Public Health, Migrant Workers and the Pandemic in Mumbai: Crisis of Work and Life [1]

The year is 2018. A procession of workers to the headquarters of the Municipal Corporation of Greater Mumbai (MCGM) with the body of a deceased worker demands that the corporation address the issues of contractual sanitation workers or *safai karmacharis.* Malati Devendra, part of this informal workforce for many years, took her life when she found herself without work and wages for two months. Loopholes in the Contract Labour Act worked to the advantage of the contractor. A representative of the union mobilising these workers in Mumbai, pointed out that there had been 108 deaths of contractual sanitation workers in the past five years. Cut to Mumbai in May 2020: two men in vests and shorts, barefoot, almost knee-deep in sewage, cleaning a drain. Men and women in uniform orange jackets over their clothes sitting next to an open manhole, in a by lane, eating their lunch. Home-made masks, flimsy gloves, loading hospital waste onto a truck with an ordinary spade. A small room of 10*10 feet, reached through narrow lanes in a slum, home of a worker who died after being infected by the COVID-19 virus. The men and women are contractual sanitation workers who have been 'frontline warriors' in the city's war against the pandemic. They say they have not received minimum wages, that women are paid almost 200 rupees less than the men for the same work, and that they have not received any protective gear while doing this work.[2] All are Dalits, the most marginalised caste based communities in the country. There is hundred percent reservation of these jobs for Dalits, an activist asserts with some sarcasm.

Several months into the COVID-19 pandemic in India, Maharashtra is among the most affected states, and Mumbai city has emerged as the city with maximum number of positive cases. The pandemic has exposed the limits of public health infrastructure with the wealthiest municipal corporation struggling to meet the requirement of hospital beds, oxygen cylinders, and ventilators. Hygiene and sanitation

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[1] Mouleshri Vyas and Manish K Jha, Professors, School of Social Work, TISS, Mumbai, and Members, CRG.

[2] What Corona Warriors are Getting for Taking Extreme Risks: https://www.youtube.com/watch?v=0m-rFss4iPA0&t=68s
BMC Contract Workers Attack on Head Office with Dead Body: https://www.youtube.com/watch?v=tZTswCLOWHw

have been central concerns over the decades, and especially with the present pandemic. Almost 35,000 sanitation workers (including several thousand contractual and casual workers) in the MCGM are engaged in a range of tasks to keep the city clean and avert public health crises in normal times; ironically, they are most vulnerable to disease and contagion due to the precarity of their working conditions, and slum habitat, where they live.

Evidence about experiences of sanitation workers and of other migrants with the pandemic, necessitates a close study of aspects of their experience. In this paper, we aim to understand this apparent indifference of the State towards the contractual sanitation workers who constitute the lower rungs of the informal economy, and face stigma and social exclusion in everyday life. Study of the history of public health in the state of Maharashtra and Mumbai city will contextualise this exploration. Approaches of the then regimes to the two earlier pandemics and governance of these crises would be studied. Contractual sanitation work and an informal settlement (Shivaji Nagar) as sites that articulate the experience of the urban poor with the pandemic will be the focus of the paper.

Mumbai has experienced other pandemics - the plague towards the end of the 19th century, and then Spanish flu in the early 20th century, impacting the Bombay Presidency, particularly its the poor and socially unprivileged sections, the most. The years 1896 to 1898 were regarded as among the most unfortunate in the history of Bombay because of two widespread epidemics of Bubonic Plague (Sarkar 2001)[3]. '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 sanitisation, 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 a severe economic crises' (Sarkar, 2014 cited in Duggal, 2020: 17)[4].

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[3] Sarkar, Natasha. 2001. Plague in Bombay: Response of Britain's Indian Subjects to Colonial Intervention. Proceedings of the Indian History Congress , 2001, Vol. 62 (2001), pp. 442-449

[4] Sarkar, Aditya (2014): "The Tie That Snapped: Bubonic Plague and Mill Labor in Bombay 1896–1898," *International Review of Social History*, Vol 59, No 2, https://www.cambridge.org/core/journals/ international-review-of-social-history/article/ tie-that-snapped-bubonic-plague-and-mill-labour-in-bombay-18961898/9100ECEA17711354 1FE8DE26E48FD9C3/core-reader.

