

Impact of COVID-19 on ultra vulnerable groups : The Banyan Experience

REVIEW AND ANALYSIS FOR PUBLIC POLICY AND SOCIAL ACTION

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To everyone we encountered in the process of writing this report, from the streets, in homeless shelters, clients accessing The Banyan's services, thank you for allowing us to tell your story.

In hope and solidarity

From,
The Scientific Review Board,
The Banyan Academy of Leadership in mental Health
Thiruvaidanthai, 603112

To
Dr Vandana Gopikumar
Principal Investigator,
"COVID 19 pandemic, health systems and mental health of vulnerable groups...social action"

Sub: Approval of study titled '**COVID 19 pandemic, health systems and mental health of vulnerable groups : Review and analysis for public policy and social action**'

Dear Dr Gopikumar,

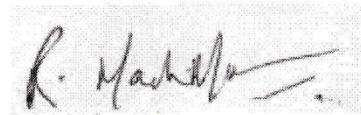
On behalf of The Scientific Review Board (SRB), The Banyan Academy of Leadership in Mental Health (BALM), I am pleased to inform you that your application for clearance toward implementation has been reviewed for research rigour and compliance with ethical guidelines as per the American Psychological Association and World Health Organisation, and consequently approved.

Your engagement with the project and approval rights are extended to you on account of your affiliation to The Banyan and BALM and is based on the description of the project submitted to the review committee. In case of any changes to your employment contract, affiliation or proposal, the SRB, BALM, must be intimated via an email to dor@balm.in addressed to the head of research, before continuing with data collection and dissemination. You may begin implementation of your project at your discretion. Please note that all published material must be affiliated with BALM and The Banyan.

All data collected must be anonymised before use; videos must include special effects on identification material of individuals. Raw data cannot be disseminated in public fora and must be kept confidential at all times. In cases where identification markers are included, explicit verbal consent with a witness must be available on records. Your project and teams may be subject to random checks from the SRB, The Banyan Academy for compliance with ethical guidelines.

Good luck with your endeavors,

Sincerely,



Mrs Menon,
Dean, The Banyan Academy,
(On behalf of The Scientific Review Board)

Abbreviations

AYUSH – Ayurveda Yoga Unani Siddha Homeopathy

BPL – Below Poverty Line

CHC – Community Health Centres

CSDH – Commission on Social Determinants of Health

CSO – Civil Society Organization

DMHP – District Mental Health Program

FGD – Focused Group Discussion

GCC – Greater Chennai Corporation

GDP – Gross Domestic Product

HP-HPLMI – Homeless Persons or Homeless Persons Living with a Mental Illness

ILO – International Labour Organization

LMIC – Low and Middle Income Countries

MGNREGA – Mahatma Gandhi National Rural Employment Guarantee Act

MPI – Multi-dimensional Poverty Index

NFHS – National Family Health Survey

NULM – National Urban Livelihoods Mission

OOP – Out Of Pocket

PHC – Primary Health Centres

PHP – Public Health Protocols

SARS-COVID-19 – Severe Acute Respiratory Syndrome Corona Virus Disease 2019

SDH – Social Determinants of Health

SDG – Sustainable Development Goals

UN – United Nations

WHO – World Health Organization

Table of Contents

Acknowledgements	2
Abbreviations.....	4
Executive Summary.....	8
Ultra-Vulnerable Persons and Populations.....	8
Tamil Nadu and the Banyan.....	10
Aims.....	10
Objectives.....	10
Methodology.....	11
Limitations.....	11
Key Findings.....	11
Socially Disadvantaged living with psychosocial distress.....	11
Homeless and Homeless persons living with mental illnesses.....	12
Irular Tribe (Scheduled Tribe).....	13
Children from Disadvantaged Backgrounds.....	14
1 Background.....	15
1.1 Introduction.....	15
1.2 India and the Spanish Flu of 1918: Commonalities and differences.....	20
2. Pre-COVID-19.....	22
Ultra-Vulnerable groups	22
Social determinants of health and healthcare.....	22
Mental Health Care.....	23
Mental health and poverty.....	24
The role of the NGO in Global Health..	26
2.1 Socially Disadvantaged living with Psychosocial Distress.....	26
Tamil Nadu: health and mental health systems – an overview.....	26
2.2 Homeless Persons and Homeless Persons living with Mental Illness (HPLMI).....	30
Social Determinants and Access to Health Care and Shelter.....	30
Mental Health Care.....	31
Tamil Nadu: how are the homeless serviced?.....	32
2.3 Remote Rural Populations and Irular Tribe....	35
History.....	36
Adivasi and Dalit Poverty.....	36
Health Care.....	37
Mental health.....	38
Irular Scheduled Tribe in Tamil Nadu..	38
2.4 Children from Disadvantaged Backgrounds... 39	
Mental health.....	39
The Tamil Nadu perspective.....	40
3. Impact of COVID-19 on vulnerable people and the need for Study.....	43
3.1 Socially Disadvantaged living with Psychosocial Distress.....	43
3.2 Homeless Persons and Homeless Persons living with Mental Illness (HPLMI).....	43
3.3 Remote Rural Populations and Irular Tribe (Scheduled Tribe).....	44
3.4 Children from Disadvantaged Backgrounds... 45	
4. Tamil Nadu Response.....	46
4.1 Tamil Nadu Response.....	46
4.2 The Banyan Response.....	47
5. Aims and Objectives.....	49
Aims.....	49
Objectives.....	49
6. Methodology.....	52
Study Design.....	52
Procedure.....	52
Analysis.....	53
7. Findings.....	54
Case Studies.....	54
Content Analysis.....	55
Background Characteristics.....	57
7.1 Socially Disadvantaged Living with Psychosocial Distress (SD group).....	57
7.2 Homeless and Homeless Persons living with Mental Illness.....	57
7.3 Irular Tribe.....	57
7.4 Children.....	57
7.5 Tables.....	58
Table 7.2 Socio-demographic information for Children sample (n=206).....	59

8. Socially Disadvantaged Living with Psychosocial Distress (SD group).....	60	9.3 Focus Group Discussions.....	84
8.1 Survey results.....	61	9.4 Case Studies.....	88
COVID-19 and Public Health - Awareness, Knowledge and Challenges.....	61	Manikandan.....	88
Impact of COVID-19 on access to essentials and Social entitlements.....	61	Shehnaz.....	90
Employment and Income.....	63	10. Irular Tribe.....	94
Health and Wellbeing.....	63	10.1 Survey Results.....	95
COVID-19 prevalence and testing.....	63	COVID-19 and Public Health - Awareness, Knowledge and Challenges.....	95
Impact on Mental Health.....	63	Impact of COVID-19 on access to essentials and Social entitlements.....	95
Coping Mechanisms.....	64	Employment and Income.....	97
Impact on Friends, Family and Home dynamics..	64	Health and Wellbeing.....	97
Impact on the Elderly and persons with disability	65	COVID-19 prevalence and testing.....	97
8.2 Focus Group Discussions.....	67	Impact on Mental Health.....	97
8.3 Case Studies.....	68	Coping Mechanisms.....	98
8.3 Case Studies.....	68	Impact on Friends, Family and Home dynamics..	98
Vijaya and Vanitha.....	68	Impact on the Elderly and Persons with Disabilities	99
Mrs and Mr Ramanathan.....	70	10.2 Focus Group Discussions.....	101
Fatima.....	72	10.3 Case studies.....	102
9. Homeless and Homeless persons living with mental illness.....	76	Geetha.....	102
9.1 Survey Results.....	77	Jaya.....	109
COVID-19 and Public Health - Awareness, Knowledge and Challenges.....	77	11. Children of disadvantaged families.....	115
Impact of COVID-19 on access to essentials and Social entitlements.....	77	11.1 Survey Results.....	116
Employment and Income.....	79	COVID-19 - Awareness and Knowledge, and prevalence.....	116
Health and Wellbeing.....	79	Impact of COVID on Accessing Resources and Social Entitlements.....	116
COVID-19 prevalence and testing.....	79	Schooling and Education.....	116
Impact on Mental Health.....	79	Health and Wellbeing.....	117
Coping Mechanisms.....	80	Parents Mental health.....	117
Impact on Friends, Family and Home and other Social Dynamics.....	80	Children wellbeing and coping.....	117
Impact on the Elderly and Persons with Disabilities	81	11.2 Focus Group Discussions.....	119
9.2 Shelters.....	82	11.3 Case Studies.....	121
Quantitative Data.....	82	Jenny.....	121
Qualitative Data.....	83	Prema.....	123
		12. Discussions.....	125
		12.1 Overview.....	125
		12.2 Discussions by Group.....	125

Socially Disadvantaged Living with Psychosocial Distress.....	125	Appendix A - Permission letter.....	143
COVID-19 and awareness.....	125	Appendix B - Survey Tool SD, Homeless and Irular Groups.....	144
Employment and Income.....	126	Appendix B - Survey Tool Children.....	145
Health and Wellbeing.....	126	Appendix C - Survey Tool Shelters.....	146
Impact of COVID on Health.....	126	References.....	147
Stigma.....	127		
Abuse and gender.....	127		
Social support and mental health	127		
Homeless and Homeless Persons living with Mental Illness.....	128		
COVID-19 Awareness and implications	128		
Access to shelter and basic amenities.	128		
Employment and income.....	129		
Health and Wellbeing.....	129		
Social support and mental health	129		
Irular Tribe.....	130		
Awareness.....	130		
Employment and income and access to amenities.....	130		
Health and Wellbeing.....	130		
Children.....	131		
Awareness and restrictions and access	131		
Schooling and education and being at home.....	131		
Health and Wellbeing.....	131		
12.3 Discussions - Poverty, Health and Wellbeing.	132		
Poverty as Key Indicator of Structural Violence and Social Defeat.....	132		
Mental health.....	133		
The looming mental health implications.....	134		
Long-term loss.....	135		
Resilience.....	136		
The Capacity to Aspire.....	137		
13. Conclusion.....	137		
13.1 Learnings: Focus on information asymmetry, health disparities and inequitable access to living standards.....	137		
13.2 The Way Forward.....	139		
Appendices.....	143		

Executive Summary

The COVID-19 pandemic started, when pneumonia of an unknown cause, in Wuhan City, Hubei Province of China, was reported to the WHO China Country Office on 31st December 2019 (WHO 2020a¹). After just 3 days, the reported cases had reached 44, and it was identified as a novel coronavirus on 7th January. By the end of January, globally there were nearly 10,000 confirmed cases, with a suspected 15000 in China (WHO 2020b²). There had also been 2 confirmed cases of acute respiratory disease as a result of the virus. As the spread of the virus continued, reaching 19 countries other than China, it became apparent to the world that this would not remain an isolated outbreak, and other nations began to take action (WHO 2020b). In India, the first pandemic lockdown came into effect on 22nd March, and the serious questions of the social and economic impact of COVID-19 pandemic began to be asked. (Khanna et al. 2020).

The initial 3-week lockdown saw the implementation of an intense campaign to disseminate information around protocols and guidelines for personal hygiene and physical distancing, with focus on contact tracing, quarantine and treatment. It was also at this time when media coverage showed the devastation the lockdown caused for migrant populations. With the termination of the majority of casual labour, the country bore witness to mass internal reverse migration as people walked back to their home states (World Bank 2020³). This very visible and distressing view of over 40 million migrants during that first month, for the most part walking to their home states, could be considered a stark reminder of the differences between those who have and those who have not. This fundamental lack of care that the migrants received gives rise to questions about vulnerable people in India, and what further effects lockdown and the subsequent policy measures and health protocols have had on them. The lockdown continued until 1st of June 2020, when unlock was phased in, meaning that many people in India were restricted, without access, resources, income or employment, health or mental healthcare, for months.

Many countries have populations and individuals who have been subjected to decades of structural and systemic forms of disadvantage and barriers, often rendering them powerless, houseless, homeless, and with scarce or inequitable access to health and social care; prone to stress and social exclusion and indeed

hopelessness and largely deemed a dispensable cultural minority. (Farmer- 2004⁴) However, these communities and individuals are increasing in number, owing to inequitable growth, relative poverty, withdrawal from a society that is apathetic and discriminatory and insufficient safety nets and almost non-existent social capital (UN in India 2021⁵). In addition, a non-inclusive development agenda could pose a double burden for such individuals who are exposed to historical oppression and subjugation, and often subject to social, political and economic inequalities. Not just are basic amenities inadequate, scarcity further impacts life trajectories and decisions making, in the background of social suffering and persistent and complex survival related problems. (Mullainathan 2013⁶).

Most of these communities in one way or the other experience intractable problems ranging from ontological insecurity characterised by housing and living instability to experience of hunger, malnutrition, associated ill health, limited access to education and workforce participation (Padgett 2016⁷). Often many vulnerable populations are also persons with disabilities, posited to be amongst the poorest globally (WHO 2011⁸).

In India there are large populations of disadvantaged people, from the migrants mentioned above, to Scheduled Tribes, homeless, the poor, and those living with psychosocial disorders. From the early days of lockdown, the effects of the COVID-19 on society could be seen as more of a challenge for those who are vulnerable. Social inequities and stark health disparities were no longer hidden and insidiously creeping into lives; they were visible more than ever before and there for all to see. Through loss of income, employment, closing of schools, restricted movement, paucity of aid and resources, how would these people manage? Will they be able to adhere to health protocols? In this context are they more vulnerable than before COVID-19?

Ultra-Vulnerable Persons and Populations

Many people may have experienced an increase in vulnerability through the pandemic, and it is not necessarily restricted to groups that could be considered the most vulnerable. It is apparent however that persons living with disadvantage, characterised by the experience of hunger and deprivation; subpar access to health, housing and livelihoods; presence of disability, chronic health condition or mental illness; and exposed

to structural barriers; likely would continue to have less options or recourse in facing the varied and life encompassing challenges of the COVID-19 Pandemic.

Reviewing the literature since the COVID-19 pandemic in India, several authors highlighted the potential impacts of COVID-19, on various marginalised populations.

Overarching deprivations as a result of poverty, social stigmas and social determinants of health (SDH), such as education, environment and employment, would have a significant relation to the effects of the pandemic (Berkhout et al. 2021⁹). The physical and structural limitations of people's homes, access to clean water, sanitation, even electricity and technology can impact upon how people cope with the pandemic (Lingham & Sapkal 2020¹⁰). Lingham and Sapkal (2020), also demonstrate that these inequalities (including secure employment) show a correlation with the incidence and fatality rates of COVID 19. The mental health implications of the pandemic would also have short and long term impacts, particularly for those who may be predisposed to mental illness, already living with psychosocial distress (Shoib et al. 2020¹¹). Mental ill health is also strongly associated with deprivation and poverty (Reddy 2019¹²; Patel et al 2016¹³). Therefore persons who are Socially Disadvantaged and living with psychosocial distress, and facing challenges of inequality in accessing health or social care needs as a result of abject poverty and structural barriers could have faced an increase in difficulty in their daily lives during lockdown and through the pandemic, and continue to do so.

Homeless and homeless persons living with mental illness were highlighted in several articles and letters, with concerns over how they would face the challenges of the pandemic (Gowda et al. 2020¹⁴; Kar et al. 2020¹⁵; Kavoor 2020¹⁶). The ongoing hardships faced by the homeless and those living with mental illness would pose a higher risk to them, including their lack of access to stable housing, constraints around living in crowded shelters, and their history of inadequate health and mental healthcare and related discrimination. The impact of the pandemic on the reach of services is unknown, however the Homeless in India have limited social support that is tailored to their situation and needs. With the majority of the homeless living in urban locations, the National Urban Livelihoods Mission's shelters and urban health centres could find themselves

overburdened, due to the restrictions placed on people by the public health protocols and lockdown (Gowda et al., 2020).

The trajectory of the COVID-19 pandemic was initially restricted to urban locations with transmission associated with international travel. India however has a large rural population, many of whom are Scheduled Tribes, who live in locations that put them at a distance from the more robust infrastructure of the cities. The impact of lockdown was readily apparent in their loss of livelihoods, difficulties in accessing health care, and basic amenities (Tripathy 2020¹⁷; Kesar et al 2020¹⁸). This impact is in addition to the Scheduled Tribes' history of deprivation, including poverty, lower levels of education, lack of land rights, and poorer health outcomes as a result of the social determinants of health.

The closure of everything, including schools would of course affect everyone in the country, however the adapted methods of learning adopted by wealthier communities (online learning), would be less accessible among the poorer communities and perhaps also less familiar, and also lead them to incur unanticipated costs. Who then would cover the cost? Children from disadvantaged backgrounds would have few options other than not attending school, and how much could this set them back? The implications of remaining at home and loss of schooling, could have long term impact, and in the shorter term will have changed family dynamics and home life. Likewise children from impoverished backgrounds such as groups discussed above would also face the challenges in maintaining good health and accessing adequate nutrition without access to the midday meal schemes and nutrition supplements offered by Integrated Child Development Services.

For purposes of this study, we examine four groups that we consider Ultra-Vulnerable, particularly with the advent of COVID-19; namely the homeless and homeless living with mental illness, persons from Scheduled Tribes, Socially Disadvantaged living with psychosocial distress and children from disadvantaged backgrounds. These groups and individuals are distinct in their social losses through the Pandemic that range from loss of employment to negligible or no access to health and health protection capabilities (sanitary measures such as soaps, toilets, ability to socially distance). They also experience greater propensity to be subjected to domestic and intimate partner violence,

social isolation and therefore, cultivate feelings of alienation and hopelessness.

In addition to examining Ultra-Vulnerable populations, in an attempt to examine local government systems and services and stakeholders' experience during the Pandemic-lockdown, this report would also provide insight into their responses to COVID-19. Therefore, stakeholders such as the National Urban Livelihoods Mission, through the shelters for homeless programme, played a key role in promoting safe spaces and restorative livelihood options, and The Banyan's mental health professionals and community mobilisers who also contributed in developing a robust perspective of the Pandemic response.

Tamil Nadu and the Banyan

The Banyan is a non-government organisation (NGO) based in Chennai, Tamil Nadu, that works with persons with mental health issues, living in states of homelessness, poverty and social disadvantage. It is through this ongoing outreach and other services that The Banyan provides that access to participants was possible during later stages of the lockdown, through the pandemic. The Banyan was in a position to collect information at a time when there were considerable restraints, as they continued their work to support people from disadvantaged backgrounds. Therefore, it was through the following services in Tamil Nadu that participants were sampled.

The Banyan operates various services along a continuum ranging from emergency care to rehabilitation and long term care to address diverse needs for homeless persons living with mental health issues. These include Emergency Care and Recovery Centres (ECRC) in Mogappair, Chennai, Chengalpet and Kerala which has been accessed by over 3000 homeless people living with mental illness of whom a half have satisfactorily transitioned back to mainstream living across India.

The Banyan's NALAM programme (Nalam means well-being in Tamil) is a well-being oriented, community based mental health care programme driven by grassroots workers who offer multi-tiered, multi-interventional packages of mental health care delivered through grassroots mobilisers. NALAM mobilisers work in coordination with the Health and Wellness Centres (HWCs) across rural and urban spaces

including scheduled tribes, with focus on community inclusion.

As part of the outreach services NALAM works extensively with youth and children from marginalised communities and vulnerable backgrounds including children of parents with mental illness, tribal communities, Dalit communities and those living in poverty. Learning centres are located in 9 panchayats in Thiruporur taluk, Chengalpet district and caters to over 450 children, largely first-generation learners.

Home Again (HA) offers 243 individuals with long-stay needs an environment that fosters choice based, inclusive living spaces through clustered or scattered homes in rural or urban neighbourhoods with a range of supportive services based on individual need. All programmes of the Banyan are embedded within a social justice framework and intended to address structural barriers and social factors that impact well-being, as much as the bio- medical.

Aims

This report aims to explore and understand the impact of COVID-19 on the social health and mental health of persons experiencing multiple vulnerabilities including homelessness, deprivation, abject poverty, ill health and disability or social disadvantage.

It further attempts to understand pathways to care and safety networks that support well-being and address distress and deprivation.

Findings from these inquiries will help support development of progressive public policies and plans in the context of mental health and ultra-vulnerable groups.

Objectives

1. To examine the socio-economic impact of SARS-COVID-19 on ultra-vulnerable population, persons from homeless groups, Scheduled Tribes, and socially disadvantaged persons living with psychosocial distress both rural and urban, as well as children from disadvantaged backgrounds.
2. To examine the impact of SARS-COVID-19 on accessibility to health care and well-being needs among these ultra-vulnerable populations.

3. To further determine the impact of social losses experienced by these ultra-vulnerable populations, as a result of the Pandemic and Pandemic – Lockdown.
4. To examine responses of the state public health system to the needs experienced by ultra-vulnerable population, during the SARS-COVID-19 pandemic.

Methodology

This study has used a multi-methods design. A total of 5 groups were recruited into the study. To be eligible, participants had to belong to one of the following groups from either urban or rural areas in Thiruvallur and Kanchipuram Districts, Tamil Nadu.

Group 1: SD Group - Socially Disadvantaged living with psychosocial distress: these persons accessed or continue to access care at The Banyan's Out Patient health posts. (n=382)

Group 2: Homeless Homeless and Homeless persons living with mental illnesses, many of whom access The Banyan's services; a few who were serviced as part of the Banyan's outreach programme: (HHPLMI) (N= 108)

Group 3: Irular - Irular Tribe (Scheduled Tribes) who access the Banyan's services (N= 155)

Group 4: Children - Children from Disadvantaged Backgrounds: where at least one member of the family accessed the banyan's services (n=206)

Group 5: Stakeholders: National Urban Livelihoods Mission (NULM) Shelters (20); Data collectors (employees and interns from The Banyan and the Banyan Academy of Leadership in Mental Health)

The survey tool aimed to understand background characteristics of disadvantaged groups and the impact of COVID-19 on their vulnerabilities. Using frameworks from social determinants of health and mental health, domains included income, gender, education, social and psychological health outcomes, access to essential commodities and amenities and the ability to pursue capabilities and achieve a state of well-being. The role of Structural barriers (eg. gender, class, caste, power) in precipitating disadvantage was also explored.

Thereafter, in an attempt to better understand the experience behind the trends, in depth qualitative interviews were used to gather descriptive information. This was then developed into case studies that further supported results from the survey by providing further depth to the quantitative data. Focus Group Discussions (FGDs) with The Banyan staff (data collectors) was next initiated to bridge gaps in both the survey results and trends and themes emerging from the case studies. This was then transcribed and analysed by a researcher, otherwise not part of the research team to triangulate findings and supplement information, where essential.

Limitations

Convenient sampling was adopted as the primary sampling strategy considering travel restrictions, organisational priorities and the study's focus on vulnerable groups. As a result, generalisation of results may not be possible. However, objectives of understanding circumstances that led to distress as a consequence of the Pandemic and predisposing, precipitating and in some cases, perpetuating as well as the protective factors that enabled pathways out of crisis and social suffering may offer insights, into future health systems and social care systems planning.

Key Findings

Key findings embrace all the sources of data collected through the report, including the survey results, case studies based on qualitative interviews, and data from interviews and discussions with stakeholders.

Socially Disadvantaged living with psychosocial distress

1. Almost all were aware about the onset of the Pandemic.
2. While a majority complied with using masks and washing hands with soap, few were able to purchase sanitisers and more than half found it difficult to socially distance, particularly within their own homes.
3. Besides of fear of infection, there was also the fear of testing positive because of the stigma and processes involving admission to a hospital or isolation.

4. People stated loneliness, uncertainty about the future and grief or sadness as the major impact caused by the pandemic on their mindset with faith or spirituality and talking with friends or relatives being the primary coping mechanisms
5. Almost half those surveyed took loans or pawned jewellery to manage during this period.
6. Many also decreased food intake as jobs were lost and many had meagre or no savings, having worked in the unorganised sector.
7. The socially disadvantaged reported an increase in domestic violence, and substance use post the pandemic with a majority reporting no change in family dynamics.
8. Improved familial and social connectedness was reported by a substantial number of the group, and mutual support is reflected their stories.
9. The closing of religious establishments also seems to have impacted this group with a majority claiming loss of hope besides a loss of support network and in some cases income.
4. More men were found within the City of Chennai – they had travelled for jobs or to access health care and were stranded in the absence of transport to return home.
5. Many persons from the above mentioned group were employed in the unorganised sector (construction primarily or as house/ hotel help) and therefore lost housing facilities with their jobs in the absence of stable housing and safety networks.
6. More women who had been homeless for extended periods were found in rural areas.
7. Many homeless found basic amenities including food, water, shelter, sanitary items (for women during menstruation) inaccessible.
8. Homeless persons faced the double burden of being homeless and seen as a prospective spreader, unprotected; therefore weren't welcome in most localities.
9. Most therefore found shelter on the streets and/ or under bus shelters.

Homeless and Homeless persons living with mental illnesses

1. Awareness on protocols or even the pandemic itself was much lower in this group, particularly amongst those with mental illness who often had wandered away from other parts of the country and didn't speak the local language (Tamil).
2. Besides a third of them claiming to use masks, no other precaution was taken as the resources were unavailable to them, especially during the initial phase of the Pandemic Lockdown when the Corporation of Chennai and Health Departments were getting prepared with what seemed most important – testing, treating and contact tracing to prevent spread.
3. Their primary support – access to religious institutions and people came to a standstill with the shutting down of institutions and people staying indoors. Access to food and money stopped entirely, as a result. Those with locomotor disabilities and psychosocial disabilities seemed particularly affected.
10. Homeless persons living in the same locality over years/decades (sometimes generations) with marginally higher social capital continued to be supported by their neighbours Most homeless found health access unavailable during the early days of the pandemic.
11. After the initial phase of stabilisation, the Greater Chennai Corporation stepped in rapidly to enable care pathways through their outreach that served food and water as well and welcomed persons into their NULM shelters.
12. The GCC have 53 shelters, more than most states; however large numbers of out of state workers and other homeless persons filled up spaces immediately leading to overcrowding in shelters that were also poorly staffed.
13. More shelters were opened in due course to respond to the growing demand.
14. The Health department began offering testing and treatment services to homeless persons in collaboration with NULM shelters and organisations such as The Banyan.

15. The Public health system responded very effectively to other co- morbidities that homeless persons with mental health issues experienced despite the large health crisis and beds filling up in almost all hospitals. No care was forthcoming from private hospitals even in situations of crisis for this group despite ability to pay.
16. There was a marked increase in support and collaboration between different civil society players. CSOs came together immediately and effectively to offer food, provisions and interim livelihood options for residents, especially women through bulk orders of shelter-made products, especially masks. These income generating activities were crucial in alleviating distress and in ensuring financial safety.
17. Volunteers were stated to be pillars of strength at the night shelters when access to public transport was suspended and shelters were short staffed. Residents also stepped in to input into shelter activities and supporting their more vulnerable co-residents, especially children, the elderly and persons with disabilities.
18. Greater Chennai Corporation also established toll-free mental health helplines to provide access to psychosocial support immediately after the lockdown was announced. This helpline, run by partner NGOs and volunteers was an important referral channel for individuals and families experiencing acute distress.
19. Reintegration back to families was delayed during the lockdown as a result of which frustration loomed among current shelter residents and impeded admission to shelters for those in acute need.
20. While, many People stated uncertainty about the future, hopelessness, loneliness and anxiety as the primary impact that the pandemic had had on their mind, some mentioned that this was their lot even in non- pandemic times and that feelings of being segregated wasn't new.
21. They found faith and spirituality along with speaking with family and friends the favoured way of coping. A solidarity group was also formed between homeless persons who supported each other.
22. Homeless persons with mental illness within institutions found it difficult to remain couped up indoors over extended periods of time and following protocols in many psychiatric nursing homes including The Banyan was a challenge.
23. With regards to their mental health, a third experienced an exacerbation of symptoms while a fifth felt distress at the current situation.
24. Public toilets were accessed largely – those in hospitals, train stations etc. Women often felt unsafe and chose timings at the crack of dawn or earlier and post-midnight to relieve themselves.
25. Those NULM shelters and NGOS that managed to access identity cards could enable access of social entitlements and relief measures; but for those on the streets, access to relief measures others than the basics of food water and access to a shelter was unavailable. They were excluded from the Direct Bank Transfers as a consequence.

Irular Tribe (Scheduled Tribe)

1. Compared to other socially disadvantaged groups, the Irular had even less knowledge about the pandemic, its protocols and the reasons for the subsequent lockdown. While they attempted to purchase masks and soaps for their protection, more than half could not afford to leading them to adopt traditional methods of cleansing such as turmeric and cow dung.
2. Over two thirds lost their jobs and struggled to find another during the pandemic. Most opted to go for agricultural labour and in many cases took a pay cut of more than half.
3. This population found anxiety, sadness and anger the primary emotions caused by the current situation with over half of them identifying faith and spirituality as their main source of support.
4. While many sought out part time jobs, a large proportion also took out loans and pawned jewellery in order to survive this period.
5. Children who were 13 years and above, who appeared mature, went to work in agricultural fields, companies and as domestic help.

6. Being located in remote areas, they were cut away from food supplies particularly vegetables and health services and depended on their local goddess, 'Kanniamma' to heal the when unwell.
7. More than half felt a sense of hopelessness with the closing down of religious establishments.
8. Often meals were plain rice and water and maybe an onion or chillies.
9. Lack of identity cards delayed relief to members of this group, and therefore their struggle was longer. Access to transport also delayed their access to formal health care.

Children from Disadvantaged

Backgrounds

1. Most children spoken to were aware of Covid-19 pandemic, its transmission and protocols to prevent its spread.
2. Between 50-60% had the option of alternative schooling of which only about half were able to take advantage as the rest did not have a smartphone or a television.
3. About half the children interviewed in Chennai city perceived that they were facing problems due to the lockdown including not being able to meet friends, not having school, boredom, and to a smaller degree father's substance use, while only a third of the children felt this way in rural Chengalpeta district.
4. Most picked an adult to talk to regarding their problems over a peer, and helped themselves feel better through distraction (TV, Playing, Books etc.) or seeking out a family member or friend.
5. Children staying in homeless shelters were reported to feeling extremely anxious and frustrated at not being able to go to school and getting additional help with education. This was exacerbated in the case of children appearing for board exams (competitive exams that determine admission into college).

1 Background

1.1 Introduction

The COVID-19 pandemic has shaken the world, and as of February 3rd 2021 there have been 113,467,303 confirmed cases and 2,520,550 deaths worldwide (WHO COVID-19 Dashboard 2021)¹⁹. The impact of the pandemic is still being investigated across many fields of study, but with the prediction that the virus will continue to be active for the foreseeable future²⁰, the world should expect far reaching and long-lasting impact on nearly all aspects of society including economies and health and social care systems (WHO 2020b²¹).

Different approaches have been attempted to mitigate the impact of the virus, including measures for containment and closure, economic support internally and externally, and policies and interventions in the health sector (Hale et al. 2020)²². In India from the first cases in January and February 2020 to the sharp increase in cases at the beginning of March, the response was to initially restrict travel, and states were invoking the Epidemic Disease Act 1897, to enable effective quarantines, while guidelines, policies and campaigns were developed around proper hygiene, preventative measures, and contact tracing among others (Ghosh 2020²³, Khanna 2020²⁴). This was followed by the first lockdown on 22nd March, when the Prime Minister initiated the “Janta Curfew”, followed by a nationwide lockdown on 24th March. This lasted 68 days, until the unlock phases, from 1st June, at which point India had 190535 cases and 5164 deaths. The distribution of the cases however skewed to more metropolitan areas, with 4 major cities having nearly 40% of the cases (Ghosh 2020). Despite the growing research of the COVID-19 pandemic in India, many studies focus on general measures taken to control the spread and cope with quarantine of those who have become infected, and base trajectories of the virus based on official reports of the number of cases (Hale et al. 2020) This focused approach is particularly significant in relation to the population of India, as India’s population is not homogeneous, or equal in terms of socioeconomic status or health (Sarkar 2016²⁵). Several authors have noted that vulnerable populations such as homeless, homeless living with mental illness, socially disadvantaged communities both rural and urban, and children need to be addressed both by policy and research in the ongoing

COVID-19 situation (Kavoor 2020; Kar et al; Gowda et al. 2020; Tripathy 2020; Kesar et al. 2020; Unni 2020²⁶; Balasubramanian et al 2020²⁷).

India is known to be a low-middle income country, with a sizeable percentage of its population falling below the poverty line (Ram, Mohanty & Ram 2009²⁸). The actual figures for people below the poverty line in India are varied, however, and entail many methods of measurement. Global multi-dimensional Poverty Index (MPI) has indicated 27.9% of India are in poverty, with wide variations across states, but with improvement between 2005-6 and 2015-16 (Gour & Rao 2020²⁹). In Gour and Rao’s 2020 review of poverty measurements in India, several internal and international measurements were presented in addition to the MPI including the World Bank Poverty Line, and World Poverty Clock, where in India, the population in poverty is 21% and 6% respectively based on the poverty threshold of \$1.90 per day. These figures and numbers give very little insight into the how poverty is affecting people, and according to the World Poverty Clock, the current “extreme poverty” figures have risen to 9%. Interestingly they are also planning to provide details at higher thresholds, of \$3.20 and \$5.50 daily, and provide useful graphics to understand some of the differences between India and the world, as well as between states. The importance however, of having even a minor understanding of the socioeconomic inequalities in India, is its relationship with health and mental health (Asaria et al 2019³⁰).

The complexities of health inequalities have been highlighted by the WHO Commission of Social Determinants of Health (Commission on Social Determinants of Health 2008³¹). In the commission’s final report evidence is provided for the importance in considering living conditions, employment, socioeconomic status, geography, social and economic policies and their effects on health inequalities (Commission on Social Determinants of Health 2008). In India it is of particular interest to see the differences in health based on social determinants as there is significant disparity between socioeconomic groups, Caste and gender as well as geographical areas (Cowling et al, 2014)

Impact of COVID on the Ultra-vulnerable

The impact of socioeconomic and other inequalities on health is not restricted to people who are classed as below the poverty line, and for the purpose of this paper,

a cross-section of Tamil Nadu is examined – looking at those who we believe to be ultra-vulnerable. This is meant to be an inclusive term, covering Socially disadvantaged living with psychosocial distress; homeless and homeless persons living with mental illness; Irular tribe (Scheduled Tribe); and children from disadvantaged backgrounds.

Persons who are socially disadvantaged may face inequalities in multiple dimensions, including poverty, education, employment, health and wellbeing, access to services and social and structural barriers. Those among this group, who may or may not be below the poverty line, but are living with psychosocial distress are still vulnerable as their mental health can impact other dimensions of their lives considerably, especially in the absence of support networks. Mental illness is strongly connected to deprivation and poverty, however as has been explained the cost of treatment is not always part of the measure (Keane & Thakur 2019; Reddy 2019; Patel et al 2016). These multi-dimensional aspects of deprivation and relationships between mental health and poverty therefore make it difficult to exclude those who may be above the poverty line. Berkhout et al. 2021 have presented short and long term affects on those who are poor or in poverty, however how will those who are poor and living with psychosocial distress face the challenges of the COVID-19 pandemic, or the long term impacts on their mental health (Shoib et al 2020).

The homeless populations' vulnerabilities at this time are readily apparent. They have a severe paucity of appropriate spaces to live (even the shelters are overcrowded) and to facilities with hygienic living conditions that include access to proper sanitation, waste infrastructure, appropriate nutrition and health access (Gowda et al, 2020). In addition to these risk factors, their pre-existing socioeconomic status and health status provide additional risks in the current crisis, with a higher prevalence of anemia, injuries and wounds and skin diseases and of severe mental health issues and medical comorbidities including Tuberculosis and other non-communicable diseases (Kavoor 2020; Gautham et al 2020³²). Facing such challenges the homeless population is already marginalised and face a difficult time during COVID-19, however Homeless persons living with mental illness (HPLMI) are potentially at further risk during a time when services are struggling to reach people and the constant risk of infection. HPLMI have a significantly higher prevalence of common mental disorders and severe psychiatric illness compared

with the general population (Tripathi et al 2013³³). The intersection between mental health and homelessness, can contribute to difficulties in accessing social or mental health care (Gowda et al 2017a³⁴). In addition, people living with mental illness could be harder to reach, with care, as well as basic news and knowledge about best practice in the time of COVID.

Rural populations, particularly those who are of Scheduled Castes and Tribes are some of the poorest people in the country, and account for over 8% of the population (Census of India 2011³⁵). With low socio-economic status, limited property ownership, geographical remoteness resulting in poor access to health services, and their reliance on agriculture and Minor Forest Produce, results in a social situation filled with disadvantage (Tripathy 2020; Kesar et al 2020). COVID-19 and the subsequent lockdown had an acute influence on their financial and food security, increasing risks of malnutrition and poor health. Their limited access to resources and health services puts them at much greater risk should the infection spread to their communities. Again within these tribal and rural populations there are those who face the challenges of mental illness, who can be considered as ultra-vulnerable.

Children are universally a vulnerable population, however again some groups are more disadvantaged than others. Children of homeless, homeless mentally ill-persons, and tribal communities, Scheduled Castes and Tribes, and children who are living with mental illness themselves constitute a deprived and large section of the vulnerable populations in India and could be at high risk following COVID-19 (Unni 2020; Balasubramanian et al 2020). Street children, migrant children, children of Scheduled Tribes and Castes, and children with disability or mental illness could be at high risk of malnutrition as a result of the lockdown and loss of income in their families (Saurabh & Ranjan 2020³⁶; Panneerselvam, Perumal & K. P. 2020³⁷, Unni 2020).

Such vulnerable and disadvantaged populations, as above, deserve acknowledgement and urgent attention if equity and social cohesion is to be built and Social Development Goals pursued. While across India various programmes, policies and collaborations across government and non-governmental organisations to support these groups with access to livelihood options and health care have been initiated, challenges still remain (Cowling et al 2014³⁸). In a substantial review of

survey materials, Cowling et al 2014 provide evidence of a reduction in poverty between 1993 and 2011, using the Multidimensional Poverty Index which accounts for factors in health, education and standard of living. They do confirm however that rural communities are much more deprived than urban and Scheduled Castes and Tribes in both urban and rural locations are more deprived than other castes. The sustainability and positive impact these programmes have had can also now be viewed as being at risk, as prior practice and interventions are having to re-evaluate their approach, taking into consideration the costs and difficulties of managing in the time of COVID-19 (Gowda et al. 2020; Kesar et al. 2020; Unni 2020).

Unfortunately, the potential impact of COVID-19 on vulnerable populations is not unprecedented. Although authors as stated above are appealing for both research and action, in India there is a history of disadvantaged groups suffering the effects of an outbreak to a much higher degree than those of higher Caste or socioeconomic status. This is evident from the limited information available on the Bombay Influenza of 1918, with low caste Hindus having the highest mortality rate (Phipson, 1923). As such the narrative of vulnerability for the homeless, scheduled tribes and castes, children, and those who are mentally ill, resides in the history of India as well as the present.

The seriousness of a communicable disease such as COVID-19 for vulnerable populations in India including the homeless, children, Scheduled Castes and Tribes, and mentally ill persons, can be associated with their health risk factors and social determinants of health. Their pre-existing risk factors of communicable, non-communicable diseases, and malnutrition, can too readily be associated with being causal factors in regards to contracting and spreading the disease (Gowda et al 2020, Thresia et al 2020). This can give rise to discrimination related to COVID-19, just as front-line workers have been discriminated against for being in such close contact with the disease while trying to save people's lives (Singh & Subedi 2020³⁹). Subsequently the relevance and understanding of the social determinants of health, becomes essential in comprehending the new and ongoing factor of COVID-19. These vulnerable populations have already been carrying a burden of discrimination and inequality, from poverty to health, and COVID-19 should not further alienate these groups from being involved in efforts to improve their wellbeing.

While the vulnerabilities of these groups, which are among the poorest in India, appear to be growing exponentially, the richest in the world have had their fortunes bounce back within the year (Berkhout et al. 2021). Meanwhile the poor will unlikely recover from a financial perspective for 14 years, Berkhout et al. (2021) highlighting the increased inequalities in the world since COVID-19. Looking at these problems through a perspective of economy limits our understanding of the trials the poor have already faced and will continue to face while the entire world has to recover from the virus and the economic crisis. The social determinants of health can remind us of how interconnected socioeconomic and inequalities are linked not just to a measure of wealth or poverty, but to very real and tangible outcomes in health, education and environment.

Therefore to understand the implications of COVID-19, and the subsequent measures taken across India for containment and control, on the vulnerable and marginalised groups, one needs to understand not only India's history, but where India stood in regards to meeting the needs of these populations both prior to the pandemic, and now, when the end of the COVID-19 pandemic is not yet in sight.

In addition the complexity of socioeconomic inequalities and the link to health and mental health is difficult to unravel. However the development and understanding of social determinants of health and mental health can provide insight into the interaction between wealth, culture, structure and society and a person or populations physical or mental wellbeing (Lund et al 2018⁴⁰ Sarkar 2016; Nayar 2007). Therefore the various contributions to deprivation and inequality will be summarised for the groups mentioned above, in general and how it relates to the populations in Tamil Nadu.

At 12, Alim* and his 14-year-old sister Amina* have had to grow up fast. The pandemic that has turned the whole world upside down has also gravely affected the lives of these two children living in the small fishing community in Dooming Kuppam, Santhome, surrounded by the formerly bustling city of Chennai. These children are among hundreds in this community, who have spent the last 5 months trapped in their 1 room housing board residences, unable to attend school and spending their time watching TV, arguing with their siblings and watching their parents argue.

It has been a tough period for parents as well. Alim's father is a gardener by profession and was earning 16,000INR per month by also working as a driver for a Principal of a local school. With the schools shutting down, he lost his job and has been unable to find another one. Alim's mother has a B. Com degree and is trained as a typist but has been unable to find work since before the lockdown. Through the 5-month period they have had to make do with rice and lentils from the ration shop as well as a grant of Rs. 1000 per month which barely covers their needs. It has reached a point when the family has had to dip into their savings put away for their children's education, just to make ends meet. He has also set aside his pride and taken to requesting local NGOs and religious institutions for help and takes what he can get, under the circumstances.

Alim himself, is bored. He misses going to school and spends almost all-day watching TV. He goes to the local government high school in Santhome and they have not offered any alternative modes of teaching. He is finding it very hard to study on his own and though he has tried to pick up his books now and then, he doesn't feel he has made any progress with them. He wishes they could have introduced mobile classes since his parents are home and he would have had access to their phone. Most of all, he misses playing with his friends but he knows enough from the television and his parents that Covid-19 is a very dangerous virus.

'We're watching it on the news all the time,' his mother says, 'So we know we have to be careful.' 'Wear a mask, maintain distance, be careful outside your house,' Alim parrots. But for this small family there are more pressing matters than a threat of an unknown, mysterious illness. 'We eat only 2 meals a day,' 12-year-old Alim says, rather shyly. 'My mother hasn't worked in ages and now my father too. We cannot afford to eat breakfast or buy snacks.'

In spite of the various setbacks his family has faced, Alim insists that his major problem is only boredom. When he gets upset, he simply stays silent and watches TV for a while until he feels better. Despite of their living condition, he has never thought of running away, and has good support from his family. 'Any problem I have in school, with my friends or at home, I just talk to my parents and they help me figure it out,' he says, showing admirable acceptance of his situation and connection to his family.

1.2 India and the Spanish Flu of 1918: Commonalities and differences

COVID-19 is not the first epidemic to occur in India, and the Bombay Influenza of 1918 is one example that shows not only how India responded, but also shows the India context for how it affected the most vulnerable populations.

The Indian Medical Gazette published a thesis on the impact and spread of the Spanish flu at the time, providing insight into the variations on the spread and provision of healthcare services at least in Bombay (Phipson, 1923⁴¹). First it should be illustrated that during colonial times there was a great disparity between different socio-economic status as well as caste, and those at the least privileged end of this spectrum. In Bombay there were 10 medical dispensaries, with qualified medical persons provided free services to the poorer classes, and it was the records of these, showing use by over 100000 individuals over the course of the year that provided Phipson (1923) the information required for their thesis. Although in the first phase of the epidemic it was found that there were some groups of workers who had a low infection rate, mainly the sweepers both male and female, whereas other outside workers such as postmen and telegraph messengers showed more average infection rates. This may be a sign that despite their various deprivations their isolation during their workday had protected them somewhat as a form of social distancing. However as the disease progressed the mortality rate among the low caste and poor socioeconomic status was considered to be excessively high. It was also noted that children were at approximately double the risk as the adult population.

To clarify the impact on the Low Caste Hindus, their mortality rate was 61.6 per 1000, whereas Europeans mortality rate was 8.3 per 1000 (Phipson 1923). Based on Census data of 1901 the Hindu population of the Bombay Presidency was close to 20 million, of which the low caste population of Bombay was around 15

million (Enthoven & Edwards, 1902⁴²). Whereas the European population was much lower at a little over 30,000. Put in context then if the mortality rates for Bombay Presidency as stated in the Indian Medical Gazette, you can extrapolate the figures, to approximately 265 deaths from the influenza in the European population and approximately of the 1.2 million deaths among “Low Caste Hindus”, which helps portray how mortality estimates of the Bombay Influenza could be as high as 11 million across the country and how disadvantaged the low caste Hindu’s were in protecting themselves from the spread of the

Table The incidence of mortality among the various communities.

Communities	Population by the census of 1911	Number of deaths			Percentage of mortality
		Males	Females	Total	
Low caste Hindus	54,235	1,647	1,697	3,344	61.6
Upper caste Hindus	630,267	6,224	5,735	11,959	18.9
Mohammadans	179,346	1,873	1,574	3,447	19.2
Parsees	50,931	198	262	460	9.0
Jews	6,597	34	64	98	14.8
Indian Christians	41,273	398	363	761	18.4
Eurasians	4,188	29	21	50	11.9
Europeans	11,894	71	28	99	8.3
Buddhists	578	24	2	26	44.9
Total	979,309	10,498	9,746	20,244	

Accompaniment to the December Agenda of the Corporation, Dr Turner, Executive Health Office, Bombay City, to Municipal Commissioner, Municipal Corporation of Bombay, 25 November 1918, General Department Compilation, File no. 353, 1918, MSA.

disease.

In Bombay they contacted employers of labour and put up posters in several languages with recommendation to call for medical help or go to hospital if they are taken ill, and offers of free medical treatment and pneumonia jackets to those wanting to remain at home. Jackets were made to be an inch thick with cotton in the middle and quilted as an alternative to woollen clothing. A Medical Officer was placed on duty to assist voluntary agencies and co-ordinate the efforts of Individuals. About 100 temporary dispensaries were also put up by the Municipality and voluntary organisations to provide milk and medicines. In conjunction with the above measures, several temporary hospitals were established along with hiring of medical men to visit the poor in their own homes. Only the Municipality and the Social Service League took initiatives in setting up

medical relief infrastructure in areas dominated by both the lower class and caste population Satam, 2019⁴³). However at the time following the influenza, there had been hope that the public cooperation could provide a brighter future as the distressing conditions of the poor had been brought to light (Phipson 1923).

Although Bombay is seen as the epicentre for the influenza in India in 1918, the mortality rates in other provinces were substantially worse, up to 55 deaths per 1000 in Delhi. There are limited suggestions of why this may be, however with the spread of the influenza spreading across the states and districts by the railroads, north towards Delhi, it is likely that the migrant labourers could be integral to the spread as also evidenced by other outbreaks in India (Bhagat et al. 2020). However this highlights another facet to the Bombay Influenza and the discussion of health, mental health, and other services: The availability and access to healthcare as well as emergency recommendations (during an epidemic), for the whole population including the tribal communities, the poor and migrant workers. The rapid spread of the Bombay Influenza suggests that these resources were not present across the different principalities and colonies.

There was an organised medical service at this time, including medial dispensaries and medical men, and alongside the growth of “Western” medicine in Europe, they faced the challenges of the reluctance of the Indian populace in trusting this scientific approach to medicine (Rhadika et al 2014⁴⁴). In terms of mental health care, there was also ongoing psychological medicine at this time, with those diagnosed being admitted to Asylums, many of which were privately owned (Rhadika et al 2014; Narasimhan et al 2019a⁴⁵). The Hans Foundation report (Narasimhan et al 2019a) further explains the racial prejudice demonstrated in their diagnosis of the Indian population differentiating the ‘Native’ mind from others, the “western” mind. The availability and conditions of mental healthcare were disparate and poor respectively even post-independence, and long-term confinement for those with mental illness became a common practice for the small percentage that were admitted for treatment (Narasimhan et al 2019a). It wasn’t until the Mental Health Act 1987 replacing the Lunacy Act of 1912, that some people with mental illness were transferred from prisons to state mental health facilities (Narasimhan et al 2019a).

The impression from this time is that although there were philanthropic organisations and peoples looking to uplift and support Low Caste Hindus, as well as other deprived populations with access to medical care and other support, the impact they can have when confronted with such a deadly disease is limited. Such a large population needs systematic, widespread infrastructure, policies and funding to meet such needs as suggested by advocates of Universal Health Coverage where reducing multidimensional disadvantage (social determinants of health) are also necessary to reduce health inequalities. (Akram 2012⁴⁶; Dobe & Taklikar 2019⁴⁷; Arcaya et al. 2015⁴⁸).

As there is a dearth of information on access to healthcare and the impact of the Bombay Influenza on populations such as migrants, poor and rural tribal groups, one has to look at the history of these groups from this period and onwards to understand their socioeconomic status, quality of life, and their deprivations such as poor access to services that many take for granted in the world today. This will be explored in the sections below.

2. Pre-COVID-19

Ultra-Vulnerable groups

Social determinants of health and healthcare

Understanding the health and mental health of diverse populations in India cannot be restricted to rates of mortality, mental health conditions, health conditions, and their access to adequate care. India has complex hierarchies of socioeconomic status, caste, gender and religion, which intersect and directly impact on equity, health and almost all other aspects of life. The need to expand understanding of health is made readily apparent by the emphasis in recent times by the WHO's commission on social determinants of health (CSDH) (Sarkar 2016; Nayar 2007).

In the Commission on Social Determinants of Health 2008 final report, the Social determinants of health have been summarised as:

“The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life.” (Commission on Social Determinants of Health 2008)

The “poor” in India as with the rest of the population is heterogeneous, and interacts with a complex and highly private health care industry. Asaria et al 2019 provide evidence that links wealth or lack thereof to life expectancy with the poorest in the country on average having a life expectancy of 7.6 years less than the richest. There is also some disparity between male and female, and urban and rural.

Accessibility to health services and structures are accounted for as being an integral social determinant in understanding health inequity, but the reliance on the health care sector in addressing health inequalities is inadequate for addressing other social determinants of

health (Commission on Social Determinants of Health 2008). The health care system in India is one of the world's most dependent on private health care, with 80% of outpatient visits occurring in the private sector (Gore 2017⁴⁹) resulting in a downward slide into poverty as a result of out of pocket spending. Cashless care across all facilities is inaccessible. The private healthcare industry in India, is expected to reach a worth of over \$350 billion by 2022 and is among the among the world's best services (Grills 2019⁵⁰).

In a primarily private healthcare industry, the poorer segments of the Indian population are at a disadvantage in accessing healthcare, relying on government and NGO provided services for treatment with wide disparity in coverage across states (Bhaduri 2020⁵¹; Amrith 2020⁵²; Cowling et al 2014). Specifically, this can be seen when the out of pocket (OOP) cost of healthcare is counted as a consumption rather than necessary expenditure (Keane & Thakur 2018⁵³). Keane and Thakur (2018) calculated from 2011-12 survey, that counting OOP medical expenses, 26.4% of India would be in poverty compared to the otherwise calculated 22.3%. Additionally, this hidden cost of medical care among the poor rose between 1999-2000 and 2011-2012 from 10.9% to 18.2%. Meanwhile public spending on healthcare in India is just over 1% of the gross domestic product (GDP) which is among the lowest in the world (Angell et al. 2019⁵⁴). The private healthcare industry in India, is expected to reach a worth of over \$350 billion by 2022 and is among the among the world's best services (Grills 2019⁵⁵). The access of primary healthcare in India is skewed, with over 70% of qualified medical practitioners living in urban areas serving less than 30% of the population (Anant et al. 2016⁵⁶). Additionally nearly 70% of rural providers have no medical training, and just over 20 percent had AYUSH training (Das et al 2012⁵⁷).

