

REFUGEE WATCH

A South Asian Journal on Forced Migration

A Special Issue on Public Health

57

Mahanirban Calcutta Research Group
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Public Health, Migrant Workers, and a Global Pandemic: Towards a New Politics of Life

By

Iman Kumar Mitra*

On May 23, 2020, in the context of the COVID-19 outbreak, the Gujarat High Court admonished the state government in a remarkably harsh language by comparing the condition of one of its largest public hospitals to that of a dungeon.¹ It also invoked the metaphor of the Titanic— the celebrated ship which sank tragically in 1912— as it took note of the rising number of positive cases in the state and the government’s seeming ineffectiveness in containing the disease, and appealed to the private hospitals to admit as many patients as possible without any profiteering intention: “The foremost reason for their (private hospitals’) existence is to treat sick patients and it would be utterly shameful on their part to shy away from this responsibility at this point in time, when the country and its people need them the most. Profiting off a poor man’s health can be considered morally criminal.”²

Although quite timely and necessary, this intervention by the judiciary in the matter of increasing privatization of the Indian healthcare sector is rare and could be interpreted by many as an infringement of the right to do free business. However, it indicates a major crisis, towards which the public healthcare system has been heading over the last few decades. The government of India not only recognizes but also endorses it in the latest National Health Policy (henceforth, ‘NHP’), published in 2017, where it mentions, quite casually, four changes that have occurred since the previous NHP of 2002: ‘First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases. The second important change is the emergence of a robust [healthcare] industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to [healthcare] costs, which are presently

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estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, a new health policy that is responsive to these contextual changes is required.³ Apart from the first point, which is probably the most undisputable observation supported by medical data, and the third, which coldly presents a depressing fact that affects a large portion of the country's population, the second and fourth points are connected and present the crux of the neoliberal orientation of the present dispensation. In an ironic twist, the catastrophic increase in the cost of healthcare is argued to be taken care of by the emergent, rapidly growing (and seemingly private) 'robust [healthcare] industry' in the presence of an 'enhanced fiscal capacity'. This clarion call for privatization does not take account of the majority of the population who will barely have access to this robustly industrialized healthcare sector and it does not acknowledge poverty itself as one of the causes of the depleted medical infrastructure and the poor average health condition.

The Bhore Committee Report and the Constitution of the 'Social'

It is curious to see how far we have come from the Report of the Health Survey and Development Committee (henceforth, 'Bhore Committee'), published in 1946. On October 18, 1943, a press communique was issued by the government of India announcing the appointment of a committee chaired by Joseph Bhore, a retired ICS official, 'to make a broad survey of the present position in regard to health conditions and health organisation in British India and to make recommendations for future development'.⁴ The formation of the Bhore Committee, as the communique itself mentioned, took place 'in connection with post-war reconstruction plans'.⁵ As we know, it was the same motive of reconstruction which initiated a similar overhaul of the existing social policies in Great Britain during World War II and gave birth to the idea of the British Welfare State with the publication of the Beveridge Report in November 1942⁶— about a year before the appointment of the Bhore Committee. The link between the two becomes even more prominent when we recall that it was the Beveridge Report which recommended a National Health Service for British citizens as part of its comprehensive framework of social insurance schemes. Authored by the noted economist William Beveridge, the report identified three guiding principles of its recommendations:

- The first principle is that any proposals for the future, while they should use to the full the experience gathered in the past, should not be restricted by consideration of sectional interests established in the obtaining of that experience. Now, when the war is abolishing landmarks of every kind, is an opportunity for using experience in a clear field. A revolutionary moment in the world's history is a time for revolutions, not for patching.
- The second principle is that organization of social insurance should be treated as one part only of a comprehensive policy of social progress. Social insurance fully developed may provide income security; it is an attack upon Want. But Want is one only of five giants on the road of

reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness.

- The third principle is that social security must be achieved by cooperation between the State and the individual. The State should offer security for service and contribution. The State in organizing security should not stifle incentive, opportunity, responsibility; in establishing a national minimum, it should leave room and encouragement for voluntary action by each individual to provide more than that minimum for himself and his family.⁷

The Beveridge Plan, apart from everything else, was a call for breaking free from the conservative mores of the British society plagued by five obstacles in the way of progress: want, disease, ignorance, squalor and idleness. Needless to say, all five of them were interlinked where a comprehensive social policy must take cognizance of the grid of bureaucratic and intellectual apparatuses that could establish the links between public health and urbanization, unemployment benefits and education, job security and creation of effective demand. A mere patchwork would not do; what was needed was a complete reorganization of the ‘system’— a call made popular in the years between the Wars by both the Left and the Right. What became important, therefore, was the question of agentive responsibility: who would lead this total overhaul? Maintaining distance— although not equal— from both the Soviet model of centralized planning and the Fascist programme of anti-individualistic totalitarianism, Beveridge argued for a scheme of cooperation between the state and the citizen where the individual’s pursuit of maximum happiness would be bolstered by the ‘national minimum’ set by the state.

Over the years, this would become the most iconic model of the welfare state. A progressive tax system would ensure the redistribution of wealth and the availability of basic minimum services in the domains of education, health, and infrastructure. The ‘insurance’ part in the ‘social insurance’ of Beveridge was the guarantee of this basic minimum. But what constituted the ‘social’? Daniel Defert, while giving us a genealogy of social insurance in France, lists the shifts that occurred when the ‘old technique of life annuity’ was replaced by the discourse of life insurance in the nineteenth century.⁸ One of them was to find a ‘way to manage populations which conceives them as homogeneous series, established in purely scientific terms rather than by way of empirical models of solidarity such as a trade, a family or a neighbourhood.’⁹ When Beveridge said that social insurance ‘should not be restricted by consideration of sectional interests established in the obtaining of [past] experience,’ he was reiterating the same point. Thus, we see how he proposed to divide the British population into six classes in a section of the report, titled ‘The People and Their Needs’: ‘I-Employees; II-Others gainfully occupied; III-Housewives; IV-Others of working age; V-Below working age; VI-Retired above working age.’¹⁰ Organized around a strict definition of work (‘gainful employment’), this mode of classification was thought to have disavowed the conservative class structure and initiated a

need-based scheme of assistance. The eight primary causes of need were: unemployment, disability, loss of livelihood, retirement, ‘marriage needs’ of women, including compensations for widowhood, separation, maternity etc., funeral, childhood, and physical disease.¹¹ Apart from those below working age (Class V) and above (Class VI), the ‘other four classes all [had] different needs for which they [would] be insured by contributions made by or in respect of them.’¹² What is important to notice here is that the compensation was meant for any kind of interruption in the continuous flow of work— be it disability, age, disease or death— performed by different classes under the imagined identity between life and livelihood. The idea of interruption had most definitely arisen from the history of social insurance itself, which came to materialize when the state wanted to deal with industrial accidents by itself: ‘What we today call social insurance was originally established in France by nationalizing the industrial accident departments of the private insurance company.’¹³ The ‘social’ in ‘social insurance’ was, therefore, an outcome of making this interruption at work a matter of public action— a problem that could no longer be left to the individual’s capacity for self-reparation.

When we read the Bhoire Committee report today, we may find a semblance of the same argument advanced by Beveridge: only a comprehensive and interconnected approach to policy would yield a systemic reconstruction of the society. In its own way, the Bhoire Committee tried to tackle the questions already raised by the Beveridge Plan: the links between life and livelihood, and the constitution of an ideal ‘social’ with an uninterrupted flow of work. It was quite candid in explaining how the early attempts at health administration in British India fell short of conceptualizing health as an indicator of social progress and focused mainly on disease-control through coercion and religious sanction. ‘The idea of prevention came much later,’ the report stated, ‘partly as the result of the observation that diseases were often communicated from the patient to those in close association with him. Thus arose the conception of segregation of the sick and of the enforcement of quarantine against those who were in contact with patients.’¹⁴ After noticing the inadequacy of such measures carried out ‘many centuries before the causes for their incidence had become known,’ the report concluded that, with the advancements in ‘modern sciences, such as bacteriology, parasitology and pathology,’ the need for ‘active interference by man with the natural environment’ was acknowledged and a ‘coordinated application of curative and preventive measures’ was recognized as the ideal strategy for controlling diseases.¹⁵

However, a significant point of departure for the Bhoire Committee was the way it sought to define health: ‘The term health implies more than an absence of sickness in the individual and indicates a state of harmonious functioning of the body and mind in relation to his physical and social environment, to enable him to enjoy life to the fullest possible extent and reach his maximum level of productive capacity.’¹⁶ Three points need to be noted here: health is not the mere absence of sickness and, therefore, must not be conflated with disease-control only; harmony with the physical and social environment is of paramount importance; and the link between

fulfillment of life and maximization of productive capacity. These three elements of public health expanded its horizon beyond the narrow confines of standard curative practices and inaugurated a theory of the 'social', which was in dialogue with the schemes of social insurance and discourses of work that the Beveridge Plan flagged. In this connection, the first volume of the report named the prevalence of unsanitary conditions, low level of nutrition and inadequacy of medical infrastructure at the levels of both institutional care and pedagogy as the reasons for the poor health condition in India.¹⁷ It also elucidated on 'the social background of ill-health', which included unemployment, poverty and social customs like purdah and early marriage.¹⁸ At this point, it mentioned even the Beveridge Report to strengthen its case: "In a reaffirmation of the principles regarding health policy in connections with discussions on the Beveridge Report, the British Medical Association emphasized that 'the health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities, and upon the facilities of exercise and leisure.'"¹⁹

The second volume of the report contained recommendations to the effect of the establishment of a 'progressive health service' that aimed to accommodate 'all citizens, irrespective of their abilities to pay for it' with 'all the facilities required for the treatment and prevention of disease as well as for the promotion of positive health'.²⁰ It also introduced the idea of 'social medicine', which would study disease 'as a community problem' incorporating 'social and economic factors such as housing, nutrition, poverty and ignorance of the hygienic mode of life'.²¹ Evidently, the Bhore Committee was trying to infuse the postcolonial imagination of a 'healthy' nation with a specific biopolitical infrastructure sustained by a wide variety of governmental techniques, institutions and knowledge practices. The 'social' in 'social medicine', therefore, was a dynamic process, which would evolve out of an experimental modality of nation-building where surveys and 'controlled experiments directed towards influencing the life of selected communities through the provision of improved health services, better nutrition, a cleaner environment and health education'²² would also create the 'public' of the 'public healthcare' system.

It took the government of India a long time after Independence to formulate its first NHP in 1983, but even there one may find the reverberation of the Bhore Committee's imagination combined with the seemingly socialist rhetoric of the Indira Gandhi regime: 'The Constitution of India envisages the establishment of a new social order based on equality, freedom, justice, and the dignity of the individual. It aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities to develop in a healthy manner.'²³ By making public health a constitutional responsibility of the state along with eradication

of poverty and enhancement of knowledge, the NHP, 1983, tried to give the 'social' a firm definition, which the later NHPs would try to dismantle.

The Two NHPs and the Management of the 'Social'

It was the second NHP, 2002, which brought the private sector into the discourse of public health infrastructure. Dismissing the 'spirit of optimistic empathy' of the NHP, 1983, which promised universal health care by 2000, the new NHP set out 'realistic' parameters for a policy framework corresponding to the existing financial and administrative capacities.²⁴ One such realistic consideration was to welcome 'participation of the private sector in all areas of health activities' and conceive a combination of 'social health insurance scheme funded by the Government' and 'service delivery through the private sector' for 'an appropriate solution' to the problem of scarcity of public resources.²⁵ The involvement of NGOs and other civil society organizations in delivering health services was also encouraged and the need for simplification of the procedures of government-civil society interfacing was emphasized.²⁶ The public-private partnership model thus envisaged relieved the government of its 'social' responsibilities of reaching out to the greater public and re-inscribed 'service' in the private domain of corporate healthcare and NGO-based community development. The apparent de-socialization of the governmental state actually initiated a reconceptualization of the 'social' in terms of a series of risk management activities within the global networks of finance capital and prepared the ground for complete privatization of the health sector.

The latest NHP, 2017, has already been severely criticized²⁷ for its lackadaisical attitude towards public health, in spite of making a call for strengthening the role of the government in 'shaping health systems in all its dimensions'.²⁸ If one takes stock of these dimensions, it becomes clear why public health activists and commentators find the policy as following the neoliberal stipulations that have been part of the political architecture of the Indian state for over the last three decades: 'investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross-sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance.'²⁹ At a surface level, these objectives sound fair and spirited. Coupled with an overarching narrative of universal healthcare, which promises equity, affordability, accountability, inclusion and pluralism, it may look even more progressive than the previous NHP, 2002, which was much maligned for introducing the idea of 'alternative medicine' in the public health framework.³⁰ A crucial difference between the two policies is how the latest one deploys a particular language of decentralization that stands for deregulation and/or privatization. The previous NHP was framed in a matter-of-fact way, starting with a list of achievements in the health sector since 1951, showing rise in life expectancy, fall in epidemic outbreaks, and strengthening of infrastructure. 'While noting that the public health initiatives over the years

have contributed significantly to the improvement of these health indicators,' the Policy had said, 'it is to be acknowledged that public health indicators/disease-burden statistics are the outcome of several complementary initiatives under the wider umbrella of the developmental sector, covering Rural Development, Agriculture, Food Production, Sanitation, Drinking Water Supply, Education, etc.' By recognizing the role of what one may call the social sector in the ambit of health infrastructure, the NHP, 2002, followed the footsteps of the NHP, 1983, which linked the programme of poverty alleviation with the strategies of public health improvement and thus, prescribed a holistic approach that retained traces of the recommendations of the Bhore Committee. By 2017, however, the rhetoric shifted to that of a seemingly non-interventionist state, which is expected to suture the public and the private in a model of managing partnerships between communities, medical professionals, and corporations. One of the most interesting recommendations of NHP, 2017, is to create:

[A] Public Health Management Cadre in all States based on public health or related disciplines, as an entry criteria [*via*]. The policy also advocates an appropriate career structure and recruitment policy to attract young and talented multi-disciplinary professionals. Medical & health professionals would form a major part of this, but professionals coming in from diverse backgrounds such as sociology, economics, anthropology, nursing, hospital management, communications, etc. who have since undergone public health management training would also be considered. States could decide to locate these public health managers, with medical and non-medical qualifications, into same or different cadre streams belonging to Directorates of Health. Further, the policy recognizes the need to continuously nurture certain specialized skills like entomology, housekeeping, bio-medical waste management, bio-medical engineering, communication skills, management of call centres and even ambulance services.³¹

Apart from a very pronounced rhetoric of management and service-delivery mechanisms, what this idea tends to generate is an epistemic orientation that speaks to the framework of an interdisciplinary liberal education recently championed in the New Education Policy— another example of the neoliberal agenda of the present dispensation. The desires to privatize both health and education, therefore, converge in the figuration of a corporate-state complex that adheres to a logic of decentralization and plurality where the expansion of a choice set driven by the market is projected as the most significant expression of freedom and equality.

This is not very new. As Imrana Qadeer points out, the shifts between various NHPs in the last forty years need to be contextualized within the shifts in the paradigms of planning since India's Independence. 'By the end of the 1970s,' she argues, 'the contradictions between comprehensive health care planning through social sector growth and integrated disease control strategies, and techno-centric approach to disease control through vertical programmes, and the requirements for primary health care and tertiary

care became evident.³² This draws our attention to a distinct genealogy of the liberalization and re-conceptualization of the health sector as a service industry through a model of technocratic interventions of control and a speculative mode of capital formation from a time much before the actual liberalization of the economy took place. The history of neoliberalism in India is often mired in a narrative of rupture where the deliberations of the government in the early 1990s, after the Washington Consensus, are prioritized against a seemingly unperturbed discourse of state-led growth in the previous decades. When we read the history of public health along with the politics of development funding and a financialized modality of infrastructural capitalism, we can see a highly technologized version of the ‘social’ emerging in the nation-state’s imagination that patterns the crisis of public health in a language of insurance, risk management, diversification of investment portfolios and extraction. The project of alleviating ‘social crisis’ (poverty alleviation and population control), therefore, takes the form of managing a ‘crisis of the social’ where the boundary between public and private seems to dissipate. Whereas in a ‘social crisis’, it is the crisis that is conceptualized and approached as a social phenomenon — which would have repercussions in the constitution of the ‘public’— in the ‘crisis of the social’, the ‘social’ itself— the collective that is supposed to exist as a reminder and as a site of the state’s responsibility towards its ‘public’— is reconceptualized and relegated to the domain of crisis management, as exemplified in the figure of the public health manager. Even with the apparently socialist rhetoric of the NHP, 1983, the Indian nation-state was already on a journey to internalize the contradictions of postcolonial capitalism that would only become more visceral in the present time.

This story, however, gets a unique twist with the outbreak of COVID-19. In the rest of my article, I shall argue that the pandemic and the long march of the migrants have revealed the contradictions between the two ‘socials’ of ‘social crisis’ and ‘crisis of the social’ in such a way that will have a much larger implication in terms of a new politics of life and its capitalization, and reconstitution of a ‘public’ implicated therein. Talking about how the fight against the virus assumes a rhetoric of war, Ranabir Samaddar observes, ‘[t]he enemy— the virus— is not of public health, but is of life, which will therefore require and legitimize all kinds of governmental prohibitions and interventions. Humans are anxious.’³³ Taking a clue from this observation, I would like to emphasize three axes of the present predicament: life, governance, and the ‘human’. It is probably unfashionable to emphasize the ‘human’ in this time of human–nonhuman interface when the inadequacies of all the humanist discourses have been exposed at the face of various levels of crises— political, economic, environmental— that define our individual and collective existence. But this is precisely the reason why one may think of venturing into a project of freeing the ‘human’ from humanism. In order to do so, we need to revisit the concept of biocapital and how that dehumanizes labour by channelizing a particular theory of life.

A New Politics of Life?

Kaushik Sunder Rajan, in his landmark study of the human genome project, explores the workings of biocapital around the exchanges and circulations that thrive on the epistemic centrality of life and life sciences in modern times.³⁴ The co-production of the knowledge about life and the techno-capitalist processes that make use of that knowledge is a unique feature of the modern episteme. As Michel Foucault shows in *The Order of Things*, by the end of the eighteenth century, a new discourse of biology made its appearance where the study of living beings was no longer dependent on the tabular modality of classification through interlinked grids of observable characteristics. Similar to developments in the field of political economy, where the invisible labour is delineated as prior to all visible exchanges, in the modern life sciences, the invisibility of life gets prioritized over the visibility of the signs or markers that distinguish one species from the other. The anatomical imaginary, therefore, is conceived in terms of systemic distribution of organic functionalities such as the nervous system, the respiratory system, the digestive system etc., all of which are working for preservation of life whose *a priori* existence gives meaning to them. This new epistemic order had two great implications: (1) in the political domain, it led to reconceptualization of the nation-state in terms of a biological entity whose life would be tied to the lives of the multitude not simply by a logic of territoriality but also by a unique chronology of growth and decadence, an organicist historicism; (2) in classical political economy, the new order of things cut through the circularity of the time of exchange and proclaimed the linear, continuous time of production. By the mid-nineteenth century, however, life was itself turned into a site of myriad calculations and speculative investments riding on the deployment of what Francois Ewald calls a technology of risk.³⁵ Insurance— especially life insurance and/or insurance against bodily damages— as a technology of risk transforms the incalculable— the loss of a dear one, for example— into an estimate based on statistical techniques and medical surveillance. But more importantly, by turning life into an investible asset, the technology of risk made way for a regime of exchange and circulation— namely biocapital— which was not simply a specific form of capital but a central motif of financial capitalism in the twentieth century. In fact, one may say that we have been trained to incorporate the same kind of rationalization of risk against a probable compensation or reparation in almost all of our everyday transactions.

The same appraisal and capitalization of risk have come to the forefront of the public health discourse in its deliberations on the current pandemic. The decisions regarding the length of the lockdown, the strictness of the social distancing protocols, and the durability of the medical infrastructure are all based on the statistical calculations that render life an asset and death an accident. The anxieties that fill our minds are often outcomes of the lack of information on the basis of which one can contemplate and assuage the risk of socializing— the burden of the neoliberal

subject. In this context, migrant workers have emerged as dangerous figures as they have exposed two fundamental contradictions in this biopolitics of risk management: between life and livelihood, and between the life of labour and the life of capital. As we may remember, it was the association between life and livelihood that marked the advent of social insurance and the welfare state. However, the neoliberal state is increasingly unwilling to accept this association. Although Article 21 of the Indian Constitution guarantees the right to life and personal liberty, and prohibits its deprivation 'except according to procedure established by law', there is no clear indication if it includes the right to livelihood as well. In various rulings, it has been observed that, even though, in a broader sense, the right to life can be interpreted as a right to live with human dignity and proper livelihood options, there is no absolute association between the two and, if proper legal procedures are followed, both the state and private entities can deprive others of livelihood—for example, acquisition of land in public interest or firing an employee citing actual reasons. In most cases, the merits of the claims and counter-claims are judged on procedural accuracy. It is, however, a different matter how the relationship between life and livelihood plays out during the time of a pandemic, when conducting one's livelihood activities may be perceived as a threat to others' lives. In each of these cases, life trumps livelihood with a disturbing realization that, without livelihood, life will cease anyway. Even though the opposition between life and livelihood has become everybody's reality, for most of the migrant workers belonging to the informal sector, without job security and social support, it becomes insurmountable. The discomfort with the figure of the migrant worker also gets more pronounced with the metaphorical association between them and the virus—both unwanted, foreign entities engendering a randomness that upsets the existing technologies of risk and warrants an overhaul of the regime of calculations, facing which most governments of the world look genuinely clueless.

The other contradiction exposed by the migrant worker is between the two lives of labour and capital respectively, a contradiction which has surfaced more concretely after a series of constraining interventions by the governmental state controlling the movement of the workers and forcing them to leave the host town even during the lockdown. The discourse of life that characterizes biocapital since the second half of the twentieth century conflates human labour and nonhuman capital in the concept of human capital where both labour and capital are assumed to generate identical streams of revenue over a period of reproduction and depreciation. Wage defined as revenue earned from the deployment of labour is, therefore, a surplus over the investments that one makes to acquire different skills; in other words, education loans. The labouring body as an assortment of skills—or as Foucault calls it, an ability-machine—is completely dehumanized where the life of labour does not have any privilege over the life of capital. At first glance, this does not look very different from the theory of abstraction of labour into labour power within the Marxist framework where the reduction into the socially necessary labour time results in a disappearance of the concrete bodily form of the individual labourer. However, as Marx has

pointed out many times, there is a special character of the labour congealed as social substance in every exchanged commodity— its essential humanity expressed in terms of an exclusive physiological fact that all productive activities ‘are functions of the human organism, and that each such function, whatever may be its nature or form, is essentially the expenditure of human brain, nerves, muscles, &c’.³⁶ As Thomas Keenan puts it, ‘[a] spectre is haunting this analysis. The spectre of humanity’.³⁷ This spectral humanity is also the ethical basis of Marxian radical politics. What the discourse of human capital does is to de-essentialize the physiological aspect of the life of labour and de-prioritize its role in the production process. Thus, one of the fundamental contradictions of capitalism— the one between living labour and dead labour— is cancelled in favour of a symmetrical framework of organic assemblage made popular by post-humanist discourses.

The predicament of the migrant worker, however, reveals the implicit asymmetry in the conflation of the lives of labour and capital when in movement. During the pandemic, while the movement of labour was severely controlled, commodities were allowed to move freely. Not only that, delivery services like Amazon and Flipkart have been able to expand their businesses in an unprecedented manner, both in terms of volume and reach. Although it has been observed time and again that the virus survives on the non-living surface as well— even though the duration is disputed— it is the living labour which is projected as the principal mode of transmission. The lack of a symmetrical perception of threat certainly pertains to a fundamental asymmetry that is usually covered up in the neoliberal technologies of risk. Thanks to the pandemic and the coercive interventions, this asymmetry has once again reared its head and the present regime of biocapital must not be allowed to repudiate this moment of the return of the ‘human’.

Coming back to the question of the ‘human’, as we can see, the pandemic indicates possibilities of a new politics of life— a politics which is critical of the anthropocentrism of liberal humanism but not averse to point out the asymmetries between the human and the nonhuman and their respective life trajectories— within the technologies of risk. What implications will it have for the discourse of public health and the concept of ‘public’ inhering that discourse? The constitution of the ‘public’ in liberal humanism, as we know, is contingent on the ‘social’ that it presumes and contextualizes through contractual transactions and rights-based subjectivities. The conceptualization of humanity of this ‘public’ is limited by these two dimensions, which are not necessarily curtailed by the neoliberal risk technologies: a case in point is the paradoxical nomenclature of the ‘contract worker’, where the precariousness of the worker is intensified by the arbitrariness of the contract itself. In most of the narratives on the plight of the migrant workers, we see a reverberation of the same discourse of liberal humanism where the sympathy for the migrant can only lead to the organization of temporary relief provisions initiating a passive revolution of sorts. The call for a reorganization of public health, therefore, is usually reduced to a nostalgic endorsement of the humanist ‘social’ in ‘social crisis’. A

more difficult task is perhaps to recover the ‘human’ sans humanism in the moment of the ‘crisis of the social’. I am not yet sure how that will pan out in the long run but the pandemic has given us a great opportunity to engage with this politics of life more creatively and energetically.

Notes

¹Rutam Vohra, “Covid-19 in Gujarat: High Court uses Titanic metaphor to stress on need for collective response,” *The Hindu Business Line*, May 24, 2020, <https://www.thehindubusinessline.com/news/national/covid-19-in-gujarat-high-court-uses-titanic-metaphor-to-stress-on-need-for-collective-response/article31663998.ece#>.

²Ibid.

³*National Health Policy*, Ministry of Health and Family Welfare, Government of India (2017), 1, https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf.

⁴*Report of the Health Survey and Development Committee 3* (Delhi: Government of India Press, 1946), Annexure 56, 335.

⁵Ibid.

⁶For details on the Beveridge Report, see Brian Abel-Smith, “The Beveridge Report: Its Origins and Outcomes,” *International Social Security Review* 45, no. 1-2 (1992): 5–16. I am grateful to Ranabir Samaddar for drawing my attention to the Beveridge Plan.

⁷*Social Insurance and Allied Services: A Report by William Beveridge* (1942), 6-7.

⁸Daniel Defert, “‘Popular Life’ and Insurance Technology,” in *The Foucault Effect: Studies in Governmentality*, ed. Graham Burchell et al. (Chicago: University of Chicago Press, 1991), 212.

⁹Ibid.

¹⁰*Social Insurance and Allied Services*, 122.

¹¹Ibid., 124-25.

¹²Ibid., 124.

¹³Defert, “‘Popular Life’ and Insurance Technology,” 211.

¹⁴*Report of the Health Survey and Development Committee 1*, 21.

¹⁵Ibid.

¹⁶Ibid., 7.

¹⁷Ibid., 11–17.

¹⁸Ibid., 17.

¹⁹Ibid.

²⁰*Report of the Health Survey and Development Committee 2*, 6.

²¹Ibid., 7.

²²Ibid.

²³*National Health Policy*, Ministry of Health and Family Welfare, Government of India (1983), 1.

²⁴*National Health Policy*, Ministry of Health and Family Welfare, Government of India (2002), 5.

²⁵Ibid., 31.

²⁶Ibid.

²⁷Vikas Bajpai, “National Health Policy, 2017: Revealing Public Health Chicanery,” *Economic and Political Weekly* 53, no. 28 (2018): 31–35.

²⁸*National Health Policy* (2017), 1.

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³⁰*National Health Policy* (2002), 19–20.

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³²Imrana Qadeer, “Health Planning in India: Some Lessons from the Past,” *Social Scientist* 36, no. 5/6 (2008): 57.

³³Ranabir Samaddar, *Burdens of an Epidemic: A Policy Perspective on Covid-19 and Migrant Labour* (Kolkata: Calcutta Research Group, 2020), 1–2.

³⁴Kaushik Sunder Rajan, *Biocapital: The Constitution of Postgenomic Life* (Durham and London: Duke University Press, 2006), 12.

³⁵Francois Ewald, “Insurance and Risk,” in *The Foucault Effect: Studies in Governmentality*, ed. Burchell et al., 198.

³⁶Karl Marx, *Capital* 1 (1887), 47,

<https://www.marxists.org/archive/marx/works/download/pdf/Capital-Volume-1.pdf>.

³⁷Thomas Keenan, *Fables of Responsibility: Aberrations and Predicaments in Ethics and Politics* (Stanford: Stanford University Press, 1997), 116.

Pandemics, Public Health, and Sanitation Workers in Mumbai: Crisis of Work and Life

By

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Introduction

By March 2020, COVID-19 was a global threat. While the final body count was still growing at the time of writing of this article in November, 2020, with over 85,91,731 infected cases and a death toll of 1,27,059 had already been reported in India and in the past eight months, the world witnessed the collapse of healthcare systems. The Indian government and the society were taking solace in the fact that in comparison to its population size, the corona-positive cases and the mortality rates have been lower than in many other countries. However, in terms of total numbers, the country continued to be severely affected epidemiologically, economically and socially. A century after the last pandemic, the Spanish influenza of 1918, COVID-19 brought the spotlight back on health and disease in general and aspects of public health in particular. Though it touched lives and circumstances across the class divide, the precarity around migrant workers, their habitats and access to health and hygiene started drawing attention in a renewed manner. It also created a category called ‘frontline warriors’ comprising medical practitioners, health workers and sanitation workers among others. In this paper the concerns of sanitation workers of Mumbai while tackling the pandemic are dealt with and draws upon three instances that provide an insight into their condition.

