



mariwala
health
initiative

UNFILTERED

**MENTAL HEALTH
STORIES FROM THE
MARGINS**



April 2025

Unfiltered: Mental Health Stories from the Margins

PRESENTED BY: Mariwala Health Initiative

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CONTENT WARNING

Mentions of suicide, self-harm, caste-based discrimination, gender-based violence, depression, and heterosexism. In the case of material being triggering or upsetting, you can reach out to iCALL at (+91) 9152987821 or icall@tiss.edu



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DIRECTOR'S NOTE

As a teenager, I discovered zines about gender, sexuality, and feminism. I was hooked from then on. Later, I joined a group that created a zine. Throughout history, self-published pamphlets and zines have helped amplify marginalized voices and spark social change. In the 1970s, the pocket-sized 'Chakravarty' by the Dalit Panthers and the Fish pamphlet from the Mental Patients Union both fought against casteism and ableism. Similarly, "The Radical Therapist," a journal from that time, critiqued psychiatry and argued that therapy should include social and political change.

When I started working on Mariwala Health Initiative, one of my guiding lights was (and still is) Asylum Magazine.

In gratitude for this history and holding it close, I hope this zine can be one of many spaces of non-linearity and plurality, of knowledge that challenge ableisms and other forms of oppression.

RAJ MARIWALA
DIRECTOR
MARIWALA HEALTH INITIATIVE

FOR REWORLD

At Mariwala Health Initiative (MHI), our work focuses on making mental healthcare accessible to marginalised individuals and communities. We approach mental health from a psychosocial and rights-based perspective, acknowledging how caste, gender, religion, region, ability, and sexuality contribute significantly to mental health distress.

A key part of this work is bringing forward narratives in mental health that emphasise structural factors and amplify the voices of historically marginalised communities.

During my first in-person interaction with MHI's Director, I was handed a short, comic-style book. Using simple language and engaging illustrations, this book unpacked a complex and deeply sensitive topic. It sparked an important question: How can MHI not only centre lived experiences but also make the often jargon-heavy, complex concepts of mental health more accessible?

The answer took shape through submissions for the sixth edition of ReFrame—MHI's annual journal. Among them were six deeply moving stories, five rooted in lived experiences. These stories explore the intersections of mental health and social justice, showing how factors like gender, disability, nature of work, and geography impact mental well-being.

The authors of these pieces have shown immense strength in sharing deeply personal aspects of their lives. Their stories help humanise mental health, making it about real people and lived realities rather than abstract data points or medical terms. These stories bring a raw authenticity that helps reframe how we think about mental health.

To make these powerful narratives even more impactful, we turned them into a zine. Why a zine? Because tough, complex, and often difficult topics can feel overwhelming. A zine, with its blend of simple language and compelling illustrations, makes such content easier to engage with and understand. Each story is complemented by artwork from different artists, whose interpretations add depth and accessibility to the narratives.

With these six stories, we aim to shift the narrative around mental health—moving away from clinical language to an intersectional and inclusive perspective. By highlighting these voices, we hope to inspire a broader understanding of mental health that is compassionate, contextual, and rooted in social justice.

ANUGRAHA HADKE
COMMUNICATIONS MANAGER
MARIWALA HEALTH INITIATIVE

NOTE FROM THE EDITOR

When we began putting together this zine, we knew we wanted to draw inspiration from the riot grrrl movement of the '90s, which saw the proliferation of hand-made self-published works on issues ranging from women's liberation to body politics to racism to political representation. What started on the messy desks of women punk rock musicians in the USA eventually took on a life of its own, expanding into zines of all kinds. The clash of colours, lettering as bold as the ideas they presented, and the very clear demand that our stories will be in our own hands – it's what made zines such literary treasures. And we were curious, too, to see what would happen when we brought some of that energy into conversations on mental health.

A rallying cry in most zines of the era was to recognise the status quo and then adamantly challenge it. These (sometimes palm-sized) publications made it known that it is not simply where and when we are born that's the trouble, but the structures of power that deliberately disable us. This understanding is equally important in the context of mental health. Social situations, economic burdens, health shocks, traumatic events and other concerns can precipitate mental health challenges and disorders. Accessing care for the same, however, is determined by one's position on a hierarchy, one's proximity to a facility, or the existence of appropriate care infrastructure. As the two processes run in tandem, they create unique experiences of deprivation. The stories in this zine reflect the impacts these structures have on people, while also acknowledging the solutions that can also be culled out.

Mental healthcare experiences of marginalized communities are complex and multifaceted. And to bring this out too, the zine-making process was necessarily a collaborative one. Early in 2024, we had a group of writers sharing stories from across positions of gender, caste, class, (dis)ability, region, queerness, and more. By autumn, we had teamed up with five illustrators to bring each narrative to life in their signature styles.

And today, we're proud to share the outcome of this collaboration here on your screen!

Our heartfelt thanks go to the authors of these stories, Shinjini Singh, Khyati Pokar, Mahasweta Chakraborty, Veena Hari, Seetha Lakshmi, Astha Sharma, Isha Math, Dr. Sravannthi Maya, Sakshi Nikhil Shah, and Dr. Siva Mathiyazhagan. We remain in awe of the four brilliant artists, Ghana NB, Anushka Bansal, Shoi, and Ipshita Thakur. Further, we are grateful to the communities whose voices find representation in these stories.

This zine is as much about storytelling as it is an exercise in building and finding solidarity.

We hope the zine resonates with you, that the stories give you insight into the lives around you, and that they trigger thoughts and actions that lead to a more equitable world.

SHAMBHAVI SAXENA
EDITOR

YOU'RE
SO BRAVE

OH,
YOU POOR
THING!

WHY
IS SHE
WEARING
MAKE-UP?
SHE CAN'T SEE.

LET ME
HELP YOU,
IT'S GOOD
KARMA

WHO'S
GOING TO
MARRY
HER NOW?

YOU
SHOULDN'T
LEAVE YOUR
HOUSE

I FEEL SO
SORRY FOR
YOU

YOUR ABLED GAZE: MY DISABLED RAGE

STORY BY
ASTHA SHARMA

ART BY
SHOI

W

hen I was 20, I was diagnosed with progressive bilateral vision loss.

While my immediate concern was how I would read 40 or 50 research papers for my college thesis, others were more concerned about who would want to marry me.

Up until my diagnosis, I lived a hyper-independent life. But the second I was diagnosed, people saw me differently.

My parents would try to help me by taking away certain tasks from me.

At their house, I wasn't allowed to cut vegetables, even though I do the cooking at my home.

When I went to get my Unique Disability ID, the first thing I was asked was "Who is your attendant?"

The notion of a disabled person being independent or capable of independence is non-existent in our society.

It didn't take long before they turned their attention to my husband, trying to sideline me from a crucial procedure related to my own life.

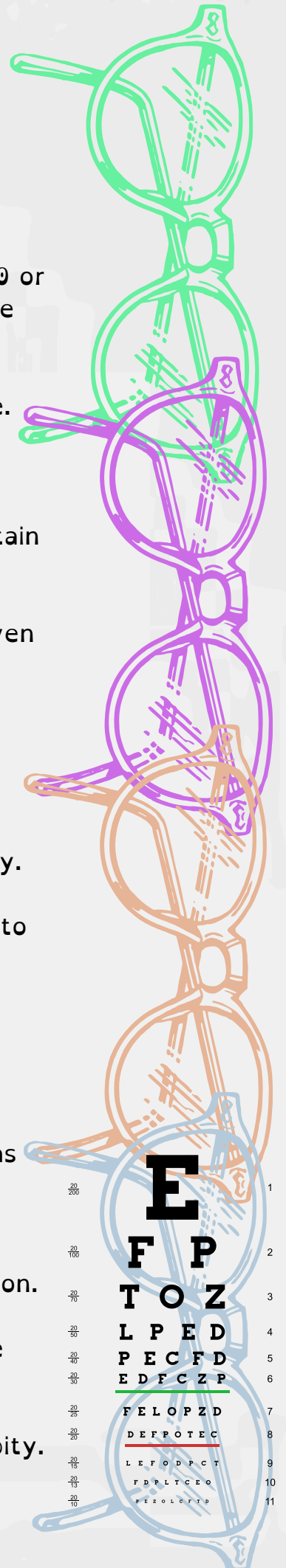
People around me who knew of my disability started trying to help, whether I needed it or not.

After being pitied and dismissed, I began to be used as an example.

I felt it when I was awarded my Junior Research Fellowship to pursue my PhD in Mental Health Education.

I worked for it just like everyone else did, but people will say it was because of the "disabled quota".

Had I not succeeded, their tone would be laced with pity.



Disability has historically been viewed through the lenses of pity and reverence.

E

Emperor Chandragupta Maurya, for instance, promoted a tolerant attitude towards disabled people at a time when disabilities were considered the result of wrongdoings in one's past or present life. He emphasised the virtues of 'mercy, charity, truth, purity, kindness, goodness and above all, non-violence.' Chandragupta initiated what we would now regard as vocational rehabilitation of those considered physically, socially, and economically challenged within the kingdom.

His successor, Ashoka, also extended philanthropic work on a mass scale in keeping with the precepts of Buddhism



source: world history encyclopedia



source:
world history
encyclopedia

"In ancient India, when the State and the joint family, and to a certain extent, the caste, took care of the individuals who needed shelter and protection against the rigours of life, the [disabled] did not present a problem. In the compact rural community, the headman was entrusted with the task of looking after the welfare of its distressed and disabled members."

