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SOCIAL REPRESENTATION OF HEALTH AND COVID-19 AMONG FEMALE DOMESTIC WORKERS IN DELHI-NCR

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Abstract

Economically vulnerable populations in urban areas have been disproportionately affected by COVID-19 and the subsequent lockdowns, social distancing norms and minimisation of work opportunities. While the government announced several schemes and relief packages, the benefits have not reached everyone in need. Further, as economies shut, lack of land and housing added to the existing precariousness of the economically disadvantaged groups majorly employed in informal sectors. As such, taking social responsibility and applying health information adhering to the latest COVID-19 protocols has different implications for the economically vulnerable groups compared to others, as they are pushed beyond the margins. Considering this context, the present study aims to explore shared thinking about health in general and COVID-19 in particular among female domestic workers in Delhi-NCR. This qualitative study draws on the social representations theory to uncover the participants' representations of health. Data were collected using semi-structured interviews and were subjected to thematic analysis. An understanding of the representations around health literacy and COVID-19 among the urban poor is more topical than ever to manage public health emergencies. Understanding discourses surrounding health and illness have essential implications for the identification of gaps in awareness and struggles of individuals within a community. It would also help increase cognizance of failures at the systemic level which would benefit from policy changes and public health interventions.

Keywords: COVID-19 pandemic, health, health literacy, social representations theory, female domestic workers

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1. Introduction

Since the establishment of modern medicine during the nineteenth century, the concept of health has been revised from the biomedical view of 'mere absence of diseases' to a conceptualisation including complete physical, social, and psychological well-being (Callahan 1973). For instance, Kazarian and Evans (2001) defined health in terms of objective signs of dysfunction in the body as well as subjective symptoms marking disease or injury. Health has also been defined on a continuum with health being the dominant state at the wellness end of the continuum and illness or injury on the other end of the continuum (Sarafino & Smith 2014). Over the last two decades, cognitive psychologists have investigated lay representations of health and well-being in numerous studies, pioneered by Leventhal and colleagues (1980). The suggested model, which includes representations and labels for symptoms, consequences of problems and modes of healing, has been criticised for ignoring the socio-cultural context in people's representations.

Social Representations Theory (SRT), introduced by Moscovici (1988) focuses on such contextual issues. Using qualitative methods, studies applying SRT attempt to uncover the social and cultural contexts of the researched. This becomes especially important as individuals living in socially-constructed spaces with other individuals develop over time 'codes' for understanding and relating to one another. These common codes become the foundation on which social relationships, power dynamics and cultural practices are built and practised.

In this chapter, we examine the meaning of health among female domestic workers (FDWs) in Delhi-NCR, the capital territory of India. A region marked by high levels of labour migration both skilled and unskilled, for employment opportunities, Delhi-NCR is estimated to be home to around 500,000 domestic workers (ILO 2016). Domestic workers are workers in domestic households, expected to perform a wide variety of tasks, ranging from *'chutkan kaam*' (specific, short tasks) of cleaning the house, washing utensils and doing the laundry to larger responsibilities around childcare or elder care and cooking. Due to the informal and unorganised nature of the sector, domestic work provides an important entry point for females into the workforce. According to a policy brief by Women in Informal Employment: Globalizing and Organizing (WEIGO), flexibility around deciding one's

schedule, ease of entry to the profession and the low skill and educational requirements make it a viable option for females migrating from other states (Alfers 2020). The same report also highlights that the majority of these workers have multiple employers, as the demand is largely for part-time work, raising their workload to over 40 hours per week. The unorganised nature of the sector, without any work contracts 'invisibilizes' workers' rights (Mahanta & Gupta 2019). FDWs are currently not covered under protective labour litigation, despite work-related risks including at-work injuries, lack of bargaining power, poor treatment by placement agencies and sexual harassment. Further, while several government schemes offer healthcare services to FDWs, it becomes difficult for them to access good quality health care and receive maternity leave or other benefits. Their benefits and rights are usually dependent on the generosity of the employer rather than ascertained by legal protection. Lack of awareness around such rights makes the available resources even more inaccessible.

