related to this, where children are born matters significantly for the risk that they will experience poverty, including chronic poverty.[86] South Asia contains enormous socioeconomic disparity, and much of the poverty is concentrated in rural areas and in low-income states, provinces or districts. The SDG India Index & Dashboard (2019) publication found stark differences among the states and union territories in terms of the proportion of people living below the poverty line. For example, in 2011-12, nearly 40 per cent of people in Chhattisgarh were living under the poverty line while a much smaller proportion lived in poverty on the Andaman and Nicobar Islands or in Goa state.[87] While the Gini index of inequality is relatively moderate in India, there is continued divergence in per capita incomes between rich and poor states, and location alone explains one third of the variation in living standards in the country (Balasubramanian, Kumar and Loungani 2021).

Children are particularly vulnerable to temporal effects. Income and consumption surveys capture monetary poverty in a given moment in the life of households rather than the resources available to households at critical periods of child development, such as during pregnancy, over the first 1,000 days of life, or when children need to establish their core learning skills. Even if household income may have recovered by the time a survey is run, deprivations suffered at such critical moments of child development will be carried throughout childhood and may emerge years later: for instance, when statistical surveys measure child outcomes. The deprivations may even produce intergenerational effects, for example, through women's poor health and nutrition during pregnancy.[88]

Remaining in poverty or exposure to transient poverty does not have the same implications among adults as it does among children. For young children and adolescents, even a temporary spell of poverty or income loss may derail child development in lasting, irreversible, or tragic ways. The experience of poverty or income loss likewise does not have the same implications for young men as it does for young women.

Accelerating inflation, especially food inflation – as experienced in 2022 across the region – tend to hit families with children more than households without children. Raising children reduces time available for income-earning activities, and although nominal wage growth of parents may catch-up eventually with price increases, the hardship caused by temporary setbacks in real income and consumption can derail child development.

Appendix C highlights demographic patterns and trends that are important determinants of the monetary poverty of households raising children and reflect conventional and new models of economic coping strategies. Chapter 3 discusses how poverty, distress and household economic coping mechanisms, together with disruptions in basic social services, are expected to increase the prevalence of negative coping mechanisms, such as child marriage, child labour, and/or school dropouts in the context of the pandemic.

[85] The analyses used a combination of statistical surveys. For instance, the Pakistan Social and Living Standards Measurement Survey (2018–2019 and 2019–2020) reported on education, health (immunization and contraception), housing, information, sanitation, and monetary poverty. It thus enabled cross-tabulations of child deprivations with households experiencing monetary poverty (Chaudhry, Raza, and Gorjon 2021).
[86] For a study that found that rural poverty is more severe and more likely to be chronic, while urban poverty is often transitory, see Arif, Ghulam Mohammad (2007), 'Chronic and Transitory Poverty in Pakistan: Evidence from a Longitudinal Household Survey,' June 2007 Pakistan Development Review 46(2):111-127. DOI:10.30541/v46i2pp.111-127.
[87] See http://www.indiaenvironmentportal.org.in/files/file/SDG-India-Index%202019-20.pdf.
[88] See, for example, a summary on intergeneration effects by Victora, Cesar G. et al. (2008), 'Maternal and child undernutrition: consequences for adult health and human capital,'' https://www.thelancet.com/article/S0140-6736(07)61692-4/fulltext, or Bird, K. 2010, 'The Intergenerational Transmission of Poverty: An Overview,' Chronic Poverty Research Centre Working Paper No. 99, Jun 2010, Overseas Development Institute (ODI). Behrman, Jere R. et al., 'Intergenerational Transmission of Poverty and Inequality: Young Lives', Working Paper 117, Young Lives, University of Oxford, Oxford, 2013.

Informal employment and low female labour force participation heightened economic vulnerability

The first few weeks and months after the introduction of stringent measures in March-April 2020, when hard lockdowns prevailed, were devastating for livelihoods, especially in urban and semiurban areas where many of the people whose incomes are only slightly above the poverty line live.[89] Much of the impact fell on informal workers who had little or no job security, no social insurance, and little savings. Migrant workers from rural areas constituted a particularly vulnerable group in urban settings.[90] They mostly worked in sectors that were hit hard by the COVID-19 lockdowns, such as construction, transport, small trades, and leisure services. Many of these people, especially day labourers, are earning a wage that lifts them only slightly above the poverty line. When lockdowns were announced overnight, these workers found themselves jobless and without the option of travelling back to their families in rural areas because trains and buses were also grounded by the lockdowns (Singh 2020). Urgent help was needed on a massive scale, but social assistance systems were mostly targeting poverty in rural areas.

Pre-COVID studies by the International Labour Organization found that over 80 per cent of the workforce in South Asia is engaged in the informal sector, and many of the people who work in the formal sector have informal jobs (for example, see Rothboeck and Kring 2014). However, access to formal jobs varies significantly by country: in Maldives over two thirds of workers, and in Nepal almost half, work in the formal sector, implying some access to social security and job security.

As Table 2.1 shows, with the exception of Nepal and to some extent also in Bhutan, female labour force participation (in terms of paid employment) is still very low in the region. Compared with other global regions, female employment rates in South Asia are far below average, particularly in Sri Lanka, Pakistan, India, and Bangladesh (Scott et al. 2021). Moreover, with the exception of Sri Lanka, women who work face worse access to formal sector employment than men.

[89] Lockdowns, moreover, spread like wildfire across all global regions, causing further disruptions in international trade and global supply chains. This aggravated the situation, creating a vicious circle.
[90] The size of the internal migrant population had been increasing very significantly over the last two decades before COVID-19- especially in large urban settings. In India, the 2011 Population Census put the total number of internal migrants (inter- and intrastate) at 450 million, an increase of 45 per cent since 2001. The 2017 Economic Survey estimated the interstate migrant population at 60 million and the average annual flow of migrants between states at 9 million. See Khan and Arokkiaraj (2021).

Table 2.1: Labour force participation and informal employment

Country	Labor force participation rate, % (2021)			Share of employment outside the formal sector by sex and economic activity, %				
				Male		Female		Reference year
	Total (% of total population ages 15+)	Male (% of male population ages 15+)	Female (% of female population ages 15+)	Total	Of which agriculture	Total	Of which agriculture	
Afghanistan	41.4	66.5	14.8	73.7	96.3	94.7	99.5	2021
Bangladesh	57.0	78.8	34.9	80.5	99.2	84.7	99.5	2017
Bhutan	60.1	67.4	51.6	-	-	-	-	-
India	45.6	70.1	19.2	80.3	99.6	80.7	99.6	2019
Maldives	56.2	67.5	34.3	29.1	84.8	41.6	99.4	2019
Nepal	79.6	80.8	78.7	56.6	86.8	63.5	89.7	2017
Pakistan	50.1	78.1	20.7	69.1	99.6	86.6	99.9	2021
Sri Lanka	48.6	68.5	30.9	63.5	91.9	53.8	87.8	2019
South Asia	47.6	71.8	22.0	-	-	-	-	-

Source: Labour force participation rate: The World Bank data: https://data.worldbank.org/indicator/SL.TLF.CACT.ZS?locations=8S. Share of informal employment: ILOSTAT explorer: https://www.ilo.org/shinyapps/bulkexplorer3/?lang=en&segment=indicator&id=EMP_PIFL_SEX_ECO_RT_A.

Notes: Labour force participation rates are modeled ILO estimates.

When lockdowns were announced, women working in tourism, catering, the garment industry, or similar sectors hit hard by stringency measures and the disruption of trade and global supply chains faced a high risk of income insecurity.[91] Global studies have found that, in times of crisis, women and youth are confronted by a higher-than-average hazard of losing their jobs or remaining without work.[92]

Economic growth in 2022 was already in the second year of a rebound, and jobs were showing initial signs of recovering in much of the region. However, World Bank (2022) data show that job recovery rates were higher among men than among women, and higher among workers with some education than among workers with no education. In Afghanistan, India, and Pakistan, the gender gap in job recovery rates is more than 10 percentage points, indicating that women are substantially disadvantaged in the labour market recovery.

[91] "Factories producing woven goods employed higher shares of women and also experienced greater revenue declines during the pandemic", note Boudreau and Naeem (2021, 4). "The fact that job losses were larger for factories with relatively higher shares of female workers suggests that female garment workers may have been more adversely impacted by job loss."
[92] "A given negative impact of the pandemic on real GDP [gross domestic product] in a country translates into a much larger reduction in employment for young people than adults", highlight O'Higgins and Verick (2021, 5). "For young people, on average, a 10 percentage point decline in GDP translates into an 8.1 percentage point decline in youth employment compared to 6.3 percentage points for adults."

2.2. Social protection: Focus on shock-responsiveness and improved delivery

When lockdowns meant that people could not go to work, households needed assistance with an urgency and at a scale never before seen. Besides topping up health budgets to cope with the direct impact of COVID-19 on population health, governments turned to social protection to address the indirect effects of the crisis on households. Indeed, in responding to the challenge of COVID-19, the population coverage of social protection and related programme expenditures have risen substantially across the globe during the pandemic (Gentilini et al. 2022). South Asia is no exception: in fact, some of the largest social protection responses to the pandemic were implemented in the region, building on programmes that were created at the time of the 2007-2008 food, fuel and financial crisis.

Social protection systems going into the pandemic

Only about 15 per cent of the population of South Asia enjoyed coverage by social insurance in the years before COVID-19, reflecting the lower prevalence of formal employment.[93] Accordingly, few women and men earned access to entitlements, such as old-age pensions, unemployment support, maternity and parental leave, sick leave, or a child allowance, through employment or the social transfer or tax system.[94]

The twin problem of low coverage and insufficient adequacy (both in programme design, frequency and benefit level) was a challenge prior to the pandemic. According to the World Bank, 23 per cent of people in South Asia had no access to any form of social protection.[95] Almost two thirds of the population – 62 per cent – benefited from social assistance[96] directly or indirectly on an either regular or occasional basis, including emergency in-kind food transfers. Indeed, it is difficult to get a clear picture of the coverage and adequacy given the reporting challenges due to fragmented systems and the sheer number of institutions involved in delivering social protection programs, both at national and sub-national levels.

Child-sensitive social protection programmes existed but had limited outreach.[97] ILO data quoted in UNICEF's State of the Worlds' Children indicate that only 22 per cent of children under 15 receive child or family cash benefits (contributory or non-contributory) on average in South Asia, with significant differences among the countries (see Table 2.2).[98]

[93] Data of ASPIRE (Atlas of Social Protection Indicators of Resilience and Equity) (dashboard), World Bank, Washington, DC, http://datatopics.worldbank.org/aspire/. Data refers to countries' most recent value between 2010 and 2018. In high-income countries, it is chiefly contributory social insurance that provides protection against idiosyncratic risk along the life cycle among individuals and that mitigates the impact of aggregate shocks on households and the economy through offering automatic stabilizers.
[94] For example, see Maternity and Work (dashboard), Paycheck India, Indian Institute of Management, Ahmedabad, India. https://paycheck.in/labour-law-india/maternity-and-work#MaternityMaharashtra.
[95] Data of ASPIRE (Atlas of Social Protection Indicators of Resilience and Equity) (dashboard), World Bank, Washington, DC, http://datatopics.worldbank.org/aspire/.
[96] Social assistance or social safety net programs are non-contributory transfers in cash or in-kind and are usually targeted at the poor and vulnerable. Some programs are focused on improving chronic poverty or providing equality of opportunity; others more on protecting families from shocks and longstanding losses they can inflict for the unprotected poor. These programs, also known as social welfare, include cash transfers (conditional and unconditional), in-kind transfers, such as school feeding and targeted food assistance, and near cash benefits such as fee waivers and food vouchers.
[97] Pulling together the nine largest child-oriented social assistance programmes, Arruba et al. (2020) find that there were 38 million child beneficiaries pre-COVID. This represented only 6.2 per cent of the total child population in the region.
[98] Ratio of children/households receiving child/family cash benefits to the total number of children/households with children.

Table 2.2: Effective coverage of social protection cash benefits (%)

Country	Effective Coverage	Effective Coverage by Function			
		Children	Maternity	Disability	Old Age
Bangladesh	28.4	29.4	20.9	18.3	39.0
Bhutan	8.8	13.5	10.4	-	-
India	24.4	24.1	41.5	5.6	42.5
Maldives	21.2	8.2	26.2	42.7	100.0
Nepal	17.0	22.9	9.8	13.7	84.2
Pakistan	9.2	5.4	-	1.7	5.8
Sri Lanka	36.4	32.0	29.4	18.0	35.7

Source: ILO: World Social Protection Report 2020-22: Social protection at the crossroads – in pursuit of a better future, wcms_817572.pdf (ilo.org)

Notes: Effective Coverage: Proportion of population covered by at least one social protection cash benefit. The proportion of the total population receiving at least one contributory or non-contributory cash benefit, or actively contributing to at least one social security scheme. Children: Ratio of children/households receiving child/family cash benefits to the total number of children/households with children (aged 0-14 years). Maternity: Ratio of women receiving maternity cash benefits to women giving birth in the same year (female population aged 15-49 years). Disability: Ratio of persons receiving disability cash benefits to the number of persons with severe disabilities. Old age: Ratio of persons above statutory retirement age (65 years and above) receiving an old-age pension to the number of persons above statutory retirement age (including contributory and non-contributory). Data refer to 2020 or latest available year. The source does not have data for Afghanistan.

In addition, the relevance to poverty reduction is brought into doubt by data showing that social protection systems in South Asia delivered the lowest level of benefits globally: on average, only US$0.20 at purchasing power parity.[99] Indeed, using the Luxembourg Income Study database of 49 high- and middle-income countries, research has found near negligible effects of tax and benefit systems on household income inequality in South Asia.[100]

Important steps were taken to address the ineffectiveness and improve the administrative efficiency of social assistance over the last 15 years (see Box 2.2). The political and administrative returns on these reforms had become undeniable when COVID-19 and associated restrictions had brought the region to a near standstill in March-April 2020, and governments were trying to put together long lists of beneficiaries and scale up the delivery with great urgency of two items: cash and food.

Box 2.2: The introduction of large, centrally driven programmes accelerated reform

The long-standing ambition to reduce chronic, extreme poverty in South Asia has received a large boost over the last decade and a half in two main steps. First it was recognized that economic growth alone is not enough for addressing chronic poverty: the stability of livelihoods remained an issue. Apart from the food, fuel and financial crisis in 2007–2009, climate emergencies battered the region. Drought and other weather-related events reduced prosperity in rural areas where about two thirds of the population live. New assistance schemes were therefore introduced in several countries to confront income and food insecurity. These included the Mahatma Gandhi National

[99] Data of ASPIRE (Atlas of Social Protection Indicators of Resilience and Equity) (dashboard), World Bank, Washington, DC, http://datatopics.worldbank.org/aspire/.
[100] Globally, relative income redistribution was at over 25 per cent (ILO 2021).

Rural Employment Guarantee Scheme (M-NRGES), which offered 100 days of public works annually in India, as well as unconditional, means-tested programmes, such as the Benazir Income Support Programme (BISP) in Pakistan.

Economic reforms aimed at better targeting of the disadvantaged also played a role. In India, for example, food and energy price subsidies were cut and transformed into subsidized food and cooking gas rations for poor households and available in fair shops. The new programmes were also meant to address the protection of human rights, especially the right to food and the empowerment of women. According to the recommendations associated with the M-NRGES, at least a third of beneficiaries must be women. Likewise, BISP applications are only open to women with valid IDs.

These reforms added millions of new or newly identified beneficiaries– and they also added large and numerous administrative tasks. Checking and managing entitlements and delivering services were complicated by the fact that most old assistance systems had been paper-based and consisted of literally hundreds of mostly smaller programmes, especially in the larger countries, addressing livelihood issues such as disability, old age, gender inequity, early child development, industrial injuries, and so on. These were run by a multitude of ministries or other levels of government (local, state, etc.). Most programmes had their own registry lists that were not linked together, signalling system fragmentation. With low capacity to raise public revenues and administrative rules, for instance, that eligibility depends on means testing (implying a local official assessing household wealth on the spot), the resulting system was complex, inefficient, under-resourced, and prone to biased beneficiary selection and leakages (Asri 2017).

The second main step therefore was administrative reform focusing on service delivery. The initiatives sought to introduce individual ID numbers and low-income programme entitlement cards that could be used as a common system for beneficiary identification. Instead of distributing cash through officials, payments went through banks. Paper-based administration was increasingly replaced by digitalized systems. This process raised new issues around confidentiality and access (the last mile that excluded those who could not open bank accounts, travel to cities, and so on, or who remained excluded for other reasons), but made the task of serving hundreds of millions of beneficiaries across many programmes more manageable.

Overhauling a system that supports the livelihoods of a large part of the electorate is an uphill battle politically and may require additional resources. In the large, lower-middle-income countries, the new, larger programmes were introduced without major changes in existing programmes and entitlements, although steps were taken to strengthen coordination and streamline administration.

The government and stakeholders in some South Asian countries upgraded their social protection systems giving priority to a life cycle approach. Maldives implemented a radical overhaul and simplification of its social protection system by introducing a two-tier universal old-age pension for people over 65 in 2008, and a universal health insurance system in 2012 (Sun 2016). Bhutan, where essential health services are public and provided for all, introduced a life cycle measure in 2018: a social pension for citizens over 60 (GNHC 2019). In both of these middle-income countries, only a small part of the population – mostly civil servants – had had access to old-age security before the reforms. Combining poverty reduction and human capital development objectives and unifying two earlier programmes, the government of Bangladesh introduced a life cycle measure in July 2019: the Maternal and Child Benefit Programme (Nawaz, Newar, and O'Connor 2020). Encouraging participation in behavioural change communication sessions, the programme offers a monthly allowance of US$9 to over one million pregnant and nursing mothers for their own and their young children's basic nutritional needs (Thapa 2020). Similarly, in 2015, Sri Lanka expanded its food allowance for pregnant women into a universal programme, providing vouchers worth LKR 2,000 per month for 10 months.[101]

[101] Bird, Tilakaratn, Moreira Daniel, Sumanthiran, Chrétien, Alvarenga, and Arruda (2022). Public expenditure review for social protection in Sri Lanka, Public expenditure analysis for social protection in Sri Lanka (unicef.org)

The expansion of social protection during the COVID-19 crisis

At the outset of the pandemic, it was clear that governments had to focus first on the largest, preferably near-universal programmes in order to make a decisive impact. This task had four main dimensions:

- **Coverage:** identify and enrol all those who are vulnerable to crisis impact
- **Benefits:** provide adequate support
- **Delivery:** ensure that those who are eligible receive and can take up their benefits
- **Timeliness:** ensure that benefits are available to recipients promptly

Given resource and capacity constraints, significant trade-offs have been made among these four dimensions. Although programmes such as Ehsaas Emergency Cash and Druk Gyalpo's Relief Kidu were able to provide timely cash support at scale (see Table 2.3), in many other cases, support reached target populations with substantial delays because of difficulties in expanding coverage quickly. In Nepal, for example, the political decision to expand existing assistance programmes, including the geographically targeted Child Grant programme, was made swiftly, but preparing guidelines and enrolling new beneficiaries through paper-based applications and carrying out verification processes at the local level delayed response, yet the measures were then adopted into the design, including the increase in coverage and benefit level (Khatri, Murthy, and Owens, forthcoming). Likewise, in Bangladesh, though the government were swift to announce support, most programmes undertook new registration (using door-to door and on-demand approaches), verification, and enrolment of individuals and households which takes time in the absence of pre-existing data on potential recipients.

Lack of well-established nationwide social registries offering unified beneficiary lists that cover all social programmes (health, education and social protection) was a major barrier, although countries showed a great deal of ingenuity in addressing this. In Sri Lanka, where the flagship Samurdhi Programme provided cash support to nearly 1.8 million low-income households before COVID-19, the complicated verification process was made lighter, and people already on the programme waiting list were accepted (Khatri, Murthy, and Owens, forthcoming). In Bangladesh, the government introduced cash support programmes among workers in export-oriented industries (ready-made garments, footwear and leather goods) utilizing the employee databases available in factories (Tayeb 2021). For workers in the informal economy, such as rickshaw pullers, hawkers, maids, transport workers, and hotel workers, the government allowed substantial local discretion in programme implementation (ADB 2020).

Governments with pre-existing social registries or other databases with high population coverage used these tools very effectively. Pakistan's new Ehsaas Emergency Cash Programme has been rolled out by providing top-ups to the beneficiaries of the existing flagship Ehsaas Kafaalat Programme (Benazir Income Support Programme).[102] Taking a whole of government approach, the government progressively widened coverage beyond the Kafaalat programme through a partnership with Pakistan's National Database Registration Authority, district and provincial governments, and interministerial coordination to deliver benefits using biometric data (fingerprints) to about 14.8 million individuals and households, covering 44 per cent of the population. Likewise, in India, the Pradhan Mantri Garib Kalyan Yojana relief package, which was announced a day after the first lockdown, scaled up the cash and food assistance offered by several large, well-established programmes using India's direct benefit transfer system to transfer benefits to the bank accounts of beneficiaries. Over 320 million people living in poverty received financial assistance under the package by April 2020.[103]

[102] Kafaalat means nurturing. The Ehsaas Kafaalat Programme supplies the poorest women and their families with monthly or quarterly support benefits. For the Ehsaas Emergency Cash Programme, see Emergency Cash (dashboard), Ministry of Poverty Alleviation and Social Safety, Islamabad, Pakistan, https://www.pass.gov.pk/Detailf90ce1f7-083a-4d85-b3e8-60f75ba0d788.
[103] Press Information Bureau, GoI, Ministry of Finance: Pradhan Mantri Garib Kalyan Package: Progress so far, 13 April 2020. See: https://pib.gov.in/newsite/PrintRelease.aspx?relid=202210

Countries also took advantage of the opportunity provided by the scaling up of social assistance at the onset of the COVID-19 crisis to improve equity. For example, India's central relief package included supplementary funds targeting women, senior citizens, and returnee migrant workers. Moreover, COVID-19 has brought attention to the problem of food subsidies in India being tied to place of residence: migrants have faced difficulties in obtaining ration cards that entitle them to food subsidies. As a result, the government has instituted the One Nation, One Ration Card programme to ensure the portability of benefits.

Table 2.3 provides an overview of 35 national programmes in the region that have received priority and helped frontload support since 2020. As it demonstrates, much of the extra support was temporary, although several programmes were extended as it became clear that more substantial or more durable assistance was necessary. Over two thirds of the interventions involved a one-off cash benefit or a temporary top-up in existing programmes, and, in most cases, the increased benefits were associated with an extension in coverage to individuals and households that were on waiting lists or that had become newly vulnerable because of the COVID-19 crisis.

Table 2.3: Adjustments to social assistance programs in South Asia 2020-2022

Country	Name of response	Coverage, entitlement, notes
One-off transfers		
Bangladesh	PM's Cash Support Scheme	5,000,000 individuals [Targeted coverage] BDT 2,500. One-off payment for informal workers made jobless by COVID-19 without any social benefits.
India	PM Kisan Samman Nidhi	87,000,000 individuals [Targeted coverage]. INR 2,000; One-off Advance Payment of regular benefit.
	Financial Assistance to Mid-Day Meal Beneficiaries* (due to school closures)	Announced May 2021 for 118 million students [Targeted coverage]
Nepal	Cash Grant for COVID-19 affected economically deprived households	500,000 [Targeted Coverage] (0.5 million households). NPR 10,000; one-off payment
Pakistan	Emergency Cash /BISP emergency cash program	A cash transfer targeted 16.9 million households (about 50% of the population) from April to July 2020. The benefit was a lump sum of PKR12,000 (34 per cent of the average monthly household income), paid through biometric payment points. Actual coverage was 88% of planned.
Sri Lanka	Senior Citizen Allowance	559,109 individuals [Targeted coverage: 416,764 existing and 142,345 new]. LKR 2,000; increased to 5000 (three one-off temporary top-ups)
	Disability Allowance	119,300 individuals [Targeted coverage]. [84,071 and 35,229 newly registered]. LKR 5,000 [Benefit same as pre-COVID level: 2 one-off payments]
	Chronic Illness Allowance	39,170 individuals (25,320 patients and 13,850 newly registered patients). LKR 5,000 [Benefit amount same as pre-COVID level, two one-off payments]
	Emergency Cash Grant for Farmers' and Fishermen's Pension Scheme	160,675 farmers, 4,600 fishers enrolled in the scheme received an emergency cash grant besides usual pension. LKR 5,000; two payments
	Food relief to self-quarantined families (October 2020)	417,427 individuals [Targeted coverage]. LKR 10,000 worth of dry food items, one-off
	Cash allowance to quarantine families who lost their livelihoods (October 2020)	1,409,578 individuals [Targeted individuals]. LKR 5,000; one-off
	Emergency Cash Assistance (ECA) to those who lost income with COVID-19 (April 2021)	1,700,000 individuals [Targeted coverage]. LKR 5,000; one-off
	ECA to low-income families who did not receive existing cash assistance (August 2021)	[Coverage data not available]. LKR 2,000; one-off

Benefits up to three months		
Bangladesh	Cash Assistance for Laid-Off Workers in Export-Oriented Industries	1,000,000 individuals [Targeted coverage]; BDT 3,000/month up to three months, but expected to exit the programme if they find new employment
India	PM Ujjwala Yojana	80,000,000 individuals [Targeted coverage]. Subsidy transfer to purchase LPG cylinders; for three months. (April to June 2020)
	PM Jan Dhan Yojana	200,000,0000 individuals [Targeted coverage]. INR 500 per month; for three months. (April to June 2020)
	Indira Gandhi National Old Age Pension Scheme (IGNOPS)	30,000,000 individuals [Targeted coverage] INR 1,000; for three months (April to June 2020)
	Indira Gandhi National Widow Pension Scheme (IGNWPS)	
	Indira Gandhi National Disability Pension Scheme (IGNDPS)	
Pakistan	Emergency Cash	A cash transfer given to 16.9 million households (about 50% of the population) from April to July 2020. The benefit was a lump sum of PKR12,000 (34% of the average monthly household income), paid through biometric payment points.
Benefit Up to 12 months		
Bangladesh	Old Age Allowance	500,000 individuals [Targeted coverage]. BDT 500 per month; paid quarterly for a year
	Allowance for Widows, Deserted and Destitute Women	350,000 individuals [Targeted coverage]. BDT 500 per month; paid quarterly for a year
	Allowance for the financially insolvent disabled	255,000 individuals [Targeted coverage]. BDT 700 per month; paid quarterly for a year
India	Mahatma Gandhi National Rural Employment Guarantee (MGNREGA)	144,000,000 individuals enrolled (as of 15 September 2020). INR 202 (instead of INR 101) per day for 100 days
Maldives	Income Support Program	22,946 individuals (as of 1 July 2021). MVR 5,000; monthly for 10 months
Program/benefit still ongoing (as of May 2022)		
Bhutan	Druk Gyalpo's Relief Kidu*	Unemployment support/ loan subsidy from 20 April 2020 to July 2022; Nu 12,000 (complete)/ Nu 8,000 (partial)/ Nu 800 (Child Support); monthly
India	PM Garib Kalyan Anna Yojana	Monthly 5 kg grains for free to 800 million people
Permanent expansion or new programme from 2021 or 2022		
Nepal	Prime Minister's Employment Program (PMEP)	171,000 individuals [Actual coverage in FY 20-2021. NPR 577 per day. Budget allocation was doubled for the year to expand coverage]
	Child Grant*	1,300,000 individuals [Targeted coverage]. NPR 532 per month/paid every four months

Nepal	Senior Citizen Allowance	1,360,000 individuals [Targeted coverage]. NPR 4,000 per month/paid every four months
	Disability Allowance	130,000 individuals [Targeted coverage]. NPR 4,000 for Red Card Holders; NPR 2,200 for Blue Card Holders
	Single Women Allowance	750,000 individuals [Targeted coverage]. NPR 2,660 per month/paid every four months
	Endangered Ethnicity Allowance	20,000 individuals. NPR 1,330 per month/paid every four months
Sri Lanka	Samurdhi Program	2,397,054 individuals [Targeted coverage]; 1,770,086 individuals [Actual coverage as of 2020]. LKR 5,000. Permanent increase by 28%
India	Financial Assistance to COVID-19 orphaned children (PM Cares for Children) *	Monthly stipend from the age of 18, with a corpus of INR 1 million invested to support children's education and health. The stipend is deposited into the beneficiary's Post Office Savings Bank Accounts. When the beneficiary reaches the age of 23, they will receive a lump sum payment of INR 1 million
Pakistan	Raashan	20,000,000 families [Targeted coverage]. PKR 1,000 subsidy on the purchase of flour, pulses, and cooking oil from February 2022
	Kafaalat Scholarships 2022	Existing beneficiaries of Ehsaas Kafaalat (formerly BISP) can apply for a quarterly stipend of 1,500-3,500 PKR conditioned to 70% school attendance. Female students receive 500 PKR more.