D. Rama Mani, in "The Physically Handicapped in India: Policy and Programme"

This social system, albeit flawed, ensured a place for disabled people within the community. However, this system seems to have collapsed during the colonial era. The colonizers' 'biomedical advances' viewed disability as a 'disease'.

'Blind Indians were believed to offer a unique opportunity for the enactment of colonial benevolence, biomedical advances, and Christian philanthropy.'

Aparna Mair's analysis of W. Rutherford's
"Andhi: The Story of a Hindoo Waif"

Medical practices and public health laws isolated and oppressed disabled persons such as 'lepers'*, [mentally disabled], and poor people; they became confined to poor houses, asylums, or prisons.

This attitude persists even today.



*Lepers is an outdated and insensitive term; the appropriate terminology in use today is 'persons cured of leprosy'



A person in a wheelchair, or an individual with a visual impairment, for instance, cannot safely navigate the city. Footpaths and pavements are broken or obstructed by trees, transformers, hawker stalls, and parked vehicles; it forces disabled individuals to travel on busy roads and navigate through traffic. You just can't move independently and safely.

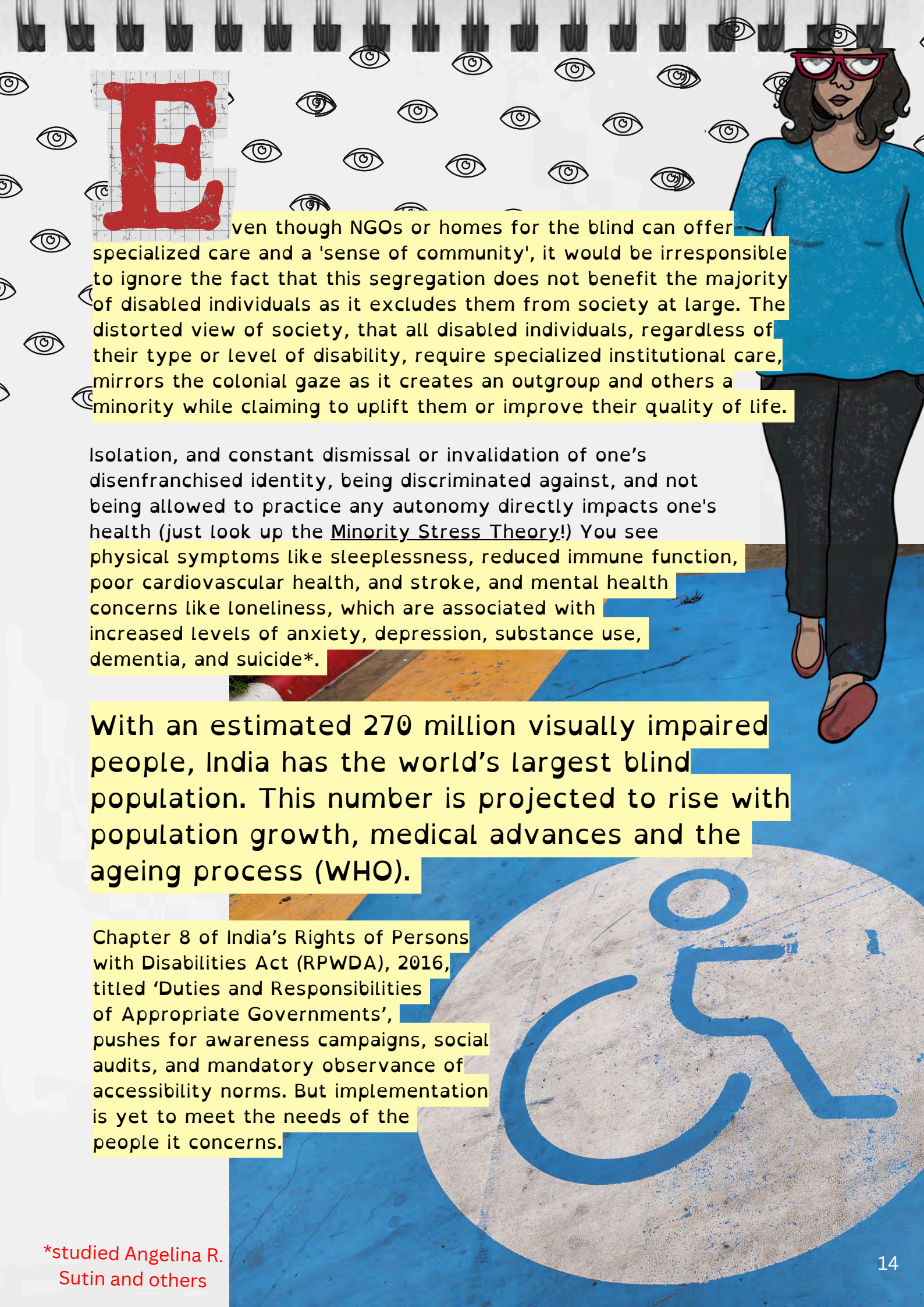
For disabled individuals, especially if they've recently acquired a disability, this means not leaving home unless necessary.

With banks, shops, and restaurants having no accessible entrances and elevators with touchpads instead of tactile and braille-imprinted buttons or floor announcements, it's as if no one expects disabled people to occupy public spaces. It further excludes us.

**It shows that
we are, at best,
an afterthought.**

"[T]ackling the roots of social exclusion - in particular, discrimination, inequality and lack of opportunity - is an essential part of the vision of a successful and prosperous society."

**THE UK'S NATIONAL
ACTION PLAN ON SOCIAL
INCLUSION (2003-05)**



E

ven though NGOs or homes for the blind can offer specialized care and a 'sense of community', it would be irresponsible to ignore the fact that this segregation does not benefit the majority of disabled individuals as it excludes them from society at large. The distorted view of society, that all disabled individuals, regardless of their type or level of disability, require specialized institutional care, mirrors the colonial gaze as it creates an outgroup and others a minority while claiming to uplift them or improve their quality of life.

Isolation, and constant dismissal or invalidation of one's disenfranchised identity, being discriminated against, and not being allowed to practice any autonomy directly impacts one's health (just look up the Minority Stress Theory!) You see physical symptoms like sleeplessness, reduced immune function, poor cardiovascular health, and stroke, and mental health concerns like loneliness, which are associated with increased levels of anxiety, depression, substance use, dementia, and suicide*.

With an estimated 270 million visually impaired people, India has the world's largest blind population. This number is projected to rise with population growth, medical advances and the ageing process (WHO).

Chapter 8 of India's Rights of Persons with Disabilities Act (RPWDA), 2016, titled 'Duties and Responsibilities of Appropriate Governments', pushes for awareness campaigns, social audits, and mandatory observance of accessibility norms. But implementation is yet to meet the needs of the people it concerns.



SOLUTIONS
MUST
CENTRE
DISABLED
PEOPLE





UNIVERSAL DESIGN

Addressing accessibility benefits everyone. A ramp at a store entrance, for example, will not only help a wheelchair user but also a parent with a pram. Psychologists, psychiatrists, therapists, and other healthcare providers need an upgrade in skills. Psychology programs need to offer training in community development and conflict resolution, as they improve one's communication and relationship skills through collaboration, mediation, and negotiation techniques, fostering understanding.



DEI POLICIES

Diversity, Equity, and Inclusion practices can address the problem of isolation by hiring qualified disabled individuals and extending equal opportunities.