The question that we began with was why the working conditions of sanitation workers remain unchanged during the pandemic, in spite of their recognition as ‘frontline warriors of Covid’? In 2018, several sanitation workers marched to the headquarters of the Municipal Corporation of

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Greater Mumbai¹ (MCGM) with the body of a deceased worker, demanding that the corporation address the issues of contractual sanitation workers or *safai karmacharis*— Malati Devendra was a part of this informal workforce for many years and took her life when she found herself without work and wages for two months. Loopholes in the Contract Labour (Regulation and Abolition) Act, 1970, had worked to the advantage of the labour contractor. A representative of the *safai karmacharis* union in Mumbai pointed out that there had been 108 deaths of contractual sanitation workers since 2013. In May 2020, two men in vests and shorts were barefoot and almost knee-deep in sewage, cleaning a drain. Male and female *safai karmacharis* in orange uniform jackets over their clothes were seen sitting next to an open manhole in a street, eating their lunch— some had put on homemade masks, flimsy gloves, and were loading hospital waste onto a truck with an ordinary spade. The workers asserted that they had not received any protective gear or minimum wages with women being paid almost two hundred rupees less than men for the same daily work. The sanitary workers are all Dalits— the most marginalised caste-based communities in the country— and there has been one hundred percent reservation of these jobs for the Dalits.² The difference in the images of 2020 is that they are taking a midst the COVID-19 pandemic. Mumbai, the financial capital of the country, built by migrants since the 20th century, has been hit particularly hard by the pandemic, accounting for almost 61 percent of Covid cases and death rate was almost 14 percent of the state population. In fact, a few months into the pandemic, Mumbai accounted for as much as 21 percent of the cases nationally and 25 percent of the deaths.³ Many questions about the origin of the present pandemic, its unusual epidemiological features and the basis of its pathogenicity remain unanswered and resulted in attempting several measures to contain the spread. The decision of the nationwide lockdown with less than four hours' notice and the subsequent spectacle of thousands of migrants walking back in desperation and insecurity of livelihood and habitat contributed to anxiety as well as political posturing. In the midst of this confusion and fear, we heard about the 'Dharavi model' of tackling the contagion. In the 2.2 sq.km. area of Dharavi, the population density is six hundred times the national average. Despite the fact that 80 percent of the residents depend on community toilets and physical distancing is a near impossibility, the 'Dharavi model' brought the spotlight back on community and voluntary efforts. Simultaneously, at the city level, the pandemic exposed the limits of public health infrastructure with the wealthiest municipal corporation struggling to meet the requirement of hospital beds, oxygen cylinders and ventilators.

More than 60 percent of Mumbai's population nearly 13 million people are jammed into concrete and corrugated-metal mazes and makeshift shelters in the city's slums. Access to safe drinking water, sanitation and a ventilated habitat etc. remains as a serious concern for the health and well-being of migrant workers from within and outside the state, who inhabit the slums and other unsafe spaces. Over the decades, among the public health issues, shifts in state policy defining the approach to slums, hygiene and

sanitation have determined living conditions for migrants. These spaces display multiple vulnerabilities— epidemiological transmissions and social protection failures. The fear of contagion and spread of virus within such cramped neighbourhoods and through them to others, dominated initial concerns of state agencies and residents.

Ensuring adequate hygiene and sanitation has been a key civic responsibility of the MCGM over the decades which increased manifold with the Covid crisis. Almost 35,000 sanitation workers (including about 6,500 contractual and casual workers) are engaged in a range of tasks that include street sweeping, garbage collection and transportation, and cleaning of public toilets to keep the city clean and avert public health crises in normal times. They are also the most vulnerable to disease and contagion due to the precarity of their working conditions and the slum habitats where they live. Through these months, of the city's battle against the pandemic and public health challenge, sanitation workers have worked with clearing large volumes of solid waste and increasing quantities of biomedical waste. In March 2020, when the pandemic broke out, the quantum of biomedical waste generated daily in Mumbai averaged 11,230 kg.⁴ The city generated three times the daily average COVID-19 waste in July as compared to April and forty-two times compared to that of the twelve days of the pandemic in March. By July, the city was generating almost the same amount of COVID-19 waste as regular biomedical waste in pre-pandemic times.⁵ Such a crisis was bound to challenge the civic authorities in carrying out its responsibilities. However, the institutions and systems of city administration, the staff at the Solid Waste Management (SWM) Department and so on, remained the same as they were in the pre-pandemic times. The visible recognition that these are special circumstances emerged only through enforcement of policy measures such as the Bio-Medical Waste Management Rules, 2016, and the provisioning of Personal Protection Equipment to workers.

In attempting to understand the approach of the municipal administration to migrant sanitation workers during the present pandemic, we began with the following questions: What do we learn from the history of pandemics/epidemics in the city that has implications for public health management, sanitation policy and habitat for the labouring migrants? How has this history shaped the current policies and practices of public health? How were the governance and management of informal settlements organized to attend to the issues of hygiene, sanitation and other public health concerns? How do we assess the risks, threats and vulnerabilities of workers during a pandemic? What do over-crowding, insanitary conditions and the dehumanizing living conditions tell us about public health and its access by the migrants in the city and its slums? How did the urban poor and sanitation workers, in particular, deal with the prescription of social distancing, isolation, sneezing and coughing etiquettes, containment, etc.? How did they deal with physical injuries, illnesses and death in these months? What do the everyday experiences of the migrants as residents and workers in regard to healthcare and services, their access, alienation, refusal, the sight of fear and anxiety tell us about the city's handling of the pandemic?

Engagement with these questions leads us to three broad aspects—the city’s history of pandemic handling; slum habitats and the public health question; and the sanitation worker as a pandemic warrior and as a subject of public health. The analysis of these historical and present-day aspects of the pandemic situation is informed by two sets of concepts viz. David Harvey’s political economy of ‘space’, the argument of the non-neutral nature of space and its employment for furthering ‘accumulation’ by capital. The second draws from Michael Foucault’s *biopolitics* and technologies such as segregation, segmentation, and surveillance, explicating the interface between the sanitation worker and the waste they handle; and the nature of control exercised by the state over the migrants as residents and as labour.

Encountering the Epidemic and Pandemic: From Bombay to Mumbai

Mumbai has the unfortunate distinction of being the centre of all major epidemics in the country, including the bubonic plague of 1897 and Spanish influenza of 1918. In the backdrop of public discourse around migrants, slum life, and the situation of their work, habitat and health, the earlier epidemics of 1897 and 1918 could be looked upon as moments that affected the nature of life, circumstances and experiences of working-class migrants and shaped the ideas of hygiene, sanitization, public health and community responsabilization and policies and practices of governing informal settlements that evolved in the city for over more than a century.

What one witnesses today evokes comparison with earlier epidemics and images of city, its working class, migrants and the condition of housing and health infrastructure. At the peak of the spread of plague in the city, attention was drawn towards the risk to public health due to the sordid housing and deplorable sanitation conditions of the labouring class. Instant sanitary fortification and several harsh measures were undertaken to deal with the epidemic. A ‘popular panic’ gripped the city, as much in response to the administration’s attempts to survey, control and attack the bodies and congested neighbourhoods of the city’s working poor as to the fact of the epidemic itself.⁶ By the beginning of 1897, roughly 400,000 people had fled, which amounted to a little less than one-half of the city’s total population.⁷ The epidemic brought the city to near collapse. “...while the city itself wore the aspect of a ‘City of the Dead’, the railway stations teemed with masses of fleeing humanity... Business was paralyzed, offices were closed and thoroughfares, ordinarily teeming with life, were characterized by a desolate emptiness.”⁸

The unhygienic sanitary conditions in the habitats of working class were constructed as conducive to the spread of the epidemic. Being alerted by the plague and insanitary conditions, the Bombay City Improvement Trust (BIT) was formed in 1898 with the “intention of clearing the city of its insanitary areas and mitigating the problems caused by the abysmal living conditions of the urban poor.”⁹ The trust was mandated with

“making new streets, opening out crowded localities, reclaiming lands from the sea to provide room for the expansion of the city, and the construction of sanitary dwellings for the poor.”¹⁰ Autonomous of the municipal corporation, BIT was also assigned the responsibility to construct sanitary dwellings for the poor.¹¹ The spaces were appropriated and regulated through acquisition of land and slum demolitions and clearances. However, much of these spaces were subsequently diverted for construction of private buildings and other purposes for financial incentives.

The plague prompted decisive actions by the municipal authorities in Bombay where they assumed special powers that authorized the segregation and hospitalization of suspected plague cases.¹² Several hundred slum-dwellings were destroyed in the hope of extirpating the disease before it could fully establish itself.¹³ To deal with the plague, “health officers, sanitation workers, the police, and port authorities attempted to identify, quarantine, and racialize unhygienic natives.”¹⁴ However, quarantine and control became hugely controversial and led to widespread resistance. Gradually, it was realized that demarcation and isolation as epidemic administration are ineffective and unsustainable.

The attention of epidemiology shifted to the slums, which due to the concentration of migrant workers— living in conditions that lacked ventilation, adequate lighting, faced problems with disposal of waste— were considered unhygienic. Slums were viewed as a public health concern and sites for spreading of contagion. Kidambi claims that epidemic diseases are products of locality specific conditions of filth and squalor that exercised significant influence over the colonial state’s war against plague.¹⁵ Public health officers were confronted with the chronic overcrowded tenements of a notoriously ill-fed working class and the devastating effects of the early industries on the living conditions in the cities with their pollution, noise and smells. A sanitary discourse opened up the holistic bodily metaphor featured in medieval thinking and emphasized the interface between bodies and their surroundings.¹⁶

As Foucault explained, under the colonial rule, medicine and health policies too became a tool to colonize the society and land and not just the body. To assuage the fear of plague, a major public health response came in the form of the Epidemic Diseases Act of 1897— a product of the colonizing efforts of the Indian Medical Service officials— gave the civic authorities a free hand in exercising their whims. It allowed for inspection of ships, isolation and quarantining to prevent the spread of disease. Through several health and sanitation processes, the city was turned into a space of spatial reconfiguration and mobility control. Police cordons conducted house-to-house searches to identify plague cases, deaths were reported, the sick were isolated, dilapidated houses were vacated and disinfected and the occupants removed to camps.¹⁷ These officious and harsh public health interventions were considered insensitive and numerous direct or clandestine ways to resist or escape such intervention were reported. There was widespread anger and fierce resistance against the municipal authorities. Reacting to the rumours that the hospitals were deliberately killing the sick, the millworkers rioted.¹⁸

The plague epidemic in Bombay impacted the relationship between the colonial state and its subjects. This was the first instance when the state acquired juridico-legal powers for an apparently humanitarian cause: to prevent the spread of the epidemic. It specifically targeted the poor and the migrant workers, seen as the carriers of the disease, restricting their movements, demolishing their homes, and subjecting their bodies to medical experiments. This became the model for the subsequent governments to use disease or epidemics to justify authoritarian measures over the decades till the current pandemic.

In fact, first the plague and 20 years later, the Spanish flu of 1918 fundamentally shaped the policies and practices of city governance in Bombay. In 1919, Radhakamal Mukerjee, while visiting these slums immediately after the Spanish influenza pandemic of 1918-19— that had already caused fifty million deaths worldwide and posed a full-blown threat and warning to public health— observed an extremely unhygienic and unhealthy living conditions in the slums and highlighted:

“...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 2,000 souls live, the Bhangi, Scavenger, has not been for a little less than a fortnight, and all the filth has accumulate[d].... 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.”¹⁹

This epidemic was, after HIV, the second deadliest pandemic of the modern era.²⁰ Between 1918-20 an estimated eighteen million Indians lost their lives to influenza or its complications, making India and the city of Bombay the focal point of the disaster in terms of mortality. The provincial death rate in the Bombay Presidency was a relatively high 54.9 people per thousand inhabitants.²¹ The severity of the disease in Mumbai led researchers to call it ‘The Bombay Influenza’ or ‘The Bombay Fever’. Unlike the plague, the response of the colonial regime was less stringent during the influenza epidemic. While the 1918 flu did not lead to sanitary reforms as the plague had, it did do something else— mobilize communities into donating their time and money and creating a new culture of social work and civic engagement. Additionally, the colonial accounts of dirt and disease in India represented the aggressive modernist perceptions of hygiene, order and ‘appropriate’ use of public and private spheres.²² Such understanding and response of authorities had substantive consequences for urban development and policies in Bombay.

The experience of epidemics influenced the administrative approach towards health, disease, housing conditions and its overall interface with the city. To control the relations between human beings and their environment,

the milieu in which they live was approached through biopolitical intervention. Examining the nineteenth century urban reform, Gandy, traced the formation of the 'bacteriological city' as a distinct constellation of a changing hygiene discourse, the problematization of urban metabolisms and several technical developments.²³ Numerous other studies on colonial India elucidated the deplorable situation of housing and hygiene. Florence Barnes's report, based on research conducted in 1922, revealed: "in one room measuring some 15 ft [sic] x 12 ft... six families living. On enquiry, I ascertained that the actual number of adults and children living in this room was 30...This was one of many such rooms I saw."²⁴ Lecturing on the "Evils that afflicts millworkers of Bombay" Dr Harold Mann remarked, "I never felt the meaning of the term "warehousing labour" as I did when I saw the chawls in Bombay. I found 14 workers living in a single room."²⁵

In dealing with these pandemics, state control was established and legitimized, laying the ground for authoritarian interventions in times of such crises. Physical sanitization became the main problem of public health intervention. Health and the space of the city became related in significant new ways in the emerging sanitary discourse. Instead of focusing on occupants of the poorly ventilated dwellings, the spatial relations formed by them caused concern. Most of the public health discourse and health policies emerged in this backdrop within a span of two decades in Bombay. These fundamentally changed the relationship between the colonial state and its subjects and foregrounded the idea of public housing, sanitation, hygiene and related aspects of housing and health services.

Differentiated Citizenship, Splintered Accessibility and Public Health Conundrum

Public health services are an essential part of a country's developmental infrastructure. They help control diseases through measures such as food safety, provisioning of clean drinking water, hygiene and sanitation, managing solid waste, and others. Structural inequalities result in social and economically marginalized populations being more impacted by the absence of these services and public goods. Public health services are both pro-growth and pro-poor as they target the poor, who face maximum exposure to disease.²⁶ However, accessibility of public health services for residents in cities like Mumbai is splintered for a number of reasons that have historical antecedents.

In colonial India, policymaking and planning for public health was systematic and aimed at addressing major threats to public health. As discussed in the previous section, colonialism provided the first model of using scientific means of pandemic control for the large-scale and often coercive regulation of people's lives and livelihoods, and it continued to influence the policies and practices in postcolonial times. The British lived in residentially segregated areas with good environmental sanitation. Public health measures were focused on British civilians and cantonment areas. The motives behind this focus could have been a hesitation to invest in the well-being of the native population or impose 'alien' practices upon the Indians.

“The cantonments and the British residential areas were segregated from Indian areas, with spacious roads and grounds which averted diseases spread through crowding. Municipal areas were privileged with machinery to assure good sanitary conditions, including the management of water, solid waste, and liquid waste. For towns and rural areas, the services were focused largely on early detection and control of outbreaks of contagious diseases with high fatality rates— such as cholera and the plague— before they could spread, and even menace the more privileged populations.”²⁷

The colonial period witnessed the drawing up of public health legislations, and the establishment of institutions and infrastructure to monitor and provide public health services at the federal and provincial levels. Municipal governments hired their own public health staff— medical doctors, and sanitary inspectors to enforce sanitary regulations.²⁸ However, there was a gradual and systematic atrophy of public health institutions and public health as a priority in post-Independence India; this was a result of several factors: the refinement and mass production of antibiotics since the 1940s that made it possible for the elite to procure these as cures for diseases rather than having to follow preventive measures such as environmental hygiene like the rest of the population; a shift towards financing curative technologies rather than public health systems; private goods (such as medical care) holding greater electoral value than public goods (such as sanitary measures to protect the health of the public as a whole), resulting in curative systems overtaking the preventive; and public health becoming more medicalized, with medical doctors coming into health systems and public health professionals getting side-lined. Public health systems faced severe shortage of funds due to dissonance between the Centre and states and little elbow room for fiscal autonomy for the states. Public health services were dismantled through ‘neglect of public health regulations and their implementation’; ‘diversion of funds from public health services’; and ‘organisational changes inimical to maintaining public health’.²⁹ Through the 1950s, the importance of sanitation for controlling communicable diseases was recognized, though little was done about it and by 1960s water and sanitation that had been a part of health planning had been moved out of the health sector, and the sanitary inspectors’ role receded into the background.

These developments led to carving out of domains in the health sector, enabling segmentation and separation of power, control and responsibility between the state and private entities. In subsequent decades, the role of the state in ensuring public health and providing services was reduced, and these were increasingly privatized through various arrangements such as public-private partnerships, and a simultaneous push for insurance to replace public services/infrastructure. Bereft of insurance, social security and any form of medical assistance, the poor are the ones who bear the burdens of privatization and decline of the public health system. The country has failed to deliver comprehensive public health services, leading to public health problems like undernutrition (caused by factors such as inadequate food, poor

access to water and sanitation causing recurrent infections) and poor availability of curative care. This is evident in the condition of health workers including sanitation workers, who live in informal settlements, and the treatment meted out to them.

The living and working spaces of the informal labour in Mumbai, most impacted by poor access to curative care, add to their peripheralization. Over half of the Mumbai city's population lives in informal settlements of varying infrastructure, income, economy, ethnicity, and religion, squeezed into whatever space that could be found, from bridges and railways to pavements and shantytowns. The growth in informal settlements reflects both the spectacular rise in real estate prices during the 1990s driven by the city's economic growth,³⁰ and the inadequacy of the state's social housing commitment.³¹ Most people in informal settlements lack security of tenure, live in poor-quality housing vulnerable to monsoon rains, suffer from frequent bouts of state or private demolition, lack access to sufficient and clean water and sanitation facilities, and live in highly polluted environments where they are vulnerable to illnesses.³² These settlements, frequently depicted and perceived as zones between legality and illegality, occupy a contentious space, where inhabitants often experience differentiated citizenship as mere 'populations' rather than as 'citizens'. Here, a range of services and facilities are "extended on a case-to-case, ad hoc, or exceptional basis, without jeopardizing the overall structure of legality and property."³³ These services are focused on populations rather than citizens, in the terrain of what Chatterjee calls the 'heterogeneous social' rather than the homogeneous social of citizenship. Additionally, these urban spaces are sanitized through a logic of demolition rather than improvement with the aim to "rid the city of encroachers and polluters and, as it were, to give the city back to its proper citizens."³⁴ As an illustration of differentiated citizenship, Risbud's analysis of data indicates that a very limited number of only 5 percent of slum inhabitants have access to individual water connections while 49 percent have to share standpipes and often rely on handpumps and tube wells.³⁵ Individual toilets are almost non-existent and around 28 percent of the people defecate in the open and 73 percent of the people use community toilets. Slums built on municipal land are provided with services while slums on private land are not entitled to any, those on state lands are in between these two conditions. Whether the slum is notified or not is another criterion of discrimination.³⁶ The distinction is particularly complex in Mumbai as it is tied to 'cut-off' dates, exposing the politics and political economy that affects the migrant's access to health services. This policy arose in response to democratic pressure from slum-dwellers, who form a large proportion of Mumbai's electorate.³⁷

A discursive transformation in Mumbai was influenced by the experiences and lessons from the earlier two epidemics whereby the aspects of sanitation, ventilation, housing, settlement pattern etc. informed the shape of health. To give the city a semblance of ordered space, the idea and conception of shelter and housing for the poor became vital in city planning and aesthetics. Despite being the wealthiest municipal corporation, sanitation and hygiene in poorer neighbourhoods' have remained disorderly. Drawing from

experiences of earlier epidemics when deployment of ‘scavengers’ was not easy, attempts were made to settle them in identifiable localities so as to secure their services as and when required. Informal settlements have grown into hubs of service providers in the city. Informal settlements have grown into hubs of service providers in the city. In Mumbai, they are spread across the city, creating neighbourhoods’ that are mixed in terms of class, and ensuring that for the middle and upper classes, service providers such as sanitation workers are near at hand.

Sanitation Workers: Segmentation, Surveillance, and Biopolitics During the Present Pandemic

Though the Covid pandemic has impacted lives and circumstances across the class divide, the precarity and uncertainty around migrant workers, their habitat, and access to health and hygiene has emerged with a renewed focus. There is an eerie similarity with the concerns that were highlighted and planned to be attended vis-à-vis public health after the late nineteenth and early twentieth century epidemic. Informal workers in Mumbai have struggled through earlier epidemics. At the time of the plague, mill workers constituted 80,000 of the total 8,50,000 population of the city. Forced to face harassment under plague-control measures, which involved sanitization, quarantine, and separation of sick family members in poor conditions and even destruction of their dwellings, they resorted to striking a number of times in early 1897. “Within three to four months of the start of the plague, 4 lakh people, including many mill workers, fled from Bombay to their villages, pushing the city into severe economic crises.”³⁸ Both in their spaces of residence and of work, labour has continued to be treated as a non-citizen of the city.

Sanitation workers, ensuring social reproduction of labour, are involved in a direct confrontation with disease. Features of the regime for governance of sanitation workers highlight their place— at the intersection of informality, selective control by the state apparatus, and the biopolitics of handling waste. As detailed earlier, solid waste management, articulated as maintenance of hygiene and sanitation, was treated as an imperative of the public health system in the colonial era, with sanitary inspectors monitoring conditions at provincial and municipal levels. After Independence, and with the setting up of municipal governance systems and institutions across towns in the country, solid waste had to be managed, and as an urban issue, this became a key responsibility of the municipalities. Increasing urbanization and specialization of functions over the past several decades led to the management of solid waste being assigned to SWM or health departments of the municipalities. These departments undertook recruitment, organization, and management of the work and labour. The MCGM currently is the largest municipal corporation in the country in terms of its annual budget and area.³⁹ The SWM department has employed increasing numbers of workers for city cleaning through several tasks that include cleaning of public toilets, sweeping

the streets, collection and transportation of solid waste (household, industrial, biomedical waste) to landfill sites.

In Mumbai, waste is poorly managed by residents; it is often scattered and thrown into gutters for removal by street sweeping crews. Lack of discipline and inadequate placement of bins are among the reasons for the challenge in keeping the city clean.⁴⁰ Segregation of waste, enforced by municipal authorities, is not followed adequately and effectively; and waste collection and transportation remains as the essential responsibility of the sanitation workers. Additionally, waste pickers in the informal economy play a crucial role in segregation and recycling, a contribution that is not formally recognized by the municipal corporation. Labour is, therefore, at the centre of different processes in the management of different types of waste in the city. These processes turned out to be excessively crucial during the pandemic due to the risk of contagion from various sources.

In the past two decades, policy changes have allowed for the entry of private firms and organizations in managing solid waste and city cleaning. Consequently, there has been segmentation of tasks with some such as street-sweeping largely handed over to the private firms and contractors, segmentation of areas with certain neighbourhoods entirely managed through fixed-term contracts, and, most importantly, the segmentation of labour with municipal bodies like the MCGM getting the work done by standard (permanent) as well as non-standard (contractual) workers. Hence, SWM, while distancing itself from public health as a goal, is aimed at managing waste. It has grown in a hybrid format— with permanent or standard workers and contractual or non-standard workers both engaged in similar work, but under different conditions.⁴¹ This expansion of the existing biopolitical imperative of the state is evident in the normalization of the contract system with insecure conditions for labour. “Sanitation workers...collect refuse from residential and commercial establishments in a truck designed for this purpose, which they may also drive. Among risks involved in this occupation are those resulting from lifting heavy refuse receptacles, trauma and others...”⁴² Informal sanitation workers confront lack of basic amenities and services, including healthcare, unless they are organized into unions. As a caste-based occupation, the social stigma faced by these workers, irrespective of gender, has affected generations of households. The inherent irony of sanitation work is the difficulty of accessing healthcare services for those who are actually engaged in ensuring it for the public.⁴³ The situation resonates with what the *Bombay Chronicle* observed a century ago: “The sweeper, while he is the most neglected human being in ordinary times, is nevertheless among the most important.”⁴⁴

There is a high congruence between poverty, vulnerability and informal work in India.⁴⁵ The informal economy is marked by diversity in terms of occupations, working conditions, and nature of insecurity; and slum-dwellers and those living in informal settlements, such as on the pavements, work in precarious conditions with the labour market and broader social insecurity as defining elements.⁴⁶ For contractual sanitation workers, the pandemic has exacerbated their insecurities due to poor working conditions

and public health services. Over the past twenty years, their struggles for entitlements have been long drawn-out, resource intensive and yielded mixed results.⁴⁷ Occasional strikes in protest for minimum wages, protective gear, basic amenities at the workplace, and social security have led to city-wide physical conditions that portend a public health crisis for the city. The 2005 Mumbai floods provided a small window when their contribution came to be recognized, even valued, but the larger prejudices against low-status of sanitation workers returned once the disaster was over, and went back to their precarious livelihoods having some of the highest mortality rates of any occupation in the city.⁴⁸

Governance of the city, of labour working for the municipal authority, and other sectors of the economy, is central to examining sanitation work and the worker in Mumbai. Not unlike what Foucault explicated several decades ago, governance of the pandemic at the state and city levels led to “strict spatial partitioning...a prohibition to leave the town...the town immobilized by the functioning of an extensive power... a whole set of techniques and institutions for measuring, supervising and correcting the abnormal...”⁴⁹ Patton asserts, “pandemic management has become a post-modern, spatio-temporal paradox— populations require constant surveillance because disease is potentially anywhere, virtually everywhere but only ever actualized at some particular place at some specific time.”⁵⁰ Yet, managing the pandemic requires more than surveillance and control. The experience of the plague in Surat had some important lessons in terms of the role of stigma in inhibiting efforts to contain the spread, and the importance of initiatives aimed at reducing stigma and anxiety; very importantly, it led to immense improvement in sanitation and primary health care, and the realization that safety of ‘first-line healthcare providers’ and their families need to be ensured “or they may be forced to choose between the good of their families and the good of their larger society.”⁵¹ Since fear, uncertainty, anxiety and stigma influence the impact of the techniques of controlling and managing the pandemic, they need to be taken into account in the governance of populations. Nowhere do all of these converge as clearly as they do in the space of the sanitation worker or *safai karmacharis* handling the waste, and of their interaction with other subjects.

Experiences of sanitation workers through nine months of the pandemic from March to November 2020 highlight the city’s handling of the pandemic. While *safai karmacharis* have been recognized as frontline workers along with medical workers, through gestures such as beating of plates, and lighting of candles, a temporal view of sanitation workers confirms the continuance of their peripheralization through segmentation and surveillance that marked the city administration’s handling of the situation. When the infection was on the rise across the city, a nationwide lockdown was announced, and local train services were suspended from the midnight of March 22, as officials feared that it would lead to the spread of the virus. This immediately impacted the mobility of sanitation workers. In an overt control over labour and labour process by the corporation, they were warned against

taking any leave from work as the BMC was summoning all its resources to fight the spread of the virus. Not turning up for work meant losing the day's wage. The *Kachra Vahatuk Shramik Sangh* in their notice to the Mumbai Municipal Commissioner complained that they were not provided with proper masks, hand gloves, uniform, shoes and soap or sanitizers.⁵² Ashok Yamgar, the Chief Engineer, however, asserted that contractors had been instructed to provide Personal Protective Equipment (PPE) and if they were not doing so, the workers needed to complain at the municipal-ward level. Narrating their work condition during the pandemic, Shankar Kunchikorwe, whose service area is in Dharavi, said that, "there are six workers in each vehicle that carries waste. "Equipment like metal basket is shared by two people on the field. The workers are at serious risk and the BMC should think of taking care of us..."⁵³ During this period, the BMC adopted mechanisms that were historically at its disposal to manage the pandemic in the city— control and command to demanding attendance of workers and continued non-provision of protective gear.

By April, some discussion started around the risks to sanitation workers and rag pickers from 'unmarked medical waste'— discarded masks, gloves, and tissues etc.— from homes where COVID-19 patients were quarantined. Although guidelines were issued by the Central Pollution Control Board (CPCB) about how the waste was to be segregated at the source, and how it was to be disposed of;⁵⁴ but the lack of civic awareness and fear of contamination created obstacles in successful implementation of the system.

"Residents say that they are not even aware of the need for segregation inside their homes. "It is scary to touch medical waste that is being used regularly for fear that I may contract the disease as well. So we try to put everything in one bag and give it to BMC because they know how best to separate it," said a 44-year-old woman from Jijamata Nagar, a containment zone in Mumbai's Worli, whose husband tested positive for Covid-19... Mumbai has been generating 9 tonnes of Covid-19 waste and 6 tonnes of non-Covid biomedical waste every day, BMC estimates."⁵⁵

With Mumbai and Delhi having one incinerator each and a total of 200 such facilities in the country, there was a possibility that the waste would have to be transported to neighbouring states for processing. The scale of biomedical waste generation in big metropolitan cities like Mumbai and its management were the emergent challenges.

