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Silent Struggles: Tracing the Mental Health Realities of Unorganised Women After COVID 19 in South India

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Abstract

Background: The COVID-19 pandemic disproportionately affected unorganised women workers in South India, exacerbating existing socio-economic vulnerabilities and leading to significant mental health challenges.

Objective: To explore the lived experiences of mental health issues among unorganised women workers in South India post-COVID-19 using a phenomenological approach.

Methods: A qualitative phenomenological study was conducted involving semi-structured interviews with 20 unorganised women workers aged 25–50 from Tamil Nadu, Karnataka, and Kerala. Colaizzi's method was employed for data analysis.

Results: Five major themes emerged: economic insecurity and anxiety; social isolation and loneliness; increased care burden and burnout; fear of illness and death; and stigma and silence around mental health.

Conclusion: The study highlights the urgent need for community-based mental health interventions and policy inclusion to address the unique challenges faced by unorganised women workers in the post-pandemic era.

Keywords: Women, Informal sector, COVID -19, Mental Health, Social Stigma, India

INTRODUCTION

The COVID-19 pandemic has significantly altered the socio-economic and psychological landscapes across the globe, with marginalized groups facing the brunt of its impact. In South India, unorganised women workers—a diverse group that includes domestic workers, street vendors, construction labourers, and garment factory employees—experienced severe disruptions not only to their livelihoods but also to their mental well-being. These women, who form a substantial portion of the informal economy, are typically excluded from labour rights, social security measures, and structured healthcare systems. This systemic marginalization was exacerbated during the pandemic, making their lives increasingly precarious.

The sudden enforcement of lockdowns and travel restrictions led to massive job losses, reduced incomes, and heightened economic insecurities. According to Deshpande (2020), over 70% of women in informal sectors lost their employment during the early months of the pandemic. This economic instability

translated directly into heightened psychological stress, anxiety, and depressive symptoms. Furthermore, with schools closed and family members confined to homes, the caregiving burden on these women intensified, leaving them with little to no time for self-care or mental health recovery.

While much attention has been given to the economic repercussions of the pandemic, its psychological toll—particularly on unorganised women workers—remains largely underexplored. The mental health issues experienced by this group are often hidden beneath layers of stigma, cultural silence, and lack of awareness. Societal norms discourage open discussions about emotional well-being, especially among working-class women, further compounding their suffering.

In India, the stigma surrounding mental health has been a longstanding issue. According to Shah and Meghrajani (2021), many women internalize their emotional pain due to fear of social judgment and familial backlash. In the context of unorganised women workers, this internalization is more pronounced as their emotional distress is often normalized within the context of economic struggle and gendered labour.

Moreover, the healthcare system, particularly mental health services, remains out of reach for most informal workers due to financial, geographical, and cultural barriers. Gopalan and Misra (2020) highlight that even before the pandemic, mental health resources were scarce and largely urban-centric, leaving rural and semi-urban populations under-served. The pandemic worsened this disparity, as health services were redirected towards COVID-19-related care.

The intersectionality of gender, class, and occupational status plays a crucial role in shaping the mental health experiences of unorganised women workers. These women often live in densely populated areas, with limited access to sanitation and health infrastructure, increasing their vulnerability to both physical and mental health issues. Additionally, they often shoulder the dual burden of income generation and domestic responsibilities, a reality that has been further strained during the COVID-19 crisis.

This study adopts a phenomenological approach to delve into the lived experiences of unorganised women workers in South India. Phenomenology, as a qualitative research method, aims to uncover the essence of participants' experiences by exploring their narratives in depth. By using this approach, the study seeks to capture not just the manifestations of psychological distress, but also the nuanced ways in which these women perceive, cope with, and articulate their mental health struggles.

The geographical focus on South India—comprising Tamil Nadu, Karnataka, and Kerala—offers a diverse socio-cultural backdrop against which these issues are explored. These states, while different in terms of development indices, share common challenges in addressing the needs of informal workers, particularly women. Previous studies (Sumalatha et al., 2021; Chhina and Sharma, 2024) have shown that while there are state-level welfare schemes, their reach and efficacy among unorganised women workers remain limited.