Source: Bangladesh: Hebbar, M., Muhit, S., & Marzi, M. (2020). ; Bhutan: Druk Gyalpo's Relief Kidu, Bhutan; India: Ministry of Information and Broadcasting, GoI (2022). ; Sighal, A (2020) India Today. ; Ministry of Finance (2020) ; Narayanan, S., Oldiges, C., & Saha, S. (2020). ; PM Garib Kalyan Anna Yojana ; Ministry of Women and Child Development, GoI ; Maldives: Ministry of Finance; Nepal: Cash Grant for COVID-19 affected households (DoP); Budget Speech, MoF FY 2020-21 ; NepalPress (2021): Social Security Allowances ; Pakistan: Nishtar, S. (2020). Ehsaas Emergency Cash, GoP; GoP, Ehsaas Rashan; https://ehsaasprogram.pk/ehsaas-scholarships-for-primary-to-secondary; Sri Lanka: Franciscon, I., & Arruda, P. (2020). IPC-IG; ILO (2020). Social Protection and the Covid-19; Public Expenditure Analysis for Social Protection in Sri Lanka, IPC-IG and Sri Lanka CO, 2022; IPC-IG Policy Brief: Social Protection Responses to COVID-19 in Sri Lanka, Sri Lanka CO, 2022.
Notes: *Programs providing or adding benefits specifically for children. Coverage data marked in italics are household transfer, but these too are given to one member of the family. For Bhutan: The Relief Kidu granted monthly income support to individuals and loan interest payment support to borrowers for a period of one year (April 2020 – March 2021). Over 37,000 people and their children have been granted the monthly income support Kidu in the last one year, while close to 140,000 loan accounts benefited from the interest payment support.

Governments strengthening systems with a focus on children's needs

Though in the second half of 2020, several of the new assistance programmes were rolled back, many programme expansions and adjustments were extended into 2021 or kept indefinitely (see Table 2.3). These decisions were justified by new COVID-19 waves (March–June 2021 and January–March 2022) and rising inflation that called attention to the need to continue support. In India, for example, monthly rations of grains and protein at subsidized prices delivered under PMGKAY– which had already covered 75 per cent of the rural population and up to 50 per cent of the urban population pre-COVID – continue to be extended to support households.[104] Were this widely available subsidy in kind valued at market prices, the results would show significant poverty-reducing impacts on the lowest-income recipients (Bhalla, Bhasin, and Virmani 2022). Likewise, the benefit top-up of the

[104] The "Targeted Public Distribution System (TPDS) is operated under the joint responsibility of the Central and the State/Union Territory (UT) Governments", according to a press release of the Press Information Bureau (PIB 2017). "Central Government is responsible for procurement, allocation and transportation of foodgrains up to the designated depots of the Food Corporation of India. The operational responsibilities for allocation and distribution of foodgrains within the States/UTs, identification of eligible beneficiaries, issuance of ration cards to them and supervision over and monitoring of functioning of Fair Price Shops (FPSs) rest with the concerned State/UT Governments."

Mahatma Gandhi National Rural Employment Guarantee Scheme – the largest public works programme in the world, which had a role in helping millions of reverse migrants to find work in 2020 – has been retained in 2021–2022. Pakistan introduced a cap on fuel and launched Ehsaas Rashan Riayat, a targeted commodity subsidy programme, to compensate eligible households for the higher prices. Under this initiative, 20 million eligible households identified through the Ehsaas Socioeconomic Registry Survey are receiving PRs 1,000 per month to purchase flour, pulses, and cooking oil at a 30 per cent subsidized rate.

The expansion of the system during the pandemic has focused on protecting lives, livelihoods and the human capital of the existing workforce. Yet the pandemic, as well as the new wave of inflation, also drew attention to a gap in child-sensitive responses. As job growth returns to the region and as the outreach and delivery capacity of social assistance is significantly upgraded, there is an opportunity for policy adjustment to make social protection function more effectively in favour of children, the next generation of workers and citizens. The fact that the child monetary poverty rate is systematically higher than the overall poverty rate across South Asia, the threat of a possible new global recession, and continued inflation in the region underline the urgency of assisting households with children in ways that consider the need for preventative action (see Box 2.3).

Box 2.3: Institutional versus residual approaches to social welfare: The case for preventative support

In countries in which the social protection system is meant to address the risk individuals face over the life cycle, the core elements – early childhood and family support, education support, unemployment, and old-age benefits – are all included and typically have universal reach. People may change entitlements, but they never leave the system entirely because their participation can always be reactivated. Poverty targeted programmes are often included as well to provide additional support to low-income families, in order to guarantee a minimum standard of living. Moreover, programmes centred on lifecycle support can readily be turned into shock-responsive programmes – for example, by topping up maternity and child allowances or pensions, either in general for aggregate crises, like COVID-19, or in certain geographical locations for localized crises, such as a flood or earthquake. This model fulfils a basic human and child right: access to social security. Moreover, when attached to formal employment and social insurance, it is directly self-financing. When delivered through a social assistance platform, it is offered with the understanding that enhancing and sustaining human capital means supporting a public good with high social returns in terms of stability and favourable long-term economic and human development outcomes.

In South Asia, most social protection initiatives have not been constructed around an expectation of economic investment. Typically, they reserve assistance only for those already in absolute poverty and deprivation to avoid destitution. They therefore display a residual approach to welfare – even if the endeavour to secure access to food as a human right had played an important role in introducing these programmes. Entitlement in this model is linked to persistently low labour income associated with low productivity (especially in agriculture) and confirmed by the paltry assets the eligible are allowed to own. Social assistance is meant to support survival and a minimal caloric intake. It is not meant to enhance labour productivity. Its targeting mechanism may create poverty traps, but the model assumes little upward income mobility in any case. In this model, those who require assistance are always those who are at the bottom of the income ladder.

The COVID-19 crisis has contested this model, in showing how vulnerability can indeed be universal. Indeed, the residual approach to welfare serves children especially poorly, as they have a particularly strong need for preventative support. If young households need to prove their poverty in order to get assistance, deprivations will already be cemented into the brain development as well as the poor nutritional and health status of children (see Appendix B). Remedial support, justified by needs, should be made available when necessary as a second floor of social protection, on a foundation of preventative support.

Immediate action is crucial in several areas in particular. The restrictions brought on by COVID-19 weakened the educational opportunities available to many children. Urgent action to reverse this is needed, and the window of opportunity to do so has begun to close. While concerted effort involving education, child and maternal health, nutrition and mental health services is needed, social transfers can clearly play an important role in policy response. For example, the decision by authorities in Pakistan in 2022 to offer quarterly stipends to mothers if their school-age children attend school is a good example of how social protection can reinforce efforts to bring children, especially girls, back to school after long periods of school closures (see Table 2.3). Likewise, the decision of the government of India to support the education and health of COVID-19 orphaned children and offer financial assistance to them, regardless of the wealth of their deceased parents, represents a new frontier in the protection of children from idiosyncratic risks along the life cycle (see Table 2.3).

However, considering the importance of cognitive capital to the development of countries in the twenty-first century (see Appendix B), the region is still largely missing the opportunity to strengthen social protection in areas in which it can provide the greatest returns on investment: adolescence, before childbirth and in early childhood. Investment during the first 1,000 or 2,000 days of life makes the biggest difference in economic growth, social cohesion and stability in the long term (see Figure 2.1 and Appendix B). More assistance would make an immediate difference among the nearly 70 million children under two years of age or the nearly 170 million children under five across these eight countries, as well as among their caregivers and communities. Indeed, research finds that if social transfers are offered regularly to households they can also have a significant effect on the local economy, with positive spillover effects on the national income (Barrientos and Sabates-Wheeler 2006).

In terms of poverty reduction and prevention, an emphasis on prenatal and early childhood interventions would move away from the less direct approach of alleviating household poverty in order to support healthy child development, since the downstream effects of this may not reach children quickly enough to be maximally effective. Instead, it would represent a preventive approach that places more emphasis on maternity and family support especially during the first 1,000 days of life, and on supporting the continued education and nutrition of adolescent girls.

Programmes that support pregnant women and children in the early years of life are available in most countries, but often in an auxiliary role, as demand-side interventions to incentivize institutional delivery and the uptake of prenatal and postnatal care (see Table 2.4). The value of their benefits, while helpful as an aid and useful as a nudge towards service uptake, rarely offers an income that could make a significant difference in the well-being of young households. Indeed, apart from a few programmes, such as the Child Grant in Nepal and the Ehsaas Nashonuma health and nutrition conditional cash transfer programme in Pakistan, interventions mostly provide cash incentives, although helpful, rather than a regular amount that might also factor into economic coping strategies. Moreover, as noted earlier, coverage is rarely wide enough to prevent malnutrition and other harmful effects on children's cognitive and non-cognitive development.

On the positive side, several programmes recently have been or are about to be expanded, which indicates that governments are paying more attention to young children, pregnant women, and their households (see Table 2.4). The COVID-19 crisis slowed this shift – but it could only be hoped that these recent changes indicate a new trend of giving higher priority to child development in South Asia in the coming years.

Table 2.4: Child and maternal benefit programs in South Asia

Country	Programme name, launched	Benefit	Coverage	Eligibility
Afghanistan				
Bangladesh	Mother and Child Benefit Program (MCBP)[105] July 2019	BDT 800	7.5 million by 2030 (targeted)	
Bhutan	Accelerating Mother and Child Health Program or Breast-Feeding Allowance[106] (Launch delayed since 2019)[107]	Nu 125 per day (national minimum wage)	25,833 (estimated monthly beneficiaries)[108]	All mothers who are not entitled to six months of maternity leave, including those in private and corporate sectors.
India	Janani Suraksha Yojana (JSY) 2005[109]	Low Performing States (LPS)[110]: INR 1,400 (rural area); INR 1000 (urban area) High Performing States (HPS): INR 700 (rural area); INR 600 (urban area) INR 500 for Below Poverty Line (BPL) pregnant women who prefer to deliver at home regardless of the age of pregnant women and number of children.[111]	9.99 million[112]	All pregnant women delivering in government health centers in LPS; All BPL, Scheduled Caste/Tribe (SC/ST) women delivering in a government health center in HPS.[113] All BPL/SC/ST women delivering in accredited private institutions.
	Pradhan Mantri Matru Vandana Yojana (PMMVY) 2017	INR 5,000 in three installments for first living child and since 2022 also for a second child, in case the child is a girl. The first installment of INR 1000 on early registration of pregnancy at the Anganwadi Center (AWC)/approved health facility; second installment of INR 2000 after six months of pregnancy on receiving at least one ante-natal check-up (ANC); and third installment of INR 2000 after childbirth is registered and child has received the first cycle of immunization. (Eligible beneficiary also receives benefits under JSY after institutional delivery, so that on average a woman will get INR 6,000.)	25.8 million (since program's inception)	All Pregnant Women and Lactating Mothers (PWLM), excluding those who are in receipt of similar benefits under any law.[114]

[105] https://www.ennonline.net/nex/southasia/2/bangladesh
[106] https://kuenselonline.com/constraint-in-the-recurrent-budget-delays-roll-out-of-amch-policy/
[107] https://kuenselonline.com/accelerating-mother-and-child-health-to-cost-nu-238m-annually/; http://www.bbs.bt/news/?p=120437
[108] See https://www.gnhc.gov.bt/en/wp-content/uploads/2020/02/AMCH-Policy.pdf p.9.
[109] JSY was launched by modifying an existing maternity benefit scheme called National Maternity Benefit Scheme (NMBS) which was launched in 1995. JSY replaced the uniform financial assistance of INR 500 to all Below Poverty Line pregnant women under NMBS with graded scale assistance based on the categorization of States as well as whether beneficiaries were from rural or urban areas.
More about JSY: https://vikaspedia.in/health/nrhm/national-health-programmes-1/janani-suraksha-yojana
[110] Low Performing States: States that have low institutional delivery rates, namely, the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir. The remaining states have been named High Performing States.
[111] https://nhm.gov.in/index1.php?lang=1&level=3&lid=309&sublinkid=841
[112] https://pib.gov.in/PressReleasePage.aspx?PRID=1776872
[113] https://nhm.gov.in/index1.php?lang=1&level=3&lid=309&sublinkid=841
[114] https://wcd.nic.in/sites/default/files/PMMVY%20Scheme%20Implemetation%20Guidelines%20._0.pdf p. 2

Maldives	Single Parent Allowance (SPA)[115] [116] 2010	Monthly allowance of MVR 1000 per child (below 18 years of age) and MVR 500 for guardian and foster parent.	2,501 parents; 4,233 children	Monthly income must be below the poverty /income cutoff, child must be below 18 years of age and attend school regularly if school aged; must have received all vaccinations as per the national guideline (for children below 6 years)
Nepal	Child Grant 2010[117]	Monthly allowance of NPR 532 (paid on four monthly)	1.3 million (targeted)[118]	Children under the age of 5 years from Dalit families (all across Nepal) as well as those living in 25 select districts are eligible to apply; restriction of two children per mother.
	Aama/Safe Mother Programme (AP)[119] 2009	Transport incentive for institutional delivery (NPR 1500 for mountain, NPR 1000 for hill and NPR 500 for terai area); NPR 400 for 4 ANC visits; Free institutional delivery and sick newborn care area); NPR 400 for 4 ANC visits; Free institutional delivery and sick newborn care	0.43 million[120]	All women with Nepali citizenship.
Pakistan	Nashonuma[121] August, 2020	Quarterly stipend amount is PKR 1,500 for mother and boychild and PKR 2,000 for girlchild. Roll out planned up to 2023.	36,675[122]	Payments are conditional upon the consumption of specialized nutritious food, immunizations and attendance in health awareness sessions
Sri Lanka	National Supplementary Food Programme/ Thriposha (T-NSFP)[123] 1973	Two take-home packs of food per month. The packs contain pre-cooked food produced from maize, soybeans, whole milk powder, vitamins, and minerals. Currently, the ration is equivalent to 50 grams per day providing 200 kcal.[124]	900,000 (2017)	Pregnant mothers, lactating mothers (during the first six months), undernourished children (from 6 months to five years) whose weight for age lies below-2 standard deviations or/and with longstanding growth faltering.
	Food Allowance for Pregnant Women/Poshana Malla (2015)	10 vouchers of Rs. 2,000 each are provided at the same time for mothers to obtain nutritious food items	238,034 (2020)	All pregnant and lactating women

[115] https://www.nspa.gov.mv/v2/index.php/single-parents-program/#:~:text=Benefit%20Amount,a%20maximum%20of%20MVR%2010%2C000.
[116] https://www.developmentpathways.co.uk/wp-content/uploads/2021/07/Evaluation-of-the-Single-Parent-and-Foster-Care-Schemes-in-the-Maldives-Final-report.pdf
[117] DRAFT- Situational report on coverage of SSA, UNICEF Nepal.
[118] https://www.nepjol.info/index.php/jsp/article/download/38211/29395/111026
[119] https://www.mohp.gov.np/eng/program/reproductive-maternal-health/safe-motherhood-programme
[120] https://openknowledge.worldbank.org/bitstream/handle/10986/36329/Main-Report-FY11-FY20.pdf?sequence=1&isAllowed=y
[121] https://www.pass.gov.pk/userfiles1/files/1_%20Ehsaas%20Nashonuma%20Brief_Aug12.pdf
[122] https://www.urdupoint.com/en/pakistan/ehsaas-nashonuma-program-disburses-rs114-mill-1327437.html ; https://www.thenews.com.pk/print/879237-ehsaas-nashonuma-programme-disburses-rs114m-among-beneficiaries
[123] http://www.thriposha.lk/thriposha-production/beneficiaries/
[124] https://socialprotection.org/discover/programmes/national-supplementary-food-programme-thriposha

Key takeaways

This chapter has looked at the ways in which public policies have tried to shield families and children from the economic impact of the pandemic over the last two years, and the factors that have enabled or obstructed this goal. This investigation is important because COVID-19 was not the first global crisis hitting the region in this century, nor the last. Much the way the responses to the food, fuel and financial crisis of 2007-2009 helped countries to develop programmes that enhanced resilience, it could be expected the policies and institutional changes over 2020 and 2021 will frame how countries will respond to the current global threats to economic stability. These will inform how countries seek to protect children and their families from high inflation and pressures for painful economic adjustment, and develop further their capacity for resilience and progress.

Scaling up social protection was a crucial response strategy to COVID-19, attesting to the importance of political commitment in bolstering the capacity of governments and stakeholders to protect people from external shocks to their lives and livelihoods. Efforts to deliver cash or distribute food can prevent or mitigate increases in negative household coping strategies affecting children, such as insufficient food intake, school dropout, child labour and child marriage. Ensuring the portability of social assistance benefits has been important in light of the mass reverse migration from urban to rural areas. At the macro level, these protective measures probably helped spark economic recovery in 2020 and accelerate the recovery throughout 2021, despite the ongoing pandemic.

Social protection measures to counter the socioeconomic fallout from the COVID-19 crisis have chiefly focused on large, centrally driven programmes and initiatives, a significant share of which represent one-off handouts or unemployment support for a limited duration. Many of these temporary expansions were rolled back subsequently, yet several countries did institutionalize the expansions. On the whole, **the social assistance systems are considerably stronger in the region in 2022 than they were pre-COVID.**

The large share of informal jobs in South Asia highlights the importance of keeping social assistance measures ready to roll in again. However, because these benefits need to be financed through discretionary measures and from general tax revenues (instead of social insurance contributions), **the fiscal base of social protection is procyclical and fragile** in the current situation. This is especially the case with the current threat of a new global recession, high public debts and further macroeconomic imbalances in the region. This macroeconomic weakness is closely related to the **high share of informal employment and limited role of social insurance,** which poorly serves mothers and children as well as the SDG targets on universal access to healthcare.

Many of the programmes assisting young families were introduced or planned either before the COVID-19 crisis or in its third year. It therefore appears that the imperative to respond to the employment-related shocks stemming from the pandemic may have crowded out the momentum behind bolstering public investment in healthy childhood development. Existing cash transfers and cash plus programmes that focus on the first 1,000 days of life provide a mix of cash and developmental interventions are often small in comparison with the needs across the region, but they represent a base upon which expansion could be built. **Boosting the capacity of social protection to respond to idiosyncratic risks along the life cycle, especially during the early years and adolescence,** would be important. Child, maternity and parental benefits **could address the higher-than-average risk of monetary poverty among households with children.** Lifecycle-centred social protection could also ensure better care for newborns, the sick, orphans, children, adolescents and adults with special needs, a minimal pension for the aged and so on – and serve as a platform for resilience to the ongoing and future shocks that threaten South Asia.

Boosting statistical surveys and countries themselves making "nowcast" projections on real income and monetary poverty of different household types is a strategy that could underpin more timely policy responses to threats, such as inflation and the macroeconomic need for policy adjustment in the post-lockdown era. Panel-type surveys that allow temporal effects and poverty dynamics to be investigated would particularly be helpful in capturing the scarring effects of poverty and shocks on child development.

Child poverty is understood in the region as the poverty of the households that raise children. This means a substantial share of children experiencing material deprivation may be left off the policy radar as household wealth does not always indicate the degree to which children's needs are met. Hence,

the importance of attention to child poverty: monetary as well as multidimensional child poverty, which is rarely reflected in mainstream policymaking.

An important positive effect of government responses to the pandemic has been the boost in developing and enhancing social registries in the region. Several countries now utilize unique personal identification systems. As the registries of entitlements, benefits, and service users shift towards the digital space by combining phones, internet connectivity, and national IDs, a digital and innovative demand-based social protection system is being created in the region. This system could deliver more adequate, more rapid responses to external or internal shocks, including poverty, unemployment, food inflation, inequality and regression in child outcomes. Extending and using this digital public system for **multisectoral registries and monitoring has great potential** (improving vital events registration, service use in maternal, child and adolescent health services, nutrition service uptake, education enrolment and completion) that should be explored as countries are facing new macroeconomic challenges as well as the continuing pandemic.

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CHAPTER 3: THE MULTIDIMENSIONAL IMPACT OF THE CRISIS ON CHILDREN

Unlike the Spanish influenza pandemic more than 100 years ago, which killed children and young people at higher rates relative to middle-aged and older people, COVID-19 has taken comparatively far more lives among older people and far fewer among children and young adults.[125] Still, the direct effects of the pandemic and its indirect effects on families, communities and the national economy impacted children along many dimensions. Box 3.1 discusses expert estimates on the global-level impact of the COVID-19 crisis on children.

This chapter looks at the key crisis impacts on children in South Asia since 2020. It also considers trends before 2020: achievements as well as remaining gaps in access to services. Looking at pre-COVID trends and results is important, as they reflect powerful, often long-term socioeconomic changes which could mitigate or exacerbate the direct and indirect impacts of the pandemic. They likewise are implicated in the new macroeconomic risks in 2022, such as higher inflation and less fiscal space, stemming from a combination of the domestic situation and effects from the global political and economic context.

Some of the direct and indirect crisis impacts on young children and adolescents discussed in this chapter could be considered specific to the effects of the pandemic. The policy decision to close schools and shift to distance teaching, for example, would not have happened outside the context of the pandemic. The causality behind crisis impacts further downstream, such as poor maternal and child nutrition, or a rise in child marriages, is more complex, combining acute and pre-existing socioeconomic issues.

Box 3.1: Estimating the global impact of COVID-19 on maternal and child outcomes

Difficulties in completing statistical surveys and the radical change in economic and social conditions since early 2020 has triggered a demand for nowcast calculations and projections using statistical model estimates. Table B3.1.1 pulls together selected estimates researchers and international agencies have published on the expected global impact of the COVID-19 crisis on maternal and child health, nutrition, education, protection and development. Each of the projected outcomes illustrated in the table represents an alarm. Taken together, they account for deeply rooted, multidimensional, indirect impacts that threaten the lives of hundreds of thousands of young children and may mar the future of many millions more.

There is also a sense that these global projections highlight only a portion of the dangers and shocks that may be affecting the lives of 2.4 billion children since early 2020. While, geographically, the pandemic hit urban areas hardest, the individuals and communities with the fewest assets and largest gaps in access to services are expected to experience the greatest vulnerability to the impacts. There are two main caveats. First, while pulling these impact variables together is useful for the big picture, the methodologies used and the numbers shown in the table are not always compatible. The projected values along the 10 dimensions are generally take from different modeling exercises that rely, at times, on nonidentical values for the same

[125] In the United States, for example, about 1,513children were lost out of over one million confirmed COVID-19 deaths, which gives a rate of one in 700. See Provisional COVID-19 Deaths: Focus on Ages 0–18 Years (dashboard), National Center for Health Statistics, Centers for Disease Control and Prevention, Hyattsville, MD, https://data.cdc.gov/d/nr4s-juj3. (accessed on 3 November 2022).

inputs and operate to some degree independently of each other. Ideally, all the outcome variables shown should be based on one coherent set of inputs and assumptions.

Second, each of the child and maternal outcomes post-2020 shown are the result of modelling and projections based on inputs that are considered determinants of outputs and outcomes. They are also based on certain assumptions and evidence from earlier surveys on the statistical relationships among variables. The assumptions tend to reflect on uncertainty and explore crisis scenarios. Accordingly, rather than one outcome value, as shown in the table, they actually refer to a range of outcomes (on which see the original sources). More importantly, unlike the results of a representative statistical survey, these results are meant to represent not the reality, but only a simplified model of the reality.

Table B3.1.1: Projected global impact of COVID-19 on child outcomes and maternal health

Projected child impact because of COVID-19 crisis	Global estimate of impact	Source	Note
1. Rise in acute and chronic malnutrition*	An additional 6.7 million children under 5 experiencing moderate or severe wasting (a 14.3 per cent increase in prevalence) By 2022, an additional 9.3 million children could experience wasting In 2020–2022, an additional 2.6 million children will experience stunting	Headey et al. (2020) Osendarp et al. (2021) Osendarp et al. (2021)	Based on losses in gross national income per capita in 2020 compared with projections for 2020 without COVID-19
2. Rise in maternal anæmia	By 2022, 2.1 million more maternal anæmia cases	Osendarp et al. (2021)	
3. Rise in under-5 mortality*	128,600 additional deaths among children ages under 5** By 2022, this number may increase to 168,000 additional child deaths	Headey et al. (2020) Osendarp et al. (2021)	Data calculated by combining the impact of a 14.3 per cent increase in wasting prevalence with a projected year-average of a 25 per cent reduction nutrition and health service coverage, implying a 24.8 per cent increase over the baseline
4. Increase in maternal mortality*	3,600 additional cases monthly, representing a 14.7 per cent increase over the baseline	Roberton et al. (2020)	
5. Increase in the number of orphans and losses in childcare capacity	6,989,300 children losing primary or secondary caregivers by February 2022, of which 4,760,900 (68.1 per cent) will lose one or both parents; the 4.8 million children who lost parent(s) due to the COVID-19 crisis represent over 3 per cent of the global number of orphans	Real time COVID-19–associated orphanhood trends tools based on Hillis et al. (2021)	Model estimates: see CDC et al. (2021); Hillis et al. (2021) on the methodology employed. Parents and custodial grandparents are considered primary and co-residing grandparents (or older kin up to age 84 years) as secondary caregivers. The global number of child orphans was estimated (pre-COVID) as 153 million.***

6. Increase in school dropouts	24 million children at risk of not returning to school	World Bank, UNESCO, and UNICEF (2021)	Estimate includes all students from pre-primary to tertiary education
7. Increase in child marriage	7-10 million additional marriages involving girls under 18 years of age	Yukich et al. (2021)	Unmitigated scenario, based on projecting impact in five countries (accounting for 50 per cent of child marriages globally) and extending calculations to all lower-middle-income countries
8. Increase in adolescent pregnancy	1 million adolescent pregnancies in the first 12 months of impact alone	World Bank, UNESCO, and UNICEF (2021)	
9. Increase in depression and anxiety	27.6 per cent increase in depressive disorder prevalence and 25.6 per cent increase in anxiety disorders	Santomauro et al. (2021)	Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic
10. Increase in child labour	9 million additional child labourers by the end of 2022	ILO and UNICEF (2021)	A simulation model showed this number could rise to 46 million without access to critical social protection coverage

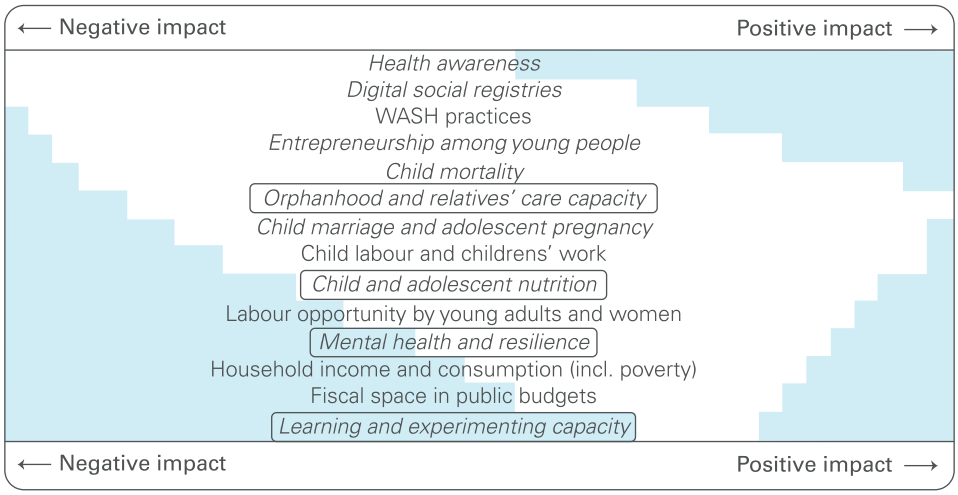
* Estimates from the modelling of impacts in 118 low- and lower-middle-income countries. The 118 countries included accounted for 97.7 per cent of global deaths among children ages under 5 and 99.6 per cent of global maternal deaths pre-COVID-19. Maternal deaths reached 294,000 cases annually (24,500 monthly), and under-5 mortality registered a rate nearly 18 times higher: 5,180,000 cases annually (431,690 cases monthly). See UN IGME (2019).

** The range reflects coverage scenarios, as described by Roberton et al. (2020), using a low of 15 per cent and a high of 50 per cent disruption in vitamin A supplementation, the treatment of severe wasting, the promotion of improved young child feeding, and the provision of micronutrient supplements to pregnant women.

*** For links to the tools, see Johns (2021). For the calculation, see COVID-19 Orphanhood (webpage), Imperial College London, London, https://imperialcollegelondon.github.io/orphanhood_calculator/#/country/Global. For the worldwide total of orphans, see Children's Statistics: UN Data on the Plight of Children (dashboard), SOS Children's Villages, Washington, DC, https://www.sos-usa.org/our-impact/focus-areas/advocacy-movement-building/childrens-statistics.

Notably, many of the aspects of the pandemic's impact on children and their communities have the potential for some amount of positive impact going forward – for example, the enhancement of social registries necessitated by the pandemic response, or the greater attention to hygiene and health. These aspects will require examination in new surveys and statistics when they become available. Figure 3.1 illustrates this idea by showing the expected negative impacts on the left and the expected positive impacts on the right. (The longer the line of the former relative to the latter, the worse the final outcome.) Through an in-depth analysis of the contrasting dynamics and underlying causes on both the negative and positive sides, insights may be gained on how to tilt the balance in favour of the positive through public interventions, programmes, and policies.

Figure 3.1: Stylized estimates of the impacts of the COVID-19 crisis on children and adolescents



Source: Authors. (Reflects qualitative summary based on the literature review by authors).

The investigation that follows is seriously constrained by the lack of data and new representative surveys and by concerns about the reliability and quality of recent administrative statistics. The pandemic has been associated with a chasm in the evidence on many fronts. The analyses therefore often use ranges instead of datapoints, and, apart from official data, they also rely on estimates and modelling efforts, including some concerning South Asia within a global landscape (see Box 3.1).

