

Disparities, Desperation, and Divisiveness: Coping With COVID-19 in India

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India enforced one of the world's largest lockdowns in the last quarter of March 2020 to minimize the impact of the COVID-19 pandemic. This commentary focuses on the mental health implications of the ongoing pandemic as well as the lockdown that lasted for more than two months and is still in place in certain areas. Whereas loneliness, stress, anxiety, and depression have been widespread, vulnerable sections of the population, including daily wage workers, migrant laborers, religious minorities, women and children, and the elderly, have been facing various forms of economic, sociopolitical, and familial stigma, racism, and violence. By and large, the COVID-19 pandemic has widened all forms of societal disparities in India.

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India, home to about one sixth of the global population, imposed a nationwide lockdown to combat the COVID-19 pandemic at the end of the day on March 24. After multiple extensions, India's lockdown continued until June 7, followed by phased relaxations, barring containment zones, where lockdowns are in place until the end of June. Although the state of Kerala in India has exemplified the response to a pandemic of this scale by aggressive testing, contact tracing, and cooked meals (Masih, 2020), the country overall has been overwhelmed. According to data published by the Center for Systems Science and Engineering (CSSE), Johns Hopkins University, India had more than 380,000 confirmed COVID-19 cases and more than 12,500 deaths as of June 19 (Dong, Du, & Gardner, 2020). Despite a relatively slow rise in COVID-19 cases count, as evidenced by less than 35,000 cases on April 30, there has been a steep increase thereafter. Considering India's close to 1.4 billion population, it is worth mentioning that India has one of the lowest daily COVID-19 testing rates ("Daily COVID-19 Tests," n.d.).

Despite potential underreporting of COVID-19 cases and deaths, it is likely that India's strategy of lockdown, or stay-at-home orders, coupled with aggressive contact tracing, quarantining, and monitoring, were successful in keeping the spread of the

virus in check initially (Vaidyanathan, 2020). The existence of the Integrated Disease Surveillance Programme, a national surveillance network, enabled India to deploy hundreds of public health workers to monitor millions of citizens in rural, suburban, and urban communities and identify clusters of disease early enough to put containment measures in place (Vaidyanathan, 2020). However, such measures came at a steep cost ever since the lockdown was announced with less than 4 hours' notice (Chatterjee, Malathesh, & Mukherjee, 2020). Despite the announcement of an economic stimulus package worth nearly US\$260 billion on May 13 (Ahmed & Roy, 2020; Bhagwati, 2020), closer analyses by experts suggest the actual value of the stimulus to be relatively low (Ahmed & Roy, 2020; Bhagwati, 2020). Lockdowns have had devastating economic impacts with job losses of hundreds of thousands of laborers, vendors, and other daily wage earners living at or below the poverty line, including the reality of deaths because of starvation from loss of livelihoods.

Another highly vulnerable group comprises senior citizens, who are at high risk of severe COVID-19 manifestations and complications (Centers for Disease Control and Prevention [CDC], 2020a). Many older adults in India live alone, do not own a personal vehicle, and/or are unable to drive. Being limited to nonexistent public transportation amid the lockdown makes it difficult to access essential items, including groceries and medicines. In addition, social distancing coupled with restricted mobility have heightened their loneliness and anxiety (Aravind, 2020). Yet, the aforementioned senior citizens represent relatively privileged sections of the society, as opposed to daily wage earners, migrant laborers, and/or those elderly individuals, who depend on their children and family for financial needs or otherwise. Indeed, of the nearly 8% above age 60 in India, more than half are estimated to live in villages, belong to poor socioeconomic status, are dependent on families, and/or are widowed (Lena, Ashok, Padma, Kamath, & Kamath, 2009; Rajan, 2001).

The ongoing COVID-19 pandemic and social distancing have resulted in enormous stress, predisposing millions across the globe

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to anxiety, depression, substance use, and other psychological manifestations (CDC, 2020b). Those with preexisting mental health problems have a high risk of relapse and/or exacerbation of their symptoms (Chatterjee et al., 2020). Mental health issues in India reportedly increased by 20% within a week of the lockdown going into effect (Naik, 2020). More than half (168) of all non-COVID-19 deaths (326) in India from the imposition of the lockdown until May 9 that were reported in the media were due to suicide (Srivastava, 2020). The mental health of women and children is at a particularly high risk, primarily because of a higher likelihood of experiencing and/or witnessing domestic violence because the potential perpetrator(s) and/or the victim(s) are at home for prolonged hours. Indeed, incidents of domestic violence nearly doubled between the first and the last weeks of March, as evidenced by complaints received by the National Commission for Women (Chowdhry, 2020). Consequences of domestic violence during a lockdown can be magnified by the isolation, inability to seek help from support networks, and school closures (Chowdhry, 2020).