As the 'bacteriological city' became visible, control over labour had to be exercised to deal with it. The BMC had by then instructed its sanitation workers to work on a rotational basis with only 50 percent staff at work during the lockdown. An additional payment of Rs300 per day for transportation and food expenses was also announced. However, it was not specified whether this would apply to contract workers and it was also unclear whether workers would be paid for the non-work alternate days that they were asked to maintain. In May, the case of a sanitation worker came to light who was tested Covid positive and inadvertently passed the infection to his wife

and in April she succumbed to the deadly virus.⁵⁶ The lack of space in the house added to the difficulty in maintaining social distancing and other precautions. The Ministry of Health and Family Welfare issued a circular saying that sanitation workers and others should be provided with PPE gears. Baburao, a contractual worker, said that they were provided with PPE only when they refused to work, and they were asked to wash the suits at home and reuse them at work. Their union protested on the grounds that the workers did not have the space and resources for washing and maintaining the suits; they asserted that this was the responsibility of the BMC, to which the latter agreed. In a social media post by a news agency, it was mentioned even in non-pandemic times, each worker is provided only one bar of soap by the Corporation⁵⁷ but one could question its sufficiency during the Covid pandemic as sustainable protection for the workers who are occupationally regularly exposed to being infected by the deadly virus.⁵⁸

The hierarchy among municipal employees is stark with sanitation workers as Class IV employees in the lowest rung and contractual sanitation workers are even further down in status due to lack recognition as employees of the corporation. Though central in its contribution in the pandemic, the worker's body was treated as the marginal figure in the machinery that runs the city. In the initial months of the pandemic itself we see the emergence of discursive sites in SWM viz. first, the policy space with government agencies (MCGM, CPCB) at the centre; second, waste generation, which attained significance in terms of quantum and nature of waste and biomedical waste in particular; third, segmentation of city areas into containment zones, hospitals, and non-containment zones each signifying levels of fear, caution, stigma, and mechanisms for waste handling; fourth, the body of the worker handling the waste with its proximity to the waste and the virus. The first space is used by the state to extend its control over the others; the second is conceptual and concerns itself with tracking and planning for managing waste at city level; surveillance by the state directly extends to the third and fourth spaces where waste is generated. The virus can spread and the bodies of the resident, the medical practitioners, and the sanitation worker are in closest proximity to it.

“When the SWM department officials in G-North ward handed over June’s schedule for daily waste collection, one of its waste collectors turned apprehensive. Earlier in the month, the 32-year-old was tasked, along with two other municipal workers to collect waste from the containment zones in block 119—a set of nine areas in Dharavi, one of Asia’s largest slums which saw a severe outbreak of the coronavirus pandemic—and load it into a vehicle that would take the biomedical waste to the city’s only treatment facility located adjacent to the Deonar dumping ground. “The fear of contracting the virus never leaves the mind,” said the sanitation worker, who asked not to be named as he is not authorized to speak to the media. “But work is work, and it has to be done.” His job is risky, as very often residents of the containment zone do not segregate the waste they generate into hazardous biomedical waste (yellow bag) and household waste (black bag). “Though residents were provided separate yellow and black coloured bags, we continue to receive one bag every day with all types of mixed waste

including masks, gloves, banana peels, gowns and plastic bags that are spilling over,” said the worker. “It is scary when residents toss black bags in large garbage collection bins over the sealed boundary of the containment zone towards us.” ... BMC agrees that workers in the 46 waste segregation centres are at risk...some of this waste is also making its way to the city’s landfills...where workers...tested positive for Covid-19 and recovered.⁵⁹

Segmentation of the city, and demarcation of containment zones created a narrative of special treatment by authorities, and of fear and necessary distancing by others. The biopolitical imperative pushes the worker into closest contact with the waste and the unseen virus, while the aim of the actors making policy decisions, and at containment and other zones is to distance themselves from these as rapidly as possible.

In August, the contract *safai karmacharis* found that they did not have access to water and toilet facilities in one of the areas they work in. These were provided only after the union took up the issue. Workers of one of the wards complained to the Labour Commissioner about not being paid the minimum wage and were denied work by BMC officers and contractors. Control and punishment were used to discipline the workers in check. In September, the case of Ashok Taare, came to light. He was denied leave when he was unwell and passed away due to suspected COVID-19 infection. He had been a contractual worker for many years and obtained permanency of employment under the BMC due to the legal battle waged by the union. When the *mukadam* of his *chowki* tested positive for COVID-19, they shut the *chowki* and asked all the workers to move to another in the same area. After a week Ashok started feeling unwell and requested for sick leave (having not taken any of the 21 days he was entitled to this year); and for a medical test. The leave was denied because every worker was required to work. He continued working and passed away at the end of May. Ashok’s co-workers wash and re-use the masks. Their union raised their concerns by forming a human chain across some parts of the city.⁶⁰

Each incident points to the conflictual relationship between the state and the workers marked by resistance on both sides and the state’s unwillingness to take full responsibility for contract workers and asserting that it is the contractors who must do so. In analysing this relationship, it emerges that it remains unchanged through the pandemic times.

Conclusion

The four spaces viz. policy, waste, geographic zones, and the worker; through the functioning of its ‘spatial practice’ enable the accumulation and expansion of the interests of capital.⁶¹ Non-provision of entitlements to sanitation workers— wages and protective gear, water and sanitation at the workplace, paid sick leave, access to healthcare among others— are ways by which the contract regime thrives and profit margins for contractors increase when they do not meet minimum wage and protective gear requirements. The pandemic results in an extension of spaces of accumulation; presently, this extended

space can be expected to last as long as the pandemic does— through segregation (quarantine facilities) and segmentation (demarcation of containment zones) of city areas, and controlled deployment of workers. In the management of the pandemic in these months, the four discursive spaces have become closely intertwined— vertically and hierarchically as well as horizontally and merging with each other. Policy and guidelines are enforced and determine the daily work schedule of the sanitation worker, the geographies that they interact with through the tasks of waste segregation, collection, and disposal. The nature of the city zones determines the quantity and type of waste that the worker has to handle. The waste itself has no agency, but is the outcome of economic, social, and epidemiological determinants of the people in the zones; it can be a carrier of the virus and spread disease and is, therefore, imbued with properties that elicit fear, disgust, stigma, apprehension and keenness to distance oneself from it. The worker as a subject acted upon by the other three spaces is central in the prevention and control of the virus, engaged in a biopolitical equation with these spaces and in the proximity to the waste and virus, embodying that which is most fearful about it. Yet, a certain distancing and detachment from the work, symbolized by the protective gear is necessary in order to be able to do it. The pandemic has emerged as an extension of the space for control of the worker and labour process, and for accumulation.

Though the conviction that filth and poor sanitation were the primary causal factors in the outbreak and spread of epidemics; diseases dominated the discourse in colonial India, the present pandemic has little correlation with the earlier conception. The authoritarianism in dealing with public health that emerged through the beginning of the 20th century, was diluted in later decades through its medicalization. However, ill-ventilated, overcrowded tenements in the city's unsanitary localities housing migrant workers are surely perceived as more likely bearers of contagion due to their inability to maintain sanitation, hygiene, distancing and isolation protocols.

Sanitation workers who bear a large burden of the pandemic and its control protocol today, ultimately pay heavily in terms of safety, security and are hugely susceptible to disease and death. They bear the burden of fighting the pandemic at risk to their health and well-being and remain in the trap of neoliberalism that keeps their employment contractual, and a society that keeps them at the margins. In the process of governing contagion and infectious disease, the most susceptible and vulnerable are at the threshold of epidemiological management. The public health management that gave primacy to law-and-order approach to ensure lockdown, distancing, isolation, containment, etc. has contributed to what *The Economist* refers as 'coronopticon',⁶² with data gathering, tracking, and surveillance as central to pandemic management. As the fight against the pandemic moves into virtual spaces; in the future, newer answers to questions about who the epidemiological 'frontline warriors' are, and on what terms they may be called so, may emerge. For the 2020 experience, the battle and the war was on the ground with the sanitation workers body in the midst of it.

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Trust and Everyday Healthcare at a Resettlement Colony in Delhi

By

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Introduction

April 2020: Anita Kapoor— a founding member of the Shehri Mahila Kamgar Union (a union for women migrant workers; ‘the union’ hereafter)— and I were working out the details of how to maintain physical distance while distributing dry ration, when we started to receive requests for medicines and sanitary napkins. During one of our many conversations, Kapoor commented, ‘Everyone is saluting ASHA (Accredited Social Health Activist) workers, doctors, nurses; no one recognizes the role of the local doctors in neighbourhoods such as these. They are the first point of contact for a migrant worker.’ Bengali *daktars* and *jhola chhap daktars* are emic categories of medical practitioners who do not possess medical degrees and are, therefore, 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 and incorrect diagnosis at the hands of these practitioners. However, their role in India’s public healthcare system, particularly in migrant neighbourhoods, cannot be ignored. The very mention of health workers conjures three images in our minds: first, registered medical practitioners; second, nurses, especially the transnational care-work around healthcare; third, community health work. However, the scholarship on neighbourhood medical care in India has suggested the presence of Bengali *daktars* who play the role of an important

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† I have been working with the Shehri Mahila Kamgar Union since 2016 in different capacities. I collaborated with them for a research essay on domestic workers where I interviewed fifty women, and an art research project on smells in 2019 which involved focussed group discussion on ‘Work and smells’. While I am not involved in any official capacity with the union, there are fictive affective ties with my respondents since 2016. I am as much an insider as an outsider in the union.

intermediary in this fragile system. By following the lives of migrant workers in a resettlement colony, I propose to examine the workings of trust between migrant workers and health workers. Alberto Corsín Jiménez in his work on trust warns that most of the literature views trust as ‘a moral commitment, character disposition or a dynamic of encapsulated interests’.¹ Though the notion of trust might be mysterious, it is important not to ponder on what trust is, but what trust does.² In doing so, building from Corsín Jiménez, I am cautious that trust is as much ‘an anthropological object’ as well as ‘an object of social knowledge’.³

My journey into trust stems from its equivalent Hindi word *bishwas* that emerged in my conversations with migrant workers about neighbourhood medical care facilities (primarily, local clinics managed by Bengali *daktars*), in my conversations with pharmacy owners, and in the conversations between the *daktars* and the pharmacy owners. Moving beyond the question of the legality of these practices in India’s healthcare system, I propose to show how healthcare services for India’s urban poor are shaped by trust. More often than not, these relationships are viewed as a result of the lack of information about medical facilities and schemes targeted towards the urban poor. However, in this paper, I propose to study the workings of trust in the context where people visit Bengali *daktars* and pharmacy owners for *dawa* (medicine) when they fall sick, despite information about state-sponsored free healthcare provisions and facilities. The workings of trust, as this paper will demonstrate, indicate the following possibilities: mistrust between the migrant worker and the state, and the dual nature of trust— i.e., the material manifestations of trust and the affective nature of trust.

The outline of the paper is as follows: in the first section, I discuss the challenges of conducting fieldwork during a pandemic. Since the research project was conceived and planned during the first phase of the COVID-19-induced lockdown in India, it becomes important to revisit the ideas of ‘field’ and ‘fieldwork’.

‘Fieldwork’ during a Pandemic

India announced a lockdown to curb the spread of COVID-19 on March 24, 2020. Following the lockdown, horrifying images of migrant workers walking down India’s national highways and being sprayed with disinfectants at state borders appeared on the front pages of the leading news dailies. Within days into the lockdown, we started reading horrifying accounts of stigma around migrant workers, who were perceived as a threat by the state in its efforts to contain the spread of the pandemic through a severe lockdown. Parallel to this, the stigma faced by healthcare workers in metros such as Kolkata and the lack of protective gear for health workers in COVID-19 facilities revealed how the pandemic was a social disease. On May 24, 2020, Ambika P.K., a nurse at Kalra hospital, Delhi, died. Somya Lakhani, in her report, draws upon interviews with Ambika’s fellow nurses who complained that while the doctors were given fresh PPEs, the nurses were asked to reuse them. The management of Kalra Hospital and a few other nurses denied this.⁴ On May 9,

the Manipur government gave transit clearance and travel permits to more than 185 nurses working in Kolkata, according to a newspaper report.⁵ On May 20, 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.⁶ At the bottom of this pyramid are the ASHA workers and the sanitation workers. ASHA workers are community health activists. They have played an important role in urban and rural areas to help with awareness about the pandemic and in contact tracing. They received a meagre allowance of Rs. 1,000-3,000 across Indian states (except in Andhra Pradesh and Karnataka) and were at the forefront of India’s #frontliners: a taxonomical classification used for healthcare professionals—doctors, nurses and ASHA workers. In Delhi alone, there are around 5,900 ASHA workers 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 only visit pregnant women and, mostly, try and coordinate over the phone. ASHA is a community health worker programme under the flagship National Rural Health Mission, introduced in 2005 after a long process of deliberation.

Dr. Sujatha Rao, in her book on India’s health system,⁷ comments that the National Rural Health Mission and its agenda of health for all came in at the turn of the millennium, primarily due to the unconnected factors from 2000-2004. Rao observes that the year 2000 was critical. First, it heralded the launch of the Millennium Development Goals and, second, the Report of the Commission on Macroeconomics and Health was released. Rao also points out that Dr. Manmohan Singh (who would become, in 2004, the Prime Minister of India) and Isher Judge Ahluwalia, two noted economists, were part of this Commission and feels that they were instrumental in prioritizing health in India’s governance. Isher Judge Ahluwalia headed ICRIER, initiated a study on the health system and published the first comprehensive health report, *India Health Report* (2003).⁸ By 2002, India had its second National Health Policy.⁹ Significantly, it is only at the turn of the millennium that public spending on health rose to 2-3 percent of the GDP. Primary healthcare became a subject of national concern and efforts were made to control and contain communicable diseases. Parallel to this, due to encouragement of public-private partnerships in healthcare, there was a mushrooming of private healthcare in the area of diagnostic clinics, speciality hospitals, treatment centres, so much so that India became one of the cheapest and most attractive locations for medical tourism in the areas of assisted reproductive technology, neurology, geriatric care, ENT, physiotherapy and orthopaedics.¹⁰ Subsequent governments would push towards ‘insuring’ medical care by rolling out insurance schemes.

It is against this fragile public health infrastructure as part of the larger study on healthcare for migrant workers that I began to examine the nodal points of access in India’s healthcare system for a migrant worker. This work emerged in collaboration with the union and migrant workers who were resettled in a colony bordering Delhi and Haryana. Kapoor and other

members of the union played a key role in conducting phone-based interviews with local doctors, ASHA workers, migrant workers and pharmacy owners. During the course of the interviews, the word *bishwas* emerged several times, pointing to how bodily trust— social, physical and intimate— informs the work of healthcare. The loss of trust that we witnessed in the newspaper reports between migrant workers and the state, through the political act of walking or an inevitable failure of the right to ‘return’, showed how the workings of trust have to be revisited in the time of the pandemic. With this objective, I began to work on the ideas of trust that the local doctors shared with pharmacy owners. The limitations of methods require a separate and detailed discussion. However, as I navigated the world of local doctors, pharmacy owners and migrant workers through the phone, I wondered if we read the technological interface. Is it part of the field or is it another technological gaze that has come to occupy an important role in the times of pandemic research? How do we reconfigure the arrival, exit and self-reflexivity of an anthropologist studying trust in healthcare through a mobile phone in a resettlement colony?

Resettlement Colony and Health Work

As one enters the resettlement colony, one can see tarred roads broken at the edges and waterlogged or a heap of sewage waiting to be collected near the rows of houses allotted to the displaced by the Delhi government a decade ago. Like most urban settlements of Delhi, additional floors have been added in the hope of earning rent. Undocumented displacees 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 regularized colonies. The neighbourhood has a Primary Healthcare Centre with a trained medical doctor, along with a designated Auxiliary Midwifery Nurse, followed by an ASHA worker chosen from within the community. Drawing from the ‘ethnographic’ inquiry, I would like to offer preliminary observations on the trust shared between the network of health workers and migrant workers. These observations are based on my engagement with the union to organize relief work in the first phase of lockdown and in-depth phone interviews I have been conducting since July 2020 with migrant workers on accessibility to healthcare facilities in the neighbourhood. Two important actors emerged in these conversations: Bengali *daktars* and pharmacy owners. Gradually, by August 2020, I started to conduct phone interviews with these two actors.

Veena Das explains in her book¹¹ that Bengali *daktars* are ‘a ubiquitous category of doctors who practice in Delhi’. According to her, the term has a range of implications. First, they come from West Bengal; second, they are trained and armed with degrees ranging from a Bachelor’s in Ayurvedic Medicine and Surgery to a Bachelor’s in Homeopathic Medicine and Surgery. The same category of practitioners is referred to as *jbhola chhap* in Uttar Pradesh and Bihar because of the bag in which their medicines are carried. Das draws upon a study by the ISERDD and the World Bank, which points to a relatively high presence of unlicensed doctors in low-income

neighbourhoods. She lists six types of practitioners. First, the practitioners who have no training or degree but were trained as an apprentice to a practitioner. Second, 'Registered Medical Practitioners', who could have a degree or diploma or be recognized on the basis of experience. Third, those with degrees in alternative medicine (*unani* and *ayurveda*). Fourth, those who have degrees from medical colleges. Fifth, those with a degree in homeopathy. Sixth, a mixed bag of practitioners who could have a degree or completed graduation in a non-medical subject or are high-school graduates. She then goes to examine how these practitioners make sense of their craft. Healing, gift, service (*sewa*) and social healing (*hunar*) are some of the words that remain central to the experience of the craft of those who do not have degrees. However, Das adds a disclaimer that not all of them talked about healing. For some, it was about being able to look scientific, charge fees and diagnose. Healing, Das would like to propose, is a two-way process and, in exchange, the practitioner received *hunar*. In other words, there are moments when social healing and medical 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. These are the moments that allow Das to argue what the art of healing demanded and, in the garb of biomedical worlds, moral lives seeped in.¹² I propose to move away from the practitioner's sense of the craft and instead ask what, apart from the fact that it remedies a missing link in the healthcare system, allows for the sociality of this network of Bengali *daktars* to exist and thrive despite the regulatory mechanisms in place. In the next section, I will explore 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 migrant workers, one of the concerns that were raised was that they could be carriers of contagion. Migrant workers were left stranded along the state borders and sanitisers were sprayed on them as they became the suspected carriers. It is within this context that I want to place the migrant subject who lies at the end of the (mis)trust. Starting with citizenship to the precarity of jobs, the outbreak of the zoonotic disease acted as a catalyst to trust her/him a little 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 the lockdown and the closure of industries, there was a breakdown of 'transplanted networks'.¹³ Scholarship on migration studies and migrant experiences has time and again alerted us to the economies of trust in remittance networks, recruitment networks, etc. Ethnographic accounts of the working conditions of migrant workers have alerted us to the (mis)trust of the state towards the migrant as evident in immigration laws, labour laws and identity documents. In the case of internal migrant workers, it is in the difficulties they face in their everyday encounters with the state— in terms of misspelled names or mismatched names at the workplace and assumed identity— that a relationship of trust could be constituted.

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 Dr. Singh charges fees of Rs. 50-100. She works as a construction labourer and receives a daily wage of Rs 350-400. 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 to buy medicines. If I have to pay someone to write and someone to give me medicines, it 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 the ASHA worker. If she were not here who would have gone door to door to check on people when they tested positive? Everyone was busy drawing white circles. We would have died of hunger if not by the 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 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, the *kothevale* (employers) transferred money to my account and then it stopped. Now, they don't call.' I understand. Returning to healthcare in her neighbourhood, she says, 'There is magic in Dr. Singh's hands. He gives medicines. If we don't recover within 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 that the medicines which Dr. Singh gave her have worked. Dr. Singh is one of the doctors who has a medical degree and 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 the 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, allopathy; second, ayurveda (you must have heard of Baba Ramdev); third, homeopathy. The qualified doctors like us might combine the treatment of homeopathy and allopathy. Now, when it comes to Bengali *daktars*, they are known to treat fever, piles and fissures. They don't have a degree. I come from a humble background. In fact, Appu knows everything. I used to work in one of the clinics in the area (implying the slums before the 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 the 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 his registration number, sharing an 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 he enjoyed his period of training in Patna, he replies that it was an ‘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 the 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 pharmacies 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 write the name of the medicines on these notepads. Ma’am, no one will tell you this.’ I ask the pharmacy owners who comes to buy the medicines and how they sell the drugs. One of them comments, ‘Ma’am, people are not educated. They will say, ‘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 or women. Body pain is the most common problem. During the time of change of season, for instance, now, people complain of ‘loose motion’ and 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 *jhola chhap*. We have years of experience and I can look at you and tell you if you are ill. Mostly, people come with *chhotimoti bimari* (diseases that are not serious) like cough and cold, stomach infection, fever, body pain, diabetes and TB. For TB, there are state hospitals which I recommend. If the patient requires dialysis, I refer him to a private nursing home. Rest of the ailments can be cured by buying drugs over the counter. In today’s date I treat people with medicines and charge them Rs. 30-50. During the early phase of the pandemic it is people like us who might have suggested patients to visit big hospitals and testing centres.’ I intervene: ‘There were reports that doctors were returning patients who had a 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 call. One of the union members who had organized 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 emphasized that doctors don’t charge any fees from patients if they prescribe medicines on paper. In most cases, this paper is the notepad of local chemists or

pharmacies. For most of the migrant workers, the sign of a red cross, an image of the stethoscope and the time for recovery are the benchmarks of a good doctor. Most migrant workers point to easy access to *dawa* in the neighbourhood and the time for 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 employer can take leave from work when she has a fever. At the maximum, no one complains if I take two days of leave in a month in my line of work. *Bimar parna* (to be sick) is a curse. If it is a *chhotimoti bimari* then we can go to local doctors but in case 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 employer to a hospital for her daughter's check-up. In big hospitals, they have eating places with air conditioning. (Another union member joins to confirm, sharing names of such hospitals). Just like hotels. 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 for my health. Don't you remember I asked money for sanitary napkins during the lockdown?' When I ask her if she has ever been to a *sarkari* hospital, she says, 'Yes, because there was an ASHA *didi*.' The social network of local doctors and pharmacy owners functions through a myriad forms of the materiality of trust—clinics, *dawa*, testing facilities, nominal fees, and even no fees. *Dawa* emerges as one of the important material manifestations of trust in this social network.

Affect and Trust

One of the ASHA workers reminds me that they are on a strike and even though the government and media have hailed them for their role in containing the pandemic, they do not have a stable salary. She said she was supposed to receive an extra allowance of Rs. 1,000 for her service during the pandemic 'Most of us earn Rs. 4,000-5,000 and these are based on incentives. The payment is irregular and at times our payments get delayed by two months. Our demand is a fixed salary.' Time and again, in my conversations and interviews with migrant workers and local doctors, they emphasized that to understand the social network of healthcare, I should speak to an ASHA *didi*. They are the nodal points of access to the public healthcare system. '*Sinj ASHA didi ke pass line nahin lagti bain. Wo apne bain* (You don't have to stand in a queue to reach ASHA *didi*. She is ours).' The scholarship on ASHA workers have time and again pointed to the 'intimate labour' that shapes the nature of their work. Apart from these affective ties, the state has failed to enter the imagination of poor neighbourhoods in creating affective trust.

With increasing shift towards insurance, the state discourse on public healthcare is shifting towards identifying risk rather than mechanisms of care. Let me turn your attention to how insurance is perceived among the migrants and healthcare workers of this neighbourhood. 'I have insurance. I don't know if I can use it 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 employer wanted to gift me 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 my hometown? There are no hospitals in the vicinity. I asked her if the insurance company would pay money to a private hospital in the nearby town. She kept quiet. Besides, insurance is for the future.’ When I ask her why she invested in life insurance, she giggles, ‘That is my insurance for 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 healthcare? These conversations around insurance are built on a notional understanding of affective care for the 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 an 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 migrant workers. From the proliferation of public-private partnership models in healthcare facilities to the privatization of hospitals, India’s urban poor is lumped under the category of the ‘Economically Weaker Section’ schemes of private hospitals.

Conclusion

The study shows that though there has been a shift in the acknowledgement of the role of community health activists, especially ASHA workers, in the aftermath of the 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 pharmacies are undermined in the emerging rubrics of the materiality of trust— *dava*, and a loss of affect and trust— to insure life.

Notes

¹Alberto Corsín Jiménez, “Trust in Anthropology,” *Anthropological Theory* 11, no.2 (2011): 178.

²Ibid., 179.

³Ibid.

⁴Somya Lakhani, “Nurse’s death: Colleagues say had to wear used PPEs,” *Indian Express*, May 26, 2020, <https://indianexpress.com/article/cities/delhi/nurses-death-colleagues-say-had-to-wear-used-ppes-6427321/>.

⁵Tanmay Chatterjee, “Migrant nurses leaving Bengal for safety; private hospitals face manpower shortage,” *Hindustan Times*, May 16, 2020, <https://www.hindustantimes.com/kolkata/migrant-nurses-leaving-bengal-for-safety-private-hospitals-face-manpower-shortage/story-htjzRdHYup8IP713ZOObAM.html>.

⁶Atri Mitra, “‘No pay, heckling’: 300 nurses leave Kolkata hospitals, go back to Manipur,” *Indian Express*, May 20, 2020, <https://indianexpress.com/article/india/no->

pay-heckling-300-nurses-leave-kolkata-hospitals-go-back-to-manipur-cornavirus-6418278/.

⁷Sujatha Rao, *Do we care? India's Health System* (New Delhi: Oxford University Press, 2017).

⁸Rajiv Misra, Rachel Chatterjee and Sujatha Rao, *India Health Report* (New Delhi: Oxford University Press, 2003).

⁹The first National Health Policy was formulated in 1983. For details on the second National Health Policy, see https://nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/national_nealth_policy_2002.pdf.

¹⁰See <http://www.indiahealthcaretourism.com/>.

¹¹Veena Das, *Affliction: Health, Disease, Poverty* (New York: Fordham University Press, 2015).

¹²*Ibid.*, 179.

¹³Charles Tilly, "Trust Networks in Transnational Migration," *Sociological Forum* 22, no. 1 (2007).

In Search of Other Worlds: The dalit in *De Facto* Statelessness in Avinash Dolas's "The Refugee"

By

Debojoy Chanda *

Introduction: A Confession

In this article, I discuss the position of the dalit citizen of India as one of *de facto* statelessness. To embark on my discussion, I delineate the dalit¹ body as primarily marked by the absence of the materiality of intimate touch from the caste-Hindu. This absence of touch allows me to locate the dalit body within social distance, that is, in empty space as the site facilitating the pure existence of humiliation. The humiliation, I allude to stems from the habitation of the dalit body in a perpetual state of alterity, given the absence of the warm touch of the other encasing it. This framework of humiliation stains the body in corporal lowness— a lowness in which the ruins of the consciousness inhabiting the body are trapped. Such a state of entrapment may lead these ruins of consciousness to go to great lengths to do violence to their bondage in social distance, as I demonstrate through my reading of the suicide letter written by dalit doctoral student and activist Rohith Vemula (1988-2016). Seeming to drift as the dalit body does in the perennial liminality of social distance, Marathi dalit write rand activist Avinash Dolas portrays the figure of the dalit as akin to that of a refugee in the Indian nation-state. Through a reading of Dolas's short story "The Refugee," I aver the untenability of this portrayal. Indeed, the dalit can, I suggest, perhaps be said to occupy a position which is closer to that of an internally displaced person— a person disowned by Brahminical touch and recognised in her internal displacement as a figure that the United Nations would term an 'invisible citizen' of India. This state of invisible citizenship, I argue, situates the dalit in *de facto* statelessness within an international juridical regime of human rights. Though the dalit's claim to these human rights will not ensure that her body is liberated from the

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humiliation of social distance, her voicing of such a claim will set a tussle against caste privilege in motion. This tussle, as I show in broad strokes, bears the possibility of ending with the dalit being able to articulate her human rights as political rights.

I am aware that my arguments are defined by the lack of a solid grounding in dalit experience, thus perhaps structuring my sweeping enunciations about the dalit body within a lens of erring. It is my habitation of this framework of erring that prevents me from attempting to dive into the terrain of, for instance, class—an aspect that is inextricably intertwined with the functioning of caste.² Nor do I pretend to much other than ignorance about the ways in which caste and untouchability function across locations and groups in India. It is from within this flawed foundation of erring that I speak about the dalit body through the lens of the only—and often largely inaccurate—determinant of dalit identity that has been historically handed down to me as a savarna scholar.³ The determinant I allude to is, of course, that of the absence of intimate touch from the caste-Hindu. However, perhaps I should not stop myself from the act of erring as I blindly grope my way through an outside, especially if my effort be to make the dalit feel touched despite her segregation in social distance.

Social Distance and Encounters with Alterity

According to psychiatrist Damir Huremović, even before the onset of Novel Coronavirus Disease in 2019, the term 'social distancing' had begun to be used to indicate physical distancing as a means to break a chain of infection through the separation of infected populations from unaffected individuals.⁴ This separation, stated Huremović, was effected through a combination of methods such as isolation as a means to separate populations infected with communicable diseases, shelter-in-place as a variant of quarantine, and the maintenance of a sanitary cordon for the restriction of movement of people within a larger, defined geographic area.⁵ Perhaps the dearth of touch marking all of these methods can be historically traced to the beginnings of the concept of social distance—a concept that was fleshed out in the Bogardus Social Distance Scale.