3.1. Maternal survival, parental health, and caregiving capacity have suffered

Parents and other primary and secondary caregivers are of crucial importance for children. Research has repeatedly shown that stability in attachment to at least one loving adult – preferably a parent or both parents – during childhood is pivotal in several key areas, including better nutrition, early development, health, progress in learning, and ability to deal with lifestyle-related risks in adolescence and success later in adult life. The role of grandparents and other older relatives is also significant, especially given the prevalence of large, multigenerational families in the region and the pressure on parents to migrate for work. Adult life expectancy used to be low in South Asia, but it was rising steadily in the region up to 2019.[126] Accordingly, the risk that a child would lose a parent or another primary or secondary caregiver was declining pre-COVID. Estimates suggest that this declining trend in the risk of orphanhood and additional care needs has been reversed by the pandemic.[127]

COVID-related orphanhood rose, and care capacity fell

Table 3.1 shows model estimates suggesting that, because of the pandemic, a minimum of 298,100 children in South Asia lost a primary caregiver between March 2020 and February 2022, and independent experts estimate that this could have been much higher. Among these children, 97 per cent lost one or both parents. In addition, at least 139,400 children were estimated to have lost a secondary caregiver (typically a grandparent) because of the COVID-19 crisis.[128]

[126] See https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-life-expectancy-and-healthy-life-expectancy.
[127] The size of the parental generation has been swelling over the last two decades: For example, 36.8 per cent more adults ages 30–34 were living in the region in 2020 than in 2005 (UN DESA 2019a, 2019b). Falling fertility rates tempered the effect of this on the size of the child and orphan populations, but, in absolute terms, the size of the child population experiencing the loss of one or both parents had been rising for several years before COVID-19.
[128] Grandparents as secondary caregivers are counted if living in the child's home and aged between 61-85.

Table 3.1: Children affected by orphanhood and caregiver loss

Country	Estimated losses associated with COVID-19, March 2020–February 2022					Prevalence of orphanhood, population ages 0–17, before COVID-19 (d)	
	All caregivers (a = b + c)	Secondary caregivers (b)	All primary caregivers (c)	Parents (e)			
	Children, 1,000s				Rate per 100,000 0–17 age group	Children, 1,000s	Rate per 100,000 0–17 age group
Afghanistan	15.4–93.1	1.4–8.3	14.0–84.8	13.4–80.6	70–421	—	—
Bangladesh	10.4–52.0	3.9–19.7	6.4–32.3	5.8–29.2	11–55	2,181.2	4,000
Bhutan	0.0	0.0	0.0	0.0	0.0	—	—
India	348.9–3,421.8	126.5–1,240.9	222.4–2,180.9	216.9–2,127.7	50–487	22,161.1	5,000
Maldives	0.0	0.0	0.0	0.0	33	2.4	2,000
Nepal	3.3–9.3	1.4–3.9	1.9–5.4	1.7–4.8	17–47	425.0	4,000
Pakistan	51.2–406.6	3.6–28.6	47.6–378.1	45.2–358.7	50–397	4,337.4	5,000
Sri Lanka	8.3	2.6	5.7	5.2	86	147.3	2,400
Total	437.5–3,991.1	139.4–1,303.9	298.1–2,687.2	288.3–2,606.3	47–423	29,254.4	-

Source: COVID-19 Content Portal (dashboard), Center for Systems Science and Engineering, Johns Hopkins University, Baltimore, https://systems.jhu.edu/research/public-health/ncov/; COVID-19 Orphanhood (webpage), Imperial College London, London, https://imperialcollegelondon.github.io/orphanhood_calculator/#/country/Global; Data (database), DHS Program (Demographic and Health Surveys), ICF International, Rockville, MD, http://www.dhsprogram.com/Data/; data of the Regional Office for South Asia, United Nations Children's Fund; Global Excess Deaths Associated with COVID-19 (Modelled Estimates) (dashboard), World Health Organization, Geneva, https://www.who.int/data/sets/global-excess-deaths-associated-with-covid-19-modelled-estimates; Hillis et al. 2021; MICS (Multiple Indicator Cluster Surveys) (dashboard), United Nations Children's Fund, New York, http://mics.unicef.org/; UNICEF Data Warehouse (database), United Nations Children's Fund, New York, https://data.unicef.org/dv_index/.

Notes: The data represent estimated numbers of children losing a caregiver over the trend (which has been rising slowly because of demographic factors linked to population growth). The lower range of estimates on children affected by caregiver losses reflects cases in which the deceased caregiver was identified as having had COVID-19 (officially registered COVID mortality cases). The upper range reflects estimates for caregiver losses over trend during March 2020–February 2022 using recent World Health Organization (WHO) model estimates on excess deaths associated with the COVID-19 crisis, for Bhutan, Maldives and Sri Lanka, estimates from the Johns Hopkins University COVID-19 database. This range is calculated using the methodology described in Hillis et al. (2021). The lower range of the estimates has been calculated by the Regional Office for South Asia of the United Nations Children's Fund based on the methodology of Hillis et al. (2021), but using the official (registered) COVID cases instead of the model estimates on COVID-19–related excess deaths. Absolute numbers for Bhutan and Maldives are too small to be captured by the unit of measurement. The data in the last two columns of the table are based on DHS and MICS data and data of national surveys. Shares of orphans are converted into rates per 100,000; calculations on the rates use child population data taken from the UNICEF Data Warehouse.

However tragic, this loss constitutes only a relatively small proportion of the children who may have been exposed to parental loss while growing up in the eight countries. As the last two columns of Table 3.1 attest, a much greater share of the child population in the region was exposed to the scarring experience of losing a parent pre-COVID because of various infectious diseases, chronic health problems, injuries, and so on. Representative household surveys carried out in six South Asian countries in the latter half of the 2010s found that nearly 30 million children had lost one or both parents.[129] Population censuses at the beginning of the 2010s established that, on average, about 1 per cent of the child population – around 6 million children – were living in skip-households: households without any parents in which grandparents raise the children (Waidler, Sunny, and Rees 2021). Before 2020, there was already a significant orphan and care problem in the region; the COVID-19 crisis exacerbated it.[130]

Pre-COVID, about 1.6 million children had lost a parent annually in the eight countries. This means that 3.2 million children would have lost a parent over the 24 months if there had been no pandemic. Assuming that all official COVID-19 mortality was untimely and there was no other effect on the trend, the lower estimate for the period would add another 9 per cent (288,000 children), raising the total newly orphaned in the 24 months in question to nearly 3.5 million children. The higher estimate in Table 3.1 would mean the incidence of orphanhood had almost doubled.[131]

In India, the Supreme Court has directed authorities to identify all children who have lost one or more of their parents or who have been abandoned for any reason during the pandemic. The National Commission for Protection of Child Rights has been tracking children who meet these criteria since 1 April 2020 (WCD 2022). Information on each child is captured, verified and examined in an effort to extend proper care, protection and benefits to all such children. As of February 2022, 153,827 children had been registered on the relevant portal, including 142,949 children who had lost one parent, 10,386 children who had lost both parents, and 492 abandoned children (WCD 2022).[132]

Few countries publish COVID-19 mortality data by age, which makes it difficult to see how many adults of child-rearing age may have died during the pandemic. Appendix D looks at COVID-19 mortality by age and sex using data from Nepal, the only South Asian country that provided such evidence to the World Health Organization (WHO). It then compares data from Nepal with COVID-19–related mortality data from two European countries. COVID-19 case fatality rates appear comparatively higher among youth and the middle-aged in Nepal than in Norway and the United Kingdom, while people over 75 appear to have some survival advantage in Nepal in comparison with their peers in the UK (although they still experience higher fatality risk than younger adults). Indeed, a systemic review finds that age-stratified COVID-19 infection fatality rates are about two times greater in developing countries than in high-income countries among people ages under 65 (Levin et al. 2022). This has implications for children living in developing countries. Hence, they may run a higher risk of becoming COVID-19 orphans.

[129] While principally a separate issue, at least 3 million children live in orphanages and similar institutions in the region, although reliable, comparable statistics are difficult to find on social orphans left without parental care or care by relatives and placed in public or private institution. Unofficial estimates cite 30 million orphans, 4 per cent of the child population (ILM 2021). An estimated 3 million children are in institutions in India.

[130] The lower estimate on additional incidence of orphanhood uses the official registered cases of COVID-19 mortality as basis for the calculations. According to this estimate (see Table 3.1), fewer than 5 children in 10,000 in the region lost a parent from February 2020 to the beginning of March 2022. The group of researchers at the Imperial College London who developed the methodology for estimating caregiver losses from death statistics have estimated that significantly greater numbers of children have lost one or both parents. According to their projections, 42 children in 10,000 lost a parent because of the direct and indirect impacts of the pandemic over the two-year period investigated. This is the upper estimate.

[131] According to this pessimistic scenario, instead of the total that might have been expected on trend (3.2 million new orphans), 80 per cent more – that is, altogether, 5.8 million children – may have been exposed to parental death during the 24 months between March 2020 and February 2022.

[132] The 153,335 children registered because they had lost one or more parents by February 2022 is not far from the estimate for India (217,000) up to April 2022. One reason for the relatively good fit between the data in Table 3.1 and the registration data may be that a similar source is used: those who registered COVID-19 deaths in vital statistics may have also registered children left behind as orphans in India. However, administrative monitoring is meant to cover all cases of parent death and not only COVID-19 deaths. The 2019-2021 National Family Health Survey (NFHS-5) found that 5 per cent of children were orphans (a ratio which, according to this survey, was the same as 5 years earlier). Therefore, unless the situation changes drastically, about 0.28% of the total population aged 0-17 will lose a mother or a father or both annually in the country. Over the 23 months since April 2020, therefore, relatives should have registered over 2.3 million orphans and semi-orphans according to this calculation by February 2022; but the actual number reported was only about 153,000. This suggests that few relatives did so, attesting the ineffectiveness of registries that offer no financial incentives. It should be noted that it is unclear how the COVID-19 crisis has influenced the results and the implementation of the 2019-2021 representative National Family Health Survey, but the fact that it does not show any significant change in the ratio of orphans in comparison to 2014-15 in the child population is surprising. However, it does not exclude an uptick in annual losses of parents to death since April 2020 (https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf).

The earned income of many South Asian households hinges to a large extent on a male breadwinner. In the region, husbands are, on average, significantly older than their wives: in Bangladesh, for example, the average age gap in marriage is 8.4 years, and, in India and Pakistan, it is around 5 years (Dommaraju 2021). Because of the dominance of this family model and low female participation in the wage labour market, the high mortality toll among middle-aged men implies a significant rise in economic insecurity among household members, including widows and orphans. The untimely deaths of husbands leave women to play a key role in household income-generating activities.

Moreover, although COVID-19 hospitalizations have been reduced, the pandemic is not yet over. The more infectious variants of the virus, together with the lingering current and chronic health impacts of COVID-19, raise the prospect that, in the future, employers and wage earners will have to cope with more frequent sickness and constrained income-earning capacity. On average, only one worker in seven in the region has social insurance, and the social assistance programmes built around the informal sector are designed to offer protection against aggregate shocks and are poorly equipped to counter such idiosyncratic risks (see Chapter 2). Because of this, the less dramatic, less visible, but recurrent effects of COVID-19 infections could more easily erode household economic security.

COVID-19 created environments less conducive to reducing maternal mortality

Pregnant women are generally considered vulnerable to broadly defined environmental impacts because of the physical and mental health risks associated with pregnancy. Many countries in South Asia reported disruptions in maternal and child health services in the second quarter of 2020, and the repeated COVID-19 waves and related pressure on medical services did not promote regular check-ups and access to potentially life-saving interventions. Moreover, the risk of becoming infected with COVID-19 and the need for social distancing have created a stressful, unsupportive environment for everyone, including new mothers and children.

While parental deaths are always heart-breaking and frequently put young lives on a more troubling trajectory, statistics reveal that poor maternal health and maternal mortality are particularly scarring for children (Kapoor et al. 2020). The deaths of women from complications related to pregnancy and childbirth account for a significant part of neonatal and young child mortality (see Atrash 2011, for example). Despite rapid progress in reducing the maternal mortality rate since 2000, about 57,000 lives were lost to pregnancy-related causes annually in the region as of 2017 (UNICEF 2021d), implying a rate of 163 per 100,000 live births (see Table 3.2). Nearly all of these deaths are preventable.

Table 3.2: Maternal mortality and the female population of fertile age, South Asia

Country	Maternal mortality rate, per 100,000 live births		Women of fertile age (15–49), 1,000s		
		2017		2020	2025
Afghanistan	1,450	638	7,718	9,245	10,915
Bangladesh	434	173	43,488	46,216	48,035
Bhutan	423	183	195	208	217
India	370	145	336,150	357,411	374,985
Maldives	125	53	110	114	119
Nepal	553	186	7,967	9,029	9,631
Pakistan	286	140	49,764	55,396	61,185
Sri Lanka	56	36	5,339	5,324	5,319
South Asia	395	163	450,731	482,942	510,406

Source: UNICEF Data Warehouse (database), United Nations Children's Fund, New York, https://data.unicef.org/dv_index/; WDI (World Development Indicators) (dashboard), World Bank, Washington, DC, https://datatopics.worldbank.org/world-development-indicators/; World Population Prospects 2019 (database), Population Division, Department of Economic and Social Affairs, United Nations, New York, https://population.un.org/wpp/.

Notes: Maternal mortality ratio: number of deaths of women from pregnancy or childbirth-related causes per 100,000 live births during the same time period (modelled estimates). Women of fertile age: estimates as of 1 July 2015 and 2020; low variant projection for 2025.

If the nearly 15 per cent rise in maternal mortality projected globally is valid for South Asia, households in the eight countries would have lost an additional 8,550 expectant mothers annually over the trend (Roberton et al., 2020). A separate South Asia–specific study came to a similar conclusion (SickKids 2021).

The direction fertility has been taking during the COVID-19 years is not yet clear, but there is no reason to assume that the long-term trend of lowering fertility did not continue after 2020. However, between 2015 and 2025, the number of women of fertile age will have increased by around 60 million (see Table 3.2), which is expected to strengthen the demand for maternal and child health services.

3.2. Pandemic-related declines in child and maternal health and nutrition

From the start of the pandemic, malnutrition was a major concern in South Asia. The main threats from the indirect impacts of the COVID-19 crisis, disruptions and lockdowns were related to the following:

- Less food available, poor access to markets, fewer resources to purchase nutrient-dense foods;
- Less time available and misinformation leading to less breastfeeding and poor feeding practices;
- Greater monotony in diets leading to micronutrient deficiencies;
- Greater reliance on industrial food products high in fat, sugar and salt and leading to a larger risk of overweight and obesity;
- Disruptions in maternal and child health services, including antenatal counselling, immunization, nutrition supplements and treatment of severe wasting in young children; and
- Disruptions in school feeding programmes.

Box 3.2 describes the impact of COVID-19 on maternal and child nutrition in South Asia in the context of longer-term trends, which were showing improvements, but also important gaps and inequalities. The analysis that follows discusses disruptions in health and nutrition services during the pandemic and estimates the indirect impacts on stunting and wasting associated with the COVID-19

crisis and the related surge in poverty. These impacts are likely to persist much longer than the pandemic itself. While the return of economic growth to the region, the upgrades in social protection and the fresh attention to hygiene should have positive effects on household purchasing power and food consumption, the extent to which the nutrition of disadvantaged families, adolescent girls and young children is going to benefit from these effects is not clear. There is a risk that the economic dislocations associated with supply chain disruptions and rising food and fuel prices will hobble social recovery, good nutrition and maternal and child health.

Box 3.2: Progress in maternal and child nutrition pre-COVID-19, yet slower than desired

The greater economic insecurity and service disruptions associated with the COVID-19 crisis have been a particular concern in South Asia because progress in poverty reduction and sanitation pre-COVID-19 were often shallow, and strong economic growth was accompanied by less than expected improvement in undernutrition among young children and adolescents. The prevalence of nutrition deficiencies among pregnant women have remained a concern. Table B3.2.1 shows results from the latest representative surveys. It is clear from the table that a significant share of the children in South Asia were nutritionally deprived before the COVID-19 crisis.

Table B3.2.1: Progress and gaps in nutrition outcomes among mothers and children, 2009–2021

Afghanistan		Bangladesh		Bhutan	India		Maldives		Nepal		Pakistan		Sri Lanka	
MICS 4	AHS	MICS 5	MICS 6	MICS 4	NFHS-4	NFHS-5	DHS	DHS	MICS 5	MICS 6	DHS	DHS	DHS	DHS
2010–11	2018	2012–13	2019	2010	2015–16	2019–21	2009	2016–17	2014	2019	2012–13	2017–18	2006–07	2016
Children under breastfed within one hour of birth, %														
53.6	63.7 *****	57.4	46.6	59.0	41.5*	41.4	64.3	66.5	48.7	41.7	18.0	19.6	—	90.3
Non-breastfed children ages 6–23 months receiving minimum acceptable diet, %**														
59.5	15.0 *****	—	16.6	36.3	14.3	12.3	39.9	47.6	22.8	22.2	9.9	8.0	—	44.6
Stunted children ages under 5 (moderate and severe), %														
51.6	36.6	42.0	28.0	33.5	38.4	35.5	18.9	15.3	37.4	31.5	44.8	37.6	—	17.3
Wasted children ages under 5 (moderate and severe), %														
13.9	5.0	9.6	9.8	5.9	21.0	19.3	10.6	9.1	11.3	12.0	10.8	7.1	—	15.1
Children ages 6–59 months with anæmia* (< 11.0 g/dl), %**														
33.7	—	—	—	—	58.4	67.1	—	49.7	—	—	—	53.7****	32.6	—
Pregnant women 15-49 years old with anæmia* (<11.0 g/dl) %**														
16.3	—	—	—	—	50.3	52.2	—	62.0	—	—	—	—	34.0	—

Source: IIPS and ICF International 2022; MICS (Multiple Indicator Cluster Surveys) (dashboard), United Nations Children's Fund, New York, http://mics.unicef.org/; Ministry of Health and ICF International 2010, 2018; NHSRC and UNICEF 2019; NIPS and ICF International 2013, 2019; Statistics Sri Lanka 2009, 2017.

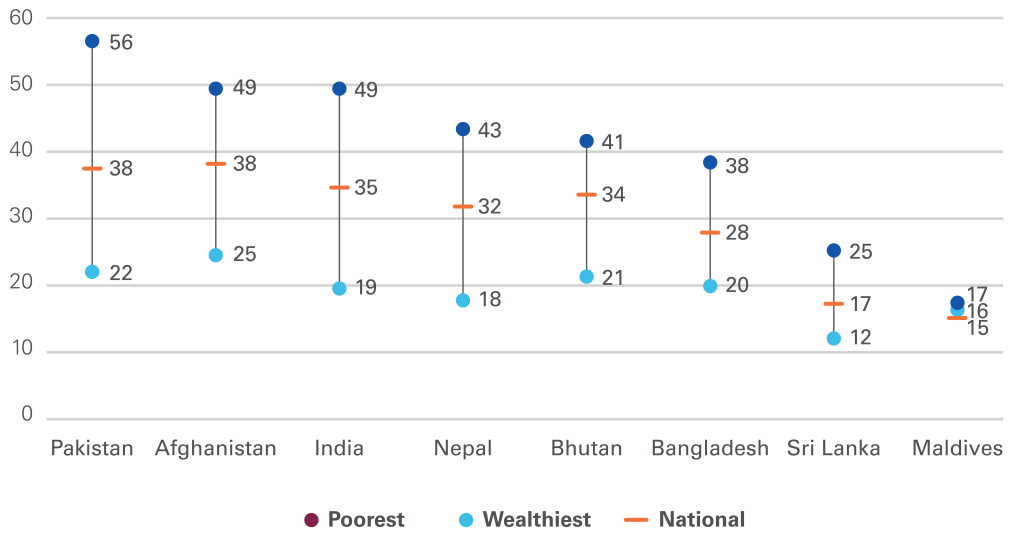
Notes: Bhutan: data are not available after 2010. DHS = Demographic and Health Surveys. MICS = Multiple Indicator Cluster Surveys. NFHS = National Family Health Survey (India).

* Children ages under 3.

** Non-breastfed children ages 6–23 months, receiving minimum acceptable diet: share of non-breastfed children ages 6–23 months who had received at least two milk feedings and had had at least the minimum dietary diversity, not including milk feeds and the minimum meal, frequency during the previous day. Afghanistan 2010–11 and Bhutan 2010: non-breastfed children ages 6—23 months receiving at least two milk feeds a day.
*** Includes mild, moderate and severe anæmia.
**** Children ages under 5.
***** The source: 2015 DHS

In Bangladesh, stunting prevalence in young children declined considerably between 2012 and 2019, but wasting prevalence stagnated.[133] A similar trend is observed in Nepal with a decrease in stunting, and a slight increase in wasting, where breastfeeding rates have fallen. In India, the latest National Family Health Survey (NFHS-5), which collected data shortly before and at the beginning of the COVID-19 crisis, found some progress both in stunting and wasting, though, also observing an increase in anaemia (IIPS and ICF International 2022). It found severe stunting, at rates of 15.1 per cent nationally. Urban areas had lost their former advantage on this critical indicator (IIPS and ICF International 2017, 2022). This is particularly worrisome, given that COVID-19 hit urban areas especially hard also because of the expected formidable effects of rising food prices on nutrition.

Figure 3.2: Share of children ages under 5 affected by stunting, by household wealth quintile



Source: UNICEF, WHO, and World Bank 2021.

Focusing only on the latest survey results, Figure 3.2 adds two important points. First, lower stunting prevalence across the region appears to correlate with better results among young children in the poorest wealth quintiles, implying greater nutrition equality. Second, the prevalence of chronic nutrition deprivation among young children in the wealthiest quintile is still considerable and actually similar across the region. This finding calls into question the efficiency of the widescale practice of narrowly targeting child-sensitive interventions and the efficacy of existing food assistance (see Chapter 2 and Table 2.4) in reducing malnutrition among pregnant women and young children.

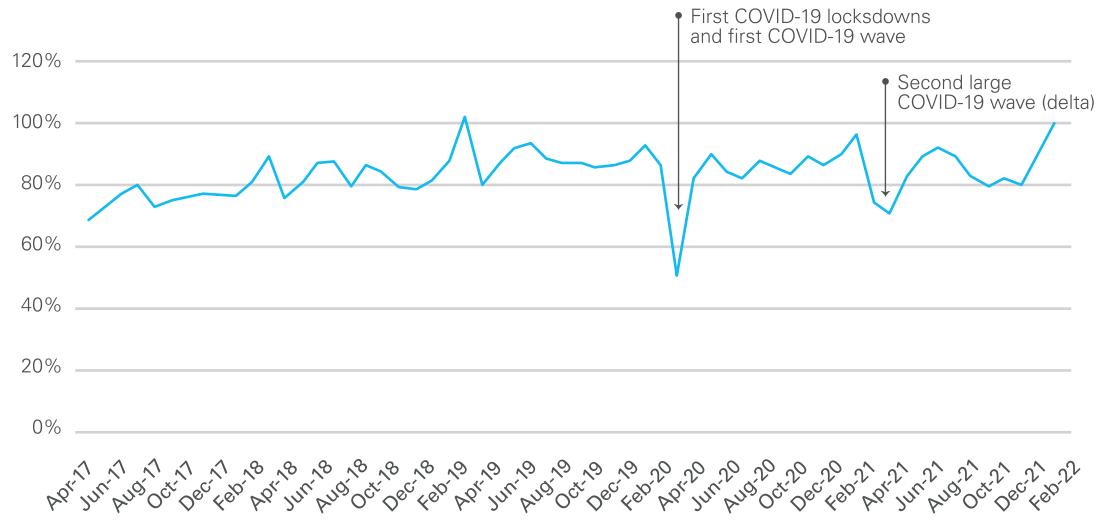
[133] Children are considered stunted if their height-for-age is more than two standard deviations below the WHO Child Growth Standards median (WHO 2015). Low weight-for-height is known as wasting (WHO 2021).

The impact of COVID-19 on maternal and child health services and nutrition

In early 2020, even before WHO declared COVID-19 a pandemic on 11 March 2020, the coverage of maternal, child and adolescent health services was already being affected in several countries in South Asia (SickKids 2021). The delivery of family planning, antenatal care, facility births, postnatal visits, routine vaccinations, zinc for the treatment of diarrhœa, and so on, were all significantly affected, especially from the second quarter of 2020 onward. This was partly because of falling demand associated with the fear of infection and partly due to the pressure to divert health workers to the COVID-19 response. These service disruptions occurred to a large extent in all countries of South Asia, with implications for young child morbidity and mortality and maternal health (SickKids 2021).

As Figure 3.3. shows with the case of iron and folic acid supplements in India, countries have made significant efforts to recover from the shocks of COVID-19 waves and return service coverage to the longer-term improving trend. Still, even temporary drops in access to maternal and child health related interventions can have serious consequences: it is not always possible to reverse the damage that higher maternal stress or service disruptions cause in the process of early development (e.g., risk of fetal miscarriage or birth defects).

Figure 3.3: Provision of iron and folic acid tablets to pregnant women in India



Source: Health Management Information System (HMIS) of Ministry of Health & Family Welfare, Government of India (https://hmis.nhp.gov.in/#!/).

Notes: Graph adapted from the India's Women Nutrition Factsheet 2022. (https://mcusercontent.com/32390edec9a6d376d3ae2c133/files/9f6a41b3-382e-c90b-8728-57db780e195b/India_s_Maternal_Nutrition_Factsheet_2022.01.pdf)

Still, between 2019 and 2020, the region experienced a sharp decline in the share of children receiving three doses of the diphtheria-tetanus-pertussis (DTP3) vaccine, falling from 90 per cent to 84 per cent, including a drop of 9 percentage points in Nepal, 7 percentage points in Pakistan, 6 percentage points in India, 3 percentage points in Sri Lanka and 2 percentage points in Afghanistan and Bhutan (UNICEF 2021b). Inasmuch as these figures reflect upon worse access to health interventions and higher morbidity risk among young children, they imply a similar decline in the nutritional status of young children – influenced also by falling household income and rising poverty in 2020 (see Chapters 1 and 2). Model estimates by UN system experts for 2020 warn that wasting prevalence may have increased by up to 15 per cent (see Box 3.3) due to a combination of different factors.

Box 3.3: Modelling stunting, wasting and obesity in South Asia

Stunting is the devastating result of poor nutrition in utero and early childhood. Children suffering from stunting may never attain their full height, and their brains may never develop to their full cognitive potential. These children begin their lives at a marked disadvantage. They face greater learning difficulties in school, earn less as adults, and encounter barriers to participation in communities. In South Asia in 2020, 53.8 million children under 5 years of age were estimated to suffer from stunting. This is 36 per cent of the global figure of 149.2 million children.

The method used by the group of experts from various entities within the United Nations system projects a slight decline in stunting prevalence (from 33.2 per cent to 31.8 per cent) between 2019 and 2020. However, the experts warn that the impact on stunting may take years to become fully manifest, and prevalence may increase substantially because of constraints in accessing nutritious diets and essential nutrition services during the COVID-19 pandemic. The pandemic may also lead to increases in childhood overweight, especially in settings where food choices and physical activity have been negatively influenced by COVID-19 mitigation strategies. The impact on overweight may persist through the lifetime of those affected. Poor dietary and physical activity habits (shaped by restrictions during COVID-19) may continue through adolescence and adulthood. In South Asia, an estimated 4.5 million children (11.6 per cent of the global number) were considered obese in 2020.

Wasting and severe wasting, characterized by a loss of muscle and fat mass, can develop rapidly because of poor nutrient intake or disease. Children suffering from wasting have weakened immunity, are susceptible to long-term developmental delays and face an increased risk of death, particularly if wasting is severe. They require urgent treatment and care to survive. In South Asia, 24.8 million children under 5 (14.7 per cent) were affected by wasting in 2020 according to the latest model estimates, of whom 7.6 million (4.5 per cent) were severely wasted. Because losses in muscle and fat mass can be reversed rapidly, it may be difficult to retrospectively assess how wasting prevalence was affected over the course of the pandemic. However, among children who survive episodes of wasting during the pandemic, height is likely to be affected, meaning that some of the pandemic's enduring impact on stunting may be attributable to prolonged and recurrent episodes of wasting.

The prevalence-based estimates presented in 2020 were basically the same as in 2019, but the group of experts warn that the actual rate of wasting may be 2.2 percentage points higher (i.e., showing a rise of nearly 15 per cent). The analysis notes that, because physical distancing prevented the generation of representative survey data during the pandemic, only modelled predictions are possible.

Source: UNICEF, WHO, and World Bank 2021.

Table 3.3 explores the nutrition impact regionwide during the initial COVID-19 years. It shows estimates using the International Food Policy Research Institute's general equilibrium model (Benfica 2021). The moderate scenario suggests that the growth of an additional 780,000 children will be stunted during their first five years of life by the impact of the COVID-19 crisis in South Asia.

High levels of anæmia among expectant mothers and newborns are also an issue because of the repercussions for the cognitive and physical growth of children. Still, it is the 6 million additional children experiencing wasting that is the most worrisome projection given that wasting, especially in the severe acute form, is a major threat to the lives of young children.[134]

[134] Malnutrition has been implicated in 68 per cent of child mortality in India (India State-Level Disease Burden Initiative Malnutrition Collaborators 2019).

Table 3.3: Indirect COVID-19 effects: Estimates of child wasting and stunting, South Asia, 2020–2022

Indicator	Scenario		
	Pessimistic	Moderate	Optimistic
Wasted children	9,340	6,210	4,360
Stunted children	1,110	780	500

Source: Osendarp et al. 2021.
Note: Given the cumulative nature of stunting, to avoid double counting, data refer to the number of children ages 6–59 months who were stunted at the end of the three-year period.

