Health workers at the fringe: Notes from a migrant neighbourhood in Delhi[1]

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Introduction

April 2020. Anita Kapoor, a founding member of ShehriMahilaKamgar Union (a union for women migrant workers) and I were working on the details of how to maintainphysical distance while distributingdry ration. We started to receive requests to arrange for medicines and sanitary napkins. In one of the many conversations, Anita Kapoor commented, 'Ishita, everyone is saluting ASHA worker, doctors, nurses, no one recognises the role of the 'local doctors'' in neighbourhoods such as these. They are the first point of contact for a migrant worker'. 'Bangalidaktar' and 'JhholaChhapDaktars' are emic categories for medical practitioners who do not possess medical degrees and therefore are referred to as unlicensed medical practitioners. Commonly referred to as quacks, media reports indicate their presence in poor income neighbourhoods. There are reports of deaths due to overdose, incorrect diagnosis in the hands of 'quacks'. However, their role in India's public health care, particularly 'migrant' neighbourhoods cannot be ignored.By following the lives of migrant workers in a resettlement colony I propose to examine how trust acts as the foundation for assigning meanings to health workers.

Resettlement colony, and health work

The study is based on a resettlement colony in Delhi bordering Uttar Pradesh. As one enters the resettlement colony, one can see tarred roads broken at the edges, waterlogged or a heap of sewage waiting to be collected with rows of houses allotted by Delhi Government to the displaced a decade ago. Like most urban settlements of Delhi, additional floors have been added in the hope of earning rent. For some of the undocumented displaces they have 'made homes' in these 'extra floors' in exchange of rent. Resettlement colonies such as these attract migrants because the rents are lower compared to 'regularised colonies'. The neighbourhood has a Primary Health Care Centre with trained medical doctor, along with designated Auxiliary Midwifery Nurse referred to as ANM, followed by ASHA (Accredited Social Heath Activist) chosen from the community. Drawing from ongoing 'ethnographic' inquiry I would like to offer preliminary observations on the 'trust' shared between the network of health workers, and migrant workers. These preliminary observations are based on my engagement with the union to organise relief work in the first phase of lockdown and in-depth telephone interviews I have been conducting since July 2020 with migrant workers about accessibility to healthcare facilities in the neighbourhood. Two important actors emerged in these conversations: Bangalidaktar, and Pharmacy store owners. Gradually, by August 2020 I started to conduct telephone-based interviews with these actors. BangaliDaktar/ Bengali Doctor as Veena Das (2015) in her work argues that Bengali Doctors are 'a ubiquitous category of Doctors who practice in

[1]Let me state a few disclaimers. This is a work in progress. I have been working with ShehriMahilaKamgar Union since 2016 in different capacities. I collaborated with them for a research essay on domestic workers where I interviewed 50 women, an art research project on smells in 2019 which involved focussed group discussion on 'Work and smells'. I am not a member of the union but there are fictive affective ties with my respondents since 2016. I am as much of an insider/outsider in the organisation. I am not involved in any official capacity with the organisation.

Due to COVID 19 related contingencies the conversations with pharmacy store owners, and community health workers are in progress. For the purpose of this presentation I limit myself to the ongoing conversations since lockdown followed by indepth telephone interviews completed with 10 migrant workers from this neighbourhood, 3 'unlicensed medical practitioners' and 1 'licensed medical practitioner', 2 pharmacy store owners and 1 Asha Worker. The indepth interviews were conducted over telephone facilitated by ShehriMahilaKamgar Union (a union for domestic workers) . I remain grateful to union members Anita Kapoor, Appu and Neetu for facilitating these conversations in 'trust'.

Delhi'. According to Das (2015), the term has a range of implications. Firstly they come from West Bengal, they are trained and armed with degrees ranging from Bachelor of Ayurvedic Medicine and Surgery to Bachelor of Homeopathic Medicine and Surgery. These same category of practitioners are referred to as JhholaChhap in Uttar Pradesh and Bihar because of the bag carrying medicines (2015: 182). In this book Das (2015) draws upon a study by ISERDD and The World Bank (2002) where she points to a relatively high presence of unlicensed doctors in low income neighbourhoods. She lists six types of practitioners. Firstly, practitioners who have no training or degree but were trained as an apprentice to a practitioner. Secondly, a 'Registered Medical Practitioner'. In the second case they could have a degree or diploma or recognised on the basis of experience. Thirdly, degrees in alternative medicine (Unani and Ayurveda). Fourthly, Degrees from Medical Colleges. Fifthly degree in homeopathy and Sixthly mixed bag of practitioners who could have a degree, completed graduation in a non medical subject, and some who could be high school graduates. She then goes to examine how do these practitioners make sense of their craft? 'Healing', gift and service (sewa), hunar are some of the words that remained central to the experience of the craft of those who did not have degrees. However Das (2015) adds a disclaimer that not all of them talked about healing. For some it was about being able to look scientific, charge fees, diagnose. Healing, Das would like to propose is a two way process and in exchange the practitioner received hunar/ social healing. In other words, there are moments when social healing and medicala healing converge through acts that are not necessarily biomedical. For instance, a doctor reminded Das that there is always a risk of infection – bodily and otherwise from the patient. It is these moments that allows Das (2015) to argue what the art of healing demanded and in the garb of biomedical worlds moral lives seeped in. (2015 :179) I propose to move away from the practioner's sense of the craft and instead ask a question as to what allows for the sociality of this network to exist. Apart from being the missing link in healthcare system, what allows for Bengali doctors, JholaChhap to thrive despite regulatory mechanisms in place. In the next section I will take you the idea of trust and the lack of trust around migrant lives.