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

> "…under such overcrowded conditions the spread of diseases is easy and an outbreak of plague, cholera or small-pox will drive away all those *who can* escape. The recent influenza epidemic has affected the poorer classes in the Chawls and Bustees much more than the upper classes. How can it be otherwise ? In Bombay some of the Chawls are absolutely filthy. In one in which no less than 2000 souls live, the Bhangi, Scavenger, has not been for a little less than a fortnight, and all the filth has accumulated… 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 (Mukerjee 1919:291-292)[5]."

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

Much of the public health discourse and health policies emerged in the backdrop of these two pandemics 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. In fact, 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 post-colonial times. Through this paper, we shall revisit the history of pandemic control and management that had direct bearing for the labouring poor in the city.

In colonial and postcolonial times, the city grew into a nodal centre of finance and prosperity, providing livelihood opportunities for large numbers of migrants. The economic history of the city through most of the 20th century, is marked by textile mills being the mainstay of livelihoods, and drawing migrants from the hinterland. Over the decades, among the public health issues, shifts in state policy defining the approach to slums, hygiene and sanitation have been concerns, though not matched with adequate investment and outreach, especially for the urban poor.

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[5] Mukerjee, Radhakamal. 1919. Phases of Slum Life in India. The Modern Review for September 1919. Retrieved from http://www.southasiaarchive.com/Files/sarf.120016/204501/011

Public health services, which reduce a population's exposure to disease through such measures as sanitation and vector control, are an essential part of a country's development infrastructure. The critical agenda of public health is to reduce the population's exposure to disease through food safety, safe drinking water, ensuring hygiene and sanitation and monitoring waste disposal. It is widely recognised that any compromise on public health has severe consequences for society at large. However, it is especially crucial for migrant workers in the city. They pay a higher price in terms of reduced earning capacity, expenditure on health, and mortality. Public health services are thus both pro-growth, as well as pro-poor in that they are self-targeted towards the poor, who face the maximum exposure to disease (Das Gupta 2005)[6]. Through disasters such as flooding, that the city experienced in 2005, and crises including the present, some sections of labour are most vulnerable; additionally, health services for the migrants living in slums and other informal settlements are hugely compromised. In wards in Mumbai with large slum population, the services are at the bare minimum. That more than 145 people have to share a community toilet is a telling statement of the political economy of public health and the reality of hygiene and sanitation that places these communities in perpetual risk.

A century after the last pandemic, the city is again confronted with a public health crisis, and the spotlight is back on health and disease in general and aspects of public health in particular. Mumbai is a hotspot accounting for a huge burden of 61% of cases and deaths for a population that is proportionately 14% of the state population. In fact, Mumbai accounts for as much as 21% of the cases nationally and 25% of the deaths (Duggal 2020)[7]. Though the 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 as a focus. More than half of Mumbai's nearly 13 million people live in slums and informal settlements, where inadequate and poor access to primary health care, schools, nutrition, safe drinking water, toilets, open spaces, and ventilated houses are almost normalised. All these factors work in concert to create a unique set of challenges that compromise the

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[6] Das Gupta, Monica. Public Health in India: Dangerous Neglect. EPW. Vol. 40, No. 49 (Dec. 3-9, 2005), pp. 5159-5165.

[7] Duggal, Ravi. Mumbai's Struggles with Public Health Crises, From Plague to Covid- 19. Economic & Political Weekly, Vol. LV, No. 21 (May 23, 2020), pp. 17-20.

health of migrant workers living in the slum (Abdi et al, 2018).[8] There is an eerie similarity with the concerns that were highlighted and planned to be attended vis-à-vis public health after the early 20th century epidemic.

Even among the slum population, there are visible differences in the provisioning of basic amenities: in 2012, 59% of slum settlements in India were inhabited by people living in non-notified settlements and suffering from poorer access to piped water, latrines, electricity and public transportation when compared to notified slums (GoI).[9] The divide between notified and non-notified slums 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 (Subbaraman and Murthy 2015).[10] People living in non-notified slums have historically been unable to legally connect to this system, forcing many of them to illegally tap into city water pipes out of desperation – a survival strategy that can compromise the safety of the water supply through cross-contamination.

