STIGMA, ACCESS, AND TREATMENT GAPS IN WOMEN'S MENTAL HEALTH DURING COVID-19: A CRITICAL REVIEW OF THE INDIAN CONTEXT

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ABSTRACT

The COVID-19 pandemic creates a parallel mental health crisis in India and exacerbates the challenges faced by women who experience a disproportionate amount of psychological distress due to long-standing gender norms, stigma, and unequal access to services. Mental health issues are commonly seen through social judgment and moral frameworks in India and as a result, there is pressure on women, whose identities are inextricably linked to their roles as caregivers and representatives of their families to not disclose their illness or to seek help. The lockdowns resulting from the COVID-19 pandemic have increased these vulnerabilities by disrupting livelihoods, limiting mobility, increasing domestic responsibilities, and restricting access to mental health services. The paper examines how demand side barriers such as stigma and social judgement interact with structural barriers around access, cost, and knowledge of services to create and perpetuate gaps in treatment for women's mental health in India during the COVID-19 pandemic. This research uses both qualitative and quantitative forms of research for a complete understanding of the impact the stigmatization of mental illness has on help-seeking behaviour as well as how specific areas disrupt access to care. Through utilising secondary data from peer-reviewed journals, governmental policy documents, and data from publicly avaiable resources there are four themes of emerging evidence from the literature identified: stigma and gender-specific barriers to help-seeking; structural barriers that disrupt access to care; widening gaps in treatment during public health emergencies; and possible intervention points. The analysis also highlights how the disruption of services as well as fear and restrictions of movement are increasing during crises which ultimately yields significant treatment gaps due to increased control of women's autonomy within the household. Finally, although several governmental initiatives exist regarding digital mental health care, their effectiveness is dependent on a number of factors (e.g., awareness, confidentiality, affordability, and cultural competence).

According to the research paper, circumstances leading to unmet mental health needs in female patients are not due to unpredictable service failures, but rather are due to systemic gender-based factors; thus, in order to address these gaps in service delivery and create more equitable outcomes for female patients, emergency mental health services must be gender sensitive and use a combination of expanding service availability, reducing stigma around mental health care, and improving practical access to those services.

Keywords: Women's mental health, COVID-19, stigma, treatment gaps, tele-mental health

1. INTRODUCTION

The ongoing and ever-evolving COVID-19 pandemic has created not only an unprecedented public health emergency of global proportions, but it has also produced an equally unprecedented and long-term mental health crisis here in India and around the world. In India, this crisis developed due to deeply entrenched gendered social structures which have created a disproportionate burden of psychological problems for women. Women's experiences of pandemic-related stress have been exacerbated by pre-existing social stigma, limited autonomy, unequal caregiving expectations, and a lack of access to mental health services, among other contributing factors. Furthermore, mental illness, in general, is often interpreted through moral and social lenses rather than via a biomedical lens in Indian society; therefore, emotions and feelings of distress are interpreted as either weakness or an inability to live up to the social norms that are typically placed upon women. Due to the fact that, for women, their identities are directly tied to family honour, caregiving functions, and emotional strength, as result of all these cultural norms and expectations women experience significantly greater barriers to disclosing mental health difficulties and to seeking help (Banerjee & Rao, 2020).

Due to the COVID-19 pandemic, lockdown measures, mobility restrictions, income shocks and disruption of health care services put additional strain on women who now experienced multiple stressors: they were required to take on more unpaid domestic work; they had to care for children and/or elderly relatives; they were afraid of contracting the virus; and they were financially insecure. The closure of schools, the shift to working from home and lack of domestic service support concentrated even more emotional and physical labour on women in the home. Simultaneously, restricted freedom of movement; diversion of health care resources to emergency pandemic response; and lost access to the regular mental health services that most women rely on made it even more difficult for women to receive timely support for their needs (Gopalan & Misra, 2020).