The COVID-19 pandemic exacerbated the challenges for FDWs. Around 80–90 per cent of the domestic workers in the region have been estimated to have lost their jobs as housing societies and resident welfare associations (RWAs) restricted their entries citing safety concerns (Bhandari & Babu 2020). There were also problems with the collection of salaries for the month of March 2020 due to these mobility issues (Agarwal 2022). For live-in domestic workers, many had to serve as caretakers for families who employed them even when they tested positive for COVID-19. For a few others, the lockdown trapped them for months with abusive employers (Saluja 2022). Since many of the domestic workers belong to lower caste or ethnic minorities, systemic discrimination through separation of utensils and restrictions around entering temples inside homes is also extant (Torgalkar 2017). Due to the fear created by the pandemic, domestic workers were not hired back even after the lockdown restrictions were lifted. While the government provided support to informal workers through cash grants, domestic workers were largely unable to avail them as they were not covered by the Unorganised Worker's Social Security Act 2008. As of today, domestic workers have filed a written petition for an ex-gratia amount for money they were earlier denied. Domestic workers have also not been able to access other assistance schemes including ration assistance as some did not have ration cards (Bhuniya 2022). Not having access to smartphones and the long processes involved in availing these services have also acted as deterrents (Ghosh & Kaur Bilkhu 2021).

Even outside of the COVID-19 crisis, healthcare remains an important issue of social protection for domestic workers (Alfers 2020). In fact, the same WEIGO report outlined that ill-health and injuries related to work were the most frequent reason for domestic workers to miss work. The same report also highlighted that 50 per cent of domestic workers studied in the project reported serious injuries or illnesses in the past 12 months, and around 56 per cent mentioned that these injuries or illnesses resulted in them missing work. Over 70 per cent of these participants were also not paid for sick leave.

The social and economic crisis accompanying the global health emergency presented by the COVID-19 pandemic brought forth the vulnerabilities of the FDWs and the larger group of the urban poor. High-density living arrangements and lack of adequate sanitation facilities extended a big challenge in containing the pandemic, especially within slum areas or informal settlements (Friesen & Pelz 2020). One of the major issues was implementing social distancing due to the high density of dwelling and persons per dwellings in such areas (Dahab et al. 2020). The greater prevalence of co-morbidities like hypertension, diabetes and other lung issues among socially disadvantaged groups, also increases the severity of the course of COVID-19 (Howard, Safford et al. 2017; Jordan, Adab & Cheng 2020).

While researchers and administrators have been working on plans to contain the spread of COVID-19 among different sections of the community, a more thoughtful, long-term approach would be essential to manage public health emergencies effectively in the future. This would include greater awareness around FDWs conception of health and the economic, infrastructural, cultural and geographic influences on them. Friesen and Pelz (2020) suggest the inclusion of the local communities in taking community-appropriate measures. In the same vein, the use of SRT allows for understanding (i) the varying and sometimes competing systems of knowledge and information, (ii) the role of representation in maintaining one's practices albeit stigmatising, and (iii) the impact of such representations on health and well-being at the individual, family level and the larger social level (Howarth, Foster & Dorrer 2004). To elucidate, SRT provides a space for different knowledge systems to be examined in their own context, rather than looking at them as errors, deficiencies, or biases (Moscovici 1984). It perceives differences as a result of varying perspectives and values behind these knowledge systems. Representations are seen as generational and can be

understood as 'taken for granted' realities (Marková 1996). These representations can have psychological, economic and social consequences.

One's definition of health may influence health practices, alienate oneself from the healthcare system, and have poor consequences on compliance to treatment or practice of preventive health behaviours (Rodin & Salovey 1989). The facilitation of health behaviours also needs to be tailored to the health beliefs of the target population. Cultural explanatory models (CEMs) for instance have been employed by multiple studies to explain health (Rajaram & Rashidi 1998; Norman & King 2003). These models can explain the personal and social meanings of health and may influence health behaviours. Understanding patients' CEMs can improve the effectiveness of communication between doctors and patients and also the effectiveness of treatment strategies (Rajaram & Rashidi 1998). Further, patients are less likely to adhere to treatment plans if the healthcare system is seen as complex, aloof, and domineering. Lack of knowledge also serves as a deterrent in this context.

Keeping this context in mind, this paper seeks to explore the knowledge, beliefs, attitudes, community and cultural practices among the FDWs in the context of health in general and COVID-19 in particular. This extends a well-established line of research using the social representation approach to study health (Campbell 1997).

