Chapter 12
Gender Insights into a Unique Threat to Human Development

Madhu Bala Nath

Abstract Both primary and secondary data are examined to study the gender dimensions of the pandemic. While maintaining a focus on health, the author discusses the linkages of health, poverty, and women's agency. The COVID-19 pandemic has impacted the human development index that incorporates literacy, income, and life expectancy.

COVID-19 has severely impacted women's reproductive health. Unintended pregnancies, abortions, and maternal mortality have increased as a consequence of the pandemic. The demand for services, especially nutritional services, child immunizations, and family planning services was not met. Research shows that sexual and gender-based violence increased during the pandemic. Mental health problems also increased. All these problems affected women disproportionately. The impact of stigma on women's health is discussed. Its effect on LGBT communities is underscored. The suicide rate in India was higher than that in other countries in South-East Asia even before the pandemic. COVID-19 exacerbated this problem.

The author suggests that the government should support disadvantaged communities including the LGBTQ community by transferring leased assets as an eligible collateral for working capital loans. It is recommended that relief packages for COVID-19 should be reworked so they are gender responsive.

COVID-19 is threatening the gains made by India to increase women's education, livelihood opportunities, and labor-force participation. It is also affecting women's physical and mental health. The author argues for strengthening women's agency, a critical imperative for countering these problems.

Introduction

No disease in living memory has posed as a great threat to global health as COVID-19. Some scholars have remarked that it is time that we start treating this pandemic on the scale of a thermonuclear war and making investments needed in a timely

M. B. Nath (✉)
Gender Specialist, New Delhi, India

S. Pachauri and A. Pachauri (eds.), *Health Dimensions of COVID-19 in India and Beyond*,
https://doi.org/10.1007/978-981-16-7385-6_12

manner so that the consequences of inattention do not harm humanity. We must not allow the unthinkable to become the inevitable.

This chapter examines the impact of COVID-19 on men and women, trans-men and trans-women, lesbians, and gays. Learning from earlier epidemics and using research-based evidence, the gender dimensions of the pandemic are presented. While maintaining a focus on health, the interlinkages of health and poverty are discussed. Within this framework, factors such as supporting women's physical and mental health and strengthening women's agency as well as that of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community in the response to COVID-19 are examined.

A forward-looking strategy that encompasses the engagement of *panchayats* to strengthen women's self-help groups at the local level is presented. The objective is to promote health by improving food security and generate livelihoods for reducing hunger and malnutrition. In addition, health and wellness centers, locally owned and managed by self-help groups, are envisaged. Health workers at the village level should be trained using functional digital literacy to respond to health-related challenges. The spirit of the recommendations is to leave a legacy wherein COVID-19 is not seen as a disaster that had to be endured but rather, understood by generations to come, as a challenge that was addressed.

An Unprecedented Pandemic

The world is experiencing an unforeseen, unprecedented pandemic of an intensity that has paled all other epidemics and pandemics. COVID-19 has taken the world by storm. The virus can mutate which makes vaccine development a challenge. Sudden and quick progression to death happens in fractured health systems and this impacts negatively on the morbidity and mortality indicators of nations. The ability of the virus to stay alive on surfaces for days and its ability to transmit infection from one person to another even with a low viral load is a challenge. These are serious challenges in resource-poor settings where infrastructure is weak. The impact of COVID-19 on health systems has been crippling. The healthcare system is dependent on the availability of functioning facilities and a robust health workforce. The lockdowns affected the erstwhile vibrant and robust economies which was devastating. Suddenly, and without any warning, countries came to a screeching halt. For a large number of Indians, the pandemic triggered an intertwined health and financial crises. Overcoming these two crises together has been challenging.

The Gendered Gains of Globalization—A Reversal

The pandemic is increasingly reversing the gains of globalization. For example, the sealing of borders by countries in the Middle East had an impact on the livelihoods

of large numbers of migrants from South Asia, including India. These migrants had benefitted from relatively better economic opportunities in these countries. A number of nurses and domestic workers lost out. The ban on the export of essential drugs to other countries by the Government of India could have a very negative impact on the health of men and women. Pharmaceutical exports were restricted for drugs such as paracetamol, antibiotics, and vitamins as well as hormonal drugs like progesterone which is used during pregnancy and for menstruation-related problems by women as well as by trans-women for gender affirming therapies. Indian drug makers rely on China for almost 70% of the active ingredients. Industry experts have forecasted that India could face shortages of drugs if the COVID-19 pandemic continues [1].