The pandemic revealed that India had a considerable number of vulnerable individuals who required mental health services prior to the COVID-19 outbreak. The National Mental Health Survey of India states that women faced even greater challenges than men in accessing treatment for mental illnesses such as depression or anxiety due to cost, a lack of knowledge about mental illness, and stigma associated with seeking assistance (Murthy, 2017). The problems associated with access to treatment are not reflective of a lack of need; rather, they stem from a lack of adequate systems for adequate treatment delivery, a lack of mental health professionals, and a lack of awareness of resources in the community. Therefore, the systemic

deficiencies in mental health delivery systems have been dramatically portrayed during emergency situations like COVID-19, where there were significant increases in the level of psychological distress, yet mental health resources were either marginal or unavailable. As a result, the increased levels of psychological stress experienced by women due to the COVID-19 pandemic resulted in an increase in the number of women who had unmet mental health care needs due to insufficient access to care during the pandemic.

The Indian government's response to the increasing burden of mental health issues is to expand access to psychological services through multiple policy changes. One of the most significant developments was the National Tele Mental Health Programme called Tele-MANAS launched in October 2022, which included free 24/7 tele-counselling via a national helpline and emphasises a move toward digital, scalable, and remote access to mental health care. Updates from the Ministry of Health and Family Welfare (2023) indicate Tele-MANAS is being rolled out across states, with trained mental health professionals being integrated into the program, and a rise in call volumes due to greater awareness and demand for these services. These actions represent an important recognition by policymakers that mental health is a public health issue and that institutions have an obligation to address barriers to access during and after the COVID pandemic.

While access to tele-mental health services is increased by technological advancements and service delivery has been improved, there are many infrastructural barriers preventing women from accessing these services. Women's access to services is significantly hindered by factors including stigma, limited understanding of mental health issues, concerns around affordability, the digital divide and lack of privacy at home. Judgment by family members can create a climate of fear which prevents women from disclosing their challenges with mental health. Women's dependence on family for economic support and less agency to make decisions about accessing health care creates additional barriers to getting needed care. The technology used for digital interventions assumes that women have access to personal devices, private space, and are familiar with the technology, which is not the case for all women at all socio-economic levels. As a result, although there have been many innovative policy initiatives, there continue to be significant treatment gaps, raising questions about the inclusivity and effectiveness of emergency mental health services.

This paper is about investigating the reasons for the increase in the number of untreated cases of mental illnesses experienced by Indian women during the COVID-19 pandemic, although there has been a recognition of a growing potential public health issue - mental health - and its staggering impact on social and economic stability as well as health care systems in India, that might lead to increased rates of mental illness in the future.

With this in mind, the goal of this review is to explore the current scientific literature that discusses how stigma, lack of access to care, cost of services and lack of awareness about mental illness all contribute to the gap between need and access to mental health services among Indian women during public crises.

This paper will also explore pathways for developing gender-sensitive, scalable interventions to improve access to care in emergency situations and to reduce the number of "unmet" mental health needs in women. The focus will be on community and policy-level strategies for addressing mental health issues in women in the Indian population.

The Research Methodology used for this Review involved using a Narrative-Critical Review approach with an Transparent and Reproducible Search Strategy. The peer reviewed journal articles that were included in this Review were obtained using systematic database searches of both Scopus indexed and other reputable scholarly databases. The articles from peer reviewed journals that constituted the basis of the Results for this Review were augmented by the use of open access government reports, policy documents and programme evaluations to inform contextual and systemic issues within the research Study area(s). The following four thematic clusters grouped the keywords used in the search process to develop the Study Search Terms: 1. Women AND Mental Health AND COVID-19 AND India; 2. Stigma AND Help-Seeking; 3. Access/Affordability AND Treatment Gap; 4. Emergency Mental Health Interventions/Tele-Mental Health. Inclusion Criteria for journals to be considered in this Review were either published in or after the COVID-19 Pandemic and described either empirical or analytical evidence related to Mental Health Stigma, Access to Services and Affordability, Treatment Gap and/or Help-Seeking Behaviours with Respect to Gender in the context of India. Exclusion Criteria included non-scholarly Opinion Blogs, Paid-Only Sources That Could Not Be Validated Independently, and Studies That Did Not Address Mental Health Outcomes and/or Barriers to Accessing Services Specifically. The Review Process was tracked and documented using a Structured Screening Flow consisting of Identification, Screening, Eligibility Screening and Final Inclusion to ensure methodological clarity and to support the analytical rigor of the Review Process.