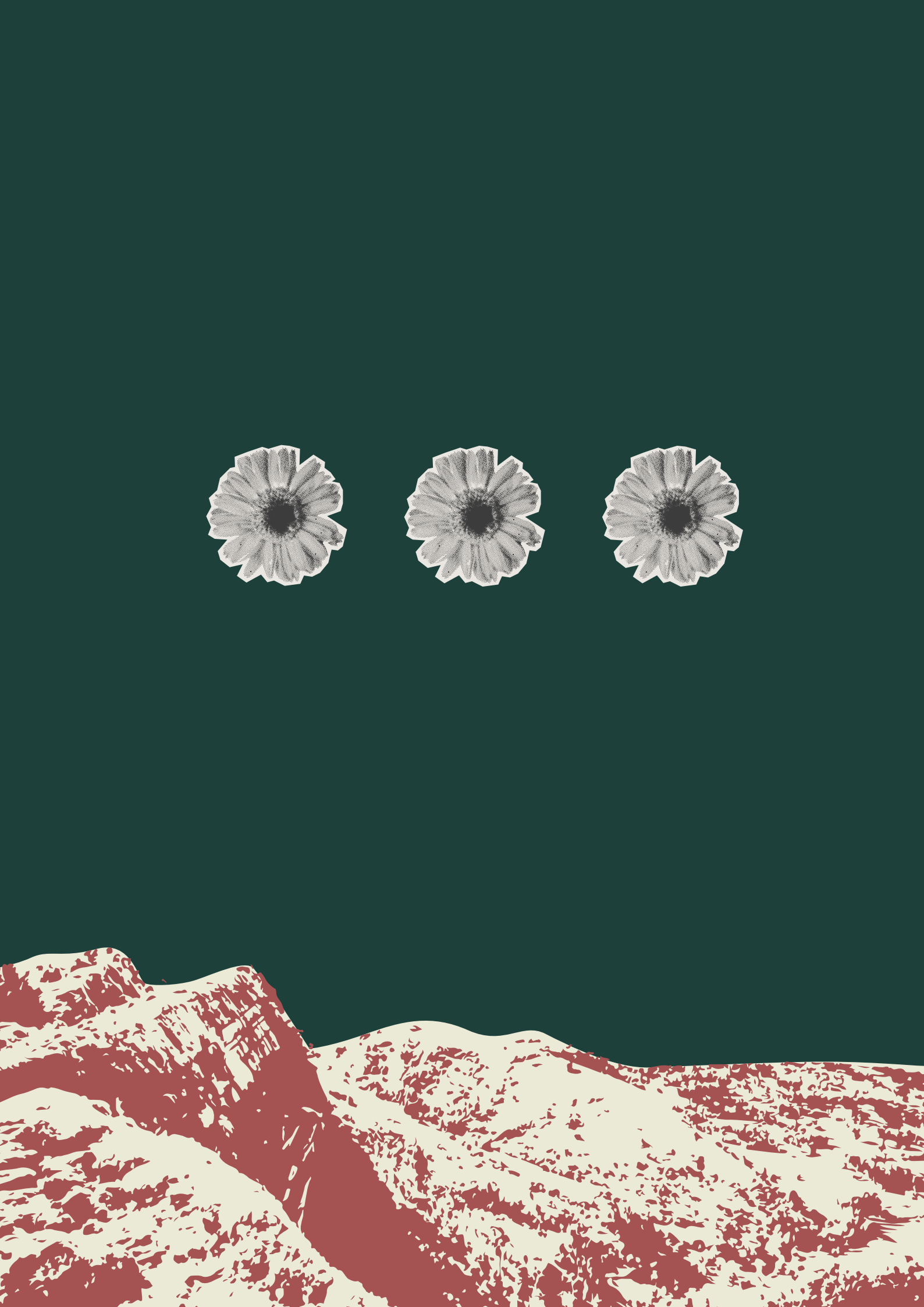
REPRESENTATION

Disability representation in mental healthcare also makes care models more effective. I'm a mental health professional. And my personal experiences help me deliver better care to clients coming from similar experiences.



Changes need to happen at both the policy level and in the minds of people.

Only then can we avert the abled gaze, meet the real needs of the disabled population, and unlock their potential.

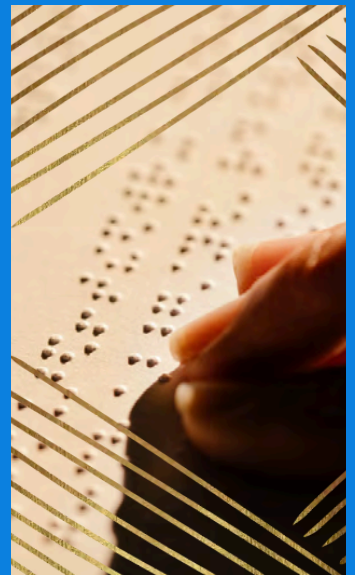


What do you think of when you hear the word **DISABILITY?**



Perhaps you think of locomotor disabilities, wheelchairs, and canes. You may think of visual impairments and braille. Take a bird's-eye view and you might see it as an issue of accessing resources.

Society fosters a certain understanding of the 'able body and mind'. Similarly, its definition of disability is incredibly narrow.



STORY BY
SEETHA LAKSHMI

ART BY
SHOI

I'm a first-generation Dalit scholar at a university. I am queer and neurodivergent. My disability is in trying to fit into society.

THE WORLD

YOU MUST BE
NEUROTYPICAL
TO ENTER →



As a neurodivergent person, I live with 'invisible disabilities'. There are issues of delayed comprehension; issues in interpersonal relationships when people do not clearly communicate their intentions yet expect me to take the hint; issues with social situations, emotional regulation, sensory overload, constant fidgeting and stimming*, and chronic psychosomatic pain**.

Looking back as an adult, it's clear the causes lay in my childhood. An uncle who sexually abused me and a brother who followed his example. I was labelled "bad-tempered" for showing my feelings. My father called me a "snake" for expressing my opinions. My home was not a safe space for my emotions.

Growing up this way, the mind is not calibrated to 'normal' because of the abuse I've faced since I was a baby. My body stores the trauma. Constantly being in fight, flight, or freeze mode has taken an enormous toll on my nervous system and gut. As a result, I live with chronic pain. I struggle to feed myself. I need accommodation to be functional and healthy.

But I live in a system that will not meet my needs.

***Stimming:**

Repetitive movements or sounds that people make to cope with emotions or self-soothe, such as biting their nails, flapping arms or hands, rocking back and forth, humming or singing, picking at their skin or scabs, pulling their hair, cracking their knuckles, even hitting oneself or objects, etc.

****Psychosomatic Pain:**

Physical pain such as chest pains, back pain, nausea, dizziness, tremors, high blood pressure, etc., that is caused by stress, anxiety, depression, or traumatic experiences.



This system is built on two hundred years of industrialization and capitalism and will not make accommodations for people with disabilities.

For example, assistive technologies like screen-readers and braille keyboards, scribes for school exams, sign-language interpreters on the nightly news, and furniture with adjustable height for wheelchair users. Those with invisible disabilities may require flexible work and study schedules, written instead of verbal communication, visual aids for those who need them, and controlled environments to ease sensory processing issues, among others. And then there's the cost of all these 'features'. This system has cemented standards that we struggle to adhere to, to survive under, which marginalize us because of our gender, our caste, our sexuality, or our disability.

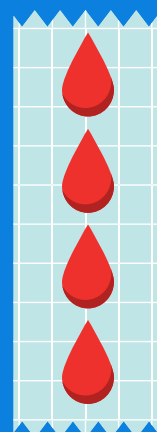
Female-bodied people will tell you that our bio-cycle spans a month, closely linked to the menstrual cycle. It affects psychosomatic pain, too. But our society runs on a 24-hour cycle that works for men and the able-bodied. We've been conditioned to see this cycle as 'normalcy', something any person should do. And with this demand of 'normalcy' looming over me, it's hard to see myself as a 'functional' individual in society. A neurotypical world places several potentially damaging hurdles. Every day, I am expected to sign in at my office

physically, spend more energy than I have, skip meals to reach on time, and pay for transport back and forth. The impact on my body, gut, and finances is not considered.



YOU MUST BE
THIS NORMAL
← TO ENTER

Unable to meet these standards **creates feelings of guilt, shame, and failure.** It breeds a disconnection from the community and the self. People from spaces like mine don't feel a sense of belongingness in their own bodies.



There is a further disconnect in how we address these problems – a one-size-fits-all approach to mental health. You cannot force your own ideas of “care” and “health” upon people. Care is incomplete without factoring in the realities and narratives of caste-based or gender-based discrimination, among other things.

THE PERSON IS NOT THE PROBLEM; THE PROBLEM IS THE PROBLEM!



Source: [JOOSTERAS/Wikimedia Commons](#)

In the Netflix TV series ‘Atypical’, we saw a Prom with noise-cancelling headphones for students with autism who would feel overstimulated by loud music, allowing them to participate with their classmates. It was refreshing to see how people had created a safe space with respect and curiosity, not just assumptions about what someone with a disability needs.

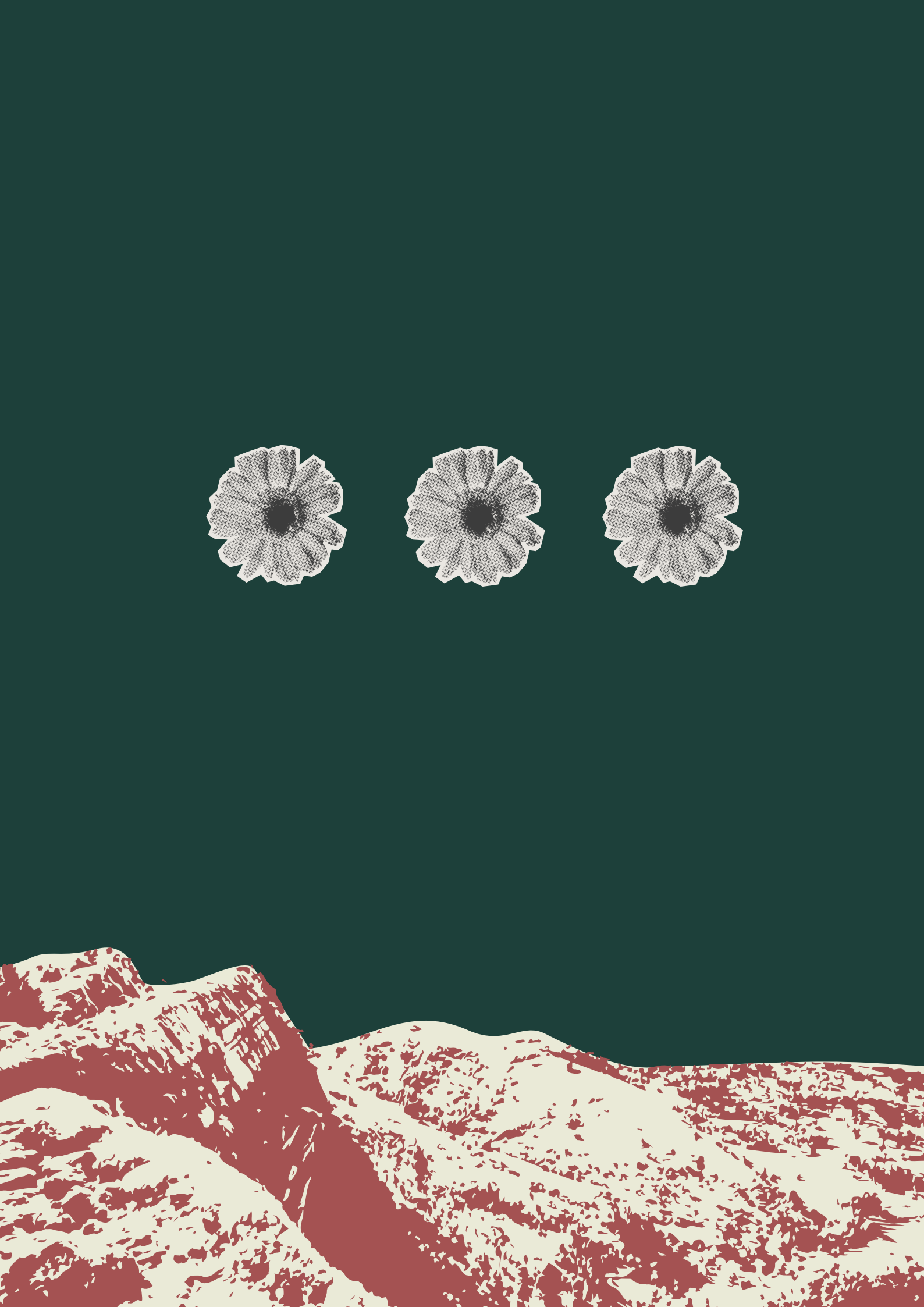
Instead of that one-size-fits-all approach to mental health, an eclectic approach is necessary. Trying different