South Asians and Indians seem to be at a greater risk of COVID-19. On June 19, 2020, James Gallagher, the BBC Health and Science correspondent reported a study of COVID-19 patients in the United Kingdom which showed that people from South Asian backgrounds were 20% more likely to die from COVID-19 than white people. This research involving public health bodies, universities, and 260 hospitals was published in the Lancet. It showed that South Asians are at greater risk of dying, due at least in part to a higher prevalence of pre-existing diabetes. Out of every 1,000 white people who were admitted to hospitals for COVID-19, 290 died. For South Asians, the figure was 350 out of every 1,000.

COVID–19 Has a Gender Face—Self-perception of Risk

The right to lead a life free of disease and disability is an entitlement according to the Indian constitution. But access to health information and services has a gender face. Special efforts are needed to reach women and members of the LGBTQ community.

A study by the Population Council in Bihar and Uttar Pradesh (UP) in April 2020 sought to assess the extent to which individuals personally felt at risk of COVID-19. The study showed that although all participants were aware of COVID-19, their risk perception was very low in both Bihar and UP. Prominent reasons for low-risk perception were absence of any positive case in their neighborhood and no history of traveling outside their neighborhood. At the same time, there were misconceptions among those who perceived that they were at no/low risk. Women were more likely than men to attribute their low risk to the belief that they were young and healthy, God will protect them or the virus will not spread in hot weather [2]. Women also had less accurate information on the symptoms of the disease and preventive behaviors.

The consequences of low self-perception of risk are evident. India reported 15,712 cases by April 2020. These accounted for just 0.7% of the COVID-19 cases worldwide. In just a few months, India ranks second in the list of the worst affected countries with more than eight million people testing positive. This rings alarm bells in terms of the socioeconomic consequences of COVID-19.

Like most development issues, the causes and consequences of COVID-19 are rooted in the gender construction of sexuality. Gender differentials have impacted power relations between men and women and between trans-men and trans-women.

This social construct is a 'deprivation enhancer', and so needs to be monitored and addressed in all development interventions, including COVID-19. The World Bank has estimated that the pandemic will drive more than 12 million Indians into poverty [3]. Women and members of the LGBTQ community are likely to be over-represented as discriminatory, and patriarchal values thrive in the social fabric in India. It is important to protect employment, health, including mental health, and social security for men and women, trans-men and trans-women, and lesbians and gay communities. The Reinsurance Group of America's (RGA's) global analytics and data teams recently analyzed data from a number of countries. They observed that in most countries a greater percentage of men than women died from COVID-19 (Appendix 1).

Human Development and Gender Equality: A Reversal

The United Nations Development Programme's (UNDP's) 1990 human development report moved the global discourse on development from economic indices to other indices that capture human well-being like life expectancy, literacy, and per capita income. These indicators inform the human development index. All three indices are interrelated. Thus, high literacy and high per capita incomes result in longer life expectancy. With the COVID pandemic, there has been rising unemployment and lower per capita income along with rising numbers of deaths of young and old. COVID-19 has resulted in hunger, unmet need for health services, and lower life expectancy. As mid-day meals are no longer available to school children, child malnutrition is becoming a serious problem.

A study undertaken by the Population Council in UP and Bihar showed that because of the lockdown and ensuing economic slowdown in India, as of April 17, 2020, the finances of migrant households were likely to last for a very short time. Seventy-three percent of the migrant households reported that they had lost their jobs. Eighty-nine percent needed rations to survive, 46% needed cash, 24% needed medicines urgently, and eight percent needed cooking gas. About two percent of migrant households in Bihar and UP had lost someone close to them due to COVID-19. Return migration with relaxation in the lockdown made them highly vulnerable; 40–50% of these migrant households had no separate room to quarantine, and close to 45% had elderly people with pre-existing medical conditions living with them [4].

These findings indicate that India may suffer inter-generational poverty with long-term deprivation and dependency. This prognosis is endorsed by the empirical discourse according to which descent into poverty is associated with lifestyle changes and crises like ill health. The key causes of the declining economic and inter-generational poverty are structural factors like the loss of human and financial assets and adverse market conditions. These are usually due to the sudden onset of a long-term illness and poor access to health care, and COVID-19 has created exactly the same situation in India [5].

According to the findings of a study commissioned by the United Nations, women and children are losing more than 20% of their health and social services as a result of COVID-19. Globally, approximately 13.5 million children have missed life-saving vaccinations over the past four months. According to the annual report issued by the U.N. Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent, some children from low-income countries may never receive these routine shots. This report shows that even before the pandemic, maternal mortality was declining at a slower annual rate than what was required to meet the Sustainable Development Goals by 2030. As a result of COVID-19, 2,95,000 women are estimated to die during or shortly after pregnancy in 2020 [6].