2. STIGMA AND GENDERED HELP-SEEKING BARRIERS IN INDIA

Social judgment and stigma on demand side act as strong barriers that influence Indian women's view of themselves, their experience of mental distress, and how they respond to it. In the context of Indian society, a mental illness is typically treated as a personal failure or moral failure instead of a health issue. This kind of framing of illness disproportionately affects women. Women's emotional weakness, emotional lack of endurance and inability to maintain domestic-life responsibilities are the common narratives that society has about them. Because of these types of narratives, women do not openly acknowledge their symptoms and create an environment where mental illness is unacknowledged or minimised and normalised or silenced. These same symptoms and stigma were magnified during COVID-19 because of increased psychological distress related to fear, uncertainty and isolation which have increased women's mental health need invisibility (Banerjee, 2020).

Public stigma is one of the most visible types of stigma associated with mental health issues; it is expressed through community-based judgements and social labels. In many Indian cultures, a woman who discloses that she has anxiety, is depressed or has an emotional disorder may be labelled 'weak', 'unstable' or 'incapable' of carrying out expected social duties. The impact of such labels has long-lasting social ramifications, especially in terms of marriage prospects, family honour, and social status. Quantitative evidence shows that fear of being gossiped about and fear of social rejection causes many women not to share their mental health issues with anyone in the community except for their close family and friends, even when they are experiencing debilitating symptoms (Rao et al., 2021). Public stigma continued to be an issue during the time people were locked down from their neighbours and had to rely on digital platforms for

connecting with their community; rather than decreased during this time, public stigma actually took new forms through the use of online judgements and informal community-based vigilante methodology.

A significant barrier for those seeking support is family stigma. In Indian culture, family endorsement and collective notoriety are unique and primary drivers associated with health decisions, especially with respect to female populations. Stigma towards mental illness is frequently linked to notions of shame with regard to the family unit and therefore families subsequently discourage women from disclosing their mental health problems or seeking treatment. Women are often urged to remain silent, conform to the role of a wife/mother, be strong, and so on, instead of using mental health professionals to address their problems. The stigma is especially strong for married women, for whom disclosing mental health issues may be perceived as a threat to the stability of their marriage or as proof of their ineptitude as wives and mothers. During the pandemic, family members were active participants, preventing their wife/mother from using mental health services due to fear of being outed or for fear of the financial cost of treatment, ultimately leading to delays in and/or cessation of treatment for the women (Grover et al., 2020).

Self-stigma is produced when someone has been exposed to either a public or familial stigma for too long. These experiences can cause women to unconsciously relearn the stereotype associated with mental illness and can lead to feelings of shame, guilt and self-blame. Once a woman has developed internalised stigma, she will often reinterpret the psychological symptoms she experiences as general stress, personal weakness, or something private that she should simply endure. As a result, she will significantly decrease her clinical contacts regardless of whether she continues to experience symptoms of anxiety, depression, or trauma. Research from Murphy, 2017, suggests that women often delay seeking help until their symptoms are unmanageable. At this point the intervention is both more complex and less likely to be effective. The self-stigma during COVID-19 has been reinforced by the characterization of stress being something that everyone experiences and is therefore not a reason to seek help, thus further reducing a woman's perceived need for care.

The stigma surrounding mental health issues deeply influences how gender roles and the expectations of caregiving can prevent someone from seeking out help. In Indian culture, women have been taught to think about other people's needs first and that to keep going when we are upset is a positive thing. Women have been viewed as the emotional strength of the family because of cultural norms where they have had the responsibility to keep the family stable, even during difficult situations. Covid-19 created an increase in that expectation for women when they were being asked to care for family members who had been affected by the virus, and providing emotional support to their family members. Therefore, women may have viewed asking for assistance regarding their mental well-being as being selfish or inappropriate and the stigmas continued to grow with silent suffering and continued suppression of their emotions (Rao et al., 2021). Therefore, the expectation of women being emotionally resilient prohibited women from getting the support they needed.

The pandemic context amplified stigma-related barriers by reducing privacy and increasing social control. Lockdowns confined women to domestic spaces where personal conversations could be overheard and

movements monitored, limiting opportunities to seek confidential support. Family surveillance increased, and women's phone usage, online interactions, and time allocation became more visible to others in the household. As a result, even digital mental health services were underutilised due to lack of private space and fear of being questioned or judged. Social networks, both offline and online, became primary sources of judgement, reinforcing conformity and discouraging deviation from expected norms of endurance and silence (Banerjee, 2020).

