The Long 2020 and the Informal Care Economy in India: Case studies of Select Careworkers

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The health system in India consists of a public sector, a private sector and an informal network of care providers. Though for the formal sectors there have been policies, schemes operative for long, in case of the informal network, due to various reasons (limited access, further worsened by the poor functioning of public health system is one among many), the act of 'caring' takes place mostly in an unregulated environment.It is important to realize that the health care crisis following COVID19 pandemic in India has been a result of collective economic strategies adopted by various governments which gave primacy to big capital, infrastructure and financial services and comparatively, less importance was attached to social sectors like health and education.

Independent India, keeping in line with the Montgomery-Chelmsford Constitutional Reforms of 1919 (whereby public health, sanitation etc was transferred to the provinces), declared health to be a state subject. Though the states enjoy autonomy, when it comes to health, however, the government at the center has been framing policies, providing frameworks, making laws that impact the whole of India. Such a tendency not only continued but intensified during the pandemic, wherein most crucial steps or responses were framed at the central level. When and where to impose a lockdown, travel bans, screening at entry points, testing etc, all important decisions were taken by the center and the states had to strictly comply.

During the 50s, 60s and 70s, the focus has been preventing the spread of communicable diseases, family planning, setting up more teaching hospitals (to produce more doctors and nurses). All of it happened with the realization that the primary healthcare system in India was inadequate (Rao 2016, 13). Further with the economic reforms of the 90s the goal of Alma Ata Declaration , which was "health for all by 2020" was sort of reframed as "health for the underprivileged under the 8th Five Year Plan and the first Health Policy (1983) gave emphasis to strengthening primary healthcare in India and setting up a network ofprimary health-care services using health volunteers. National Rural Health Mission, was launched in 2005, keeping the above goal in mind and a cadre of women volunteers dubbed as ASHA (Accredited Social Health Activists) workers was formed.

Like all pandemics, COVID19 threatened all communities alike, hence collective measures at the societal or community level was crucial during the pandemic, in India and it is here that these ASHA *didis* as they are popularly known, played important role in checking the spread of the disease by going house to house making people aware of the do's and don't's, tracking down, covid infected patients, monitoring returnee migrants etc. Though the work of these workers is officially acknowledged in government documents, but it was during the pandemic that they and their work became 'visible'.

In big towns and urban areas, *ayahs* working in both public and private spaces are careworkers who are mostly untrained, yet have become crucial in providing care. They hail mostly from the informalsector, doing all the 'dirty work' that otherwise nurses would not want to do from helping family members to take care of old, ailing family members, the

demand for their work has increased overtime and their services were highly sought after during the pandemic.

Using qualitative methods (interviews, focus groups etc.) this research endeavour would like to probe if there has been a break in terms of cultural perceptions, official responses, nature of work, perception of the 'self' when it comes to these two categories of careworkers mentioned above, or is it continuity masqueraded as 'change'? This work would also try to compare pre- pandemic and pandemic scenarios with regard to these two categories of women and also try to assess the lasting impact of the pandemic (if any) on their future.