POLICY BRIEF

ON

EXTREME POVERTY IN RURAL KERALA

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Policy Brief on Extreme Poverty in Rural Kerala

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Introduction

Kerala has made significant strides in reducing poverty through a combination of measures such as land reforms, expansion of education and healthcare, Kudumbashree, social security pension schemes, public distribution system and decentralisation of governance and administration. Kerala's poverty rate is the lowest in the country. As per the NITI Aayog index of multidimensional poverty based on NFHS-5 (2019-21) data, only 0.55 per cent of the population in the state is multi-dimensionally poor. The corresponding proportion at the national level is 14.96 per cent.

Given the success in reducing overall poverty levels, Kerala focussed on alleviating extreme poverty through tailor-made solutions. Kerala started systematic interventions to address the issue of extreme poverty as far back as 2002 through the Ashraya programme launched as a subcomponent of Kudumbashree. The novelty of the programme design was the formulation of micro plans for each household identified using a multidimensional risk index. The micro plans were implemented in its spirit initially, but were not revised regularly, and now it largely offers uniform services/materials to extreme poor households. The programme was later renamed Agathi Rahitha Keralam or Destitute Free Kerala (DFK). At present, it covers more than 1.5 lakh families.

About two decades later, in 2021, a new programme, viz., Extreme Poverty Eradication Programme (EPEP), was launched to eradicate extreme poverty in Kerala by 2026. A survey was conducted to identify extreme poor households not covered by DFK, focusing on four key factors: food, safe shelter, basic income, and health status. The survey identified 64,006 families living in extreme poverty. Under the new initiative, the plans are to incorporate immediate care, short-term interventions, and long-term strategies. Micro plans are to be prepared for each household to facilitate tailor-made solutions.

The present study on extreme poverty in rural Kerala was initiated when the EPEP was in the campaign phase. The study is primarily based on

extensive fieldwork in three Grama Panchayats (GPs), which were chosen to capture geographical diversity and ensure representation of different marginalised groups. The GPs are Panamaram in North Kerala, which has the highest concentration of extreme poor households and a significant presence of tribal population; Alappad in South Kerala, with a sizable fisher population; and Asamannoor, a peri-urban GP located in Central Kerala. A survey among 120 randomly selected extreme poor households (60 in EPEP and 60 in DFK) in the three GPs and depth interviews with 30 individuals in a sub-sample and other stakeholders were conducted as part of the study.

Key Findings

Living in Extreme Poverty

Extreme poor grapple with material deprivation, intensifying health concerns, and limited access to basic necessities, education, and employment. Spatial and environmental challenges pose additional obstacles. They have minimal assets and resources. The major assets owned by the extreme poor households include land and house. But 12 per cent of the extreme poor households did not have any land. Only 59 per cent of the respondents live in their own house with a title deed. Another 13 per cent have a house but do not have the title deed. Few families (5%) are living on rent-free arrangements. Out of the 120 sample households, five were not electrified, eight did not have a latrine, and more than one-fourth had no separate kitchen. More than three-fourths of the sample households have a mobile phone, and more than half have durables such as a fan, mixer/grinder and TV set. Many of them reported their inability to recharge mobile phones and repair damaged electronic goods.

Spatial vulnerability compounds their challenges by restricting their access to essential resources and opportunities. The study found that 15 per cent of the households do not have a road leading to their house. One-fifth of the households do not have vehicular access. One-third of the sample households in Alappad GP are located in areas prone to sea

erosion. Similarly, in the tribal areas, access to services is constrained, as pointed out by one of the respondents

> *"no one comes to our house except the ASHA worker. Our house is located away from other settlements, and during rains, we are completely isolated."*

Only eight per cent of the members of the extreme poor households have post higher secondary education. One-fourth have no formal schooling. Only about half of the households have at least one member who is employed. Half of them work on daily wages, and one-third participate in MGNREGS work. Only one-tenth is in regular employment. It is significant to note that two in five members of the sample households are unable to work due to old age, illness, disability, or caregiving responsibilities. Less than one-fifth of the households have per capita monthly income (self-reported) above Rs 2500.

The disadvantageous position of the extreme poor households is also due to the peculiar household composition. For instance, the average size of extreme poor households in the sample is 2.2, just about half of the average household size in Kerala. Two in five households have only a single member. One-fourth have only elderly members. More than half of the households have elderly members; half have a member with a disability, and one-fourth have a member with mental issues. This places significant caregiving responsibilities on women, limiting their work participation and contributing to their "time poverty". One-third are women-only households.