2. Method

2.1 Design

Considering the nature of the research objectives, a qualitative approach was deemed suitable for this work. The qualitative approach allows a deep exploration of people's perceptions and subjective experiences, generating rich descriptive data. It enables participants to have more control over directing the flow of communication, especially in the context of marginalised and vulnerable communities that may not be able to assert their voices on other platforms. Such a design allows power sharing and co-construction of knowledge. This study draws on SRT towards understanding the representations of health among FDWs employed in households in Delhi-NCR. In order to elicit the participants'

personal meanings regarding health, semi-structured interviews were conducted as they allow a deep exploration of people's meaning-making processes.

2.2. Participants

Participants included ten women between the age range of 21 to 45 years (M=30.4 years, SD=8.64), serving as domestic workers in Delhi-NCR. Part of the unorganised sector, the participants were working in multiple private households on a part-time basis, and were responsible for tasks such as cooking, cleaning, washing clothes, babysitting, etc. The methods of purposive and snowball sampling were used for procuring the sample and sufficient care was employed to ensure diversity in the participants' backgrounds. The sample size for the study was informed by reaching data saturation.

While two of the participants belonged to Delhi-NCR, others migrated to the city in search of employment opportunities. Regarding their residential status, the participants stayed in settlement colonies and slums near their places of work. Most of them reported staying in small rooms (*kamra*s) with their families, while others resided in make-shift houses (*jhuggies*). There was also considerable variability in the sample with respect to participants' educational level and family size (see Table 1).

Table 1

The demographic profile of the participants [N=10]

S. No.	Pseudonym	Age	Religious Orientation	Educational Background	Marital Status	Family Size	Migration Status?	Working hours
1.	Manju	28	Hindu	Till 8th Grade	Married	9	No	9
2.	Meenakshi	35	Hindu	No formal schooling	Married	7	Yes	8
3.	Anita	21	Hindu	Till 8th Grade	Unmarried	6	Yes	8
4.	Komal	26	Hindu	Till 6th Grade	Unmarried	4	Yes	7

5.	Chandni	24	Hindu	Till 3rd Grade	Married	11	Yes	7
6	Gita	45	Hindu	No formal schooling	Widowed	3	Yes	7
7	Rani	24	Hindu	Till 5th Grade	Married	3	Yes	11
8	Pooja	31	Hindu	No formal schooling	Married	15	Yes	10.5
9	Nidhi	25	Hindu	Doesn't recall	Separated	8	Yes	7
10	Seema	45	Hindu	No formal schooling	Married	7	Yes	8

2.3. Procedure

This study employed semi-structured interviews for the purpose of data collection, which were conducted in a face-to-face setting with each participant. Owing to the flexibility of the interview process and the scope it offers in eliciting people's subjective understanding and experiences, this method facilitates rich data (Brinkmann 2018). The schedule was created in Hindi, the language used was simple, inclusive and reflected the general vernacular of the participants. The questions were designed in an open-ended format, i.e., the participants were allowed to talk freely. Appropriate probes and prompts were incorporated wherever necessary. The questions covered the participants' perceptions about health, their health behaviours, and their understanding and experiences of the COVID-19 pandemic. As each interview was conducted, it was duly transcribed by the researchers and was subjected to thematic analyses using Braun and Clarke's (2006) method.

2.4. Ethical Considerations

The potential participants were provided sufficient information regarding the nature of the study, the required level of engagement from them, their rights as participants, and how the data would be utilised. They were also duly informed that participation is voluntary and

that they can choose to skip any questions that they find uncomfortable. Since the interviews needed to be audio-recorded, due permission regarding the same was also sought.

To maintain confidentiality, their real names and other identifying information have not been included. Instead, pseudonyms have been assigned to each participant and adequate precautions were implemented in data handling. Finally, a small compensation was provided to the participants in lieu of their time and contribution.

3. Results

The primary objective of the paper was to understand representations of health and the COVID-19 pandemic among FDWs in Delhi-NCR. The emergent themes are discussed below.

3.1. Understanding health

The researched were asked various questions about their conceptualisation of health. Three key ideas emerged in this context.