modalities is necessary, be it practices from Cognitive Behaviour Therapy, Art and Movement Therapy, or Rational Emotive Behavior Therapy. Prioritizing the health seeker’s agency is necessary. Perspectives of living in gendered bodies, marginalised bodies, or with invisible disabilities need to inform accommodations at school, work, and beyond. Only then can we genuinely provide mental health treatment options that work.

So, how do you address the specific mental health needs of someone who is queer, Dalit, and disabled?

You draw on the insights and experiences of the person themselves!





A MOTHER IS A BODY, NOT A MIND



I am a mother to a five-year-old. I am also a feminist. I hold both these identities close to my heart. But more often than not, these are in conflict with each other.

I first became aware of the schism between these two identities when I became pregnant.

STORY BY
VEENA HARI

ART BY
ANUSHKA BANSAL

ascending series of indignities

PAIN COMPLAINTS NOT
TAKEN SERIOUSLY

TSK, DON'T
BREASTFEED HERE!
THAT'S SO VULGAR

SLEEP? NOT
FOR YOU

JUDGEMENT, CRITICISM,
AND CONDESCENSION
FROM OTHERS

A WOMAN IS NOT COMPLETE
WITHOUT HAVING A CHILD

INFO FOR NEW MOTHERS?
FIGURE IT OUT YOURSELF.

Through this journey of motherhood, my observations, questions and critical thinking were an obstacle at best and annoyance at worst. A mother is a body, not a mind.



I grew up always wanting to be a mother. As a five-year-old, I watched my mother pull down hot chapatis from the stove with her bare fingers and not be burnt. In my mind, my mother and all mothers gained a mythical air. Mothers can do anything. I wore a long nightdress like my mother's, flowing like a cape behind me and dreamed of becoming a supermom, my own version of an indestructible and invincible superhero.



When I eventually did become a mother, it was a lot different. My own experiences with pregnancy and new motherhood were intense. I woke up at night screaming with nightmares and pain – physical and emotional. I felt the tight squeeze of dread in my chest as the evenings approached and I knew I'd have to wake every hour through the night. Changes in routine felt catastrophic and I was constantly hypervigilant around my baby.

Through the brain fog that is new motherhood, I could not stop thinking of all the information and community support a new mother needs and most often, does not have.

I first found myself looking for community while breastfeeding challenged me.



Late one night,
I found a group on
social media.

M

Is my milk enough in quality n quantity?

Need to express at least 150ml per feed

12:05 pm ✓✓

F

Moms! Nipple cream reccos? Facing a lot of dryness and cracking :

(

02:28 pm

H

Baby wouldn't stop crying today. I'm going to start crying too. N my mother-in-law is making weird suggestions without any scientific basis 🙄

11:20 pm

I'm so sorry :((calling you, just vent ok?

11:24 pm ✓

Today

C

F

Moms! What's the best nipple cream?
Facing a lot of dryness and cracking :(

I'm using xxbrand, try it out?

03:23 am

Awake again? 🤪 Must b breakfast time for baccha

03:30 am ✓✓

M

hahahaha

03:31 am

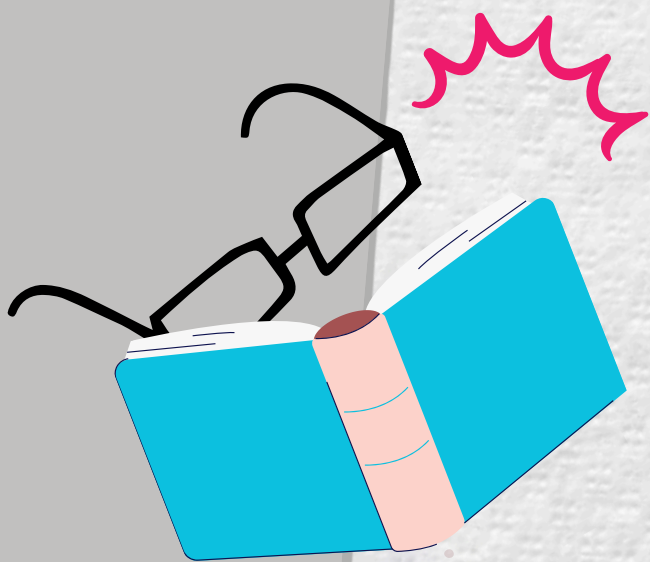
C

Every hour is breakfast time 🙄

03:32 am

But outside this community, it was quite the opposite...

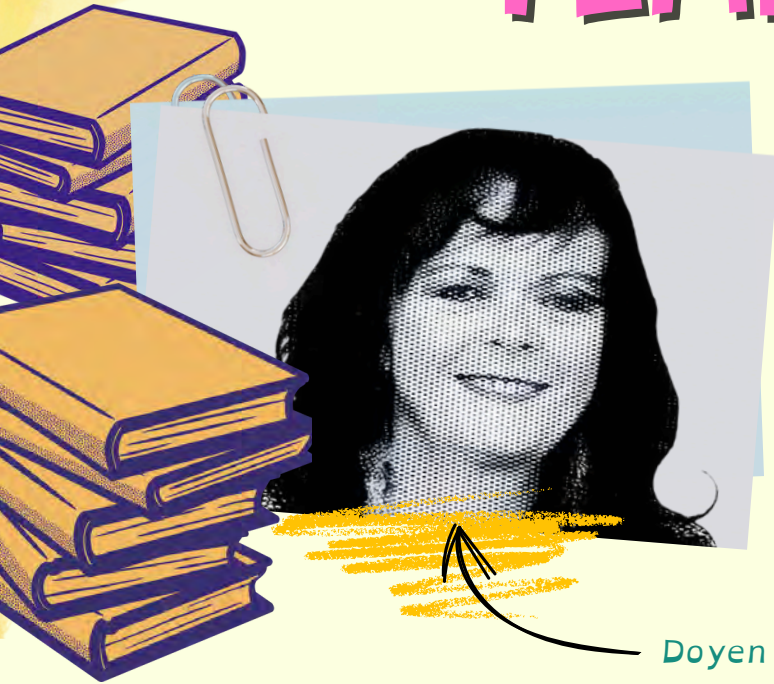
**WE KNOW
YOUR BODY
BETTER
THAN YOU**



While doing an advanced course in perinatal psychotherapy, I read somewhere that the postpartum period is the perfect storm: with the biological, social and psychological changes it entails. Given what we now know about the profound brain changes that happen during and after birth, the support system and practices around the perinatal period do not reflect the science.

Which is why we need

MATRICENTRIC FEMINISM



In her paradigm-shifting book “Matricentric Feminism”, **Prof. Andrea O'Reilly** shares that mothers need a feminism of their own. The category of ‘mother’ is distinct from the category of ‘woman’ and many of the problems mothers face are specific to women’s role and identity as mothers.

Doyen of Motherhood Studies in Canada



As a group, mothers and anyone who engages in motherwork remain disempowered despite the decades of feminism. Indeed, motherhood is the unfinished business of feminism. There have been recent advances in maternal theory and matricentric feminism in the last two decades but these fail to feature in mainstream feminist discourse. For many of my contemporary feminist friends and colleagues, matricentric feminism is an unexplored concept.



The medicalization of pregnancy and childbirth has caused a loss of bodily agency for mothers.

Remember the ascending series of indignities? Add to this mixture the inequalities that exist under the patriarchy. The patriarchy benefits from women being quiet through their reproductive experiences. The imposed

silence also allows the system to place all the heavy-lifting of reproductive work well outside the economic sphere.

What do I want for mothers?

In short, I want **decolonized, feminist, and accessible** mental health services.

I envision mandatory screening for new mothers at each interface with doctors: from follow-ups, to vaccination appointments, and beyond.

I envision a shift from a medical model to community based models that use traditional knowledge and wisdom and integrate body, mind, and soul. I want these models to be led by women who can accurately reflect the specific needs of mothers in that context.

I envision policies and their implementation to make all this a reality.

I envision adding depth and nuance to the narrative around motherhood, questioning the pedestalization of motherhood and increased public awareness about perinatal mental health.

