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*Response and Resilience***



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Editorial

This special volume on “Health and Mental Health in Pandemic: Response and Resilience” is the outcome of scholarly contributions by academicians, research scholars and field practitioners. Articles are varied in nature viz; review, empirical, qualitative and qualitative which may sustain the reader’s attention. I am thankful to the Editor-in-Chief of the South Asian Journal of Participative Development, Pune for giving me this opportunity to work as guest editor. All the articles have taken a context of Covid-19 Pandemic breakout and tried to explore, describe the lived experiences of different sections of society.

Praful and colleagues in their paper tried to explore the distress among farmers due to Covid-19 pandemic. They explored that psycho-social interventions to reduce the burden of mental health issues in farmers. Due to continuous lockdowns farmers could not sale their crops because of lack of transport facilities made impact on their level of depression. With the help of standardized tools authors made initial screening, diagnosing, monitoring and measuring level of clinical depression. After screening the individuals, psycho-social care training is devised for training for community workers and family members. This empirical paper come up with the community mental health model which have pragmatic value in replication in other parts of Maharashtra.

Kheyali and Shaurya in their paper tried to explore the disparities between kknowledge and utilization of rreproductive hhealthcare sservices among aadolescents in slums of Balasore, Odisha. It is always seen that adolescent girls struggle in the utilization of reproductive healthcare services due to various reasons. The present study follows the eclectic approach of research. Primary and secondary data has been collected using semi-structured questionnaires, focus-group discussion, and case studies from two slums. The findings reveal a significant relationship between knowledge

and utilization of reproductive healthcare services among adolescent. The reasons for disparity revolve around lack of healthcare services, lack of proper knowledge, social stigma, customary practices, affordability, and shyness. These findings surely can be instrumental in providing and raising standards of healthcare services.

Sanjoy has tried to explore the parameters on which the transformation of family values and beliefs are based during Covid-19 with special reference to India. The review article also reflects upon Domestic Violence (DV), particularly Intimate Partner Violence (IPV). The findings reveal that there are primarily six parameters due to which there are evident changes in family system and relations during the pandemic. The article concludes that for us to wait and watch the prioritization pattern of this generation; whether they choose to rekindle family values or consider devaluing the family beliefs and prioritize their liberty over everything else.

Chitkala in her paper tried to explore the very cornered population of students with special needs. She studied about prevalence of Attention Deficit Hyperactivity Disorder Symptoms and Family Preparedness Plan in the Management during Covid-19 Pandemic in Karnataka State. Families have reported reduced access to mental health and education services and challenges with remote learning. The social, emotional, and psychological support parents receive during in-person interactions with school systems which were absent in lockdowns which aggravated the symptoms in children. She proposes radical suggestions for such parents.

Rupa and her colleagues explored the challenges faced by front-line healthcare workers with special reference to selected districts of West Bengal. The explored the role of ASHA workers in Covid pandemic in the purview of public health care system. Their study reflects the inability of public health care system to tackle emergency situations like this

pandemic. Through this empirical research, they asserted the infrastructure development, supportive policies, training programs and use of technology to cater the emergency health care needs.

Nabhas has also reviewed the economic implications of ASHA workers in Kerala and their employment situation in Covid-19 pandemic. He discovered that ASHA workers face significant financial challenges, lack of satisfaction about the treatment they get, poor wages and incentives, lack of social security benefits and consistent wage delays. They are overburdened in pandemic situation and suffer from mental physical and mental burnout. At the end he suggested measures of policy design to handle this problem.

R. Janaki Rao has reviewed very gray part of our society that is domestic violence against women during this Covid-19 pandemic. Researchers have confirmed the inevitable consequences of domestic violence (physical, sexual, and emotional) in increased vulnerability to psychopathologies in addition to physical morbidity. Domestic violence cases are vast in India, and the numbers are further aggravated at an alarming rate during the Covid-19 pandemic. The impact of the Covid-19 pandemic on women was unprecedented and worse than before. Home containment as a measure to protect the health and well-being of the general public has resulted in increased sufferings for women in terms of both sufferings from diseases and increased domestic violence.

Shireen and Ramesh have reviewed the impact of Covid-19 pandemic on mental health of Muslim women. There are many women's issues that affect Muslim women today, they deal with not just the everyday stressors of life but also the responsibility of defending basic religious rights and values of normal and acceptable. A lack of adequate domestic and emotional support can have consequences of women's mental health. Women reported significantly more perceived

helplessness as compared to men. Authors advocated online support activities for combating stress, anxiety, depression and frustrations among Muslim women.

Sandeep has tried to explore the voices of transgenders from Solapur city. In social life, there are different discriminations are embodied by people. They even don't know that they are some or other way practicing and silently advocating it. People who are living with incongruence have altogether different scenarios of life. This empirical article is based on personal interviews with six transgenders about their life in general and life in lockdowns in particular. His paper tries to explore the life of transgender people, issues of their concern, exclusions faced, their frame of reference etc. especially in the context of Covid-19 pandemic as qualitative inquiry. His article intends to document the lived experience of transgender community in general and living with incongruences and stressed on the policy issues. He suggested continuous consultations, accepting equality bill as measures.

Geeta and Ketaki explored the vulnerabilities and challenges faced by different service providers in Maharashtra while combating with Covid-19. Their empirical article based on exploratory research design proved that among all service providers police personnel were more vulnerable followed by nurses and doctors. District-wise differences were found in vulnerability on their basis of population and availability of resources. They concluded that during this pandemic period they were confronted lot of challenges considering their severity and its effect on physical and mental health. Followed by profile of the Sarathi Youth Foundation's in the eyes of Adv. Javed and Gangadhar has done a cogent book review for the contribution of Yusuf Bennur.

Sandeep Jagdale
Guest Editor

Farmers Distress During the Covid-19 Lockdown: Psychosocial Response

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Abstract

Background: Covid-19 outbreak in the nation have significantly affected the farmers. The farming economy is totally dependent on rain in India, however this time it is Covid-19 that have put the agriculture and farmers under threat situation. Farmers who have the crop in their hand but are unable to sale in the market as unavailability of transport facility, shutdown at many places across nation. The distress of farmers has increased due to nationwide lockdown. The obstacle caused by the Covid-19 pandemic will drop the country's struggling rural economy that supports nearly half its population into further distress. Covid-19 pandemic is become major stressor for most of people.

Aim: *To examine the distress among farmers due to Covid-19 and explore the psychosocial interventions.*

Objective:

- *To examine distress among farmers due to Covid-19.*
- *To Develop Psychosocial support and care plan for farmers with distress.*
- *To Create Community Awareness for Prevention of Covid-19.*
- *To develop plan of training the community level worker in delivering psychosocial care.*

Tools:

Patient Health Questionnaire PHQ 9 - *The screening to be conducted using the Patient Health Questionnaire – 9 (PHQ-9). The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring severity of the depression. This is widely used standardized tool, also validated for Indian population*

Conclusion: *The Covid-19 lockdown is an opportunity for families to strengthen family bonds. Among all the family members. Therefore, parents should be educated to encourage their children to engage in more creative activities including board games, gardening and drawing. Parents should find time to play with the children and engage in daily rituals which strengthens the family.*

Key Words: Farmers Distress, Covid-19, Lockdown Psychosocial Response

Introduction

Covid-19 outbreak in the nation have significantly affected the farmers. The farming economy is totally dependent on rain in India, however this time it is Covid-19 that have put the agriculture and farmers under threat situation. Farmers who have the crop in their hand but are unable to sale in the market as unavailability of transport facility, shutdown at many

places across nation. The distress of farmers has increased due to nationwide lockdown. The obstacle caused by the Covid-19 pandemic will drop the country's struggling rural economy that supports nearly half its population into further distress. Covid-19 pandemic is become major stressor for most of people.

Socio-economic impact is highly disastrous. Farmers are having the biggest loss due to this lockdown. And there are psychosocial consequences of this disaster needs to be recognized and addressed efficiently. These consequences include feeling sadness, anxiety, lack of interest in doing daily activity, low mood, depression, suicidal thoughts, lack of sleep, use of substance, domestic violence.

The Covid-19 lockdown is basically a chance for families to support family bonds. However, studies reveal that during this time, there is significant increase in domestic violence cases (Bradbury & Isham, 2020), unavailability of personal space in the family and high dullness during this lockdown (Wang et al., 2020). Home-makers may have burden highly shortage of supplies and the sudden need to care for the entire family. Parents might be stressed by the thoughts about the future of their own jobs as well as the education of their children. Spending more time inside the house can lead to physical inactivity and delay in milestones (Glynn & Boland) among all family members. Therefore, parents should be educated to encourage their children to engage in more creative activities including board games, gardening and drawing. Parents should find time to play with the children and engage in daily rituals which strengthens the family relationship and helps to pass time (World Health Organization, 2020), With this abnormal situation across the nation, it is imperative to have the focused psychosocial intervention to address the farmer's

distress. In view of this need following intervention model proposed to reach out the farmers in community.

Aim: To examine the distress among farmers due to Covid-19 and explore the psychosocial interventions.

Objective

- To examine distress among farmers due to Covid-19.
- To Develop Psychosocial support and care plan for farmers with distress.
- To Create Community Awareness for Prevention of Covid-19.
- To develop plan of training the community level worker in delivering psychosocial care.

Tools

Patient Health Questionnaire PHQ 9 - The screening to be conducted using the Patient Health Questionnaire – 9 (PHQ-9). The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring severity of the depression. This is widely used standardized tool, also validated for Indian population (Thombs et al., 2014).

Intervention Model

Distressed farmers to be identified through the screening, identified people to be informed in detail about Covid-19. Participant to be informed about the program in details and informed consent to be sought to participate in Psychosocial treatment program. Below diagram shows the process of intervention.

The trained counsellors will be appointed to carry the intervention across the community.

Interventions with individuals: -

Screening and identification: Primary screening method to be used to screen the household population Secondary

screening method to be adopted initially to identify the farmers with distress. Rapport with key community stakeholders is required. Counsellors to establish the rapport with key stakeholders in the villages. To organize the focused group discussions along with these key stakeholders to be conducted (by maintaining social distancing). The key stakeholders will be informed about the aims and objectives of the program, consent to be obtained, explain the signs and symptoms in detail, myths and misconception about Covid-19, available treatment approaches to be informed to the participants, encourage to participate in the study and intervention program. This stakeholder engagement will lead to the high identification of farmers with distress in villages. Further counsellors will initiate the screening of these individuals with standardized tool PHQ-9 (Thombs et al., 2014) to identify the depression. The cut off score for the PHQ-9 (Thombs et al., 2014) is 5. People who have scored above cut off will be informed about the illness in detail and condition they are in and seek their consent to participate in the program.

Enrollment and assessment

People with distress will be ask to give written consent and to participate will further be enrolled in the program. The detailed case assessment of will be conducted by the counsellor. Assessment includes socio-demographic profile, history of present illness, family history, personal history, premorbid history, mental status examination, suicide risk assessment, etc.

Home based counselling

Counsellor will provide the home-based counselling to the enrolled farmers; the counselling sessions will be directed to address identified issues through individual assessments. Counsellors to use various therapeutic approaches including

solution focused, problem solving approach, rational emotive behaviour therapy, cognitive behaviour therapy, relaxation therapy, exposure and response prevention therapy etc.

Follow up care

Farmers with who are taking medication will be followed up on regular basis to ensure quality care and regular follow up. Counselors will monitor the patients for drug adherence and regular follow up. There will be high chances of patients quitting their medication following a month of medication, however counselors will follow up with the patients for regular consultation and drug adherence.

Interventions with families: -

Family Education

Family Education regarding Covid-19 it includes, to create awareness about the myths, misconceptions and stigma which is prevalent during this Covid-19. Counsellors will initiate the engagement with these family members and start educating them about the Covid-19 illness. Family education will include Information regarding signs, symptoms, treatment options, myths misconception, stigma etc were included in the education, explain them the importance of social distancing and using protection mask, etc.

Established Support Group with Family Members: -

E-Support groups of family members of the Covid-19 would be established, the main objective of the support groups will be to share experiences of caring Patients with Covid-19 and to share the knowledge to handle Covid-19 during quarantine in the family. During the Support Groups Meeting each family members can share their experiences about illness. Through discussions family members will learn various aspects of caregiving. This also enabled positive change in the attitude of family members towards Covid-19 Patients.

Awareness:

Key stakeholder meetings

Key stakeholders in the village included gram panchayat members, Anganwadi workers, ASHA workers, etc. to approach stakeholders from the beginning of the program. Regular meetings will be conducted to educate them about the program, Covid-19, various aspects of mental health during Covid-19 lockdown and discuss about their role in referral and awareness about mental health in the community. The regular engagement with these stakeholders will help in a greater way to addressing the distress among farmers due to Covid-19 (Johal 2009).

Gatekeeper identification /sensitization

To identify the community gatekeepers from each village. Gatekeepers are the volunteers to keep an active watch on the vulnerable individuals. These volunteers are self-motivated and willing to work for these people. To provide the sensitization training and also basic orientation of Covid-19. This will include identification of farmers with distress, providing an information to family members, creating awareness about the illness. Participation in various community awareness program and coordinating with counsellors for village-based activities (Kar et al., 2020).

IEC material distribution

A standard IEC material will be developed to create the awareness among villagers. To develop the community awareness material, use of Government of India norms and prepare the material in local language and share in communities.

Wall paintings

Wall Painting is a source of information for the villagers about the Covid-19, and Mental Health. This will help people

to reach out for information and discuss their concerns with counsellors directly. Wall Painting will also be helpful to reduce their myths and misconceptions about the Covid-19. And reach out to larger population in effective way.

Case Studies:

Mr. M, 37-year-old farmer from the Patapangara Village have reported in words that this lock down has brought significant difficulties. Have disturbed the total economy for as he was working in 3 acer of land the in the current season, he had harvested 60 qt. of cotton which is being stored in home. Since this lockdown all the buyers have stopped purchasing the cotton. The moisture is fading now which will result in low weight of the cotton. Even in that case no ginner is ready to take the cotton. I used to do labour work in agriculture nearby to earn some money but due to lockdown have lost that income too.

I had taken loan from the relative they are calling repeatedly for money, I was unable to understand this CORONO virus I am feeling anxious and sadness due to this, have very less interesting in eating food, confused for most of the time. Feeling stressed all the time.

Emotional disturbances: feeling sad all the time, worried, fear of getting contaminated, preoccupation of illness/ I may get contaminated, feeling stressed due to lockdown and social distancing, Symptoms of: Sadness of mood, anxiety or worry, fear of contracting an infection (or a combination of all these). Inability to cope (giving up) and some degree of dysfunction. Sleep and Appetite disturbances. In adolescents, these symptoms might be associated with oppositional behaviour or truancy.

Psychosocial Response:

Your reaction is normal during this Covid-19 outbreaks when people experience very high anxiety, distress, and sadness, however are still managing to move on. Because you are feeling this anxious, sadness, distress, etc. This is due to adjustment disorder. Generally, in this kind of health disaster it is common to have such feelings and, in some people, there would be following symptoms. You should seek help and discuss with counsellors share the emotions seek the counselling and support.

Mr S 59-year-old male from Akpuri village have I am alone in my family as all the family members have died sometime back. I do labour work in nearby farms; I have the fits and due to that feel headache all the time. Now due to lockdown am not able to get the work because of this have not been able to buy the food for myself. Since there is nobody in the family, I feel alone all the time feeling sad, have feeling that what will happen, who will take care of me unable to cope with this difficulty.

Emotional disturbances: feeling sad all the time, worried, fear of what will happen to him, preoccupation of illness, feeling alone, feeling stressed due to lockdown and social distancing, Symptoms of: Sadness of mood, anxiety or worry, fear of contracting an infection (or a combination of all these). Inability to cope (giving up) and some degree of dysfunction. Sleep and Appetite disturbances.

Psychosocial Response:

Your reaction is normal during this Covid-19 outbreaks when people experience very high anxiety, distress, and sadness, however are still managing to move on. Because you are feeling this anxious, sadness, distress, etc having seizures, and this is due to adjustment disorder. Generally, in this kind of health disaster it is common to have such feelings and, in

some people, there would be following symptoms. You should seek help and discuss with counsellors.

Mr S 35-year-old male from Shirol village have mentioned that during this Covid-19 we are facing lot of difficulties, I have lost my employment since Covid-19 breakdown am feeling fear, anxiety, have worry that how my family will run. I do labour work in nearby farms but since lockdown my employment have completely gone. I feel, worried, emotionally unstable, have headache all the time. Now due to lockdown am not able to get the work because of this have not been able to buy the food for myself. I feel alone all the time feeling sad, have feeling that what will happen, who will take care of me unable to cope with this difficulty. This kind of difficulties reported.

Emotional disturbances: feeling sad all the time, worried, fear of what will happen to him, preoccupation of illness, feeling alone, feeling stressed due to lockdown and social distancing, Symptoms of Sadness of mood, anxiety or worry, fear of contracting an infection (or a combination of all these). Inability to cope (giving up) and some degree of dysfunction, sleep and Appetite disturbances (Kar et al., 2020).

Psychosocial Response:

Your reaction is normal during this Covid-19 outbreaks when people experience very high anxiety, distress, and sadness, however are still managing to move on. Because you are feeling this anxious, sadness, distress, etc having seizures, and this is due to this might be the adjustment disorder. Generally, in this kind of health disaster it is common to have such feelings and, in some people, there would be following symptoms. You should seek help and discuss with counsellors if you are feeling lot of anxiety/depression.

Mr S 32-year-old male from Kinhi village have mentioned that during this Covid-19 is hell of disease, which significantly affecting me, I feeling restless, worried all the time that it will happen to me, feeling worried all the time, facing lot of difficulties, my business has stopped from lockdown, I have lost my income since Covid-19 breakdown am feeling fear, anxiety, have worry that how my family will run. I do labour work in nearby farms but since lockdown my employment have completely gone. I feel, worried, emotionally unstable, have continuous headache all the time. Now due to lockdown am not able to get the work because of this lockdown, I am unable to buy the food for myself. I feel alone all the time feeling sad, have feeling that what will happen, who will take care of me unable to cope with this difficulty. This kind of difficulties reported.

Emotional disturbances: feeling sad all the time, worried, fear of what will happen to him, preoccupation of illness, feeling alone, feeling stressed due to lockdown and social distancing, Symptoms of Sadness of mood, anxiety or worry, fear of contracting an infection (or a combination of all these). Inability to cope (giving up) and some degree of dysfunction.

Psychosocial Response:

You have the normal reaction to this abnormal situation during this Covid-19. It has out broken when people experience very high anxiety, distress, and sadness, however are still managing to move on. Because you are feeling this anxious, sadness, distress, etc having seizures, and this is due to this might be the adjustment disorder. Generally, in this kind of health disaster it is common to have such feelings and, in some people, there would be following symptoms. You should seek help and discuss with counsellors if you are feeling lot of anxiety/depression.

Mr S 32-year-old female from Hivari village have mentioned that during this Covid-19 is hell of disease, which significantly affecting me, My husband repeatedly hitting me slapping me, he demands have repeatedly hit by husband I feeling restless, worried all the time that it will happen to me, feeling worried all the time, facing lot of difficulties, my business have stopped from lockdown, I have lost my income since Covid-19 breakdown am feeling fear, anxiety, have worry that how my family will run. I do labour work in nearby farms but since lockdown my employment have completely gone. I feel, worried, emotionally unstable, have continuous headache all the time. Now due to lockdown am not able to get the work because of this lockdown, I am unable to buy the food for myself. I feel alone all the time feeling sad, have feeling that what will happen, who will take care of me unable to cope with this difficulty. This kind of difficulties reported.

Emotional disturbances: feeling sad all the time, I am worried, some fear is following me happen to him, preoccupation of illness, feeling alone, feeling stressed due to lockdown and social distancing, Symptoms of Sadness of mood, anxiety or worry, fear of contracting an infection (or a combination of all these). Inability to cope (giving up) and some degree of dysfunction.

Psychosocial Response:

You have this very normal reaction to this atypical situation during this Covid-19. It has out broken in vary larger way and what you when people experience very high anxiety, distress, and sadness, however are still managing to move on. Because you are feeling this anxious, sadness, distress, etc. you must do an effort to keep your healthy and deal with this efficiently.

Conclusion

Covid-19 has emerged as the global epidemic. Since till date no vaccine or medication to combat the illness developed. Hence it is essential to follow WHO guidelines for prevention of this illness. Washing hands frequently, following social distancing, following the lockdown guidelines will ensure the prevention from the Covid-19 infection. Farmers with distressed can be helped with this model of psychosocial care and support to reduce their distress due to lockdown. The Covid-19 lockdown is an opportunity for families to support family bonds. However, studies have revealed that during this time, there is an increase in domestic violence cases lack of personal space in the family and boredom.

Home-makers might be burdened by shortage of supplies and the sudden need to care for the entire family. Parents might be stressed by the thoughts about the future of their own jobs as well as the education of their children. Spending more time inside the house can lead to physical inactivity and delay in milestones among all family members. Therefore, parents should be educated to encourage their children to engage in more creative activities including board games, gardening and drawing. Parents should find time to play with the children and engage in daily rituals which strengthens the family relationship and helps to pass time (World Health Organization, 2020). Hence it is recommended to use this model to address the distress among farmers in the community (Kar et al., 2020; Mackolil & Mackolil 2020)

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Disparities between Knowledge and Utilization of Reproductive Healthcare Services among Adolescents in Slums of Balasore, Odisha

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Abstract

Reproductive health knowledge and services utilization are the most crucial aspect to be observed amongst rural adolescents. It is always seen that adolescent girls struggle in the utilization of reproductive healthcare services due to various reasons. The findings of the present can enhance the efforts towards promoting the use of reproductive services in slum communities. The present study follows the eclectic approach of research. Primary and secondary data has been collected using semi-structured questionnaires, focus-group discussion, and case studies from slums, i.e., Talashai and Jadabpur in Balasore, Odisha. The study's findings reveal a significant relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in

slums of Balasore, Odisha. The reasons for disparity revolve around lack of healthcare services, lack of proper knowledge, social stigma, customary practices, affordability, and shyness.

Keywords: Covid-19, Corona Virus, Psychological effect, Mental Health, Co-morbidities, Elderly.

Introduction

Reproductive health knowledge and facilities usage amongst the adolescents residing in slums hung around the lower frequency. There exists a significant relationship between age, economic status, and reproductive health knowledge. Further, it can also be stated that utilization of reproductive healthcare services establishes a significant relationship with age and level of reproductive healthcare knowledge. Reproductive health is a sensitive topic to the adolescent, and also it concludes counselling, peer education, parent-adolescent communication, etc. (Abajobir, A. A., & Seme, A., 2014). Adolescence is identified by notable physiological, psychological, and social changes that put adolescents at high risk of sexual and reproductive health (SRH) problems. (WHO, 2005).

Knowledge of reproductive health care among female university students was found unsatisfactory. Government and concerned organizations should promote and strengthen various health education programs to focus on reproductive health care (Islam Mondal, M. N., Nasir Ullah, M. M., Khan, M. N., Islam, M. Z., Islam, M. N., Moni, S. Y., Hoque, M. N., & Rahman, M. M., 2015). The frequency of the utilization of reproductive health services among adolescents was low. Discussion with a sexual partner and peers and risk perception of oneself towards acquiring human immune-deficiency virus were predictors of reproductive health services usage (Tlaye, K.G., Belete, M.A., Demelew, T.M. et al., 2018). Limited health literacy and its impact on women's health are important

challenges for policymakers and healthcare professionals dealing with the reproductive health of the female population. Significant positive effects on improving health literacy levels in women can be achieved by increasing reproductive health protection, promoting healthy lifestyles, and empowering women and their active participation in the community. In addition, multidisciplinary work and cooperation of the Ministry of Health with various educational institutions, sports associations, public media, local self-government, non-governmental and humanitarian organizations, and associations—can significantly contribute to women's overall health and well-being. (Milena, M., Goran, S., Vanja, P., Milos, S., Ognjen, D., Zivanovic, M., et.al, 2021).

India is fronting a remarkable growth in the population, mainly in the urban area. This has constituted a noteworthy opposition for the nation as this expansion has led to an increase in the number of slum dwellers with their associated health problems. Not being able to reach this population with health services could hamper the nation's growth and development towards the health MDGs. There is a remarkable distinction in the utilization process of reproductive health services among adolescent groups residing in the slum and non-slum areas. There is a need to start awareness regarding reproductive healthcare services. The NUHM should start monitoring and evaluating the programmes of reproductive healthcare in the slum area (Hazarika I., 2010). The rapid growth of urbanization influences the slum population in the nation. As the slum population increases day by day, it also affects the healthcare system in the slum area (John D, Chander SJ, Devadasan N, 2008). There is minimal service in the healthcare system in the slum area of our country. The adolescent population of the slum area faces many problems in their day-to-day life, and one of the most remarkable problems is in reproductive healthcare services availability

(The Lancet, 2005). The migration problem is one of the main problems in increasing the slum population in India. Health problems are a regular feature of the slum population in India (Khan MM, Kraemer A, 2008). The livelihood pattern, illiteracy, and poor environmental conditions are responsible for the health condition of the slum population. (Aggarwal P, Singh MM, Garg S, 2007).

The utilization of maternal healthcare services, which is the key to combating the rate of morbidity among mothers, is less frequent and distributed irregularly among different strata or subcategories in Odisha. The present situation is quite visible in underprivileged groups having poor and illiterate backgrounds. Hence, it can be pointed out that reproductive healthcare services must be distributed regularly among underprivileged and disadvantaged groups in society. Upgradation of health infrastructure, including positioning skilled health personnel in public health centers in underprivileged and rural regions, can be the main priority in health planning and programmes. Large-scale healthcare awareness programmes and promoting female literacy are pertinent to enhancing the maternal healthcare-seeking behaviour in Odisha. (Prushty, RK, Gouda, J., Pradhan MR, 2015). Adolescents mainly face a lack of awareness, population explosions, myths and misconceptions, illegal abortion, and female foeticide. The strategy that should minimize the problems is creating awareness about STDs, Contraception, Menstruation, ARTs. To educate the adolescent through government and non-government organizations, sex education, and audio-visuals and discuss the ill effects of a large population. (Pattanaik N, Kar K, Satapathy DM, Pattanaik A, 2021).

Objectives

1. To assess the reproductive healthcare services of adolescent girls in slums of Balasore, Odisha.
2. To measure the level of disparities of reproductive healthcare services of adolescent girls in slums of Balasore, Odisha.
3. To identify the factors that determine the disparities of reproductive healthcare services of adolescent girls in slums of Balasore, Odisha.

Research methodology

This is a community-based cross-sectional study conducted among adolescent girls in the age group of 10-19 years residing in Talashai and Jadabpur slum in the Balasore district in the state of Odisha. The researchers conducted the present study during the month of August 2021. An eclectic methodology is used with the objective to explore the disparities between knowledge and utilization of reproductive healthcare services among adolescent girls in the selected slums of Balasore district Odisha. The choice of eclectic methodology was kept in mind to fulfil the research objectives. Primary and secondary data have been incorporated through fieldwork and in the forms of reports, newspapers, and literature regarding reproductive healthcare services among adolescents. The reproductive healthcare status, personal and environmental menstrual hygiene have been assessed to understand the disparities between knowledge and utilization of reproductive healthcare services among the adolescent girls in the selected study area. The techniques of semi-structured questionnaires, focus-group discussion, and case studies have been considered for the purpose of primary data collection. Simple random and purposive sampling has been adopted for this particular study. Confidentiality, social distancing, and government norms are strictly followed during the data collection.

The researchers have formulated a hypothesis to support the scientific evidence of their findings.

H₁: There exists a significant relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha.

H₀: There exists no significant relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha.

Findings

Population Profile and lifestyle factors

This study includes two slums named Talasahi and Jadabpur. Talasahi slum falls under Balasore Municipality. This slum is 2 km far from the district head hospital. Geographically the slum Talasahi is located on the west side of Balasore town. 250 families are settled there. The health condition is very poor in this slum. The surroundings are very unhygienic. Jadabpur slum is also under Balasore municipality. This slum is surrounded by Ranipatna towards the east, Arad Bazar towards the west, Nuya Bazar towards the north. 1043 families are settled there. An unhealthy environment, unhygienic living conditions, unstructured housing patterns, lack of sanitation facilities, hazardous working conditions, the poor structure of socio-economic conditions are the main features of the slum population. Due to the uneven development of the economy in capitalism, thousands of people from different parts of India are moving here and there for their livelihood. They are living in very unhealthy conditions.