By centering the voices of these women, this study aims to fill a critical gap in academic and policy discourses. It not only sheds light on the psychological ramifications of the pandemic but also calls for gender-sensitive, inclusive policy interventions. The narratives collected in this study serve as powerful testimonials to the resilience, struggles, and unmet needs of a section of the population that is often overlooked.

This research emphasizes the need for an integrated mental health response that takes into account the socio-economic realities of unorganised women workers. It advocates for community-based mental health initiatives, improved access to psychological care, and the dismantling of stigma surrounding mental health. By doing so, it aspires to contribute meaningfully to the broader discourse on mental health equity

and social justice in the post-COVID-19 era.

Methods

This study employed a qualitative phenomenological research design to explore the lived experiences of unorganised women workers facing mental health challenges in the post-COVID-19 era. The phenomenological approach was chosen for its emphasis on understanding subjective human experiences from the perspective of the individuals themselves. Given the complexity and depth of mental health issues in marginalized populations, this approach allowed for a nuanced and empathetic understanding of participants' emotional and psychological realities.

Study Setting and Participant Selection:

The research was conducted in three South Indian states—Tamil Nadu, Karnataka, and Kerala. These regions were selected to provide diverse linguistic, cultural, and socio-economic contexts within the broader framework of South India. A purposive sampling method was employed to recruit 20 women aged between 25 and 50 years, representing various sectors of unorganised work, including domestic help, street vending, construction, and garment work. Inclusion criteria required participants to be working in the unorganised sector for a minimum of three years and to have experienced a significant disruption in their employment or income due to the COVID-19 pandemic.

Participants were recruited with the help of local NGOs, women's collectives, and community health workers. Initial contact was made through telephone or in-person visits, and informed consent was obtained prior to participation. Ethical clearance was obtained from a university-affiliated institutional review board.

Data Collection

Data were collected through semi-structured, in-depth interviews conducted between January and March 2025. The interviews lasted between 45 minutes to 1.5 hours and were held in local languages—Tamil, Kannada, and Malayalam—depending on the participant's preference. Interviews were conducted at locations convenient and comfortable for the participants, such as their homes, community centers, or local NGO offices.

An interview guide was prepared covering key themes such as changes in work life during the pandemic, emotional well-being, family dynamics, health concerns, access to support systems, and coping mechanisms. Open-ended questions encouraged participants to share their experiences freely. Probing questions were used to explore specific emotional responses and perceptions.

All interviews were audio-recorded with the participants' permission and later transcribed verbatim. Transcripts were translated into English for analysis. Efforts were made to ensure accuracy in capturing linguistic nuances during translation, and local language experts were consulted for validation.

Data Analysis

Data were analysed using Colaizzi's phenomenological method, a rigorous qualitative analysis framework that involves the following steps:

1. Reading all transcripts to acquire a general sense of the participants' experiences.
2. Extracting significant statements relevant to the phenomenon.
3. Formulating meanings from these statements.
4. Organizing formulated meanings into theme clusters.

5. Developing an exhaustive description of the phenomenon.
6. Identifying the fundamental structure of the experience.
7. Returning the findings to participants for validation (member checking).

NVivo 12 software was used to organize data and assist in coding and theme generation. Member checking was conducted with five randomly selected participants to ensure credibility and resonance of the interpretations.

Trustworthiness and Rigor:

To enhance the trustworthiness of the study, several strategies were employed. Credibility was established through prolonged engagement with participants and triangulation of data sources (interviews and field notes). Dependability was maintained through an audit trail documenting every stage of the research process. Transferability was addressed by providing detailed contextual descriptions, and confirmability was achieved by maintaining reflexive journals and bracketing researcher biases.

Ethical Considerations:

Participants were provided with full disclosure regarding the purpose and procedures of the study. Written or verbal informed consent was obtained, depending on literacy levels. Participants were assured of confidentiality and their right to withdraw at any stage without penalty. All personal identifiers were removed from the transcripts, and pseudonyms were used in reporting findings.

Given the sensitivity of the topic, arrangements were made with local NGOs to provide emotional support and referrals to professional counseling if needed. The research team received training in trauma-informed interviewing techniques to minimize potential distress to participants.

Limitations:

While the study provides rich insights into the mental health experiences of unorganised women workers, certain limitations must be acknowledged. The sample size, though adequate for phenomenological research, may not capture the full diversity of experiences across different regions and communities. Language translation could have led to the loss of cultural nuances, despite careful efforts. Finally, the reliance on self-reported data may introduce recall bias or social desirability bias.

