COVID-19

The "invisible" among the marginalised: Do gender and intersectionality matter in the Covid-19 response?

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Abstract

The spread of Covid-19 and the lockdown have brought in acute deprivation for rural, marginalised communities with loss of wages, returnee migrants and additional state-imposed barriers to accessing facilities and public provisions. Patriarchal norms amplified in such a crisis along with gender-blind state welfare policies have rendered women in these communities "invisible". This has impacted their access to healthcare, nutrition and social security, and significantly increased their unpaid work burden. Several manifestations of violence, and mental stress have surfaced, diminishing their bare minimum agency and rights and impacting their overall health and wellbeing. This article looks at these gendered implications in the context of rural, tribal and high migrant areas of South Rajasthan. We have adopted an intersectional approach to highlight how intersections of several structures across multiple sites of power: the public, the private space of the home and the woman's intimate space, have reduced them to ultra-vulnerable groups.

Keywords*: marginalised communities, gender-blind policies, migrant returnees, intersectionality, tribal women*

Background

The region of South Rajasthan is predominantly rural and tribal with 46% households (1) having a migrant member employed in the informal sector. As the nationwide lockdown was announced in India on March 24, 2020, over 50,000 migrants (2), caught in a crisis of wage loss and lockdown restrictions, travelled hundreds of kilometres on foot, back to their villages in Southern Rajasthan in extreme hardship. With low wages and no savings, existing health needs, widespread malnutrition and limited means to buy and stock perishables, these Adivasi[1] families have been struggling mentally, physically and economically to cope. The rapid spread of rumours and myths around the nature and spread of Covid-19 have further fuelled their anxieties, given their low levels of literacy and poor access to authentic information. These myths (3) range from coronavirus being a "disease created by the rich to kill the poor" to an apocalyptic event that can be averted by fasting to placate local deities. Similarly, screening of migrant members for Covid-19 was interpreted through hearsay as "police and health authorities picking up migrants and shooting them to death". These accounts reflected a heightened sense of fear and uncertainty in the community around Covid-19, amplified by the harsh challenges imposed by the lockdown.

The economy, across strata, has been severely impacted by the nation-wide lockdown to curb spread of the disease. However, the health risks, impact and burdens, significantly vary across the intersections of caste, class, gender, ethnicity, etc. Both central and state governments in India undertook several measures to contain transmission and mitigate the aftershocks of prolonged lockdown. Implementing these welfare measures in an ethical, inclusive and equitable manner requires taking cognisance of the "invisible" groups who are worst affected, and prioritising them within the ambit of welfare. However, in implementation of the current policy measures, the gendered implications across structural intersections have been overlooked and remain a blind spot (4, 5). There is a dearth of research that takes gender as an intersectional lens to analyse the implications of Covid-19 and the lockdown. Therefore, despite response mechanisms being in place, several forms of deprivation, challenges and barriers continue to affect the lives of women from marginalised communities.

Intersectional approach to understanding gendered implications of Covid-19 and lockdown

Analyses of the impact of Covid-19 and lockdown have often looked at diverse vulnerable population groups as "homogeneous units" (6) such as all women, all migrants, the elderly, etc. Such homogenisation has overlooked several layers and experiences of the impact, which are determined by structures of power and social position. This results in missing out the vulnerable, even among the marginalised, from the

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ambit of uniform policy implementation. An intersectional approach is needed to understand the interplay among structures such as caste, class, race, ethnicity, gender and demonstrate how individuals across population groups share more relative disadvantages than others, at a given point in time and space.

Rural southern Rajasthan, home to lakhs of families across five prominent districts of Banswara, Udaipur, Dungarpur, Kherwada and Pratapgarh, is a region with extremely low development indicators. The characteristics of migration (7), geographical remoteness and their predominant presence in the informal sectors of the economy have persistently kept these communities out of the agenda of development. Within these communities, women are further marginalised with female literacy being as low as 30% (8), 55% of women being malnourished (9), 78% of rural women working as unskilled manual labour (10), in addition to lack of access to landholdings. Therefore, across spaces governed by patriarchal norms, these conditions render women from these Adivasi communities "invisible" with little or no agency, further aggravated by the pandemic and the unprecedented lockdown.