The researchers have taken 50 adolescent girls from each slum for this study.

Reproductive healthcare awareness

There is a lack of awareness regarding reproductive healthcare services in India, and a similar situation has been reported in

the studied area due to illiteracy and ignorance. There are many social taboos and customs regarding reproductive health. Mainly the term reproductive has some shyness in it to the people. Many traditions make people secretive about reproductive health, and thus the problem spread far and wide. Reproductive healthcare awareness is an approach that is mainly coming under the educational policy. This is a very sensitive issue to most of the community people. Reproductive healthcare includes preventing and treating sexually transmitted infections, family planning services, counselling, information, education, communication and services, prenatal care, infertility, abortion, responsible parenthood, etc.

Access to Reproductive healthcare services

The reproductive healthcare providers mainly focus on capacity building and sensitization regarding reproductive healthcare, improved outreach activities, improved access to reproductive health. Reproductive health is a condition of absolute well-being of physical, mental, and social spectra and merely not the absence of infirmity or disease in all matters relating to the reproductive system and its functions and processes. So, it is essential to access reproductive healthcare services. There are many policies and programmes of government and non-government organizations regarding reproductive healthcare services among adolescence. The adolescents of the studied area are less knowledgeable about the benefits and don't know the facts. They do not utilize the knowledge appropriately, and even they do not take these issues seriously. Most adolescent girls are not aware of the policies and programmes that are mainly focused on them only.

Choice of Reproductive healthcare providers

The essential reproductive healthcare interventions are comprehensive sexuality education, counselling, and services for a range of modern contraceptives with a defined minimum number and types of methods. Antenatal, childbirth, and postnatal care, including emergency newborn care. Information, counselling, and services for reproductive health and well-being. The adolescent of slums mainly chooses the government healthcare providers as they rarely visit the educational institute. So, the government healthcare providers should give proper knowledge about reproductive healthcare and also should be trustworthy. The adolescent girls mainly make their choice of health care providers from shared decision making.

Disparities between knowledge and utilization of reproductive healthcare services

From this study, the researchers found that there exists a substantial disparity between knowledge and utilization of reproductive healthcare services. In this section, the researchers have elaborated the level of knowledge, reasons for disparities, and the relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha.

Relationship between knowledge and utilization of reproductive healthcare services

In order to support the scientific evidence of their findings, the researchers have formulated and tested the hypothesis accordingly. This will help the researchers to establish the relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha. The result of the tested hypothesis is explained below:

H₁ –There exists a significant relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha.

H₀ -There exists no significant relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha.

$$\chi^2 = 12.05$$

Degree of freedom = 2

The critical value of χ^2 at 5% significance level at 2 degrees of freedom is 5.99, and the calculated value of χ^2 at 5% level of significance at 2 degrees of freedom is 12.05. So, the research hypothesis is accepted, and the null hypothesis is not accepted.

Thus, it can be observed that there exists a significant relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha. The findings accepted the research hypothesis and rejected the null hypothesis. Hence, it can be concluded that there exists a significant relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha.

Level of knowledge of reproductive healthcare services slum wise

In this section level of knowledge of reproductive healthcare services slum-wise among adolescent girls has been outlined.

Slum	Low knowledge (%)	Moderate knowledge (%)	High knowledge (%)
Talashai	40	50	10
Jadabpur	50	30	20

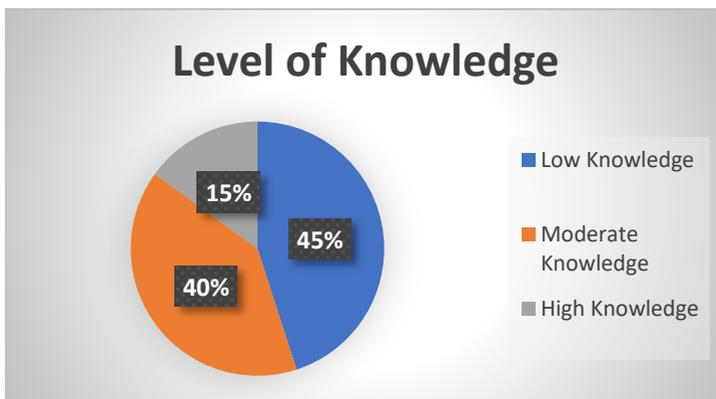
Source: Author's compilation

Table - 1: Level of knowledge of reproductive healthcare services slum-wise

From table – 1, it can be clearly seen that the respondents have reported their level of knowledge of reproductive healthcare services as low, moderate, and high knowledge. In slum Talashai, it can be observed from the table that 20, i.e., 40%, 25, i.e., 50%, and 5, i.e., 10% of the respondents fall under low, moderate, and high knowledge, respectively.

Similarly, in slum Jadabpur, it can be observed from the table that 25, i.e., 50%, 15, i.e., 30%, and 10, i.e., 20%, of the respondents fall under low, moderate, and high knowledge, respectively.

Thus, from the above discussion, the level of knowledge of reproductive healthcare services among adolescent girls in both the slims can be understood.



Source: Author's compilation

Fig. - 1: Level of knowledge of reproductive healthcare services

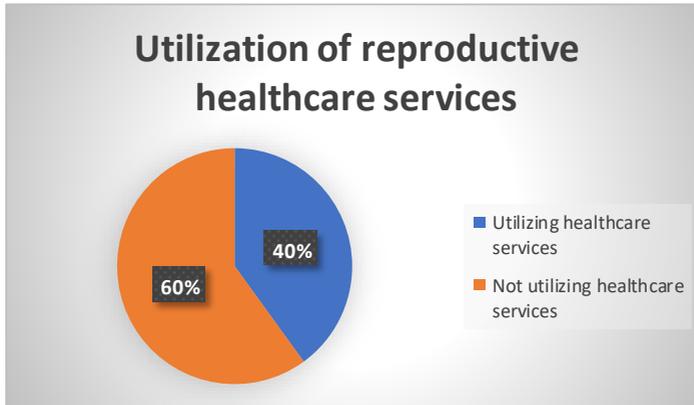
From fig. – 1, we can outline the level of knowledge of reproductive healthcare services among adolescent girls in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha. From the present study, 45, i.e. 45%, 40, i.e., 40% and 15, i.e., 15% of the respondents reported low, moderate, and high knowledge, respectively.

Thus, it can be concluded that the majority of the respondents possess a lower level of knowledge. Hence, it can be easily said that there is a need to enhance the knowledge of reproductive healthcare services among adolescent girls in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha.

Utilization of reproductive healthcare services

The availability and accessibility of the services are the key components to meet the requirements of our society. Merely availability of the services can't enhance the well-being of the community. In order to attain holistic development, availability and accessibility are to be considered as the epitome of the service delivery system. In this section, the researchers have explained the utilization of reproductive healthcare services among adolescent girls in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha.

There are many policies and programmes of reproductive healthcare services by Government and Non-Government organization, but the level of utilization of these services are very low in the studied slum area.



Source: Author's compilation

Fig. - 2: Utilization of reproductive healthcare services

From fig. – 2, it can be clearly seen that only 40, i.e., 40% and 60, i.e., 60% of the adolescent girls, are utilizing the reproductive healthcare services in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha.

Thus, from the above discussion, the researchers have highlighted that majority of the adolescent girls are not utilizing the reproductive healthcare services in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha, which is a significant concern for the holistic development of the community.

Reasons for disparities between knowledge and utilization of reproductive healthcare services

Reproductive health knowledge and services utilization must be enhanced among adolescent girls in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha. The present study reveals that there is a massive disparity between knowledge and utilization of reproductive healthcare services. In this section, the researchers have explored the reasons for

the disparity between knowledge and utilization of reproductive healthcare services.

Reasons of disparities	Percentage (%)
Lack of healthcare services	15
Lack of proper knowledge	45
Social stigma	5
Customary practices	7
Affordability	18
Shyness	10

Source: Author's compilation

Table – 2: Reasons of disparities between knowledge and utilization of reproductive healthcare services

From table – 2, the researchers have explained the various reasons for the disparity between knowledge and utilization of reproductive healthcare services among adolescent girls in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha. It can be seen that 15, i.e., 15%, 45, i.e., 45%, 5, i.e., 5%, 7, i.e., 7%, 18, i.e., 18% and 10, i.e., 10% of the adolescent girls in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha reported lack of healthcare services, lack of proper knowledge, social stigma, customary practices, affordability, and shyness as the reasons for the disparity.

Thus, from the above table, it can be concluded that the major reason for the disparity between knowledge and utilization of reproductive healthcare services among adolescent girls in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha is lack of proper knowledge related to healthcare services followed by affordability and lack of healthcare services.

Case summary

Adolescents aged between 10 and 19 years are the most vulnerable group. They need proper guidance and support for their holistic development. The present paper focuses on the disparities, and the relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums, i.e., Talashai and Jadabpur of Balasore, Odisha.

In this particular section, the researchers have penned down the case summary for a better understanding of the factors associated with the disparities of reproductive healthcare services of adolescent girls in slums of Balasore, Odisha. The participants had insufficient knowledge regarding reproductive health management, and the majority of them depended on their peers for reproductive health information. Reproductive health services are available in their place, but utilization level is shallow as they perceive a negative attitude towards reproductive health. Many of them are engaged in unprotected sexual practices to survive, which makes their reproductive health low. They are not much aware of the medical practice. Many times, they use local methods to induce abortion. One of them said that they understand reproductive health services as the services that teach them how to protect themselves from getting pregnant through using condoms during sex and using contraceptives. Most of the participants prefer friends to get information about reproductive health. Some adolescent girls were also believed that healthcare providers do not treat adolescents who seek reproductive healthcare services well. Some believe that adolescents who seek reproductive healthcare services are known as 'bad' or 'spoilt'.

Discussion & Conclusion

Reproductive health knowledge should be a part of the life of adolescents as this is a preeminent aspect of health. There are some barriers to the utilization of reproductive healthcare services like the socio-cultural, attitude of healthcare providers, lack of privacy, and confidentiality. Some healthcare providers should change their approach regarding reproductive healthcare services to adolescents. This study found that both in-school and out-school adolescents in slums, i.e., Talashai and Jadabpur, of Balasore district in Odisha did not have comprehensive reproductive healthcare services. The lack of knowledge and low utilization status on reproductive healthcare services makes adolescents vulnerable to unsafe reproductive health behaviour and wrong choices. This also affects the future reproductive health status of adolescents. It is also found that there exists a significant relationship between knowledge and utilization of reproductive healthcare services among adolescent girls in slums of Balasore, Odisha. Further, it is concluded that government and non-government agencies should organize awareness campaigns to inform adolescents on the importance of reproductive healthcare services.

In India, discussing reproductive health problems and reproductive healthcare services openly and freely with anyone is considered taboo. Reproductive health problems are known as a significant health concern, and mainly the adolescent population faces the problem most. Lack of awareness and proper guidance regarding reproductive health makes adolescents vulnerable to sexual exploitation. It is essential to make the adolescent aware of reproductive healthcare as an adolescent is a future mother. The lack of knowledge about reproductive healthcare services can influence the overall health of the adolescent population in the slum population.

Hence, the present study concludes that the adolescent population in the selected slums of Balasore, Odisha, has little knowledge about reproductive healthcare services. There are also visible disparities in knowledge and utilization of reproductive healthcare services. They are engaged in risky reproductive health choices, negatively affecting their reproductive health. Social systems influence the utilization of existing reproductive health care services. Reproductive health promotional activities can break social barriers. To decrease the disparity between knowledge and utilization of reproductive healthcare services, community sensitization, and healthcare providers' training should be required. There is a need for healthy livelihood practices and maintaining a healthy lifestyle to minimize the reproductive health care problems among adolescent girls in the slum area.

Recommendations

There are some strategies to improve access to reproductive healthcare services like providing education on reproductive healthcare, on-campus STI screening, telehealth services, mobile health clinics, school clinic partnerships. Healthcare providers should empower adolescent girls to protect their health with comprehensive sex education. The government should invest in high-quality adolescent-friendly health services to the slum population. We should combat stigma as a barrier to care. The health care providers can also guide the individual to proper health check-ups timely and determine the extent to which an individual can self-monitor and self-managed healthcare. The health care providers also can manage their self-care practice for emotional resilience, health, and well-being. Healthcare providers should work on adolescent-friendly approaches to reproductive healthcare services. Regular health check-ups can make aware the adolescent population regarding reproductive health care services. The adolescent population is busy with their daily

schedule for earning daily food. So, if the government and non-government organizations can make an effort to educate them about the utilization of reproductive health care services in the time which they prefer, it will be fruitful. The parents also can take part in these awareness services to make the reproductive health of the adolescent health.

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Indian Family System, Relations and Attributes during Corona-virus Disease (COVID-19): Towards Transformation

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Abstract

Corona Virus Disease (COVID-19) pandemic has touched all the aspects of our lives, including individuals, families and communities. The entire social set up is going through massive transformation including family system and relations. This article explores the parameters on which the transformation of family values and beliefs are based during Covid-19 with special reference to India. The article will also reflect upon Domestic Violence (DV), particularly Intimate Partner Violence (IPV). Inferences have been drawn through review of secondary published articles and papers. The findings reveal that there are primarily six parameters due to which there are evident changes in family system and relations during the pandemic. At the end, the article concludes that it is for us to wait and watch the prioritization pattern of this generation; whether they choose to rekindle family values or consider devaluing the family beliefs and prioritize their liberty over everything else.

Keywords: India, Covid-19, Pandemic, Domestic Violence, IPV, Family

Introduction

Family refers to a universal, permanent and pervasive institution characterized by socially approved sexual

admittance and reproduction, common residence, domestic services and economic co-operation. The family is generally regarded as a major social institution which plays an important role in the socialization of individuals. The family is also the locus of much of an individual's social activity. It is considered to be the primary social group that shapes our attitude, beliefs and values and essentially gives us a sense of belongingness. Despite this feature of family, there are cultural differences and variations in the family dynamics. The world is currently grappling with a pandemic that has shaken the global community. It has not only led to community disorder but also decline in income generation majorly due to precincts on travel and work, downfall in businesses and loss of lives from within the family and community (Inter-Agency Standing Committee, IASC 2015).

Governments all across the world have taken drastic measures to stop the transmission of the virus and save lives by enforcing strict social distancing norms and nation-wide lockdown in various phases. Yet, there is a cultural imbalance in how strictly these rules are being followed by citizens of various countries including India. This article analyses the changing scenario of our family system, changing relationships, attributes and the conditions of the vulnerable groups in the family during corona virus disease (Covid-19) pandemic and how they cope up with it. The article has also made efforts to draw attention towards an important, yet frequently ignored risk during a pandemic which is the potential increase of domestic violence (DV) and intimate partner violence (IPV).

Background

Violence within families has seen a huge surge in recent times especially during the current Covid-19 pandemic. The violence is related to various factors ranging from economic

stress, fewer support options and more exposure to abusive relationships (Peterman et al., 2020). International organizations took notice of a steady increase in Domestic Violence during the Covid-19 pandemic across the world primarily caused due to distancing regulations and subsequent lockdowns. 15-30% increase in distress calls made by women, restricted to confined places with abusive partners have been reported by several countries (Oxfam India)

Indian family system

Families exist in groups and cannot exist in isolation. The subtleties of a family are quite often understood in the perspective of their social and cultural background. Culture has proven to be base in determining family structure and is key to shaping family dynamics (McGoldrick et al, 1996, McGill, 1983). Each family member has a specific role to play which is hugely decided by cultural factors. Also, the problem-solving techniques are defined by culture (McGoldrick et al, 1996; Schwartzman, 1983). In most of the studies, Indian families are supposedly joint families with a patriarchal and collectivistic structure embracing several generations vertically and extended family horizontally. Joint families in India are supposed to be a close-knit group of people, closely interconnected and strong. The families are not individualistic and focus on family loyalty, integrity and resilience in place of individual choice, privacy and freedom along with personal space (Mullatti, 1995).

The Indian family system is ‘collectivistic’ unlike western society where the families are more ‘individualistic’. The structure of Indian joint families includes a line of three or four generations staying together and often using the same kitchen with most of the times a common kitty with contribution from all. The family members function within the principal of ‘collective responsibility’. The earning members

are the torch bearers and supposed to support all dependent of the household (Sethi,1989; Chekki, 1996). Indian families promote coexistence and cooperation wherein the family is the focal point of this social structure. Hence, we can safely conclude that Indian families are close knit and have mutual care and concern for each other.

Indian Families: Challenges during COVID 19

India has an intense family structure and is largely a collectivist society, with a greater number of people displaying high preference for the need to belong to a larger social framework in which individuals are expected to act in accordance to the greater good of one's defined in-group or primary group. In such situations, the actions of the individual are influenced by various concepts such as the opinion of one's family, extended family, neighbors, work group and other such wider social networks that one has some affiliation toward. It is not only cultural factors that determine how individuals and families cope during a global pandemic like COVID-19 but also the economic factors which are important in helping families navigate these difficult times as at present, we are grappling with economic slowdown and a recession like situation. The pandemic has led to economic stress which is continuing and is predicted to continue as a long-term consequence to the imposed lockdowns. A developing nation like India, wherein more than 81% of its people are employed in the informal sector, has to bear the brunt of this pandemic more severely. Approximately 60-80% of workers from the informal sector lost their employment during lockdowns. There were huge instances of salaried people returning to informal employment as casual workers or self-employed (Abraham and Basole, 2021).

Intimate Partner Violence (IPV)

In collectivist societies like India, people rely on their primary groups for support and care and they are expected to maintain loyalty within the in- group. In these cultures, members tend to prioritize group interests over personal interests and tend to fulfil obligations of their social role in order to maintain group harmony. One of the major features of such societies is social conformity and strict adherence to social and cultural norms. This may provide the social legitimacy for the government to implement regulations to deal with a public health crisis such as Covid-19. Past pandemics have shown that the length of quarantine increases the risk for serious psychological consequences. An important, yet frequently ignored risk during a pandemic and its socially disrupting response is the potential increase of intimate partner violence (IPV). IPV is defined as physical, sexual, psychological, or economic violence that occurs between former or current intimate partners. As per Stockl et al. (2013) about 40% cases of femicide across the world are caused due to intimate partner violence. While men can also be affected, IPV is largely a gendered phenomenon in which violence is perpetrated against women by male partners. IPV survivors describe that social isolation (i.e., from family and friends), functional isolation (e.g., when peers or support systems appear to exist but are unreliable or have alliances with the perpetrator), surveillance, and control of daily activities have a direct impact on the kind of relationship they share with their partners. Forced isolation along with economic stressors has an impact on intimate relationships. Covid-19 pandemic has led to mobility constraints intensified the imbalances (loss of employment or compromised alimentary intake). Previous studies have established that there is a direct relationship between unemployment and continuance of abusive behavior. Any change in the status of men as economic providers leads to frustration which is ultimately vented out on their partners. Enhanced consumption of alcohol is also considered as one of

the primary reasons for higher IPV (The Wire). Violence against women during the current pandemic was predicted as a cause for concern by activists all around (Campbell, 2020). The United Nations Populations Fund (UNFPA) put a number to the increase by predicting an increment of 15 million additional cases with each quarter extension of lockdown overestimated 31 million increases in gender-based violence (Bellizzi et al., 2020)

Intimate partner violence is considered to be a taboo topic or a private matter which isn't politicized enough and this can have detrimental effects on individuals, families and communities in times to come (Van Gelder et al., 2020).

The Study

Not much is written or reported about the impact the current pandemic is leaving on the family system in India. Literature reviewed is minimal and lacks in depth study. Hence, the gaps are huge and a lot is yet to researched. We have tried to focus on answering the following questions:

1. What are the major factors contributing in surge of Domestic Violence (DV), especially Intimate Partner Violence (IPV) cases during Covid-19?
2. How is it impacting the relationships within families in India?
3. What are the changes in the pre-existing family structure in India caused due to the ongoing pandemic?
4. What are the major parameters causing change in family values and beliefs?

Methodology

In order to reconnoiter the situation of Indian families during the Covid-19 pandemic, we referred online articles, newspaper data of Indian newspapers and market-based facts. Extensive review of published articles in renowned journals on similar area was carried out by the authors. There are limited academic publications and government reports on domestic violence particularly intimate partner violence cases specially records of such instances during Covid-19. One of the major drawbacks in considering newspaper articles is that the reports are of severe physical trauma and rarely covers economic, mental and emotional abuse. Due to effects of coronavirus, we have been unable to gather data from multiple sources. Hence, the article provides a glimpse of this precarious situation and tries to discuss the impact novel coronavirus is directly and indirectly leaving on families in India. How it is gradually transforming the deep-rooted family system, culture and relationships.

Discussion and Analysis

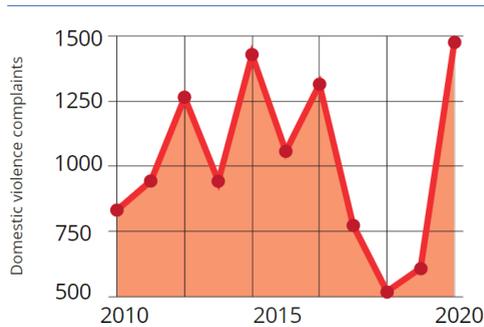
The impact of Covid-19 pandemic and consequent lockdowns have brought about extreme changes to every aspect of our lives. In this section we are going to discuss and analyze the impact the current pandemic is leaving on family system, beliefs and values and separately discuss the impact on women Covid-19 has had during subsequent lockdowns. We have also tried to understand the factors causing these changes.

Changing Family System

Government data of India has shown that the number of joint families in urban India spiked to 29% as opposed to just 2% in rural India, between 2001 and 2011 (Times of India, 2017).

The main reason for this spike is that as more and more people are settling in urban areas for employment reasons, they also require a place to stay. As per the data broadcasted by UN, percentage of extended family is 37.1% (Refer Graph 1) (population.un.org). Hence, coexisting in the same space makes financial sense. Another reason for the spurt in joint families in urban India is the mere fact that many families run joint businesses. Whatever the reason, this arrangement has made social distancing extremely difficult during a pandemic like Covid-19. Many don't have the luxury of staying away for the sake of family in order to maintain physical distancing. Also, the collectivist nature of Indian society expects individuals to offer support and loyalty to members of their primary groups especially family, during a crisis. The main source of stress for families in India during Covid-19 is financial insecurity. Even in nuclear families, the earning member has the responsibility to cater to not just their immediate family members but also their extended families as social norms dictate it. The fact that many Indian families have only a single breadwinner creates extreme dependence on the earning member, which is mainly the man. This calls for the family to stay close together during a pandemic like Covid-19 which has affected many people socially as well as economically. The pandemic has exposed the great digital divide that exists in India. For many migrants who are away from home, it has been difficult to avail internet services to stay close to their family members through digital platforms. This has created a great deal of anxiety because of their inability to connect with close family members both virtually as well as physically. Although India is home to the second largest internet user-base in the world, there are a significant number of people who are referred to as "digital-data poor" and they live in rural areas. While 66% of India's population lives in villages, only around 25% of them have access to internet services.

Graph-1: Complaints of Domestic Violence



Increase in Domestic Violence

In a society like India, the institution of family plays an important role. Themes such as family integrity, family loyalty as well as family unity are emphasized a great deal. Despite the family being an essential part of an Indian's life and marriage being considered a sacred bond, it is not always the safest space for a woman to be in. COVID-19 has exposed the dark reality of domestic violence in India (as stated in the graph). In 2020, between March 25 and May 31, 1,477 complaints of domestic violence were made by women and still increasing now (Refer Graph-1).

India's National Commission for Women (NCW) has seen more than twofold rise in gender-based violence during the lockdown in India. The Child line India helpline received more than 92,000 calls between 20-31 March, during the initial phase of lockdown in the country, seeking protection from abuse and violence (children). The extended lockdown has confined children with their abusers at home. The reasons for the spike in domestic violence and abuse are multifold. Factors such as financial insecurity, forced isolation or

confinement as well as stress could be accounted for this issue to escalate to the point it has reached at present.

With strict lockdown and work from home rules, the domestic responsibilities of Indian women have doubled. While men work from home, women have to carry the burden of domestic duties including cooking, cleaning, childcare etc. This is because there is a huge gender gap in employment between men and women. As family planning services and abortion facilities have taken a hit during the pandemic, there is a possibility of an increase in unplanned pregnancies. About 88% of the elderly in India live with their children, so their risk of infection from other family members remains high. The reason for such a huge per cent of the elderly living with their children is the joint family system. Traditionally, the elderly in India have been treated with great respect because of their prominent role in the family. This is one of the main features of a collectivist culture. This living arrangement also serves other purposes as it allows the children to take care of their parents who in turn can look after their grandchildren. This is also a non-financial arrangement and is guided mostly by respect for familial ties and relations. Despite this, living with extended family may facilitate the process of receiving adequate services. For those elderly people not living with their extended family, dependence on domestic helps or neighbors for support in day-to-day activities is common. It is vital for everyone to stay connected and maintain close relationships as it helps in navigating difficulties arising due to numerous restrictions in place as a response to the pandemic. In India, only 7% of the elderly have access to Smartphone and internet. As literacy rate among the elderly is low, it becomes difficult for them to avail important information during the present times.

In the Indian context, the new social order that the corona virus pandemic will bring forth may just be the beginning of the end for one of India's most enduring cultural practices—living in joint families. As we prepare to live in a low-touch world of physical distancing, these units of six or seven people may no longer work. The brutal irony in this is that it is likely to unfold at a time when the elderly is especially vulnerable to the virus and need care. But younger Indians, who will return to work gradually, will not want to expose their elderly relatives to the infection they might be carrying. Younger people are at a lower risk of developing severe symptoms of the infection, and many might never show any, while older people, likelier to have co morbidities, have a higher chance of getting seriously ill. Having a potentially asymptomatic carrier and a vulnerable elderly person in the same house will increase the risk for the latter.

Unlike Wuhan, which set up temporary hospitals to care for Covid patients with mild symptoms, India is unable to even test every person with symptoms (leave alone 100 per cent population testing). In such a situation, the only way to protect oneself and one's family is by maintaining physical distance from them. It's possible if family members live on different floors of the same house, or have a large enough space that means each individual can pretty much live in their room. But many don't have this luxury. With real worries about the health of older relatives, many will look to move out of home as soon as they can.

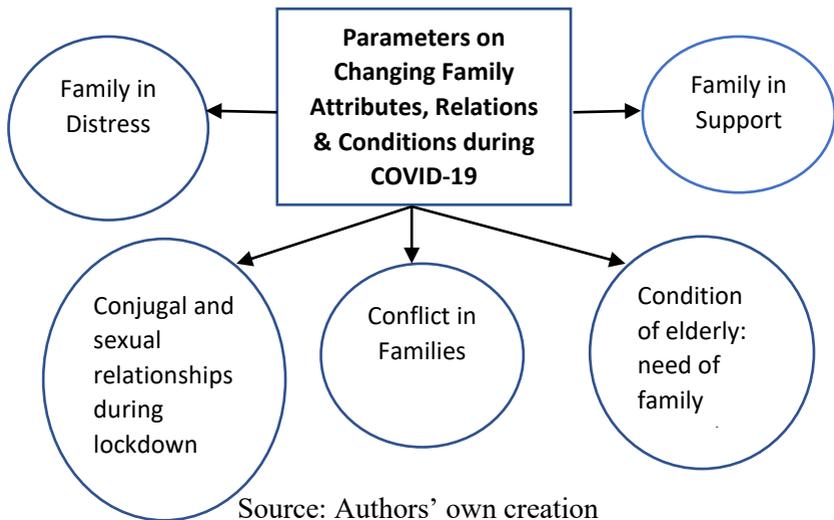
India has always taken pride in its age-old joint family system, even at the cost of giving to the world overgrown, entitled children who cannot, or are too lazy to, fend for themselves. The typical urban Indian does not move out of the family home until they are married (and many times, not even then). They're used to an army of grandparents, aunts, uncles and cousins to help with everything from boredom to

homework. And there's always been someone to cook and clean. But now, in the absence of domestic staff, many young urban Indians, who have never or rarely wielded a broom, have stepped up to do household chores with aplomb. In addition to working from home, many have taken on the daily tasks of cooking, cleaning and doing the dishes so that the elders in the family don't have to. And armed with these skills, they are looking to move out of home, not because they don't get along with their families, but precisely because they love them. Perhaps, then, one fallout of the Covid-19 pandemic is that India will finally get over its romanticized notion of the joint family as a symbol of sanskaar, love and duty, and will embrace the idea that moving out on your own is good for the individual as well as for the family. The impact of the corona virus pandemic and the consequent lockdown has certainly brought forth sudden and drastic changes in the way families and societies function. It has acted as both as a catalyst and as an agent. The families with healthy relationships got an opportunity to stay in touch and spend more time together. However, a surge in cases of divorce also shows that erstwhile functional families also faced issues owing to this lockdown where spending more time together (under the constant stress of a pandemic and consequent economic troubles) lead to a loss of compatibility.