Nearly one-fifth of the households have one or more members consuming alcohol, and one-third consuming tobacco. Lottery tickets have become a hope for some of them, and one in eight households regularly buy them. The small amounts won occasionally by people in their community reinforce their belief that they could also win. They do not keep a tab on the amount they spend on lotteries and take it according to the cash in hand.

Shocks and Stressors

Poverty is dynamic, with households experiencing various transitions

-some born into poverty, others falling in and out. The poor and even non-poor can be pushed into extreme poverty due to shocks and continued stress. Further, the extreme poor are often exposed to shocks and stressors that perpetuate poverty. Shocks, which are unplanned or unforeseen events, result in abrupt and detrimental consequences on people's lives. Due to their poor resilience, inadequate social safety nets, and restricted access to resources, the extreme poor are more susceptible to shocks. Stress arises from the cumulative effect of ongoing stressors and shocks, while poverty itself can be a reason for the same. Vulnerability is about how susceptible people are to the damaging effects of shocks and stressors. Extreme poverty and vulnerability coexist, and people are more likely to experience significant shocks, making it very difficult to recover. Thus, a poverty trap is created by the interaction of shocks, stressors, vulnerability and extreme poverty.

Nearly one-third of the extreme poor households were pushed into extreme poverty because of a major shock, the most important being the death of an earning member followed by accidents or health emergencies leading to permanent disability or bedridden situation of the breadwinner. The impact of this shock is more severe if the deceased/disabled is the sole earning member. It exacerbates the vulnerability of the household. Apart from the loss of income, the loss of social relations and the need for caregiver support aggravates the vulnerability.

Many households reported continued stress due to factors such as the absence of earning members, disability, chronic illness, lack of social protection, lack of support from children, debt trap and alcoholism. Nearly one-third of households identified the absence of a member who goes to work as a stressor. The situation of the household worsens when it acts along with other vulnerabilities such as disability, bedridden situation, or old age. The lack of provisions for managing disability and mental illness is a major problem reported by some of the respondents. It can cut off income and increase expenses related to treatment, medicines, and transportation. About one-fifth of the families could not

identify a primary shock or stressor. This may be because the present situation is the result of the interplay of several events/ shocks / stressors over a long period of time.

Old age, disability, mental illness and chronic ailments also increase the caregiving responsibilities of other members. Several women had to give up their work or were unable to enter the labour market due to care responsibilities. It also restricted some of them from pursuing education and attending social functions. Some of the caregivers are old with health issues and are taking care of their bedridden sons, daughters or their spouses.

The stressors acting in tandem with shocks or in isolation create a challenging environment, making it difficult for households to come out of extreme poverty. The social protection mechanisms, both formal and informal, determine, to a great extent, how the shocks and stressors are absorbed and help them escape from the trap of extreme poverty.

Social Protection

The concept of social protection has evolved in response to new challenges with increasing emphasis on the role of community and social networks in providing support. Greater emphasis is now given to both formal and informal support structures.

•Formal Social Protection Mechanism

Formal social protection measures comprise of a wide range of government programmes and services designed to improve people's standard of living. The social security pension scheme for the aged, widows, persons with disabilities, unmarried women aged above 50 years etc., is the most important among them. The strong public healthcare system and public distribution system, DFK, subsidised health insurance scheme, the social security initiatives of the Kerala Social Security Mission, the community-based palliative care programme of the Local Governments and Health department, assistance to meet medical expenses of the chronically ill, and assistance to meet the needs of children with special needs are examples of Kerala's extensive formal

social protection measures.

It is found that large majority of the extreme poor households have at least one member receiving social security pension. It is the primary source of income for nearly half of the households which helps them absorb the stress and some of them are solely dependent on it to cover their household expenses. This was made possible partly because the coverage and quantum of social security pension in Kerala is much higher than the commitments to be made under the centrally sponsored scheme of NSAP. The social security pension for elderly, widows, and persons with disabilities in Kerala is Rs 1600 per month. The central share is just 13 per cent in old age pension, 19 per cent in disability pension if the person is aged below 80 years. It is 31 per cent for those aged 80 years in both categories. The central share in widow pension is 44 per cent irrespective of the age group. In terms of coverage, the central share is received for only 7 per cent of the current beneficiaries of disability pension, 15 per cent in the case of old age pension; and 23 per cent in the case of widow pension. Apart from following a different eligibility criteria and larger quantum of assistance to make the scheme more inclusive, the state government also extends social security pension, without any central assistance, to many other groups such as agricultural labourers aged above 60 years and unmarried women aged 50 years and above. Of the 52 lakh beneficiaries of social security pension in Kerala, the Union government's share is received only for 8 lakh beneficiaries (15%).

