



**NCAER releases findings of  
Round 4 of the Delhi NCR Coronavirus Telephone Survey**  
conducted by its National Data Innovation Centre

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New Delhi (Wednesday, January 20, 2021): **The National Council of Applied Economic Research, NCAER**, released the results of Round 4 of its **Delhi NCR Coronavirus Telephone Survey (DCVTS-4)** today.

The DCVTS team carried out **Round 1** in early April shortly after the first lockdown started. **Round 2** in late April gauged household reactions to a continuation of the first, stringent lockdown. The team fielded **Round 3** at a crucial moment in mid-June when restrictions were gradually coming off starting June, but Coronavirus infections in the NCR were accelerating rapidly. **DCVTS-4** was launched on December 23, 2020 and completed on January 4, 2021, just before the vaccination drive was launched.

As the nation begins its recovery from the Coronavirus pandemic through a massive vaccine rollout, facilitating speedy recovery will require a better understanding of the overall impact of the pandemic as well as efficient vaccination effort. In spite of the opening of the economy in recent months, employment and income levels have not seen a uniform recovery. Schools and colleges have remained shut since March 2020, and classes have begun only recently in some States. Moreover, the disruption of routine health services has emerged as a major area of concern in the wake of COVID-19. The recovery appears to be taking different pathways for different people, what some have called a K-shaped recovery.

This press note reports findings from DCVTS-4 on:

- The extent to which individuals are willing to get vaccinated and their willingness to pay for the vaccines;
- The level of disruptions in routine and emergency healthcare when the pandemic continued to put pressure on the health system for more than 9 months;
- The extent to which young students in the age group of 6-14 years have been able to participate in online classes held by schools, and coaching centre-based and home-based learning during the period when schools have been closed;

- Economic recovery, occupational shifts during the pandemic, and vulnerability among different occupational groups; and
- The levels of distress and financial hardship experienced by households and whether the most vulnerable households have had access to safety nets.

DCVTS-4 resurveyed households contacted in the earlier rounds of DCVTS and completed interviews of 3,168 rural and urban households from the Delhi NCR, which includes Delhi as well as rural and urban areas from selected districts of Haryana, Rajasthan, and Uttar Pradesh.

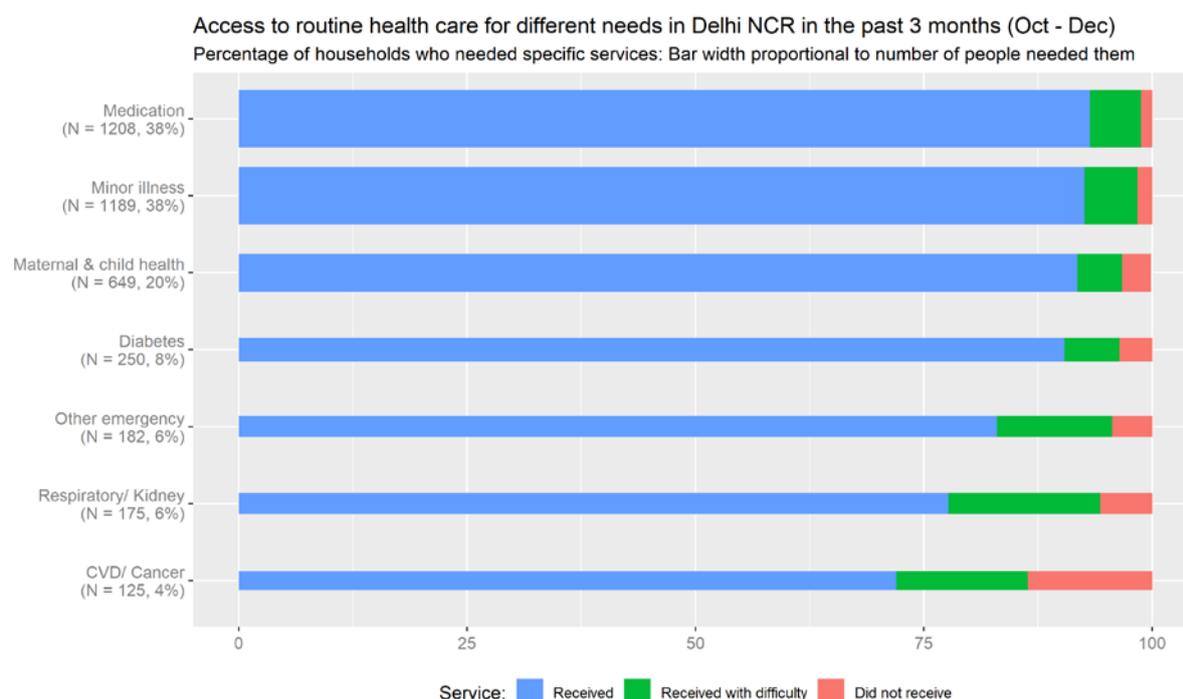
### **Key findings of the DCVTS-4 and implications**