This lockdown showed us that the primitive role of family is still prevalent with the family being a major source of support for earning as well as dependent members. The student community is one which was majorly sought back by family to seek safe refuge at times of the pandemic. Not only that, the family was seen to be a major support for people with anxiety issues and mental health issues. Those far away from the family leaving in isolation and loneliness have reported to have depression and anxiety more. While many are saying, that this lockdown has given a chance to rekindle our

relationships with our family which may have been severed over time due to miscommunication, non-acceptance etc, it is believed that this can result in strengthening of family bonds in the future to come. The Indian Grihasthi model is a great foundation where family members play their roles as a team which means ‘together everyone achieves more’. Under forced circumstances, the five attributes (5-C) of family bonding- commitment, care, concerns, communication and connectedness have received more strength and contemporary lockdown situation has once again highlighted the importance of such bonding.

Graph-2: Changing Family Attributes, Relations and Conditions during Corona Virus (COVID-19)



The change in family values and beliefs would be majorly on Six Parameters (Refer Graph 2):

1. Conflict in Families

There has been a noted rise in sexual abuse and domestic violence, all across the world, irrespective of developing or developed countries. As per an article dated 22nd June 2020 in 'The Hindu', women filed more domestic violence complaints than ever in a similar phase in last 10 years [The Hindu]. There has been an estimated 47.2% increase in complaints related to domestic violence (Pandit, 2020). Rise in Domestic violence was reported not only from countries like India and Israel but also from European Countries and Australia, urging the United Nations to take a stringent call giving directives to help out the victims. Also, it must have been a pathetic situation for children who have to stay in home with relatives who might be abusing them sexually, most importantly, it goes unreported. At the same time, Homosexual children find it difficult to hide their feeling's sexual identity that have to live with their parents now and have no idea or no acceptance about their identity. Hence, it might not be such a privilege to live with their families in the lockdown for all, even in cases where the family is in condition of utter destitution, and children sitting at home without any financial contribution can be seen as a burden now which can definitely strain the relations ahead, if the frustration of all the living conditions are blurred out on parental- child relationship.

2. Parent-child relationships and adjustment in other relationship

Disturbed family relationships can have the maximum negative impact on the children growing up. They might be a witness physical violence, might be subjected to abuse and can even suffer from psychological trauma because of it. This pandemic is bad news not only for our health and economy but impact well-being of our families through a spiraling process of factors which can drive certain stressors (Prime et al., 2020). Not only that, grown up children who have spent

much time away from their family, can find it difficult to adjust to family norms and situations, hence, bringing chances of rift between them. Also, non-acceptance and no adjustment from the side of the family can also bring in conflict between children and parents or extended kin of the family. As mentioned before, for families in ultimate destitution, dependent family members may be seen as a burden and giving out the emotions in a wrong way to express all frustration on the dependency can bring a major disbelief in institution of family and marriage among the younger generation. Also, generation gap is an issue everywhere. However, in such traditional cultures, it is possible that when parents try to push the children in fitting in or excessive questioning or pressure to confirm, it can result in mental issues for children and also bring a rift in relationships.

3. Effect of economic hardship and deprivation on family

To compare the effect economic hardships, have on families in developing and developed, we need to look into the policy level-structural barriers as well as the real-life situations the families are going through. In most of developing countries including India, the poor families are the worst hit. 84% of households in India have witnessed drop in income during the lockdown. The economic distress is beyond comprehension. The families have lost their jobs and have also to bear the expense of feeding and educating their lives, also with most of the unskilled professions closed down due to lockdown, the children, who are often indulged in child labour are also forced to stay home- hence, putting major economic hardships and dependency which puts the family in a tough position. Following school closure measures, more than half of the young respondents said they are worried about their studies, exams and future education and employment. About half of them are stressed from not being able to leave their homes.

4. Family as a Support System

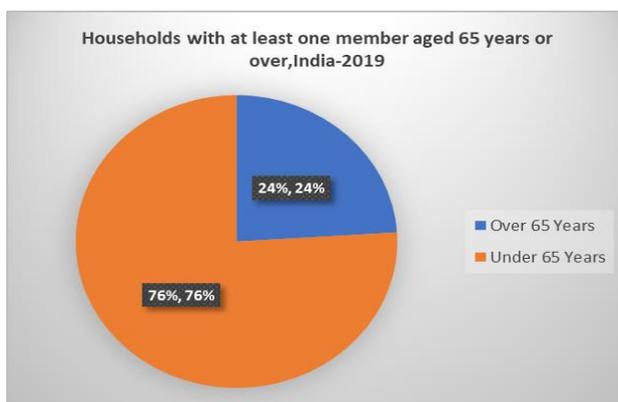
The lockdown period all across the world has said to bring an important factor in view: that is the sociologically functionalist role of family- to support and maintain the social institutions of parents, children and extended kin living together. It had been predicted that during the pandemic women will usually be involved in maximum domestic labour (Ruppanner et al., 2020), yet men have also shown keen interest in contributing towards the family like taking care of children (Petts et al., 2018; Scarborough et al., 2019)). There have been several instances in Indian families where male members of the family have shown greater participation in household chores like cleaning and cooking. Families who will be able to live by the mantra ‘We are all in this together’ will probably be able to brave this pandemic better. As this was an unusual phenomenon in the western “individualist’ culture, there are many cases where the family has come to live together in countries like USA as well.

5. Condition of Elderly

In India, there was a report by Anadulo Agency, which states that 50% of the coronavirus related deaths are due to population above 60 years. Also, 10% of the 1.3 billion of South Asian Nations accounts for elderly people. In India about 24% of the households have at least one senior citizen (Refer Graph 4). As per These reports show that elderly population is extremely vulnerable in both the developed and developing countries. The elderly is even being vulnerable because they have weaker immunity and also various physical ailments pre-existing. Hence, the virus can easily affect them. At the same time, due to isolation and loneliness, elderly also are facing mental health issues. This a major problem for those who stay away from their family, even in old-age homes, these desperate times call for even more support from

the family but as the pre-existing family dynamics may exist, there are many families where children stay away from parents of have not been able to reach home due to the lockdown. At such times, the elderly is more prone to depression, heart attack, palpitation and several other morbid diseases.

Graph-3: Household with at least one person 65 years or over, India-2019



Source: Population.un.org

Hence, on the part of the family, it is important that they keep in touch with their elderly parents or relatives and ask them about their well-being. If they are in old age homes and however distant the family dynamics are, the least that can be done is to talk to them always. At the same time, the community can play a great role in assisting elderly people who stay alone and keep a check on them and provide them with necessities if they cannot manage it. At the same time, those elderly who do not have any family support or any shelter home, needs to be protected by giving shelter, medical facilities and daily necessities by the state and also

organizations that can provide for the elderly with proper safety regulations.

6. Conjugal and sexual relations during lockdown

As we saw in the research about “conflict in families during lockdown”, there are many marital relations, who have seen a much darker side in the lockdown which was suppressed earlier to this in the name of custom and keeping a silence. Earlier it was easy to maintain a distance or break out of a toxic ambience at home due to working schedules or going to the market or gym. But now, with all the couples locked together in the home, the cases of violence have gone up very sharply, which shows a bleak side of marriages in both developing and developed countries. In such cases, it is also possible that conjugal relations are forced that is forced sex takes place between couples. Although marital rape is not legally criminalized in several countries, it is highly possible that the cases of marital rape have also increased.

At the same time, for married couples who have not stayed with their parents since long can find it hard to adjust due to lack of privacy and free space which they otherwise experience, due to which there might be complications in the sexual/conjugal life of such couples. It is also possible, that negative family dynamics can take a upper-hand and suppressed family issues can come up which can lead to an unhealthy family space under the same roof, especially in joint families where sharing personal lives with elders is quite a taboo. Due to cultural liberty and flexibility in developed countries, this might not be so severe problem there.

Many experts have written about how to maintain health family relations during lockdown as there are cases where staying together and staying apart have both risen complications in relationships. In self-isolation where partners

are either in isolation or apart from their partners, can bring in issues related to long-term relationships. Insecurities, miscommunication, high expectations can often result in problems in relationships. In the same way, toxic marriage relations with controlling, coercive spouses can come to a negative turn at this time. However, this lockdown would simply be a time to either mend relations or check whether the relations can at all work out. Even space between partners gives them time to think over and clear their thoughts about compatibility and life goals. The extreme conditions of violence can also be an eye opener for many women who can ultimately decide that whether it would be better to give up on such a toxic relation or to find ways to develop mutual trust, respect and open communication. Although the idea to be separated or walking out of a toxic relationship is more possibly to be seen in developed countries due to increased awareness, education and cultural acceptance whereas it is highly shameful in patriarchal societies of developing countries to break off marriages and hence women might have to continue in them without any choice. Only the educated sections can support such a step.

Conclusion

The unforeseen arrival of Covid-19, a pandemic, has jolted the global community. It has brought about a crisis in not just the healthcare system but has also brought about social, political and economic crisis. The pandemic like Covid-19 along with numerous rules and restrictions like stay in place edicts and social distancing norms that has been thrust upon people all over the world, has affected the institution of family, which is considered to be one of the major social institutions and the primary group that is responsible for a person's sense of identity and belongingness. Many observers believe that this lockdown would rekindle family bonds as it will be a major support to all, hence, emphasizing on the

traditional role of family as a collectivist model performing the functions of enunciating and confirming societal norms along with providing support, the cases of abuse, violence, suicide and family feud due to lack of acceptance and adjustment on both ends, shows that this period can be a major danger to the social institution of joint family as well. The pandemic of Covid-19 has surely changed a lot of things and also impacted family relations as well. It is all about the understanding, acceptance and emotional bonding and balance during the lockdown which will prove in future where the family structure is headed- whether this generation will prioritize their liberty above all and devalue all their belief in the institution of family or they will rekindle their family bonds or that there will be a mutual understanding between the parents and children to accept and learn their way of living, while continuing in their different walks of life and ambition. Need to wait to see.

Declaration

We declare that there is no conflict of interest and no need to take any ethical approval. Few graphs which are incorporated in the article, is in the public domain. Both the authors have taken part in the process of writing the article through study.

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Prevalence of Attention Deficit Hyperactivity Disorder Symptoms and Family Preparedness Plan during Covid-19 Pandemic

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Abstract

The Covid-19 pandemic has affected all sectors of society and have a drastic impact on mental health markedly. The lockdown constraints create an alteration in the lives of an individual and particularly for children with special needs has increased risk. The current article sensitizes the readers the prevalence of children exhibiting Attention Deficit Hyperactivity Disorder symptoms pre-covid-19 and management strategies in the family focussing on child's strength and seek appropriate assistance at the initial level since it will intensify parental challenges and impacts a mental. Families have reported reduced access to mental health and education services and challenges with remote learning. Further, the social, emotional, and psychological support parents receive during in-person interactions with school systems or advocacy groups may also suffer during the COVID-19 pandemic. These factors could result in increased caregiver burden and stress. ADHD is a neurodevelopmental disorder, though inattention and hyperactivity/impulsivity are the major symptoms of the disorder. It involves a wide variety of symptoms and impairment in functioning which may be either mitigated or aggravated by environmental influences in this situation

This study was conducted in 37 (primary/upper primary schools of Dharwad city which includes Government schools (17) Private Aided schools (12) Pvt Unaided schools (8) Children from 1st to 7th std both in Kannada and English medium Schools with a sample size of 500 children were taken before by adopting descriptive design and Random sampling method. Based on the academic records (report cards) and daily learning teacher identified children initially. Each subject was rated by teacher using Conner's Teacher rating scale revised (L) with 59 items. Contact numbers of the parents was collected only those parents were included for the study those who gave consent among identified children by limiting the sample size of children to 500. The Conners Parent Rating Scale –the Long Form (CPRS-R:L) was administered to identify the symptoms of ADHD. The data were analyzed with according to the objectives and hypothesis applying one-way ANOVA, followed Tukeys multiple posthoc procedures for Pair wise comparison using SPSS 20.0 statistical software. The obtained F value of 109.14, $p < 0.05$ is significant at 0.05 level between ADHD children, their parents and teachers on perceived inattention symptoms of ADHD. The Tukeys post hoc value is 13.89 which is significant at 0.05 level ascertains ~~ht~~ the parents of children perceive higher inattention symptoms of ADHD in their children, with respect to hyperactivity behavioral pattern where $F = 3.2459$, $p < 0.05$ at 5% The Tukeys post hoc value is 7.53 It means that, the children perceive to have significant higher hyperactivity symptoms of ADHD. The obtained F value of 98.22 is significant at 0.05 level for impulsivity symptoms of ADHD. The Tukeys post hoc value is 5.02 which is significant at 0.05 level ascertains that the parents perceive to have higher impulsivity symptoms of ADHD in their children. Hence the study suggests that during pandemic the symptoms may aggravate hence the family preparedness plan in management is essential which focus on child's

strengths, working together to establish a routine, setting clear and age-appropriate expectations and rules, seeking support from teachers, paediatricians or counsellors connecting with online behaviour management resources can make the most of this unique time

Key Words: ADHD Symptoms, Family Preparedness plan, Covid-19 pandemic

Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is a common behavioural disorder that affects about 10 % of school-age characterized by a pattern of extreme pervasive, persistent inattention, hyperactivity and impulsivity who have trouble paying attention in school, at home, or at work.

These behaviours cause problems in friendships, learning, and behaviour for children to be diagnosed they must have developed symptoms prior to age 12, these behaviours must be more severe than in other kids of the same age and the behaviours must last for at least 6 months and negatively affect at least two areas of a child's life such as school, home, childcare settings, or friendships. Thus it could be broadly divided into 3 types **Inattentive type:** signs that includes trouble in paying attention to details or a tendency to make careless errors in schoolwork or other activities, difficulty staying focused on tasks or play activities apparent listening problems, difficulty following instruction problems with organization, avoidance or dislike of tasks that require mental effort, tendency to lose things like toys, notebooks, or homework distractibility forgetfulness in daily activities.

Hyperactivity: with signs that includes fidgeting or squirming, difficulty in remaining seated, excessive running or climbing difficulty, playing quiet always seeming to be "on the go "excessive talking. **Impulsivity:** blurting out answers before hearing the full question difficulty in waiting for a turn or in line problems with interrupting or intruding others,

Combined type: a combination of the other two type is the most common problem that is from mild to moderately severe.

At the National Institute of Mental Health and Neuro science (NIMHANS) 9-10% of the children brought in are diagnosed with depression. According to the CDC (Centers for Disease Control and Prevention) reports around 05.10% of US children ranging between the age of 4-17 years were reported by parents as having serious emotional or behavioural difficulties. According to the National Institute of Mental Health (NIMH) emotional and behavioural disorders affect 10-15% of children globally.

Canals et.al. (2018) conducted a study to examine the prevalence of ADHD among preschoolers, analyzing co morbidity, and the association with socio-demographic factors. They conducted a two-phase epidemiological study of 1,104 preschoolers aged 03 to 06 years in Catalonia, Spain. The Early Childhood Inventory-04 (ECI-04) was administered to parents and teachers. Children at risk of ADHD were assessed using open-ended face-to-face interviews and were observed in a school setting. The prevalence of ADHD diagnosis was 5.40%. Male sex and first-born status were risk factors for ADHD. Parents reported more symptoms (12.9%) than teachers (08.70%). Behavioural problems (odds ratio [OR]=12, p=.001), autism spectrum disorder problems (OR=9.5, p=.001), and obsessive-compulsive problems and tics (OR=5.9, p=.001) were specifically related to ADHD diagnosis.

ADHD child's relationship with his parents is burdened by the difficulties encountered throughout his development because of his temperamental problems as they lack in social, athletic, and academic skills, their inability to remember, tolerate

frustration. Gray (2014) stated that ADHD is definitely not just "psychological" nor is the solution. Modern brain scans can now detect clear differences in the ADHD brain versus the non-ADHD brain. ADHD is not just laziness or an excuse for poor performance it is not just in the "head" but it is literally in the brain. It is now proven to be a measurable physical impairment of normal brain function caused by oxidative stress. Besides that, these impairments may be either mitigated or aggravated by environmental influences

ADHD can impact children's social, cognitive, and academic abilities. These children need adequate therapies to avoid facing difficulties both at home and in the community in general. These psychosocial disabilities can impact the quality of life of both individuals and family, Barkley (2014) asserted that in some single-parent families it may be difficult to maintain the structure that some children need. Additional problems in family life, including any destabilizing events. Children need love, time and attention from parents as well as strong emotional attachments.

The (COVID-19) pandemic constraints and associated economic closings create a dramatic alteration in the mental health of children markedly. Children with ADHD symptoms are also more intense and exhibit behavioural problems staying inside the home during school closure making the child sit beyond a certain timeframe with fewer outdoor activities can be stressful dealing with these children's developmental issues will intensify parental inadequacies and social challenges. Managing multiple ADHD issues can have a negative impact on the mental health of parents. Gerdes et al., in their study, assumed that experiencing these events and, as a result, having increased pressure led mothers to be unable to react to the child's negative behaviour. It is not surprising

that these increased demands are frequently associated with more stress in marital and family functioning.

The financial burden of treating ADHD and its associated psychiatric disorders can add to these difficulties. When family environments are chronically stressful, both the adults and children are at greater risk of physical and mental health problems. In families affected by ADHD, marital conflict is common, and has been consistently linked with poorer health and mental outcomes.

In dealing with children with ADHD parents need loads of patience and consistency as the case demonstrates. Families with children with ADHD have reported reduced access to mental health and education services and challenges with remote learning. Moreover, many families with ADHD receive fewer, if any, crucial remote special education services and face disruptions in behavioural, speech, and occupational therapy services during COVID-19. Further, the social, emotional, and psychological support parents receive during in-person interactions with school systems or advocacy groups may also suffer during the COVID-19 pandemic.

While parents can expect more behavioural issues during times of stress, it is important to ensure that the child is not purposefully being disorganized, easily distracted. It is also important to remember that there are strategies and resources available to help parents with the unique challenges of parenting children with ADHD during COVID 19. Focusing on your child's strengths, working together to establish a routine, setting clear and age-appropriate expectations and rules, seeking support from teachers, paediatricians, or counsellors who know your child, and connecting with online behaviour management resources for children with ADHD can help both parents and children make the most of this unique time. This

paper tries to show the prevalence of children exhibiting symptoms and its management during Covid-19 pandemic

Objectives

- To understand the perceived symptoms of ADHD namely Inattention, Hyperactivity and impulsivity Symptoms from Children, parents, teachers
- To understand the measures in the management of children exhibiting ADHD symptoms

Hypothesis

H₀: There is no difference in the perceived symptoms of ADHD namely Inattention, Hyperactivity and Impulsivity Symptoms in Children, parents, teachers

H₁: There are measures in the management of children exhibiting ADHD symptoms

Methodology

This study was conducted in 37 (primary/upper primary schools of Dharwad city which includes Government schools (17) Private Aided schools (12) Pvt Unaided schools (8) Children from 1st to 7th std both in Kannada and English medium Schools with a sample size of 500 children were taken. By adopting descriptive design and Random sampling method research was conducted. Based on the academic records (report cards) and daily learning teacher identified children initially. Each subject was rated by teacher using Conner's Teacher rating scale revised (L) with 59 items. phone numbers of the parents were collected and contacted the parents, and asked them the suitable time to meet up at their respective places at their residence/school. Only those parents were included for the study those who gave consent among identified children by limiting the sample size of children to 500 finally.

Interviews were taken at their schools and even at their residence with parents, The Conners Parent Rating Scale-The Conners Parent Rating Scale – Revised (CPRS-R) is the parent form of the Conners Rating Scales -Revised (CRS-R). The CRS-R was designed to address the need for a multimodal assessment of children and adolescent's behavioral difficulties and contain a parent form, and teacher form, and an adolescent self-report form. The parent form the CPRS-R is appropriate for use with parents of children and adolescents from age 3 to 17. There are two forms of the CPRS-R: the Long Form (CPRS-R:L) and the Short Form (CPRS-R:S). The Long Form contains 80 items and can be completed by most parents/guardians in approximately 20 minutes; the Short Form contains 27 items and can be completed in 5 to 10 minutes. Hence, the Researcher used long Form of conners parent rating scale for parents to identify the symptoms of ADHD in school children. The data were analysed with according to the objectives and hypothesis applying one-way ANOVA, followed Tukey multiple post-hoc procedures, Pair wise comparison, using SPSS 20.0 statistical software

Results

In this section a comparison of the perceived symptoms of ADHD (i.e. inattention, hyperactivity, impulsivity by parents and teachers are studied by applying one-way ANOVA, followed Tukeys multiple post-hoc procedures are presented in the following section.

Table 1.1: Results of ANOVA Test between Children, their Parents and Teachers on Perceived Inattention Symptoms of ADHD in Children.

Sources of variation	DF	Sum of squares	Mean sum of squares	F-value	p-value
Between groups	2	1522.08	761.04	109.1473	0.0001*
Within groups	1118	7795.34	6.97		
Total	1120	9317.42			

*p<0.05

From the results of the above table, it can be observed that a significant difference is found between ADHD children, their parents and teachers on perceived symptoms on inattention of ADHD in children. The obtained F value of 109.14, p<0.05 is significant at 0.05 level. This implies that there is a significant difference in the perceived inattention symptoms in the children, their parents and teachers. Further to know the difference in perceived symptoms between the three groups Tukeys multiple post-hoc test was applied. The results are depicted in the following table.

Table 1.2: Pair wise Comparison between Children, their Parents and Teachers on Perceived Symptoms on Inattention of ADHD in Children by Tukeys Multiple Post hoc Procedures.

Groups	Children	Teachers	Parents of children
Mean	12.20	14.65	13.89
SD	2.74	2.60	2.40
Children	-		
Teachers	P=0.0001*	-	
Parents of children	P=0.0001*	P=0.0135*	-

*p<0.05

The above table reveals that a significant difference is observed between children and their teachers with respect to perceived inattention symptoms of ADHD. The difference between these groups is highly significant at 0.05 level. The mean values show that the teachers perceive higher inattention symptoms of ADHD in children than the children themselves. Further the above table also shows that there is significant difference between children and their parents on perceived inattention symptoms of the ADHD. The Tukeys post hoc value is 13.89 which is significant at 0.05 level. The mean value ascertains that the parents of children perceive higher inattention symptoms of ADHD in children than the children themselves.

The above table also explains that there is a significant difference between teachers and parents on perceived inattention symptoms of ADHD in children. The Tukeys post hoc value is 14.65 at 5% level of significance. The mean value ascertains that the teachers perceive significant higher inattention symptoms in children as compared to parents of children

Table 1.3: Results of ANOVA Test between Children, their Parents and Teachers on Perceived Symptoms of ADHD on Hyperactivity in Children.

Sources of variation	Df	Sum of squares	Mean sum of squares	F-value	p-value
Between groups	2	38.77	19.38	3.2459	0.0393*
Within groups	1118	6670.38	5.97		
Total	1120	6709.14			

*p<0.05

The results of the above table depicts that a significant difference is perceived between children, teachers and parents of children with respect to hyperactivity behavioural pattern

where $F=3.2459$, $p<0.05$ at 5% level of significance. Hence, the null hypothesis is rejected. It means that, the children, teachers and parents of children perceive different hyperactivity symptoms of ADHD in children. Further, to know the difference in perceived symptoms between the three groups Tukeys multiple post-hoc test was applied. The results are depicted in the in the following table.

Table 1.4: Pair wise Comparison between Children, their Parents and Teachers on Perceived Symptoms on Hyperactivity of ADHD in Children by Tukeys Multiple Post hoc Procedures.

Groups	Children	Teachers	Parents of children
Mean	7.53	7.18	7.64
SD	2.45	2.53	2.00
Children	-		
Teachers	P=0.0500*	-	
Parents of children	P=0.8998	P=0.1562	-

* $p<0.05$

The above table analyses shows that a significant difference is perceived between children and their teachers with respect to perceived symptoms on hyperactivity of ADHD. The difference between these groups is highly significant at 0.05 level. The mean values show that the teachers perceive higher inattention symptoms of ADHD in children than the children themselves. From the results of the above table, it can be perceived that a significant difference exists between children and teachers with respect to hyperactivity scores of behavioral patterns of ADHD at 5% level of significance. The mean value is 7.53 It means that, the children have significant higher hyperactivity symptoms of ADHD as compared to teachers.

Further, the above table also shows that there is no significant difference between children and their parents on perceived hyperactivity symptoms of ADHD. The mean value ascertains that the children perceive similar hyperactivity symptoms of ADHD when compared to their parents. The above table also depicts that there is a no significant difference observed between teachers and parents of children on perceived hyperactivity symptoms of ADHD in children. The mean value ascertains that the teachers perceive similar hyperactivity symptoms of ADHD as compared to parents' children.

Table 1.5: Results of ANOVA Test between Children, their Parents and Teachers on Perceived Impulsivity Symptoms of ADHD in Children.

Sources of variation	Df	Sum of squares	Mean sum of squares	F-value	p-value
Between groups	2	411.31	205.65	98.2249	0.0001*
Within groups	1118	2340.76	2.09		
Total	1120	2752.06			

*p<0.05

The above table explains that a significant difference is observed between children, their parents and teachers on perceived symptoms on impulsivity symptoms of ADHD. The obtained F value of 98.22 is significant at 0.05 level. This implies that there is a significant difference in the perceived hyperactivity symptoms of ADHD in children themselves, their parents and teachers. Further, to know the difference in perceived symptoms between the three groups Tukeys multiple post-hoc test was applied. The results are depicted in the in the following table.

Table 4.6: Pair wise Comparison between Children, their Parents and Teachers on Perceived Symptoms on Impulsivity of ADHD in Children by Tukeys Multiple Post hoc Procedures.

Groups	Children	Teachers	Parents of children
Mean	3.84	5.06	5.02
SD	1.55	1.36	1.36
Children	-		
Teachers	P=0.0001*	-	
Parents of children	P=0.0001*	P=0.9613	-

*p<0.05

From the results of the above table, it can be analyzed that a significant difference is perceived between children and their teachers with respect to perceived impulsivity symptoms of ADHD in children. The difference between these groups is highly significant at 0.05 level. The mean of 5.06 values show that the teachers perceive higher impulsivity symptoms of ADHD in children than the children themselves.

Further the above table also shows that there is significant difference between children and their parents on perceived impulsivity symptoms of ADHD in children. The Tukeys post hoc value is 5.02 which is significant at 0.05 level. The mean value ascertains that the parents of children have higher impulsivity symptoms of ADHD in children than the children themselves. The above table also shows that there is no significant difference is observed between teachers and parents of children with respect to impulsivity symptoms of ADHD in children at 5% level of significance. It means that, the teachers and parents of children have similar impulsivity symptoms of ADHD.

Measures:

Changes in regular routines and activities to help prevent the spread of COVID-19 can be stressful for any child. The American Academy of Pediatrics (AAP) suggests ways to help support students with ADHD and their families during this stressful time. Students with ADHD often need order to their day to be able to function their best. Different schedules and routines, whether at home or with school, can increase a child's ADHD symptoms.

ADHD may have had trouble adjusting to online learning without a teacher present to support them. Online learning often requires students to be self-guided, manage their time and motivation, and complete tasks, assignments, or projects in the required time.