Stigma is not only considered a mental illness issue but also a tool for controlling how women are expected to behave. Stigma is defined as the experience of having negative feelings, evaluations, or judgments about an individual based on specific characteristics and behaviours. Stigma acts as a barrier to accessing healthcare services, providing help, and obtaining treatment. Women have faced particular barriers to accessing mental health services during the coronavirus pandemic; stigma was one such barrier. Social norms and expectations placed on women create a unique set of barriers that prevent them from receiving appropriate mental health treatment. Stigma creates multiple levels of barriers to receiving treatment— community, familial and personal. These types of stigma collectively create barriers that are difficult to eliminate even during times of crisis. This section reaffirms that the stigma associated with mental illness systematically converts the need for mental health care into an unmet need for care. Stigma limits the identification and recognition of symptoms; limits disclosure; limits the timeliness of seeking help; and limits continuity of care. During community-wide public health emergencies (e.g., the COVID-19 pandemic), stigma and limitations to seeking help continue to become worse as psychological distress increases and access to services decreases. For women with unmet needs for mental health services, therefore, it is important to expand the availability of mental health services; however, it is equally as important to eliminate stigma as a way of controlling women's ability to access appropriate mental health care.

Table 2.1: Forms of Mental Health Stigma Affecting Indian Women and Their Effects on Help-Seeking during COVID-19

Type of Stigma	Typical Expression in Indian Context	Effect on Help-Seeking	Likely Mental Health Outcome
Public stigma	Community labelling women as weak or unstable	Avoidance of disclosure outside family	Social isolation, untreated distress
Family stigma	Fear of reputation damage and marital consequences	Restriction of permission and privacy	Delayed or discontinued treatment
Self-stigma	Internalised shame and self-blame	Reduced perceived need for care	Worsening symptoms, chronic stress

The mental health stigma illustrated in the table above presents evidence that these different forms of stigma are operated through many levels and in different ways, that all have an impact on individuals' decisions to

seek help, and create cumulative barriers to accessing care to support Indian women with their mental health needs when experiencing a crisis (e.g., COVID-19).

3. ACCESS, AFFORDABILITY, AND AWARENESS AS STRUCTURAL BARRIERS

The three elements of access, affordability, and awareness have acted as interrelated structural barriers that have impacted women's mental health treatment pathways during the coronavirus disease (COVID-19) pandemic in India. While there was increased psychological distress in women during both lockdown and post-lockdown periods, translating mental health needs into actual care was constrained because of the systemic and gendered barriers to care. The fact that these barriers did not exist independently of one another but complemented one another created treatment gaps and exacerbated inequalities. A gender-sensitive lens through which to explore these limitations highlights how structural issues interacted with women's social position, economic dependence, and domestic obligations to limit access to the mental health support they received.

Access-related barriers to mental health services include both physical and functional availability. Mental health infrastructure has historically been unstable in India with severe urban-rural differences and insufficient numbers of trained mental health professionals. The COVID-19 pandemic has magnified existing gaps in mental health delivery systems made greater by lockdowns, travel bans, and a redirection of health care resources toward emergency COVID-19 response efforts. During the pandemic, many outpatient psychiatric services have either had their hours limited or have had to suspend them completely, while many women have faced obstacles due to lack of transport and restrictions on movement to hospitals. Distance to mental health facilities became an even bigger barrier for women in rural or semi-urban areas during the pandemic, particularly in instances where there were no or limited options for public transport and also when transportation options were deemed to be unsafe (Murthy, 2017).

Women experienced limited access to mental health services as a result of gendered constraints such as time poverty and family permission. The lockdown increased the unpaid domestic labour of women (i.e., cleaning the home, preparing meals) and their caregiving responsibilities (e.g., managing online education of children, caring for ageing family members) as well as their emotional labour in the household. The combination of these responsibilities meant that women had limited time and energy to prioritise their own mental health needs. In addition, in many instances, women needed to negotiate family permission and arrange childcare in order to access professional mental health services, which is particularly difficult if mental health is not considered to be a valid health issue by the family. Even though services were available, women were frequently unable to access them (Rao et al., 2021).

