



BREAKING *the* **BARRIERS**

Pathways to addressing
mental health & long COVID
impact in India

WHITEPAPER SERIES



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FOREWORD



Dr Soumya Swaminathan

Chief Scientist, World Health Organization

The World Health Organization (WHO) declared the outbreak of the novel coronavirus as a Public Health Emergency of International Concern (PHEIC) on 30th January 2020. A few weeks later, on 11th March, it was declared a pandemic. Across the globe, we have witnessed a devastating loss of human life, leaving a long-term impact on mental health, public health infrastructure, workplaces settings and daily life, that will continue to affect us in time to come.

In terms of spread and mortality, recent numbers indicate there have been over 240 million cases and more than 5 million recorded deaths worldwide (true numbers are likely to be much higher).

The first wave of the disease created uncertainty as there was no known guaranteed protection. However, as a safety measure, norms on physical distancing, hand hygiene, masking and sanitizing were encouraged to reduce transmissibility and lockdowns were announced. To enhance the response, the scientific community developed and tested several vaccines against the virus and

reached a quick and successful response which eased tensions. While vaccination alone is not the answer against COVID-19, evidence shows that all approved vaccines reduce hospitalization and mortality due to any of the existing COVID variants.

In April 2021, the Delta variant, a variant of concern which is more transmissible and has some reduced vaccine effectiveness, was detected in India and slowly spread elsewhere. We are at a stage where the cases are low, but we must continue to follow the norms to ensure proper control of the disease.

The challenge has been one not witnessed before in living memory, and tackling the burden would not have been possible without a coming together of multiple stakeholders, be it government, non-government bodies, citizens and international organizations. The response saw a global collaboration, especially between scientists leading to vaccines that were developed at a pace faster than for any other disease in history. We also witnessed a working together of the scientific and public health community with civil society and other stakeholders to ensure a comprehensive pandemic response.

WHO regularly reviewed scientific literature produced on the disease to track the situation. We also conducted science and research forums where top scientists from around the globe came together

to determine how to tackle the disease effectively. The use of digital tools to share regular updates for people around the world also has been remarkably influential, and should be used more in the future.

In India, there was a pre-emptive and proactive response when the Prime Minister announced a lockdown for containment of COVID-19 from 25th March 2020. However, it also led to a disproportionate impact, felt severely by everyone, but especially those from marginalized and vulnerable communities. According to International Labour Organization (ILO) 2020 report, an estimated 400 million informal sector workers were at risk of abject poverty in India.

In terms of the social costs, the 'shadow pandemic' affects women who now face rising domestic and intimate partner violence and additional domestic & caregiving responsibilities. Data from National Commission for Women finds increased instances of domestic violence, with a 10-year high in cases reported despite heavy reliance on digital means to report leaving out most women from underprivileged backgrounds. UNICEF data shows that the closure of schools due to the pandemic has impacted around 247 million children worldwide, who are unlikely to return. This is especially true for young girls considering they are not a priority for education and are expected to complete household chores or get married instead.

There also is a glaring impact on mental health, which requires immediate attention. Evidence finds that major depressive and anxiety disorders increased worldwide, especially among women and youth, with an estimated 35% increase in the prevalence of such disorders in India. The post-COVID landscape is expected to be linked to many health issues, which can increase morbidity, suicides and disabilities related to mental health.

Despite considerable hurdles, there was a strong response from the government, civil society organizations, corporate social responsibility organizations, citizens and others to ensure funding and required on-ground action. During the second wave, when the country saw the biggest ever caseload with increased hospitalization, we also saw stories of survival and humanity coming from people across the country. In a display of resilience, people used social media platforms to help those affected and their families find blood donors, hospital beds, oxygen cylinders, and other facilities. Recently, India has successfully vaccinated more than 100 million individuals, and it is

imperative that we ensure that everyone, especially the most vulnerable, access a full course of vaccination.

With rising morbidity, loss of loved ones, isolation, and other challenges, the mental health effects due to COVID are likely to be severe. As we enter with the third year of this pandemic, it is critical that we understand the severity of the challenge and how it can affect us in the long run if no action is taken. We must prioritize physical and mental health in our responses to deal with the pandemic. To ensure the same, it is crucial to apply a multipronged approach and gender lens in mind to ensure that we reach all populations, especially those who need it the most.

This series comes at an opportune time and I wish ETI and PATH the very best as they work towards creating a conducive environment and gather best practices to address this critical issue.





PROLOGUE

We have learnt much about the COVID-19 pandemic and the ensuing devastation and disruption of life globally, at a scale that is probably only preceded by the India's Independence struggle. Those already disadvantaged by a range of socio-economic vulnerabilities have likely endured the adverse impacts disproportionately. National and global experts, as well as leaders have come together to develop ways to address the challenges posed by the pandemic, revive the economy and ensure access to health services across the country.

While COVID- 19 has taken a physical toll, in the number of deaths, the impact on mental health, remains relatively overlooked. The country's strategies need to recognize this burden and develop pathways to address the mental health needs of citizens.

Before the pandemic, results from the National Mental Health Survey (2015-16) point to India's massive burden of mental health challenges. It showed that nearly 150 million people require mental health services, while less than 30 million people seek proper care. The pronounced gap is attributed to stigma, structural factors like gender, age, as well as lack of awareness and shortage of medical professionals to address the issue. As stated in the Lancet-

“Disruptions to physical activity and mental health are strongly associated, but restoration of physical activity through a short-term intervention does not help improve mental health. Studies highlight the large impact of COVID-19 on both lifestyle and well-being and offer directions for interventions aimed at restoring mental health” (Guintella, et al., 2021).

The World Health Organization states that all individuals are affected by the pandemic in one way or another, and the mental health impact

of the pandemic is far-reaching. In India, with the lockdowns, the country witnessed a loss of jobs, disruption of education and health services, social isolation and separation from peers, grief, fear of contracting the infection and widespread misinformation. These were all responsible to add to emotional distress, with media reports and studies substantiating an increase in mental health symptoms of stress, anxiety, depression, anger, loneliness, as well as suicide attempts and suicides especially. Mental health is rightly starting to become the center of attention; however, working towards the challenge is only possible when we also understand and address other factors affecting it, like gender, financial ability, and digital means of technology and systems to provide universal access to mental health care.

This whitepaper series, developed in collaboration with national and international experts from different fields, attempts to highlight the impact of the pandemic on various aspects of life, the ensuing mental health crisis, and initiate a discussion on the way forward to address this. We hope this series will highlight the centrality of mental health in human life, and the urgent need to view mental health holistically, addressing not only the symptoms, but also the underlying factors in a comprehensive and sustainable manner across the country.

With a foreword by **Dr Soumya Swaminathan, Chief Scientist, World Health Organization**, the series is divided as per the following perspectives:



Scientific: The paper titled '*Understanding of Post-COVID Impact*' authored by **Dr Virander Singh Chauhan**, Emeritus Professor & Founder, ETI and **Mr Neeraj Jain**, this piece focuses on understanding the condition of long COVID, a challenge that remains novel to the COVID-19 disease, and its physical and mental effects. It also looks at the vitality of vaccination and other scientific inventions in countering COVID and long-COVID.



Mental Health: In the piece *‘Transforming Mental Health in India’*, **Dr Vikram Patel**, Founder, Sangath, and Professor, Global Health, Harvard T.H. Chan School of Public Health, details the challenges to mental healthcare in India, at a structural level from the demand and supply side. The paper guides us to the pathway and the need to change how mental health is viewed and to develop a holistic approach to addressing the issue.



Economics: **Dr Madhura Swaminathan**, Chairperson of the MS Swaminathan Foundation, in the paper *‘COVID-19 and the economy: Implications for women and children’* discusses how the pandemic and lockdowns affected the Indian economy, workers, especially the informal sector and women workers. It also focuses on the possibility of an increase in child labour which has become evident with the inability to access education, especially for children from vulnerable populations.



Gender: With COVID-19, there has been an undoing of years of progress in women empowerment. **Ms Susan Ferguson**, UN Women Representative for India, in *‘COVID through a gender lens’* writes about the rising domestic and intimate partner violence and additional care responsibilities. The latter remains invisibilized in society, despite its considerable contribution to the Indian economy.



Civil Society Experience: Important groups that remain out of focus regarding their challenges are adolescents and youth in the country. **Ms Poonam Muttreja**, Executive Director at Population Foundation of India, in her piece *‘The long-term impact of COVID-19 on women’s health: A gendered perspective’* writes about how young girls have been affected due to the lack of access to education, WASH and other facilities due to COVID 19.

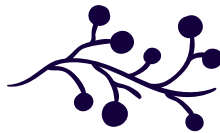


Digital India: The physical distancing guidelines only reinforced the need and value of digital means of communication to stay connected. However, the lack of proper infrastructure leads to unequal access for many, especially those from vulnerable and

marginalized populations, including women. To tackle the challenge and build the vision of 'Digital India', **Dr Hindol Sengupta**, Vice President, Invest India and **Ms Guriya**, Assistant Manager, Invest India, Development Research and Strategic Alliance Desk (DRISHTI) in their piece '***Harnessing the Power of Digitalization to Empower Women in India Post COVID-19***' write about bridging the gap in access to ensure women and girls empowerment.



Philanthropic Donor Organizations: **Dr Ulla Jasper**, Governance & Policy Lead and **Mr Siddhartha Jha**, AI/Digital Program Manager, Fondation Botnar in their piece '***Protecting our future: Addressing the mental health impacts of COVID-19 pandemic on young people in India***' raise concerns over the impact of the pandemic on the mental health of adolescents. They suggest a need for philanthropic organizations to fund innovation in mental health, to address the challenge effectively, and focus on locally developed solutions.





SCIENTIFIC

Dr Virander Singh Chauhan & Mr Neeraj Jain

Dr Virander Singh Chauhan, Emeritus Professor & Founder, ETI

Dr Chauhan is a visionary scientist and a Rhodes Scholar. He obtained a PhD degree from Delhi University and a D.Phil from Oxford University. He is widely recognised for his research contributions in the field of malaria vaccine development and the biological application of synthetic peptides.

Mr Neeraj Jain, Country Director- India and Director- South Asia, PATH

Mr Jain holds more than 27 years of extensive experience in strengthening organizations. His strengths lie in setting up new ventures, organizational development, and market development, and he has provided strategic leadership for change management in organizations across Asia and Europe.

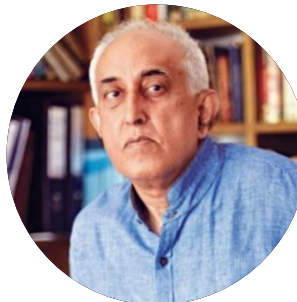
UNDERSTANDING OF POST-COVID IMPACT

ABSTRACT

With already 280 million cases and over 5 million deaths reported, the COVID-19 pandemic has led to widespread devastation never seen before in our living memory. The challenge continues with the condition of long-Covid, uniquely related to COVID-19, where symptoms persist even after a significant time post recovery.

The science of the disease is complex and remains unknown to many who fall into traps of misinformation. There is an urgent need for making evidence-based scientific information widely accessible and in simple terms. We must also learn the implications of long Covid to optimize our response.

Keywords: long covid, covid-19, long haul covid, post covid



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INTRODUCTION

The COVID-19 outbreak caused by the novel coronavirus, SARS-CoV-2, has once again brought the survival struggle between microbes and humans into the limelight. This infectious disease affects the respiratory system, and causes fever, cough, weakness, among other symptoms. Even though it is assumed that the virus most commonly strikes the lungs first, it is not simply a respiratory disease, and the lungs are not the most severely affected organ in many people. In part, this is because cells in multiple locations harbour the Angiotensin-Converting Enzyme-2 (ACE-2) receptor which the virus uses to enter cells (Marshall, 2020).

The virus spread quickly from Wuhan, China, to Europe, particularly in Italy and Spain, which faced the first brunt of COVID-19. The spread of the virus over a large part of the

world, crossing international boundaries and affecting a large number of people, led to the World Health Organization (WHO) announcing it as a pandemic on 11th March 2020, incidentally, the same day when the first case in India was reported. As the cases grew in India, a complete countrywide lockdown to control the spread of the virus. It led to widespread adverse effects on the Indian economy and vulnerable populations like the frontline healthcare workers, women, children from marginalized populations, among others. There was a gradual reopening of the economy; however, as inherent in all viruses, the coronavirus also evolved and mutated, leading to the selection of more infecting variants. As per WHO, there are five 'variants of concern' to SARS-Cov-2, Alpha¹, Beta², Gamma³, and Delta⁴ and Omicron⁵ (WHO, 2021). Out of these mutants, the highly

-
- 1 Earliest documented - UK, Sep 2020
 - 2 Earliest documented - South Africa, May 2020
 - 3 Earliest documented -Brazil, Nov 2020
 - 4 Earliest documented - India, Oct 2020
 - 5 Earliest documented – Multiple countries, Nov 2021

infectious and fast replicating Delta variant has completely taken hold of the pandemic and is responsible for more than 99 percent of all infections worldwide. Omicron which has many more mutations than the Delta variant is at least twice as infective as Delta variant, but as per the current data it seems to cause mild disease.

It is yet to be seen whether Omicron will finally outcompete the Delta variant. Many more questions need to be answered about Omicron including its ability to successfully evade immune responses induced by vaccination or upon natural exposure. Multiple studies are underway to address these questions.

Although COVID-19 spread fast, the science of it advanced quickly too. By the end of 2020, several vaccines were developed at an unprecedented speed as a result of collaborations between scientists, industries, governments and funding agencies in many countries worldwide. The countries that started vaccination programs earlier showed that vaccines could stop the link between infections and severe disease, hospitalization, and death. More than 20 vaccines have been approved for emergency use worldwide. As of now, more than eight billion shots of different vaccines have been rolled out, the access to these vaccines have remained unequal. While some countries have vaccinated more than 70 percent of their adult population, the vaccine coverage in many low and middle-income countries (LMIC) have not reached

even 10 percent of their populations.

