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Women on the Frontlines of the COVID Pandemic

Vandana Vasudevan

Abstract

While the pandemic has been harsh to several demographic groups like migrant workers and elderly people, it has been particularly so for women, rolling back years of gains that feminists fought for in the spheres of employment, education and unpaid care work. Unpaid care work for women increased, with children studying from home and heightened care needs of elders in the family. Restricted movement during lockdowns and economic stress caused by job losses increased gender-based violence exponentially. A report by the Centre for Sustainable Employment at Azim Premji University found that 47% of women workers who lost their job between March and December 2020, were made permanently redundant, compared to just 7% of male workers. Yet, women were at the vanguard of the battle against the virus. A staggering 83% of health workers in India are women. About one million female community health workers and another 1.4 million Anganwadi workers have been checking up on families in their areas for symptoms and holding sessions on how to prevent COVID-19. Women self-help groups have made millions of masks and numerous meals have been prepared by women run community kitchens. More visible contributions were made by women with higher education like doctors, scientists and teachers. This paper documents the contributions of women on the frontline of COVID-19, fighting from the trenches, almost completely unsung and unhonoured but quietly helping India get back to normal, one day at a time.

Keywords: Ethic of Care, Women's work, Care

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'Care' in the Context of the Pandemic

As the modern philosopher Virginia Held has written, being cared for is a truly universal experience because 'every human being has been cared for as a child or would not be alive' (Held 2006). What does 'care' or 'to care' mean? Feminist scholar Diemut Bubeck (1995) writes, 'Caring for is the meeting of the needs of one person by another person... where the need is of such a nature that it cannot possibly be met by the person in need herself.' In the 1980s, American philosopher Nel Noddings provided one of the first comprehensive theories of care and argued that caring is the foundation of morality (Noddings 1984). In the COVID years, between 2020 and 2022, the human ability to care for another was tested like never before in living memory. In the context of the COVID 19 pandemic, Held's words could be paraphrased to say that 'every patient with COVID 19 has been cared for or would not be alive.' In fact, many of those who died were also cared for but succumbed to the virus because of other compromising factors.

The offering of care has been at the core of the response to the pandemic. Primarily health care professionals, 70% of whom are women according to the ILO (Pozzan and Cattaneo 2020), have delivered this care. They worked relentlessly, saving lives, performing quality health work under the pressure of the pandemic risks, whilst self-isolating to avoid spreading of the virus to their own families and friends.

As the COVID-19 pandemic and containment measures drastically changed everyday life, thousands of women across the globe took on tremendous additional burdens. With schools closing, the time spent on child supervision increased along with the care of elderly family members and COVID 19 patients at home. Non-availability of helpers such as domestic workers and reduction in other public services compounded women's domestic duties (OECD 2020). A study in the US showed that compared to 14 percent of men, 44 percent of women reported being the only one in the household providing care (Zamarro and Prados 2021). Women's continuous performance of care-work, either from within their homes or outside, often risking their safety to provide essential services, kept societies and economies running through the pandemic.

This paper presents how women were at the forefront of the pandemic response worldwide but takes a closer look at the Indian context. Given the centrality of caregiving to the pandemic, it is apposite that we look at their contributions through the lens of an Ethics of Care theory. The origins of the Ethics of Care lie in the cultural feminism of the second wave of the 1970s where its proponents sought an alternative way to look at the prevailing norms on moral development. Until the 1970s, moral theory was based on androcentric research that privileged principles of justice and equality over responsibility, concern and relationships, which were the mainstay of

women's caregiving experiences. This distinction was first made by Carol Gilligan in the 1970s (Gilligan 1977) and later supported by other feminist philosophers who found much value in women's practical experiences and ways of thinking and reasoning, which they claimed should be celebrated as stemming from feminine attributes and qualities. For this reason, the Ethics of Care is also called 'feminist ethics'. The Ethics of Care approach makes the nurturing of our immediate communities and the protecting of those closest to us the highest moral obligation. The focus of this approach is not on an independent actor but on a network of interrelated individuals. The clinical application of abstract principles, such as justice and equality, are replaced by the maintenance and harmonizing of human relationships. The Ethics of Care approach is less about the fair imposition of rules and more about encouraging social integration.