The aftershocks of the pandemic have resulted in existing inequities deepening further as well as gaining visibility through the media and government authorities prioritising mitigation of the Covid-19 crisis. However, gender inequity, and more importantly, the gender interstices cutting across class, caste and region have remained unrecognised. Thus, policies aimed at managing the repercussions of lockdown have been gender-blind or based on the assumption that "all women" undergo the same experiences and hence the uniform set of measures announced would help everyone. We examine how, in this process, women from the marginalised communities such as Adivasis in rural and low-income households, have been affected during this period. We use an intersectional approach to look at the gender inequities stemming from the "multiple sites of power" (6) which these women interact with in the public sphere, the private space of the family and in the intimate sphere of the self. Even within this group, the impact and intensity are varied given the woman's position and socio-economic and cultural status within her immediate community. We use the context of these rural, tribal communities of South Rajasthan to illustrate this. The insights are informed by our engagement with women from these communities in the early phases of the lockdown (second half of March till mid-May, 2020) through a tele-counselling initiative undertaken to support the community during the lockdown. These insights have been supplemented with evidence from secondary data resources around the same time.

Excluded from the "welfare" agenda: Gendered implications in the public space

The current precarious situation demands a well-functioning and responsive public safety net to protect the communities from slipping further into a crisis. However, gender-blind public provisions across public health, social security policies and flaws in policy implementation have persistently excluded these women within the state agenda of "welfare" or "relief". Despite provision for women's representation in local governance at the Panchayat[2], the prevalence of the illegal, patriarchal tradition of *Sarpanch pati, Sarpanch sasur* or *Sarpanch devar*[3] persists unchecked (11). Such traditions entitle the husbands and even the male in-laws of the elected female representatives to act as de facto heads of the local governance body (the Panchayat) and invest them with the real decision-making power. These practices reduce the scope for women's voices to be represented in the local governing bodies. This is compounded by structural barriers (12) such as illiteracy, unequal wages and patriarchal impositions affecting access to public provisions and entitlements for women especially during a pandemic like Covid-19. The following examples demonstrate some of these inequities due to flaws in response measures and restricted access of women in the public spaces:

Suspension of essential services within healthcare

India's current health system is being stretched to tackle the spread of Covid-19, while the country shares a high burden of maternal mortality (13) and deaths due to diseases such as tuberculosis (TB). In rural and tribal areas, the burden is higher than the national average (14). According to the Tribal Health Report, 2017, 80% of the cases of malaria in India are prevalent in remote tribal areas; and prevalence of TB is over 703 per lakh population, compared to the estimated country average of 256 per lakh. With the current focus on combating Covid-19, continuity of care for managing the pre-existing burden of diseases has been severely affected in rural areas as the inefficient health system struggles to respond to both. Utilisation of healthcare services has therefore dwindled generally during this period (15), even more so among women due to their restricted movements. Despite health ministry directives on March 26, 2020 to primary health centres (PHCs), TB Units and community health centres (CHCs) for sourcing of TB medicines from nearby centres and making them readily available for TB patients (16), implementation has been poor in these areas with a lack of fully functioning PHCs, and severe dearth of self-driven and empathetic care providers. Inability to access medicines or timely care, and acute hunger due to food scarcity has meant that several TB patients, mostly men, in these remote villages have risked defaulting from treatment and increased susceptibility to drug resistance and mortality (17). Consequently, their family members have been put at higher risk of contracting the disease.

Essential routine care such as antenatal check-ups, and vaccination came to a standstill with the lockdown (15), severely impacting the health of pregnant women and children in these underserved areas dependent on monthly sessions organised by the government to provide antenatal check-ups, contraceptives, and immunisation in their villages. The prolonged stay of their migrant partners with uncertainty around their return to work and absence of contraceptive

availability have put women at higher risk of unwanted pregnancies. Similarly, menstrual health and hygiene have been affected in the absence of available options. While older women resort to cloth napkins, adolescent girls have faced challenges as they largely relied on sanitary napkins provided in schools. The closure of schools, shutdown of shops (often the only shops in rural areas) and fear of the police as a result of lockdown have pushed many women to adopt unhygienic practices such as use of old cloth and rags (that are not disinfected or barely sundried) increasing their susceptibility to reproductive tract infections.

Exclusionary and weak social security

On March 26, 2020, the Finance Minister (18) announced a flurry of relief measures aimed at helping poor widows, women beneficiaries under the Jan Dhan Yojana, the Ujjwala scheme and self-help groups under the National Rural Livelihood Mission (NRLM). While the measures announced were welcome, a substantial proportion of these poor households have been excluded due to enrolment barriers.