The second major impediment is affordability which is directly tied to a woman's financial autonomy and her overall economic standing. Due to COVID-19, a large number of people experienced loss of income and jobs; this was especially true for women working in the informal sector, who lost affordable hourly work, or women doing domestic work or working part-time to support their families. Women who had previously been financially dependent on family could no longer afford to pay out-of-pocket for services such as consultation fees, costs for prescriptions and medications, and therapy fees. In addition, women had to incur

indirect costs associated with seeking mental health support including travel expenses, lost time from household duties and internet/phone costs for tele-consultation services. Studies also show that, when experiencing financial stress, women often chose not to spend money on mental health services because they had to spend their money on the needs of their households (Gopalan & Misra, 2020).

The financial dependence of women also greatly affects the way they perceive the affordability of treatment. Even if a woman can access low-cost or free mental health services, she may still view that as an expense that she should not be spending on herself. This is because of internalised beliefs that family welfare is more important than self-care, as well as the existing stigma around spending money on mental health. Therefore, affordability is not only a material barrier to the treatment of women with mental health conditions, it is also a psychological barrier that serves to create delays in seeking help and reduce the time someone remains in treatment. This aligns with the belief that financial dependence contributes to significant treatment gaps for women with mental health problems.

The third structural barrier to accessing mental health care is awareness of mental health symptoms, available services and options for accessing care. Mental health literacy remains low in India, particularly among women from lower SES backgrounds. There were many women in the study that did not know that anxiety and depression are examples of mental health conditions and would instead view symptoms of mental illness as temporary stress, physical ailments or personal faults. During the pandemic, increased levels of distress were viewed as a natural response to a crisis, which served to further reduce women's ability to identify that they needed to seek out professional care for their symptoms. This lack of awareness about mental health can further delay the ability for women to access early intervention, and create a greater likelihood that they go on to develop chronic mental health issues (Murthy, 2017).

In addition, there was a gap in people's understanding of how to find help, as there have been various policies put in place or released to the public that did not seem to reach women effectively. Communication was primarily focused on electronic devices or other very formal types of channels (i.e.: mail) that did not take into consideration the language(s) that women speak or how many women did not have control over the media they consumed. Therefore, there were many women who did not even know about helplines or places where they could get mental health services (i.e.: Adult psychology, Youth psychology) because the services were free or very low in price.

Digital Mental Health Services were founded to help remove barriers to obtaining Mental Health Services during COVID-19. This is evident in the establishment of the National Tele Mental Health Programme called Tele-MANAS, which was formed to create remote counseling and referral systems to provide more access to Mental Health Services. Digital Mental Health Services have the potential to remove barriers/s, such as geographical distances, travel costs, and time in which to access mental health services, especially in emergencies. According to government reports, more and more people are using Tele-MANAS, showing a higher demand for and acceptance of these services (Ministry of Health and Family Welfare, 2023). However, digital access does not equate to equitable use.

The women's ability to make use of digital mental health services has been severely limited due to multiple factors including a lack of knowledge about the existence of these services, limited capability to use devices for both personal and private use due to a lack of access, lack of ability to have private conversations when living in a shared environment with others, and concerns over privacy when living in a household that shares a common living space with others. Stigmas associated with the use of mental health services have also played a role in women's ability to seek out mental health services via digital means. As such, while expanding access to treatment through digital means may help bridge the gap, the gap will remain given that access to treatment is conditioned on many other factors such as having gender in mind while designing treatment programs for women, conducting awareness campaigns to let women know about available resources, and providing safeguards for privacy and confidentiality in order to enhance the likelihood of women using these services.

Women's access to treatment services, affordability of treatment services, and knowledge of treatment services are all barriers to accessing mental health services for women. The cumulative effect of these barriers creates systematic barriers for women, rather than providing singular failure determinations. The availability of mental health services alone does not guarantee that a woman will be able to access these services due to time, finances, knowledge, and/or approval to use the services. The COVID-19 pandemic has exacerbated the barriers to accessing mental health services by increasing caregiving responsibilities, decreasing mobility, and increasing economic uncertainty.