I invite you to also question your ideas about

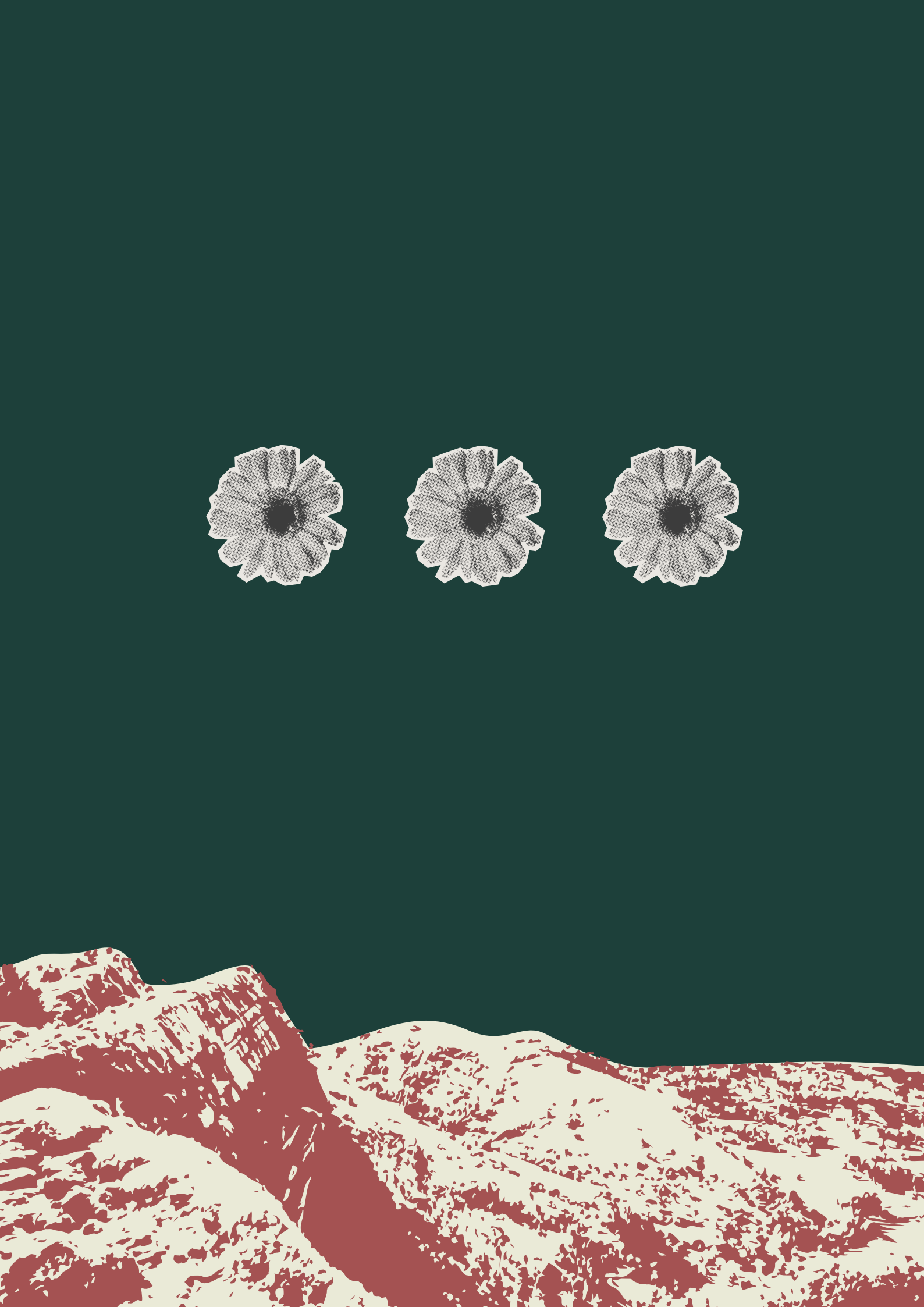
motherhood

and what it entails and rehash the division of mother work in your own home.

I invite you to look at the mothers around you in a new light and invite them to an open and honest conversation about what they need.

And I hope that the next time you meet a new mother
and she tells you she is managing just fine,
you will offer her a break anyway,
or a meal or a patient ear or a hug.







PSYCHOSOCIAL WELLBEING FOR GARMENT WORKERS IN INDIA

Long eight-hour shifts without drinking water

or restroom breaks. Rigid deadlines.

Massive production goals. These are the working conditions at garment factories we surveyed in Bangalore, Jaipur, and Ludhiana. In these environments, workers continue neglecting their health in favour of monthly attendance bonuses, overtime pay, and other employee 'benefits'.

STORY BY
ISHA MATH AND
DR SRAVANNTHI MAYA

ART BY
IPSHITA THAKUR

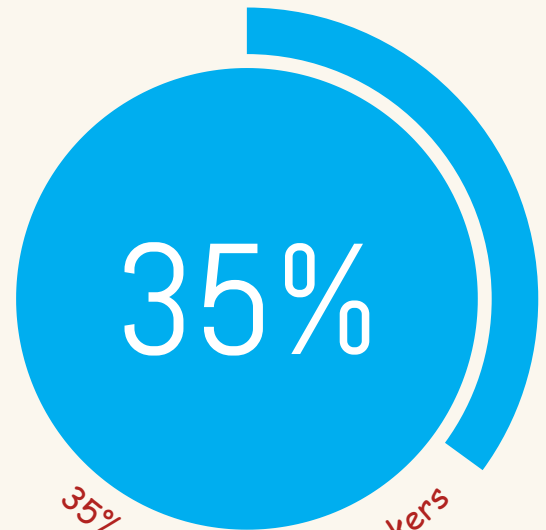
Various reasons compel workers to soldier on in these jobs. Many come from rural areas and face pressure to regularly transfer money back home. Women workers, who make up the majority in the garment industry, take up these jobs due to their lack of formal education. While the majority of them are dual salaried households, the debts are quadruple. COVID was a major setback, pushing families deep into debt. On top of that, many had partners who were battling with alcoholism or debt.

"My husband drinks a lot. I have two daughters whom I have to educate and marry off. Saving money is such a problem. I am worried he will come home drunk and either hurt me or my children."

– Tailor, Bangalore

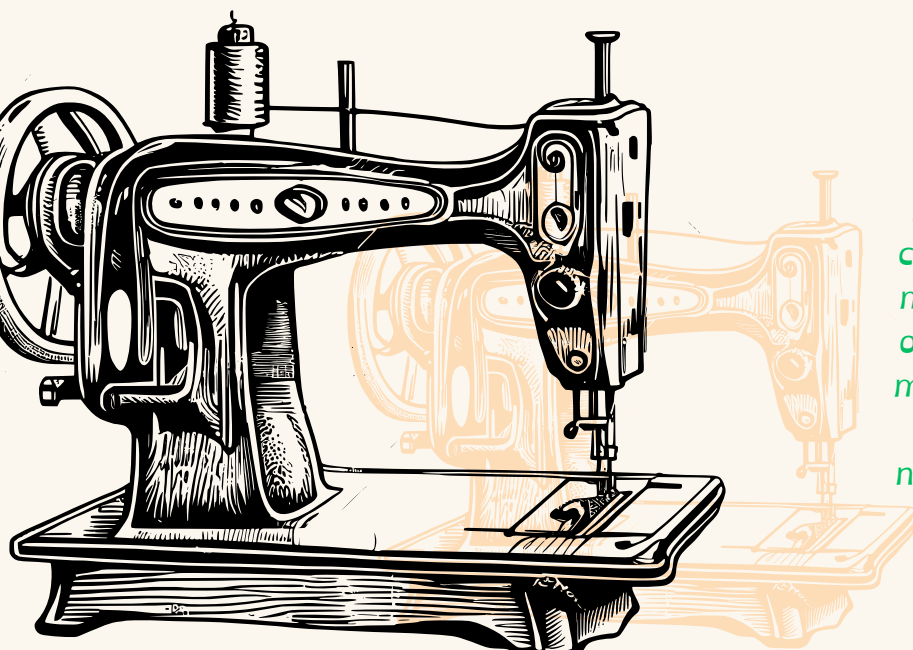
"I am here doing this work and my young kids are back home, under the care of my parents, both my husband and I work, but we are in different cities, I am always worried for them, I can't even eat or sleep properly."

– Tailor, Tirupur

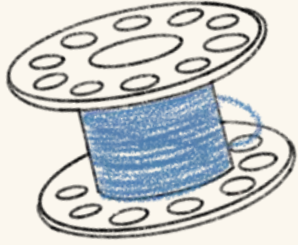


35% of the women workers in the garment industry have rated their emotional well-being as negative (Joseph & Shanbagh, 2012)

Studies show women experience difficulty in striking a balance between personal and professional life. Diabetes, anemia, and high blood pressure become common. One worker was prescribed anemia treatment, but refused because she was concerned that it might harm her reproductive health or make her unsuitable for marriage.



Sumithra Bai, a tailor at a clothing company, began faltering in her production targets while plagued by headaches, hair fall, and leg cramps, falling asleep only at midnight, and having to jump out of bed at 6 a.m. the next morning. Her haemoglobin fell to 8.5g/dL, much below the normal level of 11.6–15 g/dL.



Another worker from Tirupur said she sleeps only three hours at night due to obsessive thoughts about work. She's the type to take things on herself rather than delegate tasks. As a result, she has been struggling with chronic acidity for over 20 years despite eating on time.

Women refrain from taking steps towards their healthcare or self-care, as the distinction between self-care and selfishness is blurred in their perception.

This combination of biological, psychological, and sociological (especially gendered) pressures have immediate and long-term impacts.

Health@Work addresses the shortcomings in traditional business and factory systems.