Within 6 months of the pandemic, several studies had begun to show that COVID-19 was different in that a sizeable number of people continued to have disease symptoms months after they recovered from the infection. These after-effects of COVID-19 in some infected individuals have now been reported from all over the world.

It is quite clear that the continued existence of symptoms in a sizeable number of those who suffered from COVID-19 will require special attention from healthcare givers and policymakers. Here, we have attempted to provide the current state of knowledge of the so-called long-COVID.

Long COVID refers to the condition where

LONG COVID

people with COVID-19 infections continue to experience symptoms for much longer than what may be considered usual after the infection. It is also referred to as post-COVID, post-acute sequelae of COVID-19 (PASC), long-tail COVID, post-Covid-19 condition (PCC).⁶ It can be divided into two stages, post-acute COVID with symptoms extending past three weeks but less than 12 weeks, and chronic COVID with symptoms extending past 12 weeks (Raveendran, et al., 2021). WHO's clinical case definition for post-

.....
6 Used interchangeably

COVID-19 reads, “It occurs in individuals with a history of probable or confirmed SARS CoV-2 infection, usually 3 months from the onset of COVID-19 with symptoms that last for at least 2 months and cannot be explained by an alternative diagnosis”. Common symptoms include fatigue, shortness of breath, brain fog, cognitive dysfunction and others that impact daily functioning. These may be new post initial recovery from an acute COVID-19 episode; they may also fluctuate or relapse over time (WHO, 2021).

In a study from Columbia University, USA, it was found that between 32.6 percent and 87.4 percent of patients showed at least one symptom persisting after several months after infection (Marshall, 2021). The symptoms reported included breathing problems, fatigue, throat/chest pain and anxiety/depression. The organ specific sequelae include new or worsening diabetes mellitus, dyspnea, decreased exercise capacity, hair loss, and others (Raveendran, et al., 2021). Another study from Oxford University and the National Institute for Health Research showed that at least one long-term COVID symptom persisted in 37 percent of people 3 to 6 months after the infection (OxfordUniversity, 2021).

In India, a study from Max Healthcare found that out of 990 RT-PCR confirmed COVID-19 patients, 31.8 percent of them had post-Covid symptoms beyond three months, and 11 per cent had them for around 9-12 months (Budhiraja, 2021). Compared to the first wave,

there was a four-fold increase in cases of long-Covid infections during the second wave. The deadly Delta variant led to a higher viral load and more distinct symptoms like high-grade fever, diarrhoea, severe lung infection followed by post-Covid complications, like falling oxygen levels and lung fibrosis that continued even eight or more weeks after testing positive. Scientists attributed this to a low-grade cytokine reaction or some type of immune dysregulation in the body and which the body has not been able to handle (Mordani, 2021).

Several current studies suggest no conclusive underlying condition inflicting long-COVID. Available evidence suggests that potential contributors to PASC due to acute SARS-CoV-2 infection include injury to at least one more organs, continual reservoirs of SARS-CoV-2 in some tissues, immune dysregulation leading to re-activation of neurotrophic pathogens like herpesviruses, the interactions of the virus with host-microbiome/virome communities, clotting/coagulation problems, dysfunctional brainstem/vagus nerve signalling, ongoing activity of primed immune cells, and autoimmunity due to molecular mimicry between pathogen and host proteins (Proal & VanElzakker, 2021). The virus can also activate the immune response in a way that leads to long-term auto-antibody production⁷(ibid).

In another study from Oxford University, researchers found that around 60 percent of people from South-Asian backgrounds

7 These arise as a result of molecular mimicry, or sequence homology, between host & organism peptides and proteins.

and 15 percent of individuals from European ancestry carry the high-risk version of the COVID-gene⁸. (Mundasand, 2021). Whether the same remains true for long-Covid is yet to be seen. Current evidence suggests that middle-aged people and women are at a higher risk of having long-Covid (Taquet, et al., 2021).

According to the UK Office of National Statistics, long-COVID is most common among middle-aged people where the prevalence was found to be 25.6 percent at five weeks for those aged between 35 to 49 years, while it was 10 percent for those between 18-49 years (Marshall, 2021). Women, especially the middle-aged, are prone to autoimmune conditions that attack healthy cells and organs, and thus to long-COVID.

A study published in Lancet comparing long-COVID condition in men and women under 50, three weeks post-discharge, showed that the women were five times less likely to feel fully recovered from the virus, seven times more likely to be breathless and twice as likely to report worse fatigue. They also reported difficulties related to memory, mobility, vision, and hearing (Sigfrid, 2021).

A Covid-19 “long haulers” study from Saint Louis Veteran Affairs Medical Centre, USA, reported that individuals with symptoms related to the disease after six months

exhibited multiple health problems; and were also at a higher risk of dying. They had a 59 percent increased risk of dying within six months, which translated to eight extra deaths per 1,000 patients (Gale, 2021). It also found that beyond the first 30 days of illness, those with COVID infection who were hospitalized had an increased risk of death and were more likely to exhibit a broad array of incident pulmonary and extrapulmonary clinical manifestations (nervous systems, neurocognitive disorders, and others) (Al-Aly, et al., 2021).

Long COVID also affects people’s ability to resume normal life and their capacity to work (TheLancet(ed.), 2021). Given the diseases’ unpredictability and symptoms’ longevity, it is also associated with depression, anxiety and loneliness (Dey, 2021). While these symptoms lack tangible markers and seem insignificant, they distinctly affect the daily lives of those who carry them, severely affect their mental health (Barnagarwala, 2021). The anxiety disorders are characterised by extensive worrying, tension and nervousness as well as physical symptoms like heart palpitations, sweating, and tremors. Many people reported feeling ‘dismissed’ by the system and receive conflicting advice, which only adds to their pain (Bond, 2021).

Long-COVID is also associated with physical exhaustion and irritability, including the inability to breathe for some people, which leads to

8 Human Betacoronavirus is a spherical or pleomorphic single-stranded RNA associated with a nucleoprotein within a capsid comprised of matrix protein. Genes for structural proteins in all coronaviruses occur in the 5'-3' order- as S, E, M and N (Mousavizadeh & Ghasemi, 2020)

a significant risk of experiencing depression, post-traumatic stress disorder (PTSD) and anxiety (Naidu, et al., 2021) Combined with the inability to work, socialize and exercise, these factors can have a devastating impact on mental well-being. For people living with mental health disorders already, long COVID can worsen their psychological well-being further.

VACCINATION & LONG-COVID

While vaccination does not guarantee safety against contracting the disease, evidence strongly suggests it almost eliminates the chances of hospitalization and mortality, even in breakthrough COVID-19 infections (Bahl, et al., 2021). However, establishing any links between vaccination and long-COVID is inherently a complex task.

But, several studies have shown that unvaccinated individuals are more likely to have long-COVID compared to fully vaccinated ones. For example, a study from King's College found that fully vaccinated adults were 49 percent less likely to have long COVID if they contracted the infection (King's, 2021). It is quite logical to assume that any efficacious vaccine which produces strong antibodies and T-cell responses should be able to significantly reduce viral replication cycles before hidden reservoirs in the body can be established. Further, this is likely to

allow the body to generate targeted immune responses when the virus infiltrates the body and thereby stopping non-specific immune from targeting normal tissues.

However, with the emergence of the Delta variant, there was a concern as this variant can compromise with the ability to neutralize antibodies generated upon vaccination, and appear to be 8 times more likely to cause breakthrough infections among vaccinated people⁹ and 6 times less sensitive to serum neutralising antibodies of those recovered, compared to the Alpha strain (Mlcochova, et al., 2021). But, large-scale vaccination in different parts of the world has shown that most vaccines have remained efficacious against all variants, including the Delta. In India, also, the vaccination program that was almost entirely based on AstraZeneca's Covishield and Covaxin of Bharat Biotech showed that fully vaccinated individuals were protected from severe disease and hospitalization during the pandemic driven mainly by the Delta variant (Kumar, 2021).

However, with the emergence of the Delta variant, there was a concern as this variant can compromise, at least partially, with the ability to neutralize antibodies generated upon vaccination, and appeared to be eight times more likely to cause breakthrough infections among vaccinated people (Mlcochova, et al., 2021). But, large-scale vaccination in different parts of the world has shown that most vaccines have remained efficacious against all variants, including

the Delta. In India also, the vaccination program that was almost entirely based on AstraZeneca's Covishield and Covaxin of Bharat Biotech showed that fully vaccinated individuals were protected from severe disease and hospitalization even during the second-wave of the pandemic (Kumar, 2021).

THE WAY FORWARD

Testing and tracing continue to be of utmost importance to track the spread of the virus, especially as the economies have reopened and people-to-people contact has enhanced. It is critical that as we move forward, the testing & tracing infrastructure is made affordable, innovations are encouraged and promoted to meet emerging needs. The emergence of Omicron only makes it more imperative that surveillance of new viral mutations remains a top priority.


Genome sequencing, crucial for tracking the mutations and developing strategies for containment, needs to be ramped up as well. Genome sequencing is essential for a more comprehensive response towards the virus as the information assists epidemiologists and other healthcare workers in understanding the spread of the virus and its mutations as well as assess the effectiveness of interventions to make required changes. According to

Global Initiative on Sharing All Influenza Data (GISAID), till September, India lagged behind many others, having only sequenced a little over 82,000 samples which accounted for only 0.2 percent of the cumulative cases (Kaur, 2021).

With the recent evidence developing around antiviral drugs and monoclonal antibody therapy (mAB)¹⁰, there are now more efficient methods for COVID-19 control. Recent announcements by pharma giants, Merck and Pfizer regarding the treatment of COVID-19 using oral pills may well be the game-changer in controlling the pandemic, particularly in LMICs where the vaccination drives have been very slow, mainly due to the non-availability of vaccines. These pills, Molnupiravir and Paxlovid™, reduce severe infection and hospitalization by 30 and 90 percent respectively, can be easily manufactured at scale, are highly cost-effective, safe and stable as well as easy to distribute in difficult locations. Moreover, both Merck and Pfizer have already announced that these drugs can be manufactured and distributed in developing countries at much lower and affordable prices.

The recent huge infection wave in European countries, the UK and USA, where two-thirds of the population are fully vaccinated, should serve as a reminder that the pandemic is very much here. India has a steady decline in the number of reported cases and has cautiously

10
A form of immunotherapy using monoclonal antibodies to bind monospecifically to certain cells or proteins to stimulate the patients' immune system to attack those cells.



opened economic and other activities, and we should continue all our efforts, particularly COVID-appropriate behaviour, even when one is fully vaccinated.

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MENTAL HEALTH

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Dr Patel's work has focused on the burden of mental health problems across the life course, their association with social disadvantage, and the use of community resources for their prevention and treatment. He is a co-founder of the Movement for Global Mental Health, the Centre for Global Mental Health (at the London School of Hygiene & Tropical Medicine), the Mental Health Innovations Network, and Sangath.

TRANSFORMING MENTAL HEALTH IN INDIA

ABSTRACT

Despite the high numbers of people who require mental health care, India has neglected the issue and remains rooted in stigma. The COVID pandemic has created isolation, fear of contracting the virus, loss of opportunities, emotional turmoil and other social determinants which directly affect mental health well-being. People are becoming aware of its importance, but we are still far from making it accessible for a vast majority of the population, primarily vulnerable communities. To tackle this critical aspect of health, we need to come together and build collective social responsibility. It becomes crucial to mobilize the political will, resources, and community demand to address this crisis.

Keywords: Mental health, COVID, Long COVID, Social responsibility, stigma, health



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INTRODUCTION

The challenge

A wide range of health conditions are subsumed under ‘mental health problems’, from autism and intellectual disability in childhood to mood, anxiety, trauma, substance use and psychotic disorders in adulthood, to dementia in older age. The National Mental Health Survey, 2016 (G, 2016) reported that at least 100 million people in this country are currently affected by mental health problems, and tens of millions more if we count their family members. Beyond these astonishing numbers, what remains disturbing is that the vast majority of these persons, exceeding 90% in rural communities, had not received any treatment or care.

The impact of this monumental unmet need for care is profound but remains hidden from public view except when we see an unwell person living rough on the streets and read about suicides. India has become the epicentre of global suicide mortality in recent times, accounting for about a quarter of all male and a third of all female suicide deaths.

These have worsened with the COVID-19 pandemic as India reported more than 1.53 lakh suicides in 2020, highest in the last 10 years as per the National Crime Records Bureau.

Suicide mortality is concentrated in young people; approximately two-thirds of all suicides occur in people under 30 years. Youth is a vulnerable period for suicide as it is characterised by unique neurodevelopmental changes alongside dramatic transitions in one’s self-image and aspirations, and one takes the most important life decisions related to education and relationships. Usually, youth suicide attempts are impulsive – triggered by acute disappointments such as a poor examination result or the loss of a romantic relationship. A curious observation is that the epicentres of suicide are in the more highly developed states of India, for example in the South (Patel, 2012). One may speculate that a critical reason for this is the growing gap between the aspirations of educated youth and the reality of a harsh society in which they find themselves trying to find a foot.

The impact of mental health problems, further aggravated during the pandemic, extends to reduced opportunities in education and employment, higher out-of-pocket expenditure on health care due to doctor-shopping for relief (including consulting other systems of medicine), stress on caregivers, and the pervasive effects of stigma.