A positive feature of the pension payment system in the state is the provision for receiving it at the doorsteps of the beneficiaries which is effected through the large network of cooperatives. At present, more than half of the beneficiaries are getting it this way which is a major relief to the elderly and persons with disability who have limited mobility. It is also found that the extreme poor often defers payments to the local shops or the auto rickshaw driver who accompanies them to hospital on the promise of paying it when they receive pension. Thus,

the social security pension acts as a guarantee for the sustenance of the extreme poor households which is lost when there is a delay in pension payments.

Large majority of the extreme poor households depend on the public health care system. However, 13 per cent of them depend exclusively on private hospitals/clinics, and another 15 per cent depend on both private and public sectors. Reasons for depending on the private sector, despite severe economic constraints, include trust in the doctor or the hospital, which they have been depending on for a long time. The choice is often based on the convenience and preference of the caregiver/accompanying person, facilitated by features such as low waiting time, closeness to their home/workplace and familiarity with the doctor. Apart from the healthcare institutions, some of the households were getting support from the large network of palliative care units in the state. ASHA, the grassroots level health worker, had visited three-fourths of the extreme poor households in the last year.

Extreme poor households face significant stress in the form of accidents, surgeries or continuous treatment for chronic illness with recurring expenditure for treatment and medicines. Such situations force them to take loans or delay or forgo treatment. Universal health insurance is a mechanism which can absorb stress to a great extent. However, only 40 per cent of the extreme poor in the sample are covered by any health insurance scheme. All of them are covered by the Karunya Arogya Suraksha Padhathi (KASP), which provides a coverage of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalisation. Half of the households that did not have insurance were elderly-only households, which may be due to the lack of information and or capability to get enrolled. Nearly one-fourth of the households have a member with mental illness who is at increased risk of economic hardship as they are more likely to be unemployed and have very limited social networks and access to services. There is very limited provision in the existing extreme poverty eradication programmes to address this

issue. Elected representatives in the local bodies reported that mental illness is seldom taken into account in the initiatives to address the healthcare needs of the extreme poor. It is also found that even though institutional care is the only option for some of them, they are not getting it now.

PDS is the primary source of food grains for the large majority (90%) of the extreme poor households. The small group of extreme poor who do not depend on PDS do so because of their inability to cook food, absence of ration cards and restricted mobility/disability. There is a provision for home delivery of free food kits to the extreme poor in DFK. The food kit consists of pulses, oil, spices and other essential items such as soap, toothpaste, etc., which are not available in ration shops. The beneficiaries consider it a great help as they largely manage their daily life with the kit and provisions from the PDS. A positive feature of the DFK programme is the home delivery of food kits, especially to the elderly, persons with disabilities and those with chronic illness, by involving Kudumbashree, neighbours, relatives and elected representatives. However, about half of the DFK households reported irregular delivery of food kits.

•Informal Social Protection Measures

A primary pillar of support for extreme poor households is their family members, who meet their essential needs like food, clothing, and daily expenses and extend support in accessing essential services and institutions such as hospitals, banks, and government facilities. Three-fourths of the households received financial assistance from the family and kinship network over the past year. In emergencies, two-thirds rely on their family and kinship network. However, the assistance is often erratic and minimal, considering the economic struggles of the family members themselves, though instances of a complete takeover of responsibilities were also reported.

Even though family plays a major role, community support was also significant in the case of extreme poor households. For instance, two in

five households depended on the community, which includes neighbours, friends, employers, neighbourhood shops and local money lenders for financial support. In households where food is not cooked as there is no able-bodied member, family or the community often provide food. Further, the auto rickshaws from the locality are often relied upon for transportation, especially during emergencies. The auto drivers, who are usually from the neighbourhood, also assist in purchasing medicines and other essentials, and accompany them to hospitals. As noted earlier, payments for the ride are often deferred till the family receives a social security pension. The poor keep the contact numbers of auto drivers who are considered reliable support. The community also sometimes assists in accessing services such as PDS, especially in the case of households where the members have limited mobility due to old age, disability or chronic ailments. Community networks are also major sources of information on various government schemes and services. Friends and neighbours also sometimes extend emotional support to the poor by listening to their grievances, accompanying them while going outside, sharing food or buying gifts for children. However, it is observed that such support is limited in the case of households with a member having a mental illness who exhibits violent behaviour. In the case of persons living on the streets, the community sometimes steps in to fill the gap left by the family and kinship networks. However, the nature of assistance is voluntary and irregular.