It offers a viable avenue toward modernizing emergency medical response systems by solving long-standing difficulties related to information accessibility, timeliness, and continuity of treatment. The combination of QR code technology with digital health tracking presents a possible pathway toward this transformation. The purpose of this study is to demonstrate how instant access to crucial patient data, when paired with real-time physiological monitoring, may considerably improve clinical decision-making during critical situations. This, in turn, can reduce diagnostic delays and minimize the risk of medical mistakes. For the purpose of giving quick access to patient health profiles, the literature reveals that QR codes provide a method that is low-cost, scalable, and user-friendly. Additionally, wearable devices and mobile health platforms make it possible to continuously monitor important indicators. When these technologies are brought together within a framework that is based on the cloud and is safe, they provide a coherent ecosystem that connects pre-hospital care with services provided in hospitals. An integration of this kind enables enhanced coordination between emergency responders and healthcare professionals, as well as speedier triage, individualized treatment techniques, and other similar benefits. In spite of these benefits, there are still a number of obstacles to overcome, including as restrictions in interoperability, problems with data synchronization, concerns over privacy and security, and impediments to user acceptance, particularly among groups who are technologically deprived and old. Standardized data architectures, effective encryption and access-control methods, regulatory harmonization, and inclusive system design are all necessary components for addressing these difficulties. Furthermore, large-scale clinical validation studies are needed to quantify the impact of these integrated systems on response times, patient outcomes, and healthcare resource utilization. In general,

the utilization of QR codes in conjunction with digital health tracking is a significant step toward the development of emergency care frameworks that are more intelligent, more responsive, and more focused on the patient. It is possible for healthcare systems to get closer to more proactive, educated, and efficient emergency interventions if they make use of technology that are easily available and data that is collected in real time. In order to fully achieve the promise of this integrated strategy in terms of enhancing emergency medical care and saving lives, future research should concentrate on establishing platforms that are interoperable, increasing security governance, and assessing deployments in the real world.

Table 3.1: Access–Affordability–Awareness Barriers and Their Mechanisms of Treatment Gaps for Women

Barrier Category	Pandemic-Related Constraint	Mechanism Creating Treatment Gap	Women-Specific Vulnerability
Access	Service disruption, travel restrictions	Reduced continuity and reach of care	Time poverty, mobility limits
Affordability	Income loss, treatment costs	Delayed or avoided care-seeking	Economic dependence
Awareness	Low mental health literacy	Failure to recognise need for care	Stigma and normalisation of distress

The barriers (for example, barriers to access, financial costs and lack of awareness) have different mechanisms by which they create treatment gaps as shown in the the table above. For Indian women, the obstacles they face are further compounded by gender roles, economic dependency and limited autonomy; this is especially true in times of crisis (e.g. the COVID 19 pandemic).

4. TREATMENT GAPS DURING PUBLIC HEALTH EMERGENCIES AND INTERVENTION PATHWAYS

The COVID-19 pandemic showed the world that public health emergencies produce systemic changes that increase the existing treatment gaps for people with mental health issues. Women in India began the pandemic in a vulnerable place because of stigma, their financial dependence on men, lack of autonomy, and unequal access to health care. As emergency conditions developed, these issues became magnified, meaning that there were many more women who required mental health care than there were available services. The lack of access to services for women due to COVID-19 is directly linked to the interaction of structural, social, and gendered factors working together rather than being viewed as a momentary inability of service providers to meet the needs of people with mental health issues during this time (Banerjee, 2020).

(a) Why Treatment Gaps Widened during COVID-19

The disruption to mental health services during the pandemic was one of the ??? – it caused treatment gap? When the world went into lockdown, outpatient departments, counseling centers, and all other non-emergency medical facilities closed or had their hours restricted. Mental health resources were being

redirected for COVID-19 related care, causing many appointments to be cancelled and interruption of continuity in treatment for those already suffering from mental health issues. For Women, who before the pandemic already had limited access to mental health services, this loss of service caused most women to become completely disengaged from accessing mental health services, increasing their risk of relapse and still suffering from untreated distress issues (Kola et al., 2021).