There is a high congruence between poverty, vulnerability and informal work in India (NCEUS 2007).[11] 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 labour market and broader social insecurity as defining elements (Arnold and Bon-

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[8]Abdi, Sarah, Avanti Wadugodapitiya , Sandra Bedaf , Carolin Elizabeth George , Gift Norman , Mark Hawley and Luc de Witte. 2018. Identification of priority health conditions for field-based screening in urban slums in Bangalore, India. Retrieved from https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-018-5194-2

[9] National Sample Survey Organization. Key indicators of urban slums in India. National sample survey 69th round. July 2012-December 2012 [Internet]. New Delhi: Ministry of Statistics and Programme Implementation; 2013. Available from: http://mospi.nic.in/Mospi_New/upload/KI_SLUM_report69round_24dec13.pdf

[10] Subbaraman, Ramnath and Sharmila L Murthy. 2015. The right to water in the slums of Mumbai, India
Bulletin of the World Health Organization; 93:815-816. Retrieved from https://www.who.int/bulletin/volumes/93/11/15-155473/en/

[11] National Commission for Enterprises in the Unorganised Sector. 2007. Report on Conditions of Work and Promotion of Livelihoods in the Unorganised Sector. Government of India

giovi 2012).[12] The informal economy in India, with more than 93 percent of the workforce comprises wage workers and self employed persons engaged in the primary, secondary and tertiary sectors. Since the 1990s, some sectors such as solid waste management, have 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[13]' This expansion of the existing biopolitical imperative of the State is evident in the normalisation 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, and which they may also drive. Among risks involved in this occupation are those resulting from lifting heavy refuse receptacles, trauma and others…' (Mamtani and Cimino 1992: 27).[14] Informal sanitation workers, confront lack of basic amenities and services, including health care, unless they are organised into unions. As a caste based occupation the social stigma that these workers - men and women - face, has affected generations of households. The irony is impossible to miss: the difficulty of accessing health care services for those who are actually engaged in ensuring it for the public.[15] The situation resonates with what Bombay Chronicle observed a century back "The sweeper, while he is the most neglected human being in ordinary times, is nevertheless among the most important".[16]

Most contractual sanitation workers live in slums across the city. Several live in Shivaji Nagar, one of the most densely populated slums of Mumbai, situated in the M-East municipal ward. The M–Ward is a stark example of skewed development in the metropolis, with virtually all indicators showing an urgent need for action that is multi-

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[12] Dennis Arnold and Joseph R Bongiovi. 2012. Precarious, Informalizing and Flexible Work: Transforming Concepts and Understandings. American Behavioral Scientist. XX(X). 2012. pp.1-20. Sage Publications.

[13] Vyas Mouleshri, 2009. Unionization as a strategy in community organisation in the context of privatization: the case of conservancy worker in Mumbai. Community Development Journal, Vol. 44, No. 3 (July 2009), pp. 320-335. Oxford Journals.

[14] Ravinder Mamtani and Joseph A. Cimino. Work Related Diseases Among Sanitation Workers of New York City. Journal of Environmental Health, Vol. 55, No. 1 (July / August 1992), pp. 27-29. Stable URL: https://www.jstor.org/stable/44534430. Accessed: 10-05-2020.

[15] Manish K. Jha, P.K. Shajahan, and Mouleshri Vyas. 2013. Biopolitics and Urban Governmentality in Mumbai in *Biopolitics of Development, Reading Michael Foucault in the Postcolonial Present.* Sandro Mezaddra, Julian Reid, and Ranabir Samaddar (Eds). pp. 45-65. Springer India.