Social determinants of health are essential in understanding health inequalities, but also broadly describe a group's disadvantages in multiple areas of life. With such a diverse population in India this becomes particularly relevant to help understand the context of health for different communities. It is understandable in such a scenario that the poor of the country are at a disadvantage in purely accessing healthcare, and this scarcity of access differs not just between states, but also between urban and rural regions and between communities (Gore 2017; Sarkar 2016). The gains in public health as evidenced through the National Family

Health Survey (NFHS), have primarily been through health provider driven programs (Sarkar 2016). Unfortunately, these health gains have not reduced the wide disparities in health between different regions of the country (Sarkar 2016).

Beyond access the social determinants of health in India can provide insight into factors that required more urgent remedial action and planning. Cowling et al's 2014 study provides a summary of the inequalities of social determinants that are risk factors that contribute to poor health outcomes including differences between populations such as SC/ST, gender divides, rural and urban and socioeconomic status. Five main points of particular concern included, air pollution (inside and outside), child undernutrition, unimproved sanitation, employment conditions and gender inequality, which correspond with risk factors impacting health. Also demonstrated were the disparities shown in the Multidimensional Poverty Index, which includes health, between urban and rural populations, Non-ST/SC and ST/SC, and gender inequalities in education, health, economics and politics (Cowling et al 2014; Dutta et al. 2019⁵⁸).

Despite programmes and policies focusing on the health and wellbeing of rural communities and the poor, including SC and ST and their incremental impact on improving health, there has been limited progress on reducing the inequity in health and the social determinants of health across populations and gender (Cowling et al 2014; Mohindra & Labonté 2010⁵⁹). These disparities continue needing to be addressed across India, however some states have had more success than others, but these studies importantly do not include statistics of mental ill health, and the reach of mental health among primary care services. In a systematic review by Lund et al. (2018), they formulated a framework linking social determinants of mental disorders in relation to the UN's sustainable development goals (SDGs), highlighting the interconnectivity of social determinants for wellbeing in general, and found consistent associations between poor mental health and paucity within the categories in SDGs(UN General Assembly, 2015⁶⁰).

Mental Health Care

The matter of mental health is a worldwide health concern, and has even been included in the UN's Sustainable Development Goals (SDGs)(UN General Assembly, 2015). India has committed to achieving the

SDGs, and therefore has continued to support development of mental health programmes (NITI Aayog 2020⁶¹). There are an estimated 150 million people, in India, in need of active interventions for mental health and nearly 12 million of those have severe mental disorders (Lahariya 2019⁶²). To put this in perspective there is less than one trained psychiatrist for every 250000 people, and with the rest of the mental health workforce, there is less than 1 per 100000 population (Lahariya 2019; Gururaj et al. 2016⁶³). Nationally there are only 37 state-run mental health hospitals, and there are very limited alternatives.

In India, The National Mental Health Programme (NMHP) was launched in 1982 following on from the WHO's multi-country project "Strategies for extending mental Health Services into the Community" between 1976 and 1981 (Sadh et al, 2019)⁶⁴. The NMHP aims were to decentralise mental health services, to ensure availability and accessibility of mental healthcare for all, particularly the most vulnerable and underprivileged sections of the population primarily in rural areas. The NMHP was ambitious, however it was unrealistic in its targets considering its resources, funds, and manpower, and setting up psychiatry units in district hospitals would be very expensive (Kapur 2004⁶⁵). Additionally, with a top down approach, the realities on the ground were not taken into account, with the poor functioning of existing health infrastructure in the PHCs (Primary Health Centres) (Kapur 2004). With such issues ongoing, in 2002 the NMHP was overhauled and instead of a focus on community, psychotherapy or psychosocial treatment, the new policy emphasised the use of psychotropic medication (Jain & Jadhav 2009⁶⁶). This encouraged a large increase in funding as the Mental Health question was shown to be solvable by "the pill", and innovation by the states was encouraged, rather than adhering to a strict, prescriptive and unachievable national policy (Jain & Jadhav 2009)

The District Mental Health Programme was meant to help with this gap, and take over from the National mental Health Policy covering its limitations (Sadh et al, 2019). The DMHP was to deliver mental health services at the primary care level by training ground level staff along with a DMHP team for the area, and for it to be sustainable. Instead of focusing on curative approaches they also included preventative and promotive activities, utilising lay people in the communities (Sadh et al. 2019; Kapur 2004). There are various reports and surveys that summarise the national progress of the DMHP, with

123-241 operational DMHPs reported from National Mental Health Survey (NMHS) and Government documentation, and up to 550 from other authors (DGHS 2017⁶⁷; Gururaj et al. 2016; Singh 2018⁶⁸; Sath et al 2019). The NMHS also presented the reach of the DMHPs, where only one third of the surveyed states were the programmes reaching over 50% of the population (Gururaj et al. 2016).

Mental health legislation in India has recently seen many changes with the development of the Mental Health Act 2017 which replaces the 1987 Mental Health Act, and builds upon the National Mental Health Policy 2014 (Lahariya 2018, Pandya et al, 2020⁶⁹). To understand the reach of the services available however first it is required to understand the inequality and deprivation of many in India as it was found in the National Mental Health Survey 2016, that those in the lowest quintile of household incomes show a higher prevalence of mental disorders along with those experiencing poverty and lower levels of education (Gururaj et al 2016; Lund et al. 2018). Although the DMHP appears to have limited coverage, there has been a growth in innovative projects that have increased reach in some areas (Shields-Zeeman et al, 2017⁷⁰; Tripathi et al, 2013; Pandya et al, 2020).

Das et al 2012, found that quality of care however is not determined by training, with untrained providers being better at adhering to checklists, which suggests that effort is a defining determinant of quality of care, and raises the argument for the integrated approaches that have been more successful at reducing the health gap in some states (Bhaduri 2020; Sarkar 2016; Mohindra & Labonté 2010). In combination with the innovative mental health programmes, states such as Kerala and Tamil Nadu, find themselves in a position of successfully providing widely accessible and good quality health care (Sarkar 2016; Bhaduri 2020; Amrith 2020). This disparity between states of health and mental health services has been attributed to the intersection of NGOs, that further the reach of informal services and improve the connection between outreach and primary care services, particularly in states with a history of political and civic activism and support of state government social policies (Sarkar 2016; Kanakaraj 2008⁷¹; Pandaya et al 2020; Subramanyam & Subramanian 2011⁷²).

Mental health incidence among the poor can also be linked to social determinants as well (Lund et al. 2018).

In their summary of findings, poverty is related mostly with common mental disorders, and unemployment, lower SES and diminished wealth. In another review of studies, Cheng et al (2016⁷³) relate the links between lower levels of education and poverty to higher instances of Dementia in India. Alongside the more apparent associations between poverty and mental health disorders, gender, geography and socio-cultural domains can be further burdens to mental wellbeing. A prominent example would be the differences in substance misuse between men and women in India (men's substance misuse being substantially more prevalent), as well as higher levels of depression and anxiety amongst women (NFHS 2016; Cheng et al. 2016; Lund et al. 2018).

Mental health and poverty

A WHO Bulletin in 2003 written by Patel and Kleinman⁷⁴ presented findings and analysis from three large global mental health reports and eleven community studies since 1990. This survey confirmed that there is a strong correlation between poverty and common mental disorders, particularly depressive- and anxiety-related disorders. The authors defined poverty as “low socioeconomic status (measured by social or income class), unemployment and low levels of education” (Patel and Kleinman 2003). The authors of this study were careful to state that causal relations are not necessarily confirmed by correlations, but went on to suggest several factors associated with socioeconomic deprivation that appear to have a strong epidemiological impact upon emotional and mental distress. Patel and Kleinman indicated that income alone is not a determinative factor, whereas when it was associated with poor education and struggles for housing, the relationship with mental illness became stronger. In particular, insecurity over income, such as when a person suffers “an acute income drop in the previous six months” (Patel & Kleinman 2003) raised the risk of mental disorders, noting, for example, farmer suicides in India as falling into this pattern. Not surprisingly, they found a strong correlation, therefore, between hopelessness as a “core experience” that contributed to depression and suicide. Within this core experience of hopelessness, shame, stigma and humiliations associated with poverty were seen as more important than poverty itself. In urban contexts where social change associated with migration led to isolation, loneliness was another key factor leading to common mental disorders, as Durkheim had long ago theorised. Trauma caused by violence, actual physical or structural, coupled with a

lack of social support, played an “important role in the etiology of common mental disorders” (Patel & Kleinman 2003). Gender, the authors also found, was another factor to consider, as women

“bear the brunt of the adversities associated with poverty: less access to school, physical abuse from husbands, forced marriages...fewer job opportunities...” (Patel & Kleinman 2003).

Malnutrition, lack of access to clean water and living in toxic environments, inadequate housing, and other factors associated with poor health, were comorbid with mental health disorders. Moreover, the comorbid health and mental health problems presented increased costs and worsened poverty, contributing to a vicious cycle of psychosocial stress and poverty. The authors of this important WHO report conclude,

“Rather than actual income, factors such as insecurity, hopelessness, poor physical health, rapid social change and limited opportunities as a result of less education may mediate the risk of suffering from mental disorders. The most important implication of these findings is to place common mental disorders alongside other diseases associated with poverty which, on account of this association, attract attention from health policy-makers and donors.” (Patel & Kleinman 2003).

A more recent survey of the epidemiological literature and ethnographic study by Lurhmann and Marrow (2016)⁷⁵ found that the trajectory of schizophrenia, that most refractory of mental illnesses, was also influenced by experiences of “social defeat”, or the repeated humiliations associated with the social violence of stigma, racism, poverty, homelessness, and interactions with a healthcare industry and legal bureaucracy that was oftentimes dehumanising for the afflicted. Better prognoses were seen where housing and work was available, and “diagnostic neutrality” meant that when the emotional emphasis was lesser surrounding this medical diagnosis within the household and wider community, hope was better maintained. This study supported many earlier global studies that suggested that outcomes for schizophrenia were better in many parts of the developing world as compared to the developed world due to greater diagnostic neutrality and lesser emotional investment placed in the diagnosis itself. This study also pointed to the efficacy of community-based

care as opposed to long-term hospitalisation, as the former was more culturally nuanced and placed less emphasis on biomedical care as opposed to psychosocial interventions. Indeed, The Banyan model of community care and local rehabilitation was featured in two of the case studies within the book. As many studies of community-based care have now demonstrated, the long term efficacy of local care provided by lay healthcare workers and paraprofessionals is much greater than hospital care alone in the treatment of mental health disorders (e.g., Desjarlais et al 1995⁷⁶; Patel et al 2018⁷⁷; Kohrt & Mendenhall 2015⁷⁸).

Kleinman (2012⁷⁹), a leading medical anthropologist and psychiatrist at Harvard, has gone further in suggesting that the focus in global mental health must shift from a diagnostic model focusing on pathology vs non-pathology, towards one that addresses “social suffering” in all its multidimensional aspects linking, poverty and health in a cluster of comorbidities, in addition to understanding the psychological experience of suffering in its local and culturally shaped dimensions. As such, he has a focused attention on the sometimes dehumanising aspects of medical care, the ways it can increase social and moral defeat, despite the best intentions. Attention must be directed towards the dehumanising treatment of the mentally ill, rather than simply expanding access to pharmaceutical treatments. In the developing world, however, Kleinman points out that basic access to mental healthcare and counselling is often lacking. He asks, “what happens when we see the state not primarily as the source of powerful control over the mentally ill and through them society at large, but rather as fragile, constrained, and almost powerless to provide the most basic care for its most impaired and vulnerable members?” (Kleinman 2012). In such as context, over-medicalisation is not so much the issue as is alleviating the socioeconomic disparities that contribute to co-morbid health and mental-health problems. Healthcare policy, therefore, is necessarily conjoined to poverty eradication, increasing literacy, infrastructural development.

But creating the capacity for “aspiration” and hope, as Appadurai (2013⁸⁰) notes, also requires understanding the models for living the good and worthwhile life that only culture provides. Therefore, some understanding of locality and context is crucial. Culture is not only about tradition, heritage, and the past reservoir of ideas; rather, culture is a template and matrix for understanding and inducing social actions into the future. Indeed, it is

about the future, as a model “of” and “for” reality, as Geertz (1973⁸¹) famously argued. Much of medical anthropology, Cohen (2012⁸²) notes, has either aligned itself on the side of medicine or against it, in championing locality and culture over universal public health models of illness and disease. That is, some aspects of medical and psychological anthropology have over-emphasised that illness is a cultural construct, or is “culture-bound,” as in the emphasis on “culture-bound syndromes” in the literature. But Cohen, like Kleinman, has also pointed towards another reality: that the body, while cultural and local, is also produced at a confluence of structural conditions and local beliefs. The local body is produced, therefore, through experiences of poverty, malnutrition, and repeated social defeat, as much as it is shaped by beliefs and models for living. Simply put, structural and social violence is at the core of understanding any local context, in addition to how this body is experienced in symbolic or meaningful terms (also see Rajan 2017⁸³). Therefore, ethnographic case studies are invaluable in understanding context in all its symbolic, embodied, and material forms; and as such, indispensable within public health and poverty-alleviation interventions. Understanding social suffering and social defeat cannot be measured in a one-size-fits-all instrument without accounting for the experiences and voices of individuals within particular social and cultural contexts.

The role of the NGO in Global Health

As many scholars and studies have suggested, the expanded role of the NGO in public health and development-related goals and initiatives is likely to increase. This is due to the scale of the problems in complex societies, where healthcare systems are not particularly well entrenched, coupled with the forms of “philanthro-capitalism” (Sunder Rajan 2017) that links funding for public health and development initiatives to wealthy donor organisations at the global level and corporate and/or individual philanthropy. The potential downside of dependence upon NGO work at the local level might be a marked “neoliberal” retreat of state responsibility in providing basic healthcare, coupled with privatisation interests within the pharmaceutical and health insurance industries. On the positive side, NGOs working with community-based models and the strong evidence of their efficacy in reducing symptom recurrence, might be more effective conduits, particularly when stakeholdership is increased within communities along with capacity building at the local

level for sustained efforts. While producing more academic knowledge is useful, participatory forms of community engagement, democratising knowledge, and prioritising local values and beliefs as models for living is also critical, as the capacity for hope and aspiration is rooted inevitably within culture.

2.1 Socially Disadvantaged living with Psychosocial Distress

As research into social determinants of health and mental health has demonstrated, there are relationships between a higher prevalence of mental illness and multidimensional measures of poverty. In the context of this report, we are utilising the concepts of social determinants of health and mental health to present persons from disadvantaged backgrounds who live with mental illness (Lund et al 2018). Persons experiencing psychosocial distress as a result of mental illness or learning disabilities are distinct from those who are not, particularly among persons who are socially disadvantaged (Patel et al 2016; Shoib et al 2020; Reddy 2019). Will the challenges of COVID-19 be different for those with common or severe mental illness? And will the short term effects particularly on mental health have a long term impact on mental wellbeing for persons both living with psychosocial distress and not?

To answer these questions, it is necessary to draw upon the experiences of socially disadvantaged persons living with psychosocial distress. Understanding their circumstances in the location of the study population will help elucidate their access to services, health and mental health care, and the inequalities that socially disadvantaged face.

Tamil Nadu: health and mental health systems – an overview

Nationally the scope and complexity of mental health and health services in India cannot not be sufficiently described, without delving into a more contextual and local understanding. However, with the limited research available it can be seen that it is not just those in “poverty and BPL” in India who are impacted by social and material deprivations which can impact their health and mental health but a whole segment of the poor who face additional challenges with physical and mental wellbeing. With disparate and limited research across India the discreet and separate data (in small studies) provides some insight into social determinants of health

and mental health, that can at least be an example of the problems people face.

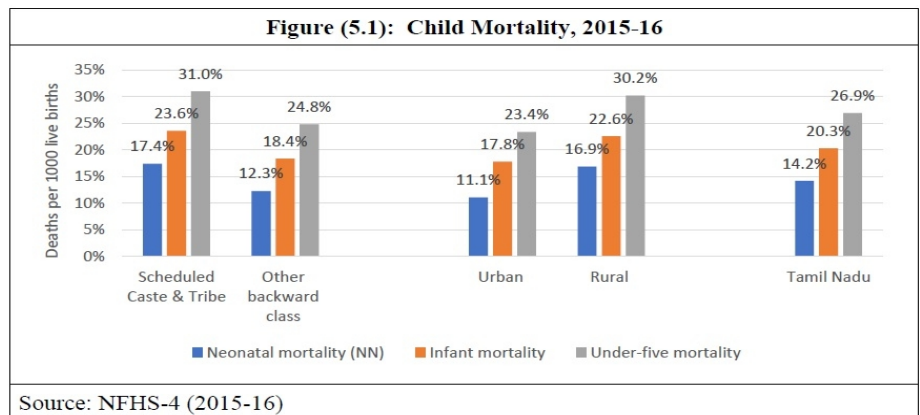
In Tamil Nadu there are less people living in poverty than in other states, and using multidimensional methods, Dehury and Mohanty (2015⁸⁴) estimated that there are 12.7% poor. When compared to the lowest of 5.5% in Kerala, and 19.4% nationally. Health and mental health services for the poor are likewise different across states, and like Kerala the services and policies in place impact health outcomes across socio-economic strata. An important point raised by Subramanyam & Subramanian (2011), was that despite improvement made in Kerala in health outcomes, the rates imply that the differential in disparities (between the poor and wealthy) has not been reduced by their policies. Therefore even in states that have robust infrastructure in place are still struggling with reducing systemic inequalities in health.

In Tamil Nadu there are 18.8% and 69.4% of the population identifying as Scheduled Castes and other Backward Class respectively (NFHS 2016). In terms of poverty, from a national perspective, there are 3.5% in the lowest and 14.7% in the second lowest quintile of wealth in Tamil Nadu. In terms of BPL (and the associated benefits of holding a BPL card) it was found that less than 40% of the lowest two wealth quintiles actually hold a BLP card, therefore the majority of poor households do not have access to this benefit. It is also worse in urban areas compared with rural (Ram, Mohanty & Ram 2009). As found by the disaggregated data from NFHS and the report by Hasan (2019⁸⁵), despite better health outcomes compared to other states, there is still significant inequalities for the poor including tribal and urban populations reflecting the social determinants of health, including socioeconomic status, education, geographic and ethnic disadvantages.

There is a gradient in health and mental health outcomes for the poor, which reaches beyond the poverty line, and as noted previously this can be explained somewhat by the cost of private care, and how these expenses are seen

6.2.2.2 Inequality in Health

51. At the aggregate level, Tamil Nadu performs well on health indicators relative to other states in India; however, the disaggregated data reveal poorer health outcomes, access to and utilization of health services among tribal populations, urban poor, and those living in select districts, reflecting socioeconomic, geographic and ethnic disadvantages. Child mortality, for example, is substantially higher among the Scheduled caste and tribes and those residing in rural areas (see Figure 5.1).



Hasan, R. A. (2019). Final Environmental and Social Systems Assessment (ESSA)-Tamil Nadu Health System Reform Program-P166373 (pp. 1-0). The World Bank.

as consumption rather than necessary (Keane & Thakur 2018). When combined with severe health or mental health conditions these costs can be considerable, and often impact the whole family with needs for treatment and caring roles. Tamil Nadu does present more robust health outcomes as well as health and mental health services, in combination with the NGOs in the State (Cacatorta et al. 2015⁸⁶; Vishwakarma et al. 2020⁸⁷; Hasan 2019). However, inequalities persist, even if to a lesser degree in comparison to most States in India. The opportunity to right this wrong, however is significant.

Nandan, a 45-year-old man, lives with his wife of 20 years and his severely intellectually disabled sister, Shoba in the coastal village of Vadanemmeli in Chengalpet district of Tamil Nadu. Born to a former panchayat or village leader, Nandan and Shoba lost their mother at a young age and were raised primarily by an absentee father and extended family. It was when they lost their father, that Nandan developed mental health issues from finding it increasingly hard to provide and care for a disabled sister and his wife.

The family did find some succour in local organisations. The National Institute for Empowerment of Persons with Multiple Disabilities (NIEPMD) located in the nearby village of Muttukadu, provided treatment and training for his sister's condition along with a day care service and even trained his wife in tailoring. The Banyan provided outpatient care and counselling for Nandan when he was struggling with his mental health. They were also able to access the disability allowance from the government for his sister, and Nandan's wife used the training she received as a tailor to start a small business in her house to supplement the income she obtained from doing housekeeping work in several houses.

Even pre-pandemic, Nandan struggled with finding and sustaining work but eventually found part time employment at The Madras Crocodile Bank Trust and Centre for Herpetology for two days a week doing odd jobs. All together the family subsisted on an income of about INR7000 a month, with Nandan's wife being the primary breadwinner. The role did not sit entirely well with her and she laments, "I do not have any children and all I have is my husband and sister-in-law. Both are dependent on me for even one meal in a day. I wish my husband did not have mental health concerns and we lived a normal life".

The Covid-19 pandemic and country wide lockdown was a huge blow for this small family. Both Nandan and his wife lost their jobs and their income decreased to a mere INR2000 which they received from the government as Covid and disability allowances. They had to manage with this and dry rations received from the government and The Banyan and having to spend long hours together at home, their interpersonal relationships did not improve. Nandan's wife in particular, found it difficult to cope with Shoba's behavioural issues and disability further straining the relationship between husband and wife. It is only with the lifting of the lockdown and resumption of work and routine that the family is slowly finding peace again.

2.2 Homeless Persons and Homeless

Persons living with Mental Illness

(HPLMI)

As of the last Census of India, there are a total of 1.82 million people that are considered to be houseless however this is not necessarily accurate (Census of India, 2011). Many organisations that work with the homeless provide different figures than the census particularly for urban areas, suggesting that there could even be more than 3 million homeless. The trend in previous censuses was for a larger proportion of homeless to be in rural areas, whereas in the last 3 decades this has changed with a significantly larger homeless population being in urban areas (Sattar, 2019⁸⁸). The socio-cultural and socio-economic status of homeless persons are varied, however large proportions of the population fall into deprived segments of the community, including scheduled castes and tribes, Muslim minorities, casual workers and migrants, including women and elderly (Sattar 2019). Homeless children are unknown as a population, with limited studies based in a few cities in India, there is a dearth of information to understand their deprivation (Dutta 2018⁸⁹).

Social Determinants and Access to Health

Care and Shelter

With the definition of social determinants of health, the places that people live can have a major impact on their health throughout a person's life (Sarkar 2019; Goel et al. 2017⁹⁰). Housing therefore is an important social determinant of health, and the lack of suitable housing is often related to economic disadvantages (Sarkar 2019; Mander 2009⁹¹). In India, approximately 37%, actually have a 'permanent' address (indicative of stable housing) as to where they originate from. However, in the cities where they seek work, they live mostly in work sites such as construction sites or hotels or in group housing with shared toilets and inadequate amenities (Mander 2009). There have been schemes that attempt to support the homeless in urban centres, from 1988-89, and onwards including provision of night shelters and later sanitation facilities, under the Ministry of Urban Development (Goel et al. 2017). In 1998 the National Housing and Habitat Policy was drafted with a goal of 'Shelter for All', to provide again dormitories or halls, to sleep in at night, and provide other social support during the day such as healthcare and training. This scheme was withdrawn however in 2005 as the States were not able to utilise the funds. In 2010 it was discovered that the conditions of the night shelters from these schemes were only marginally better than staying on the street, and that their condition was appalling. And it was found

that many casual workers also needed shelter during the day when they could not find employment, and new orders were given to improve the provision of the shelters making them 24-hour refuges. In 2013 the National Urban Livelihood Mission was launched (NULM) to provide a framework for State governments to operate these shelters, however since the establishment of these shelters, from a study in Uttar Pradesh, it has been found that the provision of basic needs has been lacking (Goel et al 2017). There was close to no provision for separate shelters or rooms for women and children, and basic needs, such as bedding and washrooms, forcing people to go back to the streets and sleep rough. Reports and testimonials from homeless persons reiterate why they choose to reject shelter services (Ghildial 2016⁹²).

The urban homeless shelter initiative has undergone multiple iterations over the past decade to adapt to the diverse and changing needs of key constituents. Some of these changes include additions in number of makeshift shelters under flyovers to take refuge in when climactic conditions are extreme (Ghildial 2016). Increase in the number of specialised shelters across the country, especially in Tamil Nadu and adopting new service frameworks in keeping with legislations focussed on protection of fundamental rights and equal participation in civil society. The Ministry of Housing and Urban Development has also created monitoring committees across all states to track quality of services, adherence to basic quality norms, and in creating/facilitating innovations that aid in rehabilitation and centres of excellence.

Overall impact of shelters is yet to be ascertained in their entirety but is critical in charting a new course for robust and inclusive services. Variance in shelter services across different states needs further understanding in terms of political and systemic barriers and motivating factors including intersectoral collaboration, fewer bureaucratic impediments, timely release of funds and adequate staff client ratios, and trainings for service providers.

Lack of identity, and such limited access to services, means that the homeless poor are in an untenable situation, facing deprivation and human rights violations, with ineffective schemes that are not providing the basic necessities including shelter to a large proportion of the homeless (Goel et al. 2017). With such uninhabitable living conditions poor homeless persons' health is far from ideal and likewise mental health can be seen as both a cause of homelessness and caused by homelessness.

Prasad (2012⁹³) summarises the status of the homeless and their access to health care in India succinctly,

considering the global drive for universal health care. He draws on Mander 2009's report on Living Rough in India, where the homeless are considered "vaguely dangerous and intractably on the wrong side of the law" and highlights two prominent issues. First that there have been limited to non-governmental schemes put in place for the homeless, and second, that with begging being criminalised, they are socially ostracised from the rest of India. Even in seeking medical or mental health support, the homeless can face additional barriers than discrimination, including the socio-cultural issues such as illiteracy, language barriers, isolation and lack of social support (Prasad 2012). With this in mind, both Prasad and Mander present the health situation of the homeless in India in stark contrast to the rest of the population with over 100% of the homeless population in Mander's report having major health problems, and 56% needing hospitalisation, but not agreeing to treatment. From the limited material available it is apparent that health is a serious issue for those who are homeless, but also it can be the cause of homelessness (Prasad 2012). Prasad 2012 discusses how a health

condition, injury, or mental illness interacts with a level of poverty, lack of employment or other social support, causing a decline in health and wealth into poverty, debt and homelessness. Therefore the cost of healthcare can lead to poverty and homelessness.

Mental Health Care

Alongside physical health problems mental health can also be a result or a cause of homelessness. Historically the reach of mental health services and programmes has been limited in reaching the homeless persons living with mental illness (HPLMI) (Tripathi et al 2013). With the emergence of the Mental Health Act 2017, there are signs of change, in providing further rights to people living with mental illness and homeless persons (Swaminanth et al 2019)⁹⁴. Some areas of India have benefited from robust systems put in place by Non-Government Organisations (NGOs) but the majority of India is still struggling to provide adequate access to mental health services. The difficulties in reach, access, training and infrastructure are particularly troubling in the context of the homeless, who have a significantly

Fig 6. Collaborative care models which utilise community care only: characteristics and relationships (n = 8).

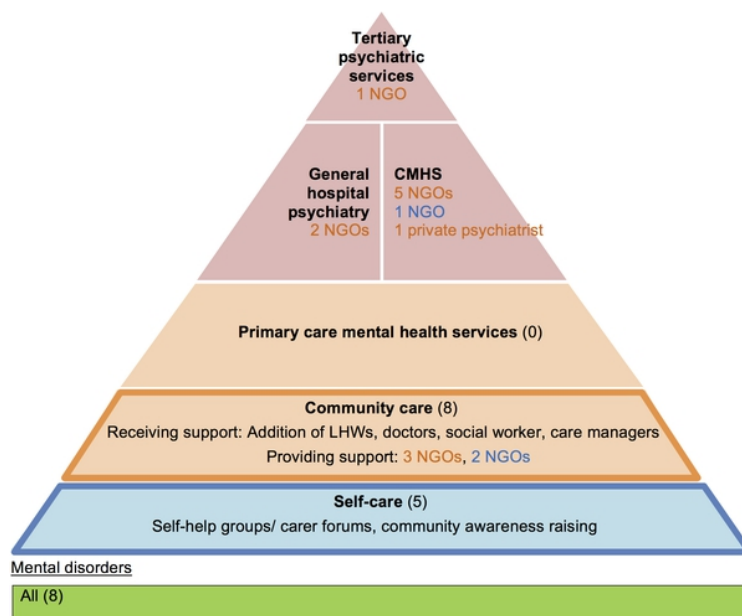


Fig 6. Collaborative care models which utilise community care only: characteristics and relationships (n = 8).

The colour of the font represents which non-specialist level (primary-, community- or self-care) the organisation supports. CMHS: community mental health services; LHW: Lay health worker.

van Ginneken N, Maheedhariah MS, Ghani S, Ramakrishna J, Raja A, et al. (2017) Human resources and models of mental healthcare integration into primary and community care in India: Case studies of 72 programmes. PLOS ONE 12(6): e0178954. <https://doi.org/10.1371/journal.pone.0178954>

<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0178954>

higher prevalence of common mental disorders and severe psychiatric illness compared with the general population. Figures likely vary across India, however it has been highlighted that prevalence of mental disorders is higher for marginalised sections of society, including those with lower income, less employment and lower levels of education (Gautham et al 2020). From surveys of HPLMI who are receiving treatment, we can see figures from 30% to over 50% having severe psychiatric illnesses (Tripathi et al 2012, Gowda et al 2017a). Approximately 65% had psychotic disorders, with Schizophrenia being the most common. Although it is difficult, with limited data, to extrapolate from these studies to the broader homeless population it is estimated from surveys that there could be as many as 15,000 homeless persons living with mental illness in each state (Tripathi et al 2013, Gowda et al 2017a). The disadvantage of the homeless and the prevalence of mental health problems (which can also be the cause of homelessness) coalesce into an array of interconnected social, economic and health difficulties which this population faces. These include poor access to education and healthcare, poverty, discrimination and neglect.

From the limited studies on HPLMI there is hope in their receipt of treatment, with half of those showing improvement, being able to return to their families (Gowda et al 2017b⁹⁵). The reality however is that the number of MIHPs receiving care is unknown, and they have few alternatives beyond staying on the streets, other than institutionalisation or shelters (Narasimhan et al 2019b⁹⁶).

NGO's provide some of the support required by the MIHPs, and in some states are not only linking them with mental health care, but supporting the patients in returning to the community and avoiding long term hospital admission (Tripathy et al 2013, Gowda et al 2017a). This is evidenced by organisations it is possible to support HPLMI through treatment, recovery and returning to the community or family, however as noted above only some areas in India have established organisations and infrastructure.

Tamil Nadu: how are the homeless serviced?

Data from the Census of India 2001, indicates that there are 86, 472 homeless in Tamil Nadu, which at the time accounted for 4.4% of the national homeless population. Global data suggests that persons with mental health conditions and comorbid substance use issues constitute 25-35% of the Mander argues however that this can only

be taken as an estimate, as the homeless are a largely invisible group. Enumeration of homeless persons requires planning and robust technical assistance to ensure that it is as inclusive and consistent with reality as possible.

Although more recent census data shows a reduction in the homeless, the population in urban areas is growing while, rural homeless population is decreasing (Sattar 2019). The majority of respondents from Mander's (2009) study, in Chennai and Madurai (Cities in Tamil Nadu), reported that they became homeless due to extreme poverty, 73.75% and 24.39% respectively. Role of caste in worsening marginalisation and perpetuating broken support networks is an undiscussed yet crucial piece in the intergenerational homelessness narrative.

The large numbers of homeless at this time, in Tamil Nadu, could have been inflated due to the 2004 tsunami, which made over 1 million people homeless worldwide, and caused high risk factors for post-traumatic stress (Government of India Ministry of Home Affairs 2004⁹⁷; Pyari et al 2012). However, in Tamil Nadu there are relatively good provisions for the homeless and homeless living with mental illness, from Government schemes and NGO programmes.

Shelters for Urban Homeless (SUH), of the National Urban Livelihoods Mission, is a Ministry of Housing and Urban Affairs project. Night shelters were initiated in all major cities as a response to the Honourable Supreme Court of India's judgement in 2010 (Writ Petition 196 of 2001) mandating their 24/7 accessibility to all homeless persons free of cost. These shelters are required to provide basic amenities such as food and bedding, in addition, healthcare and livelihood opportunities towards rehabilitation. Special shelters for vulnerable groups including children, elderly, persons with disabilities including mental health issues, transgender persons, individuals affected by HIV were also mandated by the Supreme Court.

In response to this rule, shelters were initiated by the Greater Chennai Corporation's Health Department in Chennai city from 2011 onwards. As on date, there are 53 shelters in the city, out of which over 50% are special shelters. All shelters are run through a public-private-partnership with Non-Governmental Organisations, including the Banyan, which runs a 30 bedded shelter for homeless men with psychosocial needs. In Tamil Nadu they follow the collaborative care models

integrating community programmes with state run services (Narasimhan et al 2019b). This provides a comprehensive mental health service that provides significant access for HPLMI in Tamil Nadu. More specifically The Banyan's Emergency Care and Recovery services, in Chennai, provides a 120-bed facility for homeless women with mental illness in the urban centre that is Chennai. Their success has meant that approximately 60% of their patients have re-joined their families all over India, with 20% in employment, and 61% engaged in household occupations. And their results are not restricted to the sequential treatment and discharge of patients, but providing long term plans and out-patient services, meaning that 73.3% did not return to homelessness and 84.4% received ongoing treatment (unpublished data from The Banyan's aftercare database).

With adoption by the Government of Tamil Nadu, there are now 5 centres, collaboratively run in District hospitals. And further there are community based options for long term care needs for those who are not able to return to their families, with homes of formed families, in both urban and rural locations (Patel et al 2018). With 24-hour support, they have personalised care option with facilitation of work, socialisation, economic transactions, daily living and leisure. This precludes the need of long term institutionalisation in psychiatric facilities.

Tamil Nadu also faces the same predicament as other states with large urban homeless populations, however they have various mechanisms in place to support and help this population. The impact of being homeless however is not necessarily overcome with shelters and health and mental health treatment. There are long term effects of poverty, poor nutrition, unemployment, poor education, stigma and discrimination which will need long term policies and schemes to address (SDH - Sarkar 2019; Goel et al. 2017; Prasad 2012).

Kalpana's story brings to the fore the plight of many persons living with a mental illness during the unnatural circumstances of the pandemic. It also highlights the non-homogeneity in experiences of mental illness and the impact of having a strong support system in one's family.

Kalpana comes from a military family, with her father serving in the army, and was always strong-willed. Graduating with a BA in English literature, she had some success in employment until mental illness struck. Gradually, she began to withdraw from people, including her family. She kept to her room or sat in corners of the house refusing to engage. When her mother succumbed to an illness, Kalpana was shattered and withdrew even more.

Unsure how to manage his daughter and concerned for her safety, her father began to confine her to one room in the house. Disaster struck when during the midst of the Covid-19 pandemic, Kalpana broke all the locks in her room and disappeared into the streets. Having no information about her whereabouts and knowing that she was without her medication, Kalpana's father was forced to lodge a police complaint.

Kalpana was eventually found one evening near a movie theatre by The Banyan outreach team dressed in odd clothes, carrying a bag with a water bottle and photo album, and eating some food that had been provided by local volunteers.

When approached, she was cordial and conversed in fluent English, but expressed no knowledge of COVID-19, or what precautions she should be taking. She instead claimed that she was waiting for the theatre to open so she could release her new film. With multiple visits and persistent engagement, the outreach team were able to discern her family's whereabouts and contact her father. When he finally saw his daughter, he was overwhelmed with emotion.

After spending time with Kalpana's father and brother, the team sensed their commitment to caring for Kalpana and helped orient them to the kind of care she needed at home. They also referred her to a hospital near her home for further treatment. Kalpana too, was willing to return home with her father. Subsequently, the family has been in constant touch with The Banyan and were particularly relieved when Kalpana's Covid test came back negative, in spite of her time on the streets.

2.3 Remote Rural Populations and Irular Tribe

History

First reviewing the history of tribal populations, there is limited to no information on the impact of the Bombay Influenza on their population, or if they had access to health services. However, the attitudes and views of the tribal population pre-independence can provide some insight into their circumstances and deprivations. During British rule land, both forests and farmland was made the property of British designated landlords, who used the land to maximise profits, bringing in outsiders to work it (Meena & Singh Meena, 2014)⁹⁸. This brought about many exploitative actions that deprived the tribes of their resources and forests, while also enforcing taxation on these poor groups forcing the adivasis to take extortionate loans from moneylenders or the landlords themselves. This enforced many into becoming bonded labourers, and their children would inherit the debt, and have to continue working for the landlords. Alongside these exploitations and deprivations, the adivasis were often isolated groups and were at very high risk of infection by the various diseases brought in by outsiders.

In 1935 Scheduled Castes were introduced to the Government of India Act, which categorised the depressed classes (Meena & Singh Meena, 2014). After Independence the definition of Scheduled Castes and Tribes was retained in the constitution. There were measures and provisions made to safeguard the interests of the tribals and their development, however there are two opposing views from isolationists to nationalists. Isolationist would cut off potential development to preserve their way of life, and Nationalists would aim to “uplift” the tribes rapidly integrating them into India. The Indian Constitution adopted a policy of progressive acculturation of tribal communities, with the aim of advancing but not to lose their culture and histories. History however has shown how the supposed plans for uplifting, education and development have not been as successful as the provisions set out had aimed for.

Adivasi and Dalit Poverty

Recent studies of poverty among disadvantaged groups in India have shown that Adivasi (Scheduled Tribe) rates of socioeconomic deprivation is “more striking when compared with that of other disadvantaged groups

such as Dalits and Muslims” (Guha 2007⁹⁹). The historian, Ramachandra Guha, has drawing upon the work of demographer, Arup Maharatna (2005¹⁰⁰), presented findings that underscore the vulnerabilities facing Adivasis in quantitative measures, whilst also noting that several ethnographic and historical works, including the ones he himself has authored, have illustrated the hardships and iniquities of tribal life. He writes: “when assessed by the conventional indicators of development, the adivasis are even worse off than the Dalits. For example, the literacy rate of adivasis is, at 23.8 per cent, considerably lower than that of Dalits, which stands at 30.1 per cent. As many as 62.5 per cent of adivasi children who enter school, dropout before they matriculate. While a shocking 41.5 per cent of Dalits live under the official poverty line, the proportion of adivasis who do so is even higher—49.5 per cent. With respect to health facilities, too, the adivasis are even more poorly served than the Dalits, 28.9 per cent have no access whatsoever to doctors and clinics; for Dalits the percentage is 15.6 per cent.” (Guha 2007); also see Lerche & Shah 2018¹⁰¹). He goes on to point out that access to safe drinking water and immunisations also breaks down along similar lines of inequality. Moreover, Adivasis, he shows, are far more likely to have their lands alienated for commercial forestry, dams, and mines. Displacement is thus a recurring problem, and suggests that “a tribal is five times as likely as a non-tribal to be forced to sacrifice his home and hearth by the claims and demands of development and/or conservation” (Guha 2007:, p3306; Shah & Lerche 2018¹⁰²). Selvarajan, (2012¹⁰³) in a statistical study of alienated tribal lands in Tamil Nadu, points to another problem: indebtedness brought on by the inability to cultivate lands, crop failure, and locational disadvantages led many to sell their land. He also notes a special difficulty in Villupuram and Chengalpet districts, the areas close where the Irulas in this study reside. In these districts there has been encroachment by non-tribals upon tribal lands, as leased lands to non-tribals by tribals were not returned about the ending of a lease. Also, the government in 1984 had issued an order “that if tribes could prove they have been in possession of the lands for a three-year period, they could be assigned lands” (Selvarajan 2012:p111). But as many tribes practised shifting cultivation, proof on continuous use and residence upon a tract of land was hard to produce.

The economist K.P. Kannan (2018:p35¹⁰⁴) utilises a different set of data sets but comes to similar conclusions, showing that Dalits and Adivasis, in particular, had the highest rates of poverty, followed by Muslims and OBCs (Other Backward Classes).

In a recent ethnographic study of an Irular and Dalit community in Cuddalore, South of Chennai on the Coromandel (East) coast found that both communities faced significant challenges and precarity in finding work in an area dominated by a large chemical production factory (Donegan 2018¹⁰⁵). Old patterns of patronage and servitude were reproduced through patron-clientele within the local political bureaucracy. Access to land and jobs were determined by older pre-existent hierarchies, such as caste-based land lordship and tenancy, but recast in modern bureaucratic forms. As such, Dalits and Adivasi Irulas were sometimes pitted against one another in the struggle for income and services, if not land and housing. While seasonal migrant labour was practised by both, intermediaries contracted labour through patronage networks. These intermediaries, according to Donegan, practised “divide and rule” tactics, not only between the Dalits and Irulas, but also with migrant labourers who came from Odisha and other states, and were willing to work for even lower wages. In his nuanced account, new forms of power were exercised to exclude Irular from gaining access to land and “community certificates” attesting to their legal rights as belonging to a scheduled tribe. Obtaining community certification, however, is complicated by local political dynamics of patronage as well as internal divisions within the community, particularly when some members have accepted SC certification in order to access educational placement in a local college. Donegan, in short, describes a complicated socio-political context, internally divided by factions and different lines of patronage, all of which would be difficult to discern without ethnographic research. But as a whole he found that Irulas had less access to education and jobs, and were stigmatised as “tribals” by other communities (Donegan 2018. p112). Donegan’s account of the extreme marginality faced by Irulas has echoes in the present case studies and aggregate data (see also, Srinivasan & Ramakrishnan, 2020¹⁰⁶).

This is not to suggest a perfect fit between older forms of hierarchy and the current predicament faced by vulnerable and marginalised communities. As Shah and Lerche point out, “access to livelihoods in the informal

economy for Dalits and Adivasis occurs beyond the old bounds of the patronage of village hierarchies.” But, the relative “processes of inequality involving their inherited powerlessness in relation to the power of dominant social groups and institutions,” has circumscribed their ability to access secure income, education, and land rights, not to mention sufficient nutrition and healthcare access (Shah and Lerche 2018: p17). Specifically, Shah and Lerche propose three interrelated processes that entrenches inequality and precarity for Dalits and Adivasis: “inherited inequalities of power; super-exploitation based on casual migrant labour; and conjugated oppression (that is, the intertwined multiple oppressions based on caste, tribe, class, gender, and region)” (Shah & Lerche 2018:p2).

Health Care

With the history of deprivation, the Scheduled Tribes and Castes are not unique, and are among a universal group in the world of indigenous populations who suffer health and wealth inequalities (Srinivas 2019¹⁰⁷; Subramanian et al 2006¹⁰⁸; Stephens et al 2005¹⁰⁹). This deprivation is not limited to health inequalities, and Scheduled Tribes continue to have a significant difference in their level of literacy and education, poverty and material wealth, food security, nutrition and clean water, access to sanitation, mental health and health services, maternal and child health (Kanagaraj et al, 2019;¹¹⁰ Mohindra and Labonté 2010). Therefore, there is an intersection of social determinants including caste and class, in relation to rural health and their access to health services.

In terms of policy measures for STs, there has been a focus on healthcare and rural access to such services, whereas other social determinants of health, including poverty, food security, access to sanitation and discrimination provide challenges to Scheduled Tribes that policy has not fully addressed (Mohindra & Thresia 2016)¹¹¹. In reviewing the India National Family Health survey 1998-99, Subramanian et al’s (2006) study shows a significant gradient in mortality and health behaviours (such as smoking and drinking) related to indigenous people’s socioeconomic status. The health divide between “indigenous” and “non-indigenous” populations is explicitly evident in the differences in mortality rates, with 2.6% and 2.2% respectively (Subramanian et al 2006). In addition to this relationship scheduled tribes continue to carry the burden of higher proportion of infectious diseases, malnutrition and maternal mortality (Mohindra & Thresia 2016). There

exists a wide consensus that tribal populations are the most marginalised and deprived communities and there exists scant and scattered information regarding the burden and patterns of illnesses they suffer from.

Mental health

With the advent of the District Mental Health Programme in 1996, there was hope for rural areas to gain better access to mental healthcare, however despite how long this programme has been in effect, implementation has been lacking (van Ginneken et al 2017; Gururaj 2016)¹¹². There still exists a large mental health gap, and there are various impediments to supporting the mental health needs of rural populations, including poor or limited training for PHC medical professionals, overburdened systems, and low levels of funding (Mahajan et al. 2019¹¹³; Kapur 2004). The geographical constraints to providing mental health care and even physical health care cannot be ignored, with villages often being located kilometres away from the Primary Health Centres (PHC) with limited to no transport to access the service.

As such many Non-Government Organisations (NGOs) have attempted to fill the treatment gap, and are implementing innovative models to deliver mental health care in geographically remote areas (van Ginneken et al, 2017; Shields-Zeeman et al, 2017). NGOs are leveraging the potential in lay health workers (LHWs) in furthering their reach, and relying heavily on Specialists as supervising and training resources across the mental health care provision. In terms of LHWs, volunteers, self-help groups, farmers groups, other community non-specialist health workers are trained to identify mental disorders, and given the tools to support people in accessing further support, including social benefits, providing awareness and promoting well-being. As identified in evaluation of these programmes, there are benefits in utilising local resources, not only for sustainability and scalability but as these local partners providing access mental health care and some counselling are already part of the community and provide an easier transition into primary care services when required (Pandya et al 2020, Shields-Zeeman et al, 2017).

Irular Scheduled Tribe in Tamil Nadu

In Tamil Nadu there is a low percentage of the population that is of Scheduled Tribes, only 1.9% which is much lower than other states, however due to the high

population figures the absolute population of ST is higher than many other states (Vishwakarma et al. 2020). Irular is one of the Scheduled Tribes in Tamil Nadu (Gnanamoorthy 2015¹¹⁴). They were traditionally rat and snake catchers and are now involved in occupations such as cattle-breeding, working in the fields, and fishing. The Irular tribe inhabit the lower-regions of the Western Ghats which cover the South Indian states of Tamil Nadu and Kerala (VR & Mani, 2014¹¹⁵). Since they are spread across such a vast region there are some parts of the community that live in urban areas whereas some reside in more interior villages. This difference in location affects their access to healthcare. A study by Saheb (2006¹¹⁶) explored the indigenous health care practices of the Irular population and found that access to healthcare determined the kind of resources that would be preferred by the community. And since in the interior villages, primary healthcare centres and hospitals were not available a lot of the people there relied on traditional methods such as herbal medicines, magico-religious practices including prayers and spells. With lower incomes and poor infrastructure, rural communities are at once both, at higher risk of health and mental health problems, and have difficulties in accessing health and mental health care services.

Restricted access to medical facilities and dependence on non-medical professionals for treatment has further led to poorer health outcomes for the Irular tribe. A study by Santhosam and Samuel (2013¹¹⁷) looked at the health condition of elderly Irular women in the Kancheepuram district. In their study, they found that all respondents reported some or the other ailments and the most common were hypertension (22%), arthritis (17%), diabetes (10%), anaemia (10%), skin problems (12%), and vision problems (18%). The women also reported that doctors were not usually available at the nearest Primary Healthcare Centres which in itself was 20 km away from their village. They also said that they could not afford private healthcare since most of the women were homemakers and no longer had any disposable income.

A study by E and Mahadevan (2015¹¹⁸) looked at some of the psychosocial factors that were involved in poorer health results for the Irular tribe. They found that many people in the community do not have *patta* (community certificate) for their residence which would affect their access to government scheme benefits. The Irular tribe was also further affected by factors such as poor housing conditions, poor sanitation, early marriage, and

alcoholism. There was also a high prevalence of anemia (58%) and thinness (63.5%) in young girls in the Thiruvallur district and these conditions only worsened with age. Additional conditions such as typhoid (8%), HIV (3%), and Syphilis (10%) were also noted in the Irular tribes of the Marakkanam district. This study also noted that the proximity to an urban centre influenced the kind of healthcare that was accessed by the tribal population. There was greater trust in 'Western/modern' medicine in the tribes that were closer to hospitals or primary health care centres. Extreme poverty and low literacy levels were also attributed to factors for poorer health outcomes.

Substance abuse and alcoholism were also seen as major public health concerns in the Irular population (E & Mahadevan, 2015). 22 percent of the women in the study said that they regularly used tobacco, 31 percent said that they consumed alcohol and 3 percent said that they smoked. The severity and dependence of alcohol abuse were noted to be higher in the tribal populations compared to other social groups. Substance and alcohol abuse was also understood in the purview of lack of finances, lower socio-political status and lack of employment.

As can be seen in the studies above, there are correlations between socio-cultural/political status and poor health, as well as lower socio-economic levels, and all of the above ties into the concept of social determinants of health and mental health. In terms of mental health there can be considered to be.

2.4 Children from Disadvantaged

Backgrounds

Inheriting the disadvantages of their parents, children in poor communities face the same challenges as their parents, many missing out on schooling to support their family by working for low wages, and many suffering from stunting due to poor nutrition and lack of resources (NFHS 2016; Cry.org 2021¹¹⁹). Specifically in India, 38% of children are stunted, with 58% having anaemia, and these conditions link to their mothers' nutrition and even education (NFHS 2016). Nationally there is higher neonatal mortality for those in the lower quintiles of wealth, and the same is generally true for mortality up to the age of 5 years old (NFHS 2016). There are also higher neonatal and child mortality rates among parents with fewer years of education.

With a higher prevalence for poor nutrition and being at risk of stunting, children then proceed to be poorly catered for with education, with 1 in 4 children not attending school. Education is a highly relevant indicator for both socioeconomic status and health, where more years in education correlate with improved health outcomes, increased wealth also correlates with more years in school (NFHS 2016). The survey also points out the importance of education in relation to utilising the health services that are available.

Within poorer populations the prevalence of child labour is higher, with 80 per cent of working children living in India's villages, where most of them work in agriculture (Cry.org 2021; Ganguly (ed). 2019¹²⁰). The Census Reports indicate that out of all social groups the incidence of child labour was highest among Scheduled Tribes in 2011. Additionally, within the poorer populations in rural and urban India, children even voluntarily turn to work, to support their families (Ravichandran 2020¹²¹) who are with their families will often turn to work in order to support their family's wellbeing, ensuring that they have enough income for food and health needs. This is evidenced by another under-represented group, Street Children, where with minimal educational options, even if they are living with their families

Female children suffer the additional burden of marriage with 42% of the women in India being married below the legal age and age of majority (District Information System for Education (DISE 3). 45 lakhs under 15 were found to be married with children with 70% of them having two children (Census of India 2011).

Mental health.

Suicides among youth continue to be a major cause for concern with fear of failure in examinations as the second highest cause of suicides in children (Accidental Deaths and Suicides in India ADSI 2014¹²²). The NCRB data shows that 10,159 students died by suicide in 2018, with an average of 28 per day, over 1 every hour. Tamil nadu was second in the country with 953 childhood suicides. 270,605 children are homeless across the country with 68% of street children being illiterate, 40% working in the unorganised sector and 35% dealing with substance abuse. The 2011 census also found 10.13 million children below the age of 14 and 33 million below the age of 18 engaged in labour rather than going to school. Over the last 10 years, crimes against children have increased over 5-fold with 150

children going missing everyday across the country (National Crime Records Bureau 2016).

A strong connection exists between parental mental illness and lifetime mental health risk for their children (Ruud et al., 2019¹²³). Compared to other children, those growing up with a parent with a mental illness are at risk of a range of adverse behavioural, developmental and emotional outcomes. Bell et al. (2018¹²⁴) found that children of parents who had been hospitalised for a mental illness were much less likely to be school ready. Worldwide, 15-23% of children live with a parent with a mental illness. These children have up to 50% chance of developing a mental illness (Leijdesdorff, 2017¹²⁵).

The Tamil Nadu perspective

The social determinants of health as seen among the poor and deprived populations of India above are just as valid for the children in these communities. It is disheartening, that the children in India face such difficulties, and that there are currently not enough resources to prevent the inheritance of poverty and deprivation.