The unmet need for care for mental health problems can be attributed to both supply and demand-side barriers. On the supply side, primary care physicians and other frontline providers have limited training in mental health care. There are only about 10,000 specialist mental health professionals, most of whom are concentrated in cities and big towns and work in the private sector. Public expenditure is a miniscule 1 percent fraction of the overall health budget, focused entirely on hospital care. It is estimated that more than three-quarters of all in-patient beds for mental health care are situated in about 40 large mental hospitals. The District Mental Health Program (DMHP) was initiated as one of the foundations of the National Mental Health Programme (NMHP) to provide mental health services at the community level by integrating mental health with the general healthcare delivery system way back in 1982, making India one of the first low-income countries to adopt this goal. However, actual implementation was only initiated in 4 districts in 1996 and was expanded to just 123 districts (RS, 2011). Community based mental health care, the most cost-effective and person-centred approach, is not available in any part of the country. These barriers are even

greater for specific groups in the population, especially children and adolescents, people with substance abuse problems, and older adults with dementia.

Demand-side barriers, apart from the cost and lack of access and poor quality of care are related to the high levels of stigma associated with mental health problems, alienation from the narrow biomedical care model, which focuses on the “3D” of Doctors, Diagnoses and Drugs which is out of sync with widely held illness narratives associated with mental health problems, and the historic association of mental illness, typically conflated with ‘madness’ in folk traditions, incarceration, sedation, loss of fundamental rights and bad omens. Substance use, notably alcohol and opiate abuse, present a unique challenge: India continues to implement prohibition with stringent penalties, despite evidence that this policy is ineffective, criminalizing a health problem and fuelling the criminal mafia, which thrives on prohibition and deaths due to illegally brewed alcohols. The absence of alternative public health policies to address substance use instead of criminalizing the behaviour pushes the affected, particularly low-income individuals, to the margins of society.

THE OPPORTUNITY

Several recent developments serve as the foundations of the opportunity to reimagine and transform mental health care in India:

The Mental Healthcare Act, community health worker, delivered mental health care, and opportunities for prevention by acting on social determinants of mental health. The Mental Healthcare Act is the first legislation enshrining the right to health care and the government's responsibility to fulfil this right. This goal has remained elusive for the broader health aspirations of India's people.

The most innovative health care delivery solution emerging from India is one that reimagines the human resource mix for addressing the enormous inequities in access to health care through task-sharing with non-physician frontline providers. The deployment of over a million ASHA and other community health worker cadres in the past two decades to deliver a range of health interventions is a testimony to the national policy impact of this innovation. It is one of the significant contributors to the improvements in maternal and child health indicators, which has now been adapted to deliver mental health interventions. Much of the science needed to design and evaluate this approach has been led by Sangath, a pioneering research organization that has demonstrated the effectiveness of task-shared brief psychosocial interventions for the prevention and care of a range of mental health problems, from autism in childhood to emotional problems in adolescents to psychoses, depression and harmful drinking in adults. The global impact of Sangath's work is evidenced by the fact that one of its interventions, the Healthy Activity Program, delivered by lay counsellors (Patel, 2017), has now been

adapted for delivery in Canada and the USA. A key element of Sangath's approach is the active engagement of community stakeholders to design, plan, deliver and hold mental health interventions accountable. Bringing together community stakeholders helps develop a holistic approach to improve healthcare delivery and management, and act according to the changing landscape.

A blind spot in mental health has been the lack of attention to primary prevention despite the compelling evidence of the role of social determinants on poor mental health. There is now a strong evidence base demonstrating the many opportunities for prevention, targeting social determinants such as poverty, gender-based violence, quality education, community social capital and, most important of all, early life adversities such as child neglect and deprivation.

Our strategies need to promote nurturing environments at home and school, such as through parenting interventions and enhancing school climate, cash transfers for low-income families, combating gender-based violence and other types of discrimination. Building life skills focused on social and emotional competencies. Many of these actions will help realize other major development priorities, and investing in these will also improve population mental health.

While there has been a flourishing of initiatives to address this rising tide of mental health problems in response to the pandemic, most notably through telemedicine platforms, these

rely on specialist providers, who are scarce and are affected by inadequate internet connectivity and digital illiteracy, especially among vulnerable populations. However, telemedicine also allows for remote delivery for improved accessibility to specialist care in under-served regions. It recognizes the value of psychological therapies, often ignored, and is provided by a diverse range of providers who offer counselling interventions.

THE WAY FORWARD

Mental illnesses were already a leading cause of suffering and the most neglected health issue globally before the pandemic. The pandemic, worsening the social determinants of mental health, compounded this crisis. Extensive morbidity, fear of contracting the virus, isolation, loss of opportunities and others caused emotional turmoil, anxiety, increased negative thoughts, inability to sleep, and concentrate. While Indian evidence is limited, global studies indicate how these cause traumas. One such study finds that 13.2% had Post Traumatic Stress Disorder symptoms associated with the infection or taking care of those infected. (Bridgland, 2021)

The pandemic presents a unique opportunity to reimagine mental health care, as it fully exposed the inefficiency of the existing mental healthcare system. This may represent an opportune moment to mobilize the political will, resources, and community demand for scaling up the science, demonstrating the

need to embrace the diversity of experiences and interventions to address this crisis. Political will is needed not only to contribute materially but to support the engagement of a more diverse workforce to deliver mental health interventions and empower persons with the lived experience to hold services accountable. The Lancet Commission on Global Mental Health laid down these three key principles for reframing mental health. (Patel, 2018)

First, we need to move beyond the narrow diagnosis-driven approach to classifying and labelling mental illness for reasons elaborated earlier, viz. This approach is neither supported by decades of basic and epidemiological science nor acceptable to communities globally. Offering mental health care must not be contingent on a ‘diagnosis’, and a ‘diagnosis’ must not automatically mean the person needs to be ‘treated’ by a specialist mental health professional. Instead, the need of the hour is to scale up the rich evidence on the effectiveness of frontline health workers delivering low-cost psychosocial interventions to build the foundation of mental health care in the community.

That said, one size does not fit all for mental health care. There will always be persons who need more specialized care, including medications that can be transformative (think of antipsychotic drugs for schizophrenia or lithium for bipolar disorder) and brief hospital stays for acute crises. Even the much-maligned electroconvulsive therapy (ECT) has an important role when used judiciously

for persons with severe and potentially life-threatening depression. Thus, collaborative care, involving a close partnership between primary and community care providers with mental health specialists working in tandem to help the person realize their desired outcomes (the hallmark of person-centred care) in a coordinated, seamless manner, would comprise the best evidence-informed delivery model. This is, of course, the same delivery model for all chronic conditions and offers the opportunity to integrate the care of physical and mental health concerns, bridging a chasm that has historic roots in the evolution of modern medicine.

Second, we need to reject the debate about whether mental health is determined by nurture or nature. Evidence demonstrates that both play a role: the ‘convergence’ of genetic factors, early and contemporary life experiences, the social worlds influencing these experiences, and biological systems (from neurodevelopmental transitions to the gut microbiome) explain the mental health of each individual. Importantly, each of these domains includes both risk and protective factors. Given the enormous diversity in these domains, the sum of the permutations of elements across all domains is potentially infinite. The final clinical picture captured in a diagnosis tells us nothing about this personal story. Moreover, the convergent approach emphasizes the role of social determinants, particularly in the first two decades of life when the brain is most responsive to environmental influences and recognizes the importance of nurturing environments in promoting mental

health and preventing mental illness. Much of the effort to address prevention will lie outside the health sector, e.g., the Ministries concerned with Women & Child Development or Education, indicating the importance of inter-sectoral partnerships for mental health.

Third, we need to reframe mental health through the lens of human rights. At least three specific kinds of rights are particularly relevant. The first is the right to be protected from known harms that adversely affect mental health, particularly adversities in childhood, violence through the life course, facing any form of discrimination, and the damaging effects on the mental health of living in conditions of poverty. Second is the right to receive care, on par with any other health condition and regardless of the ability to pay for a mental health condition. Third, and most importantly, is the right to the freedom to choose what type of care, if any, a person wishes to receive, without any coercion or fear. This right is aligned with the UN Convention for the Rights of Persons with Disability’s vision of equality for persons with psychosocial disability on all matters, including the right to refuse treatment for a health condition. The Mental Healthcare Act requires the regulatory provision of District Boards, consisting of a district judge, psychiatrist, users and caregivers, to ensure that the rights of persons with mental health problems are respected during care. This is a significant step towards realizing the goal of supported decision-making to enable a person with a mental health problem to decide on the treatment in their interest, replacing

the historic approach of decision-making being substituted through a legal process.

It is critical that mental health screening is incorporated with an increased focus on high-risk populations for early intervention to prevent the development of long-term symptoms. One way to increase access to these communities is by removing healthcare providers' financial and social barriers. Policymakers can improve access by increasing telehealth services and introducing community health worker delivered mental health care across the country. There is a need to reach out to people with lived experiences as their testimonials can help destigmatise attitudes and encourage help seeking behavior.

In the spirit of the Sustainable Development Goals, the moral imperative for mental health care is to leave no one behind by implementing evidence-informed community delivered programs for the care and prevention of mental health problems, embedded in a universal health coverage and empowerment framework. Investing in such a reformed mental health system can enable individuals to regain hope for the future and the necessary cognitive and emotional capabilities to work effectively and participate meaningfully in one's social world. Collectively, it can help build stronger, more cohesive communities, improving their capacities to confront the pandemic and the crises that loom in our post-pandemic future. Ultimately, we need to recognize and celebrate mental health as a fundamental, universal human quality, an inseparable part of health necessary to all people in all communities, and care for which should be regarded as a national public good.

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ECONOMICS

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COVID-19 & THE ECONOMY

ABSTRACT

The COVID-19 pandemic and subsequent lockdowns caused a grave threat to economic and social well-being globally. While the world recovers from the aftermaths of the fatal virus, the challenges remain severe for developing countries such as India, which were already grappling with socio-economic inequalities. We must understand the differential impact of the pandemic on different groups, especially workers in the informal sector, women workers and young girls and boys. Bold measures are needed to strengthen the path of recovery and address some of the longer-term economic and social consequences of the pandemic.

Keywords: COVID-19, economy, jobs, women, care work, child labour.



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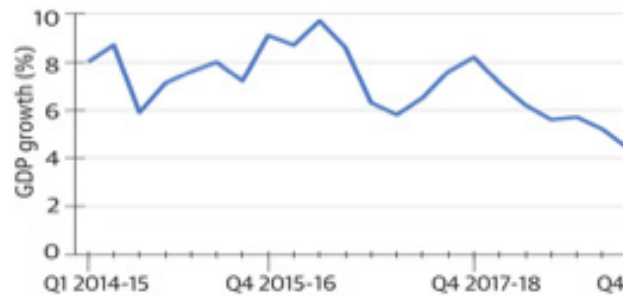
INTRODUCTION

The COVID-19 pandemic and subsequent lockdowns led to nationwide shutting down of businesses, and subsequent loss of jobs, in India as in many other countries of the world. The combined health and economic crisis have led to a clear worsening of already existing socio-economic inequalities with the most adverse effects of the pandemic being borne by the most vulnerable populations. As the economy reopens and recovers, there is an urgent need to take concrete measures to recognize these inequalities and address the long-term implications of the pandemic on the well-being of the vast majority of our population.

This paper aims to look at how the pandemic and lockdowns have affected the Indian economy. In particular, the focus is on the impact on women and children, who have experienced severe constraints during the pandemic.

IMPACT ON INDIAN ECONOMY

The Indian economy had begun to slowdown even pre-pandemic. In the first quarter of 2019, the Real Gross Domestic Product (GDP) grew



Source - Hindustan Times

at 5 per cent, which was the slowest rate in the past six years (Vashisht, 2019). The pandemic led to a global economic crisis resulting in a 24 percent drop in GDP in the first few months of the lockdown, and a further 7.4 per cent in the second quarter of 2020-21. The country witnessed the sharpest ever contraction of the economy in the last financial year (FY 21), of 7.3 per cent.

The impact on employment was visible to all. The global unemployment rate peaked, with a loss of 255 million full-time jobs in 2020 relative to the last quarter of 2019 (Dasgupta 2021), “an impact which was four times bigger than during the 2009 (financial) crisis” As Dasgupta points out, a matter of concern in the pattern of job loss and unemployment is the rise in “inactivity” or people dropping out of the labour force. This has particularly affected young people, women and less skilled workers. As she notes, “the crisis accentuated the skill divide, the gender divide and the digital divide.” (ibid.)

The sudden announcement of a nationwide total lockdown put workers in the informal sector in urban areas – footloose, migrant workers, under severe duress. ActionAid estimates suggest that up to 80 per cent of

workers in the informal sector lost jobs as the lockdown progressed, including daily wage workers, street vendors, and others (ActionAid, 2020). Migrant workers, who form a large part of the informal sector, suddenly found themselves out of jobs and, by extension, were unable to survive in their current urban location. Workers in the informal sector are largely outside the net of social protection. Not only did workers lose their jobs, many were not paid for the days they had worked, others lost their accommodation, and most did not have access to basic food security, such as through the Public Distribution System. Abandoned by their employers and the State, these workers were forced to go back to their villages and home towns, resulting in an unprecedented reverse migration from the big cities to rural India. Data from June to August 2020 shows that migrant workers' incomes had fallen by an average of 85 per cent after returning to their rural areas of origin (Dutta & Paul, 2021). Many households became vulnerable to debt traps. An ActionAid India study showed that 57 percent workers incurred debt, mostly from informal lenders at high interest rates (ANI, 2021).

In India, the agricultural economy displayed resilience and became the major source of recovery in growth. Agricultural output grew at 3.6 per cent during 2020-21, with a record 305 million tons of food grain production (Mishra, 2021). Employment in agriculture became available to rural workers, supplemented by public works employment through the MGNREGS, while non-agricultural sources of employment, most importantly construction,

recovered very slowly.

Another major component of the informal sector, Micro, Small, and Medium Enterprises (MSMEs), were seriously affected as these small firms could not bear the financial losses, and many closed down during Covid-19. A joint survey conducted by Magma Fincorp and SPJIMR found that approximately half of the MSMEs across the country experienced a loss of 20-25 per cent in revenues.