Marie Stopes estimates that 9.5 million vulnerable women and girls in 37 countries including India are likely to be affected [7]. According to the Guttmacher Institute, globally there is a 10% decline in the use of short- and long-acting reversible contraceptives which means an additional 49 million women with unmet need leading to 15 million unintended pregnancies. The Guttmacher Institute predicts a 10% decline in the coverage of essential pregnancy-related and newborn services which means an additional 1,68,000 newborn deaths [8].

During the pandemic, Indian authorities struggled to keep track of about 4 million pregnant women and 4.75 million newborns. In other words, 76% of pregnant women and 83% of newborns did not appear in government data sheets during a period of three months. As medical professionals/health workers and frontline workers including ASHA workers were actively fighting the virus, many pregnant women were either denied care and/or admission to the hospital. Others failed to reach the hospital on time because an ambulance was not available. An estimate by the Foundation for Reproductive Health Services, India (FRSHI), suggests that 25.63 million couples were not able to access contraceptives due to the interruption in the provision of reproductive health services during the lockdown [9].

A study undertaken by the Population Council in Bihar and UP which sought to assess the demand and supply of Reproductive and Child Health (RCH) Services found that the demand for nutrition services was the highest, followed by child immunization, and family planning services. Fifty-two percent of women wanted nutritional services; 38% wanted child immunization services; and about 28% wanted family planning services. The demand for these services was much higher in rural areas than in urban areas. Among those who wanted services, a negligible proportion received them. An important reason for this state of affairs was the inefficient and dysfunctional public health system in India. A study by the Indian Council of Medical Research (ICMR) revealed that while India accounts for 20% of the global burden of disease, it has only 6% of hospital beds and 8% share of doctors and nursing staff [10].

The 75th Round of the National Statistical Survey Organization (NSSO) in 2019 showed that there were a significant number of vulnerable people. The healthcare vulnerability index was worked out for all the states and union territories of India. There was high and medium level of vulnerability in the states of Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, West Bengal, Arunachal Pradesh, Kerala, Rajasthan,

Gujarat, Karnataka, Telangana, Andhra Pradesh, Assam, Tripura, and Uttarakhand [11].

In India, there is one doctor for every thousand people. About 40% of the patients admitted to hospitals suffer from chronic diseases. And so, the burden of care at home is also high. It is the women who have to bear the burden as caregivers within the household and also as frontline workers. Women constitute 47.2% of all health workers and almost 89% of nurses and midwives [11]. The vulnerability index could serve as a guide as COVID-19-related responses are formulated. As of now, the various relief packages like the *Atma Nirbhar* have very little to offer women.

COVID-19 and Mental Health

Lockdowns and quarantine have the potential for creating social isolation and emotional vulnerability. There is ample evidence to show that poverty and vulnerability are interdisciplinary and complex. They intersect with other forms of social exclusion such as gender, caste, and ethnicity, disability, sexuality, and spatial disadvantage. All these factors have a bearing on mental health and are recognized as forms of emotional violence.

Domestic violence is known to increase during crises. An increase in sexual and gender-based violence was witnessed in 2014–16 with Ebola and in 2015–16 with the Zika epidemic. Violence increased with COVID-19 because of quarantine and stay-at-home measures. Women and children suffered violence at the hands of controlling men. Vulnerabilities also increased with the use of the Internet. A study by Child Rights and You showed that 9.2% of adolescents surveyed (630) in the Delhi-National Capital Region experienced cyber-bullying [12].

> Recently, in a gruesome incident in Badaun (UP), a father of five daughters allegedly ripped open the stomach of his pregnant wife one evening. The 43 years old laborer returned home in an inebriated condition and got into an argument with his wife. He then slit the stomach of his wife with a sharp-edged weapon allegedly to find out the gender of the baby. The injured woman was rushed in a serious condition by the family with the help of locals, to a hospital in Bareilly. She is now battling for life [13].

Women filed more allegations of domestic abuse during the COVID-related lockdown than had been reported over the last ten years during a comparable time period. About 32 complaints per one million women were received in Delhi. The opening up of liquor shops after May 3 increased the number of cases of domestic violence. Ghaziabad reported 291 cases of domestic violence between March 25 and May 5; the number increased to 342 cases between May 5 and May15 [14]. The number of

complaints received in June 2020 was the highest since September 2019. There were reports of 13 police apathy allegations and 100 cybercrime allegations [15].

According to a news report published in the Indian Express on April 29, 2020, the helplines run by an NGO called 'Save Indian Family' that worked on men's rights received about 68 calls a day from men experiencing violence from their spouses at home. Compared to 342 women who reported crimes of domestic violence in just 15 days from just one district of Uttar Pradesh, Ghaziabad, the numbers of men reporting violence is very small.

Mental health issues resulting from increasing violence because of COVID-related lockdowns need to be countered by media campaigns on local television channels. These campaigns should aim at building public opinion against increasing violence. Information should be provided on domestic violence, its prevalence and consequences, and penalties associated with the breach of the laws on violence.