For children in these communities their health inequity and disadvantages start from before their birth. Child bearing can often happen at a younger age when from a poorer background, and in Tamil Nadu, 5% of women are childbearing in their teenage years (NFHS 2016). Child stunting in Tamil Nadu is better than the national average at 27%, however it was also found that those in rural areas are more likely to be stunted, and still represents the equality differential between those who have and those that have not. In Tamil Nadu they have nearly 100% attendance for births in Health Facilities.

The impact on health and wellbeing for children is often dependent on their family's status. Cacatorta et al. (2015) examine the state differences in nutrition for rural India, and highlight Tamil Nadu as a good performer. Social determinants such as education of the mother, smaller households, lower incidence of anaemia among mothers is positively related to child nutrition. However other factors in Tamil Nadu are worse than other states, such as levels of land ownership. Child mortality (under 5 years of age) among Scheduled Tribes (ST) and Scheduled Castes (SC) in Tamil Nadu in 2011 was reported as 58.1 and 51.5 per 1000, whereas Non-ST/SC was reported as 47.7 per 1000 (Vishwakarma et al. 2020). Vishwakarma et al's (2020) review of census and National Family Health Survey, also showed

immunisations to be significantly lower among scheduled tribes in Tamil Nadu.

Reviewing some of the more specific literature, can provide insight into the correlations between social determinants and specific health conditions. For example, acute respiratory infections were more common among families residing in semi pucca and kutcha homes, with poor ventilation and smoking in the family, and malnourished children among others (Savitha & Gopalakrishnan 2018¹²⁶).

Although Tamil Nadu has adopted health reforms positively, the inequalities for children from poor or disadvantaged backgrounds is still evident in the literature. Any specific count of the number of disadvantaged children may not be possible, but the statistics suggest that they along with the adult population would benefit from improvements in their quality of life and social determinants of health and mental health.

Padma was born into a family with alcoholic parents who regularly fought under the influence. Due to this unstable environment at home, Padma and her siblings moved to their grandparents' home where Padma went to work at a farm so she could support her siblings through her meagre earnings.

At a young age, she was married and she describes her marriage saying, "If I know what happiness is all about, it is because of my husband."

Post the birth of her second child, Padma experienced her first seizure post which she began to withdraw emotionally and socially.

It was then that she learnt of The Banyan through its grassroots workers, the Nalam or well-being mobilisers and began treatment.

Her condition seemed to be improving when the Covid-19 pandemic hit.

Left without a source of employment and no money for basic necessities such as food for the family, she was forced to travel barefoot with her husband to nearby towns in search of a source of income. As they were unable to afford masks, they were treated extremely harshly by authorities who would stop them and send them back from where they came. Slowly, as NGOs began to step in and government measures announced, there was some respite. They were able to collect dry rations and medication from The Banyan and also received an allowance of INR1000 from the government. When they developed Covid like symptoms, they were engulfed with stress as there was limited access to local and affordable healthcare.

The couples' main worry however remains the impact the pandemic has had on their children's education. "Just now for the past few years we have come forward and started to send our children to school and we are worried that during the lockdown, the education might get disturbed and we might take a step backwards. The question of what if my child loses interest in studies constantly haunts me."

3. Impact of COVID-19 on vulnerable people and the need for Study

This section explains the need for the study in the context of Ultra-Vulnerable groups, based on concerns raised by policy makers, human rights advocates, public health researchers and practitioners, social scientists, mental health and development professionals and most importantly members of these groups themselves about the short and long term impacts of COVID-19 on socially disadvantaged persons living in psychosocial distress, homeless and homeless persons living with mental illness, persons from the Irular tribe (Scheduled tribe) and children from disadvantaged backgrounds. This will put in context potential challenges and effects of the pandemic and the pandemic- lockdown in the context of these groups, in India, and highlight some of the actions taken by the government and NGOs.

3.1 Socially Disadvantaged living with Psychosocial Distress

Describing the “collateral damage” of COVID 19 Dore (2020) explores the extent of distress experienced on account of essential hospital and health services being restricted following the lockdown. Across India many patients couldn't access dialysis, transport services were sporadic, disrupted or altogether non-existent, hospitals worked below capacity, postponing elective surgeries, and some closing down completely due to their staff testing positive. Collating anecdotal evidence, there were three groups – the first that avoided hospital visits for fear of spread of infection, the second that couldn't reach a hospital and was therefore, not able to access care and in some extreme and tragic circumstances lost their lives at home and the third that was refused care, especially by private hospitals who in the initial period turned away almost everyone who seemed to have any symptom that resembled COVID-19. Needless to say, it was mostly the poor that were turned away despite expressing ability to pay. Many high risk groups including those with progressive diseases and / or those in need of acute care had to contend with multiple problems including the lack of transport and functioning hospitals. Some efforts had been made to provide virtual solutions. With guidelines from central government for healthcare needs to be met and passes issued for transport during lockdown, the reality was that many could not access these services.

Mental health was also affected, most likely across all populations. Shoib et al (2020) have highlighted the psychological impact of pandemic resulting in increased anxiety and stress, post-traumatic stress disorder, depression, loneliness, and the risks this increase in mental health issues could have on suicide rates. The spike in death by suicide post the Pandemic is now well evidenced. In the case of those living with severe mental disorders one observed exacerbation of symptoms and the inability to seek emergency admissions, placing the mental health service user and their caregiver in situations of distress.

Inequalities impacted the way in which the poor coped with the Pandemic and the Pandemic - Lockdown (Berkhout et al. 2021). In terms of housing the poor were at a disadvantage during the COVID-19 Pandemic, with limited space and opportunity to socially distance. It was highlighted in “The Inequality Virus” report as to how almost two thirds of India's population live in one- or two-bedroom houses (Berkhout et al. 2021). In addition, inadequate access to clean water, sanitation, electricity further impacted coping strategies (Lingham & Sapkal 2020¹²⁷). Lingham and Sapkal (2020), also demonstrate that these inequalities (including secure employment) have a correlation with the incidence and fatality rates of COVID 19.

Secure employment has a weighted contribution to a person and family's wellbeing, where options for statutory support are limited. Close to 90% of the workforce in India works in the informal sector (Shekar & Mansoor 2020¹²⁸). Shekar and Mansoor go on to describe the varied impacts of COVID-19 on the informal sector, including on those who are self-employed was particularly harsh. With the migrant workforce during lockdown, having to return home, and losing their income, it can be somewhat extrapolated that the loss of income in the informal sector is going to be a considerable concern, and affect people from some of the most disadvantaged backgrounds.

3.2 Homeless Persons and Homeless Persons living with Mental Illness (HPLMI)

HPLMI live with a multitude of vulnerabilities, and are commonly exposed to many comorbidities. Both Kavoor (2020) and Kar et al, 2020 highlight the social disadvantage and risk the homeless and HPLMI

experience from being particularly vulnerable, owing to limited access to information, inability to access adequate sanitary measures and not being able to social distance, particularly when they are admitted into shelters, mental hospitals or prisons.. Additionally, they are at greater risk due to poor immunity (malnutrition), limited health awareness, poor help seeking behaviour and increased mortality rates.

Since the lockdown there have been efforts to help the homeless and HPLMI. Shelters and nutrition have been increased and improved respectively for the homeless population including HPLMI, utilising Chatrams (Choultry/marriage ceremony halls), community halls and other unoccupied buildings (Gowda et al. 2020). Many shelters screen for communicable diseases, and provide basic health care, however few states do not have the provision of night shelters even. Furthermore, special shelters that provide mental health care are scarce, placing the most vulnerable amongst the homeless at greatest risk of being made invisible and exposed to harm and social suffering as a result of the Pandemic; despite being so alienated that perhaps this was one of the few groups when sleeping rough to be least exposed to infection.

3.3 Remote Rural Populations and Irular Tribe (Scheduled Tribe)

Rural populations in India rely heavily on craft to supplement their income, which was significantly affected by the Lockdown (Tripathy 2020; Kesar et al 2020). The Lockdown in March prevented rural communities from engaging in minor forest produce (MFP) and farming (Tripathy 2020; Kesar et al 2020). When such populations are already at severe disadvantages due to poverty and the health gap, the ramifications of the lockdown are far reaching from economic stress to health and food insecurity (Kesar et al 2020; Panneerselvam, Perumal & K. P. 2020). Tripathy 2020 explores this impact for the rural tribes of Odisha, and identifies how restrictions of the lockdown in March severely affected the rural tribes' income. With MFP providing tribal people with up to 40% of their income, and also a subsistence income during lean seasons, the loss of this severely affected their financial liquidity (Tripathy 2020). The restrictions were not limited to the loss of MFP, also preventing markets from being open and even when MFP collection was allowed with social distancing there remained no means to sell their produce (Tripathy 2020). Overall, in rural areas of

India, those with low incomes of less than 10,000 rupees per month, there were a loss of employment for Scheduled Castes and Tribes was up to 61% and 55% respectively, and those who managed to stay in employment had around 50% less earnings during the lockdown (Kesar et al 2020). In conjunction with employment and earnings, food security was just as severely hit, with 75% of rural populations reporting, in Kesar et al's 2020 study, that they were consuming less food than before, 35% reporting having not enough money for essentials, 33% taking loans and 65% not being able to afford rent for the next month.

Many financial efforts had been made to support disadvantaged groups, including poor rural communities, migrants and other poor persons (Kesar et al 2020). The effectiveness of financial measures however appear to have had limited reach, with 59% reporting not getting Jan Dhan transfer, 76% not receiving PM-Kisan transfer, 33% not receiving social security pensions, and 42% state or central cash transfers. In comparison however the rations being provided reached 92% of the rural community (Kesar et al 2020). Already disadvantaged prior to COVID-19, the Lockdown measure had a serious impact on poor rural communities, their food security, employment and income, and these are all social determinants of health.

Panneerselvam, Perumal & K. P. 2020, also relate impact on health and mental health due to the lockdown measures, affecting livelihoods and way of life and focus on the tribes of Tamilnadu. In conjunction with tribal population's limited access to healthcare facilities, there is further concern with the ongoing nature of the pandemic for several reasons. The remoteness of rural tribes in Tamilnadu further disadvantages them due to more limited information and awareness, and they are more likely to rely on their cultural practices to fight COVID-19 than relying on input from the Government. Community and social gatherings are a frequent and regular part of indigenous communities' way of life, and the pandemic would provide great risk in these circumstances (Panneerselvam, Perumal & K. P. 2020). With known prevalence for with infectious and non-infectious diseases, tribal populations would be at higher risk should their population be struck by the pandemic, and would have limited resources, both medical, systematic, and infrastructure to manage the outbreak (Thresia et al 2020¹²⁹; Panneerselvam, Perumal & K. P. 2020).

3.4 Children from Disadvantaged

Backgrounds

Of 460 million children in India 40 million from poor backgrounds have been said to be affected by the lockdown, which was just the start of the COVID-19 crisis (Rana 2020¹³⁰). Although children have been less affected by COVID-19 infections from a medical perspective, the countrywide effects from lockdown, social distancing, loss of income, employment and closing of schools are not insignificant (Unni 2020; Balasubramanian et al 2020). Street children, migrant children, children of Scheduled Tribes and Castes, and children with disability or mental illness could be at high risk of malnutrition as a result of the lockdown and loss of income in their families. The loss of the Mid-Day Meal Scheme in particular would have had a severe impact on the nutrition of children among poor communities. In rural areas, the difficulties in accessing rations and financial benefits would also impact the health and nutrition of rural children. Interruptions in regular vaccination schedules for infants and young children could potentially lead to a new health crisis. (Panneerselvam, Perumal & K. P. 2020, Unni 2020).

Let alone the loss of a reliable source of nutrition, the closure of schools has been extended for a protracted amount of time. This will have long term effects on children's level of education, particularly those in poorer communities, increasing their disadvantages (Alvi & Gupta 2020¹³¹). Additionally, children, being at home with limited options for studies, have little else to do except to support their household, with home duties or even child labour (Alvi & Gupta 2020). It has put in stark focus the inequalities that the poor are facing, as they also do not have access to the technological solutions for education that others may have.

COVID-19 can be attributed to increased mental health stressors, with increased anxiety, and loss of social interaction with the closure of schools and restriction of activity (Saurabh & Ranjan 2020). In discussing the potential impact on children from the pandemic and measures taken in India, increased risk of mental illness and access to healthcare have been highlighted along with the effects of social isolation, and reduced access to education (Naseri & Hosseini 2020¹³²). With street children, migrant children and children within Scheduled Tribes and Castes, who already face the challenges of inequality and health inequities, and are much more likely to be malnourished, the COVID-19

pandemic presents a concerning development in their health and wellbeing. Children need to be spoken to, and their health, social and educational development need to be addressed, so as not to cause further harm to an already vulnerable group.

4. Tamil Nadu Response

In Chennai, from a modelling study it was found that those with experience of lower socioeconomic status (SES) were at higher risk from COVID-19. Their measures include social determinants of health, poor housing condition, low asset possession, poor availability of water, sanitation and health services, lack of household amenities and services, and gender disparity (Das et al 2020¹³³). As highlighted by the authors above and reviewing the history of other pandemics, inequalities that people in lower SES groups experience can place them at greater risk (Ahmed et al. 2020¹³⁴).

4.1 Tamil Nadu Response

In the early phases of the pandemic, Tamil Nadu had a large number of those who tested positive (psrindia.org 2020¹³⁵). Psrindia.org summarised their key actions in response to the COVID-19 pandemic in January 2020, including the formation of rapid response teams; setting up a control room; thermal scanning of travellers; creating isolation wards in 4 city hospitals; starting awareness campaigns and opening up newer services as the need arose.

Further to the above from March 13th 2020, the Tamil Nadu government continued with best practice recommendations, such as 14 days of quarantine for travellers, containment measures, and isolation wards in hospitals when required. The lockdown was also observed with the shutting down of establishments such as schools, malls and theatres, gyms, museums, bars and clubs, and banning interstate travel (psrindia.org 2020).

In March, Tamil Nadu, also put aside additional funding, for health and transport services, as well as direct bank transfers as a relief measure (Rs 1000) for family or ration cardholders, and freer access to the public distribution system scheme which Tamil Nadu excels in, historically (psrindia.org 2020). Further the Tamil Nadu government expanded their welfare provisions, including Rs 1500 and rations for differently-abled persons.

By July the COVID-19 cases had continued to rise, and Tamil Nadu was the 3rd most affected (swachhindia 2020¹³⁶) However they also continued to increase their response to the virus, instituting 85 testing facilities across the state including 45 government and 40 private laboratories.

Concentration of cases were mainly in urban areas of Tamil Nadu, with Chennai facing the most cases (swachh india 2020). To help fight COVID-19 The Tamil Nadu government involved primary health centres, for the long term management of the virus, rather than the emergency measures instituted during the earlier phases (The Hindu 2020¹³⁷).

Primary Health Centres: While urban health centres cater to persons living within city limits; the primary health centres (PHCs) and community health centres (CHCs) are nodal centres also affiliated to the state government, mandated to deliver health care services to rural populations and adopt a lifespan approach in managing various health problems. PHCs are equipped with special wards, maternal care centres, obstetrics, general health management. During the pandemic they were also mandated to include special wards for COVID care, enhanced awareness programs and information centres; district collectorates focused on welfare measures, and containment management through adequate testing and fever camps (The Hindu 2020).

Support for migrants and refugees: As migrant workers prepared to return to home states by foot prior to rollout of special trains, the Government of Tamil Nadu, established makeshift shelters in schools where food and basic necessities were provided. Travellers were then clustered in batches and sent home through special trains. Refugees who were not part of camps and hitherto unsupported were reached out to, and provisions made for their food and stay in makeshift shelters.

Greater Chennai Corporation's specific focus on mental health: A helpline was created at the Greater Chennai Corporation's headquarters to address mental health needs of COVID-19 patients in home quarantine and their caregivers, in collaboration with Loyola College, a premier arts and science institute in Chennai. The helpline also played an important role in contact tracing.

Impetus on Public Private Partnerships: The GoTN and the Greater Chennai Corporation collaborated with civil society organisations to enhance quality of services offered to marginalised communities. This included preparation and implementation of minimum standard guidelines for food distribution by preventing distribution of cooked food in shelters and on the streets, and distribution of provisions instead. Additional 'Amma Canteens', offering affordable and nutritious food and popular amongst blue- and white-collar

workers alike were established across the state, and large quantities were prepared for distribution through government workers, NGO teams and volunteers. The government also engaged volunteers for the helpline, during food distribution, and transportation of individuals with acute health conditions to hospitals. CSOs also played an important role in creating awareness on public health protocols to prevent community transmission and individual safety.

Social Action by Political Parties: Political outfits from across the state stepped up their outreach to promote safety and wellbeing of deprived communities. Food, drinking water, *Kabasura Kudineer*, blankets, clothing and masks were distributed en mass in strategic pockets, including highways throughout the state.

4.2 The Banyan Response

At The Banyan's Emergency Care and Recovery Centres (ECRC) which cater to homeless persons living with mental health issues, a strategic task force was created who in turn developed a set of guidelines to be followed through every phase of the Pandemic.

1. Protocol Development: the first step taken during the Covid-19 pandemic was the setting down protocols and guidelines (based on evidence and guidance from the Indian Council of Medical Research, Department of Health, Government of India, World Health Organisation and other health advisory bodies) to be followed by each level of staff and for all clients. The next step was the dissemination of information among all clients and staff, so maximum support and cooperation could be sought and client turned collaborators in ensuring adherence to protocols and containment. This was done in small groups with the help of visual aids, role playing and demonstrations to make clear the nature of the illness, its origin, symptoms and precautionary measures by the nursing team along with mental health professionals, without being alarmist but ensuring preparedness. Sessions were offered in different languages to accommodate all the clients and ensure each person knew the ill effects and implications of Covid-19 and the need to abide by the strict protocols.
2. Ensuring strict entry and exit options for guests, Mental Health Practitioners and health workers: No donor, volunteer, intern or non-shift worker was allowed within the premises. Due explanations were offered with posters conveying our processes clearly at the entrance of every campus. The centre was run with only essential staff moving in house and covering shifts in two-week rotations which gave them enough time to quarantine at home before returning to work.
3. Mood and Mental health: Clients were kept engaged with daily music and movie sessions, training in different livelihood options and those who were employed outside were given jobs within the institution so they did not lose their income. For those with severe disabilities this was a struggle since the need for masking up or for physical distance wasn't clearly understood and often came in the way of supportive therapies that enabled cultivation of trust and fostering a climate of hope. However, dance and music sessions increased as did small meeting group to clarify concerns and address fears.
4. Public Health protocols at The Banyan ECRC pre-covid that supported the organisation through the pandemic: Pre-existing protocols of having a maximum of 14 persons per ward, maintaining client to caregiver ratios at 1:10, ensuring enough space for people to social distance made, use of sanitisers and training clients to wash their hands through the help of posters and other visual aids all came in use during the pandemic. The numbers were further decreased and every ward had no more than ten persons with beds spaced out and separators used when needed. all vitals including oxygen saturation (SPO2) levels and temperature was routinely measured twice daily. Focus on early identification and tracking of symptoms, timely isolation and quick response. All staff were trained in using PPE, and the centre was equipped with oxygen cylinders so that care for Covid-positive patients were provided on-site where possible. Those with comorbidities were taken to well-equipped government hospitals.
5. Outreach for the homeless on the streets: As the organisation initially could not bring in new

homeless persons with mental health issues, outreach efforts were undertaken where the team took to the streets and offered food and clothing to the homeless in different areas across Chennai and Chengalpet districts. The Banyan also collaborated with other NGOs to distribute cooked food in NULM shelters that were overcrowded at the time of the lockdown. In total 147 people were serviced on the streets in Tamil Nadu and 73 in Kerala during this period.

6. **The Quarantine Centre:** While Critical Time Interventions were stopped at the ECRCs, one centre of The Banyan was converted into a quarantine centre so that new admissions could be taken in. Homeless persons found during the pandemic were offered a place here and the newly admitted were tested and maintained here for 14 days before transferring to one of the ECRCs provided they tested negative and had no symptoms of Covid-19. The staff in place maintained isolation and wore full PPE with new clients pre-testing. Through this service, 42 people were serviced over 6 months in the quarantine centre
7. **Mental health and social needs care of OP clients:** The outpatient service of The Banyan covers 200,000 populations across 10 locations through the ECRC and CSNL. They ensure continued social and clinical care beyond the stay of a homeless person with mental illness within an ECRC and the Centre for Social Needs and Livelihoods extends the social care services to other marginalised and disadvantaged groups in the community, particularly those living with mental illness. During the pandemic, 1553 persons were contacted as part of these services and followed up to ensure they had access to basic amenities and medication. Of those contacted, screening was done for:
 - Single or elderly caregiver including single breadwinner households caring for a PWMI
 - Loss of job / income / Those employed in the unorganised sector
 - Families with incomes less than INR10,000 per month

- Children from disadvantaged background

These categories were chosen for the distribution of dry rations as well as for direct bank transfers/unconditional cash transfers. In total 654 dry ration kits were distributed and 209 direct bank transfers were done for those in need. Additionally, 124 scholarships were also granted to children from disadvantaged families during this period. Alternative methods for reaching medication to all The Banyan's outpatient clients was also devised which included door-to-door distribution and postal delivery for those who were unable to travel to any of the clinics.

8. **Home Again:** Personal assistants (PA) worked in shifts but were entirely residential and rested in the homes. In many homes, a client took the role of the PA and supported the home. Some social workers also lived in the homes and helped during this difficult time. While the clients in Home Again are usually move around at will, their movement had to be somewhat restrained during the initial period in view of safety protocols that all had to follow as a member of a responsible community in which these houses are located. All food and provisions had to be delivered to the homes and the clients entertained themselves by watching television, engaged in a lot of handicraft production, chats and art. They also kept busy keeping in touch with their friends and therapists from other locations.
9. **The Banyan Academy:** In order to further support this population in the community, The Banyan in collaboration with the Banyan Academy instituted a helpline for the aftercare clients and other families with a member with a mental illness where people could call in for counselling, troubleshooting, or if they needed any particular support including relief kits, dry rations.

5. Aims and Objectives

Aims

This report aims to explore and understand the impact of COVID-19 on the social health and mental health of persons experiencing multiple vulnerabilities including homelessness, deprivation, abject poverty, ill health and disability or social disadvantage.

Literature suggests that these groups already face a burden of inequality, and hence suffer poorer health and mental health. Understanding the more immediate impact of the pandemic on these groups may provide insight into the long-term effects. As noted by Berkhout et al. (2021) in their report on the “Inequality Virus: Bringing together a world torn apart by coronavirus through a fair, just and sustainable economy”, the long-term impacts on the economy will continue to affect those in poverty for as long as a generation (15 years) or more. The psychosocial impacts are not going to disclose their long-term effects through calculation, however this report aims to make a start on understanding some of the implications (Gopikumar et al. 2020¹³⁸).

It further attempts to understand pathways to care and safety networks that support well-being and address distress and deprivation. Social support can take on many forms, as demonstrated by collaborative care models. Research around the impact of social determinants of health indicate that improvements in areas such as education, sanitation, social relationships, work etc. could improve health outcomes for a population (Gore 2017; Sarkar 2016). For this report both the positive and negative impacts on these care pathways and social networks as a result of the COVID-19 pandemic will be explored.

Understanding where people draw their support from in the local context, and exploring both highlights and challenges helps build new knowledge that may feed into the development of adaptive and dynamic health and mental health systems. Findings from these inquiries will help support development of progressive public policies and plans in the context of mental health and ultra-vulnerable groups.

Objectives

1. To examine the socio-economic impact of SARS-COVID-19 on ultra-vulnerable populations, especially persons from homeless communities, Scheduled Tribes, socially disadvantaged persons living with psychosocial distress in rural and urban locations and children from disadvantaged backgrounds.
2. To examine the impact of SARS-COVID-19 on access to health care and well-being needs among the above-mentioned groups.
3. To determine the nature and impact of social losses experienced by these communities and persons
4. To examine responses of the state, civil society and public health and social care/ welfare system to the needs of ultra-vulnerable populations.

Mala is a differently abled person who lived through a difficult childhood. A witness to her father's violent and abusive ways towards her differently abled mother and a victim of his substance abuse and erratic employment, Mala was forced to start working at the age of 7 as a housemaid to provide for the family. Though she was able to complete her middle school with support from her employer, she was quickly married off to her uncle who resumed the cycle of abuse and created the situation of living with a family member with substance use once again.

Being a strong and motivated person, Mala sought and found support through a local self-help group which helped her procure a wheelchair as well as a wet grinder for *idli* and *dosa* batter so she could set up a small business. With her initial income she was able to start a petty shop, a store with items for everyday use, and soon began to earn more than her husband. With a social bent of mind, Mala also began to assist grassroot workers from The Banyan, referred to as Nalam or Well-Being mobilisers and helped them with conducting surveys and spreading awareness on mental health in her community. She learnt to drive a scooter and began to help others in her village with rides to nearby destinations.

Despite her success in other areas of life, Mala was unable to escape the abuse at home and the frequent taunts about her disability and infertility by her husband was a huge blow to her self-esteem. Her contact with the Nalam mobilisers convinced her to seek out counselling and she began to visit one of The Banyan's outpatient clinics. Though she constantly tried, she was unable to get her husband to come along with her.

Facing domestic abuse on a frequent basis takes a toll at any time, but during the pandemic and the lockdown that followed it, with families being forced to spend time together as a result of social distancing everybody else, instances of abuse increase and external sources of support are cut off. Mala's financial independence also took a hit with fewer customers coming to her store and her access to materials being limited. Spending more time at home with her husband has resulted in a recurrence of old issues of poor self-esteem and confidence. Mala however has shown great resilience and, despite her troubles at home, has volunteered to spread awareness on Covid-19 and general health in her community.

6. Methodology

Study Design

Multi Method Design (Hesse-Biber & Johnson 2015¹³⁹).

Sample and Recruitment: A total of 5 groups were recruited to the study. To be eligible, participants had to belong to one of the following groups from either urban or rural areas in Thiruvallur and Kanchipuram Districts, Tamil Nadu.

Group 1: SD Group - Socially Disadvantaged living with psychosocial distress: The Banyan's outpatient services cater to this population on a regular basis. A purposive sampling technique was adopted and 800 active clients were identified during the period June-July 2020, across rural and urban areas, from 6 clinics and were sampled to the study. However, given the safety protocols, face to face interviews were not possible with this group. Data collection was thus attempted using telephones. As a result, only 45.75% (n=382) of the original 800 persons remained accessible and was included to the study¹.

Group 2: Homeless - Homeless and Homeless persons living with mental illnesses: Individuals experiencing unstable housing, sleeping rough and experiencing severe mental illnesses, living in Chennai city limits and outer Chennai, Tamil Nadu, India, were recruited to the study. A convenient sampling technique was used for recruiting participants who were contacted through outreach programs employed by The Banyan or public referral systems. All homeless persons recruited were offered need based, supportive services, that ranged from providing food and basic amenities to inpatient care services, during the course of the study. N= 108

Group 3: Irular - Irular Tribe (Scheduled Tribe): This group includes persons from the Irular community. Purposive sampling technique was used to recruit persons living in Thiruporur Block Kanchipuram District, Tamil Nadu, India. The population lives across 40 villages within the Thiruporur Block. 3 households from each village were selected based on availability. The resultant sample included (n= 155) has been included in the study.

Group 4: Children - Children from Disadvantaged Backgrounds: Children and adolescents who belonged to the categories of 1. having a parent with a mental illness currently seeking treatment from The Banyan 2. Attending The Banyan's afterschool programme either in an urban fishing community in Chennai or rural tribal and non-tribal communities in Chengalpet district, were interviewed along with a parent to assess the impact of the Covid-19 pandemic and the subsequent lockdown. A purposive sampling technique was used to reach out to all children in families who had accessed a service of The Banyan and a sub-group (n=206) who were accessible by phone or in person were taken into consideration for the study

Group 5: Stakeholders: Additionally, to understand the impact of COVID-19 on stakeholders and access to mental health care, data was also collected from National Urban Livelihoods Mission (NULM) shelters operating within Chennai city limits.

NULM Shelters - National Urban Livelihoods Mission Shelters (20); NULM Shelters: An intact sampling technique was used and shelters across Chennai city (n=53) were accessed for data after obtaining appropriate permissions . 20 shelters responded to the survey. Shelters catered to a mixed demographic including adults, children and elderly. No exclusion criteria were incorporated.

Data Collectors (Mental Health professionals, researchers and community mobilisers from the Banyan's services): Data Collectors were mental health and social care facilitators of the Banyan working at outreach and in-patient services they provide in urban and rural Tamil Nadu - Including: social workers and psychologists, community mental health workers called Nalam mobilisers, and learning centre coordinators for the children (n = 15).

Procedure

Ethical Clearance

Ethical clearance was obtained from the scientific review board, of the Banyan Academy of Leadership in Mental Health.

A permission letter for data collection (Appendix A) was submitted to the Deputy Commissioner (Health) of the Greater Chennai Corporation. This letter was forwarded to the City Health Officer who circulated it to

¹ During the course of the study, some clients were also provided with supportive needs that included dry ration, health care assistance, transport allowance etc to manage their livelihoods during the COVID-19 contingency period; this may have impacted the findings of the study.

all 53 homeless shelters for further action. All participants gave informed consent to be part of the study.

All data was made anonymous and stored securely.

Data Collection

Data collection entailed a rapid survey, detailed interviews, case studies and focus group discussions (FGDs).

The survey tool (Appendix B, Appendix C - Children) was developed by the research team, by incorporating questions of query gathered from literature. Survey tool aimed to understand background characteristics of disadvantaged groups and the impact of COVID-19 on their vulnerabilities. Using the concepts from social determinants of health and mental health, domains included were income, gender, education of children, mental health of person with diagnosed mental illness, if applicable and their caregiver status; access to health care and access to basic needs; as applicable during the time of the lockdown during the months from March-September 2021. The role of Structural barriers (eg. gender, class, caste, power) in enhancing disadvantage was also explored.

For the surveys, groups 1, 2 and 3 were approached by senior mental health professionals and an outreach team comprising of a social worker and community level worker. Face to face interviews were conducted with groups 2 and 3. To ensure COVID-19 protocols were maintained, only one key informant was approached from each household, in group 2. For group 1, telephone interviews were conducted with each participant by mental health professionals. The survey was administered in the local language or English, as appropriate. In addition to the survey, conversations were conducted with each participant which yielded details qualitative responses.

The data included in the case studies were collected by lay community workers, trained in mental health and already acquainted with the participants in the study. Some interviews were held face to face while others were contacted by telephone after the survey data was collected at a later date with participants that agreed, to hold a qualitative interview.

For the NULM Shelters, the survey instrument (Appendix D) was emailed to concerned authorities.

Responses were obtained through email and collated manually into a spreadsheet.

FGDs were conducted with The Banyan staff to understand experiences related to working in the field during the pandemic. The available data collectors were put into 3 groups to conduct the FGDs with the aim of covering the different groups that have been focused on. The SD Group and Irular FGD was held with 2 Nalam mobilisers and 2 programme associates, while 3 social work practitioners, 2 psychologists and one psychiatrist attended the FGD for the Homeless. Themes and domains from the survey instrument and data were utilised to prompt discussions with the participants, with the aim of triangulating the information gathered from the survey and qualitative interviews. FGDs were transcribed and thematic analysis was completed by an objective third party, otherwise not a part of the research team. Data from focus group discussions (n=3) was analysed manually using thematic analysis (Nowell et al. 2017¹⁴⁰)

All Data was collated into spreadsheets manually, and lead investigators from each group checked for validity of data using data triangulation and methodological triangulation (Carter et al. 2014¹⁴¹). Data was subsequently, cleaned manually, missing information was clarified and input post-hoc through triangulation, or where possible, the participant was contacted a second time. The final data (n=641) was used for analysis.

Qualitative information from observations, interviews and telephone calls was collated and developed into detailed case studies (n=9). These were analysed using content analysis to draw out the themes the participants expressed (Bengtsson 2016¹⁴²).

Analysis

Quantitative data obtained was cleaned and coded on SPSS v 22 (ref). Owing to the differences in the survey tool, the data obtained for groups 1,2, and 3 was analysed separately from that obtained for group 4. Homogeneity in operationalisation of terms and semantics across data sets were ensured during cleaning. Proportions were computed to understand between group differences.

7. Findings

Before the results of the survey, focus group discussions, and case studies, the content analysis of the case studies is provided. The content analysis puts into context the results from other data collection methods which follow, highlighting various themes. The case studies themselves are included within the results of each group.

Case Studies

In what follows, we present a few representative case studies, drawn from a larger set of qualitative interviews, rather than present the totality of qualitative case studies. These cases are meant to illustrate some of the complex sociocultural and economic variables that influence a sense of wellbeing; and, moreover, how the pandemic has impacted upon already vulnerable communities. The decision to present representative cases was not done to merely save space, but, rather, to illustrate the complex and nuanced experiential and socioeconomic consequences of the pandemic within particularly vulnerable communities.

Thematically, a content analysis of the full set of qualitative case studies reveals some unsurprising findings. Most prominent among these was the impact the pandemic has had upon wage earning. As daily wage labour is the primary mode of survival for Adivasi, homeless, and the rural poor, the pandemic has struck at the very core of subsistence. The difficulty in accessing labour sites during lockdowns added to the already heavy burden of poor transportation networks for many of the individuals interviewed living in rural or semi-rural areas. When work was available, the daily earnings per adult after a full day of labour ranged from 100-120 INR (less than 2 USD), which, in turn, impacted upon daily nutrition. One consequence of this was the necessity of supplementary income through child labour within the household, though parents of children who participated in this necessity were saddened by the loss of educational opportunity for their children.

Even when children were not working, access to schooling was made difficult for most households due to the poor transportation infrastructure that exists in remote villages. Virtual learning was also extremely challenging for the rural and poor students due to poor or lacking connectivity. Most research participants emphasised the need for better housing, as well as the stresses associated with maintaining their mud and

thatch homes during heavy rains, flooding, and other environmental challenges. For the Adivasi respondents, gaining government-subsidised housing and infrastructural amenities involved the significant hurdle of obtaining a “community certificate” for their scheduled tribe status. This proved difficult for many. In short, and unsurprisingly, depressed wages, access to work, transportation infrastructure, and diminished educational opportunities emerged as the key themes repeated throughout the interviews. All of these factors contributed to significant stress and raised the risk of significant health factors, including, but not limited to, depression and anxiety.

Perhaps less obvious or easy to measure, the interviews indicated the critical role that faith and traditional healing practices continue to play in establishing a sense of wellbeing and fortitude in the wake of the structural violence that impacted material conditions within these communities. Community resilience and aspirations towards a better future were not only dependent upon assistance from outside sources, but were integrally linked to cultural and spiritual resources already established within the community. Therefore, any outside interventions and mobilisation of community empowerment would be more effective when conjoined to meaningful models for living that exist within communities, as aspiration and culture go hand in hand (Appadurai 2013).

The case studies presented here are by no means representative of the kind of nuanced ethnographic analysis that might be useful in understanding the predicaments faced by the most vulnerable segments of the population. That work is still to be done, and is crucially important. Nonetheless, the case studies do present, as stated at the outset, a constellation of themes that invite further investigation. The Banyan is well equipped to carry this work forward as an NGO that is committed to multi-method and inter-disciplinary forms of data collection in the service of program implementation, medical care, counselling, and social work. As, for instance, COVID vaccination programs are scaled up, understanding how local communities might gain access to vaccines, information, and/or respond to disinformation, will be critical. More importantly, perhaps, the long-term psychosocial impact of the pandemic will require a sustained effort and attention by NGOs and healthcare workers, given the scale of the problem and limited government capacities.

The content analysis was completed through examining the themes and categories that emerged in the case studies transcripts, which were compiled into an index form. The frequency of these themes is then calculated, to ascertain converging sentiment, concepts or concerns. The prevailing themes in the case studies as identified by the content analysis, are discussed below.

Content Analysis

Content analysis of the case studies reveals, unsurprisingly, that the pandemic exacerbated economic, social, and psychological distress within already quite vulnerable groups and individuals. While there is some variation in the challenges faced by the rural and urban poor, the homeless, or between the specific Irular Adivasi struggles for rights and recognition versus those of other particularly vulnerable communities, there are a few recurring themes that traverse the different social groups. These themes centre upon heightened economic precarity with the lockdown; the relationship between mental health and worsening economic precarity; a lack of information about COVID-19, as well as interrupted humanitarian aid distribution; the reliance upon government and NGO support for both economic and psychosocial needs; and, the resilience that centres on faith traditions as a source of wellbeing.

Worsening economic conditions as a result of insufficient wage-earning opportunities was the most salient consequence of the pandemic across the case studies and different group categories. Daily wage labour came, in some cases, to a grinding halt during the lockdown. A descent into worsening poverty, an inability travel to work-sites, pay rent, or afford sufficient foodstuffs clearly impacted the health and wellbeing of those interviewed in profound and palpable ways. While many were already living on the edge of survival, the pandemic produced severe hardship. In many cases, the quantity and quality of food consumed was alarming. Missed meals, and meals of just “ration rice” mixed with whatever favourings could be obtained revealed significant nutritional deficiencies. Tension within the household was also exacerbated by economic despair, with conflicts erupting over work, or the lack thereof, and arguments over necessary versus unnecessary expenditures. Homelessness was caused by an inability to pay rent, and children suffered interruptions in education, as they had to work to contribute to the family income. Remote learning was not an option for the very poor, given a lack of access to the internet.

The case studies illustrate a correlation between mental health and economic precarity. Distress, stress, and depression were recurrent themes, as was shame over the stigma of mental illness. Those caring for family members with mental illness were additionally burdened by the economic crisis and lockdowns, as they could not access the care and assistance they might have obtained prior to the pandemic. The enduring stigma around mental illness also exacerbated familial tensions and conflicts. Without the support of NGOs, such as The Banyan in these cases, several of the individuals interviewed would have fallen into greater despair. The coupling of economic desperation and mental illness contributed to experiences of social defeat, exacerbating the structural violence of extreme inequality, a point the conclusion to this chapter elaborates further. Mental illness and stress, particularly as it exacerbated familial conflict, was influenced by substance abuse (alcohol) in some cases. This not only worsened economic vulnerability, but led sometimes to gendered violence within the home. It was also the case that co-morbid conditions, particularly diabetes, seemed to be a recurrent challenge to the wellbeing of individuals and families, both in terms of the challenges of treatment during the pandemic with difficulties in accessing and affording care, as well as the anxiety and stress the condition put upon caregivers who were already experiencing economic distress.

Information about COVID-19 was lacking, to a degree, the case studies also suggested. In many instances, individuals learned about PPE and social distancing in a very partial manner, perhaps through an employer, not having access to, or being exposed to official information campaigns. In addition to a lack of information reaching the most vulnerable and/or rural populations, the lack of mobility during the lockdown caused significant hardship for the poor. Public transportation, in particular, was not accessible, making it difficult to reach potential sites of employment, or even accessing funds within ATM machines. The lockdown also disrupted the distribution of medical and food aid to the very poor and homeless. In some of the cases, those interviewed mentioned that without the help provided by the NGO, they would not have been able to survive this disruption, underscoring the pivotal role of humanitarian aid during the crises of lockdown and beyond.

Related to the last point above, it was apparent that reliance upon both government and NGO assistance was

critical to these vulnerable communities. Many earned daily wages through the varied MGNREGA schemes, which demonstrated the reliance upon government work schemes for the economically distressed. At the same time, some reported that these guaranteed work schemes were interrupted for various reasons (transportation being one), and/or were insufficient in meeting a family's daily wage-earning requirements, leading people to seek other modes of employment within the informal sector. This could, in turn, also include child labour to supplement family incomes. In addition to the centrality of government-funded work schemes, the role of the NGO in meeting the medical and psychosocial needs of the vulnerable and distressed was present in nearly all of the case studies, and should be underscored. Many of the individuals received counselling and medical treatment through the NGO, as well as, in some cases, rehabilitation through employment. Indeed, the NGO, and in these cases, The Banyan, primarily, provided holistic care for distress and rehabilitation, alleviating anxiety and despair for some individuals, whilst providing necessary treatment for mental illness. Key to the impact of the NGO was an emphasis on counseling around psychosocial needs. Hope and a capacity to aspire, as reported by some in the interviews, was tied more to the inner-strength and resilience that individuals kindled through psychosocial interventions provided by the NGO, as opposed to merely receiving biomedical care. That said, biomedical care was also important and was enabled through NGO work, suggesting that the healthcare system requires partnerships between healthcare-providing NGOs, working in tandem with public hospitals and clinics. As indicated in the conclusion of this section, community-based health care, particularly around mental health and wellbeing interventions, is efficacious in so far as it grounded at the grass-roots level, and builds cultural bridges between local understandings and biomedical expertise. These case studies seem to suggest that an expansion and scaling up of very localised forms of care, through community-based models, might be a critical step in meeting the psychosocial needs of distressed individuals and communities. In this regard, the case study methodology, combining interview and ethnography, is seen to be important in capturing the nuanced perspectives of community members, which, in turn, facilitates collaboration and rapport at the grass-roots level.

As mentioned above, education was one of the ubiquitous concerns raised in the interviews, across

social categories. Children and their parents, in some cases, faced a kind of double-bind. On the one hand, with extreme economic distress, and, in some cases, comorbid health conditions limiting the types and amounts of labour the parents could perform, children contributed to the family earnings through daily wage labour in the informal sector. While this was of necessity, it added to anxiety and stress within the family, as parents in many cases reported how they knew this to be wrong, and that it was through education for their children that their future aspirations were to be realised. The interruptions to education through child labour was a nagging concern, among parents, that the short-term necessity would derail the long-term wellbeing of their children. Education, in short, was understood by most of those interviewed (as both parents and children expressed) to be the path towards upward mobility and economic security.

Finally, the resilience and generosity of individuals facing significant distress was witnessed throughout the case studies, despite the desperate circumstances that people faced. While despair was certainly not absent in these cases, there were many expressions of hope and the capacity to aspire towards a better future. Moreover, expressions of care, love, and generosity for those less fortunate was often displayed, particularly by those who had themselves experienced hardship and tragic loss. This resilience, in turn, was often expressed through faith and religion. Indeed, wellbeing and an ethics of care throughout the case studies was framed through spiritual life and faith. In that sense, the aforementioned cultural bridges were critical. That is, biomedical or economic interventions alone did not provide in themselves hope and resilience. Though obviously important, the capacity to aspire was also rooted in a world-view and a requisite faith in it. Therefore, the surprising resilience displayed by those facing poverty, illness, and psychological pain, emerged from a dignity and sense of humanity that could only be sustained through an ethics of care and faith. This, in turn, illustrates the need for psychosocial interventions to encourage these resilience-building capacities, again pointing towards the importance of community-based and holistic forms of care, rather than a one-size-fits-all top-down care delivery models that can unwittingly exacerbate conditions of social defeat. The conclusion to this section elaborates further on this dimension.

Background Characteristics

7.1 Socially Disadvantaged Living with Psychosocial Distress (SD group)

The mean age of participants of the Socially Disadvantaged group (N=382) was 39.24 (SD=13.61) (Table 7.1). The youngest was 30 with the eldest 80 years of age. The gender difference was not substantial for the SD group, with 54.5% female participants and 45.5% male. Hinduism was the more prevalent religion among the SD Group, with 77.5% Hindu. Christianity was the next most common religion with 16.5% followed by Islam with 5.2%.

The majority of the SD group were either married or single, with 42.1% and 39.5% respectively. 8.6% were divorced/separated, and 9.2% were widowed. Living in a nuclear family (82.7%) was more common than living in a joint family (13.6%) or living alone (2.4%).

Of the SD Group 49.7% were unemployed, 28% employed, and 21.7% daily wage workers. 35.3% reported that they were in unorganised employment, with 4.5% in organised. However, 10.5% could not define their nature of employment.

7.2 Homeless and Homeless Persons living with Mental Illness

It must be noted at the outset that this population, either because of their state of homelessness or because of them living with a severe mental illness, found many of the questions not applicable to them, difficult to answer or impossible to comprehend. Some also chose not to answer the majority of the questions because of the state of their mental health. The mean age for the Homeless group (N=104) was 42.41 (SD=14.08). Homeless participants were 62.5% male, with 37.5% female. The majority of the Homeless group reported being Hindu (52.9%), with 8.7% reporting they were Muslim, and 10.6% Christian. 27.9% either did not answer the question or did not claim to follow any of the above religions.

Marital status among the Homeless group was varied, with 9.6% divorced/separated, 27.9% married, 30.8% single, 10.4% widowed and 21.2% did not answer the question. The majority of the homeless group reported having a nuclear family structure (46.2%). 3.8%

reported living alone, and 14.4% living in a joint family structure, probably prior to homelessness.

A high proportion (76%) of the homeless sample were not employed, with 2.9% employed and 4.8% being daily wage labourers. 5.8% of the Homeless group reported that their employment was unorganised compared with 1.9% reporting that they worked in organised employment. 16.3% did not respond about their current occupation or nature of work.

7.3 Irular Tribe

Irular group's (N=155) mean age was 32.94 (SD=11.47) with a high proportion of female respondents (92.9%). This is demonstrative of the sampling and the increased accessibility of women in the rural villages of the Irular. Irular mainly reported to be Hindu (98.7%) and 1.3% Christian.

The majority of the Irular group were married (81.9%), with 1.9% divorced/separated, 7.7% single, and 8.4% widowed. The participants mainly reported living in a nuclear family (80.6%), with 16.1% reporting living in a joint family and 1.9% living alone.

The majority of the Irular group were daily wage labourers (72.9%), with 19.4% being employed and 7.7% not having employment. The majority of the work for the Irular was also unorganised (78.7%), with only 7.7% reporting that their employment was organised and 5.8% finding that the nature of employment was not applicable to the classification.

7.4 Children

The socio-demographic information on children interviewed from urban Chennai (n=107) and rural areas outside of Chennai city (n=99) is found in Table 8.1. The population of male and female children are approximately evenly distributed across location, but the median age is higher in the urban population (Median=13, IQR=3) than rural (Median=11, IQR=4). The children belong to nuclear families with the median number of family members higher by 1 in the rural population (Median=4, IQR=1) than urban (Median=3, IQR=1). A majority in both locations lived in non-rented homes - 91.6% children in rural locations and 56% of children living in urban locations, with a median of 2 rooms in rural locations as compared to 1 room in urban locations.

The fathers of the children interviewed in the urban population (Median=9, IQR=4) had completed two more years of education than those fathers in the rural population (Median=6, IQR=8) while the mothers in both locations completed the same number of years (Urban - Median=8, IQR=5, Rural - Median=7, IQR=4). At the time of the interview, post onset of COVID-19 lockdown, a majority of the parents in urban population were unemployed while in the rural population 69.9% of the fathers were employed while only 32.3% of the mothers were employed.

7.5 Tables

	Homeless (N=104)	Rural (N=155)	Socially Disadvantaged Living with Psychosocial Distress (N=382)
	%	%	%
Gender			
Female	37.5	92.9	54.5
Male	62.5	7.1	45.5
Current Occupation			
Daily Wage Labourer	4.8	72.9	21.7
Salaried Employee	2.9	19.4	28.0
Unemployed	76	7.7	49.7
Unknown	16.3	0	0.5
Nature of Employment			
Not Applicable(unemployed)	76	7.7	49.7
Organised	1.9	7.7	4.5
Unorganised	5.8	78.7	35.3
Unknown	16.3	5.8	10.5
Marital Status			
Divorced/Separated	9.6	1.9	8.6
Married	27.9	81.9	42.1
Single	30.8	7.7	39.5
Widowed	10.6	8.4	9.2
Unknown	21.2	0	0.5
Structure of family			
Joint	14.4	16.1	13.6
Living alone	3.8	1.9	2.4
Nuclear	46.2	80.6	82.7
Unknown	35.6	1.3	1.3
Religion			
Christian	10.6	1.3	16.5
Hindu	52.9	98.7	77.5
Muslim	8.7	0	5.2
Unknown	27.9	0	0.8

Table 7.2 Socio-demographic information for Children sample (n=206)

		Urban (N=107)		Rural (N=99)	
		N	%	N	%
Gender	<i>Male</i>	58	54.2	49	49.5
	<i>Female</i>	49	45.8	50	50.5
Fathers Employment	<i>Employed</i>	43	44.3	65	69.9
	<i>Unemployed</i>	54	55.7	28	30.1
Mothers Employment	<i>Employed</i>	30	28.8	31	32.3
	<i>Unemployed</i>	74	71.2	65	67.7
		Median	IQR	Median	IQR
Characteristics	Age	13	3	11	4
	Number of Family Members (including self)	3	1	4	1
	Years of Education	8	3	7	4
	Fathers Years of Education	9	4	6	8
	Mother Years of Education	8	5	8	10

8. Socially Disadvantaged Living with Psychosocial Distress (SD group)

Disadvantage and advantage have been theorised by many as a phenomenon to be understood in pluralist forms. Two well developed theories include the 'complex equality' theory proposed by Walzer and Miller and the 'Capabilities theory' by Nussbaum and Sen (Walzer & Miller 1995¹⁴³; Nussbaum 2001¹⁴⁴; Sen 2001¹⁴⁵). In the context of the Pandemic we lean towards the latter and draw from the framework that:

“what matters for an individual is not only the level of functioning he or she enjoys at any particular time, but also their prospects for sustaining that level. To put this in another way, exceptional risk and vulnerability is itself a disadvantage whether or not the feared event ever actually happens.” (Wolff & De-Shalit 2007, p9¹⁴⁶)

Therefore the list drawn up by Nussbaum ranging from Life (both in terms of longevity and quality) to bodily integrity, to emotions, affiliation and play assume importance. Most importantly, control over one's environment that signifies the ability to participate as a social, moral and political organism and enjoy equal opportunities and a plethora of rights on par with every other citizen, equitably, is paramount and correlated to a state of well-being and a just society (Nussbaum 2001). Unfortunately, disadvantage usurps a vast majority of these rights.

The social context influencing differential exposure, vulnerabilities, health outcomes and consequences has now been evidenced rather emphatically (Blas & Krup (eds.) 2010¹⁴⁷). Therefore, social determinants of ill health are almost always at the centre of a crisis that perpetuates poverty, trauma and loss of agency or control. In the context of the Pandemic, those affected included persons living in acute socioeconomic distress, particularly those employed in the unorganised sector, most of whom experienced income insecurity and as a catastrophic consequence of the Pandemic, suffered income loss and a downward spiral into abject poverty in the absence of remedial or relief measures.

The gendered nature of the Pandemic further affected women significantly, with the majority of women work in the informal sector losing employment and less likely to find employment (IWWAGE 2020¹⁴⁸); often

subjected to violence and often also the primary care provider to children, women faced an unequal burden of the Covid-19 Pandemic, balancing responsible caregiving with personal safety and well-being (Vora et al. 2020). Lack of stability and consistency in access to housing, income and nutrition, education and other opportunities even in the normal course impacts participation; in the context of the Pandemic, outcomes were much worse, enhancing the extent of isolation.

Structural barriers such as caste, class, identity and gender posed immense challenges, even as the multi-dimensional facets of what one refers to or visualises broadly as poverty (as Angus Deaton 1992¹⁴⁹) were unraveled with intersectionality between variegated aspects, less subtle and more blatant.

Psychosocial disorders, distress or severe mental illness can cause additional stigma, discrimination and disadvantage (Patel & Kleinman 2003). Poorer outcomes in physical health as well as social dimensions of employment, income, education are related to mental illness, and the pandemic has directly affected access to these social determinants (Sarkar 2016; Nayar 2007; Lund et al. 2018). Facing challenges of employment, education, poverty and inequality can also have a negative effect on mental wellbeing, thus putting people at further disadvantage during this time (Paremoer et al. 2021¹⁵⁰).

For purposes of this study, clients of The Banyan (outpatient mental health services) are representative of this group, by having one or more disadvantages from social determinants such as wealth, education and employment to psychosocial distress such as mental illness or learning disability.

8.1 Survey results

COVID-19 and Public Health - Awareness, Knowledge and Challenges

As seen in Table 8.1a The Socially Disadvantaged group had a good awareness of the COVID-19 pandemic (87%) and the health protocols they were meant to follow (88%). However, there were challenges to following these protocols, including financial constraints as reported by 55.5% of the sample (Table 8.1b). 7.6% reported that there was not enough space in their house, and 9% that they were unaware of the protocols.