American sociologist Emory Bogardus (1882-1973) developed his Social Distance Scale in 1924 to ethically interrogate the United States of America's white supremacist prejudice against Asian immigrants in general and Japanese-Americans in the state of California in particular.⁶ This prejudice that Bogardus intended to question, was manifested through the segregation of Japanese-Americans in the early twentieth century. The act of segregation, Bogardus implied, was articulated by the physical distance that a more powerful body empirically maintained from the body of his perceived other, thus depriving this other of familiar touch. Through this absence of touch, the other was made to bodily inhabit empty space as the site of the pure existence of humiliation, as jurist, politician, and social activist Bhimrao Ramji Ambedkar (1891-1956) had put it in the context of the dalit body.⁷ It was the

infiniteness of space, then, that could be said to have paradoxically defined the internment camps within which a multitude of Japanese-Americans found themselves confined during the Second World War.⁸ After all, the practice of internment connoted the lack of an empathetic mutuality of touch between white American and Japanese-American skin. This lack rendered Japanese-American bodies unable to geographically locate themselves in a community unbounded by alterity connoting an encounter delineated by the want of affectionate material touch from the power-wielding other.⁹ Such alterity constituted the lived experience not only of Japanese-Americans, but also of African-Americans in the American south, haunted as both groups were by segregation.¹⁰ The realisation of this fact led Bogardus to subsequently think of extending his Scale to study social distance as a marker of white American prejudice against mulattoes.¹¹

I emphasise the matter of fleshly touch as a marker of intimacy by drawing upon the work of Robert Park (1864-1944), an American urban sociologist and a precursor to Bogardus in the study of social distance. Park had argued that Bogardus Scale could help "reduce to something like measurable terms the grades and degrees of understanding and intimacy which characterize personal and social relations" in the United States.¹² Evidently, then, a poignancy marks Bogardus Scale, given its connotation of the lack of the reciprocity of "understanding and intimacy" between two groups. Social distance, I would accordingly claim, implies the forced insertion of space between two fleshly bodies, with the more powerful of the two bodies denying the subjugated body intimate and fraternal touch on self-proclaimed grounds of ethnic or caste superiority. Unsurprisingly, social distancing as a medical practice is marked by the spatial separation and quarantining of individuals, that is, by the situation of these individuals in a state bereft of touch.

German sociologist Georg Simmel (1858-1918), Park's guru, had added that the absence of tactile closeness reduced the ethnically stigmatized body in the United States to a "potential wanderer."¹³ Simmel's point, I think, makes light of a larger problem within the juridical framework of the United Nations, according to which nomads and wanderers find "all places they visit [to be] part of their usual environment...their country of residence."¹⁴ From this perspective, I suggest that the absence of the convivial mutuality of touch finds more resonances in the figure of the refugee—a figure who, lacking sociably intimate touch, never feels at home in the world, shorn as she is of "any place of usual residence to which to refer."¹⁵ Groping for fleshly contact as a means to phenomenological grasp a geographic area she occupies, the refugee, in bodily terms, can be said to drift in empty space. Perhaps, then, the figure of the refugee is inseparable from social distance as contextually descriptive of the picture of the tangibility of segregation that Bogardus paints.¹⁶ The lack of the intimate touch of the empirical other, I thus conjecture, marks the bodies of citizens who are deprived of their political rights—an act of deprivation that renders these bodies unable to determine the worlds they liminally inhabit, owing to their pure experience of alterity.¹⁷

Though Bogardus and Park had applied the concept of social distance only to Asian-American and African-American bodies, I propose that the dalit body crystallises the concept by embodying social encounters with alterity through the very fact of its physical existence in the circuit of caste. I trace my proposition to the fact that the dalit body was theoretically codified solely in terms of untouchability as far back as 1768 in British East India Company officer Alexander Dow's *The History of Hindostan*.¹⁸ Perhaps, then, the dalit body, in theory, floats in spatial distance in the absence of the touch of the other, marked by a phenomenology of alterity in caste-Hindu society.¹⁹ Through a convergence of these factors, the concept of social distance, in conjunction with the figure of the refugee, can conceivably help us grasp the position of the dalit as a citizen of the Indian nation-state. After all, if the body of the dalit bears overlaps with the figure of the refugee in their commonality of inhabiting geographies of social distance, these overlaps may allow us to fall back on the refugee to tease out a dalit's political rights. To unravel these rights, then, we first need to conceptualise the dalit body (and, if we dare, a dalit consciousness) in the absence of touch.

An Assay at Touching the Dalit Body

The dalit's occupation of space marked by the dearth of the touch of a caste-Hindu 'friend' theoretically produces a condition for the caste-Hindu to maintain perennial dominance over the dalit body. This is because the dalit's capacity to inhabit the space of her body becomes crippled: owing to the absence of the touch of a 'friend,' a dalit is left un-homely in her body, oscillating between entrapment within and alienation from the body. This oscillation defers the possibility of the dalit body being definable as anything but 'bare' and, by that rationale, located beyond categorisation as 'human' in some platitudinous Enlightenment-inflected sense.²⁰

The closing of spatial distance, human geographer Paul Rodaway suggests, is a prerequisite for a body to be able to locate itself in its world, touch as an active sense being integrally involved in a body's perception of space and its consequent relationship to place.²¹ Needless to say, by this logic, the skin is the fundamental means by which a body acquires its sense of the world— or, to be more precise, of the world it finds itself limited to inhabiting.²² This is significant because, according to Aniket Jaaware, touching an object would be tantamount to laying claim over it,²³ making possession of the sensuous geography of one's world indivisible from one's ability to exercise autonomy over one's body. To put it differently, one's haptic autonomy allows one to be at home in one's world. However, a dalit's ability to be at home in her body is compromised in more ways than one.

As the labouring body on the back of which the privileged edifices of caste-Hindu economy, society, leisure, and power are built, the dalit body is subjected to the prejudiced operation of segregation. The rationale behind this operation of prejudice through separation in terms of space—if prejudice can or, indeed, need be rationalised—is that in terms of touch, the dalit body is

framed within waste. It is therefore primarily perceived from a caste-Hindu position as an object that would evoke what Martha Nussbaum calls "projective disgust"²⁴ implying disgust displaced by the privileged upon marginalised peoples or groups²⁵ because the latter are apparently, in their very existence, 'impure' "like vomit or feces."²⁶ Privileged communities accordingly punish marginalize depopulations by cordoning them off on the grounds that in their 'impurity,' these populations exemplify the "basely animal," as opposed to the "truly human."²⁷ 'Primary disgust, however, is constituted by objects that a privileged body itself excretes— objects in a state of decay that make a "truly human" body confront the fact of its own putrefaction and the eventuality of its corporeal death.²⁸ By the logic of these two kinds of disgust, dalit bodies are rendered objects of projective disgust and cordoned off in spaces sans the 'human' touch of caste-Hindus— that is, in a state of social distance— because they work on waste as the stuff evocative of primary disgust.²⁹

The dalit body's being trapped in a *cordon sanitaire* by the operation of projective disgust need not, however, be quite literal: cleaning the excreta of the "truly human" body in caste-Hindu households, dalit janitors may find themselves segregated in and through plain sight by being overlooked into invisibility.³⁰ Rendered un-homely in the world through this state of social distance in the economy of caste, a dalit would ostensibly feel unsettled by her fleshly isolation in the humiliation of alterity.³¹ Unlike the primary disgust that a privileged body would face, the disgust exuded by a dalit body upon itself, encased in waste, could estrange the consciousness residing in it. After all, the gruesome forms that the dalit body's location in waste historically assumed, would probably have forced the body into perennially confronting the instant of its death and the concomitant fact of its expendability. For instance, dalits in the south of Bihar, threshing crops during the first harvest since the early-twentieth century, had to bodily absorb the deadly microbial matter released by the crops during this threshing, if only for the benefit of caste-Hindu landowners' bodies and lives.³² *Doms* have generationally cremated corpses and also dissected decaying cadavers in early-twentieth century medical colleges in Bengal, thus having had to expose their bodies to the decaying material that the objects of their work released.³³ At a time when vaccination against cowpox involved the arm-to-arm method of transferring bodily fluids contaminated by disease, most of the vaccinifers available were only dalit children.³⁴

In more figurative roles, dalits, as participants in rituals in caste-Hindu Bengali households, symbolically absorbed the death-dealing 'touch' of goddesses of epidemics like smallpox and cholera, thus emblematically protecting the caste-Hindu inhabitants of the households from these epidemics.³⁵ In the process, the dispensability of their bodies was spelled out to them in terms of disease and death. In a similar capacity, dalits in northern India functioned as scapegoats in rites representing the expulsion of diseases from villages.³⁶ Existentially, though the enactment of the role of the scapegoat or that of the absorbent of epidemiological material would not make the dalit body wallow in death, it would— as with all the roles I have

outlined so far— ontologically wound any consciousness inhabiting the body. This consciousness would, after all, find itself in a cycle of continued negation and depletion because of the marking of its physical habitat in terms of lowness. The cycle of projective disgust atrophying the death-bearing dalit body would, indicates Ambedkar, eventually shatter this perpetually negated consciousness into ruins,³⁷ displacing the 'plague' of the body upon these ruins to mark them as epitomising a "moving moral plague."³⁸

In an effort to escape death as their empirical fate, the ruins of the dalit's wounded consciousness, drifting in the quarantined space of their fleshly habitat, would attempt to escape this habitat and float into the space outside the body. Needless to say, they would be unable to execute any such escape. The oscillation of these ruins between the unwillingness to stay and the inability to leave their sensuous geography would continue *ad nauseam*, marking the body in terms of a gap between itself and the ruins of the consciousness trapped in it. Such a gap would make the body cavernously yawn into existential bareness— a bareness that would coincide with the body's inability to claim the category of 'human' for itself. After all, the caste-Hindu body would already have claimed possession of this category by displacing its own contagion and death upon the dalit as its empirical other.

Perhaps, though, the ruins can lay claim to being 'human' by having the untouchable dalit tongue testify to their ontologically-wounded state. This, though, is an act of testimony that is deferred into impossibility. After all, the ruins occupying the bare dalit body would themselves disavow the body in which the tongue resides. Furthermore, within an ontologically-inflected juridical framework of rights, Nussbaum would hesitate to prescribe such a project of testimony because though the law recognised that some dehumanised figures— like dalits— experienced emotions, only those emotions that the consecrated traditions of Western law validated as "human experiences," could help a body attain political recognition as "human."³⁹ This juridical aporia notwithstanding, Dipesh Chakrabarty would consider the dalit body's appropriation of 'human-ness' necessary because in its absence, a dalit tongue could perhaps speak only after the ruins of consciousness had successfully executed their escape from the body. To clarify this point, Chakrabarty draws attention to the testimony of Rohith Vemula, speaking after Vemula had committed suicide.

The Importance of Being 'Human'

On January 17, 2016, the 28-year-old Vemula, then a doctoral student at the University of Hyderabad, committed suicide to make a statement with his body against his penalization by the University authorities— an act of penalization that he was subjected to for his participation in dalit activism.⁴⁰ His suicide letter was, by my reading, in essence, his tongue articulating the lot of the ruins of the consciousness that had once inhabited his body. This is why his tongue could speak only after the ruins had vacated his body and floated off into the infinitudes of space— a fate Vemula preferred not merely

because of his love for the work of astronomer and astrophysicist Carl Sagan.⁴¹ Vemula's suicide letter, in its cryptic non-linearity could, by his own abject confession, "fail to make sense."⁴² That is why I here perhaps mis-read the letter by casting it in a mould of linearity. This is an act for which I can only excuse myself by confessing to a calculated erring as the foundation from which I receive Vemula's message, sent as the message was by the unrecuperable tongue of an evacuated body.

In the letter, Vemula wrote that the ruins occupying his bare body had been devalued through the devaluation of his claim to being a "man," the fundamental denominator of a dalit as a 'man' being, according to him, that he be "treated as a mind" rather than as a "thing." Having been reduced by the powers-that-be to a "thing"— a non-human "monster" that only counted as a vote or, worse, as a statistic— Vemula had found an increasingly "growing gap between [his] soul and [his] body."⁴³ This yawning gap was the bareness separating the ontologically-scarred ruins of his consciousness from the body they occupied in a sociality of "loneliness."⁴⁴ The perpetual increase of this existential bareness defined the ruins of his soul in terms of the desire to float away from the body they were trapped in, reduced as these ruins were to feeling "just empty" and "desperate to start a life."⁴⁵ By committing suicide, the ruins were attempting to flee the body, to "travel to the stars" in search of "other worlds."⁴⁶ After all, these worlds would perhaps bear the promise of the intimacy of touch, thus affirming Vemula's body as historically constituted not in terms of death-dealing material but as "a glorious thing made up of star dust."⁴⁷ Though the threshold density of the touch of stardust composing these worlds would not necessarily be the same as the density of the wounded ruins of the consciousness floating toward them, the two would perhaps intimately intertwine in oneness, leading these ruins to gain the fullness of life through a caressing reciprocity of touch. Vemula's start of life after death— a state he could best describe as "after-death"— would thus be a phase in which he could feel at home in a world other than the fleshly one he had inhabited in alterity.⁴⁸ Unsurprisingly, he ended his letter by succinctly describing his journey from the bareness of his body to the fullness of life in "after-death," as a journey "[f]rom shadows to the stars."⁴⁹

Throughout his letter, Vemula underscores the need to recognise the "mind" of a dalit as that of a "man"— a 'human'.⁵⁰ Such an act of recuperation can perhaps be legitimately effected for the benefit of a dalit in keeping with the Indian Constitution's juridical emphasis on collapsing the distance between caste-Hindu citizens and dalits through an admission of their "EQUALITY."⁵¹ However, making 'human' equality across castes and classes workable in keeping with the letter of the law would require that we in turn recognise Western juridical and political yardsticks as necessary. After all, though these yardsticks categorise a 'thing' as a non-human figure,⁵² they simultaneously bear the possibility of granting recognition to a figure as a "man"— a 'human' in possession of political rights.⁵³ Indeed, if 'human,' as a juridical category, functions as a marker of political rights, it is interesting to note that Vemula had been reduced to a "thing" precisely by being allowed a

carnavalesque moment in which he could eloquently express a political right he possessed—a right that a caste-Hindu would possess in equal measure.

As a dalit, Vemula located himself in a chain of equivalence—the equivalence between “a vote...a number...a thing.”⁵⁴ Before discarding this chain as reductive, we should admit that within the parameters of the Western nation-state, the chain comprises three *almost* equivalent objects. After all, while the wounding reduction of a consciousness to a statistic or a thing might be in keeping with the neoliberal nation-state's administration of ‘things,’ the casting of a vote sees Vemula counteracting this act of administration by exercising political sovereignty over the Indian nation-state. In this sense, before setting out to start a life in a state of ‘after-death,’ Vemula leaves his mark as a “man” within the Western nation-state's paradigm of “Man” as a citizen in possession of political rights.⁵⁵ This allows us to make another observation about the dalit body.

I have conjectured at the start of my article that the dalit bears convergences with the figure of the refugee. After all, just as Vemula exercises popular sovereignty in an always already transitory manner—touching the ballot only to be reduced to a ‘thing’—a refugee is a figure in incessant transit—a figure who starts her journey into liminality as a citizen with political rights, only to find herself reduced to a statistical category within a statist administration of ‘things.’⁵⁶ However, the *bareness* of the dalit body, with contagion and death-dealing waste displaced upon it, marks the body in terms of dispensability, with its life unacknowledged within the economy of caste. This unsanctified dispensability, Giorgio Agamben would perhaps suggest, is not the same as the life of the refugee as *barelife*—a life that is politically deemed sanctified and needing to be killed despite the acknowledgment of this sanctity.⁵⁷ This would explain Vemula's possession of at least one political right, unlike the refugee who is stripped of all political rights to be killed.⁵⁸ Evidently, the resonances between the dalit and the refugee should not be overstated, though both are definable in terms of social distance and the search of tactile geographies of homeliness—geographies that would allow them to feel at home in the world. Is there, then, a counterpart to the figure of the refugee that we can examine—a figure that bears overlaps with the dalit and that can help bespeak a dalit's political rights in India? For the answer, I turn to Marathi dalit writer and activist Avinash Dolas's short story “The Refugee” (trans. 1992), set against the backdrop of the Bangladesh Liberation War of 1971.

“Desperate to Start a Life”

If social distance would leave the dalit body longing for the intimacy of touch, it would also have the body wandering in search of sociality sans alterity, as I have stated before. Challenging his fleshly habitation in alterity, Vemula demonstrated that when a dalit was liberated from her sensuous segregation as a thing, she could hunt for other worlds—worlds that bore possibilities beyond alterity. Caste being the inside that located the dalit body in the

humiliation of alterity, the liberation of the dalit from the circuitous logic of caste could free her to search for such other worlds. Santu, the 21 year-old Mahar protagonist of Dolas's "The Refugee," experienced this liberation from caste as he found himself evicted from a caste-Hindu dominated village, the outskirts of which he lived in. In perpetual exile from the un-homeliness of the village, once expelled, he found himself freed from living in a state of social distance determined by caste, thus gaining the opportunity to "start a life."

Living with his family in a Mahar settlement segregated from the village, Santu is disgruntled with his lot as a Mahar. The course of events that sets him off in search of other worlds begins when a Mahar woman from the settlement draws water from a well solely used by caste-Hindus. As retribution, the caste-Hindu inhabitants of the village beat the woman for having polluted the well with the 'impurity' of her body. To make matters worse, they stop giving the Mahars work, even depriving the Mahars of water and food.⁵⁹ Revolted by the violent response to the 'pollution' of the well, Santu resists the retribution heaped upon the Mahars. In response to his resistance, the caste-Hindus demand that Santu confess he has done wrong, seek forgiveness from them, and prostrate his body before them. If he refuses to do so, they vow to burn the settlement that Santu and the other Mahars of the village live in. Faced with this demand, Santu, instead of reducing his body to abjection, argues and "protest[s] for [his] rights" until his mother, to prevent further retribution upon the Mahars, pleads with him to leave the Mahar settlement— and, metonymically, the village— forever.⁶⁰ After all, according to his mother, a Mahar self-evidently has no rights. Predictably, Santu is unable to demand his rights in juridical terms through the mediation of 'human' as an indicator of equity: the plenitude marking 'human' as a category has been appropriated by the Mahars' caste-privileged aggressors.

Expelled from the charmed circle of caste and, by extension, from what seems to him to be his last opportunity of seeking intimate sociality despite alterity, the yawning of social distance before and behind Santu stretches to breaking point as the realisation dawns on him that "[h]e [i]s an outsider."⁶¹ Finding himself apparently devoid of the last promises of the convivial touch of his empirical other, Santu feels diminished to a 'thing' drifting in emptiness. Looking ahead of him, he thinks of the stretch of ground separating him from the village of his origin as perceptible only in terms of space: "It was as if nothing had happened. There was no village, and there were no people, no animals."⁶² Alienated in un-homeliness from his body which is now purely situated in humiliation, he fails to cognise his tears as affective markers of "human experience," saying to himself, "One shouldn't call them tears. This is just water. It...knows no other way but to leak out of the eyes like this."⁶³

As Santu arrives at a nearby railway station to board a train and fumble for other worlds, the social distance that ties him to his village snaps, allowing him to emerge from "[t]he tenuous folds of casteism [that had] hem[med] in *his mind*."⁶⁴ This emergence of the ontologically-wounded ruins of his consciousness from the emptiness of space into a "mind," manifests

itself as Santu grasps the sights and sounds of the railway station by disavowing caste-Hindu scriptural wisdom:

[W]herever you went, you'd find only human beings. Shameless, thieving, servile, wretched dogs who sit chewing the crumbs thrown to them, and *getting beaten like mad dogs*...Some bark at the morsels thrown to them—*just like me!* Thinking in this manner, he had called himself a dog.⁶⁵

Drawing on the discursive material he has inherited from caste, Santu realises he has accidentally alluded to the woman beaten in his village as a "mad dog" and has compared himself to a "dog" who barks.⁶⁶ He instantly disowns these thoughts— and the received wisdom of caste— to board a train on a journey to Bombay. His embarking on this journey annihilates his habitation of pure space by allowing him the opportunity to "start a life" beyond the sanitary cordon of a Mahar settlement, thus undoing his ties to caste.⁶⁷ A journey beyond such a cordon in a village can, after all, according to Ambedkar, allow the dalit as a "mind" to challenge preconceptions about her body being marked unto death by waste, bareness, and dispensability.⁶⁸

While on the train, Santu meets Surji, a refugee who has escaped being massacred in erstwhile East Pakistan during the Bangladesh Liberation War. Surji, like Santu, is heading for Bombay where he has relatives with whom he will put up.⁶⁹ In conversation with Surji who has also had to break ties with his place of origin, Santu is left in a tangle of thoughts:

A man leaves Bangla Desh [sic] to see his relations in Bombay. *The government of India gives shelter to thousands and millions of the homeless* [stateless persons from Bangladesh] *And here am I, a citizen of this country!* On one side there was Bangla Desh in turmoil and on the other, the community of the Mahars, in agony. One homeless Bangla Deshi [sic] was going back to his relations after twenty years. And *one Mahar, even after twenty years, was homeless in his own country.*⁷⁰

Leaving the inequity of social distance behind him, Santu may have begun to feel at home in his body. He is, though, yet to feel at home in the Indian nation-state. In essence, he is, after all, an internally displaced person [IDP]—a person who, in keeping with the definition of an IDP by the United Nations High Commissioner for Refugees, has had to leave his(un-homely) "home" because of "conflict or persecution."⁷¹ His expulsion from the village leaves him disillusioned because like all IDPs, he has to "rely on [his] own government for protection from persecution"— a government that seems palpably "unwilling to provide such protection."⁷² Indeed, Santu is well aware of the fact that the Indian state, through its indifference toward the Mahar settlement in his village— or to the lot of dalits as such— helps caste-Hindus 'keep dalits in their place,⁷³ so to speak. In this sense, the state shapes the Indian nation as what I would term a 'caste-nation'⁷⁴— a formation that estranges a dalit like Santu into the inability to articulate his political rights as a "man," a 'human.' This state of affairs leaves Santu romanticizing Surji's

refugee status as one marked by the privilege of receiving rights from the Indian state. Indeed, Santu ends up believing that among the two of them, *he* is the refugee, given his homelessness in the country of his citizenship.

Santu's belief that the Indian state is unconditionally sheltering millions of refugees from Bangladesh is, of course, misplaced: India was not within the international juridical regime for the protection of refugees in 1971, not having been a signatory to the 1951 Convention Relating to the Status of Refugees. Given the state's consequent abjuration of accountability to the United Nations, erstwhile Prime Minister of India, Indira Gandhi (1917-1984) could call for the repatriation of refugees from Bangladesh since at least June of 1971, the responsibility of the Indian state toward the refugees being rooted in humanitarian and not political grounds.⁷⁵ Though Indira promised that the refugees would be repatriated only if "conditions for their safe return were created" and if they could return in 'safety and dignity,'⁷⁶ which when embedded in a humanitarian framework, became malleable as juridical concepts. This malleability allowed Indira to withhold rations and the promise of future transport for refugees. In essence, then, Indira did not leave the refugees with much choice apart from that of self-enforced repatriation.⁷⁷ Surji, returning to his relatives in India after twenty years, may have been subjected to such self-enforced repatriation— a story that remains untold in Dolas's narrative.

Protecting/'Patriating' the *De Facto* Stateless Dalit

To merely view Santu's political status as that of an IDP might prove reductive. Santu does, after all, possess an excess over Surji because his journey will not end in self-enforced exile from the Indian nation-state. However, if Santu, alienated and expelled from the 'caste-nation' as a political formation, has to articulate his rights as a 'human,' he has first to be 'patriated,' that is, to be owned by the caste-nation in filiation shorn of alterity. Without this possibility of patriation, Santu, as an IDP, will be reduced to what the United Nations terms an "invisible citizen."⁷⁸ It is in such a state of invisibility that Vemula, casting his vote, left a transitory mark upon the ballot— a mark that, in its ephemeral visibility, facilitated his political reduction to a 'thing,' forcing him to seek liberation from the alterity of the caste-nation through suicide. How, then, might a dalit be juridically recuperated from her state of invisibility so that she can verbalise her rights as a "mind"— a mind that the caste-nation would distinguish as 'human' and that the Indian state would find itself under obligation to protect?

The first step toward the telos of recognising a dalit as 'human,' I would suggest, is to comprehend that her position as an IDP might be considered akin to that of a stateless person. After all, if Santu finds his body marked and disowned by the caste-nation, he is, within a rough-and-ready equation of 'nation' and 'nationality,' "*not considered as a national by any State,*" according to the 1954 Convention Relating to the Status of Stateless Persons.⁷⁹ However, the Indian state, as I have mentioned, has not been a signatory to the Convention. Furthermore, Santu has, in theory, not been

deprived of his Indian nationality, and is therefore still within the purview of Indian law. In this sense, he is a *de facto* stateless person—a person who, according to Charlotte-Anne Malischewski, might face a plight similar to that of the *de jure* stateless person, but for whose precise status the Convention has no legal definition.⁸⁰ Indeed, the only figure in whose case the bonds of nationality are legally recognised as having been loosened beyond remedy is the refugee.⁸¹

Having stumbled on the first step toward our telos, the second step, I would propose, is to acknowledge the fact that the Convention Relating to the Status of Stateless Persons draws on the 1948 Universal Declaration of Human Rights as its bedrock—"human beings shall enjoy fundamental rights and freedoms without discrimination."⁸² India, it should be noted, was not only a signatory to this Declaration,⁸³ but also contributed to its drafting.⁸⁴ By acceding to the Universal Declaration of Human Rights, the Indian state was and, presumably, still is under oath to fulfil the extension of "fundamental rights and freedoms without discrimination"⁸⁵ to all of its citizens, its self-location outside the Convention relating to stateless persons regardless. The 'human' rights in question would, by that logic, apply as much to the members of the caste-nation as to those on its peripheries, such as the dalit in her *de facto* statelessness. This applicability would grant a Santu, the status of 'human' by situating the Indian state within an international juridical regime of 'human' rights. Taking this point a step forward, I would assert that within the international regime promulgated by the Universal Declaration as a conduit, the Indian state would—once again, if only in theory—have no option but to assent to Santu's unspoken call for unmarked patriation within the caste-nation. After all, according to Article 15 of the Universal Declaration, "[e]veryone has the right to nationality," and "[n]o one shall be arbitrarily deprived of his nationality."⁸⁶ In this way, the human right of demanding patriation through the mediation of nationality as a filial bond, translates within the letter of the law into a political right that a *de facto* stateless person can voice. This filial bond would insist that the Indian state assume the responsibility of protecting the political rights of dalit and caste-Hindu citizens alike.

The problem inherent to the solution I have posited is that according to the 1955 Citizenship Act of India, an Indian citizen can lose Indian nationality through the most nebulous of causes—ensconced in the most enigmatic of legal terms—such as 'deprivation'.⁸⁷ Furthermore, the Indian state alone can address a problem that requires the bridging of the gap between Indian nationality and its loss,⁸⁸ making the expulsion of a dalit from the caste-nation imminent in spite of a perhaps transient moment of patriation. This would entrench a Santu within the fallacious belief that his mother tries to instil in him—that a dalit cannot claim the right to sociality without alterity from the caste-Hindu. That a dalit should face such a predicament is hardly surprising, given the fact that untouchability, though outlawed by the Constitution of India, is still in practice under the aegis of the caste-nation.⁸⁹

In the face of the conundrum I have outlined, I can only conceptualise a deferred end to the teleology for the recognition of a dalit as 'human,' that is, as a figure who can claim the right to situation outside alterity in the caste-nation. The foundation of the caste-nation is the fact that India is a Hindu-majoritarian state, with caste and untouchability functioning as the polarities that constitute the 'Hinduness' of the state. If the Hindu religion survives, caste and untouchability also survive, and if both are eradicated, the Hindu religion—and, by implication, any claim that India might have to being a Hindu-majoritarian state—dies.⁹⁰ With this death, the caste-nation and the dalit as closed and separate categories fade out. Until then, the call for the unconditional patriation of dalits within the caste-nation will continue, as perhaps will, in juridical terms, a duel to prove whether the Universal Declaration of Human Rights has humanitarian or political roots. The intention underpinning this duel will be the caste-nation's attempt to prove that 'humanitarian,' as a concept, is hollow and, by insinuation, separable from 'human' as some uncontested category, if only to deprive the dalit the opportunity of being recognised as 'human' in political terms. Until this last duel is resolved in favour of dalits, the dalit body floats in the alterity of *de facto* statelessness, segregated in social distance, seeking liberation from this distance in search of other worlds than the caste-nation. Waiting for the resolution of this duel, the only positionality we can assume is that of the futility of hope.

Notes

¹Following in the footsteps of Aniket Jaaware, I do not capitalise the 'd' of 'dalit,' if only to indicate that a dalit, in terms of a body marked by birth, would not necessarily be able to lay claim to a proper name. See Aniket Jaaware, *Practicing Caste: On Touching and Not Touching* (New York: Fordham University Press, 2019).

²B. R. Ambedkar, *Castes in India: Their Mechanism, Genesis and Development* (Jullunder City: The Awami Press, 1916), 19.

³For a discussion of the inaccuracy framing this determinant, see Kancha Ilaiah Shepherd, *Why I Am Not a Hindu* (California: SAGE Publications Inc., 2019), xi.