> Dr. Himabindu (aged 30 years plus) received an urgent message from a COVID hospital on March 23 Monday night asking her to come to work. Telangana had by then 22 positive cases of COVID-19. Doctors without adequate protection were under great risk and stress. What was never imagined was that a woman doctor would be stopped by police on her way to work, abused, assaulted, hauled into a police station and then made to work a 12-h-shift with bruises all over her body. The police officer snatched her phone, slapped her across the face, and called her a 'bloody bitch'. '…He grabbed my hair and dragged me into the Jeep; his fellow officers began hitting me across the thighs and legs with their batons. They groped me all over, including my private parts [16]'.

Stigma accompanies most epidemics. The real-life incidents given below highlight the human costs of stigma and discrimination. Stigma was not localized; it was reported across geographies by disempowered sections of the society such as women and members of the LGBTQ communities. As the coronavirus crisis grips the globe, the earlier consensus is being replaced with a new reality. There is less data privacy with COVID-19. 'Track and Trace' seems to be the emerging *mantra.* Tools, such as location tracking and smartphone applications, are being used to track and trace.

The impact of stigma on women's health is brought out succinctly in Neelam's case. According to news sources, Neelam, 30 years of age, breathed her last on Friday June 5, while she was in her eighth month of pregnancy. She had symptoms of COVID-19. After being turned away from hospitals in Noida, her family traveled by car around Noida and then went by ambulance to eight hospitals. All the hospitals denied her care. Neelam died in the ambulance thirteen hours later [17].

Subhadra, an ASHA worker, was attacked at home in Orissa. She said that she was abused while she was collecting data on COVID-19 cases. The ASHA worker and her family members were later rescued by her neighbors [18].

As COVID-19 cases rose in Telangana, Lacchamma, an 82-year-old woman was forced to live in an isolated makeshift shed in a field. Because she tested positive

for COVID-19, she was abandoned by her sons. Lacchamma was the mother of four sons and a daughter and was unable to move without a walker. She was found passing her days near an agricultural well in *Peechara* village of *Veleru Mandal*. When her daughter later learnt about her condition and the inhuman behavior of her brothers, she rushed to the village to take care of her ailing mother [19].

A transgender shared the experience of severe violence that she faced during the lockdown period. She got married to a boy, and everything was alright for as long as she provided him with the money that she earned. But soon after the lockdown, her income stopped, and the violence started. She was beaten, sexually abused, and harassed. He took all her money and documents and abandoned her. She went to the police station to register a case, but the police did not help her due to her transgender identity (personal interview).

A peer counselor affiliated with Delhi's *Nazariya*, an NGO, who preferred to remain anonymous, reported that people from the LGBTQ community were at a very high risk of domestic violence. 'Many of the cases that we dealt with came from their native families because queer people stay with their parents, where they are continuously policed, beaten, and verbally assaulted', he explained [20].

The collage of incidents given above highlights that there has been an increase in violence because of the COVID-19 pandemic. This is across the board and includes uneducated women, working women professionals, and some men. Violence takes place not only at home but also in public spaces. The perpetrators of violence are not just illiterate men but men from the enforcement agencies of the government. The impact of violence on women's health has been well documented but the poser that arises here is—Are women in these circumstances able to access help?

A survey was conducted in May 2020 by the Suicide Prevention in India Foundation (SPIF). About 65% of 159 mental health professionals surveyed reported an increase in self-harm among their patients. More than 85% of the therapists surveyed said they were experiencing caregiver fatigue, and over 75% said that fatigue had impacted their work. Another survey in April 2020 by the Indian Psychiatric Society showed that of 1,685 respondents, 40% suffered from common mental health disorders such as anxiety and depression. The lockdown may have eased, but the situation was not improving. There was anxiety because of uncertainty about when normalcy would return. Mental health problems, including suicide, were increasing even before the pandemic. And the health system to address these problems was inadequate. COVID-19 has exacerbated the problem. The system in place is being stretched to its limits. Thus, the demand for mental health services has increased, but there is very inadequate supply of services as reported by the Suicide Prevention India Foundation (SPIF) [21].