- recognized by the United Nations Foundation's Universal Access Project
 - validated by the research of Tufts Labor Lab (2022)
 - Early adopters include Levi Strauss Foundation, Amazon, Kontoor, VF Corporation, Landmark Group, and Auchan Foundation
 - 140K apparel workers from 180+ factories across India, Bangladesh, and Lesotho
- 

Finding solutions then requires a biopsychosocial approach. This was the approach we used when implementing the Health@Work program in garment factories.

Even in the context of health, there is persistent stigma around words like 'mental'. This meant introducing ourselves as a psychosocial support team.

We explained the term 'psychosocial' as the impact of social issues on our psyche or brain. Translating the concept into Kannada, Hindi, and Tamil further helped workers to connect with us and what we do.

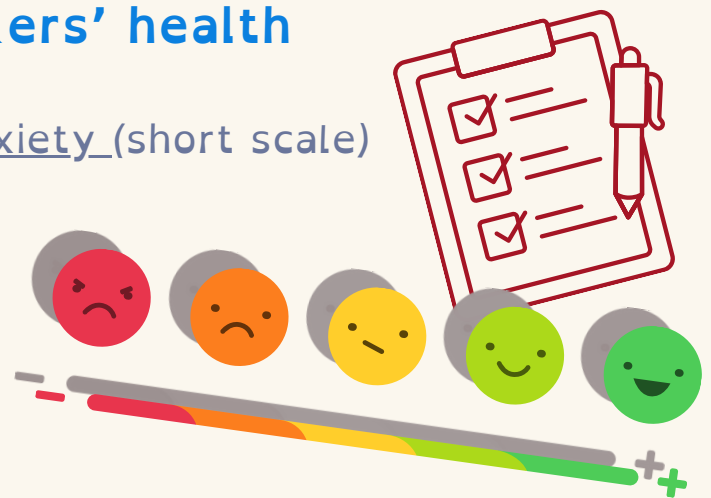


Our initial conversations on physical health were gradually steered towards emotional health in ways that workers could relate. Lakshmi, a 45-year-old tailor in a Bangalore garment factory, shared how her daughter's physical symptoms were connected with unresolved family stressors.

“For months now, my daughter's stomach swells in the morning and contracts by evening. I never thought emotions could make someone sick.”

We used several psychological tools to assess the garment workers' health

- ✂ Beck's depression and anxiety (short scale)
- ✂ mood scale
- ✂ hunger-satiation scale
- ✂ single item stress scale
- ✂ sleep scales
- ✂ visual analog pain scale



After workers opened up about their experiences, we introduced them to role-playing activities on supportive listening. As a result, they developed the ability to offer empathetic support. Workers are able to spot symptoms of distress in others and refer them to counselors in time.

Another important intervention was offering healthcare through telephonic support. On weekdays, garment workers cannot simply take time off work to seek treatment; on weekends, many health facilities are closed. To receive healthcare while working has made a big difference.

Sumithra Bai, who suffered from low haemoglobin, received timely medical care in the form of an easy-to-use tonic. With improved health and increased energy, Sumithra was able to produce 80-90 garments every day, successfully achieving her daily targets.

An encouraging outcome of interventions was that factory workers reported lower absenteeism and increased visits to primary healthcare providers.

"Mental health was something we never spoke about," said one HR manager from a Bangalore factory. "Now, I see a behavioral change after psychosocial training sessions. Workers are accommodative, relaxed, and more productive. It's huge!"

Access to psychosocial care is limited. While government-run health facilities try to serve marginalized communities, service delivery is simply piggy-backing on primary health, and therefore not as effective. Not to mention that staff at Primary Health Centres have little to no understanding of mental health issues. And, of course, social stigma hinders the few services that exist. That's why care has to be tailored to the needs of communities, be it garment workers or others.



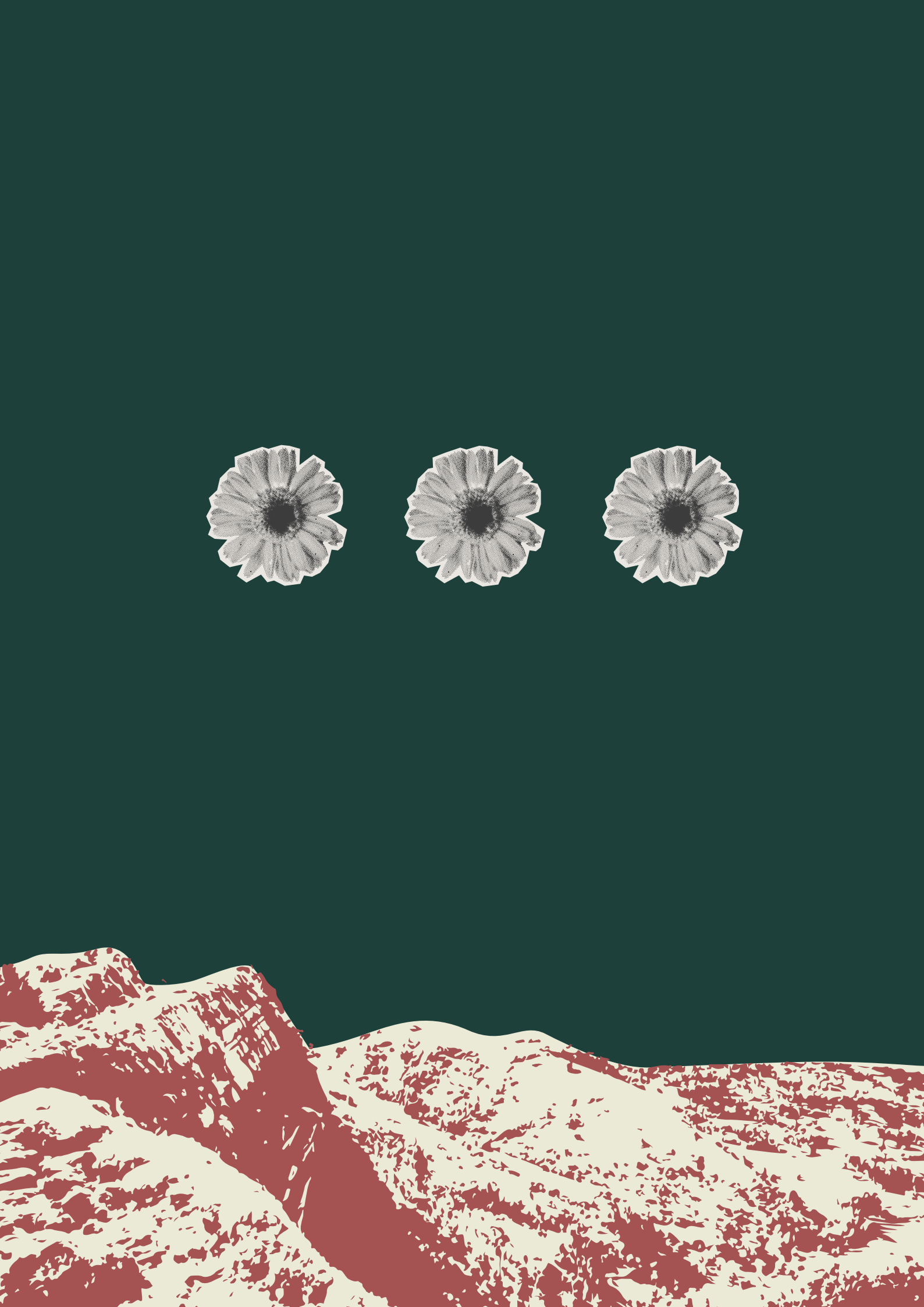
To reduce stigma and increase acceptability of psycho-social care, discussions in school settings can foster a culture of awareness and understanding at an early age. And in the age of social media and shortened attention spans, Instagram reels, YouTube shorts or other short-form content on psychosocial health helps a great deal, moreso if it's in a variety of Indian languages.

When it comes to psychosocial services, we have a long way to go. Merely a handful of professionals aim to work with marginalized communities. Rigid beliefs and outdated systems continue blocking our path. Challenges exist across the board.

But that will not stop us.

Small steps lead to a bigger and better world.







FOR LEADERS FROM MARGINALISED COMMUNITIES, **THE BURNOUT IS REAL**

STORY BY
SHINJINI SINGH,
KHYATI POKAR, AND
MAHASWETA CHAKRABORTY,

ART BY
GHANA NB

Working on the non-profit
frontline as a community leader or
member of a local NGO involves
confronting the root causes of
vulnerability and discrimination. And
anybody who does this work knows
the toll it takes.

It means dealing with complex issues like...

climate crisis



disability



gender and caste

*...and seeing up close the harm
that people face every single day.*

The state of mental
health within these
organisations is being
studied by Dasra in four
locations



Godhra,
Gujarat



Puducherry



Mt. Abu,
Rajasthan



Kolkata,
West Bengal

Understanding the mental health needs of diverse communities served by these organisations is crucial to developing a Global Mental Health Solution. Why? Because a one-size-fits-all approach just won't cut it. Every community's lived reality and local context deserve to be represented at a global platform for mental health.

For people from marginalised communities, what are the norms, practices and needs regarding their mental health and well-being? Dasra's conversations around on burnout with proximate leaders reveals a lot.

Proximate leader: someone from within a marginalised community being served by the organisation they work with. They have the most accurate understanding of the community's struggles, and are best placed to encourage co-creation of solutions.



MOTHERS OF CHILDREN WITH DISABILITIES HAVE UNIQUE WELLBEING NEEDS



Puducherry

Satya Special School serves not just children with disabilities, but their mothers too. The mothers are from dalit, religious minority and middle to low-income households. They've had to face stigma and blame for their child's disability. It's physically demanding and mentally exhausting to care for a child who is hyperactive and has a short attention span; a child who needs exercises for physical therapy and motor movement; to cut out junk food and make sure only nutritious meals are available; constantly wondering, "What happens when I'm no longer around?" With already limited socio-economic agency as well, these mothers were not getting the mental health support they needed.