Two caveats apply. First, an ongoing collaboration between the International Food Policy Research Institute and UNICEF examining nutrition interventions has found low coverage of preventative nutrition-specific interventions even in those communities in which access to maternal and child health services are adequate, pointing to an opportunity gap that can and should be closed by expanding interventions. Second, the scenarios shown in Table 3.3 do not take into account declines in mitigation through nutrition-specific and nutrition-sensitive interventions. Indeed, nutrition-specific programmes associated with school attendance in the region have been seriously affected, including by school closures. The same is true of child protection services. These outcomes will have an impact not only on child and adolescent nutrition and health, but also on learning effectiveness and equity.

Meanwhile, social protection in kind, especially subsidized food distribution as part of the crisis response of governments, was enlarged in several countries in the region. Even more radical changes have occurred in cash-based social assistance, a nutrition-sensitive intervention that became a major avenue for crisis response following lockdowns. Scaling up this type of intervention has great potential and could radically change the environment for COVID-19–related nutrition projections and scenarios as well as post-lockdown prospects for child development.

The impact on the mental health of women and children is expected to be substantial

In addition to nutritional stress on households, alongside shrinking availability of interventions, the pandemic has brought about a similar pattern with regard to mental health – particularly for children and women. There is emerging global evidence that COVID-19–related health service disruptions have affected mental health services, at the same time that greater stress and personal and economic insecurity associated with the pandemic have had a significant negative impact on mental health (Idele and Banati 2021). While data from the region do not always allow comparison over time, evidence from Bangladesh and other countries suggest that mental health with a strong gender focus should be high on the public health agenda (Mamun et al. 2021).

Mental health has been defined as "an asset or a resource that enables positive states of wellbeing and provides the capability for people to achieve their full potential" (Patel et al. 2018, 1562). Critical periods for mental health include pregnancy, early childhood, and adolescence with long-term implications (Zhou et al. 2020). The Global Burden of Diseases, Injuries, and Risk Factors Study 2019 ranked the two most common mental disorders – depression and anxiety disorders, which can be quite disabling – among the top 25 leading causes of health burden globally, including in South Asia.[135]

A major study covering 204 countries and territories projected large COVID-19–related increases in depressive and anxiety disorders globally (COVID-19 Mental Disorders Collaborators 2021). The study suggested that, in South Asia, the prevalence of major depressive disorders could rise by 36.1 per cent and the prevalence of anxiety disorders by 35.1 per cent because of the pandemic. Both figures are around 10 percentage points higher than the expected global increase in mental disorders. Chiefly driven by the reported SARS-CoV-2 infection rates, rises in mortality and reductions in human mobility, the model suggested Bangladesh, India, Nepal and Pakistan were more greatly affected, while Afghanistan and Bhutan were less highly impacted within this regional picture. The prevalence of depressive disorders and anxiety disorders per 100,000 people was estimated at 3,627 and 4,078, respectively, in South Asia (more than a third higher than pre-COVID).[136]

[135] See GBD 2019 (Global Burden of Disease Study 2019) Data Resources, Global Health Data Exchange, Institute for Health Metrics and Evaluation, Seattle, https://ghdx.healthdata.org/gbd-2019.
[136] It should be noted that mental health Issues often overlap. Surveys show, for example, that 60-70 per cent of those with depression also have anxiety. See https://www.psychologytoday.com/us/articles/200310/anxiety-and-depression-together

The study projected a larger increase in prevalence among women than among men, resulting in an even greater difference by sex than pre-pandemic. Adolescents and young people were also more affected than others.[137] While the model could have captured some of the child-specific effects (for example, school closures associated with overall mobility restrictions), it did not explicitly include the impact on young girls and boys as well as adolescents staying at home instead of attending schools and being with friends. Nor did it specifically consider impacts on domestic violence, parental stress, and anxiety within overall adult mental health effects.

If the above estimates on prevalence and incidence were also valid for those under 18 within the general population, the number of children with depressive disorders would show an increase by nearly 6 million cases, pushing prevalence up to 22.4 million children in South Asia. The prevalence of anxiety disorders among children would be even higher, reaching 25.2 million cases, with 6.6 million estimated additional cases due to pandemic-related impacts.[138]

Unlike the case of infectious diseases in which a pathogen is either present or not, mental health exists in a continuum wherein, beneath the pathogenic thresholds for depression and anxiety, there is a broader array of mental health issues.[139] Accordingly, increases in mental health diagnoses may indicate a much broader mental health impact associated with less obvious manifestations that ought to be concerning as well. This is not only a health or welfare issue. It is a problem that has implications for children's cognitive capital, progress in school, and eventual earnings in the workplace, especially when combined with effects from poorer nutrition and reduced childcare capacity.

3.3. The Impact of School Closures

The policy decision to close schools beginning generally in March or April 2020 and to undertake remote learning from home had an immediate, far-reaching impact on 434 million students in South Asia. In addition, an estimated 22 million children missed out on early childhood education during critical preschool sessions as COVID-19 caused the closure of childcare and early education facilities.[140] While countries in the region had prepared comprehensive emergency plans to deal with major disasters, these tended to focus on responses to safety concerns, medical emergencies and infrastructure problems (UNICEF and UNESCO 2021). Likewise, some forms of online learning have been present in higher education for some time, but few primary or secondary schools were ready to shift to distance education overnight (Hodges et al. 2020). Accordingly, the dramatic shift from face-to-face learning to remote teaching across all levels of education, from preschools to tertiary institutions, across the region has been a tremendous challenge that has resulted in a major education emergency on top of the ongoing health emergency.

Indeed, learning assessments carried out since 2021 confirm that children's academic skills have suffered a major setback due to the pandemic.

Attending school, moreover, means much more than learning the essential academic skills. For communities, the state and other stakeholders involved in child development, the school is a key policy tool and programme platform to deliver a broader range of basic social services. School closures were accompanied by broad restrictions on public gatherings, including those associated with cultural, leisure and sporting events. Parents of young children and adolescents were discouraged from participating in socializing opportunities that, in normal times, would have been a crucial part of child development. School closures can be implicated in negative effects on child health and nutrition as well, as it generally removes access to school-based health services and feeding programs.

[137] Measuring the prevalence of mental health issues among young children is particularly difficult; therefore, mental health statistics generally refer to adolescents (i.e., 10–19-year-olds) rather than children aged 0-17. This, however, does not mean that those under the age 10 are not vulnerable to mental health effects.
[138] Calculated with 2020 child population numbers. The 2021 prevalence estimate by the COVID-19 Mental Disorders Collaborators quoted above indicates significant uncertainty intervals along all age groups in terms of the modeled COVID-19 impact.
[139] A UNICEF analysis, based on estimates from the Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease Study, 2019 on a broader group of mental conditions (depression, anxiety, bipolar, eating, autism spectrum, conduct, substance use, idiopathic intellectual disability, attention deficit/hyperactivity and certain personality disorders) has suggested that globally 1 in 7 adolescents experience mental health Issues. (See the 2021 State of the World's Children Report.) Applying this ratio to the 353 million strong adolescent population of South Asia, the number of 10-19-year-olds with such mental health Issues could be estimated about 45 million in 2019. Considering the region-specific impacts from the study of the COVID-19 Mental Disorders Collaborators, 2021, the pandemic may have increased this number by 12 to 20 million.
[140] Education (dashboard), Regional Office for South Asia, United Nations Children's Fund, Kathmandu, Nepal, https://www.unicef.org/rosa/what-we-do/education.

Box 3.4: Enrolment was rising pre-COVID, but left gaps in attendance and completion

During the 2010s, school enrolments increased at an impressive rate in South Asia. Several low- and lower-middle-income countries narrowed disparities in basic education enrolment with upper-middle-income countries. By the end of the decade, most young children in the region were benefiting from some preparatory classes before the first year of basic education. The exception was Afghanistan, where only one child aged 5 in two was enrolled in preschools or madrasas. The gross enrolment ratio was high in primary school, but dropped 10 percentage points in lower secondary school, and declined further in upper secondary education, where the weighted gross enrolment ratio was 64 per cent in the region (UNICEF and UNESCO 2021). Only Sri Lanka stood out, with a 98 per cent gross enrolment ratio.

Despite the rising trend over the last decade and the high gross enrolment ratios (which also reflect late entries and repeating grades), about 12.5 million children in primary school and 16.5 million children at the lower secondary level were out of school in South Asia.[141] The ratio of out-of-school children varied significantly across countries, and varied by gender (see Table B3.4.1). In Bangladesh, Bhutan, Maldives and Sri Lanka, more boys than girls were out of school, chiefly because of the higher prevalence of child labour for boys. More girls than boys were out of school in Afghanistan, India, Nepal and Pakistan. Lack of disability-inclusive education is also a factor, as few schools in the region are accessible to children with disabilities (Amaltas Institute of Human Development 2019; UNICEF and UNESCO 2021).

Table B3.4.1: School attendance and out-of-school rates, by sex (%)

Decile	Afghanistan DHS 2015	Bangladesh MICS 6 2019	Bhutan MICS 4 2010	India NFHS-5* 2019–21	Maldives DHS 2016–17	Nepal MICS 6 2019	Pakistan DHS 2017–18	Sri Lanka DHS 2016
Net primary school attendance	63.7	85.9	95.2^	94.8	94.8	74.5	61.9	95.7
Females	52.6	88.5	94.8^	94.7	94.6	75.9	58.8	95.6
Males	72.0	83.3	95.5^	95.0	95.0	73.2	64.9	95.8
Primary out-of-school	37.0	6.4	7.9	-	1.0	5.6	23.0	2.1
Females	47.1	4.5	7.1	-	0.9	6.6	26.7	2.1
Males	27.8	8.1	8.6	-	1.2	4.6	19.4	2.2
Lower secondary out-of-school	40.0	13.0	19.0	-	4.0	4.3	26.9	0.9
Females	56.1	8.0	18.4	-	3.8	4.5	31.9	0.7
Males	25.4	17.9	20.2	-	4.1	4.2	21.7	1.0

Source: ADB and NSB 2013; IIPS and ICF International 2017; UNICEF Data Warehouse (database), United Nations Children's Fund, New York, https://data.unicef.org/dv_index/, based on household surveys.

Note: The survey data are the most recent pre-COVID. For the terms, see UIS (2009, 2021).

Bhutan ^2012 Living standard survey

*India's 2019–2021 National Family Health Survey (NFHS-5) has data on attendance, but not on out-of-school rates: IIPS and ICF International (2022).

[141] Education (dashboard), Regional Office for South Asia, United Nations Children's Fund, Kathmandu, Nepal, https://www.unicef.org/rosa/what-we-do/education.

When schools were closed, around 35 million children ages 5–14 (about 10 per cent of the age group) were little affected, as they had never entered or had already been out of the system for some time. There is a dearth of knowledge on how these children, some of whom live in institutions run by charities and communities, and many others in disadvantaged households under the poverty line, were impacted by the lockdowns and waves of COVID-19 in the region. It is widely anticipated that the number of out-of-school children will rise considerably as schools reopen and distance learning is replaced. Likewise, the share of young people not in employment, education, or training could swell.

Changes in school enrolment since 2019

Educating a child is a long-term investment that needs to be consistently nurtured within the household, the school, and the community. The household cost of education is substantial. It involves both direct expenses in cash and in kind (school fees, books, equipment, extracurricular lessons, commuting, participation in school events) and opportunity costs among parents, other carers and the children. Since 2020, a large share of the population in South Asia has experienced a drop in household income, falling expectations about the prospects of employment and wages, and the effects on their children of the struggles of distance learning. There is thus a risk that the perceived value and sustainability of the household investment in education will plunge, especially as the urgency of alternative uses of household resources rises. Household attitudes towards education are critically linked to learning outcomes among children. Table 3.4 compares school enrolment in the 2021/2022 school year with enrolment pre-COVID (2019–2020) in private and public schools in three South Asian countries on which data were available.

Table 3.4: Changes in school enrolment, Bangladesh, Bhutan and India, 2019–2022

Country	Total enrolment (thousands), school year							
	2019–2020 or earlier				2021–2022 or latest			
	Public schools		Private schools		Public schools		Private schools	
	Males	Females	Males	Females	Males	Females	Males	Females
Bangladesh								
Pre-primary	868.6	898.7	1,095.4	1,085.2	767.7	802.9	791.4	868.6
Primary	5,061.6	5,592.1	3,534.3	3,415.0	6,053.9	5,860.1	2,529.4	n/a
Secondary	282.7	260.6	3,784.4	4,716.4	n/a	n/a	n/a	n/a
Bhutan								
Pre-primary	3.6	3.6	0.8	0.7	4.5	4.4	0.9	0.8
Primary	19.1	18.9	1.1	1.0	20.5	20.6	0.9	0.8
Lower secondary	34.5	35.4	0.3	0.3	32.0	33.1	0.4	0.3
Upper secondary	21.3	22.9	4.9	5.3	22.9	25.9	4.4	4.6
India								
Pre-primary, less early								
Child development centres	1,391.0	1,398.0	5,925.0	4,841.0	1,246.0	1,233.0	4,457.0	3,709.0
Primary	32,865.0	33,910.0	30,387.0	24,525.0	34,174.0	34,484.0	29,356.0	24,008.0
Lower secondary	25,054.0	26,887.0	28,446.0	22,951.0	26,006.0	27,481.0	28,342.0	23,031.0
Upper secondary	4,443.0	4,984.0	8,888.0	7,632.0	4,882.0	5,399.0	8,972.0	7,670.0

Source: Data of Ministry of Primary and Mass Education, Bangladesh; Ministry of Education, Bhutan 2020, 2021; Ministry of Education, India 2021, 2022.
Note: In Bhutan the academic year is from February to December and children can attend preschool from age 3. For India data only includes students who attend preprimary classes at Govt or private schools and the age of entry varies among states. Data refer to students who attend pre-primary classes at government or private schools but exclude those who attend ECD centres and standalone pre-primary centres. The school year data refers to is 2019-2020 and 2020-2021.

In Bangladesh and India, there was a notable reduction in the number of preschoolers enrolled, especially in private education institutions, but the reduction is also evident in public preschools.[142] In Bhutan and also in Pakistan, on which no data by school ownership are available, preschool enrolment increased, which may be explained by less dramatic COVID-19 impacts.

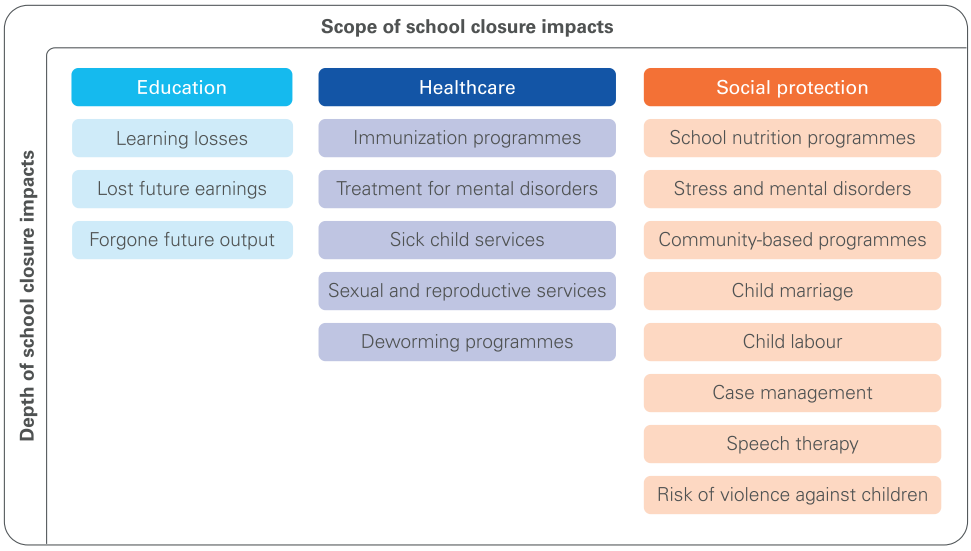
At the primary school level in India, there has been some movement from private to public schools, which appears to be the result of economic coping strategies, although improving perception of public education could also have played a role (Barman 2022). A similar shift from private to public schools has also been observed in Bangladesh, but only among boys. Among girls, the enrolment in private primary education has risen by over 1.6 million, with a significant share of these students new to school. The lack of recent enrolment data prevents a clear picture in Bangladesh on changes in school enrolment at the secondary level, where a rising trend in child marriages could show up in lower enrolment rates. In India, the number of enrolled students in lower secondary education has increased more among boys than girls, indicating that more than 100,000 girls had to leave school when they reached ages 11–12.

Disruptions of learning and access to supportive services for children

Although there was wide variance in school closure policies in South Asia, ranging from 14 (Maldives) to 61 (Bangladesh) weeks of full closure and from 0 (Bangladesh) to 51 (Bhutan) weeks of partial closures, children throughout the region suffered serious disruptions in face-to-face learning. Except for Maldives, full school closures across South Asia were longer than the global average. School closure policies were particularly fluid in India, Pakistan, and Sri Lanka, which opened schools in mid-2020, but subsequently imposed a series of partial and full school closures in response to fluctuating infection rates.

Figure 3.4 shows the scope of the services that school closures affected. It also illustrates the depth of the impacts, starting with learning losses that will undermine future earnings and economic output. Prior to COVID-19, more than half the children already suffered from learning poverty in South Asia. On average across the region, by age 10, 58 per cent were unable to read and understand a short, age-appropriate text (EduAnalytics 2019). Because the acquisition of skills and knowledge is a cumulative process involving the

Figure 3.4: The scope and depth of the impacts of school closures



Source: Coursac and Townshend 2022.

[142] Preschools are not available in a number of states and ECD centres do not report enrolment data which blurs the picture on COVID-19 related change makes.

gradual development of children's lifelong competencies and the improvement of their future opportunities, a successful transition from school to distance learning and back to school is a delicate process.

The combination of school closures and household economic pressures can raise dropout rates, especially among vulnerable students, as disadvantaged children become disengaged from education systems and face competing pressures. A major concern is therefore that the combined effects of poverty and school closures will erode further learning outcomes: the United Nations Educational, Scientific and Cultural Organization has estimated that, in South Asia, 1.3 per cent of girls and 1.4 per cent of boys are at risk of not returning, or delaying their return, to education institutions (UNESCO 2020).

Figure 3.4 also highlights school closures as a pathway to changes beyond education and skills training. Schools additionally serve as delivery platforms for cross-sectoral services, including social protection, health care, well-being and nutrition, and sanitation. In many places in South Asia, particularly in rural areas, schools also serve as a hub for community meetings, gatherings, and exchanges. The critical role of schools in supporting the development of healthy relationships and connectedness should also be acknowledged as an important protective factor consistently associated with reducing the likelihood of a variety of health and social risk behaviours.[143] School closures therefore have had complex and diverse impacts on children, adolescents, and their communities.

Disadvantaged children who should benefit from school-based and non-school-based interventions and supports include children living in households in extreme poverty, such as households in urban slums, children in disadvantaged households, such as households in remote areas or households in which the members speak a minority language, children at risk of dropping out or exploitation, girls at risk of early marriage and pregnancy, children on the move (migrants and refugees), children with physical disabilities, children with special learning needs, and young children (UNICEF and UNESCO 2021). Too often, it is these children who risk missing out on services.

The sudden loss of vital health and nutrition services delivered through school platforms meant that many vulnerable children lost or had limited access to nutrition programmes, while poverty rates were simultaneously rising. Children therefore lost out on subsidized nutritious meals at the moment when downward pressure on income was limiting the ability of households to increase out-of-pocket consumption expenditure. Realizing the risks, governments and stakeholders in some countries in the region, such as India, established special assistance programmes to deliver midday meals during 2021.

Routine school-based health service delivery across South Asia was also interrupted. Based on reports in Southeast Asia that apply widely across Asia, the most common health care services that faced disruptions that affected children include routine immunization, the diagnosis and treatment of non-communicable diseases, sexual and reproductive health services, and the treatment of mental health disorders and sick child services (WHO SEARO, PHFI, and IIPHG 2020). Other disrupted school services include speech therapy, peer support groups, and crucial deworming programmes that have been highly effective in preventing common parasitic worm infections in many South Asian countries (World Bank 2020).

School closures also led to the suspension of community-based child protection programmes and case management for many children requiring supplementary personalized care, including child

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[143] Connectedness often refers to a sense of being cared for, supported, and belonging and can be centered on feeling connected to school, family (that is, parents and caregivers), community, place of worship, or other important people and organizations in their lives (CDC 2020).

victims of abuse and children living with disabilities (United Nations 2020). Research indicates that children with disabilities and their families are more likely to experience violence, hunger and poverty (UN DESA 2019c). While this vulnerable group of children are prone to underlying health conditions and face an increased risk of serious complications from COVID-19, they have typically had difficulty benefiting from support and useful response measures (UNICEF 2020b). Moreover, quarantine and isolation conditions can place children, especially those with disabilities, at increased risk of discrimination and violence within the household (UNICEF 2021a). Box 3.5 illustrates selected impacts of school closures on child marriage and violence against children.

Box 3.5: School closures have heightened concerns about child protection

In South Asia, the risk that a girl will be married in childhood has declined by more than a third over the past decade, from nearly 50 per cent to 28 per cent (UNICEF 2021d). This achievement is inseparable from the progress in education and is largely driven by great strides in reducing the prevalence of child marriage in India, a world leader in efforts to reduce child marriage by encouraging girls to stay in school and raising awareness. Still, South Asia is home to more than 40 per cent of all child brides globally, and the combination of the pandemic-driven economic shock, school closures, and rising poverty rates represents a serious threat to this progress.

A recent global study estimated the impact of the pandemic on child marriage through five main channels: (a) death of a parent, (b) interruption of education, (c) pregnancy risk, (d) household income shocks and poverty, and (e) reduced access to programmes and services (Yukick et al. 2021). It suggests that, without effective mitigation, the pandemic's impact on child marriage in five countries with the world's largest burden of child marriage will result in 3.5 million to 5.0 million additional child brides over the next decade. The model predicts an increase by nearly 230,000 and 700,000 additional child marriages in Bangladesh and India, respectively, within 14 years of the onset of the pandemic because of a slowdown in the long-term trend in the reduction of child marriages. Programmes that support families, offer services and inspire girls to return to or stay in school could reaccelerate the reduction in the number of child marriages.

School closures, reduced access to health care services and physical distancing increase the likelihood that children and adolescents will become more vulnerable and more exposed to violence. Lockdowns imposed to curb the spread of the disease have caused children to spend more time in their homes where – with increases in family poverty and economic instability – they face new stresses and multiple sources of vulnerability, including physical and psychological health risks and violence. Over a third of the respondents ages 15–24 to a multi-country phone survey in the region in March 2022 stated that the relationships they have with the people with whom they live were intense, bad, or very bad, and 1 respondent in 20 said their biggest challenge over the previous 30 days had been domestic violence (U-Report South Asia 2022).

In countries affected by COVID-19, records from helplines, police forces and other service providers indicated there had been a rise in reported cases of domestic violence, particularly violence against children and intimate partner violence against women. These more frequent reports may only represent the tip of the iceberg because an estimated 418 million children aged 2–17 had experienced violent discipline or corporal punishment at home before the onset of COVID-19 (UNICEF 2020c).

With the advent of lockdowns and school closures, helplines, established pre-COVID, have reported a surge in the number of calls received. Thus, calls to helplines in Bangladesh increased

fourfold. Other South Asian countries, including India, also witnessed a rise in the number of calls. Initially, children called for information on COVID-19 prevention measures and to calm their anxieties. While these calls decreased in number, the children who continue to call frequently report abuse. In Maldives, 1,770 cases of violence against children were reported in 2020, 13 per cent more than in 2019. In Nepal during lockdown, an alarming rise in violence, abuse and neglect was detected, with a 50 per cent increase in calls to the Child Helpline and a threefold increase in calls to Khabar Garaun 1145, the National Women Commission helpline for partner violence.

The push to undertake distance learning likely raised the risks associated with children's online activity. According to a 2019 UNICEF U-Report poll, one child in three in India reported being bullied online. More than half these respondents were not aware of the services to report online violence (UNICEF 2019). According to a survey in 2016, around 58 per cent of respondents, largely women, reported being trolled, bullied, abused, or harassed (Pasricha 2016). India accounts for nearly 12 per cent of the child sexual abuse material in circulation (Stroebel and Jeleniewski 2015). The International Justice Mission has also warned of an increase in online grooming cases globally, including cyber-trafficking, grooming, sextortion, sexting, and live streaming of child sexual abuse (Hindu 2020). Empowering children, especially girls, with the skills to use the internet safely, and offering and promoting mental health and psychosocial support services online, is therefore even more urgent now than before COVID-19 (Global Partnership to End Violence against Children 2020).

Remote education has opened new possibilities, but heightened risks as well

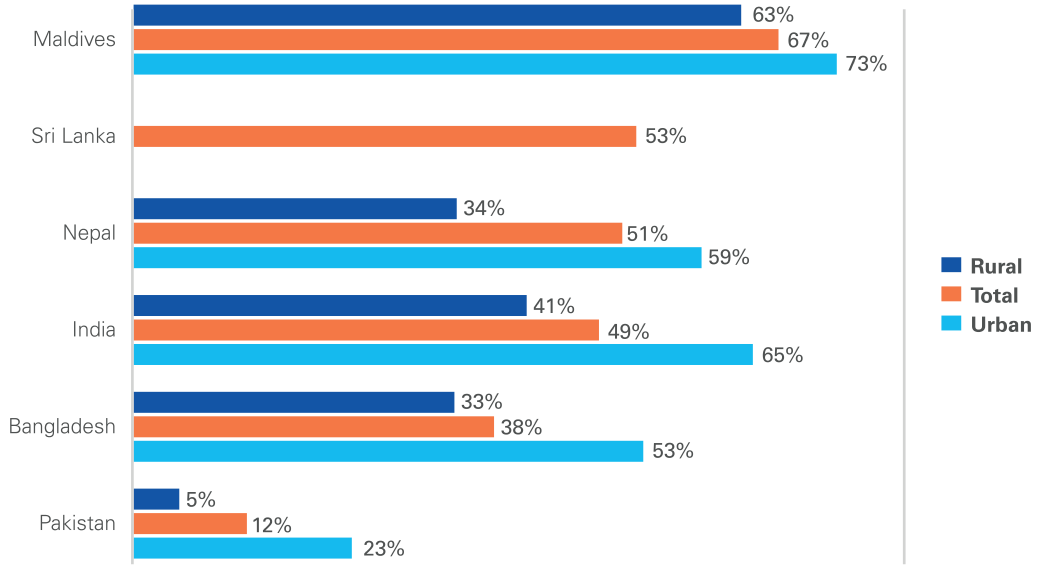
Given the lengthy and rolling school closures, remote learning offerings represented a critical response by governments that were trying to maintain learning continuity.[144] Most governments offered a wide spectrum of remote learning modalities across primary and secondary schools. However, the remote learning systems applied during school closures were perceived by a large proportion of teachers and students across South Asia as an imperfect substitute for in-person lessons (UNICEF 2020e). The Asian Development Bank estimates that 55 per cent of the learning-adjusted school year in 2020 was lost in the region (ADB 2021).

With the pandemic driving schools to adopt remote learning, inequalities and gaps in learning and school-based support widened. Poorer households and remote or excluded communities have limited access to the internet and the devices needed to access online classes. The uptake rates of high-technology options (notably online platforms) were typically low because of insufficient access among many students, especially in rural areas, to the necessary infrastructure to utilize these resources (UNICEF 2020a). A survey in India found that more than 60 per cent of children attended online classes regularly when these were offered. However, lack of access to devices was a major impediment among the children who did not participate (NCAER-NDIC 2021). In a regionwide opinion poll, a large majority of young people – 7 in 10 – said that studying had been particularly challenging during the pandemic (U-Report South Asia 2022).[145]

Figure 3.5 shows the wide variation in household internet access between urban and rural areas. For example, the share of households with a fixed internet connection in Nepal in 2019 was 59 per cent in urban areas, but 34 per cent in rural areas. In Pakistan, 1 household in 5 in urban areas has internet access; in rural areas, 1 in 20.

[144] "Assessing progress on multiple, different learning modalities presents a huge challenge and has to date yielded few good examples of best practice. However, UNICEF, in partnership with Cambridge Education, is producing guidance on how to assess learning against different modalities, such as radio, TV, mobile phone, digital and paper. The World Bank is also producing guides on digital assessment. Once finalized, these packs will help countries build a new model for monitoring and evaluation and assessing learning impact" (UNICEF and UNESCO 2021, 83).
[145] These respondents all had access to a mobile phone. This was the platform the survey used. Even the youngest participants were over 14 years of age.

Figure 3.5: Share of households with access to internet (per cent)



Source: IIPS and ICF International 2022; MICS (Multiple Indicator Cluster Surveys) (dashboard), United Nations Children's Fund, New York, http://mics.unicef.org/; Ministry of Health and ICF International 2018; NIPS and ICF International 2019.
Note: Countries are ranked by the totals. For Sri Lanka, data refer to the share of the population at the beginning of 2022, and rural/urban data are not available. In Pakistan the Social and Living Standards Measurement Survey (PSLM) 2019-20 showed 32.7 per cent of households had access to the internet (in urban areas 47.8 in rural areas 23.3 per cent).

The digital divide in South Asia left an estimated 147 million children without effective access to digital and broadcast media (Ackers, van Cappelle, and Coursac 2021).[146] Moreover, household access does not automatically translate into regular – or even any – access for students. This is demonstrated in Pakistan, where only 25 per cent of children who had access to devices in the household always had the devices available (Ackers, van Cappelle, and Coursac 2021). Most governments thus focused on low- or no-technology (offline) modalities, such as television and take-home packs, and leveraging the relatively widespread availability of mobile phones to keep students and teachers connected.