3.1.1. Health as central to life and livelihood. Several participants tied the idea of good health to their ability to work and earn their livelihood. Pooja, one of the participants shared, '*If we are healthy, we can do everything. We can move around, work well, earn well, and work with complete dedication.*' Motivation to work is seen as a direct reflection of one's good health. Interestingly, the idea of health was linked to their capacity to provide for their child's education, considered necessary to elevate their financial status. Ill health is seen as a situation that would prevent them from doing their best for their children.

3.1.2. The physicality of health. Most participants expressed that the health of an individual can be assessed by merely looking at them. For instance, Meenakshi mentioned, '*...You can tell by just looking at their faces. If the face looks down, it means health can't be good. If the face is 'blooming' you can tell health is good.*' Only one participant referred to the 'invisibility' of health problems referring to an instance wherein, '*..the person in front of you may be suffering, they may be in pain but you cannot see it. You may expect them to work well but because they are in pain, you can't see they can't work*.' Participants have also connected the idea of health with the size of an individual. For instance, being overweight

was seen as a symbol of poor health by some, other participants have tried to talk about balance, '*It should be medium. A person should neither be too fat nor too thin.*'

3.1.3. Stress as a deterrent to good health. Psychological well-being has been included as an important element in the conceptualisation of health with frequent references to the need for avoiding 'tension', or the importance of having a happy disposition. Some participants have mentioned that stress can exacerbate health problems and can even interfere with the uptake of nutrients in one's food. Talking about her father's illness, Rani narrates, '*...my father had a lot of tension. He died because of that. His mind was stressed. The stress gave him TB and the TB led to his cardiac arrest.*' Participants have also spoken about how their stress emerges from not having the resources to meet the responsibilities they have. For some, money is the key factor influencing this perception and influencing their level of stress. Problems with members of one's family or irresponsible behaviour of significant others was another source identified by the participants.

3.2. Engagement with health-related behaviours

3.2.1. Knowledge around health-relevant behaviours. The level of awareness around health-related behaviours varied across participants. Almost all participants referred to the consumption of 'good food' as the primary requirement for being healthy. The idea of good food, however, varied across participants with some emphasising the importance of balanced, nourishing, home-made food whereas a few mentioned consuming whatever they can manage. Fruits and milk were identified as 'good food'. A couple of participants referred to the importance of diversity in diet. One participant who usually cooks for different households also referred to the need for minimal consumption of oil. Most participants also agreed on the need for consuming food in a timely manner. For instance, one participant while expounding on the importance of eating food on schedule narrates the case of one of her employers, '*People who have food on a timely basis don't even need medicines… they have food on a fixed time everyday. Even on Sundays, they finish their breakfast by 8. They are healthy.*' Participants also spoke about the need to exercise, with many specifically referring to yoga. They cited examples of their employers who exercise early in the morning or go for a walk in the evening in order to remain active.

3.2.2. Behavioural intentions and actual behaviours. Participants' need to engage with health behaviours often begins with the need to ensure good health for their children. This includes cooking healthy meals for their children and also imparting to them knowledge about nutritious food and the need to stay active. Rani spoke about the need for family planning while referring to having a single child to ensure a good life for them, '*...many people ask me why we don't try for a second child even after so many years of marriage. But I want this one to have a good life. I want to take care of him. Many people have 6-7 children, my own neighbor has 13 children. How would one take care of so many?*'

Actual health behaviours, however, were influenced by financial and time constraints. Many participants explicitly stated having no time to take care of health, '*I wake up at 6 AM. I complete some work at my house and then rush to the society. I start working at 6:30. And I keep working till 1-2. Then I rush back home, do some work, cook, take a bath, have lunch, rest for some time and then I am back here and cook for 5 hours again. This is my exercise. This is my yoga.*' While participants emphasised the need for exercise in building a healthy life, they believed that the nature of their work itself served as its replacement.

Many participants also expressed that they attempt to manage health with their available resources. For instance, one participant mentioned, '*..we eat what we can afford.*' A couple of participants also mentioned that they couldn't take good care of their children's health because of the hours they worked. The time constraint also results in participants tending to use over-the-counter medications to manage their symptoms instead of resting so as to not miss work.

3.2.3. Perceived status of one's own and family's health. The majority of participants believed that they are healthy. Many also believed that the nature of their work and exposure to varied living conditions builds resistance to illness. Pooja, a participant speaking about the belief in one's own health says, '*..a lot of our employers give us food. I can't say no to them but none of the food does us any harm*.' Only one research participant mentioned having poor health.

