Migrants in India's Health Infrastructure : Ethnography on India's frontline workers

Summary:

On 24 May 2020, Ambika P.K., a nurse at Kalra hospital, Delhi died. Somya Lakhani, in her report draws upon interviews with her fellow nurses who complained that while the doctors were given fresh PPEs, the nurses were asked to reuse PPEs. The management of Kalra Hospital, and few nurses denied this.. On 9 May Manipur Government gave transit clearance and travel permits to more than 185 nurses working in Kolkata, according to a newspaper report. On 20 May 2020, it was reported that 300 nurses from Manipur who worked with state government run and private hospitals left their jobs and returned home. They were heckled by their neighbours as Corona, or Chinese and could not go to stores to buy medicines.At the bottom of this pyramid are the ASHA workers and the sanitation workers. ASHA (Accredited Social Health Activist) workers are community health activists. They have played an important role in urban and rural areas to help with awareness around COVID 19, and played a key role in contact tracing. They receive a meagre allowance (except in Andhra/ Karnataka) of Rs 1000-3000 across Indian states and are the forefront of India's #frontliners - a taxonomical classification used for the health care professionals – doctors, nurses, and ASHA health workers. They are risking their lives with minimal protection in times of COVID 19 to assist in door to door survey. There are around 5900 ASHA workers in Delhi and they work on the basis of incentives, not fixed salary. Each worker caters to 400 households in her neighbourhood. In the initial phase of the lockdown, ASHA workers visited designated neighbourhoods but now they visit pregnant women with medicines and mostly try and coordinate over phone. ASHA – acronym for Accredited Social Health Activist – is a community health worker programme under the flagship National Rural Health Mission which came after a long process of deliberation in 2005. Dr.Sujatha Rao (2017) in her book on India's Health System, comments that the run up to National Rural Health Mission and fulfilling the mandate of Health for all came in at the turn of the millennial primarily due to the unconnected factors from 2000-2004. Rao observes that the year 2000 was critical. First it heralded the launch of Millennial Development Goals and secondly the Report of the Commission on Macroeconomics and Health was launched. Rao also points out that Manmohan Singh (who would later become the Prime Minister of India under UPA led Government in

2004) and Isher Judge Ahluwalia, two noted economists were part of this commission and Rao feels that they were instrumental in prioritising health in India's governance. Isher Judge Ahluwalia headed ICRIER initiate a study on health system and published a first comprehensive health report – *India Health Report* (2003) and by 2002 India had its second *National Health Policy*. What is significant to note it is only at the turn of the millennium the public spending on health was 2- 3 % ofthe GDP, primary health care became a subject of national concern, efforts to control and contain communicable diseases were some of the trends that were observed post 2000. Parallel to this, due to encouragement of public private partnerships in health care, there was mushrooming of private health care in the area of diagnostic clinic, speciality hospitals, treatment centres so much so that India became of the cheapest and attractive locations of medical tourism in the areas of assisted reproductive technology, neurology, geriatric care, ENT, Physiotherapy and Orthopaedic according to the webportal dedicated to healthcare tourism by Services Export Promotion Council under Ministry of Commerce and Industry. Subsequent governments would push towards 'insuring' the medical care through rolling out of insurance schemes.

Questions

However in this imagination of health care, there is no overall roadmap for access of migrant workers to public healthcare. It is against this backdrop the proposed research would like to examine the following:

Firstly, a close examination of medical governance through a critical reading of lack of specialised bureaucracy (post dissolution of Indian Medical Service in British India) dedicated to healthcare apart from officials chosen through Combined Medical Services Examination (unlike Indian Revenue Service, Indian Forest Service, etc) under Union Public Service Commission.

Secondly, studying the insurance schemes targeted for rural poor and its efficacy in the life of the migrant worker.

Thirdly, the nodal points of access in India's health care for a migrant worker.

Method

The proposed study will be based on review of health policies, and secondary literature with a special focus on Delhi – one of the cities that attracts migrant workers across India. For this study I will conduct telephone and / face to face interviews with bureaucrats involved in Ministry of Health, indepth interviews with pharmacy stores in migrant neighbourhoods of Delhi, and community organisers representing migrants/ interests alongside a collaborative

participatory enquiry in one of the resettlement colonies in the border of Delhi – Gautampuri Resettlement Colony. This neighbourhood attracts a lot of migrant workers. I propose to collaborate with ShehriMahilaKamgar Union to conduct interviews with local doctors referred to as JhholaChhap (Bangalidaktar), ASHA workers, Sanitation workers and primary health care centre in the neighbourhood to understand the nodal points of health care for migrant workers.