The nature and magnitude of informal community support are observed to depend on societal values. Population groups which depend on common resources, such as fishers or tribes, tend to have stronger informal social protection systems. The sense of togetherness appears to be more in these communities. A norm of social responsibility is developed wherein people help even when there is no expectation of reciprocation. For example, the community believes and follows the norm that no one should die out of hunger. The fishers often share a small portion of their catch with family members of retired fishers and

the poor who wait at the landing sites, which they believe is their responsibility. Even in other contexts, a sense of responsibility prevails to assist others who are less fortunate.

Community-based institutions such as youth clubs, political organisations, faith-based organisations, etc., extend support to address issues related to health care, marriage and education, mostly in the form of financial assistance. However, some considerations such as religion, caste, political affiliations, and social norms may work in such cases. However, the general notion of helping the poor often replaces these considerations. While informal support is often without regard for return in exchange, the poor also receive support in a limited way on the basis of reciprocity. For instance, the purchase of essentials from local shops on credit and travelling on autorickshaws to hospitals and other places promising payment on receipt of pension are examples of balanced reciprocity.

Social Participation

Social participation of the extreme poor is largely limited to involvement in Kudumbashree. But, only half of the households in the sample have membership in Kudumbashree. As the membership is restricted to women, 18 per cent of the households that have only male members are excluded from the Kudumbashree. Even if we exclude the men-only households, two in five households with a female member were not part of Kudumbashree due to old age and health issues, inability to pay thrift, NHG being inactive or due to absence of vacancy in the NHG or conflict with other Kudumbashree members. Even though paying thrift is not compulsory, the extreme poor are apprehensive about the arrangement for reasons such as the fear of being left out or being humiliated when they are unable to pay thrift. As pointed out by a respondent, in their struggle for survival, they feel, *"where is the time for meetings and social activities?"*. Due to their lack of voice and representation, the poor are unable to influence decisions that affect their life and livelihood. It can deepen their poverty by lessening the

chances of securing their rights.

Kudumbashree is the main source of credit for extreme poor households, as securing credit from other formal institutions is challenging for them. Apart from being a source of financial support, examples of Kudumbashree helping the poor with support for livelihood improvement were noted during the study. In one such case, a woman who is a caregiver for her bedridden husband could improve the livelihood of the family without hindering caregiving responsibilities. Being outside Kudumbashree is disadvantageous to all households, including men-only households, as it is the state's poverty eradication programme, a platform for social participation, and the major source of information on programmes for the poor.

Reported Needs

The extreme poor were enquired about their needs. The most cited needs were related to shelter, its maintenance and facilities such as toilets, provision of drinking water and electrification. Other needs reported by the households include home delivery of free medicines, financial support for treatment, support for livelihood improvement, support for the education of children, support for getting documents that entitle them to get benefits of government initiatives, improvement in physical access to their houses, assistive devices, and food kits. Few of them reported the need to have institutional care. Mental health needs were neither efficiently acknowledged nor attended to.

Recommendations

•**Address people at risk of falling into extreme poverty:** The state government's initiatives for eradicating extreme poverty are laudable. However, it is important to recognise that both extreme poverty and vulnerability are dynamic in nature and are often intertwined. One may fall into extreme poverty and experience different dimensions of vulnerability due to a single shock or multiple shocks and continued stress. The present programmes for eradication of extreme poverty, both EPEP and DFK, target only those identified as extreme poor. It is

important to focus on early identification of people at risk of falling into extreme poverty and address their issues. This calls for a new component in the programme to eradicate extreme poverty targeting such households.

•**Early identification of extreme poor:** A delay in identifying extreme poverty will be a costly mistake. The longer a household is in extreme poverty, the more difficult it is to get out of it. Therefore, the challenge is in the early identification of people at risk of falling into extreme poverty and those who have already slipped into extreme poverty and support them before it becomes more complex and difficult to address. Obviously, this can be achieved only at the local level. A committee consisting of elected representatives of the ward, Kudumbashree representatives, ASHA and Anganwadi workers shall be formed in each ward to coordinate these activities. The extreme poor households may be visited annually by the ward-level committee to assess their change in status and their needs afresh. The micro plans shall be reworked periodically based on this assessment. The improvement or worsening of the situation of extreme poor households in the ward shall be included in the agenda of the grama sabha/ward sabha.