Given the technological constraints, paper-based materials were a widely used modality in Nepal and Sri Lanka. In Sri Lanka, 45 per cent of sampled learners in government schools reported that they used special printed packs as the main learning tool during school closures in 2020 (Ackers, van Cappelle, and Coursac 2021). The Bhutan government also created self-instruction learning materials for students, particularly those in rural areas without phones or household TV and internet connectivity. However, last-mile distribution and access remained a challenge despite nationally coordinated efforts to distribute take-home packages to students in Afghanistan, Bhutan, India, Nepal, Pakistan and Sri Lanka (UNESCO et al. 2021).

A second major challenge with take-home packages is that some students struggle with the autonomous learning that is expected to occur through these resources, particularly students in lower grades who have not yet developed foundational literacy skills. To address this second challenge, schools in Bhutan supplemented take-home packages with teacher contact through home visits and social media applications (UNICEF 2021c). Still, the speed and urgency with which remote learning resources were developed tended towards a one-size-fits-all model. Vulnerable students who need tailored learning resources, such as resources in local languages or materials supportive of those with disabilities, were very often excluded.

A third challenge was that teaching models relied on the assumption that, if a household had a connection to the internet, the home environment of the student would be conducive to learning. However, access to

[146] In light of the spectacular rise in the access to internet among households in India in recent years, the number of children without access to digital and broadcast media may have been reduced, but it is still significant in absolute terms. NFHS-5 (2019–2021) indicates that almost every second household has an internet connection, while NFHS-4 (2015–2016) found only 1 household in 10 with a connection. See IIPS and ICF International (2017, 2022).

technology is a necessary, but not sufficient condition for effective remote learning because it needs to be suited to the context in which it is deployed. For many students, in poor families in particular, the home environment is not one in which they can learn for a multitude of reasons, not least of which are longstanding gender norms that require girls to look after siblings or carry out domestic tasks. In Nepal, where nationwide school closures affected more than eight million students without access to remote learning possibilities, two thirds of the children were unable to attend classes, according to some reports (HRW 2021). Considering that the involvement of parents has played a mitigating role in the face of some of the limitations of remote learning, the engagement of students in remote learning activities has been determined to a large extent by the home environment and the amount of parental support.

Many children in South Asia live in households in which no adults can offer direct assistance with learning tasks. A recent study found, for example, that, pre-COVID, 37.5 million children – one child in eight – aged 10–17 who had completed six years of education lived in households in which no adult had at least six years of schooling.[147] Moreover, even if many adults or siblings had more education, passing that knowledge on to their young family member might not be a role they were ready for. As distance learning has put more responsibilities on parents and the home environment, the equalizing function of education may have weakened. However, a promising outcome of the lockdowns has been the implication that digital technology can help children, including those in remote areas, by improving the breadth and quality of learning if the technology is supported and used properly (see Box 3.6).

Box 3.6: Promising practices in countries show the potential of mobile phones in learning

While issues remain around the use of mobile technology for education delivery, mobile phones hold great potential for facilitating remote learning in South Asia (UNICEF 2020d). For example, while only 6 per cent of the poorest households in Bangladesh own a television, 92 per cent have a mobile phone. Even in Afghanistan, where internet penetration rates are low, 85 per cent of households in rural areas have mobile phones. The use of mobile phones can enhance one-way forms of remote learning, such as paper-based materials. For example, in Bangladesh, facilitators used mobile phone calls to provide students individualized guidance and support with paper-based materials (Chávez et al. 2021). In India, Pratham used curated text messages or WhatsApp messages and tailored the instructions based on the kinds of phones households owned (i.e., basic phones versus smartphones) to engage with students and parents daily and support continued learning during school closures. This combined use of mobile phones and paper-based materials can increase the reach and richness of remote learning (UNICEF 2020d).

During school closures, teacher strategies and educational content had to be adjusted to support learning through mobile devices: for example, sending assignments and feedback through SMS or social messaging apps and phone calls. Feedback and assessments of learning levels and progress could be generated using these interactive elements even with the most basic devices.

Source: Coursac and Townshend 2022.

[147] On these 'pioneer children', see Alkire, Ul Haq, and Alim (2019).

Learning outcomes are expected to weaken, impairing future earning capacity

Learning losses can be measured in terms of learning-adjusted years of schooling (LAYS), which capture both the quantity and quality of education. Average LAYS for a given country or region are measured as the number of years of schooling a child can expect to obtain by age 18, adjusted by average student learning outcomes. This is measured using standardized test scores that are harmonized to be comparable across countries (Patrinos and Angrist 2018). The framework of Azevedo et al. (2021) is used to measure the losses in learning and in potential earnings of students affected by COVID-19 school closures. This framework assumes that school closures affect LAYS through two components: the expected years of schooling (quantity effect) and the harmonized test scores (quality effect). Both effects are mitigated by the effectiveness of remote learning.

The indirect effect of income shocks also reduces the expected years of schooling. In South Asia, the loss in learning is equivalent to 0.55 LAYS, or 8.6 per cent of the 2020 baseline for LAYS expected by age 18.

In terms of lost earnings, every year of schooling lost is equivalent to 9.7 per cent less in potential earnings. Using the private returns to education at primary and secondary levels for each country with available data, the Asian Development Bank estimates a present value of the total losses at US$1.25 trillion in developing Asia. This is equivalent to 5.4 per cent of the region's gross domestic product (GDP) in 2020 (ADB 2021).[148] For South Asia, the percentage decline in earnings per student per year would be around 4 per cent. This equates to lost future earnings of US$1.0 trillion–US$1.9 trillion. These learning and earning losses are likely even higher given that tertiary students are excluded from this analysis.

Box 3.7: Transforming education: How should systems adapt to the future of learning?

As a first priority for action, countries need to ensure learning recovery "to prevent this generation of students from suffering permanent losses in their learning and future productivity, and to protect their ability to participate fully in society" (World Bank, UNESCO, and UNICEF 2021, 4). Beyond recovery, the crisis revealed the urgent need to rethink and transform education systems to withstand future shocks, better respond to shifting learning and competence requirements, and deliver on the Sustainable Development Goal 4 commitments. Education needs to become more resilient, more equitable, inclusive, relevant, and flexible to deliver learning, skill attainment, and well-being for all.

To deliver on this broad vision, the International Commission on the Futures of Education Report (2021) invited governments and education stakeholders to rethink and reimagine the purpose, content, and delivery of education, with a view to achieving a peaceful, inclusive and sustainable future for all. It aims to respond to the key current challenges of growing social fragmentation, democratic backsliding, the crisis of climate change, and growing exclusion and calls for a new social contract in education to face our common challenges. It identifies five main areas for transformation: pedagogies, curricula, the teaching professions, schools, and the creation of a learning ecosystem. The report can serve as a basis for reflection and debate about what choices should be made in formulating policies. The vision, principles and proposals contained in the report have been discussed and endorsed at the recent 2022 Transforming Education Summit.[149]

There needs to be a reflection on the key competencies that learners need to acquire to live and work in, contribute to, and shape rapidly changing societies and economies. Building on various conceptual frameworks proposed by the United Nations and multilateral organizations (the European Union, OECD, UNICEF, United Nations Educational, Scientific and Cultural Organization, World Bank), these key competencies include the following:

- Proficiency in foundational literacy and numeracy skills and basic digital skills
- Twenty-first century skills, transferable skills and higher order competencies, particularly communication, collaboration, problem-solving, critical thinking

[148] In the optimistic scenario of the effectiveness of remote learning, total losses are equivalent to US$0.8 trillion (3.6 per cent of 2020 GDP). US$1.8 trillion (7.6 per cent of GDP) is the pessimistic scenario of developing Asia.
[149] On the initiative of the United Nations Secretary General, the global Education Summit was part of the 2022 Autumn United Nations General Assembly. See Transforming Education Summit (dashboard), United Nations, New York, https://www.un.org/en/transforming-education-summit.

- Skills for work, including employability, entrepreneurship and information and communication technology skills
- Competency for independent and lifelong learning and skilling
- Competencies to respond to climate change and environmental degradation, promote sustainable development, and engage with the world as creative and responsible global citizens
- Values and attitudes that promote the following:
  - » Resilience and adaptability
  - » Treasuring and sustaining diversity and pluralism
  - » Promoting justice and human dignity.

Source: World Bank, UNESCO, and UNICEF 2021 and https://transformingeducationsummit.sdg4education2030.org/FollowUp

Key takeaways

Written in 2022 and published just a few months after the last major restrictions had been lifted in South Asia, this chapter, like the one preceding it, looks backward. It surveys **the impact thus far of the COVID-19 crisis on the over 600 million children** in the region. This analysis is vital. The fact that adults, especially older people, had proven to be highly vulnerable to the SARS-CoV-2 virus, inevitably diverted attention away from the indirect effects of the pandemic on mothers and children – who normally are at the centre of policy attention when it comes to vulnerability and opportunity. With inflation and the standard of living crisis enwrapping the globe and threatening progress and social recovery it is high time for policymakers to return their focus to children, whose future is at stake. The main findings of the chapter for South Asia are summarized and reflected upon in the next chapter of the report, which focuses on policies, and which is forward-looking.

This chapter concludes with takeaways on data, a crucial enabler of policy adjustment and reform. Here the following three lessons on data stand out as highly relevant for a child-sensitive economic and social policy agenda:

1. **Need for more data for child-sensitive analysis:** The impact of the COVID-19 crisis on young children and adolescent girls and boys was not very clear in 2020, and a serious lack of reliable data on almost every area of child rights and well-being means a child-centred analysis still has to work with many assumptions and gaps in the pieces of evidence. This point is important because it calls attention to the need for a comprehensive rethinking of the way countries conceptualize the key problems, develop measurement tools, collect data and carry out analyses to inform policies. Yet countries such as India are working towards more timely evidence, such as the NAS 2021 on COVID 19 impact on learning.

2. **Key areas urgently requiring more data:** Fresh data from new surveys, administrative registers, and quantitative and qualitative sources cannot arrive quickly enough. The discussion in this chapter suggests prioritizing evidence in the following areas due to their particularly urgent need for evidence-based interventions:
   - » The number of children who have lost their caregivers, their situation, social background and support needs
   - » The number of young children and adolescent girls and boys who are experiencing mental health issues, the type of problems they manifest and experience, and their social background and support needs
   - » The number of children who are not growing to their potential because of insufficient food intake, poor hygiene, and lack of stability in care and support – as well as the deeper underlying causes of these outcomes
   - » The number of children who do not return to schools or cannot make progress in learning, together with information about their individual characteristics, household and community backgrounds, and support needs.

3. **Need for rethinking how data for social indicators and child-focused analysis are being collected and used:** Throughout the tables and figures of the report, the lack of fresh data and the long intermittent period between representative statistical surveys was a major issue hindering the

breadth and robustness of analysis. However, for economic statistics these gaps and long delays do not have the same impact, as they have been bridged by indicators and methods that are part of a coherent system – the System of National Accounts – and the well-established practice of using estimates until the final data series are established (not infrequently, after several years and revisions). These powerful and widely used and accepted estimates – on GDP, on consumer prices, and so forth – are made possible by two enabling conditions: (a) access to and proper use of routine, administrative data (b) an ever-improving understanding of the relationships between different issues and datapoints.
In terms of routine social statistics, this report encountered many gaps. While routine, administrative data production – often on a daily or monthly basis – is widescale practice in the countries of region, the results are rarely made public on an ongoing basis. The reasons for this could be various, and could include incompleteness. However, the practice of keeping data for internal use only not only denies a wider group of stakeholders access to essential information, but it prevents the data from triggering the sort of feedback and recurrent analysis that could be useful to enhance the quality and completeness of the information.

In the absence of new data, the report frequently benefitted from the work of international experts who published (and often revised) their best estimates on key pertinent issues, using statistical models for the region and/or globally. While these models often contradict or do not fully appreciate national data, it would be in the interest of all stakeholders in child rights and resilience-serving social statistics for national ministries and statistical agencies to draw on and build their own "interim" model estimates and including these into the standard national statistical practice.

Modelling therefore should not be left to international agencies or academics only. Concurrent modelling with feedback loops using artificial intelligence, if necessary, and statistical data as they become available could help produce estimates in real time that could be fed into planning and reporting along the public financial management cycle. The experience with modelling impacts of the protracted pandemic offers lessons as well as an opportunity for a comprehensive rethinking of the way countries conceptualize the key problems, develop measurement tools, collect data, and carry out analyses to inform policies for the benefit of young children, adolescents, adult women and men and the elderly, with a particular focus on disadvantaged groups.

A broader debate is due on how disruptions in the lives of children could be countered and opportunities for the next generations promoted and enhanced among the changing and challenging conditions experienced in our world today.

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CHAPTER 4: RESPONDING TODAY FOR TOMORROW

In the years before the pandemic, South Asia had become a global economic powerhouse. The new macroeconomic risks in 2022 – taking the form of inflation, rising pressures on borrowing and debt service, and larger import costs of fuel, fertilizers and other commodities – are constraining growth rates and public budgets. Moreover, they are lowering the standard of living of millions of families who are still grappling with the devastating impacts of the pandemic. With Bangladesh and India back to rapid growth, economic recovery is projected to continue in all South Asian countries except Sri Lanka this year. However, forecasts have mostly been revised downward as countries have begun to apply belt-tightening measures to varying degrees. If the global economic slowdown turns out to be longer and deeper than currently foreseen, then macroeconomic imbalances could worsen further, triggering new rises in poverty, service disruptions and social tensions in an increasing number of countries.

This chapter considers how impacts on children and their families could be mitigated in this context, and how responses to major crises and emergencies could be used as an opportunity for system-strengthening and policy change in South Asia. It looks at how countries are addressing the negative effects of the COVID-19 crisis on children and how positive developments since 2020 could be strengthened further to accelerate economic growth, as well as progress in child rights, gender equity and poverty reduction. The chapter concludes with a set of recommendations for "Responding Today for Tomorrow". These include recommendations on the prioritization of key interventions for children and families in national plans, and on ways to invest most effectively in human capital when resources are constrained and nations are facing macroeconomic, health, nutrition, protection, education and climate-related emergencies layered upon each other.

4.1 Priority areas for child-sensitive economic and social policy

The current threat to macroeconomic stability and families' standard of living is already the third global crisis to reach South Asia in the last fifteen years. Each of these aggregate shocks has impacted the lives of the more than 600 million children in the region, bringing substantial risks along with occasional opportunities. The way governments handled the 2007-2008 food and fuel crisis, the way they have responded to the repeated waves of the COVID-19 pandemic over 2020-2022, and the way they will manage the 2022-2023 inflation shocks, trade and balance of payment risks have far-reaching consequences for everyone, but especially for their youngest residents.

South Asian countries entered the twenty-first century with a number of opportunities for system-strengthening to unleash their full potential for human development. History shows that when nations encounter extraordinary challenges, this can actually be an opportune time to address issues that require sweeping reforms in order to open new pathways to prosperity and human rights.[150] The title of this report refers to the opportunity to respond to crises with forward-thinking, interrelated large-scale systemic reforms and policy initiatives that can accelerate sustainable development in the region. The analysis below presents ten economic and social priority areas that act as important structural determinants and accelerators of progress for children and vulnerable populations, as well as the future of countries across South Asia.

The first priority area is pursuing **fiscal responsibility and prudent government debt management.** Together with sound macroeconomic policies, these are essential for containing the human costs associated with sovereign debt crises and balance of payment problems. As recent developments in Sri Lanka demonstrate, these types of problems can lead to painful economic adjustment periods that push up poverty rates, ruin livelihoods, set back human development, discourage foreign direct investment and place nations at a slower pace of economic growth over the longer term. Moreover, high indebtedness reduces nations' resilience and increases their vulnerability to external shocks. As chapter 1 discusses, the fiscal package that Sri Lanka was able to put together for easing the impact of the liquidity and job crises that stringent COVID lockdowns created was a fraction of that of other South Asian countries with lower stock of debts at

[150] The experience of countries in Europe, North America and Asia shows that comprehensive health, education and social protection systems were typically developed through a few bold steps. Wars, economic crises or natural emergencies had often precipitated these reforms. UNICEF (2021) notes that "countries that have experienced such impetus [for Universal Health Coverage] include New Zealand (1938, following the Great Depression), France (1945), the United Kingdom (1948), Japan (1961, in the aftermath of World War II) and Thailand (2002, following the Asian Financial Crisis). Interestingly, one of the earlier triggers for Sri Lanka's universal free health reforms launched in 1951 was a series of devastating malaria epidemics in the 1930s and 40s."

that point.[151] The country, which in early 2021 was named among the 10 nations that best managed the COVID-19 pandemic,[152] was pressed by its growing balance of payment problem to lure international tourism back to its shores before adequately immunizing its vulnerable populations. This very likely contributed to its soaring infection and high COVID-19 mortality rates during the Delta wave beginning in March 2021 (see Chapter 1).[153]

The second priority area involves pursuing **countercyclical macroeconomic policy.** This entails that in times of economic expansion governments reduce their debts, cut back spending and/or raise taxes, while central banks raise interest rates and reduce liquidity. This reduces the risk of inflation and allows authorities to implement fiscal expansion, stimulate growth, and sustain human development in times of recession or crisis. During the 2007-2008 food, fuel and financing crisis, it was participation in internationally coordinated countercyclical policy by large number of developed and developing countries that helped South Asia to avoid economic recession, increase its trade and post dynamic growth and impressive poverty reduction over the ensuing ten years.[154]

To support countercyclical policy options and enhance the social safety net, the third priority area is **promoting the formalization of employment and expanding social insurance.** The fact that four out of five workers hold informal jobs and do not pay social insurance premiums in the region reduces the extent to which South Asian countries can count on automatic stabilizers in times of macroeconomic problems, and it increases the risk of procyclical fiscal policy (see Chapter 1). The ubiquity of informal work, moreover, enhances the vulnerability of both countries and families to shocks, and reduces funding available for health and social protection. Formal employment and social insurance also hold the potential to mitigate the disproportionate burden of caregiving that tends to fall to women.

Relatedly, the fourth priority area calls for **continuing to improve gender equity in income-earning opportunities.** In the decade before 2020, South Asia continued to narrow gender disparities between female and male life expectancy at birth, expected years of schooling, and estimated earned income. The low gender development Index score of the region in 2019, was due primarily to large differences in education levels among older female and male adults and, despite some progress over the last decade, continuing meagre income-earning possibilities reserved for women.[155] According to the World Bank, gender-based violence, adverse gender norms that limit women's mobility, and unpaid domestic labour norms explain why only 24 per cent of women participate in the paid labour force on average in South Asia (with significant differences among countries) – 56 percentage points below male labour force participation rates.[156] It is likely that uneven access to family support policies that could ease the childcare burden in the region (Waidler et al. 2021) is also an important factor here. Lower incidence of a second wage earner in families with children may partially explain why households with children are estimated to face higher monetary poverty risks than those without children (see Chapter 2).

The fifth priority area requires **securing adequate levels of public revenues.** Low levels of public investment in human capital in South Asia is related to the traditionally low tax ratios over GDP in the region.[157] Over the last decade there has been significant progress in securing higher levels of public revenues, through a combination of rapid growth and tax system reforms. Still, as table 1.4 in chapter 1 shows, tax revenues in Sri Lanka fell to under 10 per cent of the GDP following tax cuts, and Bangladesh taxes only 10 per cent of the GDP. Such low levels of income redistribution weakens sectors that need public spending. It also weakens state capacity to borrow, as the cost of the servicing of public debt needs to be financed from the budget, increasing the risk of a vicious cycle of debt spiral.

To advance human rights as well as future economic growth and resilience, the sixth priority area involves **investing in human capital,** particularly

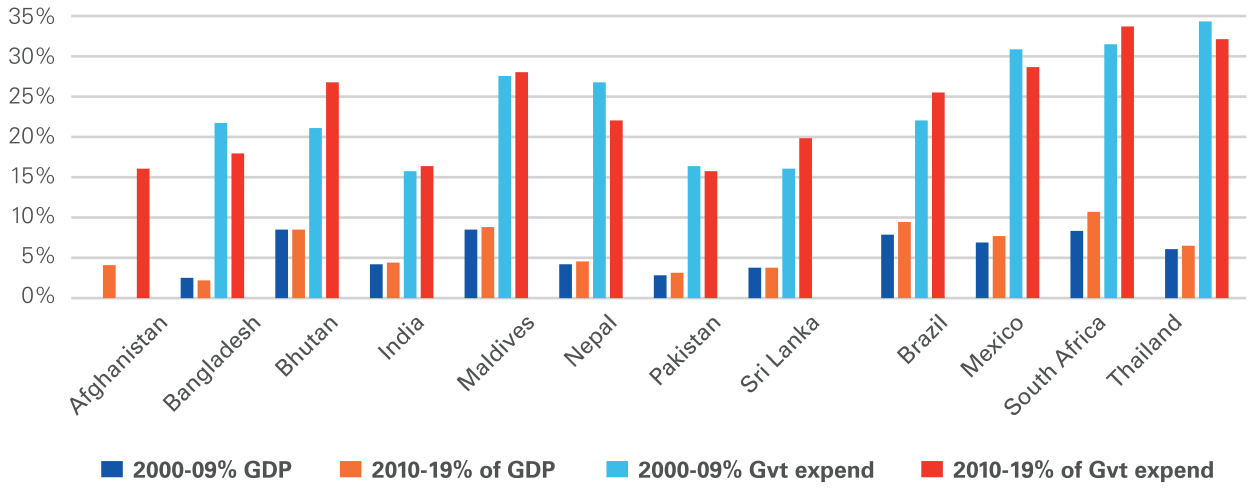
[151] As an IMF working paper notes (Chen et al., 2019), the same happened also during the great recession: countries with macroeconomic imbalances were more exposed to the negative impacts of the crisis.
[152] New Zealand came first on the list of countries which have responded best to the Covid-19 pandemic, Sri Lanka sits ten. The Government Official News Portal- Sri Lanka. See: https://www.news.lk/news/world/item/31494-new-zealand-came-first-on-the-list-of-countries-which-have-responded-best-to-the-covid-19-pandemic-sri-lanka-sits-ten
[153] After keeping borders closed from April to November 2020 Sri Lanka opened to international and regional tourism in December 2020 and kept it open throughput the Delta wave in early-mid 2021. See https://sltda.gov.lk/en/monthly-tourist-arrivals-reports-2021.
[154] Many other parts of the global economy were slow to recover from the ensuing 'great recession' because of accumulated private sector 'subprime' debts and irresponsible lending practices especially on the side of the commercial banks, which were less of an issue in South Asia.
[155] Gender Development Index (GDI). See: https://hdr.undp.org/gender-development-index#/indicies/GDI
[156] World Bank. 'South Asia Economic Focus. Reshaping Norms: A New Way Forward'. Spring 2022. See https://www.worldbank.org/en/events/2020/02/18/south-asia-women-in-the-workforce-week and https://www.worldbank.org/en/region/sar/publication/south-asia-economic-focus.
[157] However, tax ratios do not by themselves explain these low levels of social investment. While tax ratios over the GDP improved in several countries during the decade before COVID-19, the social sectors benefitted relatively little from these additional revenue flows.

through public social expenditures in line with the countries' development objectives.[158] National data and estimates by international agencies both attest that public spending on health, education and social protection is particularly low in the South Asia and rarely conforms with international recommendations. UNICEF's 2021 State of the World's Children showed that, over 2010-2019, average government expenditures on health in the region amounted to 0.9 per cent of the GDP and public spending on education was 3.5 per cent of the GDP. ILO data show that, prior to COVID-19, South Asia spent 1.5 per cent of its GDP on social protection – again, a very low level of commitment. Moreover, within this number, several South Asian countries spent as little as 0.1 per cent of their GDP on social protection programmes where the primary beneficiaries were children (ILO 2021). While spending on social protection has increased since 2020, child-sensitive programmes were mostly left out of this expansion (see Chapter 2). The health sector received extra funding to cope with COVID-19 in 2020, but support to basic education largely remained flat until the 2022/23 school year.[159] As Chapter 2 of this report cites, investment in human capital is crucial for increasing the productivity of labour, countries' competitiveness and long-term economic growth. Box 4.1 adds a comparative perspective to this argument.

Box 4.1: Underinvestment in social sectors in South Asia bodes poorly for human capital

For several decades, the region has been lagging in both spending on education and domestic financing of health, relative to other regions and countries that could be seen as competitors on the global market, such as Brazil, Mexico, South Africa, or Thailand (see Figure B4.1.1). The share of gross domestic product (GDP) going to total education expenditures, and health expenditures from domestic sources, in South Asia was 3.5 percentage points lower on average than among the four countries listed above. The difference between average shares of total government expenditures was 10 percentage points.

Figure B4.1.1: Public health and education expenditures, as percentages of total government expenditures and GDP, 2000–2019



Source: Data of the World Bank https://databank.worldbank.org/source/world-development-indicators

Notes: Health expenditures refer to public expenditures on health from domestic sources. Country averages account for missing data in some years, if any.

[158] Reflecting on the failure of structural adjustment policies of the 1980s in the developing world, it is now widely recognized that the state has a key role to play in development. Even in cases where it is not the best suited to deliver essential health, education and social welfare services, it must have a decisive role in financing these services because they represent a vital public good on which the country's productivity and competitiveness hinges.
[159] The 2022/23 Union Budget of India foresees a 11.6 per cent boost for Department of School Education and Literacy. See https://www.downtoearth.org.in/blog/governance/union-budget-2022-23-more-funds-for-children-s-education-but-what-is-the-priority--81574.

The seventh priority area refers to the **universal access to and adequate quality of basic social services:** addressing gaps in in social protection floors and inequity in access to quality education, health, and child protection services. The WHO and World Bank Universal Health Coverage (UHC) Index shows that at the regional level less than 60 per cent of people across the region had access to a set of essential health interventions pre-COVID, with the UHC Index ranging from 37 (Afghanistan) to 67 per cent (Sri Lanka) in 2019.[160] That year about 30 million children aged 5-14 – nearly one out of 10 – did not attend school (see Chapter 3). Linked to the high prevalence of informal work and the low levels of public investment in human capital, over 400 million people in South Asia did not have access to any form of social protection in 2019. In addition to service exclusion, quality issues have been hindering effective delivery. For example, too many health centres lack emergency obstetric care capacity, basic water, sanitation, hygiene or waste management services. Poor education quality keeps children in learning poverty. Food subsidies, while widespread, have been insufficiently effective at countering wasting and stunting in young children.

As the previous chapters discuss, coverage by cash and food-based social assistance grew rapidly during the initial months of the COVID-19 crisis, with several benefits receiving top-ups. Although some programmes were rolled back in 2021, others were sustained. As social service provisions recover, they are now faced with a double challenge, and often without expanded resources: to remedy gaps created during the lockdowns, while continuing to deliver their regular daily tasks. In this context, the enhanced use of technologies for both registry and delivery systems created during the pandemic can be used to soften the impact of inflation and economic shocks, increase effectiveness, and accelerate recovery.

The eight priority area highlights the importance of harnessing the **benefits of digital innovation with focus on equity,** given the leadership and pyritization of public digital innovation in South Asia. South Asia's investment in digital technology has already shown results in protecting lives and livelihood delivering rapid support to households during the COVID-19 crisis. Indeed, the pandemic has greatly accelerated the use of digital technologies and children and women stand as the greatest potential beneficiaries of this trend. Moreover, the digitalization of technology helps "greening the economy" and increase resilience. It can build and protect human capital through improved service delivery, job creation and empower through inclusion and trust (WB 2021). Yet the digital divide, if left unaddressed, risks intensifying inequalities among children and between men and women. Gaps in cybersecurity adds further risks.

The ninth priority area involves ***addressing uneven development and exposure to global economic shocks.*** Inequities in human development among different states or provinces within national boundaries, as well as between urban centres and rural areas, or better-off urban areas and slums, have been major factors in vulnerability to COVID-19 (see Chapter 1). The pandemic has also highlighted vulnerabilities related to migration for work and substandard urban development. The former is linked to the widespread informality of jobs; the latter is closely related to risks from environmental degradation and climate change (Ellis and Roberts, 2016). Spatial concentration of poverty could best be addressed by geographical targeting of transfers and other income support, investment in human capital as well as in infrastructure. Regional and urban development require close collaboration or coordinated action between the state, the private sector and development banks. Foreign direct investment can help to address subnational disparities in development – e.g., by investing in energy and transport sectors – but it tends to flow to skill-intensive sectors in better-off areas (Mahmood et al. 2021). Typically, central governments need to play an important role through redistributing public revenues from richer to poorer areas through intergovernmental transfers – a tool that could also be used for improving subnational government performance and accountability in the social sectors (ADB, 2020). Increased trade and economic integration between the nations of South Asia could yield powerful results, and here development banks and agencies for region-wide collaboration (such as SAARC) can play an important role.[161]

The tenth priority area refers to opportunities for **addressing environmental degradation and climate change.** The incidence of environmental and climate-related shocks in South Asia is one

[160] Coverage of essential health services (SDG 3.8.1): WHO, The Global Health Observatory. See: https://www.who.int/data/gho/data/themes/topics/service-coverage
[161] World Bank: OneSouthAsia. See for example, https://www.worldbank.org/en/programs/south-asia-regional-integration/overview.

of the highest globally (UNICEF 2021e). Priority actions here could include reducing emissions and other forms of pollution, improving sanitation and waste management, and collaborating decisively in international efforts to address climate change and transition to green growth including through harnessing the benefits of digitalizing the homes and the workplaces. Despite COVID-19 lockdowns, pollution continued to rise in 2020 in the region, including in India, Pakistan, Bangladesh, and Nepal – four of the top five most polluted countries in the world.[162] Life expectancy at birth in these countries would be between 3.8 years (in Pakistan) and 6.9 years (in Bangladesh) higher on average if pollution concentrations complied with the WHO guideline (see Table B.4.2.1 in Box 4.2 and Greenstone, Hasenkopf and Lee, 2022). While the region saw an outstanding progress, whereby the proportion

Box 4.2: Impacts of pollution and climate change on children

2022 will be remembered as a challenging year, with extreme temperatures and long heatwaves taking lives, worsening crop yields, and hindering education in much of the region. In addition, large floods in Bangladesh and Pakistan, and tropical cyclones in India, will have negative impacts on poverty reduction, agricultural output and public health.