Under the Food Security Act, families were entitled to additional foodgrains as part of relief. However, 25% of the families in these villages do not possess a ration card (9). Moreover, several supply chain and distribution glitches marred by corruption have left out vulnerable families from the ambit of relief. The Government of Rajasthan had also announced additional food packages for single women (19). However, ground reports from two rural blocks of Udaipur highlight that only 25 packets were delivered per Panchayat in the month of April, making it five families per village. The implications for ultra-vulnerable families such as single women-headed households with ailing family member have been even worse, leaving them in hunger and deprivation. With a very limited social network and community collective, very few women, especially single women have the agency to contest corrupt practices and illegal hoarding. Similarly, many migrants returning from the cities did not find themselves enrolled in any of the existing social security schemes available in the village. It was only in May 2020 that the Government of Rajasthan announced free distribution of rations for migrant families in which 1.2 million migrants from Rajasthan were able to register themselves online (20).

Similarly, in the wake of acute food scarcity, closure of *Anganwadis* [4] (day care creches) has further affected pregnant women, lactating mothers and children with no alternate access to food (21). In such crises, patriarchal norms constrain women and girls to reduce their own intake of food for the rest. This eventually results in inadequate nutrition in new-borns and poor feeding practices among children, thus perpetuating the malnutrition cycle. During this period, food shortages had disproportionately affected the nutrition levels of young married women and young girls in the household.

Launched in 2016, the Ujjwala scheme, aimed to provide free cooking gas cylinders to 50 million BPL beneficiaries. Only 67% of the 3000 families across six rural blocks of this region had access to gas cylinders under the scheme, according to a study undertaken by Aajeevika Bureau in 2020 (22). By the beginning of 2019, the provision of kerosene, as the alternative to liquefied petroleum gas (LPG) had also been discontinued under the public distribution system which increased the demand for LPG cylinders. As part of lockdown relief, those not enrolled under the Ujjwala scheme were eligible for 2.5 litres of kerosene oil for the three months of April to June 2020. However, our observations in the community revealed that the implementation is yet to be undertaken. Currently, women and girls from the excluded households for gas cylinders are bearing the additional burden of collecting firewood during the lockdown. This also puts them at a higher risk of respiratory conditions due to prolonged exposure to indoor air pollution caused by the smoke from cooking on firewood (23).

Under the Pradhan Mantri Jan Dhan Yojana, women beneficiaries are entitled to INR.500 per month as relief support. For an average family size of five, this amount is small and narrowly targeted. In our interaction with e-mitras in Udaipur's Gogunda block, we had found that over 30% accounts had become inoperative within a month of opening. Even among the women account-holders with active accounts, obtaining the amount meant walking up to 10 -15 kilometres to get to the nearest bank during lockdown. Additional barriers in accessing their accounts were erratic network or biometric inactivity. For single women with children, these trips involve the extra responsibility of managing time out to visit the bank. In some pockets of this region, disbursement has been innovatively done through bank correspondents (24) who are point persons for cash withdrawals and enquiries on bank balance in the village. However, scaling such initiatives in these areas remains a challenge due to dearth of educated and trained locally available persons, organisations, and Panchayat members who can coordinate the initiative effectively and transparently.

State imposed barriers to access

State-imposed measures for ensuring lockdown have intermittently turned oppressive, curbing women's ability and agency to navigate the public space. Several first-hand accounts of women from these areas reveal a rise in strict police enforcement of the lockdown. The lockdown amplified by the imposition of the patriarchal institution of the police pushed women further into their homes, snapping access to the public space. Absence of transport facilities and overall strict imposition of lockdown has created additional barriers for women in seeking healthcare and essential goods. This has a detrimental impact, especially when appropriate care-seeking among women (25), more so among tribal women (14), is lower in frequency and promptness than among men due to lack of autonomy, paucity of time, and distance. Concurrently, police checks have also posed additional burdens and anxieties for women. Typically, cattle grazing is an activity undertaken by both men and women, especially adolescents. Due to the stringent lockdown, cattle grazing has been curbed, resulting in women bearing the additional burden of procuring water and fodder for cattle.