The Ethics of Care has been critiqued by some feminist as contributing to the age-old stereotype of women as being caring, motherly and gentle in contrast to the tough, pragmatic male. This, they believe will further oppress women and encourage their occupational segregation by restricting them to jobs which are seen to require such traits. However, care ethics has kept pace with postmodern thinking and still sits well with third wave feminism as it has freed itself from its gender-essentialist roots (Moreton 2017).

In the analysis of women's contributions that follows, we ally with one of the most popular definitions of care, offered by Joan Tronto and Bernice Fischer, which construes care as "a species of activity that includes everything we do to maintain, contain, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, our environment and other persons". (Tronto 1993) This definition posits care fundamentally as something to be practiced. Tronto further identifies four sub-elements of care that can be understood simultaneously as stages, virtuous dispositions, or goals. These sub-elements are: (1)attentiveness, a proclivity to become aware of need; (2) responsibility, a willingness to respond and take care of need; (3) competence, the skill of providing good and successful care; and (4) responsiveness- willingness of the one cared for to receive the care. Integrated as a whole, these four elements demonstrate the necessary attitudes or virtues that should be present in order for caring to be successful (Tronto, 1993).

In the following sections, we attempt to place women's contributions in each of these four categories. We spotlight how Indian women health sector professionals, journalists, self-help groups, social entrepreneurs, farmers, teachers and millions of women working at home, played an exceptional role during the pandemic. As examples of each of these runs into hundreds, only a few representative cases are mentioned. Needless to add this is but a small snapshot of the staggering scale at which women at various levels have been battling the pandemic.

Elements of Care

Attentiveness- A Proclivity to become Aware of the Need for Care

Attentiveness, or "caring about", is the phase of recognizing the correct need and realizing care is necessary. Caring relations extend well beyond the sorts of caring that takes place in families

and among friends, or even in the care institutions of the welfare state. It can extend to the social ties that bind groups together, to the bonds on which political and social institutions can be built, and even to the global concerns that citizens of the world can share (Held 2006). By recognising the exigencies of the pandemic early on, several women leaders at national, regional and local levels across the world demonstrated an awareness of the need for care.

Women leaders across the world have stood out for their success in responding to COVID-19. One study found that outcomes related to COVID-19, including number of cases and deaths, were systematically better in countries led by women. (*The Guardian* 2020) Another looked at governors in the United States and found that states with female leaders had lower fatality rates. At the level of local governments in the United States, women mayors showed proactive leadership. Even before the novel coronavirus, COVID-19, was declared a pandemic, prominent women mayors in the United States enacted proactive and innovative policies to prevent local outbreaks and soften the social and economic repercussions. Several Black women mayors, in particular, have led the way in local pandemic response efforts (Kendall 2020).

A diverse group of LGBTQ and women community leaders have navigated the Bay Area, California, through the pandemic, drawing from their experience of responding to the HIV/AIDS crisis. To meet the needs of at-risk and communities of colour they implemented a language access team and a racial and health equity team to address disparities (Cassel 2020).

Internationally, women innovators and scientists had been researching vaccines and pioneering treatments. One of the most essential research that made the COVID vaccine possible was that of Katalin Karikó, which focused on the therapeutic possibilities of mRNA. Özlem Türeci of Turkey, is the co-founder of the biotechnology company BioNTech which in 2020, developed the first approved RNA-based vaccine against COVID-19 (UN Women 2021a).