It is increasingly recognized that human activities, especially greenhouse emissions, are responsible for a significant proportion of climate change. An increase of 1.5 degrees Celsius in the average global temperature is already having consequences in terms of extreme weather events with drastic impacts on lives and livelihoods, ecosystems and economies. Consequently, reducing emissions is a major international objective. As Table B4.2.1 demonstrates, children in South Asia are particularly impacted, partly because of the frequency of environmental shocks and partly because of their vulnerability as measured by a combination of health, nutrition, water and sanitation and education indicators.

Table B4.2.1: The Children's Climate Risk Index in seven South Asian countries, 2021

Country	Riverine floods	Coastal floods	Tropical cyclones	Heat waves	Climate and environmental shocks	Child vulnerability	Children's Climate Risk Index	Rank
Afghanistan	6.8	0.0	0.0	7.3	7.3	7.9	7.6	15
Bangladesh	10.0	10.0	5.5	8.0	9.1	5.1	7.6	15
Bhutan	3.6	0.0	0.0	7.3	4.3	3.3	3.8	111
India	9.5	9.3	5.0	7.8	9.0	4.6	7.4	26
Nepal	8.0	0.0	0.0	7.4	7.5	4.2	6.1	51
Pakistan	10.0	7.2	2.2	8.9	8.7	6.4	7.7	14
Sri Lanka	7.7	0.0	1.3	7.9	7.0	3.3	5.4	61

Source: UNICEF 2021e: Children's Climate Change Risk Index (CCRI). August, 2021. https://www.unicef.org/media/105376/file/UNICEF-climate-crisis-child-rights-crisis.pdf

Notes: The CCRI has two components with equal weights: severity of expected climate shocks and children's vulnerability to impact. Both types of risks are rated along a range between 0 and 10. Darker colours in the columns indicate greater risk. Global rank is also shown, with higher-ranked countries having greater risk; the bolded values highlight the three countries in the region with particularly high children's climate risk globally, out of those studied. Maldives is not included in the source dataset.

[162] Greenstone, Hasenkopf and Lee, 2022.
See https://aqli.epic.uchicago.edu/wp-content/uploads/2022/06/AQLI_2022_Report-Global.pdf.

It may be less well recognized that air pollution – particulate matter (PM) emission – is also a silent health emergency in itself. Inhaling small particulates from the air on a regular basis reduces life expectancy through increasing the risk of cancer and cardiovascular diseases. While the reduction in overall economic production and urban traffic in 2020 is well documented, satellite-derived PM2.5 data showed that in South Asia, the world's most polluted region, air pollution actually rose during the first year of the pandemic (Greenstone, Hasenkopf and Lee, 2022).[160] Table B4.2.2 shows the estimated impact of air pollution by calculating the years gained in life expectancy at birth if WHO or national air quality standards were maintained.

Table B4.2.2: The impact of air pollution on life expectancy at birth

	Life expectancy gains (in years) from reducing pollution to:	
	WHO standard (5 µg/m³)	National standard (varies)
Afghanistan	1.1	0.6
Bangladesh	6.9	6.0
Bhutan	2.3	-
India	5.0	1.6
Maldives	0.8	-
Nepal	4.1	-
Pakistan	3.8	2.9
Sri Lanka	1.3	0.0
Total	4.9	-

Source: Greenstone, Hasenkopf and Lee, 2022.

of people practicing open defecation fell from 65 percent to 34 percent between 1990 and 2014, over 600 million people in South Asia still practiced open defecation at the end of that period (over 60 per cent of the global burden; see UNICEF 2015). Relatedly, human development in the region is also undermined by recurrent malaria, dengue, cholera, and other environment-related disease outbreaks. Models developed by the Intergovernmental Panel on Climate Change (IPCC) predict that the increasing frequency of extreme weather events will continue. If climate risks are not effectively addressed by the international community, rising sea levels could, over the longer term, submerge the Maldives completely and lead to the destruction of coastal megacities and agricultural land throughout the region, with a disproportionate effect on low-lying Bangladesh (ICPP 2022).[163] Box 4.2 discusses climate and environmental risks for the region's 600 million children.

Principled action on these ten pillars of child-sensitive economic and social policy is essential for resilience to upcoming challenges, as well as for renewing progress toward the 2030 Sustainable Development Goals and beyond. However, as the COVID-19 crisis has demonstrated, there are also other factors that matter in crisis response, such as governance (for example, government capacity to make essential but at times unpopular decisions, and public trust and collaboration in implementing these decisions). Moreover, both the COVID-19 crisis and the current macroeconomic and cost-of-living crisis create specific problems that need to be addressed.

[163] Climate Change 2022: Impacts, Adaptation and Vulnerability. See: https://www.ipcc.ch/report/ar6/wg2/.

4.2 Mitigating the effects of the pandemic and cost-of living crisis through principled action for children

Principled action for children means action that safeguards and promotes child rights. It also means addressing the underlying structural causes of the pressing problems children are facing today by improving the capacity of institutions and systems to withstand shocks and accelerate sustainable development for all.[164] This section looks at how the current cost-of-living crisis and economic adjustment policies may impact children and their families in South Asia, and what solutions countries may be able to implement in response. As with the pandemic, this will depend on how long disequilibrium in the world markets – commodity price inflation, higher interest rates, and bottlenecks in global supply chains – will continue. Because these are the results of many different factors – such as the spike in money supply in the United States, Russia's war on Ukraine, the energy crisis in Europe, extreme weather events in a large number of countries, Omicron-related repeated lockdowns in China, as well as the still ongoing COVID-19 pandemic – solutions will not come overnight. Countries differ in terms of exposure to and depth of these impacts. However, as the COVID-19 crisis has **shown, strong policy responses make a difference.**

There is a risk that countries will consider the current disruptions in peace, global trade and collaboration temporary, and will not respond with the scale and determination of their initial COVID-19 responses, but instead rely on more superficial measures. Temporary fixes, such as administrative price caps on energy, may prove more costly and less efficient in the long run than accelerating systemic reforms. They may also leave public budgets with limited funding for essential health, education and other social services, and may not involve optimally socially and environmentally responsible strategies.

There is a second, related risk as well: that the current macroeconomic problems will crowd out the political attention and fiscal space that are urgently needed to address the damage done by the pandemic to the physical, cognitive and emotional development of young children and adolescents. Delays in social recovery could therefore further undermine child rights, as well as long-term prosperity, by making this damage to the cognitive and other human capital of young people permanent. This would have far-reaching implications for hundreds of millions of children, as well as for countries' future labour productivity and development trajectory.

The section first discusses policy responses to the higher cost-of-living and pending macroeconomic adjustments (in certain cases related to possible debt reconciliation). Albeit due to different immediate and underlying causes, the policy implications here closely relate to adjustments in the social protection system during the COVID-19 crisis. The analysis also considers broader responses that run on economic and institutional tracks. The section then recaps current and systematic challenges to population health, child and maternal nutrition and education the COVID-19 crisis has highlighted and exacerbated. These too require urgent and decisive responses – especially in the face of the rapidly shrinking fiscal space as well as the new standard-of-living challenges that children and their families are facing.

Responding to the current cost-of-living crisis through systemic reforms

In South Asia, as chapter 1 of this report mentions, some countries had already accumulated considerable sovereign debt before COVID-19 hit

[164] As noted earlier, the urgency of responding to shocks should not mean applying ad-hoc solutions. The latter may be necessary as a temporary solution until better policies with less collateral damage are not available.

the region. Moreover, debt has increased further in most countries over 2020-2021. This does not necessarily imply weak fiscal responsibility or poor debt management.[165] However, now that the cost of servicing debt is increasing rapidly, as are the costs of imported food, fuel, fertilizers and other commodities, high public debt is a considerable drag on the economy and a potential source of balance of payment problems. Indeed, IMF data show that in 2021 all South Asian countries posted a negative current account balance (i.e., what they received from exports and remittances sent home was worth less than what they had to pay for imports and for servicing their debt).[166] Moreover, IMF projections prepared in the first quarter of 2022 suggest significant worsening in current account balances across the region this year (IMF 2022).

Prior underinvestment in the key pillars of child-sensitive economic and social policy mentioned above has made it harder for the current administrations to respond effectively to COVID-19 and to navigate the latest global pressures, as the previous section discusses.

Principled responses to external shocks can address these structural causes of vulnerability – as exemplified in the benefit top-ups and/or expanded coverage of social assistance undertaken by governments in response to COVID-19 (see Chapter 2). In times of shocks and economic adjustment, authorities need to identify individuals and households who will be significantly affected, and/or are the most vulnerable to impact, and provide meaningful support – preferably before adjustment measures hit.

On a technical level, this will be easier to implement in 2022 than it was in 2020, thanks to the significantly expansion and digitalization of social registries during the pandemic (see Chapter 2).[167] On a political level, however, there will be pressure on governments to expand protection against inflation to producers and the general public through price caps and subsidies, e.g., reducing the price of fuel and/or food at the point of sale, rather than targeting support to those vulnerable populations who will benefit most from getting it. Because space for fiscal expansion in 2022 and 2023 will be more limited than it was in early 2020 (due to increased commitments and cost of public debt service over the last two years), ballooning subsidies will easily crowd out funds that should be used instead for human capital investment. The Hackman curve (see Figure 2.1) suggests that assistance to pregnant women and families raising young children will have the highest returns in terms of health, nutrition, cognitive and non-cognitive human capital, later earnings and tax contributions. Children who without extra support will be excluded from education due to poverty, gender, caste, ethnicity or disability should also be prioritized. Workers and their families facing catastrophic health expenditures require access to social protection to avoid falling into poverty overnight. Children and parents whose mental health has been affected by the pandemic need support and services, which may never arrive without public assistance.

Available evidence suggests that countries in South Asia have thus far been applying a mix of generic and targeted support, as well as temporary policies and more systemic measures, as response to risks from inflation and slower economic growth. Understandably, emphasis has been put on strengthening food-based interventions, which have been a longstanding mainstay in the region. India has responded to food and fuel inflation by cutting excise duties and providing subsidies for those buying fuel and fertilizers (ADB, 2022). The federal government has also decided to keep the country's large free-food distribution system (reaching over half of the population) at the higher rations introduced during the COVID-19 crisis. In Pakistan, the new Ehsaas Targeted Commodity Subsidy program plans to reach over half of the population with a monthly subsidy: a discount capped at Rs.1,000 per family is given on the purchase of flour, lentils, and ghee or cooking oil from designated grocery stores starting this calendar year. Eligible households are identified through the Ehsaas National Socioeconomic Registry (NSER) survey completed in November 2021 (Gentilini et al. 2022). In Maldives, the government has also reprioritized public expenditures towards food and fuel through subsidies (ADB 2022).

The current global crisis in food, fuel and fertilizer prices is therefore creating pressure to maintain the core pillars of the existing system. It is clear,

[165] In good times, such as the 2010s in South Asia, governments often engage in major infrastructural investments, such as transport, communication, water and energy to create public goods that help future progress. In hard times, such as during the pandemic, it is often smart policy to increase liquidity and public expenditures to prevent profitable enterprises or children and needy families from falling victim to shocks.
[166] Technically speaking, a negative current account means that the sum of net income from abroad, net current transfers, and the balance of trade is negative. This needs to be balanced out by a surplus in the country's capital account (net sovereign debt plus net foreign direct investment).
[167] Existing social registries in the region place large emphasis on establishing the income-consumption levels of households i.e., information that helps poverty targeting. However, this does not necessarily entail the exclusive use of registries for poverty targeting: registries also collect information on household/family type (demographic structure) or geographic characteristics that help categorical targeting.

for example, that providing entitlements via food distribution offers beneficiaries protection from higher food prices (which burdens the public budget instead). However, because in most countries both food aid and cash assistance are used, inflation is distorting the existing social assistance systems as the higher cost of keeping in-kind entitlements in place is combined with the lower value of nominally unchanged cash benefits.

This tendency could penalize families with children, as child-related entitlements are often established in cash while generic poverty support programmes often use food aid. Unless entitlements in cash (such as the child grant in Nepal, the cash element of the Mother and Child Benefit Programme in Bangladesh, the Pradhan Mantri Matru Vandana Yojana in India, or the Ehsaas Nashonuma in Pakistan – see chapter 2) are adjusted regularly for inflation projections, beneficiaries will suffer a loss in the purchasing power of their benefits.

Still, the bigger issue is the fact that a comparatively very small proportion of families raising children receive child-related cash or in-kind aid, such as child grants or family support benefits – while their income tends to lag behind those without children (see Chapter 2). As the COVID-19 crisis has highlighted, children who lose one or both parents were not getting adequate support from the existing social protection systems unless governments introduced new, COVID-specific support programmes (see Box 4.3).

Box 4.3: The rise in orphanhood during the COVID-19 crisis highlighted the need for social protection systems to focus on vulnerability related to lifecycle risks

The pandemic highlighted a gap in welfare provision in South Asia: inadequate support for children affected by the death of parents and other primary caregivers. Following the large COVID-19 wave in the spring of 2021, India responded by establishing an orphan programme, PM Cares, for children who lost both parents or their primary caregivers to COVID-19.[168] As of early June 2022, 4,345 children, somewhat fewer than half of all applicants, had received entitlement for financial support, boarding and lodging support, rehabilitation, access to health insurance, assistance for primary and secondary education and education loans for higher education.[169] In Pakistan, the government of the Sindh province decided on 27 April 2021 to pay Rs1 million as compensation to families of employees who died of COVID-19. The compensation is also applicable to the contractual employees of the Sindh government.

While these new support programmes help, the majority of the nearly 30 million children across the region who had lost one both parents before COVID-19 (or unrelated to a COVID-19 infection; see chapter 3) tend to have access only to local, often poverty-targeted schemes or assistance from relatives and charities. This raises the issue of horizontal equity: treating child citizens facing similar issues the same way. It also highlights the plight of a highly vulnerable group of children. Orphans and semi-orphans are probably overrepresented among those who drop out of school, have learning difficulties, do not have access to proper nutrition or have a significant risk of becoming a low-income adult, except for those who can count on unfailing support from their relatives or family friends. These children may be particularly vulnerable to aggregate shocks as they likely do not have access to the same level of support that other children do. Social protection systems that follow a lifecycle approach to risk recognise and respond to the special vulnerability of these groups of children.

[168] Other major determinants include hygiene and sanitation (preventing frequent episodes of diarrhoea, as well as emotional stimulation that loving parents and carers deliver. See https://www.unicef.org/documents/conceptual-framework-nutrition.
[169] See PM CARES for Children (dashboard), Ministry of Women and Child Development, New Delhi, https://pmcaresforchildren.in/.

If countries continue to reserve only 0.1 per cent (or less) of the GDP in their general government budgets for child-related social protection, then it is inevitable that, for example, nutrition-sensitive programmes will have very limited power to address the high prevalence of stunting, at a third of children aged 0-4 in the region even before COVID-19 and high food inflation. Likewise, conditional cash programmes will have limited power to reverse school dropout, which affected nearly one out of ten school-aged children in the decade before COVID-19.

Calculations in a recent UNICEF publication show that offering a meaningful child benefit to all families with pregnant women and children under age 2 would cost around 0.2 per cent of national GDPs. This could fend off the effect of food inflation on young families' household budgets, and create further positive spillover effects (UNICEF, 2021f). It could also reduce stress, and give mothers and young children expanded food choice. Indeed, broader population coverage of such programmes could go a long way towards removing the income disadvantage of young families that is characteristic of the region (see Chapter 2).[170]

Structural changes within existing social assistance systems, such as devoting a larger share of benefits to young mothers and to supporting early child development, could significantly enhance the efficacy of social protection. They could protect a crucial proportion of vulnerable populations, promote the development of human capital, and enhance long-term economic growth. However, this type of reform would require continued support from general tax revenues, as does the current system. Furthermore, it could help only marginally with idiosyncratic income and expenditure shocks (e.g., when sickness in the family triggers catastrophic health expenditures, or when breadwinners are lost).

Countries may therefore want to consider action along a parallel track: increasing the share of formal employment in which income earners and their employers pay social insurance contributions. This would increase wage costs but free up general budget revenues for social assistance. As the COVID-19 crisis has demonstrated, the security of formal employment makes a substantial difference in times of aggregate shocks. It is also important for protecting employees and their families from idiosyncratic shocks and challenges such as losing a job, falling ill, establishing a family, or transitioning to retirement. Expanding formal employment would support countercyclical macroeconomic policy through automatic stabilizers (via unemployment benefits) and smooth income over the lifecycle (through entitlements for children and the elderly).

The current supply-chain pressures on world markets linked to strict COVID-19 policies in China and the general price increases in international trade create a favourable context for this kind of reform in South Asia. Social insurance premiums increase wage costs, entailing risks of losing markets, especially external ones. However, as international supply chains may increasingly appreciate a politically stable, resilient business environment, this risk may be limited for South Asia at present. Enforcing a compulsory social insurance premium on wages in areas where informality in jobs is widespread could also be pursued gradually: introduced first in countries, states, sectors and professions where the post-lockdown recovery in employment is strong.

Moreover, enforcing insurance premiums on wages could be accompanied by active labour market policies to sustain incentives for employers to hire women and young workers, who have been comparatively left behind by the post-lockdown labour market recovery (ILO 2022). Because informal employment tends to be especially widespread among young people, the combined effects of active labour market policies and promoting formalization would particularly help with employment and wage stability as well as access to health insurance for women and young families.

Policies to promote employment including self-employment (e.g., through simplified administration, registration, tax policies that are easier to follow, facilitating access to credit for small and microentrepreneurs (e.g., as done by the MUDRA Bank in India), could usefully escort and complement a drive towards more widescale formal employment in the economy.

[170] The authors of the UNICEF Working Paper (Stephen Kidd, Diloá Athias and Anh Tran) propose that this type of universal benefit for those under the age 2 then be expanded in every year by one more year until age 17 is reached. They note that "each year governments would be required to invest only a small additional budget, which could be easily found. [...] Once all children up to the age of 17 years are included, the annual budgets will begin to fall due to a combination of the proportion of children in the population shrinking and economic growth." Having all children covered by a child benefit would, indeed, provide governments with a powerful tool for crisis and emergency response with no need for cumbersome income-targeting processes, as children should have the right to social security. Furthermore, this benefit should pay for itself over the long term through the strengthened human capital of the next generation, and their consequent higher income earned and taxes paid over the life cycle.

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Addressing malnutrition among women and children is an urgent multisectoral priority

The overlapping crises of the COVID-19 pandemic since 2020 and the cost-of-living crisis in 2022 are both expected to have a major impact on malnutrition among women and children in South Asia – where over a third of the global child malnutrition cases were recorded even before these two crises.

In 2020, an estimated 54 million children under 5 suffered from chronic malnutrition (stunting) in the region (see Chapter 3). 25 million children had acute malnutrition (wasting), with a third of these children showing signs of severe wasting, a life-threatening condition. Modelling calculations by independent experts suggest that an additional 800,000 young children will experience stunting and 6.2 million will suffer from wasting over the first three years since the pandemic began (Osendarp et al. 2021). However, these numbers are likely to be higher still due to the rapidly rising food and energy prices that post-dated these calculations. The affordability of quality food is a major determinant of these nutrition outcomes; hence the current cost-of-living crisis is a serious additional concern.

In this context, the nutrition sector would benefit especially from a major upgrading of gender- and child-sensitive social protection and active labour market policies as above. Moreover, success in containing the rise of chronic malnutrition and pushing back wasting prevalence would have windfall effects. Poor nutrition in the early years, as well as during the school years, significantly lowers the likelihood of school completion, decreases earning and productive capacity in adulthood, and has been implicated in the intergenerational transmission of poverty (Manjula 2021; Smith and Haddad 2015).

Access to quality supplementary food among pregnant women should be of particular concern in countries undergoing high inflation and experiencing food and medicine shortages (such as Sri Lanka in 2022) because there is a real risk that undernutrition, including anæmia, will rapidly increase. This would have an effect on low birthweight, stunting and wasting in early childhood with spillover effects to health, including mental health.

Inflation is harder on families with children, due to their lower average household income and higher proportion of consumption expenditures spent on food (see Chapter 2). As noted, the cash component of social assistance programmes for children and pregnant women tends to be more exposed now to inflation than aid in-kind; in countries where local prices vary greatly, cash benefits can quickly lose their value unless they are adjusted regularly. Accordingly, the local prices of nutritious food items and the quality of diets should be monitored: the recent initiative of Ashoka University in India – a daily food price index to track inflation in retail and wholesale food markets in real time – shows how monitoring could be done (PTI 2022a). Strengthening nutrition surveillance and systematic analysis to identify hotspots within countries that are more vulnerable to impacts in food security, poverty and nutrition can help designing preventative programmes and interventions.

Inflation also puts extra burden on public expenditures that offer nutrition services and supports. In countries with significant malnutrition, high-impact nutrition interventions across the life cycle are needed, with a special focus on improving nutrition for children, adolescents, and pregnant women. However, higher food costs will put pressure on budgets for supplementary nutrition programmes and for food benefits in kind, such as subsidized grains and school lunches.

When preventive actions fail, it is essential that negative outcomes, such as maternal anæmia or severe wasting among children, are detected and treated early. However, the current capacities of relevant programmes in the region often require strengthening: for example, through closing the gaps between health screening, nutrition assessment and support for pregnant women, and improving collaboration at the local level among health and social workers, or between civil society representatives and authorities.

Regarding the prevalence of nutritional deprivation among different social groups, it is widely assumed that children living in extreme poverty and those experiencing chronic malnutrition belong to the same households. This is true to a large extent, but not entirely. Poor anthropometric outcomes among children are frequent in South Asia even among those with income-consumption levels above the national poverty lines. In terms of the prevalence of maternal and child malnutrition, the COVID-19 crisis has been expected to hit urban poor households and migrant labourers harder, with rural households benefitting from the exemption of agricultural production from lockdowns, but the cost-of-living crisis may change this picture (see Chapter 3).

Addressing health risks through better prevention and the universal health coverage agenda

In September 2019, only a few months before the first cases of COVID-19 were recorded in China, world leaders endorsed the most ambitious and comprehensive political declaration on health in history, with two key objectives: (1) progressive expansion

of health services to cover 1 billion additional people, with a view to covering all people by 2030, and (2) to reverse the rise of catastrophic out-of-pocket health expenditures and eliminate impoverishment due to health-related expenses by 2030 (UN UHC 2022). The two objectives are closely related because universal health coverage means that "all people can access quality essential health services, without having to suffer financial hardship to pay for health care."[171] Globally, close to 100 million people are pushed into extreme poverty each year because of catastrophic health expenses, according to the World Bank.[172]

Box 4.4: The Kathmandu Call to Action: Strategies to accelerate progress towards universal health coverage in South Asia

High-level representatives of governments, civil society, the private sector and international agencies gathered virtually in Kathmandu on 14 December 2021 as part of the "High-Level Roundtable on Accelerating Progress towards Universal Health Coverage in South Asia in the context of COVID-19". Reinforcing their commitment towards universal health coverage in the region, participants suggested these strategies to accelerate progress:

- Promoting and reinforcing policies and legislation to remove financial barriers to access to services, including early access to and utilization of maternal and child health services, and mechanisms to remove out-of-pocket expenditures on health care.
- Promoting and adopting Health in All policies, strategies, and approaches to engage beyond the health sector and to leverage resources from all sectors to address determinants of health such as poor housing and sanitation, air pollution, poor diet, physical inactivity, lack of education, and so on.
- Adopting and using at scale modern e-health information and communication technologies to increase access, utilization and coverage, rapid knowledge dissemination and sharing that contribute to strengthening health information systems, including digital health information on high-risk populations.
- Implementing policy actions and mechanisms for the recruitment, training, efficient and adequate deployment and distribution, motivation, and the support of a health workforce, including community health workers, with the aim of improving population access, and addressing inequalities related to geography, gender, age, educational level, and income.
- Strengthening community systems with a focus on community health worker programmes, local governance and the effective participation of communities and civil society in establishing governance, accountability, and transparency mechanisms and the delivery of health promotion, preventive, curative, and rehabilitation services.

Source: UNICEF Regional Office for South Asia.

[171] See 'Going Universal: How Countries Are Implementing Pro-Poor Universal Health Coverage Reforms', World Bank, Washington, DC, https://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series.
[172] The overarching goal of the SDGs – ending extreme poverty – will remain out of reach without universal health coverage as long as 800 million people spend more than 10 percent of their household budgets on health care. See 'Going Universal: How Countries Are Implementing Pro-Poor Universal Health Coverage Reforms', World Bank, Washington, DC, https://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series.

Although global public spending on health care increased over 2020–2021, its utilization was absorbed by the COVID-19 response. Consequently, progress in health coverage towards the 2023 and 2030 milestones is not on track (UN UHC 2022). As Box 4.4 describes, political commitment in South Asia remains strong. However, the reduced pace of economic growth, inflation, new pressures on public coffers, and the need to keep public health capacity on alert to respond to any eventual additional wave of the pandemic make it difficult to advance universal health coverage in the way that was envisioned less than three years ago.

Principled action along the tenets of child-friendly economic and social policy could help in this context. Addressing financial barriers for patients – payment for services and medicines, as well as indirect expenses such as transportation and opportunity costs while seeking care – is essential for universal health care in South Asia (see Box 4.4).

Decisive action on promoting the formalization of employment and expanding social insurance would help with social recovery. It would also mobilize revenues channelling significant new funding into the health system allowing progress on the supply side, including more doctors and other health personnel, as well as equipment and infrastructure. On the demand side, having health insurance would help with the direct costs and lessen the threat of a catastrophic cost event. Having more development expenditures in the public budget would eventually also reduce the indirect cost of service uptake for users through improved accessibility, shorter queues, and lower transportation costs.[173] As noted earlier, broader coverage of social insurance could also free up resources for subsidized health care as a social assistance mechanism for those who do not have health insurance.

Boosting general revenues – e.g., through "sugar tax" and other taxes on unhealthy products, or introducing carbon tax in polluting industries, could strengthen prevention as well as add more financing for health care through general tax revenues. When new variants of COVID-19 arrive, or should a different epidemic hit the region, these measures would make a large difference: over 2020-2021 countries and geographic areas with more developed social sector infrastructure have posted better case fatality rates than less developed ones (see Chapter 1).

Further child-sensitive economic and social policy priority areas could also be involved in the universal health care agenda. Fiscal responsibility, sound macroeconomic management and countercyclical policy measures help to ensure that essential import goods such as medicine keep arriving, and that the population is not exposed to hyperinflation and aggregate poverty shocks. Action on the environment would help with some major environmental determinants of health, such as sanitation and air quality. Reducing emissions would drastically reduce the prevalence of chronic circulatory and respiratory problems as well as cancer – key public health issues as well as comorbidity factors in COVID-19 mortality – and help to slow climate change. As noted earlier, action here would help to prevent conditions and infections that are major killers of young children and their parents in the region, reducing orphanhood.

Increasing public expenditures on health, especially on primary health care, would deliver important efficiency gains through prevention, health awareness and access to basic services. This is also the area where urgent steps are needed in the post-lockdown period. First, while mortality risks to COVID-19 are significantly reduced for vaccinated people, the morbidity burden associated with COVID-19 is still significant. Mild COVID-19 cases are expected to continue causing missed days of school and work. In addition, the debilitating effects of infection among a significant minority of COVID-19 survivors ("long COVID") is an increasingly important public health issue and contributing factor to the overall disease burden. It shows significant gender- and age-related differentials, with the greatest effect among young girls (Smith, 2022). This suggests the importance of better understanding and addressing the implications of COVID-19 for child and adult health.

Second, improving mental health and resilience should be a major part of the development and crisis recovery agenda. The COVID-19 lockdowns, together with the pandemic-induced rise in monetary poverty that disproportionately affected households raising children, have had substantial impacts on the mental health of parents, caregivers and an entire generation of children and young people (see Chapters 1 and

[173] Accordingly, progress would reverberate in a number of priority areas: adequate levels of public revenues, investing in human capital, universal access and adequate quality of basic social services. Progress in addressing uneven development would also be accelerated especially if revenues were to go a central budget and get reallocated to disadvantaged areas and groups so that further barriers to service uptake (such as lack of information, health awareness, actual or presumed discrimination etc.) could also be addressed.

2). Projections suggest that the prevalence of anxiety disorders and major depressive disorders may have increased by 35 per cent and 36 per cent, respectively, because of the pandemic (see Chapter 3). Providing mental health and psychosocial support is also an important part of the learning recovery in schools. Indeed, many mental health conditions can be effectively treated at relatively low cost. Still, effective treatment coverage remains extremely low across South Asia (Patel et al. 2016).