(Mis) trust of the migrant

When India woke up to horrifying images of the migrant one of the concerns that were raised was that they could be carriers. Migrants were left stranded along the state borders and sanitisers were sprayed on them as they became the suspected carriers. It is within this context I want to place the migrant subject who lies at the end of (mis) trust. Starting with citizenship to precarity of jobs, the outbreak of the zoonotic disease acted as a catalyst to trust her/him a litte less. It is not a mere coincidence that during the course of interviews many workers reported that they have not been asked to return to their place of work. With lockdown, and closure of industries there was a breakdown of 'transplanted networks' (Tilly). Scholarship on migration studies and migrant experiences have time and again alerted us to economies of trust in remittance networks, recruitment networks etc. Ethnographic accounts of working conditions of migrant workers have alerted us to the (mis) trust of the state towards the migrant as evident in the immigration laws, labour laws, identity documents. In the case of internal migrant workers the difficulties they face in their everyday encounter with the state in terms of misspelt name, mismatched name at workplace and identity, assumed identity so that a relationship of trust could be constituted. How do we view trust? Alberto Corsín Jiménez (2011) in his discussion on trust points out that most discussions on trust point to 'a mutual co –implication of interests on transacting parties'. In a sense, trust becomes a 'cognitive category' and everything narrows down to the trustworthiness of a person. There is a certain mysteriousness about trust. CorsínJiménez (2011) says though reciprocal expectations is one way of conceptualising trust, we must try and understand that trust 'is distributed in a variety of human and non-human forms'. 'It is as much a cognitive category as well as a material one' and 'it belongs to the realm of intersubjective as much as it belongs to interobjective'. Building upon this idea what trust can do rather that what trust is I offer two tentative propositions around how trust comes to shape the health infrastructure. First, the material manifestations of trust, Secondly, the affective nature of trust.

Trust and materiality

During the course of my conversation with Dr. Singh, one of the practitioners in the resettlement colony he insisted that I write down the name and address of his 'Clinic' – Balaji Medical Centre. 'Clinics' such as these proliferate in the lanes and alleys of this resettlement colony. Earlier in the day during an interview with one of his patients she mentioned that he charges a fees of Rs 50- Rs 100. She worked as a construction labourer. In between her work, she mentions that she receives a daily wage of Rs 350-Rs 400. After a day's work she suffers from body ache, and at times fever. Mostly she visits clinics such as these as they give 'dawa'. Another worker adds, 'if I go outside they will write medicines in the prescription, then I have to go to the pharmacy store to buy medicines. If I have to pay someone to write and someone to give me medicines that is a lot of money and time'. In this case the migrant worker calls out to my facilitator, 'Appu, Introduce Didi to the ASHA worker. Didi, she will be able to tell you what women do when they are pregnant. For us, by the time we return from our place of work, her work schedule is over. We know about ASHA worker. If she/ they were not here who would have gone door to door to check people when they tested positive. Everyone was busy drawing white circles. We would have died out of hunger if not virus. I used to work at four houses. How can they take us back? We travel in shared transport. Now due to new regulations we have to pay Rs 60 one way to reach our place of work. Who wants to step out? I fear for my children and old parents. My husband has not been called back. We have not paid rent since May. In the first two months, kothewale (implying employers) transferred money to my account and then it stopped. Now they don't call. I understand. Returning to health care in her neighbourhood, she says, ' Dr Singh ke hath meinjaduhain (there's magic in Dr. Singh's hands). He gives medicines. If we don't recover after 1-2 days he will refer us to big places. She heaves a sigh of relief that she doesn't have to go to 'hospitals' and the dawa/ medicines that Dr. Singh gave her has worked for her. Dr. Singh is one of the doctors who has a medical degree, has a registration number and discusses the three things that are important to receive 'permission' to run a clinic. He says, 'Ma'am you need to have a medical degree, get your registration number from Delhi Medical Association, and submit a police verification form at the local Police Station. In India there are three kinds of medical treatment available. First Alloepath, Second Ayurveda (You must have heard of Baba Ramdev) and third, Homeopath. The qualified doctors like us might combine a treatment of homeopathy and alloepathy also referred to as angrezidawa. Now when it comes to Bangali doctors (Bengali doctors) the fourth kind they are known to treat fever, piles and fissures.Inke pass degree nahinhain (They don't have degree) I come from a humble background. Infact, Appu (facilitator) knows everything. I used to work in one the clinics in the area (implying the slums before displacement). I worked as a compounder. Prior to that when I was in school I used to assist a local doctor in my hometown in Bihar. He encouraged me to study further. You must have heard of Medical Entrance for Medical Studies, M.B.B.S. degree. I cleared it but could not complete my medical studies…. I came to Delhi. I started assisting a doctor. I appeared for Premedical Allahabad (BIMAS). You might not find it on google. Do you want my registration number? You might need it for your research'. Singh's insistence on 'registration number', sharing address, and details about medical degrees, are material manifestations of trust. As soon as Appu introduces me to Dr. B he asks me, 'Do you understand Bangla?' He says that he has a RMC degree from Patna, Bihar. When I ask him how did he enjoy his period of training in Patna he replies that it was 'open type'. After this he worked in a Nursing home for three years to gain experience. He adds, 'We give medicines and keep a patient under observation for 1-2 days'. When I ask him about the source of medicines he says at times people from companies visit our clinics and at times we buy from Chemist. None of the patients had records from these clinics in the form of prescriptions. One of the workers pointed out that like most neighbourhoods in Delhi there is a nexus between the pharmacy store and the doctors. 'At my place of work, the doctors give prescriptions and would advise to go to a certain medical store. Here pharmacies share a notepad with doctors and at times they will the name of the medicines on these notepads. Ma'am no one will tell you this'. I ask the pharmacy store owners about who comes to buy medicines and how do they sell drugs. One of them