The International Monetary Fund has projected India's growth rate at 8.5 per cent for 2022 (PTI, 2021). While the predictions for the current Financial Year (FY 22) are positive, we have to note the long-term effects of the previous year. Some enterprises have closed, as noted earlier, and making a recovery seems impossible (such as small tourist operators). Workers who lost jobs and became indebted may find it difficult to get out of the debt trap. The economic downturn worsened inequalities that need to be specifically addressed in the process of recovery.

The Covid-support package of the Government of India was notably meagre and far from sufficient to address the massive crisis of livelihoods. While the size of the stimulus package proposed in May 2020 was around 10 per cent of India's GDP, the expenditure directed towards social protection measures was estimated to be between 1.2 and 2.2 per cent of GDP (FTC 2021). Specifically, the relief measures announced for the most vulnerable sections of society – cash transfers and food subsidies have been too inadequate. Of the

2 lakh crores of direct fiscal outlay, “only Rs 76,500 crores was direct money transfer to the people (including free food)” as CBGA (2020) reports. This amounted to an outlay of 0.38 per cent of GDP for hundreds of millions of families without livelihoods.

While State governments also announced specific relief measures, it is important to note that in the current fiscal regime, the fiscal resources of States remain highly constrained. There were, of course, variations across States, with some state governments, notably Kerala taking the lead in ensuring that no one went hungry (Swaminathan & Johnson, 2020).

Loss of livelihoods has detrimental effects on health, especially on social and psychological well-being. A systematic review of 15 studies from across India found that out of 98 participants, 63 per cent underwent loneliness, 51 per cent felt anxious, 58 percent experienced frustration and tension, and three-fourths of the participants were diagnosed with depression (Jesline, 2021). The World Health Organization estimated that India would suffer a staggering economic loss of \$1.03 trillion because of mental health issues till 2030, and the numbers are rising with the pandemic (Birla, 2019).

WOMEN WORKERS & COVID-19

There was striking gender inequality in the effects of the pandemic, lockdowns and economic downturn.

India has a peculiar problem in which women’s work participation has always been “officially” low, partly on account of the fact that most women engage in informal labour, family-based labour such as on the family farm or taking care of animals within the households, and these are often not measured accurately. Even at these low rates of work participation, there is evidence that unemployment and job losses affected women more than men. The chances of women losing their jobs during the lockdown was 7 times more than that of men, but they were 11 times less likely to return to their jobs even after the end of the crisis (Abraham, et al., 2020). Women are over-represented in the informal sector, in jobs without social security, in less-skilled occupations, and so on.

Domestic work or care work (cooking, cleaning, caring for children and the elderly) is assumed to be the responsibility of women, allowing men to be employed outside the home. By one estimate, women and girls in Indian put in around 3.26 billion hours of unpaid care work every day which contributes to at least Rs. 19 trillion a year (OxfamIndia, 2020). A study before the pandemic in rural Karnataka showed that the total hours worked by women in economic activity and care work was at least 60 hours a week (Swaminathan, 2020). The invisible burden of care work has increased manifold during the pandemic and is a constraint in returning to employment.

In desperation, many women sought low-paid jobs. There was a two to three-fold increase in the number of women engaged in domestic

work during the pandemic (Mitra, 2021). Not only is domestic work a form of precarious employment with no legal protection, but many women are also subject to sexual harassment.

At the same time, many women have been frontline workers during the pandemic. I refer here to Accredited Social Health Activists or ASHA workers who were responsible at the village level for many Covid-related tasks, including the spread of information, tracing and quarantining. ASHA workers, the majority of whom are women, are not even recognized as workers by the government nor paid regular salaries (Niyati & Mandela, 2020).

THE QUESTION OF CHILD LABOUR

In terms of long-term generational effects, the section of society perhaps most affected by the pandemic is that of children. Schools in India were closed for more than a year. Teaching shifted to a digital mode. Inadequate digital infrastructure and lack of proper services led to a widening of pre-existing inequalities with serious implications for poorer children. The ASER (Rural) 2020 Wave 1 survey finds that the ratio of 'out of school children' to all children rose from 1.8 per cent in 2018 to 5.3 per cent in 2020 for children between the age of 6 to 10 (Kalra & Jolad, 2021). The same report found that only 18.3 per cent children in rural areas enrolled in government schools accessed video recordings, and 8.1 per cent attended live online classes, while the proportion was

slightly better for those enrolled in private schools. More recently, the ASER 2021 report found that school enrolment fell during the pandemic and even among those admitted, only a third of the population surveyed between age 6-14 had access to the learning resources or support (Jebraj, 2021). There is a high risk of mass illiteracy and the impact will be felt on the all-round development of children, their health, nutrition, learning, and psychological well-being (Dreze, 2021).

The pandemic has widened existing gender gaps and is likely to exact a toll on an entire generation of young girls deprived of their right to education. According to UNWOMEN, more girls than boys dropped out of school during the pandemic. 65 per cent of parents surveyed were reluctant to continue the education of girls, with some resorting to child marriages to save costs (UNWomen, 2021).

The pandemic "exposed existing disparities and inequality in schooling" and "also aggravated them" (Oshikawa & Chakraborty, 2021). Online education, for example, worked better in government schools in Kerala, where school infrastructure had been improved prior to the lockdown. The ASER (2021) study found wide disparities in access to online education: only 13 per cent of children from West Bengal had access as compared to 91 per cent from Kerala. While all children globally were affected, the worst-hit were children from the poorest families, from families of manual workers, from Scheduled Caste families, from families who had no place other than school to study, and no support at home.

Economic distress of their families sent many children into the workforce, bringing a renewed challenge to the country in terms of stemming child labour. A survey by the Campaign Against Child Labour in 24 districts of Tamil Nadu found that child labour increased by 280 per cent after the pandemic, with children being involved in at least 23 different types of occupations in the services sector and working more than eight hours a day (Narayani, 2021). The survey also highlights the abuse -- mental, physical and verbal that children face at their workplaces.

Inability to continue with normal schooling, lack of physical contact with friends and teachers, and problems in the home environment have affected the psychological well-being of children, with a reported rise in suicides (Balacharan, et al., 2020).

THE WAY FORWARD

While the Indian economy is gradually recovering, policy response must learn from the crisis and experience of other countries in taking pro-people measures.

The first priority is to rethink the fiscal stance and adopt an expansionary fiscal policy. Taxation policy has to be made more progressive (such as by an inheritance tax) and by higher corporate taxes (many companies with an online presence made huge profits last year). To assist States with the financial crunch, the Centre should take measures

such as expanding fiscal deficit limits (CBGA, 2021).

There is an urgent need to scale up relief measures. Direct benefit transfers to around 80 crore persons amounted to Rs 73,000 crores, as noted earlier, but the actual income loss, according to SBI Ecowrap, for 37.3 crore workers was approximately INR 4 lakh crores. There is a need to provide assured minimum income support for at least another six months.

Employment generation programs such as MGNREGS need big expansion. Similar public works need to be started in urban areas on the lines of the Kerala initiative termed Ayyankali Urban Employment Scheme (Chatukulam, et al., 2021).

The inclusion of women in the workforce must be part of the strategy of economic revival. Specific attention has to be paid to the generation of skilled employment for women. At the same time, the drudgery of care work must be recognized, and innovative means must be found to reduce this burden.

The crisis of healthcare during the pandemic stands as a reminder of the need to raise investments on public healthcare, both in terms of infrastructure and by deploying additional trained health personnel (Sundaraman & Ranjan, 2020). The provision of basic mental health services should no longer be neglected.

Government expenditure on school education has to be stepped up along with plans to

address the learning gaps that have emerged over the last two years and ways to bring children back into school.

Last but not least, the experience of Kerala in handling the health crisis shows that people's participation combined with planning by governments (and decentralized decision making by local governments) is key to implementing a successful strategy. This experience must be absorbed going forward in strategies of economic recovery that specifically address the crisis of inequality, including gender and caste inequality.

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GENDER

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COVID THROUGH A GENDER LENS

ABSTRACT

The long impact of COVID-19 threatens to reverse the gains made towards gender equality in India in the past decades. Disturbing data indicate the disproportionate impact on women and girls in terms of means of livelihood generation, burden of care work, access to sexual and reproductive health services, nutrition, education, leading to a shadow pandemic of gender-based and sexual violence. A deeper assessment of the current situation enables in envisioning immediate and long-term recovery plan; requiring a working together of relevant stakeholders, service providers, non-governmental organizations, international humanitarian agencies and others. Learning from the lived experiences of individual women and women's organizations would be beneficial to place the current crisis in perspective and develop sustainable solutions. An overall gender lens in recovery plans and state policies is said to contribute to just and equitable development, economic resurgence, and help keep pace with the achievement of the Sustainable Development Goals.

Keywords: COVID-19, gender lens, Sustainable Development Goals, Shadow pandemic, labour, health



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Not all effects of COVID-19 can be measured or converted into data for evaluations. Nevertheless, several national and international reports point to a disturbing trend in the gender-based impact of the pandemic on the lives of women and girls. Parallels have been drawn to past outbreaks, like the Ebola virus disease (2014-16) in West Africa and Zika virus outbreak (2016), to suggest that women and girls as caregivers within families and front-line health-workers are more likely to be infected by the virus, be at the receiving end of violence, or due to social norms less likely to have resources and redressal mechanisms to exercise autonomy over sexual and reproductive health needs (C et al., 2020). Data over the past year and a half concretely show how women have been hit harder by the pandemic, and there is a reversal in the efforts made towards gender equity and social justice in the past decades (Bill and Melinda Gates Foundation, 2021; O'Donnell et al., 2021). Nevertheless, many reports also show how civil society or women-led initiatives and community interventions have made attempts at grassroots levels to support women in these challenging times. If there has been discrimination and inequity, there has also been evidence of collaboration, resilience and hope. This paper builds a gender-based assessment of COVID-19 on the lives of women and girls

on three fronts: un/paid care work, gender-based violence, and health and nutrition. The issues at hand can be ascribed to the challenges of the pandemic but substantially emanate from pre-existing structural and systemic gender gaps and social norms which marginalise women in varied ways – at intersections of class, caste, religion, region and so on – in patriarchal societies. Even before the pandemic, women had little agency over their bodies, education, health and workforce participation; and according to the World Economic Forum's Global Gender Gap Index 2021 (which covers most of these parameters), India's ranking has dropped 28 places to 140 amongst 156 nations.

WORK: UNPAID CARE & JOB LOSSES

Women constitute a substantial portion of the informal workforce. Their labour force participation in India in the decade before the pandemic had been declining, and their earned income had been estimated to be one-fifth of men's (Ferguson, 2021). As COVID-19 hit, 17 million women in April 2020 lost their jobs, 23.5 percent were estimated to be less likely to be reemployed than men, and those who could retain their jobs experienced extreme pay cuts (Dutta, Sardar,

Mahendru and Mishra, 2021, p.14). Women also experienced a lack of ‘fallback options’ whereby they left the workforce from every employment option, while men who lost their jobs moved towards self-employment (Azim Premji University, 2021, p.20).

The case of female health workers has been illustrative of the current state of women’s labour, extent of economic crisis, and state and social indifference. Three cadres of workers – Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs) and Auxiliary Nurse Midwives (ANMs) – have been at the front-line since the beginning of the pandemic. Working ‘voluntarily’ around the clock in precarious conditions, amid absence of PPE kits or access to vaccination, they have been documented to be economically, mentally and physically strained (Rao and Tiwari, 2020). A study conducted by the digital gender platform BehanBox (Roy and Chowdhury, 2021) with 200 health workers in 10 states highlights how they have been at the receiving end of discrimination, attacks and violence while conducting their community-based duties, many losing their lives to the virus, and majority seeing drop in incomes, delayed honorariums and increase in debts. Livelihood loss amongst women during the pandemic amounted to not only a direct effect on their earnings, but also indirectly affected intra-household dynamics subjecting them to hunger, violence, loss of assets and savings, opportunities of mobility and social interaction (Agarwal, 2021). Their time spent on care work increased due to the employment loss in households, closing of schools and childcare centres like anganwadis, and as work from

home for some sections of society became the norm. Girls, in especially poor households, have had to shoulder the responsibility of disproportionate care work and chores meaning that a substantial number of them would marry early and many may never return to school once the current crisis is over (Ghatak, Yareseeme and Jha, 2020; Khabar Lahariya, 2020).

Even prior to the pandemic, India’s first Time Use Survey had shown that compared to men spending 80% of their working hours on paid labour, women’s ‘time poverty’ is such that they spend 84% of their working hours on unpaid labour (Kamdar, 2020). Gender-based norms devalue women’s unpaid labour, derecognising Rs.19 trillion a year contribution to the Indian economy (Ferguson, 2021). Moreover, an unpaid care work survey in 2019 had found how deep patriarchal mindset runs with 41% respondents feeling it was acceptable to beat women for failing to prepare a meal, 33% thought so for failing to care for children and 36% for leaving an ill adult or dependent unattended (Oxfam 2019). Some of these factors have directly contributed to increase in domestic violence reported against women during the pandemic, ‘expected’ to shoulder these duties.

GENDER-BASED DOMESTIC & INTIMATE PARTNER VIOLENCE

According to WHO estimates (2021), one in three women worldwide are subjected to violence – sexual or physical; a majority

of which is intimate partner violence. What has been commonly termed as ‘shadow pandemic’, violent and abusive behaviour against women and girls has intensified during COVID-19 related restrictions since 2020, with countries such as France, Argentina, Cyprus and Singapore reporting as much as 30% increase (UN Women, 2020). This is in the wake of restrictions on mobility, economic uncertainties, alcohol/substance abuse and loss of access to support systems to escape abusive arrangements. Healthcare services, police sector, civil society organizations and others have had to redirect their resources to deal with the pandemic. While domestic violence support services have been adapted to digital/mobile technologies through reporting apps, video referrals, telephone helplines, online campaigns and others, many women remain under close surveillance, and others – especially from lower-income and marginalised populations – may not have access to or control over their use.