•**Strengthen resource mobilisation:** Apart from the funds of the local governments, sources such as the CSR funds of corporates, NRIs and the local community who share a sense of compassion for those who are in the most vulnerable situations shall be tapped for the programme.

•**Integrate DFK and EPEP to form a single programme for extreme poverty eradication:** It is important to recognise that, despite several years of well-intended interventions, many households included in DFK programme face challenges similar to the ones faced by the extreme poor households covered by EPEP. At the same time, there are DFK households which have improved their situation and now have earning members and better income. Therefore, the LGs shall initiate an assessment of the living status of DFK households to identify households to be included in the state's programme for eradicating

extreme poverty. Instead of continuing DFK and EPEP as two separate schemes to eradicate extreme poverty, the schemes shall be integrated.

•**Ensure continued support:** The complexity of the issues necessitates continued support to keep the households out of extreme poverty. Hence, EPEP shall be continued even after five years, focusing on strategies to prevent the presently targeted households from relapsing into extreme poverty and preventing new households from slipping into it.

•**Provision of shock absorbers:** A significant shock that pushed some of the households into extreme poverty is the sudden death or disability of an earning member. The impact is severe if the person is the sole earning member and there are no other able-bodied members in the household. The situation would be much worse if social relations and caregiving were primarily the responsibility of the deceased. Such a single shock can push a household into extreme poverty unless timely support is received, as has been the case of some of the households in the sample. Early identification of such situations can be done only at the neighbourhood level (ward). In such situations, it is important to ensure immediate support, including financial support. For this, a distress relief fund shall be initiated at the local body level to address such emergency situations, which can push households into extreme poverty. Such a scheme shall be implemented jointly by the state and local governments on a resource-sharing basis and using contributions from the community.

•**Review the selection mechanism:** Since a single shock of the death or permanent disability of the sole earning member can push families into extreme poverty, households experiencing such shocks shall be included in the list of extreme poor without waiting for the annual or biannual revision of the list. This also indicates that a uniform approach or standard set of criteria or scoring technique may not be suitable for identifying extreme poor. The selection mechanism and inclusion criteria shall be revised considering these aspects and based on the

experience of implementing EPEP and DFK.

•**Consider Ex-ante strategies:** Ex-post strategies help households recover from shocks and regain stability, while ex-ante strategies aim to build resilience and reduce the likelihood of falling into poverty. The ex-post strategies currently followed by the extreme poor households include relying on informal social protection mechanisms, borrowing money, delaying health care and prioritising needs. The study finds that ex-ante adaptive strategies are minimal in these households. They have fewer assets and very limited social capital to build resilience. The geographical vulnerability adds to it. Therefore, the long-term strategy of extreme poverty eradication shall focus on ex-ante components such as increasing livelihood opportunities and diversification of income sources, improving educational outcomes of the children in such households and addressing spatial vulnerability.

•**Integrate formal mechanism with informal social protection:** While informal social protection can be a critical source of support and assistance for people living in extreme poverty, there are also limitations and potential risks. Their social networks may be limited in size and diversity. The prevalent social and cultural norms can also exclude certain groups or individuals. Those who are not abiding by the dominant moral and social codes prevailing in society are likely to be excluded, thus limiting their social capital. It is also dependent on the resources available within the community. Therefore, it is important to integrate formal social protection mechanisms with informal social protection systems so that they complement each other to provide a sustainable safety net for people living in extreme poverty.