Responsibility – A Willingness to Respond and Take Care

Responsibility, or "taking care of", is the element of care that involves "assuming responsibility for the identified need and determining how to respond to it" (Tronto 1993). One of the most rapid responses to the changing circumstances came from school teachers. School teachers in India, most of whom are women, were expected to quickly learn the ropes of online teaching while many of them also struggled with lack of good internet access and adjustments to the work-from-home mode – managing their own children and controlling the children on screen. On May 28, 2020, UNESCO reported that around 2.7 million teachers from India who had been impacted by the pandemic are untrained to handle the changed situation. From that point, helped by trainings organized by the Central Board of Secondary Education (CBSE), they adapted quickly to the digital mode. Online classes became the norm in city schools and processes were streamlined in a remarkably short time. In rural areas, as Anganwadis (Child care centers in India) were closed, workers went door to door to teach young children and keep them engaged. For example, in Odisha, where 16 lakh children were locked at home, Anganwadi workers in collaboration with UNICEF launched a calendar based activity

program, often involving the menfolk in each house, to ingrain equal childcare responsibility (Ravichandran 2020).

Self Help Groups (SHGs)

In India, women's SHGs rose to the extraordinary challenge of COVID-19 pandemic. They met shortfalls in masks, sanitizers and protective equipment, ran community kitchens, fought misinformation and even provided banking and financial solutions to far-flung communities. Presented below are four areas which withstood the onslaught of the pandemic largely because of the women's SHGs. (The World Bank 2020)

Making protective gear
More than 2.96 lakh SHG members came together in the three months after the pandemic was declared, to produce more than 22.47 crore face masks by July 2020. Various categories of masks were produced by women SHGs, adhering to the advisories of the Ministry of Health and Family Welfare (MoHFW), Ministry of Consumers' Affairs and instructions of Health Departments of state. Women SHG members trained and experienced in stitching, used the opportunity of lockdown and initiated production of the masks. (GOI 2020)

Food security
Women workers and volunteers from non-profit organizations like the Self Employed Women's Association (SEWA) distributed rations, essential commodities and provided information about COVID-19 prevention to women and girls from the poorest and most marginalized communities. Women's SHGs ran ten thousand community kitchens set up by the Ministry of Rural Development in Bihar, Jharkhand, Kerala, Madhya Pradesh and Odisha among others. These kitchens spread across 75 different districts cooked nutritious meals, which were free or at very nominal rates, twice a day for nearly 70,000 daily wage labourers, migrants and homeless (GOI 2020).

Saheli Samanvay Kendra (SSK) community centers set up by the Indian government across the country act as local incubation centers to promote women's SHGs, provide skills training and public health information. The SSKs operate within Anganwadi centers that are part of the Indian public health care system, providing basic health care services and education for children in rural and marginalized areas. During the COVID-19 pandemic, the SSK centers have remained open, providing free meals, immunization and health check-ups for children, pregnant and lactating mothers, and helping women access government assistance programs (UN Women 2021b).

Restrictions on the movement of people and goods – including border closures, lockdowns and other measures to contain the spread of COVID-19, disrupted agricultural value chains and food systems. While this affected all rural farmers, women farmers faced barriers and disadvantages that made them less able to recover than men. A women-led agricultural cooperative, the Rural Urban Distribution Initiative (RUDI), scaled up procurement of seasonal

produce from small and marginal farmers and collaborated with delivery apps for last-mile delivery in urban areas (Salcedo-La Viña, Singh and Elwell 2020).

Enabling access to finance and livelihoods

"Since access to finance is critical for people to sustain themselves during the lockdown, SHGs women who also work as banking correspondents have emerged as a vital resource. Deemed as an essential service, these bank sakhis have continued to provide doorstep banking services to far-flung communities, in addition to distributing pensions and enabling the neediest to access credits into their accounts through direct benefit transfers" (GOI 2020). Deepa Pawar, Founder-Director, Anubhuti, an NGO working toward equity, justice and building awareness of rights, recognized that the most marginalized communities, which includes the tribal communities and the nomadic tribe that she belongs to, would face the brunt of the pandemic's economic impact. In the first week of lockdown in March, Deepa and a team of volunteers started identifying nomadic tribe families across Maharashtra. The team transferred money to 88 families in 10 districts, especially remote areas with no "awareness of even helplines and relief operations (Norzom 2020a).