The situation in India has been no different. Within two months of the first lockdown being announced, during March and May 2020, the National Commission for Women (NCW) reported a 10-year high in complaints against domestic violence, where after they had to launch a Whatsapp helpline to make complaints without the fear of being overheard (NCW cited in Dutta, Sardar, Mahendru and Mishra, 2021, p.14). Some countries, like France and Spain, early on during the pandemic put systems in place where survivors could head to pharmacies and use code words like ‘Mask-19’ to report domestic violence (Kottasova, 2020). Subsequently in India, the National

Human Rights Commission (2020) conducted an impact assessment about women’s rights during the pandemic and came out with an advisory where prevention of violence and survivor support were recommended through state interventions. A majority of women – 70% according to NFHS-5 data (2019-20) – never reported the matter, and a handful ever sought help (ibid). Domestic violence has reportedly taken the form of physical and sexual abuse with new numbers indicating a 21-year high in complaints during January to May 2021 (Sen and Nihalani, 2021); apart from an increase in brutality and severity, and lack of state support – which had been already observed in cases as early as March-April 2020 (Bhandare, 2020).

UN Women et al (n.d.) call for synergy amongst governments, civil society and UN bodies to address gender-based violence. It is suggested that we send strong public messages about violence against women and girls not being tolerated, providing financial support, medical referrals and safe shelters to survivors, conducting rapid assessments and building data pools for planned interventions, operating national helplines 24/7, sensitising police personnel to work with battered women, and encouraging community members to be responsible citizens and stand by them.

HEALTH & NUTRITION

Health inequalities are indicative of socio-economic inequalities and gender is one of the dominant factors in perpetuating them.

In many households as food scarcity grew, women continued to eat last and least to bear hunger related inequalities. In some of the most marginalised communities in Bihar, Uttar Pradesh and Madhya Pradesh, due to livelihood losses and poverty, they have been documented to be more vulnerable to nutritional deficiencies, anaemia, maternal and infant mortality, and lower work ability (Mishra, 2021).

Many government hospitals were converted into COVID centres and the focus on handling the pandemic put additional pressure on the ASHAs and Anganwadi Centres, who are the first point of contact for women especially in hard to reach geographical locations for nutritional and maternal requirements. This also caused a disruption in providing sexual and reproductive health and family planning services, like contraceptives, counselling, referrals, support with access to safe abortions, nutritional supplements and others, to already vulnerable women. Such data is corroborated by the CommonHealth (2021) study which collated anecdotal narratives of most vulnerable women (poor, living with HIV/AIDS, sex workers, disabled women, Dalits and more) in peri-rural and urban areas in 8 Indian states about the effects of the lockdown on their health, especially abortion, contraceptives and maternal care services. These women noted how the already limited agency over their bodies and health was further undermined, especially in cases where they could not access public healthcare for abortion services. They had to continue with unwanted pregnancies or seek help clandestinely for the fear of familial retribution,

pay more money to visit private facilities, self-medicate, use home remedies, and rely on quacks. These scenarios caused mental stress, physical trauma and further financial crises to women and families already reeling under the burden of the pandemic. Moreover, it is estimated that in a 'likely' scenario, overall about 26 million couples in India would have been unable to access contraceptives and there would be nearly 2.4 million unintended pregnancies (Chandrashekar and Sagar, 2020).

Women and girls are often the last to receive medical attention and perhaps also did in cases where they contracted COVID. In terms of mental health, during the first wave of the pandemic, studies found that 33.9 percent women compared to 18.3 percent men experienced anxiety, anger, irritation and sleep deprivation (Mahendru et al, 2021, p.106). This has been ascribed to an increase in burden of women's unpaid care work, food insecurity, unequal access to health care, rising cases of domestic violence and a lesser probability of reemployment. Development practitioners have also advised to prioritise and build robust evidence towards women's mental health in low-income households and rural areas where access to medical healthcare infrastructure (especially mental health) would have been gravely affected the past year (Sanyal, 2021).

Information and access to safe menstrual hygiene products and sanitation facilities have been affected since the first lockdown in 2020. Girls who depended on state schemes for receiving sanitary products at school, women and girls in low-income households

where food and shelter have been prioritised over buying pads, or those living in closed quarters with family members, have found it difficult to manage their menstruation needs (Piccin and Madhavan, 2021). A survey was conducted by Dasra Adolescents Collaborative (Dasra, 2020) with 111 youth serving organizations across 25 states in India to assess the adverse effects of COVID on young people. It was found that 74% of girls were unable to access or encountered difficulties in accessing sanitary napkins since the lockdown began – 43% amongst them had not found it difficult before. Moreover, with schools being shut, girls have missed out on important information about menstrual hygiene management, many having begun with their period without knowing what is happening with their bodies; while frontline workers in the medical sector have also found it challenging to manage menstruation on duty in PPE kits (Guha, 2021).

Even in terms of vaccinations, despite more women getting vaccinated in the early days of the campaign due to their roles as healthcare and frontline workers, 871 women for every 1000 men as of 30 May 2021 had been vaccinated (Rukmini S., 2021). In similar data put out by The Centre for Economic Data Analysis portal (Team CEDA, 2021), Ashoka University, it has been found that 86 women for every 100 men are getting the vaccine. Some reasons for slower vaccination pace for women have been noted to be based around gaps in information about how it affects pregnant women, menstrual cycles and fertility, or more prominently in terms of prioritisation of men's vaccination, women

having limited access to digital technologies to book their slots, especially in rural areas and low-income households (until walk-in registrations became possible), and others (Walker and Mehta, 2021). Self-Employed Women's Association (SEWA, 2021) study with 1500 members across 9 states extends our understanding about this gender-based vaccination disparity. Poor women in the study were notably concerned about being pushed out of work in the event of falling sick for some days after getting the vaccine, cited issues of mobility and far distances to get to the vaccination centres, and were held back by misconceptions about the vaccine negatively impacting their health in the short and long run.

CONCLUSIONS & RECOMMENDATIONS

The long impact of COVID on women is likely to roll back gains made towards gender equality in the past decades. Women in the past have been disproportionately impacted by disease outbreaks and continue to in the current pandemic; whereby, policy responses and investment decisions need to reflect sensitivity and inclusivity in the recovery plans. Prioritising gender-equitable response policies and plans of action are said to have benefits beyond women's immediate lives. The United Nations (2020) notes that "Putting women and girls at the centre of economies will fundamentally drive better and more sustainable development outcomes for all, support a more rapid recovery, and place us

back on a footing to achieve the Sustainable Development Goals” (p.21). They emphasise three cross-cutting strategies to achieve it (ibid): a). ensuring individual women’s and women’s organizations’ representation and support in recovery and response; b). transforming women’s participation in the un/paid care economy – vis-à-vis health services, teaching, care work at home and so on – in gender equitable ways; c). mitigating the socio-economic impacts of the pandemic on women and girls by consciously integrating their lives, futures and ideas of social protection in development of fiscal stimulus packages and social assistance programmes. (UN Women 2021) has been working with the Indian government, private sector and grassroots organizations towards a women focussed recovery from the pandemic. They have been engaged in efforts to provide food security, personal protective equipment, cash assistance, support for employment, education and vocational training to women; apart from running public awareness campaigns about disease prevention, vaccination, gender-based violence, and providing monetary, legal and safe shelter assistance to survivors of violence.

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THE LONG-TERM IMPACT OF COVID-19 ON WOMEN'S HEALTH A GENDERED PERSPECTIVE

ABSTRACT

COVID-19 has presented unprecedented challenges for all sections of society but its ramifications have been more pronounced for vulnerable population groups, particularly women and girls. The differential impact of the pandemic has affected women and girls across all spheres, including education, health, nutrition, safety, economic security and access to technology, threatening to reverse decades of progress made towards achieving gender equality. Evidence from past epidemics, including Ebola (2014-16) and Zika (2016) underscores the increased susceptibility of women to the adverse outcomes of emergency situations. Yet, less than one per cent of published research papers on both Ebola and Zika outbreaks focused on the gender dimensions of the emergencies (Davies & Bennet, 2016). Research on the gendered implications of previous health emergencies is even more scarce. This whitepaper explores the differential impact of COVID-19 and makes recommendations to ensure that women and girls remain central to COVID-19 response planning and recovery efforts.

Keywords: Keywords: COVID-19, gender lens, Sustainable Development Goals, shadow pandemic, labour, health



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ECONOMIC IMPACT

Across the globe, women earn less and are more likely to be employed in the informal sector. In developing economies, 70% of women work in the informal sector with limited access to social protection (ILO, 2018). It is estimated that worldwide, 47 million women and girls have been pushed into extreme poverty since the pandemic began (Oxfam, 2020). While women lost their jobs, their unpaid care and domestic work burden have increased significantly during the pandemic. Insights from household surveys in Bangladesh and Kenya have reported increased workloads and domestic chores in the household for 22 per cent of girls, along with childcare responsibilities (Sajeda, et al., 2020). Findings from Population Foundation of India's study to assess the impact of COVID-19 on young people in three states showed that 51% of female respondents in UP, Bihar and Rajasthan experienced an increase in domestic workload during the nationwide lockdown, as compared to 23% male respondents (PopulationFoundationofIndia, 2020).

In the past too, outbreaks such as Ebola and Zika resulted in a downturn in women's socio-economic security. (Bandiera, et al., 2018) The quarantines during the Ebola outbreak in West Africa closed markets and destroyed livelihoods of traders in Sierra Leone and Liberia, 85 per cent of whom were women

(Kabia, 2016). Although men lost their jobs, 63 per cent had returned to work 13 months after the first case was detected, whereas only 17 per cent of women could resume work (Bandiera, et al., 2018).

The lack of economic security, along with the increased caregiving burden, not only threatens to push many women to quit the labour market permanently but will also significantly compromise their mental and physical health outcomes. It is imperative for policymakers to recognize women's caregiving responsibilities and include them in economic metrics and decision-making.

HEALTH IMPACT

1. Access to Sexual and Reproductive Health Services

Evidence suggests that during past public health emergencies, resources have been diverted from routine health care services toward containing and responding to the concerned outbreak. These re-allocations constrain already limited access to sexual and reproductive health (SRH) services, such as clean and safe deliveries, contraceptives, and pre-and post-natal health care (Camara, et al., 2017).

The ramifications of the COVID-19 pandemic

were similar as lockdown measures disrupted contraceptive supply chains and the ability to access health facilities across the world (Sadinsky, et al., 2020). According to the Guttmacher Institute, the pandemic resulted in 218 million women with unmet need for modern contraceptives, 111 million unintended pregnancies, 30 million unplanned births and 35 million unsafe abortions in 2020 in low and middle-income countries (Guttmacher Institute, 2020). According to the World AIDS Report 2020, COVID-19 limited access to contraceptives for 26 million couples in India (UNAIDS, 2020). A UNICEF 2021 report titled “Direct and Indirect Effects of COVID-19 Pandemic and Response in South Asia” estimates that disruptions due to the pandemic will result in significantly higher numbers of maternal and child deaths, unwanted pregnancies and disease-related mortality in women and adolescents than in previous years (UNICEF, 2020). India alone is likely to record an additional 154,000 child deaths. Maternal deaths are estimated to rise by 18%, and stillbirths by 10%, and 3.5 million additional unintended pregnancies are estimated due to disruptions in access to reproductive healthcare in the South Asia region.

According to the Menstrual Health Alliance India (MHAI), there are 336 million menstruating women in India, of which 121 million use sanitary pads, i.e. 1 billion pads per month. While there has been an increase in sanitation coverage, numerous women and young girls across the country lack access to proper sanitation and toilet facilities.

A recent study conducted by the MHAI

showed that the pandemic had disrupted the production of menstrual hygiene products, with many small and medium scale manufacturing units facing a shortage of labour, raw material and working capital (MHAI, 2020). Population Foundation of India’s three state study also reported an unmet need for menstrual hygiene products among young women and girls (Population Foundation of India, 2020).

2. Menstrual health and hygiene

As most adolescent girls from low-income households depend on school-based supply of menstrual hygiene products, the closure of schools has compelled girls to resort to unhygienic methods during menstruation which could lead to adverse health outcomes in the long run. Many women reported going back to unhealthy menstrual practices like the use of cloths or rags. These lead to bacterial and fungal infections affecting the reproductive and urinary tract and even causing skin irritation. It also leads to higher chances of anaemia, urinary tract infections, which 75% adolescent girls suffer from already (Bagaria, 2020).

3. Violence against women and girls

According to the WHO, violence against women remains a major threat to global public health and women’s health during emergencies. Restrictive social norms, gender stereotypes, home quarantining and diversion of resources to respond to the COVID-19 pandemic can limit women’s ability to access health services as well as make them more susceptible to risks on several fronts. The COVID-19 quarantine measures resulted in

a spike in domestic violence levels, although cases remained grossly underreported. The National Commission of Women in India also reported a surge in the reported cases of violence in the country during the lockdown in 2020. Stress, disruption of social and protective networks, and decreased access to services can all exacerbate the risk of violence for women. For women already in abusive relationships or at risk of such abuse, staying at home increases their risk of intimate partner violence. Violence not only negatively impacts women but also their families, the community and the nation at large. It has tremendous costs, from greater health care, legal expenses and losses in productivity, impacting national budgets and overall development (Women, n.d.).