Additionally, fear of infectious disease was another major obstacle to seeking assistance. In addition, there were widespread beliefs that hospitals/clinical settings had the highest risk of transmitting COVID-19 when this pandemic first began. Women would rather stay home and prevent exposing their children, elderly family members or immunocompromised family members to excessive risk by not seeking out healthcare services. Research out of India has indicated that avoidance due to fear has dramatically reduced in-person visits for these services even though they were available, creating an even wider treatment gap (Grover et al., 2020).

During lockdowns, restricted mobility added even more barriers to having access to health facilities. Limitations on travel and public transport restrictions, as well as curfews, limited women's access to the health facilities, particularly in rural and peri-urban areas. Women's ability to move about is often dependent upon permission from their families and household duties. As such, the restrictions put in place during lockdown made the constraints upon women more severe. In addition, the additional household work created for those women during the pandemic restricted their ability to pursue care by limiting their time and flexibility for doing so. Therefore, women experienced delays in obtaining treatment (Rao et al., 2021).

Increased surveillance and control of households is limiting the ability for women to obtain the support that they need. For example, when a woman is confined to the house because of lockdown, she may remain living with family members or domestic violence partners, and in doing so, she cannot get privacy for phone calls or online consultations with a mental health professional (such as having previous experiences or emotions discussed). Women who are experiencing violence or coercive control may have increased risk in obtaining psychological help. Some studies indicate that women were more likely not to disclose a history of violence in their home when access to psychological counselling is restricted (UN Women, 2020).

The combination of service disruptions, fear of being caught going out, restrictions on mobility, and scrutiny and control from family members have combined to create a significant gap between women who can access treatment and those who cannot access treatment. The experience of these conditions is more than just removing women's access to treatment; it is also changing their community to discourage them from seeking help, particularly for women who already have limited autonomy.

(b) Feasible Interventions during Public Health Emergencies

Despite numerous obstacles during the global epidemic, intervention approaches were still possible if they were designed correctly and occurred during periods of emergency. The development of tele-mental health as an approach for delivering services to patients was one effective way to provide uninterrupted services. In India, there was a rapid growth of digital service delivery systems, including the growth of digital platforms and telephone helplines, which ultimately resulted in the implementation of Tele-MANAS in October 2022,

as part of a national mental health support system across India. The initiative is a recognition at the policy level that remote and scalable mental health services are needed during national emergencies (Ministry of Health and Family Welfare, 2022).

There is substantial evidence showing that tele-mental health by itself is not a solution for addressing the issue of treatment gaps for women. The level of uptake of these services is based upon; awareness, trust, digital access, and confidentiality. Women with limited ability to control their private devices, low digital literacy, or do not have a confidential space will not be able to use these services effectively. Furthermore, the associated stigma of mental illness, will further decrease women from using telephone helplines, etc., even if the service is anonymous. Furthermore, studies strongly suggest that all digital systems should have targeted awareness campaigns and community-level engagement to have effective impact on reaching women (Patel et al., 2018).

Another possible method of intervention is to use community-based services. Local women's groups, self-help organizations and community health workers can become trusted intermediaries during emergencies by helping those in need to identify distress, providing basic psychosocial support and making referrals. These models work especially well for women who do not trust formal systems or have difficulties with mobility. In low and middle income countries, task shifting approaches, where trained individuals (non-specialists) deliver basic mental health services, close treatment gaps during times of crisis (Kola et al., 2021).

Integration of mental health into primary healthcare is also critical. Primary care settings often remain accessible during emergencies and are less stigmatised than specialised psychiatric services. Embedding mental health screening and counselling within routine primary care can normalise help-seeking and reduce barriers related to stigma and distance. For women, this integration allows mental health concerns to be addressed alongside physical health needs, increasing the likelihood of engagement (Patel et al., 2018).

Providing communication material related to stigma reduction is complementary to the expansion of service provision. Current messaging during pandemic times focuses on physical safe modes of interaction; however, mental health communications have either not been addressed or they frame distress as a "private," normalised aspect only experienced by the person in distress. Gender-sensitive methods of communication that validate women's emotional experiences and support help-seeking as an acceptable role are vital. Research supports the theory that culturally appropriate stigma reduction messaging delivered through trusted resources will increase service use and decrease the likelihood of self-stigma (Rao et al., 2021).