Research by UN Women During the Pandemic

Between July and October 7, 2020, research undertaken by UN Women on the socioeconomic impact of COVID-19 underscored, in clear numerical terms, the speed and

intensity of the depletion of human capital [22]. The key areas of this empirical enquiry were a gender analysis of the impact of the pandemic on people's lives and livelihoods and consequent food insecurity, health insecurity, well-being, and empowerment. The respondents represented the religious, social, and cultural mosaic of the population. Representative samples were selected from ten million plus people in cities as well as some rural areas from 14 states. Although the focus of research was to access the impact of COVID on women's lives, its impact on the lives of men and on the lives of the members of the LGBTQ community was also studied. A total of 1221 persons were surveyed. These included 210 men, 970 women, and 41 members from the LGBTQ community. This empirical research explored the impact of COVID-19 on their health and well-being. Its key findings are discussed below:

Health and Livelihoods

The study showed that there was a huge drop in the number of female workers from 65% pre-lockdown to 36% post-lockdown. The biggest drop was in the LGBTQ community—from 87% pre-lockdown to 15% post-lockdown. The figures for men were 88% pre-lockdown and 61% post-lockdown. These findings clearly point to the need of focusing interventions on those who are most affected—women and the LGBTQ communities. The same pattern emerged when the earnings of casual laborers were analyzed. Sixty-three percent women and 75% of the LGBTQ community had no earnings post the lockdown. The figure for men was 46%. Among the salaried employees, women (39%), the LGBTQ community (75%), and men (15%) were looking for jobs after the lockdown was lifted. Eighty-six percent of the LGBTQ community had no work post-lockdown. It should be noted that all three groups, men, women, and LGBTQ community members had enough money to last them for one month only. Their survival was clearly at stake. Most were entering a state of indebtedness. Only 32% seemed to be in a position to pay off their loans.

Food consumption by men, women as well as by the members of the LGBTQ community had decreased after the lockdown. The LGBTQ community was the hardest hit. More women than men consumed less food than they had consumed before the lockdown. Sixty-four percent of the respondents had to curtail several food items in their diets. Men, women, and the LGBTQ community members were similarly impacted in this area. And so the health and nutrition of families and households living in deprivation was affected.

Disease Prevention and Treatment

This research showed that knowledge about COVID-19 and its prevention was high among men, women, and the LGBTQ community. Thus, the information campaigns undertaken by the Government of India and NGOs seemed to have been successful.

People had information on wearing masks, washing hands, not going out unnecessarily, and maintaining social distance. However, they did not know how to translate this knowledge into behaviors for prevention and care. This was because although 44% of the respondents lived in *pucca* houses and 34% in semi-*pucca* ones, 48% had to use shared toilets outside their homes, and 39% had no water supply. A number of these individuals were living with ailing senior citizens, pregnant women with newborns and infants in small premises. This shows that COVID-19 is not just a health issue. It is a structural issue. And, therefore, there are several challenges that need to be addressed. The situation of the LGBTQ community was worse in terms of infrastructure as 48% were living in very small spaces.

Very few of the respondents had undergone a COVID test. Only three positive cases had been diagnosed—one each among the 29 women, ten men, and four members of the LGBTQ community who had been tested. Regarding care of ailing senior citizens, in 88% cases, care was being provided by women and girls and only 12% by men. The study revealed that access to emergency health care was minimal. Only 23% of the women had been visited by an ASHA worker since the pandemic began. And only 58% of the women had access to medicines when they needed them. A mere six percent of the women who needed contraceptives had been able to obtain them. Vaccination was available to 41% of the pregnant women. Only 25% of infants got their regular vaccinations. As many as 30% of the respondents had no knowledge about the availability of healthcare services.

Violence and Mental Health

The UN Women study did not confirm the findings of the literature review regarding an increase in the reporting of violence by women. Although 42% of the women had information about the helplines that had been set up for reporting abuse, only 3% used these helplines. Another 3% had filed a first information report (FIR) with the police. Eighty-four percent of the respondents did not report domestic violence. Only 10% of the women reported that they were facing violence in their homes. Of these, 51% were facing emotional violence, 47% were facing physical violence, and 2% sexual violence. The focus group discussions (FGDs) confirmed that women had difficulty in reporting violence as they were under watch all the time by their abusers. Some women reported violence when the abusers were not within earshot. This state of affairs is indicative of the reality that women need safe spaces even to report violence. Safe spaces need to be created as an integral part of the COVID-19 response. The repercussions of violence on mental health could be serious if there is no enabling environment for reporting violence. The study showed that violence was on a rise but was not being reported.

Seventy-five percent of the respondents believed that the underlying reason for increase in violence was hunger. Twenty-five percent believed that the increase in domestic violence was because of excessive drinking by their husbands who had no jobs to report to. Because alcohol was not available during the lockdown, men

became violent. According to the women, 71% of the perpetrators of violence were men, and 29% were women.

Violence against the LGBTQ community increased on several fronts—landlords, neighbors, and even their own family members perpetuated violence. Some shared that the behaviors of family members changed after their incomes stopped. They were not given proper food and care as before. The LGBT community was accused of spreading the disease which had led to an increase in neighborhood violence.