3.2.4. Relationship with healthcare. Participants' relationship with healthcare was influenced by a wide range of factors including their assessment of their health situation and challenges in accessing healthcare. Many participants used alternative medicines and home

remedies for children. Nidhi, for instance, mentions, '*I am the doctor for my children. I can take care of basic problems at home. We go to doctors only in case of something serious.*'

With respect to institutional healthcare, the nature of illness becomes a deciding factor. While government hospitals provide free consultation and medication, they are visited only for illnesses considered 'serious' as the hospitals are difficult to access. A large proportion of people are dependent on these government institutions for quality health care, resulting in longer queues and waiting time—a privilege that FDWs do not have. Further, doctors are seen as largely busy with limited time for each patient. Private hospitals are considered 'money-making' enterprises. Most participants mentioned approaching low-fee private clinicians as their consultations are cheaper and more accessible. During the pandemic, private healthcare providers also became the only viable option so as to avoid crowds in larger hospitals.

Some participants also discuss difficulties in seeking healthcare in larger hospitals as interactions with doctors and hospital officials seem more intimidating. Pooja says, '*We don't know what they say, whether we would be able to understand what they are saying*', reflecting an alienation from the larger healthcare system.

3.3. Representations of COVID-19

3.3.1. Initial confusion and varied definitions. As per the participants, the onset of the COVID-19 pandemic was marked by considerable disorientation. Amidst the limited and often contradictory information available about COVID-19 during the early days, the participants reported feeling confused and came to decipher the pandemic situation in varied ways. For most of them initially, COVID-19 was considered like other known diseases such as the common cold, dengue and malaria. For some, it was conceptualised as a foreign phenomenon, one that they assumed would not percolate in their vicinity. Thus, in their representations of the disease, they expected it to be low in severity, limited in its transferability, and also experienced low perceived susceptibility to the disease.

However, all the participants narrated specific turning points where their early perceptions experienced a potent shift. Some described the government-imposed lockdown as a wake-up call, which forced them to confront the seriousness of this illness, whereas others

explained that it was during the devastation caused by the second wave of the pandemic and the associated fatalities that allowed them to realise its severity. Komal explained, '*At first, when COVID began, we thought that it's okay, it's just going to be like cough and cold... but when we saw that people were dying, then we were also very scared. We realised that this is a very bad thing in reality*.'

In this regard, the participants also mentioned the various sources from which they continued to seek information in order to better understand the situation. Most of the participants reported relying on the media and the government as a source of information, others explained that they depended on people around them (such as family members, employers, and other domestic workers) to provide them with reliable updates.

3.3.2. Bearer of suffering. For most of the participants, the descriptions of the pandemic mostly centered on it being a bearer of suffering, posing as a source of illness, loss and pain. They cited many examples of the impact of the virus on people's health as well as the many cases of COVID-related deaths around them. As Pooja mentioned, '*It brings sickness to the body. It will destroy the body with sickness, what else? It is killing people.*'

Overwhelmingly, a description of the situation as '*bad*' and '*terrible*' was presented repeatedly by the participants. They explained it as a thoroughly difficult situation, using phrases such as, '*...bad time for everyone*', '*nasty disease*', '*bad thing*', '*a lot of trouble*', and '*so many people died*'. The virus as a source of fear was a recurrent idea, with many participants frequently talking about the fear and panic they would experience at the slightest sign of illness around them during this period. Almost all of them reported being significantly stressed about the unpredictable nature of the disease and struggled with making sense of what would happen against an illness that does not seem to go away. As described by Chandni, '*Sometimes I feel that it's never going to end. Who knows for how long this will go on?*' Komal stated, '*I thought, what is this? Or what will happen? We were so afraid of this thing, right… Didn't think that something like this would happen since things were so bad… We were very scared… like what is this*?'

Another important factor that was specified as a major cause of COVID-related suffering was the loss of livelihood experienced by many participants. They also acknowledged that many of the negative outcomes associated with COVID-19 impacted all

classes of people in a similar way. As an extension of this idea, one of the participants described the pandemic situation as a teacher, imparting to her a deeper appreciation and value of life. She mentioned, '*Corona was such a deadly disease. It taught us the value of everything… work, money, people… Many people with money were also not able to save [themselves].*'

3.3.3. Strategies for keeping safe. A salient aspect of the participants' definitions regarding the pandemic moved beyond their understanding of the situation but instead focused on the various attempts made by them to keep themselves and their families safe. Thus, in many cases, the explanations about COVID-19 revolved more around their behavioural responses to the situation.