Addressing children's mental health requires multisectoral approaches (see Box 4.5) much the way action on nutrition does. It is essential in this context that the universal health coverage agenda fully embrace mental health in the wake of the COVID-19 crisis. This entails making specialised mental health service a major priority area for investment. It also requires mainstreaming mental health into all primary health interventions, with arrangements for monitoring and referral, including in the area of maternal and child health services. Mental health should be integrated into all levels of health care. Community health workers and social care workers, as well as teachers, should receive training in recognizing early symptoms of depression and anxiety in children, young mothers and parents, and community health centres should provide professional mental health care to children and their families.

While the larger prevalence of anxiety and major depressive disorders is of serious concern, there is now also a window opportunity to put a spotlight on the issue as awareness on mental health among the general population is high, and the stressful events in 2020-2022 may help to remove the stigma that has been a major barrier to action. Countries could seize the opportunity provided by post-lockdown awareness of the issue and develop national action plans for promoting prevention in mental health and delivering comprehensive and integrated services in community-based settings. These could take inspiration from the WHO Comprehensive Mental Health Action Plan 2013–2030.

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Box 4.5: Addressing mental health is a multisectoral agenda

Strengthening the mental health of children and adolescents is hugely important in the current context. Following the COVID-19 lockdowns and school closures in response to the pandemic, the prevalence of mental health problems has risen among children globally, including in South Asia (see Chapter 3). Although Russia's current war in Ukraine is geographically far from South Asia, some of its stressful economic effects are very tangibly present in the daily life of families here.

Leadership in promoting mental health means creating and sustaining a supportive legal, sociocultural, and financial environment for mental health among the population. It requires evidence and support from a range of public policies and programmes, as well as intersectoral coordination. Countries and communities need to collect information that enables timely action focused on minimizing risks and strengthening protection. Evaluations can help identify appropriate interventions and stimulate support from a broad range of stakeholders in child development.

Throughout childhood, from the antenatal stage through late adolescence, nurturing and supportive parenting is one of the most important protections of mental health. Interventions that promote early childhood development, nurturing care and responsive caregiving are crucial. Evidence shows that such interventions have great preventative capacity among boys and girls, often accompanied by curative impacts that ease the symptoms of depression among young mothers. (UNICEF 2021d)

Relevant positive experiences in South Asia include a care for child development project in Sindh Province, Pakistan, whereby female community health workers offered mothers with newborns training in responsive stimulation.[174] In some cases, nutrition interventions were also provided. An evaluation carried out after the two-year implementation period of the project found positive impacts on child development as well as on the incidence of maternal depression. A follow-up randomized impact evaluation among children at age 4 confirmed that the positive effects were sustained in the quality of maternal care and on cognitive, language, motor and socioemotional skills, including executive functioning among children, which is crucial indicator of school readiness (Yousafzai et al. 2016).

A recent systematic review of the literature found little evidence that interventions that were exclusive to the educational setting and narrowly focused on preventing anxiety and depression among children and young people ages 4–18 were effective (Caldwell et al. 2019). Whole-school preventative interventions that consider the wider household and community context in which interventions are implemented and which are delivered by mental health professionals rather than teachers hold greater promise. In Bihar, India, a large-scale, whole-school, multicomponent mental health promotion programme has been found to be effective in creating a positive school atmosphere that promotes strong, nurturing relationships between teachers and students and fosters a sense of belonging. The result was lower rates of depression, bullying and violence (Shinde et al. 2017, 2018, 2021).

However, in terms of prevention and to have a significant impact on mental health, it is not necessary that interventions include specific mental health components. Livelihood-strengthening programmes among ultra-poor households can benefit mental health as well. The results of randomized controlled trials of BRAC's graduation model programme in six countries, that is aimed at overcoming poverty traps arising because of limited assets and life skills, confirm that the mental health effect of the programme is positive and significant, even years after the interventions concluded (Banerjee et al. 2015).[175]

[174] Care for child development interventions encourage caregivers to use household items or homemade toys to stimulate a child's motor, social, cognitive and language skills, effectively using play to strengthen parenting.
[175] Likewise, it could be inferred that adolescent health initiatives providing sexual and reproductive health support could lessen stress and anxiety among girls as well as boys. Social protection interventions with a gender equity focus or nutrition interventions targeting young children and mothers could also have positive impacts on mental health, as could retraining programmes among young people who are not in education or employment.

Finally, maternal and child health remains a crucially important area in its own right, as well as in light of the continued risks around maternal and child nutrition in South Asia discussed previously. Although South Asian countries have made great strides in reducing maternal and neonatal mortality rates over the last two decades, the current levels are still of concern. Every year, over 800,000 newborn deaths (35 per cent of global total) are registered in the region and there are an estimated 615,000 stillbirths (UNICEF221d). Maternal mortality rates also vary significantly within the region. While Sri Lanka and Maldives had 36 and 57 maternity-related deaths respectively per 100,000 live births, the regional average was 163 (close to those in the larger countries of the region), and Afghanistan had 638 cases per 100,000 live births pre-COVID-19 (UNICEF 2021d). Risks are the highest for mothers and babies born in rural and tribal villages far from access to essential care; emergency settings; adolescent and child mothers; poor mothers; those with little or no education; malnourished mothers; and most significantly for underweight and sick newborns.

More resources will also be needed for maternal and child health within primary health care due to demographic trends: the number of women entering reproductive age will rise further in the coming years, increasing demand on primary health care, even if fertility rates continue to fall.

Moreover, experience suggests that maternal mortality rates often shoot up during emergencies, crisis and service disruptions: as noted earlier, the COVID-19 pandemic has been associated with a 15-per-cent projected rise in what has been widely considered an improving, but still unacceptably high, level of perinatal and maternal mortality risk in the region. Rising food and fuel prices may make it harder for families to bear the direct and indirect costs associated with pregnancy, as well as child delivery in health facilities, which is a major policy goal in the region.

As the pandemic has demonstrated, immunization is often life-saving – and it is an incredibly efficient intervention in terms of economic returns. Immunization, as a key component of the primary health care programmatic platform in the current context, notably requires delivering shots to children who missed their regular immunizations due to the pandemic. As with the learning crisis, efforts to address pandemic-related gaps in regular immunization schedules should focus on delivering vaccinations to hard-to-reach urban and rural "zero-dose" child populations: the 3 million infants and young children in South Asia who have never had any immunization.[176] This too will necessitate extra efforts and resources. However, improved outreach on immunization will create a platform that can also be used for delivering essential and emergency nutrition interventions and other services for pregnant women and young children. For older children and adolescents, school enrolment can provide an important cross-sectoral platform for delivering essential nutrition and youth health services (including, among others, facilitating continued immunizations against COVID-19).

Efforts to deliver primary health services better and more efficiently could get an important boost from accelerated digitalization – one of the silver linings of the pandemic. A digitalized health system uses digital tools, registries and platforms, such as a common data repository, to collect, store and retrieve all health information that doctors, and health workers need. For example, in Bangladesh, a system under advanced development will replace fragmented data systems with an integrated system of health records for pregnant women and under-5 children, utilizing a health identifier code linked to national ID cards. This enables improved efficiency and service delivery – both in person and through telemedicine – and it makes the administration of health services more transparent and accountable.[177] Because digital health systems could include information on the nutritional status of mothers and children as well as geographical information, they could also help with intersectoral coordination and outreach – for example, enabling better targeting of nutrition-specific and nutrition-sensitive social sector programmes.

Addressing the learning crisis and transforming education

The COVID-19 pandemic and related school closures (see Chapter 1) have precipitated the largest education crisis in history, and students of primary school age are at particular risk. According to a major report, learning poverty – the inability to read and understand a simple text by age 10 – may

[176] https://www.unicef.org/rosa/press-releases/covid-19-reversals-childhood-vaccinations-south-asia-undo-years-progress-new-who. See also https://www.vaccinestoday.eu/stories/zero-dose-children-almost-14-million-get-no-vaccines/.
[177] See https://sdgs.un.org/partnerships/digitalization-health.

reach 70 per cent globally, up from 57 per cent pre-pandemic, because of the long school closures and the ineffectiveness of remote learning in ensuring full learning continuity (World Bank et al. 2022).[178] In South Asia, the report predicts that 78 per cent of 10-year-olds currently lack minimum literacy proficiency, up from nearly 60 per cent before the pandemic. Schoolchildren in the region had lost almost 700 billion hours of in-person learning by the end of February 2022 because of COVID-19 restrictions.[179] Representative surveys carried out in the region in 2021 show an even larger negative effect on student progress than what had been projected earlier and, as expected, a disproportionate impact among disadvantaged children (see Chapter 3). Dropouts and lack of enrolment and attendance that already affected nearly 30 million children before COVID-19 are expected to rise further (see Chapter 3).
Responding to this crisis offers also an opportunity for transforming education for the future of learning. To accelerate progress toward the SDG 4 targets, all components of the education system will require adjustment, according to the recent Bangkok Statement [180] (see Chapter 3) and the Transforming Education Summit in New York. To address the root causes of learning deficits in South Asia and improve the quality and relevance of education, curricula will need to be redesigned to provide learners with foundational, digital, twenty-first century and socioemotional competencies. The tasks ahead in enhancing the quality and relevance of education and fostering equity, inclusion, and gender equality include nurturing a highly skilled generation of teachers, digital transformation, and upgrading planning, school governance and monitoring. Better investment in education is the most important enabling factor.

Because strong foundations are the cornerstone of any learning trajectory, it is recommended that governments and stakeholders in South Asia prioritize pre-primary education for increased investment and reach the universal completion of primary education, with foundational literacy and numeracy. To facilitate mother-tongue learning in the early years and strengthen data systems to detect, register and target support for the most marginalized, governments and stakeholders should complete a wide array of system-level transformations to promote inclusion, equity and gender equality.

In secondary education, strengthening equitable access to learning requires the development of a more modular approach to foster greater flexibility, including online or self-study courses, allowing students to complete secondary school at their own pace, and to validate their learning and skills acquisition through equivalence and certification processes. For adolescents and youth, skill development in general, programme content, and pedagogies in secondary education or vocational training should be allowed to adjust to the needs of the labour market, taking into account rapidly evolving technologies, scientific innovations and the digital and green transition of economies. It should aim at providing a wide array of competencies, such as life and employability skills, creativity, digital literacy and entrepreneurship.

Because school connectivity and digital transformation will be gradual, plans will also need to include the provision of good-quality, contextualized and flexible low-technology and no-technology solutions to reach those who are not yet connected. To avoid the pitfall of the commercialization of online education through the unregulated engagement of private sector for-profit education technology companies in the online space, regulations and safeguards need to be developed to guarantee that online education and learning technologies remain a public good, free and accessible to all learners, and with data privacy protection.[181]

Governments need to capacitate and empower teachers, revise teaching standards and

[178] The report suggests that the generation of students impacted by COVID-19 risks losing US$21 trillion in potential lifetime earnings at present value, or the equivalent of 17 per cent of today's global gross domestic product (GDP), up from the US$17 trillion estimated in 2021 (World Bank et al. 2022).
[179] Education: From School Closure to Recovery (dashboard), COVID-19 Recovery, United Nations Educational, Scientific and Cultural Organization, Paris, https://www.unesco.org/en/covid-19/education-response.
[180] "Education and its systems must be transformed to become resilient and prepared for future shocks, address inequalities and the learning crisis, and contribute to peaceful, inclusive, and sustainable futures of humanity and the planet. Such transformation requires a holistic system reform that entails the review and strengthening of its interlinked components across policy, planning, financing, and implementation through consultative and participatory processes..." (UNESCO 2022, 2).
[181] Developing public and public-private partnerships to provide free, inclusive and equitable access to online education and open education resources can be explored. But, to avoid the fragmentation of actors and lack of standards, it is crucial to develop coherent and costed policies and regulations for the integration of technology in education that are aligned with education sector plans and broader national information and communication technology policies.

competency frameworks, improve teacher selection processes, establish and enforce high quality standards for public and private institutions, and enhance related legal and accountability structures. Making these changes will take time and require additional resources. However, it will also make learning more rewarding, the teaching profession more attractive, and the education system as whole more efficient and effective in contributing to the human capital and labour productivity of countries.

These reform objectives should also inform current efforts to address drops in enrolments and losses in learning during the COVID-19 lockdowns. Experts have formulated the RAPID framework for establishing a learning recovery program, comprising five key actions (UNESCO, UNICEF, and World Bank 2022):

- Reaching every child and retaining them in school
- Assessing current learning levels
- Prioritizing fundamentals
- Increasing catch-up learning
- Developing psychosocial health and well-being.

Progress in these five areas is essential for an education recovery that is centred on children's rights to education and equalizing learning opportunities. Box 4.6 focuses on the first step: addressing non-attendance and dropout – a risk that is currently heightened by the cost-of-living crisis and related family coping strategies.

Box 4.6: Strategies for reaching every child and retaining them in school

All countries in the region have a national education management system, which shows the number of students enrolled by sex and grade. Because these data are based on compulsory reporting by public and private schools, every municipality and district will have information on the number of children who returned to school.[182] Understanding the barriers faced by those who have not returned is more difficult, but crucially important. District and provincial education authorities and local governments need to check their files, conduct outreach visits among vulnerable households, collect information (for example, though qualitative surveys and focus group discussions) to understand the issues families face and how local resources might be used most efficiently to bring children back to school and keep them there.

Reaching previously out-of-school children and those who do not appear in any school registry is equally important. Conducting new out-of-school surveys and potentially using innovative ways to identify, register and enrol children in the nearest school, as well as linking them to other social-sector benefits to increase the likelihood of sustaining school attendance, should therefore be an immediate priority in reaching and retaining all children. For example, the state of Gujarat in India, with technical support from UNICEF, is piloting a drive to identify and enrol out-of-school children using a phone application. This is a promising initiative considering that, even among poor households, a majority of people in the state own mobile phones and can thus be easily contacted after registration to maintain continuity in multisector support. In addition, the out-of-school survey identification and registration process would also serve to detect out-of-school children who have dropped out and migrated, given that these children would be missed using only an education management information system or a local effort to reach them based on previous enrolment location.

Many of the barriers to access appear at the household level and are associated with child labour, monetary poverty, and the direct and

[182] Many private schools did not survive the pandemic, and family coping moved a large number of children to public schools (see Chapter 3). Accordingly, a careful examination of these administrative reports is warranted for completeness and reliability.

indirect costs of attending school. Evidence from Bangladesh shows that the Primary Education Stipend Programme, a conditional cash transfer, has been effective in countering such impacts (Yunus and Shahana 2018). This joins a large pool of cash transfer programmes that rigorous impact evaluations find are effective in stimulating school enrolment and attendance.[183]

Barriers may also manifest through discrimination or exclusion on the basis of gender, orphan or minority status, or disability.[184] In India, the Samagra Shiksha scheme – an integrated approach to education from preschool to upper secondary level – provides central government support to inclusive education with a strong focus on equity, teacher training and the digital capacities of schools.[185]

Individual- and group-level barriers in given education environments often interact with household- or community-level factors, such as safety or distance to school. In a recent survey in Afghanistan, 28 per cent of households reported that there is no school in the area or that the local school is too far; this share was more than twice the share of the households that reported that they needed their sons to work instead of attending school (ICCT 2022). In contexts like these, community schools can be a cost-effective solution, as can other efforts to provide safe passage to school, from busses to bicycles to community-escorted walks.

Other school-level barriers, such as lack of adequate water, sanitation, and hygiene, actual or perceived lack of teacher quality, thin staff presence, or missing learning materials and teaching aids, can also have a negative effect on enrolment, attendance and learning. Examples of ways to address these challenges include training personnel in traditional schools how to fix broken water pipes so they may become custodians of water, as in Bhutan; supporting menstrual hygiene management by delivering products through marginalized schools, as in Sri Lanka; strengthening good-quality early childhood education by investing in professional development among staff at all vertical levels (local, district and state), as in India; and building the capacity of teachers with regular high-quality professional development training in remote learning and digital skills, as in Maldives (UNICEF 2020, 2021b, 2022a).

Strong national-level education drives and national- or state-level social protection initiatives, such as relaunching school midday meal programmes, as India did in April 2022, may be pivotal in bringing children back to school and keeping them there. However, re-entry to schools and the re-enrolment of children should be a multi-stakeholder effort with the involvement of local and central governments, civil society, volunteers, and business partners. Scouts in Bhutan, school-based youth champion clubs that engage with out-of-school youth in Pakistan, and children participating in the development of COVID-19 response plans in Nepal are examples of what children and young people can do if their participation is encouraged (UNICEF 2022a). Recognizing that challenges may be specific to local contexts, central authorities may want to secure more autonomy for schools through school grants that enable schools to find their own solutions to issues that affect learning quality and retention among students.

[183] See García-Jaramillo and Miranti (2015) for a global review. For a conditional cash transfer programme in Turkey, see Ring et al. (2020).
[184] In developed countries, data science and machine learning have led to an explosion in the development of technology-enabled solutions, helping boost the popularity of personalized learning. There is some evidence that these solutions enhance learning outcomes, especially in closing the education gap affecting lower-achievement students. See UNICEF (2022c).
[185] See Samagra Shiksha (dashboard), Department of School Education and Literacy, Ministry of Education, New Delhi, https://samagra.education.gov.in/.

Once children are back in school, the assessment of their learning is important on two levels. First, education authorities need reliable information on learning losses over the last two years to design policies and launch remedial strategies to address gaps. The extent of learning losses may diverge in rural and urban areas or among different parts of a country, perhaps reflecting differences in access to remote learning or the way lockdowns were implemented. For this reason, India organized and recently completed a large, nationally representative learning assessment survey, the National Achievement Survey 2021, on the nationwide curricula and requirements, but offered the states the option of designing their own learning recovery programmes.[186]

Second, diagnostic assessment is also needed at the individual level, as schools and teachers must determine where there are gaps in competencies. In Central and Uva provinces in Sri Lanka, for example, education authorities organized a learning recovery programme immediately after the end of the first lockdown, in August 2020, to minimize learning losses and provide remedial education. Later, when schools were closed again, activities and corresponding formative assessments to gauge student progress were undertaken at home by parents or caregivers until the schools reopened in late 2021 (UNICEF 2021a).

The practice of the near-automatic transition of students to the next grade may have been a factor in the unsatisfactory progress in student learning performance pre-COVID, but it was likely more a symptom than a cause, and giving up the practice in the post-lockdown recovery context does not seem to be a good idea. Toxic stress associated with academic performance is a major contributor to mental health issues in adolescence (UNICEF 2021d), and adding pressure to catch up or be kept back could intensify this effect.

A strategy to promote learning recovery through better curricula, emphasizing the essential ingredients of quality education, and addressing all dimensions of need among disadvantaged students, with contributions from all stakeholders, appears more viable.[187] It also resonates better with the principles of child-friendly schools that centres on education quality through inclusion, trust and encouragement, which are essential if all children are to achieve their full potential (UNICEF 2009).

4.3. Conclusions and Recommendations

The evidence summarized in this report shows that the COVID-19 pandemic hit South Asia in a time when the region had posted some of the highest growth rates globally, and social indicators were, for the most part, improving year after year. It is therefore particularly distressing that the COVID-19 crisis and related lockdowns between early 2020 and early 2022 have had such a harmful effect on the wellbeing and rights of children in the region.

Some of these effects were indirect and emerged from the fact that, by and large, it was impossible to protect the lives of 1.86 billion people from the devastating effect of the greatest pandemic of the last 100 years without putting a brake on the human-contact-intensive parts of the economy, including retail trade, tourism, transport, manufacturing, construction and so on. Children were affected through parents and family members not being able to go to work, getting reduced pay, or losing their jobs and wages altogether. The most drastic impacts of lockdowns on employment, wages and poverty were relatively short-lived and, in most cases, the economy had started to show signs of recovery in late 2020, before the terrible Delta wave of the virus. However, reverse migration from urban to rural areas, economising on food and other necessities, using up savings, arranging early marriages, taking children out of school and other household coping strategies amid the pandemic-related shocks inevitably led to often-dramatic, lasting changes in the lives of hundreds of millions of families and children.

The new macroeconomic shocks reaching the region in 2022 are also bringing potentially large and devastating indirect effects. However, unlike the lockdowns that collapsed demand for labour overnight, this time household real incomes and public budgets are being slowly but increasingly undermined. The crisis works through monetary effects: raising the prices of food, fuel and other commodities as well as premiums on lending, with little hope for a quick turnaround. This is bad news for countries that are net food and energy importers or that need to service large debts. It is also bad news for millions of low-income rural families, most of whom are net food purchasers rather than net producers, and for urban households with limited labour opportunities, whose energy and transport bills will increase.
While there is little hard evidence yet on the expected

[186] Comparing the results of the 2017 and 2021 National Achievement Surveys confirms that there was pandemic-related deterioration in learning (Gohain 2022). See also UNICEF (2022b).
[187] UNESCO, UNICEF, and World Bank (2022) highlights various strategies to enhance classroom instruction, including targeted instruction, self-guided learning programmes and small group tutoring. These strategies should be tailored by country

impact of this cost-of-living crisis on children, initial reports from Sri Lanka suggest that economic adjustment can particularly be painful for children and their families. There, formerly distant macroeconomic threats have turned into a dire daily reality of empty pharmacies, child nutrition programmes on hiatus, and workers not receiving pay adjustment amidst hyperinflation. The financial vulnerability of young families and children is implicated in fact that households with children were estimated to have a higher risk of finding themselves in monetary poverty in all eight countries of South Asia even pre-COVID, that most women in most countries still have meagre opportunities to find paid employment, and that they as well as younger workers are having now a worse chance of benefitting from ongoing labour market recovery.

Although the immediate causes behind the impacts of the current macroeconomic shocks and the preceding COVID-19 crisis are different, this report identifies a number of underlying and structural issues that present opportunities in the region for enhancing resilience to external shocks and ushering renewed progress, especially for the youngest generation. This chapter has called these the ten priority areas for child-sensitive economic and social policy. The most centrally important of these is the need for countries to invest better in human capital in the early years of life, when this investment is the most crucially important and brings the largest individual and social return, and sustain support through childhood and adolescence. Considering that labour productivity – the key to sustained poverty reduction and economic growth – is still low in most parts of South Asia, countries should not allow repeated external shocks to damage this critical asset: the right of children to develop to their full potential. Sustaining children's rights in difficult times serves not only them, but the future of their country.

The first recommendation of this report, therefore, focuses on addressing the indirect effects of crises on children through the ten priority areas. It posits crises as opportunities for achieving paradigmatic shifts to expand the capacity of economic and social policies to address the structural reasons underlying the economic vulnerability of households with children.

1. **When responding to crises and aggregate shocks through economic and social policies, consider opportunities for strengthening and safeguarding investment in the human capital, and especially the cognitive capital of children, particularly in the early years.** Governments should investigate potential avenues for facilitating this through:

    a. Pursuing fiscal responsibility and prudent debt management;
    b. Implementing countercyclical macroeconomic policy; and
    c. Ensuring adequate levels of public revenues.

Observing these principles may require that countries consolidate debt, announce fiscal or monetary policy measures that hold back public spending in real terms and/or put constraints on household consumption. In such cases, 'ex-ante' econometric modelling, such as cost and benefit calculations, should ensure that the resulting policy package protects vulnerable populations and healthy child development. Cost savings on the expenditure side could also find support from evidence, especially evaluations. Social sector proposals that give clear priority to interventions that give the best value for money always have a better chance of success in the public financial management process. Identifying what works and where priorities should fall in the public budget, and how budget execution could be kept true to the spirit of good governance requires excellence in transparency and reporting, data and analysis.

Policies should also seek ways for public investment to crowd in private investment, and counter negative household coping strategies. Emerging evidence suggests that such effects were considerable during the COVID-19 crisis, and they had a particularly negative impact on the rights of girls, young women and mothers. Further priority areas could help in this context; especially:

    d. Pursuing universal access to, and adequate quality of, basic social services;
    e. Investing in human capital, particularly through public social expenditures in line with the countries' development objectives.
    f. Reallocating public revenues and engaging in multi-partner collaboration to address uneven development; and
    g. Combatting climate change and environmental pollution.
    h. Harnessing the benefits of digital innovation and directing them towards disadvantaged youths.

Principled action on these areas would yield significantly better social and physical environments for healthy child development, but will need significant funding to scale properly. The fact that most countries in the region post significant (Bhutan, Nepal, Maldives) or very strong (Bangladesh, India) economic growth rates despite headwinds implies continued growth in public revenues. However, on the expenditure side, fiscal space will be limited by higher costs of servicing public debt due partly to the trend of rising interest rates and, in the case of sovereign debt, the depreciation of national currencies.

Countries where external debt levels reach high proportions of either the GDP, the value of exports, or tax capacity may want to return to countercyclical policies, reducing debt levels. This could absorb a large part of public revenues in times when domestic producers, social sectors and households will demand higher subsidies and better protection against inflationary tendencies. In this context the reform steps that are needed notably include:

i. Formalizing employment and expanding social insurance; and
j. Promoting the paid employment of women.

These two actions – which are also related to each other, because it is in paid, formal employment that women face the largest labour-related disadvantage – could act as critical accelerators for poverty reduction and economic and social progress in South Asia. Separately and together, they would yield a significant rise in public revenue GDP ratios, increasing funds for social protection and health care. They would also reduce effective demand – and free up resources – for social assistance: an area for which the pandemic and the current cost-of-living crisis has necessitated significant new funds and enhanced response. Actions here would help to expand gender-transformative family support policies, and underpin countercyclical and sound macroeconomic policy frameworks. Governments should also investigate how the digitalization and new work patterns that the COVID-19 crisis has brought forward could help with this agenda.

Principled action on these ten priority areas of child-sensitive economic and social policy, discussed earlier, would help stability and progress. However, without help from actions on sectoral policy areas, this would not guarantee addressing the **direct effects of the COVID-19 crisis** on children and on the carers, institutions and systems that support them. All aggregate crises have such effects. However, these debilitating impacts were unusually large and devastating for children due to the direct impact of the pandemic on their parents and carers, and through the repeated lockdowns and service disruptions.

Because these effects preceded the current economic environment, this report sees a risk that the urgency of addressing them will be overshadowed by political and economic pressure to focus attention on macroeconomic imbalances and the rising costs of living today. This risk is real – and particularly urgent because in most cases the effects of COVID-19 crisis on children brought to the surface areas where policies and systems had been struggling when COVID-19 appeared. As the report discusses, the impacts thus far are estimated to include:

- A significant rise in the number of children orphaned. Even by conservative estimates, at least 300,000 children lost one or both parents to COVID-19-related causes over the 24 months between March 2020 and February 2022 – in addition to an estimated 3.2 million children who lose a parent biannually due to all-cause related mortality in the region. Estimates by independent researchers put these numbers even higher.

- An estimated additional 7.5-8 million children with serious mental health conditions. Major depressive disorders among children may have increased by nearly 6 million cases, pushing prevalence up to 22.4 million children in South Asia. The prevalence of anxiety disorders among children could be even higher, reaching 25.2 million cases, with 6.6 million estimated additional cases due to pandemic-related impacts; many of these children may also experience major depressive disorders.

- Deterioration in nutrition outcomes among children and pregnant women. General equilibrium models suggested that between 5.3 and 9.3 million more young children will have experienced acute malnutrition in the three-year period following the first lockdowns and COVID-19-related disruptions in health and nutrition services. These impacts are of serious concern, especially when considering that even before the pandemic 25 million children under 5 – one out of seven – experienced wasting in South Asia.

- A serious learning crisis among students in South Asia. Learning poverty – defined as 10-year-olds who cannot read or understand a simple text – may now be as high as 78 per cent in the region. Previous estimates had this number at 60 per cent in 2019; now, learning poverty is estimated to have increased dramatically.

Millions of children may have joined those who were out of school in South Asia at the beginning of the COVID-19 crisis. Most preschools were also closed for most of the two-year period beginning in 2020. Combined with the impact of the pandemic on nutrition and mental health, the development of

the cognitive and non-cognitive skills of at least 200 million children under the age of 15 is likely to be showing serious gaps across the region. Action is urgent, as these scars could become permanent if left unaddressed, affecting an entire generation. The situation is especially pressing for those vulnerable children whose families and communities are under pressure by the current cost-of-living crisis.

Therefore, the second major recommendation of this report is as follows:

2. Recognize the need for child recovery from the compounding effects of the COVID-19 crisis and the current cost-of-living threats, and accelerate systemic reforms in the social sectors.

This entails establishing clear priorities in public budgets and national and sectoral plans so that health, education, social protection and child protection systems can respond to setbacks and accelerate progress through systemic reforms.

In the area of child-sensitive **social protection**, this could mean:

a. Adopting social protection floors that build on a preventative lifecycle approach to risks for children and adults and benefits from social insurance, as well as assistance enabling stronger responses to idiosyncratic and aggregate risks;
b. Integrating such floors with shock-responsive systems using digital registries;
c. Scaling up decisive support for the first 1,000 days of life, including maternal and child health as well as nutrition;
d. Enhancing support to orphans and other especially vulnerable children in a coherent fashion; and
e. Reviewing and adjusting cash and non-cash support regularly and when economic adjustment policies require.

In the area of health and nutrition, this would entail:

f. Accelerating universal health coverage as per the Kathmandu statement and expanding health insurance as well as assistance;
g. Strengthening mental health within the universal health coverage agenda and in health resource allocations;
h. Prioritizing funding to primary health care, especially neonatal and maternal health;
i. Using joint platforms for immunization, maternal and child health and nutrition programmes;
j. Improving intersectoral collaboration around nutrition-specific and nutrition-sensitive programmes, with special attention to maternal nutrition during pregnancy and lactation;
k. Improving capacity to monitor acute malnutrition and respond with life-saving interventions; and
l. Taking advantage of digital health approaches and expanding comprehensive data and service support systems to nutrition monitoring and response.