Development, testing and approval of COVID-19 vaccines have been achieved within a record time. On one hand, this is an unprecedented achievement of scientists, industrialists, and policy makers but on the other hand it might lead to **vaccine hesitancy** due to concerns regarding compliance to study protocol and approval process, particularly in the absence of effective communication. DCVTS-4 asked its respondents, “In few months if vaccines were to be available to prevent COVID, will you be willing to take it?” DCVTS-4 findings show that about 20% respondents are certain about not taking the vaccine. A significant rural (22.4%) and urban (17.5%) differences were observed. An additional 4% of respondents mentioned that they will not take it as they are already infected. Another 15% are unsure about taking the vaccine. Combining all these three categories, one can argue that at this current time point vaccine hesitancy is quite high (39%) in Delhi NCR.

No significant association was observed between age, gender of respondent and vaccine hesitancy. Less educated (0-4 years of complete education) respondents are more hesitant to take vaccines (52%). Improved trust in vaccine development and approval process as well as overall trust in the government health systems may play an important role in reducing vaccine hesitancy.

In the context of the debate whether vaccine is a public or private good, DCVTS-4 asked about people’s **willingness to pay** for two doses of coronavirus vaccine to those who are willing to take vaccine or unsure about it. About 41% respondents think that the vaccine should be provided free either by the government or their employer. An additional 14% said they will not pay more than Rs 500. Proportion of respondents expecting free vaccine is significantly higher among respondents from poor economic status (48%) and casual wage workers (51%). Interestingly, about similar proportion of people (40%) are willing to pay as much as required for two doses of the vaccine. Understandably, this proportion is higher (45%) among respondents from rich households.

**Figure 1: While the pandemic disrupted routine health care services, in NCR region this disruption appears modest: DCVTS-4 (23<sup>rd</sup> Dec 2020 – 4<sup>th</sup> Jan 2021)**



Because of COVID-related pressure on the health system, the **disruption of routine health services** emerged as a major area of concern in the wake of the COVID-19. To understand the current situation of healthcare access, DCVTS-4 asked about the experience of household members in availing medical services in the last 3 months (October-December) for a varied range of health needs. The findings (Figure 1) suggest that the prevalence of disruption of medical services is dependent upon the type of services. Services that are commonly used and are generally available close to home, e.g., access to medication, treatment of minor illnesses like fever, cough and cold, diarrhea, pregnancy and delivery related services, childhood immunization, the level of disruption is low. However, specialized services that often require traveling outside the village or the local neighbourhood, e.g., care for cardiovascular diseases, cancer, chronic respiratory illness, and kidney disease were more difficult to avail. However, due to their rarity this affected a smaller proportion of households. For example, 23% of 175 households experiencing chronic respiratory illness or kidney disease faced difficulty (either did not receive the service or received with difficulty) in availing medical care. The proportion of disruption is 28% for cardiovascular disease or cancer care among 125 households who needed required care. In comparison, 7.5% had trouble obtaining treatment for minor illnesses. This may reflect both demand and supply constraints. DCVTS-4 data suggest that that 37% households believe that the healthcare service capacity is below the normal level. At the same time, about 22% respondents reported that they would either avoid visiting medical facilities even now or visit only if there is an emergency.

In DCVTS-4, households where there were children ages 6-14, interviewers asked about **educational experiences** of the youngest child in this age group. DCVTS-4 collected data on 1,530 children about their extent of participation in educational activities through different modes of learning. Among these children, 1352 children were currently in school while 126 (8.4%) were unable to enrol due to

the pandemic. Most of these left out children were 6 and 7 years old who could not enrol because of school closures. About 37% children were not offered online classes taught by teachers from the school and 30% children were not provided recorded lessons or online learning videos by teachers. An estimated 25% children were neither offered online classes nor received any recorded lessons from school during the period when remote learning was the norm. Government and private schools both found themselves unable to cope with unexpected technological demands. Area of residence (rural vs urban) seems to be a major factor in determining access to different modes of blended learning during the pandemic time and not the type of school (public vs private). Significantly more children in rural area (45%) were not offered online classes relative to 25% in urban area. When online classes were offered, about 62% children attended classes regularly (48% in rural areas and 75% in urban areas). For the remaining children, lack of access to laptop or smartphone seems to be a major impediment.