[16] Bombay Chronicle, 2 February 1922.

dimensional, comprehensive and strategic to serve its burgeoning population. Currently, over 77% of the M–Ward population lives in slums. The slums in M–East Ward, in particular, have emerged as areas highly vulnerable to environmental hazards and deficient in essential services such as safe water and sanitation. Further, access to health care systems is weak: the population per hospital is 66,881, that per dispensary 27,438 and that per Anganwadi centre is 2,175. Cumulatively, this explains how the ward and, in particular, the slum areas register the highest infant mortality rate in the city of 66.47 per 1000 live births, among all the wards in Mumbai. Infant mortality is an expression of vulnerabilities and hardship in the living conditions in the slums. Several aspects of the life of low income communities continue to be invisible, their contribution to the city unrecognised and their aspirations and voices unheard. The ward has been used to locate the most 'undesirable' activities (dumping ground, polluting industries) and people (beggars' home, homes for other institutionalised populations, resettlement colonies). Shivaji Nagar is a microcosm of extreme urban poverty and deplorable situation of migrant workers, with nine out of ten residents as Muslims. Without a hospital, maternity centre and several other services, one can understand how the pandemic prescription must have unfolded here and in similar habitats housing scores of informal workers.

Governance of the city, of labour working for the municipal authority, and other sectors of the economy, is central to examining the multi dimensional impact of the pandemic on lives of migrants in Mumbai. Not unlike what Foucault explicated several decades back, 'governance of the pandemic at the state and city levels led to 'strict spatial partitioning…a prohibition to leave the town… the town immobilised by the functioning of an extensive power… a whole set of techniques and institutions for measuring, supervising and correcting the abnormal…'[17].

As highlighted earlier in the paper, governance of contractual *safai karmacharis* could provide insights into state- society relations with regard to public health. City cleaning is an essential service in the time of the pandemic and these frontline workers in Mumbai have been recognised as such along with medical workers, through

[17] Foucault, Michel. "Panopticism" from "Discipline &Punish: The Birth of the Prison". Race/Ethnicity: Multidisciplinary Global Contexts, Vol. 2, No. 1, The Dynamics of Race and Incarceration: Social Integration, Social Welfare, and Social Control (Autumn, 2008), pp. 1-12.Indiana University Press. Stable URL: http://www.jstor.org/stable/25594995 Accessed: 27/09/2013.

gestures such as beating of plates, and lighting of candles. However, data from various states highlights the continuance of peripheralisation of contractual sanitation workers in terms of wages and working conditions. Rules for waste management must be followed: 'according to the amended Bio Medical Waste Management Rules 2016, bio medical waste has to be segregated at the source from other waste material. Hospitals are required to maintain four colour-coded bins — yellow for human anatomical waste, animal waste, body waste, tissues etc; red for biotechnological waste from labs, solid waste such as disposable items including PPEs; blue/white/translucent for sharps waste which are devices or objects used to puncture or lacerate the skin; and black for discarded medicines, ash from biomedical waste, chemical waste like insecticides and disinfection'[18]. Evidence shows that contractual sanitation workers often work without protective gear. A couple of months into the pandemic in the city, the workers were provided Personal Protective Equipment (PPE) and told that they were to maintain these themselves - wash them at home each day and then use them the following day. Due to reduced mobility of city residents and waste generation, contractual workers were not called in to work everyday, leading to a reduction in income since they are paid on a daily wage basis. These are a few illustrations of the present tenuous conditions for sanitation workers.

This paper would explore and analyse the history and experience of how disasters and crises have shaped the public health policy and practices in Mumbai, and public health provision, governance, and management in the city. More specifically, questions that we would attempt to answer are: What has been the history of epidemics in the city that shaped the policies and practices of public health? How were the governance and management of informal settlements organized to attend 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 dehumanising living tell us about public health and its access for the migrants in the city and its slums? How have the technologies of governance been deployed in organising the bare life of the sanitation worker? How did the urban poor, and sanitation workers, in particular, deal with the prescription of so-

[18] (Manish S. Meshram and Ramila Bisht, The Coronapocalypse and Sanitation Workers in India. The Wire. 29 April, 2020. https://thewire.in/rights/the-coronapocalypse-and-sanitation-workers-in-india accessed 27 June, 2020.

cial 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 migrants as residents and workers in regard to health care and services, their access, alienation, refusal; the sight of fear and anxiety, tell us about the city's handling of the pandemic?

We plan to draw on archival and secondary data sources, as well as telephonic interviews with sanitation workers, their union leaders, and key informants from Shivaji Nagar.

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