In the area of education, this would mean:

m. Addressing the learning crisis through the implementation of education reforms as per the Bangkok Statement, emphasising the need for curriculum reforms, teacher training and student support;
n. Reaching out to children not in school, and addressing barriers through understanding better why children are out of school;
o. Placing a particular focus on early childhood education and mental health as accelerators;
p. Developing remote/digital education further and enhancing the resilience of the education system to aggregate shocks;
q. Utilizing the capacity of social protection to support school attendance and learning; and
r. Making sectoral plans based on interventions with evaluative evidence on what works and at what cost: prioritizing cost-effectiveness alongside equity.

Progress and reforms in all of these areas would entail better access to evidence and enhanced national capacity to use evidence for policy development and adjustment. For this reason, the third and final recommendation of this report is as follows:

3. Found national development agendas, systemic reforms, action plans, social sector monitoring and comprehensive situation analyses on updated and improved evidence. Enhancing funding to social statistics should enable representative surveys, censuses, and administrative data management information systems implemented more effectively, at greater frequency and using innovative methods. As the analysis in this report has demonstrated, evidence-based policymaking has greatly helped crisis response during the pandemic, and it remains the key to improving outcomes across South Asia going forward.

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APPENDICES

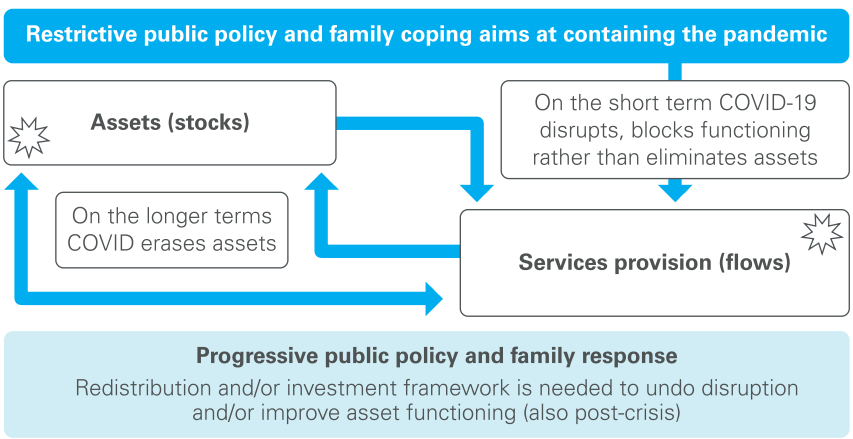
Appendix A: A framework for the human development impact of the COVID-19 crisis

The novel coronavirus has created an impact scenario that is different from the corresponding scenarios involved in financial and economic crises or natural disasters by switching first- and second-order effects and enlarging the scope of the crisis. Disasters are local. They demolish homes, schools, and roads, which are assets. Financial and economic crises are typically regional, and they have collateral impacts in other regions. Both also tend to create stress and take human lives. However, they do not represent a universal threat. COVID-19 has threatened lives and human development everywhere. The resulting lockdowns and physical distancing led to widescale disruptions in production, trade, and medical and education services, while leaving relatively intact the assets that were meant to deliver these functions and services. Life was supposed to continue later, and assets were to be put back to use as before once the threat of COVID-19 receded.

Figure A.1 shows the assets that are needed for the economy and people to thrive and the associated services they deliver in normal times. As the figure illustrates, the longer disruptions in service provision continue (because of restrictive public policy and the concerns of households to use services as long as the virus is a threat), the greater the chance that unused or underutilized assets are damaged, lose value, or disappear. Governments recognized the dangers in keeping productive assets stalled and sought ways to reduce scarring even at the cost of redistributing the impact to the most highly affected employers and workers elsewhere.

The scars in the cultivation of human capital – which takes place primarily in childhood and adolescence – will become evident chiefly over the longer term when the COVID generation re-enters school and the labour force. Nonetheless, they are important. The short- and longer-term impact of service disruption chiefly on these types of assets thus needs to be highlighted, especially on basic social services, such as health care, education and social protection, which are crucial for the cultivation of human capital. At the same time, it is useful to broaden the attention to other types of assets involved in the cultivation of human capital, such as parental educational attainment, knowledge and awareness, and societal norms, that can temporarily and partially reduce the scarring effect on child development and human capital if the operation of basic social services is blocked, but which – similar to physical assets – require maintenance and reinvestment.

Figure A.1: COVID-19 impacts on assets and related services



Assets is used here in a broad sense, denoting all stock-type indicators, such as the following:

- Health of adults and children, including the capacity to fight off disease and deprivation and the capacity to benefit from education
- Acquired immunity to viruses
- Survival, health and education of the mother, parents or caregivers of the child
- Income-earning capacity of household members
- Housing and the physical environment (for instance, clean air, water and sanitation facilities)
- Friends, peers, social capital and social cohesion among family members and the community
- Social sector entitlement and capacity to deliver (health centres, health personnel, schools and teachers, social protection and social care personnel, and so on)
- Social norms, laws, culture, and habits
- Knowledge and awareness
- Partnerships
- Recognition, branding
- Infrastructure, financial and production assets, and so on

Likewise, services is used here in a broad sense, denoting development, care, nutrition, health intervention, education, employment, safety, and the love and protection parents and caregivers deliver through assets to young children and teenagers. Production, revenues, income and other yields are also services within this framework.

Time and space matter to the direct effects of COVID-19 on population health as well as to the indirect effects of the pandemic. These latter are manifested in disruptions in services, production, and life in general. The longer the virus circulates unobstructed across continents and within countries, the bigger the share of the people infected will be. New variants will be created, and more lives will be lost. As Figure A.1 illustrates, the longer the disruptions in service provision continue, the greater the chance that unused or underutilized assets will be damaged or become otherwise unusable.

This is true not only of economic assets, but also of human assets. Skills and mental and physical health weaken; human capital dissipates. Service providers close; teachers change profession; doctors retire. Family links and friendships wither away. Solidarity and trust in government and science or even people's trust in their own capacity to respond are undermined. Reintegrating in the system children who have dropped out of school is much more difficult and costly than keeping children in school who are already there. The more protracted the COVID-19 crisis, the more the assets will be scarred on which child development and, hence, the future of nations hinge.

Progressive public policies and strong societal responses should focus on rebuilding and protecting these assets. They are the building blocks of social recovery and the foundation of child health and development. Unlike sudden disruptions in service provision, which are more easily tracked and reversed, the slow depreciation of a broad array of assets affecting child health and development may remain hidden for a long time, but may have impacts that are felt for decades in population health, in school achievement, and in economic production. To prevent long-term scarring, the first step is to understand and measure these impacts so that policies can respond, programs be developed and financed, and implementation be monitored and sustained with the participation and contribution of stakeholders.

Appendix B: Childhood deprivations undermine cognitive capital and future productivity

Sustainable, long-term economic growth in South Asia hinges on labour productivity, as Chapter 1 notes. Investing in cognitive capital is particularly important in this context.[a] Cognitive capital drives the most rapidly growing sectors of the modern economy and develops optimally in boys and girls who benefit from good nutrition, stimulation and a supportive and secure family and social environment. Investing in cognitive capital requires focus on early childhood development and child- and gender-sensitive social protection across the life cycle. Scientific research repeatedly highlights the positive feedback loops among brain development, the health and education of mothers, and children's evolving cognitive, emotional, and social capacities (Huebner et al. 2016).

As Nobel Laureate James Heckman demonstrates, the rates of return on investments in human capital decline with age: a dollar spent during the prenatal and early childhood years gives, on average, between 7 per cent and 10 per cent greater yields than investments made at older ages (Carneiro and Heckman 2003). Feedback loops also work in the reverse direction. Brain research shows that genes provide no more than an initial blueprint for building brain architecture, and environmental influences determine how the neural circuitry actually gets wired (Shonkoff 2011; Victora et al. 2008). Adverse conditions for development during fœtal growth and the first two years of life can lead to suboptimal development and alterations to a child's brain that have implications for learning, behaviour and health across the lifespan.[b]

What does a young child's brain need from his or her environment to grow to its potential? There is a vast amount of evidence on the importance of sufficient, healthy and nutritious food intake, especially during the first 1000 days of life when the body gives strong priority to brain development. However, apart from getting the proper nutrients adequate for age, the body should also be able to keep them. Food safety, clean water and good sanitation are therefore also essential. Finally, the child's body should be able to use nutrients optimally for building the brain (UNICEF 2014). Stimulation and feeling safe, loved and protected greatly help this process. Breastfeeding epitomizes the holistic interaction between these three key dimensions of need: securing optimal nutrients, hygienic environments, and intensive personal interaction.

Besides nutrients and proper health conditions, children therefore need safe, stable, and nurturing relationships as well as psychosocial stimulation for their brain development and evolving cognitive capacity. In a randomized controlled trial involving disadvantaged Jamaican children, those who received psychosocial stimulation and nutrition supplements up to the age of 2 years scored higher on intelligence quotient tests by the age of 6 years than did a control group receiving only nutrition supplements. Those who received only stimulation did somewhat less well, but strikingly still better than the group treated only with nutrition supplements (Walker et al. 2010; World Bank 2015).

Exposure to prolonged periods of stress, on the other hand, prevents the brain from fully benefiting from stimulating or enriching educational experiences. It also has the potential to impair the part of the brain that is responsible for self-regulatory skills and hence essential for success in school and adulthood. Toxic psychosocial stress – generated by physical and emotional abuse, chronic neglect, and family violence – is increasingly considered highly disruptive for the brain architecture, the development of other organs and the ability to deal with stress (Hoff and Pandey 2006; Shonkoff and Garner 2012). Similarly, social stigma undermines children's cognitive performance.

Violations of children's human rights to development entail significant social as well as economic costs for nations. Stunting in young age significantly increases the probability of chronic disease, low educational attainment, reduced income and decreased birthweight of offspring among adults (Victora et al. 2008). Stress and anxiety in infancy have cascading negative consequences for later achievements (Hoff and Pandey 2006). A National Bureau of Economic Research paper found that, keeping other factors constant, violence and maltreatment in childhood doubles the probability of engaging in crime later in life (Currie and Tekin 2006). Adverse prenatal and early childhood environments thus lead to deficits in adult skills and abilities. This drives down productivity and increases social costs, adding to fiscal deficits that burden national economies, hampering long-term growth and development. World Bank research shows that adults who have suffered from prenatal and early childhood malnutrition lose 12 per cent of potential earnings because of lower labour productivity, costing China and India, for example, billions of dollars a year in forgone incomes (World Bank 2006).
Multifaceted, evidence-based action can, however, ensure that children thrive in times of adversity. Painful economic adjustment policies (e.g., budget and subsidy cuts) leading to inflation and drop in real wages could be compensated by cash transfers

(the ultimate effect of which could be modelled, and programme expansion implemented in the same time when the restrictive policies are announced). A careful combination of protective measures could even soften the severe adversity of parental loss – an issue the COVID-19 crisis gave unfortunate prominence. While parental loss tends to be relatively rare for children, it is more common among children born into poverty. Losing a parent is also associated with a higher risk of poverty, child mortality (especially among infants and young children), and health, learning and behavioural issues, especially among adolescents (for example, see Cas et al. 2014). By reducing family stress and securing financial and mental health support and social protection, social care and child protection services could work with surviving parents or relatives to create an effective safety net that prevents children from being placed in residential care.[c]

Source: Compilation based on Samson, Fajth, and François 2016.
a. Cognitive capital represents the complete set of intellectual skills, primarily nurtured prenatally and in early childhood, that determines human capabilities. Hence, cognitive capital refers to cognitive skills, as well as noncognitive, socioemotional and executive function skills that allow for creativity, flexibility and ability to work collaboratively (Samson, Fajth, and François 2016).
b. For example, significant adversity in childhood can alter the connectivity between the amygdala, hippocampus and prefrontal cortex, leading to potentially permanent changes in stress physiology, learning and executive functioning (Shonkoff 2011).
c. Residential care is part of the continuum of care and child protection, but it generally represents a challenging environment for child rights and optimal child development. It may therefore be viewed as a last-resort placement solution that needs strong gatekeeping. See United Nations (2010).

Appendix C: Marriage and family patterns are part of household economic coping strategies

Household, marriage, and fertility patterns prevailing in the region have implications for child poverty, parental and youth employment, social protection, and gender equality. Reductions in fertility – the number of children born to women in their childbearing years – normally reduces the incidence of child poverty. Apart from Afghanistan and Pakistan, fertility rates in South Asia resemble those in the countries of the Organisation for Economic Co-operation and Development (OECD) with one important difference: the age when women have their first child rose continuously in rich countries over the last decades, while, in South Asia, it hovered at around age 20 pre-COVID.

Typically, South Asian families live in multigenerational households with three, four, or sometimes five generations residing together.[a] This intricate family network model implies sharing basic necessities and offering care and support to even those relatives who do not live under the same roof. In South Asia, the family acts as a powerful informal social protection system, one that is typically directed by a male head of household and delivered by women and younger men in the family. Indeed, because unemployment benefit systems were largely absent when business in urban areas came to a standstill in early 2020, many South Asian workers likely needed to seek protection and shelter in the larger family system.

However, single-parent families account for a significant share of households in South Asia, except in Afghanistan (see Table C.1). COVID-19 and the associated lockdowns and school closures must have represented a particular challenge to these families.

There is also a considerable age gap between spouses in the region: husbands tend to be about 5 years older than their wives. Husbands – and therefore fathers, too – are older especially in rural, low-income settings, while the parental gender age gap is relatively smaller among more well-off urban families (Dommaraju 2021).

Table C.1: Family structure and child marriage in South Asia

Country	Average household size, persons (year)	Distribution of households		Women ages 20–24 who were first married or in a union	
		Extended family, %	Single-parent with children, %	Before age 18	Before age 15
Afghanistan	8.0 (DHS 2015)	46.9	1.0	28	4
Bangladesh	4.5 (DHS 2014)	37.1	6.0	51	16
Bhutan	4.5	—	—	26	6
India	4.4 (NFHS-5)	37.1	6.3	23	5
Maldives	5.4 (DHS 2017)	51.2	9.0	2	0
Nepal	4.2 (DHS 2016)	41.8	15.0	33	8
Pakistan	6.8 (DHS 2013)	48.8	6.4	18	4
Sri Lanka	3.8	—	—	10	1

Source: Data (database), DHS Program (Demographic and Health Surveys), ICF International, Rockville, MD, http://www.dhsprogram.com/Data/; Database on Household Size and Composition 2019, Population Division, Department of Economic and Social Affairs, United Nations, New York, https://www.un.org/development/desa/pd/data/household-size-and-composition; IIPS and ICF International 2022; Proportion of Women Aged 20–24 Years Who Were Married or in a Union by Age 18 (%) (dashboard), Global Health Observatory, World Health Organization, Geneva, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/proportion-of-women-aged-20-24-years-who-were-married-or-in-a-union-by-age-18-(-); UN DESA 2017; UNICEF 2021a, 2022b, 2022c.

Notes: DHS = Demographic and Health Surveys. NFHS-5 = the fifth round of the National Family Health Survey (NFHS) of India, conducted in 2019–2021. Average household size is the average number of usual residents (household members) per household. Total fertility is the sum of the age-specific birth rates for all women of childbearing age. It is expressed as live births per woman. Extended family households include one or more members outside the nuclear family unit. Single-parent households with children are households composed only of a single parent and his or her biological, step, adopted, or foster children, irrespective of the children's ages. Both marriages and informal unions are covered under the first married or in a union indicator. Informal unions are generally defined as those in which a couple lives together for some time (cohabits) and intends to have a lasting relationship, but have not participated in a formal civil or religious marriage ceremony.

One reason for the age gap by gender is that child marriages for girls – mostly arranged by parents – are still common, although not in all countries. Thus, half the women ages 20–24 reported in recent surveys in Bangladesh that they had been married or living together informally with their current spouses or partners before their 18th birthday, but the share was only 2 per cent in Maldives (see Table C.1). The incidence of child marriage follows socioeconomic and cultural patterns similar to patterns in the spousal age gap; both are part of traditional economic coping strategies and local traditions.[b]

In Bangladesh and India, a gender age gap among spouses is explicitly promoted by legislation prescribing a minimum legal age of 21 for boys, but not for girls (see Table C.2).

The participation of most South Asian countries in the demographic transition to lower fertility rates has been relatively recent – except for Sri Lanka, which was an early adopter (see Chapter 1). The reductions in the total fertility rate have, nonetheless, been rapid over the last three decades (see Table C.3). By 2015, the total fertility rate in six countries was already close to 2.1 children per woman (the population replacement rate), a hallmark in the demographic transition to low fertility. Available evidence suggests that the declining trend continued at least through 2020.

Table C.2: Legal age of marriage, South Asia

Country	Girls	Boys
Afghanistan	16, exceptionally 15	18
Bangladesh	18	21
Bhutan	18	18
India	18	21
Maldives	18	18
Nepal	20, exceptionally 18	20, exceptionally 18
Pakistan	16, 18 in Sindh Province	18
Sri Lanka	18	18

Source: Data of Child Marriage Atlas (dashboard), Girls Not Brides, London, https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/atlas/.; UNICEF 2022c.

Notes: The Muslim Marriage and Divorce Act and secular laws on marriage are in conflict in Sri Lanka. The General Marriage Registration Ordinance 1997 sets the minimum age of marriage at 18, although a minor may still be married with the consent of parties. The Muslim Marriage and Divorce Act has no minimum legal age of marriage and allows children under age 12 to be married if quazis – magistrates or judges of Sharia courts – give the approval.

Table C.3: Total fertility rate, live births per woman

Country	1980	1985	1990	1995	2000	2005	2010	2015	2020
Afghanistan	7.5	7.5	7.5	7.6	7.5	6.9	6.0	5.0	4.2
Bangladesh	6.4	5.5	4.5	3.7	3.2	2.7	2.3	2.1	2.0
Bhutan	6.5	6.2	5.5	4.5	3.5	2.8	2.3	2.0	1.9
India	4.8	4.5	4.1	3.7	3.3	3.0	2.6	2.3	2.2*
Maldives	7.1	7.1	6.0	4.2	2.8	2.3	2.2	2.0	1.8
Nepal	5.7	5.5	5.2	4.7	4.0	3.1	2.5	2.1	1.9
Pakistan	6.5	6.4	6.2	5.7	5.0	4.4	4.0	3.7	3.4
Sri Lanka	3.4	2.9	2.5	2.3	2.2	2.3	2.3	2.2	2.2

Source: Data of 16 February 2022 of GHO (Global Health Observatory) (database), World Health Organization, Geneva, http://www.who.int/gho/en/; World Population Prospects (dashboard), Population Division, Department of Economic and Social Affairs, United Nations, New York, https://population.un.org/wpp/.

Notes: The total fertility rate is the sum of the age-specific birth rates for all women of childbearing age. It is expressed as live births per woman.

* The NFHS-5 in India (2019–2021) finds a total fertility rate of 2.0.

Expansions in literacy, including female literacy, have been closely related to these changes. Only Maldives and Sri Lanka had high female literacy rates in South Asia 40 years ago. In Bangladesh and Pakistan, one woman in seven could read and write, and the situation was not much better in Bhutan or India. Thanks to gradual increases in school enrolments among boys and girls, which received a strong boost through the Millennium Development Goals over 2000-2015, young men and women are more well educated today. Still, partly because of dropouts or because adult education never caught on, about a third of women – mostly women ages more than 50 – were illiterate when COVID-19 appeared in the region. Relative to people who can read and write, people without literacy skills are generally much more vulnerable to abuse and misinformation, which affect their health and access to social protection and the health and well-being of their households. They face disadvantages in job markets and challenges in entering their names on social registers. There is also a higher-than average chance their economic and social disadvantages will be passed on to their children. In a smuch as COVID-19 has increased school dropout rates, it is contributing to future vulnerability to shocks.

a. The World Bank (2022) has investigated related issues. See also guidebook-style short summaries on local customs and cultural traditions (including those around the family and gender) in various countries at Cultures (dashboard), Cultural Atlas, International Education Services, Multicultural NSW, Special Broadcasting Service, Artarmon, New South Wales, Australia, https://culturalatlas.sbs.com.au/countries.
b. "Marriage patterns in north India, for example, are built around a tradition which assumes that all men and women in a village are part of a single kinship network, and hence, marriage within one's natal village is proscribed. In contrast, the Hindu kinship pattern in south India is built around the concept of encouraging marriage between close kin, with uncle–niece and cross–cousin marriages being favoured" (Yeung, Desai, and Jones 2018, 479).
c. The literacy rate is the percentage of the population of a given age group that can read and write. The adult literacy rate corresponds to ages 15 or more. See UIS.Stat (dashboard), Institute for Statistics, United Nations Educational, Scientific, and Cultural Organization, Montreal, http://data.uis.unesco.org/.

Appendix D: COVID-19 mortality: Increased risk among the middle-aged and youth?

At the individual level, COVID-19 fatality risk largely depends on personal characteristics, such as age, sex, individual health history and the presence of comorbidities. Because COVID-19 is associated with different fatality risks by age and by sex, looking at fatality risk by these characteristics is important. However, such data are largely unavailable in South Asia. The exception is Nepal (see Table D.1).

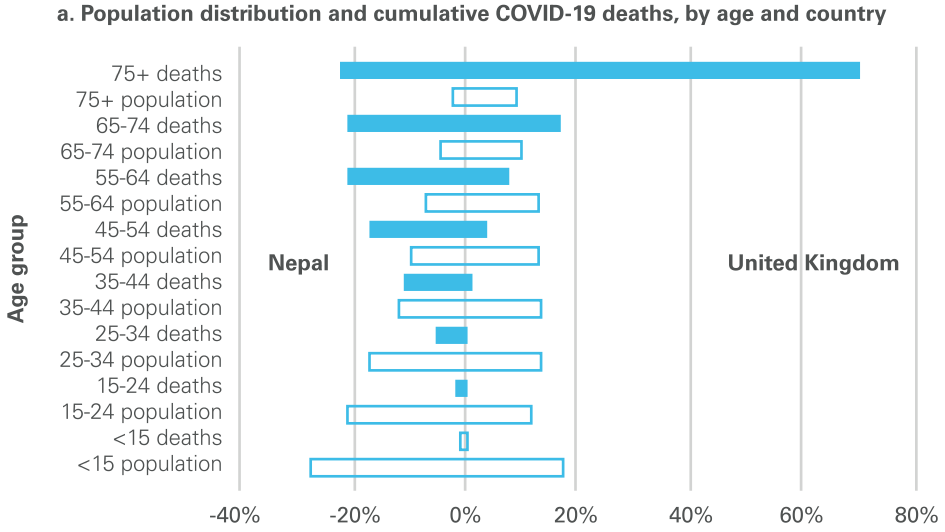
The data in Table D.1 confirm common perceptions about COVID-19: fatality is highest among the elderly and higher among men than among women. However, comparing these data with data on Norway and the United Kingdom reveals a worrisome pattern: youth and the middle-aged in the South Asian country show worse COVID-19 fatality rates relative to youth and the middle-aged in these two countries of the Organisation for Economic Co-operation and Development (OECD). Figure D.1 investigates this by comparing the distribution of COVID-19 deaths among population cohorts in Nepal and the United Kingdom (panel a) and by examining age-specific COVID-19 rates in Nepal and the two OECD countries: the United Kingdom (which suffered through large exposure to COVID-19 before vaccines became available) and Norway (which did not) (see Panel B).

Table D.1: Age- and gender-specific COVID-19 fatality, Nepal

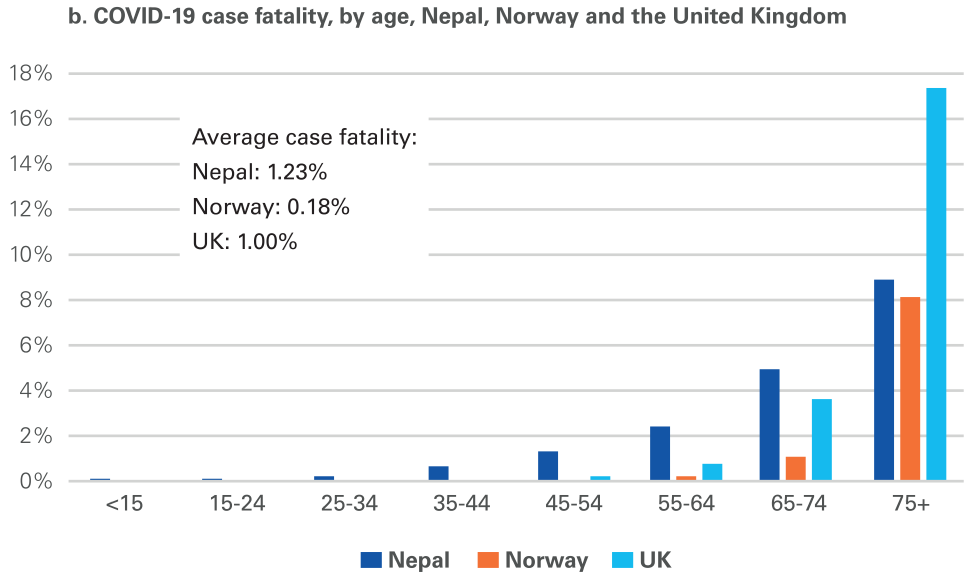
Age, years	Deaths per 100,000 relevant population		Deaths, number			Women's deaths, % of total
	Women	Men	Women	Men	Total	
<15	0.8	0.7	31	27	58	53.4
15–24	3.5	3.8	112	118	230	48.9
25–34	8.8	18.4	261	397	658	39.6
35–44	19.9	61.7	440	844	1,284	34.2
45–54	38.9	103.4	624	1,317	1,941	32.2
55–64	73.1	174.5	778	1,642	2,420	32.1
65–74	133.3	284.8	862	1,587	2,449	35.2
75+	282.9	650.6	932	1,705	2,637	35.3
Average	25.2	55.4	4,039	7,636	11,675	34.6

Source: World Population Prospects 2019 (database), Population Division, Department of Economic and Social Affairs, United Nations, New York, https://population.un.org/wpp/; WHO Coronavirus (COVID-19) Dashboard, World Health Organization, Geneva, https://covid19.who.int/.
Notes: Population estimates are interpolated, based on United Nations estimates by sex and age groups in 2020. The low-fertility projection variant is for 2025. Reported cumulative number of COVID-19 deaths by age and sex add up to 1.7 per cent less than the total reported deaths. Data as of 31 March 2022.

Figure D.1: Nepal: increased risk of COVID-19 mortality among the middle-aged?



Source: World Population Prospects 2019 (database), Population Division, Department of Economic and Social Affairs, United Nations, New York, https://population.un.org/wpp/; WHO Coronavirus (COVID-19) Dashboard, World Health Organization, Geneva, https://covid19.who.int/.
Notes: Nepal: left side. United Kingdom: right side. Population: white bars. Deaths: grey bars. Data as of 20 March 2022.



Source: WHO Coronavirus (COVID-19) Dashboard, World Health Organization, Geneva, https://covid19.who.int/.
Notes: Based on weekly reports of cases and deaths by age group. Case fatality is based on the assumption that COVID-19 mortality has, on average, a two-week lag with COVID incidence and is calculated as the ratio of cumulative COVID deaths by the week starting on 26 December 2021 to the registered cumulative cases by the week starting on 12 December 2021, presented as a percentage. Data as of end of March 2022.

The elderly still face the highest case fatality risk in Nepal. However, Figure D.1, Panel A, shows that confirmed COVID-19 deaths are highly skewed towards the oldest cohorts in the United Kingdom, while the risk is spread relatively more evenly by age in Nepal. In the United Kingdom, more than 70 per cent of the deceased are over 75, while, in Nepal, this share is only 22 per cent. In the United Kingdom, COVID deaths rates increase rapidly after 75; in Nepal, the slope is not so steep. Accordingly, younger adults account for a comparatively larger share of COVID-19 deaths in Nepal than in the United Kingdom.

A look at age-specific mortality rates (panel b) confirms that COVID-19 mortality rates among youth and the middle-aged (up to age 65) is significantly higher in Nepal than in the two OECD countries. However, this is not so among the older age cohorts: Nepali adults over 75 exhibit lower mortality risk than the same cohort in the UK. There is also a difference between the two OECD countries: COVID-19 case fatality is consistently lower in Norway than in the United Kingdom, suggesting that the Nordic country was more effective in saving youth and the elderly who had become infected.

There is no clear explanation of why case fatality among people ages more than 75 is lower in Nepal than in Norway or the United Kingdom, but other studies have also found among the oldest age cohorts lower COVID-19 case fatality in low- and middle-income countries than in the rich countries. One possible factor involves less comprehensive reporting of COVID-19 infection prevalence among the oldest people in developing countries. However, there may be another explanation: the presence of selection effects. Worse socioeconomic conditions generally lead to higher mortality at younger ages, and only the fittest, which often correlates with socioeconomic advantage, survive up to ages 70 or 80. A positive survivor bias thus builds up along the life cycle among those who survive the first six decades of life, and this effect is stronger in developing countries than in the rich world.[a] The flipside of this effect is comparatively larger mortality risks at younger ages (that is, among children, youth and the middle-aged) in Nepal and in other low- and lower-middle-income countries already before COVID-19 appeared.

a. "High quality medical care in wealthier countries keeps many older people alive despite weak health conditions that make them vulnerable to COVID-19," note Demombynes et al. (2021, 16). "It may be that older people in developing countries are on average healthier than those in wealthier countries because those with ailments would have been at high risk for death at a younger age."

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