In this context, all the participants emphasised the importance of taking precautions. When talking about the pandemic, most of them immediately listed many of the safety measures that they undertook to ensure their health and well-being. This included masking in public places, ensuring proper hygiene through repeated hand washing, sanitisation, maintenance of social distancing, isolation of sick family members and getting vaccinated.

Some of them mentioned that they regularly followed the instructions provided by the government officials, while others learned about the important precautionary measures from their employing families as they were expected to abide by the employers' rules in order to continue their work. However, some participants also dismissed such precautions and claimed that they felt safer resorting to alternate medicines and home remedies. They also mentioned changing their eating habits in the form of only consuming homemade food, restricting their intake of cold drinks and food items, drinking decoctions and avoiding food given by others. As shared by a participant, '*Where I used to work, they told me what to eat… to eat more onions, to drink neem-giloy decoction, to not eat or drink cold things. They said Corona will attack those who have cold and cough. They even told us not to eat food given by others. Earlier we would eat things that people would give but not now*.' Notably, Gita stated that they ultimately relied on God's grace for protection and regularly prayed and engaged in religious activities as a coping mechanism.

3.3.4. Re-orienting Perceptions. Participants reported a significant change in their perception of COVID-19 over time. Across their accounts, this change unfolded in multiple

ways. For some of the participants, this change simply reflected a shift at a much larger societal level. Participants reported experiencing lesser anxiety in light of declining cases, the relaxation of COVID-related protocols, accompanied by a change in attitudes of their employers and people around them. This reduced adherence to precautionary measures. For example, Nidhi stated, '*Recently, I had a cold and a cough… and I told them [the employer], but nobody asked me not to come.*" Some of the participants also complained about the inconvenience they experienced while accessing necessary precautionary resources and its interference with their work. For instance, Anita explained, "*It was very difficult, because we used to go to work and every time we had to first use sanitizer, wash up properly and then start work. So, half the time was wasted in that. Wearing a mask the whole time was difficult. Then when you leave from there, change the mask again, wash your hands… it was very inconvenient.*'

Further, for other participants, a change in perception of the pandemic was motivated by their pressing need for resuming work. As an economically and socially disadvantaged group, FDWs' livelihood were severely impacted by the COVID-19 pandemic. With the imposition of the lockdown and the continued suspension of work activities even after the lockdown was lifted, FDWs found themselves without support to sustain their families. Even when work resumed, many participants complained about being continually afraid that the situation would worsen, leaving them out of work again. Thus, their accounts reflected a certain need to reorient their perceptions, so that they could re-enter the workspace with ease. As Meenakshi stated, '*If you keep thinking about the disease, how will you work in the future? How will you eat? Now, this disease is going to stay, but it is also very important for us to get out and work. If we continue this way, we would not be able to ever leave the house. How will we earn and eat?*' This type of rationalisation about the situation was evident across multiple interviews. Many participants emphasised the need for lowering one's guard and to not continue feeling afraid of the disease. As Chandni casually mentioned, '*...we'll see what happens.*'

Interestingly, the same participants who earlier described their initial evaluation of COVID-19 as a scary disease and listed many precautions followed by them, later reclassified it as a hoax. Such participants cited examples of other domestic workers and neighbors around them who never contracted COVID-19, even when they were situated in congested

living conditions amidst poor access to important resources. This allowed some of the participants to re-evaluate their original positions about the pandemic. Moreover, the idea that COVID-19 is a 'rich people' disease also came up during the interviews, with a participant implying that their own lifestyle accords them with greater immunity. As she explained, '*I am not afraid. I have worked with everyone. I will work even if someone has* COVID *here, I am not afraid. I have never even suffered from a cough. I have never taken leave using sickness as an excuse... It's all in the head.*'