When the COVID-19 pandemic wreaked havoc on the lives of migrant workers, Shipra Sharma Bhutani, a former economics professor created a database of 55 lakh people returning home and focused on upskilling them. Shipra who founded skill development platform Capacita Connect helped 20,000 migrants find work in healthcare, retail and logistics sectors during the pandemic (Norzom 2020b).

Communication – Educating people and curbing rumours

The Ebola crisis in the DRC showed that not only could women be employed as healthcare workers and technical or operational experts, but they also fulfil vital functions as social mobilisers and contact tracers. Women are uniquely qualified to take a lead in information management and rumor mitigation, as well as ensuring hygiene in the home (Kapur 2020).

Women SHGs helped curb rumor and misinformation by systematically using their vast network and providing critical support to the government. In Jharkhand, where large numbers of people migrate to other states to work, women were running a dedicated helpline for returning migrants and other vulnerable families. (The World Bank 2020)

Kudumbashree – Kerala's model Self Help Group

The model for SHGs is however, the women's community network called Kudumbashree in Kerala. In the first wave of the pandemic in the summer of 2020, the world watched in disbelief as Kerala flattened the curve winning accolades about the 'Kerala model of pandemic management, despite being the state where India's first coronavirus patient was detected. It is widely acknowledged that this would not have been possible without Kudumbashree. The name Kudumbashree in Malayalam means 'prosperity of the family'. It is a community network of over five million women that covers the entire state and is arguably one of the largest women's networks in the world. It consists of a three-tier structure with Neighbourhood Groups (NHGs) as primary level units, Area Development Societies (ADS) at the ward level, and Community

Development Societies (CDS) at the local government level. The women's SHGs of Kudumbashree were tireless in their efforts to support, uplift, feed, motivate, educate and heal COVID affected people in Kerala. A few of their many interventions across the pandemic period are presented in Table 1.

Table 1: Kudumbashree: Kerala's sisterhood that helped flatten the curve.
Communication
• Kudumbashree has formed 1.9 lakh WhatsApp groups with 22 lakh NHG members to educate them about Government instructions regarding COVID-19 during lockdown and to caution that elderly people should take special care to prevent the pandemic.
Masks and sanitizers
• Kudumbashree prepared and sold more than 71.55 lakh cotton masks through around 306 tailoring units. Also, 21 micro enterprise units have prepared 9,322.65 liters of sanitizers. The double layered, reusable masks priced at an affordable Rs.10, were supplied to frontline institutions such as private as well as government hospitals and primary health care centers, district administration, district panchayats, airport authority, tourism department, Food Corporation of India, Indian Oil Corporation etc. Soon several residence associations, apartments, pharmacy shops also became customers.
• In the production of masks and sanitizers, women faced challenges like shortage of raw materials, abrupt price hike of raw materials and huge demand to be met with in a short time. However, the SHGs tactically overcame all these difficulties with the help of district management teams by finding new vendors, sourcing raw materials from other part of the state and by working in shifts.
Food and groceries
• Kudumbashree units engaged in canteen/catering services were entrusted with providing food to people in Corona Care Centres. Given the scale of the challenge, these groups dramatically ramped up their efforts and set up nearly 1500 kitchens. As there were few hotels near the check posts in Kerala and truck drivers faced hurdles in getting enough food, the Transport Department asked Kudumbashree to establish take away counters in these areas.
• The Women and Child Department instructed Kudumbashree that there should not be any dearth in the supply of Amrutham Nutrimix powder (fortified health supplement for 6-month to three year old kids) due to lockdown. Kudumbashree ensured that Nutrimix units started working in all districts to produce enough quantities of Nutrimix powder.
• Civil Supplies Department of Government of Kerala sought the help of Kudumbashree volunteers to prepare grocery kits for 87 lakh families.