No wages, no benefits, no safety: Excluded within the workforce

Although there has been a rapid feminisation of informal labour over the past 30 years, Adivasi women are unable to access better paying or skilled jobs which are less dependent on intermediate contractors (10). Uncertainty because of the pandemic looms large for the female workforce in these communities. Engaged in the lowest paying tasks in labour intensive work such as construction, there is an increased anxiety around availability of employment opportunities post the lockdown.

Provisions under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) have played a vital role in generating employment opportunities for women in these areas. On April 15, 2020, after the temporary suspension of MGNREGA, resumption of work and payment of pending wages under the Act was announced (26). However, work remained suspended in many villages with only 68,340 households being provided with work across Rajasthan in April, 2020 (27). With migrant returnees who have lost job opportunities, the demand for work at MGNREGA sites has increased to the point that current provision is grossly inadequate to meet the need (28). Additionally, in the absence of strong local governance systems, many individuals in these remote tribal villages still had not received the pending wages announced by the government.

For women engaged in the construction sector, in brick making and cane cutting work, the conditions are equally dismal. Women's individual entitlements in such forms of work have not been recognised in the labour law regime (10). In construction work, women are engaged in the lowest paying and the most labour intensive work, such as carrying cement and bricks on their heads, mixing soil and cleaning work sites. Moreover, about 42% of rural women migrant workers (10) are engaged in pairs where they work with a male counterpart from the same family (known as the *jodi* system). In this system, the male is seen as the primary worker and the woman is not even recognised as an independent worker. This leaves no scope for individual income or entitlements for women workers tied to these patriarchal systems of employment. It is for the same reason, many women construction workers have not been registered under the Building and Other Construction Workers (BoCW) Welfare Board, and hence not eligible for the current financial relief provision (29).

Locked down at home: Gendered implications in the private space

With migrants returning home, there has been a higher risk of Covid-19 transmission among family members, greater susceptibility to domestic violence, and increase in domestic work with no respite or support. The following examples demonstrate the implications:

Double burden and increase in unpaid care work

With children home-bound and husbands back at home, women's dual burden of managing home and the field have intensified with additional responsibilities piling onto existing ones. While household income fell, there has been an increase in the women's unpaid labour in domestic activities such as fetching water, cooking meals, washing clothes – to ensure the survival of the household (30). This has further delineated them from being income-dependent labour and pushed them into the socially engendered role of "caregiver" associated with unpaid labour.

With the increase in unpaid work and the absence of support from male family members, the women's mental and physical exhaustion have also been aggravated by the lack of food, income, and an uncertain future. Single women households, with a limited social network and no savings are finding it extremely difficult to manage during the lockdown. India has 71. 4 million single women, with 62% of them living in rural areas (31). Many single women with limited resources and children to feed had to walk long distances to work as wage labour in households owning agricultural land (32). Living a dignified life remains a distant utopia for them.

Unsafe homes and absence of a support system

Globally, the most horrific impact of the lockdown has been an increase in domestic and intimate partner violence (33). According to the National Commission of Women, India, 40% cases they received were related to domestic violence (34) during the first phase of the lockdown. It was no different in these tribal communities where the women recounted incidents of harassment and violence inflicted by husbands (35). Problems imposed by the nationwide lockdown - unemployed male family members, severe income loss in the household and alcoholism - were compounded by the underlying gender discrimination of patriarchal family structures, thus creating social sanction for widespread domestic violence in these communities, during the lockdown. Lack of access to a police station for help, obstruction of movement by the perpetrator, and more importantly, unresponsiveness of the police posed barriers to access timely help. Although, the Commission released a WhatsApp number as helpline, rural Indian women's access to mobile phones is merely 30% (with access to the social media even lower) (36). According to NFHS 4 (37), only 25% of tribal women in Rajasthan can use a mobile phone, of which only 45% can read a text message. It is therefore evident that several cases relating to violence in rural, tribal areas have gone unreported. In most of these rural, tribal pockets incidents of domestic violence are resolved through community congregations involving members of the Panchayat. However, such informal means of conflict resolution with no representation of women and no voice for the survivor results in a token bare minimum compensation offered to the head of her maternal family, or more often, the survivor is instructed to return to the perpetrator's family.

Who is responsible? Gendered implications in the intimate space

Within the intimate space of the "self", woman's agency is shaped by experiences from the intersecting structures of

power across different domains. Thus, when Adivasi women interact with exclusionary policies, faulty implementation systems and the patriarchal order with in family, they find themselves the "object of blame". This leads to internalising a sense of being responsible for their own predicament. Due to myths around Covid-19 and its cure, women in Adivasi households have internalised gendered ritualistic norms such as assuming accountability for warding off the disease by continuous fasting. These practices will, further disproportionately impact women's health especially for those with existing morbidities such as tuberculosis, severe anaemia, or disability who are also stigmatised due to pre-existing disease and seen as a burden and easily dispensable by family members in patriarchal households.