4. Education

In April 2021, United Nations Educational Scientific and Cultural Organization (UNESCO) reported that globally 1.5 billion children and youth were affected by school closures from pre-primary to higher education ever since the onset of the COVID-19 pandemic (UNESCO, 2020). The single most significant effect of lockdowns on young people was the closure of educational institutions and a shift to distance online learning. The UDAYA study highlighted the lack of access to the internet and digital devices among adolescents and inadaptability to newer means of learning, which in turn make online learning difficult (UDAYA, 2021). Challenges in access to education, poor quality of education compounded by gender disparities put adolescents and young girls at a disadvantage in seeking employment

and securing their future. Prolonged school closures will exacerbate inequalities, deepen the learning crisis and expose the most vulnerable children to a heightened risk of exploitation.

Further, schools are not mere places for learning, but they also provide social protection, nutrition, health and emotional support, especially for the most disadvantaged. The World Food Programme estimates that 370 million children are not receiving school meals as a result of school closures (Anon., 2020). While distance learning has filled the gap for some, millions of young people in under-resourced settings are being left behind. UNICEF estimates that over 24 million young children will drop out of schools altogether, cutting them off from immunisation and health promotion programmes (UNICEF, 2020). Several young girls may never return to school, being forced into child marriages by their families. According to UNFPA's projections, COVID-19 will disrupt efforts to end child marriage, potentially resulting in an additional 13 million child marriages taking place between 2020 and 2030 that could otherwise have been averted (UNFPA, 2021).

5. Mental Health

The pandemic and consequent lockdown have had a profound impact on mental health and well-being. Women, on average, perform 76.2% of total hours of unpaid care work, more than three times as much as men (ILO, 2018). An online survey covering men and women across 17 countries revealed that COVID-19 has taken a disproportionate toll on women

(Focus2030 & WomenDeliver, 2021). Young women were the most affected, with 53 per cent of those aged between 18 and 24 years reporting that their load of household work had increased as opposed to 34 per cent of those aged 60 and above. Female respondents reported experiencing more emotional stress or mental health issues. This stress was worse for those aged between 18 to 44 years. Population Foundation of India's study showed that during the lockdown, there was a felt need for mental health services among young women, and they resorted to informal sources for information regarding mental health in the absence of adequate formal channels (PopulationFoundationofIndia, 2020).

Furthermore, COVID-19 has overwhelmed health systems worldwide, making it harder for people to seek the medical care they need (OECD, 2020). In most countries, women are more likely than men to have experienced physical illness since the pandemic was declared, but in some places, they encountered either more or as many barriers to visiting a doctor. These barriers in health-seeking could take a severe toll on the physical and mental well-being of young girls and women in the long run.

6. Role of civil societies in pandemic relief measures

Civil society has played a vital role in COVID-19 response and recovery efforts across the world, stepping in where government capacity for providing basic necessities was lacking, in addition to complementing rebuilding efforts. When the lockdown was announced, the Prime Minister called on

NGOs to help the government by providing basic necessities to the underprivileged, supplying medical and protective gear and assisting with awareness campaigns on social distancing (IndianExpress, 2020). In addition, the NITI Aayog reached out to more than 90,000 NGOs and civil society organizations (CSO) in the first week of May 2020, seeking assistance in delivering services to the poor as well as health and community workers (Singh, 2020).

The collective strength of Self Help Groups (SHGs) run by women rose to the extraordinary challenge of the pandemic by addressing shortfalls in masks, sanitizers and protective equipment, running community kitchens, delivering essential food supplies, sensitizing people about health and hygiene, combating misinformation and providing banking and financial solutions to far-flung communities.

Evidence from a study conducted by the Ashoka University among 50 Non Profit 1s across the country during the lockdown period and beyond included last-mile delivery of relief material such as dry ration and sanitation kits, community awareness and sensitisation, setting up health camps and isolation facilities, rescuing stranded labour, provision of direct cash transfers and rehabilitation of the distressed communities (CSIP, 2020).

ChildRightsandYou(CRY),alongwithitspartner NGOs,spread awareness and distributed relief materials, along with advocating for access and availability of services to the communities and children (Marwaha, 2021). In its response to the COVID-19 outbreak, Plan International tailored its approach and programmes to address the needs of vulnerable communities

(PlanInternational, n.d.). They also support the government to maintain essential services for adolescent girls and young women, such as sexual and reproductive health services and maternal, newborn and child health services (PlanInternational, 2020).

The RCRC group, a coalition of over 60 CSO members, did exemplary work in very difficult geographies, providing relief and livelihood support to millions of people affected by the pandemic (RCRC, 2021).

Population Foundation of India contributed towards combating the COVID-19 crisis by making small but agile emergency grants to organizations working with poor and marginalised communities and reaching out to 50,000 families, men and women (PopulationFoundationofIndia, 2020). In addition, we, along with our NGO partners, worked towards identifying a consolidated approach to ensure that essential health information and services continued to reach clients. Taking cognisance of the significance of generating evidence to address the differential impact of COVID-19 on vulnerable population groups, we undertook research studies on the differential impact of the pandemic on women and young people (PopulationFoundationofIndia, 2020). The other learning that was underscored by the pandemic was the significance of behaviour change communication strategies to impact health outcomes. As part of our COVID-19 response, we created engaging and educational static and video communication materials for the Government of India MyGov platforms. Our outreach with NGOs and state health departments ensured that these materials reached over 150 districts in 24

states and union territories.

The resilience shown by CSOs and NGOs against COVID-19 is phenomenal. The current crisis poses several challenges to the roles of civil society, which includes monitoring, accountability, advocacy, and promoting citizens' participation (Mullard & Aarvik, 2020). Nevertheless, CSOs have leveraged this opportunity to stimulate creativity, innovate, experiment and scale up actions on the ground. While the pandemic is ongoing, it is important that CSOs collaborate with the government in a constructive and meaningful way to enhance India's emergency preparedness and response mechanisms.

What is required from the grassroots and government to assist women and young girls in emergency situations?

In order to combat the aftermath of the COVID-19 crisis, the following recommendations must be considered and implemented:

- Women and girls are often invisible to decision-makers due to inadequacies in gender-disaggregated data availability which may impede policy decisions and programme operations. There is an urgent need to incorporate gender analysis, collect gender-disaggregated data to assess the differential impact of the pandemic.
- Ensuring women's equal representation in all COVID-19 response planning and decision-making targeting women and girls in all efforts to address the socioeconomic impact of COVID-19
- There is an urgent need to acknowledge violence as a public health issue and

develop a health systems response to it. This should include training healthcare workers to identify and address gender-based violence and provide respectful care and support to those affected.

- There is a need to strengthen partnership mechanisms between government and civil society organizations to ensure an uninterrupted supply of sexual and reproductive health services, especially during disruptions in the ecosystem.
- Extending basic social protection to informal workers is imperative to ensure economic security for this large section of society.
- There is a need for health systems strengthening and increased health budget allocation to make the public health system resilient to combat emergency situations.
- Capacity building of community-level health workers to ensure continued access to reproductive health services, including family planning services, improved quality of care and counselling services to women.
- Strengthening counselling services through helplines, telemedicine services, community radios, chatbots, and mobile services is the need of the hour.
- Greater health awareness through social and behavior change communication campaigns- stepping up advocacy and awareness campaigns, including targeting men.
- Emphasizing health education as a preventive and promotive healthcare strategy.
- Ensuring psychosocial support for women

and girls combatting mental health issues and stigma.

COVID-19, though devastating, has provided a unique opportunity to governments and CSOs alike to reflect on effective strategies and measures which would build communities that are safer, healthier and more resilient. Going forward, gender must be central to COVID-19 recovery measures as well as future pandemic preparedness in order to ensure no one is left behind.

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DIGITAL INDIA

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HARNESSING THE POWER OF DIGITALIZATION TO EMPOWER WOMEN IN INDIA POST COVID-19

ABSTRACT

The COVID-19 pandemic has had damaging consequences for lives and livelihoods, but women have been particularly hard hit. Women across the world have been deeply affected which has heightened the large and small inequalities—both at work and at home—those women face daily. There has been and will continuously be rapid migration to digital technologies driven by the pandemic which will be part of the recovery for countries. Closing the gender gap in digital inclusion is a priority for recovery post the pandemic in India. The Government of India has worked towards rapidly increasing the process of digitalization with a particular focus on women to increase access to digital infrastructure, address gender stereotypes that inhibit women's access to mobile phones, improve digital financial literacy for women and girls, address online sexism, and collect sex-disaggregated data to close the gender gap in the new digital economy. Various initiatives taken by

the Government of India, namely Digital India, Make in India, Start-up India, Skill India and Innovation Fund have significantly contributed towards the creation of a conducive eco-system for faster growth in the digital sector. Further, it recognizes the prevalent gaps and challenges of the digital gender divide and is concerted towards reducing it to build an inclusive digital India with other stakeholders such as private enterprise and civil society partnerships.



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Keywords: COVID-19, gender, digital economy, digital inclusion, health, cyber violence, telemedicine, e-learning



INTRODUCTION

The global pandemic COVID-19 is defining the health crisis of our times with severe economic impact across countries and sectors. In India, the government issued a countrywide lockdown advisory for its population of 1.3 billion people to curb the spread of the virus. The pandemic triggered a deep health economic crisis for people. This crisis significantly accelerated the shift to digital technology for a multitude of functioning such as the collection of data for disease prevention, reporting crime and violence, conducting businesses, accessing services like education, health, market, and work from home. Digital technologies arose as being particularly pertinent during different phases of the lockdown and were tapped extensively for information generation and awareness on COVID-19.

Continual research by global and Indian research agencies pointed that women and girls shouldered a heavier socio-economic burden due to the pandemic, experiencing a greater loss of employment than men and a far higher unpaid care burden (IWWAGE, 2020). The pandemic exacerbated gender gaps amongst economies with increased instances of gender-based violence, women's exit from the workforce, and lack of credit for women-run/owned enterprises, to name a few. At the beginning of the pandemic in

April 2020, about 17 million women lost their jobs, estimated to cost India's GDP 8% or USD 218 billion (Dutta, et al., 2021). Women were further pushed to the margins with the wide-reaching move towards digital technology in many sectors, furthering their wage gaps and job losses. Nearly the same time as the pandemic was setting in, the National Family Health Survey (NFHS-5) data released 22 States/Union Territories from 2019-20 showed that there is not only a gender disparity in access and use of the internet but also a regional disparity with there being half the number of smartphone users in rural India compared to urban India (Dutta, et al., 2021). The recent India fact sheet in NFHS-5 released in November 2021 reveals that 33.3 per cent of women in India use the internet, with 24.6 per cent in rural and 51.8 per cent in urban regions (MoHFW, 2021). For female entrepreneurs in the formal and informal sector, the lack of information, knowledge, and skills to understand, acquire, and utilize digital tools for their business operations—to support market access and identification of new delivery channels for their products—has led to lost income and livelihoods, further exacerbating inequalities compared to men (Shaffner, 2021). But beyond livelihood, digitisation for women became a matter of access to health and education, personal safety, equal opportunities for all-round

wellbeing and socio-political participation.

However, the Government of India took these challenges provided as an opportunity for enterprises to thrive by adapting to a new reality, becoming contactless and digital. Digitalization has taken on a new meaning, and it will continue to affect a growing number of sectors. To create a strong foundation of digital infrastructure and expanded digital access through the Digital India Programme, India is poised for the next phase of growth — the creation of tremendous economic value and empowerment of citizens as new digital applications permeate sector after sector.

This paper aims to establish efforts undertaken by the Government to bridge the digital gender gap. It provides evidence on the role of digitalization to assist women and girls' access and use digital technology by enhancing universal digital literacy to move closer towards achieving women and girls' empowerment, gender equity, sustainability, and nation-building. The paper highlights the gender-based assessment of the challenges faced by women vis-à-vis digital technologies during COVID-19 in India; an overview of the gaps and possibilities in on-ground inclusive practices towards digitisation; and a way forward for building an equitable and inclusive digital India.

COVID-19 & GENDER-RELATED DIGITAL INCLUSION CHALLENGES

There are many barriers to women's use

of digital technology, including gender norms, low levels of digital literacy, lack of awareness of the use of digital tools and their benefits, and sometimes distrust towards digital technology. Another reason is men's ownership over productive assets/resources within the patriarchal households. The following with women's existing marginalised socio-cultural and economic status prevents them from buying devices or ensures that they have limited access to them (Naciri and Okuda, 2021). Moreover, women's access to digital devices is controlled within the households for reasons such as arguably to secure their reputation, provide safety from online risks, emphasise their focus on domestic chores, and are also supervised to abstain them from exercising autonomy through online exposure. A study by Initiative for What Works to Advance Women and Girls in the Economy (IWWAGE) revealed that around 12% of women do not use the internet due to the negative perception, 8% due to the lack of acceptance by family members. Moreover, given the economic inequalities amongst women and men, women usually have less disposable income to access and use digital technology.

A report by International Center for Research on Women (ICRW), 2020, highlighted some of the impact of COVID-19 on women's workforce participation – a survey conducted with self-employed, casual, and regular wage workers across 12 Indian states (Lahoti et al., 2020) which had around 52 per cent of respondents as women workers highlighted that overall, 67 per cent workers lost their employment

and women workers were at a higher risk of food insecurity as compared to men (Shaffner, 2021). A large-scale study report by Dalberg released in 2021 illustrated that women, on average, lost over two-thirds of their incomes during the lockdown, and as their increased unpaid workload reported a loss in their rest time (Dalberg, 2021). Moreover, it highlighted that the increased household burden can create higher barriers to re-entry to the workforce, leading to long term economic consequences. Further, the burdens of the crisis were worse for historically vulnerable women, including Muslim, migrant, and single, separated, widowed, or divorced women. In 2018-19, women represented a 55 per cent share of workdays under the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS). With activities stalled during the lockdown and pending wages from last year, casual wage workers are facing imminent poverty (Dalberg, 2021). Occupational gender segregation, pay gaps and issues of social security are said to have contributed to women's disenfranchisement, as highlighted in some studies on the impact of COVID-19 on women in the workforce. Women tend to be overrepresented in sectors, such as garment factories, workshops, domestic labour, small firms, food processing units, schools, travel agencies and others, that have been more gravely impacted by livelihood losses during COVID-19 (Reuters, 2021).