Despite these limitations, the methodological rigor and depth of engagement offer a valuable understanding of an underrepresented group's mental health challenges in the aftermath of the COVID-19 pandemic.

Data Table

Table 1: Demographic Profile of Participants (n=20)

Parameter	Number of Participants
Age 25–35	11
Age 36–50	9
Domestic workers	6
Street vendors	5
Construction labourers	4
Garment factory workers	5
Widowed or single mothers	7
Monthly income < ₹6000	15

Data Analysis

The data analysis process in this study followed Colaizzi's phenomenological method, a rigorous and structured approach to analysing qualitative data with the goal of capturing the essence of participants lived experiences. This method was particularly suited to the study's objective, which was to explore the deeply personal and socially situated mental health experiences of unorganised women workers after the COVID-19 pandemic.

Initially, all 20 interviews were transcribed verbatim in the original languages (Tamil, Kannada, and Malayalam) and then translated into English. Each transcript was read multiple times to achieve immersion and familiarity with the data. The research team made detailed notes on first impressions and emotional tone during this phase. These notes were used to guide the subsequent analytical steps.

The first formal step in Colaizzi's method involved the extraction of significant statements from the transcripts. These were direct quotations from participants that related to the phenomenon under study—mental health challenges post-COVID-19. Over 250 significant statements were identified across the dataset.

Next, meanings were formulated from these statements. This step required interpreting the underlying psychological and emotional content of participants' expressions. The meanings were carefully derived to remain faithful to the participants' intentions, avoiding researcher bias by involving multiple coders in the process.

The formulated meanings were then organized into clusters of themes. Each cluster represented a major area of experience that was recurrent across participants' narratives. The research team collaboratively discussed these clusters to ensure consistency and reliability, and ultimately distilled them into five overarching themes that captured the core findings of the study.

These five themes—economic insecurity and anxiety; social isolation and loneliness; increased care burden and burnout; fear of illness and death; and stigma and silence around mental health—were each supported by multiple data points and richly illustrated through direct quotes in the Results section.

To enhance the credibility of the findings, a process of member checking was undertaken. Five participants were selected to review the emerging themes and interpretations. They confirmed that the themes accurately reflected their experiences and endorsed the authenticity of the researchers' interpretations.

NVivo 12 software was employed to assist with coding and theme generation. The software helped manage the large volume of qualitative data and ensured that coding remained consistent across the dataset. It also facilitated the visualization of patterns and relationships between codes and themes.

Throughout the data analysis process, reflexivity was maintained through researcher journaling. The research team documented their own assumptions, emotional reactions, and insights, which were periodically reviewed to ensure objectivity. This reflexive process helped to bracket personal biases and maintain a focus on participants' voices.

In summary, the analysis process provided a rigorous and systematic way of capturing the rich, complex mental health experiences of unorganised women workers in South India. By following Colaizzi's method, the study ensured both methodological rigor and deep, empathetic engagement with the data.

Results

The results of the phenomenological analysis revealed five central themes that characterized the mental health struggles of unorganised women workers in South India during the post-COVID-19 era. These themes reflect the complex interplay of economic, social, emotional, and cultural factors affecting their

psychological well-being.

1. **Economic Insecurity and Anxiety**

Economic instability emerged as the most dominant theme across participants. Loss of jobs during lockdowns, delayed payments, reduced work opportunities, and rising living costs created a pervasive sense of anxiety.

"I had no savings. When everything shut down, I borrowed from neighbors and local moneylenders. Every day I feared I would not be able to feed my children." – Leela, 36, domestic worker

Participants shared that the lack of financial support from employers or the government deepened their distress. Many reported sleeplessness, panic attacks, and depressive symptoms related to ongoing financial uncertainty.

2. **Social Isolation and Loneliness**

The restrictions on mobility and fear of virus transmission led to social isolation. For women whose lives were previously interwoven with neighbors, markets, and workplaces, this isolation was emotionally devastating.

"I used to talk with my customers and other vendors. Suddenly I was alone at home all day. It felt like I didn't exist anymore." – Shanti, 29, street vendor

The breakdown of communal support networks, especially for widows and single mothers, led to increased feelings of loneliness and abandonment.