⁴Damir Huremović, "Social Distancing, Quarantine, and Isolation," in *Psychiatry of Pandemics: A Mental Health Response to Infectious Outbreak*, ed. Damir Huremović (Switzerland: Springer Nature Switzerland, 2019), 85.

⁵*Ibid.*, 89-90.

⁶Colin Wark and John H. Galliher. "Emory Bogardus and the Origins of the Social Distance Scale," *The American Sociologist* 38 (December 2007): 390.

⁷Gopal Guru, "Experience, Space, and Justice," in *The Cracked Mirror: An Indian Debate on Experience and Theory*, eds. Gopal Guru and Sundar Sarukkai. (New Delhi: Oxford University Press, 2012), 99.

⁸David K. Abe and Allison Imamura, "The Destruction of Shinto Shrines in Hawaii and the West Coast During World War II: The Lingering Effects of Pearl Harbor and Japanese-American Internment," *Asian Anthropology* 18, no. 4 (June 2019): 266-281.

⁹Aniket Jaaware, *Practicing Caste: On Touching and Not Touching* (New York: Fordham University Press, 2019), 182.

¹⁰Wark and Galliher, "Emory Bogardus," 386.

¹¹*Ibid.*, 389.

¹²Robert E. Park, "The Concept of Social Distance," *Journal of Applied Psychology* 8(1923): 339.

¹³Wark and Galliher, "Emory Bogardus," 390.

¹⁴C. Michael Hall, Dieter K. Muller and Jarrko Saarinen, *Nordic Tourism: Issues and Cases* (Bristol: Channel View Publications, 2009), 10.

¹⁵Ibid.

¹⁶Given the long history of segregation from the intimacy of touch that comes with the territory of social distance, I find it no surprise that well into the World Health Organization's third press briefing on Novel Coronavirus Disease, Dr. Maria Van Kerkhove, American infectious disease epidemiologist and a participant in the briefing, added a caveat to erstwhile working definitions of social distancing. In the first of the two of these briefings concerning Novel Coronavirus Disease (Virtual Press Conference, 11 March 2020), Dr. Michael Ryan, Executive Director of the World Health Organization's Health Emergencies Programme, had used 'social distancing' to self-evidently imply 'physical distancing,' while in the second briefing (Virtual Press Conference, 18 March 2020), he had used the two terms interchangeably. Perhaps to imply that the historical problem of social distance was ingrained in the medical practice of social distancing, Van Kerkhove qualified Ryan's idiom by saying, "[Y]ou may have heard us use the phrase physical distancing instead of social distancing and one of the things to highlight in what Mike [Michael Ryan] was saying about keeping the physical distance from people so that we can prevent the virus from transferring to one another; that's absolutely essential. But it doesn't mean that socially we have to disconnect." The third press briefing in which Van Kerkhove makes the point I have alluded to, see World Health Organization. COVID-19, 20 March 2020.

¹⁷Giorgio Agamben, *Means Without End: Notes on Politics*, trans. Vincenzo Binetti and Cesare Casarino (Minneapolis: University of Minnesota Press, 2000), 15-28.

¹⁸According to Dow's text, anybody excluded from the "four principal [castes]," of the Hindus, were "for ever [sic] shut out from the society of every body [sic] in the nation," becoming members of the "Harri" [sic] caste in the process. Nicholas Dirks conjectures that this "Harri" caste that Dow writes about, is manned by figures Dow refers to as "untouchables." See Nicholas B. Dirks, *Castes of Mind: Colonialism and the Making of Modern India* (Princeton: Princeton University Press, 2001). Ambedkar had paved the way for the outlawing of untouchability in a formally decolonised India in the first draft of the Indian Constitution, with those subjected to untouchability being subsequently, at least in the letter of the law, identified as 'Ex-Untouchables.' However, Barbara R. Joshi rightly argues that the term 'Ex-Untouchable' romanticises untouchability as an issue blighting the past in India, leading her to persist in using the term 'untouchable' in the context of the Indian present "not to demean but to prevent euphemisms from obscuring what is often a persistent reality." See Barbara R. Joshi, "'Ex-Untouchable': Problems, Progress, and Policies in Social Change," *Pacific Affairs* 53, no. 2 (1980): 193.

¹⁹Gopal Guru, "Experience, Space, and Justice," 2012.

²⁰Martin L. Davies ed., "Introduction: The Enlightenment: Something to Think About" to *Thinking about the Enlightenment: Modernity and Its Ramifications* (New York: Routledge, 2016), 2.

²¹Paul Rodaway, *Sensuous Geographies: Body, Sense and Place* (New York: Routledge, 1994), 42.

²²Ibid., 44.

²³Jaaware, *Practicing Caste*, 33.

²⁴Martha C. Nussbaum, *Hiding from Humanity: Disgust, Shame, and the Law* (Princeton: Princeton University Press, 2004), 129.

²⁵Ibid.

²⁶Ibid., 107.

²⁷Ibid.

²⁸Ibid., 171.

²⁹I am aware that my effort at rationalising untouchability is problematic because a dalit need not be marked by untouchability through some phenomenology of waste. Ambedkar has pointed out that a village would indeed effect the territorial segregation of dalit bodies by having them interned behind "a *cordon sanitaire*...a barbed wire...a sort of cage," in ghettos lying on the outskirts of "[e]very Hindu village." However, he has also indicated that such segregation as a marker of the 'impure' was unnecessary. After all, the very fact of caste-Hinduness binding the village was enough to mark the dalit body as 'untouchable,' with the absence of the familiar touch of the caste-Hindu ensuring that "[t]he Untouchable has no escape from Untouchability." In both articulations, though, Ambedkar insists that the habitation of dalit bodies lies in social distance. See Jesús Francisco Cháirez-Garza, "Touching Space: Ambedkar on the Spatial Features of Untouchability," *Contemporary South Asia* 22, no. 1 (2014): 37-50, 42-43.

³⁰Dipesh Chakrabarty, "The Dalit Body: A Reading for the Anthropocene," in *The Empire of Disgust: Prejudice, Discrimination, and Policy in India and the US*, eds. Zoya Hasan, Aziz Z. Huq, Martha C. Nussbaum, and Vidhu Verma (New Delhi: Oxford University Press, 2018), 9-10.

³¹Gopal Guru, "Experience, Space, and Justice," 99.

³²Gyan Prakash, *Bonded Histories: Genealogies of Labour Servitude in Colonial India* (Cambridge: Cambridge University Press, 1990), 31.

³³David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley and Los Angeles: University of California Press, 1993), 1-3.

³⁴Ibid., 141-142.

³⁵Ibid., 124.

³⁶Ibid., 176. ; The spatial distantiating of the dalit body through the act of expulsion is, in this case, unsurprisingly redolent of social distancing as a practice that involves the separation of infected populations from uninfected individuals. Given the discursive trajectory from social distance to social distancing, it is no coincidence that the unwitting assumption of a death-dealing virus is, today, entrapping the dalit in the clarion call of her own body, while concomitantly segregating her body in pure space through distancing as if her body *is* the Novel Coronavirus. See the testimony of dalit scavenger Polamma in Priyali Sur, "Under India's Caste System, Dalits are Considered Untouchable. The Coronavirus is Intensifying that Slur," *CNN*, April 16, 2020. <https://edition.cnn.com/2020/04/15/asia/india-coronavirus-lower-castes-hnk-intl/index.html> .

³⁷I use the term 'ruin' here in the sense in which Walter Benjamin utilises it in his notes on the *Arcades* project. According to Benjamin's notes, a ruin is an object that the historical past has prevented from reaching fulfilment, making this object consequently emblematised decay. However, the object also bears the promise of being graspable as a seamless whole if one makes the ethical effort to read it not as an object of merely empirical but also transcendental proportions. This effort can unmark the ruin and take it toward fulfilment through the intervention of "humanity" as a lens mediating the act of reading it. See Walter Benjamin, *The Arcades Project*, trans. Howard

Eiland and Kevin McLaughlin (Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 1999).

³⁸Gopal Guru, "Experience, Space, and Justice," 90.

³⁹Nussbaum, *Hiding from Humanity*, 50.

⁴⁰Dipesh Chakrabarty, "The Dalit Body: A Reading for the Anthropocene," in *The Empire of Disgust: Prejudice, Discrimination, and Policy in India and the US*, eds. Zoya Hasan, Aziz Z. Huq, Martha C. Nussbaum, and Vidhu Verma. (New Delhi: Oxford University Press, 2018), 1.

⁴¹P. Pavan, "The Value of a Man Was Reduced to His Immediate Identity," *Bangalore Mirror*, January 18, 2016. <https://bangaloremirror.indiatimes.com/news/india/killed-dalit-student-aspired-to-become-carl-sagan/articleshow/50628141.cms>.

⁴²Ibid.

⁴³Ibid.

⁴⁴Ibid.

⁴⁵Ibid.

⁴⁶Ibid.

⁴⁷Ibid.

⁴⁸Ibid.

⁴⁹Ibid.

⁵⁰Pavan, "The Value of a Man.;" In an interview, Marathi dalit writer Sharankumar Limbale (1956-the present) has said that "economic issues are not of import to us [dalits] in isolation. Along with those, we have issues of our self-respect, our fundamental rights, our status. 'We are human beings': This language...is of even greater importance to us than economic issues...Before anything else, we are human beings—we will first talk about this. This is because we have not yet been recognised as human beings." See Sharankumar Limbale, *Towards an Aesthetic of Dalit Literature: History, Controversies and Considerations*, trans. Alok Mukherjee (Hyderabad: Orient BlackSwan, 2004), 140.

⁵¹The word 'equality' is in capitals in the draft form of the Constitution. See Joshi, "'Ex-Untouchable,'" 193.

⁵²Nussbaum, *Hiding from Humanity*, 50.

⁵³Ibid.

⁵⁴P. Pavan, "The Value of a Man."

⁵⁵Agamben, *Means Without End*, 15-28.

⁵⁶Ibid., 5.

⁵⁷Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life*, trans. Daniel Heller-Roazen (Stanford: Stanford University Press, 1995), 8.

⁵⁸Agamben, *Means Without End*, 15-17.

⁵⁹Avinash Dolas, "The Refugee," in *Poisoned Bread*, chapter trans. Y. S. Yalamkar, ed. Arjun Dangle (Hyderabad: Orient BlackSwan Private Limited, 2009), 253.

⁶⁰Ibid.

⁶¹Ibid., 248.

⁶²Ibid., 249.

⁶³Ibid., 248.

⁶⁴Ibid., 249.

⁶⁵Ibid., 250. Emphases added.

⁶⁶The sudden switch from "human beings" to dogs can be understood if one views the dalit body through the lens of untouchability as handed down by Hindu scriptural texts: even the most empathetic classical Sanskrit texts contain references to dalits masked as narratives about dogs. Wendy Doniger ties this to the fact that Hindu

scriptural material often portrays dalits as eaters of the cooked bodies of dogs. This, according to Doniger, is in keeping with the Hindu religion as such in that within the parameters of the religion, "you are what you eat." See Wendy Doniger, *On Hinduism* (New York: Oxford University Press, 2014), 488. The scriptural portrayals Doniger refers to cannot be dissociated from death-dealing waste as a determinant of dalit bodies: dogs are not quite welcome in Varanasi—a city hallowed by the Hindu religion—because they are perceived as "dirty...wandering over the cremation *ghats*, feeding on whatever they might find there," that is, on decaying corpses. Also see Lawrence Cohen, *No Aging in India: Alzheimer's, The Bad Family, and Other Modern Things* (Berkeley: University of California Press, 1998), 263.

⁶⁷Dolas, "The Refugee," 251-252.

⁶⁸Jesús Francisco Cháirez-Garza, "Touching Space: Ambedkar on the Spatial Features of Untouchability," *Contemporary South Asia* 22, no. 1 (2014): 46.

⁶⁹Dolas, "The Refugee," 252.

⁷⁰*Ibid.*, 252-253. Emphases added.

⁷¹UNHCR Teaching about Refugees, "Internally Displaced Person," streamed on October 23, 2017, *You Tube* video, 2:29, [youtube.com/watch?v=DCzpVQkencw](https://www.youtube.com/watch?v=DCzpVQkencw).

⁷²UNHCR Teaching about Refugees, "Internally Displaced Person", *You Tube*, October 23, 2017.

⁷³Gyanendra Pandey, *A History of Prejudice: Race, Caste, and Difference in India and the United States* (Cambridge: Cambridge University Press, 2013), 38.

⁷⁴By using this term vis-à-vis caste-Hindus, I am not disavowing the fact that caste is practiced in India in religions other than the Hindu religion.

⁷⁵Peter Grbac, "India and Its 1971 Refugee "Problem"", in *McGill Blogs, McGill Human Rights Interns*, July 28, 2014,

<https://blogs.mcgill.ca/humanrightsinterns/2014/07/28/india-and-its-1971-refugee-problem/>.

⁷⁶*Ibid.*

⁷⁷Paula Banerjee, Module F: Ethics of care, public health, and the migrants and refugees, in *Fifth Annual Research & Orientation Workshop in Global Protection of Migrants and Refugees* (online), Calcutta Research Group, November 18, 2020. Paula Banerjee pointed out that the South Asian countries had not been signatories to the 1951 Convention Relating to the Status of Refugees. The reason, Banerjee stated, was that these countries had reservations about the non-refoulement clause constituting Article 33(1) of the Convention. According to the non-refoulement clause, "No Contracting State shall expel or return ("*refouler*") a refugee in any manner whatsoever to the frontiers of territories where his [or her] life or freedom would be threatened on account of his [or her] race, religion, nationality, membership of a particular social group or political opinion." Evidently, if the Indian state in 1971 be a case in point, the South Asian countries wanted to retain the leeway to repatriate refugees by force if necessary—a leeway that they would not have been permitted as signatories to the Convention Relating to the Status of Refugees. See UNHCR. *Non-Refoulement Obligations Under International Law. Advisory Opinion on the Extraterritorial Application of Non-Refoulement Obligations Under the 1951 Convention Relating to the Status of Refugees and Its 1967 Protocol*.

⁷⁸United Nations, "Invisible Citizens—The Challenges Facing Internally Displaced People (Explainer)," streamed on November 28, 2018, *You Tube* video, 2:09, <https://www.youtube.com/watch?v=hGg13b1Ssxc>.

⁷⁹For a detailed discussion on the definition of the term 'Stateless Person' according to the 1954 Convention relating to the status of the stateless person, see UNHCR,

introductory note to *Convention Relating to the Status of the Stateless Persons: Text of the 1954 Convention Relating to the Status of Stateless Persons* (Geneva: UNHCR, 2014), 6. Emphasis added.

https://www.unhcr.org/ibelong/wp-content/uploads/1954-Convention-relating-to-the-Status-of-Stateless-Persons_ENG.pdf

⁸⁰Charlotte-Anne Malischewski, "Legal Brief on Statelessness: Law in the Indian Context," in *The Robingya in South Asia: People Without a State*, eds. Sabyasachi Basu Ray Chaudhury and Ranabir Samaddar (New York: Routledge, 2018), 140.

⁸¹Ibid.

⁸²UNHCR, *Convention Relating to the Status of the Stateless Persons*, 5.

⁸³Satvinder Juss, *Human Rights in India* (New York: Routledge, 2020).

⁸⁴Miloon Kothari, "Remembering India's Contribution to the Universal Declaration of Human Rights," *The Wire*, December 20, 2018,

<https://thewire.in/rights/indias-important-contributions-to-the-universal-declaration-of-human-rights>.

⁸⁵UNHCR, *Convention Relating to the Status of the Stateless Persons*, 5.

⁸⁶Michelle Foster and Helene Lambert, *International Refugee Law and the Protection of Stateless Persons* (Oxford: Oxford University Press, 2019), 57.

⁸⁷Malischewski, "Legal Brief on Statelessness," 144.

⁸⁸Ibid., 141.

⁸⁹Joshi, "'Ex-Untouchable,'" 193-222.

⁹⁰Kancha Ilaiah, *The Weapon of the Other: Dalitbajjan Writings and the Remaking of Indian Nationalist Thought* (Delhi: Pearson, 2010), xxvi.

In Search of Healing: Healthcare Inequities and Internal Migration in India

By

Deeksha *

Introduction

People living with chronic medical conditions have travelled across geographies through centuries in pursuit of treatment, conducive climates and technology. Human movements to access better healthcare facilities, spanning across the spectrum from the spiritual to the biomedical, are rather commonplace across the globe. Over the last two decades, academic and policy attention in this context has been primarily focused on medical tourism, a deeply contested term, which primarily implies a North-South movement for affordable and, most often, elective medical treatments. Within this more extensive, one-size-fits-all umbrella term, intraregional and domestic movements for healthcare emanating from unequal regional development and other factors like war, violence, etc., are often subsumed without much attention. Over the decades, the terminologies have moved towards an increasingly critical understanding of the phenomenon, conscious of its social, political and economic underpinnings.

Intraregional travel for medical treatments precedes the development of medical tourism in the region. Recent studies have shown that intraregional travel within South Asia is an important aspect of human mobility in the region and needs closer scrutiny to explore various facets of medical travel. Very interestingly, Hudson and Li quote Cohen, highlighting that the emergence and expansion of the medical tourism market are owed more to the intraregional movement of medical travellers in the developing world, and medical tourism from the West to these destinations began only after the medical hubs were well-established. The trajectories of intraregional migration for healthcare are varied but follow pre-existing and fairly established patterns of labour migration as in the

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case of Bangladeshi health-seeking migrants in Singapore and other forms of South-South medical travel.

India is one of the leading global destinations for medical tourism and South Asia as a region is the focal point of medical tourism in the world. While the income and opportunities ushered in by the medical tourism boom have been a significant contribution to the region's economic development, it has simultaneously highlighted the glaring inadequacy and inaccessibility of quality healthcare for India's low-income patients. In this context, India makes an interesting geographical and social space, wherein access to quality healthcare is too irregular, varying not only by region but also by class, caste, gender and other factors. Moreover, illness and disease are important contributing factors to poverty in India and other parts of the developing world.

In an extremely mobile society, like India, internal migration is diverse, a phenomenon across class, caste, gender and other social locations. The focus has been primarily on labour migration, which does constitute a large proportion of migrant movements. In the wake of the COVID-19 pandemic and the subsequent migrant crisis in India, it can be claimed that migration is reasonably well-researched but poorly understood as a social and cultural phenomenon in the country. Migration to access healthcare, despite being a popular mechanism to cope with the unequal development of health infrastructure and services in some parts of the country, remains an underexplored area of study. While I understand migration for healthcare as a distinct process with nuanced intricacies, to study it within the realm of migration in India's context enables one to widen the knowledge on migration and reach beyond the binaries of push and pull.

In this paper, I focus on internal migration for healthcare in India, looking specifically at cancer patients migrating to access healthcare in the metropolitan city of Mumbai, Maharashtra. Through an urban ethnographic approach, I draw from the everyday life of migrant patients and their families and caregivers, to explore the phenomenon of migration for healthcare as it pans out in urban centres in India. How does this contribute to the broader debate on migration patterns? I conceptualize migration for healthcare as the phenomenon of travelling to another destination, usually inter-state, to access medical treatment for chronic conditions over a period of time. I go with the term healthcare, instead of medical, as the participants of the study are migrating to seek secondary and tertiary medical treatment rather than elective or advanced treatments, resulting in crucial differences in experience. The ethnographic study locates the migrant for healthcare at the crossroads of migration, health-seeking and the urban space. In the next section, the phenomenon of migration for healthcare is analysed within the public healthcare context of India, tracing the country's experience with healthcare as a public good and the subsequent neoliberal turn in the 1990s. The lack of affordable and quality public healthcare is the main push factor for individuals migrating to access healthcare. In the third section, I draw from ethnographic interviews with patients and their

families, in Mumbai, who are seeking cancer care at a prestigious oncology hospital. Through a glimpse of their everyday life in the city, the paper explores vulnerabilities and challenges which characterize the migrant journeys of those seeking access to healthcare. In conclusion, I argue that it is essential to conceptualize migration for healthcare as distinct from other forms of migration, internal labour migration, as well as medical travel.

While migrants seeking healthcare are most often referred to hospitals in these cities by their local referral hospitals, the role of the hospitals in the city is limited to providing medical treatment. Most public hospitals in the cities do not have the required infrastructure to assist and accommodate a large number of local and outstation patients seeking healthcare. Patients, and their family members, are often left to fend for themselves in unfamiliar cities and a diseased situation. Such an illness experience is therefore not limited to seeking treatment but is characterized by an unanticipated— and, in most cases, an unwanted— encounter with the city. That experience, lived daily by large numbers of migrant patients and their family members, requires study.

Migration for Healthcare and India's Healthcare Trajectory

Historically, cities have been hubs of medical care which, besides providing healthcare to its own urban population, also provide tertiary and quaternary care to the rural population. In a post-neoliberal world, the nature of cities has undergone a tremendous change with global capital pouring in and shaping cities in instrumental ways. In contemporary times, cities as concentrations of medical care have been taken to a global level with the advent of private hospitals and clinics which tap into world-class medical expertise, technology and facilities, and attract local and global patient-consumers.

While independent India ushered in a journey of development with a particular focus on health and education, and conscious investments in these sectors, the shift in the development approach of the 1980s changed the contours of development in the country to a growth-centred paradigm, expecting the benefits of economic development to 'trickle down'. The subsequent growth of the private sector in medical care and shifts in investments exclusively into population control created pressures on the existing healthcare planning and structure to change. The Structural Adjustment Plans of the International Monetary Fund and the World Bank made unprecedented healthcare reforms a must in India. Health-sector reforms promised innovation in the planning and execution of health systems and introduced terms like 'new public management' and 'public-private partnership' with the potential to invigorate health systems in developing countries. However, the way in which the Structural Adjustment Plans panned out in India and other developing economies resulted in the healthcare system suffering irreversible cuts in public-sector investment. Donor-driven priorities of health planning and management were initiated

and privatization of medical care accelerated. The dominance of the private sector in healthcare continues—consisting of individual, qualified, unqualified or underqualified practitioners, who provide primary level, outpatient care and are located both in urban and rural parts of the country. In secondary healthcare, nursing homes of varying bed strengths, quality and capacities are mainly concentrated in urban areas except for states where private-sector growth is high. Tertiary-care provision by the private sector is limited to large cities and consists of multispecialty hospitals offering inpatient and outpatient care and have grown to become one of the biggest beneficiaries of government subsidies in the form of loans and land.

The historical trajectory of healthcare in India has led to significant gaps in health services, with rural India lacking secondary and tertiary services and urban India enjoying a concentration of those services, both in the public and private sectors. What is often called ‘the urban bias in healthcare’, then becomes a factor necessitating internal movements for healthcare from rural areas and small towns to cities. The dominance of the private sector as the choice for healthcare provisioning—in both inpatient and outpatient categories as well as urban and rural areas—is presently well established. 75 percent of outpatient care is provided by the private sector while 55 percent of inpatient care is received from the private healthcare providers. And yet, the use of public hospitals continues to have a ‘pro-poor’ trend with people in the lower-income quintiles using them more than those in the upper quintiles. There is also a sharp increase in the average expenditure on healthcare as assessed in the seventy-first round of NSSO data. Amidst the debates on universal health coverage and an insurance-led approach to universalizing healthcare, it is interesting to note that coverage of government-funded insurance schemes is only 13.1 percent in rural India and 12 percent in the urban areas. The benefits of the government-funded insurance schemes have not reached the neediest patients. They are still far from providing financial protection and raise concerns regarding the insurance-led healthcare schemes being introduced in the country as public provisioning of healthcare services.

Nearly 70 percent of India’s healthcare expenditure comes from the households’ out-of-pocket expenditure, while the government’s contribution is limited to one-fifth of the total 4.2 percent of the GDP spent on healthcare in India. Such a pattern of out-of-pocket expenditure has been found to have a visible implication on impoverishment and catastrophe owing to healthcare expenditure. Out-of-pocket spending refers to any direct expenditure by households, including all kinds of payments to health practitioners, suppliers of pharmaceuticals, therapeutic appliances, and other goods and services for improvement in the health of individuals, and is typically a part of private health expenditure. Healthcare in low and middle-income countries is often paid for out-of-pocket by the people. It is well known that high out-of-pocket spending for health brings a financial burden on families and it also influences the health-seeking behaviour with delayed treatments. Catastrophic spending on health occurs when a household reduces its basic expenses over a specified period, sells assets, or accumulates

debts to cope with the medical bills of one or more of its members. Studies in India show that the chances of impoverishment owing to catastrophic health expenditure is higher among rural households as compared to their urban counterparts and also among those who seek private medical care rather than the public health facilities. The lack of robust and quality public health infrastructure in rural areas makes rural populations increasingly at risk of seeking treatment from private facilities and, hence, incurring substantial health expenditures.

The impact of macro policies and expenditure trends on healthcare trickle down to the lives of the most marginalized in our country in the form of a financial burden, sometimes escalating to high levels of debt, catastrophic payments and a cycle of impoverishment that becomes difficult to overcome. While infrastructural deficits vis-a-vis public healthcare facilities are a characteristic of the lives of many in India, the impact of expenditure on healthcare may have negative repercussions on essential aspects like education and nutrition of other members of the family as well.

The phenomenon of migration for healthcare exists across a rural–urban continuum with individuals and families moving to the cities to access medical treatment for prolonged periods. Sharma and Naraparaju explain that according to NSSO data for tourism in 2014–15 alone, there were 36.6 million health and medical-related trips in India. Of these trips, 28.7 million were in rural areas and 7.9 million were in urban areas. 92 percent of the trips were within state boundaries. More than 60 percent of these trips were in the states of Uttar Pradesh, Maharashtra, West Bengal, Tamil Nadu, Bihar, Kerala and Rajasthan. The average duration of a health-related trip is two days, and it is assumed that these trips are not for severe health conditions. The average expenditure per health-related trip is Rs. 13,654 in rural areas and Rs. 21,437 in urban areas. Being the only official source to gauge the internal movement for healthcare, the numbers suggest that while only 8 percent of health and medical-related trips take patients and their family members outside state boundaries, the number remains considerable. In the case of complicated and chronic medical conditions such as cancer, these trips can be as long as over a year.

Migrants seeking Healthcare and their Places of Belonging

In our village there is no doctor or hospital to go to but there is a compounder who can be called for in case somebody is sick. Most often his *golis* (tablets) work and there is no need for doctor and all. It is not like he has studied *dactari* (medicine) ... but he can read and write and for one year he worked at a medical shop in Bettiah. This is how people learn ... so he can give injections; he has tablets for all diseases. He is called to our house also when the men are unwell. He is the doctor in our village ... he treats everyone. If there is something that he doesn't understand or his *golis* don't work, then he only suggests taking the patient to Bagha ... where they say big doctors sit in hospitals. But in the village, everyone trusts the compounder with all treatment ... old, young, everyone. — Dulari Devi, 36.

Dulari's account of her experience with healthcare in a very remote village in Bihar is reflective of the still very elusive nature of basic healthcare in pockets of the country. She is accompanying her husband for his cancer treatment in Mumbai. While the healthcare system in the rural parts of India has not extended and expanded adequately, especially in states like Bihar, newer health concerns have definitely seeped into these regions, including the prevalence of medical practitioners having only nominal know-how about conditions like cancer wherein early detection is the key to effective treatment. The absence of good quality, institutionalized and accessible networks of medical care and treatment results not only in delay in the right treatment worsening the medical condition but also depleting the already meagre financial resources of patients and their families.

The participants of this study came primarily from villages and small towns with very few of them hailing from smaller cities of the country. A majority of the research participants belong to states which have shown poor demographic indicators and have a significant percentage of their population below the poverty line. States like Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh lag behind the national average in healthcare and have been historically deemed as the 'demographically sick' states of the country and continue to face deficits in healthcare infrastructure and services resulting in poor health outcomes. Apart from healthcare services, these states, along with states like Orissa and West Bengal, fare poorly regarding poverty alleviation. According to the OECD Economic Survey, data from 2011-12 indicates that the states of Assam, Bihar, Jharkhand, Uttar Pradesh, Orissa and Madhya Pradesh fall below the national average regarding rural poverty, and West Bengal and Maharashtra do only slightly better. The regional and spatial disparities of income are reflected in the inability of poor patients in these states to seek private healthcare and who, instead, embark on city-ward journeys to access public-funded and affordable healthcare services. It is also important to highlight that considering the rampant rural poverty in the states mentioned above, the burden of healthcare expenditure for patients from these states is magnified in the instance of a necessary migration to the city to access healthcare, bringing a continuum of poverty and deprivation to their lives in the city.

The regions and states to which the research participants belong are also indicative of the social and cultural variations which exist not only amongst these states but also concerning the urban agglomerations like Mumbai and New Delhi, which boast of a cosmopolitan culture. Aspects of everyday life like food habits, language, routine and ways of interpersonal exchange vary in significant ways, and these diversities stand out uniquely in the almost homogenized urban landscape. Amidst the discussion on economic differences and social and cultural diversity, one ought not to forget the sheer physical distance which separates these spaces, spanning from a distance of not less than 1,000 km in the case of most participants. The vastness of the distance along with arduous train journeys increases the difficulty of mobility, restricting patients and their family

members from commuting regularly between these distant locations. While distance and crowded trains are factors discouraging their mobility back to their homes, the uncertainties and lack of understanding associated with illness are essential in understanding the reasons why patients and their family members prefer to remain within proximity to the urban hospital during their treatment.