Table 8.1a Awareness of COVID-19 - Socially Disadvantaged living with psychosocial distress (%)

Awareness of COVID-19 Pandemic	87
Awareness of COVID-19 protocols	88

As a population they therefore found some aspects of the public health protocols easier to follow than others. They reported that use of masks and using soap to wash their hands was most convenient, at 82.7% and 79.3% respectively (Graph 8.1a). Sanitiser for the majority (6.5%) was not used. Gloves and physical distancing were less common as well, with only 34.6% and 43.5% reporting adherence to these practices (Graph 8.1a). Only 9% reported that they weren't following any of the

Table 8.1b Challenges to adhering to public health protocols - Socially Disadvantaged living with psychosocial distress (%)

Lack of space in the house	7.6
Lack of safety on streets [as applicable]	0
Poor sanitation	4.2
Financial constraints [to buy medical aids such as masks and gloves]	55.5
Unaware of protocols	9

public health protocols.

With the majority of the SD group coming from more urban areas around Chennai, their access to supplies would be expected, however the additional cost to their daily lives was something that affected the majority of them.

Impact of COVID-19 on access to essentials and Social entitlements.

The Socially Disadvantaged living with psychosocial distress reported minimal changes in their access to essentials and basic facilities. What is presented however, is that only 49.1% had access to sanitary pads before May 2020, and afterwards this reduced to 48.3%. This indicates potential limits to their access as an ongoing situation. The majority of the SD group reports having access to food, water, Clothing, and private toilets, with nearly all being within stable housing situations (Table 8.1c).

Graph 8.1 Adherence to Public Health Protocols - Socially Disadvantaged living with Psychosocial Distress %

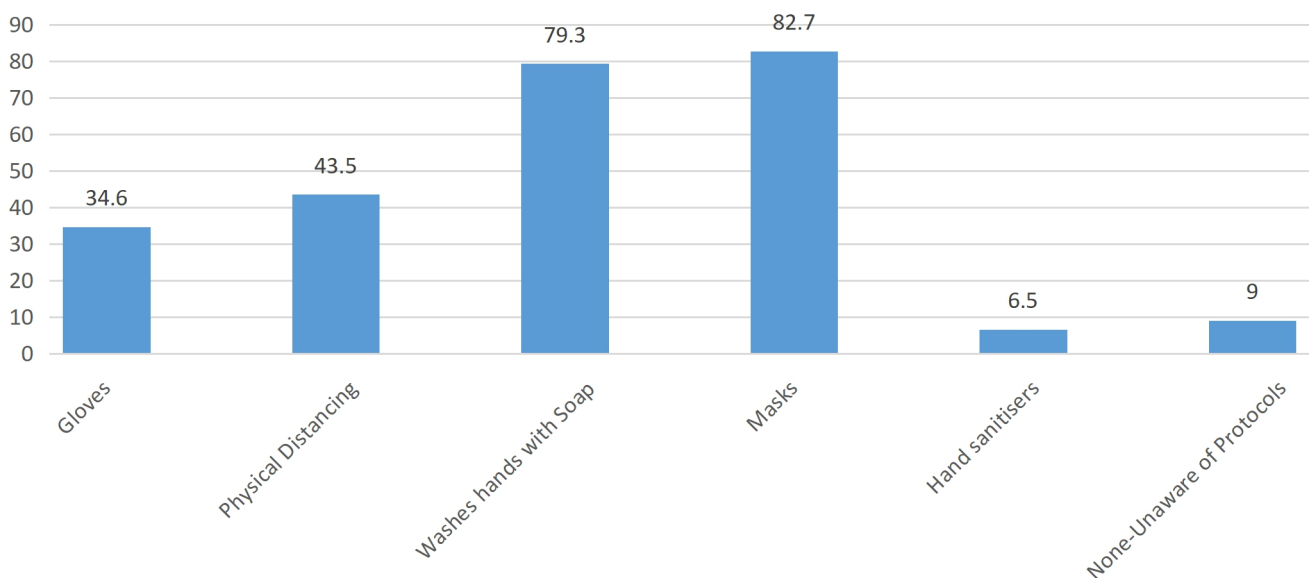


Table 8.1c describing the impact of COVID-19 on the access to basic needs Socially Disadvantaged living with Psychosocial Distress

		Pre-COVID	During COVID
Access to Food	No	2.2	1.1
	Sometimes	0.0	0.0
	Yes	97.8	98.9
Access to Water	No	3.7	1.6
	Sometimes	0.0	0.0
	Yes	96.3	98.4
Access to Clothing	No	2.7	1.6
	Sometimes	0.0	0.0
	Yes	97.3	98.4
Public Toilet use	No	98.9	98.9
	Yes	1.1	1.1
Private Toilets	No	11.5	9.1
	Yes	88.5	90.9
Sanitary pads	No	50.9	51.7
	Yes	49.1	48.3
Access to Soaps	No	10.4	5.9
	Yes	89.6	94.1
Access to Shelter	No	95.5	96.8
	Yes	4.5	3.2
Access to Government shelter	No	100.0	100.0
	Yes	0.0	0
Access to Stable Housing	No	5.3	2.9
	Yes	94.7	97.1
Access to Relief	No	98.7	98.9
	Yes	1.3	1.1

In terms of access to social entitlements, 82.1% of the SD group were able to access ration provisions (Table 8.1d). Direct Bank Transfer was accessible to 3% of the group where as the Dearness Allowance and other allowances were accessed by 29% of the group.

Table 8.1d Proportion of persons with access to various social entitlements during the COVID-19 pandemic (June-September 2020)

Dry rations	82.1
Direct Bank Transfer	3
Disability Allowance and Other Allowances	29
Cooked Food Distribution	0

Employment and Income

The effects of COVID-19 can be readily examined through the loss of employment and income. As can be seen in Table 8.1e, just 72.8% of respondents in the SD group had no change in their employment, and this was reflected by the respondent spouses retention of employment at 77.7%.

3.9% of the SD group had to take leave without pay, and 16.8% lost their job are were unable to find employment. As a result of COVID-19 3.4% of the SD group reported that they had a reduced income. 5% of participant reported that spouses had reduced income, 12% lost their employment, and 2.1% had leave without pay.

It was a similar situation for participants' parents where applicable, with 12% losing their jobs, and 5% having a reduced income.

Working children were also reported where applicable, with 1.8% reporting increased workload, 6% losing their job, 1.8% having a reduced income, and 1.6% having started work as a result of COVID.

Impact of COVID-19 on Employment	Impact of COVID-19 on Employment (self)		
	Category	Percentage (%)	
Impact of COVID-19 on Employment (self)	Leave without pay	3.9	
	Lost Job/unable to find employment	16.8	
	No change	72.8	
	Reduced Income	3.4	
	No response/ Unknown	3.1	
Impact of COVID-19 on Employment (Spouse)- if applicable	Leave without pay	2.1	
	Lost Job/unable to find employment	12	
	No change	77.7	
	Reduced Income	5	
	No response/ Unknown	3.1	
Impact of COVID-19 on Employment (Parents)- if applicable	Lost Job/unable to find employment	12	
	No change	75.1	
	Leave without pay	5	
	Reduced Income	5	
	No response/ Unknown	2.9	
Impact of COVID-19 on Employment (Children)- if applicable	Increased workload	1.8	
	Leave without pay	0.3	
	Lost job/unable to find employment	6	
	No change	85.9	
	Started working	1.6	
	Reduced Income	1.8	
		No response/ Unknown	2.6

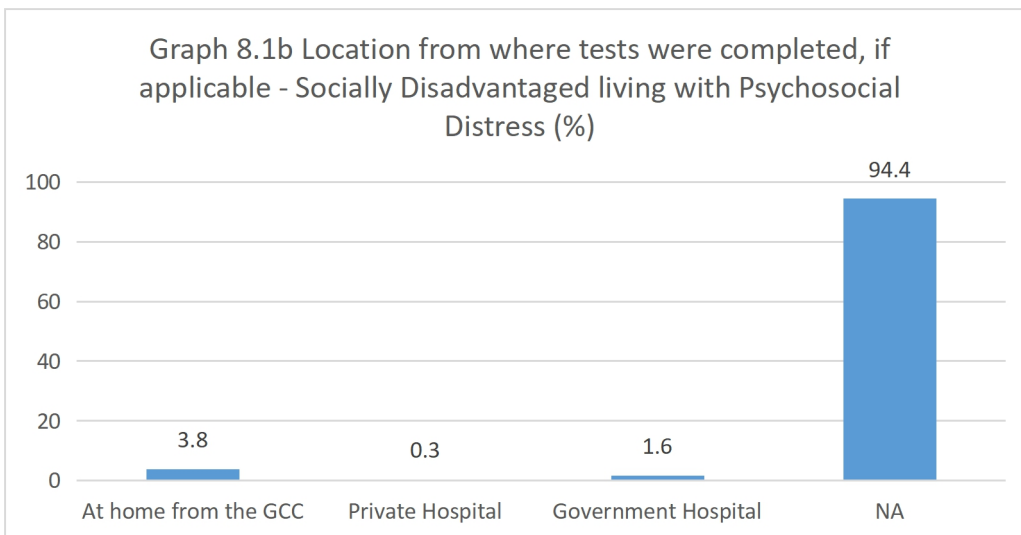
Category	Percentage (%)
Experienced COVID-19 Symptoms	8.1
Tested Positive for COVID-19	2.4

Health and Wellbeing

COVID-19 prevalence and testing

Of those in the SD group, 8.1% reported experiencing COVID-19 symptoms, however just 2.4% tested positive (Table 8.1f)

Including the entire SD Group, 3.8% were tested at home, 0.3% at Private hospital, and 1.6% at Government Hospital.



Impact on Mental Health

The impact on mental health was self-reported based on multiple choice. 30.2% of the respondents from the SD group reported no changes to their mental health (Graph 8.1c). The most prevalent impact reported was worries

about finances as a result of COVID-19 (28.3%). This was followed by concerns about their health at 19.1% and feeling distressed 15.6%. 4.9% reported a combined concern over their finances and health.

The SD group also reported what the effects of COVID-19 and related issues had on their mind. The most common response (24.6%) was feelings of loneliness. At 12.6% and 14.4%, feelings of an uncertain future, and grief and sadness were also not uncommon. Others expressed hopelessness (9.7%), anxiety (9.2%), anger (8.6%) and fear and anticipatory anxiety (9.2%) as prevalent feelings since COVID-19 began.

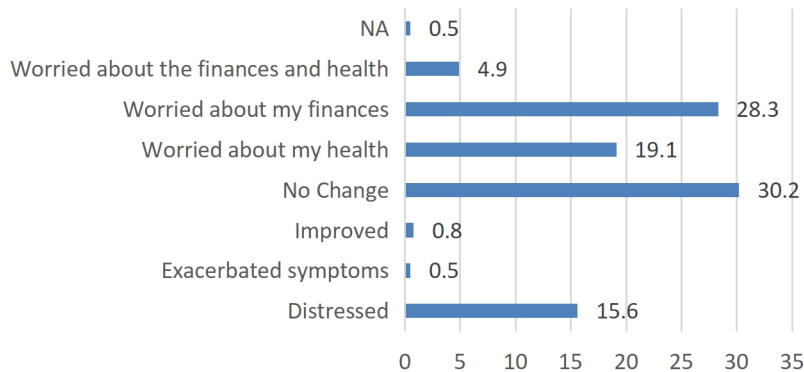
Impact	Percentage (%)
Loneliness	24.6
Hopelessness	9.7
Anxiety	9.2
Uncertain Future	12.6
Loss of Control	0.8
Anger	8.6
Substance Use	0.3
Fear and Anticipatory Anxiety	9.2
Grief and Sadness	14.4
Denial	1.6
Numbing	0.8
Other	2.6

Coping Mechanisms

Coping with all the changes since the pandemic was described by the participants in a multiple choice question. Coping with the physical impacts of COVID-19 and lockdown was reported in the survey, and many of the SD group reported (Table 8.1h) having taken loans to cope with the changes in their finances (44.5%).

Coping Mechanism	Percentage (%)
Loans	44.5
Sale of Property	0.5
Pawning	2.4
Part-time jobs	6
Sent Children for Work	0
Seek Professional Help	8.4
Other	0

Graph 8.1c Impact on Mental Health - Socially Disadvantaged living with Psychosocial Distress (%)



It was reported in Table 8.1i that they coped through faith and spirituality (27.5%) and speaking with friends and family (23.6%). 6% of the SD group took to part-time work to help manage this situation. Others reported that they slept more (7.3%) went for walks (1%), found support in volunteering (0.3%) and their pets (0.5%).

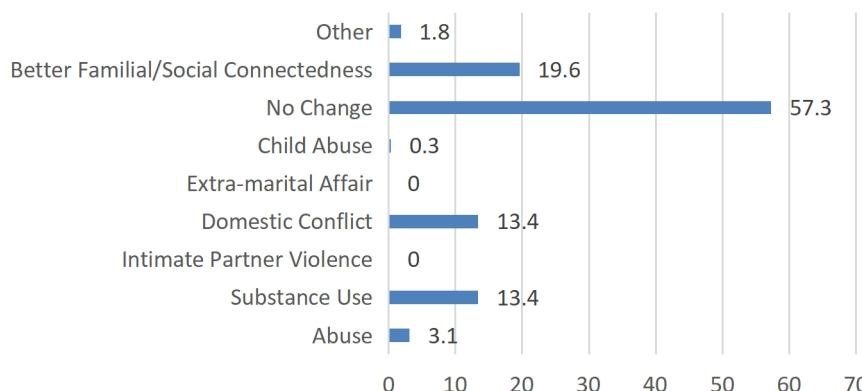
Table 8.1i Emotion focused Coping - Socially Disadvantaged living with Psychosocial Distress (%)

Coping Mechanism	Percentage (%)
Walks	1
Speaking with family and friends	23.6
Aspirations	0.8
Faith Spirituality	27.5
Volunteering	0.3
Pets	0.5
Sleeping	7.3
Other	0

Impact on Friends, Family and Home dynamics

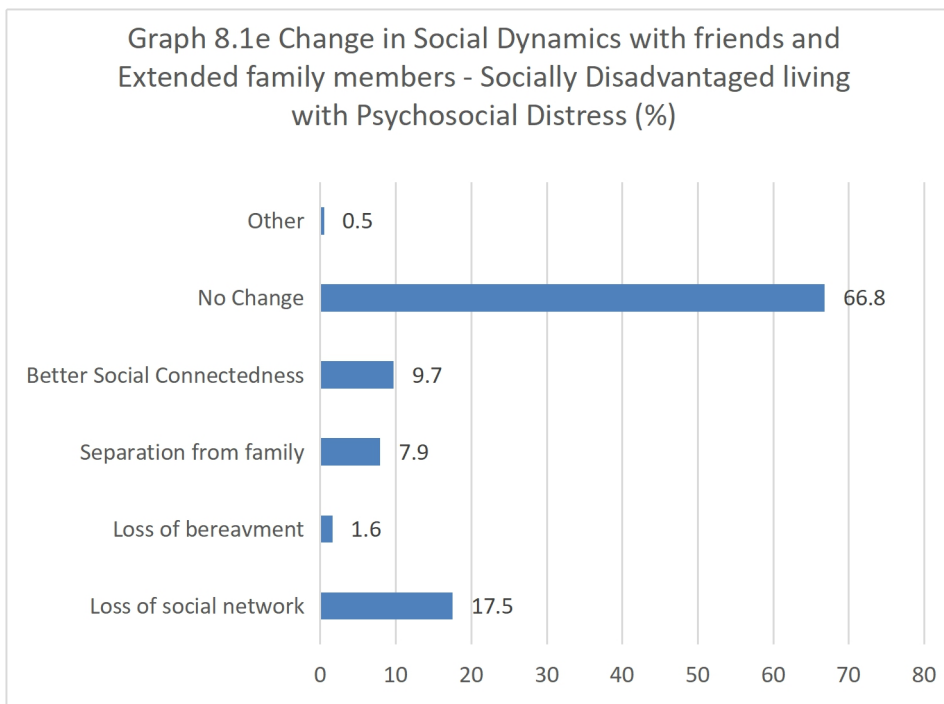
As seen in Graph 8.1d, the SD group reported an increase in domestic conflict (13.4%), abuse (3.1%) and substance misuse (13.4%). There were fewer reports

Change in Social Dynamics with Immediate Family - Socially Disadvantaged living with Psychosocial Distress (%)



among this group of intimate partner violence (0%) and extra-marital affairs (0%), and other changes (1.8%). A majority of 57.3% reported no changes in this area, and 19.6% reported improvements in their connections with their family.

In terms of changes to the social dynamics with friends and family the majority (66.8%) reported no changes. As seen in Graph 8.1e there was even a reported improvement in social connections as reported by 9.7% of the group. Others however reported a loss of social network (17.5%), separation



Loss of Income	15.4
Loss of support network	15.4
Loss of Hope	32.2
Loss of Recreation	15.4

from family (7.9%) and bereavement (1.6%).

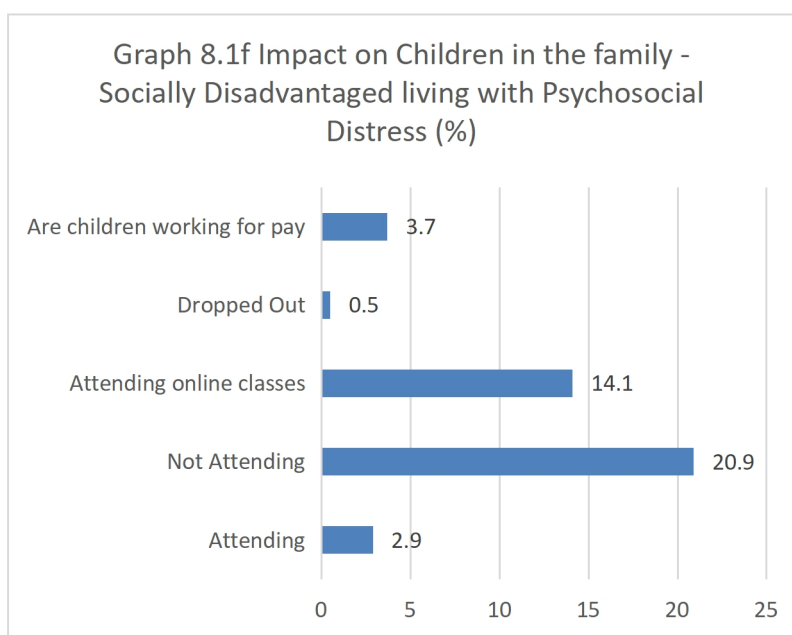
In addition to family and friends, there was also the loss of connection with establishments such as religious affiliations. Table 8.1j shows that this impacted their lives in multiple dimensions, including loss of income (15.4%), loss of support network (15.4%), loss of hope (32.2%) and loss in access to recreation (15.4%).

Children were also reported to have been impacted by all the changes. As seen in Graph 8.1f the SD group reported that 14.1% had access to online classes, and 2.9% were attending schooling. A substantial 20.9% of their children were not attending classes, with 0.5% having dropped out completely. Participants reported that 3.7% of children had started to work to contribute to the family.

Impact on the Elderly and persons with disability

Restricted movements was most reported by the participants as an impact on the elderly at 18.6% (Table 8.1k). Loneliness was reported by 7.9 percent and other illnesses at 8.6% were reported as an impact of COVID.

Others reported no access to basic needs (2.4%) no access to health care needs (3.4%) and loss of recreation (4.2%). In addition, an increase to their



Loneliness	7.9
Restricted Movements	18.6
Abuse	0.8
No Access to Basic Needs	2.4
No Access to Health Care Needs	3.4
Other Illnesses	8.6
Loss of Recreation	4.2
Fear of Death	4.2
Fear of Abandonment	1.6
Other	0

fears of death (4.2%) and abandonment (1.6%) was reported.

Persons living with a disability were reported to have been impacted 9.2% by the restricted movement as a result of COVID-19 (Table 8.11). Otherwise small proportions of those living with disability reported lack of access to basic or health care needs (2.1% and 2.6% respectively). Loneliness was reported at 3.9% and loss of recreation was seen to be an effect by 4.2%.

Loneliness	3.9
Restricted Movements	9.2
Abuse	0.3
No Access to Basic Needs	2.1
No Access to Health Care Needs	2.6
Other Illnesses	3.1
Loss of Recreation	4.2
Fear of Death	0.5
Other	0.5

8.2 Focus Group Discussions

Fear and knowledge around Covid-19

Access to television meant that much of the socially disadvantaged population characterised by poverty and having a family member with a mental illness, were aware of Covid protocols and attempted to follow them to the best of their ability.

“Community members were aware about the reasons for these protocols and managed to follow them as much as possible – they did not entertain people getting close to them and ensured their children were hygienic. While they could not follow physical distancing within the house, they were able to practice it within their community. They managed to reduce their group interactions within the community even though they could not afford soaps and sanitisers on a daily basis.”

While there were no active cases reported at the time of the survey, the lockdown and news of the pandemic created a lot of fear, especially surrounding their children. There was a lot of misinformation and partial awareness among this community. Some felt it was a virus that came from China, while others said that it had been spread by particular religious groups who had neglected their health while several others still had no understanding of why the lockdown had been declared.

Several people began to avoid hospitals even if they had other health care needs due to the fear, not just of infection, but of getting tested. They felt that if they tested positive, they would have to get admitted and would be isolated

Children’s Education

It was widely reported that families were stressed about their children’s education. They felt that they had no supervision at home and would fall behind their peers because of the gap in their studies. While alternatives were being offered, few had the luxury of owning a smart phone and therefore were cut off from classes.

“While trying to educate the people about an alternate [TV] channel for online classes, it was learnt that most of them did not have television at home.”

Their only access to an education were local tuition teachers and afterschool classes, many of which were also closed during the lockdown.

Loss of public transport

The ceasing of all public transport services across the country was a huge blow to the socially disadvantaged and ultra-poor. Many lost their livelihoods from being unable to travel to work and others suffered from not being able to visit aged parents, attend funerals, or even visit the hospital.

“Those without personal vehicles faced most trouble during the lockdown as they could not access the hospitals. For instance, one particular family had to relocate to their native in fear of money lenders and no income and since they did not have personal vehicle, they had to go by foot carrying some of their belongings and children.”

8.3 Case Studies

8.3 Case Studies

Vijaya and Vanitha

Family, finance and facing mental health challenges

Vijaya is a 45-year-old woman who lived with her son and her sister, Vanitha. Both the sisters along with their youngest sister were born and brought up in the Thiruvallur district in Tamil Nadu. When they were young their father, who was an alcoholic, passed away making their mother a single parent raising three girls. The mother worked as a daily wage labourer to provide for her daughters. They grew up in exceedingly difficult circumstances, often going through days without a proper meal, living without suitable housing or electricity. The youngest sister is now married and lives in a nearby village where she raises her own family. Poverty was one of the contributing factors that led to Vijaya and her sister to developing mental health problems when they were young adults. Managing their mental health through the COVID-19 pandemic exacerbated the challenges that the sisters faced, illustrating how social gradients, poverty, and structural violence correlated with common mental health disorders (Patel and Kleinman 2003; Lurhmann and Marrow 2016).

Vanitha was first to experience mental illness due to tensions with her husband coupled with poverty. Vanitha ended up homeless, without family support, which led to severe mental distress. She was supported by The Banyan in the early 2000's, and was rehabilitated and reunited with her mother and sister. Vijaya (Vanitha's sister) was then married, after falling in love with her husband. This marriage, however, was disapproved of by his community, as he belonged to a higher caste than hers. Together they had a son. Describing the rejection of her husband's family, Vijaya said,

“I fell in love with another caste man and married and got out son. He was a Naidu and I am Arundhadiyar. His home did not accept me. I did not go to them and they did not come to us.”

This relationship did not last. Vijaya's husband abandoned her after she developed initial symptoms of

mental illness, such as not eating, insomnia, and reduced communication with others. While this was an additional strain on their relationship, there was already history of domestic abuse with her husband drinking and physically abusing Vijaya. This abuse combined with the management and treatment of her sister's mental illness, they reached a breaking point, leaving Vijaya to leave him and live with her mother and sister, both sisters receiving treatment for their mental health while raising her son. Her husband, moreover, she said,

“passed away when my son was nine months old due to a snake bite. Ever since, my mother and sister raised my son.”

Loss: COVID-19 impacts on livelihoods, family integrity, and mental health

In early 2018, Vijaya's and Vanitha's mother passed away, which left both sisters alone along with the Vijaya's son who was only sixteen years old. Both sisters struggled with grief, having lost their greatest support, in their mother. The sisters faced further challenges when Vijaya's son befriended boys that they did not approve of. These boys were not attending school, nor were they employed, and were drinking regularly. In a family where spousal abuse had already been experienced, Vijaya's son, at just sixteen years of age, started to behave violently towards his mother and aunt.

Even through familial and mental health difficulties they had some income, with their youngest sister working at a Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGS) job for 300 rupees per day, managing their household needs. This, however, was their only income, and with the lockdown this was reduced to nothing; and, with no work they had to rely on what their youngest sister could help them with, a meagre hundred or two hundred rupees a day. There was some relief, with the Tamil Nadu Government providing a benefit of Rs. 1000 for all ration card holders in the month of April, which acted as temporary support to buy day-to-day basic needs like rice, lentils and sugar. The Banyan also supported the sisters with dry rations and disability allowances each month; however, they still had to depend on their youngest sister to buy vegetables and milk.

Vijaya's son was an additional pressure at this time, as he demanded money to socialise with his drinking

friends. With only about 2500 rupees each month to live on, there was nothing to spare; however, he persisted with demands for money and was not willing to help or look for employment. As Vijaya described the situation at home,

“(my) son used to drink and abuse. No money for food. Fights at home. No peace of mind.”

The tension at home weighed heavily upon Vanitha. This, in turn, led to an emotional crescendo for Vanitha, reminding her of the times when their mother would take care of them under similar duress, and, significantly, of a time when she did not have to take the responsibility alone. Vijaya described these earlier times as difficult:

“When my mother was there. She used to work at people’s homes. Times were difficult then. We used to have two meals. Sometimes she used to get three meals at the places she worked. We will have that. We used to get ration rice which we used to have with water instead of sambar. Used to be difficult then.”

While Vijaya derived strength from the memories of her mother’s struggles to care for the family, Vanitha expressed feelings of worthlessness and hopelessness about her life, and that she did not want to live, to her sister, who in turn consoled her saying that,

“life is short and let’s try to live to its fullest with a smile.”

The family, especially Vanitha, faced stigma at the work place and within the community due to her mental illness, and the fact that she took medications for it. This led to harsher feelings of being worthless and not having a purpose in life. Moreover, she could not visit The Banyan during lockdown and therefore lacked a source of support and comfort, as well as a place to express her overwhelming negative emotions and despair. It was clear that the repeated social defeats caused by stigma, and the sense of negative self-worth it produced, was too much to bear. According to Vijaya, her sister said to her,

“the other people are laughing at us and making fun of us’. I used to tell her let others say what they want, we should not mind it. We should take medication and get well. She used to tell us both to take poison and commit suicide. She used to

be on the heavier side. She felt others are making fun of that and that she looked like a buffalo.”

With these all-encompassing pressures, Vanitha was not able to cope with the pandemic, lockdown, stress of employment, loss of support, grieving, and her nephew’s demands. She decided to commit suicide by consuming rat poison, feeling depressed and hopeless. Immediately, and realising the consequences of her act, she told it to her sister what she had done, who with the help of their neighbours in the middle of the night, rushed to the hospital which was half hour away by autorickshaw. Vijaya described the tragedy in this way:

“She said she was reminded of our mother and wanted to go to her. I told her not to speak like that. I told her we should manage without mother, am I not managing and younger sister is also there. And I don’t know when she bought the medicine (poison) and kept it at home. Suddenly she woke me in the middle of the night saying ‘I had poison, take me to the hospital’. They gave her injection and gave glucose but suddenly passed away after a few drops from the drip. Then they put her in a room. Then we informed my younger sister and we brought her home. This is what happened...what to do.”

Sadly, as Vijaya described it, they were too late to save Vanitha. Distraught, Vijaya, who was already experiencing severe mental health symptoms, did not even cry for many days and took a long time to cope with the loss. The only source of support for Vijaya was her youngest sister and son. She said she was coping with the situation, thinking that she must live for her son who has a future, given that he was now abstaining from alcohol and had gained employment in an NGO. Vijaya said she did not worry as much about her son anymore and that she was hopeful that he would succeed. This renewed hope helped reduce her stress, and improved her sense of wellbeing.

Vijaya’s resilience in the face of tragedy was aided, obviously, by the memory of her mother’s struggles and dignity. Whereas her sister, experiencing the crushing blows of stigma and hopelessness, could not carry on without her mother’s care. Vijaya was able to find hope in the psychosocial interventions that The Banyan provided. As she said,

“Now it is better. You have also helped. You helped in getting a job. Our difficulties have come down.”

Moreover, like her mother, she felt the weight of responsibility in caring for her son, saying,

“(I) need to think of him. She has committed suicide like that. If I also do, who will take care of my son.”

When Vijaya would get upset, she utilised the counselling she had received at The Banyan to reach out to others in times of duress, saying,

“I call Banyan, I call my younger sister and I call my son and I talk to them... Life is short. We should be happy as much as possible and go only when God has called.”

Perhaps most importantly, and in addition to the need to reach out share difficulties with others, including counselling services as provided by NGOs like The Banyan, inoculating oneself from the negative dimensions of stigma, and more generally, of the opinions of others, was an important source of resilience that mitigated against social defeat and its pernicious effects on wellbeing. This was expressed concisely and eloquently by Vijaya when asked what people facing difficulties should do:

“They should call (Banyan) and tell them (their) difficulties. They will listen to it and offer consolation. We can do that. After that our worries will reduce. Other than that, can talk to people at home. We should be happy for ourselves and not worry or think about what other people talk about us.”

Extrapolating a more general point from Vijaya’s insight, we can see that providing work and reducing the stigma around mental illness are two of the most potent weapons against despair, worsening psychological symptoms, and the risk of suicide. In short, there are simple but necessary remedies to the structural violence faced by the most vulnerable segments of the population, which might require a shift in priorities from emphasising biomedical care towards more weight being placed upon psychosocial interventions and raising public awareness in order to reduce stigma.

Mrs and Mr Ramanathan

Mrs. Ramanathan is a 57-year-old married woman who has been accessing The Banyan services for 25 years. She had been diagnosed with Treatment Resistant Schizophrenia. Mr. Ramanathan, her husband, loved and felt very connected to his wife from the day he met her. She, sadly, started showing signs of mental illness, such as withdrawing from others, having auditory hallucinations, and had wandering tendencies after just a few months of marriage. Mrs. Ramanathan gave birth to a boy after two years of marriage, and faced raising their son and managing her developing mental illness at the same time. Managing daily living for many has proved difficult during the time of COVID-19 with a loss of income and self-isolation; however, having the additional stresses, in Mr. Ramanathan’s case, of caring for someone with mental illness and a child was even more challenging, stretching the family’s resources and ability to cope.

Mental health and strength in partnership

Mr. Ramanathan took some time to understand what was happening, but did not know where to seek support from. He was determined, however, to sustain his marriage and support his wife. Her parents told him that she was under the influence of “black magic.” Therefore, he had to take her to different temples to perform many *pujas* (prayers) and by bringing home local priests to drive away the “evil forces.” The family also spent a large amount of money for these rituals, both at home and at religious institutions.

Mr. Ramanathan’s own family disowned them; and his parents and siblings urged him to abandon his wife. But he was not willing to do so, and as a consequence, they cut off nearly all family ties. His mother, however, supported him for a year by taking care of his wife. Having a parent to support him was of great help and comfort, though it did not last. His brother, who lived in the same house, refused to share the burden. When Mr. Ramanathan looked back at this point of time in his life when he could not find any sort of support system, he wondered how things might have been different if mental health services commenced with care providers asking what social support clients needed. This, he felt, could help to prevent homelessness and the additional stresses of facing poverty coupled with mental illness, each factor exacerbating the other.

Finding the right support

Mr. Ramanathan required help as he was looking after his child while also being the main caregiver for his wife from a young age. This was a huge responsibility. He was often not able to afford treatment for his wife, as he did not have sufficient income to sustain the family and he struggled to raise his son while working as a stenographer for an automobile company. Meanwhile, caring for Mrs. Ramanathan, who had complex and severe mental illness, continued to challenge him, particularly when she began to go missing for periods of time. The first time Mrs. Ramanathan went missing she was away for a month-and-a-half. Mr. Ramanathan did not know where she had gone. The Banyan found her living on the streets and took her into their care, reconnecting her to her family. Mr. Ramanathan, grateful, expressed that The Banyan was able to understand his needs and enabled him to think positively. The Banyan's services and counselling enabled him to find inner strength, and not to feel engulfed by negative thinking. As he put it,

“because you people are supporting me, I am getting all the benefits from you people, (and) I am surviving myself. Otherwise, I could not have. Where could I be...I cannot say anything.”

He also, subsequently, started having more faith in God and believed that in everything would be set right. Help from The Banyan had given him an anchor to face his challenges, such as the loss of his family's support and the stigma he faced due to his wife's illness, as well as the fact that his son was caught in between these struggles.

Mr. and Mrs. Ramanathan had been accessing The Banyan's help for more than fifteen years. His wife was now much more mentally stable, though she still required treatment. Mr. Ramanathan added,

“She is a mentally sick lady, you see, Banyan is supporting her... because of her support I am getting this treatment from you people. Luckily (it) saved my life.”

They accessed disability allowance and additional financial support whenever possible. He was referring, too, to the fact that he gradually developed a nephrological condition. The Banyan, as part of Mrs. Ramanathan's continued care, was made aware of their plight and urged him to immediately seek medical

attention. He was rushed to the hospital and was diagnosed with kidney failure. He could not afford all the medical expenses. The Banyan helped finance his dialysis, and his condition was stabilised; but he had to stay near the hospital for regular treatment. He was offered long term care through housing support from The Banyan. But they relied on the help and care of their son, who was now 38 years old and working in a stationary shop.

Mr. Ramanathan frequently reflected on his past and recollected the pain that his son had endured. In short, he regretted that his son did not have a normal childhood. He felt that his son did not receive an adequate education due to the challenges the family faced. The Banyan, he felt, however, provided critical support in the absence of a primary caregiver and, most importantly, they supported him through the loss of social support and family ties. This was pivotal in helping him cope,

“From experiences I learned that my will power took me to greater heights, The Banyan being a great support to keep the family together,”

and gave him the willpower to persevere, he reiterated, also stating,

“another learning was that my level of patience was increasingly taking control of things.”

The reality for full-time caregivers

COVID-19 and its impact on employment affected Mr. Ramanathan's family. Mr. and Mrs. Ramanathan relied on their son's earnings, while he would care for them at home. He was, however, laid off due to the parent company losing money during the pandemic. Additionally, Mr. Ramanathan, unfortunately, had to undergo a major surgery for his renal problems during the pandemic. The Banyan helped them with organising this, but it resulted in their son caring full-time for both father and mother. After his surgery, and during the month of August, the family had to shift from their current house, as Mr. Ramanathan could not climb stairs anymore. During these difficult times, they not only had to manage their health and mental health, but had to find a house which was located on the ground floor with affordable rent that allowed them to continue to access the support services they needed. The family continued to struggle without income while their

son was looking for employment while taking care of his parents. Speaking of COVID, Mr. Ramanathan said, it

“had become difficult to run the family, although Banyan is only supporting me.”

He reflected further on his inability to move about during the lockdown, making it impossible for him to utilise his ration card, which was still located in the old house. As he put it,

“It is very difficult to survive in this world unless you have plenty of money in stock—it is very difficult. People like me should get support from the people or government, or organisations like yours so that I can survive.”

Though his predicament was grim, he realised that there were people worse off, particularly the homeless and mentally ill. He reflected,

“There will be (more) struggle for them than people like me...Struggle for life and die in that state only. There is no other way. Government should support them...government should come forward and support struggling people.”

As in the other cases we have seen, the additional stress of the lockdown and losses of income incurred during the pandemic had worsened an already precarious existence. Moreover, common mental health disorders and poverty were, once again, comorbid conditions, with the one exacerbating the other (Patel and Kleinman 2003). With the pandemic causing extreme hardship for those homeless, or teetering on-homelessness and facing poverty, the cases above suggest a looming mental health crisis could worsen significantly without resources directed at job creation and supplementary economic relief, coupled with enhanced NGO networks at the grassroots level, such as the efforts of organisations like The Banyan. As the cases here were already under The Banyan’s radar, and, thus, had some support to offer to the individuals discussed here, the cases also remind us, as Mr. Ramanathan had, that those without NGO or government support will suffer a worse fate, and “struggle for life.” Finally, Mr. Ramanathan also points out that psychiatric interventions without psychosocial support, will not be as helpful, and might contribute to homelessness, as we recall his comment that medical care should commence first by listening and addressing the client’s social needs.

Fatima

Twelve years ago, in despair over a daughter with intellectual disability and seizures, Fatima came to Kovalam, a seaside village in Tamil Nadu to seek the healing powers of a famous local dargah, the final resting place of an Islamic saint said to have powers over mental illness. It was from there that she was directed to The Banyan’s rural mental health programme where she was able to get free treatment, day care for her daughter, and was connected to various social entitlements and welfare measures. Her husband continued to run a tailoring shop in Chennai, and although they had some debts, they were able to live relatively comfortably off of his income.

Loss of identity

A year prior, Fatima’s life was turned upside down. At the age of twenty, her daughter who defined her life’s purpose as a caregiver to a severely disabled child, passed away leaving her feeling empty and with long meaningless days in front of her. She found herself losing interest in her day-to-day activities and found it nearly impossible to stay at home. Describing her state of despair,

“As long as my daughter was alive, I was somehow fine. But after she passed away, I am just not able to stay at home. I am not able to stay alone...”

Prior to her daughter’s passing, she had found comfort and purpose in Kovalam through the medical care her daughter received at The Banyan, noting that the doctor treating her daughter offered more than medicine, but hope and dignity. As she put it,

“more than medicine, it was his words where I found comfort,”

inspiring her with a purpose to care for her daughter by emphasising that,

“treatment is not about medicines--it is more of seeing the ‘client’ as a person, recognising their value systems and protecting their rights, marking the pathway to empowerment.”

In short, her identity and purpose as a caregiver was lost upon her daughter’s death. Moreover, economic strain and the need to care for her ailing husband, who had lost

work during COVID, prompted her to seek income in the midst of her despair.

Fatima found herself returning to The Banyan's Health Centre, although she no longer had a clear medical reason for doing so. She accepted an offer for a housekeeping job there in order to make ends meet. In spite of her husband's misgivings that his wife was going to work for the first time at the age of fifty-five, she found this a worthwhile use of her time, and began to use her extra earning to repay old debts and loans. The staff at The Banyan, however, noticed that she seemed to tire easily and had other symptoms, such as weight loss and excessive sweating, and insisted she receive a full medical workup. Fatima was subsequently diagnosed with diabetes; and with the right medication, her mood and physical health improved significantly.

Impact of the Covid -19 pandemic

Things seemed to be finally looking up after her daughter's death when the Covid-19 pandemic hit, resulting in strict month-long lockdowns. News brought home from the television and chatting with her neighbours about the dangers of the virus made her fear for her husband who was in his mid-seventies. Realising he could no longer safely travel to his shop in Chennai to work, the couple were suddenly faced with a new problem – poverty. While Fatima continued to make 8000 INR with her housekeeping job, they now no longer had her husband's income, and with a rent of 3000 INR and assorted other expenses for food and maintenance, there was hardly enough to last the month. They could no longer repay their loans, and sometimes struggled to even procure milk and coffee. As she described her predicament when the pandemic occurred,

“Terrible difficulties! Terrible difficulty. I could not even buy a packet of milk...I used to come here and cry. I come here (Banyan) to eat and even pack food to take for my husband...Somehow, I have been managing for seven months with my single income, and avoiding sending him outside to work. If I (did not have this income) there is nothing I could have done. I do not have words to explain...after this Corona has come. Somehow, we are managing to stay alive. If I leave this (job) I have no other means. After Corona there is no income, husband is at home, he is speaking to himself as if

he has gone mad. If you ask him he says, ‘I am not able to go out, I am not earning.’”

Change in family roles

From being the primary caregiver of a disabled daughter, Fatima was now her husband's care provider, which was difficult for him to accept.

Fatima's husband, who had always been the provider for the family was deeply affected. He felt ashamed that his wife had to work to support him, and that his age, health, and current situation with the pandemic, was no longer permitted him to work.

“After so many years of providing well for you and keeping you safe, I now have to send you out to work. That's making me very upset. If I am also able to work, we will have a decent income together,”

he told her. He had shut himself in the house and refused to venture out even to the nearby store or bus stand.

“You should have seen my husband before this. He was strong and brave. It didn't matter if there was money at home or not. He would be courageous. Now he has completely changed,”

Fatima lamented.

Fatima worried further about her husband, saying,

“Now he's at home all the time, he's become a bit strange. He talks to himself and does odd things. When I ask him about it, he says, ‘I am alone at home, I have no work, what else will I do?’”

She worried her husband could be developing mental illness and was trying hard to get him to go for short walks or work on some tailoring, his prior job, from home. But he felt that he was physically unable to do so anymore. Fatima made inquiries locally in hopes that a tailoring job could be found for her husband. Moreover, her husband has said he will only work from home if he had a “powered machine,” noting that his leg

“has become bent because of diabetes. His toes are splayed and he says he needs a motored machine only to be able to work. To buy that will cost 15,000-16,000 rupees, I and do not even have any jewellery to pawn.”

While her husband's inability to work seemed to cause him depression and a lack of motivation, Fatima's job had, at least, provided for their basic survival needs, though she herself admitted to encouraging his confinement within the house:

"Because I am working here, my husband is able to get his meals on time. Seven months ago Corona struck. Since then, my husband has not set a foot outside. He is completely at home. He has become so old that if he goes out people are telling me he will get Corona. So, I have made him stay completely at home, and I come here for work. In the afternoon I take food from here to my husband."

While Fatima's desire to keep her husband safe was logical, given his age and underlying medical condition, she had begun to encourage him to stay socially active and work, if possible, fearing for his psychological wellbeing,

"I suggest he goes out and makes friends, but he does not like getting to know people around. He's always indoors... he refuses to leave the house. Whenever I ask him he responds by asking me to get him a sewing machine so he can sit at home and stitch."

Fatima admitted that her husband's condition was worrying, and put a strain upon their marriage,

"Look at my husband now...Now for seven months...you just see how he is now. He's so different. Past few days I have also been thinking...I never thought this would happen to him. I have told him, I do not think Corona likes the both of us to be together. By the time it is over either you will go or I will go. That is what I have told him."

Much of tension in her household concerned not only his odd behaviour, as she put it, but also his lack of understanding of their limited financial means and his requests for spending money for snacks and drinks. While she earned around 8000 INR per month, the family had large debts from a sizeable loan, which took a large chunk of her monthly income, in addition to the 3000 she paid on rent for their home. This left no money for anything but basic necessities, creating tension at home. In terms of financial support, Fatima mentioned that they had received 1000 INR from the

government, in total, though they also received some rice.

Finding strength

Sometimes, Fatima felt so badly about the loss of her daughter and her current situation that she contemplated ending it all. She put it this way,

"Then I have a thought. Why do we have so many problems? For so many days I struggled with my daughter. Not able to go anywhere, having to be constantly with her, you know how much I struggled? Now that she is gone, why should we live? I do not want life anymore. What great things am I going to accomplish now? I have nothing. I have sometimes decided to just die. Then I think, what will people around say. They will ask who will look after your husband if you go. They will say when money is there you want your husband, and when it goes you do not want him anymore. For that alone I am trying to survive."

She added, wiping tears away,

"I have lost everything in my life. My identity. My support systems, my love and everything, yet life has also taught me many things. I am vulnerable and, in this vulnerability, lies my strength. My daughter and her disabling condition, in a way, empowered me, that I am independent now realising my strengths and abilities....I believe Allah will not let me down and that in his blessing I thrive."

At times like these her faith and inner strength, a gift from her daughter, would carry her forward. Fatima would think about her husband and how much he had supported her over the years and felt she must at least be around to do the same for him. In spite of all her hardships, Fatima remained generous and brave. She continued to work every day and diligently cared for her husband, while paying down family debts. Moreover, she recognised that there were others worse off, who had no livelihood and/or were homeless. Therefore, she also cared for those around her. For instance, when a young family with small children in her neighbourhood lost all their income, she gave up the rice that was given to her by the panchayat leaders so they would not go hungry. Despite continued financial hardship and worry over her husband's health and wellbeing, Fatima was proud that

even though it took her so long to become so, she was now independent and could provide for herself and her household, having found some faith in both God and herself. As she put it,

“When I wake up in the morning I think of God and pray that the day should go well. And then the day does go well to an extent. So, God, I do believe in. It has been fifteen years since I have come to this village. Until today He has not let me down. Somehow things keep going.”

This case, like the others we have witnessed, suggests that sources of resilience and wellbeing not only comes from work and the obvious dignity and material survival it enables, but from sources of motivation and self-worth found in family, care for and by others, and faith deriving from various spiritual traditions. The pandemic, on the other hand, shows that a loss of work and social isolation are contributing, not surprisingly, to sources of familial and psychological tension, with potentially ominous warning signs regarding a potential rise in mental illness.

9. Homeless and Homeless persons living with mental illness

One of the most universal and sweeping crises of our times that affects individuals, regardless of racial, gender or national identity is homelessness. There is no single definition of homelessness, however it is often agreed that housing is a universal right. There are various cultural contexts which influence the way in which it is understood and experienced from one region to another. The United Nations has defined “primary homelessness” as persons living without a shelter or living quarters and “secondary homelessness” as including persons with no place of usual residence. Certain cultural contexts experience homelessness as both a lack of access to land as well as to shelter (Singh et al., 2018). Two crucial factors that define the way in which homelessness is experienced in a region is the economic condition and inequality in a country. The Institute of Global Homelessness has proposed as a global definition: “lacking access to minimally adequate housing”, while listing various categories of living situations that fall within this general definition (Singh et al. 2018).

There has been a great positive growth in urban homelessness in India, especially between 2001 and 2011. Simultaneously, the rural homeless population has reduced during this time period. It is also noticeable that more than half of the homeless population resides in only five of the most populous states: Uttar Pradesh, Maharashtra, Rajasthan, Madhya Pradesh and Andhra Pradesh (Singh et al., 2018). The Census of India provides a choice between three types of household: ‘normal,’ ‘houseless,’ and ‘institutional.’ Also, the Census of India defines homeless households as those “households which do not live in buildings or Census houses but live in the open or roadside, pavements, in hume-pipes, under fly-overs and staircases, or in the open in places of worship, mandaps, railway platforms, etc. are to be treated as Houseless households” (Census of India, 2011). The various defining features highlighted by Census of India’s definition of homeless households reveals the underlying matrix of issues such as socioeconomic conditions and cultural norms. Moreover, the way in which Census of India defines ‘homeless households’ is particularly done specifically for the vulnerable demographic of India. The vulnerable

demographic in India is also the ‘invisible’ population that is rarely recognised for their humanity and involvement in the economy; they are not seen by policy makers, governments and institutions (Singh et al., 2018). This ‘invisible’ population consists of the most vulnerable members of society including women, children and the disabled.

Homelessness is an issue of social exclusion with no one-time solution or single cause. Unprecedented urban homelessness has risen in tandem with changes in economic and social processes. Economic and institutional factors play just an equal role as social and psychological justifications. Some common causes of homelessness include breakdown in familial relationships, financial difficulties & lack of affordable housing, constrained housing options, lack of political stability, natural disasters, and forced migration amongst others. A single individual may face one of the aforementioned difficulties or in more common cases, an interplay of factors. Poverty is closely tied to homelessness because precarious work along with a combination of low wages, hunger and lack of affordable housing forces individuals to the streets. Often, those in the vulnerable demographic take on precarious work that forces them to live a life without a stable home. Social exclusion and the vast effects of poverty stems from structural barriers. These effects have a cascading effect into other aspects of an individual such as mental health.

Mental illness, domestic abuse, violence, addictions and mental illness are often understood to be antecedents to homelessness. This results from a failure of institutions to support individuals during times of suffering. If individuals are not provided assistance when they are on the brink of becoming homeless, they become even more invisible once they are on the streets. At this point, individuals are not seen as citizens but as “illegal” members of society. To further cement this notion, individuals do not have voter identity cards. This leaves them out of social security schemes and government programs. The marginalisation of this ‘invisible’ demographic exacerbates the homeless situation making individuals prone to challenges such as alcohol and drug abuse. Homeless persons are also exposed to other factors such as inadequate nutrition, very limited social support, limited access to medical care, repeated abuse and violence, unsafe sexual practices and unsafe shelters.

Evidently, homelessness is a multi-faceted issue that needs solutions that take economic, psychological, social and institutional factors into consideration. More importantly, it is important to prioritise individual needs including privacy, space, control, personal warmth, comfort, stability, safety, security, choice, self-expression, and physical and emotional wellbeing. The vulnerable demographic that suffers the most from homelessness needs more than a roof over their heads. These individuals need to become a contributing member of society, so they too can feel seen and stay off the streets, permanently.

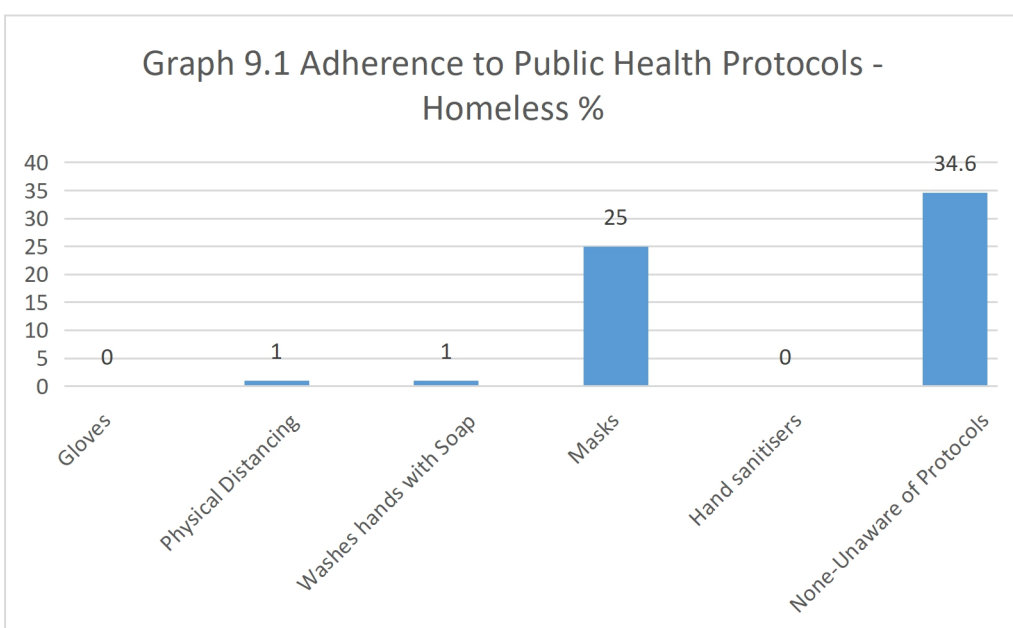
With the outreach services, working on the streets of Chennai, the staff found the opportunity to not only provide services etc but to interact and learn about their lives

9.1 Survey Results

COVID-19 and Public Health - Awareness, Knowledge and Challenges

As seen in table 9.1a 44.3% of the homeless participants reported that they were aware of the pandemic, and 37.5% reported that they were aware of the COVID-19 public health protocols.

Awareness of COVID-19 Pandemic	44.3
Awareness of COVID-19 protocols	37.5



Lack of space in the house	1.9
Lack of safety on streets [as applicable]	19.2
Poor sanitation	5.8
Financial constraints [to buy medical aids such as masks and gloves]	14.4
Unaware of protocols	34.6
Lack of space in the house	1.9

Adherence to public health protocols was limited among the homeless group, and 34.6% reported that they were not aware of the protocols (Graph 9.1a). The main protocol that was followed was the use of masks, however this was just 25% of respondents. Physical distancing, using soap for hand washing, hand sanitiser or the use of gloves was below 1.5% for the group.