With new teaching methods, some students may need new or different accommodations. that need parental supervision. With virtual learning, remind your child to take movement breaks between tasks. Indoor breaks could include dancing and simple exercises. Consider safe outdoor activities, such a bike riding or jumping rope. This can also provide exercise that may help with ADHD symptoms. Use positive attention, focusing on your child's strengths and efforts. Kids with attention and impulse control challenges often benefit from specific, immediate and bold feedback. For example, saying, "Great job getting started on your assignment right on time

Many students have difficulty learning new information in stressful times. Students with ADHD may benefit from going over the material that their teachers already taught. This can help them remember what they learned. In many cases, having more hands-on supervision and guidance from parents may help. If you're working from home, let them know when you are available try to give them undivided attention during those

times. Parents can also ask teachers what videos or web sites they recommend to help students break new information into smaller parts. According to the National Sleep Foundation, low quality sleep can make ADHD symptoms more severe in children. In a recent study by Association for Child and Adolescent Mental Health, researchers also found that adolescents with ADHD experienced more depressive symptoms and exhibited negative behaviors when they got only 6 and a half hours of sleep. Creating daily and weekly routines can help build good habits and may ease some ADHD symptoms. For example, according to Children and Adults with ADHD (CHADD), structure and routine can help reduce stress and uncertainty.

Creating a routine can include the following: Scheduling regular times for sleeping, eating, and physical activities. Setting time aside for homework, physical activity, relaxation, and hobbies. Children with ADHD tend to have more difficulty managing their behaviour and staying on task when their schedule is uncertain. This is particularly true when they don't know how long they will need to wait to do pleasurable activities.

A child's physical space can profoundly impact their mental state. For instance, they may feel more focused when they do their work in a quiet, tidy room. Similarly, children may learn better without external distractions, such as noise from a television.

The following may help create a calming environment:

- Practicing breathing techniques
- Designated rooms and spaces, if possible, for work, play and relaxation
- Keeping a journal to write down thoughts and feelings
- Listening to relaxing music

According to the authors of *Effects of Exercise on Cognitive Performance in Children and Adolescents with ADHD*, research suggests that regular physical activity leads to structural changes in the brain that may reduce ADHD symptoms in children such as improved impulse control and attention after a single 20-minute aerobic exercise session. Examples include bicycling, walking and running.

It is essential that children with ADHD continue their current treatment, which may consist of taking medication, attending behavioural therapy, or a combination of the two. Contact with their healthcare providers is very important. and now many of them offer telehealth services, where they can perform health evaluations, consultations and psychotherapy sessions by video

Children with ADHD can also benefit from staying connected with family and friends using video chat services. Talking to loved ones can help reduce feelings of isolation and loneliness. Try scheduling these calls ahead of time. It could help motivate a child to complete a project or task.

A survey in France, conducted almost a month into lockdown, included 533 parents of children with ADHD and found that the sample was split into roughly three equal groups, where 30.96% of the children were doing better, 34.71% were worse and the rest-maintained status quo in their condition. While improvement in the child's anxiety, less school-related strain, flexible schedules, lesser exposure of their children to negative feedback, and improved self-esteem could explain a good outcome in more than two-thirds of their sample; the authors also found influences of optimal lockdown life conditions like sufficient space at home to possibly mediate some of these outcomes.

The paper titled “impact of COVID-19 and lockdown on children with ADHD and their families: an online survey and a continuity care model” has shed light on the impact of lockdown on individual symptoms of ADHD in children in an Indian context, and performed a brief text-message based intervention to assess feasibility of such an intervention.

Among 48 parents who participated, half of the children were found to have worsening of ADHD symptoms with slight or marked increase in the activity level (50.1%), irritability (45.8%), and disturbing or disruptive behaviour (47.9%). They also found that the lockdown was “associated with certain positive outcomes,” as reflected in about half of the children spending more time with studies, engaging in creative activities and helping out their parents with household chores. The authors found that their text-based intervention was a “feasible” alternative to usual care under the changed circumstances. The findings of this study add to the overall pool of data and informs best practice in ADHD management during this pandemic.

The appropriate use of behavioural parent training strategies is important during the COVID-19 pandemic, especially as families are confined together for long periods where tensions may escalate out of control. When face-to-face support is not available, under the current circumstances, parents may have to rely on self-help versions of evidence-based systems. Six essential tips are provided for parents of children with ADHD: (1) keep positive and motivated; (2) make sure all family members know what is expected of them; (3) build your child’s self-confidence and trust in you; (4) help your child to follow instructions; (5) promote better behaviour; (6) limit conflict

It is also important for parents to understand how difficult these times are for adolescents with ADHD as the loss of

daily school and homework structure, hobbies and friends can be stressful, in addition to being with their parents and siblings much of the time. Parents must stay connected with their adolescent, ask about their feelings and discuss their daily schedule if needed. ADHD creates a huge impact not only on the child alone but also upon the whole family. From the very initial consultation parental factors such as perception of parents/caregivers, the dynamics within the family, emotional difficulties of parents themselves, and their parenting skills, areas of concern where parents have a very important role to play.

Parent educators should opt for that parenting which fosters learning and loving rather than one which promotes fear and mistrust. The general principle here is that children like adults need to be understood especially by someone important to them. Children have feelings. recognizing those feelings and letting the child know that it is recognized often helps the Child to feel better.

Energin et.al. (2015) studied "Nutritional status of children with Attention Deficit Hyperactivity Disorder". The purpose of this paper was to compare the nutritional status and certain anthropometric characteristics in school-age children with Attention Deficit Hyperactivity Disorder (ADHD) and healthy controls. A total of 200 children (ages eight to 11), half with ADHD and the other half healthy participated in the study. A three-day food consumption record was taken and evaluated based on energy and macro-micro nutrient requirements. Weight, height, waist, hip, mid-upper arm circumferences and hand grip strength were measured. Energy, protein, fat, saturated fatty acids, monounsaturated fatty acids, carbohydrate, niacin and zinc intakes were found significantly lower than healthy controls for female participants, and all nutrient intakes were found significantly lower than healthy controls for male participants ($p < 0.05$).

Children with ADHD had lower anthropometric measures ($p>0.05$). The study sample size was too small to make results general and subtypes of ADHD and medication types were disregarded during the data collection process which limited the interpretation of the study results

Martin (2015) highlighted –Parents' perceptions on the natural-holistic treatment plan for Attention-Deficit Hyperactivity Disorder (ADHD)‡. The purpose of this qualitative study was to investigate the perceptions of Korean parents in South Korea whose children were receiving natural-holistic treatments for their diagnosed ADHD in terms of its impact on: (a) physical well-being (b) psychosocial development (c) academic competency (d) household behavioural interactions amongst family members. The data was analyzed using a technique of pattern matching and cross-case analysis. The study found that parent participants believed that a natural treatment plan consisting of longer sleep, more exercise in addition to other factors had a perceived positive impact on their children's ADHD treatment.

Williams (2013) tried to measure the impact of Cognitive Behavioural Theory (CBT) techniques and clinical Social Work practices with a 6-year-old boy with attention deficit hyperactivity disorder (ADHD) and Anxiety. The study included bi-weekly 30-minute individual therapy sessions over a five-week period. The scales used are the Ohio Youth Problem, Functioning, and Satisfaction Scales Parent Rating (OHIO), Screen for Child Anxiety Related Disorders -Parent Version (SCARED), and a Swanson, Nolan and Pelham-IV scale (SNAP-IV). A Single Subject AB Design allowed for the assessment of pre and post scale scores. A significant change was found for the client's ADHD symptoms, Anxiety symptoms, problem severity, overall functioning, and treatment satisfaction

Canillas (2011) made an attempt to determine if differences exist between the parenting practices of ADHD-diagnosed children and non-ADHD children? Ninety- five parents participated in an online survey, significant differences were found within the areas of parental monitoring, appropriate discipline, harsh and inconsistent discipline, and clear expectations. Parents of children diagnosed with ADHD tend to use more appropriate discipline, yet they also practice more harsh and inconsistent discipline. They also employ clearer expectations in their parenting practices. Parents of non-ADHD children tend to monitor their children significantly more than parents of children diagnosed with ADHD. No significant differences were found when examining physical punishment, positive verbal discipline, or praise and incentives. These results infer important areas of parenting to consider when looking at how parenting practices influence children_s behaviours.

Vicky (2010) highlights Self-management strategies focused on reducing the behavioural symptoms and increasing the academic achievement of students with ADHD. There is a strong correlation between self-management, skill development, improved behaviour and academic achievement and argues for the nurturing of a home to school connection when teaching children with ADHD in the United States educational system.

Suggestions:

Suggestions for Parents of School Children Exhibiting Symptoms of ADHD

Self-Instructional Training: It is probably the most commonly used cognitive therapeutic approach in the psychological treatment of ADHD. It comprises several different techniques, including cognitive therapy, modelling, self-evaluation, self-

reinforcement. The therapy involves helping the young person develop a more planned and reflective way of thinking and behaving by learning how to adopt a more reflective, systematic and goal-directed approach to tasks and problem solving.

Length of Tasks: Students are much more likely to misbehave when too much work is given easily can feel overwhelmed and simply not start, or they might be unable to maintain attention and thus fail to complete the task. Thus, the length of the task has to be designed.

Positive Attitude: Relate the criticism to the action-NOT the child. Instead of "You're really creating disruptions in the class" try "Your behaviour (being specific if possible) is causing upset and making it difficult to teach. It's a subtle difference but with one you're condemning the child with the other the activity. This leaves the child free to improve whereas the other makes him feel worthless.

Never Call the Child Good or Bad: Address the behaviour which is not acceptable. Avoid accusations which make the child feel he or she is not good as a person and put up their defences. Build on strengths rather than contribute to a child's frustrations by focusing on his or her weaknesses. Give the child frequent feedback on his or her work. Be honest but positive in approach.

Entrusting Responsibility: One of the main ways children develop self-confidence and internalize values is through helping maintain the family living area, inside and out. Raise a confident child by giving them household duties, making them responsible. This helps them feel more valuable and instead of depending on others entirely they must try to know they are potential and complete the task independently. Help

them to set goals and avoid too much pampering which makes them stubborn and lazy.

Family Environment: Strategic family therapy is based on the view that difficulties stem from repeated patterns of dysfunctional family communications and marital conflicts which has to be avoided, and it has to be ensured that family planning measures have to be adopted for a small healthy family.

Discipline: Yoga/Massage/Green Settings will be helpful to overcome hyperactivity limit television, mobiles, social networking sites will also be very helpful. There is evidence that limiting these activities can improve behavioural and academic functioning. Use these activities as rewards for appropriate behaviour or academic accomplishments.

Awareness: Early identification and treatment is necessary and there are a number of excellent books on ADHD that are aimed at helping parents understand the nature of ADHD, and what they can do to help their child succeed. Better understanding the nature and its effects can help parents actually reduce parent stress along with improved communication between schools and physicians.

Social worker initiates research related to ADHD and gives necessary orientations to improve it. They support the teacher to draft the Individual Educational Plans to create an acceptance climate in class to follow up their performance, work with parents etc. social workers could emphasize home visits and dialogue with parents about how to carry over and modify school action plans for home is the question. They are the bridge that bring together families, school and social services to promote and support students' academic and social success. School social workers do direct counselling with individuals, groups, and families, advocacy, consultation,

community linkage, interdisciplinary team co-ordination, need assessment, program and policy development etc.

Thus, a comprehensive treatment program includes ADHD education, medication, school and family interventions, and co-morbidity interventions. A combination of behaviour management training and problem-solving, communication training has been shown to be effective for addressing conflict between parents and children with ADHD. An effective intervention for school problems should include a home and school communication system. Berk (2013) said to offer opportunities for divergent thinking and praise them so that they become creative to explore new fields rather than just accepting the interests that one values. The challenge is to provide the upcoming generation with the awareness, abilities and mental strength they need to take responsibility for their own lives, and to make their contribution to society

Gomez (2011) in his study seeks to understand how social work students and social work professionals increase their knowledge about ADHD and how they formulate their attitudes about the disorder. The literature provided illustrates the many components of ADHD risks, etiology, treatments, and professional opinions about the disorder. ADHD is one of the most studied childhood mental health disorders in the nation. However, there is little research providing insight to social workers knowledge and attitudes about the disorder. This is especially alarming because social workers are one of the largest professional populations to provide mental health services to children and their families. Practitioners' knowledge and attitudes about the disorders has an impact on the patient-clinician relationship. It can have an affect the likelihood that the client will adhere to the treatment plan and it affects the professional relationship between the clinician and other treatment professional

Conclusion

ADHD and their families benefit from the huge amount of research undertaken in centres all over the world; In the present era where every day we are stepping ahead to technological advancement with the increasing pressure in children to get 100% in every activity including academics needed to develop at their own pace. George et. al. (2006) stated that if a child gets poor marks, we brand him lazy or stupid. The feeling of being wanted and loved is vital to the development of the child with the adults who are charged with the responsibility of looking after them.

Behavioural problems and psychiatric syndromes in children are a matter of concern as the consequences can seriously impair their ability to become useful and productive citizens of tomorrow. Bhatia et.al (1998) asserted that around 60.00% of ADHD children will carry some of their behaviour into adulthood in the last decade, symptoms gradually abate with increasing age generally following a predicted pattern

Multimodal interventions usually are required to successfully address the problems presented by children with ADHD. The need for multiple interventions necessitates that professional from many disciplines be involved in the care of these children. Children have feelings. recognizing those feelings and letting the child know that it is recognized often helps the Child to feel better. Visser (2001) pointed out aims for intervention strategies which centre upon raising pupils' achievements as well as their personal and social development. He urges teachers to develop an awareness of 'emotional literacy' asserting its importance for pupils in the wider social and economic changes which are part of all societies in the twenty-first century.

It is extremely important however to realize that a parent can recognize a child's feelings and communicate that recognition without either criticizing or praising him. In pharmacological treatment of ADHD, the effectiveness of medication has been well established. However, medication alone cannot and should not serve to be the sole modality of treatment that parents must know. Of recent increasing evidence has demonstrated the role of multi-modal treatment for effectively addressing the diverse difficulties of children with ADHD.

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Covid-19 Pandemic and Challenges Faced by Front-Line Healthcare Workers: A Study in Select Districts of West Bengal

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Abstract

With the world-wide upsurge of COVID-19 which has already been declared as a pandemic by the World Health Organisation, healthcare systems in India are being put to stupendous strain to curb the spread of the deadly virus. Greater burden of COVID 19 management is being shouldered by the frontline health care workers and they have been relentlessly putting their lives in saving the lives of people. This paper makes an effort to highlight the dire challenges being faced by frontline health care workers and their coping strategies in select districts of West Bengal and also suggests certain recommendations.

Keywords: Covid-19, Pandemic, Front-Line Healthcare Workers, Public Healthcare System, ASHA

Introduction

An epidemic can be defined as an outbreak on an infectious disease that affects a large number of populations. When an epidemic spread to a much wider areas then it is termed as a pandemic. It refers to the worldwide spread of disease. In most cases, the disease is caused by a new virus or a new strain of virus which is unknown to the human race. Humans have no immunity against the virus. It is reason that it spreads quickly. Earlier the pandemics which has converted the earth as death beds are Spanish Flu (1918-1920), Small Pox Epidemic (1974), Plague in Surat (1994), SARS Epidemic (2002-2004), Dengue and Chikungunya Outbreak (2006), Swine Flu Epidemic (2014-2015), Nipah Virus Outbreak (2018).

On December 2019, Wuhan city of China reported multiple pneumonic cases of unknown cause. Later scientists identified and referred it as '2019 novel coronavirus' or '2019-nCoV.'

Cases of COVID-19 began to increase rapidly in an alarmingly way. The unprecedented emergency had major impact on the global healthcare system. There has been a huge challenge for the healthcare workers to provide treatment for COVID-19 and regular healthcare service simultaneously. Countries like Taiwan, South Korea and Canada handled this crisis situation in better way than others (Bremmer, 2020). The government and public healthcare system play a crucial role in tackling these situations. United States, India, Brazil and Russia are the worst-affected countries all over the planet. In India, the first case was reported on 30th January 2020. After the inception, it spread nationwide in an upward direction. India has encountered many epidemics and

pandemics through time. The reason could be the lack of proper hygiene and sanitation, malnutrition and lack of a proper public healthcare system.

Since the inception of COVID-19 outbreak, the healthcare workers are working restlessly all around the world. They have been the backbone of the country. They are also being referred as ‘frontline soldiers.’ Still, there are cases being reported all around the world regarding the attacks on healthcare workers. They are being abused and stigmatized all over the world. World Health Organization (WHO) defines attack on healthcare workers as ‘any verbal or physical act of violence, obstruction or threat that interferes with the availability, access and delivery of healthcare services (World Health Organization, 2020). The attack on healthcare workers varies greatly from physical assault to denial of services to psychological threat.

In Mexico, the healthcare workers were not allowed to use public transports. Similarly, in Malawi, doctors and nurses were reportedly abused on public transport and evicted from rented apartments. Out of fear, the nurses prefer to wear civilian clothes in public and carry uniforms in their bags (Kakhobwe, 2020). According to a survey by Amnesty International, there is shortage of protective gears for the health workers in nearly 63 countries including India, Brazil and several countries of Africa. In Mexico, health workers were spending 12% of their monthly salary for buying their own Personal Protective Equipment (PPE) kits (Ambast, 2020).

All over the world, millions of healthcare workers are on the front lines of the COVID-19 outbreak. We should not lose sight of our friends and relatives working in emergency or intensive care settings who have to deal with a heavier and more stressful workload than usual. Data reveals that social

and psychological interventions could significantly enhance healthcare worker well-being during the COVID-19 outbreak (Chen, et al., 2020).

Healthcare workers are at an increased risk for ‘moral injury’ when dealing with critical patients under extreme pressure. The factors for moral injury include critical decisions like how to allocate meagre resources to equally needy patients, dealing with severe cases with inadequate resource and medical facilities and not being able to support families of terminal patients adequately (Greenberg, Docherty, Gnanaprasadam, & Wessely, 2020).

During the stress phase, the healthcare workers who are directly dealing with COVID-19 patients found to be suffering from severe sleep related problems like insomnia and sleep associated symptoms consistent with nightmares, incubus attack and sleepwalking. It indicates that healthcare workers have been subjected to a huge amount of stress related to large exposure to a new pandemic disease with unknown consequences, directly impacting on their sleep (Martin, et al., 2020).

Healthcare workers across the world are facing stigma and discrimination. It might act as a hindrance for regular testing and providing health care and for continuing treatment. Stigma is the consequence of multiple socio-cultural drivers (fear and misinformation) and facilitators (caste, religion and poverty) (Logie, 2020). Infodemic that is, excessive circulation of misinformation acted both as a driver and facilitator for stigma (Ransing, et al., 2020).

Unfortunately, most of these drivers and facilitators were not properly addressed in many countries. In certain cases, the reinforcement of negative stereotypes and prejudice, plus social processes of labelling, further fuelled already existing

social inequalities, which were then reinforced by some public health enforcement measures (e.g., arresting people for breaching quarantine) (Logie, 2020).

Review of Literature

Public Healthcare System in India: Historical Background

In post independent phase, the government of India made many changes and developed a well-organized healthcare system in India. The changes were made on guidelines provided by the Bhole Committee. India came a long way in terms of improvement of health status of the people in the country, it still has long way to go to improve the overall health index and achieving the 'Health for All' in an equitable sense.

India has a 3-tier public healthcare system. Sub Centres, Primary Health Centres (PHCs) and Community Health Centres (CHCs) in grassroots level, Small-District Hospitals at small towns and settlement and District/General Hospitals and Medical Colleges at top-most level.

Social welfare coupled with advanced scientific development has led to the decrease in mortality rate in the country (Duggal, 2016). Private healthcare services comprise of 70% of the total healthcare system in India. Due to high expense, private hospitals and nursing homes are accessible only to a small number of populations. According to the 2011 census report, 68.84% population reside in rural areas. It clearly indicates that majority of the population are deprived of proper healthcare facilities.

There are many challenges with the existing public healthcare system. Even primary health centres and sub-centres are made available in all parts of the country; the service they provide

has a very limited scope. They provide limited childcare, services related to pregnancy care and services related to certain national health programmes. They are unable to provide sufficient care during health emergencies like COVID-19 pandemic. The government budget for public healthcare is very low (nearly 1.2% of the GDP) and per capita public health spend is less than \$15, less than Bhutan, Thailand and Philippines (Kumar, et al., 2020).

The aim should be to build a resilient public healthcare system that can promote good health, prevent diseases and respond quickly to minimise loss of life when faced with an outbreak pandemic. For tackling emergency situations and building resilient public healthcare system, it is necessary to shift the focus towards preventive care. For this, health workers at grass root level i.e., Accredited Social Health Activists (ASHA) and Auxiliary Nurse Midwives (ANM) should be well-trained. They can identify early signs of outbreak in the communities. The government spending should be doubled (2.5% of the GDP) for better healthcare infrastructures (Kumar, et al., 2020).

The COVID-19 pandemic has in many ways exposed the loopholes in public healthcare system in India. In the second wave, India has the highest number of cases with about 1 million cases every third day. The community transmission of the COVID-19 virus made it even difficult to deal due to the high population density in India. The high population density also makes the social distancing impossible. Better sanitation practice and proper usage of masks also didn't work out well in the country due to lower literacy rate and patchy social compliance. Moreover, hot and humid weather also didn't support the concept very well. Moreover, India has completely or partially vaccinated about 12% of the population against the COVID-19 virus. The low vaccination rate can be attributed to vaccine hesitancy nature and vaccine

shortage. These are failures are seen as the major loopholes in the risk-management model. Large election rallies, religious gatherings, social and festival celebrations are other major contributors of the more severe second wave pandemic (Mohammed, 2021).

Corona and Healthcare Workers: Indian Context

World Health Organization (WHO) defined healthcare workers as ‘people whose job it is to protect and improve the health of their communities’. In India, healthcare workers include doctors, nurse and midwife, pharmacists, grass root level workers (ASHA) and people related with public healthcare profession. A study by National Sample Survey Organisation reveals that India has 20.6 healthcare workers per 10,000 people. It is less than the minimum requirement of 22.8 healthcare workers per 10,000 people marked by the World Health Organization.

There is an uneven distribution of healthcare workers in private and public sector as well as in different geographical locations. More than 80% of doctors and 70% nurses are employed in private hospitals and clinics. Moreover, most of the total healthcare workers are concentrated in states like Delhi, Kerala, Punjab and Haryana (Hindu, 2019).

The healthcare workers are often been termed ‘front line worker’ as they are the ones who are fighting selflessly with the virus. Everyone is locked up inside their home, but only health workers are working day and night and putting their own lives at risk for the sake of saving people’s life. Many had sacrificed their lives while battling with the virus (Pandey & Sharma, 2020).

An Accredited Social Health Activist (ASHA) is a community healthcare worker. They are the first point of contact for any

health-related-needs in the rural areas. According to a data by MoHFWA, there are at present 1047324 ASHAs in India(PIB Delhi, 2020). Amidst of the COVID-19 pandemic, ASHA workers are playing a key role in spreading awareness on prevention of corona virus. The ASHAs have been oriented about the process and can help in early detection of the disease and provide proper treatment (Ministry of Health and Family Welfare, 2020).

In India, it is seen that health workers dealing with COVID-19 patients faced substantial social exclusion; they were asked to vacate the rented homes, and were even attacked while carrying out their duties. There are concerns about the safety and hygiene of the health workers as they are not provided with sufficient protective gears.

Till 7th August, 196 doctors had lost their lives to COVID-19 in India. There have been reports of doctors and their families not getting beds for admission and also in many situations' unavailability of drugs. Govt must assure doctors of access to timely hospital and quality care. It is putting a demoralising effect on the whole health care sector. The Indian Medical Association (IMA) requested PM to ensure that if the health workers and their families get affected with the virus, they should at least get a proper treatment (Perappadan, 2020).

Despite the directions of Supreme Court and guidelines issued by Ministry of Health and Family Welfare (March 24) on appropriate PPE based on the risk of infection associated with a work area, an online survey by health researchers revealed the shortage of personal protective equipment (PPE) for health workers. Health workers in Belegata ID (Infectious Disease) Hospital and Kolkata Medical College and Hospital (MCH) were provided plastic raincoats due to the shortage of protective gears (Newsable, 2020).

Accredited Social Health Activists (ASHAs) are the most negatively affected group of frontline workers. They are not being paid or provided regular wages (Raman, 2020). The anganwadi and municipal workers were more exposed to the disease. During the door-to-door contact tracing, they were the part of government's pandemic response team but had "no proper protection" (Joseph, 2020).

It is a very difficult situation for female health workers wearing protective suit during their menstrual days. They will be more prone to menstrual infections. It makes the situation worse for the health workers who are already over-burdened. In *Pt. B.D. Sharma PGIMS, Rohtak*, duty-roster are made for COVID and non-COVID wards according to the menstrual cycle of the female doctors and nurses (Kakkar, 2020).

Corona and Healthcare system in West Bengal

As of October 2020, 41 doctors have died due to COVID-19 in West Bengal (The Times of India, 2020). Koushiki Lahiri, a member of West Bengal Doctors Forum stated that there is shortage of PPE kits for the healthcare workers. The healthcare workers are facing threats from their neighbour and the people are socially boycotting them (Team Newsable, 2020). There are various complaints against the hospital administrative by the patient family as well as the healthcare workers. The Standard Operating Procedure for COVID patient death certificate is not being followed.

Most of the COVID-19 cases are referred to the public healthcare facilities. It is crucial to improve the public hospitals and health centres to provide healthcare in an efficient manner. Isolation wards are required for COVID-19 positive patients. According to a survey by National Health Profile (2019) there are 7, 13,986 beds available in government hospitals in India. There are 0.5 beds per 1000

people. For elderly, the statistics are 5.2 beds per 1000 elderly (Singh, Ravi, & Chakraborty, 2020). In College of Medicine and Sagore Dutta Hospital (CMSDH), West Bengal, number of beds allotted for COVID-19 patients is only 280 but the government data is showing the capacity of 500 beds(Ghosh, 2020).

In India, most of the population cannot afford private healthcare facilities due to its expense and its non-availability in rural and remote areas. For COVID-19 critical patients, intensive care unit is required. There is no actual data on the number of intensive care units but according to an estimate there is approximately 57,000 intensive care units with ventilators in government hospitals (Singh, Ravi, & Chakraborty, 2020).

Measures taken by Government for Healthcare Workers

On 26 March 2020, the Government of India announced a special life insurance scheme for healthcare workers. The scheme promised 50 lakhs rupees to the family of healthcare workers those who died on COVID-19 while on duty. But unfortunately, after a year when the country is still fighting with more deadly second wave of COVID-19 pandemic, the scheme has lapsed without any extension of the same (Johari, 2021).

In the light of COVID-19 pandemic situation, Union Cabinet amended the Epidemic Diseases Act, 1897. They added that any act of violence against health workers will be regarded as cognizable and non-bailable offence. The offender shall be punishable with imprisonment for a term ranging between 3 months to 5 years and with fine ranging between 50 thousand to 2 lakh rupees (Ministry of Health and Family Welfare, 2020).

On 6th May 2020, West Bengal's Chief Minister Mamata Banerjee announced 51 crore rupees 'performance-based incentives' for the ASHAs (The Times of India, 2020). On the counterpart, she introduced a package of financial incentives for trained Honorary Healthcare Workers (HHWs) to build a robust primary healthcare system in urban areas (The Indian Express, 2020). Both the ASHAs and HHWs will be involved in community and door-to-door tracing. They'll also be a crucial element in care of infants, pregnant women, immunisation, elimination of TB and other diseases through door-to-door visits.

Objectives

The main focus of the study were (a) to explore the challenges faced by the healthcare workers during COVID-19 in public healthcare system and; (b) to find out various coping strategies used by the health care workers to deal with pandemic. It will also look at how the public healthcare system responded to the outbreak and revised their existing protocols. The situation of the public healthcare system from healthcare workers' perspective is crucial for building a resilient healthcare system. It will ensure proper management of such emergency situations in future.