That's where Satya Special School comes in. Not only are the kids enrolled here, it doubles as a safe space for moms. The school's feminist perspective means responding to the unique social realities and needs of each mother. It's providing crucial things like: **Learning to think of disability differently**

Skills to understand their children's needs and triggers

Skills to foster patience and resilience

Mothers' circles, where moms can talk, laugh, cry, and share food.

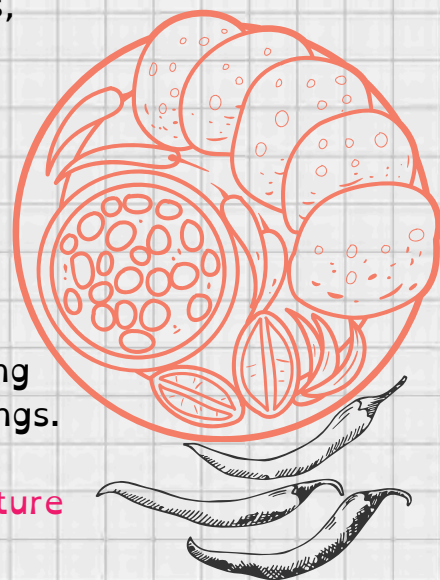
And so, even amidst daily stresses, there are **moments of joy.**

And **moments of pride.**

Like seeing their child doing things for themselves.

Like seeing them being cared for by their siblings.

Like seeing **a better future**



I DIDN'T KNOW ABOUT THE SPECIAL OLYMPICS FOR PEOPLE WITH DISABILITIES. I PLAY BASKETBALL, AND NOW MY SON PLAYS TOO. I WANT HIM TO JOIN THE SPECIAL OLYMPICS.

PLEASE DON'T BE SHY! GET A UNIQUE DISABILITY ID AND USE THE BENEFITS FOR YOUR LITTLE ONE.



For Garasiya, Bhil, and Gameti tribes in the foothills of Rajasthan's Mt. Abu, life is not easy. The land here is hilly, tough to travel through, and prone to drought and uncertainty. There are limited livelihood opportunities. People rely on the forests for most things, but communities have lost their traditional rights over land and forests due to restrictive laws and encroachments by external parties. The hostility of the land pales in comparison to the displacement of tribal people, loss of their livelihood sources, and the erosion of indigenous knowledge systems. How do you address the wellbeing crises that arise out of these unforgiving conditions?

BUILDING TRUST IS THE FIRST STEP TO TALKING ABOUT MENTAL HEALTH

Jan Chetna Sansthan (JCS) found that the way in was through community relationships. Trust and a supportive work environment emerged as pillars for nurturing relationships.



Mt. Abu



Interruptions to people's daily routines – for the sake of program implementation – wouldn't do. It was necessary to respect indigenous ideas of time. So JCS initiated night time gatherings to have open conversations about the needs of people trying to survive in this region. Here, people had a direct say in intervention design, and have since come together as community collaboratives or 'Sangathans'.



Careful to bring gender in focus, it works tirelessly to strengthen Panchayati Raj Institutions (PRIs) through capacity building for elected women representatives.

As conversations around mental health have been sparked by **Dakshas** (community mobilizers), and members of these tribes begin to voice their concerns.



“Right now, support is via dialogue or offering space to stay and offering song and dance.”

Here in Mt. Abu, the community has begun evolving its model for mental health support.

ACCEPTANCE, DIGNITY, FREEDOM FROM STIGMA FOR CHILDREN OF SEX WORKERS

The outside world is quick to judge and stereotype the women who work in Kolkata's 'red light areas'. Worse still is how they view their daughters as incapable of studying. Saraswati, now a

Mass Communications student in Calcutta University, came to South Kolkata Humari Muskan (SKHM) in 2015, joining other children of sex workers and trafficked women. The women from scheduled castes like Bauri, Muchi, Dhoba, Pod, and Namasudra. Many are trafficked from various regions, including Bengal, Bihar, Rajasthan, Madhya Pradesh and neighbouring countries of Bangladesh and Nepal.



Here in Sonagachi and Bowbazaar, two of Kolkata's red-light areas, sex workers and their children are often reluctant to move out. Living anywhere else means hostility from neighbours and threats to their security.

So for the daughters of sex workers to break out of the cycle, an alternative livelihood is crucial. And so SKHM initiated the Learn and Earn program, through which they get a chance to study and a stipend of their own.

But the children's daytime education would amount to little if their mothers were not supportive and understanding at night. So to prevent the second generation from falling into prostitution's grasp, SKHM launched its Dignity Program back in 2017, providing marketable skills like cooking and candle making.

While a sustainable income eases financial stress of mothers and their adult children, the health and wellbeing of young children

require attention too. Children often struggle to express their feelings and thoughts verbally.



Emotional and psychological challenges can feel crushing. So SKHM's play therapy allows children to communicate and process their emotions through various forms of play and creative expression. Additionally, a 'peer support' system has been introduced, where responsive children assist or prevent unresponsive ones from falling into detrimental patterns.

Not only have these mental health interventions help children grow into healthier young adults, they are able to proudly acknowledge their origin from a red-light area. Each of them aspires for a future of opportunity and dignity.





Godhra



A PIECE OF PEACE FOR TRIBAL WOMEN LEADERS

A remote, hilly drought-prone landscape.

Travelling for hours in search of water.

Scrambling for firewood in a dying forest.

Untreated asthma and tuberculosis.



This is what women from Bhil, Dalit, Chamar and Harijan communities in Godhra are up against, day in and day out.

Not to mention deep-rooted gender inequalities. Decisions about healthcare or better farming practices – things that directly impact the quality of life – are taken by their husbands and in-laws.

Feelings of anxiety and fear that arise out of these are glossed over for lack of access to mental health resources.

By the late 80s, the Gujarat-based organisation SARATHI (Social Action for Rural and Tribal In-Habitants of India) began working with women from these four communities, building leaders from the ground up.





Over the years, more and more community leaders have emerged, taking ownership and carrying out SARTHI's work on tribal women's development.

But it is undoubtedly a high stress job. And it soon became clear that each woman's well being is tied to her role as a leader.

They derive satisfaction and purpose from a job well done.

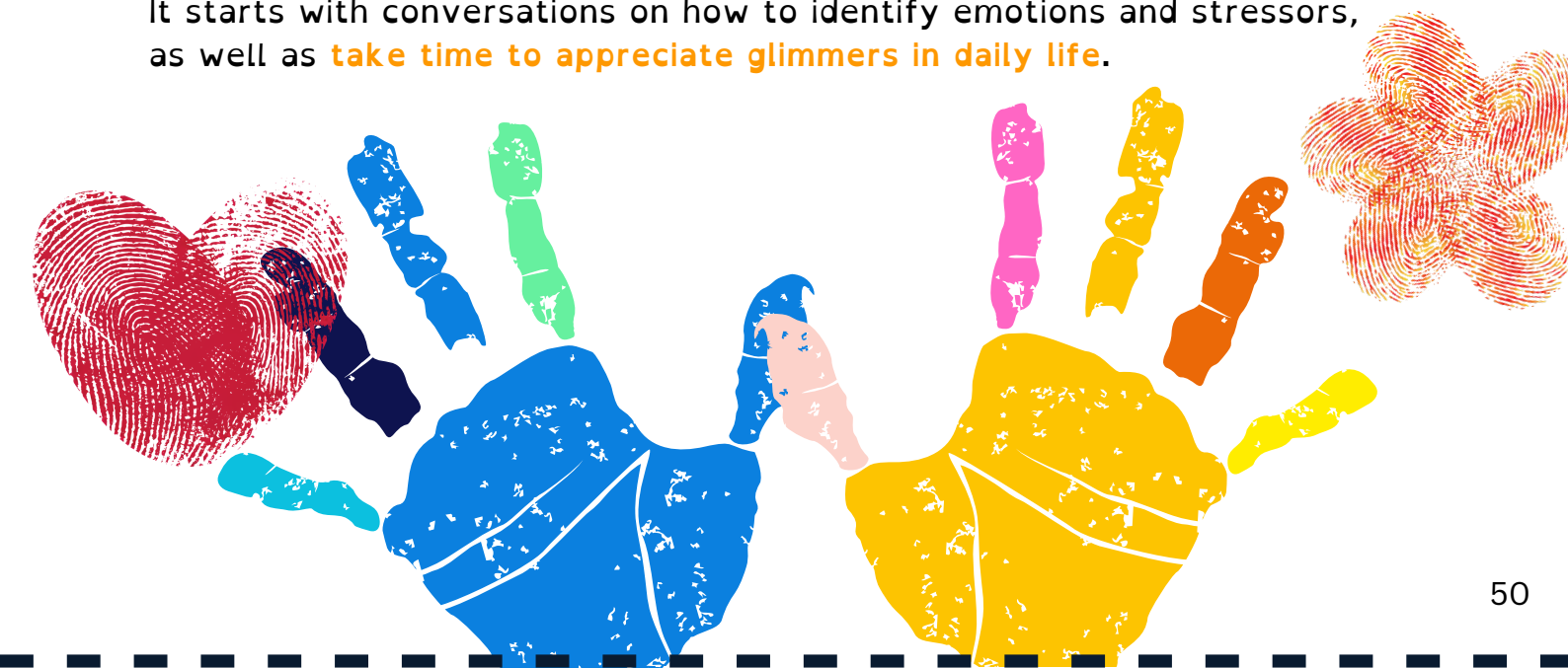
And for issues like declining staff, financial constraints, and adapting to difficult but now almost indispensable digital technologies, they have to develop stress management and coping mechanisms.