Child Abuse and Child Marriage

The research showed that parents were willing to take their children to their workplace to earn extra money during these difficult times. Child begging had increased. Women were taking their kids along for begging to get public sympathy. Children were being used to sell addictive substances and were, therefore, exposed to drugs as well as to the coronavirus.

Cases of child marriage increased because of a government order which permitted only 20 people to be present at weddings. People felt that they would not have the resources to feed the entire village if they postponed their daughter's marriage. Therefore, they wanted to marry off their daughters as early as possible—while the government order was still in force. Cases of elopement also increased because girls were running away from forced marriages.

COVID-19 and the LGBTQ Community

The LGBTQ community lives under the same patriarchal system as other women. Though their experiences may differ, many of their needs overlap. And their problems require the same solutions. Stonewall's research shows that one in four lesbians and bisexual women experience domestic abuse in their relationship. Almost half (49%) of all gay and bisexual men had experienced at least one incident of domestic abuse from a family member or partner since the age of 16 [23].

The United Nations made a call for all states to assess the impact of COVID-19 on lesbian, gay, bisexual, transgender, and gender diverse persons when designing, implementing, and evaluating measures to combat the COVID-19 pandemic as violence may disproportionately affect LGBT communities [24]. National health organizations have warned that some members of the LGBTQ community may be particularly vulnerable to the effects of the disease. The reasons for increased risk include higher rates of cancer, HIV, and smoking, as well as discrimination in health care. There are also concerns about reduced support for LGBTQ members, particularly for those living in unsafe family environments [25].

Transgender may be able to conceive even while taking testosterone. The intrauterine device (IUD) and other non-hormonal methods are good contraceptive options

for those who are on testosterone. In one study, 88% of trans-men reported using no protection. Pregnancy appeared to be desired in some trans-men; 68% had a planned pregnancy, while in 32% cases, pregnancy was unplanned. Bisexual adolescents have higher rates of unplanned pregnancy than their heterosexual peers [23].

LGBTQ communities in India are experiencing the winds of change. In October 2015, the Lucknow bench of the Allahabad high court directed the Uttar Pradesh Government and the State Election Commission to provide for inclusion of the third gender in documents including nomination papers. This followed a judgment by the division bench of the chief justice, D Y Chandrachud and justice Shree Narain Shukla who gave the order on a public interest litigation (PIL) for providing a column for the third/transgender in forms for the *panchayat* elections in Uttar Pradesh. In Pune on October 18, 2017, Dnyaneshwar Kamble, 40 years of age, was elected as Maharashtra's first-ever transgender *sarpanch*. These positive changes have been kept in mind as the following recommendations are made.

Need to Orchestrate a Multi-stakeholder Response

As women toil as producers and carers, they have a precarious existence. The threat of sudden dispossession is ever present in their lives. This is often associated with structural factors which get accentuated by unforeseen events like the COVID-19 pandemic. There are strong arguments in favor of increasing women's knowledge on health care including mental health and in strengthening women's agency.

Institutions of local governance are needed for creating a poverty buffer for women and the LGBTQ community. Due to the lack of health security and depleting financial resources of those infected and affected, a grave situation has resulted which has led to hunger, starvation, and food insecurity. This should be addressed by transferring assets in the form of common property resources to deprived communities including women and the LGBTQ community. In rural areas, key asks include a recognition of leased assets as eligible collateral for working capital loans usually provided through government schemes such as *Atma Nirbhar* which provide initial activation capital.

Relief packages for COVID-19 prepared by the Government of India need to be reworked in terms of their gender responsiveness. The experience of unpaid work in the area of health care by women in their homes or by ASHAs in the health delivery system has not been a rewarding experience. The COVID-19 pandemic offers an opportunity to correct this aberration by making these paid services. Local government resources could be pooled to create dedicated premises that can serve as low-cost, no-frills community health and wellness centers especially in locales where the government primary health center is more than five kilometers away. This will not only enhance the much-needed health infrastructure in rural areas, but will also promote community participation in infection prevention and will reduce stigma and discrimination. A partnership approach between the *panchayats*, local NGOs, women's SHGs, and representatives of the LGBTQ is recommended. It is imperative that the medical insurance packages provided by the government under *Ayushman*

Bharat to men and women should cover the running costs of the newly set up health and wellness centers. Insurance companies should finance the costs of the medical services and of the much-needed human resources.

The challenges of weak primary health centers (PHCs) in India are being increasingly recognized and acknowledged. The National Health Policy, 2017 recommended strengthening the PHC system by investing more funds. There will be an increase in overall government funding for health to 2.5% of the gross domestic product (GDP) by 2025, against 1.18% in 2015–16 [26]. Following on the National Health Policy 2017, the Government in India announced the *Ayushman Bharat* Program in February 2018. This program has two components: (1) health and wellness centers (HWCs) to strengthen and deliver comprehensive primary healthcare services; and (2) the *Pradhan Mantri Jan Arogya Yojana* for secondary- and tertiary-level care for the bottom 40% families.