Methodology

The research is Eclectic and exploratory in nature as it aims to explore the situation and challenges faced by the frontline healthcare workers. The study was focused on three distinct districts of West Bengal namely Kolkata, North 24 Parganas and South 24 Parganas. From this specific geographical location 104 frontline health workers had been selected for the study applying convenient sampling. The primary data was obtained using mixed method i.e.- both qualitative and quantitative methods. Interview schedule and case studies

were used for the collection of data. 5-point Likert scale was used to quantify the answers which were qualitative in nature. The obtained data had been codified and analysed using computer software. For quantitative data, SPSS was used to draw inferences. Correlation was drawn among various variables. Descriptive statistical tools such as frequency tables, crosstabs, pie charts and bar graphs were used to analyse the data. Qualitative data was used to corroborate with the inferences drawn from quantitative data. The qualitative data was thematically analysed.

Results and Discussion

The data are presented in two different sections. Section I presents the profile of the respondents with implicit demographic and family features and the challenges faced by frontline healthcare workers. Section II presents strategies used by healthcare workers as coping mechanisms.

Section I

Profile of the Respondents

The total number of respondents was 104 and all of them were frontline health workers. The respondents were conveniently selected from three districts of West Bengal. The healthcare workers consist of doctors, nurses and ASHAs. Majority of the respondents were doctors (43.3 per cent), then followed by nurses (37.5 per cent). Due to limited reach in rural areas and pertaining pandemic situation, the sample consists of only 19.2 per cent of ASHAs. As majority of the sample consists of nurses and doctors, the majority respondents have graduation as their educational qualification followed by post-graduation, secondary education and senior secondary education. The study comprised of 60 females and 44 males. The sample

reflects about 15% more female respondents than male as all the ASHAs were female.

The samples of the respondents are distributed into three age categories that are, 18-30 years, 31-45 years and 46-65 years. As the study only deals with healthcare workers, it does not include respondents below 18 years of age. Middle-aged respondents constitute almost 50 per cent of the total sample (Table 1). There was also a category of 65 years and above but there were no participants in this category.

Table 1: Age wise distribution of Respondents

Age	Frequency	Percentage
18-30 years	18	17.3
31 to 45 years	51	49.0
46 to 65 years	35	33.7
Total	104	100.0

Challenges Faced by Front line Healthcare Workers

This section displays the challenges faced by the healthcare workers during the COVID-19 outbreak. It will help us explore different kind and intensity of challenges faced by the healthcare workers. There was lack of isolation rooms, intensive care units, treatment beds and PPE kits. Within 31st May, 2020, hospitals in West Bengal ran out of isolation beds (Srinivas, 2020). Even in the second wave of COVID-19 pandemic, the things have not improved much. Top-rated private hospitals ran out of bed within just few days of the second wave pandemic (Hindustan Times, 2021). Moreover, the private hospitals also don't show the bed availability (The Hindu, 2021). The results are fully obtained from primary data and are displayed in form of frequency table and bar charts.

Healthcare Setting

More than 50% of the respondents were primarily serving in Medical Colleges. 24% were serving in Sub Divisional Hospital and 19.2% were serving in Primary Healthcare Centres. Only 3.8% of the respondents were working in Community Healthcare Centres.

Table 2: Healthcare Setting

Setting	Frequency	Percentage
Medical College	55	52.9
Sub Divisional Hospital	25	24.0
Community Healthcare Centre	4	3.8
Primary Healthcare Centre	20	19.2
Total	104	100.0

PPE Appropriate

86.5% i.e., 90 out of 104 respondents said that the PPE provided to them were inappropriate and was not enough to protect them for the COVID-19 virus. The major reason was that most of the healthcare workers weren't provided full set of PPEs. Some was provided just the surgical mask, some got surgical masks and gloves, some of them received face shields etc. Anything except the full PPE suit is insufficient against COVID-19 virus. Due to the shortage of PPE kits, the healthcare workers had to wear raincoats and re-use the same mask, putting both patients and themselves at risk of contracting the virus. Moreover, the study shows that proper training was not provided to the healthcare workers regarding the use of PPE kits. The result shows that 37.5% of healthcare workers didn't received any proper training regarding the use of PPE. The training was very much crucial as proper wear and usage of PPE makes healthcare workers less prone to the virus. All the PPE gears were not provided to the healthcare workers. They also had to re-use the same PPE gears for

multiple times. Most of the healthcare workers also had to buy PPE gears on their personal expense.

Table 3: PPE Appropriateness

PPE Appropriateness	Frequency	Percentage
Appropriate	14	13.5
Inappropriate	90	86.5
Total	104	100.0

Shortage of PPE

The shortage of PPE was often there in the public healthcare setting. 38.5% of the respondents opted 'sometime'. No one said that there was never a shortage of PPE in the healthcare facility.

Table 4: Shortage of PPE

Shortage of PPE	Frequency	Percentage
Sometime	40	38.5
Often	63	60.6
Always	1	1.0
Total	104	100.0

Sanitization

59.6% of the respondents said that the public healthcare setting where they were working was being sanitised on regular basis. Rest 40.4% of the respondents claimed that the healthcare setting was not being sanitised on regular basis.

Table 5: Sanitization

Sanitization	Frequency	Percentage
Yes	42	40.4
No	62	59.6
Total	104	100.0

Risk Allowance

There was also no risk allowance for the healthcare workers for working in such adverse condition. The state government made a stipend hike for junior doctors. These include interns, house staff, post-graduate trainees and post-doctoral trainees (Yengkhom, 2020). A notice was also brought up by the Health & Family Welfare Department of West Bengal that the frontline workers will be given free treatment in public healthcare facility and death benefit of Rs. 10 Lakh if the death is attributable to COVID-19(Health & Family Welfare Department, 2020). But when the situation came, the respondents claimed that these benefits were not provided to them.

All the respondents claimed that they were not provided with any kind of risk allowance (both monetary and non-monetary). There were few schemes by Union and State Government, but according to them, it was just on paper.

Table 6: Risk Allowance

Risk Allowance	Frequency	Percentage
No	104	100.0

In the second wave of COVID-19 pandemic, supply of oxygen has been a major problem. About 70-80 per cent of COVID-19 patients who has tested positive during the second wave requires oxygen support (Yengkhom, Bengal hospitals asked to ramp up oxygen storage capacity, 2021). In support to this fact one ASHA worker respondent as *'You should have proper weapons when you go for a war. What has been the problem is we are fighting with a strong opponent bare hand.'* (ASHA-1). Manas Gumta, Secretary of the Association of Health Service Doctors (AHSD) said that condition of the state is such that there is an acute shortage of beds and oxygen. Tests are not done on adequate scale. The total

healthcare system is on the verge of collapse (Chakraborty & Das, 2021).

Public Utility

There were several challenges faced by the healthcare workers during the COVID-19 pandemic. A breakdown of trust was reported between neighbours and community people. Healthcare workers reported that they were asked to leave their rented apartment by the neighbours. Some of them also refrained themselves from sending their children to tuitions. The neighbours were fearful that the healthcare workers might spread COVID-19 virus.

Table 7: Public Utility

Public Utility	Frequency	Percentage
Never	28	26.9
Seldom	68	65.4
Sometime	8	7.7
Total	104	100.0

65.4% of the respondents claimed that they seldom had faced any resistance from using public utility services. 26.9% of them said that they never faced any resistance from using public services. Only 7.7% claimed that they were sometime denied from using public utility services.

Sleeping Disorder

The healthcare workers who are directly dealing with COVID-19 patients found to be suffering from severe sleep related problems like insomnia and sleep associated symptoms consistent with nightmares, incubus attack and sleep walking. It indicates that health workers have been subjected to a great amount of stress related to large exposure to a new pandemic disease with unknown consequences, directly impacting on their sleep. A correlation was checked

between the marital status of healthcare workers and the sleeping disorder. About 18% of the single respondents always had sleeping disorder. No other group showed such results. On the contrary, 24% of married respondents never had sleeping disorder. It is also a unique feature of this group. 42.9% of divorced respondents often had sleep related problems, followed by 33.3% widowed, 22% of married and 17.1% of single respondents.

11.5% of the respondents never had sleep related problems like sleep terror, insomnia etc. On the contrary, 6.7% of the respondents always had sleep related problems. Most of the responded, i.e., 41.3% of the respondents chose ‘sometime’ as their status regarding sleep related problems.

Table 8: Sleeping Disorder

Sleeping Disorder	Frequency	Percentage
Never	12	11.5
Seldom	19	18.3
Sometime	43	41.3
Often	23	22.1
Always	7	6.7
Total	104	100.0

The finding shows that significant number of single healthcare workers always had sleeping disorder or insomnia. None of them ever faced any kind of sleeping disorder. On the contrary, there are no healthcare workers having their marital status as married, widowed or divorced always having sleeping disorders. Sleeping disorders or insomnia among single healthcare workers can be attributed to stress related to loneliness (Ta, Gesselman, Perry, Fisher, & Garcia, 2017).

Caffeine/Nicotine/Alcohol dependence

Healthcare workers were also working for long hours. They were working for extra hours. To sustain for long hours with continuous stress and without proper sleep, the healthcare workers had to depend on different substances like caffeine, nicotine, alcohol etc. With the entire traumatic situation all around, it was very difficult for them to work in a proper mental state. Healthcare workers also spoke about the trauma that they went through from watching their colleagues die.

34.6% of the respondents had always increased their caffeine/nicotine/alcohol intake than usual. 26.9% of the respondents had neither consumed nor never increased their caffeine/nicotine/alcohol intake.

Table 9: Caffeine/Nicotine/Alcohol intake

Intake	Frequency	Percentage
Never	28	26.9
Seldom	13	12.5
Sometime	5	4.8
Often	22	21.2
Always	36	34.6
Total	104	100.0

The relation between marital status and substance intake was also checked. The respondents whose marital status is single tend to consume more substance than any other group. The married respondent group were the highest in not relying on any kind of substance intake for overcoming their stressed phase.

Meeting Family

33.7% of the respondents were seldom meeting their family and friends on a regular basis. 30.8% respondents never met

their family and friends. There was no one who was meeting their family on a regular basis.

‘I left my home and family on 14th April, 2020 and since then I’ve not been back to my home. My mom and dad are above 60, so they’ll be at a high-risk. I hope that soon I’ll be able to see them.’ (Doctor-1)

The COVID-19 virus affected how healthcare workers interacted with their families. Many of them were not visiting home for long period. Some healthcare workers reported that they were pressurised by the family to discontinue work and stay at home. There have also been instances of healthcare workers leaving their jobs. They were compelled to work with less or without pay or protective gears.

‘My family, friends and my relatives they told me to leave the job of nursing...It is Covid time and it is very dangerous...Your life is more important...But still I came here to work.’ (Nurse-1)

Table 10: Meeting Family and friends

Meeting Family and friends	Frequency	Percentage
Never	32	30.8
Seldom	35	33.7
Often	22	21.2
Sometime	15	14.4
Total	104	100.0

Variation among gender and occupation

The preparedness of public healthcare facilities and the challenges faced by the healthcare workers were not same

among types of healthcare workers and gender. There were certain groups who suffered more than other groups either due to different kind of challenges or due to the already-existing system. This variation was distinctly seen among ASHAs and women healthcare workers.

Vulnerabilities of ASHA

As the questionnaires are on general basis, these variations were extracted from the Accredited Social Health Activists (ASHAs) were the most negatively affected group of frontline workers. Training and workshops were seen in the urban healthcare settings but it was absent in primary healthcare centres. It has been seen that female workers, rural female workers (ASHAs) in particular, have less access to training and resources. Similarly, there was overall shortage of PPEs, but the situation was even worse in the rural areas. The media were also covering the urban and metro hospitals but the problems and conditions of rural areas were unheard. There was no proper protection for the frontline workers like ASHAs. They were more exposed to the disease. During the door-to-door contact tracing, they were the part of government's pandemic response team but had "no proper protection". Among all the healthcare professionals, they had the least number of personal protective gears. They are the people who work on the grassroots level and meet many people daily. Most of them had to work with only surgical mask and gloves. This puts them in a great risk of contracting the virus. There is a sub-altern take to it. They are the face of public healthcare system in rural area. They assist in deliveries; run immunisation drives, sterilisation camps etc. They were doing the COVID duties in addition to their normal duties. Still, they were not being paid or provided regular wages. They are not entitled for a permanent status as a government employee and job benefits (Upreti, 2021).

Gender & Vulnerabilities

The second most important variation among the data was of female. According to the data (Chart 3) women are more in number than men. Globally also, women make 70 per cent of the total healthcare workforce (Bonio, et al., 2019). In our country, women are also known as the home-maker. It impacted women those who also have care-giving duties. It is very difficult for them to balance life between extra-shift work and domestic responsibilities. Studies shows that there is behavioural change among male and female healthcare workers while dealing with the patients. Female healthcare workers are more empathetic in dealing with their patients (Roter, Hall, & Aoki, 2002) (Jefferson, Bloor, Birks, Hewitt, & Bland, 2013).

This can lead to more burnout in women than men. Female healthcare workers need more protection beyond mask (Crimi & Carlucc, 2020). Female healthcare workers are facing mental health problems, physical exhaustion and have to think about care-giving to their families but not to expose them to risk. The protective gears are also designed from a biological male perspective. Even the smallest size of the PPE was too big for some female healthcare workers. There is no consideration for females who'll also be wearing the same protective gears during their menstrual period. It was a very difficult situation for female health workers wearing protective suit during their menstrual days. They were more prone to menstrual infections. It makes the situation worse for the health workers who are already over-burdened.

Section II

Coping Strategies adopted by Healthcare Workers

This section primarily focuses on several coping strategies were used by the healthcare workers during the COVID-19 pandemic. It will help us explore the things that helped them

to continue their service despite of such hardships. The results are fully obtained from primary data.

Service to Society

Many healthcare workers identified the COVID-19 virus as a threat to the community or society. They exhibited a sense of duty to serve the community during the crisis. They felt that they should continue to provide care to the society despite threats on their own life. Some healthcare workers spoke about the importance of family and peers in difficult times. The healthcare workers were getting encouraged by seeing their colleagues or senior's commitment towards the work. According Doctor 2- *'whenever I reach my PG after so much of work, I always check my temperature...I try to smell things around...am I positive?'* which makes us understand that every moment the doctors and the other health workers were under constant monitor with a fear but still they were ready to fight the situation. Most of the respondents, i.e., 83.7% were against the fact that they were working in sense to serve the society. 16.3% respondents often had the sense to serve the society.

'We're working for the interest of the community. The whole humankind is fighting with this virus all over the world. So, it is my responsibility to do it for the community.' (Doctor-1)

Table 11: Service to Society

Service to Society	Frequency	Percentage
Often	17	16.3
Never	87	83.7
Total	104	100.0

Family Support

14.4% of the respondents always had their family support which helped them work in such distressed conditions. 27.9% respondents often received support from their family. 38.5% of the respondents were seldom supported from their family and rest were in the middle.

Table 12: Family Support

Family Support	Frequency	Percentage
Seldom	40	38.5
Sometime	20	19.2
Often	29	27.9
Always	15	14.4
Total	104	100.0

Social Media

There were many social media pages who continuously kept on encouraging the healthcare workers during the pandemic. Amount of usage of social media for leisure time was checked across the different age groups. Half of the young population (18 to 30 years) always used social media like Facebook, Instagram and YouTube etc. during their leisure time. The social media contents helped them burst some of the stress. Many of them said that they had multiple WhatsApp groups of healthcare workers where they used to share funny posts and videos. The number of respondents who never used social media as coping strategies were nil in the age group between 18 to 30 years. But it grew gradually to about 2 per cent in age group between 31 to 45 years and about 6 per cent in the age group between 46 to 65 years.

‘We have a WhatsApp group called COVID WARRIOR. Every morning when I wake up, I see text messages and pictures all about motivation. Every morning we take a pledge of kicking COVID out of this society.’ (Doctor-2)

The less usage of social media among elderly can be attributed to insufficient knowledge of the mobile phones. Some of the respondents replied that after the working hours, they have their certain family responsibilities to look after. When they are free during the working hours, they prefer to talk to their children and family members rather than spending time on social media.

10.6% of the respondents always used social media as their coping mechanism during the distressed situation. 2.9% of the respondents never relied on social media. 47.1% of the respondents seldom used social media as their coping tools. 23.1% often used and 16.3% sometime used social media.

Table 13: Social Media

Social Media	Frequency	Percentage
Never	3	2.9
Seldom	49	47.1
Sometime	17	16.3
Often	24	23.1
Always	11	10.6
Total	104	100.0

Faith/Religion

Findings showed that religion also played a vital role in the coping mechanism. In India, the profession of doctor is always associated with God. The doctors are also seen as personification of God on earth. Many healthcare workers said that when they saw the collapse of the entire healthcare system due to the pandemic and people dying everywhere, they only had faith in God at that time.

'I have left everything to God. We are doing everything what we can do. Still, I see so many people dying every day around

me. So, I just have my faith on God and continue working.'
(Nurse 1)

There are numerous explanations attached to the theory that younger people are less affiliated to religion than the older population. It is said that as you grow older, your faith in religion becomes more. Another explanation is that the world had shifted and the young generations have much easier lives than their elders, hence less religious in nature. There were no respondents who never believed that service is core to their religion. 25% seldom believed, 26.9% sometime believed, 27.9% often believed and 20.2% always believed that service was core to their religion. This helped them to cope up and continue working despite of numerous hardships and difficulties.

Table 14: Faith/Religion

Faith/Religion	Frequency	Percentage
Seldom	26	25.0
Sometime	28	26.9
Often	29	27.9
Always	21	20.2
Total	104	100.0

Prayer

They also had group prayers in the morning before starting their work. Findings reflect that the eldest group (46 to 65 years of age) associated their service giving as core to their religion. It shows that they are much more affiliated to the religion than the younger age groups. It is because when you grow old, your responsibilities also increase. Also, it is a proven fact that association with religion has multiple psychological benefits. It brings hopeful attitude towards life, which can be predicted to bring better health. It also brings in a sense of purpose in life which contributes in strengthening

and enhancement of social relationships. Hence, it helps the healthcare workers to cope up with the distress situation (Kaplan & Berkman, 2021).

‘We lost so many brave workers during this pandemic. I lost one of my colleagues and after few days I got to know that she was positive...Then I started questioning myself...the time that I was taking care of him did I dress properly? I was over-thinking about the situation. After few days I became sick, my mind was sick.’ (Doctor-2)

7.7% of the respondents were praying more than their usual days. 33.7% opted for ‘seldom’, 23.1% opted for ‘sometime’ and 29.8% opted for ‘often’ as their response to the increase in frequency of their prayer than usual.

Table 15: Prayer

Prayer	Frequency	Percentage
Never	6	5.8
Seldom	35	33.7
Sometime	24	23.1
Often	31	29.8
Always	8	7.7
Total	104	100.0

Despite such challenges, the healthcare workers showed resilience in their character. Without proper PPEs, trainings and many incentives, they still continued to work. The healthcare workers have absorbed much of the shock themselves. The resilient nature was facilitated by social media, religion, regular praying, support from friends and family and sense of commitment towards society. It is not that there was no preparedness from the public healthcare system at all. But it’s just that it wasn’t adequate to tackle such a mass pandemic.

'Armies have always been giving up their lives on the boundary...for the country...to save the country. Now, it's our time to show some commitment towards our country.'
(Doctor-3)

Despite of such a huge impact on India's healthcare system during the first wave, the conditions have not improved much. Still, there are shortages of isolation beds and oxygen in the second wave of COVID-19 pandemic. K. Vijayraghavan, Principal Scientific Advisor to the Union government, said in an interview that after the first wave, the 'sense of urgency' to strengthen the public healthcare system declined. In West Bengal, the number of oxygen-supported beds declined to 25.75 per cent and ventilators declined to 26.37 per cent between September 22, 2020 to January 28, 2021 (India Today, 2021).

Recommendations

The major policy implication for having a resilient public healthcare system would be an approach towards achieving quality universal health coverage. SDG 3 aims for ensuring healthy lives and promote well-being for all at all ages. During COVID-19 pandemic, the government has increased their budget for health by 137 per cent. But when we looked at the breakup of funds, we noticed that most of the funds were into secondary or tertiary care through insurance. The focus and funding should be directed towards primary healthcare. It has always been proved that country with better primary healthcare system not only has better health and well-being but also equitable health and well-being. The schemes for allowances and incentives should also be general or health insurance rather than life insurance. While the later will require the healthcare worker to die to avail the benefits, the former will help the infected healthcare workers who will need financial assistance for medications and hospitalisation.

There has to be a neutral policy for all. It should not favour any gender, race, and type of occupation, urban-rural divide and many more. PPE should be designed taking into consideration the biological body type, minimum wage and salary should be there regardless of the type of occupation, training and allocation of resources should be equal whether it is a medical college in metros or sub-centre in remote areas.

In a developing country, most of the people are reliant on public healthcare system. They cannot afford the private treatment. During the study, it was found that there is no proper care for public healthcare facilities, especially in rural areas. The rural healthcare system in India is associated with poor infrastructure, lack of healthcare professionals and lack of quality treatment. There has always been a trend that always the people in periphery suffer due to the lack of accessibility to the centre. It goes the same for the public healthcare system. Public healthcare service should be seen as service for public good and not just any market commodities. There are provisions for remunerations by the government but in reality, the healthcare workers are not getting it. There are provisions and schemes provided by both the Union and State governments but the focus should be more on the implementation part. Through the study, it was found the main problems lies with the implementation. There should also be a proper complaint and grievance mechanisms in the public healthcare system for both the service-providers and service-receivers. There should also be a regular counselling session for the healthcare workers. Family, friends and psycho-social support will help them to cope up with stigmas during such pandemic situations. There are external coping mechanism factors such as social media, financial support and training and workshops. Internal coping mechanism factors include religion, commitment to serve the society, family and peer support. In an emergency situation, internal coping

factors are stronger and more effective than during stable times.

Conclusion

This study exhibits the situation of healthcare workers during the COVID-19 pandemic with moving experiences of healthcare workers as they continued and try to work and protect their nation and communities. At the same time, the study reflects the inability of the public healthcare system to tackle emergency situations. The COVID-19 pandemic exposed the loopholes in the public healthcare system in India. Primary healthcare centres are doing all the COVID related activities from testing to early detection of cases to various preventive measures. They also play a key role in the vaccination process. But still, they lack of basic supplies and infrastructure and shortage of skilled human resources, who are already burdened of long hours and meagre pay. More and more focus should be given to preventive treatment. Preventive approach will help reduce the cost of treatment for the public as well as reduce the burden on the healthcare system. Supportive policies, training programs and more tech-infrastructures should be pursued, alongside rebuilding a resilient public healthcare system. Healthcare workers are the front-line soldiers during pandemics, therefore listening to their needs will help them stay committed to their job during crisis. There should be strengthening of Research and Development in the medical field. New inventions in the country will cut the cost on huge importing capital which can be used for improving basic healthcare facilities. The challenge is building a resilient public healthcare system and building the coping mechanisms into routine and be ready for such future emergencies.

Avenues for further research

The study was carried out during pandemic. Hence, the sample size was small and scope of the study was focused only on 3 districts in West Bengal. As it is a very current issue, there were dearth of research studies. As the ASHA workers were not very fluent in English and Hindi, the researcher had to use his limited knowledge in Bengali language which restricted the flow of the conversation.

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Economic Issues of ASHA Workers in Kerala during Covid-19 Pandemic

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Abstract

The ASHAs (Accredited Social Health Activists), over one million in India, represent one of the vital components of an already weakened public health care system. Their labour as a necessary link between health care and the population has had nationwide impact in a short amount of time. This demand has been aggravated by the Covid-19 crisis, with the ASHAs acting as the direct link between the state and the population. The demand has led to increased workload for an already underpaid workforce of women.

The ASHA workers face significant financial challenges despite being employed in the public health sector and expressed deep lack of satisfaction in the treatment of ASHA workers by the state. The issues ranged from their non-inclusion as permanent employees, poor wages and incentives, lack of social security benefits and consistent wage delays. The expenses incurred by the extensive travel responsibility of ASHA workers, aggravated by Covid-19, present another major challenge to these workers. Up to 20-30% of their income is lost to work related expenses. The ASHA workers also suffer from mental and physical burnout caused by increased workload of the pandemic where they are often forced to work almost twice as much as pre pandemic times.

This study explores the economic implications of ASHA workers in Kerala and their employment on the frontline during the Covid-19 pandemic focused on issues pertaining the financial aspects of ASHA work. The study aimed to qualitatively understand the motivations of women employed as ASHAs in the Peringome-Vayakkara Gram Panchayat of Kannur district in Kerala.

Keywords: ASHA, Community Health Work, Health, Labour, Covid, Kerala

Introduction

The introduction of Accredited Social Health Activists (ASHA) under the National Rural Health Mission (NHRM) was made in 2005 as an effort to revamp the public health sector and counter the growing health crisis. The ASHA is a network of women exclusive community health workers that operate between the public health system and the population.

The ASHAs have been extensively employed on the frontline during the pandemic. But they are employed as activists or volunteers. They are poorly incentivised, overworked and lack employment security. Even though various states have taken steps to regularize their employment and provide fixed wages, the nature of their work, especially under the influence of the pandemic, has retained its exploitative character, with increasing burden of work and limited incentives.

In the state of Kerala, the government has slightly improved the incentives to ASHA workers, ensuring an income of around Rs.10000 including incentives. But their wages are not comparable to the lowest standards in the health sector. With the coming of the pandemic this exploitative nature of their job has risen without any significant benefits gained. The

overwork and pandemic related risks have taken a toll on the physical and mental health of ASHA workers.

The ASHA Workers Union has put forward various demands in the time of the pandemic. They include provision of safety gear, free testing for all ASHAs, insurance and treatment coverage for ASHAs and their family members, Rs.25000 a month incentive for ASHAs on Covid-19 duty and a payment of Rs.5 lakh for ASHAs infected by Covid-19.

This study tries to focus on the challenges faced by ASHA workers in North Kerala during the pandemic prioritising the financial challenges of community health care work, up against the economic, social and moral burdens of an ongoing pandemic.

Objectives of the study

- To understand the motivating factors behind taking up ASHA work, focusing on the financial aspects
- To examine possible irregularities/delay in receiving wages among ASHA workers
- To study the impact of COVID-19 on work hours of ASHA workers, their personal health and whether the wage incentives match the increase in work hours during the pandemic

Methodology

Based on the nature and objectives of the study, the researcher utilized a qualitative approach. Research utilizing semi structured interview schedules was chosen as an effective method for the specific study. The interview included collecting basic details and a questionnaire that focused on various aspects of the study.

ASHA workers employed as frontline workers during the Covid-19 pandemic in Kerala was the target population for the pilot study. Two of the selected ASHAs have been employed since 2008 while the other has been since 2013. All three workers were in the 40-50 age group, and were deployed on the Covid frontline since March 2020, and have been involved in implementing ground level protocols and programs.

Samples were selected from Peringome-Vayakkara Gram Panchayat of Kannur district. The study was limited due to restrictions imposed by the lockdown, and the researcher had to settle for 3 samples that were accessible. For determining samples, the only norm maintained was that the respondents must be ASHA workers who were employed as frontline workers during the pandemic. The researcher used purposive sampling method for determining the samples.

The data was collected using self-administrated interview schedules. Semi structured interviews were used to collect personal information and address the objectives. The responses were collected directly. Voice recording was used for backup. The interviews were conducted in Malayalam.

Challenges faced by Community Health Workers in India

The lack of proper recruitment of ASHA workers were visible in some areas. This meant the ASHA workers would be responsible for populations between 2000-3000. This also affects proper delivery of services and causes burnout. A large number of ASHAs don't receive payments in time. This dissatisfaction was observed more among ASHAs working in the tribal areas in Wayanad because of high expenses for travel and other needs. They also demand monthly payments towards telephone expenses. Proper transportation facilities for expectant mothers are often not available or costs much.