For grassroots communities, introducing 'Mental Health' as a separate, distinct idea runs the risk of alienating people. Instead, the women leaders of SARTHI, who play a vital role in designing and implementing programs, have found another way: integrating mental health awareness into their community work.



One way that's worked particularly well has been to engage young people within their communities.

It starts with conversations on how to identify emotions and stressors, as well as **take time to appreciate glimmers in daily life.**

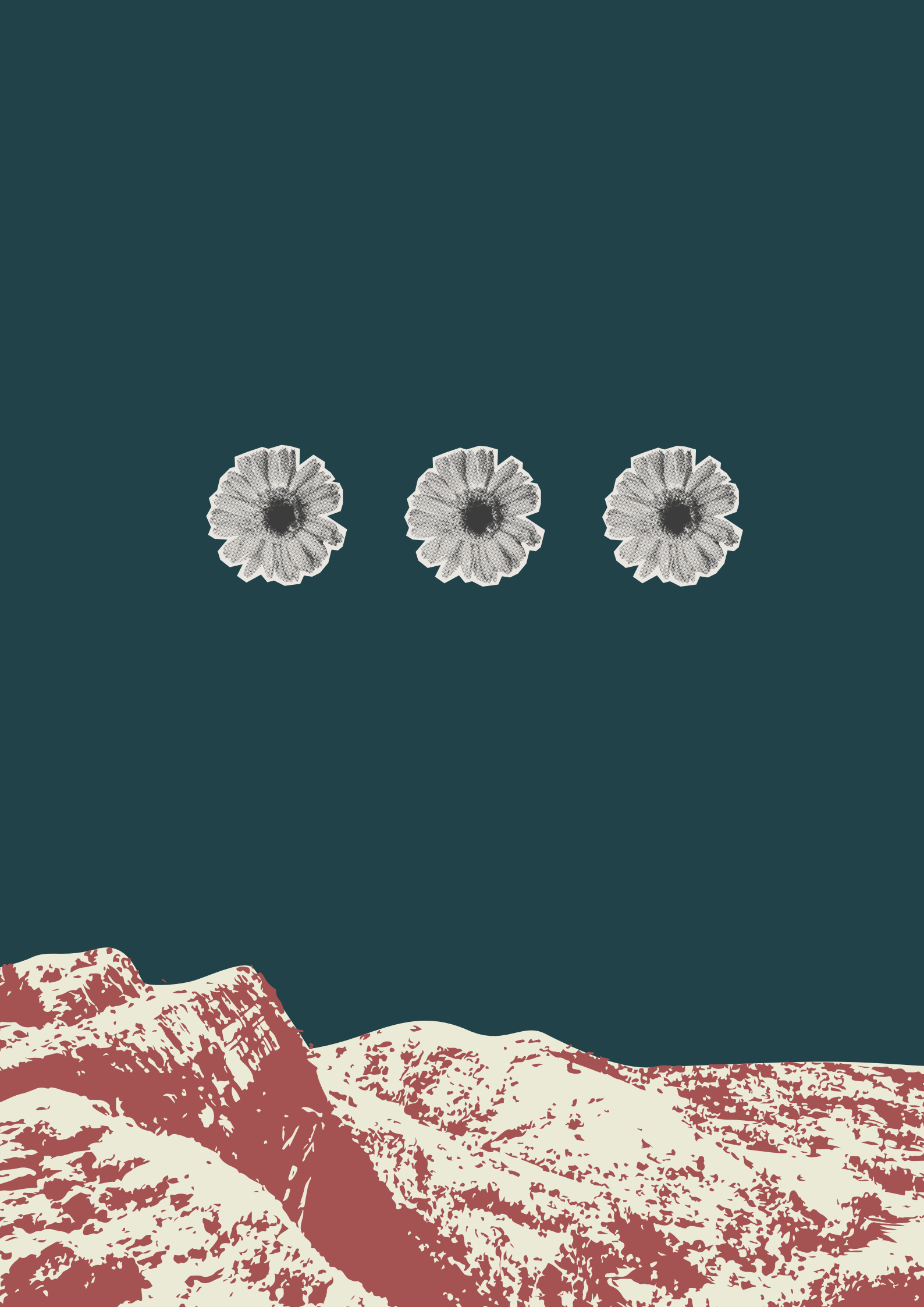




Indigenous and marginalised communities have endured.

More importantly, they have built unique community based mental health resilience models that nurture well being despite intersectional challenges.

It's time for these models to find space in the Global Mental Health Solution.



THE WAY FORWARD

STORY BY
SAKSHI NIKHIL SHAH AND
DR. SIVA MATHIAZHAGAN



A plush couch. A professional with a notepad. Maybe even incense. A conversation about your childhood. A prescription.

Pop culture would have us believe this is what mental healthcare looks like.

A fifty-minute session, and you're out the door.

It's a model created and influenced by Eurocentric biomedical research, policy, and practices. How much of it can be applied in a different cultural context?

It might be useful to the English-speaking office worker in a metropolitan city in India. But can this model provide care to a factory worker? To a wheelchair-user navigating the frustrations of a city with no accessible buildings? Does it understand the specific needs of someone who has faced caste-based violence?

Social determinants such as caste dynamics, gender disparities, religious extremism, communal divisions, sexuality, abilities, natural and man-made disasters, as well as digital threats, play substantial roles.

Without a proper understanding of these, mental healthcare models are incomplete.

Things that are difficult to quantify – the subjective side of mental health – are things that provide context to symptoms, struggles, and recovery journeys.

CULTURE INFLUENCES OUR MENTAL HEALTH



'Family' in the Global South has a huge influence. It extends beyond the nuclear unit to encompass grandparents, aunts, uncles, cousins, godparents, and certain segments of the community. Families fiercely guard values like pride, respect, and dignity. In circumstances where a person's mental health might bring shame upon the family, a person's health-seeking behaviour changes.

A person's role in society, too, can be a source of stress. The patriarchy assigns men the primary roles of providers and protectors and assign women roles that confine them to domestic responsibilities. Failing to fulfil these duties means stigma and various forms of violence, which means further mental health burdens.

Similar expectations (read: restrictions) are placed on people from certain communities. In the case of caste, the denial of basic human rights further adds to the mental health burdens of people from marginalized communities.

All of these prevent people from receiving the care they need.

Mental healthcare must address the entrenched structural inequalities prevalent in the Global South.

Simultaneously there are opportunities for alternative models of care in indigenous healing practices of the Global South.

Ceremonies, songs, stories, dances, and prayers in local languages and styles can offer an outlet for complex emotions. In Tamil Nadu, Oppari and Gana songs are performed at death ceremonies. Another example is the 16-day family ritual (Ezhavu Aatruthal, or 'Heal the Loss') that helps people to process grief and other emotions with the support of family, relatives, and community members.

For dramatic effect, an **oppari** singer uses not only her vocal prowess but performs through her entire body. She strikes her fists on her collarbone; dramatically extends her hands, and even clap, to retain the attention of her viewers. Interspersed with sobs, shrieks, wails, and groans, oppari is a truly remarkable spectacle to witness.

Priyadarshini Panchapakesan, Sahapedia, Sep 2021

Language is another factor. Making mental health educational resources available in native and local language improves access to mental health information. Moving away from English and other dominant colonial languages provides a sense of ease and can reveal more about cultural contexts.

Just as including languages of the Global South breaks the western biomedical hegemony, it is imperative to dismantle oppressive approaches within mental healthcare.

Psychology students need to have caste, feminism, and queerness in their curriculum. Research and practices should include indigenous community-based participatory healing. There must be a mandate for cultural competency training programs for mental health service providers. And anti-oppressive, anti-discrimination approaches must be a part of mental health programs.

CULTURALLY RESPONSIVE HEALING SCIENCE

There isn't enough empirical evidence, people-centric research, and policy measures addressing mental healthcare within these socio-cultural and environmental contexts.

Even then, scientific empiricism can only do so much. It's our unique socio-cultural characteristics, economic conditions, and environmental factors that significantly influence mental health.

Paying attention to a health seeker's cultural context to help them feel safe and understood. Mental health research, education, practice, and policy simply has to become mindful of these contexts.

Cultural Competency Training for Therapists

- *Address personal and institutional biases*
- *Build knowledge of local cultural contexts*
- *Practice culturally sensitive communication*
- *Recognize culturally specific symptoms*
- *Understand and counteract broader systemic biases and disparities*
- *Integrate traditional healing practices when appropriate*

For mental health practitioners and researchers These experiences inspire compassion, reduce stigma, and enhance people-centred approaches.

Moreover, involving communities is crucial.

People who have lived experiences with mental health challenges can significantly contribute to the field by sharing their unique insights and knowledge to build a culturally responsive healing science.

WE ARE LOOKING AT ONE OF THE MOST PRESSING PUBLIC HEALTH CRISES IN THE GLOBAL SOUTH.



More than 77% of global suicides occurred in low- and middle-income countries.

40% of patients have to travel more than 10 KM to avail mental healthcare.



And there are far too few resources.



WHO member states allocate only 2% of their health budget to mental healthcare.

lived experiences don't fit into a western biomedical model or funding priorities.

In conclusion, understanding lived experiences of different communities is important for creating models of care that work for everyone.



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