Health and wellness centers would address the existing challenges in the PHC system. But their effectiveness will depend on the translation of policy to implementation with the engagement of communities, civil society, and other stakeholders. There is a need to shift services from a 'doctor-centric' to a 'team-based' approach with the involvement of mid-level healthcare providers with limited prescription rights. This approach has been given legal status by its inclusion in the National Medical Commission (NMC) Act, 2019 [27].

Strengthening Women's Agency: Including LGBTQ Community

The COVID-19 Task Force does not have gender parity for providing a gendered response to this unprecedented pandemic. The COVID-19 Task Force has two women and 14 men; a mere 14.3% of its members are women. A ground swell to push for a gendered approach is needed. The multiple stakeholder response discussed above to create a strong women's agency would help to address the challenges of this unprecedented pandemic. Why is an expanded and strong women's agency needed to stall the gendered impact of this pandemic? The examples given below are self-explanatory and provide the evidence.

During the economic crisis in 2009, more than 13 million people lost their jobs because of the slowing economy and the drastically reduced expenditures on social services. Health care moved from being an entitlement to a service that needed to be purchased. With no purchasing power in the hands of the people, the burden was borne by women. Women came to the rescue by subsidizing care costs by their unpaid labor. Thus, they saved the countries from falling into inter-generational poverty.

The learnings from the HIV/AIDS epidemic were no different. When sickness depleted social capital within communities, again women came to the forefront to replenish social capital by taking on the added burden of caring for the sick. In African countries where the problem of HIV was very severe and health infrastructure was

inadequate, women caregivers in the community responded. A large number of young girls, who had to be taken out of school, became caregivers. There are documented examples of how husbands ran away from their homes in order to avoid the burden of caregiving. In this situation, women experienced a negative economic shock, as some researchers put it. Negative economic shock indicates that household income is reduced to very low levels in a short time span.

But amidst these dark statistics there was a ray of home. The grip of the HIV virus pulled Zimbabwe away from development and prosperity. All indicators such as life expectancy, child mortality, per capita income, and literacy were on a decline. But in spite of this, the country made progress on the human poverty index. The human poverty index (HPI) provides an aggregated measure of the prevalence of poverty in a community. The HPI draws attention to deprivation in three elements, namely longevity, knowledge, and a decent and healthy standard of living. The human development report of 1999 showed that because of HIV, 50% of the population was income poor. But going by this indicator, only 25% of Zimbabweans were experiencing poverty [27].

Today, businesses are rapidly adopting flexible work arrangements, which are likely to continue. Could working from home be empowering for some women? Could this be an opportunity for equalizing gender relations? With schools and day care centers closing, many fathers have had to take primary responsibility for childcare. Could this erode social norms leading to a lopsided division of labor that burdens women? Could women, if trained well as caregivers, become the much-needed resource as India is expanding its health infrastructure? Is this an opportunity to get the 3Cs (cooking, caring, and cleaning) counted as work?

Concluding Comments

Over the last three decades, women in India have achieved greater control over their fertility. Life expectancy has increased. Women have more opportunities for education and employment. Economic growth and expansion of the service sector which employs large numbers of women will be important in supporting women to avail of the development gains. Before the pandemic in countries like India, where they were no pension plans, women remained economically active even after the age of 50. COVID-19 is threating these gains. It is affecting the physical and mental health of women and other deprived sections of society. Preserving human capital is, therefore, a priority. Timely investments should be made to develop enabling strategies. Women leadership should be strengthened using modern technologies for providing functional digital literacy. Strengthening women's agency is a critical imperative.

Appendix 1. Number of Confirmed Cases, Number of Deaths, and Percent Male Deaths by Country

Country	Total number of confirmed cases	Confirmed cases (% male)	Total number of deaths	Deaths (% male)	Date reported
U.S	2,239,121	NA	103,337	54	Jun 17, 2020
Peru	257,447	58	8,223	71	Jun 22, 2020
Spain	248,335	43	20,527	57	May 21, 2020
Italy	238,050	46	33,209	58	Jun 16, 2020
England	228,742	43	37,664	57	Jun 17, 2020
Germany	190,431	48	8,880	55	Jun 22, 2020
Mexico	185,122	55	22,584	66	Jun 22, 2020
Pakistan	185,034	74	3,695	71	Jun 22, 2020
Bangladesh	115,786	71	1,502	77	Jun 23, 2020
South Africa	105,308	43	2,100	52	Jun 23, 2020
Canada	101,276	44	8,412	46	Jun 23, 2020
Sweden	60,837	41	5,161	55	Jun 23, 2020
Belgium	60,567	37	7,016	51	Jun 19, 2020
China	55,924	51	2,114	64	Feb 28, 2020
Netherlands	49,631	38	6,095	55	Jun 23, 2020
Indonesia	47,896	53	2,535	61	Jun 23, 2020
Argentina	42,785	51	1,016	57	Jun 22, 2020
Columbia	40,719	55	1,308	61	Jun 08, 2020