The challenges however would have been considerable to following such protocols, and 14.4% reported that their finances limited their adherence (Table 9.1b). 34.6% reported that they were unaware of the protocols to be able to follow them. Otherwise lack of safety was the prime reason that people reported as a challenge to their adherence to public health protocols at 19.2%. Lack of space and poor sanitation was less reported, with 1.9% and 5.8% respectively.

Impact of COVID-19 on access to essentials and Social entitlements.

Access to essentials was reported quite positively by the homeless group with regards to food and water. The proportion responding that they had access to food did decrease however since COVID-19 started going from 100% to 94.4% (Table9.1c). Access to water also reportedly decreased due to COVID going from 95.8% to 91.7%.

Clothing access was relatively consistent, however a majority of the homeless did not have access to clothing before or after the pandemic (76.4% and 77.8% respectively).

The homeless group mainly

Table 9.1c describing the impact of COVID-19 on the access to basic needs Homeless(%)			
		Pre-COVID	During COVID
Access to Food	No	0	5.6
	Sometimes	0	0.0
	Yes	100.0	94.4
Access to Water	No	4.2	8.3
	Sometimes	0.0	0.0
	Yes	95.8	91.7
Access to Clothing	No	76.4	77.8
	Sometimes	0.0	0.0
	Yes	23.6	22.2
Public Toilet use	No	25.0	29.2
	Yes	75.0	70.8
Private Toilets	No	91.7	98.6
	Yes	8.3	1.4
Sanitary pads	No	95.8	100.0
	Yes	4.2	0.0
Access to Soaps	No	90.3	95.8
	Yes	9.7	4.2
Access to Shelter	No	98.6	100.0
	Yes	1.4	0.0
Access to Government shelter	No	100.0	93.1
	Yes	0.0	6.9
Access to Stable Housing	No	95.8	100.0
	Yes	4.2	0.0
Access to Relief	No	100.0	100.0
	Yes	0.0	0.0

reported using public toilets prior to COVID-19 (75%), and although this did decrease to 70.8% during the pandemic, only 8.3% reported access to private toilets before and 1.4% after the pandemic. Access to sanitary pads was also low at 4.2% prior to the pandemic, and decreased to 0% during.

Shelter and housing was difficult to find for the homeless group prior to the pandemic, with 4.2% reporting having access to stable housing, before the pandemic, and 1.4% reporting the use of a Shelter. During the pandemic however Government shelter access increased from 0% to 6.9%, and access to stable housing and Shelter reduced to 0%.

None of the Homeless reported having access to relief before or after COVID-19. As corroborated by Table 9.1d , the Homeless group had severely limited access to social entitlements, with 0% accessing dry rations, Direct Bank Transfers or disability allowances. Just 15.5% reported having access to cooked food distribution.

Table 9.1d Proportion of persons with access to various social entitlements during the COVID-19 pandemic (June-September 2020)	
Dry rations	0
Direct Benefits Transfer	0
Disability allowance and Other Allowances	0
Cooked Food Distribution	15.5

Employment and Income

The Homeless group, as seen in table 9.1e mostly reported that there was no change to their employment status, at 37.5%. Most of the rest, 21.2% however reported that they could not find work or lost their employment and 1.9% reported reduced income. 39.4% however, refused to respond to the question.

In relation to their families, the majority reported no changes as a result of COVID. For their spouses, they reported 50% no change, 2.9% loss of job and 1% reduced income.

For their parents there was even less change at 52.9% and 2.9% reported loss of jobs

For their children where applicable, 48.1% were reported to not have experienced a change in their employment, 4.8% lost their jobs, and 2.9% started working as a result of COVID-19.

It must be noted that on account of being homeless, many could not answer accurately for their spouses families or children and thus declined to do the same.

Table 9.1e: Describing the impact of COVID-19 on employment of the respondent (self) spouse, parents and children - Homeless (%)

Impact of COVID-19 on Employment (self)	Leave without pay	0
	Lost Job/unable to find employment	21.2
	No change	37.5
	Reduced Income	1.9
	No response/ Unknown	39.4
Impact of COVID-19 on Employment (Spouse)- if applicable	Leave with pay	1.9
	Leave without pay	0
	Lost Job/unable to find employment	2.9
	No change	50
	Reduced Income	1
Impact of COVID-19 on Employment (Parents)- if applicable	No response/ Unknown	44.2
	Lost Job/unable to find employment	2.9
	No change	52.9
	Leave without pay	0
	Reduced Income	0
Impact of COVID-19 on Employment (Children)- if applicable	No response/ Unknown	44.4
	Increased workload	1
	Leave without pay	0
	Lost job/unable to find employment	4.8
	No change	48.1
	Started working	2.9
	Reduced Income	0
No response/ Unknown	43.3	

Table 9.1f Proportion of persons who have experienced COVID and Tested Positive for COVID

Experienced COVID-19 Symptoms	0
Tested Positive for COVID-19	2.9

Health and Wellbeing

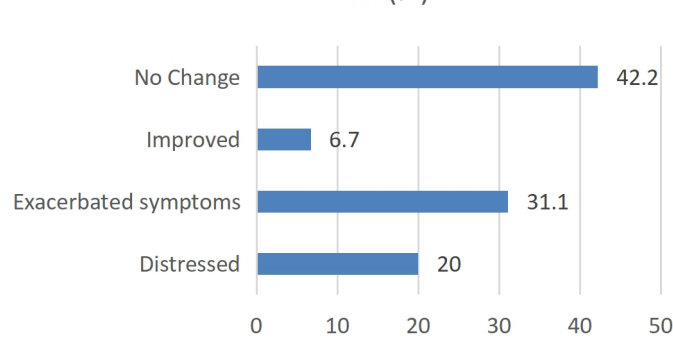
COVID-19 prevalence and testing

The Homeless group did not report having experienced COVID-19 symptoms, however 2.9% reported having been tested and being positive Table 9.1f. Shown in Table 9.1g, all of those tested advised that they were tested at home (2.9%)

Table 9.1g Location from where tests were completed, if applicable

At home from the GCC	2.9
Private Hospital	0
Government Hospital	0
NA	97.1

Graph 9.1b Impact on Mental Health - Homeless (%)



Impact on Mental Health

42.2% of the Homeless group reported no changes to their mental health as a result of COVID-19 (Graph 9.1b). As seen by the graph, 20 percent reported that it had caused them distress. Some reported an improvement in their mental health (6.7%) however

many more reported that the situation had the effect of exacerbating their symptoms.

As shown in Table 9.1h, the result of COVID-19 and related issues had varied impact on the Homeless Group. The most commonly reported impact was feelings of an uncertain future (22.1%). This was followed by hopelessness (14.4%), loneliness (10.6%) and anxiety (10.6%). A few also reported feelings of anger (2.9%) and denial (2.9%), fear and anticipatory anxiety (1%). 2.9 percent reported substance misuse, while 1% reported feeling something other than the options provided in the survey.

Coping Mechanisms

Not all respondents reported having emotionally focused coping methods, however 19.2% reported relying on their faith and spirituality (Table 9.1i). Additionally speaking with friends and family, and going for walks were their reported coping methods, at 14.4% and 8.7% respectively.

Coping Method	Percentage
Walks	8.7
Speaking with family and friends	14.4
Aspirations	0
Faith Spirituality	19.2
Volunteering	0
Pets	0
Sleeping	0
Other	1

Again not all the homeless reported how they coped with the problems they faced during COVID-19, however most 19.2% reported seeking professional help. In addition to this they reported taking loans 1.9%, having their children start to work (1.9%) and taking on part-time jobs (15.4%).

Coping Method	Percentage
Loans	1.9
Sale of Property	0
Pawning	0
Part-time jobs	15.4
Sent Children for Work	1.9
Seek Professional Help	19.2
Other	0

Table 9.1h What impact did COVID 19 and other related issues have on your mind

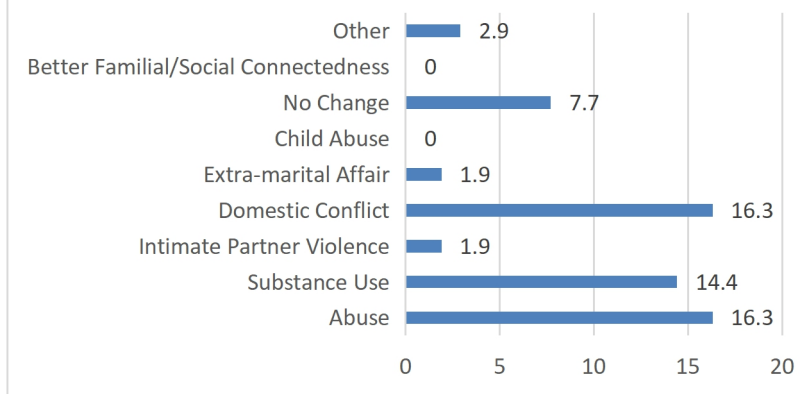
Impact	Percentage
Loneliness	10.6
Hopelessness	14.4
Anxiety	10.6
Uncertain Future	22.1
Loss of Control	0
Anger	2.9
Substance Use	2.9
Fear and Anticipatory Anxiety	1
Grief and Sadness	0
Denial	2.9
Numbing	0
Other	1

Impact on Friends, Family and Home and other Social Dynamics

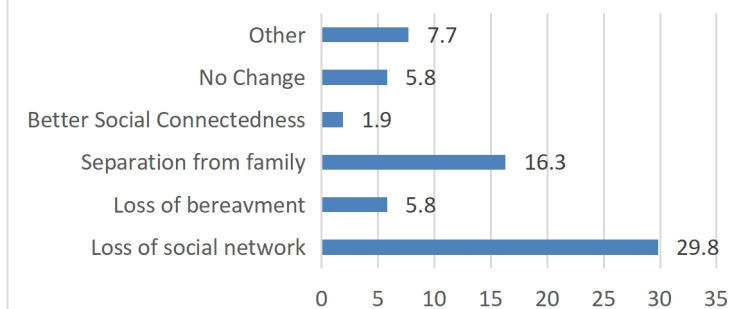
The Homeless group reported a mix of changes in social dynamics with their immediate family, with 16.3% reported an increase in abuse as well as domestic conflict (graph 9.1c). Additionally 14.4% reported an increase in Substance misuse, while 1.9% reported extra-marital affairs, and intimate partner violence. Other changes in social dynamics with family was reported by 2.9%.

With extended family and friends there was a loss of social network was reported as the most common effect of COVID-19 by 29.8% of participants (Graph 9.1d). 16.3% reported separation from their family, and 5.8% had loss or bereavement. As can be seen by the graph a small percentage (1.9%) reported that they had an improvement in their social connectedness. Just 5.8%

Graph 9.1c Social Dynamics with immediate family - Homeless (%)



Graph 9.1d Change in Social Dynamics with friends and Extended family members - Homeless (%)



reported no change, and 7.7% reported other changes as result of the pandemic.

The effects of COVID-19 on the interaction of the

Homeless group with religious affiliations and religious establishments were considerable. As seen in table 9.1k 25% of the homeless reported a loss of income as a result. Loss of hope was reported by 26% and loss of recreation was reported by 25%. Loss of a support network was reported by less of the homeless at 1.8%.

Table 9.1k Changes in Religious Affiliations and affects of closing of religious establishments

Loss of Income	25
Loss of support network	1.8
Loss of Hope	26
Loss of Recreation	25

Table 9.1l Impact on Children in the family - Homeless (%)

Attending	6.7
Not Attending	7.7
Attending online classes	0
Dropped Out	0
Are children working for pay	3.8

There were low reports of the impact on children of the homeless, however 6.7% reported their children were attending school, while 7.7% reported that they were not attending. Another 3.8% was reported to be working for pay.

Impact on the Elderly and Persons with Disabilities

The impact of COVID-19 on the elderly was reported by the homeless, with 22.1% reporting that they did not have access to basic needs or access to basic health care needs (Table 9.1m). 6.7% reported an increase in loneliness, and 1% a fear of abandonment with 2.9%

Table 9.1m Impact of COVID amongst the Elderly

Loneliness	6.7
Restricted Movements	2.9
Abuse	1.9
No Access to Basic Needs	22.1
No Access to Health Care Needs	22.1
Other Illnesses	0
Loss of Recreation	0
Fear of Death	0
Fear of Abandonment	1
Other	1

reporting the impact of restricted movements. An increase in abuse was reported by 1.9% and other impacts were reported by 1%.

Similar to the effects of COVID-19 on the elderly, the effects on persons living with disability similarly reduced access, with 20.2% reporting no access to basic needs and 19.2% reporting no access to health care needs (Table 9.1n). Many reported an impact on being

Table 9.1n Impact of COVID amongst the Persons with Disability

Loneliness	33.7
Restricted Movements	12.5
Abuse	20.2
No Access to Basic Needs	20.2
No Access to Health Care Needs	19.2
Other Illnesses	2.9
Loss of Recreation	1.9
Fear of Death	0
Other	4.8

lonely (33.7%), along with 12.5% reporting restricted movements, and 1.9% loss of recreation. 2.9 percent reported other illnesses as a result of the pandemic, while 4.8% reported other impacts than the options provided. Abuse of those living with disabilities was reported at 20.2%.

9.2 Shelters

For this study, permissions were sought from the City Health Officer to conduct a survey on the impact of COVID-19 on homeless persons and shelter services. Questionnaires were sent online to all 53 shelters, out of which responses were sent by 20 shelters. Responses were received via email over a period of 5 months. There are missing data points, especially to qualitative questions, and 2 shelters did not respond to questions on number of clients currently staying at their facility. Breakdown of responses can be seen in Table 9.2a. Apart from the shelter dedicated for care of homeless persons with mental health issues, other 19 shelters accommodated a total of 13 individuals into their facility.

	Number of shelters	Total population
Children	6	85
Elderly	6	143
Persons with disabilities	1	48
Homeless persons with mental health issues	1	100
Adults	5	176
Transgender women	1	21

Quantitative Data

Of the 23 shelters interviewed, over 50% of them reported seeing an increase of the number of homeless mentally ill persons on the streets since the lockdown (Table 9.2b).

The majority of admissions can be accounted by elderly and children, with 41.2% and 29.4% respectively. Adults account for 17.6% with those between 18-55 years account for 5.9% (Table 9.2c).

Graph 9.2a Describing the referral pathways for admission into shelters within Chennai City Limits (n=23)

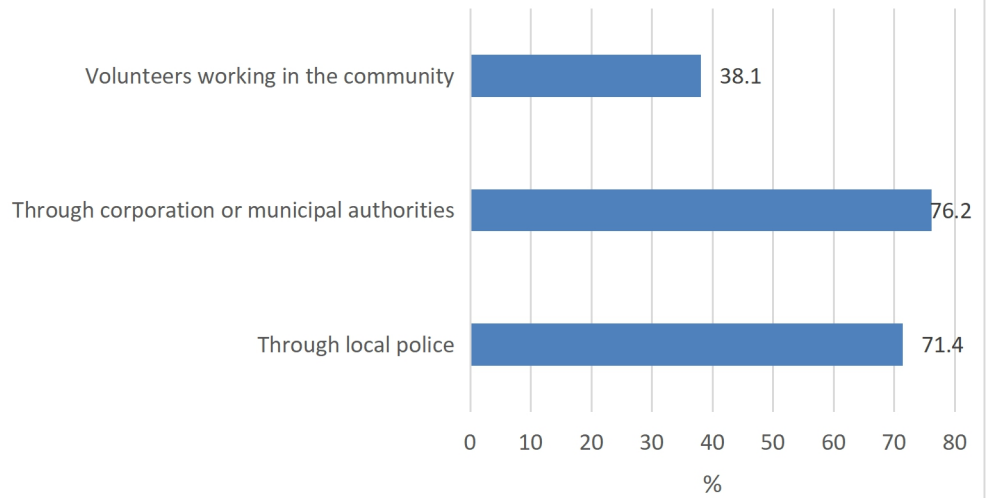


Table 9.2b. Have you seen an increase or decrease in the number of homeless mentally ill people on the streets since the lockdown began?

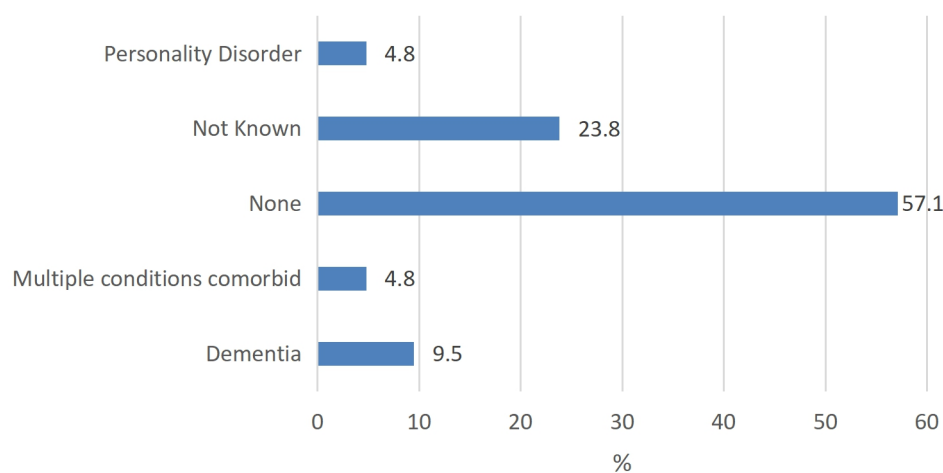
Decrease	27.3
Increase	54.5
No	9.1
Unsure	9.1

Referrals to the shelter were through police, municipal authorities and the police (Graph 9.2a). The admissions were reported to be mainly through corporation or municipal authorities, followed by the police. The least referrals came from volunteers in the community at (Graph 9.2a). Of the admitted, it was reported that the majority did not have any mental illness. However 23% of the admitted were unknown to have mental illness (Graph 9.2b).

Table 9.2c Sociodemographics of admissions in shelters during March-September 2020

Population accessing shelter	Mean (SD)
Males	18.54 (44.78)
Females	8.45 (14.56)
Homeless individuals	2.95 (10.40)
Type of persons admitted	%
Adults	23.5
Children	29.4
Elderly	41.2
Unknown	5.9
Average months of collaboration with GCC	55.17

Graph 9.2b Describing the diagnostic profile of homeless persons with mental illnesses admitted into shelters within Chennai city limits (n=23)



Qualitative Data

Presence of HPWMI in the city

A majority of respondents felt that the number of HPWMI increased after the lockdown. One of them mentioned their inability to admit more HPWMI owing to restrictions posed during the lockdown. Few respondents reported seeing fewer people on the streets during the lockdown.

Challenges experienced by homeless persons

Lack of availability of food and more importantly water, was a key feature in responses. A few days into the lockdown, homeless persons staying in “hotspots” received food and water from the government, NGOs and community volunteers, but those in more isolated spaces went hungry for prolonged periods of time. In addition, owing to lack of awareness, movement of homeless persons could not be restricted either. Loss of livelihoods amongst homeless persons was mentioned as amongst the worst impact of the lockdown.

Mental health impact of the lockdown

A recurrent theme expressed by the coordinators was the limitation to movement during the lockdown that caused a lot of distress and frustration amongst the residents, especially the elderly and children. NGOs working exclusively with persons with mental health issues mentioned that as a result of increased admissions (50 during the lockdown) there were no dedicated spaces for distressed clients, and it posed a challenge in managing

them. Clients staying at some shelters had increased anxiety being located in the same premises as the COVID ward.

Challenges faced by residents of shelters

Livelihood again remained a recurrent theme as an impact of the pandemic. Another significant result reported by coordinators was the frustration experienced by children, especially those preparing for Board (competitive exams), since they were unable to go to school or access afterschool special classes and tuitions.

Challenges at the shelter

Lack of access to staff members was presented as an important impediment to delivering services at the shelter. As staff members could not avail of public transport, the staff to client ratio increased significantly, resulting in burnout of residential staff. Coordinators emphasised on the criticality of support extended by the residents to assist in day-to-day activities to try and ensure smooth functioning of the shelters. Volunteers were also engaged to support existing staff during this period.

Support extended by the Greater Chennai Corporation

Most respondents were appreciative of the help provided by the GCC through the lockdown period, towards food, clothing and bedding, especially when provisions were difficult to access. Transportation was also available for rescues and medical emergencies provided by the Corporation. Periodic COVID-19 testing was conducted at all shelters. A few shelters were also able to facilitate social entitlements and identification cards for residents.

Access to Awareness and Protocols in Shelters

All shelters conducted awareness sessions with constituents on the pandemic, sanitation and social distancing protocols. Masks, sanitisers and new sheets were provided to all residents during the lockdown. Clients who tested positive were immediately shifted to the hospital and others tested and quarantined to prevent

community transmission. Separate rooms were provided for mothers coming with children. All shelters ensured that no visitors were permitted into the shelter during the lockdown to prevent any risk of transmission. Staff members also stayed with residents 24/7, so as to prevent movement outside the shelter.

Collaboration with civil society organisations

Homeless shelters received support, primarily for food and provisions through other NGOs during the lockdown period. In addition to food, one shelter working with children also had haircuts sponsored by a partner NGO. Another NGO working with women also received orders for cloth masks from a partner, which helped them facilitate livelihoods and basic income for residents who had lost their jobs, which was helpful in alleviating distress.

Testing and treatment for COVID +ve residents

Out of 20 shelters, 3 had 7 COVID positive residents, who were referred to hospitals for quarantine and treatment. Staff members accompanied the residents for all 14 days of quarantine. Other residents were tested immediately by the Greater Chennai Corporation.

9.3 Focus Group Discussions

The pandemic, lockdown and homelessness

In Chennai city, large number of people were rendered homeless because of the pandemic and related distress emanating from loss of wages, unstable housing and ill health. The lockdown further restricted mobility with interstate movement being curtailed. Many who had travelled to access health services, besides employment were unsupported and couldn't return home. A small sub sect comprised persons with mental health issues in comparison to those in rural Chelgalpet, a district based in Tamil Nadu, where a larger number of persons had experienced chronic homelessness, many from around the time of the tsunami that hit the coast of Tamil Nadu in 2004.

“...people who had just become homeless because of the pandemic, because they got stranded because they could not get any transportation, especially women. They got a lot of support from people who have already been homeless for a long, long time. Like the they were the

ones who were providing them with food and everything”

A few persons whom the data collectors met were separated from their family or had lost family members in the chaos of the early months of the Pandemic. They had come to Chennai for health care and these facilities were somewhat difficult to access since COVID care dominated.

Stigma and social vulnerabilities

Some of the women on the streets were found to be commercial sex workers who were reluctant to return to their families out of fear of rejection. Those who lived with a mental illness, often displayed well encapsulated, systematised delusions. They reported no change in their lives and seemed happy to engage with their hallucinations and appeared content.

“Because this whole journey of insight is very different from person to person, but to understand the fact that, you know, when, when you have a different reality of your own, you are in a much more better place where you don't sense to suffering around you. Because there were people who told us very profound experience where they said, what, what is, because my life has always been like this? My life is always like this. So, it's no different whether there's COVID, or there's no COVID.”

Others, for example those who were grieving the loss of a loved one and subsequent homelessness, also perceived no change in their life as they viewed their lives as equally bad before the advent of the pandemic.

“Both of them were experiencing grief and they were completely unmoved by the COVID situation like the COVID situation did not make any sort of difference in their lives, just they were just choosing to stay on the streets and stay in their condition and they were just absolutely not at all moved by, you know what was going on around them also. That was also something I saw.”

There were cases reported of persons becoming homeless as a result of testing Covid-positive and having a family member test positive as well; both being separated within the hospital during treatment. Ostracisation against caregivers and positive patients was high during the pandemic as was fear; as a

result, many from disadvantaged groups lost housing access and couldn't find alternatives.

Many of the homeless gathered together in groups, either of families or friends who knew each other for a long time. In this way persons living with mental illness were easily distinguishable as they were alone.

“But we could even for men, men and women with mental illness, we were able to identify them very easily, because most of the time they were alone. Even if they are able to make certain decisions for themselves, they were still isolated, because they were either being seen talking to themselves...”

“... people with mental illness were again in the bottom of the pyramid and he was saying that you know men are more women are less. I don't see many women coming out.”

“So, when we came across people with mental illness, men and people who did not have, so I felt that women and men in the category who had mental illness did not have any basic support. They still had really poor clothing, they still had, they didn't have a footwear they were eating food that was just given to them. They were malnourished, and all of those things.”

Gender disparity

In general, more men than women were observed in the streets. Amongst the women, most were middle aged or elderly in the peri-urban and rural areas and younger women were seen in the urban areas. Several women on the streets had been in religious establishments before the pandemic and the abrupt closing down of these centres meant they suffered a sudden loss of basic amenities and were bereft of all support.

“...it wasn't because of COVID; women have been homeless for a longer period of time and have been managing their stay at various places such as Dargah and so on. Now due to COVID, they don't have a place to stay, they've become homeless.”

It was also reported that women found it much more difficult to access basic amenities than men, especially in peri-urban regions. The reasoning behind this was thought to be that the men had been homeless in the same area for several months or years preceding the pandemic while the women were all new to the area and only there for 2-3 days before moving.

Men, however, were clustered around zones that were better resourced in terms of area where stores were still open and therefore struggled less to access food and water. Many of them were out of state workers who had lost their job or were unable to find employment during this period and were stuck on the streets without housing or transport to return home.

“For men, it was more easier because the people, the men that I came across, they were mostly near the mains main zones like central or the bus stand, where the access to toilet was little more easier.”

Men found toilet access easier as women feared for their safety in public toilets and often used empty lanes to relieve themselves, usually late at night or early in the morning. Menstruating women also suffered with no change of clothes or access to sanitary napkins or cloth.

“And most of the women did not prefer to use public toilets, because of safety reasons. And so they chose different timings of the day. So, it's beyond 10pm, or whenever it's dark, or they found very narrow streets or wherever there is a lot more safety and they would hide and they would defecate or urinate. But rather they would refuse to use public toilets. “

“...during the initial days of lockdown, the women we met did not have access to proper clothing; food, they were able to get from a shop nearby or would manage on snacks but they did not have proper clothing and access to sanitary napkins. When we met them, their only requests were proper clothing and self-care kit and during our subsequent follow-up, we prepared a kit based on their requests and provided them.”

Solidarity among the homeless and support from private citizens

“We saw a lot of community support from the other homeless people. And these homeless people were boys who worked together, and they go out for like this small employment work and all of that. And then there's a community that is nearby, where elderly women come and take care...”

It was observed that women seemed to band together to help each other. Especially in supporting other women who were newly homeless.

“I have observed; this primarily among women, this solidarity and sort of protective, you know, just trying to

protect this person who has become homeless newly she's been there for five days and I saw this person being really protective of her..."

"We found a middle-aged woman near Thirupporur... We offered biscuits and food for her but she refused to take it from us and she didn't trust/believe us one bit. We moved from that place; almost a km away, we met another old lady, who was also homeless who communicated very well with us. She said she was homeless for a very long time and was staying in a temple nearby. Due to this lockdown, she could not stay there further. While she accepted the food we gave her, a little later, on our way, we found this middle-aged woman sharing food with the woman we met earlier and that woman had also accepted the food.

People also came together based on religious beliefs. It was reported that homeless Muslims lived near mosques and helped each other as well as received help from other Muslims in the community during this period. Many reported their spirituality as the source of resilience and spoke about how their religious beliefs kept them going.

Several people came forward to help the homeless during this period including police, apartment security guards, auto drivers and pharmacists. Some of them had been providing food and support to the homeless from before the pandemic and the lockdown did not stop them for long.

"To quote the tea vendor here as an example, we had a conversation with him and he mentioned that when the old man comes to his shop for tea, there is no one around to drink tea at that time. We asked him why he continued supplying tea for the old man when he didn't have customers and that would further increase his loss, for which he said that he wasn't earning much himself and that he was only giving what he could afford/manage and that I am okay with doing this. Supplying tea for the old man also gives him satisfaction and no one else were affected by this."

Food Scarcity

Access to food varied, with men finding it a bit easier. In the urban areas it was possible to access lunch and dinner but almost impossible to find someone to provide breakfast owing to people being busy during the morning hours. Many had to wait till 1-2pm to access their first meal of the day. Fruit vendors also distributed

fruit that could not be sold the next day during the evening or night time.

In the peri-urban and rural side women reported difficulty accessing food when they had been able to before the lockdown. Conversations with people in the community revealed that many who were in the habit of distributing food for the homeless had now stopped because of the fear of infection.

Shortage of food was also linked to loss of income, as they were completely dependent on charity. Some homeless persons collected scraps and sold them to scrap yards in an attempt to make a small amount of money to be able to afford food.

It was also noted that while many families who had a ration card were able to access INR1000 a month and dry rations, this was not available to the homeless as they had no identity proof.

"Overall, during the total lockdown period, with strict rules, the homeless people had no access to food and also had difficulty in accessing food as well. Some people have gathered the garbage and sold them and from that money, they've bought food, but there were people who didn't do that and had to go without food – they've been without food an entire day or two as well."

Many also developed the habit of hoarding food and eating stale food over a number of days so that they did not go hungry.

"They've gathered [saved] food in that manner, in spite of the foul smell from the food, they didn't pay heed to that and have had food due to their hunger at least till before we've visited them."

Response from Government and Civil Society Organisations

The Corporation of Chennai and other government institutions took some time to assess the needs and respond. Initial months were therefore particularly tough on the homeless with people going without any food for 2-3 days. Only those with good connections in the community were able to manage this period with any kind of comfort. Religious establishments also pitched in to help serve those who gathered around their premises but still many were left out. Even when shops began to reopen, they found it difficult to purchase food

without an income and were also turned away from stores because of stigma based on their appearance.

The data collectors felt that policy makers should investigate further into why so many people became homeless during this period. They also felt that there should have been better prepared to care for those left without shelter and that the rapid closing downs of old age homes and other NGO run shelters left many destitute. There was also no clarity as to where people were getting resources from as it was all ad hoc.

“Now we're all saying that the data shows the quantitative data shows that they had access to food and water. But what is that water? Is it from the gutter? Or is it from it was also raining that time. So were they drinking water from stagnated water or puddles?”

Organisations on the other hand, were reluctant to take any one new in or provide help due to the risk of Covid-19 infection of their existing clientele. Old age homes and even government hospitals were discharging patients without any family available rendering them homeless.

In the rural side, situated in Chengalpet district, many were happy with the response shown by the government hospitals. Although they were short staffed, they explained how to care for patients at home and once surgeons became available again, scheduled procedures.

“Chengalpet hospital, they had supported us very well during this entire period, during the pandemic, and also post pandemic. I mean, the lockdown period. So, in that way, the government hospital, Chengalpet Hospital was very proactive, and also the PHCs were very proactive in supporting our needs.”

The Institute of Mental Health, a large government hospital in Chennai, opened a Covid-19 ward for persons with mental illnesses who appeared to have symptoms of Covid but this largely catered to their own clientele and people with homes who developed symptoms due to isolation or stress. This initiative was therefore not entirely for the homeless and very few were able to access it.

The general health care in government hospitals however was smooth and good. Covid-19 testing was done for large batches of clients of The Banyan with full observations of protocols and those who were found

positive with co-morbidities were admitted and looked after very well.

Panchayat or village heads also pitched in and organised for dry rations and cooked food to be distributed to the homeless in their villages.

Post the first few months of the pandemic and at the start of the lockdown, the Corporation of Chennai became concerned about the number of homeless people on the streets and saw them as a potential threat to spreading the virus.

“...what they did was they had a few buses, okay, buses, or minivans, which went around the city. So it went around the city and wherever they saw people who were stranded in or looking homeless, or probably they were going through some sort of distress because of separation from their families, they were brought in, okay, but there was no clear criteria as in whom they were bringing in, I think it was a kind of an instruction given by the government saying that we shouldn't have these people on the streets only because probably they will infect the community further, because they didn't know where these people are coming from.”

People were brought to migrant centres in large numbers and while Covid-19 testing was done for all of them eventually, there was no option of social distancing. The large number of people in these centres meant that the government had to quickly think of exit options. They began to force people to get into trains and buses and return to their homes. In some cases, persons living with mental illnesses who were unable to clearly denote their homes, were still put on these buses and sent to other districts and states.

9.4 Case Studies

Manikandan

Mental health concerns among the homeless are significant, and can negatively impact employment and social engagement within a community. Finding support for both mental health and socio-economic problems can be particularly difficult for this group. Manikandan's story illustrates some of these challenges, epitomising themes more widely shared within this population. With COVID-19 impacting employment opportunities, Manikandan, like many others, struggled to find work or means to support himself. He was found by Banyan staff at a bus stop opposite Kilpauk Medical College, where social workers had met with him more than once. Appearing to be in his mid-thirties, he carried a stick and kept two bags close to him, with his wallet secured in his pants. Although in difficult circumstances, Manikandan possessed some knowledge about COVID 19, the need to wear a mask, and social distancing through his reading of newspapers. The Banyan approached Manikandan to offer mental health care and social support in finding employment. He accepted care and support, agreeing to come to the Banyan's centre at Kovalam. As with a large part of the workforce in India, Manikandan felt the effects of the Lockdown through a loss of income and employment, which, in turn, resulted in his involuntary homelessness.

Family and employment stress

Manikandan was originally from the Ramnad district in Tamil Nadu. He explained that as a child he preferred to be alone and was not interested in studying. Manikandan said that he hailed from a joint family, with two brothers and a sister. His sister was married and lived near Trichy, whereas a brother was in Sengundram near Red hills in Chennai. His other brother committed suicide by hanging, tragically. He mentioned, in an undoubted understatement, that he felt a "disturbance" upon seeing his brother's body, which, he said, had troubled him ever since, suggesting he had experienced a deep trauma. Though he did not have a great relationship with his siblings, he was attached to his parents and wished he could visit them. Manikandan mentioned that while working in Coimbatore, prior to his arrival in Chennai, he would visit home

"once in four or six months, or three months. When there was a difficult time, then I would go

home and stay for some time and then come back to the city to work, (this) used to be my wish. But in a difficult situation I could not go home in spite of efforts... Difficult, difficult situation. It is good to go home, right? So, I had the liking to (go)?"

It was not clear whether the difficult situation was specifically COVID-related, but he mentioned that buses and trains would not go, suggesting this was due to the lockdown. Moreover, he had only very recently moved Chennai. The picture, however, that emerged of home and familial life, he suggested, was complicated by interpersonal tensions.

Manikandan said he "liked to be alone," mentioning, too, that he avoided tobacco, alcohol, and drugs as part of his avoidance of others, perhaps alluding to other homeless individuals on the street, as well as issues within his family and/or social circle from his youth. Indeed, as he grew up, he had a limited circle of friends, and whenever relatives used to visit his house, he made sure he "was not there," as he felt there would be a misunderstanding. Therefore, he preferred to avoid them, suggesting some measure social avoidance was symptomatic at some point of his childhood. In 2014 his family proposed a marital alliance for him. However, the marriage fell through due to family issues, and, this, he reported, had deeply affected him, perhaps adding to his ambivalence about visiting family members. In the same year he also suffered financial difficulties. He reported that he had invested close to 60,000 rupees in various informal saving schemes and had lost it all. Manikandan felt that the financial loss combined with that of the lost relationship took a toll on his mental health. Social avoidance, while an issue with Manikandan prior to these losses, was now more pronounced and, perhaps, debilitating. This social avoidance was now also expressed through its inversion: that people were *now avoiding him*. Avoidance, on both sides, now was "due to different competition (and) jealousy for survival due to differences. All this is common in all towns," Manikandan said. He added,

"because of this only I stayed away from home for a long time."

Seeking clarification on this point, the interviewer from The Banyan asked whether he stayed away from home for this particular reason—that is, that others avoided him, specifically. Manikandan replied that a lack of work opportunities was another pressing reason, but

underscored, at the same time, the dual nature of his avoidance, pointing to a more generalised distrust of social intimacies:

“The reason is work opportunities were less, so you could take it that way, too,”

adding, however,

“I did not expect anyone to be affectionate with me. Right from childhood I wanted to work hard, earn money and buy a vehicle, good clothes and livelihood, and did not expect anyone to be affectionate with me.”

Minutes later he reiterated his avoidance of others when asked if he had friends in his childhood,

“yes, had many friends in childhood...Did not continue later because I avoided having friends to avoid trouble later. I used to have friends at workplace but at some situation I starting avoiding friends to avoid trouble.”

While generalised avoidance of social intimacies seemed symptomatic, Manikandan reiterated that he continued to have a difficult relationship with his family, and that he did not like to associate with people who abused alcohol, intimating that his brothers both used alcohol, and, perhaps, was also suggesting that friends at work would similarly get into trouble with substance use, though this could only be inferred. What was clear was that he had painful experiences of social defeat (Lurhmann & Marrow 2016) that had contributed to his avoidance and distrust of others.

Despite his personal difficulties, Manikandan had previously met with some success in employment, mentioning that he had spent almost two years working as a juice maker in Malaysia and also had the same job in other companies. He had also travelled widely around his home area, Madurai, Dharmapuri and Tirunelveli, and had held other jobs, including that of shopkeeper.

COVID-19 and after

Many people who are homeless work in the informal sectors of the economy. As such, they have no food or employment security. With the advent of the COVID-19 pandemic, Manikandan was one of the many who lost their employment and means of income during the Lockdown. He had been unemployed for five months

when he was first approached by The Banyan, and had not been able to return home to his family. Being homeless and without work, Mr E struggled to sustain himself, relying on what people gave him, mentioning specific individuals who gave him rice and tea. He acknowledged that, “many helped during corona time.” This benevolence and generosity from individuals notwithstanding, the impact of the lockdown on a population reliant on government aid, NGO support, and the informal labour to survive was severe, and stretched the limited resources of the vulnerable and poor to the maximum.

Aspiring for the future

As mentioned above, Manikandan agreed to receive support from The Banyan. Having been evaluated as suffering physical and psychological distress, he was taken by ambulance to Kovalam for medical treatment. On admission to the centre he requested a separate room to avoid all human interactions, yet he sat in the corridor every day. Under observation it was discovered that he held many letters in a bag that were written to people at different administrative levels, claiming that his life was at risk because of politicians. He admitted that he suffered depression. His particular definition of depression, however, was that “Politicians (were) trying to change my mind,” suggesting, perhaps, that paranoid delusions were affecting him, exacerbating his distrust of others. He also mentioned that the police would target him, and that the “police assignment at this time is wrong,” perhaps, indicating the precarity felt, in particular, by the homeless and mentally ill on the street. Stating further that a “misuse of power” was indicative of a “public” that is “not at one stable state,” seemed to suggest his capacity to critique, and, indeed, aspire for betterment through a critique of social ills remained intact (Appadurai 2013). Indeed, despite his illness presentation, Manikandan was philosophical, and did not “take to heart” the social defeat or violence that was directed towards him by the public or by the police. Rather, he offered his own diagnosis of society gone awry with ethical poignance, suggesting what a good life and a good society can be aspired towards, indicating that social hierarchies, such as those created by caste and class were at the heart of social suffering and structural violence:

“Without caste if every (one) thinks and lives humanity, it will be good... Religion or caste is a life support thing but human discipline is more

important. For some culture or rituals caste has been there, (but) humanity is the most important thing.”

Here, Manikandan pointed to his hope for a future where he would not be marked by the social violence that discriminates and dehumanises within society; but, rather, recognises a common humanity. The “good life” he imagined was one where economic employment and familial harmony went hand in hand:

“Good family, good home, good wife, good children, good job, good economic status and life...Good job which is basis for good life support, good economic progress which will beget good wife, good house. Good job is the basis for all. Then good life will occur. No only for me but for *everyone*.”

In addition to his philosophical outlook, and despite his personal suffering, Mr E had also found solace and beauty in nature and wished to live a life in harmony with nature, eating healthily, he was fastidious about food preparation, and wanted to cook his own meals once again, and preferring solitude.

Mr E had his Aadhar Card with him, so it was possible to have the police trace his family. It was found that his brother was living at Red Hills, in Chennai. This brother came down to meet him at The Banyan. Despite renewed contact, Mr E was still not comfortable around his family as he believed they were prone to drink. He believed further that most men abuse alcohol. Therefore, he was reluctant to form friendships with other men as this would disturb his peace of mind.

Following his psychiatric evaluation, Mr E was started on antipsychotics. It was found that the best way to communicate with him was through talking about work. He oftentimes said that it is the right of every person to work, and that no one should be denied that right. We will recall his emphatic insistence that all beneficence arises from a “good job,” as the “basis of all.” He was very clear about what he wanted, and also has clear aspirations for his future. Since he always spoke about the need to work, the Cafe at BALM was discussed with him as an option for work, and with excitement he accepted work there.

Manikandan spent some time working at the café at the Banyan. “The cafe is big and nice to work. Hope I get lot of customers,” Manikandan said. He found a sense of

purpose in his work. He, like many others who have made marked improvements in their emotional and psychological wellbeing at The Banyan, benefitted from the organisation’s emphasis on work, and the dignity that comes through earning wages and possessing a skill that garners social recognition and respect. This has proved to be a pivotal part of rehabilitation and de-institutionalisation. Moreover, in Manikandan’s case, finding it difficult to trust people and preferring to be alone, he was reluctant to deviate from his work schedule or accommodate others into his routine. Rather he had a strict daily routine that seemed to mitigate against excessive rumination and the paranoid symptoms he had suffered from. Manikandan had made sufficient progress at The Banyan to plan a return to Coimbatore, where he would work and get married when he felt he was ready. After his discharge, he found work in a cotton mill earning Rs. 300 per day. During his leisure time he sold spinach for additional income. Manikandan’s family was very happy with the progress he had shown and with his commitment to continuing with his medications, which seem to have helped him overcome his symptoms of distrust and paranoia.

Shehnaz

Shehnaz’s link to Chennai ran deep. Born and raised in the city, she was married there – though to a person from another district—and gave birth to her children in Chennai. As she put it,

“This big city, Chennai only. It was here that I was born and raised. Everything in Chennai, and I will live only in Chennai.”

Descent into homelessness

When she was younger, she received a modest income working in a leather factory. Now at the age of thirty-two, her health no longer permitted her to stand for long hours or put in manual labour. Her husband had, moreover, run away, and in desperation she had to give up her children and leave them in a “safe place.” Shehnaz was now homeless on the streets of a city she knew well. As she put it,

“Now there is only God. I think only of God. On the streets I eat whatever I can get, and somehow live. I even sleep on the street....”

“My parents are both dead. My mother, when she was alive was my only constant companion but now that she is gone, I have only God on my side,”

she lamented.

“I have brothers and sisters but they are all in similarly difficult situations. They come and check on me but I never ask them for help and they never offer because they have nothing to give... they are also struggling like me. Because under these circumstances everyone is suffering...Right now, I don't even have work.”

Shehnaz, with health and employment declining or non-existent, while in a desperation, was articulate and expansive in her description of her predicament. With resignation, she said,

“What to do? I live here and there. Sometimes I have food; I live hand to mouth...My whole life has become just like this...I pray to my mother, like a god, God is my only support—I have no one else.”

But pre-pandemic, Shehnaz's situation was a bit better. With her earnings from her housekeeping job, she was able to rent a small house which she furnished with the few utensils and furniture she had saved up for over the years of doing odd jobs. The house was small and had no bathroom; but she felt protected within its walls. When the pandemic hit, she lost her job and was unable to pay rent for four months. The owner demanded that she either pay the rent, or else he would hold all her hard-earned possessions as collateral. In order to avoid more debt in the form of rent, Shehnaz has moved to the streets and left her possessions behind and hopes to earn enough to pay the back rent and, thus, to get them returned from the landlord. But this was a daunting task during the pandemic. As she put it,

“for now, these four months, I haven't been able to pay rent anywhere. I have no work or income...I still have to pay back my rent. ‘Give me the rent to take all your stuff’, the landlord said. They have locked all my stuff. What can I do? I don't have the money. Even now that is my main thought: all the stuff that I struggled so much to buy. Not just one or two things. Everything was (purchased) through saving one and two rupees and buying one thing at a time.

Only I know what it is worth...how can I just let it go?”

The value of these possessions was, in other words, not merely their use or intrinsic value, but, rather, represented the evidence of her many years of hard labour, and, as such, validated her sense of dignity and self-worth as a productive member of society, now made victim of circumstances beyond her control.

Life on the streets

Life on the street was far from easy for Shehnaz. With the advent of the pandemic, access to food became scarce. She was often at the mercy of few charitable individuals who would give her some money, food, or a cup of tea. Before, when she was engaged in house work, she made enough money to at least purchase rice and water (*kanji*) to eat. But with the fear of COVID, potential employers were reluctant to bring in outside help into the home. This left Shehnaz without jobs and scrambling to make ends meet and feed herself. As she put it,

“if I get to eat twice a day, the next day there is nothing. Sometimes I get a meal and then the next two meals nothing...How many days I have just starved. Today I have not eaten anything since when I woke up.”

Sleeping on the streets presented risks beyond food security. The police, Shehnaz said, hassled her every day and asked her not to sleep on the streets, telling her,

“‘You shouldn't lie down here. You shouldn't be here! Go away!’”

The police pressures notwithstanding, she added indignantly,

“Outside this place, this area, where are we to go... where am I supposed to go if I leave my area or my city?”

Bathing and toileting were also perpetual challenges on the streets. Every day she would wait until well past midnight, when it was dark and no one was left on the streets in order to bathe using a pipe on the street or by begging for water from the neighbouring houses, explaining that,

“I can’t bathe anywhere during the day because in the bathrooms men scale the walls and jump in. So that’s why during the night, right here, I bathe.”

Shehnaz explained that she did not trust the public bathrooms as she said men would often try and “peep” or jump the walls and enter, “doing all sorts of things.” She did, however, have no other option than to use the corporation (public) toilets each morning.

Another problem she has faced multiple times living on the streets was thievery. Even recently, as she slept, someone rifled through her belongings and stole her meagre earnings leaving her with nothing.

“They stole the money with my purse. This really disturbed me...How many problems can one person have? I worked so hard just to make enough to eat,”

Shehnaz said with distress.

Shehnaz also had a history of health problems. Both her children were delivered through C-section followed by an operation for sterilisation. She never really recovered from these surgical procedures. Early on in her life on the streets, she suddenly became very ill with fatigue, body pain and a bloated abdomen, that was, as she put it, “hugely swollen.” She was admitted in the hospital for two months and tested thoroughly before being discharged with a clean bill of health. But Shehnaz was never given a clear idea of what was wrong with her, though,

“for two months, they scanned my body, did lots of tests and said it was nothing and I was perfectly normal.”

She was given medications, “to make my body strong,” as she put it, which she was continuing to take, without knowing exactly what these were or what they were for. Shehnaz was grateful, nonetheless, for these medicines as she now had the energy to work and the strength to, at least, “lift a pot of water.”

Life post pandemic

Shehnaz was rather resigned to her situation brought on by the pandemic:

“We have faced so much as children; and I, as an adult, and through it all I feel I am eating the same old rice and water. I do wonder, why has Corona come, what is it and is it even real?”

In spite of her resignation, life had definitely worsened for her in multiple registers that were palpable (e.g., income, health, food security) during the pandemic. Moreover, her resignation was undoubtedly also a function of her sense of wellbeing and mental health living with such precarity and repeated experiences of social defeat (Lurhmann and Marrow 2016; Patel and Kleinman 2003). Previously, there were other NGOs or individuals who would come and offer cooked food to the groups that lived on the street. But since the onset of the pandemic, the police had been discouraging direct assistance in this way, claiming that distributing food in person could spread the COVID infection. As Shehnaz explained,

“Before somebody or the other would come, Sikhs or Christians, somebody or the other would bring things and distribute...Even that they threw dirt on. They (police) said it should not be given, why are you giving, you go and stay in a shelter...Occasionally someone on some rare day will come and give something.”

The government offered provisions (rice, oil, wheat flour) for one month. But for a person like Shehnaz, without a home or a kitchen, this meant begging households in the area to cook the provisions for her, but keeping some of the food for themselves:

“I am aware that what I give them is more than what is necessary for one person, but what I receive is food just for me. But what can I say... they are helping me.”

It is, perhaps, ironic that the ultra-vulnerable homeless population would be forced to share the government-directed aid that they receive with those more fortunate than them—an aspect of structural violence that is less visible than policing or other forms of direct abuse directed at the homeless.

When asked what she would require most, Shehnaz answered quite pragmatically:

“A house, nothing else. I will drink *kanji* and water and stay in that house. If I had a job, I would be alright and I will not trouble anybody.

That's all I want. A place to stay in the rain, for when it rains in the night, I just get completely drenched. Completely soaked, and I feel so cold. All newly washed clothes will be completely wet."

What she sought most was safety and employment. Her dreams of a life when she or her children would not have to struggle seemed depressingly far away. But Shehnaz's dreams and anguish extended to a broader understanding of humanity and suffering that surmounted her own personal tragedies with poignancy and compassion. Her resilience came from faith. Indeed, throughout her interview, she mentioned God several times, and accepted whatever fate God willed, saying,

"Whenever will death come? Let it come. That is all that God has given us."

Her faith, however, was challenged by the closing of places of worship during the lockdown,

"Sometimes if God is in the mind, then no worries, everything ends up good... But they have shut all the temples. Where will I go then?"

Wounded, but certainly not broken, Shehnaz struggled to retain hope, but had not abandoned it, given her deep faith and the presence of her mother firmly present within her memory as a source of strength, "With so many difficulties, my mother...is like a god to me. I have something like that inside me. So, I am good."

The case of Shehnaz is a story, ultimately, of tragedy and hardship, but also of dignity and redemption. As the homeless are often represented as abject in the media, or dehumanised in statistics without a face, in Shehnaz's story, we see someone very human, and, indeed, humane, as witnessed in her concluding message:

"If you have also, you shouldn't refuse others. You should give... They need to eat—for their stomach we must give...There are so many people are suffering like me—so many others with difficulties. There are even children struggling without anything to eat. When I see those children I feel very depressed. I think that the child doesn't have any food. It is extra suffering. I should not be that way... All children should be healthy. They should be well. That is all I want."

10. Irular Tribe

The Irular are a tribal group indigenous to India falling under the category of Scheduled Tribe as recognised by the Government of India. The 2011 census revealed a population of 1,89,661 residing in Tamil Nadu with small groups also present in the neighbouring states of Kerala and Karnataka, bringing the total population in the country to 2,14,085 (Census of India 2011). While primarily residing in the Nilgiris, the tribe is semi nomadic and many have migrated to the plains of Chengalpet, Kanchipuram and Thiruvallur district in Tamil Nadu. The group under study here are the migrants who have settled in Chengalpet district, Thiruporur block.

Having migrated to this district less than a century ago, the Irular live in pockets spread across 13 panchayats, alongside with people of other castes and social groups although restricted to one street or a small area known locally as 'irullarpaguthy'. In a majority of cases they are yet to claim rights over the land and live in 'Kaccha' houses made of homemade bricks, logs of wood, and roofed with palm fronds. While the previous generation paid very little attention to education and marriages were conducted at a young age, the current generation of children are being encouraged to complete their schooling.

While initially involved only in agricultural labour which included pest and snake catching, the Irular of Chengalpet are now branching out to other form of daily wage labour including construction and working in factories. A majority however continue to work in fields making their employment both seasonal and erratic. Consistent employment in the organised sector remains rare. In most households both men and women work, and often even in old age. It was found in the context of the pandemic, that even children who were forced to stay home from school went to work in the fields and factories.

Some of the problems plaguing this community is the lack of formal status as defined by the community certificate. Due to their migrant status they are unable to claim welfare benefits that are owed to them based on their schedule tribe status or stake claim to the land which they are currently occupying and have done so for several years. Another issue is alcohol abuse. While both genders are known to drink in this community, in Chengalpet this is largely a problem of men who often

spend a large portion of their earning procuring alcohol, leaving the women to support the family. Yet another issue is stable housing. As they live in thatched roofed incomplete houses, they are often left exposed during heavy rains, storms or floods and often have to rebuild their homes from scratch after a particularly bad weather event.