3.4. Experiences During the Pandemic

3.4.1. Struggles in a disorganised system. The most salient aspect of the participants' experiences during the pandemic referred to the wide array of struggles they experienced across different domains. While some of these struggles were described as personal in nature, others resulted from failure at a larger systemic level. With respect to personal struggles, participants elaborated on the difficulties they faced due to being stuck at home. A reference to feeling '*caged*' was reported by multiple participants. Large family sizes and living in compact spaces also made it difficult to isolate sick family members. The financial stress resulting from the loss of work was another crucial hardship. Owing to the financial pressures of city life, many participants moved back to their villages where they received greater social support as well as could rely on farm produce to feed their families. As explained by Pooja, '*In the village, you can seek help from others. Whom do we ask here?*'

However, traveling to-and-from the city was also a challenging experience. For many who remained stuck in the city, access to food was a major problem. Participants cited many examples of systemic failure, which considering their vulnerable position in society made this period exceedingly difficult. For instance, ration distribution endeavours by the government did not reach all stakeholders. Even when participants could avail of this facility, they found the food distribution drives to be disorganised and poorly executed. Some even referred to the government's poor execution of the lockdown.

3.4.2. Financial constraints. A major pain point expressed by the FDWs centered on their experience of suffering due to loss of gainful employment opportunities. As the lockdown set in, FDWs found themselves out of jobs. While some employers agreed to pay

them their wages even when they could no longer attend to work, many of them were denied their salaries or received only a meager portion of it. The lifting of the lockdown also did not mean immediate resuming of work, since many employing families continued to do their household chores by themselves in order to maintain social distancing. Thus, many of the participants found themselves jobless for much longer than they anticipated. In this context, a lack of financial support became a major challenge during this period. For instance, Rani shared, '*Our work stopped. We were behind rent for two-three months. It was difficult to arrange for food… the prices increased, shops were not opening… ration was not available.*' Similarly, Seema lamented, '*It affected us greatly. We had to leave for our village. There was a lack of food… there were many problems. No one could earn anything, there was no work. Only we know how much poor people like us had to suffer.*'

For many participants and other FDWs around them, their basic needs for food and shelter could not be easily met. Many of them resorted to taking loans, emptying their savings and borrowing resources from other people in order to sustain themselves and their families. In many households, the FDWs' spouses also lost their jobs, further widening the problem. Meanwhile, in some families, the domestic worker was the only earning member. Therefore, many such families had to cut back on important expenses and struggled to utilise the limited resources available even to cover the basic expenses. As one of them stated, '*I am doing it alone. You have seen how big my family is. For my children's tuition, I have to pay Rs. 3500. So what should I do? Should I ask them to leave school? Should I cut back on food? Or their clothes? What should I do?*'

3.4.3. The pain of missing work. The findings revealed that the loss of financial stability wasn't the only repercussion of loss of work. Many participants elaborated on the other ways in which missing work affected them. While some simply talked about experiencing boredom and restlessness due to being confined to their homes, others explained that they found this experience considerably uncomfortable and difficult. Talking about receiving help from their employers during the lockdown period, one of the participants shared her discomfort in taking money without doing any work. She acknowledged that receiving such help is not a sustainable solution, since, in the long run, no one would want to pay someone without any work in return. She explained, '*For how long will anyone pay you for nothing? We need employment, we need good work. Otherwise, if you don't do anything,*

you will not get paid for long…. And the person receiving help will also feel bad for taking free money. Someone who works, they feel good about eating food out of their hard-earned money.' In a similar vein, Komal referring to her despondence of not being able to work shared, '*It was terrible. We are working-class people and that is how we run our households. People like us cannot rest. We got tired of sleeping [during the pandemic]. How much ludo will you play? How much TV will you watch?*' Thus, the meaning of work went beyond its economic necessity and also covered its implications for how the participants viewed themselves.

3.5. The Way Forward

3.5.1. Lessons from the past. COVID-19-induced lockdowns while a challenging period for most of humanity exacerbated the precariousness of living and working conditions of FDWs. Most participants acknowledged and appreciated the support received from their employers. Some participants mentioned receiving up to two months' salary from their employer which came as a big support to many domestic workers. A few also acknowledged the support received from the government in the form of direct bank transfers, with feelings of gratitude. Gita, who had lost her job in a plywood factory during the first lockdown mentions, '*The government sent Rs.500/- to our account every month. For a poor person, this is it.*' Participants also mentioned receiving support from various other bodies through the lockdown and believe that some of the support was essential for them to tide over the rough months.