•**Income generation and employment:** The study finds that extreme poor households experience low and irregular income flows due to poor livelihood opportunities and the inability to work outside their homes due to limited mobility and caregiving responsibilities. The state and local governments shall take the following measures to address the issue:

i.Support skill development of the extreme poor by partnering with

Deen Dayal Upadhyaya Grameen Kaushalya Yojana (DDU-GKY), Kerala Academy for Skill Excellence (KASE) and Kudumbashree.

ii.Support caregivers in taking up income-earning activities that can be undertaken in their homes.

iii.Create opportunities for the elderly in extreme poor households to engage in less strenuous work, which not only provides them additional income but also the satisfaction of getting engaged fruitfully. There are examples of social entrepreneurs who have started home-based initiatives for the elderly such as making lamp wicks, brooms etc. Such initiatives can be linked with Kudumbashree or the elderly forums in the locality. The necessary seed funding shall be provided from the funds of the local government.

iv.Entrust elected representative and ASHA in charge of the locality to ensure that all eligible members of the extreme poor households and the most vulnerable among the poor (say, beneficiaries of Antyodaya Anna Yojana) receive the social security pension.

v.Give priority to extreme poor households in MGNREGA work allocation and Aswasakiranam programme.

vi.The state government shall ensure that cash transfers such as social security pensions and financial assistance to caregivers are disbursed every month without interruption. To facilitate this, such information shall be incorporated in the relevant database to distinguish them from others.

•**Ensure free health care for the extreme poor:** The following recommendations are made for ensuring health care for the extreme poor:

i.Three in five extreme poor households in the sample are currently not covered by any health insurance scheme. Universal health insurance coverage for the poor is essential not only for lifting people out of extreme poverty but also for keeping others from falling into extreme poverty. Often, the cost of medical care associated with a major accident or chronic illness can push people into extreme poverty as they end up selling even productive assets to

pay medical bills. The state government may prioritise universal health insurance for the poor as it is one of the most effective interventions in extreme poverty reduction. The ASHAs shall be entrusted with the responsibility of enrolling all poor households (not just extreme poor) in Karunya Arogya Suraksha Padhathi. ASHAs shall also support the households in availing of scheme benefits as many of them may not be capable to do it on their own.

ii.The awareness of various schemes implemented through FHCs, which address non-communicable diseases, depression, pulmonary diseases, etc., is low among the extreme poor. Timely identification, regular monitoring and follow-up and free supply of medicines are key elements of these programmes. ASHAs shall ensure that the extreme poor are brought under the coverage of the relevant healthcare programmes.

iii.ASHA is the primary link between households and the public health system. It should be ensured that the visits by health workers to extreme poor households, especially elderly-only households, are undertaken routinely. Nearly three-fourths of the sample households had members suffering from various chronic health conditions, many of whom require regular monitoring of glucose levels and hypertension. ASHAs shall be trained and provided with a BP apparatus and a glucometer for regularly monitoring the health of the of the chronic patients in these households during their routine home visits. The ASHA shall report their health status to the Medical Officer, and the follow-up can be integrated with NCD clinics or appropriate programmes of the PHC/FHC. Medicines could also be dispensed to patients with limited mobility through ASHAs. It is also important to ensure the reach of the palliative care system to the extreme poor.

•**Focus on mental illness:** As noted earlier, one-fourth of the extreme poor households have a member with mental illness and inadequacy of their health care is a major problem faced by these households. The stigma attached to acknowledging the problem and consequent delay in

seeking care leads to the worsening of the health condition. ASHA may link suspected cases of mental health issues with Aswasam, the depression screening and management programme implemented through FHCs. The project includes screening and diagnosis with referral and treatment support, including the provision of medicines. The possibility of engaging retired medical professionals, at least at the block level, to address mental health issues may be explored. Some of the mentally ill, especially those living alone, need to be supported through institutional care. It is to be noted that DFK and even the new EPEP programme have not included the necessary measures to address mental health issues in the healthcare component of the programmes.

•**Support the caregivers:** The caregivers in the family, in most cases women, grapple with stress and minimal opportunities for employment while engaging in caregiving. They shall be given training in care practices and shall be offered counselling services. It was found that none of the caregivers in the sample households receive assistance under the Aswasakiranam programme of the Kerala Social Security Mission for the caregivers of the bedridden members, and most of them are not even aware of the scheme. The programme shall be made more inclusive, and priority may be given to caregivers of bedridden members in extreme poor households.

•**Door delivery of essentials and other services:** With the high incidence of old age and disability in extreme poor households, access to essential provisions and services is limited. The delivery of medicines, food kits, and other necessities can be facilitated through a system involving the informal support network, which includes family, kinship, and community members including local autorickshaw drivers as well as the support of the LSGI and the Kudumbashree. Identifying the existing support system and linking it to service delivery can yield better outcomes. The interactions between those delivering the services and household members can also provide emotional support, alleviate loneliness, and provide insights into the households' well-being.