In 2005 The Banyan began work in the Thiruporur block of Chengalpet by setting up its Rural Mental Health Programme. While carrying out community outreach, they discovered the small communities of Irulas spread across the block. For several years, in spite of awareness programmes and repeated attempts at interactions, the irulas kept to themselves and refused any of the free health or community development services offered by The Banyan. Through these interactions, it was discovered that the group mainly prioritised their children's education and this was an area in which they were willing to seek help. Afterschool centres were thus initiated in 5 panchayats catering to 173 children. This initiative helped build rapport with the adults and soon they started accessing the mental and general health clinics of The Banyan. At present there are 40 Irulla clients seeking help at these clinics. Post the 2015 flooding of Chennai and the surrounding districts, a community of Irulas was identified for a housing intervention and houses were constructed for 12 families that were the most affected.

Gendered impact of the Pandemic

A gendered view of the impact of COVID-19 can be restrictive if not accounting for social and hierarchical norms and variegated socio-cultural and political contexts. India fares poorly in its Gender Equity Index, measured using health, education and work/political participation as criterion. In this background, female roles that were often centred around unpaid labour including child care, managing the household, and catering to needs of the family, has only increased with the advent of COVID-19 and related lockdowns leaving less space for pursuit of individual needs. Increased burden of rationing basic needs, and patriarchal norms continuing to govern choices of women result in multidimensional forms of distress. With this in mind, we have chosen to foreground to Irular women at the outset.

10.1 Survey Results

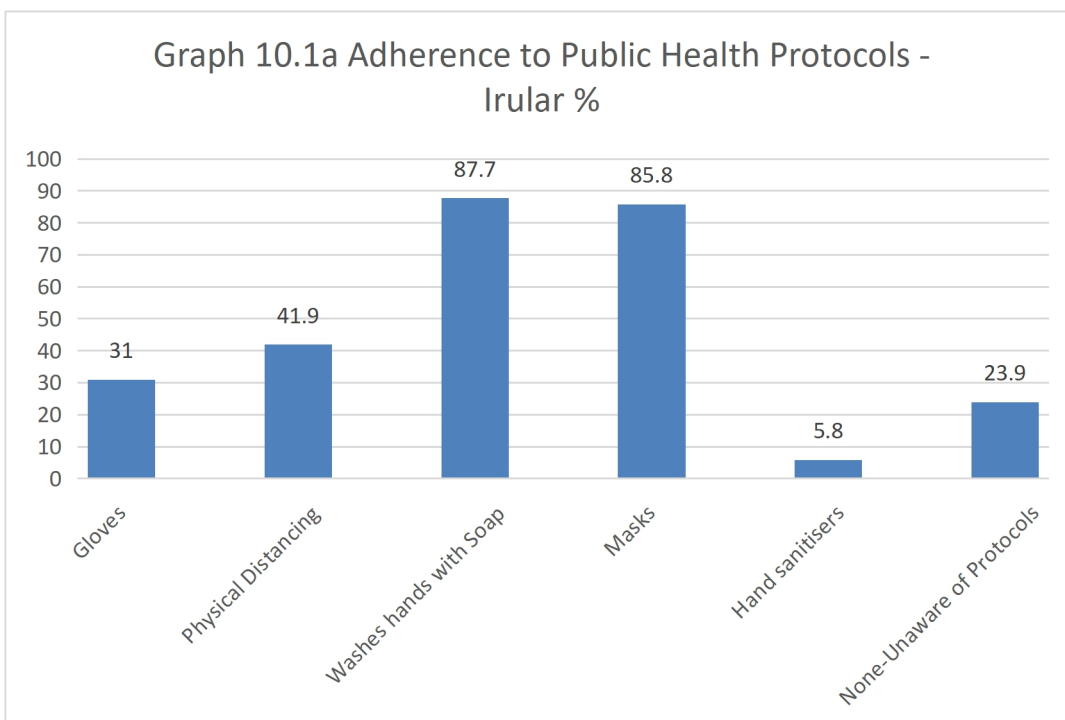
COVID-19 and Public Health - Awareness, Knowledge and Challenges

As seen in Table 10.1a the majority of the Irular were aware of the pandemic and public health protocols when the data was collected. 71.6% Irular participants reported that they were aware of the pandemic, and a similar 76.1% reported that they were aware of the public health protocols that should be followed.

Awareness of COVID-19 Pandemic	71.6
Awareness of COVID-19 protocols	76.1

Graph 10.1a shows the majority of the Irular participants were able to wash their hands with soap and use masks, 87.7% and 85.8% respectively. 31% reported they had been using gloves, 41.9% were able to adhere to physical distancing, but sanitiser use was limited at 5.8%. Only 6.5% reported that they were unaware of the protocols.

For the Irular group, they reported financial constraints as the main challenge to adhering to health protocols, at 53.5%, and this was followed by lack of space at 24.5% (Table 10.1b). Poor Sanitation was reported to be a challenge by 18.7%, and 23.9% reported that they were unaware of the protocols.



Lack of space in the house	24.5
Lack of safety on streets [as applicable]	0
Poor sanitation	18.7
Financial constraints [to buy medical aids such as masks and gloves]	53.5
Unaware of protocols	23.9
Lack of space in the house	24.5

Impact of COVID-19 on access to essentials and Social entitlements.

Access to food was reported to have increased since the pandemic began, increasing from 87.7% to 96.1% (Table 10.1c). Likewise water access increased from 91% to 94.2% for the Irular participants. Access to clothing was reported to have decreased however, from 87.1% to 84.5%.

Public toilet use decreased from 16.7% to 13.2% over the course of COVID-19, however the same occurred with private toilet access, decreasing from 15.8% to 14.8%.

Table 10.1c Describing the impact of COVID-19 on the access to basic needs - Irular			
		Pre-COVID (March 2020-May 2020)	During COVID (June 2020-September 2020)
Access to Food	No	11	3.2
	Sometimes	1.3	0.6
	Yes	87.7	96.1
Access to Water	No	8.4	5.2
	Sometimes	.6	.6
	Yes	91.0	94.2
Access to Clothing	No	12.3	14.8
	Sometimes	.6	.6
	Yes	87.1	84.5
Public Toilet use	No	83.3	86.8
	Yes	16.7	13.2
Private Toilets	No	84.2	85.2
	Yes	15.8	14.8
Sanitary pads (March 2020-May 2020)	No	66.7	60.6
	Yes	33.3	39.4
Access to Soaps (March 2020-May 2020)	No	44.2	40.0
	Yes	55.8	60.0
Access to Shelter (March 2020-May 2020)	No	99.4	99.4
	Yes	.6	.6
Access to Government shelter (March 2020-May 2020)	No	100.0	100.0
	Yes	0.0	0.0
Access to Stable Housing (March 2020-May 2020)	No	87.7	89.0
	Yes	12.3	11.0
Access to Relief (March 2020-May 2020)	No	97.4	100.0
	Yes	2.6	0.0

Sanitary pad access increased through the pandemic from 33.3% to 39.4%. The Irular reported that access to soaps also increased, from 55.8% to 60.6%.

Only 0.6% reported that they had accessed a shelter before and after COVID-19, and no-one reported accessing a Government shelter. Access to Stable housing was reported to have increased for the Irular group, going from 87.7% to 89%. However access to Relief was reported to have decreased from a low 2.6% to 0%.

As seen in Table 10.1d access to Dry Rations for the Irular was reported by 94.2% of the participants. Access to cooked food distribution was reported by 37.3% of

the group. Access to social benefits however was lower, with 41.6% reporting access to disability allowance and others, and 22.4% reporting access to Direct Bank Transfer.

Table 10.1d Proportion of persons with access to various social entitlements during the COVID-19 pandemic (June-September 2020)	
Dry rations	94.2
Direct Bank Transfer	22.4
Disability Allowance and Other Allowances	41.6
Cooked Food Distribution	37.3

Employment and Income

The Irular group's employment was heavily affected by the COVID-19 pandemic, with 66.5% reporting that they had lost their jobs or were unable to find employment (Table 10.1e). Just 31.6% reported no changes, and 1.3% reported leave without pay.

The majority of the Irular participants reported that their spouses also lost work or were unable to find employment at 63.2%, with 0.6% having to take leave without pay, and 1.3% having a reduced income.

Where applicable, the Irular group reported that 23.9% of parents had lost their jobs or couldn't find work, but the majority faced no changes at 72.9%.

For their children 91.6% of the Irular reported no changes to their children's employment, with 1.9% reporting that they had started working as a result of COVID. 5.2% of the Irular participants reported that their children had lost work or couldn't find employment.

Impact of COVID-19 Employment	of/on	Impact	Percentage (%)
Employment (self)	on	Leave without pay	1.3
		Lost Job/unable to find employment	66.5
		No change	31.6
		Reduced Income	0
		No response/ Unknown	0.6
Employment (Spouse)-applicable	if	Leave without pay	0
		Leave with pay	0.6
		Lost Job/unable to find employment	63.2
		No change	34.2
		Reduced Income	1.3
Employment (Parents)-applicable	if	Lost Job/unable to find employment	23.9
		No change	72.9
		Leave without pay	0
		Leave with pay	0.6
		Reduced Income	0
Employment (Children)-applicable	if	No response/ Unknown	2.6
		Increased workload	0
		Leave without pay	0
		Lost job/unable to find employment	5.2
		No change	91.6
		Started working	1.9
		Reduced Income	0
		No response/ Unknown	1.3

Health and Wellbeing

COVID-19 prevalence and testing

Of the Irular group, 5.2% reported that they had experienced COVID-19 symptoms, however only 0.6% reported having been tested positive (Table 10.1f).

As seen in Graph 10.1b, the Irular who were tested, were tested in a private hospital.

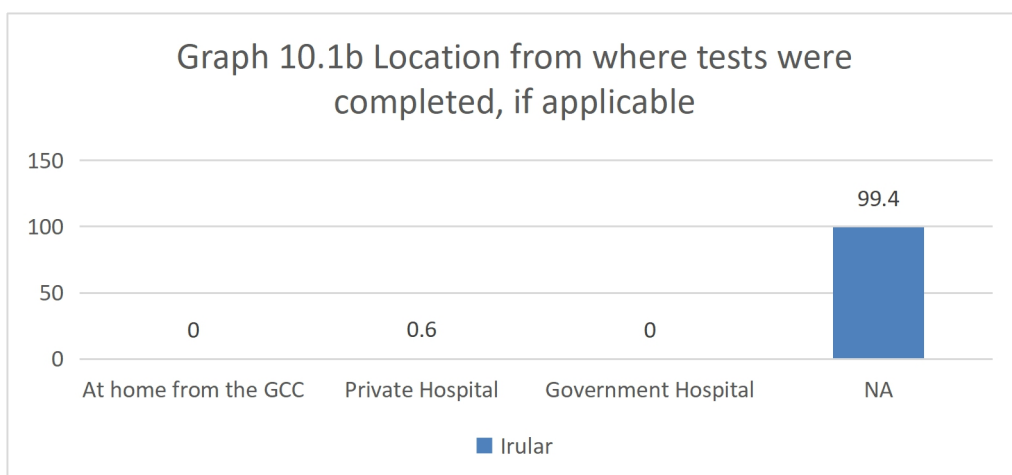


Table 10.1f Proportion of persons among Irular who have experienced COVID and Tested Positive for COVID

Experienced COVID-19 Symptoms	5.2
Tested Positive for COVID-19	0.6

Impact on Mental Health

Table 10.1g shows the impact on Irular in terms of mental well-being, and shows that 62.6% of the Irular reported feeling grief and sadness, and 57.4% reported increased anxiety. 49% also reported feelings of anger.

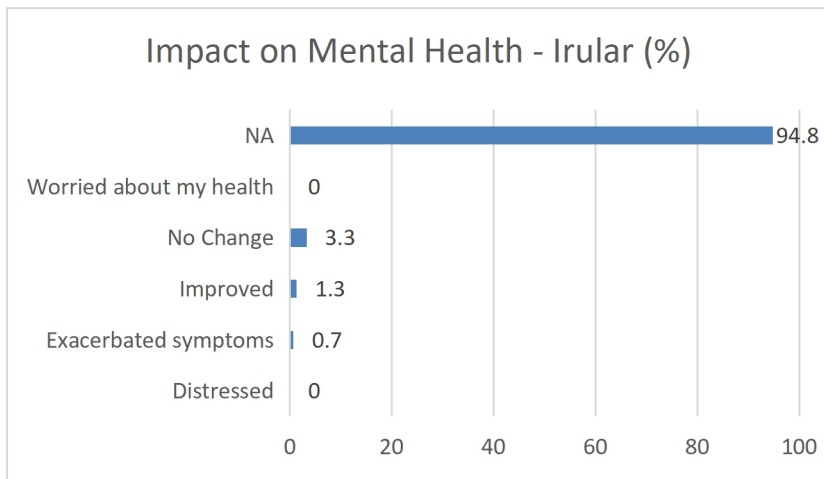


Table 10.1g What impact did COVID 19 and other related issues have on your mind

Loneliness	2.6
Hopelessness	11
Anxiety	57.4
Uncertain Future	0
Loss of Control	0
Anger	49
Substance Use	0
Fear and Anticipatory Anxiety	0
Grief and Sadness	62.6
Denial	0
Numbing	0
Other	0.6

Others reported feelings of hopelessness (11%), loneliness (2.6%), and other feelings (0.6%).

When reporting on the impact of COVID-19 on their mental health, 94.8% reported that this was not applicable, and 3.3% reported no changes. 1.3% reported that their mental health had improved, while 0.7% reported that their symptoms had been exacerbated.

their children to work, and

5.8% reported seeking professional help. Other methods were reported being used by 3.9%.

Coping Mechanisms

The majority of Irular found strength in their faith and spirituality with 52.9% reporting that it was useful for emotion focused coping (Table 10.1h). Others reported that speaking with family and friends helped (15.5%), their pets (3.2%) or other methods (8.4%). Additionally 1.3% advised that their aspirations helped and 0.6% focused on volunteering.

For facing the problems since COVID-19, 44.5%

Table 10.1i Problem Focused Coping - Irular (%)

Loans	29.7
Sale of Property	0
Pawning	15.5
Part-time jobs	44.5
Sent Children for Work	2.6
Seek Professional Help	5.8
Other	3.9

Impact on Friends, Family

Table 10.1h Emotion focused Coping - Irular (%)

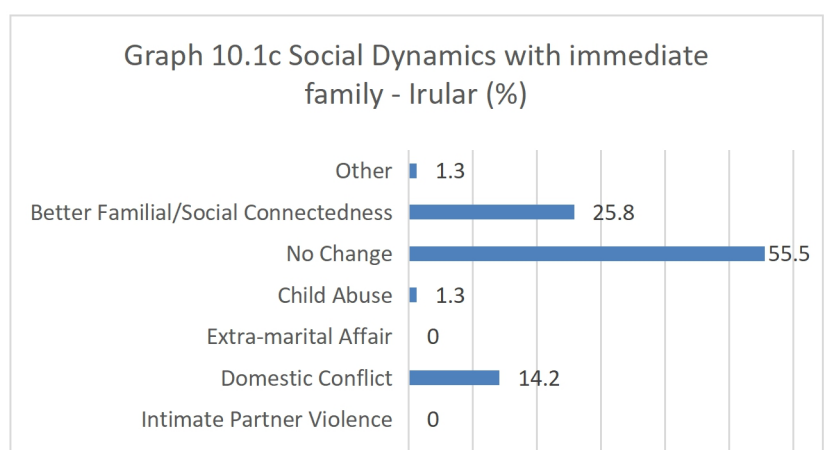
Walks	0
Speaking with family and friends	15.5
Aspirations	1.3
Faith Spirituality	52.9
Volunteering	0.6
Pets	3.2
Sleeping	0
Other	8.4

and Home dynamics

Graph 10.1c demonstrates the impact of COVID-19 on the Irular respondents' social dynamics with their immediate family. A majority (55.5%) reported no changes and 25.8% reported better familial/social

reported that they had to seek part-time jobs to sustain themselves, while 29.7% reported taking loans (Table 10.1i).

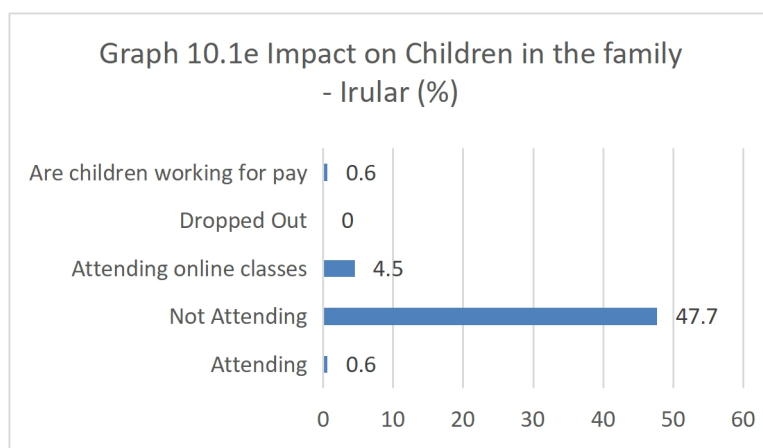
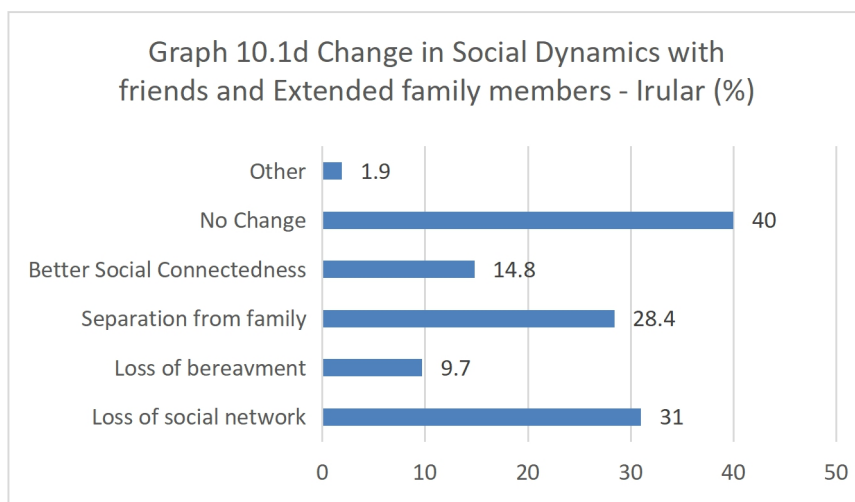
Pawning was also not uncommon, with 15.5% using this to get access to some more immediate funds. Only 2.6% reported sending



connectedness (Graph 10.1c). Others reported an increase in Domestic conflict (14.2%), Substance misuse (13.5%), abuse (1.3%) and child abuse (1.3%). Other changes were reported by 1.3%.

Similarly Graph 10.1d shows the changes of social dynamics the Irular group experienced with their friends and extended family. Within the Irular participants, 40% reported that there was no change since the COVID-19 pandemic. The other primary changes reported was a loss of social network (31%) and separation from family (28.4%). Others reported loss or bereavement (9.7%) and other changes (1.9%). In terms of positive changes 14.8% reported that they had better social connectedness since the pandemic.

The impact on Irular children was reported to be mainly regarding school attendance based on the choices for this question. Graph



access to health care needs by 6.5%. Others reported that there was an impact on loneliness (1.3%), restricted movements

Loss of Income	34.2
Loss of support network	0
Loss of Hope	53.5
Loss of Recreation	34.2

10.1e shows that 47.7% reported that their children were not attending classes, with only 4.5% reporting access

to online classes. Only 0.6% were actually attending school, while another 0.6% reported that their children had started working for pay.

Meanwhile the lockdown also ensured changes to the community and access to the Irular's religious affiliations and establishments. Loss of hope was reported by 53.5% of the Irular in this respect, while it also impacted them through loss of recreation (34.2%), and loss of income (34.2%).

Impact on the Elderly and Persons with Disabilities

As reported by the Irular participants, seen in table 10.1k, a low number reported effects on the elderly, but they covered many of the different potential effects. No access to basic needs was reported by 1.3% and no

Loneliness	1.3
Restricted Movements	2.6
Abuse	0
No Access to Basic Needs	1.3
No Access to Health Care Needs	6.5
Other Illnesses	0.6
Loss of Recreation	5.8
Fear of Death	2.6
Fear of Abandonment	0
Other	0.6

(2.6%), loss of recreation (5.8%), fear of death (2.6%), and other illnesses (0.6%). Just 0.6% reported other impacts not included in the survey instrument.

Table 10.1% shows the reported affect on persons living with disability, with 1.3% reporting restricted movements and 2.6% reporting other impacts.

Loneliness	0
Restricted Movements	1.3
Abuse	0
No Access to Basic Needs	0
No Access to Health Care Needs	0
Other Illnesses	0
Loss of Recreation	0
Fear of Death	0
Other	2.6

10.2 Focus Group Discussions

More female respondents

The large number of female respondents was due in part to the fact that more women were available to talk to during the time of the survey. Men who were approached were reluctant to speak, stating that since there was no tangible outcome to answering these questions, there was no point in wasting their time. In many other families, the men encouraged their wives to answer in their stead.

“No, the men did not hesitate to answer because of the gender; they only wanted to know the reason for this interview. While some of them clearly stated that they were not interested in answering the interview, many of them felt their wives can answer better; probably the numbers of women are more than men in the community.”

Access to basic needs

With regards to basic needs, the Irular communities did not have any problem accessing shelter, clothing and water. Their main concern was food. While they were able to access rice through the public distribution system, they could not afford any vegetables or other provisions.

“Parents ensured that their children did not skip their meals; parents ensured that they skipped their meals for the sake of their children. There was one panchayat unit, comprising of 4 or 5 Irular families where they did not receive any support. Their only support for basic needs was from a neighbouring school for food and that too for those children studying in that school. A family reported of wanting to commit suicide because of lack of food; they had no support and survived with water.”

While almost all families had access to dry rations during the lockdown period, some families who shifted home recently did not avail the rations as they had no supporting documents to support as proof of identity. People belonging to the scheduled tribe communities often do not have supporting documents as culturally one is considered as belonging to a new family after marriage and must reapply.

“People in the community believed that they should not depend on their neighbours for their basic needs. While they are also struggling to meet their ends, it would not

be fair to further burden their neighbours. People have managed to meet their ends by accessing available resources”

Few had access to private toilets and most used public toilets or resorted to open defecation.

“Access to public toilet use was a difficulty; earlier, their only option was open defecation. In a construction site nearby, women have difficulty in using the same and hence they had to use the toilet space much before sunrise and managed through the day. Without proper access to public or private toilet use, women faced difficulty in hygiene.”

Employment during the pandemic

Pre-pandemic, mostly people in the Irular community were involved in agricultural labour, housekeeping and other daily wage options, many of which dried up during the lockdown. They also lamented that since the public transportation system was shut down, many could not get to their places of work.

“While it is neutral that both men and women are employed, it was in one particular community where children also contributed to household finances by going to work; the reason being income and survival.

Conversion to different religions

While collecting survey data it was noted that some families of the traditionally Hindu Irular community had converted to Christianity. The reasons given for this were that many enjoyed the prayer meetings, it gave them a forum to express their distress and they felt supported. Some families even received monetary benefits for joining the church. In the case of one woman, she suffered a prolonged illness and was cured only after converting to Christianity. Some men also managed to quit their alcohol habit with the support of the church. When asked if these families were ostracised by the rest upon conversion, it was reported that they were not and their status in the community was unaffected by their decision.

Adherence to Covid-19 protocols

With regards to adherence to protocols and personal hygiene many reported that they were unable to follow them as they did not have enough money to purchase soaps, sanitisers and masks. Many followed traditional

methods of protection such as consuming herbal drinks and washing their hands with turmeric water.

10.3 Case studies

The first two case studies underscore the particular vulnerability faced by Scheduled Tribes, as discussed above. The Irular community is dispersed in various parts of Tamil Nadu, and may be comprised of several sub-sets, though the historical relationships between various tribal people calling themselves “Irular” is still murky, owing to a paucity of written records before modern times. The Irular tribes, however, have a history of being traditional hunters and were known for their special expertise in snake trapping. With the ban of exporting snake skins by the Indian government under the 1976, Wild life Protection Act, a traditional and substantial source of income loss incurred, except in a more limited way within venom-extraction industries, forcing the tribes to reluctantly take to alternative work as daily wage laborers, or in some cases, within factories (Donegan 2018). During the past few decades, some migration and integration of Irulas with non-Irular communities has taken place in the wider Chennai-Cuddalore region, complicating their tribal identity, and with it, their rights as a scheduled tribe (Donegan 2018; Srinivasan and Ramakrishnan 2020). The Irular in the Chengelpet area, where this research was carried out, struggle for adequate employment, housing, infrastructure, land access, education, all worsened significantly by the COVID-19 pandemic. Uncertainty over the future and increasing distress wrought by socioeconomic hardship underscores the crisis that may be looming in healthcare, health, and general wellbeing within this community.

Geetha

Geetha lives in Panagattupakkam village, hailing from the Adivasi “Irular” community, meaning “dark skinned.” By profession, Irulas are daily wagers, though their traditional occupation was animal hunting, honey collection, fishing and farming. Geetha completed 5th grade and soon married a man of her choice at the age of ten. Being a close-knit, kinship-based community, marrying outside of their social group was unacceptable at that point. As a consequence, Geetha received no support from her family, and moved out of her hometown, managing her household with her husband’s meager income. However, disaster struck as her husband succumbed to an illness.

Left with limited options Geetha went back to her village and gradually remarried her brother-in-law who offered her the solace and companionship that she sought. Both her husband and Geetha worked as agricultural laborers on lands owned by individuals who belonged to an “upper caste” community. Much land was given to land holders of a higher caste during colonial times, leaving indigenous peoples with limited or no property ownership, and having to rent and work on land owned by others (Irschick 1994¹⁵¹; Donegan 2018). Geetha and her husband often experienced segregation and humiliation on account of their tribal background. However, they persisted, despite a somewhat tumultuous relationship with their employers, in order to break their cycle of intergenerational poverty and trauma and to educate their twins.

COVID and its impact: Safety guidelines and adherence to health protocols

Much of daily life came to a grinding halt with the pandemic. Information around health protocols reached them much later, owing to their remote location. Their ability to follow these protocols was invariably limited. Most individuals of this village, and indeed other villages inhabited by Irulas, shared toilets, sometimes 50 persons to one public toilet. Physical distancing was hardly an option with as many as 6 on average sharing a home; in one instance 13 individuals lived in a 200 sq. ft. thatched house. Access to sanitary products was secondary to obtaining adequate amounts of food, the main concern for most individuals.

Under these conditions, knowledge about the pandemic within the community was lacking, though they were also impacted by the restricted movements imposed by authorities. As Geetha put it when asked by our interviewer about “Corona”:

“We don’t know anything about that. We do as we are told...Nobody told us anything or given us any information. It is this or that, we don’t know. We just know what is on the news and TV.”

When pressed on what she had learned from the television news, she replied,

“We don’t know much. But we should not travel out of the village, we shouldn’t spend the night outside of home, we need to stay home, we shouldn’t allow outsiders into the house, that’s the sort of thing we know.”

When asked about hardships associated with these restrictions, she pointed to both economic and sociocultural dimensions,

“Because of this Corona we are not able to go anywhere, if there is any function also, we can’t attend. If anything happens in a relative’s house, we can’t go. We can’t go buy vegetables. So that has been very difficult for us, getting this ration rice and eating. If we go to the regular stores to buy anything, they are asking for increased prices. We have to pay extra money and buy, we don’t have that level of income. We aren’t getting proper work also.”

Emphasising the nutritional impact of the pandemic, she said,

“We are getting ration rice (provided by the Tamil Nadu government), we are just boiling that in water and drinking it like kanji (porridge) and somehow managing.”

Loss of Livelihoods and access to Relief measures:

Geetha and her husband both lost their jobs; one of the hazardous impacts of being employed in the informal sector. With negligible savings, no assets and almost no access to safety nets nor securing alternate forms of livelihoods, Geetha and her family subsisted in the initial stages on the support that the Government extended – dry rations (rice and oil, primarily) and a monthly allowance of Rs. 1000. When asked if she had any employment, Geetha replied, “I don’t work anywhere. If somewhat calls I go for daily wage work.” This daily wage work was supported by MGNREGA, a government scheme that guarantees 100 days of wage labour work per year for the rural poor. She added, “If you are asking about my one days work, if I go in the morning and come back around in the evening, I will get 100 rupees.” When asked how she is coping with this difficult situation, she replied,

“Any work at all, and we run and do it. Whoever calls, even if it is far away, we wake at 7 (am), we pack rice with water and green chilies and run to the work site. We walk, even if it is far away, for example to Kolathur, we walk all the way and do the work. But we get paid only 100-120 rupees as daily wage. If we reach at 6 am and work until 6 pm, we get 120 rupees.”

Within the family, nutritional needs and consumption patterns in families were gendered, to a large extent. This meant prioritising the needs of her children and her husband over her own. On many days, the family, and in particular, Geetha, could afford just one meal; which mostly comprised, as mentioned above, of rice and water. Dry rations provided by the government did not include vegetables; and, in the absence of local transport, the closest market place was a few kilometers away. In the absence of nutritious meals, looming uncertainty, associated fears and anxiety, the energy to walk for over an hour to access vegetables seemed impossible. Malnutrition and undernourishment plagued the Irulars in a pre-COVID world (Donegan 2012; Guha 2007; Kannan 2018), but now an already difficult situation had become desperate.

Health access and local remedies/ faith healing:

Vulnerability to illness is also high within the Irular community, given limited access to basic healthcare and adequate nutrition. Geetha’s daughter, for example, and like many within tribal communities, was not vaccinated as an infant. Health and wellbeing were largely under the jurisdiction and support of ‘Kanniamma’ their local goddess to whom they prayed to during every time someone fell ill. Rituals when sick included tying a yellow thread, followed by a visit to the temple, and, perhaps, the sacrifice of a hen upon recovery. As many Irular men used to practice snake catching, the protection of Kanniamma in this dangerous occupation was central to their worldview and sense of identity. Healing through faith to Kanniamma was thus not peripheral to healthcare, but central to a sense of security, auspiciousness, and wellbeing. As Geetha expressed when asked about the core traditions within the Irular community,

“In my house, if somebody falls very ill, we ask the Gods for a cure. For our people it is the Goddess Kanniyamma. We go to her and ask her what this is and why it has happened. Is it something from the air? Or is it something from within the body itself? That is what we ask. To which she may say that it is only a fever, if you go to the hospital and take treatment it might go away. Then we do take them to the hospital. If she says, ‘No, this is a curse from God’, then we do whatever she asks us, and the person gets better.”

When pressed by our interviewer whether most cases are treated by the Goddess or end up being treated in the hospital, Geetha replied,

“No, we don’t need to go to the hospital. They recover fast. If we think of Kanniyamma and treat the person, they recover. Even now, the if children go somewhere, to the forest, or a grove of trees, and they get scared, at night we think of Kanniyamma and tie a string—with some money and a string soaked in manjal (turmeric) and tie it around the wrist. The children become alright, they become well.”

The efficacy of faith-based healing for psychogenic and psychosocial stress has long been established in the mental health and anthropological literature in what is sometimes referred to as ethnopsychiatry. What is relevant in the current context is the resilience and hope this faith provides in the midst of the pandemic. It is reasonable, and therefore, impossible to imagine a more holistic and sustainable healthcare system without it being anchored in local and meaningful symbolic worlds. But along the same lines, a doorway is opened to biomedical care in Geetha’s judgement. The Goddess herself ordains it if circumstances are such that when affliction derives from “natural” causes in the “air” or “body.” Organic causation is now part of their understanding of illness, and has a remedy outside of the supernatural, though oracular confirmation, paradoxically, might lead to this conclusion (see Willford 2021¹⁵², on this point within another Irular community). But both fear and access to hospitals and clinics are factors that inhibit biomedical care. For minor ailments, traditional remedies are relied upon, “If we are not well, we boil oil well and add camphor.” This is used for common fever, cough and colds,

“We boil the oil and rub it in. If there is a cough, we take moringa leaves, some lime and apply it on the chest. If you do that, they will sleep well through the night, children I mean. If it continues, just rub it in three days and it will go away on its own. If children have a bad cold, we take pepper, cumin, garlic—grind it all together and give it to them, and the congestion will melt away. We also take karpuravalli (curry leaves) and tulsi and boil it in water and give it to them.”

On the question of access and fear of hospitals due to COVID, Geetha said,

“Right now we not going anywhere near the hospital, and we are scared. When we watch the news on TV, we are very scared. It might be like what they are showing, but nobody here has had cough, cold, or fever. If one odd day they are feeling unwell, we use our methods, and they are alright again. Because sometimes they sleep outside and are affected by the morning dew, or sometimes it rains and our roofs leak, in those cases they feel unwell. When wind blows strongly over the pond. Times like that.”

This said, under better circumstances, while there might be a preference for traditional treatment, locals might access clinical care, as Geetha emphasised,

“Going to the hospital is tough, and none of us are going anywhere near hospitals. If people had vehicles or transport they would definitely go. They would go without any fear of Corona and check (receive care). But nobody has vehicles or transport so nobody is going. It not, Ammapettai hospital, Kelambakkam Government Hospital are places we go to check.”

Ideally, an integration of traditional and faith-based care that both symbolises *and* provides hope, is culturally meaningful and offers acceptable, less-stigmatising approaches to care; and one that is integral to a person’s identity can be a source of wellbeing and resilience, particularly when combined with biomedicine when necessary. This form of “medical pluralism” (Abraham 2014) arguably, serves rural and poor populations better and save lives, as it requires an investment in a community-based model, such as the ones championed by local NGOs, such as The Banyan, but validated in global research (Lancet Commission on Mental Health 2018) on efficacy and sustainability.

Impact on Children:

Geetha had enrolled her children into school amidst great difficulties, considering individuals from indigenous communities are amongst a vulnerable group that has consistently found accessing essential documents such as Community Certificates and Aadhar (national identity card) a barrier over the years, and which are now a necessary for gaining admission into schools. Not one to give up easily, Geetha faced every hardship that came her way and ensured her daughter and son could attend school, though this, too, was an arduous struggle.

Schools had been closed as per Government regulations from March xxx. Meanwhile, Geetha's daughter, influenced by her gritty mother decided to contribute to the family's income and found herself a job in the neighbourhood doing housework. But her daughter missed going to school and meeting her friends, and yet, demonstrated responsibility that was well beyond her years.

The hardship and injustice of this situation was not lost on Geetha, who worried about the future for her children and for those within her community. Aside from required certificates and school closures, a lack of transportation and the need for additional income through child labor discouraged school attendance. Geetha lamented at length on these interrelated and ultimately harmful causes,

“The main concern is that it is at a stage when they are unable to go to school. It is like there is no link to studies now. Even if they are giving books, we are unable to go and collect them.”

When asked why they cannot collect the subsidised or free books, the problem of transportation was mentioned, followed by emphasising the need for additional income within the household,

“We do not have any vehicle or means of transport. If we have to walk and get it, it will take a long time and the children will get tired and the children will get tired by the time we get there, which is why we have not gone and picked it up.”

As to what the children were doing now, she replied,

“My daughter wakes up in the morning and goes for housekeeping work. She sweeps, puts ‘kolam’ (auspicious designs before the front door), and goes to collect water. She gets 500 rupees (around 8 USD\$) per month for this.”

But this money is not simply added to the general expense budget, Geetha insists. Rather, her daughter is “saving it up for her studies.” Taken at face value, this reveals both an ethical commitment to the future, and specifically, for her daughter's need for an education, despite the precarity of the present that unjustly demands child labour, something that Geetha regrets, indeed laments. As she points out below, education is not only for the individual's benefit, but impacts the whole community, as with literacy and education comes

better access to information, knowledge of legal rights and government assistance. First, however, she pointed out that children as young as 13 were working full days in agricultural fields, out of economic necessity, “harvesting the crops the whole day.” Her daughter, she added, while mainly employed in “housekeeping work,” would also

“come to harvest crops...If we go and do this job, we get hip pains and we can't work continuously. But children are able to do that. You need to bend and cut. *That is what is upsetting me.* When school was there they would wake up, catch the bus and go to school and then come back only in the evening and go to tuition. Now there is nothing like that. *We are struggling* and they are coming to work with us. If they come we can earn (an extra) 100 rupees, at least. We can use for expenses. That is why they come as well.”

We can sense in her words the profoundly stressful double-bind she and other members of her community experience when simultaneously worrying about the interruption in their children's education, yet requiring additional income during this crisis, compounding their already vulnerable position within society. This was made poignant when she was asked if it was right that a 13 year old child had to work:

“(A) 13 year old should not go to work, it is wrong. It is wrong by law, even we know that. But since she is there, she is doing it. To help fill our stomachs, the children are also coming to work.”

As if to assure herself, and perhaps the interviewer, betraying her sorrow at this state of affairs, she quoted her daughter as telling her, “‘When school opens, we will not come to work anymore, Amma. But it is shut, and we have no means to study now.’” Even the promise of education's resumption, however, did not assuage the gap in education she felt her children suffered, saying,

“One main problem is, children no longer remember everything they have studied. We do not have the means to help keep all this in their mind. None of us have studied, how can we teach them? They do not remember. They have forgotten.”

By mentioning, too, that the elders have not studied, Geetha underscored the correlation between literacy and

poverty, that is most characteristic, as noted earlier, of Adivasi communities. In this sense, sacrifices being made in the present were also simultaneously a threat to the future aspirations of this community, as Geetha was painfully aware.

Conflict at Home:

Loss of livelihoods, a sense of hopelessness and use of substances, particularly alcohol on the part of her husband led to frequent conflicts, violence and disruption in the family, resulting in the husband's leaving home with his son. In addition to the pandemic and its socio-economic repercussions, Geetha and her children found the emotional distress of the separation overwhelming and an additional burden that they had to contend with. Geetha's daughter arbitrated on behalf of her mother and some peace was eventually brokered. While things had now settled and returned to some semblance of normalcy with the family together again, and the parents gradually returning to work, one must remember that their income never exceeded Rs. 3000 per month, well below any measurable poverty-line; that caste-based barriers continued to persist, that health care will continue to remain a concern, and that Geetha and her daughter will be lower down in the priority chain with lesser access to nutrition, education and work; and, moreover, with greater potential exposure to violence and insecurity. The pandemic only underscores and makes visible these disadvantages, social hierarchies, and inequities that lead to disparities that are always further exacerbated in extraordinary and catastrophic circumstances.

Community Certification for Scheduled Tribe Status (ST)

As was mentioned earlier, obtaining a Community Certificate for ST status was important for Adivasi communities, the Irular being no exception. Given their social and economic marginality and high rates of poverty, the material benefits of obtaining this certification, though limited, are essential. But it is not an easy process for the Irular when they are dispersed and live within the same villages as non-ST communities. Obtaining the certificate requires activism, cultivating support within local government, and persistence given the reluctance of officials to grant certification to all claims made (see Donegan 2018; Selvarajan 2012; Srinivasan and Ramakrishnan 2020). In Geetha's words, the housing amenities and rights to

land that would come with certification have not happened in her village as they struggle without government assistance. Regarding certification, she had much to say about her own family's intergenerational struggles to obtain it:

“From my grandfather's time nobody has had this certificate. Even in my father's time nobody got it. When I grew up I was married into a family from Padappai. We lived there only for a year before moving here and we have been here since. After coming here I started a (self-help) group with some of the women. Through the group, we slowly started asking for things we wanted, facilities and means. We said that only if we had certain identifications, people would notice us. I myself tried slowly, met everybody I was supposed to meet. I came to The Banyan and asked for help and then went to Thiruporur and got it. Aadhar card. But now only the adults have got. They have said that even children get so we still have to do that. It was a big risk, but we took it—and we took it as law—and went and got it. Yes, we are working towards it. We started in 2015 to apply for community certificate. Until now we do not have this certificate in our hands. Our people can be united, but suddenly if something comes up, they will withdraw and go away. In those situations, I take the responsibility. I go at the times we are asked to go. I accept that they are in some difficulty and that is why they cannot come. For this, I have walked all the way to Chengelpet three or four times. I have gone to enquire, and when I have asked they have said, ‘Sure, we will do it’. But they have done it for all other villages but only not for our village. Now, in the next village also they have done it, but it has not come to our place—the certificate. Now they are saying, if we go and put a signature, they will get the certificates ready. That is what they are saying right now.”

There is much to unpack in Geetha's comments about certification. We might note that NGOs, such as The Banyan, have a significant role to play, not only in accessing healthcare, but also for advocacy and information—an important conduit in connecting disempowered communities to local governance. Moreover, she illustrates the characteristic and repeated bureaucratic hurdles this process entails, whilst also

pointing to the worries that some individuals might have that inhibit their participation in legal efforts, be they pragmatic, or fears of repercussions from officials or other communities (Donegan 2018). As a contentious (within and between communities) and arduous process, in this case, taking many years, Adivasis, being the most economically and socially vulnerable, may be intimidated without reserves of courage that not all possess. On this point, Geetha spoke powerfully as an activist for her community,

“About courage, if our children are able to get social entitlements, I’ll be satisfied. All children should get it, right? So, whether they are my enemies or they are people who like to fight with me, I will do it for the sake of their children. They can scold me behind my back how much ever they want, but since this for the children, I will get it done. When I’m doing, I feel very happy and that blessing will eventually go to my children. So, I feel I should do this for my children and others. Even if I do not talk to the parents, I will call the children and tell them the instructions and they go tell their parents.”

Geetha indicates, albeit indirectly, that friction between community members over her activism has impacted upon her social relationships within the village, adding to her stress, and threatening her wellbeing. Adding further, she admits,

“I have suffered a lot during this time, but I do not think it is appropriate to share that with others. I have overcome that for the children, and whatever is necessary. They (the government) think we are seeking land. They are asking from where all these people have come. Because people have had children and they have gotten married and have their own children...So, when they have kids and separate into independent families our population count is just increasing. But we need support for all. I have written an application only for 14 families, but with that the children can easily go to any school and come. We need community certificate. They actually call us and warn us, ‘Do not come here without the community certificate.’ The school calls...and warn... ‘Certificate is not ready, please get the certificate.’”

As in other documented cases, suspicion over claims for community certification at the government level are

common, as with these claims land disputes arise. Within ST communities, resistance to intermarriage with outsiders is not only about preserving cultural and kinship identity, but often also involves land disputes between households, and internal suspicions that outsiders will attempt to benefit from ST certification through intermarriage. There is little social support provided by the upper-caste and -class, non-ST members in the village. Irulas are paid less than non-Irulas, as well, for manual labor. Obtaining the community certificate has the added difficulty for Geetha’s Irular community because when the government officials come for verification to the village, the more powerful non-ST community members do not support her, claiming that there is no need for community certification when there are no more Irulas living there. This is due to the fact that if these Irulas were recognised in the census through ST certification, the upper-caste people living within the village fear that they might vote in elections, make land claims, and generally request housing and amenities that would potentially weaken the local hierarchies, of which, currently, the Irulas rank lowest (Donegan 2018). Here we see, for whatever reason, internal suspicion impacting upon Geetha, adding to her already high levels of stress during the pandemic over education and income. As Selvarajan (2012) also indicates, land sales and alienation of tribal lands, including in Irular communities of the Chengalpet region, is a regular occurrence, mostly as designated lands are sold by community members out of debt and economic hardship.

In terms of what certification is hoped to bring, aside from educational opportunities and access to land, adequate housing is the principal concern in Geetha’s account, to which she links education and health:

“Children should be able to study well. We should have good housing. Here and there they (the government) have built group houses...If they could do that for us... During rainy season, how many times we will take apart our house, travel great distances to find palm fronds, stamp on them until they are nice and flat, and store them. Then, after a week, we have to go to the forest or the places where we work and cut wood for the poles and dry them. Then we tear up saris to tie them and rebuild our houses. They have to climb up palm trees to get the fronds. If somebody falls by mistake, there is nothing we can do... Our village should be like all the villages around us, at

least. What wrong did we do that all the surrounding areas have gotten these amenities, they have even gotten land. In the land that we have if they can help us build houses, that is enough...”

When asked about expectations for the future, and government assistance, she underscored the need for proper housing,

“we mainly want a house. When it rains, water just pours in, right in the middle of the house...the children struggle to sleep. That too the mosquitos come inside and bite the children until their arms are full of lumps. Because of that the children do not get sleep and they are getting sores on their feet...the mosquitos that bite and cause those lumps...Some days there is electricity, some days it gets cut. If the power goes during the rainy season we really suffer.”

Anxiety and Stress

The long term economic and health-related impacts of the pandemic are still unknown. But we can see in Geetha’s story many sources of stress and anxiety converging, which will not be mitigated without taking a holistic and multidimensional approach to understanding. Here, and in convergence with the wide body of research on community-based models of care, we can see the importance of cultural beliefs, local social dynamics, and building local and participatory support systems as important first steps. Much of the heightened stress stems from uncertainty and a lack of information. Geetha, despite her courageous efforts, admits to suffering from the stress heightened by the pandemic,

“I am not getting sleep at all, my sleep is entirely gone. As we listen to the news, our sleep is really getting spoilt...Definitely very stressed. What I do with my stress is I collect cow dung and rub it all over my house. It (the virus) should not come into the house. I have children. Everyone in my family, to prevent it from coming into the house, is sprinkling cow dung dissolved in water and turmeric around the house and tying neem leaves to our front porch. We also keep neem leaves inside, and next to the God in our prayer area...we pray to God and say, ‘Kannihamma, mother, do not let it come to us.’”

While faith is clearly an important source of resilience and understanding, as was mentioned earlier, it cannot provide all the answers, nor does it inoculate a population from a deadly virus, or its more diffuse psychological impact. Sleeplessness, poor nutrition, and worry about the future will certainly take a psychological and physical toll that must be understood and addressed through varied forms of psycho-social and economic relief. Geetha is pushed to the edge of reasoning, where words and sleep fail her, “sleep is difficult to get. Why is this happening to us?...Coping...we are finding it hard to deal with these problems. *We are not able to digest this situation...I do not know how to express...*” In sum, COVID has produced a significant rupture in an already distressed community, leaving even its most courageous and activist individuals at a loss of understanding, with consequences not yet fathomable. But we draw hope, however, in that persons such as Geetha, look beyond themselves and aspire to transform lives challenging one systemic barrier at a time.

Jaya

Jaya is from Panagattupakkam village which is located in Thiruporur block of Chengalpet district. There are 19 families living close by. She also belongs to the Irular community and lives with her family near the local pond at the edge of the village. Like others from her community, due to the history of rural agricultural land belonging to the Zamindars (landlords), a landholding pattern that was worsened during the 19th century under colonial rule (Irschick 1994), she faced extreme difficulties in claiming land or property. As Srinivasan and Ramakrishnan (2020¹⁵³) point out, only the Irulas of the Nilgiris (mountainous region in Tamil Nadu) have been recognised without controversy as a Scheduled Tribe. Irulas who migrated down to the plains, whenever this occurred over history, have faced much greater difficulties in obtaining certification. Srinivasan and Ramakrishnan report, citing social activists fighting for community certification, that Irulas who approach government officers face racial stereotypes, and are even asked to prove their Irular status by demonstrating rat and snake catching before the incredulous and bemused officials (Ramakrishnan, 2020; also see Donegan 2018). Impoverishment, in her case, and in many others we surveyed, produced material, social, and psychological challenges. In particular, limited access to transportation, work opportunities, and the struggle to obtain ST rights in the community were, as in the case of Geetha, underscored in her description of the pandemic's impact on her and her family.

With rigid social hierarchies still existent in rural villages where Irulas live adjacent to wealthier non-Irulas, they, as Adivasis, are among the most disadvantaged, marginalised and oppressed after generations of socioeconomic deprivation (Kannan 2018; Donegan 2018). In this context, Irulas have to work hard to support their families, facing these social challenges, and now face the significant impact of COVID-19 on their lives. As in the case of Geetha, traditional ideas, rooted in religious beliefs, form a first line of defence against the effects of the pandemic, and more broadly, maintaining a sense of wellbeing.

Large Families, Family planning, Irular Rituals and Health

Jaya is 45 years old and a mother of 13 children. She got married at the age of twenty, and at that time, her husband was twenty-four years of age. Her first husband died at the age of thirty from a snake bite after the birth

of their fourth child. As mentioned earlier, Irulas were employed as snake catchers, and, indeed, became famous for their hunting skills. But this occupation is inherently dangerous, and stories abound within Irular villages of death by snakebite. She moved to Panakattupakkam from Kanchipuram for economic reasons and began working as a “coolie” (porter). Prior to the second marriage, she said,

“I used to cut wood and he was into odd jobs in the farm, we got to know each other and then got married.”

At work Jaya met her future husband and got married for the second time and they had seven children together. Jaya explained that four of her children were married but none were happy in their family life, and that this was causing her additional worries. One of her daughters is pregnant and diagnosed with diabetes, receiving treatment in a Government PHC. Jaya is worried about taking care of her daughter while also caring for the rest of her family and her younger children at home.

Despite having 13 children, Jaya had not attended to any family planning. Instead, she relied on faith and rituals as a means of preventing further pregnancies. Moreover, having children was a blessing, and a consequence of having faith in God. As Jaya put it, “When we pray to our God we have children.” When asked if she worries that a 14th child will come, she replied,

“No, it will not happen. We pray to our God for that...we pray to our God saying that we do not want any more children, and it will not happen.”

When asked how an Irular belief that certain signs on the umbilical cord indicate whether more children will be born or not, she answered, “Some knots show in the umbilical cord during childbirth after, say, the 5th or 6th child being born. But after the 13th there were no knots. So we pray to God and trust that we will not have any more (children).” Queried further on how the cord is ‘read’, she explained that, “We take the cord, put it in a ‘palai’ and apply vermilion turmeric and light camphor and worship. On the seventh day, we pray that we should not be blessed with more children and light camphor.”

Asked what happens next, she added,

“We place it as it is and bury it in the earth along with neem leaves, turmeric and light camphor.”

She was later emphatic that through faith alone, they would not have more children, saying,

“We believe that God will not give any more and *we trust our God so much.*”

While she and her husband have faith they will not have more children, five of her now-adult children are married and do practice family planning, a point we will return to.

Jaya and her family have taken precautionary measures against “Corona,” keeping the house clean, using traditional methods such as neem leaves mixed with turmeric paste and Chlorine powder, which is then spread around the house. Her family members use masks, when possible, when they go out; and, they also used to pray to their God to ensure that no one will get the disease. As there are many living people under one roof, social distancing is impossible among family members at home. When asked about “Corona,” and what she knew about it, she answered,

“There was news in town that there is Corona—should not step out, unable to go to shops, bazaar. Cannot commute—we are living that scare.”

When asked what she thought Corona was, she replied with uncertainty,

“Not sure what it is, but we are scared of it. Once we heard of Corona, we immediately prayed to our God saying we should not get it and we believe it. Nothing else.”

Beyond Corona, Jaya and her husband utilise traditional medicine and faith in God as their sole means of healthcare, for the most part. When asked what she did when her children fall sick, she replied with confidence, “If we get fever, we boil dried ginger, coriander seeds, jaggery and (fresh) ginger and drink, we will get better. And we pray to our Kanniamma Goddess and tie a yellow thread, that we should be fine. We will be fine as much as we pray and we will be normal.” As she trusts God “*so much*” she, like many in her community, particularly of her generation, rely on traditional remedies and faith over and above hospital care for illness,

“When I, myself, or my children fall sick, we pray to our God, tying a one-rupee coin in a yellow (turmeric stained) thread saying we will offer

kozhi (chicken) and hen sacrifice in the month of Aadi and we will offer the same, we will be fine.”

Upon hearing this we asked whether this practice is continuing and whether even be the case in the event of serious illness, she would not go to the hospital. To this she affirmed,

“Yes, we have this practice. No, we do not go to the hospital.”

This was even true for childbirth,

“Even for that we pray to our God for safe delivery instead of doctors. Our God should be there instead (of doctors) and it will happen as we prayed only.”