Before coming to Mumbai, we spent Rs. 1 lakh on treatment for the illness. We did many tests for my wife, 3-4 hospitalizations in Raipur, and so many expensive medicines and treatment for 4-5 months. Doctors told us it is a simple infection, but things never got better. We felt cheated; all our savings were gone before we were referred to Mumbai. — Mukesh, Chhattisgarh.

Mukesh is accompanying his wife for cancer treatment and his narrative explains the frustrations of accessing affordable and quality healthcare in even the capital cities of many Indian states. In most cases, patients and their family members spend huge amounts of money before reaching a reliable and quality healthcare service. Many participants also raised concerns about their lack of trust in local private and public hospitals, leaving them with no other option but to journey to the city for trusted options in healthcare.

Patterns of Migration for Healthcare

After getting treatment from the local doctor and ayurvedic doctor in Saharanpur for about six months ... without any improvement in the condition of my husband's ulcer of the mouth, the doctor finally asked us to go to AIIMS in New Delhi ... The first emotion was obviously very difficult ... we got a sense that it is something serious. From Saharanpur, where we lived, Delhi is 5 hours away by train ... so going to Delhi was not very difficult at least to think about. I quickly spoke to my neighbours and they agreed to look after my children during the day and feed them. I would make all arrangements for their school and take a train at 4.30 a.m. to reach Delhi around 9 a.m. For the first few days we commuted daily from Saharanpur ... it was very difficult and tiring but we could come back to home and our children. Treatment at AIIMS was very slow ... we would get time for OPD once in 7-10 days but would have to be there for tests, reports and all that. Then we contacted our *guruji* in Saharanpur and he told us that we can go live in the *gurudwara* (Bangla Saheb) in Delhi ... then things got a little convenient. We knew about Delhi from others ... our local MLA was also helping us with his contact in AIIMS ... Although it was our first time in Delhi or in any other big city, the people were like us, it was easy to understand directions, food was like what we ate. After waiting for 6-7 months to get regular treatment in Delhi, our doctor referred us to Bombay. — Anita Verma, 43.

Relocation to the city to access healthcare, in most cases, looks like the relocation of the entire household. The patient is accompanied by a female family member who becomes the primary, informal caregiver. She is the spouse, mother or sister in most cases and is responsible for food, clothing and other aspects of daily routine which women traditionally look after. The role of the female caregiver also has affective importance in most cases. Patients are often also accompanied by a young, male relative, usually from the same village, to assist the family in negotiating the complex urban systems and enable them to access all available services. These kin are usually literate and responsible for helping the patient get charity and donations from various trusts in the city and providing assistance in the hospital. In cases, where the female caregiver is literate, she takes up the roles and responsibilities of the kin and provides all forms of support to the patient. There are instances when patients, especially those from nuclear families, are compelled to bring along young children to the city, not only disrupting their education but also risking their health and safety in the unfamiliar city spaces.

However, very often, some family members return to the village and are replaced by others. During the agricultural period, many of the caregivers who work in the field are replaced in the city by older family members for a brief duration. It is also common for relatives and friends from near and far to visit patients in the city and become part of the phenomenon of the migration for healthcare.

Significantly, the journey to cities like Mumbai and Delhi is not the first preference for most patients, which is obvious for practical reasons like referrals required, but also characterizes the experience of seeking healthcare for cancer patients. Migrants for healthcare make considerable out-of-pocket expenditure over a period of some months before the diagnosis is confirmed. The participants of the study reported expenditure on medical services—including doctors' fee, diagnostic tests, medicine, hospitalization and surgeries—amounting up to Rs.1 lakh before they even reach their destinations in the cities. With private hospitals and practitioners reaching remote locations and often projecting an image of technological advancement and quality, many participants avail of such medical services and end up spending huge amounts of money with hardly any benefits in the treatment process. However, the spending is not limited to the services offering treatments within the Western medicinal paradigm, and many participants of the study have engaged in ayurvedic and homeopathic treatments, along with some cases where money was spent on spiritual healing by taking the patients to spiritual *babas* and temples.

Expenditure is one aspect of the experience of medical treatment before reaching the city and accessing its health services. It is coupled with the common incidence of unjustified delays in seeking treatment and seeking inappropriate and wrong treatment. Especially in the case of cancer treatment, where delays in appropriate treatment can become a matter of life and death, the psychological impact of delayed treatment is immense amongst participants. However, even upon reaching the city and

accessing treatment in the hospital, many participants continue to engage in alternative treatments like ayurveda and natural remedies, sometimes secretly, ensuring that their journey into the city is not equivalent to a rejection of local and cultural healing practices.

In most cases, after the nearby town, patients travel to the closest city with available medical service and most of them prefer hospitals which are either run by the government or by charitable trusts. This movement to a nearby city can be understood as migration to an intermediate location before having to travel to larger cities. Migrants for healthcare choose cities and towns which are within proximity and offer assistance through existing networks. For example, Vicky decided to seek treatment in Patna owing to some villagers who worked in the city and could help with appointments, food and a place for the family to stay. On the contrary, Janaki Devi and her husband chose Varanasi for treatment owing to physical proximity to Varanasi, added to their familiarity with the pilgrimage city. Patients follow different trajectories and use their networks and social capital to access medical treatment in such a scenario. Both Vicky and Janaki Devi belong to Bihar and yet chose to seek treatment in different cities. While Vicky depends on migrant networks to facilitate treatment, Janaki Devi relies on networks of spirituality to arrange for the process of treatment.

Livelihoods Left Behind

A chronic condition like cancer in the family translates into disruption of work and regular life. For low-income households, it also means unprecedented financial difficulties. The occupational profiles of the research participants of the study indicate that most families have some or the other source of regular income and, while the income might be small and insufficient to pay for healthcare, the families would not fall into the category of 'poorest of the poor'.

I am from Darbhanga district in Bihar, but worked in construction in Hyderabad for the past eight years. We have two acres of land in the village; my father and the women of the family look after agriculture. Now I am not fit to work in construction at all, so the whole family and my treatment is dependent on the land. — Deepak, 37.

While participants like Deepak have been migrant labourers living and earning in Hyderabad for the last eight years, many participants own and cultivate small tracts of agricultural land in their villages. Others have salaried jobs in the private sector where, in the wake of illness and extended leave from work, there are no expectations of any financial support. Many participants also ended up selling or mortgaging their land to pay for their treatment and, apart from the mounting debt, also do not have any means of livelihood to return to. Regarding livelihood, the differences are vast. While some participants have the comfort of owning

land, others have a somewhat hand-to-mouth existence. What is common to all participants is the financial and social capital required to undertake the journey to the city, with as little as Rs. 500 in their pockets. The occupational profile of participants raises concerns about the inability of specific populations to become migrants for healthcare.

Owing to their extremely vulnerable financial situation, many migrant patients or their family members are compelled to do odd jobs in the city to meet daily expenses. Many take up jobs in the hospital's vicinity as NGO volunteers, security guards and also tailoring and stitching jobs offered by some NGOs. Many of these migrants for healthcare merge seamlessly into the labour migrants of the city— not only sharing livelihoods but also housing and existing migrant networks.

Conclusion

This paper only presents a glimpse into the lives of migrants for healthcare in the city of Mumbai, and their journeys characterized by frustrations and loss but also hope. While access to oncological care brings them to the city, the everyday life in Mumbai goes beyond the medical aspect of the migration process. As many participants highlighted, making a living in the city becomes as important as accessing medical care.

A socio-economic profile of the participants of the study provides an important insight into the lives and experiences of migrants for healthcare before their journey to the city and sets the context for a study of their everyday lives in Mumbai. The experiences of the participants indicate that the states which lag in national averages of development indicators send many patients to seek treatment in the cities. Patients often travel thousands of kilometres to access healthcare in the city; this journey is no short commute, as one may imagine.

It was common for participants to go to other cities and towns before being referred to Mumbai for treatment and make significant amounts of out-of-pocket expenditure not only on private healthcare but also on alternative medicine and healing practices, which turn out to be ineffective in most cases. Regarding livelihood, the participants have some source of steady income at their places of residence or are engaged in the informal sector in labour and private salaried jobs. The occupational profile reflects the financial status of the families and indicates that the participants in the study had or could arrange the prerequisite financial and social capital to undertake the journey to the city. The narratives presented in this paper enable us to understand the phenomenon of migration for healthcare in depth, highlighting aspects which establish that movements for healthcare need to be seen as distinct from both popular understandings of internal labour migration as well as international and intraregional medical travel.

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Conflict and Public Health Services in Suchetgarh, a Border Village of Jammu Region

By

Marvi Slathia *

Introduction

Borders are both physical as well as imaginary. The state of Jammu and Kashmir with its unique and distinct history and political dynamics— being both cause and consequences of the Indo-Pakistan conflict throws up a more complex border narrative that cannot be simply defined by marked territories and presence of a formidable fencing. The border of the Jammu and Kashmir came to the limelight since its accession to India in 1947. Being a Muslim majority region, Pakistan made combative attempts to encroach upon the areas which are now known as the Pakistan Occupied Kashmir.¹ The manoeuvring of Pakistan to encroach areas of Jammu and Kashmir led to the migration of lakhs of Sikhs and Hindu families to towards safer places, leaving behind a trail of destruction of their house and hearth, valuables and also losses of near and dear ones.² The pages of history explain why Jammu and Kashmir had to witness four full scaled war between Indian and Pakistan. But despite these wars, peace remains eluded over the border villages with incidents of ceasefire violations becoming a routine affair.

India shares 3,323km long border with Pakistan of which 221km of the International Border (IB) and 740km of Line of Control (LOC) falls in Jammu and Kashmir. This 221km long international border in Jammu stretches from Tehsil Akhnoor of district Jammu to district Kathua of J&K. The war hysteria has everyday prevalence in the minds of the people residing closer to the Indo-Pakistan border. This area has become insecure since the past few decades in the face of the repeated cross-border violence. The tension and fear escalated the large scale of temporary displacement of people

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residing on the edges of the borders of Jammu and Kashmir.³ The continuous shelling, till the recent past, made the life of border dwellers crippled and forced many to abandon their homes and migrate to safe zones on frequent occasions of cross-border firing between Indian and Pakistani armed forces along the fenced lines— leaving signs of trauma on people either physical or mental as an everyday affair in the lives of the border dwellers. In the last few years, especially since 2011 till 2020, the cases of cross-border ceasefire violation have seen an upward trend increasing the vulnerability of lives and livelihood of the residents at the edges of the borders. The year 2019 marked the highest number of ceasefire violation with 3200 cases out of which nearly 1565 cases were recorded after August 5, 2019 when the Central Government revoked the special provision under Article 370 and Article 35A granted to Jammu and Kashmir. These incidents affected the normal life of border residents, who had to frequently abandon their homes and are forced to live in makeshift accommodations in the safer place established by the government during the shelling at borders.⁴

This article provides the case for the border-edged village of Suchetgarh of Jammu district (Fig.1). Suchetgarh tehsil falls within a striking distance of Pakistan Rangers guns as the international border of Indo-Pakistan runs along the villages and often becoming the hotbed of public discussion whenever things get violent and tensions escalate between the two neighbours. A cloud of uncertainty and mortal danger perpetually hangs over the populace as it is never certain for how long the local life will remain normal. Ironically, the present situation stands in sharp contrast to the pre-partition days when the famous Jammu-Pakistan rail link passed through the area running towards Sialkot in Pakistan. The village Suchetgarh lies within a close proximity to Sialkot with a distance of only 11 kilometres (Fig.2). At present the village has a total of 1400 households of which majority are refugees either from Dev Batala, or from the adjoining villages of West Pakistan and few families are the settlers (Dogras) of the land residing before the 1947. The research draws on from the ethnographic field work conducted during 2016- 2021 among the zero-line residents of the village Suchetgarh. At the time of the fieldwork most border residents have adjusted to this lifestyle of uncertainty in their everyday life. But beyond the ground observations, it seems that their relationship with the non-conflict zone people is quite different as far as the benefits of the basic rights entitled to the masses by the government are concerned.

There are two kinds of questions I am delving in detail in the paper. First, how these border residents continue to face the brunt of conflict since the last seven decades with availability of minimal health care facilities? And second, how the government authorities are responding to the issues of health care requirements of the border residents particularly so that they can also lead a life at par with the citizens residing in non-conflict areas? The article suggests that normal living for the border residents is a core demand at present; they need a peaceful life like other citizens of non-conflict zones of Jammu. It will also show how the government schemes especially regarding the health care are being implemented in this area. Apart from this, the paper

will also try to locate and understand other special package or schemes of the government for the people of border residents. The data for the present study is collected from focussed group discussions and in-depth interviews with the residents, especially those who have bodily injuries, physical deformities and mental stress due to prolonged conflict in their habitations. The article will move back and forth between the experiences of conflict zone residents and the public health care services provided by the government in these areas to frame a critical analysis of the problematic through a qualitative lens.



Figure 1: R.S Pura tehsil of Jammu showing its villages and medical institutions, “Map of Jammu District Showing Medical Institutions,”
<http://www.jkhealth.org/admin/images/districtmaps/jammubig.jpg>

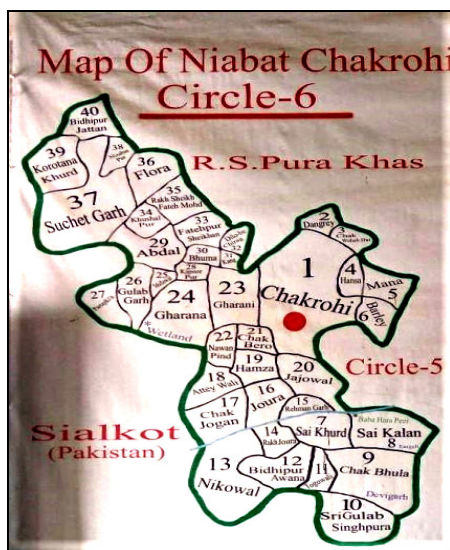


Figure 2: Naibat Chakrohi area of J&K indicating closeness of Suchetgarh to the border.
(©Author, tehsil Suchetgarh office on June 20, 2017)



Figure 3: Entrance gate of the Model village Suchetgarh (©Author)

Being with the Barbed Wire and Boundaries

Before 1947 the village Suchetgarh was dominated by Muslim inhabitants while Hindus formed a small minority; but after the partition of Jammu and Kashmir in October 1947, majority of the Muslims migrated towards Pakistan and their lands were given to the Hindu refugees by the elected government of Jammu and Kashmir.⁵ At present Hindus make majority of the village population; while on the basis of their caste composition, Suchetgarh has high percentage of Dalit families who are called West Pakistan Refugees (WPR) as they have migrated from Sialkot in West Pakistan. Other refugees in the village are *Jats* commonly known as *Chowhdabay* refugees from the Chamb Sector (Dev Batala) and few families of other backward castes are residing here. The village has one old mosque located at the centre of the village and nearly about nine shrines of Peer Babas located in different areas of the same village. The village is surrounded by lush green fields with fertile land and is best known for its indigenous Basmati rice and seasonal vegetables as well as for milk production. The village has an octroi border out post which is guarded by the Border Security Force (BSF) and has been developed as a tourist destination by the state government. The border outpost also has an old temple and two strong rows of barbed wire more than 10 feet in height that separates the last line of defence with Pakistan. The combat BSF jawans keep their guard along the fence lines as well as from the watchtowers. The Pakistani flag hoisted over a watchtower on the either side of the border could be easily seen from the fields surrounding the octroi, while Pakistan's fields

are easily visible to the naked eyes. The closeness of the Pakistan also means that the bullets fired from the guns of Pakistani Rangers easily landed into the houses of natives.



Figure 4: The watchtower in the picture is Pakistan (©Author)

From discussions with the elderly people of the village, one can get the idea how the border after partition of 1947 transformed the dynamics of the locality. Recalling the past, octogenarian Milkhi Ram said that there were no barbed wires separating the boundaries between Indian and Pakistani villages and people could move freely to either side. If the cattle of the villagers from India or Pakistan strayed to the other side, villagers would bring them back home moving freely between villages on either side. Milkhi Ram's family, like many other refugees, migrated from Sialkot during partition settling permanent lying Suchetgarh village and started agriculture wherever they got land. The village lands where the refugees started residing were owned by the Muslims before 1947. As per revenue records, ownership of majority of lands of village Suchetgarh still rest with the Muslims, who had migrated to Pakistan. Milkhi Ram said, "our fields were open till the year 1999. We used to work together along with Pakistani counterparts chatting with them as both speak could speak the same local dialect Punjabi. After the year 1999, when Kargil war broke out between India and Pakistan, borders were completely fenced and land mines were planted in the agricultural fields as part of preparation for war with Pakistan. Since then, the situation along the border took a different turn. Apart from the fence, which separate India and Pakistan at zero line, another fence has been erected by the security forces in Suchetgarh village, creating another border for villagers."⁶

Vast stretches of the agricultural land of the villagers have been sandwiched between the two fences, making the land of villagers out of bounds for them round the clock. Entry to this vast stretch of land depends upon the dictates of BSF personnel who have fixed timings to allow farmers to cultivate or to tend the crops. Even when the farmers are allowed to venture into the fenced portion of agricultural land through gates, the BSF jawans accompany the villagers during the entire period of work within the encircled fenced lands. The villagers can only have a glimpse of Pakistani counterparts but not even think to speak with them as BSF soldiers ensure the same. Villagers claimed that since the year 1999, the border in their village is similar to the border depicted in the Bollywood movies.



Figure 4: The gates from where the villagers have to move with BSF to work in the fields
(© Author)

The villagers also explained that as the refugees arrived in Suchetgarh, a new shift in the demography of the village took place. After Pakistan and India had fought their second battle in 1965 there started an influx of refugees from Dev Batala region. These ‘new guest’ refugees are called Chamb refugees. Joginder Kour who has served the village Panch of the Panchayat for past two terms said, “My family moved to village Suchetgarh during 1965 Indo-Pak war. We were allotted land here by the government and since then we are residing here.” Horrifying memories of the year 1965 are still fresh in Kour’s memory— “We had to leave our homes and hearth, lands, valuables, cattle beside other things during the war. Apart from feeling a loss of valuables, the physical torture, migration and settlement woes are so deeply etched in my mind and will only be erased with my death.”⁷ The land available

in the village, which was being cultivated by the WPRs were redistributed among the new guests, who came from Chamb area of Jammu and Kashmir.⁸ The WPRs suffered loss of lands to the new guests impacting their economy as the primary occupation of the villagers mostly depended upon agriculture and rearing of cattle especially the cows and buffaloes for milk products. Few were engaged in the menial jobs such as mason, labourer in the construction works, auto driver, carpenter and only handful were in the government jobs like Scale III and IV of state government or were serving in the paramilitary force, army but most of them were from the upper castes and not the Dalit families.

Causalities and Vulnerabilities at the War Zone

The residents of Suchetgarh said that the guns never fall silent here. Bullets can arrive any time during dawn or dusk often causing fatal injuries. Most of the villagers are poor and have no alternative to move from here. Those who are earning well and have financial resources to buy land outside the conflict zone have already migrated or are migrating. The three decades of the militancy in Jammu and Kashmir in general and the locational exposability to violence of this border-edged village compounded with the problems of health, education and roads and other infrastructural facilities made everyday living even more difficult for the villagers. The health facilities are poor in the village. The villagers depend on the BSF for their healthcare needs during the time of ceasefire violations and it depends on the whims and fancies of unit officers to help the residents with minimum facilities. The village has only one Primary Health Care Centre (PHC) with one MBBS doctor, two nurses and two paramedical staff. For severe health care services, the residents have to go to R.S.Pura Sub-district hospital, which is around 6-7 kilometres away from the village or to the Government Medical College(GMC) Jammu which is located nearly 25-30 km distance from the hospital.

On the analysis of the interviews with the locals it could be easily suggested that women and children are more vulnerable to become victims of the hostilities. The womenfolk cater to the houses as men of the family are mostly out for work. This increases the possibility of women getting killed or injured or being left with physical deformities during cross-border violence; and often the women have to take care of themselves in the process of recuperation. Resident of Suchetgarh, Rajkumari aged 45 years, injured in 2003 narrated the realities of her victimhood;

“Though we all villagers are aware that there are mines planted in the fields but we are uncertain about the exact location of the mines as the fields were not de-mined by the security forces after the year 1999. People are forced to visit their fields for different requirements as to cut green grass for animals to water crops or to harvest crops. I remember the day when I accidentally stepped on a mine while going into my field for nature’s call. A big bang occurred and I lost consciousness and later when I regained consciousness, I found myself in a hospital bed at Government Medical College (GMC)

Jammu. I was pregnant at that time and the first thing which came to my mind was that I would have lost my child but the child was fine. Then I thought about my other body parts and realised that I had lost my right leg in the blast. I remained admitted at GMC Jammu for one month as the deep wound was healing very slowly. After being discharged from GMC, I was again admitted at R.S. Pura Sub-district hospital for fifteen more days to get the wound properly healed. After few months, I delivered a baby girl. Though it was difficult to bear the pain caused by amputation of my right leg but God gave me courage to bear the pain. *Jo dukh deta hai bo uss se ladne ke himat bi deta hai.* Those were the most horrible days of my life.”⁹

The pain was palpable in her voice as she was fumbling while recalling the incident. On being asked what kind of support she received from the government, she replied that they did not have to pay for the daily charges at the government hospital where she was admitted, while rest of the expenditure on medicines and injections were borne by the family. Her prosthetic limb was donated by the Red Cross Society, Jammu. Even today when she has to change her artificial limb after every three years, the Red Cross Society renders help. Without this organizational aid it would have been too expensive for Rajkumari to fix and replace the artificial leg as the health care facilities are too expensive for someone poor like her who don't have any family person in government jobs from where they can get the money for treatment. Similar to her ordeal, many other residents share same details with whom I had in depth discussion during my visit at Suchetgarh village. Most of the respondents' reported that they don't even have a proper first aid facility in the village. Most of the time, help is voluntarily rendered by the youth of village by shifting the injured person during ceasefire violations from village to Sub-district hospital or GMC Jammu in their personal vehicles as the village has no regular public transport facility.

Referring to the case of the Rajkumari, the *Panch* of the village, Vikas Choudhary strongly opined that the incidents as well as responses of government machinery in the last few years made it clear before the villagers that government help would be negligible and villagers are left to fend for themselves during most of emergency situations. Choudhary further said the area has witnessed frequent cross-border hostilities causing regular casualties but the health care rendered by the only dispensary of Suchetgarh has negligible role to play. At the high time of firing, the doctor and the staff of the dispensary, who usually come from peaceful areas are unable to reach the dispensary as transportation facilities to the area is stopped. Vehicle movement on the roads leading to villages has been restricted by the administration. When the casualties occur, the villagers have to take responsibility to take care of the wounded while saving their own lives. “*Goli toh dekh kar ni aati hai, bo toh charo taraf se aati hai.* People are saving themselves by hiding inside the room, under the bed or in the community bunkers which are in a pathetic state.”¹⁰ During visit to the community bunker, I found that there was neither a proper toilet facility nor kitchen although it is meant to shelter 40-50 persons. The pregnant women, lactating mothers are more vulnerable and face hurdles on account of their special health requirements.

From infants to adults each one has to stay in these bunkers and there is no concept of maintaining privacy and hygiene in these bunkers. Such conditions inside the bunkers provide ideal breeding ground for the spread of communicable diseases among the inmates. The *Panch*, said, “We border residents are leading life similar to the animals as we are huddled together in the small space inside the bunkers with no concept of proper hygiene and privacy.”¹¹

The firing also affects the cattle stock of the residents, which is the mainstay of the rural economy. During the last firing in 2018-19, the villagers had lost a large number of animals. A single family of Suchetgarh had lost a total of seven cows as a mortar shell from Pakistani rangers had landed over the cowshed killing the cows. Vikas Chowdhary also said that they make efforts to save humans by taking shelter in the makeshift arrangements made by the government in schools or panchayats buildings but it is difficult to shift the animals. Because of these animals in the households the residents had to routinely come back to the houses during morning and evening hours to feed the animals. If some mortar shell struck an animal, it is not possible to take them to the hospital for surgery. Due to lack of surgery most of these animals die after few days from the injury caused by the splinters of the mortar shells.

The other residents of the village claimed that those who were killed in militancy related incidents in Kashmir valley were paid more compensation than those people who were killed by the stray bullets coming across the border. The villagers said that those who have splinter injuries remained in pain for years together without any compensation paid to them for the injury as well as any financial or other aid for the treatment of the injury. Children who are victims of the ongoing conflict are living without proper care and consideration. A case of two cousin sister depicts how public healthcare institutes are working in the conflict zone like Suchetgarh. Sakshi was 12 years old, when she had lost her vision in one eye due to a splinter injury during firing while Sanjana was 9 years when she had to undergo multiple abdominal surgeries following a splinter injury. On being asked what kind of help they received from the government, Kamlesh Devi, mother of Sanjana narrated the incident,

“Our courtyard was drenched in blood. We four members of the family were injured that day when the mortar shell landed in our courtyard. Our injuries healed with time. Sanjana was a little child when she had to undergo a five hours long surgery in GMC Jammu. The bullets had hit her in the abdomen and legs. The villagers rushed and took the cousin sisters on motorcycle to R.S.Pura Sub-district hospital which was around 10 kilometres away from the village. Though the government claims to have made all the arrangements for transportation to border residents during the time of firing and shelling and also to place ambulance to shift the injured to hospital but ironically nothing on the ground is available. We have spent over Rs.1.5 lakh on the medical treatment of both the girls and the treatment is still going on. We did not receive any help from any quarter expect for Rs10,000 from the civil administration and Rs.5,000 from the Red Cross Society. We feel to be treated as second class citizens in our own country. The politicians think that

border residents are meant for such conditions only and the benefits of the public welfare initiatives are only for rich and not for poor.”¹²

Mentioning about the case of the Sakshi, her aunt Kamlesh Devi narrated that they were unaware about her eye problem and thought that she was absolutely fine as she underwent all the medical check-ups in the hospital during her three days stay over there. But after two months her condition changed totally. There was swelling on her face and she reported of pain in the eye; and they initially thought it was due to cooking on earthen stove but after some days she reported of low visibility. It was only then that they went to the GMC Jammu, and found that her eye was hit by splinter causing the infection of her eyes. Doctor suggested to take her to Amritsar, as the eye needed a quick operation to prevent complete loss of eyesight. They moved to Amritsar where Sakshi underwent eye surgery and the treatment cost was around Rs.50,000. Doctors suggested her to take fish oil supplements for three months which was an additional burden to the already ailing family economy. Kamlesh said. “Even today her medicine like antibiotics and eye drops are still being used but due to lock down and Corona spread we were not able to visit the hospital and still waiting to get the things normal to have check-up of Sakshi.”¹³ The eye-problem hinders Sakshi from pursuing her graduate studies in Humanities and feels hopeless about her future ordeal in life and with numb eyes she said,

“I want to study more but due to my eye problem and due to poor financial condition, the family members want to marry me. We are poor and don’t have sufficient money for treatment and to pursue my education. Family apprehends that if I concentrate on studies and spend time on reading it might hurt the eye, so they don’t want me to pursue studies. I have to abandon my desire of studies. Without any financial help or aid from the government side sometimes I think if in the past if I would have got the proper treatment on time this won’t be a problem. I feel hopeless about my future, *Zindagi barbaad ho gayi hai* (My life has been ruined).”¹⁴

Kamlesh said that they just want that the government to give some pension to these kids who were the victims of the cross-border turmoil so that at least they could bear the cost of their treatment and with this financial support they won’t have to depend on the family. She said there is policy for compensation when someone lost their life but with injuries to the residents, there was a paltry compensation and that too is paid to only few.¹⁵ The firing victims have to carry scars and pain till their last breath.

These anecdotes of the border residents revealed the cases of death, destruction and physical deformities caused by the border skirmishes was the visible normal of border life. Repeatedly the residents felt that they were betrayed by the different political parties and no government had paid any serious concern to their problems. They felt themselves as second class citizens in comparison to the inland population.

Government's Role in Providing Health Care Facilities

Acknowledging the special needs of the people residing close to the border, the Government had launched Border Area Development Programme in 1986 and in J&K it was introduced in 1992-93.¹⁶ When enquired about the status of health services both the provider and receivers claimed that these schemes have failed in the border-edged villages. Dr. Raman Sharma working in the Primary Health Care Centre (PHC) of Suchetgarh, said that the government has upgraded the Primary Health Centre into a Comprehensive Health Care Hospital under Ayushman Bharat Scheme, which is an initiative by the government to provide health insurance cover to all families; healthcare facility at a lower cost and reduce morbidity, disability and mortality, further reducing need for secondary or tertiary care.¹⁷ Under this scheme the health and wellness centres will not only provide primary healthcare but also preventive, rehabilitative and curative care for an expanded range of services encompassing reproductive and child health services, treatment of communicable and non-communicable diseases, palliative care, elderly care, oral health, ENT, and basic emergency services. The healthcare centres will have both Mid-Level Health Care Provider (MLHP)/Community Health Officer (CHO) and Medical Officer (Rural/Urban). But the service provider on the ground said that, there is no availability of proper infrastructure and staff in the health centre in Suchetgarh village.