•Living arrangements: Among the study participants, there are persons who are aged/ chronically ill/bedridden/with disabilities who are living alone or on the streets. It is important to provide care arrangements for them. In cases where family support is lacking, alternative institutional support shall be planned to ensure their well-being. The feasibility of having assisted living arrangements needs to be examined at the Block level, if not at the GP level. Extreme poor without houses or houses in poor condition shall be given priority in LIFE Mission. Given the low capability of such households, the possibility of implementing it as a housing scheme of the local government shall be explored.

•Facilitation of transport: Access to transport and non-availability of someone to accompany have been reported as barriers to accessing health care facilities. Most households often rely upon autorickshaws as a means of transport, especially during emergencies. A list of autorickshaw drivers willing to provide such services to these households, when required, could be prepared at the local body or ward level. The cost for the same could be subsidised or borne by the Panchayat in the case of extreme poor households. Such a team could also be made use of to procure and distribute ration and other essentials to these households.

•Ensure food security: It is found that 15 per cent of the sample households do not cook food as there is no able-bodied member. Some of them now depend on their family or neighbours for food. However, the continuity of such support depends on various factors and can be erratic. Therefore, the LGs should supplement such efforts to ensure that there is no break in the provision. A combination of suitable options can be tried. The first option could be to entrust the Kudumbashree NHG or a neighbouring household to provide food to such households without interruption. The provisions from PDS and the food kits supplied under DFK could be routed to these NHGs/ households. To meet the expenses for any additional materials to be

purchased and the cost of labour, a fixed amount shall be provided from LG funds or by mobilising funds from the community.

•**Additional nutritional support:** The beneficiaries have greatly appreciated the initiative to provide food kits under the DFK programme. The same may be extended to households covered by EPEP. Similar to the Amrutham Nutrimix powder provided to children in anganwadis, a suitable product may be given to the elderly and bedridden in extreme poor households. It can be included in the food kits.

•**Make AAY more inclusive:** The study finds that only a little more than one-fourth of the households included in the Extreme Poverty Eradication Campaign are beneficiaries of AAY. More than double this proportion is found among DFK beneficiaries. More families are likely to be eligible to be beneficiaries of AAY. Therefore, it is recommended that the extreme poor households are screened again for their eligibility to become beneficiaries of AAY.

•**Make Kudumbashree more inclusive:** Being outside Kudumbashree, the state's poverty eradication programme can be a major disadvantage to the extreme poor as it is the main avenue for social participation, the main source of credit and an important source of information on government schemes. Most of the anti-poverty programmes are also implemented by Kudumbashree. However, about half of the extreme poor households are not part of the Kudumbashree network, and only 14 per cent of the extreme poor have received credit from Kudumbashree. To make Kudumbashree more inclusive, the following recommendations are made:

i.Kudumbashree shall design a mechanism to include those who are not able to pay thrift. It is also important to facilitate the portability of Kudumbashree membership. When a household migrates, membership in the new neighbourhood is offered only if a vacancy exists. It is suggested that the membership shall be extended in such cases irrespective of whether there is a vacancy or not.

ii.Being the state's poverty eradication programme, the systematic exclusion of extreme poor households having only male members is not justifiable. Many such households have elderly or persons with disability. A mechanism to link such households with the state's poverty eradication programme may be developed.

iii.Kudumbashree shall strengthen the programme to improve the financial literacy of the poor so as to empower the poor to be cautious from falling into the trap of extreme poverty.

•**Stimulate social participation:** Social participation needs to be stimulated to improve the resilience of the extreme poor. At present, it can be initiated only by Kudumbashree as it is the main organisation reaching out to the poor now. The support of other community-based organisations can also be facilitated by it.

•**Upward mobility through education:** One of the ways in which the extreme poor can escape from the poverty trap is through education. While no fees are charged in government and aided schools, the non-fee private expenditure is substantial as one moves up the educational ladder. While some components of private costs, such as uniforms and textbooks, are managed up to Class VIII, the families have to spend money on these items afterwards. Once a household is recognised as extreme poor, the educational expenses of the children, including at the higher education level, shall be shared equally by the state and local governments. An assessment of the private cost of education shall be undertaken before fixing the quantum of assistance. The local government can fund its share through contributions from the community, corporations, and NRIs. But finance is not the only problem. They also require support in their studies and for employment/self-employment. For this, a mentorship programme shall be initiated with retired teachers and other students from the community pursuing higher education as mentors to these children. The local clubs or libraries shall also be included in such initiatives with the support of LGs.

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