At several levels, the interaction of women in the constricted public and private spaces and the unquestioning internalisation of the gendered burden and blame have percolated into mental health issues of anxiety and depression, with no space to vent or seek support. To combat mental health concerns due to prolonged lockdown, government and private organisations have launched initiatives such as telephonic helplines and entertainment medium. However, these facilities (by design) remain accessible only to women of the urban upper and middle classes with their own mobile phones. For many women in deprived communities, who can only receive calls or have to rely on their husbands to dial up contacts for them, helplines remain inaccessible. Stringent lockdown also results in an inability to access their existing support system in the neighbourhood. Undoubtedly, for women from these rural, tribal areas with aggravated stress due to increased work burden, uncertainty around food and income, compounded by fear of abuse, there has been no respite or escape.

Policy recommendations

The global pandemic and the lockdown have brought to light the dire ethical repercussions of neglecting structural influences while designing and implementing policies. Now more than before, the experiences of vulnerable communities are increasingly finding prominence. However, the intersections of structures of power are yet to be considered significant enough to respond effectively. The insights we have gained make it imperative to use a gender and intersectionality lens to understand and mitigate the deprivations that have stemmed from Covid-19 and the lockdown. We recommend below immediate steps and long-term actions that need to be implemented:

Immediate steps:

1. *Current social protection schemes need to be inclusive*
    - Universalising MNREGA for all members of a household, above 18 years, and mandatory payment of pending wages must be ensured promptly. This should be supported by direct disbursement of cash through the panchayats in the interim period, especially for ultra-vulnerable families such as single women households, and households with chronically ill family members.
    - Speedy registration of women construction workers under the BoCW, at the panchayat level must be done as the lockdown is being phased out. This should be implemented with immediate effect to ensure social security for women construction workers.
    - Cash disbursement under Jan Dhan Yojana needs to be increased to at least INR 9750 -based on the recommended minimum wage rate of INR 375 per day (38) - and disbursed through panchayat level cash payments. This should be specifically assured to vulnerable migration-dependent families or single women families.
2. *Leveraging existing services of health and nutrition*
    - Ensuring services under the Integrated Child Development Scheme (ICDS) as well as routine care under PHCs (antenatal care, immunisation, postnatal care access to contraception and safe abortion), access to sanitary napkins and access to medicines for chronic ailments should be deemed "essential services" and prioritised.
    - Ensuring fully functioning PHCs and sub-centres responding to other health conditions, especially disease burden prevalent in these areas, with 104-108 services catering to the transport of the needy.
    - Reorganisation of essential healthcare services must be initiated in public health facilities by drawing on best practices from several non-governmental primary healthcare organisations, and response models of successful states like Kerala for ensuring continuity of care.
    - Access to food grains should be universalised under the Food Security Act through PDS and in these challenging times, transparent implementation needs to be prioritised and closely monitored by the supervisors.
    - Anganwadis should resume services by redesigning service delivery in the form of cooked meals distributed to the households or at the least ensure take-home ration provided to the beneficiaries.
3. *A state level, operational, toll-free women's helpline is extremely necessary*
    - This should be available for counselling as well as reporting incidents of violence. Alternatively, female community members such as Accredited Social Health Activists (ASHAs), Anganwadi workers or leaders of self-help groups or womens' collectives should be trained and prepared as trusted point persons for identification, reporting and providing immediate support in cases of harassment or violence.

- This needs to be backed up by ensuring prompt responses from the police for intervening in reported incidents of violence.
- Additionally, it requires capacity building of community members who are in direct contact with households such as Rapid Response Committees for Covid 19 (operating in rural areas to identify susceptible corona cases), teachers, Panchayat members, primary healthcare providers to identify signs of depression or violence in households and sensitisation of these members on gender and gender-based discrimination.
- It is also critical that Adivasi women have dignified access to counselling and rehabilitation for which ensuring availability of a counsellor at the block/ district level is a must.