Figure 5: Two room Primary Health Centre of Village Suchetgarh (© Author)

Dr. Sharma, elaborating about the health issues and services at the centre said, “there is only one doctor, one nurse and one paramedical staff working at present in the upgraded PHC. With this minimal staff, how we can manage the population of over three thousand. Suchetgarh panchayat comprised of six villages, while five other villages which is part of this administrative unit are too far from each other. In spite of availing the benefits at this PHC they prefer to go to R.S.Pura Sub-district hospital or to the GMC Jammu as the upgraded PHC don’t provide them round the clock health services and other needful facilities. How can we turn a two-room dispensary into a running hospital when the infrastructural facility is only sufficient to give first aid treatments to the residents and other basic medicines for gastric problems, pain killers and common flu? Since Pakistan is just few kilometres away from Suchetgarh, during cross border tensions, the hospital did not even have an ambulance to shift the patients to Sub-district hospital or GMC Jammu. The village only get the ambulance from the Block Medical Officer R.S.Pura that too on demand and only in case of emergency. Even during firing incidents, no pre-arrangements like allotting an exclusive ambulance for the residents is made by the administration.”¹⁸

Describing about the other health issues faced by the people apart from splinter or bullet injuries, Dr. Sharma said there is high percentage increase in the cases of tuberculosis, high blood pressure, diabetics and thyroid among general people. Though these ailments are also common in the people of cities but the border dwellers are related to agricultural economy and have physical working part of their life. The stress level due to living under continuous threats might be responsible for such ailments. Though the people have coped up with the physical situations of the border but uncertainty over their life could be a determining factor. He further said that, people also hesitate to discuss about their health problems. There is a total population of 3600 in the panchayats but only 300 people are coming to the PHC for treatment while rest of the families follow traditional methods of treatment. They believe more in the supernatural powers and self-styled godman for their treatment.¹⁹ Dr Jagdish Thappa, former head of Psychiatric Disease Hospital Jammu said that people are not aware about the mental illness, if they witness such cases, they follow the line of *Jaddu, jadhjuek*, instead of visiting psychiatric hospital for proper treatment. They spend thousands of rupees for such treatment which results in no recovery of the patient. He had patients from the border villages who complained about anxiety, panic attacks and insomnia problems but if they aren’t treated in time the problem will get worse leaving their families disturbed.²⁰ He further explains that the ongoing violence has greatly impacted the psychology of the children. They use to play with guns and similar such games. During my visits to Suchetgarh, when I asked the children what their aspiration was to become in the future, majority of them responded that they will join the army and fight against the nation’s enemy Pakistan.

Raj Kumari who is an Accredited Social Health Activist (ASHA) of the Panchyat Suchetgarh said there are a lot of maternal issues in the village, women follow the poor dietary habits and most of them are anaemic with

blood haemoglobin ranging from 7gm/dl to under 10gm/dl. The ASHA workers provide them iron tablets and also assist them to go to the hospital for further treatment. Describing the trials faced by an ASHA activist, she said, 'I am also the frontline worker in the Corona awareness programme but I was not even paid my monthly salary on time. We are like contractual workers getting Rs. 2,000 per month with an additional Rs 1,000 as an incentive for the COVID-19 surveys. We ASHA workers and community health workers have been at the forefront of the COVID-19 battle, ensuring the safety of others at a great risk to our lives.' She further lamented of not having access to masks, gloves, PPE kits and sanitizers. Initially they were provided for with four masks and two small bottles of hand-sanitizers but they ran out of sanitizers in no time and the masks were torn within a matter of weeks. Even the health care workers were not paid a minimum salary on time, it was difficult for an ASHA worker to sanitize the women folk with no salary and large area of operations.²¹

Explaining about the problems of people in the conflict zone, Booth Level Officer (BLO) Bodh Raj, a government teacher by profession said there is a lack of awareness among the people about the different health schemes for them like the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) launched by Prime Minister Modi, Social Endeavour for Health and Telemedicine (SEHAT) scheme that extend health insurance coverage in J&K. Through this scheme free of cost insurance cover up to Rs. 5 Lakh will be provided to all the residents of the J&K. 'It's going to help all the class of people residing in the village. Through it's not an exclusive scheme for the border dwellers but surely we too will also be benefited.'²² However the facility is not an exclusive one for border residents and the city residents are also getting the same facilities despite having staying in peaceful zones.

Conclusion

The study was an attempt to give an insight into the condition of healthcare facilities in village Suchetgarh of tehsil Suchetgarh of district Jammu. It is evident from the field study that there are no proper health services available for the border dwellers, whose lives have been relegated to second class citizens. The relegation is not a deliberate attempt but could be attributed to the failure of the administrative structures to provide for the special requirements to reduce the vulnerabilities prevalent in border societies. Here I agree with Giorgio Agamben's 'bare life' concept where he refers that there is no priority to the quality of the life lived, and persons who are legally reduced to survive a mere life which can be subjected to any manner of violence with impunity. Such an understanding will provide an alternative image of the region where at one part of the region people are residing with all the basic rights and on the other side it has drastically created the 'other for the citizens.' Though the thorough plans of protection are framed at the government level, majority of the work remained confined to papers while the implementation part of the scheme is restricted to ensure security of the

border areas by erecting barbed fences and walls across the border and increasing gunman's number. In the high age of warmongeries', protectionism of the citizens should be the primary level of concern so that casualties could be stopped permanently but at the same time such an environment could be established so that the border dwellers be able to lead a healthy life with peace and other social justices ensured. The paper finds that everyday conflict has become a permanent problem for border-edged villages and they are fighting for their survival issues in their mundane life but also the hopes are continuously lingering for the better days.

Notes

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⁸The Chamb refugees had to migrate from the Chamb sector, a strategic area along Line of Control, which was attacked and occupied by Pakistan forces during the Indo Pak war of 1971.

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¹⁰Vikas Choudhary, Village Suchetgarh, R.S.Pura, interviewed by author, February, 13, 2021.

¹¹Choudhary, interview.

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Refugees and Migrants in Turkey: Differential Status and Access to Healthcare

By

Gonca Savas Dogan*

Introduction

The impact of the Syrian crisis on the lives of the people in the region and in Turkey has been devastating. At the same time, its effect on the lives of other groups of migrants is even further. Due to its geographical position, Turkey has been witnessing the flow of migration since its early history while bridging the East with the West, the South with the North.¹A vast majority of people have been moving from one place to another since early history, seeking better lives, more secure environments, stability with freedom; escaping natural or human-made disasters, economic deprivations, harmful cultural practices. Turkey has witnessed a significant proportion of this movement because of its geographical location neighbouring countries suffering from political and economic instabilities. While having a role as both a transit country and a country of immigration, Turkey is dealing with a diverse migrant population with different backgrounds and motivations, and with various claims in addition to their specific individual needs.

Before the Syrian crisis, the UNHCR was dealing with the registration and documentation of refugees and asylum seekers in Turkey. The main motivation of these groups of people was obtaining resettlement to a third country. Notably, in 2011 prior to the outbreak of the Syrian [c]risis, the number of foreigners under international protection in Turkey was merely 58,000² mostly coming from Iran, Iraq, Afghanistan, Somalia and other African countries. Turkey, with its geographical reservation to the Refugee Convention of 1951, is obligated to give refugee status only to “those fleeing as a consequence of ‘events occurring in Europe,’”³ and was dealing with comparatively lower numbers. With the perception of temporality, the legal

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Refugee Watch, 57, June 2021.

status or basic needs of refugees and asylum seekers did not raise any attention of the public or the government until the beginning of the Syrian crisis. A few NGOs, together with the UNHCR, were dealing with the immediate needs of that population and, if needed, government services such as healthcare and education were provided with the help of the advocacy and referral efforts of those organisations. At the same time, resettlement was one of the most critical responses to this vulnerable and limited population.

This practice changed sharply with the Syrian crisis and the consequent cross-border movement of the Syrian people to neighbouring countries. This movement affected Turkey the most. Turkey has its longest land border with Syria— around 911 km— and received more than 3 million refugees from Syria in a few years. This massive number of newcomers made Turkey the country hosting the highest number of refugees in the world and it has kept that position since 2014.⁴In addition to the Syrian crisis, the new instability in the region due to the threat of ISIS forced other people— prominently Iraqis— to flee from their lands. Only in Turkey, there are ‘around 4 million refugees and asylum-seekers, including almost 3.6 million Syrian nationals and close to 330,000 registered refugees and asylum-seekers of other nationalities.’⁵ The estimated number of Syrian nationals who moved to the neighbouring countries in the region is 6.6 million; another 6.7 million Syrians became internally displaced.⁶

In the last decade, it is not surprising that the migration issue mostly covers the political agenda in national, regional and global discussions and negotiations. It is also not surprising to see that host governments started to think about how to treat these people in terms of legal status, legislation, access to healthcare and education, social cohesion, livelihoods and protection. At the same time, this process created layers on the types of migrants. It produced legal statuses based on the country of origin, the motivation of the movement, and the claim. If a person escapes from fear of being persecuted based on his/her race, religion, nationality, membership of a particular social group, or political opinion, then he/she will be treated as an asylum seeker under international protection and will be provided refugee status after the process of registration and refugee status determination. However, if a person is a national of Syria or coming from Syria and crossed to Turkey after March 2011, then he/she will be provided with temporary protection by the public authorities in Turkey. Therefore, he/she will not be able to apply for international protection even though he/she has a well-founded fear of being persecuted in his/her own country of origin.

While the numbers increased sharply, resettlement also lost its meaning while turning into a small chance for the very vulnerable, minimal portion of the population. Under these circumstances, Turkey designed legal instruments for such a diverse group of people who had to stay longer than expected in its territory. Consequently, the Law on Foreigners and International Protection (LFIP) was introduced in April 2013, and the Temporary Protection Regulation was announced in October 2014. While these instruments can be seen as a big step towards the establishment of a

detailed and inclusive national legal framework, it still fails to cover all the layers and types of migrants, and thus provides an unequal distribution of rights and services to different groups of migrants.

In this paper, I will analyse how this uneven landscape— particularly concerning legal status— is produced, by whom and under what conditions, focusing on the provision of healthcare services. I will conclude with an analysis of how this uneven landscape affects the lives of migrants amidst the current national, regional and global discussions.

Background

In the last few decades, Turkey's policies towards migrants and refugees have been shaped and reshaped by specific events and can be seen as a direct reflection of the political developments at national, regional and global levels. This process in Turkey can also be interpreted as a transformation of the country from a source of emigration to a territory of transit and immigration. Before the Syrian crisis, there had been groups of migrants fleeing from persecution, or protracted crisis in their country of origin, or leaving their countries with economic motivations. According to Ahmet Icduygu and Deniz Sert, 'People from different parts of the South and East have begun to use the Turkish peninsula as a bridge to the West and the North, where they hope to find better living conditions.'⁷ The motivation behind these movements have been either obtaining resettlement, or to pass in transit towards Europe, or obtaining legal or illegal employment opportunities in Turkey. Before the Syrian crisis, public authorities in Turkey had limited motivation for designing legislative instruments to protect these groups and guarantee their access to rights and services while referring to itself as a transit country or a country for only a temporary stay of migrants. Its geographical reservation to the Refugee Convention strengthened this position,⁸ and the UNHCR has been the agency responsible for the documentation and registration of refugees and asylum seekers and for proceeding with refugee status determination, resettlement, and immediate assistance during their stay in Turkey.⁹

Before the turn of the millennium, there had been mass movements and consequent government-led relocation programs for migrants and asylum seekers in Turkey, such as for people fleeing from the Middle East because of the Gulf War or those fleeing the Balkans because of the collapse of former Yugoslavia. However, all of these crises were managed with ad hoc regulations in the absence of coherent migration legislation until the LFIP. While irregular immigrant workers contributed to the economy informally, they did not become a major concern until more than 3 million forcibly displaced Syrians began participating in the labour market.¹⁰

Because of the Syrian crisis, the variety of migrant groups diversified and caused different layers among the migrant groups. The first groups are asylum seekers coming from non-European countries, mostly from Middle East, Central Asian and African countries, seeking international protection, resettlement or economic gains. Second are the refugees under international

protection who went through the UNHCR refugee status determination process, were provided refugee status and documentation, and seek resettlement in Europe or North America— most of these individuals come from Iran, Iraq, Afghanistan and Somalia. Third, there are irregular migrant workers who work in the informal economy and send their savings to their families in Central Asian countries, and would like to remain outside the radar of public authorities. The main sectors that irregular migrant workers engage in are the textile, agriculture and service sectors, where informality is relatively high.

Due to the increasing tensions in their country, Syrians started to cross into Turkey in April 2011. In the first phase, public authorities decided to provide immediate and emergency response to the thousands of Syrians in temporary accommodation centres and anticipated that this crisis would have an end in a short period of time. However, within a few years, the crisis turned into a protracted one and the Syrian displaced population increased manifold. Thus, public authorities in Turkey declared a separate status in October 2014, namely ‘Temporary Protection’. Temporary protection regulation provides advanced level of access to rights and services, but limited to the Syrians or other nationals coming from Syria only after April 2011. In addition to its limitation of only targeting Syrians, this temporary protection status prevents Syrians from seeking international protection, thereby preventing them from seeking the durable solutions of integration or resettlement. Finally yet importantly, in addition to the Iraqis under international protection, there are the Iraqis who came to Turkey after 2014, escaping the threat of ISIS, who are provided with a different kind of status. They are provided with the humanitarian residence or short-term residence permit; neither can apply to international protection, nor benefit from the inclusive and extensive level of access to rights and services like temporary protection status. The main rationale for registering different groups of migrants would be explained with the insistence of the state to keep the duration of stay of these groups in Turkey as temporary. While there had been intense negotiations and policy discussions on how remaining in a temporary status in host countries impact migrants’ lives at national, regional and global levels, the decision on the temporariness of refugee groups or migrants remains at the discretion of sovereign states.

Status-based Access to Healthcare Services: The Uneven Landscape

The perception of temporality regarding migrants and their status in Turkey place the migrants into a situation where they cannot feel permanent, and their access to rights and services is seen as temporary. Different statuses for different groups of migrants with varied levels of access to rights and services and ad hoc legislation as a rapid response to the immediate needs, rather than a detailed and framed legislation, create an uneven landscape for access to services that changes over time and according to the resources available. This

uneven landscape results in inequalities, hostilities and unfair treatment and finally triggers social tensions between the host and refugee communities and among different groups of migrant communities.

Turkey has a comprehensive health insurance scheme mostly funded by the stoppage of the legally employed persons and tax incomes. Based on the principle of full coverage, the unemployed, students, or others out of this employment scheme are entitled to pay their general health insurance contributions to access the public healthcare services. Volkan Yilmaz argues that 'Despite the relative success of Turkey in establishing public health insurance schemes and developing a public capacity for health care service delivery since the late 1940s, Turkey's health care system has largely failed to institute equality of access to health care services where income is becoming a new source of differentiation among citizens in the domain of health care.'¹¹ He refers to income-based inequality among citizens when accessing healthcare services. When it comes to the migrants' access to healthcare, this inequality is not only limited to the income-level but also the legal, economic, social and cultural status. Each group of migrants has varied levels of access to rights and services regarding healthcare based on their legal status. Syrians under Temporary Protection (SuTP) have access to public healthcare services at the same level as Turkish citizens as per legislation, regardless of their employment or tax payment status.¹² However, their temporary protection status does not guarantee promotion to a migration status in Turkey in the future, nor the international status that refugees are entitled to and which guarantee additional protection such as no forced return or access to durable solutions. Nevertheless, the temporary protection regulation protects their access to services, including healthcare. On the other hand, Iraqis under humanitarian residence or short-term residence,¹³ asylum seekers, and refugees under international protection are entitled to regularly pay their general health insurance contributions to the Directorate General for Migration Management (DGMM) of the Ministry of Interior¹⁴ in order to have access to public healthcare. Illegal migrant workers, invisible or unregistered migrants have no access to public healthcare since registration number is a prerequisite for processing health assistance.¹⁵ Besides, there can be additional payments required for different healthcare service provision levels based on migrants' status and entitlements. Under these circumstances, it is natural to say that in addition to other barriers such as language and vulnerabilities, registration and legality are among the main barriers for migrants in accessing healthcare in Turkey.¹⁶ For the irregular or invisible migrants, the additional challenge is the absence of health insurance due to their illegal status. Therefore, they need to pay out of their pocket when applying to private or public healthcare institutions. A significant proportion of women who are in the country illegally said they could not apply to public hospitals because of the fear of being caught and deported as well as from the economic barriers.¹⁷

Migrants as ‘Public’

Each sector or discipline describes the term ‘public’ from its own perspective; however, the most inclusive referrals are ‘the people’, ‘the population’, ‘the common interest’, and ‘the governmental or government-related’. In the health sector, ‘public’ refers to the people, and ‘public health’ describes the health division which aims to protect the people via either preventive measures or by responding to contagious diseases, epidemics, pandemics and outbreaks. The World Health Organization (WHO) defines ‘public health’ as ‘the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society.’¹⁸ The components of public health are vaccination; mother-child health including new-borns’ follow-up; sexual and reproductive health; mental health; GBV response; environmental health; water, sanitation and hygiene; and elderly-care for non-chronic diseases. Public health requires a multidisciplinary approach protecting the health of the population via precautionary actions to prevent and mitigate diseases. ‘These populations can be as small as a local neighbourhood or as big as an entire country or region of the world’¹⁹— it is the whole world as we currently experience the COVID-19 pandemic. Public health, based on its nature, requires an inclusive and non-discriminatory approach, which differs from all other discussions of whether the migrants, refugees, asylum seekers and illegal migrant workers are part of the society; or whether their level of access to public services should be the same as that of citizens. Being part of the ‘public’ when it comes to accessing public health has different explanations and reflections in society. When there is a common, invisible enemy having a devastating nature, such as contagious diseases and pandemics, everyone should have access to preventive measures as a means of mitigating diseases— this view is as rational as it is humane. When there is an invisible but deadly threat targeting the public with no distinction of race, religion, age, gender or region, there is also no major objection to treating everybody equally and in equity. While each individual is a target and threat to the other, there is little challenge from society to count everybody as a whole. The ‘public’ in public health is the term which covers not only citizens and the registered foreigners or migrants, but also all the residents that can be both victims and transporters of disease. It is expected that there is a tendency to unite and collaborate against an enemy, and the people are expected to team up against a common threat. Such situations can be counted as emergency or extraordinary conditions; the services can be available for everybody, with all residents, whether citizens or foreigners, perceived at the same level. That is why when most social tensions among the host and the migrant groups arise from access to specialized healthcare services, access to public healthcare does not necessarily cause struggle between the host and migrant communities. While there are arguments, discussions, objections, even physical fights at the hospitals regarding foreigners’ access to specialized doctors, nobody argues about vaccination campaigns for refugees, family planning programmes available for migrant women, or sewage and sanitation investments in the

camps and temporary accommodation centers where refugees reside. By its own nature, public health should be as inclusive as possible in order to protect the health of everybody, and people know that preventive measures can only be beneficial when it covers everyone.

In this framework, it is observed that foreigners, migrants, asylum seekers and refugees become part of the 'public' when there is another health threat which can only be prevented through an inclusive approach. However, counting migrants as part of the 'public' does not guarantee their easy and straightforward access to healthcare services. While there is no documentation needed for the idea that public health is for everyone, barriers for refugees and migrants persist. While there is no bureaucratic barrier on paper for migrants' access to public health components, it can be said that differences in language, cultural practices and social norms, stigmatisation, and fear of being caught would quickly turn into stronger barriers. EU funds under the Facility for Refugees in Turkey (FRIT) and the international community's efforts through NGOs and UN agencies (primarily the WHO) try to increase access to public healthcare for everyone, including migrants. However, gaps and needs are still valid. While international and national NGOs tried to fill the gap in service provision for refugees' access to healthcare, the shrinking humanitarian space and the limitations mentioned earlier prevent the most vulnerable groups from accessing public healthcare services.²⁰ Family Health Clinics under the Ministry of Health are public service providers for primary healthcare in Turkey. There is an address-based registration system nationwide. Based on the intensity of the population in their area of responsibility, family physicians with their medical team provide public healthcare with primary responsibilities such as follow up of pregnant women and new-born babies, vaccination, and sexual and reproductive health. While this system is relatively new, the regulation was announced only in 2010; it has weaknesses and is not performing well in practice. With the increase in refugee population during the last few years, Refugee Health Centers have been established through the *Sihhat*²¹ project, providing services in other languages. However, the project was established as an alternative and not as a compliment to the existing services.

COVID-19 and Migrants

Since the beginning of 2020, the COVID-19 pandemic is the top agenda worldwide. The WHO declared human-to-human transmission of the corona virus on 14 January 2020 and announced COVID-19 as a pandemic on 11 March 2020. Turkey reported its first case on the same day and reported its first death due to the pandemic on 17 March 2020. In such a global and interconnected world, the virus spread quickly with the help of transportation and mobility networks. In a short period of time, most of the countries started to report cases and consequent loss of lives. After the first case was confirmed in China on 1 December 2019, it took some time for the world to accept this phenomenon and take preventive measures such as travel restrictions, hygiene measures, social distancing and self-isolation. The health systems in several

countries began to be overloaded immediately and even collapsed in countries like Italy, Brazil and India.²²

Turkey with its relatively strong and well-structured health system and ‘public health centralism’²³— easily implemented by the monopolistic approach of the presidency system— prevented the health system from collapsing. The Corona virus Science Committee was established with the composition of recognized professors from different and relevant medicine units, public health and vaccination specialists and biologists under the leadership of the Minister of Health, and held its first meeting on 22 January 2020. Since then, they regularly meet and monitor the situation, and submit their advisory reports and recommendations to the president’s office. In addition to the preventive measures declared in order to control the transmission level, the medical treatment response has also been strengthened with additional regulations such that all private, foundation and public health facilities harmonize their response to the pandemic and become available for everyone regardless of their financial, legal and insurance status. As of 13 May 2021, more than 5 million infected cases and 44,059 deaths due to the pandemic were reported in Turkey; worldwide, the number of cases identified was more than 161 million and among them 3.36 million have died.²⁴

However, the declaration of everyone’s free access to the treatment and preventive measures do not guarantee easy and equal access for everyone. Under such a complicated and uncertain situation, the vulnerable people become more vulnerable due to additional barriers such as physical barriers for disabled people, language barriers for people who do not speak Turkish, additional fears of stigmatization, fear of being caught by the public authorities due to lack of legal status, and fear of losing jobs. With their officially declared population of more than 4 million, refugees and migrants with their limited resources fall into the top list of vulnerable groups in Turkey. According to WHO Turkey, ‘the COVID-19 pandemic has had a significant impact on refugees and migrants in three distinct ways:

- In health— The conditions in which they may live and the lack of access to healthcare can put refugees and migrants at greater risk from the virus.
- In income— Refugees and migrants may work in the informal sector and other occupations that lack social protection. Any loss of income is also likely to lead to a huge drop in the level of remittances sent back home, which many millions of people rely on.
- In protection— Border restrictions have been imposed by most countries around the world, making no exception for people seeking asylum from persecution. Xenophobia, racism, and stigmatization have all increased during the pandemic.²⁵

With regard to accessing healthcare services, it was declared by the public authorities in Turkey that everyone will have access to COVID-19 treatment regardless of their legal or insurance status, which enables refugees

and migrants to access treatment for the pandemic. It has also been announced that the vaccination program will be implemented based on the age and vulnerability criteria in addition to prioritization of the immediate sector workers such as healthcare workers, social workers, security forces and public servants. As of 12 May 2021, 10.6 million people have been vaccinated which makes 13% of the total population.²⁶ While the vaccination program is being implemented intensively on the ground, the large portion of the response to the pandemic is still under the mandate of the specialized healthcare service provision. In the second year of the pandemic, the figures and responses are highly criticized, and we still have limited information about the conditions and situations of the migrants in Turkey.²⁷ It is obvious that the barriers and challenges that the migrants and refugees face while accessing healthcare services have increased due to the shrinking health situation in Turkey while most of the healthcare focus is now on the pandemic. In addition, due to the lack of data about COVID-19 related cases, treatment and number of deaths among the refugees and migrants in Turkey, it is difficult to understand the situation of the people already suffering from lack of water, sanitation and hygiene-related equipment, and living below the poverty line because of unstable income. It is well documented that many refugees in Turkey live in crowded housing conditions, which may lack the necessary hygiene standards to prevent the transmission of COVID-19. Unfavourable working conditions, informal jobs and job losses during the pandemic have further complicated the situation for refugees.²⁸

The pandemic's economic consequences have been devastating globally. Border closures and travel restrictions since the first quarter of 2020 limited the volume of international trade, resulting in economic downfall and further economic crisis for developing countries such as Turkey which depend largely on the balance of import and export of goods and services. Before the pandemic started, Turkey was already struggling with rising inflation, currency devaluation and high unemployment rate.²⁹ The pandemic and its direct impact on the volume of trade and economy devastated this situation even further. According to the Rapid Needs Assessment of the Relief International, 'The COVID-19 outbreak in Turkey appears to have considerably affected Syrian refugees across different aspects of their lives: 87% reported someone in their household lost their job because of the outbreak, 71% reported that they cannot access health services, and 81% reported urgent unmet needs (most likely as result of having lost their job).³⁰ Additionally, the TRC and IFRC report on the impact of the pandemic on the daily lives of refugees in Turkey shows that 69% of refugees have lost their jobs during the pandemic.³¹ Furthermore, a vast majority of Syrian businesses either shut or limited their operations: '83% of the Syrian respondents reported that their employment status has been negatively impacted by the pandemic, which has led to a decrease in purchasing power of the households, rise in the household debt and restricted food consumption.³² Increasing economic instability and limited livelihoods capacity due to additional barriers of the pandemic have direct impact on the health and well-being of the refugees who have limited ability to afford their rent as well as other basic needs. The ones that have not

lost their jobs and still have a limited income continue working even if they test positive— a direct cause for the transmission of the virus.³³

Under these circumstances, it is obvious that the protection response of the humanitarian agencies and public authorities are shrinking due to the restrictions on physical movement, and also due to the present orientation of priorities and available resources towards health services. While protection-related support is vital for most of the vulnerable refugees, especially for the women and girls suffering from gender-based violence, not only have the resources become limited, but also the level of violence has increased due to isolation measures and increasing economic and social stress.³⁴

Creation of this Uneven Landscape

With the Syrian crisis, the existence of the refugees and migrants in Turkey became both visible and an essential item on the political agenda of public authorities. Calls for collaboration and burden-sharing, fundraising and advocacy, and the portrayal of Turkey's challenges regarding the increasing number of refugees turned into a stable theme of the international meetings and press releases. Rapid increase and intensity of the Syrian population in the border provinces of southeast Turkey and the needs and gaps in assistance provision encouraged international humanitarian agencies and global donors to have a place in filling the gaps regarding urgent needs.³⁵ Since 2012, the European Civil Protection and Humanitarian Aid Operations (ECHO) and the US government's Bureau of Population, Refugees, and Migration have been the top donors funding the humanitarian aid operations in Turkey. The first phase of the humanitarian aid operations covered the immediate needs in the 'Temporary Accommodation Centres' (refugee camps) and the urban settings through UN agencies and international humanitarian aid organizations. These operations were coordinated by Turkish authorities but focused only on the needs of the Syrians. While Turkey has more than 300,000 asylum seekers and refugees under international protection, the main focus has been on the Syrians due to the attention of regional and global institutions on the humanitarian crisis in that country.

More than 3 million Syrians, mostly located in the southeast provinces, started to become a major challenge for service sectors such as municipal infrastructure, basic-needs assistance, healthcare, education, and socio-economic support. Available international sources were directed to fulfil these needs, and health facilities were donated to the Disaster and Emergency Management Authority (AFAD)³⁶ to be used in the camps. While the Syrian refugee population was increasing, the public healthcare services also started to face a high caseload despite their limited equipment and personnel capacity. International organizations with the mandate of providing healthcare assistance such as International Medical Corps, Doctors Worldwide, and Doctors without Borders started to operate in the field in border provinces, mostly by receiving official or unofficial permission from government authorities and funding from PRM, ECHO, or other sources. While Syrians

under temporary protection had access to healthcare services provided by both the government and NGOs, other migrant groups had to fulfil additional requirements such as general insurance contributions as well as registration and documentation requirements.

While the volume of migrants and their needs were increasing, the number of refugees and migrants trying to move towards Europe increased at the same time, and migration issues became one of the core elements of EU-Turkey negotiations. With the motivation to control the migration movements and provide money in exchange for impeding further movements of the migrants toward Europe, the EU started to implement a border externalization policy,³⁷ which was replicated in Syria and Iraq by Turkey in a few years. The EU-Turkey Readmission Agreement was signed in 2013 and the EU-Turkey Statement was declared in 2016. The primary return of these agreements was the financial support (3+3 billion euros)³⁸ to be injected into the Turkish economy under the Facility for Refugees in Turkey (FRIT) to cover the cost of more than 3 million Syrians in Turkey in exchange for increased border control and anti-trafficking efforts from the Turkish government.