comments, ‘Ma’am, people are not educated. They will tell, ‘Give me that yellow pill,… they often tell us the colour of the capsules and syrup for cough. Since we know each other mostly these will be fever, allergy and body pain. Most of the people here work as labourers be it men and women. Body pain is the most common problem. During the time of change of season for instance now, people complain of ‘loose motion’, stomach ailments’. When I ask him about his relationship with doctors he tells me that their work is to ‘diagnose’ and ‘prescribe’. If there are critical cases they will refer to hospitals and private nursing homes. One of the doctors candidly confessed, ‘ Ma’am you must have heard that we are called JhholaChhap. I said, ‘yes’. We have years of experience and I can look at you and tell you if you are ill. Mostly people come with chhotimotibimari (implying diseases that are not serious) like cough and cold, stomach infection, fever, body pain, Diabetes and TB (Tuberculosis). For TB there are state hospitals I recommend. If the patient requires Dialysis I refer him to private nursing home. Rest of the ailments can be cured by buying drug over the counter. In today’s date I treat people with medicines and charge them Rs 30- 50. During Corona (implying the early phase of lockdown) it is people like us who might have suggested patients to visit ‘Big hospitals’, testing centres’. I ask, ‘There were reports that doctors were returning patients who had fever’. He replied, ‘Some of us had closed clinics because it was difficult to explain to people that you cannot sit in the waiting room’. When I ask him if he only prescribes medicines, he adds ‘if need be, I have provisions to give glucose and oxygen’. He disconnects the phone. One of the union members who had organised the conference call adds , ‘Ma’am they have all kinds of facilities. They can arrange for blood testing, CT Scan, X Ray, Ultrasound and MRI. At times they have arrangements with laboratories’. One of the migrant workers emphasise that doctors don’t charge any fees from patients ‘agar wo dawalikhkedetehain’ (if they prescribe medicines on paper). In most cases this paper is the notepad/ reference pad of local Chemist/ Pharmacy Stores. For most of the migrant workers the sign of a red cross, an image of the stethoscope and time of recovery are benchmarks for who is a good doctor. Most migrant workers point to easy access to ‘dawa (medicines)’ in the neighbourhood and time of recovery as safety networks of health. One of them adds, ‘Most of us work in places where our employers will deduct money if we fall sick and don’t report to work. We are not sarkari (government) employees. I have seen that my ma’am can take leave from work when she has fever. At the maximum no one complains if I take 2 days of leave in a month in my line of work. Bimarparna / to be sick is a curse. If it is a chotimotibimari (disease of a smaller degree) then we can go to local doctors but incase it is something like Cancer, then we have to borrow money. Ma’am bimari/ disease is not for the poor. I had once accompanied my Ma’am to a hospital for her daughter’s check up. In big hospitals they have eating places with aircondition. (Another union member joins to confirm sharing names of such hospitals). Pura hotel jaisa. (Just like hotels, Ma’am) Our hospitals smell of phenyl. If anything happens I pray that I don’t have to return to the clinic. I can afford a maximum of Rs 50 on my health. Don’t you remember I asked money for Sanitary Napkin during lockdown?’ When I ask her if she has ever been to a sarkari hospital? She says, ‘Yes, because there was ASHA didi’. The social network of healthworkers of ‘local doctors, and ‘pharmacy store owners’ function through myriad forms of materiality of trust – clinics, dawai, testing facilities, and nominal fees, and even no fees. Dawai emerges as one the important material manifestations of trust in this social network.