The case of women entrepreneurs has been especially troublesome with digital illiteracy, unfamiliarity with online platforms, high data costs preventing them from switching

over to online marketplaces. It has been found through women's self-help groups in states like Maharashtra, Andhra Pradesh, Telangana, and Gujarat that women's use of mobile phones often remains limited to personal use and does not extend to making financial transactions or conducting businesses (Nikore and Uppadhyay, 2021). The issues of the online gig economy – a largely urban phenomenon – have impacted women in the service industry and their hard-won right to equal pay and dignity of labour more than men. The digital retail and services sector saw a boost in Asia, but the benefits of e-commerce have not percolated to women in developing countries. According to the Asian Development Bank, women-led enterprises are usually small businesses with low growth potential, fewer profit margins and lesser capacity to bear overheads, and these have been rendered more disadvantaged in keeping up with cut-throat commissions and terms of service of e-commerce platforms (Aggarwal, 2020).

In terms of health, women are last to receive care and monetary support within households. During a pandemic, their access to sexual and reproductive health services, pre-and post-natal care, availability of counselling and nutritional requirements is gravely impacted (United Nations, 2020). Dalberg's survey revealed that ~16% of women (estimated 17 million) who used menstrual pads before the pandemic had no or limited access to menstrual pads between March and November, primarily because they could no longer afford these items. Further, more than one in three married

women were unable to access contraceptives, primarily due to concerns about health and hygiene (in accessing a healthcare facility during the pandemic, presumably to access female sterilization treatments, the most used contraceptive method) and lack of affordability during the pandemic (Tiwari, 2021). The Centre for Economic Data Analysis portal (Team CEDA, 2021) at Ashoka University, moreover, found that for every 100 men, 86 women were getting the COVID vaccine till early June 2021. One reason for this worrying gender gap had been noted to be women's limited access to digital technology and literacy to book their slots online (especially skewed in low-income households and rural areas) until walk-in registrations became possible in June 2021 (Walker and Mehta, 2021).

COVID-19 generated a 'shadow pandemic' of violence and abuse against women due to enhanced restrictions on mobility, inability to escape abusive situations, economic uncertainties, loss of access to support systems and so on. The National Commission for Women (NCW) reported a 10-year high in domestic violence complaints during March and May 2020. They launched a WhatsApp helpline for women to discreetly make complaints and seek help without the fear of being overheard (NCW cited in Dutta, Sardar, Mahendru and Mishra, 2021, p.14). Although support services were adapted to digital/mobile technologies in the form of apps, video referrals, helplines and online campaigns, many women continued to remain under close monitoring or did not have access to devices, especially in low-income and marginalised

sections.

Information, Communication and Technology (ICT) facilitated or cyber violence against women also increased manifold over during the pandemic. According to one report, this included sexual harassment, stalking and trolling, physical threats, exposure to unsolicited pornography and others (UN Women, 2020). These led to psychological, social and reproductive health impacts on women, affecting their safe and equitable access to employment, education, online services and digital citizenship. It also contributed to stress, depression, loss of self-esteem and created in them a sense of powerlessness.

With education moving online since schools were closed in India post-March 2020, many girls lost out on consistent and quality education due to the non-availability of smartphones or preference being given to male family members for devices and data packs (Ghatak, Yareseeme and Jha, 2020). Many girls are estimated to drop out, be married early and permanently take over domestic caregiving roles.

EFFORTS TOWARDS DIGITALIZATION FOR WOMEN

Digital innovation paves the way for new opportunities for women's economic and social empowerment. This opportunity should be tapped to bolster and support women

and girls and encourage them to be part of the digital India revolution. India is focused on providing last-mile connectivity in the rural areas, upskilling and capacity building for digital usage and digital financial inclusion. An inclusive and equitable vision of digital India will help take women along by expanding their opportunities to participate and be represented better in social, political, economic, and democratic processes. All technology-based interventions, therefore, need to be assessed with a gender lens. This would not only empower women to claim agency but also enable them to achieve development gains and build a stronger post-pandemic recovery. It is argued that women and girls as consumers of technology could itself contribute to substantial profits. The Global Systems for Mobile Communications, for instance, estimates that closing the gender gap in mobile internet usage could increase the GDP of middle and low countries over the next five years by as much as USD 700 billion (Naciri and Okuda, 2021).

The groundwork for implementing the Jan Dhan, Aadhar, and Mobile number linkage i.e., the JAM Trinity laid the foundation for the expansion of digital payment in India. It has incentivized women to use their bank accounts, hence, improving their digital financial literacy. The above facilitated direct benefit transfer of INR 9,930 crores to 19.86 crore women beneficiaries of the Pradhan Mantri Garib Kalyan Yojana (PMGKY) at the outset of the pandemic (MOF, 2021).

Several other initiatives were taken that

acted as proof of concept for the benefit of digital inclusion for women. United Nations Development Programme prioritised initiatives to support underprivileged and marginalised women's economic and livelihoods opportunities, for instance, in Haryana, which helped women list their bangle-making business on Facebook, and handloom weavers and artisans in Telangana to expand their businesses (Rasheed, 2021). It was done through investment in skilling programmes that focused on digital and financial literacy, familiarity with technological tools and access to online marketing platforms so that women entrepreneurs could recover losses from COVID-19, replenish their businesses and widen their markets. Haqdarshak, a digital application launched by Haqdarshak Empowerment Solutions Private Limited (HESPL), aimed at promoting government entitlements to women by using Self Help Groups (SHG) members as agents. The project was implemented in 4 districts in Chhattisgarh and has received over 100,000 applications for a wide range of entitlements. 34% of these applications were COVID-19 informational schemes and 46% were scheme applications, with Pradhan Mantri Bima Suraksha Yojana (PMSBY), Ayushman Bharat and Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) being the most popular (IWWAGE, 2020). Tata Trusts and Google's Internet Saathi initiative started in 2015, that trained women from villages trained on using the internet and are equipped with data-enabled devices were further re-energised in states like Bihar for communication and outreach during COVID-19 (ibid). Several community-based

initiatives to improve women's digital literacy and livelihood opportunities also emerged in Maharashtra and Gujarat. There, for instance, women were supported in purchasing mobile phones at low-cost EMIs, enhancing digital literacy through peer mentorship, providing online skill training for joining digital platforms to sell their products, and more (Nikore and Uppadhyay, 2021).

The digital gap for India's rural women has been amongst the most distressing. This prompted many grassroots groups to focus on connecting poorer women without internet access to healthcare and financial support, or simply to help them keep in contact with loved ones. Mann Deshi, an organization working towards empowering rural women, gave phones to rural women in western Maharashtra's Satara district and observed that the devices have helped them survive financially during the pandemic by conducting business operations through social media platforms such as Facebook. The phones assisted women entrepreneurs in keeping their small-time businesses going and enabled staying in touch with their family members in quarantine centres and increased their access to information and services about the pandemic, vaccination, pregnancy, job losses, domestic violence, and others (Srivastava and Nagaraj, 2021). Digital autonomy facilitated their contact with designated civil society helplines for such services, consultations with doctors, delivery of medicines and further referrals through community workers. Telemedicine overall opened an opportunity to provide access to

equitable and independent healthcare for women – a majority of which are said to be first-time users in India (Srinivasan, Singh and Sekhar, 2021).

WAY FORWARD FOR BOLSTERING WOMEN'S DIGITAL INCLUSION

As established above, digital transformation has the potential to unlock several economic opportunities for women. In the times of the COVID-19 pandemic, the need for digital transformation became even more pronounced than ever. Recognizing a paradigm shift towards the adoption of digital systems and their economic impact, India has recognized that increasing connectivity and reducing the digital divide is a priority.

The Government of India believes in collaborative methods to create a multiplier effect to tackle all issues about the highly challenging objectives of Digital India. For example, approval for the revised implementation strategy of the BharatNet programme (i.e., an initiative to provide broadband connectivity to all 2.5 lacs Gram Panchayats) through Public Private Partnership mode in 16 States of the country has been given by the Indian government (PIB, 2021). However, providing only connectivity is not enough to end the digital gender divide, therefore interventions for providing women access to digital products & services and building their digital capacities are important. The Pradhan Mantri Gramin Digital Saksharata

Abhiyan (PMGDISHA) i.e., Prime Minister's Rural Digital Literacy is one such program, that aims at making six crore persons in rural areas, across Indian, digitally literate, reaching around 40% of rural households by covering one member from every eligible household (PMGDISHA, 2021). The program would empower people to operate computers/ digital access devices (like tablets, smartphones, etc.), send and receive emails, browse the internet, access Government Services, search for information, undertake cashless transactions, etc. and hence use IT to actively participate in the process of nation-building (PIB, 2021). Over 2.59 crores of women beneficiaries are registered under the PMGDISHA scheme which is 52% of the cumulative registration count. Out of the above, over 1.78 crores of women beneficiaries are certified under the scheme which is 54% of the total certified beneficiaries under the scheme (PIB, 2021). The Government of India has also set up Common Service Centres (CSCs) across the countries. CSCs are access points for the delivery of a host of public services in rural and remote areas of India through digital mediums. By leveraging CSCs, women village-level entrepreneurs (VLE) are creating livelihood for themselves by serving marginalized and underdeveloped communities in villages. There are currently approximately 38,267 CSCs run by women VLEs (CSC, 2020).

The Government of India also recently launched the digital payment solution e-RUPI, a cashless and contactless instrument for digital payment. It is expected to play a huge

role in making Direct Benefit Transfer (DBT) more effective in digital transactions and to give a new dimension to digital governance. One of its advantages is that it is operable on basic phones also, and hence it can be used by persons who do not own smartphones or in places that lack an internet connection (PIB, 2021). For delivering the services of this tool for digital financial inclusion of the unbanked, efforts are being made to develop the mobile and digital infrastructure adequately for making it equally accessible to both men and women, in rural and urban areas (PIB, 2021).

To unlock the potential of digital technology for women, development observers in other contexts are recommending that efforts should be made to “invest and scale-up easy-to-use, low-cost technologies and digital training for girls and women while safeguarding their online privacy and safety; design and implement interventions focused on breaking harmful cultural and gender norms that keep women offline and without access; and develop policies, programmes, and tools that confront barriers to gender equality in digital access, use, and safety” (Shaffner, 2021).

To impart digital financial literacy for women, learning frameworks should be designed for a smooth transition from basic financial literacy to digital financial literacy as part of the school curriculum. At the primary level of education, it is first crucial for young girls to acquire basic alpha-numeric skills to build the foundation blocks for financial literacy skills. At secondary level education, the focus should not only be on introducing young girls

to the digital world but also on the relevance of digital financial skills and their future benefits. Further, at the tertiary level, it is necessary to equip girls with an advanced understanding of the digital financial skills' application in the labour market and the importance of building financial security for themselves. Internet and mobile phones should be made accessible and affordable for women, especially in the disadvantaged parts of India.

Simultaneously, the focus should not be limited to enhancing women's access to the digital world but also work towards strategies and policies to provide them internet safety and educate them about it. The Cyber Crime Forensic Labs have been set up, and 3,664 personnel, including 410 Public Prosecutors and Judicial Officers, have been trained in identifying, detecting, and resolving cyber-crimes against women and children.

There is also an urgent need for designing and implementing interventions that focus on breaking harmful cultural and gender norms that keep women offline and without access. Another aspect of importance is digital financial services, powered by fintech, that have the potential to lower costs by maximizing economies of scale, increasing the speed, security, and transparency of transactions, and allowing for more tailored financial services that can help women in the workforce, particularly women entrepreneurs. To support women-run/owned businesses, digitization efforts can assist them in scaling up and could serve to capture medium-term shifts in customer behaviour and bolster

longer-term business resilience. There should be efforts to include the development of e-commerce platforms and e-marketing channels, and broader ecosystem investments that provide greater efficiencies for women-owned businesses e.g., digital identification systems that can, in turn, support better access to finance and financial packages from government and/or other agencies (Dalberg, 2020).

Further, it is understood that the digital transformation strategies need to be designed to keep socio-economic realities impacting gender. Therefore, gender perspectives should be incorporated in future digital transformation programs and ongoing ones. There needs to be a focus on increasing the evidence base and availability of sex-disaggregated data for adolescent girls' and women's access to and use of digital technology. This would help in developing gender-sensitive and inclusive schemes/policies for digital India.

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PHILANTHROPIC DONOR ORGANIZATION

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PROTECTING OUR FUTURE: ADDRESSING THE MENTAL HEALTH IMPACTS OF COVID-19 PANDEMIC ON YOUNG PEOPLE IN INDIA

ABSTRACT

Along with a severe direct impact on the physical health and well-being of the population in India, the covid-19 pandemic has affected the mental health of adolescents and young people (AYP) adversely. Increased reporting of symptoms of anxiety, depression, anger, fear, and even suicides have been described in various parts of the country. The psychological effects are likely to continue to impact the lives of this age-group over a mid- to long-term. As a global philanthropic donor organization, we are motivated to work towards offsetting this impact drawing on the lessons we have learned in our work in India and elsewhere. We urge for all stakeholders to recognize mental health of the young as a priority area for concerted action and strive to develop safe, effective, efficient, holistic, and context-appropriate avenues for providing increased and sustainable access to mental health resources for AYP in the country.