Often these ASHA workers have to bear higher expenses than the sum provided under Janani Suraksha Yojana (JSY). (Joseph, 2015)

Earlier, each ASHA worker was responsible for monitoring 1000 individuals in rural areas and 1000-2500 in urban areas. During the pandemic this number has risen as ASHAs were also made to work in neighbouring areas. ASHA workers are required to reach up to 30-50 households per day. Some workers report working for more than 12 hours a day visiting not just households but also the quarantine centres to check on individuals. During these long hours of work, they have limited time to eat, rest or use restrooms. The lack of knowledge about Covid-19 also often burdened the ASHA workers with the task of acquiring information through personal efforts via internet, television etc. (Das & Das, 2021)

The work hours of ASHAs are reported to have increased by 2-3 hours per day. The new tasks for containing Covid-19 spread included surveying 30-50 households per day to track travel history, visitors' history and health profiles of individuals, providing quarantine instructions and monitoring them, preparing reports to the PHC medical officer, administering medicines for diabetic patients etc. Due to the lockdown, commute time and expense for ASHAs also increased in absence of public transport. The study also found that ASHAs have not been adequately compensated for the loss of usual incentives and for additional Covid-19 related tasks. Earlier the incentives amounted to around Rs.3500 on average. But the Covid-19 incentive of Rs.1000 is much less than the regular incentives lost due to burden of additional work. The ASHAs also reported unsafe working conditions because of inadequate protective gear and lack of proper training. The pandemic has also hindered ASHA workers from participating in additional income generating activities. (Singaraju & Mandela, 2020)

Analysis

The three ASHA workers interviewed are represented here as S1, S2 and S3. All three are in the 40-50 age group

Motivating factors

- The workers recalled they were not initially aware of financial incentives at the time of joining as ASHA workers
- The idea of having a source of income, were mentioned as initial motivating factors by all three although the numbers were quite low. The incentives then were too low to have any significant impact (Rs.500+ incentives for S1 who joined in 2013 and Rs.300+ incentives for S2 and S3 who joined in 2008)
- S1 said she has grown to enjoy her work even more than in the early years.
'ASHA work has given me the opportunity to learn more through training camps that are very enjoyable, and it also excites me that I can be involved with health officials and further understand how things work.'
- S1 mentions there is significant work pressure on ASHA workers during certain periods of the year. The delay in providing services and health equipment, on the side of the health system is cited as a challenge by all three.
- Large amount of travel (often by walking either because the areas are remote or since a rickshaw is not financially feasible) affected their work and could possibly have much adverse impact on their health. They raised concerns regarding the absence of regular health check-ups for health care workers.

- The absence of an office space is a significant challenge. The large number of records and files have become a burden at home. There is no access to computers or training for the same.

Wages

- The current wages for ASHA workers included Rs.6000 as honorarium (increased by Rs.1000 in the past year), Rs.2000 as a fixed incentive and further incentives based on pregnancies, immunization programs etc. that could be anywhere between Rs.1500-2500. The honorarium although performance based, is received in full.
- All three respondents stated objectively that the wages were not satisfactory for the amount of work they do. Various tasks such as immunization are poorly incentivized.

“Sometimes incentives for immunization programs for children are as low as Rs.20. We often end up paying more than that amount for travelling to visit the child for follow ups”- S2

- Various activities including immunization drives involved large amounts of work in creating awareness and convincing people to attend programs, and were not at all incentivized.
- When questioned whether the salaries were enough to run a household, all three answered negatively. They were dependent on other sources of income (other family members/part time jobs) for expenses. Their income only counted as an additional source.
- Wages are regularly delayed. They have almost never had a period where wages were received on time.

Wages for 2-3 months arrive as a single transfer. S1 recalled situations where she ran out of money and could not cover work-related expenses.

- The Covid incentive of Rs.1000 was deemed unsatisfactory by all three. Work has doubled, and work-related expenses are larger than incentives.
- Although time constraints affected the ASHAs ability to complete incentivized tasks, the government policy so far has been to provide such incentives in full. S2 cited this as an important and helpful step.
- S2 is self-employed in tailoring. She says business has suffered due to Covid but involvement as an ASHA worker has not influenced her tailoring work.

Work hours and Pandemic impact

- Before the pandemic S1 mentioned working up to 7 hours per day. S2 and S3 mentioned they would return home by afternoon, working for around 5 hours. They had 5-day work weeks despite that not being mandated by the government. The work increased further if there were incidents of any communicable diseases in the area.
- All workers have been working 7 days per week since the pandemic began. The work hours have increased, with each respondent working up to 10-12 hours every day. This amounts to an increase of around 5-6 hours of work, i.e., twice as much as pre pandemic times. It included maintaining protocols, assisting patients, tracing infections, testing duty, vaccination campaigns and providing feedback to officials. The work also followed them home, and they have to continuously answer queries through phone calls from patients and people in quarantine. This has taken a toll

on their mental health, since they are unable to pay attention to personal and family needs.

- S1 and S2 cited cases where they had to provide emotional support to Covid patients over the phone during late hours.

Work related expenses

- Work related expenses present a significant burden. Travel expenses were high and averaged between Rs.1000-1500 per month during pre-pandemic times. Since Covid, this has gone up and all three provide a rough figure in the Rs.2000-2500 range. They have had to travel extensively without public transport. Long travel is necessary for other responsibilities such as OP duty in hospitals, Covid test duty, submission of reports etc. When bus transport was not available, travel expenses rose up to Rs.150 a day.
- Sometime ASHA workers had to travel intermittently to buy and deliver medicines for Covid patients. This increased travel related expenses.
- S1 narrated an incident where she had to accompany a pregnant mother to the hospital for delivery, and ended up covering her travel and accommodation expenses by herself. “Sometime the recognition and applause are not enough” she says.
- Phone expenses eat up a significant amount from the wages. Each person mentioned expenses of up to Rs.500. Phone calls rose in numbers during the pandemic.
- Despite a Covid incentive of Rs.1000, the total savings did not increase. This was down to increased expenditures during the pandemic which amounted higher than the incentive.

Covid and safety of ASHA workers

- While the other two expressed satisfaction in the supply of protective equipment during Covid, S1 pointed out that gloves, masks, sanitizers etc. were provided only after workers raised complaints. The supply was also not regular and the ASHAs had to spend money for N95 masks and sanitizers.
- During monthly OP duty, ASHA workers were in regular contact with potential Covid patients, and were not provided with PPE kits. Face shields, masks and gloves were supplied nonetheless.
- No official training sessions were provided to ASHA workers. They were briefed regarding procedures and protocols mostly over the phone.

“We had much fear and anxiety interacting with people during the initial days of the pandemic. It would have been better if had some kind of formal training and counselling to allay our fears”- S1

- During Covid there were no mandatory Covid tests for ASHAs, but they had access to free tests.

Findings and Conclusion

The study conducted on three ASHA workers gave a brief insight into various aspects of their work- what inspires and challenges them, wage related issues and impact of Covid-19.

The initial motivations for taking up ASHA work revolved around participation in other community building programs and being able to interact with more people in the area. There was much less interest in detailing the benefits of financial incentives, as they were significantly lower during the time (2008-2013). The workers sought motivation in the idea of

employment rather than the money involved. But over the years the wages have increased significantly and the workers express deep satisfaction in this fact. While all remain in acceptance of the underpaid nature of ASHA work, this satisfaction in the rise (i.e., from Rs.300-500 + incentives a decade ago to Rs.6000-8000 + incentives in 2021) could be a factor that morally hinders some ASHA workers from raising complaints. The wages amounting to around Rs.10000 by October 2021 has become a significant component of their household income. It covers a fair share of their personal and household expenses and grants much freedom and financial independence who often remain unemployed and inactive otherwise.

In a way the finances itself raise major challenges too. ASHA workers have to travel extensively for their field work, and without travel allowances, it becomes expensive for them to use transport. This is a serious issue in areas where bus services are limited or non-existent. It means that ASHA workers have to cover significant distances by foot every day. It not only acts as a demotivating factor but also causes burnout, and raises various health concerns. The increased responsibility and pressure of being employed full time raises various mental and physical challenges. ASHA workers are also not provided any kind of amenities such as an office room. For the amount of work they do and its low paying nature, ASHAs should be going through regular health check-ups which should be provided by the public health system.

There is deep dissatisfaction regarding wages and other job security measures among ASHA workers as can be observed from the protests organized by the workers union. They are still treated as activists and hence excluded from most of the benefits that should be received by a public health worker. Their average wage in Kerala (Rs.10000) is extremely low compared to the wages of government employees in the health

sector. Their current income is comparable to the minimum wage standards in Kerala (Rs.600 per day) or perhaps even worse. Women in the same panchayat as the surveyed ASHAs are able to earn Rs.600 or more in daily wage employment. One of the ASHA workers surveyed pointed out that for the number of days she spends working on average, she would get more income if she was paid on the basis of daily wage standards. The incentives are also extremely low for immunization programs and the ASHA workers don't stand to earn much after their expenses are covered. Only pregnancy related incentives make a significant contribution to the income. There are various other programs such as awareness campaigns that require significant amount of effort and add to the regular workload, and yet these programs are not at all incentivised.

Wage delays seem to be something extremely common that the ASHA workers surveyed refused to mention it as a challenge unless questioned. The pay has almost always been done every 2 or 3 months and the ASHA workers have gotten used to this. This is a grave injustice committed on ASHAs on top of the existing challenges faced by them.

Work related expenses pose a huge barrier to having a decent income for ASHA workers. This includes travel expenses to remote areas, phone charges as well as other minor expenses. The surveyed ASHA workers provided a mentally calculated average of Rs.1500-2000 during pre-pandemic times and in the range of Rs.2500-3000 since Covid-19 began (travel expenses+ phone charges). Especially during the pandemic, other expenses also rose, such as purchasing N95 masks and other equipment. The workers are never reimbursed for their long travels, even to the sub centre, for Covid testing duty, or for the monthly OP duty. The Covid incentive of Rs.1000 has not really contributed to a rise in income, for these very reasons. The work-related expenses raised by Covid is likely

to be higher than the incentive itself for most ASHAs. In rare cases, the ASHA workers also have had to accompany pregnant mothers to the hospital, incurring various expenses. Hence these expenses pose a major challenge to having decent earnings and should be treated with seriousness. Losing 20-30% of the income to work expenses in an already underpaid job, would never be tolerated in another profession in the public sector.

The pandemic has brought in various concerns on the work and life of public health workers. ASHAs in Kerala have been spearheading the resistance against Covid by implementing policies at ground level. This work has become extremely consuming for ASHA workers, sometimes even doubling their total work hours. Mental and physical burnout become a possibility. Sometimes they are engaged in work late as midnight attending calls and offering emotional support to Covid patients. Work hours normally depend on the ASHA worker. They are engaged in field work 5-7 hours a day, 5 days per week. Although this is not mandated by the government, it becomes a necessity in order to complete their tasks on time. The flexibility of work hours also allows ASHA workers an opportunity to seek other sources of income as well. One of the ASHA workers interviewed was self-employed as a tailor and benefitted from this flexibility. But since the beginning of the pandemic, ASHA workers have been extensively employed on the field, and were given new tasks on top of the existing one. The work hours have increased to up to 10-12 hours for ASHAs, especially during the peak Covid times or when they have testing/vaccination duty. This represents a rise that is almost double the earlier working time, for a meagre incentive of Rs.1000. ASHA workers have remained committed due to their awareness of the serious nature of the pandemic, but have not been appropriately incentivised. Even under proper incentives, the

mentioned working time of 10-12 hours should not be normalised.

Covid-19 also presented various other challenges such as the safety and health of ASHA workers. When there was an abrupt rise in Covid cases, ASHAs were employed on the frontline without proper training or counselling. This induced much fear in their minds. Most times they had to contact officials repeatedly for advice and instructions regarding protocols, quarantine measures etc. The supply of safety equipment to workers was also not regular, and ASHAs had to spend money from their income for N95 masks and other necessary materials. Going through the various challenges faced by ASHA workers during the pandemic, it gives a feeling that the needs and requirements of ground level workers, who were extensively used in a high-risk job, were not given the right priority in policy design.

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The Shadow Pandemic: Violence Against Women during Covid-19

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Abstract

Domestic violence is one of the most pernicious gendered ailments of human society. Researchers have confirmed the inevitable consequences of domestic violence (physical, sexual, and emotional) in increased vulnerability to psychopathologies in addition to physical morbidity. Domestic violence cases are vast in India, and the numbers are further aggravated at an alarming rate during the COVID-19 pandemic. Using scientific and news report, during COVID-19, this article speculates efforts to contain the virus are vital to protect global health; these same efforts are exposing women and adolescents to an increased risk of family violence. The impact of the COVID-19 pandemic on women was unprecedented and worse than before. Home containment as a measure to protect the health and well-being of the general public has resulted in increased sufferings for women in terms of both sufferings from diseases and increased domestic violence.

Keywords: COVID-19, domestic violence, gender, pandemic

Introduction

The COVID-19 pandemic has led to a dramatic loss of human life worldwide and presents an unprecedented challenge to

public health, food systems and the world of work. The economic and social disruption caused by the pandemic is devastating: tens of millions of people are at risk of falling into extreme poverty. In general, the restrictive measures imposed in many countries have not been accompanied by an analysis of the access to the resources needed to reduce this risk. It is necessary to take urgent measures to intervene in these high-risk contexts so that women and adolescents can develop and prosper in a society which is likely to undergo profound changes, but in which the defence of their rights and protection must remain a major priority. COVID-19's response plan limited the spread of the virus, however, it weakened women's ability to respond to their violent perpetrators.

As Covid-19 cases surged in the India in March 2020, stay-at-home orders were put in place. Schools closed, and many workers were furloughed, laid off, or told to work from home. With personal movement limited and people confined to their homes, advocates expressed concern about a potential increase in intimate partner violence. Stay-at-home orders, intended to protect the public and prevent widespread infection, left many Intimate partner violence victims trapped with their abusers. Domestic-violence hotlines prepared for an increase in demand for services as states enforced these mandates, but many organizations experienced the opposite. In some regions, the number of calls dropped by more than 50%. Experts in the field knew that rates of intimate partner violence had not decreased, but rather that victims were unable to safely connect with services. Though restrictions on movement have been lifted in most regions, the pandemic and its effects rage on and there is widespread agreement that areas that have seen a drop in caseloads are likely to experience a second surge. This pandemic has reinforced important truths: inequities related to social determinants of

health are magnified during a crisis, and sheltering in place does not inflict equivalent hardship on all people. The current paper reviews the literature on the rise of gender-based violence in the times of current and past pandemics. The paper also reviews the published reports in scientific as well as mass media literatures focusing on the rise of gender-based violence during the imposed lockdown, its consequences, and the measures taken by the governments to tackle the issue.

Review

On March 11, 2020 the World Health Organization (WHO) General Director announced the corona virus COVID-19 infection to be a pandemic. With no available definitive treatment yet, preventive methods are being implemented worldwide to control the quick spread. These include proper hand hygiene, use of face masks, social distancing, and home lockdown. Lockdown is implemented for the greater good of the public; however, the strict order in place gravely impacts certain groups. Whereas some people have reported positive developments such as increased family bonding time and contributions to household chores as a result of lockdown measures (Peshave and Peshave, 2020), news outlets have indicated more domestic abuse and intimate partner violence (Godin, 2020; Jeltsen, 2020; Wanqing, 2020).

In China, according to a founder of an anti-domestic violence organization, domestic abuse reports tripled in February 2020 in one of the cities in Hubei province—the province where the pandemic began (Wanqing, 2020). Other places witnessed an increase in domestic violence reports on a country-wide scale: 40–50% in Brazil, 20% in Spain, and 30% in Cyprus (Graham-Harrison, 2020). Arab countries have also been witnessing an increase in domestic abuse. In Egypt, females reported a 19% increase in violence among family members

with 11% having been exposed to violence by their husband and verbal abuse being the most form of violence encountered, at 83.4% (UN Women, 2020b). In Palestine, service providers to female violence victims noted a 50% increase in call for help (UN Women Palestine, 2020).

In India, according to the nongovernmental organization (NGO) Kafa, (2020b) that deals with eliminating gender-based violence, the numbers of calls to their help hotline have doubled within a month since the lockdown started, and six cases of mortality of abused female victims were recorded. However, these numbers underestimate the full extent of domestic violence and intimate partner violence as women are afraid to report due to social censure, inability to report without their abuser knowing, and having nowhere to go during the lockdown.

During previous outbreaks and public health emergencies, violence against women increased as observed during the Ebola virus epidemic in West Africa in 2014–2016 and Zika virus epidemic in Central and South America in 2015–2016 (Oxfam International, 2017). That was attributed to extended quarantine measures as well as economic stressors (Rigoli, 2017; Wanqing 2020). The lesser availability of quality and access to women's sexual and reproductive health services resulting from the strain on the health care systems could have exacerbated the violence women experienced (Evans,2020 ; UN Women 2020 a).

One in 4 women and one in 10 men experience of intimate partner violence, and violence can take various forms: it can be physical, emotional, sexual, or psychological. People of all races, cultures, genders, sexual orientations, socioeconomic classes, and religions experience of intimate partner violence. However, such violence has a disproportionate effect on

communities of color and other marginalized groups. Economic instability, unsafe housing, neighborhood violence, and lack of safe and stable child care and social support can worsen already tenuous situations. Intimate partner violence cannot be addressed without also addressing social factors, especially in the context of a pandemic that is causing substantial isolation.

Therefore, the main objective of this narrative review is to describe the risk factors for violence against women that the situational context derived from COVID-19 may have generated in families around the world, and to assess them from a criminological perspective and also try to explain the more than likely high risk of child abuse during the COVID-19 crisis in the light of criminological, psychological and sociological theories.

As the COVID19 crisis continues, societies all over the world are trying to mitigate its effects in both the short and the long term. Besides looking at the risks and consequences for the mental health of children and adolescents arising from the pandemic and the measures imposed to control it, a criminological approach, in which the restrictive emergency measures adopted to slow the spread of the virus take into account the risk of family violence, is also essential. Social distancing, school and business closures, lockdown measures, and travel restrictions may reduce the transmission of the infectious disease, but they may also increase the risk of violence against children and youth around the world.

The second wave of COVID-19 in India brought unprecedented losses. The poorest and the most marginalized, including women and girls, face more risks without the means to absorb the economic shocks and mitigate the health crisis. They are caring for their families, sustaining livelihoods and

leading efforts to fight the pandemic, amidst the threat of a third wave. UN Women and health sector experts answer some frequently asked questions about COVID-19 and how it impacts women and girls in India.

For violence researchers, the measures taken in response to COVID-19 present an extraordinary opportunity to advance our understanding of the social, psychological, economic and situational mechanisms that influence rates of violence. In fact, contexts associated with pandemics create an environment in which children's socio-ecological systems are disrupted and, as a result, the incidence of child maltreatment is likely to increase. However, many child welfare organizations around the world are noting a significant drop in reports of child abuse or neglect. We know little about the amount of violence that children and adolescents have faced in their homes since the beginning of the pandemic, and institutions like UNICEF have discouraged the performance of epidemiological studies in children unless their protection can be guaranteed. Thus, it is necessary to intervene indirectly by detecting contexts of risk and by exploring the factors that may increase violence against children and youth so as to be able to take successful action.

Are women and girls at more risk of contracting COVID-19 than men?

Over 30 million people have been infected by the corona virus in India. COVID-19 can infect people of all gender and ages. However, some women and girls may be at higher risk because they are poorer and lack information and resources, or because they are at the front line as caregivers and workers in the health and service sect of nurses and midwives. Yet, when it comes to decision-making roles in the health sector, they are largely absent, and they get paid much less than their

male counterparts. Only 13 per cent of the members of the national COVID-19 task force are women.

Since women in India spend more hours caring for children, the elderly and sick family members, and masks and other personal protective equipment are often designed and sized for men, women may be at risk of more exposure to the virus. Right now, there is also a concern that less women are getting vaccinated than men in India

17 per cent more men than women have been partially or fully vaccinated, and according to national data, there are only two states where more women are taking the vaccine. Because of the fact that women have less access to internet or smart phones, they may not be able to register for vaccination. Due to the prevailing patriarchal norms, women may find it difficult to go to the vaccination centres alone, and there may be preference for male family members to get vaccinated first. There are also myths that vaccines compromise women's fertility. Unvaccinated women are at a high risk of contracting the disease, especially in the wake of the new variants.

How has COVID-19 impacted women's employment in India?

Wage inequality and the burden of unpaid care have pushed more women out of employment and into poverty. Women's earned income in India was just one-fifth that of men's even before the pandemic. Globally, and in India, more women have lost jobs during COVID-19. A recent report by the Centre for Sustainable Employment at Azim Premji University in India shows that during the first lockdown in 2020, only 7 per cent of men lost their jobs, compared to 47 per cent of women who lost their jobs and did not return to work by the end of the year. In the informal sector, women

fares even worse. This year, between March and April 2021, rural Indian women in informal jobs accounted for 80 per cent of job losses.

Indian women also spend more time doing unpaid care work at home than men. On an average, they spend 9.8 times more time than men on unpaid domestic chores and 4.5 hours a day caring for children, elders and the sick. During the pandemic, their share of unpaid care work grew by nearly 30 per cent.

The socio-economic tolls on women and girls have long-term consequences, unless policies and actions deliberately target and invest in women. There is a risk that the exodus of women from the workforce could become permanent, reversing not only gender equality gains, but GDP gains. UN Women data also shows that more girls than boys were left out of school during the pandemic and 65 per cent of parents surveyed were reluctant to continue the education of girls and resorting to child marriages to save costs. This can create an entire generation of young women without education and employment opportunities.

Economic independence is a critical factor in violence prevention. For many people who experience intimate partner violence, the financial entanglement with an abusive partner is too convoluted to sever without an alternative source of economic support. The pandemic has exacerbated financial entanglement by causing increased job loss and unemployment, particularly among women of colour, immigrants, and workers without a college education. The public health restrictions put in place to combat the spread of the virus have also reduced access to alternative sources of housing: shelters and hotels have reduced their capacity or shut down, and travel restrictions have limited people's access to safe havens. Shelters have made valiant efforts to ease

crowding and to help residents move into hotels, extended-stay apartments, or the homes of family members and friends. Though some restrictions have been lifted, many shelters remain closed or are operating at reduced capacity, which creates challenges for people who need alternative housing arrangements.

Closures of schools and child care facilities have added to the stress at home. Virtual learning often requires the involvement and supervision of parents and guardians. Some families don't have access to a reliable Internet connection, and child care obligations may fall to friends, neighbours, or family members while parents work or attempt to find work. Some parents are considered essential workers and cannot work from home, and others are required to work virtually. The added stress of balancing work, child care, and children's education has led to a rise in child abuse. Mandated reporters, such as teachers, child care providers, and clinicians, also have fewer interactions with children and families and fewer opportunities to assess, recognize, and report signs of abuse than they did before the pandemic.

Most people who experience intimate partner violence don't seek help. Medical professionals have an opportunity to identify these patients in health care settings and to provide counselling and connect people with social services. Medical offices can be safe places for patients to disclose abuse. Physical examination findings; a patient's behaviour during or while discussing physically intimate components of a breast, pelvic, or rectal examination; or an aggressive partner can be warnings signs of possible intimate partner violence. In settings such as emergency departments and labour and delivery suites, policies mandate screening for intimate partner violence when patients are alone. Evaluation in a clinic or hospital setting permits immediate intervention,

including involvement of social workers, safety planning, and a review of services available to victims and their dependents. Even this opportunity has often been absent in the Covid-19 era. As offices cancelled and rescheduled non urgent clinic visits and moved to telemedicine platforms, safely screening patients for intimate partner violence became more difficult. Not only might patients live in areas with unreliable Internet or cellular service, but abusers might be listening in on conversations, leaving patients unable to disclose escalating abuse at home.

Certain steps could promote more equitable access to services as a second wave of Covid-19 infections looms. First, communities could ensure equal access to broadband Internet service in people's homes. Access could be expanded by means of a subsidy program mirroring the Federal Communications Commission Lifeline program or the installation of wireless access points in public spaces. Such approaches would not only enable wider access to tele-health, but would also permit people who have experienced intimate partner violence to search for resources and maintain their critical social connections.

Providers can continue to screen for intimate partner violence and discuss safety planning with their patients during telemedicine appointments. Clinicians can normalize screening using standardized questions and can offer information to all patients, regardless of whether they disclose intimate partner violence. Available resources are shown in the box. Clinicians can also educate themselves about available community resources. If abuse is disclosed, the clinician and patient can establish signals to identify the presence of an abusive partner during telemedicine appointments. Such signals could include a raised fist on a video call or set phrases during an audio call. When it is safe to have a discussion about intimate partner violence,

clinicians can review safety practices, such as deleting Internet browsing history or text messages; saving hotline information under other listings, such as a grocery store or pharmacy listing; and creating a new, confidential email account for receiving information about resources or communicating with clinicians.

Results

The present review reveals that similar to the previous pandemics and epidemics, there has been an alarming rise in the incidents of gender-based violence during the COVID-19 pandemic. The present review further reveals various other risk factors that have been found attributive to the surge of gender-based violence such as economic insecurity and alcohol consumption. The results of the review indicate that despite its global prevalence, gender-based violence has been one of the most neglected outcomes of pandemics. Moreover, the legislatures and services available for such victims are often inadequate and, thus, worsening their situation.

Conclusion

Pandemic situations have been found to be associated with advancements in the medical field. However, a part and parcel of this situation is the age-old practice of quarantine that has several negative outcomes. This also includes a surge in gender-based violence that raises serious concerns about the safety of women. As the legislatures provided and measures taken by the governments are falling short in dealing with the issue, a number of non-government organizations are stepping up to provide necessary services to these victims.

The spread of the novel Corona virus has created a myriad of problems for the people to grapple with. In the absence of a vaccine and effective treatment for this virus, the governments are forced to impose quarantines to reduce the spread of the

disease. However, this has resulted in a paradox of social distancing, which includes issues such as economic instability, mental health problems, and isolation. Although there have been researches exploring the impact of COVID-19, there is a lack of rigorous literature highlighting these issues from the perspective of gender. This also involves the issue of rising gender violence during the pandemic. COVID-19 has not only led to an increase in the cases of gender-based violence but has disconnected them from their support networks. To reduce the prevalence of the issue, it is crucial to acknowledge the extent of gender-based violence, re-imagine government policies, and support networks to make it easier for the victims to access them and, lastly, create awareness about the issue as well as the resources available to tackle it. We should take the necessary measures to enable women and adolescents to develop and prosper in a society which is likely to be very different, but in which the defence of their rights and well-being must continue to be a priority.

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Impact of COVID-19 Pandemic on Mental Health of Muslim Women: A Review

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Abstract

The aim of this review was to analyse the impact of COVID-19 on mental health of women in the COVID outbreak. The COVID-19 pandemic has a significant impact on public mental health. Therefore, monitoring and oversight of the population mental health during crises such as a pandemic is an immediate priority. The aim of this study is to analyse the existing research works and findings in relation to the prevalence of stress, anxiety and depression in the general population during the COVID-19 pandemic.

COVID-19 not only causes physical health concerns but also results in a number of psychological disorders. The spread of the new corona virus can impact the mental health of people in different communities. Thus, it is essential to preserve the

mental health of individuals and to develop psychological interventions that can improve the mental health of vulnerable groups during the COVID-19 pandemic.

During the COVID-19 pandemic, people with higher levels of education had greater levels of anxiety, depression, and stress. According to recent studies, during the COVID-19 pandemic, there is an association between education levels, and anxiety and depression levels. According to a study which was conducted in China, the higher prevalence of mental symptoms among people with higher levels of education is probably due to this group's high self-awareness in relation to their own health. In addition, anxiety levels are significantly higher in people with at least one family member, relative, or a friend with the COVID-19 disease.