3.5.2. The gaps. While the participants acknowledged and appreciated support from several corners, the support was not sufficient to sustain their survival in the metropolitan context of Delhi-NCR. Two participants discussed moving to their distant villages with young children in tow, on foot, as they didn't think they would have enough resources to pay rent and buy food without being able to work. Some discussed experiences of hunger as they struggled to find affordable food or buy cooking gas. The monetary support from the government wasn't considered adequate to compensate for living expenses; several participants also claimed not to have received any support.

Relying on the 'generosity' of employers pushed many FDWs to the edge with some falling off the grid. The same necessitates the need for better welfare systems that provide a

cover for all individuals. One of the participants commented, '*...if we had some assurance that our basic needs are going to be met, we would not have set out like that*', referring to their movement back to their village. Drying up assistance from employers after a month or two also raises questions about whether alternative employment opportunities can be created for domestic workers since their salaries do not allow savings for the future and running households require money.

Participants also commented upon the disorganised state of distribution of resources made available by governments. This varied from different rules by several ration shop owners not providing ration on a monthly basis to the crowded distribution of resources. Participants can also benefit from better accessible healthcare facilities. While in Delhi, facilities like *mohalla* clinics have made healthcare accessible to many individuals, such facilities are absent in the NCR region.

4. Discussion

As explained in the results section, the COVID-19 pandemic impacted the lives of FDWs in significant ways. In this regard, understanding their representations of health and health behaviours provides important insights into their wider health-related experiences as a vulnerable section of society. The abysmal conditions under which FDWs operate have been described by various studies (e.g., Chandramouli 2018; Neetha & Palriwala 2011; Paul et al. 2018). Post-COVID, these conditions have further worsened and the issues and gaps highlighted in the results section need structural rectification. Other recent studies have also emphasised similar concerns (e.g., Ghosh, & Kaur Bilkhu 2020; Sumalatha, Bhat, & Chitra 2021).

It is important to note that the responses of a certain demographic group towards any crises is influenced in a potent form by the privilege accorded to them in a given society. In the context of COVID-19, comparing the experiences of FDWs with members from more privileged backgrounds brings out important systemic gaps. While many people belonging to upper-class backgrounds had the opportunity to maintain their pre-pandemic lifestyles even while working from home, the same freedom wasn't available to people from economically vulnerable backgrounds. For people from many occupational categories (including DW) often labeled as 'poor', their livelihood depends more on other, more powerful people than

the choices they make themselves. Thus, without being allowed to come to work, many FDWs struggled with making ends meet. Further, the rationalisation involved in changing their representations about the pandemic situation was directly influenced by the same lack of privilege. For an economically vulnerable individual, being scared of a contagious disease which requires distancing from others is not a practical option. This makes their rationalisations a motivated and necessary choice to remove any cognitive dissonance.

Notably, the impact of the pandemic also shows considerable variation with respect to gender as a social category. Chauhan (2021) highlights a widening of gender inequality and excessive burden of unpaid domestic work on women. A reference to this finding is also evident in the current study, with many participants shouldering major responsibilities within their own households. Most public health measures in times of COVID-19 assume that individuals will be able to acquire, comprehend and soundly apply health information. However, poor health literacy and one's economic situation can become major deterrents in applying health information at a fast pace. Thus, the development of any health policies cannot be executed in a social vacuum, instead, it requires an awareness of a community's social fabric and a customisation of interventions to suit the varied contingencies governing people's lives.

5. Conclusion

The present paper uses the Social Representation Theory to study the representation of health, health-related behaviours, and the COVID-19 pandemic among FDWs in Delhi-NCR. The results of the study present a shared understanding of health as (1) central to life and livelihood, (2) related to physicality, and (3) being adversely influenced by stress. Engagement of FDWs with health-related behaviours has also been discussed in the context of their extant knowledge, behavioural intentions, actual behaviours, and relationship with healthcare services. Experiences of FDWs during the COVID-19 pandemic in the context of their struggles due to systemic glitches, and their identification with work has also been discussed. It is expected that a clear understanding of representations around health and COVID-19 among FDWs will enable healthcare practitioners to tailor health messages that align with their belief systems and realities so as to encourage adherence to treatment plans.

Insights from the study also identified major challenges in applying health information. Findings are discussed in the context of policy recommendations.

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