Migrant Workers in the COVID - 19 Pandemic: Crisis of Work and Life

Summary:

While describing slum life of a bustee in Mechuabazar, Calcutta in the year 1919, Radhakamal Mukerjee writes

"I witnessed an overcrowding which is perhaps the worst on record. The busti is divided into several unequal and unsystematical blocks. The ground-space of each block is rented from the zemindar by a sub-lord who erects the dingy close-built bustee-huts, collects the rents from each of the block and handing over to the zeminder the rent of the ground space, appropriates , the surplus. Thus in one of these blocks, which measured 18 ft. in length and 15 ft. in breadth there is an over-crowding of 7 adults, 6 women, 3 boys, 6 girls (Mukerjee 1919:291)."

Probably, he had visited these slums immediately after Spanish flu and hence he indicated

"…under such overcrowded conditions the spread of diseases is easy and an outbreak of plague, cholera or small-pox will drive away all those *who can* escape. The recent influenza epidemic has affected the poorer classes in the Chawls and Bustees much more than the upper classes. How can it be otherwise ? In Bombay some of the Chawls are absolutely filthy. In one in which no less than 2000 souls live, the Bhangi, Scavenger, has not been for a little less than a fortnight, and all the filth has accumulate… Whether in Calcutta or Bombay, Cawnpore, Bangalore or Poona, Ahmedabad or Madras, one is face to face in the bustees and chawls with living human misery, the dirt and disease of hell incarnate (ibid: 292).

The observation was made at a time when the "Spanish" influenza pandemic of 1918–1919 caused over 50 million deaths worldwide and posed a full-blown threat and warning to public health.

A century after, we are at the crossroads again; another pandemic 'COVID-19' has brought the world to its knees, and has brought the spotlight back on health and disease in general and aspects of public health in particular. Though the pandemic has touched lives and circumstances across the class divide, the precarity and uncertainty around migrant workers, their habitat and access to health and hygiene is drawing attention in a renewed manner. We know that more than half of Mumbai's nearly 13 million people live in the city's slums and informal settlements. Stunting and chronic disease is part

of life, and people think that this is how children are going to grow up in this environment. Access to safe drinking water, safe and ventilated habitat, access to toilet etc. remain a severe concern for the health and wellbeing of migrant workers who inhabit the slum and other unsafe spaces.

While rapid urbanisation is an acknowledged phenomenon globally, it is estimated that over 800 million people live in urban slums at present. In India, the urban population is expected to grow rapidly from a third to half of its total population by 2030, with a simultaneous expansion of its population of urban poor. Urban slums are characterised by poverty, overcrowding, poor access to water, lack of sanitation and other facilities, and challenging living conditions, which impact their inhabitants directly and indirectly. All these factors work in concert to create a unique set of challenges that compromise the health of migrant workers living in the slum (Abdi *et al* 2018).

Even among the slum population, there are visible differences in the provisioning of basic amenities, due to various factors. Data suggests that in 2012, 59% of slum settlements in India were inhabited bypeople living in non-notified settlements and suffering from poorer access to piped water, latrines, electricity and public transportation when compared to notified slums (GoI).The divide between notified and non-notified slums is particularly complex in Mumbai as it is tied to “cut-off” dates and this exposes the politics and political economy that has huge implication for the migrant’s access to health services. Slum households who can prove that they have been living in a slum located on state or municipal land prior to a specified cut-off date can obtain notified status. This policy arose in response to democratic pressure from slum dwellers, who form a large proportion of Mumbai’s electorate (Subbaraman and Murthy 2015). People living in non-notified slums have historically been unable to legally connect to this system, forcing many of them to illegally tap into city water pipes out of desperation – a survival strategy that can compromise the safety of the water supply through cross-contamination.

There is a high congruence between poverty, vulnerability and informal work in India (NCEUS 2007). Although the informal economy is marked by diversity in terms of occupations, conditions of work, terms of employment, nature of insecurity, ease of entry and so on, it is a fact that the slum dwellers and those living in informal settlements such as on the pavements, and along railway tracks, are those that labour in precarious conditions. Voka, Standing and the

ILO have framed the idea of precarious work with labour market and broader social insecurity as defining elements (Arnold and Bongiovi 2012).

The informal economy, with more than 93 percent of the workforce in the country, comprises wage workers and self employed persons who provide a host of services and are engaged in manufacturing and marketing products across the country. Among them, sanitation workers, particularly those who work in precarious conditions on contract, contribute to and ensure public health. 'A sanitation worker is one who collects refuse from residential and commercial establishments in a truck designed for this purpose, and which he may also drive. Among risks involved in this occupation are those resulting from lifting heavy refuse receptacles, trauma and others…' (Mamtani and Cimino 1992: 27). Informal sanitation workers, confront lack of basic amenities and services, including health care, unless they are organised into unions. As a caste based occupation the social stigma that these workers - men and women - face, is something that has affected generations of households. As residents of slum settlements, and as workers, this population, struggles with water, sanitation, health care, education, and social exclusion. The irony is impossible to miss: the difficulty of accessing health care services for those who are actually engaged in ensuring it for the public.