Work and Education

Jaya’s husband used to work as a tree cutter, but with a diagnosis of diabetes, his health has deteriorated, and he is not able to work hard anymore. With COVID-19 his employment options worsened, making it extremely difficult to find work. Jaya works through the MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act), and her salary is deposited directly into a bank account. But as an example of transportation difficulties, and, more generally, an absence of critical infrastructure, she has to walk for 14 kilometres to reach the nearest ATM to withdraw funds. Now with the loss of income and work due to the lockdown, they have been relying on their daughter, who is 13 years-old. The daughter supports their family financially, earning 500 rupees per month. With this meagre income, they rely on government rations to feed the family. Due to Corona travel restrictions, she described her struggles to earn and provide adequate food for the family, though she did obtain a wage through the MGNREGA scheme:

“We are unable to get food to eat, get jobs for livelihood. We are finding it difficult.”

Elaborating further,

“We get 120 rupees per day and we make porridge (gruel) and manage. I go to labour work daily and my husband goes to work if he gets—otherwise (he) doesn’t. I go to the 100 days scheme work (MGNREGA).”

To do this work, however, she must walk, sometimes over long distances, adding,

“Yes madam (interviewer). I go and get it by walk only...yes, by walk, no vehicles available.”

When asked if she is able to buy vegetables with these low wages, she confirmed this was their only means of subsistence,

“Yes, whatever we get at that time is what it is. Otherwise, we make do with what we get, if (we) get any work, and make porridge with ration rice and give to the children.”

But she added that her thirteen-year-old daughter, as in the case of Geetha above, worked outside to help the family. This came informally, as children cannot work within the MGNREGA scheme, rather,

“it is for any farm or miscellaneous work and (will) get 100 or 120 rupees...not daily, (only) once in a while (and) that too if someone calls. There is no farming work now, if we get (a) call we go, if not, otherwise.”

She lamented, betraying anxiety,

“Due to Corona we are unable to get jobs, unable to get vegetables, commute, no buses, or do anything. That is what is affecting us.”

Through loss of work, and difficulties accessing rations, it is very difficult for Jaya to provide three meals a day for her family. Many days they have had only one or two meals, and go to sleep hungry. A few NGOs have supported them with dry rations, particularly as transportation to shops was unavailable. Having already been poor, with limited resources, the pandemic has hit her family with significant deprivations and hardship. Relying on their children to support them financially, and having “rice rations” as their main source of food is difficult to deal with in the short term; however, these conditions will have longer lasting implications on their health, nutrition, wellbeing, and, particularly, their mental health.

Education, information, and anxiety for the future

With school closures due to the pandemic, education for Jaya’s youngest children has been interrupted. As she put it,

“Children are unable to continue to study, they are not sure of what is happening and they forget studies itself...So far the children went to school regularly, without taking a day’s leave, but now the children’s studies are affected. Worried how it will affect their education. I do not know what to do about it. Not sure when this Corona time would end and when children will resume their education. I do not know what to do.”

Jaya was emphatic that her children receive an education, clearly, by pointing to their regular attendance and her worry about this interruption, and the long-term consequences it may cause as children “forget” what they have already learned. When asked directly, she confirmed that her biggest worry was, indeed, the impact the pandemic would have on their children’s education.

The uncertainty over the future, and, specifically, over how long lockdown conditions would last in “Corona time,” seemed to bifurcate time into a before and after, with the after still as yet undetermined and cloudy. Uncertainty and a lack of information, moreover, extended to knowledge about COVID, and the preventative measures their community might take. Stress was increased by these unknowns and uncertainties. When asked directly about Corona, and whether it is impacting others in the community, Jaya took this to mean whether others in her community had been infected, but then emphasised that little information has trickled down from the government to her village,

“There is no one affected (infected) in our neighbourhood and doctors who visited said the same thing. Our neighbours also pray to our God, like I said, that we should not be affected by Corona, and we trust it will not happen to anyone in our place.”

When asked specifically about hygiene prevention, washing hands or wearing a mask, she replied, “No one has come and told us anything on this. No, we do not know.” But as she was wearing a mask during the interview, she was asked how she knew that she should wear it,

“They said that you should wear this for Corona and that it spreads from one to another. If I go for 100 days work scheme, they tell us this and do this.”

Asked to clarify, she replied,

“To wear mask, that it spreads from one to another. To close face and sneeze, etc., they said this in (the) 100 days work scheme. The clerk mentioned this. Yes, we wear a mask and work and sit at a distance. They teach us to do so.”

From her account, it became clear that the information she had received had come through the government work scheme (MGNREGA), and not through health department officials coming to her village or posters/signs that had been erected in the vicinity.

Looking towards the future, Jaya has understandably practical worries about the impact of the pandemic upon her children, as well as meeting the basic subsistence needs of her family. Her husband’s health condition is an added concern, leading to her thirteen-year-old daughter having to also join her parents in daily wage work. A lack of clear information and guidance from health officials also seems to inhibit her understanding of the pandemic, possibly adding to the generalised stress caused by uncertainty. Faith and traditional means of protection against misfortune and illness seem to be her primary sources of resilience and hope, though the interview ended with an acknowledgement of changes, and the need to incorporate biomedical care into the next generation’s lives. First, she, when asked, mentioned that her grandchildren will receive vaccines, though she did not vaccinate her own children, perhaps, owing to religious ideas and faith in the Goddess Kannamma to care for their health. The same was true for family planning, as she indicated, perhaps with some ambivalence, that her daughters, unlike her, had taken up family planning techniques,

“Yes, they have done. Only I have not done in my family. Those days I did not know of birth control (so) I have given birth to so many children. Now thinking they should not be so, we have done for them after two and three children, respectively.”

Upon hearing this, our interviewer pressed Jaya, asking, “You have not done family planning for yourself and you did not have belief in that. How come you have done it for your children?” Jaya replied,

“They say in my place that children should not be like you. We should have children according to our livelihood standards. We should be able to take care of our two children well and should earn

for that. Now I am able to understand this. *My children should not be like me.* Now they all go to hospital. Now they go to hospital after two children for family planning. That is all I know.”

Her reply underscored a growing dissonance between Irular beliefs, which, on the one hand, provide hope and resilience, and on the other, are further stigmatised now, potentially adding yet another uncertainty that can exacerbate the existential psycho-social stress facing communities undergoing rapid changes (Kleinman 2012). Cognitive dissonance versus the certitude of faith must, therefore, be carefully considered when launching public health initiatives. Here, community-oriented public health initiatives need to build bridges of understanding, rather than creating generational rifts that leave people like Jaya feeling her world is being torn asunder, devalued, and with it, her sense of self-worth.

As noted at the introduction to this section, social defeat is the experience of repeated humiliations, most commonly experienced where hierarchies enact forms of structural violence, leaving individuals more vulnerable to common mental health disorders (Patel and Kleinman 2003; Lurhmann and Marrow 2016). Public health initiatives, and development initiatives more broadly, must be mindful that even the most progressive of plans with the best of intentions can create social fissures, enact new hierarchies, and leave some community members feeling more vulnerable to experiences of social defeat. As the scholarship on Adivasi communities has indicated, poverty and illiteracy is most prevalent within these communities, leaving them vulnerable to the predations of power, bureaucracy, and modernity, more broadly. Without grass-roots efforts to increase understanding and stakeholdership at the local level of development initiatives, this vulnerability, and the potential social suffering engendered within it, will not be mitigated. Conversely, local models for living derived from culture and faith are the resources of aspiration and hope, and must be considered seriously in building resilient resources for wellbeing, particularly within more ‘traditional’ communities facing the onslaught of modernity, and now, facing the additional crisis of a pandemic.

For 12-year-old Mohanraj, the one thing of primary importance in his life is a bicycle. All his friends in the village of Perunthandalam, Chengalpet district, Tanil Nadu have one and they ride around together leaving him feeling left out.

But Mohanraj's home situation prevents him from getting the one thing he wishes for. His family is one of those severely affected by the pandemic. His father, an auto driver, was left with no income source with the declaration of the lockdown. His mother, who suffers from debilitating migraines, has always been unable to work or take on much stress due to her condition, and his father has always done the majority of the housework. Just before the pandemic hit, the family had taken out loans to pay the school fees, manage household expenses and pay for utilities and now were left with no means to pay them back.

Mohanraj's mother is under treatment for her migraines and low moods. Through the course of her care at The Banyan, she has become very close to her Nalam or Well-being Mobiliser, Sarojini, a grassroots worker in the employ of the organisation. 'My mother and father always shouted at me or fought with me but in Sarojini I find an unconditional support. I am able to tackle all my small problems with a lot more strength because I have someone to talk to,' she says. While she has improved considerably, she has always regretted that she has been unable to contribute financially to the family. During this pandemic, however, her husband and she came together with rare understanding and support and decided to start a small petty shop with a food stall in order to bridge the income gap. Taking another loan for INR10,000, they set about running the shop but unfortunately customers were few and far between due the lockdown and they barely made enough to cover their expenses.

Like any mother of an early adolescent child, Mohanraj's mother complains about her son. She feels he doesn't understand the seriousness of the situation they are in, in spite of repeated explanations, and that he is selfish in always asking for a cycle. She also feels that he bullies his brother and that they are always getting into fights which further increases the family's stress.

Mohanraj, however, stresses that he does understand. He has spent part of the lockdown helping at the store and notices that they do not have many customers. He realises that many a time food is hard to come by and meals are skipped. But he feels his parents do not understand the importance of this cycle to his position in his peer group. He feels he is being an obedient child, following his lessons on TV, clearing all doubts with a neighbour, participating in the church band where he plays the drums. He also tries his best to comfort his mother when she begins to feel unwell and under strain.

Every Sunday, the family goes to church - their only outing during the pandemic. There, Mohanraj prays first that his family start making more money, then that his mother gets well, that they don't catch any of these scary diseases that seem to be around and that he can finally go back to school and meet his friends again.

11. Children of disadvantaged families

The impact of Covid-19 and the lockdown on children and adolescents' mental health is unprecedented and not to be underestimated. The worldwide accepted practice of combatting the virus which included lockdowns, social distancing and isolation have led to observable changes in the behaviour and mood of children, the long-term effects of which can as yet not be predicted. India, which has the largest population of children in the world with 472 million children, has seen a significant impact of the pandemic on 40 million children from poor families (Singh et al, 2020¹⁵⁴). Confinement to the home of children from poor and underprivileged families have left them susceptible to exploitation and at risk of abuse, with frustration and family conflict manifesting itself as violence against the children (Cooper, 2020¹⁵⁵; United Nations, 2020¹⁵⁶). The data represented below was drawn from two groups – children from an urban slum in Chennai city and tribal and non-tribal children from an agrarian rural community in Chengalpet district.

Santhome, a coastal region in Chennai city, is home to a fishing community that has existed in this location for a number of decades. Originally living on the beach in huts, they have since been given housing by the Tamil Nadu Slum Clearance Board in large housing board complexes that accommodate thousands of people in small spaces. Houses are generally one room with a bathroom and kitchen and often have multiple generations living in them. Several years of engagement by The Banyan in this region has revealed issues around alcohol abuse in adults and adolescents, early school dropouts, especially with girls, familial violence and occasional reports of sexual abuse. In order to combat some of these intractable problems, The Banyan began an after school programme co-located with a shelter for homeless men with psychosocial disabilities. Overtime this became a safe space for children, including the girls to congregate. Families were incentivised to keep their children in school and also provided opportunities to participate in sports and other extra-curricular activities.

The pandemic and subsequent lockdown however has put substantial pressure on children and their parents. With the children forced to stay at home, many

families have had to depend on a single income. Lack of privacy in the homes has led to younger children are being exposed at an unnaturally early age to financial constraints, domestic conflicts between parents and are often victims of violence themselves. They are also, in many households, now exposed to their father's alcohol consumption and associated behavioural changes as the lack of routine created by going to school is changing leading them to be awake far longer into the night.

The Thiruporur block in Chengalpet district, Tamil Nadu, is home to many rural communities including tribal populations. Adjacent to forest land as well as the coast, fishing and agriculture were the main occupations until frequent periods of draught forced many of the land owners and labourers to explore alternate sources of income and even migrate to the nearby cities and towns. Many of the children, especially from the Irular tribe, are first generation learners or have parents who have completed only a few years of schooling. The impact of the pandemic has been severe, although the number of cases of Corona have been negligible in the communities surveyed, largely due to the suddenness of the lockdown. Household incomes have dropped to half or nothing in a population that depends largely on daily wages and food was scarce.

With schools being shut down, the older children in many cases have opted to accompany their parents for daily wage labour, both agricultural and housekeeping, rather than remain idle at home. The lack of public transport has proven to be a big burden for these rural communities where children often attend a school that is far from their village. While online options were not available in government schools here, and if they were, few had a smart phone to take advantage of these, they did offer books and even testing for the virus. Few, however, were able to take advantage and pick up study material in the absence of transportation. Thus, even though parents knew that it was wrong and even illegal for their children to be working for wages, they did not stop them as they did not see a conflict with their education

11.1 Survey Results

COVID-19 - Awareness and Knowledge, and prevalence

The Children reported good awareness of COVID-19, at 87.4% and 99%, urban and rural respectively (Table 11.1a). Rural Children appear to have good knowledge of the Symptoms (96.4%), Transmission (71.1%) and prevention (56.9%). Urban children were also aware (75.7%) but less stated specifics about the symptoms transmission and prevention.

		Urban (N=107)		Rural (N=99)	
		N	%	N	%
Do you know about COVID-19?	<i>Yes</i>	90	87.4	96	99
	<i>No</i>	13	12.6	1	1
What do you know about COVID-19?	<i>Symptoms</i>	1	3.6	27	96.4
	<i>Transmission</i>	11	28.9	27	71.1
	<i>Prevention</i>	25	43.1	33	56.9
	<i>Aware but did not state</i>	53	75.7	17	24.3

		Urban (N=107)		Rural (N=99)	
		N	%	N	%
Are you aware of assistance from the government?	<i>Yes</i>	74	69.1	32	32.3
	<i>No</i>	32	29.9	65	65.6
Have you accessed any scheme?	<i>Yes</i>	64	59.8	17	17.1
	<i>No</i>	31	28.9	64	64.6
Government aid accessed	<i>Direct Bank Transfer</i>	62	57.9	17	17.1
	<i>Food Provisions</i>	43	40.1	11	11.1

Impact of COVID on Accessing Resources and Social Entitlements

A greater awareness of government aid (Ration, Disability allowance, Provisions, Cash) were observed amongst the urban population, with two third (69.1%) of the families stating that they were aware of government aid and approximately the same (59.8%) accessing it (Table 11.1b). Despite a third (32.3%) of the population in the rural locations stating awareness of the aid provided by the government, only 17.1% of them were accessing the aid. For the most part the Urban population was accessing the Direct Bank Transfer and Food Provisions at 57.9% and 40.1% respectively.

Schooling and Education

Access to an alternative to in-person classes were measured according to responses given by the children on whether their schools were offering these alternatives. The alternatives included but not

		Urban (N=107)		Rural (N=99)	
		N	%	N	%
School offering alternative to in-person classes	<i>Yes</i>	63	58.9	50	50.5
	<i>No</i>	42	39.3	49	49.5
	<i>Not Known</i>	2	1.9	0	0
Alternatives	<i>Books</i>	1	6.7	14	93.3
	<i>Online Class</i>	52	65.8	27	34.2
	<i>Whatsapp Messages/ Phone/Texts/Videos</i>	8	61.5	5	38.5
Accessing in-person class alternative	<i>Yes</i>	39	36.4	27	27.3
	<i>No</i>	26	24.3	23	23.2
	<i>Not Applicable (school not offering alt classes)</i>	42	39.3	49	49.5
If able to attend class, are you able to adjust to the new mode of teaching?	<i>Yes</i>	31	29	24	24.2
	<i>No</i>	8	7.5	3	3
	<i>Not Applicable (not able to attend class)</i>	68	63.6	72	72.7

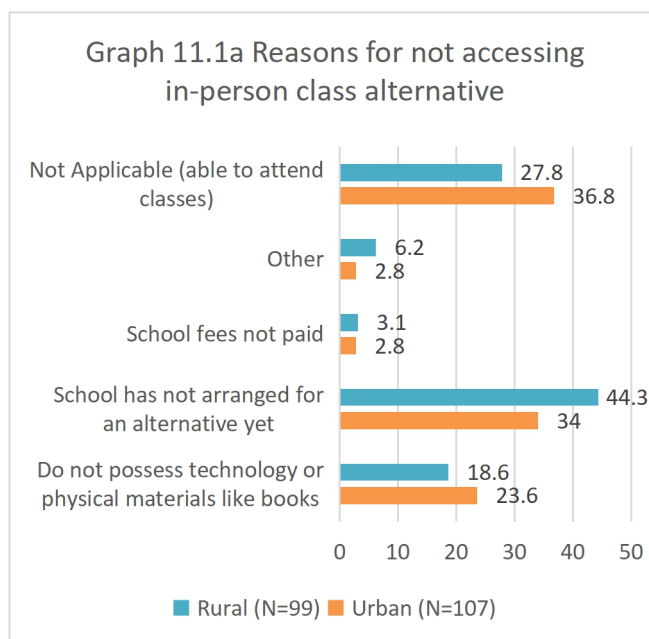
consistently across the board - books, to virtual classes, resources sent over WhatsApp messages, phone texts or videos (Table 11.1c). 58.9% of children in the urban areas responded stating their schools offered alternatives to in-person classes and 50.5% of children in rural areas responded the same. In urban locations, only 65.8% of those with alternatives offered accessed such resources online and in rural locations 34.2% accessed these resources. Adjusting to the new teaching mode as mixed, with many reporting that they were not able to attend the class (63.6 urban, 72.7% rural).

Some of the reasons for not accessing online resources ranged from delayed payment of school fees to lacking the technological or physical material like books required for online learning (Graph 11.1a). 44.3% of the rural children reported that the school had not arranged an alternative yet, whereas 34% urban children reported the same. Technology was also a hindrance, with 18.6% rural children reporting that they did not have technology or access to books for their education, and likewise 23.6% urban children reported the same.

Health and Wellbeing

Parents Mental health

According to the children, only a small majority claim that their parents seem more worried or stressed, i.e., 58.4% of urban children and 58.9% of rural children (Table 11.1d). With this context, 37.4% of urban children reported that one of their parents were clients of The Banyan, and rural children reported 24.2% for the same. Difficulties faced when one of their parents was a client of The Banyan, included access to medication during lockdown and changes in symptoms during the pandemic. Rural children reported 100%



access for medications whereas urban children reported less at 87.5%. Changed in symptoms was reported by 22.5% of the urban children and 4.5% of the rural children.

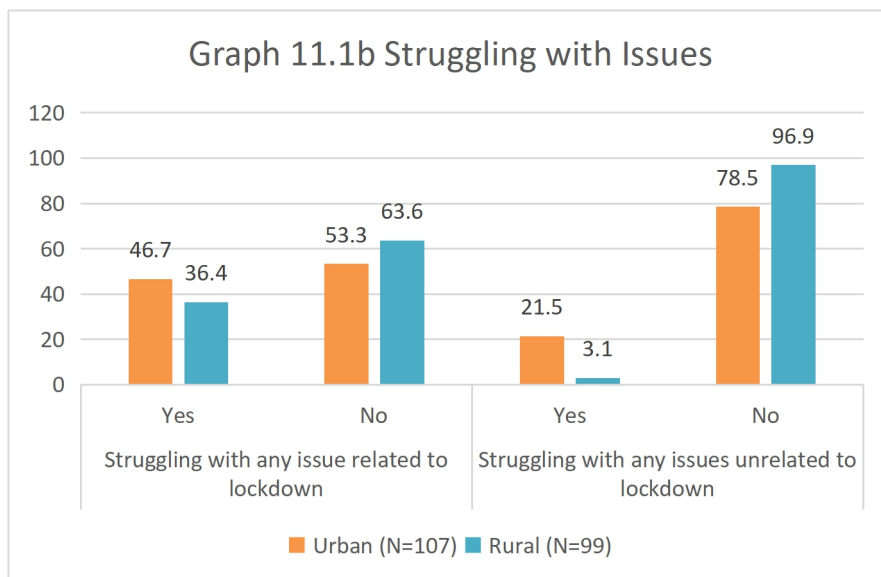
Children wellbeing and coping

The children were asked whether they were struggling with issues related or unrelated to lockdown with responses tending toward 'no'. Amongst the urban population of children interviewed, 53.3% claimed not to be struggling with issues related to lockdown and 78.5% claimed not to be struggling with issues unrelated to lockdown. Similarly, 63.6% of the rural population of children interviewed claimed not to be struggling with issues related to lockdown and 96.9% claimed not to be struggling with issues unrelated to lockdown. Some of the issues related to lockdown were due to inability to go to school and socialise, a few stated financial constraints and stressed parents. A couple of the issues that were unrelated to lockdown

		Urban (N=107)		Rural (N=99)	
		N	%	N	%
Are either parents clients of The Banyan?	Yes	40	37.4	24	24.2
	No	67	62.6	75	75.8
If parent is a client at The Banyan: Have you had access to medication during the lockdown?	Yes	35	87.5	24	100
	No	5	12.5	0	0
If parent is a client at The Banyan: Have you had a return of symptoms or relapse or new symptoms during this period?	Yes	9	22.5	1	4.5
	No	31	77.5	21	95.5
Do your parents seem worried or stressed out more than usual?	Yes	59	58.4	53	58.9
	No	42	41.6	36	40
	I don't know	0	0	1	1.1

were strained familial relationships and work and financial related problems.

The children were asked whether they had counsellor or a confidant to share their problems or seek advice from. Three quarters of the urban (76.7%) and rural (72.2%) population sought out adults in their lives like a parent, extended family member or teacher, while some (Urban – 12.8%, Rural – 16.5%) went to their peers (Table 11.1e). A few (Urban – 5.8%, Rural – 4.1%) felt like they could not speak to anyone. If they did not seek the company of family or friends to make them feel better when upset, they would seek a distraction in watching TV, listening to music, reading books, or playing games. A majority responded not (Urban – 92.5%, Rural – 95.9%) wanting to hurt oneself or wanting to live.



		Urban (N=107)		Rural (N=99)	
		N	%	N	%
Who do you talk to if you have any issues at school or home?	<i>Adult</i>	66	76.7	70	72.2
	<i>Peer</i>	11	12.8	16	16.5
	<i>Adult or Peer</i>	4	4.7	7	7.2
	<i>No One</i>	5	5.8	4	4.1
Are you upset, how do you make yourself feel better	<i>Seeking company of family & friends</i>	21	21.2	16	25.4
	<i>Want to sleep/be alone/quiet</i>	17	17.2	1	1.6
	<i>Cry or feel angry</i>	12	12.1	7	11.1
	<i>Distraction through watching TV, listening to music, reading books, playing</i>	34	34.3	29	46
	<i>Spiritual Help</i>	0	0	4	6.3
	<i>I make myself feel better</i>	14	14.1	3	4.8
	<i>Difficult to make myself feel better</i>	1	1	2	3.2
	<i>I think about committing suicide</i>	0	0	1	1.6
Felt like hurting oneself or felt like not wanting to live anymore?	<i>Yes</i>	8	7.5	4	4.1
	<i>No</i>	99	92.5	94	95.9

11.2 Focus Group Discussions

Fear of the illness

A focus group discussion conducted with grassroots workers and after school coordinators in rural Chengalpet district, revealed much about the mindset of the parents during this period. While Covid-19 brought a lot of fear of death and made them feel vulnerable and unprotected, their concern was largely for the children as they felt they wouldn't be careful enough. They themselves prioritised earning a living and often left the house in search for a source of income as most were daily wage labourers. Some households were not as worried about infection as they felt relatively isolated within their villages and also had great belief in traditional protections and remedies of using turmeric water, cow dung and neem leaves around their houses and on the streets to create barriers to the virus. In spite of the fear, many parents allowed their children to play with others in the village with the trust that none of the adults had strayed far and been contaminated by the virus.

“They felt if they caught Corona they would definitely die. About protection... at that time there were no details about the vaccines. So, there was the thought that they might die.”

“Even if they went out, they entered the house again only after bathing. They didn't want to send their children out but they were ready to go because there was a need for money.”

Parents' Employment

Survey data revealed that compared to the urban context, many more in the rural were able to retain employment. This was because in spite of the pandemic, many opportunities for agricultural labour were still available. When factories and companies closed, men and women turned to the fields and began to work there, often for half pay. If they were earning INR600 a day before, sometimes their income went as low as INR200 a day. Women found it harder to work under these conditions. Families with very young children were forced to depend on a single income as the 'Balwadis' or government run creches were closed. This also meant loss of the mid-day meal that children usually had access to and put further pressure on the family. Many women had housekeeping jobs in nearby towns and villages. The ceasing of public transport

meant that many could not travel to their jobs and others were laid off by families who feared that they would bring home the infection.

“Many families also struggled with not being able to buy the food or stuff that their children liked during this period as they were unable to find work. They had no money to buy the occasional fish or meat. They also struggled to buy sanitary pads for their daughters.”

There were some positive outcomes to parents being unable to go to work, especially in the Irular community.

“Usually, parents would go to work in the morning and come back in the evening, they didn't have much time to share with the children. During this time, because of Covid, we shared a lot with the children.”

Some houses where there was scarcity in food, shared that during this period husbands and wives and siblings all became a lot more understanding of each other and more open to sharing the meagre provisions that they had. Other households got together with their families and planted vegetable gardens and other herbs in the land around their house, hoping to provide enough for their own house and potentially sell to others.

“Many felt their parents' relationship had improved and they were talking to each other well. They were also happy that parents spent so much time with them.”

Children's schooling

Initially when the lockdown was announced, the children were delighted and saw it as a holiday. They were engrossed in playing and hardly picked up a book. This lasted for a while until boredom struck and they began to miss their friends from other villages.

“Because the lockdown was so sudden, many did not even have the numbers of their friends to contact them. For the older children, the loss in friendship really made them upset.”

Parents found the younger children were more worrisome. They seemed to only want to play, with enforcing studies a huge challenge and they also seemed to have forgotten everything they had learnt thus far in school and struggled with basic reading and writing.

While government schools were late in starting online classes, they provided all the material including books, bags and uniforms to the children early on. Many children however were in the cusp of transitioning from primary and secondary school and in the ensuing chaos, failed to secure admission into any school. Private schools did not give books but had online classes. Some of them allowed all the children to attend but some schools insisted that the full fees needed to be paid before the children could attend online classes.

“At that time the government did not make any announcements about school fees, so private schools were able to declare that they would only provide online classes for those who paid the full amount. There were families who saw this as a waste and did not pay the fees and so the children did not attend any classes.”

While Government schools slowly started offering online classes, attendance was poor because many families did not own a smart phone, or the parent took the phone with them to work. There was also a lack of supervision at home and interest on the part of the child.

Food Scarcity

Many schools gave out eggs, rice and provisions. They also collected all the phone numbers of students in government schools saying they would credit a small amount of money. This hasn't materialised but they continued to provide eggs, rice and lentils monthly. A bigger problem for families was getting vegetables. They also struggled with getting the children to eat the rice given by the government ration stores as it was a different quality to what they were used to.

‘Parents had to tell their children, “Your father isn't going to work, and I am not going to work. This is all there is to eat.”

In some families the bulk of the food was given to the children with the adults managing with just old rice and water. It was reported that they reasoned that they were not hungry because of the tension of not having a job or income.

Children Going to Work

Many of the older school and college children went to work in agricultural fields. Children who were only 15 but looked more mature were able to get daily wage jobs and some even went to factories and helped with lifting loads where they got paid around 700INR a week. Other small cosmetic companies hired these children at as low as 200INR a day. Those with their own land put their children to work there rather than hire outside help. Many parents who lost their job opened tiffin shops or sold fish and vegetables, and used their children as help. In some households, older children were not sent to work but rather given the task of completing all housework and looking after the younger siblings so both parents could set out to earn. It was reported across that none of these children were coerced, but rather saw the situation that their family was in and wanted to contribute. With the lifting of the lockdown, all have returned to school and college to complete their studies.

A focus group discussion conducted with grassroots workers and after school coordinators in rural Chengalpet district, revealed much about the mindset of the parents during this period. While Covid-19 brought a lot of fear of death and made them feel vulnerable and unprotected, their concern was largely for the children as they felt they wouldn't be careful enough. They themselves prioritised earning a living and often left the house in search for a source of income as most were daily wage labourers. Those with very young children were forced to depend on a single income as the ‘Balwadis’ or government run creches were closed. This also meant loss of the mid-day meal that children usually had access to and put further pressure on the family. In spite of the fear, many parents allowed their children to play with others in the village with the trust that none of the adults had strayed far and been contaminated by the virus.

The older children in many cases have opted to accompany their parents for daily wage labour, both agricultural and housekeeping, rather than remain idle at home. The lack of public transport has proven to be a big burden for these rural communities where children often attend a school that is far from their village. While online options were not available in government schools here, and if they were, few had a smart phone to take advantage of these, they did offer books and even testing for the virus. Few, however,

were able to take advantage and pick up study material in the absence of transportation. Thus, even though parents knew that it was wrong and even illegal for their children to be working for wages, they did not stop them as they did not see a conflict with their education.

11.3 Case Studies

The case studies featured here look at the impact of the lockdown on two such families belonging to vulnerable communities in Tamil Nadu, India. The trauma from the pandemic on these children, however small or large, is likely to stay with them for an extended period and may express itself in forms that we are yet unable to fully predict. There is, however, considerable evidence of the fact that adverse early childhood experiences leave a lasting impact on the development of the brain. Adult anxiety, depression, disorders of extreme stress and post-traumatic stress disorder may all have roots in the pre-adolescent period, especially when unaddressed immediately (Spinazzola et al, 2005¹⁵⁷).

Jenny

The Dooming Kuppam community in Santhome, Chennai has over a thousand families living in it. Originally a fishing community, it has undergone much change over the years, transitioning from a cluster of roughly made ‘kaccha’ (thatch) houses on the beach to thousands of people being stuffed into the government constructed housing complexes. The families have also strayed from fishing to a number of other urban occupations, such as construction and painting.

The housing board accommodations are 350 sq ft in total area per unit, and consist of a single room, kitchen and bathroom, which has led to offshoots of growing families slowly slipping back into the self-built temporary settlements on the beach. The flats are clustered into blocks of 12 by 16 ft which really begs the question whether social distancing is possible under these circumstances in the midst of the pandemic.

Fear of Covid-19

One of these flats belonged to the family of 10-year old Jenny who lived there with her little brother, parents and grandmother. A shy, soft-spoken girl who loved drawing, she seemed far from the trouble-maker

described by her mother. But Jenny’s family was in a state of crises brought on by the strict lockdowns and threat of the contagious virus. Family relationships had been stretched to the limit during the pandemic.

“It’s not the adults who really suffer during the lockdown, it’s the kids.”

said Jenny’s mother.

“I am afraid to send them out in case they catch the virus from the other children and I am scared to send Jenny out to play because she’s a girl and there are predators. But when they are home all-day, they really get underfoot making it extremely difficult for me to get housework done, go out in search of work or even have any peace of mind to sit and think about how to address our issues. It is impossible to keep children at home and stay. Keeping them in the house all day has made them a source of great stress.”

While Jenny’s mother knew that children needed to play outside for their mental wellbeing, as well as hers, she was wary of the risks that COVID posed, and prioritised safety over mental health temporarily,

“This COVID-19 means you have to protect your children more. It is spreading from children playing. Your hands and feet have to be clean (and) you have to wear a mask. When children go out to play, they will not follow all that—they will not continue it. So, we are keeping the children completely indoors. In a house with two children, one or the other gets really depressed. They are getting beaten a lot, the children. We are finding it very hard because of the kids. Cannot work, cannot concentrate on anything. When there are other tensions, the tension due to the children seems like a lot.”

Loss of routine

The pressures at home, in short, were felt by children and parents alike, each exacerbating the other’s tensions. Moreover, without the routine schedule of work and school, the household rhythms were disturbed. Jenny’s mother pointed out that the children often slept until mid-day, missing breakfast,

“They sleep till 11 am or 1pm. Then by the time they eat it is 2 or 3pm. Dinner is after 10pm...If the children go to school, they can be free. Because there is no school and they are at home, whatever issues there may be for adults, more than that there are problems for the kids. If they went to school they would eat on time, in the morning and the afternoon. They would study (and) sleep correctly. Now none of that is correct. We can only control them to an extent, beyond that we cannot control. Children are getting hit. That is making me really upset.”

Jenny’s mother, in short, knew that the excessive disciplining through corporal punishments was a symptom of household tensions that went beyond her children’s ability to control, given their confinement within a tense atmosphere, exacerbated by conflict between the father and mother, as she later explained.

Before the pandemic started, Jenny’s parents wanted her to go to a good school and with great difficulty, raised 14,000 INR which they paid as fees for a private school. Not only was the school shut during the lockdown, they attempted to teach classes through WhatsApp. Without a smart phone, Jenny was being left behind in lessons. The family could not afford to buy one now. As Jenny’s mother expressed her frustration and concern,

“So, she can’t attend. I do not know how to express this. I have two kids. They (the school) are sending lessons on the cell phone. We do not have a touch phone so they are not able to study properly or follow lessons.”

Domestic conflicts

Jenny’s mother identified the main problem in the household as her husband’s drinking. A painter by profession, Jenny’s father had been unable to find any work during the pandemic while her mother had found only sporadic housekeeping work. While the household struggled on a single income, the father somehow managed to purchase alcohol. Without work, he had engaged in drinking during the day. The mother worried endlessly that the fights they had, and the abusive language he used would have a long-term impact on her children as they were all stuck in the same room where they would witness everything. She especially worried that her son may take after his father in this respect. Jenny’s mother explained the

tension caused by her husband’s excessive drinking while Jenny listened,

“Their father has an alcohol habit. When he gets drunk and comes home and talks...before kids would not be home during the day and they would sleep off at night... Now because they are inside the house all the time, and he does not go for any work, there is no work, he drinks and comes home and talks in front of his children. He fights with me in front of the children. Since we have only one room, they cannot concentrate on studying. Parents also cannot be happy with the children. We cannot share any of (our feelings) in front of the children. They are really struggling—the children.”

After hearing this, Jenny, when asked how she felt about witnessing her parents fight, and how she would respond, said,

“I will not eat. I cry. I get angry.”

Jenny had internalised much the tension within the household, but also blamed her father’s drinking as a source of conflict within the home.

When asked about the sort of problems she faced during the pandemic, Jenny also claimed that her brother irritated her. This was due to their being in close proximity all the time, without other playmates. Her mother added in that the children are being beaten a lot more lately, reiterating what she had said earlier about the increased stress, increased squabbling, and discipline the children received from the parents. She said,

“We can’t help it. In this one room house, stuck together all day, we no longer enjoy the children and they no longer enjoy our love and affection. Everything troubles me, from their lack of routine to their constant squabbling. For them to be happy and free, as children should be, school has to resume.”

But the implication that their jobless father was the source of much violence within the household was also clear,

“his coming home after drinking and fighting with everyone is a huge problem. He speaks words that should never be spoken in front of a

child. That makes me feel really bad for them. That too we have a son. I cannot explain anything to him now. He is still unclear what is right and what is wrong.”

The implications of this case suggest lasting psychosocial consequences from the pandemic, and the tensions caused by unemployment and school shutdowns could extend beyond the critical lost time for education in children’s lives. Additionally, they might also be traumatised by the violence they witnessed or discipline they received within the household, which, in turn, might be internalised in different ways. Jenny’s response to violence might be, as suggested here, inward directed, whereas Jenny’s mother seemed to worry that her son might externalise this violence later in life. In either respect, the psychological consequences of the pandemic were worrisome to Jenny’s mother.

Prema

Prema* came from a large family belonging to the Irular community (discussed earlier) and lived with her parents and siblings in a small mud house with a thatched palm leaf roof. Eighth out of thirteen children, five of Prema’s older brothers and sisters were married. Four, including her, were in school and four were too young for school. Prema and her three brothers studied an hour away in the government school in Mambakkam.

Prema’s family was severely impoverished. Her mother depended on the 100 days of work scheme offered by the government (MGNREGA) and the odd opportunities of agricultural daily wage labour, while her father worked wherever possible in mills, fields, forests, etc, performing odd jobs. Given their economic precarity, the pandemic had affected their family drastically. With fear of the disease removing any possibility of daily wage labour, both parents became unemployed; and without the income, their finances dried up very quickly. With a family this large to feed, meals began to dwindle down from three to two, and eventually, to a single meal a day consisting of just rice obtained from the ration store and water. Prema’s mother despaired that the rice they obtained for free did not suit the younger children, nor provided the sufficient nutrients, but they had no other options, as this was their only means of sustenance. Eventually different organisations pitched in to help with dry

rations, and unconditional cash transfers, but this relief came late, after three agonising months.

Prema’s mother (Jaya, discussed earlier) had faced much distress in her life. Her first husband died of a snake bite, after which she was left to fend for herself and her four children. She moved from her home town of Kanchipuram to the small village of Panagattupakkam where she met her current husband and had another nine children. Following an ancient Irular practice of burying the umbilical cord with due ceremony to stop the birth of anymore children, she left it in the hands of God and ended up with too many mouths to feed. Her husband, a diabetic, was often incapacitated by fatigue and unable to go in search of work. The pandemic has brought the family to a new low.

“Some stranger has brought this disease, Corona, randomly into the country but we are somehow the ones suffering the most,”

she says.

“We’ve always struggled to exist but now it has become much worse,” she said.

By all accounts, Prema was a good student. Her parents had high hopes for her and wanted her to become someone important and make a lot of money. The pandemic, moreover, had placed a huge weight upon her shoulders. With the family in dire straits, Prema was compelled to work with her mother in the fields. Able to keep up well with the adults, she earned 120 INR for a day’s work. She tried to put away what she could for her studies but often ended up pitching in for the family’s basic needs. Some of her friends around her age were also involved in housekeeping and agricultural labour, as the pandemic had left them with nothing to do and nowhere to go with the schools being shut. Far away from school and without public transport, they had no news as to whether online or television classes were being offered or not. They had also not been able to collect books for the new school year, and had no materials to study from. In this situation, the parents were unable to dissuade them from joining the workforce.

“Even we know it’s wrong,”

said one of the mothers.

“We know that thirteen year-old children are not supposed to work, that it is wrong by law. But they have nothing else to keep them occupied and they are able to work fast and cleanly without the body pains that affect us.”

While Prema missed her school, teachers and lessons, and worried about not being able to catch up when it reopens, she was also happy about this time she had to spend with her siblings. While there have been occasional familial fights and shortages of food, they had managed it together. Prema was also part of an afterschool tuition programme that was paused during this period and she wished, at least, that this would run. When her school and tuition centre reopen, Prema was confident that she would return to her studies. She felt she was made for “big things” and would not miss the temporary occasional work or the small change that it brought to the family. As another Irular child and friend of Prema had also indicated, “When school opens, we will not come to work, anymore, Amma (mother). But its shut, and we have no means to study now.”

Given the familial commitment to education in Prema’s case, there was little doubt she would return to study. Nevertheless, there was great concern about the interruption the pandemic had caused in education. As Geetha (discussed earlier) had, about this fear, expressed,

“One main problem is children no longer remember everything they have studied. We do not have the means to help keep all this in their mind. None of us have studied, how can we teach them. They (the children) do not remember, they have forgotten.”

Prema’s mother, too, expressed this concern,

“Children are unable to continue to study, they are not sure of what is happening and they forget studies itself.”

While the commitment to education within the family was strong, there was great uncertainty about the impact of the pandemic on education, how long it would last, and whether the disruption to studies would be detrimental. As Prema’s mother expressed,

“So far the children went to school regularly, without taking a day of leave. But now the

children’s studies are effected. Worried how it will affect their education. I do not know what to do about it. Not sure when this Corona time would end and when children will resume their education. I do not know what to do.”

Geetha echoed these same concerns,

“Children’s studies have been spoilt, is the worry that we have. These are the only worries.”

Given the extreme poverty and precarity faced by the Irular community, as discussed earlier, the role of education in community and familial advancement is critical. Indeed, as was discussed, one of the motivating factors in seeking community certification as a Schedule Tribe was for the educational opportunities this might afford. Prema’s case epitomises this commitment coupled with this concern. While Prema in her youth remained optimistic about her future, and aspired towards “big things” through education, her mother and others within the community were distressed about the impact the pandemic might have, in the long run. This, in turn, suggests that economic support for this community would be required if children were to have the opportunity to resume their educations, and, hopefully, break the cycle of poverty and marginalisation experienced by the Irular and other Adivasi communities.

12. Discussions

12.1 Overview

The results of this report, provide evidence of the hardships ultra vulnerable groups have faced since COVID-19 and even before, with questions regarding the need for affirmative action that would right the wrongs around inequity and injustice at the core of differential access to a good quality of life and health based on diversities in class, caste, ethnicity and gender. Structural barrier, weak health systems, perpetuation of distress as a result of inaction and apathy, and. Most of the data is drawn in the context of The Banyan, a non- governmental organisation located primarily in Tamil Nadu and Kerala.

The term “Ultra-Vulnerable” has been utilised in this report to cover all vulnerable groups, who face inequalities that manifest themselves as poverty, hunger and unstable housing; low levels of employment and education, poor health and mental health, limited or no access to healthcare. As the UN has stated recently:

“These are places where people who have been forced to flee their homes because of bombs, violence or floods are living under plastic sheets in fields or crammed into refugee camps or informal settlements. They do not have homes in which to socially distance or self-isolate. They lack clean water and soap with which to do that most basic act of self-protection against the virus — washing their hands. And should they become critically ill, they have no way of accessing a health care system that can provide a hospital bed and a ventilator.”

UN Secretary-General António Guterres (UN 2021¹⁵⁸)

The discussions below will triangulate the different sources of data this report has gathered , combining survey results with qualitative interviews and focus group discussions with the aim to highlight the impact of the Pandemic and the Pandemic- Lockdown on Ultra-Vulnerable groups

12.2 Discussions by Group

Socially Disadvantaged Living with Psychosocial Distress

Describing the socially disadvantaged in India in the broadest sense, will encompass many theories and classifications of disadvantage and inequalities, however persons with common or severe mental illness, or with learning disabilities are distinct in that they live with conditions that others do not. This distinctness is highlighted by the relationship between mental illness or disability and measures of quality of life, socioeconomic status, education and environment and other social determinants of health and mental health - where prevalence of mental illness is higher among those disadvantaged.

COVID-19 and awareness

Almost all of the participants were aware of the Pandemic from its very onset, as also the basic precautions that they would have to take and therefore the adherence to protocols that this would require, except the homeless who were taken by surprise and took a while, as a result of information asymmetry associated with disadvantage. With regards to the socially disadvantaged group, one could relate the Banyan’s information dissemination system, outreach and continued engagement as well as familial support (which seemed to be prevalent even within nuclear families) to their sense of awareness and preparedness. Support structures around persons living with mental illness are strengthened by collaborative care models, and integration of the family and other support networks into individual care planning processes as demonstrated in the case studies and in The Banyan’s approaches in Tamil Nadu (Narasimhan et al, 2019).

The impact of disadvantage in terms of resources and material wealth was likely the main reason that the use of safety protocols was not possible for a few. The opportunity to physically distance was particularly difficult for them within their own homes, especially when an average of 5 to 8 persons (in some cases) lived in housing that was unstable, sometimes unsafe (thatched huts) and between 300 to 800 sq foot in size. The use of soap (if water was available) and masks however was generally adhered to, ensuring that there the opportunity to keep oneself safe within the household was indeed practised. In the absence of

basic amenities and an optimal quality of life, to reinforce the need to physically distance, stay at home and use sanitary products seems unrealistic and farcical. What was worse and even cruel and discriminatory was the inability for the privileged groups and the State/Country to recognise the intractable nature of problems that impeded adherence of protocols ranging from a standard and way of living that many for poorer socioeconomic groups are habituated to. Therefore a dichotomous situation emerged, which will continue unless firm action is taken to build social capital amongst poorer sections of society.

Employment and Income

The lockdown and subsequent closure of businesses had a severe effect on employment rates that rose from 8.4% before March 2020 to 27.1% in 2021 (Kumar & Sharma 2021¹⁵⁹). With majority of India's working force being in informal labour, the Pandemic-Lockdown would have had an immediate effect on this group, owing to limited job security (Shekar & Mansoor 2020). The socially disadvantaged group reported 50% unemployment at the time of the survey, and nearly 20% reported that they had lost work or income. Estimates in India indicate that nearly 400,000,000 informal workers could be affected by the pandemic (Shekar & Mansoor 2020). In addition among family units, the respondents were not alone in losing employment, with 12.4% reporting that their partners had lost work as well, and another 12.4% reporting parents losing employment. The strain that this would have on a family's income, particularly if they experienced a health shock resulting in out-of-pocket expenditure could have easily spiralled some of them below the poverty line if they weren't already living in difficult circumstances (Keane & Thakur 2018).

To cope with the shortfall in means, almost half of those surveyed took loans or pawned jewellery to manage during this period, which may have long term impact on their measurable level of wealth (Gour & Rao 2020; Berkhout et al 2021). As Aseria et al (2019) have highlighted, socioeconomic inequalities are correlated with lower life expectancy, and poorer health and mental health outcomes (Lund et al. 2018; Reddy 2019). Therefore decreased access to nutrition, health and social networks may have influenced a corresponding reduction in the sense of hope and social capital amongst a few. Equally, in the case of

families with children, education continuation could have presented an issue. Elders who lost jobs could have turned dependants and experienced not just lower self esteem and lesser participation in socio-cultural life, but also suffered feelings of insecurity. Poverty is multi-dimensional for legitimate reasons, loss of income affects diverse domains, not just the ability to access material goods. Hope studies indicate that hope deconstructed indicates the ability for individuals to plan a future, set goals and find the ability or pathways to pursue them resulting in a sense of agency, control and vitality (Luhmann & Marrow 2016). The reverse would be true in the case of states of hopelessness. The social therefore always affects the psychological and vice-versa.

Health and Wellbeing

Impact of COVID on Health

The survey data does not indicate significant loss of access to food; however many people were mostly reliant on dry food rations such as rice and dal and both case studies and focus group discussions identify people having and eating less day to day with limited options to access vegetables. The number of meals also decreased, with women often forgoing their share for others in the family. Women's health seems to be in danger of being compromised, yet again.

India fares poorly on both the hunger and gender inequity index determined by access to health and nutrition, reproductive rights, education and work force participation amongst other factors (Global Hunger Index 2020¹⁶⁰; Conceição 2020¹⁶¹). Lack of access to nutrition can impact each of these areas significantly. Further, Poor nutrition is attributed to stunting in India, which is an ongoing issue children from disadvantaged backgrounds (NFHS 2016) face. Children's lives may have been affected in irreversible ways, as a result. Further vaccination programmes came to a standstill during this period as a result of most health units being closed during the initial phase of the lockdown impacting the mobility of the village health nurse as well. This may have long term impact on many children.

Progress made on the Tuberculosis front in India; a condition that kills nearly 436,000 persons annually may have been affected as well (Jain et al 2020¹⁶²; TB Statistics India 2019¹⁶³). Since investments in health

are sub-par in the Indian Context, health systems and structures were naturally overburdened; the lack of a strong public health system, especially primary care was quite evident.

Post Covid health issues also seemed to affect many, particularly those with severe symptoms. Continued issues around respiratory distress and fatigue in particular seem to be issues that persist impeding reentry into the work force.

With estimates for the poor in the world to recover economically being as high as 15 years, employment and income losses could have far reaching effects on health and mental health (Berkhout et al. 2021); the correlation between the two have been discussed earlier.

Stigma

Testing positive often induced fear, not just because of health risks but as a result of severe stigma and discrimination, particularly in the initial states of the Pandemic. (Gowda et al 2020, Thresia et al 2020). What was further alarming was the way in which front-line workers were discriminated against for being in close contact with the those unwell, while trying to save people's lives (Singh & Subedi 2020¹⁶⁴). This is in addition to the pre-existing stigma that people living with psychosocial distress face on a daily basis made it particularly difficult for some families (Shidhaye & Kermodé 2013)¹⁶⁵.

Abuse and gender

There was a marked increase in domestic violence and substance misuse reported by the socially disadvantaged group. Patel and Kleinman (2003) highlight the burden women carry with inequalities in employment, marriage arrangements, among others, and with loss of employment families and The Pandemic lockdown families were forced to live together at home for longer periods of time, potentially in a single room and small house. The loss of access to alcohol and other substances during this period could have further frayed tempers and impacted social dynamics within the family. Results in this context are not surprising in a social and cultural context where gender-based violence can be seen as justifiable by many (Nigam, 2020¹⁶⁶) and normalised for the most part. It is already known that in India, as per the statistics released by the National Commission for Women (NCW) India, in early April 2020 that there

was a 100 % increase in complaints related to violence against women after the nationwide lockdown was imposed in March 2020. The increase in substance misuse is a problem in it's own right, however is also closely associated with domestic violence (Vora et al 2020¹⁶⁷). Being conditioned to unequal resources and rights is at the core of the social roles women adopt. A reversal in this regard requires a combination of structural, mindset, policy and societal level changes and effort towards breaking the stereotype.

Social support and mental health

In addition to increase in substance misuse, people stated feelings of loneliness, uncertainty about the future and experienced grief or sadness as a consequence. Authors highlighted early in the course of lockdown the psychosocial impact that can lead to stress, anxiety, frustration, boredom and depression and even suicidal ideation and attempts to die by suicide, which were considered to be more likely among vulnerable groups (Shoib et al 2020; Sood 2020¹⁶⁸) as a result of poor social health and socioeconomic distress. The case studies in particular substantiate this, with in depth explanations on how COVID-19 has resulted in multifactorial losses ranging from the loss of employment to a decline in familial relationship patterns; and specifically for the SD group, an increase in caregiving responsibilities, particularly amongst women folk.

What is readily apparent from the report however is that a sense of community, friends and family were important for coping with the lockdown and the pandemic for the most part, despite distress that one may have had to cope with as a result of interpersonal conflicts and violence. Faith and spirituality also provided people with coping mechanisms indicating the importance of hope inspiring social constructs, approaches and pivots in coping with distress. For people living with psychosocial distress the loss of these networks could have led to devastating effects since faith, connection and social bonds while helpful to all (social capital), are more significant in the case of those with a mental illness and are known to have therapeutic value resulting in the cultivation of constructive emotions (Stein, Aguirre & Hunt 2013¹⁶⁹; Cattell 2001¹⁷⁰; Narasimhan et al. 2019).

Homeless and Homeless Persons living with Mental Illness

Homeless and homeless persons living with mental illness (HHPLMI), face the predicament of severe disadvantages and inequalities, while having limited support options. 1.8 million persons are homeless, and 73 million families lack adequate housing and safety (Census, 2011; Habitat, 2019¹⁷¹). As demonstrated by previous research they are often at the mercy of stigma, charity and pity; and at other times are isolated and unseen (Mander 2009; Prasad 2012). In the hierarchy of disadvantage, homeless persons with mental illness were perhaps at the bottom of the pyramid, disconnected from both information and support and as a consequence, not just lacked the ability to follow protocols but even keeping themselves nourished, away from abuse and alive posed quite a challenge.

COVID-19 Awareness and implications

Less than 50% of the homeless were aware of the pandemic, and even less of health protocols or preventative measures. Deprived of most rights and dignity, this group largely lives on the fringes of society invisible, prone to worst forms of human rights violations including neglect, abuse, limited or no access to health services and houseless. The fact that the lockdown changed daily living so abruptly must have affected their lives in ways that we will never know or fully understand. From crowded streets and religious establishments where they met familiar people and found access to basic amenities that kept them alive- to all sources of support including access to even a cup of tea lost- almost overnight, they were placed in states of peril, having to struggle to survive, often alienated. Language barriers may have further worsened the ability to process information around the Pandemic. Homeless persons with mental illness were perhaps the most affected, lost and alone, and removed from all systems and structures that could offer support, especially in the initial stages of the Pandemic. Many therefore didn't access masks or other safety articles. Public toilets were out of bounds for the homeless mentally ill often. It is likely that their state of isolation and peripheral status or disconnectedness from the rest of mankind/society resulted in lower rates of infection (Gowda et al. 2020a); more so, in the case of homeless persons with mental illness whose social networks barely exist.