Children's education during the pandemic seems to be affected not only by technological challenges, but also due to lack of proper management at the school level. Schools seem to find it difficult to reimagine education in a distance learning mode; 32% children did not receive any learning material from school and 27% children were not asked to do any homework or assignment. Schools found it challenging to cope with a new environment and often made no efforts to connect with parents. About 34% respondents reported that there were no communications between teachers and parents to discuss children's progress and wellbeing over prior 3 months.

While **employment recovery** is well under way as judged by many sources, the lingering impact of lockdown should not be underestimated. During the pandemic period (April – Dec), about 80% of the households suffered some sort of economic hardship such as decrease in salary or daily wages (36%), someone in the household lost job (31%), difficulty in finding work (31%), business closed or business income declined (23%). Long term economic impacts are most apparent for small business owners and salaried workers. About 12% of households whose primary source of income was business before the pandemic changed their occupation during the pandemic; either shifted to small jobs or undertook casual wage work or currently do not have any source of income. Households whose main source of income was salaried work before the pandemic, about 14% of them have shifted their occupation to something else.

This **occupational shift** seems to have a negative impact on the household. Households that lost jobs or had to close their businesses tried to find alternative work, mostly work that was less remunerative than the work they lost. Looking at the living conditions of households that changed the primary source of income suggests greater hunger and debt in current conditions. About 44% of the households whose primary source of income did not change during the pandemic had to resort to borrowing in the last 30 days prior to the survey to meet their day-to-day consumption needs and 12% of such households faced occasional situations of not having enough food due to financial constraints. The proportion of households facing such financial hardship are much higher among the households whose primary source of income has changed during the pandemic. 64% of such households borrowed and 29% suffered from occasional unavailability of food in 30 days prior to the survey. About 2.2% of the households reported that they do not have a source of income now, possibly subsisting on borrowing or selling assets. While our small sample of 70 households with no income source only allows us to draw tentative

conclusions, nearly 40% of this sample experienced hunger compared to 14% for the full sample.

Except for additional rations, the reach of **safety nets** at this stage of the pandemic seems limited. About 50% households received additional or free ration (pulses or grains) in the month of November. The pattern of urban exclusion that was observed in earlier rounds of DCVTS, continued to exist in the context of receipt of welfare measures. While 55% rural households received additional ration, this proportion is much lower for urban households (46%). About 34% children in government schools received grains in lieu of the midday meal. In our rural sample, only 10% households received MGNREGA work or cash in lieu of work. For households that received MGNREGA work, average number of days of work received between April and December is 34.

**Conducting the DCVTS-4.** DCVTS-4 was conducted by 32 interviewers over a period of ten days, Dec 23, 2020- Jan 04, 2021. The survey resulted in 3,168 completed interviews with an overall response rate of 61.2% from all phone numbers called, excluding 74 cases of out of sample who are currently not living in Delhi NCR. The non-contact rate was 26.4%, but among those whom we were able to contact, the response rate was 83.2%. Most of the non-response cases were due to interviewers not being able to contact the households because of a wrong phone number, the number was out of service, the phone was switched off or was out of the coverage area, the phone number did not have an incoming call facility, or the phone call was not picked up. The median interview length for the completed interviews was 14.2 minutes, with some variation between the rural (14.6 min) and urban (13.7 min) areas.

### **About NCAER | The National Council of Applied Economic Research**

Established in 1956, NCAER is India's oldest and largest independent, non-profit, economic policy research institute. NCAER's work cuts across many sectors, including growth, macro, trade, infrastructure, logistics, labour, urban, agriculture and rural development, human development, poverty, and consumers. The focus of NCAER's work is on generating and analysing empirical evidence to support and inform policy choices. It is also one of a handful of think tanks globally that combine rigorous analysis and policy outreach with deep data collection capabilities, especially for household surveys, in its National Data Innovation Centre. More on NCAER and NDIC is available on [www.ncaer.org](http://www.ncaer.org).

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