Long term action

To effectively bring in ethical and equitable response and sustain it, several structural changes will need to be initiated:

1. Dire need for greater representation of women and women's voices in leadership and decision-making processes across levels from the Panchayat to the Central Ministry (1)
2. Leveraging women's voices through community collectives such as self-help groups and other forms of women's solidarity groups
3. Strengthening the health system infrastructure of the country with gender mainstreaming and intersectionality seen as a core part of health policy design for equitable access to healthcare
4. Research on gender and intersectionality needs to be leveraged in India in order to inform welfare policies across domains

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Notes:

[1] 'Adivasi' is a vernacular term that refers to indigenous tribal communities who are ethnic to a particular geographical area

[2] Refers to an administrative unit formed by a cluster of villages. Also refers to the local governance system at the village level.

[3] In the Indian system of decentralised governance, *Sarpanch* is the elected head of the local governance system at the Panchayat. Male members (from the in-laws family: *Pati* – Husband, *Sasur*- father-in-law, *Devar*- brother-in-law) related to the elected married female Sarpanch assume de facto power illegally and take all decisions in her name.

[4] *Anganwadis* are rural day care centres set up under the Integrated Child Development Services Scheme, providing supplementary nutrition, pre-school non-formal education, immunisation, and nutrition and health education, along with referral services

References

1. Sharma, A, Poonia S, Ali Z, Khandelwal R. *Their own country: A profile of labour migration from Rajasthan*. Aajeevika Bureau. 2014 [cited 2020 Apr 30]. Available from http://www.aajeevika.org/assets/pdfs/Their%20Own%20Country.pdf
2. Press Trust of India. Rajasthan migrant workers in Gujarat leave for homes on foot after lockdown. *Economic Times*. 2020 March 25 [cited 2020 Apr 30]. Available from: https://economictimes.indiatimes.com/news/politics-and-nation/rajasthan-migrant-workers-in-gujarat-leave-for-homes-on-foot/articleshow/74806974.cms
3. Dutta M, D'Souza H. Health workers offer rural tele-counseling to contain COVID-19 myths. *Village Square*. 2020 April 22 [cited 2020 May 18]. Available from: https://www.villagesquare.in/2020/04/22/health-workers-offer-rural-tele-counseling-to-contain-covid-19-myths/
4. Willmer G.'Gender blind' coronavirus policies could hinder disease fight. *SciDev.Net*. 2020 Mar 16 [cited 2020 May 18]. Available from: https://www.scidev.net/global/gender/news/gender-blind-coronavirus-policies-could-hinder-disease-fight.html
5. Kamdar B. India's COVID–19 gender blind spot. *The Diplomat*. 2020 Apr 27 [cited 2020 May 18]. Available from: https://thediplomat.com/2020/04/indias-covid-19-gender-blind-spot/
6. Kapilashrami A, Hankivsky O. Intersectionality and why it matters to global health. *Lancet*. 2018 Jun 30 [cited 2020 Apr 30]; 391(10140):2589-91. doi: 10.1016/S0140-6736(18)31431-4
7. Aajeevika Bureau. Unlocking the urban: Reimagining migrant lives in cities post-COVID 19. 2020 (cited 2020 May 18). Available from: http://www.aajeevika.org/assets/pdfs/Unlocking%20the%20Urban%20-%20English%20Summary.pdf
8. Government of India. Rajasthan Population 2011-2020 Census – Coronavirus/Covid 19 Data. New Delhi: GoI; 2020 [cited 2020 May 18]. Available from : https://www.census2011.co.in/census/state/rajasthan.html
9. Mohan P, Agarwal K, Jain P. Child malnutrition in Rajasthan: Study of tribal migrant communities. *Econ Pol Wkly*. 2016 Aug 13 [cited 2020 May 18]; 51(33):74-5. Available from : https://www.epw.in/journal/2016/33/special-articles/child-malnutrition-rajasthan.html
10. Mazumdar I, Neetha N, Agnihotri I. Migration and gender in India. *Econ Pol Wkly*. 2013 Mar 9 [cited 2020 May 18]; 48(10):57-63. Available from: https://www.epw.in/journal/2013/10/special-articles/migration-and-gender-india.html
11. Anand A.Sarpanch pati:The road block to women's political participation. *Feminism India*. 2017 Nov 14 [cited 2020 Jun 08]. Available from: https://feminisminindia.com/2017/11/14/sarpanch-pati-womens-political-participation/
12. Individual Deprivation Measure. Rural women face unique challenges: a briefing for CSW62. 2018 Mar [cited 2020 May 18]. Available from:https://www.individualdeprivationmeasure.org/rural-women-face-unique-challenges-a-briefing-for-csw62/
13. Office of the Registrar General & Census Commissioner, India. Special Bulletin of Maternal Mortality in India 2015-17. Sample Registration System. 2019 Nov [cited 2020 Apr 30]. Available from: http://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_Bulletin-2015-17.pdf
14. Ministry of Health & Family Welfare and Ministry of Tribal Affairs. Report of the expert committee on tribal health, Tribal health in India: Bridging the gap and roadmap for the future; New Delhi: MoHFW, MoTA;2018 [cited 2020 Apr 30]. Available from: http://tribalhealthreport.in/full-report/
15. Rukmini S. How covid-19 response disrupted health services in rural India. *Live Mint*. 2020 April 27 [cited 2020 May 18]. Available from :https://www.livemint.com/news/india/how-covid-19-response-disrupted-health-services-in-rural-india-11587713155817.html
16. Ministry of Health and Family Welfare, Central TB Division. Notification No. DO.No.A-66013/05/2020-TB. New Delhi; MoHFW; 2020 Mar 25 [cited 2020 May 18]. Available from : https://www.tbcindia.gov.in/WriteReadData/26032020DONTEPAdvisory.pdf
17. Mohan P, Mitra RG, Amin A. Stronger health system could have averted 500,000 non-Covid deaths in India in early lockdown period. *Scroll*. 2020 May 19 [cited 2020 June 8]. Available from: https://scroll.in/article/962147/stronger-health-system-could-have-averted-500000-non-covid-deaths-in-india-in-early-lockdown-period
18. ETBFSI. FM reinstates "Nari tu Narayani" dictum; announces Covid-19