The coup attempt in Turkey in July 2016 had a direct impact on migration management and the legal, social and cultural existence of migrants in Turkey. The increased number of Syrians and other migrants moving towards the different regions in Turkey, seeking employment opportunities or a new life in Europe, changed the dynamics of all humanitarian assistance operations. The protracted nature of the conflict in Syria and the increasing population looking for livelihoods in the region resulted in the populations in the border provinces spreading to other, more industrialized provinces in Turkey. The movement towards Europe and the rapid increase in apprehensions and casualties pushed the EU and Turkey to agree on the common grounds regarding the future of the migrants. The EU-Turkey Statement mostly focused on the stopping of irregular migration toward Europe, and introducing a FRIT mechanism for humanitarian assistance.³⁹ The state of emergency declared after the coup attempt and the following shrinkage in humanitarian space for international organizations operating in Turkey resulted in pressures over the humanitarian agencies and donors. Since the beginning of the Syrian crisis, public authorities in Turkey had a coordination role within the country with full control over humanitarian programmes. However, the additional pressure over the donors and humanitarian agencies placed the Turkish government as the single most influential actor concerning the policies and practices for migrants and refugees. More recently, the relationship between the Turkish government and INGOs has become tense mainly due to foreign policy concerns. Public authorities in Turkey summarily cancelled the work permits of INGOs such as the Mercy Corps and Médecins Sans Frontières (MSF).⁴⁰ These government decisions spread the fear of mass expulsion from Turkey among INGOs. This altered the content of both the international response and Turkey's response to the Syria crisis within its borders and increased the role

of the public sector and domestic NGOs at the expense of international NGOs.

While the existence and the increasing population of refugees and migrants in Turkey was one of the most controversial subjects of the political agenda internally and globally, Turkey started to conduct military operations in northern Syria in August 2016 with the motivation of building a safe zone and providing humanitarian assistance inside Syria in order to prevent people from moving further towards the Turkish border.⁴¹ This move complicated the situation of the refugees and migrants in Turkey even more and placed them in the middle of the discussions of war politics and security concerns.

***Sihat* Project and Citizenship**

The EU-Turkey Statement, financing the existence of the Syrian refugees in Turkey in exchange of more border controls, has made 'the humanitarian financing for the Syria response in Turkey subject to bumpy diplomatic negotiations between the two parties.'⁴² Public authorities in Turkey prefer most of the EU money came from FRIT for resilience and capacity building programmes where relevant ministries and government agencies would benefit. The Ministry of Health is the central actor in governing the financial assistance directed at healthcare service provision, receiving a sizeable portion of the financial assistance from the EU for their *Sihat* Project, namely 'Improvement of Health Status of SuTP and healthcare services provided by the Government of Turkey'. Main activities of the project were establishment and maintenance of the migrant health centers, provision of medical equipment for public health facilities, empowerment of the vaccination and immunization activities, capacity improvement for the intensive healthcare facilities, women and reproductive health support services, additional mobile health units, increasing medical literacy of the Syrians, health personnel training, additional mental health departments, child healthcare services support. According to the FRIT Steering Committee Report,⁴³ over 9 million primary healthcare consultations were delivered; 650,000 refugee infants vaccinated; 173 migrant health centers provided; and over 2,900 staff employed under this specific project funded by the EU.⁴⁴

In the eleventh year of the protracted crisis in Syria, not only do global and regional institutions follow their policies and priorities, but Turkey focuses on its priority areas and fundraising for funding their capacity development projects too. One of the most crucial parts of the activities of the *Sihat* Project was the training and recruitment of Syrian health personnel, which provided a base for giving citizenship status to these Syrian health practitioners in Turkey. Citizenship is a controversial subject in Turkey's domestic politics. Normally, the obtaining of Turkish citizenship is governed by the '5901 Citizenship Law' of 2009. According to that law, Turkish citizenship is based on blood ties. Thus, the son(s) and daughter(s) of a Turkish mother and/or Turkish father would gain citizenship. In addition, the residents in Turkey for more than five years, speaking adequate level of

Turkish, may apply for citizenship. However, the Board of Ministers suddenly decided to provide citizenship for some groups of Syrians. Therefore, the lists of the legally employed Syrians or the Syrians who can be beneficial for the common good have been collected from different ministries, especially the Ministry of Education and Health and the DGMM. As a result, more than 92,000 Syrians were granted Turkish citizenship as of 2019. In 2021, this number reached 110,000.

This ad hoc process constitutes an example of the stark differences in the policies of inclusion and the layers of exclusion among different groups of migrants in Turkey. While access to citizenship on a preferential track constitutes an inclusion mechanism for the Syrians who have the opportunity to be socially and politically included in an accelerated process despite the challenges of language, educational and occupation backgrounds or social status, such granting of citizenship reinforces an exclusionary practice for non-Syrians.

Effect of the Uneven Landscape on the Lives of Migrants

While migration and refugee movements have been increasing in this region and the world as a result of the protracted crises in the Middle East and North Africa, scepticism and populism against the migrants are also growing. In addition to the economic fluctuations and political instability, sharing the available services with the 'others' turns into social tensions among the host and refugee or migrant communities. With the lack of proper and detailed policies towards migrants, the issue becomes part of the populist measures that trigger hatred and radical feelings among the host community. Anti-refugee sentiments are being used by conservative and right wing parties as a tool of political pressure against the ethical, humanitarian and universal values protecting the vulnerable.

Anti-Refugee Sentiments

In Turkey, several studies have emerged concerning social relations and perceptions among migrant groups and the host community.⁴⁵ However, increasing economic fragility, growing unemployment rates, illegal work and their implications can be seen in specific sectors such as education, health, and employment. Refugee response programs in Turkey have also been focused on these sectors in their designing. The problem is where the migrant and the host community members need to access these specific services, share the same environment, confront each other, and ask for the same access to services. While competing for access to healthcare services, for example, the two communities share the same resources, and most probably, the host member of the community who is paying the taxes and having a citizenship status would ask for a privileged status in accessing services and while sharing the same level of access, would feel neglected. On the other hand, the migrant or refugee community may feel hesitant while challenging the language barriers and economic vulnerabilities, and feel insecure and temporary where

all national, regional, global levels of discussions, policy designs, and negotiations are reflected and directly impact the lives of the individuals.

The first group of migrants from Syria reached Turkish territory in April 2011 from the border gate in Hatay province; then the numbers increased rapidly. The perception of the media and politics had been that these groups will stay in Turkey only temporarily. They are 'guests' who should be protected, and once Syria is a safe place again with the help of the citizens of Turkey, they would safely return to their homeland. In 2021, after ten years, Syria is still unsafe for return, and the Syrian refugee children born in Turkey attend school in Turkey and speak Turkish better than their mother tongue. This research does not only focus on the Syrians—the feeling of temporariness is common for other groups of migrants as well. Before the Syrian crisis, the refugees and asylum seekers seeking international protection were also seen as people who will be resettled to a third country or illegally move towards Europe and will stay in Turkey for only a limited period. The illegal migrants from Georgia, Afghanistan, or other republics in Central Asia were also seen as invisible human beings coming to Turkey to make money. If they did not follow the rules or if they engaged in crimes, they were sent back to their countries of origin. As the migrant groups contributed to the national economy and followed the rules and regulations, being invisible as much as possible with their limited demands on the country's resources, they became the most neglected and ironically the most revered; which has also been pointed out as one of the main reasons why irregular migration toward Turkey is highly likely to continue.⁴⁶

During the past decade, the perception of the host community, the agenda of its politics, and the needs of the migrants have changed. Social tension incidents and growing levels of misinformation, misperception, and hatred turned into a typical pattern while the needs are increasing such as those for access to education, health, social services, and the available sources are less than sufficient for the existing population. Additional mechanisms have been created as a means of inclusion and exclusion. While hatred and social tension increase, citizenship is used simultaneously as a tool for inclusion and exclusion, mostly in favour of those educated migrants who speak Turkish and regularly pay taxes. While differentiating among the groups of refugees and migrants, the main perception has become ignorance as much as possible and increasing hatred and social tension when competing with each other for accessing the available services.

Conclusion

During the last decade, policies toward forced migrants have been shaped and reshaped by the specific events of Syrian crisis, the Mediterranean migration crisis and the mass movements of migrants into Europe. Only in 2015, more than a million people arrived in Europe;⁴⁷ at the end of 2020, Turkey hosted more than 4 million forcibly displaced people from Syria and other countries. This situation forced the Turkish government and the EU to take actions

regarding the migrants' access to rights and services in their respective territories. During this decade, different layers have been created for different groups of migrants and it created an uneven landscape for these groups with the help of politics at the national, regional and global levels. Migrant groups have been differentiated based on their legal status, country of origin and migration claims, and this differentiation affected their levels of access to rights and services. In this paper, I analysed how these mixed processes affected the policy of the Turkish Government, the lives of different groups of migrants, and the lives of the host community in the framework of accessing healthcare services.

Notes

¹Ahmet İçduygu and Deniz Sert, "Migrants' Uncertainties versus the State's Insecurities: Transit Migration in Turkey," in *Transit Migration in Europe*, ed. Franck Düvell et al. (Amsterdam: Amsterdam University Press, 2014), 37–54.

²M. Murat Erdogan, "Syrian Refugees in Turkey," Konrad Adenauer Stiftung, September 2019, <https://www.kas.de/documents/283907/7339115/Syrian+Refugees+in+Turkey.pdf/5d3d4091-e56d-3c42-2a9c-4e7f5d98706f?version=1.0&t=1571303379232>.

³"Turkey: Human Rights and the European Union Accession Partnership," Human Rights Watch, September 2000, <https://www.hrw.org/reports/2000/turkey2/>.

⁴Erdogan, "Syrian Refugees in Turkey."

⁵"UNHCR Turkey Stats," UNHCR, accessed May 13, 2021, <https://www.unhcr.org/tr/en/unhcr-turkey-stats>.

⁶"Syria Refugee Crisis Explained," USA for UNHCR, February 5, 2021, <https://www.unrefugees.org/news/syria-refugee-crisis-explained/>.

⁷İçduygu and Sert, "Migrants' Uncertainties versus the State's Insecurities."

⁸Ibid.

⁹Although Turkey is a party to the 1951 Geneva Convention Relating to the Status of Refugees and its associated 1967 Protocol, it still maintains the geographical limitation clause which only allows it to consider asylum applications from European countries. Nevertheless, in practice, this limitation is only partially implemented as Turkey allows United Nations High Commissioner for Refugees (UNHCR) to operate and conduct refugee status determination procedures whereby refugee status is jointly granted by the UNHCR and the Ministry of Interior with the underlying condition that accepted refugees do not locally integrate but instead resettle in a third country.' (İçduygu).

¹⁰"Operational Update: Turkey," UNHCR, April, 2020, <https://www.unhcr.org/tr/wp-content/uploads/sites/14/2020/06/UNHCR-Turkey-Operational-Update-April-2020.pdf>.

¹¹Volkan Yilmaz, "Changing Origins of Inequalities in Access to Health Care Services in Turkey: From Occupational Status to Income," *New Perspectives on Turkey* 48 (Spring 2013): 55-77.

¹²Even further, while Turkish nationals are paying healthcare services contribution for each of their visits and cost of medication, SuTP are not required to pay any amount. This better treatment of Syrians against the host community is another cause of tension between the two communities. On the other hand, there are other barriers which prevent Syrians from having equal access to healthcare services, such as language, disability, discrimination and stigmatization.

¹³Separate from the Iraqis under international protection, the Iraqis who crossed the border to Turkey in the wake of ISIS attacks in Iraq are entitled to have either humanitarian residence or short-term residence in Turkey.

¹⁴DGMM is the main government institution dealing with the documentation of refugees, in addition to its policy-making role in migration management.

¹⁵“In the countries with ‘full access’, refugees are legally entitled to receive treatments like nationals and to get the same range of health care services under certain preconditions, e.g., the ability to prove their own identity.” Larissa Bolliger and Arja R. Aro, “Europe’s Refugee Crisis and the Human Right of Access to Health Care: A Public Health Challenge from an Ethical Perspective,” *Harvard Public Health Review* 20 (Fall 2018): 1-11.

¹⁶Bolliger and Aro, “Europe’s Refugee Crisis and the Human Right of Access to Health Care.”

¹⁷Nilay Etiler and Kuwet Lordoglu, “Health issues of immigrant women: A qualitative study of domestic services in Turkey,” *SEER: Journal for Labour and Social Affairs in Eastern Europe* 15, no. 1 (2012): 109–21.

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<https://www.euro.who.int/en/health-topics/Health-systems/public-health-services>.

¹⁹“What is public health?,” CDC Foundation, accessed May 13, 2021,

<https://www.cdcfoundation.org/what-public-health>.

²⁰Saime Özçürümez and Ahmet İçduygu, “Zorunlu Göç Deneyimi ve Toplumsal Bütünleşme: Kavramlar, Modeller ve Uygulamalar ile Türkiye” (Bilgi Üniversitesi Yayınları, 2020).

²¹The word ‘sıhhat’ has Arabic origin and means wellness, health.

²²Saime Özçürümez, “COVID-19 in Turkey: Public Health Centralism,” in *Coronavirus Politics: The Comparative Politics and Policy of COVID-19*, ed. Scott L. Greer, Elizabeth J. King, Elize Massards de Fonseca, and Andre Peralta-Santos (Ann Arbor: University of Michigan Press, 2021): 393-412.

²³Ibid.

²⁴“COVID-19 Coronavirus Pandemic,” Worldometer, accessed May 13, 2021,

<https://www.worldometers.info/coronavirus/>.

²⁵“Stories of hope as refugees help tackle the COVID-19 pandemic,” World Health Organization Regional Office for Europe, June 19, 2020,

<https://www.euro.who.int/en/countries/turkey/news/news/2020/6/stories-of-hope-as-refugees-help-tackle-the-covid-19-pandemic>.

²⁶“Coronavirus (COVID-19) Vaccinations,” Our World in Data, accessed May 12, 2021, <https://ourworldindata.org/covid-vaccinations?country=TUR>.

²⁷Özçürümez, “COVID-19 in Turkey.”

²⁸Şevkat Bahar Özvarış et al., “COVID-19 barriers and response strategies for refugees and undocumented migrants in Turkey,” *Journal of Migration and Health* 1-2 (2020), <https://doi.org/10.1016/j.jmh.2020.100012>.

²⁹Ibid.

³⁰Relief International Rapid Needs Assessment, April 2020.

³¹“Impact of COVID-19 on Daily Life of Refugees in Turkey: A Remote Focus Group Discussion Report,” Turkish Red Crescent and International Federation of the Red Cross and Red Crescent Societies, Summer 2020, https://media.ifrc.org/ifrc/wp-content/uploads/2021/03/Impact-of-COVID-19-on-Daily-Life-of-Refugees-in-Turkey_.pdf.

³²Regional Refugee Resilience Plan in Response to the Syria Crises 2019-2020, 3 RP Turkey.

³³Özvarış et al., “COVID-19 barriers and response strategies.”

³⁴“Putting the brakes on COVID-19: Safeguarding the health and rights of women and girls,” UNFPA Turkey, July 11, 2020, <https://turkey.unfpa.org/en/news/putting-brakes-covid-19-safeguarding-health-and-rights-women-and-girls-4>.

³⁵Özçürümez and İçduygu, “Zorunlu Göç Deneyimi ve Toplumsal Bütünleşme.”

³⁶AFAD is the emergency relief and response agency of the Government of Turkey, working under the direct supervision of the Presidency Office.

³⁷“The EU has relied on border externalisation as the main tool of its migration management policy, to address the issue of migration before migrants reach the EU’s external border.” Bianca Benvenuti, *The Migration Paradox and EU-Turkey Relations* (Istituto Affari Internazionali, 2017). Also, Saime Özçürümez, “The EU’s effectiveness in the Eastern Mediterranean migration quandary: challenges to building societal resilience”, *Democratization* (2021), <https://doi.org/10.1080/13510347.2021.1918109>.

³⁸“The EU Facility for Refugees in Turkey,” European Commission, updated March 2021, https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/frit_factsheet.pdf.

³⁹Özçürümez, “COVID-19 in Turkey.”

⁴⁰Raf Sanchez, (2017), “Turkey forces aid group Mercy Corps to shut down its operations,” *The Telegraph*, March 8, 2017, <https://www.telegraph.co.uk/news/2017/03/08/turkey-forces-aid-group-mercy-corps-shut-operations/>. Also, Volkan Yilmaz, “The Emerging Welfare Mix for Syrian Refugees in Turkey: The Interplay between Humanitarian Assistance Programmes and the Turkish Welfare System, *Journal of Social Policy* 48, no. 4 (October 2019): 721-39, <https://doi.org/10.1017/S0047279418000806>.

⁴¹Özçürümez, “COVID-19 in Turkey.”

⁴²Volkan Yilmaz, “The Emerging Welfare Mix for Syrian Refugees in Turkey.”

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⁴⁷Gareth Evans, “Europe’s migrant crisis: The year that changed a continent,” BBC News, August 31, 2020, <https://www.bbc.com/news/world-europe-53925209>.

A Panel Discussion on Itinerant Situations in Art and Literature: A Report

By

Samata Biswas *

The online panel discussion, “The Impossibility of Politics: Itinerant Situations in Art and Literature” was the inaugural session on the second day of the two-day *Teachers’ Workshop on Research Methodology and Syllabus Making*, organized by Mahanirban Calcutta Research Group, on 21 and 22 December, 2020, at Kolkata, India. The presentations in the panel sought to enquire into migrant figures occupying liminal and marginal spaces, the scope and history of ethical engagement with such figures, and the need to look at different, aesthetic registers to locate itinerant situations.

In his introductory note “Migrant Situations and the Impossibility of Politics”, Ranabir Samaddar (CRG, India) spoke about his long-standing enquiry into the situation of the itinerant— the criminal, the lunatic and forgotten— during massive political and social upheavals. Does realpolitik seek to address people in the fringes of the society, or do the margins of society hint at a failure, a lacuna in such political engagements? He points instead at critiques of politics available through arts and literature: in itinerant figures, in characters beyond the realms of salvation and redemption, in shadows, dead bodies, hustles and in madness. Invoking Sadat Hasan Manto’s iconic figure Bishan Singh (from the Urdu short story, “Toba Tek Singh”) and Bertolt Brecht’s seminal character Anna Fierling (from the German play *Mother Courage and Her Children*), Samaddar demonstrates the foreclosed political situations— leading to a closure of language: in Bishan Singh’s gibberish and the scream before his death, in *Mother Courage*, ‘the screamers [who] don’t scream long’. Both of these extraordinary texts defy the demands of resolution, their subjectification becomes possible, only after death.

Taking cue from Samaddar’s initial comments, Subhoranjan Dasgupta (Institute of Development Studies, Kolkata, India) enquires: What is the primary characteristic of *Mother Courage* (the person and the play)? An

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itinerant traveller, a canteen woman with the Swiss military, crossing and recrossing boundaries and allegiances, during the 'Thirty Years' War (1618-1648), Mother Courage loses both her sons, and finally her daughter— yet, gives voice to a dialectical interpretation of war. '...war is but private trading'— but despite that, she extols peace. Mother courage is one of the little people, who participates in business, but does not make a big profit. In fact, in the final balance, her burden of losses is immense— left to trudge along, pulling her cart by herself, though 'there is nothing much inside it'. The impossible situation of a war that raged for thirty years, creates an ambivalent, lonely figure like Mother Courage, but does nothing to rescue or redeem her.

Oishik Sircar's (Jindal Global University, India) reading of "Toba Tek Singh" in a minor key, foregrounds the marginal figure of the lunatic, over what the story is usually celebrated for, its historical association with the partition of British India. It recounts, as it were, the happenings among a group of lunatics in an asylum in Lahore, 'Two or three years' after the partition, when the 'Higher ups' decided that the inmates of the asylums will be exchanged according to their religion, between India and Pakistan. Bishan Singh, who Samaddar also invoked in his introduction— makes possible an affective reading, as opposed to a gnostic reading that mines the text for historical meaning. Instead, he proposes an affective reading, reading in the minor key that would introduce indeterminacies in historical time and place. Coming from two distinct trajectories— both Samaddar and Sircar nevertheless reach the issue of language. For Samaddar the closure and failure of language was a failure of spirituality and ethics, following Marx's formulation (On the Jewish Question). Bishan Singh's gibberish (with its internal modifications) signals to the reader a failure of interpretation— in the ambit of the text, that constitutes the impossibility of politics.

Brett Nielson (Western Sydney University, Australia) reads the viral photo of Syrian Kurdish child, Aylan Kurdi, face down on a Turkish beach, in 2015. Traversing the circulation and the political controversies that the photo generated—the discussions in France, Canada, Germany and for a while, a change in the living and employment conditions of migrants in Germany— Nielson attempts to trace the affective purchase of the photo. The somatic reflex that the photos deliver (even in the era of deep fake where the ontology of the photographic image is in question) is bult on border crossing as a game of life and death— an impossible risk taking in the necropolitical space that denies what we consider humanity. Kurdi's body lay on a beach, a variable space— like the transformative spaces of the border. The photo becomes at the same time a logistical image (enmeshed in border crossing and travelling across digital media as a technological artefact) and a necropolitical image: both operational and spectacular. The connection between these registers is open ended, signalling what, in the context of the present panel, is the impossibility of politics.

The discussant to the panel, Subarna Mondal (The Sanskrit College and University, India) commented that the mundane and often absurd careers of these characters (Bishan Singh, Kattrin in *Mother Courage* and Aylan Kurdi, in his last photo) are carried out in the framework of great events. Although

victims of vicissitudes, their deaths embody the liminality of their existence, and the marginality of border-spaces. Bishan Singh dies literally in the no man's land between India and Pakistan, mute and mutilated Katrin climbs on the roof at the edge of a town and is shot dead by the invading army, Aylan Kurdi lies on the shoreline— a space in constant flux. These marginal figures, their recurrence in culture and in literature, reflect back upon the impossibility of politics.

The discussion was jointly moderated by Paula Banerjee (Calcutta University, India) and Atig Ghosh (Visvabharati University, India).

A livestream of the discussion is available at <https://fb.watch/5MSx3Jv1KU/>.

Book Review

By

Anup Shekhar Chakraborty *

Anindita Ghoshal. (2020). *Refugees, Borders and Identities: Rights and Habitat in East and Northeast India*. New York and London: Routledge. ISBN: 9781138192263 Pages: 248 (i-x, 1-248), Price: £ 100 (HB)

Anindita Ghoshal's *Refugees, Borders and Identities: Rights and Habitat in East and Northeast India* demonstrate how refugees presence in unexpected ways shaped the conduct and the course of political engagements in India's eastern and northeastern borderlands. Structured in five engaging chapters with an epilogue, the book examines the impact of Partition on refugees in East and Northeast India and their struggle for acceptance and political rights. Drawing on extensive research and in-depth fieldwork, the book discusses broad themes of forced migrations, displacements, and negotiations of rehabilitation, discrimination and politicisation of refugee identities that followed the Partition in 1947.

Contextualising the wave of human dispersal across the new lines of nation-states in the subcontinent, the discussions in the chapters engage in how and why the subcontinent made new meanings in the changed contexts of subject-citizen, nation-state, boundaries-walls, friends-enemies. Through the portrayal of the lived experience of crises and the emergent new refugee domain in Assam and Tripura and the evolution of a political subject in West Bengal, the book unravels the refugees socio-cultural milieu of scavenging betwixt loss, homing, becoming and wearing the badge of a refugee as an identity. The chapters impressively chart the shape-shifting administrative/governmental lens/gaze and the conduct towards the newly arrived guests in the deeply intense demography of India's northeastern borderlands and the state of West Bengal following the Partition. The book discloses the nuanced assorted vocabulary of displacement circulated in the state's gaze and refugees auto narratives vis-a-vis the host population. The discussion in the various

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chapters conjures the bewildering perspectives on the aftermath ordeal; and the construction of a refugee identity, and absorption of the same in 'a post-refugee' identity. The book charts the trajectories across time and space in refugee hosting country and the myriad forms of labellings that occur within the same. Some popular colloquial terms for the refugee like *udbastu*, *sharanarathi*, *bastubara*, *bangal*, *bhogonia*, *bohiragoto*, *bideshi*, *malaumand* *wansab* became part of the daily vocabulary in the refugee-absorbent states. Interestingly, the refugees soon discovered identity as being rather complex and multiple than singular and straightforward.

The Bengali refugees, generally categorised by religious faith, had to embrace many other identities in colloquial terms, like *baghore*, *bangal*, poor Bengali Hindu, Bengali lower-caste Hindu, *rifu* or *refu*, and *muhajir*, undoubtedly adding layers to their singular religious identities. Furthermore, in the transformation process, the concept of 'self' often shifted from religious to linguistic, cultural and economical, whereby political space and the refugee identity became complex and multi-layered. A general tendency among historians, political and social scientists have been to look at the Partition either from two-states perspectives or merely two types of refugees— Punjabi and Bengali. The other problematic angle in refugee studies lies in the fact that the refugees have always been labelled as monolithic groups. The situated co-construction of micro-interactional identities and macro-social categories draws our attention to the discursive processes that construct visibility orders. The book explores the effects of a critical marker of privilege and disqualifications affecting refugee lives, including the disjuncture between visibility and invisibility. Interestingly enough, Bengali refugees marginality has always been seen either with the background of Partition or from a religious perspective. Later, it became an essential identity of the refugees. The word *sharanarathi* or *ashrayprarthi* (who seek shelter/protection) signifies the Hindu refugees. The particular word reflects the sense of negligence of the state and its domiciles towards the refugees. The author unravels how this created a new socio-cultural category named *bangal* (an unsophisticated East Bengali), and how it became synonymous with the particular identity in West Bengal. The author engages with the life in the refugee camps and the colonies materialities to conjure a space with a distinct signifier of civilisation. For instance, the women refugees conditioned by precarity could hardly afford to invest time and money to beautify or groom themselves by oiling their hair, using powder or a *bindi*. Their primary concerns being subsistence and protecting themselves from other men. Their ungroomed appearances earned them the ridiculing moniker *iyanto Kali* (Goddess Kali in her most angry, arrogant, shrewish, tough *avatar*) and *khyapa* (rude and dangerous).

The book also charts how the partition refugees in North Bengal encountered the stigma of different labellings. For instance, in North Bengal, the immigrant East Bengalis were often termed *bhatias* (outsiders). The refugees were educated and intelligent enough to grab jobs or cope with new agriculture technologies compared to local Rajbangshis. The *bhatias* were from higher castes and became the majority in urban areas. Amidst uneven competition, the natives started losing lands. Partition helped another category

called the 'without' to emerge. The book highlights the plight of refugees in the legal documentation exercise and the limits of documents and papers. The Partition also contributed to the emergence of institutions, social categories and specific terms to define them for shared understanding in West Bengal. For instance, 'home' connoted a shelter primarily meant for raped or single women. In contrast, 'hawkers' meant a refugee businessman who had chosen the footpath to sell goods and run his family.

Despite the interchangeable usage in everyday parlance, refugee was more than a literal expression of homelessness and insecurity and less than a full legal categorisation in the administration of displaced people. The identity of refugee was affixed through the official registration of displaced persons as refugees. An important ritual that the author notes was performed upon arrival when a refugee card with a name, registration number, and arrival date was issued. This card was an essential proof in gaining a ration card, temporary and permanent housing, admission to educational institutions and employment earmarked for the Partition migrants. The Centre used terms like 'refugee', 'displaced persons', 'evacuees' and 'migrants' according to their convenience, but such inconsistencies in the official definition made the relief and rehabilitation work more difficult. In the post-Partition West Bengal, Assam and Tripura, refugees were often perceived as 'other'.

The book very interestingly charts the shifting nomenclatures in a term such as '*bangal*'. Initially, it defined one's identity as 'East Bengalis', though it generally meant the inhabitants living on the other side of the river Padma. However, after Partition, the '*bangal*' identity got merged with East Bengali refugees and minorities. The idea of '*ghoti*' and '*bangal*' also changed its dimension. The process of 'othering' between the Hindu refugees and the unwelcomed Muslim refugees was a strategy employed to exclude them from claiming citizenship rights. However, the refugees demanded that the state should drop these labels and accept them as citizens, as they were the victims of Partition's high politics. In the historiography of Partition and refugee studies, their definition and connotations had gradually changed. The monolithic treatment has been replaced by a lens that acknowledges the local crises and conditions shaped up diversely in different geographies.

The book's contribution lies in its grasp of the lived realities of those compelled to leave their home, engage in homing practices elsewhere, including chiselling an identity in defence to the host community. A segment on the Dalit consciousness among the refugees, including the non-Bengali speaking wave of displaced people, could have added more insights into the discussion theme. The book takes a powerful meaning in the wake of the murmurings of citizenship, identity, and belonging to the land amidst the cacophony of anti-CAB/CAA 2019 in India's northeastern borderlands. The collection should be handy for students and researchers of social sciences, particularly those interested in refugee studies, migration studies, border studies and policymakers dabbling with the gruelling task of rehabilitation, resettlement, and skilful utilisation of the sudden abundance of human resource.

NOTES FOR CONTRIBUTORS

Articles submitted for consideration of publication in REFUGEE WATCH should be around 5,500 -7,500 words. Book reviews can be around 1000 words and review articles can be around 2000 words. Articles will have endnotes and not footnotes. Endnotes should be restricted to the minimum. Please refer to www.mcrg.ac.in for a details style sheet. Roundtables can also be proposed for publication. Enquiries about possible submissions are welcome.

For submission of articles and all other matters, correspondence should be addressed to the Editor, Refugee Watch, Mahanirban Calcutta Research Group, IA-48, Ground Floor, Sector-III, Salt Lake, Kolkata – 700 097 or editor@mcrg.ac.in. For book review and review-articles correspondence to be addressed to Samata Biswas, Review Editor, Refugee Watch, at the same address or at bsamata@gmail.com.

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