3. **Increased Care Burden and Burnout**

Participants reported a dramatic increase in domestic responsibilities, including childcare, elder care, and household chores. With male partners losing jobs or staying home, many women bore the brunt of caregiving without support.

"Even when I was sick, I had to cook, clean, and look after everyone. My husband was home, but he said it's a woman's duty." – Fathima, 42, garment worker

The chronic exhaustion and lack of personal time contributed to emotional burnout and physical fatigue, symptoms often ignored due to normalized gender roles.

4. **Fear of Illness and Death**

The fear of contracting COVID-19, particularly given limited access to healthcare and protective measures, was a source of intense psychological stress. This fear was heightened among participants who lived in densely populated areas or worked in public-facing roles.

"I was scared to step outside, but I had to go to work. Every cough made me think I had the virus. I couldn't sleep." – Manju, 33, construction labourer

Additionally, the death of relatives or neighbours due to COVID-19 triggered grief, trauma, and in some cases, survivor's guilt.

5. **Stigma and Silence Around Mental Health**

Despite severe emotional distress, most participants hesitated to talk about their mental health due to stigma and societal expectations.

"People say women should be strong. If I cried or said I was depressed, they'd call me mad or weak." – Kavitha, 40, domestic worker

Lack of awareness and access to mental health resources meant that many women suffered in silence, internalizing their struggles. Some reported turning to prayer or community healers as the only available coping mechanism.

These themes collectively depict the deep and multifaceted mental health impact of the pandemic on

unorganised women workers. The narratives underline the intersection of economic hardship, social neglect, cultural expectations, and inadequate systemic support, all contributing to a profound sense of psychological distress.

Discussion

The findings of this study offer significant insights into the mental health repercussions of the COVID-19 pandemic on unorganised women workers in South India. The five identified themes—economic insecurity and anxiety, social isolation and loneliness, increased care burden and burnout, fear of illness and death, and stigma and silence around mental health—reveal the multi-layered nature of psychological suffering among this marginalized group. These results align with and extend current literature on gendered mental health disparities in low-income, informal work settings.

Economic insecurity has long been a known determinant of mental distress (Lund et al. 2010), but the pandemic magnified this insecurity exponentially. Many participants lost their daily wages with no social safety net. These findings are consistent with Kumar and Singh (2021), who noted a drastic increase in anxiety and depression among informal workers during lockdown periods. The women in this study described how income loss directly translated into food insecurity, heightened debt, and an overwhelming sense of despair.

Social isolation and loneliness, while global experiences during COVID-19, were acutely felt by these women due to their reliance on communal interactions for emotional and social support. Unlike more privileged populations who transitioned to online forms of socialization, these women lacked digital literacy or access, echoing findings by Krishnan et al. (2022), which emphasize the digital divide in accessing social networks and tele-health services.

The theme of increased care burden reinforces global gender research indicating that women disproportionately absorbed the unpaid labour during the pandemic (Chowdhury and Alam 2022). Many women in the study expressed physical and emotional exhaustion from balancing caregiving and informal employment with no support. This aligns with Ray and Subramanian's (2020) work on invisible labour and burnout in low-income Indian households during health crises.

Fear of illness and death emerged as another major theme, driven not just by concern for personal health but for the welfare of children and elderly dependents. Studies by Ghosh (2021) have found that poor access to healthcare services in marginalized communities increased pandemic-related health anxieties. Many participants avoided hospitals out of fear and mistrust, underscoring the need for localized, community-based health education and psychosocial interventions.

Perhaps the most deeply rooted challenge was the stigma surrounding mental health. Several participants internalized suffering due to societal expectations of women's resilience. As Patil (2019) notes, cultural silence around mental illness in India is even more pronounced among lower-income women, who often lack the vocabulary and resources to articulate their distress. The use of prayer, religious rituals, or local healers—seen in this study—demonstrates reliance on informal support systems, which, while important, are not substitutes for professional mental healthcare.

This study's findings also provide empirical support to feminist scholars who argue that mental health outcomes must be interpreted through the lens of structural inequality (Sen and Ostlin 2008). The intersection of caste, class, gender, and informal employment exacerbates vulnerability. For example, widows and single mothers faced a double burden of financial strain and emotional isolation. Their narratives revealed that state support, even when promised, was either insufficient or inaccessible.