Affect and trust

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. 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[2] led Government in 2004) and IsherJudge 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)[3] and by 2002 India had its second *National Health Policy*[4]. What is significant to note it is only at the turn of the millennium the public spending on health was 2- 3 % of the 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.[5]Subsequent governments would push towards 'insuring' the medical care through rolling out of insurance schemes. . 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. One of the ASHA workers remind me that they are on a strike and even though Sarkar (Government) and Media has hailed them for their role to contain Corona, they do not have a stable salary. She said they were supposed to receive extra allowance of Rs 1000 for her service during Corona. ' Most of us earn Rs 4000-Rs 5000 and these are based on incentives. The payment is irregular and at times our payments get delayed by 2 months. Our demand is a fixed salary'. Time and again in my conversations and interviews with migrant workers and 'local doctors' they emphasised that to understand the social network of health care system I should speak to ASHA didi. They are the nodal points of access to the state health care system. 'Sirf ASHA didike pass line nahinlagtihain. Wo apnehain (You don't have to stand in a queue to reach to ASHA didi. She is ours) harjaga line. Hospital, Clinic, Private Hospital'. Scholarship on ASHA workers have time and again pointed to the 'intimate labour' that shapes the relationship and nature of work of ASHA workers. Apart from this affective ties, the state has failed to enter the imagination of the poor neighbourhoods in creating affective trust. With increasing shift towards insurance the state discourse on public health care is shifting towards identifying risk rather than mechanisms of care. A review of insurance schemes available to India's poor will be significant and I propose to develop that in the larger study. However let me turn your attention to how insurance is perceived among the migrants and health care workers of this neighbourhood. 'I have an insurance. I don't know if I can use for medical emergencies. I invested because it will be good for future', observes one of the migrant workers who worked as a helper in a store. 'My didi (employer) wanted to gift me an insurance for my future. I think it was Mediclaim. She said it will be of use in my future. What if I decide to shift back to hometown? There are no hospitals in the vicinity. I told her if the insurance company would pay money to a private

[2] United Progressive Alliances
[3] Rajiv Misra, Rachel Chatterjee and Sujatha Rao, *India Health Report* (Oxford University Press, 2003)
[4] The first National Health Policy was formulated in 1983. For details on The Second National Health Policy seehttps://nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/national_health_policy_2002.pdf; Accessed on 1 June 2020
[5] For details http://www.indiahealthcaretourism.com/; Accessed on 2 June 2020

hospital in the nearby town. She kept quiet. Besides that insurance is for the future'. When I ask her why she invested in life insurance? She giggles, 'That's my insurance to old age. At least my children will take care of me in the hope that they will receive money when I die'. How do we understand the increasing shift towards the state discourse on insurance rather than primary health care? Insurance, as these conversations are built on a notional understanding of affect-ive care for future, rather than the present. One of the 'local doctors' comment, 'Most insurance companies reimburse. What's the use of insurance if you have to enter into a cycle of debt?' Many migrant workers who had life insurance saw it as investment for the future rather than the immediate here and now. It is here they feel that the state failed to 'care' for them. There is a constant slippage of rights and care in the state's health discourse regarding the migrant workers. With proliferation of public private partnership models in health care facilities to privatisation of hospitals, India's urban poor is lumped under the category of Economically Weaker Section schemes of private hospitals.

Tentative concluding remarks

The ongoing study shows that though there has been a shift in acknowledgement of the role of community health activists specially ASHA workers in the aftermath of public health crisis, there is a lack of recognition of how 'trust' shapes the meanings of a network of health workers in migrant neighbourhoods such as these. The social network of local doctors (unlicensed, licensed) and pharmacy stores are undermined in the emerging rubrics of materiality of trust – dawa and a loss of affect and trust – to insure life.

References

Jiménez , Alberto Corsín. 2011. "Trust in Anthropology." *Anthropological Theory 11 (2)* 177-196.

Das, Veena. 2015. *Affliction. Health, Disease,Poverty.* New York: Fordham University Press.

Rao, Sujatha. 2017. Do we care? India's Health System. Delhi : Oxford University Press