Keywords: mental health, partnerships, long-term impact of covid-19 pandemic, adolescents, young people, youth mental health



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INTRODUCTION

With 1.2 billion worldwide, the current generation of adolescents aged 10-19 years is the largest in human history. While this cohort has suffered less from the direct health impacts of SARS-CoV-2 infection, the pandemic has negatively impacted their wellbeing, and especially their mental health, in an unprecedented and presumably long-lasting manner. Even though the exact magnitude and detrimental impact on an individual depends on several factors of vulnerability – such as socioeconomic situation, education, or pre-existing mental health conditions – a large number of studies have shown by now how the pandemic, the experience of deaths and illnesses among relatives, friends and family members and governmental containment and public health strategies such as lockdowns, school closures, and other social distancing measures affected this age group over the past 18 months (Caffo, Asta and Scandroglio, 2021; Jones, Mitra and Bhuiyan, 2021; Marchi et al., 2021; Panchal et al., 2021; Tsamakidis et al., 2021). Whereas the pandemic and its implications have impacted the entire globe, our knowledge and understanding thereof disproportionately stems from the research in the High-Income Countries (HICs), which have greater resources for research, evidence generation and service provision. As a result, the psychosocial needs of children, adolescents and young people in Low- and Lower-Middle Income Countries

(LMICs) remain particularly understudied and underserved (Kumar et al., 2021).

We argue that there is a strong need for philanthropic donor organizations to close this gap and catalyse the partnerships between the country governments and the communities they serve to build an inclusive, collaborative and evidence-based action plan to address the mental health problems associated with the pandemic formidably and sustainably. Towards this, we need to build on the lessons learnt from other domains of global health, focus on developing and supporting innovative, effective solutions that are contextually appropriate, acceptable, and sustainable and strive to advance mental health as an integral and indispensable component of public health services deserving sustained and incremental investments in LMICs. To play this role effectively, philanthropic donor organizations need to reassess, adapt and prioritize their work and must answer the question of how to be most effective in this changed environment. In this paper, we reflect on key lessons that we learnt from the Covid-19 pandemic. We begin by describing the impacts of the Covid-19 pandemic on the mental health of adolescents, with a special focus on India. Subsequently, we discuss the evolving role of philanthropic donor organizations in addressing this mental health burden, especially in light of the experiences

of the past two years.

IMPACT OF THE COVID-19 PANDEMIC ON ADOLESCENT MENTAL HEALTH

Child and adolescent mental health, especially in LMICs, has typically received scant attention for two reasons: The age between 10-24 years is often and in many places considered the healthiest time of life with relatively low levels of mortality or illness (Patton et al., 2016). As a result, young people have largely been overlooked as participants and beneficiaries of global health and social policy programs. However, the National Mental Health Survey 2015-2016 has highlighted that 13 percent of adolescents residing in Indian urban metros and 10 percent of Indian youth overall had reported common mental health problems alongside high stigma and supply-side barriers (Gururaj et al., 2016; Gautham et al., 2020). The recent UNICEF 2021 survey reported that as many as 13 percent of young people in India often feel depressed or have little interest in doing things and the majority of them prefer not to seek support for it, highlighting the urgent need to address the growing mental health burden and promotion of healthy attitudes towards help-seeking among adolescents in the country (United Nations Children's Fund, 2021).

Secondly, mental health is only recently being recognized as a global health and development priority. In 2018, a Lancet Commission report stated that “Government

investment and development assistance for mental health remain pitifully small. Collective failure to respond to this global health crisis results in monumental loss of human capabilities and avoidable suffering” (Patel et al., 2018). In most countries, mental health is one of the most underfunded areas within the health sector, with lower than 2% of the total health budget allocation. The situation is no different in India, despite dedicated and progressive Mental Health Policy (2014), Mental Healthcare Act (2017) and national programmes for mental health (National Mental Health Programme, since 1982) and for adolescent health (Rashtriya Kishore Swasthya Karyakram, since 2013). In the pre-pandemic times, government expenditure on mental health in India was only 1.3% of total government expenditure on health (World Health Organization, 2018). In 2021-22, allocations for the National Mental Health Program continued to be paltry, despite the pandemic and a heightened need to address the growing mental health burden in the country (Mantri, 2021). This double negligence of adolescents and mental health has long prevented a more comprehensive examination of the mental health burden among adolescents and the development of relevant and appropriate youth mental health programmes in the country. Unless disrupted, this trend is likely to continue, and the pandemic will leave in its wake an entire generation with potentially long-lasting adverse mental health outcomes (Home | COVID-MINDS, no date).

Adolescence marks a phase of most rapid

neuro-psycho-physiological development and social transition in human life. It also marks the peak age of onset for a number of mental health problems, as about half of all mental disorders start during adolescence (Kessler et al., 2007). Thus, already vulnerable, the impacts of the pandemic on the mental health of adolescents are tremendous. Globally, studies have reported a negative impact on adolescent mental health and an upsurge in mental health problems, including stress, worry, fear, risky behaviours (Meherali et al., 2021), depression, anxiety, post-traumatic stress (de Figueiredo et al., 2021; Meherali et al., 2021), alcohol and drug use (Jones, Mitra and Bhuiyan, 2021), as well as suicide (Meherali et al., 2021). Many adolescents experienced a significant overall decline in their quality of life (Nobari et al., 2021). The pandemic has impacted the health, social and material well-being of children and adolescents worldwide, with the poorest ones, including the homeless or in detention, hit the hardest. School closures, social distancing and confinement increase the risk of poor nutrition among children, their exposure to domestic violence, increase their anxiety and stress, and reduce access to vital family and care services (World Economic Forum, 2021).

In India, a number of studies have shown a similar increase in mental health problems among adolescents (Kumar and Nayar, 2020; Pandey et al., 2020; Verma and Mishra, 2020; Kumaretal., 2021; Murthy and Narasimha, 2021; Roy et al., 2021). Quarantined adolescents experienced greater psychological distress due to worry, fear and helplessness than

non-quarantined adolescents (Saurabh and Ranjan, 2020). Moreover, an increase in domestic violence, physical and sexual abuse and related mental health problems were also reported (Ramaswamy and Seshadri, 2020). The lockdown in India last year witnessed a rapid surge in SOS calls made to the national child helpline from across the country (Press Trust of India, 2020). An increase in child labour, especially among vulnerable communities, was also reported (Narayani, 2021). The Covid-19 pandemic has left a large number of orphans and children who lost one of their parents in its wake. Between April 1, 2020, and June 5, 2021 alone, 3,621 had lost both parents to the pandemic, 26,176 had lost one parent, and 274 had been abandoned (Hamid, 2021). The closure of schools and the economic crisis faced by vulnerable families, triggered by the pandemic, are likely drivers pushing children and adolescents into poverty, and thus, child labor and unsafe migration (Educo, 2021). While the widespread digitalization mitigated the education loss caused by school-closures to some extent, the poorest children are the least likely to live in good home-learning environments with reliable internet connection. Furthermore, increased unsupervised on-line internet use has magnified issues around sexual exploitation and cyber-bullying (OECD, 2020). Living in small spaces without contact with relatives and friends could have affected the lower socioeconomic categories of urban populations disproportionately (United Nations, 2020).

The pandemic has created a “Covid

generation” of young people with its mental, economic and social health impact defining the course of their lives in the years to come (Shoichet, 2021). Having borne the brunt of the pandemic in its multiple waves, India will have its fair share of this Covid generation. How much and how far this generation will continue to suffer from the impacts of the pandemic will have to be watched carefully. It needs to be ensured that the long term impact of Covid-19 does not adversely affect the future potential and productivity of these young people.

FUNDER'S PERSPECTIVE

Keeping the above in mind, it is imperative for donors active in the wellbeing space to carefully rethink their funding strategies. As a Foundation working to improve the health and wellbeing of children and young people, at Fondation Botnar we have taken note of the gap in resources allocated to mental health. We consider it important to focus on the mental wellbeing of children and young people in developing urban environments in the years to come.

Over the past years, we have learnt a few key lessons. We see a potential to move from an individual-focused and medicalized approach towards a context-driven, relational approach to mental health. This requires a systemic perspective, an emphasis on prevention and inter-disciplinary research to understand and leverage the critical roles played by environmental determinants of young people's

mental health, community and social actors and their relationships. At the same time, there is a need to support new solutions and harness the potential of data and digital innovation towards ensuring positive mental health for all while strengthening capacity, effectiveness and reach of existing mental health systems resources. We support an inclusive, integrated and rights-based approach to mental health that emphasizes health instead of the disease and is culturally and socially rooted in the local context. This also requires a broad-based, societally anchored discourse of how to balance protection and empowerment.

Even as foundations and philanthropic donors channel their funding to help tackle different dimensions of this problem, it is important to avoid fragmentation and work together with local stakeholders in the mental health ecosystem. Indeed, proactive sharing of information and research knowledge can go a long way in leveraging the impact of limited funding resources. At Fondation Botnar we believe it is critical to work with local public sector stakeholders as sustainability and local ownership of programmes in the long run inevitably needs close partnership with the local public and private sector actors. Foundations can, however sometimes take risks with innovative interventions that the public sector cannot. Funding research led by institutions in the developing contexts along with scaling up service delivery programs that augment the capacity of existing healthcare human resources and can be integrated into local health and community-based systems is the need of the hour.

We see a catalytic role for donor foundations to fund innovation in the mental health space, support scale-up of proven interventions and reduce the burden of mental health problems. This calls for supporting and eventually scaling-up grassroots-based community-driven solutions that are locally grown rather than a ‘top down’ approach. At the same time, a considered understanding of the local needs and gaps along with the priorities of the local public health ecosystem should support identifying the right problems to solve. Otherwise, there is the risk of funding too many seeds or pilots which compete with each other and struggle to move to the next phase. A good example of such a situation analysis and engagement with multiple local stakeholders is our current project led by PATH India (Parikh and Girase, 2021).

We recommend human- and system-centred design to be at the core of any innovation funded in this space. This is all the more important when using technology-driven solutions. Researchers need to validate innovations and enable or accompany their scale-up so that knowledge generated within these programmes remains available to the wider community in the long run. Indian research institutions need to rise up to this challenge by providing for this capacity. They also have a critical role to play in making sense of the socio-economic and health data that has been made available in the last two years of the pandemic. The mental health research community should come forward to gain a better understanding of this data to create an

evidence base for guiding the governments and society for future pandemic response measures, which have in the past often been about ad-hoc trade-offs concerning decisions to prevent greater harm. Government and public health agencies in India can support these efforts not only through funding but by making the data securely available to the researchers. Foundations can step in to actively fund research to interrogate this data and generate future policy recommendations. There is a unique opportunity for philanthropic funders to work with local government in increasing the mental health research capacity within local academic and research institutions and augment the capacity of frontline health services in mental health service delivery. Last but not least, we collectively need to strengthen the voice of people with lived experience in mental health advocacy, legislation, research and service delivery, as well as its evaluation. Fondation Botnar will look up to people and especially young people with lived experience as partners in all its funded program in this space. In the recent history of public health in India, nothing has drawn the country’s attention to mental health issues like the ongoing Covid-19 pandemic. While many governmental and non-governmental organizations initiated mental health services, particularly through helplines and online counselling services, unless year-on-year budgetary allocations are increased, this much needed impetus on mental healthcare will be lost. In addition, the government can support the non-profit mental health ecosystem in the country, by recognizing their critical role, and supporting

more preventative and triaging schemes going beyond the funding of centralized or tertiary institutions (Mantri, 2021). The government can also play an enabling role by supporting a policy ecosystem that allows for partnerships between public, private, non-profit and philanthropic actors to flourish and combine their strengths toward achieving common goals. They also have a key role in prioritizing mental health in the national health spending, supporting social awareness campaigns that remove the stigma around seeking mental health care and regulation of the digital mental health services to facilitate ease of access and reduce out-of-pocket spends for example, by allowing insurance-related reimbursements.

Schools provide a major avenue to include mental health services for children and young people and the immense value of education towards contributing to positive mental health cannot be overestimated. The emphasis of the Indian Government's new National Education Policy (NEP) on the mental health of students is especially commendable (Kumar, 2020; Prakash, 2020). NEP focuses on holistic learning and emotional skills taking the focus away from competitive performance in exams which are a major stressor for young people in India (Lathabhavan and Griffiths, 2020). There could be an opportunity for local governments and schools to work together with philanthropic funders, non-profit and private sector partners to translate NEP effectively into practice in the public-school systems across the country.

Furthermore, globally active donor organizations could work together with WHO to support the translation of its recommendations in the Mental Health Action plan and key investment guidelines for national governments to ensure good mental health for its citizens effectively into practice (World Health Organization, 2021). Advocacy at global and national levels can further draw attention to such guidelines as well as support the programmes that ensure legal representation and capacity of persons with mental disorders. In India, this relates to the rights in line with the National Mental Health Policy (MoHFW, 2014) and international human rights conventions and laws, such as the Convention on the Right of Persons with Disabilities (OHCHR, 2007).

Last but not least, there is also a strong economic argument in favour of investment by governments in the mental health of its population. The global cost of mental health conditions is set to surge to 6 trillion USD by 2030 (Bloom et al., 2011). On the other hand, by some projections, investment in common mental health conditions and prevention can generate more than five times the return in terms of the value of productivity gains and reduced expenditure in other parts of the health system (WHO/UNDP, 2019). For India, where the demographic is uniquely young, this means investing in the mental health of its children and youth to reap the productivity and health system dividends in the future.

EPILOGUE

Covid-19 pandemic has forced us to reflect collectively on what matters the most deeply. As a philanthropic funding organization, we see an immense opportunity to reimagine our health and education systems to create more resilient, humane and equitable societies that encourage youth and children to flourish. We would like to invite public, private and non-profit partners to work with us to catalyse a future where communities are strengthened in their capacities to take care of their most vulnerable, where education systems put the mental health and blossoming of the individual's creative potential as its focus and where we strengthen the web of nurturing relationships including those with our environment that sustain our lives and give it meaning.

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