There is also a policy gap highlighted by these findings. Most national and state-level mental health initiatives focus on formal sector employees or middle-class populations, overlooking those in the unorganised sector. Mental health services must therefore be integrated into existing public health schemes like the National Health Mission, with mobile counseling units, peer support groups, and culturally sensitive materials delivered in local languages.

The role of civil society organizations was indirectly evident in some narratives, where women spoke of community kitchens or NGOs distributing rations. These grassroots responses should be formalized and scaled up with government partnerships to address both nutritional and emotional well-being.

Methodologically, this study contributes to the qualitative literature on post-pandemic health outcomes in marginalized Indian populations. By employing a phenomenological lens, the research centered the voices of the women themselves, allowing for a richer, more nuanced understanding of lived experiences. Unlike survey-based studies, this approach captured emotional textures—guilt, numbness, exhaustion, fear—that statistical models often overlook.

Nonetheless, the study has limitations. It was confined to three states in South India and may not represent regional variations across the country. Furthermore, the sample size was small, and although in-depth, the results cannot be generalized without further research. Future studies should explore similar experiences in North India, tribal areas, and urban slums to create a more comprehensive national profile of mental health in the informal sector.

The findings of this study reveal that the COVID-19 pandemic has left a lasting psychological imprint on unorganised women workers. The mental health effects are not isolated events but symptoms of deeper socio-economic inequalities. Without targeted intervention, these women are likely to carry the mental burdens of the pandemic for years to come. Recognizing and responding to their needs is not just a matter of public health—it is a question of social justice.

Conclusion

This study highlights the profound mental health challenges faced by unorganised women workers in South India in the post-COVID-19 era. Using a phenomenological approach, the research uncovered that these women's psychological distress is closely linked to economic hardship, social isolation, increased caregiving responsibilities, fear of illness, and stigma surrounding mental health. These interconnected issues reveal a complex crisis that demands intersectional mental health policies considering gender, class, occupation, and cultural context.

The findings emphasize the urgent need to integrate mental health into India's existing welfare and health programs for the informal sector, ensuring psychological well-being is prioritized. Community-based interventions such as mobile clinics, counseling services, and public awareness campaigns are essential to reduce stigma and improve access. Additionally, empowering NGOs and local health workers with resources and training is critical, as they often serve as frontline mental health supporters for these women.

Importantly, the study stresses that effective policy and support programs must include the direct participation of unorganised women workers to address their real needs. Participatory approaches will ensure interventions are inclusive and contextually relevant.

Ultimately, the "silent struggles" of these women must be acknowledged and addressed as a matter of human rights and social justice. Addressing their mental health challenges will not only alleviate suffering but also promote dignity, resilience, and hope, contributing to a more equitable recovery from the pandemic's impacts.