Source Reinsurance Group of America (RGA), 2020

References

1. Madan R. India working to reduce reliance on Chinese drugs as tensions rise. The Straits Times; 21 June 2020.
2. Acharya R, Gundi M, Ngo TD, Pandey N, Patel SK, Pinchoff J, Rampal S, Saggurti N, Santhya KG, White C, Zavier AJF. COVID-19-related knowledge, attitudes, and practices among adolescents and young people in Bihar and Uttar Pradesh. India: Population Council; 2020.
3. Mahler DG, Lakner C, Aguilar RA, Wu H. The impact of COVID-19 (coronavirus) on global poverty: why Sub-Saharan Africa might be the region hardest hit. World Bank; 2020.
4. Population Council India. Migration and COVID-19: Uttar Pradesh and Bihar. Poverty, Gender, and Youth, Population Council; 2020.
5. Mehta AK, Shepherd A, Bhide S, Shah A, Kumar A. Towards solutions and new compacts in a dynamic context. India chronic poverty report. New Delhi: Indian Institute of Public Administration; 2011.

6. Lieberman A. Women and children lose 20% of health, social services to COVID-19. Devex; 2020.
7. Marie Stopes International. 9.5 million women could lose access to our services. Marie Stopes International; 2020.
8. Ahmed Z. COVID-19 could have devastating effects on adolescents' sexual and reproductive health and rights. New Security Beat: the blog of the Environmental Change and Security Program; 2020.
9. Shahina KK. Missing in lockdown: lakhs of pregnant women and newborns. The Federal; 2020.
10. ETHealthWorld. Where does India stand in the global home healthcare sector? ET HealthWorld, The Economic Times; 28 Nov 2018.
11. NSO India. Key indicators of social consumption in India: Health. NSS 75th round (July 2017–June 2018). National Statistical Office, India; 2019.
12. Express News Service. Nearly half adolescents in Delhi-NCR addicted to internet: Survey. The New Indian Express; 19 Feb 2020.
13. Zee Media Bureau. Husband rips open pregnant woman's stomach to check baby's gender in UP's Badaun. India: Zee News; 20 Sept 2020.
14. Kumar S, Rana M. Lockdown reinforced gender roles, more women abused. The Asian Age; 3 June 2020.
15. Saikia P. Warriors keep fighting for women, even during pandemic. Tehelka; 17 July 2020.
16. Jha N, Dixit P. A doctor was assaulted on her way to the hospital. She's not the only medic being attacked. BuzzFeed News. 2020 Mar 25.
17. Jain MA. Pregnant during COVID-19: Expecting mothers left in the lurch by India's healthcare system as tackling pandemic takes priority. Health News, Firstpost; 12 June 2020.
18. Mohanty D. Asha worker attacked for collecting data on Covid-19 patients in Odisha. Hindustan Times; 24 Apr 2020.
19. Pandey A. Sons leave 82-year-old mother in fields after she tests coronavirus positive in Telangana. India Today; 7 Sept 2020.
20. Myupchar. Domestic abuse during COVID-19 lockdown: how to get the help you need. Health News, Firstpost; 16 Apr 2020.
21. Westcott B, Renton A, Woodyatt A, Wagner M, Hayes M, CNN. September 7 coronavirus news. CNN World; 8 Sept 2020.
22. Nath MB, Dutta M. UN Women socio economic impact of COVID-19: gender perspectives. New Delhi: UN Women; 2020 (Forthcoming).
23. Nath MB. May I have your ATTENTION please. Indian books and Periodicals; 2019.
24. Office of the United Nations High Commissioner for Human Rights. COVID-19: the suffering and resilience of LGBT persons must be visible and inform the actions of States. Geneva: United Nations Human Rights Office of the High Commissioner; 2020.
25. Kuhr E. Coronavirus pandemic a perfect storm for LGBTQ homeless youth. NBC News; 5 Apr 2020.
26. Kumar R. National Medical Commission Act 2019: white paper on accelerated implementation of family medicine training programs towards strengthening of primary healthcare in India. J Family Med Primary Care. 2020;9(1):1.
27. Malaba J. Poverty measurement and gender: Zimbabwe's experience. United Nations Secretariat Department of Economic and Social Affairs Statistics Division; 2006.