Keywords: COVID-19, Mental Health, Muslim, Women

Introduction

The pandemic caused significant changes and consequences in all areas of daily life. The impact of the virus COVID-19 completely changed the way of living and working, and consequently new working conditions were imposed on it. The daily exposure to the new conditions causes certain stressful situations for all and it has aggregated mental health suffering throughout the entire world. Indeed, the actual outbreak is leading to psychological distress and increased mental health problems, such as stress, anxiety, depressive symptoms, insomnia, denial, anger and fear (Torales, Higgins, Castaldelli-Maia, & Ventriglio, 2020). Psychological distress and mood disorders seem most likely in more vulnerable populations (Lopez-Morales, Del Valle, Canet-Juric, Andres, Galli, Poo, & Urquijo, 2020; Kajdy, Feduniw, Ajdacka,

Modzelewski, Baranowska, Sys, Pokropek, Pawlicka, Kazmierczak, Rabijewski, 2020) such as women. In the beginning of the pandemic, it was expected that men would be affected more owing to their gender role of venturing out of home to earn for their families. However, as the pandemic worsened with ensuing lockdowns, the situation reversed. A growing body of research has also evidenced a more negative mental health impact of the COVID-19 pandemic within specific, vulnerable groups such as women, the young, people with lower educational levels, lower-income, or pre-existing mental health conditions (Ausin, Gonzalez-Sanguino, Castellanos, Munoz, 2021; Kwong, Pearson, Adams, Northstone, Tilling, Smith, Fawns-Ritchie, Bould, Warne, Zammit, (2021). Previous studies on predictors of mental health during COVID-19 evidenced that women had the highest prevalence of mental health problems during the first period of the pandemic (Pierce, Hope, Ford, Hatch, Hotopf, John, Kontopantelis, Webb, Wessely, & McManus, 2020; Wong, Alias, Md Fuzi, Omar, Mohamad Nor, Tan, Baranovich, Saari, Hamzah, & Cheong, 2021).

Despite lockdown, women still had to step out of the house for groceries and other household errands. Women are tasked with collecting drinking water from crowded community water pumps in certain states where onsite drinking water is not available. There are additional pandemic specific factors such as juggling household and work from home duties. With the closure of schools and day-cares, women are taking care of children for the entire day, their online teaching, looking after the elderly with more number of family members inside the house, making the routine household and care giving

burden an endless work. This is a gender specific unpaid job with no economic security and in pandemic times like these, can jeopardize a women's source of livelihood. An Indian study by (Ravindran & Shah, 2020), revealed a higher incidence of domestic and cybercrime (abuse and bullying) complaints, although the complaints for rape and sexual assault were less. The pandemic is also expected to differentially worsen the already existing gender disparities in the medical and psychological conditions in women (Connor, Madhavan, Mokashi, Amanuel, Johnson, & Pace, 2020; Meyer, Yoon, & Kaufmann, 2013). The impact on mental health during the COVID-19 pandemic has been ubiquitous across race, religion and countries; however, it again impacted women more than men because of the differential perceived burden borne by women (Grover, Vaishnav, Tripathi, Rao, Avasthi, & Dalal, 2021). Moreover, patients with existing psychiatric conditions deteriorated further due to stress, disruption in OPD consultations/medicine supplies and diversion of already limited mental health resources in India to pandemic relief measures.

In Islam, a woman enjoys absolute equality with regard to civil and criminal laws. A woman's life, honour, and property are as sacred and sacrosanct as that of a man. If a woman is wronged, she receives the same compensation as that of a man (Haque & Kamil, 2012). There are many women's issues that affect Muslim women today. Women deal with not just the everyday stressors of life but also the responsibility of defending basic religious rights and values as normal and acceptable. The various conceptualizations as to the causes of mental illness in the Islamic framework include biological,

psychological, environmental, spiritual, or supernatural (Utz, 2012).

In a qualitative study of 14 Muslims with equal numbers of men and women, in Britain, (Weatherhead & Daiches, 2010) reported that the majority of participants attributed mental illness to life events (e.g., stress). Religious causes, such as punishment from Allah or supernatural influences (witchcraft or jinn) were also mentioned, but were less prominent. A lack of adequate domestic and emotional support can have consequences on women's mental health. The risk of anxiety, depression and post-traumatic stress disorder (PTSD) is also much higher in women (Yu, 2018; Jalnapurkar, Allen, & Pigott, 2018).

Guo, Q., Zheng, Y., Shi, J., Wang, J., Li, G., & Li, C. 2020 reported that, COVID-19 positive patients had higher levels of depression, anxiety, and post-traumatic stress symptoms as compared with normal controls. Women reported significantly more "Perceived Helplessness" as compared to men and controls. The high levels of anxiety symptoms, depression symptoms, and traumatic stress symptoms identified in this population of women are consistent with other studies of COVID-19 and during the SARS epidemic (Li, & Zhu, 2020 ; Hawryluck, Gold, Robinson, Pogorski, Galea, & Styra, 2004; Ko, Yen, Yen, & Yang, 2006 ; Kumar, Lee, Pinkerton, Wroblewski, Lengyel, & Tobin, 2021). Women may be especially vulnerable to pandemic-related psychopathology because of their higher baseline anxiety and depression (Hasin, Sarvet, Meyers, Saha, Ruan, Stohl, & Grant, 2018 ; Kessler, Chiu, Demler, & Walters, 2005).

Asim, Ghani, Ahmed, Asim, & Qureshi, 2021). The study acknowledges COVID related increase in depression and anxiety levels among adult women living in the cosmopolitan city, Karachi. It has been evidenced through research that women are prone to developing mental health problems. (Wang, Pan, Wan, Tan, Xu, 2020; Shevlin, McBride, Murphy, Miller, Hartman, Levita, 2020). According to the research conducted in China, the incidence of depression during pregnancy has increased during this period. Regarding to the concern related to vertical transfer from mother to fetus, pregnant women might delay prenatal care; so psychological issues will not be identified in the early stages of the disease. Meanwhile, many women wanted to have a caesarean section due to excessive anxiety and concern. Mothers' concerns about postpartum care, including vaccinations and screening at birth, will continue (Shahyad, Mohammadi, 2020). In contrast, a study conducted on 116 Chinese pregnant women reported that no increased risk of spontaneous abortion and preterm birth was observed. Most of these studies were case reports or observational studies which may have contributed to these discrepancies. All these uncertainties are likely to increase the level of psychological stress and may contribute to an increased risk of pregnancy terminations. (Yan, Guo, Fan, Juan, Yu, & Li, 2020).

A past study shows that, Loneliness increased during the pandemic in older women and was associated with higher stress, depressive and anxiety symptoms. Furthermore, recent study demonstrated that reappraisal interventions could help to increase psychological resilience and alleviate adverse impacts on women, caused by lockdown and self-isolation

(Wang, Goldenberg, Dorison, Miller, Uusberg, Lerner, Isager, 2021). Factors that predispose women to increased stress during COVID-19 include an increase in child care burdens brought about by school closures and subsequent virtual schooling (Kuehn BM, 2020). In order to investigate the prevalence of psychiatric disorders during the COVID-19 pandemic peak, several large surveys were conducted online in the general population. (Liu, N., Zhang, Wei, Jia, Shang, & Sunm, 2020) found a prevalence of post-traumatic stress symptoms of 7% in Wuhan (China) 1month after the COVID-19 outbreak (in 285 residents). In sub-symptom analysis of PCL-5 (PTSD Checklist for DSM- 5), women suffer more re-experiencing, negative alterations in cognition or mood and hyper-arousal as compared to men. Covid-19 pandemic has affected women much more profoundly than men, both as frontline workers and at home. Financial crisis is gradually developing and as consequence mental health issues are likely to grow exponentially. (Thibaut, & Wijngaarden-Cremers, 2020). At the organizational level, lack of training, poor infection control guidelines, work conditions that include changing policies, higher workload, and inadequate access to personal protective equipment are contributing to occupational stress, burnout, and depression in women during COVID-19 (Sriharan, Ratnapalan, Tricco, Lupea, Ayala, Pang, & Le, 2020). lack of support and recognition by their peers, supervisors, and hospital leadership (Cai, Tu, Ma, Chen, Fu, & Jiang, 2020; Elbay, Kurtulmu, Arpacioğlu, & Karadere, 2020) and work location (Xiao, Zhua, Fua, Hub, Lia, & Xiaoa, 2020; Zhang, Wang, Yin, Zhao, Xue, & Peng, 2020) are reported as common triggers of mental health issues related to the work environment. (Rahman, Hasnain, & Islam,

2021) The results indicate a higher stress level, a potential contributor to poor mental health, as food insecurity deteriorated. Policy initiatives in ameliorating immediate food insecurity during crises, improving long-term wellbeing, and expanding the reach of mental health support are warranted.

Conclusion

The present rapid review was aimed at describing the current scientific evidence on the psychological impact of the COVID-19 outbreak on women's mental health. COVID-19 epidemic and home quarantine have had different effects on the psychological and social aspects of society. Many people are at risk during this period due to insufficient financial, medical and support resources. During the pandemic women has faced various problems including physical and psychological problem. Physical problems viz, sexual abuse, domestic violence, pregnancy problem, and reproductive health problems. And the psychological problems viz, stress, anxiety, depression, and frustration. On the basis of past reviews, the researcher has found that, compare to males' women were faced more psychological problems during the pandemic. India is a multicultural country and Indian women is closer with their family they believe that family is their whole world in each and every movement they give more important to religious practices, customs, and relations. thus, during pandemic not only uneducated women but also, educated and working women faced similar mental health problems. And the evidence shows that, domestic violence increased. On the bases of this results researcher has assumed these all factors influenced on women mental health. Further

suggested that, to ensure, maintain and promote women's mental health, it is recommended to identify and treat talented people through online programs and video conference (Kuehn BM, 2020).

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Being Transgender: Living with Incongruence

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Abstract

In social life there are different discriminations embodied by people. They even don't know that they are some or other way practicing and silently advocating it. People who are living with incongruence have altogether different scenarios of life. This article is based on personal interviews with six transgenders about their life in general and life in lockdowns in particular. Present paper tries to explore the life of transgender people, issues of their concern, exclusions faced, their frame of reference etc. especially in the context of Covid-19 pandemic as qualitative inquiry. Article intends to document the lived experience of transgender community in general and living with incongruences and stressed on the policy issues.

Key words: Transgender, discrimination, incongruence, life of LGBTQ+

Introduction

After the eruption of the Covid-19 pandemic, soon after when WHO declared this is a public health emergency of international concern in January and in March 2020 it had been declared as pandemic (Cucinotta & Vanelli, 2020). Every country small or large had taken necessary steps to

prevent their populations from corona virus. It is estimated that in India, due to Covid-19 pandemic around 76.7% of the total deaths have occurred in the people of 50 and above age group. It can be understood that people have affected from all sections of society but elderly population has suffered a lot because of other complications or comorbidities after getting the disease (Willianson *et al.*, 2020; Sharma, 2020).

It is serious that lots of people have lost their lives and their loved ones. But the question of how much LGBTQ+ people have lost their lives, livelihoods, loved ones and what they are doing remains in the dark. This population has witnessed a historical neglect from many avenues like better health care facilities, better share in overall research data, fair share in public policies and programmes etc. It is too evident and largely researched that this LGBTQ+ population has vast mental health issues and great lacuna's in catering their health, occupation and mental health needs (Salerno *et al.*, 2020; Sachdeva *et al.*, 2021).

How this Covid-19 situation affected these population? Can we draw some fine lines for them? Can we reach some of them for dialogue and discussion was the initial thought when one program is organized for transgender population in Solapur city openly for their official registration drive. When this program is over the plan was executed to have individual dialogues with transgenders.

Materials and Methods

For present article, the six transgenders who have given voluntary consent for dialogue and discussion were involved. After a government sponsored program was conducted in our institute by social empowerment and justice departments' office. These six transgenders were identified with the help of local NGO representatives, coordinators and program officers.

Since, the number of transgenders in Solapur city is not known exactly; it was decided to go with local channel of working with these population. With the help of above people, six transgenders could open up and given their oral consent to have word with author. All interviews are conducted in the months of November 2021 with due convenience of participants.

Author explained everything about the article and information needed, secrecy of their identity, and using code name in the article to present vignette/ thoughts. Since, the objectives were descriptive in nature and clear for the study, there was no questionnaire used as such, instead common points were used to facilitate the interviews. Author did not document anything in front of them, rather after each interview he made his notes about what happened in each interview, based on which the author tried to build his paper. Since, the study population is hidden, non-accessible; sample size relatively low but qualitative inquiry don't intend to generalization of any kind rather its core objective is to observe and describe the things, phenomenon as seen or explained (Butina, 2015).

Narrative inquiry is one form of qualitative research in which the stories themselves become the data for research (Bleakley, 2005). This approach has been used in multi-disciplinary nature to learn and reflect more about individual's culture, his identity, lived experiences, opted lifestyles and oral histories etc (Lieblich et.al., 1998; Hoshmand, 2005). This article tries to describe the lived experiences and expressions of transgender population. The language used for conducting interview was Marathi.

Results and discussion

The analysis is solely based on the discussions, sharing's from the six transgenders from Solapur city and facilitated by the

local NGO representatives who are working closely with them. Some of the indicative excerpts from interviews are presented below;

About demographic information, all six transgenders are living in Solapur but originally from different places. Two of them are young below 30 years, three are middle aged and one is above 50 years of age. All are not having formal education (UNESCO, 2018), occupation, single. Two of them don't have residential proof and bank accounts. All of them live in an underdeveloped and semi-developed area of city.

About earnings

Responding to a question about their earnings. R1 said that *“earning as such is not at all a problem for me, people give me money even before I ask. But the problem is how they give it. Some give their money quick and some don't give at all. Some want me to give them favour. I am not a prostitute; I do this because I have to do this”*.

R6 said that *“see, I have a network, some power, people work with me and share their earnings. I don't have children to feed, spend money for them or husband nothing. I am happy with whatever I get. Now I am little old and respectable in our community. I just have work like conflict resolution, guiding new members about their safety and handling psychological issues”*.

Places where they ask money from people. Responding to this R3 said *“we have places for our Mangati (begging), we don't do it every day. Usually, every Friday or specific occasions like Marriage, Mundan, new birth of child etc are our days of earnings”*.

R4 said *“we do it at religious places like Devimandir, Railway station or Bus stand or Bazar places. Religious places are little favourite for us because there people don't hate us, we feel secure and little bit respected”*.

R5 said *“some of us are very good in their approach, work. They are good at language, performance, arts but our society is not accepting their talent. They are severely underutilized because of their sexual orientation. In-fact they don't have problem with their gender, they are clear but society is in ambiguous state, people want everything to be fixed. They will never know the beauty of nature”*.

It is established fact that cultural societies like ours has exclusionary boundaries for people who have bit congruences in accepting their sexual orientation or who are uncomfortable with the gender they assigned by their society. The financial exclusion is the base for all kind of trinities they face. But while asking about earning of them, they accepted that people give them money willingly or with some intent but they receive it. They are even feeling contented about what they are getting, begging by transgenders is accepted in our culture. People do not know how to handle, how to work with such population. Ramesh, Rashmi and Sabharwal (2018) explored that how these people face systematic exclusion from education to occupation. Badgett (2014) revealed in a survey of nearly eighteen largest states of India, more than two-fifth respondents responded negatively that they don't what their neighbour with homosexual orientation. This shows the unpreparedness at societal level to understand the basic human needs of these communities.

It is discovered that though it is understood that they have to be in grey area it is better for them to not reveal their identity to the world and practice what they desire. Culture of 'in dark everything can be ok' force them silent about their identities

(Mimiaga et.al, 2014). But some of them are too radical while expressing their views and opinions about their status and demanding society to change, because they cannot change, they have understood themselves as part of nature. They expect society has to be more accommodative, acceptable, respectable for everyone as they are. It's quite necessary to re-look the notions attached to these communicates.

Substance use and sex

It is observed that many of the respondents have some or other kind of habit from using tobacco, alcohol, pan-masala and different perfumes/ *itra*. Asking about them reveals this;

R6 reveals that *“ha ha... it is quiet usual behaviour found in our community that they have some or other kind of habits. It is largely because of the we don't have attachments; relational world and we are performing risky something life-threatening behaviours along with Mangati. Our people are left with very limited options, sex work is one. People don't know the art of sex they only rush. Fulfilling their sexual demands may put us in life-risk. That is why I am more talking about it”*.

R2 said that *“yes, some of us are engaged in sex work, and now a day's its risky. Although, the local NGO representative are quiet keen in this area, they are also working hard for our communities but this unhygienic work made us use some or other kind of substance”*.

R3 said that *“it's kind of relaxation, thinking about why, how, when, how much, up to when like series of questions trouble our people throughout their lives. This may be the reasons for what our people indulge in”*.

Though these interview excerpts are indicative but still reflect the human rights violations, right to life issue, discriminations, right to health etc. Tobacco, use of alcohol, Pan-masala, is common among them. It is observed that they too encountered with 'life questions' of what, how, when this is happened and when it will be end. When answers are not found, addictions emerge. Recent discourses are also indicating that how mental health issues of these communities are neglected and need better policy implications (Wainberg et.al, 2017; Ormiston and Williams, 2021).

Sexual behaviour, sexual preferences, sexual activities and sexual risks are areas of great concern as per as these communities because of vast neglect of their choices, health safety measures and discriminatory thinking about them. HIV-AIDS, Sexual dysfunctions, STIs are real issues of them which need dire attention from general public and policy makers in particular. Sexual services they provide are not recognized and monetized properly therefore they have issues with their sexual life.

Lack of loved ones, family relations, social positions, and the notion that no one is really close to us force them to use substances as expressed by them. But it is found that these communities have their own networks and they really take care of their people. They feel connected to their communities. However, some of them

Becoming transgender- a journey

Though people have different sexual preferences they do prefer their own gender and perform their roles accordingly. This study effort made author to understand that they do have a process to become a transgender.

Responding to this process R5 revealed that *“when we born, we did not know that what exactly we are? Its culture, surroundings define who and what we are. As a male child we are being raised, directed, instructed but slowly and steadily the heart starts telling us that there is major congruence happening with us. I am male for others but for me I am always female. It was difficult to be with given identity/ gender to us because we are not asked for what we want, it is just given and the thing is we cannot change it. People can adopt new name, parents, house, language, nation possibly everything they want but we are not given that freedom. Off course, people say today’s laws are liberal but what should be liberal in real sense it minds of people.*

I was male, but had a feeling that I am confined with wrong gender and I wanted to be free. I just wanted to take a free breath (emphases added). I just wanted to be what I am really. When I left my village as men, I come across people who have same congruence like me but more motivated, organized. They received me with grace, become my friends. Later on, after years of living as daytime male and evening time-night time female, I decided to live as female full time, every time. I undergone an operation and become full female. I am happy that I met with my soul, I achieved a peace and now I don’t care about what people think about me. I am what I am”.

This narrative revealed a journey that transgender people undergo to reach their destiny. It’s really hard to see the living with such traumatic congruence.

Expectations in Covid-19 context

While asked about what they expect from society. R3 said that *“ha... ha... really, you don’t have anything to offer us except identity. Give us identity, rest we will manage”.*

R1 revealed that *“see, identity is only one issue. First you have to accept us as we are, what we are. People have to accept that you are not alone on this planet, there are people who wanted to be associated with this world”*.

R6 revealed that *“government has everything for everyone. Only for those whom they can measure (emphasis added). They don’t know our real population they don’t want to study about us. Have you heard about any government commission for us? No. We don’t have Adhaar cards, bank accounts, we don’t have election ids, we don’t have formal education, formal occupations, caste certificates, even medical certificates what you can do?”*

R5 emotionally said that *“people accept their God’s with our traits, but they have problem with us. We are also created by them. Then we must be acceptable, lovable. don’t you think we deserve this at least”?*

R4 said that *“in lockdowns, we suffered like anything because we cannot go out for Mangati. We were not able to do sex work, we did not have savings. Past one year was worse for us as transgender. Government made some provisions for farmers, laborers, artists; NGOs also taken up relief activities for general population, special needs of people admitted in quarantine centres, transit-facilities, arranged food packages etc. but nobody thought about us. I had to ring an NGO representative for food. Then they arranged it”*.

R1 said that *“when government decides to give welfare programs and facilities to vulnerable sections of society, they must include us. There should be regular research (emphasis added) effort by authorities about our people. Do you know in Covid-19 situation how many transgenders have died?”*

While dealing with such provocative sentences, it is experienced that this section of society really needs recognition, resources and respect for their existence. The government has taken right step to registered them to provide necessary support. Now, they have to come out of their cocoons and assert their existence loudly.

Conclusion

It is fact that Covid-19 pandemic has increased the vulnerabilities more than before for different sections of society especially LGBTQ+ communities (Salerno et.al., 2020). Transgender population has had worst experiences in lockdown period. Government and civil society organization have worked for general public, Covid positive patients and their families through various initiatives but transgender missed this opportunity. It is realized that working with or for LGBTQ+ communities have intersections of structural, socio-psychological, cultural, policy and individual level challenges therefore cannot be studied alone, we have to take interdisciplinary approach while thinking or designing policy programmes. And, this can be initiated through decriminalizing sexualities, accepting Equality Bill, 2021 and regular consultations with LGBTQ+ communities.

Limitations

- Only six transgenders have interviewed for this article this may under-represent the total population.
- Individual experiences are too subjective therefore may not be able to build a concrete conclusion/thought/theory.
- Sample is from only one category among LGBTQ+ population, therefore may suffer from reflective subjectivism.

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Conflict of Interest

None

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Vulnerabilities and Challenges Faced by Service Providers in Maharashtra during Covid-19 Pandemic

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Abstract

Epidemics are known to increase or produce new stressors like anxiety and self-worry or worrying for loved ones, limitations on physical movements and social activities due to confinement and lifestyle changes that are abrupt and extreme by nature. Elderly people who have medical issues such as Cancer or Cardiovascular illness, Diabetes, Chronic Respiratory disease are more likely to become ill. Regardless of their age, any person may become seriously ill or even face death due to COVID-19. There were two broad groups found during pandemic one was people who were taken treatment or services due to infection and had perception related to it however there were frontline workers who contributed a lot in for safety of people. present paper comprehends on concerns of service provider.

Objective: *To explore the vulnerability and challenges faced by the service provider its effect on their health.*

Methodology: *The exploratory research design was used for this study. Maharashtra State was the universe of the study.*

Regions of Maharashtra were divided into five parts: Kokan, Madhya Maharashtra, North Maharashtra, Marathawada, Vidarbha. These regions were the sampling frame of the study. Five cities viz., Nagpur, Aurangabad, Pune, Mumbai and Nasik were selected for this representation. Total sample was 210 service providers using probability sampling method through stratified random sampling.

Conclusion: *Among all service providers police were more vulnerable followed by nurses and doctors. District wise differences were found in vulnerability on the basis of population and availability of resources. During this pandemic period, they were confronted lot of challenges considering the severity and its effect on physical and mental health. They kept themselves away from their family to reduce spread. It was kind of battle for them.*

Key words: Challenges, Corona, Health, Service Providers, Vulnerability

Introduction:

The current pandemic of Covid-19 is not only the health problem faced by people worldwide but also the world's largest humanitarian issue since World War – II. It is an infectious disorder caused by Corona virus which was found very newly. Nobody had ever heard of this new virus or even about the illness caused by it prior to December 2019, when this disease out broke in Wuhan, China. However, it is affecting all the nations worldwide (WHO, 2020).

Epidemics are known to increase or produce new stressors like anxiety and self-worry or worrying for loved ones, limitations on physical movements and social activities due to confinement and lifestyle changes that are abrupt and extreme by nature. Fear of getting infected, bitterness, apathy, scanty resources, sparse information, monetary loss and shame were

all identified as various form of stress in a recent study of virus flare-up and widespread (Brooks, 2020). Lockdown and isolation have been identified as significant approaches for preventing the transmission of the disease. A tree-based model is examined, in which some persons are quarantined and a few are left unreported (hidden nodes) for different reasons such as not displaying symptoms, concealing travel history, and so on, and these hidden nodes propagate the disease across the community (Arti, 2020).

During the Covid-19 pandemic, burnout is a major professional problem for healthcare providers. The forefront people is under a lot of pressure and is dealing with a lot of mental and public stresses, which can damage their rational and expressive health and contribute to burnout symptoms (Sultana et.al., 2020). As the efforts for creating pharmacological therapies for Covid-19 are in progress, social and behavioural sciences are able to important understanding on ways to manage the pandemic and its repercussions. Warnings, sentiments, insight of risks, prejudice and discrimination, tragedy, and panic all have a role in decreasing virus transmission during pandemics. The extent and pace of behaviour change is influenced by a variety of social and cultural factors. People are influenced by norms, although their impressions are frequently incorrect. People, for example, may undervalue health-promoting behaviours (such as hand washing) while exaggerating unhealthy behaviours.

Present research paper highlighted on contribution of service provider in pandemic and how they were vulnerable found in Maharashtra.

Review:

Rezaul and Manna (2021) reviewed and assess the changing pattern of social relationships among the people of India and Bangladesh due to Covid-19. Study highlighted how pandemic resulted in various social dimensions or aspects like social interactions, loss of humanity, joblessness, alienation and rise of individualism, increase in mental stress, distortion of family relationship, rise of social stigma.

Adelina Comas-Herrera (2020) investigates the Covid-19 dilemma for social care services in England and discusses possible solutions. Covid-19 increases the risk of death and deterioration of physical and mental health in people who require social care. There was need to contribute and support to frontier to battle with pandemic as volunteer because shortage of manpower. The epidemic poses enormous dispute that will require well-coordinated responses from the federal, state, and local government, as well as the health-care and NGO's.

Grover (2020) a web-based cross-sectional survey, 623 police personnel were evaluated on Patient Health Questionnaire-4 (PHQ-4) and Perceived stress scale (PSS), and a self-designed questionnaire. suggests that a substantial proportion of the police personnel on Covid-19 duty during the lockdown period have significant anxiety, depressive symptoms, and perceive significant stress. There is an urgent need to evaluate the mental health issues and provide psychological support to the police personnel who are considered as faceless warriors of the Covid-19.

Gupta (2020) conducted an online cross-sectional survey. All type of Health Care Workers and ambulance drivers were respondents. The study enlisted participation of 150 healthcare staff from four institutions. The study found that health-care workers who are vital to the pandemic's combat are suffering from psychiatric illness. To control the impact of

the pandemic on HCWs, the Nepalese government should take proactive measures to care for their psychological well-being. These could be in the form of psychological assistance.

Bauza (2021) described level of awareness, perspectives and precautionary measures taken by rural Odisha residents and representative of Zilla Parishad too. According to research, the pandemic and subsequent lockdowns resulted in a slew of obstacles and hardships in daily living, particularly in the areas of job loss. The findings highlight the pandemic's vulnerability to marginalized communities and change in strategies to set their lives of vulnerable.

Dhavale et.al. (2020) conducted an exploratory study using a qualitative approach to examine patients', caregivers', and staff's perspectives of care. A total of nine families were chosen from among the 30 patients who received care during the lockdown period. Professional Social Worker provided support their patients to ventilate and express their feelings. Palliative care is critical, especially in disaster-related situations, when any sick individual and caretakers are at their most vulnerable. However, finding ways to provide direct home-based assistance to vulnerable person in family at this time is critical in order for them to feel happy and satisfied, positive hope, and gain actual support in order to have new way normal.

Meher et.al. (2020) investigated the influence of Covid-19 and lockdown on street vendors' livelihoods. Telephonic in-depth interviews with hawker who sell fresh products for a living were conducted: Pandemic had a comprehensive impact on street merchants, they were forcefully stop working and switch to selling daily goods within a specific point in time, which resulted in economic consequence. Some participants have spoken about how the government has aided them in the form of free rations. In addition to losing money, street sellers

had to deal with mental stress as a result of the limits imposed by the authorities. Participants mentioned their desire for direct financial assistance as well as protective equipment to practice their safety.

Research Methodology:

Objectives:

1. To study the relationship between the occupation and its effect on health of service provider and their family members.
2. To know the perception of service provider about the social factors responsible for spread and transmission of Corona Virus Disease (COVID-19).
3. To explore and compare the district wise vulnerability and challenges faced by the service providers in controlling the disease directly or indirectly.

The exploratory research design was used for this study. Through exploratory research design the researcher would like to find the needs of service providers. Maharashtra State was the universe of the study. Sampling frame was the regions of Maharashtra, divided into five parts: Kokan, *Madhya* Maharashtra, North Maharashtra, *Marathawada*, *Vidarbha*. Five cities were selected for this representation viz., *Vidarbha* - Nagpur, *Marathwada*: Aurangabad, *Madhya* Maharashtra - Pune, *Kokan* : Mumbai, *Uttar* Maharashtra: Nasik

Sample selected by using probability sampling method. In probability sampling stratified random sampling was used. Thus, lists of service providers are collected from Municipal Corporation, Police Commissioner Office, and District Hospitals.