The current pandemic has amplified existing social and economic divides manifesting as frequent discrimination against religious minorities and lower castes (Sur, 2020). Specifically, the COVID-19 pandemic and concomitant misinformation have magnified the precarious situation of India's 200 million Muslims (Perrigo, 2020), who were already reeling from the impact of two recent decisions made by the Indian government. These include the revocation of special autonomy of Kashmir, a Muslim-dominated area, in August 2019, followed by a brutal crackdown on its residents, and the more recent introduction of a citizenship law that is blatantly discriminatory toward Muslims nationwide (Gettleman, Schultz, & Raj, 2020; Yasir & Gettleman, 2019). Even before the aforementioned crises, decades of unrest and violence between Indian security forces and Kashmiri militants had taken a heavy toll on the mental health of civilians, a majority of whom experienced conflict-related traumas. A survey by *Médecins sans Frontières* (2016), revealed that nearly 50% of adults living in the Kashmir Valley had significant mental distress, including 41% with depressive symptoms, 26% with anxiety symptoms, and 19% with posttraumatic stress disorder symptoms. Against the backdrop of a generalized hopelessness among Muslims, especially among those living in Kashmir, COVID-19-induced lockdowns and social distancing have resulted in a mental health crisis with an alarming increase in depression, anxiety, and psychoses (Yasir, 2020).

An early cluster of COVID-19 cases happened to be in Delhi among attendees to a religious gathering hosted by a Muslim missionary group. Although the event started prior to the implementation of the lockdowns, more than 1,000 participants continued to stay at the center, a move for which the missionary group has been widely criticized even by other Muslim leaders. Meanwhile, hundreds of congregants had already left the gathering and were traveling to more than half of all Indian states, further complicating the situation (Gettleman et al., 2020). These were widely reported, with distortions and exaggerations, resulting in a confluence of widespread coronavirus panic and religious tension. Social media campaigns with Islamophobic hashtags (Ghoshal, 2020) and fake videos (Chaudhuri & Sinha, 2020) of intentional COVID-19 transmission by Muslims spread like wildfire. Anti-Muslim rhetoric as well as physical attacks intensified as social media hate campaigns accused Muslims of deliberate "Corona

Jihad," the false idea that Muslims were weaponizing COVID-19 to deliberately harm Hindus (Perrigo, 2020, para. 6). Ironically, mass gatherings hosted by other religious groups, even after the lockdown was announced, have drawn little attention (Sharma, 2020). In addition to fears for life and safety, this stigmatization of the Muslim community could act as a barrier against symptomatic individuals' seeking health care and/or being tested.

Phobia stemming from the coronavirus pandemic has also endangered doctors, nurses, and other health care professionals as well as airline staff. As in most countries, health care workers in India are already at a high risk due to widespread nonavailability of personal protective equipment, bureaucracy, and other infrastructural issues in the health care system (Nalgundwar, 2020). Medical staff in India have been harassed while attempting to screen populations, while working in hospitals, and while living in their housing communities, sometimes even being forcibly evicted by landlords (Yeung, 2020). Furthermore, instances of harassment perpetrated against fellow citizens who returned to India from abroad earlier this year have been reported (Ghosh, 2020).

Although India's coronavirus lockdown is in effect until June 30 in the high-risk zones, the generalized phased easing of restrictions since June 8 has raised concerns among public health experts. Data from the CSSE at Johns Hopkins University (Dong, Du, & Gardner, 2020) reveal a nearly 48% increase in confirmed COVID-19 cases between June 8 and June 19, validating concerns about premature easing of restrictions. Although lockdowns have had a profound economic impact, reopening before the curve flattened could result in skyrocketing of COVID-19-induced morbidity and mortality, especially among those belonging to the lowest socioeconomic status.

India faces an uphill battle before the COVID-19 pandemic abates. An unwavering commitment to diversity and plurality, empathy, and kindness were never more important. Lawmakers, government officials, and administrators at all levels need to comply with scientific recommendations irrespective of political fallouts, walk back on some of the reopening plans if cases show an increasing trend, and be transparent in providing complete information to the public. It is imperative to provide low-cost mental health services that are widely accessible, with options for online consultation. Governments should provide unconditional economic support to millions of Indians struggling to make ends meet and ensure that the benefits actually reach those with the highest need. It remains to be seen whether this pandemic serves as a clarion call to revamp public health care in India, including an increased focus on mental health care as an essential service.

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