• In Alappuzha, SHGs of Kudumbashree left no stone unturned as they started a floating supermarket to bring essential commodities to the doorstep during the COVID-19 lockdown.
Mental Health
• Through 360 community counsellors of Kudumbashree, counselling and mental support was given to those in need to counteract various mental issues faced by those in quarantine, their family members, women and children who were at-risk of domestic violence and the elderly. Kudumbashree Snehitha gender help desk was functioning in all fourteen districts of Kerala, providing short stay facility, counselling and mental support to distressed women and children. A special campaign to spread awareness about these services was themed '*You are not alone, Kudumbashree is with you'* and publicized through electronic and social media.
Source: www.Kudumbashree.org

Competence, The Skill of Providing Good and Successful Care

Good care requires the competence to individualize care – to give care that is based on the physical, psychological, cultural, and spiritual needs of the patient and family (Vanlaere & Gastmans 2011). Good care is aimed at helping the person be as independent as possible, yet safe. Good care needs to be delivered competently, while considering the patient's context.

As the world watched in shock and dismay, Italy was devastated by COVID-19's first wave. According to Worldometers, in April 2020, Italy was placed third amongst the most affected countries, with more than 189, 000 cases out of the 2.7 million worldwide cases and over 25,000 deaths out of the more than 191, 000 deaths in the world. Hospitals were overloaded for almost two months with a massive and sudden influx of patients, with life and death decisions having to be taken on the spot, insufficient equipment and lack of conditions conducive for emergency care. Dr Giulia Manfredini Cornali, Head of the Endocrinology Unit at the Massa-Carrara Hospital in Northern Tuscany observed

> "Most of them (health workers) are women and they decided to leave their homes, stay separate from their families for fear of bringing the infection to their relatives. Some of them have not seen their kids and partners for several weeks. When they are working not only do they treat and cure patients in critical conditions but also take care of the psychological burden of those men and women who, because of the illness, are secluded from their homes and their beloved ones. There are wonderful reports of nurses and doctors connecting patients with their families with tablets, cell phones, making video calls…but there are also so many sad reports of personnel holding the hand of a patient before he or she dies without seeing loved ones again" (Soroptimist 2020)

ASHA women are community health workers in India who help implement government health schemes in villages across the country. ASHAs are also meant to serve as a key communication mechanism between the healthcare system and rural population. Their main tasks include

assisting women during their pregnancies, encouraging hospital births, ensuring immunisation of babies, promoting family planning, providing first aid and maintaining records.

True to their name (the word *asha* in Hindi means hope), ASHA workers were beacons of hope across the length and breadth of the country, when the entire health care system was teetering. Since the outbreak of the pandemic in March 2020, ASHA workers were the first line of defence against the virus, despite being given no training and barely any equipment. In addition to performing home visits, they also tackled vaccine hesitancy in the villages and help curbed rumour and misinformation. Stories of the way in which ASHA workers soldiered on in the face of challenges since the pandemic are legion among reporters covering on ground situation in the pandemic (Delugaonkar 2020).

On 17th March 2020, when a Haryana district – Sonipat, reported its first COVID-19 case, there was no action taken by the administration in other districts. Not until April 2nd, about 12 days after Sonipat reported its first case, did the administration start mobilizing the 1,270 ASHAs in Sonipat to be at the frontline, when a nationwide lockdown had already been declared. The women were sent on a door-to-door survey for a preliminary detection of COVID cases, with just two hours of training and no protective gear, such that they had to make their own masks at home (Prasad 2020).