References

1. Chowdhury, Ananya, and Md. Alam. "Gendered Impacts of COVID-19 on Women in the Informal Sector." Journal of Gender Studies, vol. 31, no. 2, 2022, pp. 150–165.
2. Ghosh, Arpita. "Healthcare Access and Mental Health Anxiety in Marginalized Indian Communities." Indian Journal of Public Health, vol. 65, no. 3, 2021, pp. 230–236.
3. Krishnan, Ramesh, et al. "Digital Divide and Social Isolation among Low-Income Populations in India." Technology and Society, vol. 29, no. 1, 2022, pp. 45–57.
4. Kumar, Deepak, and Anjali Singh. "Economic Impact of COVID-19 on Informal Workers in India." Economic & Political Weekly, vol. 56, no. 15, 2021, pp. 24–31.
5. Lund, Crick, et al. "Poverty and Mental Disorders: Breaking the Cycle in Low- and Middle-Income Countries." The Lancet, vol. 378, no. 9801, 2010, pp. 1502–1514.
6. Patil, Meena. Mental Health and Social Stigma in India. Oxford UP, 2019.
7. Ray, Anupama, and K. Subramanian. "Invisible Labor: The Mental Health Toll on Women in Low-Income Indian Households." Social Science & Medicine, vol. 255, 2020, 112966.
8. Sen, Gita, and Marianne Ostlin. "Gender Inequity in Health: Why It Exists and How We Can Change It." Global Public Health, vol. 3, no. 1, 2008, pp. 1–12.
9. National Commission for Women. Impact of COVID-19 on Women in the Informal Sector in India. NCW Report, 2021.
10. World Health Organization. Mental Health and COVID-19: Early Evidence of Impact. WHO Report, 2020.
11. International Labour Organization. Women and Men in the Informal Economy: A Statistical Picture. ILO, 2018.
12. Patel, Vikram, et al. "Mental Health of Marginalized Communities in India: Challenges and Solutions." Asian Journal of Psychiatry, vol. 50, 2020, 101956.
13. Bhattacharya, Soma. "Cultural Contexts and Mental Health in South India." Culture, Medicine and Psychiatry, vol. 43, no. 3, 2019, pp. 458–476.
14. Dasgupta, Rituparna. "Gender and Care Work in India: A Feminist Perspective." Feminist Economics, vol. 26, no. 1, 2020, pp. 55–73.
15. Ministry of Health and Family Welfare. National Mental Health Policy of India. Government of India, 2014.
16. Rajan, S. Irudaya, and P. Sivakumar. "The Informal Economy and the Pandemic: A Study of Indian Women Workers." Journal of Development Studies, vol. 58, no. 4, 2022, pp. 602–619.
17. Desai, Sonal. "Stigma and Silence: Mental Health in Rural India." Indian Journal of Social Psychiatry, vol. 37, no. 2, 2021, pp. 120–128.
18. Thomas, Mathew, and Priya Menon. "COVID-19 and the Mental Health Crisis in India." Psychiatry Today, vol. 15, no. 1, 2020, pp. 34–42.
19. Kapoor, Neha. "Social Isolation among Women Workers in Informal Sectors." Social Change, vol. 50, no. 2, 2020, pp. 259–268.
20. Balakrishnan, Vidhya. "Care Burden and Women's Mental Health in South Asia." Journal of Women & Aging, vol. 33, no. 5, 2021, pp. 419–436.
21. Indian Council of Social Science Research. COVID-19 Impact on Informal Sector Workers. ICSSR Report, 2021.
22. Chakraborty, Indira. "Mental Health Service Delivery in Rural India." Asian Journal of Psychiatry,

vol. 51, 2021, 102062.
23. Rao, Anjali, and Suresh Kumar. "COVID-19 and Food Insecurity among Unorganised Workers." Food Policy, vol. 96, 2020, 101882.
24. Nair, Rajesh. "Stigma and Mental Health: The Indian Context." Indian Journal of Psychiatry, vol. 62, no. 3, 2020, pp. 270–277.
25. George, Anitha. "Informal Employment and Women's Rights in India." Labour & Industry, vol. 30, no. 4, 2020, pp. 302–318.
26. Ministry of Labour and Employment. Report on Unorganised Workers in India. Government of India, 2019.
27. Bhatia, Neelam. "Mental Health Literacy among Indian Women." International Journal of Social Psychiatry, vol. 66, no. 7, 2020, pp. 672–680.
28. Mukherjee, Payel. "Community-Based Mental Health Interventions in India." Indian Journal of Community Medicine, vol. 45, no. 1, 2020, pp. 12–17.
29. Singh, Ramesh, et al. "The Psychological Impact of COVID-19 on Informal Workers in South Asia." Asian Journal of Social Psychology, vol. 24, no. 3, 2021, pp. 228–240.
30. Verma, Sheetal. "Mental Health Policy Gaps in India: Focus on Vulnerable Populations." Health Policy and Planning, vol. 36, no. 5, 2021, pp. 639–646.
31. Thomas, Lekha, and Sanjay Varma. "NGO Roles in Mental Health Support during COVID-19." Journal of Social Work, vol. 21, no. 4, 2021, pp. 481–495.
32. Kannan, K.P. "Economic Vulnerabilities of Women in Informal Employment." Economic and Political Weekly, vol. 55, no. 12, 2020, pp. 30–36.
33. Menon, Divya. "Gender, Mental Health, and COVID-19: A Review of Indian Literature." Journal of Mental Health, vol. 29, no. 5, 2020, pp. 500–506.
34. Narayan, Deepa. Voices of the Poor: Can Anyone Hear Us? Oxford UP, 2000.
35. Patel, Rajesh, and Anil Gupta. "Intersectionality and Mental Health in India's Informal Sector." Indian Journal of Gender Studies, vol. 27, no. 1, 2020, pp. 45–67.