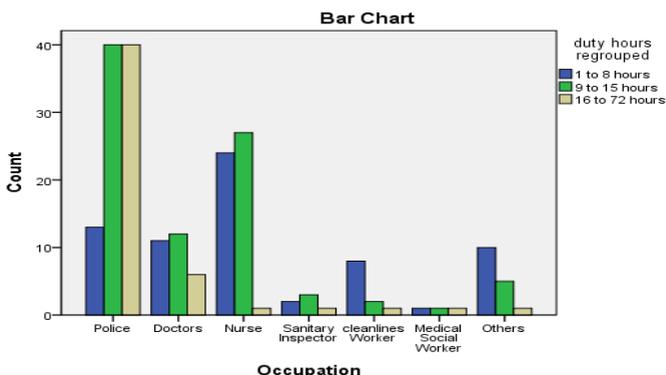
Sample in nutshell-

Service providers	A'bad	Mum	Nag	Nasik	Pune	Total
Police	12	30	16	15	20	93
Doctor	3	8	5	2	11	29
Nurse	2	15	10	5	20	52
Sanitary Inspector	1	1	2	1	1	6
Cleanliness workers	2	2	2	2	3	11
Medical Social Worker	0	0	1	1	1	3
Other	2	5	1	2	6	16
Total	22	61	37	28	62	210

Data was collected through self-structured interview schedule and analysed in SPSS by using cross tables, graphs, MANOVA, correlation factors etc.

Data Analysis:

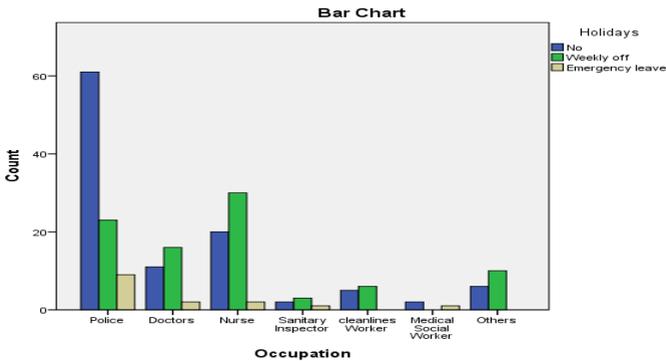
Occupation Wise Distribution of Respondents According to Their Nature of Job



$$\chi^2 = 50.35, df=30, p=0.001$$

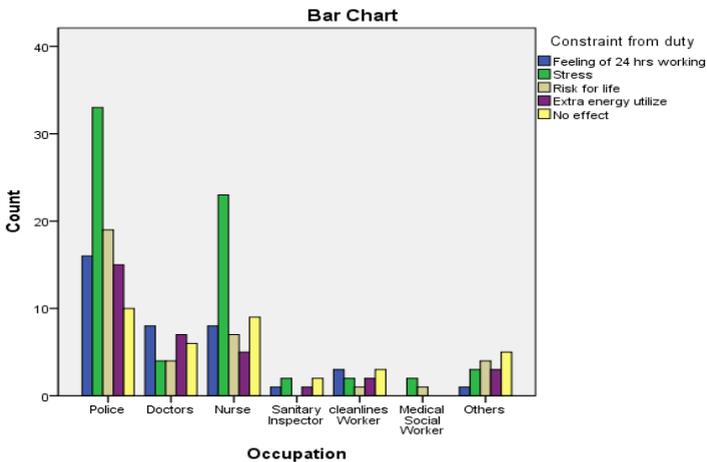
This graph highlighted duty hours with the occupation of service providers. Police personnel had longer duty hours compare to other service providers such as doctors and nurses

and it shows significant difference ($p=0.001$) in duty hours and occupation.



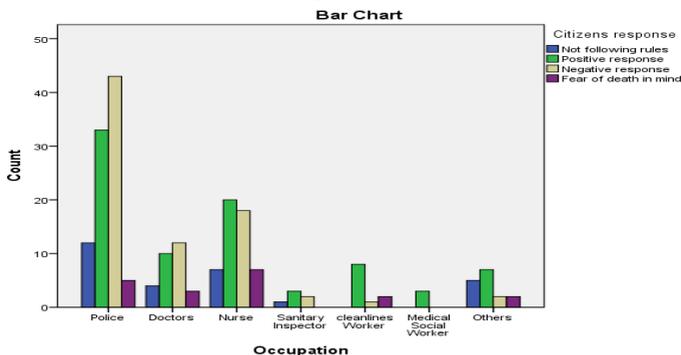
$$\chi^2=29.06, df=12, p= 0.04$$

This graph reveals holidays taken by the service providers during pandemic or lockdown period and it shows significant difference ($p= 0.004$). All service provider did not taken holidays during lockdown period however it was found maximum police personnel not taken leave as compared to other service provider.



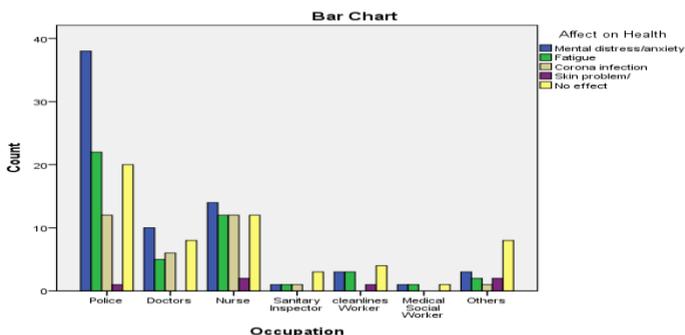
$$\chi^2=25.62, df=24, p= 0.373$$

This graph presents constraints faced by service providers. Similarity was found in constraints majority of them had stress during lockdown period, feeling of 24 hrs working, also had feeling of risk for life, some of them also reported no constraints from all service provider.



$$\chi^2=25.113, df=18, p= 0.122$$

Present graph highlighted citizens response in lockdown period. Negative response from citizen reported more by police and doctors. Nurses state that citizens were not following rules. Positive response of citizen also emphasized by cleanliness workers, medical social worker, sanitary inspector. Police doctors and nurses also identified fear of death in mind of citizens.



$$\chi^2=26.75, df=24, p= 0.330$$

Due to constantly working in lockdown period it effects on health of service providers. Lot of mental distress and fatigue was faced by police, doctors and nurses. They were also had corona infection. Some of them state that no effect on health and very few reported skin problems.

Table 1

Cross Tabulation of Opinion About Facilities They Received When Working in Frontline with Categories

Facilities received	Frequency	P	D	N	SI	CW	MSW	O	P value
Availability of Tools	More than enough	50	25	45	5	11	2	5	0.000
	Enough	11	1	7	0	0	1	5	
	Less	32	3	0	1	0	0	6	
Personal Security	Yes	70	25	51	6	11	3	13	0.007
	No	23	4	1	0	0	0	3	
Appreciation	Yes	80	24	40	4	10	2	11	0.46
	No	13	5	12	2	1	1	5	
Manpower	Less (1-5)	63	19	34	4	9	1	4	0.014
	Enough (6-10)	21	9	15	0	2	1	7	
	More than enough	9	1	3	2	0	1	5	
Training	Yes	54	25	43	5	10	3	4	0.000
	No	39	4	9	1	1	0	12	

Above table presents opinion of respondents about the facilities they received when they were serving in Covid-19 pandemic. Considering the availability of tools, majority (68.09 percent) of the respondents had opinion that tools were more than enough; however other service providers were highlighted on tools were less available thus shows significant difference ($p=0.000$). More number of respondents (85.23 percent) were reported that they received personal security however (24.73 percent) police respondents had opinion that they did not receive proper safety measures, it shows significant difference ($p=0.46$). Maximum respondents (81.42

percent) were emphasized that they received appreciation in the form of certificate as a 'COVID Yoddha', however (18.57 percent) were reported that they did not received appreciation, no significant difference found ($p=0.46$). Majority respondents (63.80 percent) were described that they worked in less manpower, (26.19 percent) were state that they had enough manpower and (10 percent) respondents were shared that they had more than enough manpower, there was significant association ($p=0.014$). More number of respondents (68.57percent) were reported that they received training either offline or through phone calls, however (31.42 percent) state that they did not receive any training to work in Covid-19. Significant association shows ($p=0.000$).

It concludes that during lockdown period all service providers reported that they there were more than enough availability of tools, safety tools or had proper personal security, received appreciation as 'COVID Yodha', received training as well however manpower was very less. No economic benefit received.

Table 2
Distribution of District Wise Respondents Cross Tabulated
with Their Feeling of Ignored

Occupation	Feeling ignored as a service provider				Total
	Always	Sometime	Rarely	Never	
Police	42	24	14	13	93
Doctor	2	14	3	10	29
Nurse	3	26	7	16	52
Sanitary Inspector	0	2	1	3	6
Cleanlinessworkers	2	2	2	5	11
MedicalSocialWorker	1	1	0	1	3
Other	1	7	1	7	16
Total	51	76	28	55	210

P=0.000

The above table highlight's opinion of all service providers about their feeling of ignorance. More number (45.16 percent) of police always had feeling of ignorance as service provider. More number of nurses and doctors (49.38 percent) were sometimes felt ignored. Sanitary inspector, cleanliness worker and others (45.45 percent) reported that they never feel ignored as service provider. There was profession wise significant difference in the opinion ($p=0.000$).

Overall service providers sometimes had feeling of ignored as service provider among them a greater number of police (45.16 percent) personnel always feels ignored.

Table 3
Distribution of District Wise Respondents Cross Tabulated
with Their Feeling of Insecurity

Feeling of Insecure	District					Total
	Mum	Pune	Nasik	A'bad	Nag	
Always	32	9	3	4	3	51
Sometime	10	23	9	10	24	76
Rarely	5	7	4	6	6	28
Never	14	23	12	2	4	55
Total	61	62	28	22	37	210

$P=0.000$

The above table explained district wise opinion of respondents about their feeling of ignorance. More number (36.19 percent) of service providers feels that sometimes they were ignored, especially respondents from Pune and Nagpur. Never feeling of ignorance reported by (26.19 percent) respondents especially from Pune and Nasik. Feeling of always ignored was reported by (24.28 percent) service providers specifically from Mumbai. Very few (13.33 percent) respondents from all

districts reported that they were rarely feel ignored as service provider. It shows significant difference ($p=0.000$).

It concludes that respondents from Mumbai felt insecure always due to highest population and issues related to metropolis and respondents from Pune, Nagpur and Aurangabad feels insecure sometimes comparatively less issues.

Table 4
Distribution of District Wise Respondents Cross tabulated with Challenges Faced by Service Providers

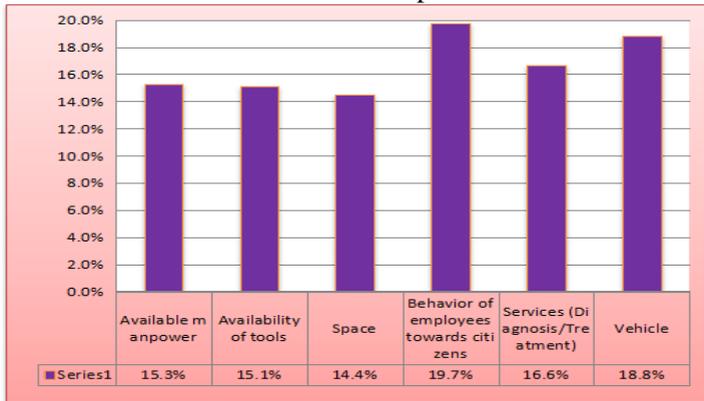
Challenges faced		District					Total	P-value
		Mum	Pune	Nasik	A'bad	Nag		
Obeying orders	Yes	54	53	25	20	37	189	0.223
	No	7	9	3	2	0	21	
Convincing/ disciplining people.	Yes	56	55	27	22	37	197	0.115
	No	5	7	1	0	0	13	
collaborate with other service providers.	Yes	10	39	21	22	37	129	0.000
	No	51	23	7	0	0	81	
Providing security / treatment to senior/ distinguished persons in the society.	Yes	36	35	22	21	37	151	0.000
	No	25	27	6	1	0	59	
Reducing the fear among people.	Yes	55	53	25	22	37	192	0.071
	No	6	9	3	0	0	18	
Take care of your own health.	Yes	54	44	26	22	37	183	0.000
	No	7	18	2	0	0	27	
Calls from other people	Yes	46	33	10	9	34	132	0.000
	No	15	29	18	13	3	78	

Table presents challenges faced by service provider in respective districts. It was challenging for all respondents from all districts to obey orders given by their respective

authority (90 percent, $p=0.233$), Maximum respondents from all districts (93.80 percent, $p=0.115$) highlighted that it was challenging to convince them about precautions need to take to disciplining people. To collaborate with other service provider was not so much challenging for respondents from Mumbai, Pune and Nasik (38.57 percent) however it was challenging for respondents from Nagpur and Aurangabad (61.42percent) significant difference found in challenges ($p=0.000$). Respondents reported that providing security or treatment to senior or distinguished persons in the society was not highly challenging in Mumbai and Pune (28.09 percent) however challenging in Nasik, Aurangabad and Nagpur (71.90 percent), the difference is highly significant ($p=0.000$). Maximum respondents from all districts reported that (91.42 percent) it was highly challenging to reduce fear among the people and difference was not significant. Majority service provider (87.14 percent) from all districts reported that it was challenging for them to take care of their own health and for few from Mumbai, Pune and Nasik did not face any challenge which is significantly ($p=0.000$) associated. Service providers from all districts (62.85 percent) were reported that relatives and other people were calling them to get information and situation in respective area, it was challenging for them to answer it however respondents from Pune, Mumbai, Nasik and few from Aurangbad and Nagpur (37.14 percent) reported that they did not receive any such phone calls which is significantly associated.

It concludes that number of challenges faced by the service providers such as obeying order given by authority, convincing or disciplining people to follow the rules, collaborate with other service providers, providing security / treatment to senior/ distinguished persons in the society, reducing the fear among people, taking care of own health and answering the calls received from other people.

Opinion of Service Providers About Facilities Provided by the Public Health Department



Multiple Choice Answers

The above graph presents opinion of respondents about the facilities provided by the public health department and it shows that higher rate (19.7percent) was given to proper behaviour of health workers towards citizens and very low rate (14.4 percent) for available space. Respondents were also highlighted less manpower and lacking in availability of tools. In public health system behaviour of staff was proper with citizen, services related to diagnosis and treatment was good, vehicle facility was also available only it was lacking in availability of manpower, tools and space.

Table 6
Multivariate Analysis of Variance of Duty hours and Years of Experience Effects on Health of Service Provider

Box's Test of Equality of Covariance Matrices ^a	
Box's M	195.009
F	3.146
df1	54
df2	5790.580

Sig.	.000
Tests the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups.	
a. Design: Intercept + VAR00014 + VAR00043 + VAR00014 * VAR00043	

Levene's Test of Equality of Error Variances ^a				
	F	df1	df2	Sig.
Experience	2.137	21	188	.004
Duty hours	8.677	21	188	.000
Tests the null hypothesis that the error variance of the dependent variable is equal across groups.				
a. Design: Intercept + VAR00014 + VAR00043 + VAR00014 * VAR00043				

Multivariate Tests						
	Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Pillai's trace	.018	.419	8.000	376.000	.910	.009
Wilks' lambda	.982	.418a	8.000	374.000	.910	.009
Hotelling's trace	.018	.417	8.000	372.000	.910	.009
Roy's largest root	.017	.796b	4.000	188.000	.529	.017
Each F tests the multivariate effect of Affect on Health. These tests are based on the linearly independent pair wise comparisons among the estimated marginal means.						
a. Exact statistic						
b. The statistic is an upper bound on F that yields a lower bound on the significance level.						

There is significant difference found Box's Test of Equality of Covariance Matrices and Levene's Test of Equality of Error Variances calculated individually. Multivariate tests show Pillai's trace and Wilks' lambda test no significant difference >0.05. Graphical presentation also shows highest duty hours and experience. Highest health issues only skin problem is not depended on duty hours

Table 7
Distribution of District Wise Respondents Cross Tabulated with Their Opinion About Causes of Epidemic Re-emerge

Cause the epidemic to re-emerge	District					Total
	Mum	Pune	Nasik	A'bad	Nag	
Negligence	20	22	5	21	21	89
Reopened lockdown	3	13	7	0	1	24
Don't know	0	5	0	1	0	6
Lack of awareness	0	6	0	0	3	9
Not following social distance	10	6	11	0	3	30
Not following rules and regulations	28	10	5	0	9	52
Total	61	62	28	22	37	210

$$\chi^2 = 95.396, \quad df=20 \quad p=0.000$$

Above table highlights district wise opinion of respondents about the factors responsible in re-emerging spread of Covid-19. District wise significant difference was found in opinion ($p=0.00$). Respondents were highlighted five factors. Negligence is major cause reported by (42.38 percent) respondents especially from Pune, Aurangabad and Nagpur. (24.76 percent) respondents reported that people were not following the rules specifically from Mumbai. (14.28 percent) respondents focused on people were not following social distancing majority from Nasik. (11.42 percent) respondents had opinion that it was re-emerged because lockdown was reopened specifically from Pune. Very few respondents had

opinion that it was re-emerged because lack of awareness among people and few of them don't know the reason.

Negligence was reason reported for epidemic re-emerge specifically from Pune, Aurangabad and Nasik. Further people were not following the rules highlighted by majority service provider from Mumbai. Lack of awareness, reopening of lockdown were some reasons in spreading Novel Corona Virus.

Table 8
Distribution of Service Providers Cross Tabulated with Their
Opinion About Services Rendered by the Municipal
Corporation

Functioning of Municipal Corporation	Responses		Percent of Cases
	N	Percent	
Rules and instructions (citizens and staff)	196	21.0%	95.1%
Control and co-operation of internal working system.	176	18.9%	85.4%
Availability of materials.	160	17.1%	77.7%
Engagement of work	162	17.4%	78.6%
Delivering help to those in need.	162	17.4%	78.6%
Dominance of political parties	77	8.3%	37.4%
Total	933	100.0%	452.9%

Multiple Choice Answers

Present table highlighted the opinion of service provider about services rendered by the Municipal Corporation during pandemic. It shows that maximum 196 (21 percent) respondents were state that rules and instructions were applied strictly and followed by the citizens too. 176 (18.9 percent) respondents were highlighted that there was good control and cooperation of internal working system. 162 (17.4 percent)

respondents had opinion that there was good engagement of work and delivering help to those in need. 160 (17.1 percent) respondents were agreeing on availability of material, and very few respondents 77 (8.3 percent) were state that there was no dominance from any political party. It means all political people were very supportive during this pandemic period.

Rules and instructions (citizens and staff) applied for all, control and co-operation of internal working system, availability of materials, engagement of work, delivering help to those in need specifically *divyang* by providing ration kits and other necessary material were some facilities provided by Municipal Corporation however there was no dominance by any political person on service provider however they were found to be more supportive in this pandemic.

Discussion:

Police personnel had longer duty hours compare to other service providers such as doctors and nurses and it shows significant difference ($p=0.001$) in duty hours and occupation. All service provider did not taken holidays during lockdown period however it was found maximum police personnel not taken leave as compared to other service provider. Similarity was found in constrains majority of them had stress during lockdown period, feeling of 24 hrs working, also had feeling of risk for life, some of them also reported no constraints from all service provider. It was highlighted by service provider that combined response from citizen received. Police doctors and nurses also identified fear of death in mind of citizens. Lot of mental distress and fatigue was faced by police, doctors and nurses. They were also had corona infection. Some of them state that no effect on health and very few reported skin problems.

It shows that when nation is in crisis all service provider is ready for their duty irrespective of all kinds of constraints. They believe on duty first and preference to work. It concludes that during lockdown period all service providers reported that they there were more than enough availability of tools, safety tools or had proper personal security, received appreciation as '*COVID Yodha*', received training as well however manpower was vary less. No economic benefit received.

Overall service providers sometimes had feeling of ignored as service provider among them a greater number of police (45.16 percent) personnel always feels ignored. It concludes that respondents from Mumbai felt insecure always due to highest population and issues related to metropolis and respondents from Pune, Nagpur and Aurangabad feels insecure sometimes comparatively less issues.

During lockdown period people were scared because of increasing corona infection and death rate was high so service provider were also felt insecure due to risk perception, unavailability of support system or relatives. It concludes that many struggling situations deal by the service providers such as obeying order given by authority, convincing or disciplining people to follow the rules, collaborate with other service providers, providing security / treatment to senior/ distinguished persons in the society, reducing the fear among people, taking care of own health and answering the calls received from other people.

Maximum service provider reported that constant fear was in mind of family members along with it they do not have proper sleep, become infected, no contact with family members, unable to keep social contact, and they were not able to give time to their family members.

Negligence was reason reported for epidemic re-emerge specifically from Pune, Aurangabad and Nasik. Further people were not following the rules highlighted by majority service provider from Mumbai. Lack of awareness, reopening of lockdown were some reasons in spreading Novel Corona Virus.

Conclusion:

Among all service providers police were more vulnerable followed by nurses and doctors. District wise differences were found in vulnerability on the basis of population and availability of resources. During this pandemic period, they were confronted lot of challenges considering the severity and its effect on physical and mental health. They kept themselves away from their family to reduce spread. It was kind of battle for them. Government should take proper measures and policy initiative to provide facilities to combat in such pandemics.

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NGO Profile

Sarathi Youth Foundation

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Sarathi Youth Foundation (SYF) is a registered Non-Profit organization under The Societies Registration Act, 1860 & Bombay Public Trust Act, 1950 in Feb. 2010, it has aim to work for & with the young people, to support them to grow as an independent, responsible and productive human being. It is founded by the Social Work Professionals, to work with the youth for their overall development.

Organization's Vision & Mission:

Vision: To create positive environment where youths can participate in developmental opportunities and bring change in their communities.

Mission: Inspire, educate and empower the youths to create positive social change through mentoring, skill development and capacity development.

Projects:

1. Perna Project:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. For such a state of equilibrium, Sarathi is working on issues like Gender sensitization, Gender equality, Teenage Body changes, body development, love & attraction, HIV/AIDS & Sexually transmitted diseases (STD) & Human Sexuality and de-addiction. In an age of rapidly evolving

technology, it has become much easier to find information about HIV. But there is no guarantee of how true this information is, how accurate it is. So, Sarathi started Prerna Project in 2010 for creating awareness about Gender sensitization, Gender equality, Teenage Body changes, body development, love & attraction, HIV/AIDS & Sexually transmitted diseases (STD) & Human Sexuality. The subject of HIV is included in the school curriculum but due to some social difficulties and inadequate information, the teachers have difficulty in presenting the subject to the students. Based on the experiences gained through the Prerna project, it has tried to give scientific answers to the questions in the minds of the youth by published the book “उकल युवा मनातील एचआयव्ही घुसमटीची”.

2. Sarathi De-addiction Project:

The growing addiction among the youth is a matter of concern and needs to be seriously considered. With this in mind, it has started **De-addiction Helpline & “Tobacco Anonymous”** meetings which provide counselling on addiction. At school, college and community level, lectures and sessions are organized to create awareness. Taking note of this work, Salaam Mumbai Foundation, Mumbai was selected Sarathi to implement Tobacco Free School Campaign in Solapur district. It had successfully implemented Tobacco Free School Campaign in Solapur district. It is also working as a member of the district committee of the District Tobacco Control Program. Along with this Skill development initiatives viz. entrepreneurship development is also taken for which it has received many prestigious awards.

3. Vocational Training Centre:

In Nov 2021, Sarathi started a vocational Training centre at Solapur in collaboration with *Yuva Parivartan*. The aim of the centre is to make the Women Bidi Worker, Loom

Worker, Construction Women Worker & Bricks Women worker financially independent. It aims at empowering Hazardous work employed Woman's. Currently, the centre conducts training in "Tailoring". In the near future, it intends on beginning more vocational training courses.

4. Pandemic Activities:

Sarathi has conducted online capacity building program called *Sakav Parisamvad* through Facebook Live during Covid Pandemic. It has distributed Food, Cloths, Groceries (Ration kit) & Arsenic album 30 (Homeopathic Medicine) to the needy.

It has also carried out various activities like Diwali with the deprived, relief to the disaster victims, distribution of clothes to the needy, distribution of food grains to the needy, medical aid, educational aid, tree plantation, blood donation camp, health camp. It has served more than 1,48,000+ youth through its work.

Book Review

Champan Movement and Social Action

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Champan Movement and Social Action

by Yusuf Bennur (2022) Current Publications, Agra.
Paperback, 104 pages, Price:350/-

The Champan Andolan of 1917 was India's first mass civil disobedience movement conceived and executed by Mahatma Gandhi in Champan district of Bihar. This movement was the successful execution of Satyagraha- not only philosophy but a mass action where powerless people internalize their power of truth, and non-violent protest. This made people to believe in power of people especially peasants, labourers, women and harijans. This movement was necessary as assumed by Gandhi for two important reasons viz., challenging colonial rule of British directly and giving hope to indigenous population that they can have rights of dissent, self-rule and economic independency.

The content of book has been divided into four chapters; first chapter addresses very important question that why Champan movement has vital revolt? Zamindari system was prevalent for long in Indian history and we know that farmers were subjected to indignity, physical abuse and economic exploitation. When Britishers forced Indian farmers to cultivate indigo forcefully in large amount as they need it for England which proved as brutal abuse of farmers. It is not that farmers agitated against it but it was not fruitful until

Gandhiji intervened. He understood the agony of farmers and devised a tool of non-cooperation as a mean to have negotiation position. It was in real sense the testing of Satyagraha. The chapter has references from Louis Fischer, D.G. Tendulkar, B.R. Nanda, Robert Payne, Eric Ericson, Pyarelal, Sushila Nayar and all their reasoning about Champaran movement. All the important events, Britishers moves, leadership shifts, political mobilization, decisions on political account have described in details made readers to revisit the era of pre-independence. Many witness the seed of Indian freedom in Champaran movement.

The second chapter deals with the Mahatma Gandhi's role in awakening against European planters as South Africa experience. After successful demonstration of Champaran, many scholars write Gandhi as a political strategist, freedom fighter and social reformer. He also had practiced various techniques to manage and implement a Satyagrah campaigns wherein his managerial perspectives came into light. He never believed on what leaders are saying instead he asserted to see the realities of India from his own eyes before making any comments. Here, the determination towards values, people's issues, virtues of ahimsa, peace can be seen in Gandhi when he refused to pay amount to get bail and said will to welcome the decision of court. Studying farmers problem, investigating it, meeting with stakeholders, reporting authorities, uniting people with non-violent ways, cooperating government to resolve farmers issue all are strategies of conflict-resolutions which Gandhi has given. Learnings of South Africa experiments are described too in this chapter.

The third chapter is dedicated exclusively for strategies and techniques practiced and advocated by Mahatma Gandhi in Champaran movement. The whole idea of Satyagraha is based on some irreversible principles viz., non-violence, non-cooperation, truth and honesty. He made Satyagraha not only a political tool for raising political

consciousness among masses and derived these ideas from philosophical and religious texts but also considered as manifestation of a higher spiritual goal, and culmination in world peace. He practiced and preached truth, non-violence, peace, honesty, and love as basic strategies influenced the world leaders like Nelson Mandela, Martin Luther King Jr.

Readers from the different walks of life may like chapter four because it is based on the theoretical underpinnings of Champaran movement. When in the first time in the history of British Raj, the strength of the ordinary and often exploited people exercised a battle with a novel, political tool called Satyagraha and yielded expected results. This modus-operandi invited greater attention from different parts of the world. What has happened in India was the seed of independence for colonized colonies. Based on his humanitarian work in South Africa, British Government has conferred 'Kaisar-e-Hind Gold Medal' for disobeying the order to return back from Champaran. This shows the determination as force to follow the path of justice and pursuance of truth.

What world had witnessed in Champaran, is Hindu-Muslim unity, communal harmony, fine use of Urdu, reconciliation, global peace, violence free world, interactive solutions for human problems, implanting hope in hopeless and helpless farmers diverting them from suicides, consultations, deliberations, public engagement, persuasive power to ensuring participation of all the stakeholders associated with a problem, shaping legislation along with constructive programmes etc. Therefore, those who have interest in conflict-resolution, peace studies, community engagement, social action, anthropology, welfare economics, social legislation, development studies, empowerment policy and good governance must read this piece of work to have understandings about facets of Satyagraha and emancipation.