There is a sense that the Corporation of Chennai and the Health Departments were seen to be getting prepared with what seemed most important – testing, treating and contact tracing to prevent spread. The homeless though far removed from the impact of COVID-19 in the initial phase, faced a double burden of stigma and isolation, considered as prospective spreaders of disease which was highlighted in reports from the focus group discussions, about people becoming homeless as a result of testing positive for COVID-19 (Kar et al. 2020; Kesar 2020).

Access to shelter and basic amenities

Access to basic sanitation and amenities is limited for the homeless, and this was reflected further in the survey (Sarkar 2019). Many homeless found basic amenities including food, water, shelter, sanitary items (for women during menstruation) inaccessible, especially during the first phase when the primary concern of the State was management of the Pandemic. In addition, all usual access points such as small tea shops and religious institutions that offered safety and shelter were now closed. Public toilets however were accessible especially in the initial stages of the Pandemic, though they remained mostly poorly maintained and overused, especially by menfolk. Women often felt unsafe and chose timings at the crack of dawn or earlier and post midnight to relieve themselves. For a long while, those rendered homeless as a result of the Pandemic especially out of state workers and those who accessed the city for better health options reported staying outside hospitals on the sidewalks, under underpasses and in bus- shelters or train stations. However after the initial phase of stabilising and gaining control over the testing and contact tracing process, The Greater Chennai Corporation stepped in as soon as was possible to enable appropriate care pathways through their outreach that served food and water and welcomed persons into their NULM shelters, run in coordination with local NGOs.

The GCC have 53 shelters, more than most states; however large numbers of out of state workers and other homeless persons filled up spaces immediately leading to overcrowding in shelters that were also poorly staffed. More shelters had to be opened in due course to respond to the growing demand. The state and country was not prepared for the large number of out of state workers who had nowhere else to turn to (World Bank 2020). Stranded out of state workers

inflated the numbers of homeless in Chennai; therefore more men were found within the City of Chennai, having travelled for jobs or to access health care and in the absence of transport were unable to return home. This is also an indication of inadequate work conditions for a large number of persons in the unorganised sector. Income insecurity and unstable housing (for those from other states) are larger issues that came to light during the Pandemic.

Those NULM shelters and NGOs that managed to access identity cards for these persons could enable access of social entitlements including cash transfers and other relief measures offered by the Government for some of the homeless, but for those who opted to stay on the streets, or didn't find place in these shelters for one or the other reason, access to relief measures other than the basics of food and water was unavailable. They were also excluded from the DBT process as a consequence.

In addition, Shelters often come with their own concerns around inadequate staff client ratios, poor infrastructure and delayed funding for ongoing activities. These gaps were somewhat more apparent during this period.

Employment and income

Loss of employment, poor working conditions in their home states, inadequate means to survive, were significant factors influencing a descent into a state of homelessness. Many participants had been so emotionally scarred as a result of the experience of scarcity and inability to find even basic needs met that the only way to cope seemed to be to resign oneself to a compromised quality of life and subpar living conditions. Uncertainty and loss of control were evident as was the experience of social defeat, which only reflects how inequitable societies can be and how dehumanising and discriminatory inequalities are (Lurhmann & Marrow 2016). These again show their worst sides in crises such as this; but remain silent perpetuating factors that influence social hierarchies, formation of dominant groups and views and the marginalised, distinct social roles and intergenerational distress

Health and Wellbeing

Most homeless found health access unavailable during the early days of the pandemic as predicted by Gowda

et al (2020) and other experts. The Health department began offering testing and treatment services to homeless persons in collaboration with the NULM shelters and organisations such as The Banyan. The Public health system responded very effectively to other co-morbidities that homeless persons with mental health issues experienced despite the large health crisis and beds filling up in almost all hospitals. No care was forthcoming from private hospitals even in situations of crisis for this group despite ability to pay indicating the extent of discrimination and marginalisation these vulnerable individuals experience.

Homeless persons with mental illness within institutions found it difficult to remain cooped up indoors over extended periods of time and following protocols in many psychiatric nursing homes including The Banyan was a challenge. Challenges within nursing homes is not unprecedented, particularly mental health residences, where there are a great many more people within one building, and personalised care and promoted independence can be greatly restricted due to these protocols (Kavoor 2020). Those homeless persons with mental health issues who continued to sleep rough suffered most, unable to fend for themselves more often than not. In the case of a few who were cognizant of their choice of a path of withdrawal from society, perhaps as a reflection of the poor lives that they suffered plagued by othering and discrimination that highlighted differences in a neurotypical world and segregated on the basis of that; or as a consequence of questioning life and its many ways, living conditions and frameworks within which people existed and related existential issues, mental illness didn't always come in the way as their quality of life on the streets was unaffected (Corin & Lauzon 1992¹⁷²).

Social support and mental health

With regards to their mental health, a third felt an exacerbation of symptoms while a fifth felt distressed by the current situation. While many people stated uncertainty about their future, hopelessness, loneliness, fear and anxiety, others mentioned that this was their lot even in non-pandemic times and that feelings of being alienated wasn't really new. They found faith and spirituality helpful, and speaking with family and friends where available was their favoured way of coping. A solidarity group was also formed between homeless persons who supported each other, indicative of their affinity groups formed on the foundation of

distress and social suffering. Resilience was apparent, in the face of trauma and multi-dimensional losses, as Dr. Rachel Yehuda describes in Southwick et al's (2014¹⁷³) paper, some displayed the "quality of never breaking despite exposure, but for many, resilience was conceptualised as a process of moving forward and not returning back".

Those who were known were perhaps in the minority, but they received support from their neighbours, and were part of the local community. Unknown homeless persons who entered a new community during this period were kept at arm's length, a reflection of not just the state's absolving itself of its responsibility, but of societal attitudes that operate based on preconditioned values, norms and social mores. The homeless outsider was seen as a threat to their health and well-being.

Irular Tribe

Awareness

Compared to other socially disadvantaged groups, the Irular had even less knowledge about the pandemic, its protocols and the reasons for the subsequent lockdown. While they attempted to purchase masks and soaps for their protection, more than half could not afford them, resulting in adoption of traditional methods of cleansing using turmeric and cow dung. The reach of knowledge, education and services in rural areas has been heavily researched in the past, particularly in regard to health coverage, and associated health outcomes (Mahindra & Thresia 2016; Subramanian et al. 2005). The onset of COVID-19 presented an unprecedented challenge in spreading awareness, and from the results of this study the distribution of knowledge appears to have failed, both in terms of reach and timescale. It was well after lockdown that the survey and interviews took place, and yet majority of the Irular Tribe participants were still not informed adequately regarding COVID-19.

Employment and income and access to amenities

Over two thirds of the participants lost their jobs lost their jobs owing to the Lockdown and struggled to find another during the pandemic. Most opted for agricultural labour and in many cases took a pay cut of more than half. As found through history and even in

more recent literature, the Scheduled Tribes in India are among the most disadvantaged and poorest populations (Donegan 2018; Meena & Singh Meena, 2014; Shah & Lerche 2018). As a result many had to seek part time work, take out loans and pawned jewellery in order to survive this period.

Their geographical isolation is limiting in contexts of education, health access and much more. Living in remote areas they were cut away from food supplies particularly vegetables and health services, in the absence of transport. Local markets were closed, and they were reliant on basic dry rations. Many reported reducing their daily meals from 3 to 2, and with children being at home, the midday meal scheme was ineffective, exposing them to further distress and (Panneerselvam, Perumal & K. P. 2020). Meals were described as often being plain rice and water and maybe accompanied by an onion or chillies.

With children being at home, and work to be done, those children 13 years and above, often accessed work in agricultural fields, companies and as domestic help. This was not often reported by participants, however it was observed by the data collectors, and is known to be a relatively common practice (Alvi & Gupta 2020; Ravichandran 2020)

Lack of identity cards delayed relief to members of this group, and therefore their struggle was longer.

The short term impacts around employment, resources and poverty were quickly identified at the beginning of the pandemic (Tripathy 2020; Kesar et al 2020), however estimating the future impact of COVID-19, on their, employment, income, and future resources, was not. The loss of livelihoods is substantial, and the long term effects on other aspects of their lives, will not be calculable for some time.

Health and Wellbeing

Access to transport delayed or removed their access to formal health care, as walking to the health centre would not be practical for them unless they felt they had no other choice. It is a testament to the rural healthcare systems that there is something relatively close by, however it is relative and there other barriers to accessing conventional medicine, and they may prefer to rely on their local goddess, 'Kanniamma' who would heal them when unwell. It is demonstrative that during such a crisis there are really

limited resources for these remote populations, and that there is still a long way to go to reconcile cultural and religious practices with conventional medicine and methodologies (Lurhmann & Marrow 2016; Saheb 2006).

This population found anxiety, sadness and anger the primary emotions caused by the current situation with more than half felt a sense of hopelessness with the closing down of religious establishments. Over half of them identified faith and spirituality as their main source of support. Although there may not be many reports of changes in their mental health, the long term impacts of their hardships, may have lasting effects on their state of mind.

Children

Awareness and restrictions and access

Most children spoken to were aware of Covid-19 pandemic, however children from rural areas had more knowledge on the symptoms, transmission and prevention. Conversely the urban children had a greater awareness of government aid, and as such they were aware of their families use of this more than the rural children. The most common reported government aid was the direct benefit transfer and food provisions, however reports from the qualitative data, and adults is that times were difficult in terms of resources and access to help. The reduced access as rural children and their families have reported, reflects their long term deprivation and separation from infrastructure, including social and structural barriers (Shah et al 2018; Selvarajan 2012). As mentioned previously poor nutrition is of particular concern when it comes to a child's health as it relates to stunting and long term health conditions, but also correlates with other inequalities such as poverty and education (NFHS 2016).

Schooling and education and being at home

Unfortunately, the closure of schools had many repercussions on children, especially those from disadvantaged backgrounds. Being at home made the financial situation of their family far more evident to them. They perceived the stress their parents were under more acutely and were able to relate it to them being at home without employment or income. They

realised they were getting less food than usual and lesser of their needs were met. In many cases their parents' frustration was taken out on them in the form of corporeal punishment or other forms of physical and emotional abuse that could leave long term effects. There was also an increase in exposure to alcohol abuse within the family as identified by the results from the adult participants and described in the case studies.

In terms of their education itself, between 50-60% had the option of alternative schooling of which only about half were able to take advantage as the rest did not have a smart phone or a television. In some private schools, online classes were offered only to those who paid the fees. Government schools offered books but many parents did not have adequate education to teach them at home.

As stated earlier, 80 per cent of working children are living in India's villages, where most of them work in agriculture (Cry.org 2021; Ganguly (ed). 2019). There were few reports from the adult groups that children were working, however from the qualitative sources, it was apparent that many children above the age of 12, rather than staying at home and not attending school, went to work as child labour in the local farms, to help support their families during a time of reduced income. Some children also used this opportunity to put aside money for their further education. Although parents were aware that their children coming to work at a young age was wrong, they did not stop them because of the urgent need at home as well as because they did not see it as disrupting their education.

Health and Wellbeing

About half the children interviewed in Chennai city perceived that they were facing problems due to the lockdown including not being able to meet friends, not having school, boredom, and to a smaller degree father's substance use, while only a third of the children felt this way in rural Chengalpattur district. Children reported that they were struggling with issues related to the lockdown and this was highlighted in their reports of boredom. They most commonly coped by distracting themselves (TV, Playing, Books etc.) or seeking out a family member or friend. There were no reports of health issues among the children, the short and long term effects of the pandemic are as yet unknown.

Children from disadvantaged backgrounds already face adversity, through poverty, education, employment and discrimination (Cry.org 2021). The economic burden of the pandemic had an instant effect of people from disadvantaged backgrounds, reducing income, increasing unemployment, and forcing a need to take loans or pawn personal items of value for short financial needs. With the economic burden effecting the poor more than anyone else, the generational effects could be staggering for their children, especially considering that disadvantages across wealth, education, employment and nutrition, can have a negative impact on health and mental health outcomes as explained by the social determinants of health (Berkhout et al 2021; NFHS 2016; Sarkar 2016).

Would the children be beholden to loans of their parents? Would children lose out on their education, subsequently diminishing their future employment options? Would family poverty, as affected by COVID-19 affect not only their parents but their own earning potential?

12.3 Discussions - Poverty, Health and Wellbeing

In India, as a low-middle income country, the situation may not be as severe as some other countries, however India ranks as one of the lowest in spending on health and mental health care, and the pandemic will only have exacerbated the difficulties for the Ultra-Vulnerable (Keane & Thakur 2018). India is home to 1.3 billion persons with approximately, 22% of the population living below the poverty line (Satapathy & Jaiswal, 2018¹⁷⁴). More specifically, 25.7% live below the poverty line in rural areas, whereas in the urban areas, 13.7% of the population lives below the poverty line (Thorat et al., 2017¹⁷⁵). Research on the social determinants of health has validated the WHO's commission 's linking social gradients and distribution of power, wealth, goods, environment, access to health care and education with inequalities in Health. The Sustainable Development Goals, taking cognisance of these inequities and their impact on health and well-being for all, reinvigorated focus on reduction of poverty , gender equity, education, housing and sanitation, universal health coverage, and mental health care (UN General Assembly, 2015). Along these lines, these intersectional ties were evident in the responses elicited from the participants who when

approached for the survey showed multidimensional disadvantages, especially in the context of those living with or caring for a person with mental ill health (SD Group); most from this group were unemployed or engaged in informal labour. The case studies in particular draw upon participants' unequal burden of pre-existing inequalities and structural barriers and their impact since COVID-19. As a consequence of living with a mental illness and related psychosocial disability, variegated challenges in everyday living, including environmental and social barriers and prejudice, further amplify their distress that is compounded by their socio economic challenges. Adverse life events and loss of support networks often are evidenced by the Homeless as reasons for their downward slide. The Irular cases present historical social barriers to their rights to land ownership, and the ongoing barriers of caste and class. Children are both directly and indirectly affected by their parents' socio-economic status, education, caste and class, impacting their outcomes for health and mental health (NFHS 2016) making this a classic example that perpetuates intergenerational distress.

Poverty as Key Indicator of Structural Violence and Social Defeat

Economic precarity emerges in the case studies and the rest of the data as a particularly critical determinant of wellbeing and mental illness. The stress caused by unemployment and under-employment has, arguably, as much impact on mental health as any underlying organic factors (Patel and Kleinman 2003; Lurhmann and Marrow 2016). As comorbidities are also related to social inequalities and even structural violence—such as in the case of land dispossession, the struggles for community certification, and the sense of loss associated with cultural attenuation in communities such as among the Irular, or surrounding the sense of precarity faced by the homeless—nutritional deficiencies associated with poverty, and an anomie associated with social defeat, community schisms, and a breakdown of traditional forces of integration are key variables requiring further research. It is a certainty, however, that these factors will impact upon mental health as witnessed even within these case studies, as stress and anxiety about an uncertain future were demonstrably present in the midst of the social difficulties faced by vulnerable individuals and the communities they reside in.

Though our study did not address this issue, a common symptom of this stress upon community wellbeing is othering, paranoia and fear. This can drive communities and families further apart. The demands of corporate identification through employment, certification, and belonging to socially constructed ethnic and religious categories and divides can also have harmful effects on self-identity and self-worth, exacerbating underlying vulnerabilities, and leading to paranoid displacements and social disintegration. This tendency to scapegoat, in particular, disenfranchised minorities, will be potentially worsened by the pandemic by providing convenient targets of blame, which fall disproportionately upon the poor, homeless, and minority populations. The etiology and consequence of social violence through othering needs to be understood better, rather than pathologising the victims of this violence as more “prone” to suicide and mental illness as some sort of cultural or social defect. Indigenous peoples, the homeless, the poor, and women tend to bear the brunt of social violence and social stigma, hastening diagnostic bias among clinicians (Lurhmann 2016; Reyes-Foster 2019¹⁷⁶), as well as worsening social gradients that might contribute to higher rates of psycho-social stress and illness that are comorbid with poor mental health outcomes. On the other hand, the present data suggests a strong correlation between the ability to work and a sense of wellbeing.

Whether anxieties over economic inequality and precarity worsen into paranoid suspicions in the era of COVID-19 is worth added vigilance, reflection and further research. As these trends were already seen in India with widening socioeconomic gaps, it stands to reason that the extreme economic hardships experienced by ultra-vulnerable communities might, too, exacerbate existential and metaphysical insecurities associated with malevolence. In other words, the already witnessed malevolence associated with the forces of modernity, or an increased but generalised othering across social categories, might be exacerbated by the uncertainties associated with the COVID contagion. The potential slippage of pandemic anxieties into demonologies that attempt to figure anxiety through the image of the Other would, obviously, not only hasten more social distrust and anxiety, worsening an already serious mental health situation due to precarity, it would also be counter-productive as it dissolves scientific expertise into a

potentially lethal populist cauldron of accusation and counter-accusation.

Mental health

India, even before the pandemic hit, faced great challenges in meeting its mental health needs. The country has one of the highest suicide rates and many of its communities face various structural conditions of precarity, poverty, under-employment, and discrimination, as documented in this study (Mitra 2020¹⁷⁷). The crisis has undoubtedly exacerbated these problems. In an ideal scenario primary health care would integrate mental health care within its ambit, and provide distinct care and referral pathways based on expressed needs. The District Mental Health programme (DMHP) was born as a result of this ideology, with its goals embedded within a framework that promoted affordable, appropriate and accessible care. It also recommended convergence between health and social sectors and involvement of local communities such that social determinants of mental ill-health and stigma related issues are better addressed. Unfortunately The DMHP while having expanded to a large number of districts with a total coverage of 32 districts in Tamilnadu (Josephine 2020¹⁷⁸) still remains largely dependent on camps and psychiatric and neurological specialist care, placing an enormous burden on major tertiary centres to serve large regions. In addition, care packages are more bio-medical in nature, with limited emphasis on addressing concerns around mental health distress, and social stressors including poverty. More often than not, Symptom reduction, is the primary goal, with community and social inclusion taking a backseat. Consequentially, in Tamil Nadu, stigma attached to mental health care persists, even if much lesser than in other States and deters many from seeking care; it is also a contributing factor to the progression of major mental illnesses. Meanwhile, Primary Health Centres (PHCs) continue to lack adequately trained staff who would address mental health issues, leading to under- or untreated clients who might, however be treated for co-morbid medical problems such as hypertension, TB, diabetes, malnutrition, pain, and fatigue. In many contexts, the reverse is also true as a result of a fragmented health system that responds only to mental health needs. In this context, there was, even prior to the pandemic, an emergent discourse about a brewing mental health crisis in India. The precarity affecting scheduled tribes and the homeless in India, as we have seen, is even

more acute, given high rates of malnutrition, economic uncertainty, increasing environmental toxicity, and social marginality. The COVID-19 pandemic has caused demonstrable and severe economic hardship, particularly within those groups already most vulnerable, which will only exacerbate the looming mental health crisis (Gopikumar et al. 2020¹⁷⁹) facing the country. The community-based care model, however, in which primary services and ongoing counselling, particularly in resource-poor settings (Patel et al. 2018).

The looming mental health implications

In terms of Adivasis, and indigenous communities globally, it is not only the case that economic or environmental stress upon these communities hastens comorbid health and mental health-related illnesses (King et al. 2010¹⁸⁰). Rather, healing and wellbeing are also related to reciprocal relations between communities, their ancestors, and their deities. Healing rituals, and its flipside, sorcery and witchcraft, speak to broken social reciprocities with the other world, reflecting broken reciprocities within communities increasingly divided over inequality and economic anxiety, over and against a more communitarian ethos (Demmer 2016¹⁸¹; Vitebsky 2016¹⁸²; Willford 2021). Existential angst and what defines wellbeing and a “good life,” requires a more nuanced study than our present research allowed for. Nevertheless, the data hints at the resilience of cultural and spiritual traditions that are at odds with changing social and economic realities, particularly around the questions of healthcare and healing practices. Bridging this gap, in turn, will require some cultural adaptation, as our examples indicated, as well as a better understanding of biomedicine, particularly around mental health. But this cannot be achieved through a culturally-blind expansion of healthcare delivery. Rather, pathways to care suggest that families and individuals continue to make use of traditional healing rituals, but are also willing to combine biomedical care with traditional therapies, when accessible.

As we saw in the case studies, even when traditional remedies or faith was the main source of protection against illness, there was room for biomedical care, particularly as the Goddess or deity in question seemed to open this possibility through oracular divination. This medical pluralism, as it continues to exist within

India, is neither a fatal flaw or harmonious whole. Understanding the positive *and* negative consequences of this pluralism requires more research (Sujatha & Abraham 2012¹⁸³; Sebastia 2009¹⁸⁴). Drawing upon sources of resilience within communities will involve creating partnerships and increasing trust between traditional providers and biomedical ones. Patronising attitudes or clinical bias among biomedical care providers, however, can hinder this trust from forming, whilst also stigmatising those who continue practice and believe in their traditions. Moreover, the disappearance of symptom repertoires that are culturally meaningful can have negative psychological implications when symbolic expression breaks down and patients fail to find idioms to express their psychosocial stress (Nichter 1982¹⁸⁵; Obeyesekere 1981¹⁸⁶; Corin 2007¹⁸⁷; Lurhmann & Padmavati 2016¹⁸⁸). Under these conditions, psychosocial stress becomes more refractory (Corin 2007). Moreover, stigma and a worsening prognosis can be witnessed as a person becomes a mental health patient, where “emotional emphasis” (Kleinman 2012) on a biomedical diagnosis becomes an overriding part of the patient’s social identity and selfhood. In that sense, biomedical psychiatry must be as attentive to structural violence, precarity, and social exclusion as much as it does to psycho-pharmacological intervention and diagnostic lexicons. Without the former, the latter becomes a small bandage over a gaping wound.

While the process of evaluation in this study is inductive, and combines data from qualitative and quantitative research methodologies, looking prospectively, it does underscore the importance of addressing the following important questions in subsequent studies, as now exacerbated by the pandemic:

- Does an emphasis on local context and cultural understanding lead to more effective outcomes for healthcare providers and social workers, as well as participating community members in terms of a commitment to care, a sense of wellbeing, and clearer access to referral networks?
- Second, does this, in turn, help us understand and identify particular support and stress factors within communities that are unique, or that are commensurable across cultural boundaries? (i.e., can we scale up from local perspectives to common features and approaches that encourage

integration of neuro- and cultural-diverse models among clinicians?).

- Third, is a community-focused health model more cost-effective and self-sustaining over a period of time through increased community stakeholder participation, innovative entrepreneurial activities that provide income and enhance self-esteem, as well as personal empowerment?
- And, fourth, is the perceived mental health crisis within local communities linked to other health and wellbeing and waste disposal, adequate nutrition, livelihood precarity, housing, infectious diseases, transportation, and pollution/toxicity within the environment? Finally, are there short-term interventions that might mitigate against the most disastrous economic and mental-health-related scenarios brought on by the pandemic? And, lastly, what sort of research is required to address the still unknown long-term psychological effects of the pandemic?

In addressing these questions, India presents a compelling case in helping us understand the effects of expanding biomedical care, as well as the persistence of local traditions replete with their own symptomologies. That is, the symptom repertoire is partially culturally determined in the same manner, arguably, that newer diagnoses such as PTSD, anorexia, and chronic fatigue emerge and manifest somatic symptoms in other cultural contexts (Young 2007¹⁸⁹; Kleinman 1988¹⁹⁰). Understanding the consequences, therefore, of India's medical pluralism, will contribute to not only understanding the role that culture plays in "healing" and wellbeing in South Asia, but will also have practical utility in the delivery of more culturally nuanced forms of psychiatric and neurologic care (Weiss et al. 1995¹⁹¹; Kleinman 1988; Desjarlais et al 1995; Patel et al 2018). Unlike physicians in the United States and Europe, psychiatrists and clinical psychologists in India know that many of their patients also seek simultaneous treatment from faith healers, oftentimes with efficacious results (Weiss et al 1995). The risk to communities, particularly in rural areas where a gap is beginning to widen between traditional and biomedical care, needs to be addressed, particularly at a moment of acute crisis (Weiss et al. 1995; Kohrt & Mendenhall 2015). Caught between the old and new lexicons and symptom repertoires leaves individuals precariously

vulnerable to pharmaceutical interventions without accompanying psychotherapies that are resonant and culturally meaningful. How widening social gaps, forged by economic and cultural disparities, exacerbates depression and anomie is a fundamental and critical question to investigate and mitigate (Patel & Kleinman 2003; Kleinman 2012; Biehl 2005¹⁹²; Pandolpho 2017¹⁹³; Garcia 2010¹⁹⁴). If we are to imagine a more just and sustainable medical system for those facing increasing precarity, particularly given the devastating economic impacts of the pandemic. Moreover, in areas that are underserved by specialist, and even basic biomedical care, cases of organic illness, such as epilepsy or other neuro-degenerative movement disorders, often go undiagnosed or diagnosed in local ethnopsychiatric traditions as a "curse" resulting from sorcery or sinful desires against more egalitarian tribal norms or caste-based moralities and normativities. While traditional healing systems can be efficacious, patients caught in this double bind do not find relief from their symptoms in traditional exorcisms and remedies, etc., and are, moreover, blamed for their failed cure (Ram 2013¹⁹⁵; Kakar 1982¹⁹⁶). In this sense, combining traditional with biomedical therapies and local understandings might be more beneficial than simply expanding one (biomedicine) without taking account of the continuing relevance of the other (traditional medicine).

Long-term loss

The ripple effects of the 10 month lockdown in the country has changed the lives of many, with most effects having affected lifestyles of individuals. While the situation perpetuated patriarchal gender roles (Lungumbu and Butterly, 2020), many have also adapted to the "new-normal" and developed personality changes (Jarrett 2020¹⁹⁷). The lockdown has had a gendered and class effect on populations with women across social class with the lower middle-income groups being one of the most affected and also unnoticed during the government's relief priorities (Livemint 2020¹⁹⁸). Similarly, children as well have experienced effects that will remain in the near future. Apart from issues related to drop out from education, various children have also experienced addictions to gadgets (), mental health of children due to separation and quarantine. (News18 2020¹⁹⁹; Singh et.al., 2020).

Further, with over 90% of India's workforce in the unorganised sector (Murthy 2019²⁰⁰). Given the

lockdown context, such activities have been managed in-house and many recruiters have adapted to situations where external help is unavailable. Further, the financial crisis in most families prevent the hiring of external help or purchases. This results in the loss of regular employment for over 21 million people of the Indian population, who will now experience increased vulnerability (Das, 2020²⁰¹). The effect is likely to continue given the innovation and speed of science catching up and aiding adaptation to survive the lockdowns. Technologies such as machines that produce cooked food at home, web-based services for working and employment, for example, nullify the need for travel, lower fuel, which results in reduced employment (Das, 2020). As a result of these surmounting effects, it is expected that vulnerable persons from various mainstream communities will remain within a poverty trap experiencing further distress, while tribal persons will suffer loss of identity and customs in addition (Berkhout et al. 2021)

Besides the precedented loss of land rights, the current pandemic context has further threatened the tribal ecosystem (Mohanaty 2020²⁰²; Rajankar & Gandhi 2015²⁰³). Even today, the people belonging to the Irular tribe are employed as rat-catchers and are held as bonded labourers. However, with the pandemic this is expected to reduce as the data obtained from this study suggests a loss in employment and income. The effect is likely worse given that most social entitlements from the government require adequate and appropriate identity proof, however less than 10% of the Irular tribe possess a community certificate, a proof of an individual belonging to a particular caste or any other government document like an Aadhar card or voter ID card. Additionally, the socio-economic background of the tribe in context, alongside poverty, malnutrition, family liability, lack of hostel facilities, early marriages, inadequate transport facilities, insufficient educational facilities, poor medical facilities, social exclusion and discrimination are major livelihood issues of Irular community (Thachil, 2016). owing to these challenges, the tribal community is opting for migration to cities in search of jobs which has significantly led to cultural declination as well (Thachil 2016²⁰⁴).

These existing deterrents are expected to further worsen during the time of the pandemic due to lack of access to basic amenities and continued loss of income. Policy developers must therefore be cognizant of these

in determining relief dissemination as well as long term recovery goals. Besides recovery from the immediate effects of the pandemic, continued psychosocial challenges are expected to increase vulnerabilities, as suggested by classical stress-vulnerability theories (Zubin & Spring, 1977²⁰⁵).

Resilience

Challenges in economies, health and social functioning of countries, worldwide, conceivable toll on mental health is foreseeable. The pandemic has created various losses on the lives of all persons, irrespective of demographic, however one of the severely hit populations include those living in vulnerable contexts including those of poverty, poor access to healthcare, illiteracy, stressful life experiences prior to the pandemic (Southwick & Charney 2012²⁰⁶).

Consistently, this study also found that loss of support, recreation, increased drop out from schools, loss of pay and/or employment has resulted in subjective distress. Related, the effect of this on psychological health is only conceivable and severity of impact is expected to depend on factors such as quarantine experience, duration, feelings of loneliness, fear of being infected, inadequate information, stigma and discrimination and may even exacerbate existing experiences of mental illnesses (Brooks et.al. 2020²⁰⁷; Vahia et.al. 2020²⁰⁸).

Recovery from the multitude of effects this has posed, requires not only individuals to remain resilient but for systems as well. Detailed study of literature on resilience suggests that individuals are innately equipped with stress-management and distress reduction mechanisms (e.g., de Kloet 2008²⁰⁹; Southwick et al. 2014). Impinging on this, health practitioners must work collaboratively with individuals to plan routine day-to-day activities, assist in promoting self-care, encourage exercise and nutritional diets (Kalisch et.al. 2017²¹⁰). It is also essential to allow individuals feel a sense of autonomy and control over their situation, as much as possible (Vinkers et al. 2020²¹¹), since people who engage in regaining control of their situations often show better resilience. However, while these recommendations may be innately possible for many within the general population, extending these liberties to persons from vulnerable backgrounds will remain a challenge (Vinkers et.al., 2020). Within the context of Tamil Nadu therefore, as pointed out in the focus group

discussions, many who did receive access to basic rations experienced a dearth of other accompaniments that could have aided in nutrition. Resilience and gradual recovery processes are a combination of increasing bio-social indices of health as seen in uptake of adequate nutritional diet, rest, and by the decrease in psycho-social stressors that impinge daily life challenges by individual self care, and assisted support systems created by responsive health systems and NGO's.

The Capacity to Aspire

The cultural and social push-and-pull factors towards resilience or its opposite, despair and precarity, therefore, must be highlighted in any impact assessment of this pandemic. Evaluating health care systems, their reach, accessibility, and sustainability, will require investment and increased advocacy for those left behind. Building this awareness within any given population requires an understanding of social processes, as opposed to narrow top-down interventions that are blind to the types of structural violence that exacerbate rates of mental illness. This study, therefore, confirms that a community-based approach to local understandings, both in terms of cultural belief systems and social dynamics, is integral to alleviating the effects and underlying causes of distress. While mitigating the effects of structural violence and social defeat, now exacerbated by the pandemic, might be the most pressing concern, as indicated in our case studies and aggregate data, the case studies, in particular, also point to the importance of culture. But, as Appadurai (2013) points out, culture cannot be thought of only as “traditions” and a repository archive of the past. Rather, it is also the means through which futures are imagined and achieved, providing goals and aspirations that only make sense in a particular worldview and social position. This means that culture is dynamic, and in no means, static or unchanging. Appadurai, a social theorist of modernity and the global condition, and a Professor at New York University, who has also researched the urban poor and their capacities for mobilisation and social change in India, provides a convenient framework for all social and development initiatives that is worth citing in conclusion: First, he argues that whenever an “outside agent” enters into a situation where poverty is a major concern, he or she should “look carefully at those rituals through which consensus is produced both among poor communities

and the more powerful”; Second, exercises in “local teaching and learning that allow poor people to navigate the cultural map in which aspirations are located” are critical in linking “specific wants and goals” to scenarios that will lead to more inclusive social contexts; Third, “it is through the exercise of voice” that “cultural capacities are built and strengthened,” and therefore, methodologies that cultivate this voice in development work, including ethnographic and participatory methods, are critical; and, Fourth, “any developmental project or initiative, however grand or modest in its scope, should develop a set of tools for identifying the cultural map of aspirations that surround the specific intervention,” (Appadurai 2013, p194) This, in short, means putting interventions within aspirational contexts that are inclusive and meaningful. Equity and justice, core pillars of human-subjects research, demand as much, which should be obvious to planners and experts in economic, social, and health policy and implementation. Our case studies and data, admittedly modest at this point, point inevitably to the necessity of taking this general framework seriously.

13. Conclusion

13.1 Learnings: Focus on information asymmetry, health disparities and inequitable access to living standards

Data from this study indicated that vulnerable individuals achieved access to some of the essential amenities, though only after an initial period of emergency responses focused around containment and therefore around testing, treating and contact tracing. Priority in the initial stage was primarily focused around addressing the serious ramifications of the pandemic; as a consequence, those who are traditionally marginal suffered the most in their ability to access even the most basic of amenities, essential to one's wellbeing. Awareness campaigns however kicked in soon enough on all platforms - ranging from mediums of print, radio and television to the use of sanitary workers of City Corporations, volunteers and village health nurses around populations serviced by a PHC, who visited communities and individual houses

both for purposes of screening and dissemination of information. However, those disconnected from the mainstream world, prior to the Pandemic continued to remain so; key amongst them were the most disadvantaged owing to their absolute state of deprivation, inability to care for themselves and complete lack of social capital – homeless persons with severe mental disorders. For those who continued to live on the margins, though better placed in comparison to HPMI, adherence to safety protocols that were developed remained/remains a challenge due to poor pre pandemic conditions around meagre incomes, poor sanitation, unstable and clustered housing, and overcrowding. Resulting in lack of space to be able to follow any form of physical distancing, difficulty in accessing private toilets and running water, particularly through the summer months as well as in sourcing sanitary products owing to lost wages, all essential in protecting oneself from SARS Covid -19. It is essential therefore, for the public health system to remain cognizant of multiple barriers to accessing health care (Wakida et.al. 2018²¹²) and to broaden the understanding of health to include the social health of populations, key to maintaining a state of wellbeing, especially since the interconnectedness between addressing the social determinants of health and better health outcomes has been established with suitable evidence. Further, studies have indicated being remotely located, with lack of adequate transport to access health and other essential services and the availability of a basic income that allows for one to subsist in difficult circumstances, in the absence of other safety networks, perpetuates a cycle of mental and physical ill health and distress (Hailemariam 2017²¹³). Amongst vulnerable populations, delivering accessible health services has always remained a challenge. Critical to addressing health concerns is a proactive health system that facilitates quick redress of emergent and non-emergent health conditions, through primary health care services, referral systems to specialist interventions and safe spaces as needed for persons in vulnerable contexts (McGough et al. 2016²¹⁴; Kakuma et al. 2011²¹⁵). This is especially crucial for developing countries with large populations and extensive geographical distribution. Nodal centres can often be hard or expensive to reach, delaying access to care, early identification of distress, often worsening an illness. Respectful and appropriate care embedded in an ethos of responsiveness, located within a public health system seemed somewhat lacking.

Despite its limitations, the public health system within Tamil Nadu, considered one of the best in India, was able to initiate helplines, information dissemination centres, coordinate health care services in the case of health emergencies other than COVID-19 and ensure that health services though shut for a brief period around the onset of the Pandemic were soon resumed to locally service populations. Other work, around mental health care, eye care, cancer care and kidney care, amongst others in collaboration with civil society organisations was also sustained, enhanced and accelerated in order to prevent further deterioration (Ramakrishnan, 2020). Data from this rapid survey suggests that, consistent with its mandate, the Greater Chennai Corporation supported the homeless in ways that they could through the NULM shelters despite overcrowding and limited human and financial resources, again a Pre-Covid issue across most institutional services ranging from state run homes for vulnerable individuals, hospitals, prisons, and child care homes. Besides access pathways to shelters, they also coordinated rescue services for those in crisis and initiated outreach services for those sleeping rough. Data also suggested that the system facilitated easy intersectoral collaborations (between government hospitals, shelters, general public and civil society organisations) allowing for referrals and successful management of persons affected by COVID-19. Additionally, the GCC and the Department of Health also established a helpline to address concerns of the public related to COVID-19 and distress alleviation services (Jesudasan 2020²¹⁶). Prevention and intervention measures were stepped up as the state health machinery inducted multiple players to deliver services such as health infrastructure readied through shelters, quarantine centres, testing facilities, distribution of services, food and medicines. To assist public health system 2000 mini clinics were opened in the capital of Chennai, to respond to covid linked detection and treatment.

Collateral damage from the pandemic could not be addressed due to the domino effect that rendered the most vulnerable prone to loss of livelihoods, social deprivations, impacting upon their health and mental health, as manifested in living on the streets, rendered job less, stress, distress, anxiety and fear (Xiong et al. 2020²¹⁷). Family structures and operational systems came under pressure with sudden cessation of work, relocation, forced home stay, density of population. Schools and other educational institutions closed

abruptly without any direction towards continued education, completion of exams. This eventually led to an increase in school dropout rate due to paucity of resources, inadequate bridging infrastructure and technical support, both in urban and rural areas (Trivedi 2021²¹⁸). Unfortunately the gendered nature of distress was evident, yet again with women often suffering more than men in their ability to access adequate nutrition and health services. Work force participation further decreased with loss of jobs in the unorganised sector resulting in decreased social capital and greater vulnerability to stress as a result of enhanced dependence of other male breadwinners. Domestic violence and intimate partner violence also increased as a consequence. Persons with disability also struggled with income loss, curtailed mobility and issues around health access.

13.2 The Way Forward

Given this, several themes have been isolated which may be extended to low- and middle-income countries (LMICs) as well.

Inequity and Disadvantage impacting quality of life and health outcomes

Between the Spanish Flu or the Bombay Influenza and the Covid-19 Pandemic, a hundred years have passed. While one has witnessed advances in science and related impact on health systems, broadly those most affected then and now remain the same. If inequity, multidimensional poverty and marginalisation had a key role in determining outcomes, in 1914, the same holds true now. Therefore, by association, the impact social advantage or capital have had on health and well-being or the lack thereof has received insufficient attention traditionally. As a consequence, this pattern is reflected in the prevalence of health disparities and differential ability to pursue capabilities, influenced by structural and social systems, even today. The inter linkages between the two have been underestimated and it is perhaps time to allow for this key finding to be assimilated with the sort of attention and reverence that it deserves, so the same inadequacies aren't afflicted on the next generation on the basis of birth, race, ethnicity, caste, gender, class, social vulnerabilities, disadvantage or privilege. Human advancement or science should ideally impact lives in ways that influence social cohesion and equitable living standards. The ability to bridge social distance

between groups seems to be of immense relevance in ensuring equal access to health for all. However, health by virtue of being linked to resources and access, discriminates between the poor and the privileged in distinct, visible, harsh and discriminatory ways. While the Pandemic itself may have affected most persons in similar ways, it has undoubtedly inflicted social suffering on the ultra-vulnerable groups disproportionately.

Health systems have to therefore innovate and re-frame themselves to ensure last mile coverage in a manner that is acceptable and appropriate so public demand is built bottom up. If indeed, health is a combination of nutrition, social roles, psychological health, social health, appropriate access and responsive public health systems, solutions that promote health have to range from bridging care gaps through cultivating a level playing field through the introduction of basic income type interventions that in turn have the potential to ensure that concerns around information symmetry are remedied, access to ethical, systemic and equitable care promoted, and dignity, choice and control valued and respected amongst all individuals. Cashless services across all hospitals should similarly be available so social mixing is initiated and public and private health services are accessed by all and equally, based on need and choice, with a foundation embedded in basic rights enshrined in the Indian Constitution. Health gains therefore should influence and improve population health and also in the process help build equity.

Strengthening of Health Systems

The current pandemic has proven that the country, especially the state of Tamil Nadu, is able to facilitate adequate health access when needed. If this is indeed the case, then strengthening health systems should assume greater importance and be prioritised in national budgets and health policies. This would translate into additional resource allocation as well as effective primary care systems and referral/escalation pathways. Training of Health and allied professionals to adhere to protocols that are especially designed to build systematic approaches to care provision is mandatory. Data management systems that proactively track vulnerable populations in particular, and communities in general, and manage care in an integrated manner requires efficacious monitoring. Psychological and social health is further an integral

component in primary care, and is further removed from services available at the primary health centre. A repetitive discussion, the government has been critiqued for the lack of focus on mental health, especially since less than 1% of the government's funding is allocated for mental health care (Vigo et al. 2019²¹⁹). Further, despite the implementation of the district mental health program (DMHP), the facilities remain inaccessible to many individuals and has been futile in delivering holistic mental health services that are also culturally valid (Jain & Jadhav, 2009). Accordingly various theories have argued for the need of strengths-based approaches such as the capabilities approach (Nussbaum, 2011). Distress and death by suicide have affected many young individuals between the age groups of 15-29 globally. India despite its sense of community has fared poorly in protecting young adults from core experiences of alienation, relative poverty, loneliness etc. This needs further introspection and reflection so as to understand the nature of impediments that come in the way of one's sense of vitality. Perhaps these answers also lie in early childhood experiences characterized by deprivation, scarcity, abuse, violence and social losses resulting in a state of hopelessness or stuckness.

Facilitating Last Mile Connectivity and Reach to Vulnerable Populations through Intersectoral Collaboration:

Within India, 197.3 million persons are affected with mental illnesses contributing to 7% of the global burden of diseases and 19% of disability-adjusted life years (DALYs) (Sagar et al. 2020²²⁰; Rehm & Shield, 2019²²¹). With large and diverse populations that require servicing and, alongside poor infrastructure, the gap in mental health care in India is estimated at 90-95%. 150 million persons are estimated to be in need of immediate mental health care (Lahariya 2019; Gururaj et al. 2016). As a result of this and various preceding events, a mental health policy group formulated in 2012 suggested the need for intersectoral coordination to enhance reach and effectively address the social determinants of ill health (Mental Health Care Bill 2013²²²; Narayan et al. 2013²²³). Mere symptom reduction may not be sufficient in alleviation of distress in the context of less privileged persons with experience of social vulnerabilities. This may result in a situation of double jeopardy; one on account of a health crisis and the other as a result of one's social capital or lack thereof.

Consistently, the Tamil Nadu State Government has worked collaboratively with variegated partners to cater to needs of persons, living in vulnerable circumstances with disability. A concrete outcome during the Pandemic resulted in enabling care pathways for those homeless and living with a mental illness (Omjasvin 2021²²⁴). As a consequence, ten emergency care and recovery centres in addition to a previous cluster of five have been initiated across districts such that care may be provided locally in government facilities in collaboration with local civil society organisations, the Institute of Mental Health and The Banyan (Gopikumar & Radhakrishnan 2020²²⁵). The impact of this partnership is significant, as close to 1000 persons may be serviced annually, treated closer to their homes and also be able to access care in a timely manner resulting in possibilities of better prognoses and after care options, with focus on community inclusion and participation.

Disability allowance

Social determinants of health have already highlighted the intersectionality of health and mental health outcomes with all aspects of quality of living (Sarkar 2016; Commission on Social Determinants of Health 2008). In combination with collaborative efforts for health and mental health treatment long term and during the pandemic, and welfare options based on need (Disability Allowance for mentally and physically disabled), momentum is required for welfare to combat other inequalities. For example land rights and labour laws, including land reforms to improve asset distribution or minimum wages which do not apply to the 90% informal sector, need to be addressed as well (Rani & Belser 2012²²⁶). Improving working conditions and health and safety could improve health outcomes for persons working in 3D jobs (Dirty, dangerous and demeaning) (Prasad 2012; Rani & Belser 2012). Improving infrastructure in poor and rural communities would improve the environment they live in, reducing the use of fossil fuels/cooking fires, and improving sanitation (Cowling et al 2014; Dutta et al. 2019).

Other studies as well indicate that intersectoral collaboration is most useful in the context of developing countries (Jain & Jadhav, 2009). Likewise, in the context of the Pandemic, this maybe especially crucial to ensure consistent vaccine delivery, adequate

identification of other health crises related or unrelated to COVID-19.

Use of public institutions to better lives and amplify wellbeing gains

Currently within the state of Tamil Nadu health-seeking behaviours among citizens depended on which strategy resulted in fastest return to regular work, especially in rural Tamil Nadu (Dodd et al. 2016²²⁷). Additionally, general mistrust among government run facilities hindered optimal use of services (Dodd et al. 2016). The “saving lives” model strongly advocated by the state government, during the pandemic must extend to distress-related services, encouraging the move away from a disease centred model of care to a patient centred model (Jiloha & Shekhawat, 2010²²⁸; Biringer et al. 2017²²⁹). Additionally creative use of science and technology assisted mediums during the pandemic aided awareness campaigns and information dissemination (Shaw, Kim & Hua 2020²³⁰). Similar mechanisms may be used as distress helplines for common mental disorders, caregiver burden, as well as for crisis relief among persons with severe mental disorders, suicidal ideation and allied health issues. Regular use of such mechanisms will also allow for systemic preparedness during national health crisis.

Similarly, the NULM shelters that service homeless persons while sparsely staffed are also inadequately equipped with safety protocols that strengthen capability to address multiple health concerns. Administrative hurdles combined with bureaucratic delays and limited scope for driven and passionate leadership have resulted mostly in sub-par shelters, particularly those based in the northern and central belts. Several states still lack in the ability to provide a shelter per 100,000 persons; resulting in a welfare system that varies between states (Goel et al. 2017). For a state to respond comprehensively and appropriately to persons in crises it is mandatory that they provide adequate amenities in an environment that cultivates trust, is respectful and cognisant of individual and collective social, cultural and psychological needs with a responsive framework that is non-discriminatory and participatory. While shelters are a great intervention for homeless persons, focus on dignity and community inclusion will ensure trust in the system, promotion of equality and greater participation opportunities that then impact self-reliance, independent thought and living and

capabilities. Longer term results emanating from the NULM programme should ideally provide shelter and impact livelihoods, housing and health in substantial and concrete ways that will dis-enable recurrent slides into abject poverty, in the absence of safety networks.

Community-Based Models of Care

The Banyan model of training health worker in communities to service persons closer to their home using population health enhancement approaches has proven successful in lowering the incidence of symptom recurrence, as well as raising the quality of life for those afflicted (Narasimhan et al 2019). Of special importance has been The Banyan’s emphasis on building grass-roots support systems within communities to both educate and meet the challenges of care in resource poor settings. In building local stakeholderhip and capacity through rehabilitation and job training, patient prognoses have been improved, over and against long-term institutionalisation (Patel et al. 2018). But the pandemic has, as the data and case studies demonstrate, strained the capacity of both government and NGOs to provide sufficient help at the grassroots level where it is most needed. NGOs, however, play an important role within the healthcare system, as it is through community engagement that significant challenges can be documented, understood, and mitigated. Moreover, NGO-facilitated social and healthcare work also provides the necessary bridge, both cultural and institutional, between local contexts and biomedical care when needs are acute.

Additionally, a rapid response team comprising of mental health and social care professionals (psychologists, social workers, psychiatric nurses, psychiatrists, diagnosticians etc) would be an essential within the public health system, to work in close coordination with emergency and ambulatory services. Most of these mandated positions are now unoccupied. This will ensure holistic care services are delivered not just during a crisis but more importantly to prevent a crisis. Additionally, during non-emergent times, this team may also be useful in strengthening existing services to improve preparedness. The findings from this study indicate that currently, while protocols were initiated for prevention various marginalised groups were unable to adhere to these protocols for various reasons including poor sanitation and lack of spaces for physical distancing. The

precedent of clustered or congested spaces, poor sanitation and awareness leading to health problems and crisis is not unknown and in fact has also been suggested to be the cause for new infections (Krieger & Higgins 2002²³¹; Neiderud 2015²³²). The public works system, health and sanitation system must therefore work in tandem to ensure that the notion of health is inclusive of well-being is achieved. The idea of a Primary Health Centre (PMC) system model has been adopted by the World Health Organisation (WHO) through the Alma-Ata declaration as the preferred method for providing a comprehensive, universal, equitable, and affordable healthcare service, and had the ability to improve access to care, reduce disability and improve social integration (World Health Organisation 2004²³³; World Health Organisation 2007²³⁴, 1978²³⁵; Hall et al. 200²³⁶). This model of mental health integration recommends that countries build or transform their mental health services to (i) promote self-care, (ii) build informal community care services, (iii) build community mental health services, (iv) develop mental health services in general hospitals, and (v) limit reliance on psychiatric hospitals (WHO, 2009²³⁷). Subsequent research has indicated that the integration could work well and reduce costs (McGough, et al. 2016; Kakuma et al. 2011).

Given the long journey ahead, the policy gaps in education and employment access must be rectified to prevent a spiral down of individuals, especially from lower-middle income groups and below. Increase in social cooperatives, increased wages for 100 days' work under the MNERAGA scheme and other innovative and perhaps even home-based programs to boost rural economies is critical. This is especially important since there is an increase in dropout rates from school. Additionally, providing health insurance is also crucial to affordable health care. 40% of the world's population survives on no health insurance (ILO 2020²³⁸). In fact, studies indicate that the utilisation of primary level services (PHC and Subcentres) is better for preventive and promotive care but remains poor for treatment of acute illness, intranatal care and family welfare services (Rushender et al. 2016²³⁹).

Social protection systems must therefore take stock of needs and deliver robust services to ensure continued intervention toward prevention of ill-health and improved well-being. Similarly, in developing ideas for vaccination supply and reach, it is important to

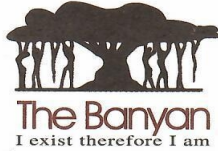
consider if the state should move beyond offering access only if proof of citizenship is provided. As stated above, many persons such as the Irular tribe do not possess adequate documents justifying their citizenship rights; therefore, will have limited access.

We hypothesise that significant progress with regards to equity and social justice centred health systems and social care can be achieved by a paradigm shift in how inclusive development is perceived by society and state. What are the markers of progress and advancement of human development? Do we as a people and State value the underlying principles that enable feelings of hope, equality and social cohesion. Conditioning and decades of social loss and disadvantage have resulted in a majority of India's population resigning themselves to a life of disadvantage and ontological instability, besides poor health. Transitions in attitude are essential to ensure policy makers plan for the most vulnerable and that society demands a fairer distribution or redistribution of resources such that all benefit and therefore build community level resilience to deal with crises such as the Pandemic. Only then with growth be inclusive and life worthy of pursuing capabilities for all, instead of a select few.

Appendices

Appendix A - Permission letter

Permission letter sent to the Deputy Commissioner (Health) of the Greater Chennai Corporation.



21st September, 2020

To:

The Deputy Commissioner (Health)
Greater Chennai Corporation
Ripon Building, Chennai - 600003

From:

The Director
The Banyan, 6th Main Road
Mogappair Eri Scheme, Mogappair West
Chennai - 600037

Respected Sir,

Greetings from The Banyan!

The Banyan and World Health Organization have entered into a collaboration to study the impact of COVID-19 on vulnerable groups including the homeless, indigenous communities and ultra-poor families, especially those afflicted with a mental health issue. To this end, we have so far collected data on the impact of the pandemic on livelihoods, wellbeing and mental health from 800 families accessing treatment and care at The Banyan through outreach, outpatient and aftercare services. We have also reached out to 43 state mental hospital superintendents to gain understanding of systemic responses in institutional settings.

The Greater Chennai Corporation has been one of most responsive systems in the country, managing the crisis from a holistic public health perspective, and also the one of the first cities to immediately take care of homeless individuals who've lost the most in this period. To this end, it would be extremely insightful if The Banyan can conduct semi-structured interviews with the following public health providers:

1. City Health Officer
2. City Health Coordinator
3. 53 Night shelter coordinators

Please note that all responses will be anonymized and utilized only for the purposes of this report. We will also send you a draft copy of the analysis prior to public dissemination.

Thank you very much Sir for your cooperation and commitment.

Yours Sincerely,

Dr K V Kishore Kumar
Director,
The Banyan, The Banyan Academy of Leadership in mental health



Registered Office :

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***Appendix B - Survey Tool SD,
Homeless and Irular Groups***

Appendix B - Survey Tool Children

Appendix C - Survey Tool Shelters

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