Outreach to women that focuses specifically on their needs is critical to providing intervention for mental distress related to either violence or coercion through an integrated system of protection measures (e.g., domestic violence hotlines, legal assistance, or shelters). A tele-mental health platform should also have referral systems in place and protocols designed to provide enhanced safety for women who may are at risk when accessing such services. If these systems are not well integrated, then mental health services will fail to adequately meet the needs of women experiencing mental distress caused by violence or coercion since they will not address the "root causes" of their distress (UN Women, 2020).

The key finding from the synthesis of themes indicates that emergency mental health frameworks should, by design, be gender-sensitive, rather than assume a gender-neutral framework by default. Gender neutral systems presume women have equal access to, and autonomy over, services and assistance as men. In doing so, they do not consider the social context and gendered realities which impact how and when women choose to seek help. To address the treatment gap in times of a public health emergency, a convergence of systems-level expansion, stigma reduction and practical access enablers are needed. While digital tools (for example, Tele-MANAS) are a necessary first step for systems expansion, there should be complementary approaches that build awareness about services, ensure confidentiality, provide gender-informed and culturally safe counselling and create strong referral pathways. Structural and gendered constraints must be addressed appropriately if emergency mental health interventions are to successfully reduce the treatment gap for women.

5. CONCLUSION AND RECOMMENDATIONS

Conclusion

According to this analysis, the treatment gap was built by both demand-side factors and structural barriers, rather than by isolated failures or temporariness. The demand-side factor of stigma and social judgment acted a important determinants in preventing Indian women from recognizing distress due to psychological disorder, from sharing their symptoms (if any) related to psychological disorder, and ultimately from seeking help from a professional. Even now, information related to mental health is interpreted through moral or cultural lenses that view psychological distress as a sign of being morally deficient or lack of capability to perform gendered tasks; therefore, many women normalized their pain through silence, even during extreme times of distress.

Simultaneously, barriers to accessing affordable services due to lack of awareness continue to hinder women's ability to utilize the services that are available. The lockdown created a lack of access to services, reduced mobility within communities, and increased awareness of caregivers within the home; therefore, the ability of women to exercise autonomy at home with their health decision-making was diminished. Women have economic dependency on caregivers, which further raised concerns about affordability and resulted in increased perceptions of lack of rights to access help. Collectively, the limitations caused by these barriers delayed treatment, interrupted the continuity of care, and caused many women not to use the services available to them; therefore, the treatment gap grew significantly due to the pandemic.

The results demonstrated that the absence of mental health services for women in crisis did not happen by chance or with no-or-very little-to no time to prepare for these services. However, they were the result of entrenched gender roles, power relations within households, and systemic weaknesses within the health delivery system. Although the expansion of tele-mental health services through policy/health initiatives has started some movement; clearly, merely increasing the number of providers does not ensure that women can access these providers. The successful implementation of digital mental health systems will depend largely on women's capacity to access these services under stigma, threat of surveillance, limited privacy and

financial dependence. If these type of situations are not considered, even if infrastructure is increased; the gap in services will continue to exist.

Recommendations

Based on the findings of this study, the following actionable recommendations are proposed:

- To reduce social stigma toward women experiencing mental illness, gender-sensitive stigma reduction strategies should be developed that challenge the social judgement against women, using culturally appropriate messaging made available through trusted community channels.
- Public awareness campaigns should present mental health help-seeking as a legitimate and responsible health behaviour, in line with physical health care, to decrease self-stigma and support early interventions.
- Affordable and low-cost mental health pathways should be improved upon with free and low-cost telephone helplines, subsidised counselling services, and a continuity of referral services, to provide ongoing access to mental health services in emergencies.
- For women to seek help in privacy, privacy-protecting tele-counselling protocols with safeguards should be implemented to protect the identity of women seeking assistance, so that even in restrictive home environments, women may safely access mental health services.
- Routine primary health care services should include mental health screenings and psychosocial support services to help ease the negative effect of stigma associated with accessing care, and to normalise the process of accessing mental health services.
- Community-based support mechanisms targeted at women, such as self-help groups, community health workers, and local women's networks, should be established to provide support for women in urban and rural communities during a public health emergency.

Together, these measures can contribute to building a more inclusive, responsive, and gender-sensitive mental health framework capable of reducing treatment gaps and strengthening women's resilience during future crises.

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