Public health services, which reduce a population's exposure to disease through such measures as sanitation and vector control, are an essential part of a country's development infrastructure. The critical agenda of public health is to reduce the population's exposure to disease through food safety, safe drinking water, ensuring hygiene and sanitation and monitoring waste disposal. It is widely recognised that any compromise on public health has severe consequences for society at large. However, it is especially crucial for the labouring poor and the marginalised sections of the society. They pay a particularly high price in terms of reduced earning capacity, expenditure on health, and mortality.Public health services are thus both pro-growth, as well as pro-poor in that they are self-targeted towards the poor, who face the maximum exposure to disease (Das Gupta 2005). Yet, the facts and evidence speak volumes about how health services for the migrants living in slums and other informal settlements are hugely compromised.

The COVID pandemic has highlighted the condition of the working poor in cities like Mumbai. Though public health concerns of

migrants' neighbourhoods, ghettos, were never on the agenda of governance, the stark conditions of these areas have exposed them to the public health crisis and brought on a humanitarian emergency. In the backdrop of 'nativist' politics and hostility towards migrants, the politics of disenfranchisement and absence of social citizenship can be discerned through nature and services in some of these slum localities. The deliberate denial to update the data of increasing population in these slums help the state claim that they do not need to bring more services or open up more health posts. That more than 145 people have to share a community toilet is a telling statement of the reality of hygiene and sanitation. Whichever ward in Mumbai has a large slum population, the services are at the bare minimum. What does this tell us? One does not need extra wisdom to realise that slums house migrant workers with whom the nativist political class has a particular approach.

One of the most densely populated slums of Mumbai that is experiencing this is Shivajinagar in the M-East municipal ward of Mumbai. The M–Ward in the city is an extreme example of skewed development in the metropolis, with virtually all indicators showing an urgent need for action that is multi-dimensional, comprehensive and strategic to serve its burgeoning population. Currently, over 77% of the M–Ward population lives in slums. The slums in M–East Ward, in particular, have emerged as areas highly vulnerable to environmental hazards and deficient in essential services such as safe water and sanitation. Further, access to health care systems is weak; for instance, the population per hospital is 66,881, that per dispensary 27,438 and that per Anganwadi centre is 2,175. Cumulatively, this explains how the ward and, in particular, the slum areas register the highest infant mortality rate in the city. The M Ward has the highest (66.47 per 1000 live births) Infant Mortality Rate (IMR) among all the wards in Mumbai. Infant mortality is an expression of vulnerabilities and hardship in the living conditions in the slums. Several aspects of the life of low income communities continue to be invisible, their contribution to the city unrecognised and their aspirations and voices unheard. The ward has been used to locate the most 'undesirable' activities (dumping ground, polluting industries) and people (beggars' home, homes for other institutionalised populations, resettlement colonies). Shivajinagar in M East ward is a microcosm of extreme urban poverty and deplorable situation of migrant workers. Shivajinagar is turning into a ghetto where nine out of ten residents are Muslim; this is a double whammy. Without a hospital, maternity centre and several other services, one

can easily realise how the pandemic prescription must have unfolded.

City cleaning work is an essential service in the time of the pandemic. The labour lives across the city, largely in slum settlements. Workers residing in one ward of the city may have to travel to another ward for work. As a service provided by the municipal corporation, and work for the thousands engaged in it, it is being reorganised at present, with tasks and details for the labour being modified to meet the requirements of the situation. For instance, contractual sanitation workers, who continued with their tasks of city cleaning, were provided Personal Protective Equipment and told that they were to maintain these themselves - wash them at home each day and then use them the following day. When they protested saying that in their small one-room tenements, they would find it impossible to do so, the municipal authorities made some alternate arrangement. Additionally, the shutting down of public transport for several weeks, affected workers who commute to their wards from their places of residence, and arrangements had to be made to manage the work. These and other issues continue to emerge.

How do the social determinants of health emerge for these migrants? What does over-crowding, insanitary condition and dehumanising living tell us about public health and its access for the migrant workforce in the city and its slums? How do we access and experience the risks, threats and vulnerabilities of workers during a pandemic? How did they deal with the prescription of social distancing, isolation, sneezing and coughing etiquettes, containment, etc.? These are some of the questions that have bothered many of us. What emerges therefore, with a focus on the urban poor, is the aspect of continued and new struggle in coping with the situation brought on by the pandemic, the demands it has made for them to reorganise their lives and work, the difficulty in accessing health care and other services in both - the place of residence and the place of work.

Therefore through this study, we propose to: (a) Delineate the evolution and subsequent trajectory of public health policy in India in general, and in Mumbai, and Mumbai slums in particular, given that health is concurrent subject; (b) Highlight Social Policy prescriptions and shifts vis-à-vis health care: public, private; social security, social insurance and social protection (keeping the workers and migrants in the centre of exploration).

In this backdrop, with a focus on informal settlements (Shivajinagar)

and informal work (sanitation work), we propose to study: The role of migrant workers in their community and through their work, particularly after the onset of the pandemic; and everyday experiences of migrants as residents and workers in regard to health care and services: access, alienation, refusal; the sight of fear and anxiety.

The site of residence and the site of work that are the focus of this study need engagement through policy and practice, and it is hoped that it will contribute towards this.