relief measures. *Economic Times*. 2020 Mar 26 [cited 2020 Apr 30]. Available from: https://bfsi.economictimes.indiatimes.com/news/policy/fm-reinstates-nari-tu-narayani-dictum-announces-covid-19-relief-measures/74828261
19. Mohammad I. Rajasthan announces -2,000 crore package for poor during lockdown. *Hindu*. 2020 Mar 23 [cited 2020 Apr 30]. Available from: https://www.thehindu.com/news/national/other-states/rajasthan-announces-2000-crore-package-for-poor-during-lockdown/article31145419.ece
20. Goswami R. Rajasthan govt identify migrant workers, distribute them free ration for 2 months. *Hindustan Times*. 2020 May 22 [cited 2020 Jun 8]. Available from: https://www.hindustantimes.com/india-news/rajasthan-govt-identify-migrant-workers-distribute-them-free-ration-for-2-months/story-6DLPKRaZw1tt3sNilbv1CK.html
21. Kumar R, Yadav P. Why women, children In Rajasthan's tribal belts are facing hunger. *India Spend*. 2020 May 30. [cited 2020 June 8]. Available from: https://www.indiaspend.com/why-women-children-in-rajasthans-tribal-belts-are-facing-hunger/
22. Aajeevika Bureau. Household survey of 3000 families conducted in six blocks of Rajasthan, 2019-2020 (unpublished).
23. Tripathi A, Sagar A. Ujjwala, V2.0: What should be done next? Policy brief. New Delhi:, Collaborative Clean Air Policy Centre; 2019 Jun [cited 2020 Jun 8]. Available from: https://static1.squarespace.com/static/59f2a2038a02c746600f6bbb/t/5d0503a7562f010001cc373f/1560609704122/Ujjwala+V2.0+Jun+19b.pdf
24. Kulkarni R. Covid lockdown: In rural India, banking correspondents bring cash, emotional support to the doorstep. Scroll. 2020 Apr 30 [cited 2020 May 18]. Available from : https://scroll.in/article/960599/covid-lockdown-in-rural-india-banking-correspondents-bring-cash-emotional-support-to-the-doorstep
25. REACH. A Rapid Assessment of Gender and Tuberculosis in India (2018). 2018 [cited 2020 Apr 30]. Available from: http://www.stoptb.org/assets/documents/communities/CRG/TB%20Gender%20Assessment%20India.pdf
26. India Today Web Desk. New lockdown guidelines: Govt says MGNREGA works allowed from April 20. *India Today*. 2020 April 15 [cited 2020 May 18]. Available from: https://www.indiatoday.in/india/story/new-lockdown-guidelines-govt-says-mgnrega-works-allowed-from-april-20-1667114-2020-04-15
27. Agarwal K. COVID-19 Lockdown: In April, MGNREGA work crashed to lowest in 7 years. *Wire*. 2020 May 1 [cited 2020 Jun 8]. Available from: https://thewire.in/labour/covid-19-lockdown-mgnrega
28. Chauhan C. 3.5 million new enrolments under MGNREGA, as 'distressed' workers return to villages. *Hindustan Times*. 2020 May 22 [cited 2020 Jun 8]. Available from: https://www.hindustantimes.com/india-news/3-5-million-new-enrolments-under-mgnrega-as-distressed-workers-return-to-villages/story-aDJHYz0vz1tSeLlelhVT7I.html
29. Jayaram N, Mehrotra R. Marooned in the city. *Frontline*. 2020 Apr 24 [cited 2020 Apr 30]. Available from: https://frontline.thehindu.com/cover-story/article31257591.ece