> *Tanuja and Alka Mulay, an ASHA colleague, have together been visiting 30-35 homes in their village every day in Nilegaon village in Tuljapur taluka, in Maharashtra's Osmanabad district.*
> *"We go door-to-door and check if anyone has fever or any other coronavirus symptom. Anyone complaining of fever is given paracetamol tablets. If they have coronavirus symptoms, the primary health centre in Andur village, 25 kilometres away, is alerted. (The PHC then sends someone to the village to collect samples for a COVID test; if the test result is positive, the person is moved to the Rural Hospital in Tuljapur for quarantine and treatment.)*
> *It is difficult for ASHA workers to keep track of everyone coming in, and keep checking that they self-quarantine, adds Anita Kadam, an ASHA facilitator who works at Kanegaon PHC in Lohara taluka of Osmanabad district. "Yet, our ASHAs do their tasks without complaining," she says. Anita, 40, supervises the work of all 32 ASHAs reporting to the PHC. For this, she earns Rs. 8,225 per month (including all allowances).*

Extracted from: "ASHAs: labouring through the lockdown" in *PARI* (People's Archive of Rural India) published on Aug 13, 2020 online[1].

Ranjana Dwivedi an ASHA worker in a remote Indian village called Gurguda in Madhya Pradesh went door to door to educate people about the coronavirus. Her village is in a hilly, remote region, surrounded by thick forests where wild animals and armed robbers roam. Twice, she fell into a river while trying to cross in a boat to reach her patients. She went beyond her brief to combat people's scepticism about vaccines and even the widespread belief that Corona

didn't really exist, by asking her young son to draw posters featuring COVID-19 do's and don'ts (NPR 2020).

Responsiveness – Willingness of the One Cared for to Receive the Care

Responsiveness, or "care receiving", is the phase in which "the object of care will respond to the care it receives". This is not always a given. At times the care-giver can be confronted by an unwilling or ungrateful recipient. Critics of the ethics of care such as Sarah Hoagland (Hoagland 1988) fault care for focusing too much on reciprocity and 'successful' caring relationships, whilst neglecting those examples where the recipient is unwelcome to care, takes it 'as entitlement' or even 'skilfully takes advantage of the one-caring.' Such instances could be seen during the pandemic where the care giver is faced with a situation where the care is rejected.

Violence against health workers, while not being uncommon during normal times, continued during the pandemic even as medical professionals were facing unprecedented stress and mental health challenges on the work front. The care givers continued offering care in the face of hostility, suspicion and accusation, to the detriment of their own mental and physical well-being (BBC News 2020).

Many female reporters risked infection as they went into poorly equipped hospitals to report on families whose loved ones were admitted in ICUs or ventured into villages to find people dying from ignorance or lack of doctors or transport. Others faced abuse and threats at crematoria where they went to count bodies. Some reporters went beyond their professional duty, using their privilege to contact influential people and resolve SOS calls during the second wave. Not being able to resolve all the distress calls they had received, often caused an overwhelming guilt and helplessness (Punwani, 2021).

Stretching the Limits of Care

Maureen Sander-Staudt (2011) has highlighted the criticism that care is a 'slave morality' in that it falsely valorizes and romanticizes care as being an activity of selfless love and sacrifice, which pays no heed either to the interests of the one-caring or the moral limits beyond which care should never be extended. Rosemarie Tong (1998) asserts that, 'There is a final limit on caring'. Such a limit may be sought by recognizing the correct balance between care of self and care of others.

With less than one doctor for every thousand people, and a medical system stretched to its seams during the pandemic, such a balance was almost impossible to achieve. Women made up 47 per cent of all health workers and more than 80 per cent of nurses and midwives, were working at the front lines of COVID-19, risking exposure to the virus (UN Women 2021a). Examples abound of women doctors and nurses whose performance of care duties pushed them to the brink of physical and mental stamina.

For example, in Patna, Dr Nimrat Kaur, Regional Deputy Project Coordinator in Asia for Doctors Without Borders worked 12-hour shifts (which means 12 hours of staying in a PPE), keeping herself mentally steady, fervently hoping for vaccines and cure, and the new normal as understood by frontline workers (Norzom 2020).