30. Naidu S.C. Domestic labour and female labour force participation: Adding a piece to the puzzle. *Econ Pol Wkly*. 2016 Nov 5 [cited 2020 Apr 30]; 51(44- 45): 101-8 . Available from: https://www.epw.in/journal/2016/44-45/special-articles/domestic-labour-and-female-labour-force-participation.html
31. Salve P. 71 million single women, 39% rise over a decade. *India Spend*. 2015 Nov14. [cited 2020 Jun 8]. Available from: https://archive.indiaspend.com/cover-story/71-million-single-women-39-rise-over-a-decade-54854
32. Agarwal Di, Dhurve P. Dola Ram's long and locked-down road home. *People's Archive of Rural India*. 2020 Apr 30 [cited 2020 June 8]. Available from: https://ruralindiaonline.org/articles/dola-rams-long-and-locked-down-road-home/
33. World Health Organization. COVID-19 and violence against women. What the health sector/system can do. Geneva: WHO; 2020 Apr 07 [cited 2020 Apr 30]. Available from: https://apps.who.int/iris/bitstream/handle/10665/331699/WHO-SRH-20.04-eng.pdf?ua=1
34. Press Trust of India. India witnesses steep rise in crime against women amid lockdown, 587 complaints received: NCW. *Economic Times*. 2020 Apr 17 [cited 2020 Apr 30]. Available from: https://economictimes.indiatimes.com/news/politics-and-nation/india-witnesses-steep-rise-in-crime-against-women-amid-lockdown-587-complaints-received-ncw/articleshow/75201412.cms
35. Rajput M, Dhurve P. *Corona maane bhook se marne ki bimari. Dakshini Rajasthan ki Adivasi mahilayein aisa kyun sochti hain?* [Corona means dying of hunger: Why do the Adivasi women of southern Rajasthan think like this?]. Junputh. 2020 May 19 [cited 2020 June 8]. Available from: https://junputh.com/open-space/stories-of-lockdown-violence-on-tribal-women-of-south-rajasthan/
36. Sanghera T. Wide gender gap in mobile phone access is hurting India's women. *India Spend*. 2018 Nov 1[cited 2020 May 18]. Available from: https://www.indiaspend.com/wide-gender-gap-in-mobile-phone-access-is-hurting-indias-women/
37. Indian Institute for Population Sciences. National Family Health Survey (NFHS 4) Rajasthan: Main Report. 2015-16. 2017 Oct [cited 2020 May 18]. Available from: http://rchiips.org/nfhs/rajasthan.shtml
38. Ministry of Labour and Employment, Govt of India. Expert committee submits its report on determining methodology for fixing national minimum wage. New Delhi: MoLE; 2019 Feb 14 [cited 2020 May 18]. Available from: https://pib.gov.in/PressReleasePage.aspx?PRID=1564590

Burnout among healthcare providers during COVID-19: Challenges and evidence-based interventions

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Abstract

Burnout is a major occupational problem among healthcare providers, especially during the Covid-19 pandemic. The frontline health workforce is experiencing a high workload and multiple psychosocial stressors which may affect their mental and emotional health, leading to burnout symptoms. Moreover, sleep deprivation and a critical lack of psychosocial support may aggravate such symptoms amidst Covid-19. From an ethical viewpoint, healthcare providers may experience moral distress while safeguarding patient welfare and autonomy. Moreover, social injustice and structural inequities may affect