In the absence of reliable institutionalised childcare facilities, nurses coped on their own, enlisting help from family members, many of whom they ended up infecting.The guidelines of the Indian Council of Medical Research (ICMR) exempts lactating mothers and those with co-morbidities from working in COVID wards. However, due to a severe shortage of nurses across the state, even lactating nurses like Nisha in the Institute of Gynecology in Chennai, were called for duty. She was put in-charge of pregnant patients who tested positive for the coronavirus. Since she had to quarantine after working in a COVID-19 ward, Nisha spent days away from her one-year-old child. Between mid-2020 and March 2021, at least 60 nurses, including Nisha, themselves contracted COVID. (Muralidharan 2021).

Shahbai, an ASHA worker in Maharashtra's Beed district, had been going from door to door tracking COVID-19 in her village. Soon she tested positive and thereafter, her 65-year-old mother was infected too. Her mother needed hospitalization that costed 2.5 lakh rupees. To afford it, Shahbai had no option but to sell her 2.5-acre farmland and jewelry (Parth M.N 2020).

The limits of caring were stretched, not only for essential service providers who worked outside but also for women doing unpaid care work at home. The 'double burden' under which most working women labour, multiplied several times as they struggled to balance demands from children, elders, husbands and employers. Inappropriate or unsuitable spaces to conduct work or having to work unsociable hours when children are asleep added to the burden. For example, in higher academia, where productivity is measured in part by the number of peer reviewed submissions, there has been a reduction in women submitting publications, whereas submissions by men remained unaffected by the COVID-19 pandemic (Minello 2021).

Conclusion

Concern for ongoing relationships, listening, empathy, even common interests have been coded as female traits and therefore devalued by political theorists eager to be seen as tough-minded. Feminist theorists of the ethics of care showed how these considerations are not contradictory but essential for the use of power, including democratic power. New research endorses their view that female-associated traits such as empathy, compassion and vulnerability have been particularly effective in the COVID-era workplace (Zenger and Folkman 2020).

It must be noted however, that there is nothing softheaded about care. The one-caring, works in what Noddings called a "problem-solving" mode in order to keep in mind the particular relationship and context. Care is not only an expression of so-called feminine emotions or an abstract value system. On the ground, it translates to 'action' which has been typically associated with a masculine work ethic of performing labor. But as we see from the various

examples in the paper, from the ASHA worker traversing rural India to the scientist researching vaccines, taking action is fundamental to the performance of care by these women.

The leadership qualities and skills women displayed during the pandemic are lessons worth noting as countries seek to rebuild their economies. Their resilience, creativity and adaptability in adjusting to all the curveballs that the pandemic threw, is worthy of documenting as case studies and should be made compulsory reading in top tier Indian management schools.

Rebuilding efforts need to be centred on women's involvement in decision-making at the political, policy and community levels. Within the health sector, women represent 70% of the global health workforce but only one quarter of global health leadership positions (Warnick 2021), which has longstanding impact on research priorities, policies and financing. This skewed representation of women in the health sector needs correction by expanding the power and influence of women in the medical fraternity. Catalyzing systemic change to achieve gender equality in leadership will result in better health outcomes for all.

The psychological trauma of women front line health workers who have watched numerous patients die as they spent days and nights in COVID wards away from their own families, should be addressed. These workers need to be provided succour through counselling to enable them to regain their mental health and avoid long term impact. The meagre amounts paid to ASHA workers who fought the COVID battle deep in the remote trenches of rural India have to be replaced with higher payments commensurate with the importance of their contributions.

The Pandemic presents us with the opportunity to make systemic changes that recognize women's contributions on an equal footing. Melinda Gates put it aptly: "This is how we can emerge from the Pandemic in all of its dimensions: by recognizing that women are not just victims of a broken world; they can be architects of a better one."

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